With the new package size of its enamel matrix derivative (EMD) Endogain, implant and restorative solutions provider Straumann has launched a cost-effective treatment option for dental professionals at Europerio 7 in Vienna. According to the Swiss company, the Endogain 015 package, launched on Thursday this week, allows a broader use in clinical settings and can be used for patients with smaller defects, as well as patients subjected to bone-grafting procedures, who are supposed to benefit from faster wound healing and less pain and swelling.

The new package contains five syringes, each filled with 0.15 ml of Endogain. This will enable clinicians to select the right amount of commercially available EMD for use with the various bone-grafting materials (Bone Ceramic, autograft, allograft, bone-derived xenograft, β-Tricalcium, phosphate or bioactive glass), thereby enhancing the patient’s regenerative periodontal outcome, the company said.

“Endogain 015 should enable the clinician to use the material more often, since it will be more cost-effective when added to bone-grafting procedures,” explained Dr David Cochrane, professor at and Chairman of the Department of Periodontics at the University of Texas Health Science Center at San Antonio’s Dental School at a press conference in Vienna.

Launched in 1997, Straumann Endogain contains a complex of proteins that play a key role in the development of tooth supporting tissues. These proteins, termed enamel matrix proteins, self-assemble to create a matrix and promote the formation of cementum on the root of the developing tooth, thus providing a foundation for all necessary tissues associated with true functional attachment of tooth-supporting tissues in the teeth and jaws.

The effects and benefits of the product have been documented in over 400 clinical publications for indications such as intra-bony, furcation and recession defects.
Bicon short implants
and metal-free prostheses

Offering the worldwide dental community a comprehensive solution since 1985, Bicon’s dental implant system has not only passed the test of time, but has also kept pace with the latest in implant dentistry. According to the company, Bicon implants offer flexibility to dentists even in the most challenging of clinical situations.

The short length of the implants allows clinicians to avoid vital structures with confidence, and may eliminate the need for grafting procedures. Combined with metal-free restorations, they result in significantly less chair time, simplified treatment and reduced costs, the company said.

Bicon recently launched innovative solutions for metal-free restorations that facilitate long-term solutions with versatility.

For more details about SHORT implants and metal-free prostheses, visit the Bicon booth at Europerio 7.

Cortex invites participants to learn about its innovative products

Cortex Dental Implants Industries is a dynamic and innovative manufacturer of dental implants, prosthetic products and surgical kits based in Israel. The company was founded in 2007 by a group of maxillofacial surgeons experienced in implantology and leading businessmen with a clear goal of designing and producing top-level implants that meet the highest requirements of quality and innovation.

The combination of a vast knowledge base, engineering creativity and an uncompromising service agenda has produced a ground breaking implant system, packed with innovations and features ensuring outstanding performance, fast operation and precision, and an impressive cost-benefit ratio, thus prompting Cortex as the supplier of choice for implantologists around the world.

Cortex’s high-end production facilities and R & D centres, located in Israel, are characterised by state-of-the-art machinery, tight quality control and sterile clean rooms of the highest standard.

To learn more about the company’s innovative products, visit its booth at Europerio 7.

How is it possible for patients with periodontal problems to improve their oral hygiene sustainably?

Dr Joerg Strate: Good product technology enhances compliance and ensures therapy success. Electric toothbrushes notably improve oral hygiene on smooth surfaces while being clearly less demanding in terms of usability.

What are the consequences of the incorrect toothbrushing techniques?

Sonicare toothbrushes from Philips offer a gentle cleaning process and require lower contact pressure than manual toothbrushes, for example. A sonic toothbrush cannot vibrate very well when used with excessive pressure and this reduces side-effects. Several studies have shown that sonic and oscillating/rotating technology removes bacterial plaque effectively and safely.

What are the day-to-day experiences in dental practices?

What factors influence toothbrush recommendations for patients with periodontal problems?

Generally speaking, individual demonstrations and training have been shown to be the most effective. A sonic toothbrush is recommended for patients with periodontal problems or implants, in particular. The patient can’t make that many mistakes, which reduces the risk of injury. However, oscillating/rotating toothbrushes have to be used with the right technique. Dependent on the model, improper use by patients, for example excessive brushing pressure, can cause long-term damage to dental tissue or gingival injury. In my opinion, sonic toothbrushes simply do not offer that many opportunities for improper use. There is no need for a special technique and even a less motivated patient can achieve good results without side-effects. Actually, we have access to medical publics who show very promising results concerning the Sonicare FlexCare.

Interproximal spaces are a significant challenge for proper oral hygiene. These areas, about 40 per cent of all tooth surfaces, are almost impossible to clean with a toothbrush only. Moreover, that’s where periodontal problems mostly arise. Do oral irrigators help with interproximal cleaning?

Very little. Oral irrigators simply do not remove the sticky bacterial plaque adhering to tooth surfaces. I don’t know how effective they are for patients with periodontitis though. A huge disadvantage of oral irrigators is low compliance—their use is time-consuming and cumbersome.

The USA is the country with the highest percentage of dental floss users. Yet, only 30 per cent of the population floss regularly. How has Philips responded to this?

With a completely new technology for interproximal cleaning. With the AirFloss and its patented microburst technology, Philips has provided clinically validated solutions to two of the biggest challenges of dental floss: the AirFloss can be used without the less attractive accompanying circumstances of flossing and a simple one-finger control replaces the challenging technique you need for effective manual flossing. The AirFloss was especially developed for all those countless patients who don’t yet do any interproximal cleaning at all.

Is there a danger of patients accidentally flushing bacteria into the gingival pockets when using microburst technology?

First of all, the design of the nozzle and especially the guidance tip make it highly unlikely for the product to be placed in an apical direction into a gum pocket (please take a look at the YouTube demonstration of the AirFloss for reference: www.youtube.com/watch?v=kSUN RVY.2AE). Of course, a small amount of the air-water mixture may be sprayed into an area, but this mainly results in a flushing rather than a compacting effect.

Does microburst technology also work with teeth that have already been damaged by periodontitis and with wide interproximal spaces?

Very wide interproximal spaces do not provide the funnel effect that adds to the efficiency of microburst technology.

What are the effects of a high-pressure spray on inflamed gums?

A healthy gingiva will show no tendency to bleed during the use of the AirFloss. An inflamed gingiva may bleed—as it does with other mechanical cleaning processes.

What additives (e.g. mouth rinses) can also be used with the AirFloss system?

Our current recommenda-tions only refer to use with water, but all material requirements are suited for use with common mouth rinses.

Thank you for the interview.
STRAUMANN® EMDOGAIN 015

DESIGNED TO REBUILD

- Cost effective treatment option
- Combine with various* bone grafting material
- Excellent clinical results1,2,3
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0.3 ml
0.15 ml
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*BoneCeramic™, autograft, allograft, bone-derived xenograft, β-Tricalcium phosphate or bioactive glass

4 Heden et al. J. Periodontol. 2006;77:295 – 301

COMMITTED TO SIMPLY DOING MORE FOR DENTAL PROFESSIONALS
“Orthodontic tooth movement is based on sterile inflammation”

With more people presenting to dental practices with symptoms of periodontitis, clinical challenges are increasing in almost all dental specialities including orthodontics. today international spoke with congress presenter Dr Frank Weiland from Austria about the effects of periodontal disease on orthodontic treatment and vice versa.

today international: Periodontal disease and orthodontics have a complex interrelationship. What new insights have been obtained in the last three years?

Dr Frank Weiland: Each intervention causes damage, which is a known fact and also true for orthodontics. Clinicians have to reckon with some attachment loss and recession down to tenths of a millimetre with orthodontic treatment. The most significant danger comes from (additional) plaque-induced infection, that is why orthodontic devices should be designed in a way that they can be cleaned thoroughly by the patient (i.e. no bands, simple biomechanics and no elastic ligatures).

Computers-supported calculations have also revealed new knowledge about the changed biomechanical requirements and the use of the treatment device in relation to the amount of force and the moment-to-force ratio.

What is the likelihood nowadays that a patient with orthodontic problems also has periodontal disease?

Since an increasing number of adults ask for orthodontic treatment, we as orthodontists are automatically confronted with more patients suffering from symptoms of periodontal disease. It is not rare that its clinical effects, such as tooth migration, are the main reason for orthodontic corrections. Periodontal problems can be of a chronic nature, but, on the other hand, be rapidly progressive and lead to tooth loss at a relatively young age. The point here is that orthodontic tooth movement is based on sterile inflammation. If you add an additional bacteria-induced inflammation, this can result in significant attachment loss.

Orthodontic correction can also have a negative effect on periodontal status. When should clinicians desist from treatment?

As I mentioned before, the most important contra-indication is periodontal tissue that is not clinically free of inflammation. With support from the dentist, orthodontist and periodontist, patients should be able to maintain conditions that are free of inflammation.

Periodontitis can also break out during orthodontic treatment. What are the clinical symptoms that orthodontists should be aware of?

The common alarm signals, including gum bleeding, gingival recession, loss of papillae and clinical signs of inflammation such as bleeding on probing.

What role does the age of the patient play?

Age is only a relative factor. It is actually more about the aggression of the periodontal disease and the extent of deterioration.

Orthodontists are recommended to consult a general dentist or periodontist prior to treatment. Is this common practice?

I am only able to speak here for my own practice. In many cases, patients who present for the first time already have the respective documentation from their general dentists and periodontists. Prior to treatment of adult patients, a basic periodontal evaluation (BPE) and, if needed, a pretreatment in our practice, or by the dentist and in critical situations by a periodontist is performed. Orthodontic treatment does not begin until these professionals have given the green light. Subsequently, regular control visits are an absolute necessity.

Is there any knowledge about whether and which treatment methods are able to halt the progression of periodontal disease?

A clear relation between tooth displacement and periodontal problems has been described. Significantly more pathogens and bacteria are found in crowded areas than in straight teeth. Of course, dental hygiene measures are also easier to perform in straight teeth than in a case of distinct crowding. It has been observed that former orthodontic patients had better oral health after correction than similar subjects whose teeth were not corrected, which is explained by routine checks and patient education.

Owing to attachment loss, tooth movements may occur that have a negative effect on future stability. An example of this is the protrusion of the upper incisors, which can cause an interposition of the lips with a leverage effect on the incisors. Clinical prospects for these teeth are significantly improved by moving them to a functional and aesthetically pleasing position. This is also valid for jiggling in the presence of periodontal inflammation, which could also lead to significant attachment loss.

Should the evaluation and monitoring of periodontal disease generally form part of orthodontic treatment?

No doubt. Regardless of the patient’s age, orthodontic treatment should never be performed if the patient’s oral health is insufficient. From my point of view, a check of the periodontal status, as recommended by the Austrian Society of Periodontology, as well as periodontal therapy of adult patients should be considered prior to orthodontic measures. Risk patients should be monitored at least every three months by the periodontist. Even after orthodontic treatment has been stopped, long-term success can only be achieved when the two “R” (Retention and Recall) are taken into account.

Thank you very much for this interview.