New NPM sintered metal disk inCoris CCB for the inLab MC X5 5-axis milling machine

By Dentply Sirona

The extensive range of inCoris disks from Dentply Sirona CAD/CAM has now been expanded to include the new inCoris CCB disk made of cobalt-chromium for the manufacturing of NPM restorations with the inLab MC X5 5-axis production unit.

LONDON, UK: Non-precious metal restorations still play a key role in the day-to-day life of a dental technician – according to estimates from Dentply Sirona CAD/CAM they contribute to around 63 to 75 percent of all work produced around the globe. However, the conventional manufacturing process, the NPM cast, is a more expensive and time-consuming production process that is more susceptible to errors due to the number of steps necessary. Integration in the digital workflow has provided an alternative approach for cobalt-chromium restorations that is faster, cleaner and safer. In addition, it additionally offers better material homogeneity and stability compared to cast work.

With the inCoris CCB disk, Dentply Sirona can now provide the dental laboratory with a pre-sintered, non-precious metal for the inlab MC X5 5-axis milling unit. The disk with a standard size of Ø 98.5 mm is available in six different heights and can be very easily managed via the inLab MC X5’s own inLab CAM Software 16.0. As with all the other inCoris disks from Dentply Sirona, each inCoris CCB blank has a QR code that can be conveniently scanned into the CAM software with a webcam. All material information such as disk name, color, height, lot no., enlargement factor and other information is thus automatically included in the workspace overview. Disks that have been partially machined can be found again later in the software via the QR code. Users save valuable input time and always have an optimal overview of their available inCoris disk inventory.

After the milling process, the NPM restoration is sintered in a protected argon atmosphere to achieve its final strength without any inclusions or voids. The prerequisite for this is the inFire HTC speed sintering furnace with the metal sintering operation from Dentply Sirona, which is already equipped with an integrated gas management system. All inCoris materials can be quickly and directly controlled via the preset programs. Existing customers with an inFire HTC speed without the metal sintering option can have this subsequently installed, depending on the serial number of their sintering furnace.

The inCoris CCB is now available from specialized dealers. More information at:

http://www.sirona.com/inlab

FIG. 1: The inCoris CCB from Dentply Sirona is available in a standard size (Ø 98.5 mm) and in six different heights.

FIG. 2: The range of materials for the inlab MC X5 now includes the NPM sintered metal disk inCoris CCB from Dentply Sirona.

FIG. 3: Each inCoris CCB disk has a QR code that can be conveniently scanned into the inlab MC X5’s inlab CAM software with a webcam.
Interview: “Our role with IFDH is to promote the profile of the dental hygienist across the globe”

By Dental Tribune MEA / CAPPmea

DUBAI, UAE: Following the long journey from Australia to the UAE, two hands-on courses and two hour lecturing at Dental Hygienists Seminar, we finally had the opportunity to interview Robyn Watson – President of the International Federation for Dental Hygienists (IFDH).

DTMEA: Please if you could share with us exactly who is the famous Robyn Watson?

Robyn Watson: Thank you so much for inviting me, it has been a pleasure to be here. First and foremost, I have been a registered dental hygienist for many years. I have had a varied career in the field of dental hygiene. My experience includes clinical practice, teaching and education as well as politics, setting up programs and designing curricula, and consulting. Looking back I have had a wonderful, fun, long career and have been fortunate to have been elected as the President of the International Federation of Dental Hygienists which seems like sometimes I had to pinch myself as to how did I get here? However, I am really enjoying this role. I have had the role now since June 2016 prior to which I was the President-elect and I see it as an avenue to really raise the profile of hygienists and improve oral health globally.

How did you choose to become a hygienist as opposed to a dentist?

I chose dental hygiene after working in dental practices as a dental assistant in high school. Some influence came from the fact that my father was an orthodontist. I was still a young teenager when I chose to go to dental hygiene school, and I would have to say that in those days 8 more years of school seemed quite daunting! This was in the late 60’s when it was unusual for women to go to dental school, and in fact there was only one woman in the dental school class at the university I went to.

I had considered whether to continue on to dental school later but found my career in dental hygiene to be very satisfying and challenging due to some of the experiences I have described.

What advice would you give to young students looking into becoming a Hygienist or dentist?

It is indeed a fact that many students we receive coming into the university initially intend to use the degree we receive coming into the university I went to. I chose dental hygiene after working as a young teenager when I chose to go to the university I went to.

What is the strategy going forward in terms of awareness for the profession as well as awareness of the challenges we face in oral health?

As the president of the IFDH, what is the strategy going forward in terms of awareness for the profession as well as awareness of the challenges we face in oral health?

The strategy with the IFDH is to promote the profile of the dental hygienist as part of an interdisciplinary team. This means really increasing the profile of the hygienists themselves which I do for instance when we started up the hygiene program, the concept was difficult for many hygienists would be economical – other health professionals that may not be as aware of what a hygienist can do which will raise the profile of the profession. On our website of the IFDH, our education committee is working on an educational page for the public which will also help raise the profile of the dental hygienist so we can be perceived as experts in prevention in oral health.

We face challenges of increased migration, social determinants of oral health, increasing elderly population, increased availability of processed foods and sugars. With our focus on social responsibility and promotion through our website we have the goal of helping to alleviate some of these challenging issues when we started up the hygiene program, the concept was difficult for the local dental profession to understand. The dentists had the idea that the hygienists would be economical – this is certainly not the case. The goal is to educate the profession, the public and other health professionals that may not be as aware of what a hygienist can do which will raise the profile of the profession.

Following your big exposure and well attended lectures and hands-on courses, describe your experience here at the Dental Hygienist Seminar in Dubai?

It has been enlightening, it has been fun and we have made a lot of new friends from the region. I have come to appreciate what is happening in the Middle East and I am very impressed with what I have seen. I am looking forward to more colleagues from the Middle Eastern countries becoming part of our global community. If I have been able to inspire them over the last two days at this conference, then I am very pleased!

Robin Watson, President of the International Federation for Dental Hygienists (IFDH)

“We want to support our members to achieve oral health goals for their patients and communities.”
COLOGNE, Germany: From 21 to 25 March 2017, the 37th International Dental Show (IDS) will be held in Cologne. After a record result last year, preparations for the world’s largest and most important trade fair for the dental industry are already in full swing again. The organisers have announced that the application deadline for exhibitors has been moved forward to 31 March 2016, as hall planning will begin in April. Over 2,200 companies are expected for next year’s IDS, with strong international representation. Organiser Koelnmesse has already received many inquiries from potential new exhibitors from abroad.

In 2015, 2,199 exhibitors from 59 countries and around 139,000 trade visitors from 152 countries attended the show. According to a representative survey, about 90 per cent of the exhibitors from IDS 2015 are planning to participate at IDS 2017, said Dr Martin Rickert, Chairman of the Association of German Dental Manufacturers, which co-organises the event.

Koelnmesse announced further results of the independent exhibitor and visitor survey in 2015, according to which 99 per cent of the participating German suppliers had reached their key customers in their domestic market and 82 per cent their key accounts from abroad. Of the foreign exhibitors, 98 per cent had made contact with their international customers and 95 per cent with their German key accounts. About 93 per cent of the exhibitors established new contacts with potential German buyers during the show, while 79 per cent of the German and 98 per cent of the foreign suppliers acquired new international contacts.

Moreover, more than three-quarters of visitors interviewed indicated their intention to visit the 2017 IDS. About 80 per cent of German and foreign attendees rated the exhibition as either very good or good, mainly owing to the comprehensive product range and numerous new products showcased. Overall, 95 per cent of the visitors surveyed would recommend visiting IDS to business partners.

As in previous years, Dental Tribune International (DTI) will be keeping its readers around the globe up to date by providing the latest news from the show. In addition to a daily issue of its IDS today newspaper, which will be published in collaboration with DTI’s German affiliate OEMUS MEDIA, regular e-newsletters will be sent out during the five-day show to ensure comprehensive coverage. Exhibitors interested in print and online advertising for IDS 2017 may consult the DTI Media Kit or contact the DTI sales team directly for special offers.

A review of last year’s IDS can be found here.
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Guided Biofilm Therapy
A New Concept for Prophylaxis Professionals

Guided Biofilm Therapy provides a two stages clinical protocol that is able to ensure complete cleaning of teeth while preserving tooth substance.

By Dr Mathieu Deudon, France

The previous protocol for the removal of hard and soft deposits, which begins with hand instruments, continues with an ultrasonic device and ends with classical polishing (rubber cups, brushing, polishing pastes), is today still widely used in dentistry. However, recent clinical studies show that this method is obsolete. It leaves distinct marks on hard tooth structure and is aggressive on soft tissue.

EMS has developed a new systematic approach for professional prophylaxis under the name of Guided Biofilm Therapy. This prophylaxis procedure focuses not only on the removal of hard and soft deposits, but also on a different treatment sequence. The procedure guarantees complete cleaning, even in the most difficult-to-reach areas and at the same time preserves tooth substance and natural tissue.

The final polishing with a polishing paste can now be avoided.

The Procedure
For optimal results, it is first necessary to make a diagnosis of the soft tissue and mucous membranes, to raise patient awareness for the benefits of good oral hygiene, and to motivate them.

Because, professional prophylaxis always has to be supported by individual prophylaxis. The primary, common and widespread technique for the preparation of the tooth surfaces is brushing your teeth. It causes the disorganization of the biofilm. Professional tooth cleaning then ensures the removal of biofilm in areas that are also difficult for patients to reach.

The Advantages of The New Concept of Guided Biofilm Therapy

This procedure guarantees efficient cleaning and a complete removal of biofilm, even in hard-to-reach areas, and preserves the tooth structure and natural tissue. The final polishing procedure using a polishing paste can thus be avoided. Furthermore, patients very much appreciate this gentle and totally painless form of treatment and are thus happy to come to prophylaxis sessions.

The Protocol

STAGE 1 (Fig. 3 to 9)
1 – Removal of Soft Deposits, Discolorations And Biofilm

This stage is carried out using the AIR-FLOW® method by EMS in combination with the AIR-FLOW® Powder PLUS. It is based on erythritol, a natural component, together with 0.3% chlorhexidine. Thanks to its fine grain size (14 µm), the tooth surface and the soft tissues are not affected. This powder enables the removal of biofilm and soft deposits in both supragingival as well as sub-gingival areas on natural teeth or implants. It is recommended to not eat any choanogenic food for 3 hours after the treatment.

2 – Rehabilitation of Deep Pockets

In the 5.9 mm deep pockets, biofilm is removed with the PIEZON® handpiece with vertical movements back and forth for 5 seconds per pocket. This technique is five times as fast as with a curette. Thanks to its soft disposable plastic attachment, the handpiece does not damage the surface of the root or the implant and adapts perfectly to the anatomic shape.

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Fig. 1: Checking the attachment and the depth of the pocket
Fig. 2: Professional diagnosis to raise patient awareness with a plaque test (EZ)
Fig. 3: AIR-FLOW® Powder PLUS
Fig. 4: Removal of supragingival biofilm and stains, also in contact with the gingiva
Fig. 5: Removal of biofilm under the gingiva ( sulcus ≤ 4 mm) Technically correct work is indispensable for successful air polishing: setting the power to 30-50%, water flow to 100%
Fig. 6: The optimal positioning of the suction tube
Fig. 7: The optimal positioning of the suction tube
Fig. 8: Probing the pocket
Fig. 9: Removal of biofilm with the PIEZON® handpiece
Fig. 10 and 11: Calculus removal from natural teeth with PS attachment by EMS. This very fine instrument allows thorough cleaning even in hard-to-reach areas, below and above the gingiva (up to 10 mm depth). Recommendation: Set the power to 30-60%, water flow to 70-100%
Fig. 12: Calculus removal on an implant with PS attachment by EMS. The tip enables cleaning of implant, implant post and crown surfaces without damaging titanium or zirconium surfaces.
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oral hygiene practices from dental professionals remain uncertain about oral prophylaxis, interdental biofilm management and interdental brushing techniques. He was the first to test for 19 major pathogens in the interdental biofilm known to be involved in periodontitis in young healthy adults. Furthermore, he has suggested interdental brushes to prevent interdental biofilm accumulation as well as to decrease the development of periodontal diseases and even systemic diseases. “An interdental brush can remove around 16 billion bacteria from each interdental space,” says Bourgeois.

Despite advances in good oral health care, many patients and dental professionals remain uncertain about oral hygiene practices and the concept of disruption of biofilm instead of elimination of dental plaque. According to various studies, conventional toothbrushing is not effective according to various studies, conventional toothbrushing is not effective in removing interproximal plaque and even systemic diseases. “An interdental brush can remove around 16 billion bacteria from each interdental space,” says Bourgeois.

In his study, an astounding approximately 16 billion bacteria were collected on average from each interdental site. The 19 major periodontal pathogens quantified in the study included Escherichia coli, Haemophilus influenzae, Neisseria species and Porphyromonas gingivalis. Tannenbaum, Forsythia and Treponema denticola were recognized as the most important pathogens in adult periodontal disease. Porphyromonas gingivalis was detected in 19 per cent of healthy subjects and represented 0.02 per cent of the interdental biofilm. As dental research has confirmed, P. gingivalis alone produces adenosine triphosphate and can induce alveolar bone loss, and in combination with T. denticola and T. lutea, periodontal disease is likely to occur. This means that the interdental biofilm of even healthy individuals is composed of bacteria that could lead to periodontitis. “The effective presence of these periodontal pathogens is a strong indicator of the need to develop new methods for disrupting interdental biofilm in daily oral hygiene,” concludes Bourgeois.

Bleeding as a clinical reference
Despite good oral hygiene habits, many patients experience interdental bleeding. “As we have seen, the interdental space is a source of bacterial contamination and has without any need for daily oral hygiene and interdental cleaning in particular. “There is a need to use interdental cleaning tools in order to achieve optimum oral health. If you do not use them, you could essentially stop using a toothbrush, as bleeding will occur otherwise anyway in the future.”

In a study titled “Efficacy of interdental calibrated brushes on bleeding reduction in adults: a modest randomized controlled clinical trial”, a test group was asked to use a standard manual toothbrush twice daily and an interdental brush daily. Based on the hypothesis that interdental brushes reduce interproximal bleeding, Bourgeois and his team instructed periodontally healthy and young individuals how to use interdental brushes daily and correctly. In addition, a calibrated colorimetric probe helped to effectively determine the interdental space and right brush size. As the study suggests, the overall interproximal bleeding was reduced by 47 per cent after one week and 71 per cent after three months. Bourgeois and his team concluded that interdental cleaning can be considered as “an effective means to help individuals maintain and/or achieve optimal oral health.”

As the general access widths of interdental spaces were mostly unknown in young adults, Bourgeois and his colleagues also assessed the distribution of widths in this group in a study titled “Access to interdental spaces in young adults: A cross-sectional study”. Importantly, 40 per cent of the sites studied showed bleeding upon passage of an interdental brush. An unexpected finding was the high number of adults (69.9 per cent) with greater than 30 per cent of bleeding sites. It was observed that this did not have a significant effect on the width of the interdental space. By measuring the interproximal space, the researchers concluded that the latest generation of interdental brushes was without accessing more per cent of interdental spaces. Over 80 per cent of the sites required a small interproximal brush (0.6-0.7 mm) from the Curaprox CPS Prime series. As a result, the study concluded that most interdental sites can be cleaned using interdental brushes, but accessibility of interdental spaces would need to be established in the dental practice by the dental professional.

INTERDENTAL BRUSHES PROVE TO BE SUPERIOR

Conventional, interdental brushes were only recommended for patients with large interdental spaces, while dental floss was recommended for narrow spaces. As technology advanced, so did the innovation with interdental brushes, and as a result, interdental brushes can now be used for very small interdental spaces to clean the space between teeth effectively. “Dental floss used to be the common tool for narrow spaces. However, dental floss is no longer preferred, as its use is not supported by conclusive scientific evidence.” Interdental brushes have now become the best tool for cleaning interdental spaces, “says Bourgeois.

According to the French professor, the interdental brush currently represents the primary and most effective method available for interproximal cleaning. Interdental brushes are specifically designed to clean between the teeth in accordance with the interproximal space access diameter. The method of choice for interdental cleaning when brush space permits is to select the largest size that can penetrate into the interdental space and then to fill this space completely without causing discomfort or trauma. By using a calibrated Curaprox IAP colorimeter, professionals can use interdental brushes to help individuals achieve optimal biofilm disruption through effective interdental cleaning with minimal trauma.

For all studies, Bourgeois and his team selected the CPS Prime series of interdental brushes of the Swiss oral care brand CURAPROX. Patient acceptance of these interdental brushes has proven to be very high during all studies.

More information can be found at www.curaprox.com.
The risks that carbonated soft drinks, alcoholic mixers and wine pose to your patients’ teeth are well-known – increased consumption of acidic food and drinks can lead to tooth erosion and hypersensitivity.

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‡ Containing 1450 ppm fluoride as MFP.

References:
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