Dubai, UAE: Those lucky enough to attend the 35th edition of the International Dental Show (IDS) in Cologne witnessed a record event with 125,000 trade visitors from 60 countries attending the world’s leading dental trade fair. 2,058 companies from 56 countries attending the world’s leading event with 125,000 trade visitors from 149 countries representing a vast amount of companies who were showcasing and introducing first time products and product displays all happening simultaneously.

The Landscape of Digital Restorative Dentistry
Dr. Ziad Salameh DDS, MSc, PhD, Lebanon
Lecturing on CAD/CAM Preparations and Cementation Protocols for CAD/CAM Restorations. Also featuring will be Dr. med. dent. Karsten Kamm from Germany lecturing together with Joachim A. Maier, MDT, Germany, on ZOLID: Base for Aesthetic All-Ceramic with Long-Term Success.

Everyone with Modern CAD/CAM Materials
Dr. Mark Morris, USA
Lecturing on CAD/CAM Revolution: Clinically The Power and Ability of CAD/CAM Technology.

The New World of Images in Dentistry and Implantology
Dr. Sandeep Deb, India
Lecturing on CBCT Imaging in Anatomical Analysis: The New World of Images in Dentistry and Implantology.

Socket preservation in the daily practice: A clinical case report
Dr. Nicolas Boutin & Dr. Bernard Cannas, France
Lecturing on Novel Directions and Clinical Applications of CAD/CAM Technology. The scientific session will also include Dr. Nicolas Boutin, France, Dr. Bernard Cannas, France, Dr. Philippe Tardieu, France, Asham Farah, CDT, Syria, Dr. Gary Severance, DDS, USA and Dr. Francisco Barbosa, Spain. As usual set up of the conference, the second day will feature the unique Dental Technicians Parallel Session providing specific at-

>> See FILLING, page 2

Dental Tribune

Middle East & Africa Edition

IDS 2013 Cologne Germany, the latest news in Digital Dentistry...

...to be shown at the 8th CAD/CAM & Digital Dentistry International Conference, Dubai, UAE 02-03 May 2013.
A record IDS: Sirona scores with 25 innovations and integrated system solutions worldwide and our continuous investment in research and development. We are pleased to see that our digital and integrated solutions are improving the dental practice and laboratory as well as patient experience.  

Sirona, Cologne, Germany: The 35th International Dental Show (IDS) in Cologne closed with record visits – results on March 16, 2013 after five days. Sirona reinforced its position as innovation leader with 25 new products and fascinated visitors with themed exhibitions, islands and design worlds at a large, modern 1,000 square meter booth.

Sirona’s booth in hall 10.2 was once again a magnet for the public at IDS 2013. The 25 new products featured at the show on close to 1,000 square meters of exhibition space were completely surrounded by visitors from all over the world on all five days of the IDS. With the innovations, which give dentists and dental technicians an important competitive edge through improved work processes, a broader range of services and time and cost savings, Sirona underpinned its claim to technological and market leadership in the dental industry.

"The enormous number of international visitors at our booth and the great interest in our 25 new products show that dentists and dental technicians consider Sirona the leader in the dental market and trust our brand," says Jeffrey T. Slovin, CEO of Sirona Dental Systems. "The company attributes its strong innovative capacity to its considerable investment in research and development. 270 scientists and engineers were involved in the new and further development of the products and services, and around 1,400 employees work at the largest production site in the dental industry in Bensheim, Germany."

The dazzling result was a array of innovations from all areas of dentistry, covering CAD/CAM and imaging systems, treatment centers, instruments and hygiene systems. In addition to the new products, system solutions were the main focus, which highlighted the particular expertise of Sirona in combining different digital technologies. At the three event centers, instruments and hygiene systems.

The event will allow the sponsors, leading dental manufacturers and distributors to showcase their latest products, materials, systems and brands at the product display area which will be the first time the companies introduce their new products in the Middle East post IDS. Platinum Sponsor Sirona – The Dental Company, experienced a record IDS with 25 new innovations and integrated system solutions once again highlighting its particular expertise in combining different digital technologies. Ivoclar Vivadent (Gold Sponsor) announced their collaboration with implant system supplier Camlog making it an Authorized Milling Partner. Another Gold system supplier Camlog making it an Announced their collaboration with implant system supplier Camlog making it an Authorization.

Jeffrey T. Slovin: "Our success at this year’s CAD/CAM & Digital Dentistry event, 3E SM celebrates its tenth anniversary on the groundbreaking Filtek line of dental composites. Amann Girrbach (Official Sponsor) introduced its infrared technology to the Dental Technicians with its new Partner Sirona – The Dental Company, experienced a record IDS with 25 new innovations and integrated system solutions once again highlighting its particular expertise in combining different digital technologies. Ivoclar Vivadent (Gold Sponsor) announced their collaboration with implant system supplier Camlog making it an Authorized Milling Partner. Another Gold system supplier Camlog making it an Announced their collaboration with implant system supplier Camlog making it an Authorization.

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Introducing Sensodyne Repair & Protect

Building a new layer of protection

Presenting advanced NovaMin® technology
Sensodyne Repair & Protect is the first toothpaste to harness the advanced reparative power of NovaMin® plus fluoride.

Originally developed for bone regeneration, NovaMin® delivers calcium and phosphate into your patient’s saliva and provides favourable conditions for hydroxyapatite-like layer formation.

Building a reparative layer
From as quickly as the first use, in vitro studies have shown a hydroxyapatite-like layer forming over exposed dentine and within the dentine tubules that is 50% harder than dentine.

Building an integrated and resilient layer
The hydroxyapatite-like layer formed binds firmly to the collagen in the patients dentine and helps protect your patients from the chemical and physical oral challenges they encounter in their everyday lives.

In vitro studies have shown that the robust layer builds up over 5 days and, with twice-daily brushing, provides patients with continual protection from dentine hypersensitivity.

Pre-brushing Post-brushing Post-acidic challenge

In vitro SEM images of the tooth surface pre-brushing, of a reparative layer formed after twice-daily brushing for 4 days and of a reparative layer post a 5-minute acidic challenge.

Think beyond pain relief and recommend Sensodyne Repair & Protect

One Exhibition, 20 New Products, One Movement: In-House That was the IDS 2013

Ivoclar Vivadent is a leading company in the field of computer-aided manufacture of dental prosthetic, and brings the collaboration between Ivoclar Vivadent and Camlog worldwide one step forward. The Authorized Milling Partner program has been growing successfully since its launch in March 2011. Camlog’s products are in-house company and presented 20 new products at one go, all relating to the CERAMILL CAD/CAM system.

Camlog is worldwide one of the leading suppliers of integrated systems and products for implant dentistry to provide comprehensive solutions in the laboratory and to insert them in the dental practice. The result is outstanding quality, ensuring long-lasting success and satisfied patients.

About Camlog, Camlog is worldwide one of the leading suppliers of integrated systems and products for implant dentistry and restorative dentistry. Many years of experience in research and development, high quality standards and the know-how of internationally renowned experts in research, manufacturing and marketing have played a major part in the company’s success on the dental market. Camlog’s products lead the way in terms of ease of use and quality and its services are fully customized to meet the needs of its customers and business partners. Dedicam completes the product range in digital prosthetics.

The company’s offering extends from implant superstructures through individual abutments to single-tooth and bridge restorations, all manufactured using high-end materials.

About the Authorized Milling Partner program. The Authorized Milling Partner program has been growing successfully since its launch in March 2011. National and international milling centres have joined the collaboration in the meantime. Ivoclar Vivadent supports the members of the partnership program with guidance on the successful use of its CAD/CAM materials.

Communication and cooperation
On Wednesday evening Amann Girrbach invited customers, dealers, suppliers and cooperation partners to an IDS Sundown-er Party at the exhibition stand. Over 300 guests took advantage of the invitation and used the party as a communication platform for a lively exchange of ideas. There will also be an exchange in the future as part of the cooperation with well-known material manufacturers and system providers to freely link the best available materials and systems to our open CAD/CAM system. All expectations were surpassed with the IDS 2013 – the interest in new products as well as the sales and the anticipat-ed follow-up transactions. We are extreme-ly pleased about the partnerships, cooper-ations and new projects created and are already looking forward eagerly to the next IDS in 2015.

Your Amann Girrbach Team

New collaboration – Ivoclar Vivadent and Camlog

Press Release: Amann Girrbach

C ologne, Germany: The 35th International Dental Show (IDS) was held from 12 to 16 March 2013 and brought the organisers truly record results with 125,000 visitors and 2,058 exhibitors. Amann Girrbach’s trade fair presence also broke records. There was an enormous stream of visitors on each day of the exhibition, the public was more international than ever before and the interest from new customers and dealers for the products was overwhelming. This is why the most important thing for us is to thank our customers, dealers and partners for attending the exhibition and providing an incredible response.

Highlights and new products
The exhibition stand itself was a real eye-catcher. There were no less than 27 Cera-mill Motion 2 machines at the stand, 12 complete CAD/CAM stations, optically elegant display cabinets with high-quality demonstration cases from Amann Girrbach Live Labs, well-known laboratories and dental technicians such as Knut Miller as well as artful presentations from AG Research & Development. However, the highlight was the “Motion Wall” – 22 Cera-mill Motion 2 machines, which impressive and synchronously demonstrated the di-verse material and indication range of the CERAMILL CAD/CAM system.

The “Motion Wall” was not only a visual feature but also a statement. With its IDS exhibition presence Amann Girrbach thus continued to position itself as pioneer of the digital in-house process chain in keeping with the motto “Amann Girrbach – the in-house company” and presented 20 new products at one go, all relating to the CERAMILL CAD/CAM system.

Naturally, Ceramill Sintrohn was at the centre of all the new products. Countless interested visitors gathered around the Ceramill Argotherm furnaces on display and the Amann Girrbach team of experts comprising product managers, heads of development and instructors. Ceramill Sintrohn was also the central topic of the Amann Girrbach press conference to which both national and international publishers and press representatives were invited.

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Your Amann Girrbach Team
EUROPEAN UNIVERSITY COLLEGE
(formerly NICOLAS & ASP UNIVERSITY COLLEGE)

FIRST INTERNATIONAL POSTGRADUATE DENTAL INSTITUTION IN THE REGION

MASTER DEGREE IN ORTHODONTICS
In cooperation with Malmo University in Sweden
Leads to Royal College Membership (MOrth)
Accredited by: MOHESR-UAE

MASTER DEGREE IN PEDIATRIC DENTISTRY
GA & OR, Facilities & Special Needs Care
Leads to Royal College Membership (MPaed)
Accredited by: MOHESR-UAE

MASTER DEGREE IN ENDODONTICS
Operating Microscope Facilities, Computerized Radiography
Leads to Royal College Membership (MEndo)
Accredited by: MOHESR-UAE

DIPLOMA IN ADVANCED EDUCATION IN GENERAL DENTISTRY
Operating Microscope Facilities, Computerized Radiography
Accredited by: MOHESR-UAE

HIGH DIPLOMA IN ORAL IMPLANTOLOGY
Comprehensive Clinical Training on Surgical & Implant Restoration
CBCT Diagnosis and Treatment Planning
Accredited by: MOHESR-UAE

COMING SOON
MASTER DEGREE IN RESTORATIVE and PROSTHODONTICS

ASSOCIATE DEGREE IN DENTAL ASSISTING

- Accredited by The Ministry of Higher Education & Scientific Research (UAE)
- In Cooperation with Swedish Universities
- Accredited by the International Association of Universities (UNESCO)
- Teaching Faculty from reputed American & European Universities
- All programs include strong theoretical & clinical training
- Global pool of international students from Asia, Europe & the Middle East

Curriculum approved by Royal College of Edinburgh
EUC Orthodontic graduates exempted from the written examination

Admissions for 2013 is currently open

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3Shape announces the official launch of its new TRIOS® Ortho solution

Press Release: 3Shape

Copenhagen, Denmark: 3Shape is now releasing a complete digital solution for orthodontic clinics that bundles the 3Shape TRIOS® digital impression solution with 3Shape’s Ortho Analyzer™ software. 3Shape TRIOS® Ortho provides intraoral scanning, clinical scan-validation, and seamless communication with the orthodontic lab. The included 3Shape Ortho Analyzer™ software gives orthodontists tools for creating digital study models from the impression followed by advanced tools for treatment planning and case analysis.

Copenhagen, January 21, 2013. 3Shape, a global leader in 3D scanning technologies and CAD/CAM software for dental applications, declares “all systems go” for the release of its TRIOS® Ortho solution.

Finally - digital impression taking for Orthodontists

By replacing manual methods with digital impression taking, orthodontists can reap a wide range of business benefits such as reduced chair time, increased patient comfort, fewer retakes, and durable impressions. The digital format allows orthodontic clinics to reduce their storage costs and systematically access their case records. TRIOS Ortho’s integrated communication tools allow orthodontists to discuss cases and treatment plans in 3D with the lab and colleagues, easing cooperation and ultimately achieving optimal results for the patient.

Complete digital workflows with Ortho Analyzer™ Software

3Shape has bundled its user-acclaimed Ortho Analyzer™ together with TRIOS® to give orthodontists a complete digital workflow all the way to the lab. The scanned full-bite situation can be uploaded directly into the Ortho Analyzer™ software running on a server PC that is included with the TRIOS Ortho solution. Ortho Analyz- er™ makes it easy to create a digital study model, including a virtual base, and perform treatment planning using 3D and 2D tools, virtual setups and digital articulators. The virtual model can then be optimized for digital appliance design in labs that use 3Shape Appliance Designer™ software and digital manufacturing machines.

Digital database for impressions integrated in your clinic

3Shape TRIOS® Ortho also includes the Ortho System TRIOS™ Invox software and the Ortho System™ database. The Ortho System TRIOS Invox facilitates efficient import of digital impressions from TRIOS® into the Ortho System™ database - which in turn can be made easily accessible from the clinic’s general practice management software and digital manufacturing machines. The virtual model can then be optimized for digital appliance design in labs that use 3Shape Appliance Designer™ software and digital manufacturing machines.

Contact Information

3Shape is a Danish company specializing in the development and marketing of 3D scanners and CAD/CAM software solutions designed for the creation, processing, analysis and management of high-quality 3D data for application in complex manufacturing processes. 3Shape envisions the age of the “full digital dental lab,” and its more than 140 developers provide superior innovation power toward reaching this goal. 3Shape’s flexible solutions empower dental professionals through automation of real workflows, and its systems are applied in thousands of labs in more than 70 countries worldwide, putting 3Shape technologies at the peak of the market in relation to units produced per day by dental technicians.

With TRIOS, 3Shape now brings its vast expertise and innovation power directly to dentists. 3Shape boosts its first-line distributor support network with a second-line support force of over 30 in-house experts placed in 5 support and service centers strategically located around the globe. 3Shape is a privately-held company headquartered in Copenhagen, with the market’s largest team dedicated to scanner and software development for the dental segment based in Denmark and Ukraine, production facilities in Poland, and Business Development & Support Offices at several locations in Europe, in North and South America and in Asia.

For further information regarding 3Shape, please refer to www.3shapedental.com. Visit us on www.facebook.com/3shape

3M ESPE Filtek Z350 XT Universal Restorative Marks Ten-Year Evolution

Press Release: 3M ESPE

Dubai, UAE. 3M ESPE is celebrating the tenth anniversary of its groundbreaking Filtek line of dental composite. First introduced in 2002, the Filtek line has come to be prized in practices around the world for its true nanotechnology, which enables dentists to use the dental composite to easily create restorations with exceptional aesthetics. After ten years, over 400 million restorations have been placed using the Filtek line.

Over the past decade, dentists around the world have seen how they can help change patients’ lives with this dental composite. Whether they prefer the simplicity of a single shade, or use a sophisticated layering technique, dentists have come to rely on the dental composite to help them deliver outstanding results.

“We are proud to celebrate a decade of helping dentists create beautiful smiles and lasting restorations with this product,” said Dr. Hesham El Misky, Business Development Manager for 3M ESPE Dental Products, MEA. “It is a true testament to 3M ESPE’s innovative technology that Filtek remains such a popular and trusted material in so many practices.”

By incorporating true nanotechnology into its Filtek line, the Filtek line provides the polish and polish retention of a microfill, while maintaining the strength and wear properties of a modern hybrid dental composite. Since the dental composite’s initial introduction, 3M ESPE has refined the Filtek formula through three other iterations, and today’s formula, 3M ESPE Filtek Z350 XT Universal Restorative, makes it easier for dentists to produce beautiful life-like results—with exceptional handling, lasting polish and single-shade simplicity.

DID YOU KNOW

Almost 1 in 5 people find stained teeth a turn-off.
Beverly Hills Formula toothpaste removes over 91% of stains to give you whiter teeth in 1 minute.

www.beverlyhillsformula.com

Press Release: 3M ESPE

Celebrating 10 years of restorations. Filtek Z350 XT. 3M ESPE

3M ESPE Filtek Z350 XT Universal Restorative Marks Ten-Year Evolution

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www.beverlyhillsformula.com
Unique 3D combination with one imaging unit

Create your virtual patient.

The Planmeca ProMax® 3D family and Planmeca Romexis® software bring together: CBCT + 3D face photo + 3D model scan

Our innovative 3x3D combination – an industry first
UAE Smiles Impacted By Bleeding Gums

62% of Surveyed UAE residents suffer from bleeding gums
Congratulations to Our Award Finalists!

The overall winners will be announced at the Grand Final!
2nd May 2013 at JW Marriott Marquis Hotel Dubai Ballroom

by Emirates Dental Society & CAPP

The Sky Dentistry achievements will be celebrated at the tallest hotel in the world JW Marriott Marquis on 02 May 2013 in Dubai, UAE.

Finalists in ‘Aesthetic Dentistry MENA Awards’ and ‘I Love my Dentist Award’ public vote will be recognized for their outstanding excellence within their field of work at the Grand Final.

Aesthetic Dentistry MENA Awards participants have been evaluated from an independent judging panel - Dr. Adel Alhadiq, BDS, MSc, PhD, Saudi Arabia, Dr. Ninette Bandy, Dr. Nadim Abujaoude, and Dr. Philippe Tardieu, France. The finalists in seven categories were selected anonymously from 19 shortlisted finalists supported by six Dental Technicians.

I Love my Dentist Award has been created to give the public the opportunity to voice their appreciation and to recognize the exceptional skills and nominate their favorite dentist. This award is open to all dentists from across the MENA region. 144 Dentists form 23 countries participated in this year Awards.

The purpose of the awards is to pay tribute to those individuals who have demonstrated outstanding excellence within their field of work. Winners from the short-list will be announced during the Gala awards dinner that recognizes and honors outstanding performances in Dentistry. The winners and nominees are some of the most outstanding people in the filed and these Awards give the recognition they deserve for their hard work and commitment.

This remarkable event will take place on the evening of the first day of the 8th CAD/CAM & Digital Dentistry International Conference at the JW Marriott Marquis Hotel in Dubai, UAE, tallest hotel in the world.

CONGRATULATIONS

Dr. Johnny Haddad, Cooper Dermatology, Dubai, UAE
Dr. Lamis Al Ayami, Al Salama Hospital, Al Khor, Qatar, Saudi Arabia
Dr. Firas H. Jumma, Dr. Firas Dental & Orthodontic Center, Abu Dhabi, UAE
Dr. Krishna Prasad, NMC Hospital, Abu Dhabi, UAE
Dr. Lamis Al Aysami, Al Salama Hospital, Al Khobar, Saudi Arabia
Dr. Oussama Alaoui, Smile Clinic, Syria, Damascus
Dr. Khadishat Sadulaeva, Standard Medical Clinic, Dubai, UAE
Dr. Rami Gamil, Rami Gamil Dental Clinic, Alexandria, Egypt
Dr. Lolita M. Lim, Aljazeerah dental clinic, Sharjah, UAE
Dr. Johnny Haddad, Cooper Dermatology, Dubai, UAE
Dr. Khadishat Sadulaeva, Standard Medical Clinic, Dubai, UAE
Dr. Nizar Ishaq, GMC Dental Clinic, Dubai, UAE
Dr. Joachim Smith, The Dental Studio, Dubai, UAE
Dr. Ajay Juneja, The Dental Studio, Dubai, UAE
Dr. Philippe Tardieu, France

The Premier Event for Professionals
Aesthetic Dentistry MENA Awards 2012

Congratulations

Aesthetic Dentistry MENA Awards

Dr. Hala Al Sakiea, American Dental Clinic, Dubai, UAE /DT: Mr. WillieGettar
Dr. Oussama Alaoui, Smile Clinic, Syria, Damascus
Dr. Joachim Smith, The Dental Studio, Dubai, UAE
Dr. Afshin Farah, Dental Laboratory, Syria
Dr. Omar Aloum, Hikma Medical Center, Abu Dhabi, UAE /DT: Dr. Michael Ray Ziegler
Dr. Rabih Abi Nader, Dubai, UAE /DT: Mr. Samer Sabbaghi
Dr. Hala Al Sakiea, American Dental Clinic, Dubai, UAE
Dr. Loi Glavon, Hikma Medical Center, Abu Dhabi, UAE
Dr. Sultan Al-Deyab, Riyadh, Saudi Arabia
Dr. Hala Al Sakiea, American Dental Clinic, Dubai, UAE
Dr. Dr. Ajay Juneja, The Dental Studio, Dubai, UAE

By Emirates Dental Society & CAPP

I LOVE MY DENTIST Awards 2012

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Dr. Firas H. Jumma, Dr. Firas Dental & Orthodontic Center, Abu Dhabi, UAE
Dr. Lamis Al Aysami, Al Salama Hospital, Al Khobar, Saudi Arabia
Dr. Khadishat Sadulaeva, Standard Medical Clinic, Dubai, UAE
Dr. Rami Gamil, Rami Gamil Dental Clinic, Alexandria, Egypt
Dr. Khadishat Sadulaeva, Standard Medical Clinic, Dubai, UAE
Dr. Lamis Al Aysami, Al Salama Hospital, Al Khobar, Saudi Arabia
Dr. Khadishat Sadulaeva, Standard Medical Clinic, Dubai, UAE

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The Premier Event for Professionals
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Dr. Hala Al Sakiea, American Dental Clinic, Dubai, UAE
Dr. Dr. Ajay Juneja, The Dental Studio, Dubai, UAE
For nearly 100 years, dentists have relied on 2-D radiographic imaging for diagnosis and treatment planning. With the 1999 introduction of cone beam computed tomography (CBCT), all dentists now have tools available for more accurate diagnosis and treatment.1 The ability to look at a tooth in any direction and orientation, as well as in 3-D, eliminates much of the guesswork commonly experienced with 2-D radiographs. We have been limited in most cases to only a buccal-lingual view provided by periapicals, bite-wing, and panoramic radiographs with the occasional axial view of an occlusal film. Medical CT scans and images began in the early 1970s and were sometimes used by dentists, offering their first multiplanar views.2

The adoption of 3-D cone-beam imaging is appropriate and has important advantages for all modalities of dentistry. From every specialist to the general dentist, the increased amount of radiographic information as well as increased accuracy will aid in the most sound diagnosis possible.

CBCT description
CBCT is a single or partial rotation of an X-ray source around the head, capturing X-rays on various flat panel arrays and sensors. The information is converted to a series of axial slices by computed tomography and stored as virtual anatomy in the computer. With the use of sophisticated software, the dentist is able to view information in several different views, including: axial slices (head-to-toe orientation), coronal slices (front-to-back orientation), sagittal slices (side-to-side orientation) all known as multiplanar reconstructions (MPR). The thickness of each slice can be varied to include more or less information.

Because the voxels (volumetric pixels 3-D) are isotropic, other MPR images can be generated by slicing data at any angle, cut or thickness through the scan to view areas critical to the final diagnosis.5,6

The final view offered by CBCT is a 3-D view that can be rotated and viewed in any direction. Once again through software manipulation, 3-D images can be viewed as conventional radiographs, maximum intensity projections (MIP), soft-tissue projections and a variety of other views.

This nearly endless ability to manipulate the data aids in the diagnosis and identification of disease, nerve canals, sinus morphology, dental canals, bone density, fractures, endodontic pathology, implant placement criteria, periodontal defects, bone pathology, fractured teeth, iatrogenic trauma, TMJ morphology and disease, third-molar position and many more healthy or diseased conditions.

Early CBCT adoption with implants
The first and primary use of CBCT for early adopters was implant placement. As the scope and the value of the information became better known, dentists of all branches began to see the value of MPRs and 3-D renderings including periodontics, endodontics, oral surgery, treatment of TMJ, orthodontics, implantology and general dentistry.1,2,3

Clinical peripapical and panoramic radiographs for the placement of implants can be misleading with elongation, foreshortening, superimposition and geometrical incorrect data.2 A look at the implant in the peripapical shows no obvious disease to an existing integrated implant. Clinically, a buccal fistula was present with edematous and slight pain. The CBCT scan (Fig. 1) reveals a more accurate view showing a buccal defect on a sagittal MPR. A surgical flap revealed a dehiscence of the crestal implant. Removal of the foreign body resulted in an asymptomatic and healthy patient

The evaluation of the available bone for the initial implant placement can be crucial for the long-term success of the case. If there is inadequate bone available, grafting may be a necessity. CBCT studies render the most accurate information available at a low radiation dose. The peripapical shows an obvious lack of bone height, but does not show the buccal-lingual dimensions or an accurate view of the sinus morphology (Fig. 2). The MPR view of the CBCT shows all necessary measurements to perform the sinus lift and grafting with the immediate placement of the implant fixture (Fig. 3). Three-dimensional views show the floor of the sinus and any soft-tissue pathology (Fig. 4). Having accurate measurements in all dimensions is an advantage of CBCT scanning.

CBCT and endodontics
Endodontics is a field that is rapidly adopting the use of CBCT and for good reason. The inherent geometric deficiencies of 2-D radiographs make the CBCT scan a valuable adjunct to investigate the root morphology in both 3-D and MPR. The typical peripapical will show superimposed canals in the anterior, bicuspid and molars as well as unwanted bone densities both buccal and lingual to the affected tooth making the image quality poor.

The ability to view MPR slices in cross-section, long axis and oblique directions gives the ability to follow all canals in any direction and show their relationship and measurements from other known structures. This virtual tour of the root morphology is a great benefit to the final treatment outcome (Fig. 5).4,5

Post root-canal infection can be difficult to diagnose with the standard periapical. The endodontic fills may appear to be normal even though other clinical findings and symptoms are abnormal. The patient presents several months post root-canal treatment with pain on palpation and pressure and avoids this side of the mouth.

A peripapical radiograph shows minimal pathology (Fig. 6). The roots appear to be filled and a small puff of sealer extends through the apex of the mesial roots. The distal root structure and fill appear normal. There is little indication of peripapical radiolucency only a widening of the periodontal ligaments of the mesial root.

A CBCT scan reveals a completely different picture. The coronal MPR reveals a short fill near the apex of the mesial lingual root and a large radiolucency (Figs. 7, 8) not visible on the peripapical radiograph (Fig. 6). Missed canals are difficult to see in a buccal-lingual projection of the peripapical radiograph as one canal is superimposed on the other (Fig. 9). Often, as viewed in this radiograph, we see peripapical pathology with an apparently normally filled canal.

CBCT scans allow dentists to look for pathology in MPR planes to identify the actual problem before invasive procedures are performed on the patient. The axial view shows a lingual canal exists and is untreated. The coronal view confirms the diagnosis and treatment can be completed (Fig. 10).

Today’s endodontists, as well as general dentists, are benefiting from the diagnostic capabilities of the high-resolution CBCT scanners available over conventional 2-D periapicals.1,2

Oral surgery
Oral surgery, with its inherent invasive nature, can be better served using CBCT with MPR as well as 3-D images. The ability to perform virtual surgery is a benefit to both the doctor and the patient. Dentists have the advantage of seeing morphology and landmarks in real time and space with accurate measurements, and patients will gain a better understanding of the problems and the solutions their doctors are offering them.

Third-molar extractions can be risky based on 2-D and panoramic radiographs. These radiographs can often superimpose nerves and sinuses over root structures. Dentists using 2-D radiographs must often rely on experience to assess the risks of iatrogenic trauma. The use of CBCT with MPRs and 3-D images reduces any guessing as well as the chance for any permanent damage to the patient. With the adoption of CBCT, the judgment is based on solid evidence and the risk will decrease.

A panorex of the superimosed third molar gave no solid evidence the canal lies between the roots. It is due to the use of CBCT and the MPRs that the nerve can accurately be seen traversing between the mesial buccal and mesial lingual root (Fig. 11).3,4

Other surgical advantages include the identification and the position of supernumerary or impacted teeth. The images show accurate positions and show definitive morphology that will aid in remov-
al of the proper teeth (Fig. 12). Knowing the exact position of many of these teeth is a benefit to both the doctor and patient. It will lead to the most precise surgical path and the least invasive procedure.

Periodontics

The explanation of periodontal problems are often misunderstood by the patient. As doctors we talk about pockets, point to X-rays and propose treatment only to have patients refuse treatment because they do not understand what we are clinically describing. Using the 3-D portion of the CBCT scan can improve the understanding and acceptance of treatment plans. The images are a picture of the problem that is owned by that patient and much easier to understand by the layperson. Illustrating periodontal defects and pockets allows the patient to better participate in the process (Fig. 13).

The MPRs and the 3-D projections aid in surgical planning for periodontists, allowing for accurate measurements and bone analysis prior to osseous surgery that doctors cannot get using the periapicals. Studies have shown that linear measurements of bony structures are more accurate using CBCT and have less distortion than currently used methods of measurement: lateral cephalometric, posteroanterior (PA) and submento-vertex (SMVT). Accurate measurements of tooth volume and tooth position can aid in accelerated treatment times and more precise treatment. Along with tooth position, density of bone and size of arches, the orthodontist also has an accurate evaluation of the temporomandibular joint and position of the condyles. Impacted teeth are easily identified and position either buccal or lingual can be confirmed prior to movement or removal. Both MPRs and 3-D projections give the clinician a complete picture of the problems and the treatment course.

With a single CBCT scan, orthodontists can produce all of the information they need: panoramic, cephalometric, PA, SMVT, tooth size and volume, crowding evaluation in any plane, TMJ evaluation and airway analysis, all with both soft-tissue and skeletal information. 1, 3, 5

Conclusion

We treat our patients in 3-D, and now, with cone-beam computed tomography, we are changing the way we diagnose from 2-D to 3-D. The addition of this technology will increase your diagnostic skills with better and more complete information at your disposal. As with any type of invasive diagnostic tool, clinicians should weigh the risk to benefit in using CBCT scans.

Judicious use of CBCT and knowledge of patient’s lifetime doses should always be a consideration as well as the availability of other diagnostic tests appropriate for the problems of the patient. When adopting new technology, training is paramount. Along with training comes the responsibility of the doctor to read and diagnose information from CBCT scans.

Do not avoid CBCT from lack of knowledge; instead, take this opportunity to become a better diagnostician and radiologist. As you review radiology and pathology, your use of CBCT will aid in making the most accurate diagnosis and the most complete treatment plans. 7

Editorial Note: A complete list of references is available from the publisher.

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Dan McEwen, DDS, is a 1982 graduate of Loma Linda School of Dentistry and has been in private practice for 26 years. He is a founding member of the World Clinical Laser Institute, achieving a mastership level of proficiency. He has been active in FDA approval of oral surgery techniques using Erbium lasers. McEwen has lectured and trained internationally in techniques using lasers in general and specialty dental fields. He is a member of the ICM and is active in implantology. McEwen has been involved in cone-beam technology for more than five years and owns 3D Imaging Center in Maryland.

CURRENT CONCEPTS IN AMERICAN DENTISTRY

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MIDDLE EAST PROGRAM

DUBAI, UAE
NEW YORK CITY, USA
APRIL 11-12-13, 2013
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Socket preservation in the daily practice: A clinical case report

by Dr. Rabih Abi Nader & Dr. Carine Tabarani

Socket preservation usually depends on the underlying bone anatomy, following tooth extraction, sockets undergo a remodeling process that influences the implant rehabilitation treatment of the edentulous areas. Socket preservation procedure following tooth extraction will reduce the need for any further ridge augmentation technique prior to implant placement and will conserve the existing bone. The aim is to preserve the original bone dimensional contours by limiting the normal post extraction resorptive process.

The overall goal of this article is to provide the dental professional with valid tools in order to help them make a conscious decision considering the indications of this therapy and dependent on each clinical case.

Keywords: Extraction, socket preservation, implant, resorption process.

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Nowadays the outcome of implant surgery is measured by the long-term esthetic and functional success and not by the survival rate. A correlation exists between the hard and soft tissues in order to assure esthetic outcomes in implant surgery. Significant changes in bone volume and morphology following tooth extraction, can make implant rehabilitation very difficult, as the time from extraction to implant placement increases.

Bone substitute in alveolar ridge preservation and prevention of additional bone grafting is highly supported and has a wide range of advantages. The socket preservation technique allows the placement of implants in sites that was considered compromised in the past. Following the conservative extraction (Figure 1,2), a bone filler is placed in the empty socket with a cross or non-cross linked membrane (Figure 3) and closed partially (Figure 4) or totally by a flap only. It stipulates that a provisional preparation is sometimes mandatory in order to guide the healing process of surrounding tissues (Figure 5,6,7).

It was demonstrated that following tooth extraction the buccal bone plate will undergo some modifications due to bone remodeling. In order to reduce the bone loss, several surgical techniques have been proposed. Nowadays it is still possible to minimize osseous deformities problems by carrying out the ridge preservation techniques in extraction sockets and using bone fillers materials with barrier membranes. Today, the advanced wide range of bone grafting materials and collagen membranes guides us into taking in charge many compromised cases.

It was noted that the resorption of bone ridge is faster during the first six months following extraction, therefore a conservative approach remains necessary. Many measures should be taken into consideration when conducting the socket preservation surgery such as: reducing the extraction trauma and limiting the flap elevation. It was found histologically that bone formation occurs over the surface of the implanted osteoconductive graft fillers. This article goes through the technical basis for socket preservation procedure and exposes its importance as an available treatment in order to prevent ridge atrophy and optimize esthetics in the anterior maxillary area.

Clinical Case:
A 49-year-old female with a noncontributory medical history, presented to our clinic with a mobile tooth 21 and an apical resorption, the chief complaint was pressure in the upper anterior left area of the central incisor. Clinical examination showed tooth 21 mobile with gray coloration. Periapical radiograph examination revealed an apical resorption with an incomplete endodontic treatment (Figure 8). The tooth was deemed hopeless and referred for extraction with socket preservation for future dental implant placement.

After tooth was carefully removed with forceps technique (Figure 9), the extraction site was grafted with an osteoconductive bone graft (Figure 10, 11). A resorbable collagen membrane was placed on the buccal aspect of the extraction socket and sutured to the palatal flap to attempt a primary closure, with an exposed membrane left on the occlusal aspect of the extraction socket. A Temporary bridge was placed to guide the healing process and conserve the esthetic in the anterior region (Figure 12). After six months surgical re-entry during implant placement showed a good bony healing, that allowed the placement of a regular platform implant within the bony envelope (Figure 13), and achieved a good primary stability that allowed the placement of single piece, direct-to-fixture provisional screw-retained restoration on site 21 in order to guide the healing process (Figure 14,15,16).

A period of three months elapsed to permit osseointegration, afterwards the patient present for final impression (Figure 17,18), it was noted that the long axis of the implant correlated to the central fossa of the expected final restoration (Figure 19). The final restoration showed an ideal esthetic restoration with healthy surrounding soft tissues.

Discussion:
The failure to preserving the anatomy of hard and soft tissues will result in esthetic failures and compromises the final results. Araujo mentioned in a paper published in 2009, the use of xenograft in socket preservation techniques will delay the socket healing but will help at the same time to conserving the anatomy. Xenografts are considered the most used bone fillers in the socket preservation procedures due to their osteoconductive matrix framework which enhances the growth of new bone around it, as their name suggests. Following tooth extraction the buccal plate formed especially by bundle bone will experience more resorption than lingual and palatal ones and is considered the first to be absorbed. Loss of vertical ridge height will also occur less than the horizontal one, reducing the
The rate of residual ridge resorption is related to the time extended since the tooth was re-
moved.

Many factors such as trauma can cause loss of alveolar bone, since many extractions are
done with no regard for maintaining the al-
veolar bone volume. With time bone re-
 sorption will evolve up to 2 mm in verti-
cal and 4 mm in horizontal directions the first year following the extraction. An ar-
ticle published by Araujo in 2006, showed that implants placed directly after extrac-
tion will not preserve the dimension of the extraction sockets. In conclusion the sock-
et preservation technique led to an esthetic success for several reasons, the absence of gray hue in the free gingiva with the pres-
servation of the interproximal bone between tooth 10 and implant 21. The dimen-
sion of the preserved bone lead us to place a narrow neck implant in ideal position, the resulting occlusal forces did not cause any overload and conserved an excellent prog-
nosis. It was noted that ridge resorption in the mandible is more than the maxilla. To-
day many have investigated that BIC (Bone Implant contact) of the natural compared to regen-
erated bone. Trisi and coll. found that BIC in rough surfaced implants is enhanced with time up to 72%. Valentinii published an article showing that the BIC at the sites grafted with bovine bone fillers is greater than in the nongrafted sites. The aim of this article is to focus on the healing patterns of bone after socket pres-
servation techniques with focusing the light on the rationale for preservation of the di-
 mensions of the extraction sockets.

Conclusion:

Loss of teeth due to caries or traumas, of-
ten result in hard and soft tissue collapse, therefore the preservation of bone vol-
ume is of major importance in order to in-
sure the proper implant and esthetic reha-
bilitations. In order to insure the success of implant therapies, a sufficient volume of healthy bone at recipient site at the time of implant placement is mandatory.

Figure 10: Introral view of the socket of tooth 21 after been filled with porous bovine bone minerals. Figure 11: Periapical radiograph showing the xenograft in place in socket of tooth 21. Figure 12: Temporary crowns prepared in order to guide the healing of the surrounding tissue. Figure 13: Implant in place six months after the healing, the figure shows successful preservation of the ridge and placement of a regular platform implant. Figure 14: Temporary crowns placed on tooth 11 and a single piece, direct-to-fixture provisional screw-retained restoration on site 21 to guide the healing process.

Figure 15: Clinical view showing the healthy soft tissue surrounding the temporary crowns. Figure 16: Ideal biopsy of the surrounding soft tissue ready for impres-
sion. Figure 17, 18: Impression on the head of the implant simulating the surrounding soft tissue. Figure 19: Clinical presentation of the final esthetic result with the healthy surrounding soft tissues. The clinical crowns conserved the gingival architecture and met the patient’s esthetic demands.

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MEDIA CME – IMPLANT TRIBUNE
IDS 2013 – another step in the successful story of Dentegris Dental Implants

Cologne, Germany: The German Implant company with a wide portfolio of Biomaterials could proceed the expansion path of the past few months. Dentegris was overwhelmed by visitors during the IDS. The actual International Dental Show (IDS) brought a lot of inquiries to Dentegris. We express our gratitude to all our old and new customers and partners. On the basis of the rapid and huge increase of new partners in Europe and all over the world and the therefore required space Dentegris has changed the location and design of the booth. Both were appreciated by visitors and partners and was a part of the success story during IDS.

As a special program Dentegris has offered interesting lectures on actual topics, especially on Soft Tissue. The interaction of the new-designed Soft-Bone Implant and Biomaterials was one of the keypoints and proved the very successful combination. Particularly in but not limited to situations with regenerated bone. Soft-Bone Implants showed very good results. The speeches were highly cherished and lead to interesting discussions with the speakers. As a highlight of the program Dr. Harald Hueskens was showing interesting cases using the “soft tissue graft from the box”, MucroMatrix. Dr. Hueskens will soon be in the Middle East for some workshops of minimal-invasive soft-tissue augmentation.

Due to the success of the last months and IDS, Dentegris is now present in a wide number of countries in Europe, Middle East, Africa and Asia whereas Dentegris has been on the German market since the early 2000s. The two fields of Dental Implants and Regeneratives complete the portfolio that is needed in Dental Implantology.

Dentegris is still offering some opportunities in the Middle-East, so do not hesitate to contact us via www.dentegris.com. Finally the IDS was a great success for Dentegris, it went by too fast and everyone is anticipating the next edition which is unfortunately two years away! We hope to see you soon in the Middle East.

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IDS 2013 – another step in the successful story of Dentegris Dental Implants
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Phibo® expands Global International presence with a Middle East subsidiary

Press Release: Phibo®

Cologne, Germany: Phibo® with 20 years of experience in dental products and services, offers solutions from bone regeneration to the final prosthesis itself, without neglecting implant systems, and always taking patients’ health, comfort and aesthetics into consideration. Phibo® offers predictability in the results, optimisation of treatment times, reduction of the possibility of error, in short we ensure better quality for the patient.

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Phibo® is present in the international market stronger than ever. This year Phibo® is expanding its global presence into Middle East, Colombia, France, Germany and Benelux, including its nowadays operations in Italy, Portugal and Spain.

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Phibo® offers the most comprehensive CAD-CAM solutions: from cemented structures to restorations on implants, from hybrid structures to removable bars in all materials – Cobalt Chrome, Zirconia, PMMA, Titanium as well as cemented restorations in IPS e.max® CAD.
Interview: ‘All parties together to have one single Dental Conference’

by Dental Tribune Middle East & Africa

Muscat, Oman: During the Saudi Dental Society International Conference in Riyadh, Dental Tribune Middle East & Africa had the pleasure to interview Dr. Jasim Al Saidi, Chairman of the organizing committee for the Oman International Dental Conference 2013.

Dr. Jasim, how are the preparations going for the Oman Dental Conference taking place on 27th and 28th of February 2013 in Muscat, Oman?

Dr. Jasim Al-Saidi: This is the first Oman International Dental Conference, of which I am the chairman, and it is going to be really international as many of our speakers are coming from both abroad and Oman.

What are the main focuses of your Conference?

Mainly it will be focusing on new developments and studies related to dentistry in all specialties including Implantology, Orthodontics, Cosmetics and some major surgeries as well.

You refer to this as the ‘First’ Oman Dental Conference although there have been several in the past, could you explain your intentions?

You are correct, this is not the first Conference to be conducted in Oman in fact we have conducted more than 15 Conferences before, however the name of the conference has been changed to the ‘Oman International Dental Conference 2013’ because the organizing committee itself has been changed for this Conference. Usually it was run by either the Ministry of Health or the Oman Dental Society, but now we are gathering everybody – all parties together to have one single ‘Oman International Dental Conference.’

How many participants do you expect?

We are expecting to have around 700-800 attendees including dentists and dental related professionals.

Will your event include an exhibition?

Will we have an exhibition. In the eyes of Oman it is a good sized exhibition, but when compared to other big events such as IDS or SDS it is not that big of an exhibition. We are expecting approximately 30 companies for this event.

You mention you will have some international speakers as well as locals. Will there be any familiar faces?

We have a number of notable speakers coming to the conference that we are gathering from all over the world. Some of these include Professor David Wray and Professor Donald Ferguson from Dubai, Louis Hadany from Lebanon, Professor Jean Pierre Bernard from France, Dr. Nahid Jabour, Professor Mike Mulchay, Dr. Mohammed Sartawi. With this being said, we are hoping this conference will be the first of its kind and we plan on having this running every two years in the future.

Dr. Jasim, you are a dentist yourself. Could you share some of your personal experience?

I have been working as a dentist for the last 12 years and I find that it is a very nice but a challenging profession. You have to be prepared for a lot of challenges when approaching situations. Not everybody can be a dentist, you have to work hard and bear in mind that at some stage you will have some back pains and headaches due to the positions in which you work! Being a dentist on its own is a specialty.

What are your thoughts of the Dental Market here in the Middle East?

I think it is blowing up very, very quickly, even in Oman. However, the problem in Oman is that until now we did not have many specialists, we need to not only encourage but support dentists to pursue further education and chose a specialty. My opinion is to support them because not many people can do this by themselves. Many dentists require sponsorships in order to go abroad as it is expensive. If dentists had more opportunities to study abroad for sure they will do so.

What can you say about the education in Oman, at the moment? As you mention some of the top Dental Schools from UAE will have their deans lecturing at your event in February such as Professor Ferguson and Professor Wray. Is UAE an example for Oman regarding the development of Dental Schools?

Yes, to an extent. We have only one dental school at the moment that was established six years back only with the first group of graduates completing just this year. We are hoping that both the size and quality will increase over the coming years in Oman.

Dr. Jasim, is there anything else you would like to address to the readers of DTMEA?

Dear Dental Professionals. We invite you to visit our conference in the lovely city of Muscat, Sultanate of Oman for the Oman International Dental Conference 2013 on 27th & 28th of February, 2013. We hope that you will be part of this historic event and join us for many years to come in Muscat. Thank you. Thank you Dr. Jasim, we wish you all the best for your conference and in all your future events.

Thank you Dr. Jasim, we wish you all the best for your conference and in all your future events.

Dr. Jasim, is there anything else you would like to address to the readers of DTMEA?
Healthy Gums, Healthy Mouth, Healthy Smile

When talking to patients, many dental professionals find that although people are attracted to the idea of a sparkling smile, many still fail to take the time and effort to care for their teeth properly. Patients often make the mistake of thinking that not brushing twice a day or forgetting to floss every now and again won’t impact on either the health or aesthetics of their teeth and gums.

Getting the oral health message across loud and clear to patients can be difficult, but as a dental professional, you have an important role to play in educating them on how to manage their oral care regime. Your advice and professional recommendation carries considerable weight and a healthy mouth message needs to underpin any form of cosmetic treatment.

Healthy habits and good oral hygiene are crucial in the fight against gum disease, one of the most common dental problems that affect all 40-50% of adults worldwide and the major cause of tooth loss in adults. These statistics are evidence that a move to a more “prevention-focused” approach is required. Patients need to take more responsibility for their oral health and introduce effective, at-home oral healthcare regimes. The message of brushing twice a day, to benefit from good oral health, and prevent decay and gum disease, needs to be reinforced to patients.

Advice given by the dental team can go a long way in improving oral health, along with an increased awareness of the importance of good oral health and fluoride-based oral hygiene products. As well as the health benefits, it is also financially beneficial in the long term, as patients can avoid costly treatments and associated expenditures, as a result of problems that may have arisen from poor oral healthcare. Bad oral hygiene can affect self-esteem and, of course, general health, with studies discovering links between gum disease and heart disease.

One way in which dentists can advise patients to take care of their oral health and aid prevention is by recommending an at-home oral care regime, including toothpaste, that has been specifically developed to offer a unique gum protection system that helps prevent the causes and effects of gum disease.

Prevent rather than treat

The variety of toothpastes available means that many choose a brand based on how effective it is at targeting some of the most common dental problems, without giving a second thought to the ingredients and the effect they may be having on their teeth and overall oral health.

The continuous developments and options available within the market mean that there is not a one-size-fits-all solution but by gaining a thorough understanding of the ingredients inside the toothpastes, you can begin to help patients make a better choice. Educate patients to discover what’s actually inside their toothpaste by looking beyond the brand and fancy packaging, and instead into the ingredients so that they can see the effects they’re having on their oral health. Any toothpaste brand with the patient at the center of their product developments will be able to offer a solution for all common dental problems.

Bleeding gums can be a cause of vitamin and nutritional deficiencies, and toothpastes which contain Vitamin E (Tocopheryl Acetate), Pro Vitamin B5 (Panthenol) and B Vitamin Folic Acid, anti-inflammatory revitalising agents, will help strengthen the gums to keep the oral tissue healthy, whilst toothpaste which contains the ingredient Permethol will help reduce bleeding. A study by Osaka University, Japan, found improvement in infection and inflammation after 3 weeks of using a toothpaste with the ingredient co-enzyme Q10, helping fight bacteria to assist in the healing and repair of the gum tissue.

Toothpastes such as Beverly Hills Formula Dentist’s Choice Gum & Whitening Expert can actually help to combat gum disease. Specifically developed to help prevent the signs and effects of gum disease, this toothpaste boasts a unique gum protection system that contains Vitamin E to invigorate and strengthen the gums, fluoride to protect the exposed root area, and Permethol to help reduce and stop bleeding gums. Panthenol, Q10 and Folic Acid are also incorporated to help promote healthy gum tissues. The desensitising agent Potassium Citrate found within this advanced toothpaste quickly and effectively blocks the transmission of pain, offering fast-acting, long-lasting protection whilst delivering a healthy, white smile. Removing 98% of stains over a 5 minute period, this toothpaste is also proven to be less abrasive when compared with other leading brands of both whitening and regular toothpaste, protecting against tooth decay whilst restoring teeth to a natural, white colour without using harsh abrasives or bleach.

Thought For The Day

To summarise, by providing your patients with a healthy mouth message, in a language they understand (no dental lingo), together with preventive measures that can be easily achieved in the home, your patient’s can start to combat gum disease. In communicating this, you will be making a dramatic improvement to their personal, professional and social life, boosting their confidence to eat, speak and laugh with friends and family again.

Nominating a “gum health / mouth health” expert in the practice or hold a “healthy mouth” day/week/month; you’ll be surprised at how many patients will come forward to end their fight against gum disease. Leave flyers/brochures on gum disease and oral care around the practice, in reception or in the waiting room, and patients will feel more inclined to tackle the subject with you.

Contact Information

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Follow us on Twitter: @BHF_Whitening

Emirate. In Dubai they have chosen Dubai Festival City Mall on Thursday 28/3/2013 to have their activity. The activity included free Dental checkups, diet consultations, Dental education for brushing and flossing, Dental experiment and competitions. The activities attracted more than 200 participants from 4:00-9:00 P.M. and the sponsor company prepared gifts for all participants.

GCC Oral And Dental Health Annual Week

Dubai, UAE. Under the patronage of Mr. Nasser Al Budoor, director of Dubai Medical District in the Ministry of Health and in corporation with Signal 2, Dental Services Department in the Ministry of Health, Dubai, the GCC Oral and Dental Health week was held in Dubai, Festival City Mall on Thursday March 28th, 2013 with organization of internship program Doctors in Al Baraha Hospital and other Dental Centers in Dubai.

Dr. Aisha Sultan always stresses on the theme of (Prevention better than Curing), as part of the GCC Oral and Dental Health Committee representing UAE. Dr. Aisha and the committee aim to have a community free of dental diseases and spread healthy smiles over to all children and adults in the Emirates.

They have chosen certain programs for their objectives among schools and primary health centers and other organization like special need centers. They have chosen March as the month to hold their annual Dental and Oral health week. This year UAE had a different event in each of their annual events like free Dental checkups, diet consultancy, Dental education for brushing and flossing, Dental experiment and competitions. The activities attracted more than 200 participants from 4:00-9:00 P.M. and the sponsor company prepared gifts for all participants.
Three stars for maximum shade accuracy

Part 3: Shade reproduction and shade control has never been so precise or reliable

When fabricating high-quality dental restorations the aim is always to reproduce the tooth shade so accurately that there is no visible difference between the crown or subsequent restoration and the natural dentition. Whereas adapting the required tooth shade to the patient’s remaining den-
tition previously required painstaking mix-
ing of nuances, step-by-step adjustment and the experienced eye of a dental tech-
nician, thanks to VITA, shade reproduction is now part of a systematic process chain comprising shade determination, shade communication, shade reproduction and shade control (as reported in Parts 1 and 2 of this series).

In order to achieve an esthetically pleas-
ing restoration, determination of the tooth shade is thus equally as important as exact trans-
fer of the shade data to the laborato-
ry and the actual reproduction of the shade using the material in question. The final step then comprises the direct comparison of the reproduction with the order sheet, in other words verification of the restoration with regard to exact correspondence with the patient’s natural tooth shade.

Shade values at the touch of a button

Thanks to the option of digital shade taking using VITA Easyshade Advance, shade tak-
ing has become even easier and more pre-
cise. In a matter of seconds, the patient’s individual shade data is available at the touch of a button on the display, and can be saved, sent, and compared. Ceramists can use this device both for shade taking as well as during layering in order to verify the lightness, chroma and hue.

Three stars indicate accuracy

However, with Easyshade, subsequent vi-
sual inspection of a restoration is no longer an imperative; instead this can be performed based on a further digital measurement. All that is left for the dental technician to do is to compare the basic shade data taken with that of the control measurement in order to check whether the reproduced shade corre-
sponds to or deviates from the patient’s nat-
ural shade nuances. If the required restora-
tion shade is 3M1, for example, the digital
display of the Easyshade measurement de-
vice indicates how closely this shade has been matched in the reproduction with a rat-
ing of 1 to 3 stars. One star stands for “inade-
quate”, three stars for “precise”. If three stars
appear on the display this also means that the lightness, chroma and hue values mea-
sured are exactly within the limits for the re-
quired shade. If the values deviate, the den-
tal technician must rework their reproduc-
tion and measure it again. The technician

Fig. 1: Shade reproduction and shade control at the touch of a button using the digital VITA Easyshade Advance measurement device
can use the differences in details – “L” stands for “Lightness”, “C” for “Chroma” and “H” for “Hue” – in the restoration for this pur-
pose (Fig.1).

This procedure can be repeated as often as required until the result is satisfactory. The range of features offered by this conve-
nient, compact device is impressive: it pro-
vides reliable measurements within sec-
onds, in 3D-MASTER, VITA classical AI-
D4, and VITABLOCS shades.

The material selected by the dental tech-
nician for the restoration is not important here – a significant advantage of VITA ma-
terials is, however, that the system compo-
nents are perfectly adapted to one another. VITA also offers a comprehensive product range in this respect: prosthetic teeth, ve-
nering ceramics, acrylics, alloys and zirco-
ie are available from VITA in the VITA SYSTEM 3D-MASTER shades and in accor-
dance with the VITA Classic shade stan-
dard A1 to D4. The corresponding materi-
als are also available for the reconstruction of bleached teeth. And since June 2011, the polychromatic VITABLOCS TriLuxe and TriLuxe forte are also available in classical shades.

Optimum shade reproduction with feldspar ceramics

The CAD/CAM fine-structure feldspar ce-
ramic VITABLOCS RealLife (Fig. 2) has been setting new standards since June 2010 in high-esthetic anterior restorations.

The three-dimensional block structure of VITABLOCS features a dentin core and enamel shell and thus has a structure com-
parable to that of natural dentition. The cur-
volved gradient of shade between the in-
cisal and cervical areas in anterior dентi-
tion is thus replicated. A special software
enables the planned restoration to be po-
sitioned perfectly in a virtual block. Posi-
tioning is flexible, allowing adjustments in all three spatial planes and providing the dental surgeon and dental technician with maximum creative scope. VITABLOCS Re-
allife is available in a total of six VITA SYS-
TEM 3D-MASTER shades.

Shade reproduction requires a solid basis

In terms of shade reproduction, VITA has also launched a new shade concept this year for coloring frameworks made from VITA In-Ce-
ram YZ - the new VITA In-Ce-
ram YZ COLORING LIQUIDS.

The new concept comprises the basic shades “light” and “medium” that allow shade re-
production in accordance with the VITA SYSTEM 3D-Master and VITA classical AI-
D4 shade system, as well as the additional

DENTAL TRIBUNE | Middle East & Africa Edition | March-April 2013

8TH CAD/CAM & DIGITAL DENTISTRY INT’L CONFERENCE, DUBAI, UAE, 02-03 MAY 2013

see the INDUSTRY at...

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VITA SUPRINITY - the new generation of glass ceramic

Press Release: VITA

With the zirconia reinforced lithium silicate ceramic, in short ZLS, VITA Zahnfabrik has developed a new genera-
tion of glass ceramic materials in collabora-
tion with Degudent GmbH and the Fraunhofer Institute for Silicate Research ISC.

The new glass ceramic is marketed by VITA Zahnfabrik under the name of VITA SUPRINITY. With a zirconium dioxide content of around ten times that of traditional CAD/CAM glass ceramic in combination with a particularly fine-grained and homo-
genous structure, ZLS ensures excellent mechanical properties. The high strength and reliability of the new material gives CAD/CAM practice and laboratory users a wide range of possibilities for application.

VITA SUPRINITY is distinguished by its outstanding mechanical strength and is also highly user-friendly. The new glass ce-
ramic allows easy manual reworking and excellent polishing, and can also be crys-
tallized without auxiliary firing paste. Fur-
thermore, its optimum edge stability en-
sures improved precision. The end results are esthetically impressive with their nat-
ural translucency, fluorescense and opales-
cence. With a wide range of indications in-
cluding anterior and posterior crowns, su-
pra-constructions on implants as well as veneers, inlays and onlays, the new gen-
eration of glass ceramic is highly versa-
tile. The material is available in the geom-
estatures LSI4 (18 x 14 x 12 mm) for the CEREC inLab MC XL system in the shades
(M1, A1, A2, A3.5, B2, C2 and D2, each try for LS14 (18 x 14 x 12 mm) for the CEREC

Fig. 2: Nature shows the way: new CAD/CAM an-
terior esthetics in three dimensions with VITABLOCS RealLife

VITA SUPRINITY

New: the zirconia reinforced lithium silicate ceramic VITA SUPRINITY (Photo Courtesy of VITA

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addition to this, the new CAD/CAM fine-structure feldspar ceramic VITA VM 11 was devel-
oped especially for the individualization of restorations made of the new glass ceramic. The market introduction of VITA SUPRIN-
ITY, together with the low-melting veneer-
ceramic and the special polishing in-
struments, is scheduled for autumn 2013.
By Dr. Derek Mahony

How We Got from There to Here and Back

20th Century allowed clinicians to encase all of the teeth with bands and solder attachments that could control the horizontal rotations. Angle developed a popular attachment known as the pin and tube attachment in 1911 (Figure 3), and it satisfied many of the requirements of clinicians; but this demanded unusual dexterity, patience and skill, so dental clinicians evolved to a ribbon arch bracket (Figure 4), which Angle introduced in 1916. It provided good control in two dimensions and became popular quickly. The ribbon arch attachment also marked the first time orthodontic attachments gained the name bracket.

From the inception of this specialty, with Dr. Angle, diagnosis never had too much importance because everyone received the same nonextraction treatment with the same expansive appliance. The marvel of it all is that the collection of orthodontic records never became important. A few months ago an orthodontist boasted that since invoking a different treatment regimen, he was treating 98% of his patient’s nonextraction. One was tempted to ask if he still took records because with diagnosis certainty such as that, records are clearly redundant. Orthodontists shouldn’t waste patients’ time and money taking impressions, cephalometric X-rays or doing treatment simulations if all treatment plans are essentially the same. One doesn’t need orthodontic records to come to such a preconceived conclusion.

Obviously, this one-size-fits-all treatment planning didn’t benefit patients a hundred years ago, and it doesn’t in our own age. But such simplicity continues to hold enormous appeal for many orthodontists. Orthodontists pride themselves in being scientists, and without doubt they receive good training in the scientific method; but it takes very little anecdotal information to eclipse the scientific judgment of many in the profession. Albert Szent-Györgyi was probably more right than he knew when he said, “The brain is not an organ of thinking but an organ of survival of a way as to make us accept as truth that which is only advantage.”

No matter how spectacularly orthodontic therapy changes, it will benefit our patients minimally if we do not have a concomitant improvement in our diagnostic and prognostic knowledge. This remains the number one imperative for those who practice orthodontics. Orthodontists should view any new therapy unaccompanied by equally sophisticated diagnostic knowledge suspiciously. Patients have already received far too much orthodontic treatment and far too little diagnosis.

Instrumentation

The first attempts to correct malocclusions used simple large arch wires ligated to the malposed teeth. Pierre Fauchard of France developed the precursor of the modern appliance – expansion arch (Figure 1).

This arrangement gave only tipping control, in one dimension, and soon proved inadequate for controlling rotations. In 1887 Edward H. Angle introduced the E arch, i.e. expansion arch that used a labial wire supported by clamp bands on the molar teeth which ligated to the other teeth (Figure 2).

Metallurgical developments by the early 20th Century allowed clinicians to encase all of the teeth with bands and solder attachments which could control the horizontal rotations. Angle developed a popular attachment known as the pin and tube attachment in 1911 (Figure 3), and it satisfied many of the requirements of clinicians; but this demanded unusual dexterity, patience and skill, so dental clinicians evolved to a ribbon arch bracket (Figure 4), which Angle introduced in 1916. It provided good control in two dimensions and became popular quickly. The ribbon arch attachment also marked the first time orthodontic attachments gained the name bracket.

When Angle launched the ribbon arch bracket, he had already started work on the edgewise bracket primarily as a supplement to his ribbon arch appliance. Nevertheless, the edgewise bracket did not suddenly spring full-grown from Angle’s fertile mind, but slowly evolved with several iterations (Figure 5). When Angle realized that this bracket could deliver three-dimensional control of the teeth with horizontal, one directional placement and simultaneous engagement of all the teeth, he changed the bracket several times until he achieved the #447 (Figure 6) in 1928. It received early and enthusiastic endorsement.
from dental clinicians throughout the United States and eventually eclipsed other useful orthodontic appliances such as the McCoy open tube appliance, the Atkinson universal appliance and the Johnson twin wire attachment.

The universal application and durability of the edgewise bracket confirmed Angle’s modest claim that it offered the “latest and best in orthodontic mechanisms.” Innovative orthodontists added minor but practical trimmings such as rotating wings, twin brackets, different dimensions, preadjusted appliances, lingual applications, etc., but the essence remained edgewise. For any instrument, particularly in the health sciences, to remain virtually unchanged (and almost as useful for close to a century) approaches unbelievable. In the auto-mobile industry, this would be equivalent to the Model T Ford remaining as the epitome of motoring sophistication.

Other than adding wings and doubling the bracket to make the popular twin edgewise bracket, Angle’s invention has remained basically unchanged. Holdaway suggested angulations for brackets to help set anchorage, parallel roots and artistically position teeth, while Lee built some ante-diluvian brackets to help set anStraight Wire Appliance.

Low-force titanium coil expanders have shown their ability to develop arches laterally, and recently Damon suggested that low arch wire forces, coupled with a passive tube and a small wire-to-lumen ratio, enable teeth and their accompanying dentotraumas to expand in all planes of space. Damon feels that using small, low-force wires such as those of Copper Ni-Ti (Ormco Corporation, Orange, CA) achieves the ideal biological forces proposed long ago by several investigators. Self-ligating brackets that essentially form a tube developed several decades ago with the Ormco Edgelo being the first, closely followed by the Speed bracket. Both of these early self-ligating systems suffered from the fact that the Straight-Wire Appliance phenomenon debuted at the approximately the same time, plus a lack of appreciation for what the newer titanium wires could achieve.

Damon has persisted since 1995 with his version of a self-ligating bracket (Figure 5) and has fundamentally changed the types of arch wires and the sequence in which clinicians use them. His experience has shown that with many patients he can often eliminate distalisation of molars, extractions (excluding those needed to reduce bimaxillary protrusions) and rapid palatal expansion. He offers compelling clinical evidence of doing this with consistency.

The Damon bracket is essentially a tube designed with the right dimensions to foster sliding mechanics where needed and enough play in the system for torque and rotational control using the larger cross section wires. Damon starts cases with a large lumen arch wire slot and 0.014 or smaller diameter-technology arch wires. Starting cases with a large dimension passive arch wire slot and small diameter wires diminishes the divergence of the angles of the slots. This lowers the applied force and binding friction.

Damon has consistently reduced arch wire forces, coupled with a passive tube and small wire-to-lumen ratio, enabling teeth and their accompanying dentotraumas to expand in all planes of space. Damon feels that using small, low-force wires such as those of Copper Ni-Ti (Ormco Corporation, Orange, CA) achieves the ideal biological forces proposed long ago by several investigators. Self-ligating brackets that essentially form a tube developed several decades ago with the Ormco Edgelo being the first, closely followed by the Speed bracket. Both of these early self-ligating systems suffered from the fact that the Straight-Wire Appliance phenomenon debuted at the approximately the same time, plus a lack of appreciation for what the newer titanium wires could achieve.

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The most logical questions readers could propose would be: why has Damon shown successful expansion whereas Angle did not? The quantity of expansion probably differs little, but the quality of expansion offers a quantum change. Mollenbaur has suggested as much with his appeal for light forces. Even though Angle used a ribbon arch, (which suggests a thin, delicate wire) the actual size of the wire had the dimension of 0.03 x 0.022 inches. Ligating to this wire would overwhelm the periodontium and prevent the development of a supporting dentoalveolus. Rather than forming new bone, the supporting dentoalveolus would simply bend and upon completion of treatment quickly return. Astute clinicians often see this with molar distalisation from headgear use and over treat such movement in order to compensate for this regressive bone bending.

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Schwartz stated that it takes 20 to 26 g/cm² of force to collapse the capillaries in the Periodontal Ligament. With RPEs and headgears this force sometimes exceeds 10 pounds! Painful! Painful! Painful!

Orthodontists are currently witnessing an interest in qualitatively different expansive biomechanics that offer patients the possibility of obviating the use of dialusters, rapid palatal expanders and many needless extractions. The bracket systems that make this possible should command the utmost respect and clinicians should use them as recommended with light forces.

I am witnessing shorter treatment in most of my Damon cases with less discomfort to my patients. The playing field seems to be leveled between adults and children. These changes I am seeing are more than enough reasons for me to question my previous orthodox systems.

Reference is available upon request. Please contact deyanov@dental-tribune.com for further information.
7th Saudi International Orthodontic Conference

The conference itself started on the 19 Feb, with the opening ceremony where Prof Suliman Alomaran, Head of SOS welcomed the distinguished guests, delegates, speaker and society members to this year’s meeting. He also summarized the achievements of the SOS Board through the last 3 years. This year is the last year of the board and handing over of responsibilities will be given to the newly elected board at the end of the meeting. The opening ceremony was followed by an important lecture titled ‘Critical evaluation in orthodontic appliance’ by Prof W. Proffit where he gave a summery of his 50 years experience with fixed appliance and what are the changes that the orthodontists could expect in the coming years.

This was followed by an interesting lecture of “Overview of CLII treatment” which was given by Dr. Tamer Buaysham from where he presented the clinically proven technique for treating CLII cases backed by number of cases that he treated himself for ranging from children all the way to adulthood and which technique has shorter time than the other. Since the temporary anchor device is to get much attention these days, Prof W. Proffit later on the day lectured on a lecture on “UNC experience with screw and mini plate”, thus giving the pros and cons of them with keys of success illustrated by some multiple cases showing perfect results and decreasing the need for surgical intervention with Orthodontic.

The first day was wrapped up by Dr. Robert Boyd lecturing on “Orthodontic and Esthetic consideration in planning and placement of Restorative Implants” where he stressed on the more demanding of aesthetic consideration in planning and placeing transverse problems and CLIII easier, which used to be thought that the main cause behind it is primary teeth. Then Dr. Hadi Almowad took the stage to speak on “Genetic in Orthodontic” and how the advancement in this field could aid in prediction and reducing malocclusion.

The second day of the conference Prof William Clark is who the inventor and developer of the famous twin block function-al appliance which is the most used one to correct CLII skeletal discrepancy in growing individuals. In his lecture Prof Clark took the audience through the different steps of diagnosis and treatment utilizing twin blocks with minimal and/or no need for fixed appliance.

He stressed the importance of patient selection, motivation and instruction to the success of treatment with such devices. The audience interacted with this lecture since some of them had there doubts about this method but Prof Clark explained to them the keys for success using this method.

Dr. Robert Boyd concluded the morning session with a talk on “How can aligners be used for complex Orthodontic cases” ranging from extraction cases to correcting of much hard vertical cases in adults with good prognosis and lasting stability. The afternoon session was dedicated to future promising subjects in Orthodontics such as distraction cheloplasty where Dr. Abdullah Alalawi spoke from his surgical background as a Craniofacial Surgeon how this minimal procedure could improve the smile dramatically without the need to more complex Orthognathic surgery involving cutting of bone or augmentation. The audience listened with attention on how to select cases for such a procedure and how the procedure is done in a very short time under one hour in some cases. Later that day Dr. Sarah Alajeh spoke on “Constraints on tooth growth by developing alveolar bone” where she pointed the causes of such problem, which used to be thought that the main cause behind it is primary teeth.

Then Dr. Chad BOTAI also took the stage to speak on “Genetic in Orthodontic” and how the advancement in this field could aid in prediction and reducing malocclusion.

The 2nd day of the conference concluded by a lecture Given by Prof Clark where he spoke on “New horizons in Orthodontic and Dentofacial Orthopedics”, he highlighted the latest development in Orthodontic thus his talk raised different questions from the audience about the technique presented and how to use them for the best benefit for the patient and practitioner. This led to the time scheduled for the lecture to extend to more than ½ hour then the scheduled time.

The conference was followed by a post conference course with the title of “The Forces System: Advance in fixed appliance technique. New technique for lingual arch developing” where Prof Clark spoke for over 6 hours over the whole day on his new invention Forces System which makes correct transverse problems and CLII easier through utilizing the lingual arch developing technique which gives faster and more repayable results as was explain by Prof Clark in comprising to fixed appliances placed from the buccal side. Accompanying the 7th conference was an exhibition dedicated for Orthodontic products and new advancements in this field with over 14 local and international companies which captured the interest of all 500 participants who attended the conference. The 7th Saudi Orthodontic conference was up to the level of expectation and gain satisfaction on venue, speakers, and overall organization which showed clearly from the feedback of the attendees. With warm smiles the participants said farewell to each other hoping to see one another around the same time next year at the 2014 annual meeting.

Acknowledgment:
Sincere gratitude is paid to Dr. Abdulaziz Alkhunaini and Dr. Mohamad Alharbi for their most valuable effort in preparation of this report.

Contact Information
Dr. Khaled Abouseada, BDS, MS, Orthodontics cert, is consultant orthodontic who is involved in private practice in Saudi Arabia, Bahrain and Egypt plus teaching orthodontics in BMC and SAMAT. He graduated from Alexandria University in 1993. Fellow of the World Federation of orthodontics and member in multiple regional and international orthodontic associations. Dr. Khaled has to his credit, various publications in national and international journals. He has lectured at many international and national dental and orthodontic forums. Winner of I LOVE MY DENTIST AWARD 2010 and 2011 and MY DENTIST AWARD 2010 and 2011 and MY DENTIST AWARD 2010 and 2011. Being the proud holder of 4 international certifications in different CAD CAM aligners systems and also practicing CAD CAM lingual and labial orthodontics, he is also a certified trainer for CAD CAM aligners, those years of practice make him one of the most experienced doctors in the continent to have practiced orthodontic CAD/CAM therapy.

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I am constantly striving to implement the critical initiatives required to meet and exceed my reader’s expectations. Working with my burning desire to be influential in introducing scientific excellence embodied in a prominent professor who is creating a superior system of leadership and interest. I have the honor to introduce with grace and respect Prof. Dr. Abbas Zaher, a celebrity who is acclaimed to worldwide attention.

I will definitely focus in my valuable interview on the professional artist who with his tremendous knowledge and vast experience is well known for creating natural and flawless smiles on peoples faces after reshaping their dental flaws bringing the face into better proportion with his talented excellence thus he is doing not just their teeth but their whole being. But I will also stress on his remarkable prominent role as a widely regarded professor in the Faculty of Dentistry, Alexandria University. I was blessed to be one of his students in Alexandria who learned from his endless priceless wisdom and group tense updates about new launches, his ethics in orthodontic principles of medical practice thus setting an unexampled expertise for highest standards of performance and commitment. I cannot disregard mentioning his extreme graciousness and friendliness extended to all his students allowing them to reach continuous learning and training, motivation, awareness and appreciation of the value of orthodontics and its welfare in Alexandria and the whole region.

You have definitely thought of other career paths before considering orthodontics, would you talk to us about them. This is a story, I always like to tell! When I was a high school student I was dreaming of a career in hotels and restaurants management. I like domain of customer’s service and I had a lot of guidance to exercise dentistry. I guess my fate directed me to the Faculty of Medicine for one year and later on to the Faculty of Dentistry. Exercising dentistry in this field has made me orientated to satisfy my patient’s (customers) main concerns. I think it is very important to customize your treatment plan to cater to the patient’s needs rather than only what you see as necessary treatment. Were there any teachers or other people who stand out in your mind as encouraging you to pursue this career.

Professor Mahmoud El Hadary, the Dean of the Faculty of Dentistry and later the President of Alexandria University, was instantaneous in guiding and leading me to exercise dentistry as a career and throughout my studies in the Faculty. He encouraged me to be involved in the students’ activities and participated in many related competitions. His supportive advice in choosing to study orthodontics put me on the first steps in my current path. Professor Samir Aboul Azm, the Head of the department of Orthodontics in Alexandria University, at that time, influenced my early years in the department. He had a vision for the specialty and was instrumental in bringing me into the service of the profession and the specialists. Since then I have assumed a role in the Egyptian Orthodontic Society Board of directors. The one person, who had great impact on my professional attitude and concepts, was Professor Samir Bishara. He was an active participant in our PhD studies in the University of Iowa. He implanted the scientific seed in my way of thinking in orthodontics and in my academic carrier. Professor Bishara was the first and my mentor, these three prominent teacher were my god fathers in my professional life.

It would be highly appreciated if you give us your thoughts on orthodontics and considering to shape his or her future with a career in orthodontics.

First do not consider malocclusions as the problem. Malocclusions happen to be attached to a person’s mouth. These persons are seeking your help to improve their smiles, looks and self-esteem. My first advice is to handle the problem. The classifications are designed to facilitate communications with colleagues but are never the basis for your treatment plan. There are no two alike patients. Measurements and cephalometrics analysis gives you an idea about the extent and the trend of the problem. Do not attempt to treat patients to cephalometrics “norms” or averages. Tailor the treatment plan according to individual and consider the aid from other specialists as needed. Always relate your ideas to your patients before the start of the treatment and do not surprise them with the need for adjunctive procedures at the end of treatment.

You are a well-known entity in the orthodontic science, how much of you are there in this field?

My patients are occupying a large part of my professional life, after that, I can easily say that in the field of orthodontics I am divided between Scientific research and teaching, and looking after the specialty welfare in Egypt and at the international level. I enjoy teaching to graduate students and conducting researches that attack clinical problems. In this respect, I also enjoy travelling and lecturing about evidence based clinical knowledge.

In what way your fruitful knowledge and rich experience will assist you in handling your responsibilities in the Egyptian Orthodontic Society? It would be appreciated if you inform us on what your work revolves around in this organization.

Travelling around the world whether to attend conferences or to lecture gave me great opportunities to interact with colleagues from various backgrounds. Also participating in the organization of several international events which is helping put, the society at the international levels. In addition, personally knowing the renowned international speakers facilitates the organization of scientific meetings for the society and inviting excellent speakers. I was elected to serve on the board of directors of the World Federation of Orthodontists for ten years and from 2015 to 2010 I served as Vice President of the WFO. During those years I gained experience in the governance of an international association, which also help in the organization of the specialty in our country. We are currently building the Egyptian Orthodontics Federation in order to supervise the level of the service of Orthodontics for the Egyptian patients.

Would you talk to us about your experience as being vice president of the World Federation of Orthodontics?

It was most enriching experience. Besides being involved in the governance of one of the largest specialty organs during my PhD studies in the University of Iowa. He implanted the scientific seed in my way of thinking in orthodontics and in my academic carrier. I had the privilege of being associated with a board of trustees made of a dedicated and talented group of individuals. Each and all of them had an impact on my professional development. It was an opportunity to join in the establishment of two very important documents by the World Federation of Orthodontists; the international board of orthodontics and the guidelines for orthodontic education. In addition, I had the chance to meet with accomplished colleagues from almost every corner of the world. This also was an opportunity to extend help and assistance in the formation of first time specialty organization in many parts of the world. Now, I have traveled to all continents and a major part of the globe. I can say that I have developed friendships in almost every corner of the world. And that is the most benefit I received from my service on the WFO board for 10 years and I treasure it tremendously.

Please identify your goals and ambitions for the next 2 years and your plans to achieve them and cultivate your profound knowledge in implementing them.

My goals for the Egyptian Orthodontic Society include; establishing the already agreed upon Egyptian Board of Orthodontists, in addition, to devise an awareness plan for the general public about the facts of orthodontic treatment and the training and studies in order to become specialized in orthodontics. These two ambitions are maintained the assistance of my members and large amount of funds.

There are conflicting studies that were rarely clear-cut, would you like to talk about any of them?

What contemporary scientific issue are you most concerned about now?

I am most concerned with scientific research that will directly apply to our clinical practice. Some of the interest that I have that is interested in is the enamel conservation during and after orthodontic treatment. My studies include, prevention, de-calcification, treatment of early enamel de-calcification, bacterial growth and control during treatment, enamel color change after treatment and what would influence it, 3D imaging and its application, orthognathic surgery and finally multidisciplinary treatment.

What is the best part of the work you do that gives you the most satisfaction? Conversely what is the downside of your work?

I enjoy tremendously my clinical work. Dealing with patients and changing their lives is my passion. I am lucky to have my work as my hobby. Teaching is another passion of mine. It is a pleasure to interact with the residents; they are always amicable and keep me motivated. On the other hand, I don’t like the administrative part of working at the faculty. I dislike reports and completing forms. but I love to handle each patient as an individual.

Do you know where your strength lies?

My strength in orthodontics lies in being critical and observational. As I say in my lectures: “Orthodontics is the art of seeing”. I can see the problem then you can solve it and treat it in order to achieve the level of the service of Orthodontics for the Egyptian patients. Would you talk to us about your experience as being vice president of the World Federation of Orthodontics?
A Comparison between Submucosal Connective Tissue Palatal Flap and Conventional Pedicle Palatal Flap for the Closure of Oroantral Fistulae

by Dr. Feraz Yabroudi

Abstract

Background and Aim: Oroantral communication and subsequent formation of oroantral fistula is a common complication of dental extraction and/or other oro-facial surgeries. Many surgical procedures have been used for the treatment of oroantral fistula, and it is believed that long term successful closure of oroantral fistula depends on the technique used, the size and the location of the defect. The aim of this study is to evaluate the success of the submucosal connective tissue palatal flap technique compared to the conventional pedicled palatal flap technique in the closure of oroantral fistula.

Materials and Methods: Ten patients suffering from oroantral fistula were recruited in the study, and they were divided into two groups. The first group was treated with the conventional pedicled palatal flap technique, and the second group was treated with the submucosal connective tissue flap technique. Suitable post-operative care and observation in both groups were achieved.

Results: It has been shown that all fistulae were closed successfully in both groups. There was no discomfort and no burning sensation in the second group. They all showed relatively faster healing. Interestingly, patients in the second group needed fewer amounts of post-operative analgesics than in the first group.

Conclusion: Both types of flap techniques provided sufficient and successful closure of oroantral fistula. However, submucosal connective tissue palatal flap seems to be preferable for fistula closure because it overcomes the disadvantages of the full thickness palatal flap. Compared with the conventional palatal flap, submucosal connective tissue palatal flap technique may appear to be more difficult in terms of flap manipulation. The surgical experience plays an important role at this level.

Key words: oroantral fistula, palatal flap, tooth extraction

Introduction

Oroantral fistula (OAF) is the communication between the maxillary sinus cavity and the oral cavity through a perforation in the sinus wall. The term oroantral communication comprises two pathological conditions; the acute oroantral perforation and the chronic oroantral perforation. Acute oroantral perforation is the result of a surgical procedure or injury to the maxillary sinus. Chronic oroantral perforation occurs in the maxillary sinus after secondary epithelialization and budge of soft tissue is created at the axis of rotation. In trials to overcome these problems, submucosal connective tissue palatal flap technique was used successfully and provided mucosal flap to cover the raw area. The aim of this study is to evaluate the success of the submucosal connective tissue palatal flap compared to the conventional pedicled palatal flap in the closure of OAF.

Materials and Methods

Ten patients suffering from OAF were recruited in the study. They were collected from the oral surgery clinic of Oral surgery and were divided into two groups, G1 and G2. Each group contained five patients. The first group was treated with the conventional pedicled palatal flap technique, and the second group was treated with the submucosal connective tissue flap technique.

A comprehensive history was collected from the patients considering the cause and onset of OAF, and about the duration of the condition. The clinical examination of the patients included the observation of remarkable features such as regurgitation of liquids from the mouth into the nose, which is the most common complaint, unilateral epistaxis, alteration in the resonance of the voice, inability to blow-out the cheek, difficulty in smoking, and foul or salty unpleasant taste. X-ray examinations revealed the presence of a fistulous tract connecting the oral cavity with the maxillary sinus.

After suitable anesthesia, in both groups of patients, the OAF was prepared by excising the epithelium from its margins and by determining the mucoperiosteum on its buccal aspect, followed by removal of diseased bone if present, so that the flap would rest on bone tissue and thus enhance successful closure.

The first group (G1) was treated with conventional pedicled palatal flap (also known as palatal advancement flap). Briefly, the flap was extending anterior and large enough with the base of the pedicle over the greater palatine foramen. The flap started approximately in the middle between the ginvogpalatal and the median palatal nare. This flap is rotated across the fistula so that its anterior suture line rests on the buccal side of the fistula (Figures 1 and 2).

The second group (G2) was treated with palatal submucosal flap. This technique is considered as a modification of the previous procedure and was achieved by separating the full thickness palatal flap into a mucosal layer and an underlying connective tissue layer.

The submucosal connective tissue flap was used to close the fistula, and the mucosal part of this flap is then returned to its original position and sutured in place to obtain primary closure (Figures 3 and 4).

The patients were post-operatively instructed to avoid any actions which may cause negative or positive pressure inside the sinus (e.g. drinking tubes, blowing the nose, sneezing with opened mouth, etc.). Antibiotics were also prescribed to avoid infection for 5-7 days, and analgesics to relieve pain. Decongestant nasal drops and inhalants to shrink the nasal mucosa and promote healing were advised, as well as normal saline mouth wash after 24 hour post-operatively. Sutures were removed after 10-12 days post-operatively.

Immediate evaluation of the surgical procedure and consequences was done at the day of the operation after complete recovery and then one day after the operation through clinical objective findings including: 1) Bleeding (ranging from no bleeding to active bleeding), and 2) Pain, could be evaluated by the amount of analgesics consumed per day.

Late post-operative evaluation was conducted in the follow-up once a week up to 4 weeks. The evaluation included healing, color of the flap, texture of the tissue, integrity of the suture line, signs of flap epithelialization, infection, pain, headache, numbness of the operated area, fistulae reoccurrence (if recurrence occurred, it would appear at the time of suture removal and not later), posterior nasal discharge and/or maxillary sinusitis, chewing and swallowing difficulties, and speech problems.

Results

Clinical results in G1

During the immediate post-operative period, all patients were complaining of pain and burning sensation with discomfort during chewing and swallowing. The early postoperative period started directly after the end of the operation till the end of the first week. All patients showed slight bleeding in the early post operative few hours.

The late observation period extended for three months. By the end of the second month the flap was healed and the raw area was covered and there was no complaint from the patient.

Clinical results in G2

During the immediate post-operative period there was no bleeding at all, no discomfort during eating, which might be presented due to the absence of bulky palatal soft tissue mass, no raw area, and no burning sensation.

The late observation period showed that the fistula was completely closed in all the patients at the time of suture removal. The edges of the flap were healed, and the granulation tissue changed into a former granulation tissue during the second week and it became completely epithelialized, with slight contraction and shrinkage. By the end of the third week the submucosal layer became completely healed and its color

Fig. 1: Preoperative photographic of fistula with 1 month duration. Fig. 2: Rotation of the palatal flap to cover the defect. Fig. 3: Preoperative photographic of fistula with 2 year-duration

Fig. 1: Preoperative photograph of fistula with 1 month duration. Fig. 2: Rotation of the palatal flap to cover the defect. Fig. 3: Preoperative photograph of fistula with 2 year-duration
started to return to the normal color of the mucosa.

**Final general results**

It has been shown that all fistulae were closed successfully in both groups. There was no discomfort and no burning sensation in G2. They all showed relatively fast healing. Interestingly, patients in G2 needed fewer amounts of analgesics than in G1 (Figures 5 and 6).

**Discussion**

The oroantral communication is a rather frequent complication of oral surgery in the maxilla. Most of these complications can be treated adequately at the time of occurrence. However, some of them become chronic later. This is more common in the upper right region and in the upper first molar region. Other cases are due to extraction of premolars or molars in the upper third molar region. Oroantral fistula in the alveolar ridge of the molar region can also occur after extraction of cysts, or surgery for treatment of maxillary sinus. Such openings are difficult to be closed surgically.

In our study, cases of oroantral communication had developed as complications after teeth extraction with a percentage of 80.2% of the communications resulted after removal of the upper first molar, four cases due to extraction of upper right first molars, four cases due to extraction of upper left first molars, one case due to extraction of upper right third molar, and one case due to extraction of upper right second premolar. Killey and Kay (1967) analyzed 250 cases of OAF. They found that 50.4% of the cases occurred after the removal of the upper first molar.

Hirata et al. (2001) mentioned that the perforation rate occurred most often after extraction of upper first molar, and that it was significantly higher in males who were in the third decade of life.

In our study, male to female ratio was 1:1, and the age range of the patients was between 25 and 59 years with an average of 40 years.

It seems to be that the incidence of OAF is more frequent in elderly patients. Pumwistikorn et al. (1994) noted that the elder the patient, the higher the chance of having OAF. Most of the fistulae are an equal degree of success and failures.

A modified palatal flap technique has been introduced and successfully used in eight patients for closure of OAF. Successful closure of OAF is dependent upon the following principles:

- Control of maxillary sinus infection.
- Removal of as much of the epithelial lining of the fistula as possible, making sure that there is a raw surface throughout the perimeter of the wound.
- Maintenance of adequate blood supply to palatal pedicle flap with minimum tension on the flap.
- Causation of minimal trauma to the pedicle flap, and the tissue around the OAF.
- Use of a nasal antrostomy, with or without a Caldwell-Luc procedure, to ensure adequate sinus drainage.

Gordon and Brown (1992) mentioned that the treatment of OAF was considered suc-

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**Modern eating and drinking habits increase the exposure of tooth enamel to dietary acid that can lead to Acid Wear (erosive tooth wear), the biggest contributor to tooth wear.**

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**Not all toothpastes are the same.**

In laboratory experiments Pronamel's optimised formulation ensures more fluoride is available at the patient's tooth surface to protect from the effects of acid. Pronamel compared to other toothpastes with the same marketed fluoride levels.

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Successful when primary healing had occurred at the time of suture removal. In our study ten cases of OAF were treated with two different types of palatal flaps, all fistulas had successfully closed without recurrence, primary healing had occurred at the time of suture removal. In all of the cases, neither nasal antrostomy, nor Caldwell-Luc procedure was used. Adequate sinus cleansing was performed by applying irrigation with antibiotics for at least five days, accompanied by vaso-constrictive nasal drops after complete excision of the epithelial lining of the fistula track through the bone defect toward the maxillary sinus, and removal of all pathologically-changed maxillary sinus mucosal tissues.

Further support to our technique was given by Car and Juretic (1998) who achieved successful closure in 38 cases of chronic Oroantral fistulas. They also mentioned that Caldwell-Luc drainage into the nose prolonged the procedure and made it more difficult. Moreover, postoperative edema and hematomas were more pronounced.

Varied palatal flap techniques based on the position of the greater palatine vessels have been advocated. These can be divided into advancement flaps and rotation advancement flaps. Straight advancement flaps do not offer great mobility for later flap coverage.

Palatal rotation advancement flaps require mobilization of large amounts of palatal tissue because of the inelasticity of the tissue. This flap also has the disadvantage of tissue bunching at the base and causing a large area of palatal bone to be exposed. This was further proven by results of our study, since all the patients of G1, who were treated with the palatal rotation advancement flap, had discomfort during swallowing and talking due to the presence of soft tissue bulge in the palate, and burning sensation from the raw bone area until complete epithelialization. However, all of the patients in this group showed successful closure.

Herbert (1974) pointed out that for a large fistula, when local tissue is unavailable, palatal tissue-dependent flap is the method of choice. The palatal flap technique results in successful closure of the fistula with maintenance of an adequate blood supply without reduction in the depth of the buccal maxillary vestibule.

Anavi et al. (2003) gave further support for the palatal rotation full-thickness flap. They concluded that the palatal rotation advancement flap is recommended for the late repair of OAF owing to its good vascularization, excellent thickness and easy accessibility. It also allows the maintenance of the vestibular depth, and is particularly indicated in cases of unsuccessful buccal flap closure.

Gullane and Arena (1998) provided the main advantages of the palatal mucoperiosteal flap including a local tissue with good blood supply, excellent mobility, limited impairment of speech and a success rate of 96.6%. These advantages compensate for the relatively prolonged period required for epithelialization of the donor site over the hard palate.

This was supported by our clinical observation among the patients of G2, since all of them showed excellent closure of the fistula without any palatal soft tissue bulge. The connective tissue flap was extremely elastic, enabling it to be rotated without tension. Another advantage is that the epithelial layer of the flap was returned to its original place to cover the donor area. This technique offered the patients minimal discomfort and also provided early healing of the wound, as there was no raw area left behind for granulation.

After healing, the palatal mucosa and the recipient site were smooth without a hole or bunching. All our cases were observed periodically and didn’t reveal sinusitis after the surgical closure.

**Conclusion**

According to the results of our observation, the following points could be concluded:

1. Both types of palatal flaps (conventional pedicled palatal flap and submucosal connective tissue palatal flap) provided enough well-nourished tissue for sufficient and successful closure of OAF (chronic or acute, large or small).

2. Nasoanterostomy is unnecessary in the closure of oroantral communications.

3. Preoperative preparation with antibiotics and good sinus irrigation is mandatory.

4. Submucosal connective tissue palatal flap seems to be preferable for fistula closure because it overcomes the disadvantages of the full thickness palatal flap (e.g. creation of soft tissue bulge and production of raw surface on the hard palate).

5. Connective tissue palatal flap offered the patients minimal discomfort, provided early healing of the wound, and did not create esthetic disturbance due to absence of the palatal raw area or any soft tissue bulge. Surgical splints or dressing were not necessary.

6. Due to the advantages of the connective tissue palatal flap, we believe that it is the safest procedure for the closure of OAF. However, compared with the conventional palatal flap, submucosal connective tissue palatal flap technique may appear to be more difficult in terms of flap manipulation. The surgical experience plays an important role at this level.

**Reference is available upon request. Please contact deyanov@dental-tribune.com**
Dubai School of Dental Medicine announces collaboration with The Royal College of Surgeons of Edinburgh

Dubai, UAE: The Dubai School of Dental Medicine (DSDM) enrolled its first batch of students in January 2013 and announced its collaboration with the prestigious UK Royal college at the recent AEEDC. We spoke to Professor Wray about the significance of this collaboration and how the first intake of students are settling in to the new facility...

We are extremely proud to announce the collaboration with The Royal College of Surgeons of Edinburgh and the opportunity this gives our students. When our students embark on a three year intensive clinical training programme at DSDM, the course has a clear didactic component and a research dissertation and students obtain an MSc upon completion of the course. In addition, our students will simultaneously graduate with a membership from the Royal College of Surgeons of Edinburgh in the UK. This diploma can subsequently be converted into a fellowship so that students will be graduating with both an academic qualification in the form of an MSc and also an internationally recognized clinical qualification, which would ultimately be a fellowship from the Royal College of Surgeons in Edinburgh.

We are extremely proud to be offering our students such a prestigious clinical qualification and we are proud that the Royal College have endorsed our programme to offer a fellowship to students sitting exams outside of their faculty, for the first time in the region. The Royal College of Surgeons of Edinburgh represents the global benchmark in specialist dental training and is the first post-graduate dental school in the UAE and it covers almost all of the departments of dentistry.

Our students are taught by an international faculty in a state-of-the-art dental school, based in Dubai Healthcare City. Our faculty specialists are highly qualified with extensive experience in dental education, research and clinical practice. They have trained in renowned institutions and are committed to bringing students and patients the most advanced dental treatment based on scientific evidence. Our first batch of students hail from across the GCC and we are keen to support Dubai Healthcare City’s ambition to build a specialised medical talent pool in the region. Moving forward we look forward to welcoming students from the UAE, the wider GCC and around the World.

Student perspective:
Name: Eman Hassan Al Nuaimi Nationality: UAE Undergraduate School: Ajman University of Science & Technology Accredited programme: Paediatric Dentistry Why did you select DSDM: I chose to study my Postgraduate Degree in Paediatric Dentistry at DSDM as the school is a well-structured institution and is an integral part of Mohammed bin Rashid Al Maktoum’s Academic Medical Centre in Dubai Healthcare City. Providing us as students the opportunity to sit for The Royal College of Surgeons of Edinburgh dental specialty examination as a graduation requirement is a great academic achievement and reflects the school’s vision in providing its residents with high standards of qualification.
What are your hopes for your dental career: Improving the quality of oral health care provided to paediatric patients by the Ministry of Health and giving more attention to medically compromised patients and patients with special needs. I also want to become involved in research programmes offered by DSDM and other academic institutions within Dubai Healthcare City. This is something that has been lacking in the past in the narrow field of dentistry in the UAE.
Name: Batool Ghaint Nationality: UAE Undergraduate School: Trinity College Dublin Accredited programme: Bachelor of Dental Science Why did you select DSDM: I wanted to complete my studies in an institution that provided the highest level of academic excellence, in an advanced clinical environment. As a postgraduate student I felt that DSDM met these requirements.
What are your hopes for your dental career: To continue my skills training and knowledge development throughout my career to enable me to provide the highest quality of care for my patients.

The DSDM Open Day Review: Dr. Najat Abdulla Saeed Mohammed Al-Hasani, potential student

Dr. Najat Abdulla Saeed Mohammed Al-Hasani by Dental Tribune Middle East & Africa

Dubai, UAE: What do you think about the school at this early stage?
It is quite interesting actually. It is the first post-graduate dental school in the UAE and it covers almost all of the departments of dentistry.

Why is it so attractive to have such a school here in UAE?
Firstly, not leaving your home country, this is the main argument. Another thing is that it follows the requirements it sets out, you know exactly what it wants from you, when you are going to practice dentistry and you know exactly what to go for.

How well were you informed about the DSDM and did you have enough information from the start?
Very much so! Professor Wray explained the ideas behind the DSDM extensively and how the programs will be, all my questions were answered.

Personally speaking, are you happy with studying in the UAE or would you rather go abroad?
We are satisfied with what we have here in the UAE, if we had the chance to study abroad, we would but we are satisfied with what we have and where we are. If I did have the opportunity to go abroad I would probably have studied either in Ireland or United States of America.

Why did you select DSDM: I chose to study my Postgraduate Degree in Paediatric Dentistry at DSDM as the school is a well-structured institution and is an integral part of Mohammed bin Rashid Al Maktoum’s Academic Medical Centre in Dubai Healthcare City. Providing us as students the opportunity to sit for The Royal College of Surgeons of Edinburgh dental specialty examination as a graduation requirement is a great academic achievement and reflects the school’s vision in providing its residents with high standards of qualification.
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What are your hopes for your dental career: To continue my skills training and knowledge development throughout my career to enable me to provide the highest quality of care for my patients.
Interview: 'The Majority of Qatari Dentists have a specialty certificate'

by Dental Tribune Middle East & Africa

Doha, Qatar: Dr. Mohammad Al-Darwish, President of Qatar Dental Society, thank for taking the time for this interview. Can you tell us about yourself and experience as a Dentist?

My name is Dr. Mohammad Al-Darwish, President of Qatar Dental Society, and Prosthodontics in Hamad Medical Corporation at Al-Wakrah Hospital in Qatar. My experience as a Dentist began when I graduated with my bachelor degree in 1997 from Alexandria University. After this time, I joined Hamad Medical Corporation as a resident for two years before I went to Chicago, USA to continue my postgraduate studies in Prosthodontics in the University of Illinois - where I stayed for 5 years before moving back to Qatar in 2005. In December, 2007 we established the Qatar Dental Society, and organizing the first Qatar International Conference in 2009 with the second conference being in April 2012. We are now in the process of establishing a Qatar Dental Journal. Could you comment on the Dental Market here in the Middle East?

I think it is very well developed, and that this is the right time to join the Middle Eastern Dental Market. Every day we hear about new dental schools and new dental clinics opening. At the moment, most of these Middle Eastern countries have a need for all of this– the market is very, very good. How is the experience level of the Qatari Dentists in general?

In Qatar we actually have 922 dentists, around 120 of whom are Qatari, and the rest being an international crowd. The majority of Qatari dentists have a specialty certificate, and in the private clinics most of the doctors are General Practitioners. We also have around 70-75 Dental Technicians, and though I know that this is still quite a way from the number that we should have, we are definitely working on it.

"Now is the right time to join the Middle East Dental market"

What can you share about the Dental Education in Qatar?

Until now we do not have a dental school, but Qatar Dental Society, Hamad Medical Corporation and other health sectors are doing continuing education courses and workshops every month in order to update all the information and knowledge of all of the dentists in Qatar. When developing the Qatari Dental Market, do you look competitively at other Middle Eastern countries in specific the GCC?

There is absolutely competition between countries: everyone wants to be the best, and make their country the best. I think we are all still developing all of this in Qatar and with time we will reach the point that we are looking for. We are waiting for the Dental School to be open in Qatar. Hopefully someday soon we will have it.

You mentioned earlier you are planning a conference in 2014, could you elaborate? Year after year the Qatar Dental Society and The Qatar International Dental Conference is growing. In 2009 we had an attendance of around 250, and by 2012 we have reached 850, we are now looking to increase this number still. In 2009, we did not have a workshop but in 2012 our workshop was fully booked! So now for 2014, we are planning to have more than six or seven workshops pre-conference. As usual, we also have a number of speakers coming from across the world, covering a variety of specialties and hot topics.

The developments sound very interesting and Dental Tribune Middle East & Africa wishes you the very best in your future endeavours. Is there anything else you would like to share with the readers?

I would like to say thank you to DTMEA for giving me a chance to speak about the Qatar Dental Society, and Qatar in general and you are all very welcome to visit us when you can.

Thank you Dr. Mohammad, we will be glad to.
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More than 2000 participants attended.

Press Release: Saudi Dental Society

Riyadh International Convention and Exhibition Center, Riyadh, Saudi Arabia: The 24th Saudi Dental Society International Dental Conference was a great success and was well attended with 2,070 participants. Exhibition included 52 international companies. There were 29 oral presenters for the scientific session and 66 for poster presentation.

Three types of different research awards were also given, the Young Dentist Research Award, Graduate Student Research Award and Poster Presentation Award. Furthermore, there were 9 continuous Continuing Education Courses and Workshops given with the attendance of 465 with different specialties like: Oral Diagnosis, Implantology, Endodontics, Evidence Based Dentistry and special course for the Dental Hygienists.

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Module 1 13th-18th June, 2013
Module 2 24th – 29th August, 2013
Module 3 3rd – 12th November, 2013
Module 4 24th – 29th January, 2014
Module 5 24th-30th April, 2014

Registration
Pre-Registration is Mandatory as it is a limited Participation Program.
For further information and registration details visit website: www.aaid-asia.org or e-mail
Dr. Ninette Banday, Coordinator Aaid-MaxiCourse UAE at dmibanday@yahoo.com.

The Faculty are as follows:

Dr. Shankar Iyer, USA
Director- Aaid Maxi Course UAE
Diplomate, American Board of Oral Implantology
Clinical Assistant Professor, University of Medicine & Dentistry of New Jersey

Dr. Ninette Banday, UAE
Head of Dental Services, AHS-SEHA
Co-Director Aaid Maxi course- Abu Dhabi, UAE

Dr. Jihad Abdallah, Lebanon
Fellow, American Academy of Implant Dentistry
Founder and Director, Beirut Implant Dentistry
Director, Aaid Maxi course Jordan

Dr. Alfred “Duke” Heller, USA
President Midwest Institute of Implant Dentistry
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Dr. William Locante, USA
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Dr. James Rutkowski, USA
President – American Board of Oral Implantology/Implant Dentistry
Acting Editor – Journal of Oral Implantology

Dr. Burnee Dunson, USA
Fellow of the AID
Diplomate ABID

Dr. Stuart Orton-Jones, UK
Founder Member, The Pankey Association
Member, Alabama Implant Study Group
Director, The Stuart Orton-Jones Institute

Dr. Philippe Tardieu, France
Invention of the Safe System
Author- CT guided reconstructions

Dr. Hilt Tatum, France
Professor, Lille University, France
Developer, Sinus Lift and Bone Expansion Techniques
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Corega cleanser
• Proven to manage denture hygiene effectively*
• Reduces plaque build-up with proven bactericidal and antifungal activity*

By recommending a Daily Denture Care Regime to your patients with dentures, you can be assured that you are helping to improve their comfort and confidence every day, day after day.

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