FDI Worldental Daily

Annual World Dental Congress 2014 NCR New Delhi

YOUR fdi ANNUAL WORLD DENTAL CONGRESS NEWSPAPER

Saturday & Sunday, 13–14 September 2014

An invite to Bangkok

IDA passes AWDC torch to Dental Association of Thailand

The countdown for the next FDI Annual World Dental Congress (AWDC) will officially begin today when the Dental Association of Thailand (DAT), together with the FDI World Dental Federation, welcomes friends and guests of both organisations to a lunch to celebrate the event in 2015. To be held from 22 to 25 September in the capital Bangkok, it will be the third time in five years that the prestigious event is held in an Asian country, after Hong Kong in 2012 and this year's congress in India.

It will be the first time, however, that Thailand will be hosting the annual meeting of the FDI. An agreement between the Geneva-based dental federation and the DAT to organise the 2015 edition in Bangkok was signed at the AWDC last year in Istanbul. The DAT is currently organising its own dental event, the Thailand International Dental Congress, of which the last was held in November 2013 and attracted around 3,000 dental professionals. To date, there are approximately 12,000 practising dentists in the South-East Asian country.

According to the organisers, the 2015 FDI AWDC will be an exceptional event that will not only highlight the rapid development of dentistry in Thailand, but also bring all professions in dentistry together. Information about the congress, the scientific programme and registration is currently available for visitors at the AWDC 2015 Bangkok booth on Level 2 of the India Expo Centre and Mart in Greater Noida.

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Further ahead, the city of Poznan in Poland, whose dental equipment market has grown noticeably over the past several years, will be hosting the AWDC in September 2016, according to an agreement signed between the FDI and the local organising committee in May. The responsibility for organising the congress will be shared between the FDI and a three-partner local organising committee, which consists of the Polish Dental Society; Exactus, a professional company that organises medical and dental congresses; and Poznan Congress Center. The event also has the support of the Polish Chamber of Physicians and Dentists, which will play an active role in preparation for the event.

For information and news about this year's event in Greater Noida, please visit the *Dental Tribune* website at www.dental-tribune.com or scan the QR code at the bottom left corner of this page.

DTI launches new edition at AWDC

Publishing group is hosting lectures and workshops at Booths B56–B65

With the launch of the new edition of its flagship publication *Dental Tribune* for the South Asia region here yesterday at the FDI Annual World Dental Congress in Greater Noida near New Delhi, the Dental Tribune International Publishing Group is celebrating another addition to its extensive portfolio of international dental media. The new edition will cover countries such as India, Sri Lanka, Nepal, Bangladesh, Burma and Bhutan, and is anticipated to reach an audience of approximately 100,000 dentists.

"The market in this specific region has been growing in many sectors and people are constantly embracing new technologies," said publisher Ruumi Daruwalla, explaining the incentive behind the new edition. "What has re-

FDI Worldental Daily » page 02

fdi worldental daily

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FDI World Dental Daily • page 01

ally been missing, however, is a publication that offers high quality and can reach the maximum number of dental professionals."

DTI CEO Torsten Oemus and *Dental Tribune South Asia* publisher Ruumi Daruwalla presenting the new edition. (Photo Daniel Zimmermann, DTI)

According to Daruwalla, *Dental Tribune South Asia* will be available in print and online. He invited visitors to the FDI congress to pick up their free launch copy of the new edition at Booths B56–B65 in Hall B at the FDI World Dental Exhibition. There, visitors can also participate in a number of continuing education sessions and workshops presented by the Dental Tribune Study Club, an affiliate of *Dental Tribune* and a platform for advanced dental education. The topics covered in the symposium presentations, which are supported by internationally prominent dental corporations and institutions, include the latest dental materials, prosthetic solutions and methods to implement implants in private practice.

"Counterfeiting of high-quality products has become a big problem recently for many premium manufacturers in India," said Jürgen Hauser from Frasaco, a company specialising in education materials for dentistry, including jaw and tooth models, remarking on his company's presentation. "Through the study club's symposium and workshops, we have the opportunity to convey the message that quality matters when it comes to dentistry."

Hiryuki Goto, Area Sales Manager of the Global Medical Business Department of Japanese dental equipment manufacturer Belmont, added: "India is a very price-sensitive market. Therefore, we are presenting our middle-priced range of dental chairs with the help of specialists, who demonstrate on how to use our products efficiently. So far, the feedback has been promising, despite a slow start on Thursday."

Live lecture yesterday at the Dental Tribune Study Club symposium at booth B56-65.

Dental Tribune Study Club lectures and workshops will continue through the weekend, starting at 10:00. Entry to the symposium is free of charge. At the symposium, participants will be able to become a member of the Dental Tribune Study Club and gain access to the substantial archive of dental knowledge and expertise it offers.

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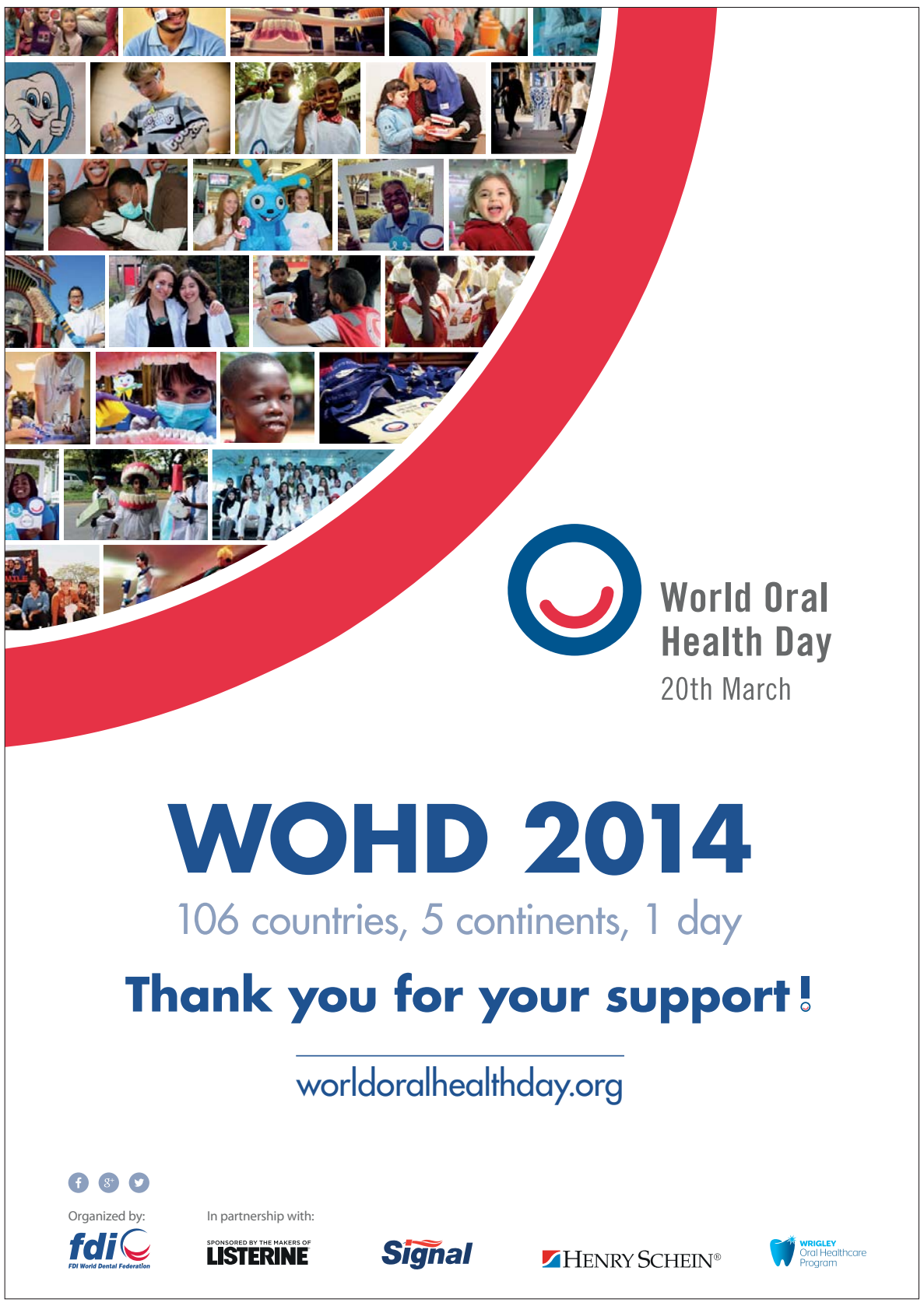

FDI-Unilever partnership "Live.Learn.Laugh." reaches decade-long milestone

By Dr Monica Carlile & Dr Virginie Horn

FDI World Dental Federation and Unilever Oral Care are celebrating an important milestone this year, the 10th anniversary of Live.Learn.Laugh., our unique global public-private partnership in oral health promotion. On this special occasion, we take the opportunity to look back with pride at our most important achievements in the long race to improve oral health around the world.

The early years of the partnership saw a pioneering phase 1 in which FDI member National Dental Associations collaborated with Unilever Oral Care local companies to improve oral health. From 2005 to 2009, 39 diverse projects were implemented in 36 countries, building capabilities in health promotion and reaching over one million people in local communities.

In 2010, the partnership moved into phase 2 of implementation and proved to be a resounding success. With a more focused goal and aligned project designs, the remarkable collaboration between dentists, other health professionals, community workers and school teachers allowed us to reach more than 41,000 people directly—including over 33,000 children—through 29 projects in 27 countries. In addition, thanks to the global and local communication campaigns, it was estimated that LLL phase 2 messages were disseminated at least to 1 million people worldwide.

This unique global public-private partnership contributes significantly to the overall FDI vision to lead the world to optimal oral health. It also contributes to Unilever's Sustainable Living Plan which aims to help one billion people improve their health and wellbeing. For the past decade, the partnership has been doing exactly that and has been successfully delivering the message to "brush twice daily with fluoride toothpaste"—a message that will continue through the implementation of phase 3 later this year.

We are proud to present the partnership, in particular the LLL phase 2 programme, to the delegates at the 2014 Annual World Dental Congress. To this end, FDI and Unilever are organizing a symposium dedicated to showcase the achievements resulting from the worldwide implementation of the 29 projects. Therefore, it is with pleasure that we invite you to attend the LLL symposium taking place on Friday, 12 September at 9:30 at "H Khorana Hall".

Please make sure to visit the FDI pavilion at the Congress for news and details on the results of phase 2 of the LLL partnership and stay tuned to learn more about the upcoming oral health promotion activities that are planned for phase 3.

Dr Monica Carlile is Global Expertise & Authority Manager at Unilever Oral Care. Dr Virginie Horn is Associate Director, Education and Development at the FDI World Dental Federation. Both are working together to manage the Live.Learn.Laugh. Partnership on behalf of the global partners.

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"Reach a point where dental restorative materials are rare for everybody"

An interview with Christopher H. Fox, Executive Director of the International Association for Dental Research

At the Public Health Section/Chief Dental Officers' Forum, which was held yesterday here at the FDI Annual World Dental Congress in Greater Nioda, experts discussed how India could prepare for the phase-down of amalgam following the adoption of the Minamata Convention in Japan last year which made way for a ban on mercury-containing products on a worldwide scale. *Dental Tribune* on behalf of *Worldental Daily* had the opportunity to speak with the Executive Director of the International Association for Dental Research (IADR), Christopher H. Fox, who attended four of the intergovernmental negotiating committee sessions on behalf of the dental profession, about the impact the convention will have on dentistry and the future of dental amalgam as a restorative dental material.

Christopher H. Fox

***DTI:* The recently adopted Minamata Convention on Mercury includes provisions on phasing down dental amalgam on a global scale. What impact do you think this will have on the dental community and particularly restorative dentistry in the long run?**

Christopher Fox: I think it must be first pointed out that the Minamata Convention is a very broad treaty designed to reduce all use of and international trade in mercury, as well as the demand for mercury in products and processes. In addition, it is intended to address the need for the reduction of atmospheric emissions of mercury, as well as mercury releases on land and in water.

Dental amalgam is included in the treaty as a mercury-added product contributing to the global demand for mercury. In this regard, it is important to note that the treaty calls for phasing down the use of dental amalgam, as opposed to phasing out or banning the use of it. This will give the industry and profession time to make a transition and preserve dental restorative choices for our profession and patients.

One of the provisions for phasing down dental amalgam is for countries to set national objectives aimed at dental caries prevention and health promotion, thereby minimising the need for any dental restoration. A greater emphasis on prevention and health promotion is indeed welcome and will provide the greatest benefit to populations.

Another provision promotes research and development of alternative dental restorative materials. So, in the long run, dentistry and restorative dentistry, in particular, will have improved dental restorative materials from which to choose for their patients.

You were involved in some of the intergovernmental negotiating committee sessions in the run-up to the Convention. What were the most discussed issues in formulating the treaty, and did the outcome meet the expectations of those involved in dentistry?

The most discussed dental amalgam issue was a ban versus a phase-down. Led by the Responsible Officer for the WHO Global Oral Health Programme, Dr Poul Erik Petersen, a coalition of concerned dental organisations was able to show country negotiators that a ban would be detrimental to population oral health. Dental amalgam is a safe and effective dental restoration and remains the best restorative choice in many clinical situations or health system situations. As with any complex negotiation, the outcome has met many people's expectations, but there are those who would have preferred a phase-out of dental amalgam and those who would have preferred no limitations set on dental amalgam.

Another area of discussion was the need for best environmental practices in dental facilities to reduce releases of mercury and mercury compounds to water and land. Dentistry must be a good steward of the environment and implement best environmental practices for dental amalgam, as well as for all other dental materials, medical waste and consumables.

You mention that in the dental community amalgam is still considered to be effective and safe. So why phase down its use at all?

Dental amalgam is a safe and effective restoration. The US National Institute of Dental and Craniofacial Research funded two large-scale randomised clinical trials on the safety of dental amalgam in children and failed to find any adverse health effects. The reason for the agreed-upon phase-down is solely the environmental and health effects of mercury in the environment, not the direct health effects of the use of dental amalgam.

Mercury poisoning from amalgam is mostly found in countries where recycling of the material is insufficient. Is this not a more pressing issue that should be addressed globally?

The proper handling of dental amalgam and its waste must be adhered to by the dental profession and the health facilities in which they work. In addition to the provision in the Minamata Convention calling for best environmental practices, there is a provision calling for dental amalgam to be used only in its encapsulated state. Only some countries require the use of dental amalgam separators and many more dental professional organisations are calling for their universal use.

Even if we were successful with our oral health promotion programmes however and could stop using dental amalgam tomorrow by the introduction of next-generation dental restorative materials, dental facilities would need dental amalgam separators in place for at least a generation as currently placed dental amalgams come to the end of their life cycle and need to be replaced.

According to the Convention, a number of products containing mercury will be banned from 2020. Do you believe that amalgam will still play a major role in restorative dentistry by that time?

Seven years is a short time frame when we are relying on a research and development pipeline to deliver improved dental restorative materials. Without being too pessimistic, a typical research and development time frame from discovery to clinical use in the pharmaceutical arena is 17 years. So, I believe dental amalgam will still be with us in 2020, but I am optimistic it will play a much-reduced role in restorative dentistry.

Alternatives to mercury-containing dental filling material were discussed last year at an IADR–FDI workshop on dental materials. Is there any viable alternative, and what needs to be done to implement and sustain its use in the future?

The symposium at the recent FDI Annual World Dental Congress in Istanbul was actually a much-condensed summary of a two-day workshop held in December 2012 at King's College London. In brief, yes, we can have much-improved, innovative dental restorative materials, but it is going to take a significant commitment from government funders, academia and industry. Keep in mind that even if a new material could be developed within a one- or two-year time frame, clinical safety and effectiveness trials and regulatory approvals will take significantly more time. Practising dentists have an important role here too, as they can participate in research networks evaluating new materials and identifying research questions, not to mention advocating for research funding with policymakers in their country.

For a more complete answer to your question, I would refer your readers to the proceedings, which have just been published in the November issue of the Advances in Dental Research, an e-supplement to the *Journal of Dental Research*.

With the advent of preventative dentistry, stem cell research and the sophistication of tooth replacements, will restorative materials become obsolete someday?

Dental restorative materials are already obsolete or nearly obsolete for the socially advantaged post-fluoride generation. Our greatest challenge is addressing the oral health needs of socially disadvantaged and vulnerable populations. The IADR has a research agenda to reduce these oral health inequalities across populations and hopefully we will reach a point at which dental restorative materials are rare for everybody.

Thank you very much for the interview.

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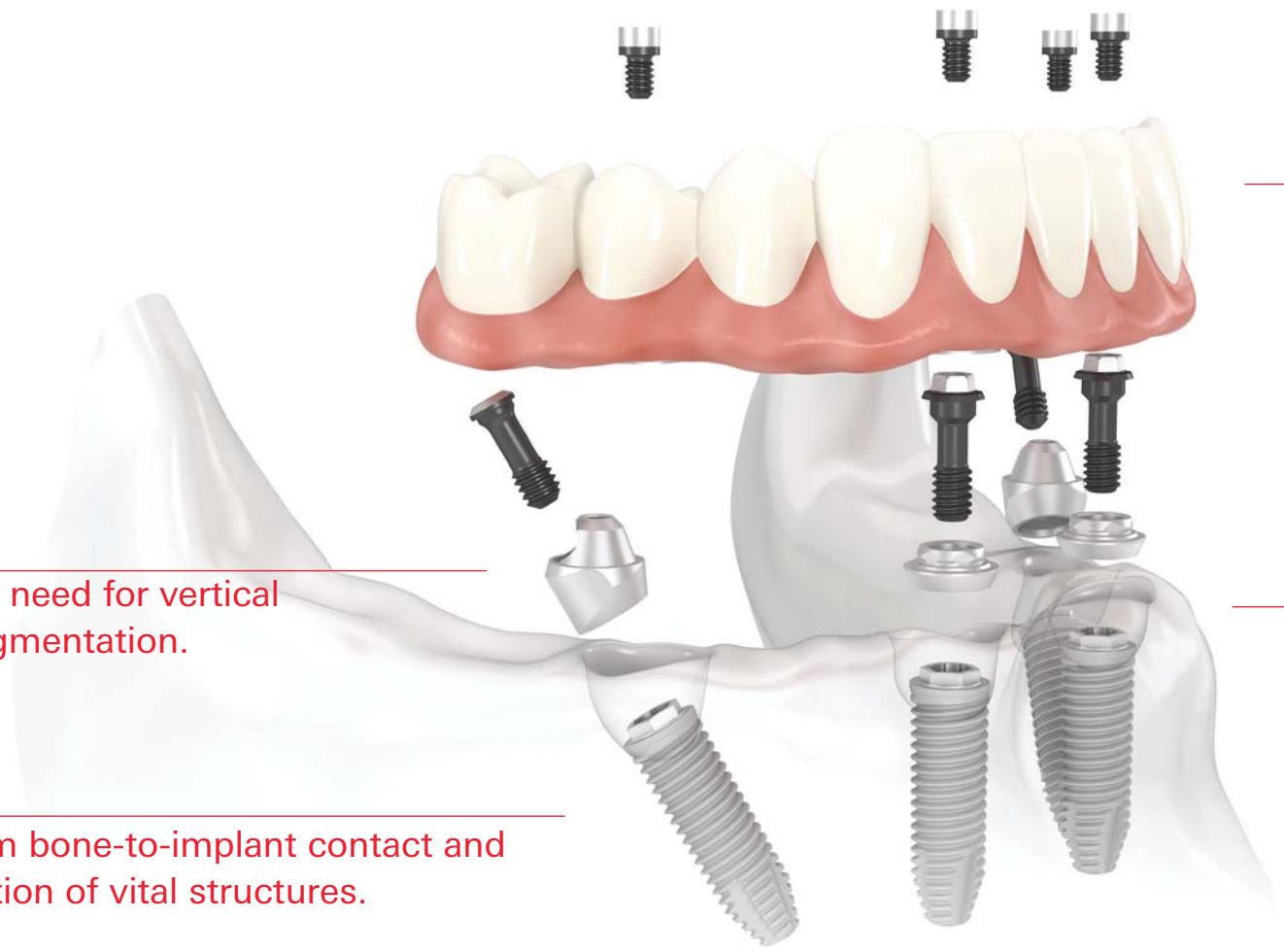

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A new focus on oral health data and indicators

FDI opens online hub for global oral data. By Prof Li-Jian Jin, Chair, FDI Oral Health Atlas Task Team.

FDI has just opened its 'data hub for global oral health', an evolving online database of oral health statistics and indicators. It has started out with a limited amount of information but it is anticipated that the content will expand and deepen in the coming months. The 'hub' has been developed under the guidance of the FDI Oral Health Atlas Task Team, and aims ultimately to provide a one-stop shop for all information pertaining directly or indirectly to global oral health.

Evidence-based decision-making is a key issue in the international healthcare community: it promotes good science, encourages transparency and professional accountability, and helps focus efforts and monitor progress. Data bring efficiency and effectiveness to the strategic decision-making process.

In the field of healthcare, data are especially important, where reliable information is crucial for the effective allocation of scarce resources. This is why it is vital to remedy the dearth of data in the field of oral health/disease and oral care. FDI's Oral Health Atlas has proved to be a landmark achievement since it was published in 2009, filling a void; nevertheless, with data dating back, in some cases, to the 1990s, and only a limited number of indicators available, its information is now in need of an update.

From the perspective of health policy, the lack of oral health data has hampered the World Health Organization's (WHO) efforts to develop, for oral health, a comprehensive global monitoring framework including a set of indicators to monitor trends and to assess progress in the implementation of healthcare strategies and plans.

FDI and its partners worked hard to ensure that the 2011 UN Political Declaration on the Prevention and Control of Non-Communicable Diseases (NCDs), from which WHO's action plans derive, recognizes that oral diseases pose a major health burden for many countries, share common risk factors with the main NCDs, and can greatly benefit from common responses to NCDs. The challenge is to quantify that burden so that, as of now, year on year progress can be made and measured.

Thus, it is anticipated that the 'data hub for global oral health' created by FDI, the leading international organization in the field of oral healthcare, and available to its member national dental associations and a wider public, will also help to provide a sound basis for a future global oral health monitoring framework.

As for content, the 'data hub' will cast the net much wider for information. For example, the crucial role of social determinants in oral health will make socio-economic data a key component. So will the data on incidence of NCDs such as diabetes where a close relationship with oral disease has been clearly established.

The originality of the hub is not in the content, which, for the moment at least, derives from a number of publicly-available sources; rather, it is in the 'packaging', centralizing the wide array of data and indicators from around the world. Contrary to traditional databases, the evolving FDI database aims at pointing out that more effort should be made towards filling the gaps in oral health data worldwide.

As such, the 'hub' will be a powerful advocacy resource for the huge efforts that urgently need to be undertaken, a unique source of data collection and an essential tool for all those who are interested in improving the state of oral health in the world.

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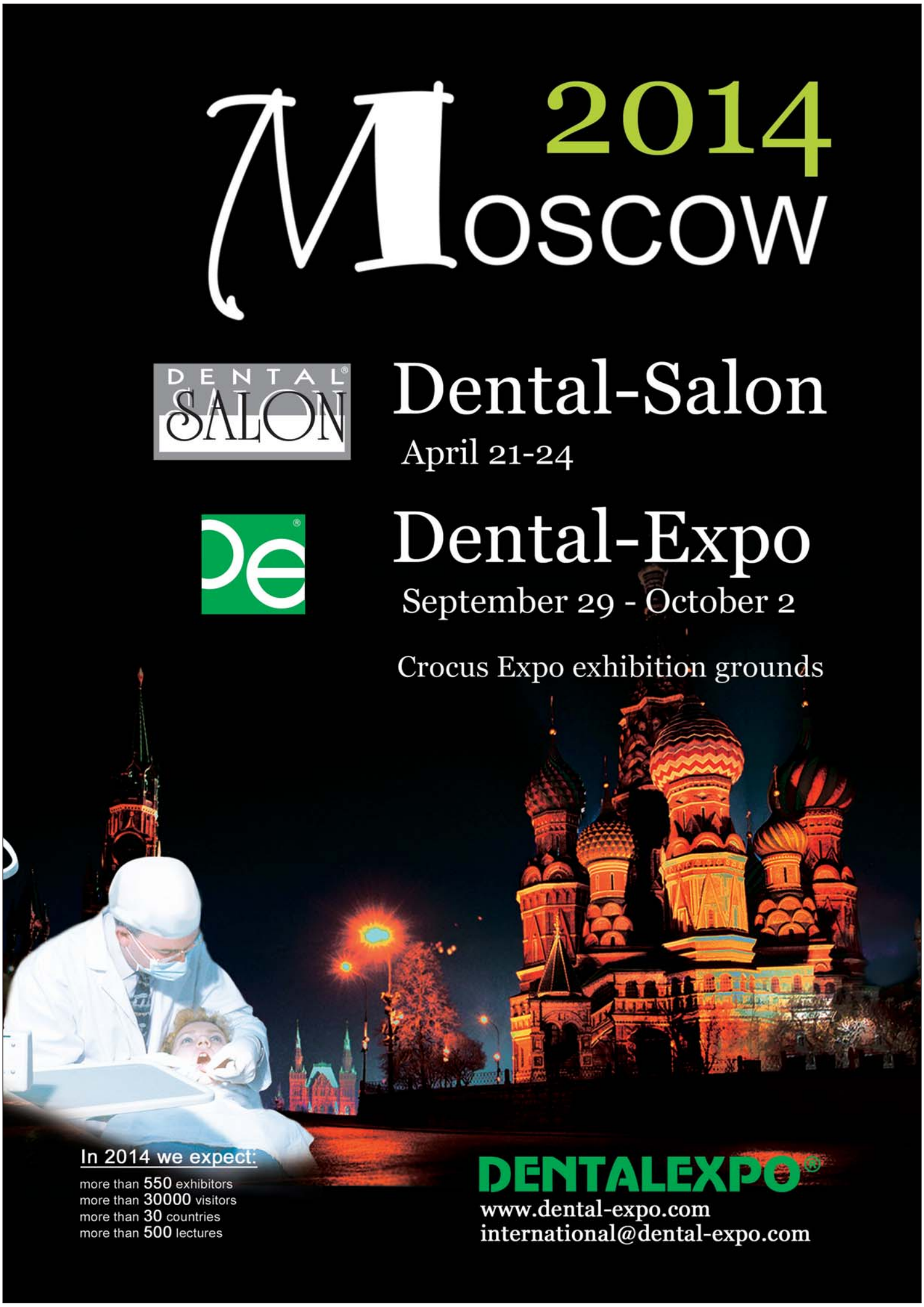

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Not meeting standards of care

Medical and dental negligence in India discussed. By Dr George Paul

Several definitions for medical negligence exist. Baron Anderson defined "negligence" in the course of the famous case of Blyth v. Birmingham Waterworks Company (1856) as "The omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do. The defendants might have been liable for negligence, if, unintentionally, they omitted to do that which a reasonable person would have done, or did that which a person taking reasonable precautions would not have done."[1]

The operative word in the definition is "reasonable". This sets the benchmark in determining "standard of care", the breach of which is the quintessence of negligence. We therefore understand that, for an act to be considered negligent, a doctor, who owed a certain standard of care, must have not maintained that standard or there must have been an injury resulting from the lack of care. (The injury should be compensable.) There should also be a connection (proximity) between the negligent act and the resultant injury.

In fact, for an act to be considered a medical negligence, it must fulfil all four criteria mentioned above. In understanding negligence, one must also grapple with the exceptions to negligence. A review of decided cases shows that some of the situations mentioned below do not fall under medical negligence. For example, absence of informed consent in an emergency or patient dissatisfaction with progress of treatment or even charging excessively are not considered negligence.[2]

A professional standard of care is generally that standard of care or skill that is determined by a body of professionals on behalf of the medical profession. It does not have to be of the highest level though. It is here that the term "reasonable care" is exercised. The test of the standard has traditionally been the Bolam test,[3] which is used to determine scientific validity and accommodates two or more deferring opinions in the treatment of a particular condition.

In this context, one must also deal with two important aspects of treatment or care, customary practice and accepted practice. Customary practice may be a common practice. However, if it is not validated by science, it is not recognised in law. Accepted practice is generally an evidence-based practice and is accepted in law. For example, many people do not use rubber dams during root canal treatment. It may be a customary practice, but it is wrong. Using rubber dams is, however, an accepted practice even if it is not applied universally. In the event of accidental ingestion of an instrument, only the accepted practice will prevail.

Contributory negligence is a mitigating clause in liability for negligence. If the patient has contributed to an undesirable outcome, the defendant doctor can claim exemption from negligence, for example, if a patient has not taken a prescription as instructed.

"Accepted practice is generally an evidence-based practice..."

LIABILITY FOR NEGLIGENCE

A doctor, dentist or hospital charged with negligence can be liable under three broad areas. The liability of a doctor arises not when the patient has suffered any injury, but when the injury has resulted owing to the conduct of the doctor, which has fallen below that of reasonable care. In other words, the doctor is not liable for every injury suffered by a patient. He or she is liable for only those that are a consequence of a breach of his or her duty.[4] The liability may be civil (torts), criminal or statutory.

In India, there is yet another liability as a result of medical services being brought within the ambit of the Consumer Protection Act (1986). This was the result of a prolonged legal battle in IMA v. VP Shantha (1995),[5] which finally decided that medical service was clearly within the definition of service envisaged under the Consumer Protection Act, which is a quasi-judicial legal premise to render swift justice in the event of a deficiency of service. It generally comes under civil or tort liability.

If charged with civil liability, the defendant is made to compensate the complainant with liquidated damages, which may be simple or exemplary as decided by the judge (or juries in many parts of the world).

Some instances of negligence may invite punitive actions under criminal law and may include imprisonment, fines or both. However, in India, there are decided cases, as in Jacob Mathew v. State of Punjab [2005],[6] in which strict guidelines have been laid down for criminal action against doctors. They cannot be arrested for death or disability caused during treatment unless a medical board determines that the negligent act was indeed criminal in nature. The relevant sections in the Indian Penal Code are Sections 337, 338 and 304A (a rash and negligent act causing simple injury, grievous injury or death, respectively).[7]

Like several other countries, India has statutory bodies in the form of its medical council and dental council, which can institute enquiries into negligent acts by medical or dental persons who are registered under these bodies. They can prescribe punitive action, ranging from removing the doctor's name from the register to imposing retraining before being permitted to return to practice. It is important for doctors and dentists to be aware of medical negligence so that they can take adequate care to prevent unnecessary litigation.

Dr George Paul maintains a private practice limited to oral and maxillofacial surgery in Tamilnadu in India. On Saturday afternoon, he will be presenting a workshop on the medico-legal aspects of dentistry as part of the FDI 2014 scientific programme. A complete list of references is available from the publisher.the *line.*

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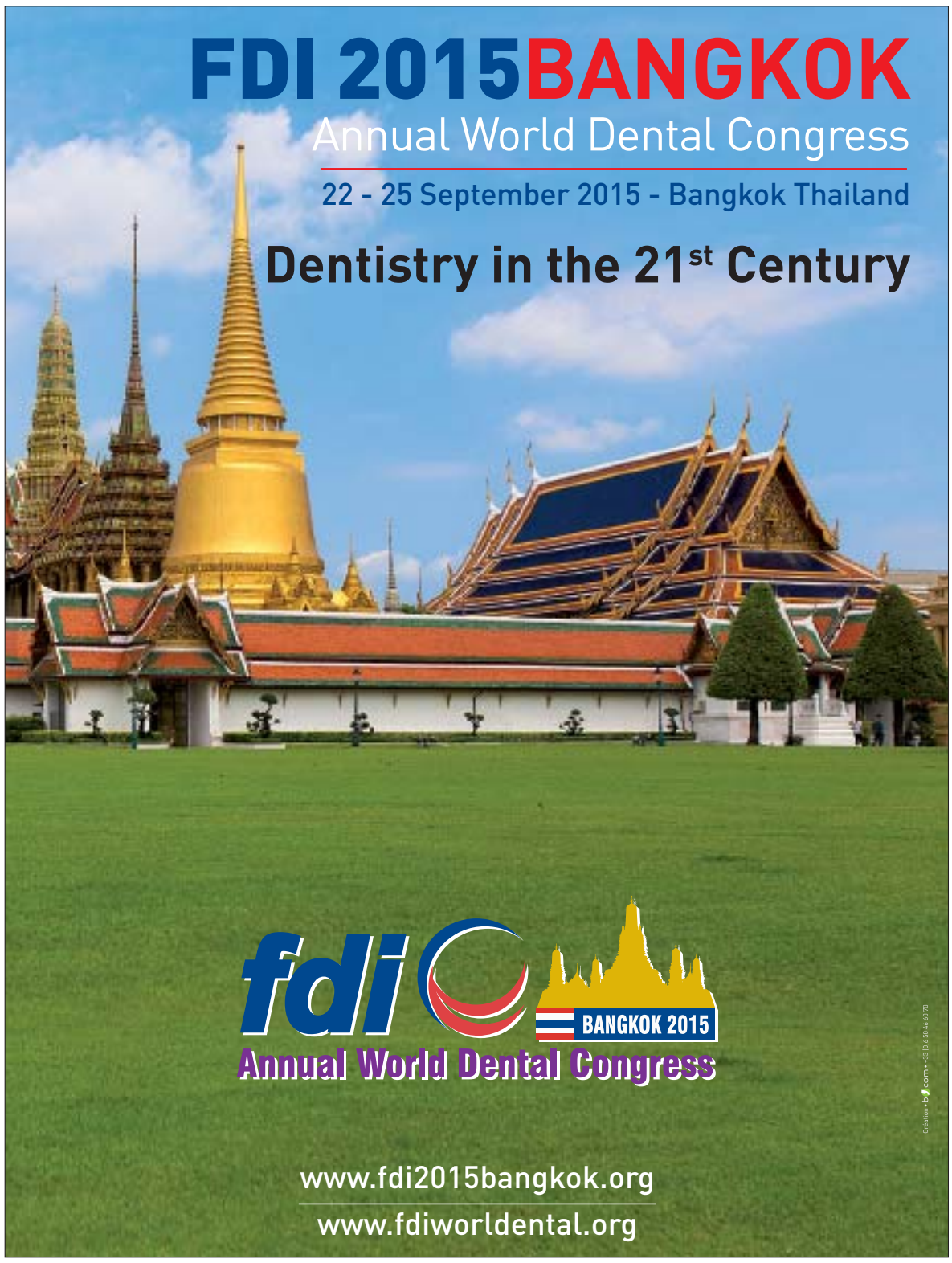

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