DENTAL TRIBUNE

The World's Dental Newspaper • Pakistan Edition

PUBLISHED IN PAKISTAN | www.dental-tribune.com.pk | MARCH, 2017 - Issue No. 02 Vol.4

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International Dental Show 2017 to Commence Next Week

DT International

COLOGNE - A tremendous amount of buzz has been generating about International Dental Show (IDS) in Cologne, Germany. The 37th edition is all set to open its doors from 21st to 25th March 2017. Numerous developments, innovations, revolutionary products and trends of international dental industries are to be showcased at the event.

Dental professionals from Germany and around the world will have the opportunity to see and experience the latest technological developments in their fields, including the newest dental materials, implants and laboratory equipment and state-of-the-art practice management solutions. Upwards of 2,300 manufacturers and dealers from 60 countries have registered to participate in the 2017 exhibition, occupying over six halls of the Koelnmesse fairgrounds. In addition to long-term exhibitors, a number of new companies will be showcasing their portfolios at this year's event. Furthermore, joint exhibitions have been announced by dental industry associations from the US, Italy, France, Korea, Brazil and the UK, among many others. According to the organizers, more than 140,000 international trade visitors are expected to attend.

"Our new exhibitors come from various fields of dentistry and their ranges will expand the already large and diverse offering at the show. Furthermore, IDS is becoming increasingly international with companies from North America, Asia and Europe exhibiting their latest products and solutions at the event for the first time," Koelnmesse CEO Katharina C. Hamma told Dental Tribune Online in February.

IDS has grown exponentially over the last two decades, having now become one of the most highly attended events of the global dental industry. Although held in Germany only every two years, industry experts deem the show one of the most important international platforms for dental manufacturers to launch new products to global markets, establish new business contacts and obtain potential new

Continued on page 14

Preparations for World Oral Health Day 2017 in full swing

DT Pakistan Report

KARACHI - World Oral Health Day (WOHD) is celebrated each year on 20th March. This campaign is dedicated to raising global awareness on the prevention and control of oral disease. WOHD spreads messages about good oral hygiene practices to adults and children alike and demonstrates the importance of optimal oral health in maintaining general health and well-being.

Dental News and Dental Tribune in collaboration with Pakistan Dental Association will be arranging countrywide activities to mark World Oral Health Day 2017 in Pakistan. The occasion will be backed by PDA, FDI, JPDA, DTI, FDI partner associations and the local sponsor Shield Corporation.

In Pakistan this will be the 7th year running where Shield Corporation as part of their CSR activities sponsored the mega event. The theme of 2017 World Oral Health Day is Live Mouth Smart.

The campaign empowers people to take control of their oral health all throughout their lives so they can enjoy a healthy, functional mouth from childhood into old age. This year, courtesy of Shield Corporation and Pakistan Dental Association, the program will expand across 17 cities and 60

Continued on page 14

Doctors' and labs uniform fees bill to be tabled again

DT Pakistan Report

ISLAMABAD - A bill proposing uniform fees for doctors and laboratories across the country could not be approved as the government contended that it was already working on the matter.

However, MNA Nikhat Shakeel Khan of the MQM, the mover of the 'Medical Consultancy and Other Services (Rationalisation of Fees) Bill 2016', said the government took such a stance whenever a bill of public interest was tabled in the house.

The MNA is very determined to table the bill time and again if she is unable to solicit the support of the legislatures as she feels that it has utmost public importance. The bill was tabled in August last year and later referred to the National Assembly Standing Committee on National Health Services (NHS).

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Pak docs may not become ineligible for USMLE

DT Pakistan Report

LAHORE - Medical graduates from Pakistan will not be eligible for appearing in examination for registration as practitioners or doing post-graduation from any institution in the United States after 2023.

By 2023, only graduates of medical schools accredited by the regulatory bodies in respective countries recognized by WFME (World Federation for Medical Education) will be eligible for appearing in USMLE (United States Medical Licensing Examination) or ECFMG (Educational Commission for Foreign Medical Graduates) certification.

Foreign graduates need to clear the USMLE for doing practice in any of the 52 states of America. Similarly, ECFMG certification is compulsory for foreign medical graduates to enter Residency or Fellowship program in the US.

If Pakistan Medical and Dental Council (PMDC) remained unrecognized by WFME as an accrediting body by 2023, medical

Continued on page 14

Training for medical teachers should be mandatory to ensure high quality medical Education: CM Sindh

KARACHI - The Chief Minister of Sindh, Syed Murad Ali Shah while addressing the gala dinner of the recently concluded Association for Excellence in Medical Education Conference 2017 held in Karachi stressed the need for mandatory training for teachers to ensure quality medical education. The conference was held in collaboration with Aga Khan University and Jinnah Sindh Medical University Karachi Pakistan.

At the gala dinner Chief Minister of Sindh, Syed Murad Ali Shah was the chief guest. He termed the health profession as a noble profession and said that the importance of doctors is most felt when one falls sick or our near or dear ones are in the need of healthcare. He stressed the need for trained teachers and said that the teachers in the medical colleges should be highly educated to ensure that the medical students get best training.

Pakistan doctors are regarded very highly throughout the world and one reason is that they are not afraid to take chances when it comes to saving lives and disregard the fear of legal suits. This gives them edge over everybody else when it comes to treating a patient.

The teachers should be fully trained in the medical education and training for teachers should be made mandatory. Referring to jobs advertised the CM said that I asked the health department to develop a test rather than any other evaluation as after 5 years of undergraduate and 1 to 2 years of training a doctor he should be considered as highly trained and a bureaucrat should not be the one assessing him or her. More than 8000 doctors passed the exam and I asked concerned department to hire them all as we have a shortfall of more than 7600 doctors in Sindh, he added.

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AEME Conference 2017

Panelists Recommend guidelines for Dental curriculum up-gradation

KARACHI - On the sidelines of the recently concluded Association for Excellence in Medical Education Conference 2017 held in in collaboration with Aga Khan University and Jinnah Sindh Medical University Karachi, a dental seminar was held aimed at upgrading the BDS curriculum.

The seminar invited panelists from various universities and colleges to converge together on a single platform and compile recommendations for upgrading the curriculum.

The panelists included Prof Feroz, Principal, (Liquat University of Medical Sciences), Prof Tasleem Hosein, Principal (Fatima Jinnah Dental College) , Prof. Mehmood Haider, vice Principal, (Karachi Medical And Dental College), Prof. Mervyn Hosein, Dean, (Ziauddin Medical University) , Prof. Saqib Rashid, President Pakistan Dental Association (CC), Prof. Ayyaz Ali Khan (Sheikh Zayed Hospital Lahore), Dr. Ahsan Sethi (Lahore Medical & Dental College, Prof. Hasnain Sakrani (Altamash Institute of Dental Medicine), Prof. Yawar Abdi (SIOHS, JSMU),Hashim Hasan (Dental Tribune) and the host Prof. Kefi Iqbal (Dean, Faculty of Dentistry, SIOHS, JSMU)

The panelists agreed on the following recommendations for the Higher education of Commission and Pakistan Medical & Dental Council.

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DENTAL TRIBUNE
The World's Dental Newspaper · Pakistan Edition

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Thermoplastic materials in dental technology

By Claudia Hermann

Thermoplastic materials have been used in aviation and space engineering for a long time. Owing to their high mechanical strength and low modulus of elasticity, they have begun to increasingly replace metal in many manufacturing industries too, particularly in those where metal has been the dominant choice until now. Implants for intervertebral discs, as well as hip and knee joints, are made of PEEK, a thermoplastic polymer. Four million implants have been fitted during the last 15 years with outstanding success. In recent years, thermoplastic materials have also been used in dental technology. This article discusses a number of common plastic materials that have become alternatives for use in the manufacture of non-metal telescopic dentures.

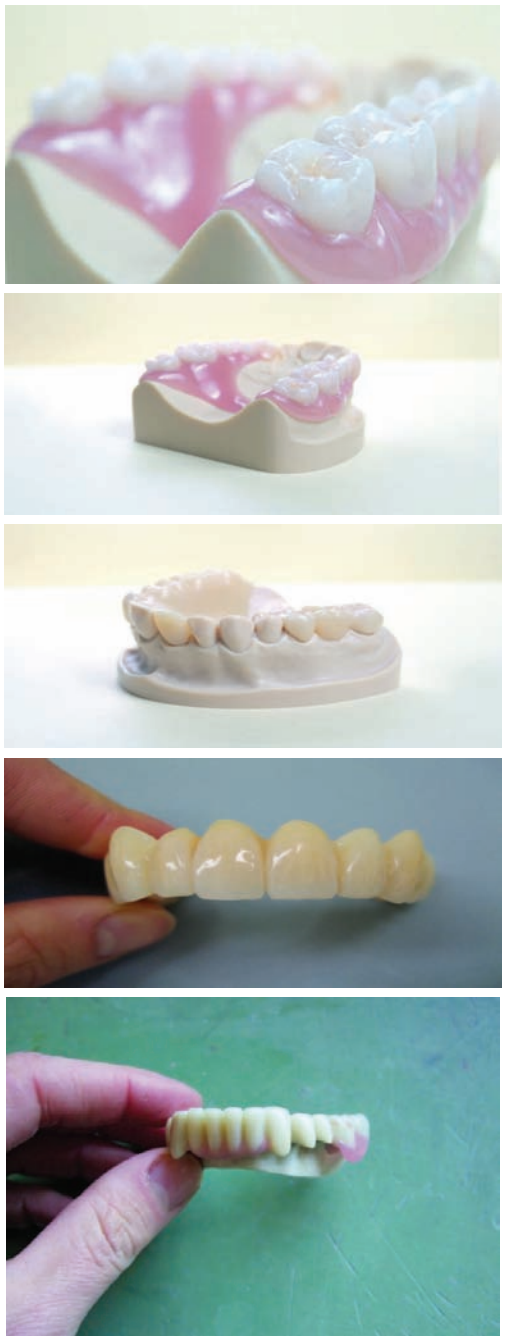
About 15 years ago, the first attempts were made, not without initial problems, to produce non-metal telescopic dentures. These dentures were made by injection moulding using a polyamide (PA) in the dental laboratory. A wax mould of the framework, bar and secondary crowns is made as an integral part, embedded in plaster in a flask and the wax boiled out. The plastic material, which is available in the laboratory as granular material, is heated in the injection moulding device and injected into the mould. After a period of cooling, which should not be shorter than specified, the prosthesis is removed from the mould and finished. Special milling cutters are needed because the material tends to become viscid when cut.

Very importantly, absolutely no metal must be entrained. If the denture were to cut by a tool previously used for cutting metal, minute metal particles would be incorporated into the thermoplastic material by the milling cutter. Friction would easily be controlled by expansion plaster. The good sliding properties and the high friction of the secondary crown particularly surprised us. When inserted, the secondary crown slides along the primary crown and is retained partly by clamping and partly by suction. Our patients found the good sliding properties and the light weight comfortable. The modulus of elasticity of PA is very low, which lends flexibility to the material. This gives the patient a sensation of a readily adapting denture, rather than a foreign body, in his or her mouth.

The low modulus of elasticity, however, turned out to be the greatest drawback of the material. The moduli of elasticity of all plastic materials used for bonding are very high and two moduli as wide apart as these cannot be bonded reliably for a long time by any means available to dental laboratory technicians. As a consequence, many dentures develop cracks and spalls in the bonds after several months. In addition, the large pores on the surface of the denture led to discoloration, particularly in patients with an altered acid–base balance.

A short while after PA, the industry launched a successor material with FPM. This thermoplastic fluoropolymer offers some flexibility, but less than that of PA, however. The modulus of elasticity is marginally higher than that of PA, but distinctly lower than that of metal. Consequently, similar problems as those encountered with telescopic dentures of PA occurred.

We have obtained good results with PMMA (Polymethylmeth acrylate). This plastic material is very hard and inflexible. Finishable in different colours, it is used for complete dentures and occlusal splints, as well as for long-term temporary dentures, crowns and bridges. The material is not susceptible to plaque, and discoloration is very inconspicuous.



The moduli of elasticity of bonding materials and PMMA are similar; thus, cracks and spalls of bonds did not occur. Patients who had previously worn a telescopic prosthesis of PA or fluoropolymer, however, complained that the denture of the new material was uncomfortable to wear. PMMA's lack of flexibility gave patients the sensation of having a foreign body in their mouth.

Unfortunately, denture breaks were reported after some time, particularly in free-end situations. Also, dentures not lined regularly and exposed to high force tended to break. We believe one reason for that is the fairly high modulus of elasticity, which makes the material somewhat brittle. The greatest problem, however, is that thermoplastic materials cannot be repaired. There is no way of repairing cracks or fractures. The only solution is to make a new denture.

PEEK (Polyetheretherketone) was first used for telescopic dentures about six years ago. In general medicine, it has been used for hip, knee and intervertebral disc implants for almost 15 years. According to German company Evonik Industries, as many as four million implants have been fitted and not a single case of proven allergy to that material has been reported. The modulus of elasticity of PEEK is similar to that of bone, with positive consequences for integration. This is one of the reasons that PEEK merits the attention of dental lab oratory technicians. Finally, there is a material with a hardness similar to that of bone, not as soft as PA or FPM plastics and not as hard as PMMA. These very rigid materials often cause dental technicians problems, for example with all-ceramic solutions for the upper jaw, where craniomandibular problems frequently arise.

PEEK is a very light-weight material with a long history of use in space flight. Non-conductive, it has been used in semiconductor technology for a long time. This property also offers benefits for use in the oral cavity.

The pharmaceutical industry uses PEEK in production. Parts in contact with the product are made of PEEK owing to its low discoloration and high resistance to wear and corrosion. Both properties are also very useful for dental technology. PEEK is indicated for removable, as well as conditionallyremovable, prostheses. Therefore, bridges, crowns, telescopic dentures and attachments, as well as screw retained superstructures, can be fabricated.

The material has very good sliding properties and patients report that it is extremely comfortable to wear.

There are two different methods of manufacture. One is injection moulding and the other is CAD/CAM milling. The minimum thickness of telescopes is 0.6 mm. The minimum thickness of frameworks and bars is distinctly higher, but varies depending on the design and the size of the telescopic prosthesis, as well as the number of available telescopes. Generally, a PEEK telescopic prosthesis will be a little thicker than a metal telescopic prosthesis. It is an absolute necessity that the primary crown be made of zirconia, as abraded metal particles would otherwise collect under the secondary crown.

The veneer bond strength was tested in a study at the University of Regensburg, Germany, in 2012. In order to pass the test, a value of 5 MPa had to be achieved. Of all the veneering systems tested, PEEK scored 10 MPa and above and passed all of the bond strength tests. In other tests, such as discoloration and shear strength, it also achieved very positive results, confirming the suitability of PEEK for use in the oral cavity. When subjected to load at fracture tests, a PEEK bridge achieved 2,354 N and was far superior to a ceramic bridge, with 1,702 N. Hence, PEEK can withstand higher loads in the oral cavity than can ceramic material, and so wide-span telescopic dentures can be made of PEEK.

It is necessary when handling telescopic dentures of PEEK to apply ceramic guidelines because the material could otherwise be weakened owing to crack propagation. In addition, the prosthetic design must follow certain criteria. For example, a prosthesis without a transverse bar must always include a backing plate in the secondary part to provide sufficient stability. Dental technicians required to make non-metal telescopic prostheses should therefore receive sufficient training and instruction so that the required high-quality level can be maintained. Those who work with PEEK only rarely and who therefore lack experience are advised to have telescopic prostheses of PEEK designed and cut in a specialised laboratory.

Even in our laboratory, we have come across PEEK prostheses with cracks, but these have invariably been due to manufacturing mistakes. Prostheses made correctly exhibit no cracks. Cracks and spalls of the veneering of PEEK dentures can

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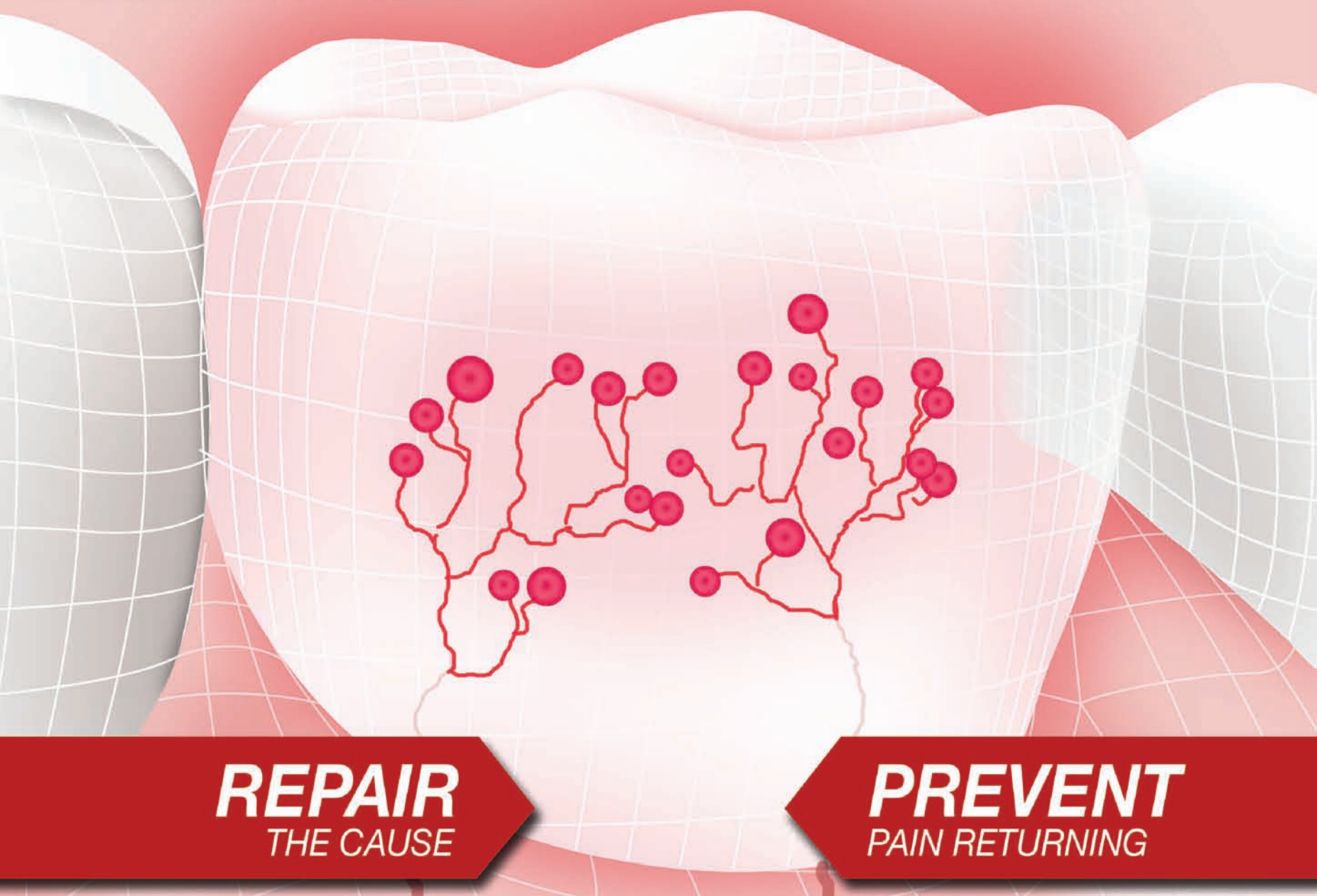

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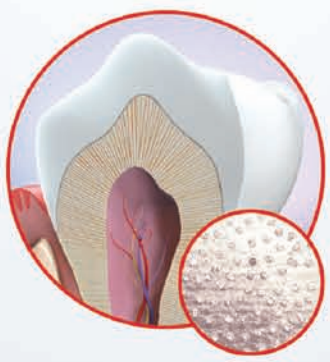

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Reference: 1. Li Y et al. J Clin Dent. 2011; 22(Spec Iss):113-120. **2.** Nathoo S et al J Clin Dent 2009: 20 (Spec Iss):123-130. **3.** Ayad F et al. J Clin Dent. 2009; 20 (Spec Iss): 10-16.

An indirect method for provisionalisation: the team approach in a complete mouth hybrid reconstruction

By Dr. Robert A. Levine & Dr. Harry Randel

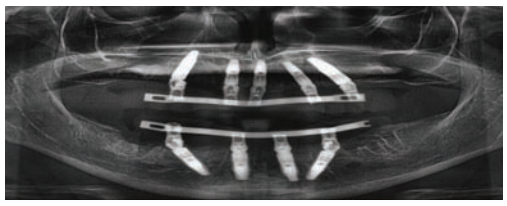
A periodontist and ITI colleague whose office is two hours from our practices referred this patient to our team. Initially, she was seen by the prosthodontist, Dr Harry Randel, and subsequently referred to the periodontist, Dr Robert Levine, for a team approach to solve her failing dentition. The patient presented at our office as a 65-year-old non-smoking female (ASA 3: Illnesses under treatment: anxiety/depression, osteoarthritis, fibromyalgia, hypothyroidism and history of myofacial pain dysfunction). There was a history of TMJ issues (i.e. clicking and pain with her right side TM joint) which presently is under control and pain-free.

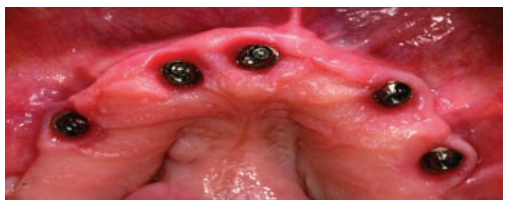
Her chief complaint was to improve her aesthetics and comfort with a desire for a permanent and quick solution to replace her failing dentition. She also desires a reduction of her maxillary anterior gummy smile in the final prosthesis. She arrived at our office for a third surgical consult for an immediate load maxillary and mandibular hybrid restoration using the Straumann Pro Arch treatment concept (tilting of the distal implants to avoid anatomic structures of the maxillary sinus, mandibular mental foramina). This treatment concept reduced the need for additional surgeries and number of implants needed to provide a fixed hybrid restoration with a first molar occlusion. A medium to high lip line was noted upon a wide smile with a bi-level plane of occlusion. Also noted was supraeruption of her maxillary and mandibular anterior teeth (FDI: #12, 11, 21, 22 and #41–43, US: #7–10 and #25–27) creating a deep bite of 6 mm. A Class I canine relationship was recorded with 6 mm overjet and 6 mm overbite. Due to her medication-related dry mouth issue, generalized recurrent caries were noted. Periodontal probing depths ranged generally from 4–7 mm in the maxillary jaw and from 4 to 6 mm in the mandibular jaw with moderate to severe marginal gingival bleeding upon probing in both jaws. Tooth #6 (FDI: #13) was noted to have a vertical fracture clinically. There was generalised heavy fremitus in her maxillary teeth and mobilities ranging from 2–3 degrees on the following teeth: #3, 7 thru 13, 20–26 and 29 (FDI: #16, 12, 11, 21–25, 31–35, 41–42 and 45). Her compliance profile was good with her previous dentists, however, she states that she has always had "issues with my gums."

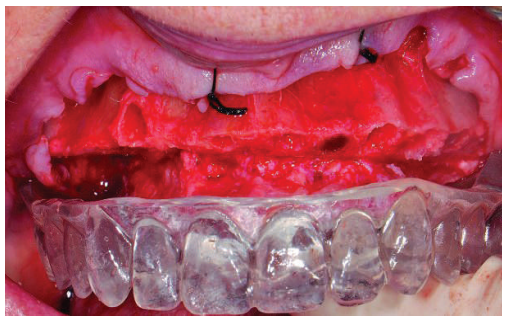
The tentative treatment plan discussed at the initial visit with the patient and her husband included the following diagnosis: generalised moderate to advanced periodontitis; generalised recurrent caries related to medication-related dry mouth; posterior bite collapse with loss of occlusal vertical dimension ("mutilated dentition"). Prognosis: all remaining teeth are hopeless.

Treatment plan: Obtain a CBCT of both arches to evaluate bone quality, bone quantity, and anatomical limitations.

Articulate study models with fabrication of diagnostic full upper denture (FUD), full lower denture (FLD) and surgical guide templates. Team discussions to develop the final surgical and prosthetic treatment plan for hybrid restorations using the Straumann Bone Level Tapered Implant (BLT) with a first molar occlusion. Utilisation of an indirect technique will be used to fabricate the converted fixed laboratory metal-reinforced







provisionals in one day.

Coordination of the surgical visit (Dr Robert Levine) with the prosthodontist's office (Dr Harry Randel), dental laboratory (NewTech Dental Laboratory, Lansdale, PA), and the dental implant company representative (Straumann USA, Andover, MA). The patient is aware of the possible need to wear one or both dentures during the healing phase if the insertion torque values are inadequate for immediate loading. This may be due to bone quality, bone quantity, or need for ex tensive bone grafting requiring a membrane technique for guided bone regeneration (GBR) and a two-stage approach. This is very important to review with all patients, especially when only four implants are planned in the maxilla, as the distal implant(s) may record poor insertion torque values due to bone quality and quantity. The ability to use longer, tapered (BLTs), and tilted implants—as in the present case—with adequate buccal bone available for the anticipated 4.1 mm implants help to reduce this possibility significantly.

Delivery of the fixed provisionals in one day in the prosthodontist's office followed.

Post-operative visits every two to three weeks with the periodontist's office for deplaquing, review of plaque control techniques and delivery of a water irrigation device at six weeks. An occlusal adjustment to be completed at each post-operative visit with the surgical and restorative offices, because the occlusion is very dynamic as the patient's musculature continues to accept her newly restored occlusal vertical dimension (OVD). Time is also needed to stabilise her TMJ symptoms. Completion of final case at least three months post-surgery. Since the patient will be spending the winter in Florida, she will commence her final treatment when she returns in the spring.

Periodontal maintenance every three months alternating between office will be observed.

Based on CBCT analysis it was decided to place five implants in the upper jaw at the following sites: #4 (FDI: #15) (tilted), #7 (FDI: #12), between #8 & #9 (FDI: #11 & #21) (midline), #10 and #12 (FDI: #22 and #24) (tilted) after vertical bone reduction for prosthetic room. Four implants were anticipated to be placed in the lower jaw at sites #21 (FDI: #34) (tilted), #23 (FDI: #32), #26 (FDI: #42), & #28 (FDI: #44) (tilted). The anticipated position of each implant is ideally palatal in the maxilla to the original teeth and lingual to the original mandibular teeth. This is to allow for screw-access holes exiting away from the incisal edges anteriorly, and if possible, lingually to the central fossae in the posterior sextants. An additional benefit of palatal and lingual placement of each implant is that their final position will be at least 2–3 mm from the anticipated buccal plates, which is beneficial for long-term bone maintenance and implant survival. If the necessary 2 mm buccal bone to the final implant position is not available, then contour augmentation (bone grafting) is recommended to create that dimension. The goal is to prevent buccal wall resorption over time using slowly resorbing inorganic bovine bone and a resorbable collagen membrane. This membrane allows easy contouring and flexibility over the graft material when wet. It is also important to evaluate tissue thickness. It is ideal to have at least 2 mm of buccal flap thickness over each implant as thin tissues are associated with bone loss and recession over time. Either connective tissue grafts from the palatal flap or tuberosity can be harvested and sutured under the buccal flap. Alternatively, an allograft connective tissue or a thick collagen material can be used to thicken the buccal flaps when necessary.

Surgical appointment

The patient was pre-medicated with oral sedation (triazolam 0.25 mg), amoxicillin, a steroid dose pack and chlorhexidine gluconate (CHG) rinse, all starting one hour prior to surgery. The patient's chin and nose were marked with indelible marker, and the OVD was measured using a sterile tongue depressor with similar markings while the patient's mouth remained closed. The patient was then given full-mouth local anaesthesia.

Starting with the maxillary arch, full-thickness flaps were raised and sutured to the buccal mucosa with 4-0 silk to provide improved surgical access and vision. The teeth were removed with the goal of buccal plate preservation using the PIEZOSURGERY (Mectron: Columbus, OH) for bone preservation (tips EX 1, EX 2, Micro saw: OT7S-3). The sockets were degranulated with

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Promoting Oral Health is everyone's responsibility

Dr. Patrick Hescot

By Haseeb Uddin

Dental Tribune Pakistan recently interviewed the president of FDI Dr Patrick Hescot on the sidelines of AEEDC Dubai. The excerpts of his interview are as follows.

DTI: The first question I would like to ask is what are the benefits of attending the upcoming FDI conference for Pakistanis?

Dr. Patrick Hescot: I think there are two levels of interest. The first level being scientific, because there will be a very high level of scientific information and there will be a lot of speakers from across the world. And it is very interesting to understand and listen to all these international dentists. And the second level is to share. For example I am French, if I just stay in France, it is good but it is not sufficient. And for Pakistanis it is the same thing. It is very interesting to go outside and to participate in the world dental conference because you can share your point of view, your opinions, and your cultures with other cultures. And for me, the most important thing is to share.

DTI: How does FDI plan to help dentists worldwide to play their specific roles in Pakistan, because we don't have very good oral hygiene condition in Pakistan, as a matter of fact, Pakistan doesn't even have an oral healthcare budget on a public sector level. Can FDI somehow support the local dentists so that they can reach out to the government, make a better impression and gauge public sector support for oral health hygiene?

PH: Absolutely. The responsibility of FDI is to advocate and to help dentists and dental assistants to promote oral health in front of the government, in front of the society, in front of the insurance, and companies as well as the general public. And I feel it will be very interesting for not only FDI but also for dental practitioners in Pakistan to work together and to learn about the situation in Pakistan and how it is possible to help the practitioners to promote oral health in Pakistan. It is very important to educate and to advocate. For example, FDI is the voice of dentistry worldwide and we are the official voice of dentistry worldwide with the World Health Organization (WHO) so advocacy is our responsibility. We must promote oral health and to promote the responsibility of the dentists in oral health. We have to promote dentistry not only in front of the governments of different countries but also in front of their media. Media support is crucial, and advocacy is the most important factor.

DTI: Speaking of advocacy and awareness, World Oral Health Day is a very important day which basically is creating awareness on a public level and is advocating with the corporations as well as the government. How do you think World Oral Health Day has changed the overall situation?

PH: It is only celebrated one day in a year but during this day especially, all the possibility to communicate and to advocate about oral health. FDI created this day but gave the possibility to all the countries and dentists to promote oral health at their individual levels. So it is the responsibility of Pakistan to decide how they want to promote it. Whether they want to organize special documentaries on television or they want to organize with students or large events with dentists. It depends on you. FDI created this event to help you, to provide you with the appropriate tools, but after that it is your responsibility to promote as you want. Because, promotion is communication. And communication is culture. You cannot communicate in the same level in France like you would in Pakistan. We all have to adapt according to our countries.

DTI: Continuing on the topic of World Oral Health Day, as of your personal opinion and from the FDI perspective, are you happy with the WOHD activities as they have been going on all over the globe? Do you think there is more room for improvement or is it meeting its benchmarks? What is your opinion on this?

PH: My opinion is very positive. We built this WOHD only four years ago, and each year we develop a new approach, and every year we have more importance in the world, and more countries participating. You must understand, you cannot even imagine building such huge events in a single year. You must work step by step each year to build it. It is very important to have close relations with all the participating countries and to develop an understanding with them to promote WOHD.

DTI: Again speaking of awareness, and the role of oral hygiene, does FDI also work directly alongside those sub-associations who are actually promoting awareness and working towards dental posterity as well. And if they are, how should one approach FDI for that?

PH: The FDI approach is to work with everybody. We have a natural relationship with Pakistan Dental Association as PDA is a regular member of FDI, and as a regular member it is our privilege to walk together. But we walk with everybody. For example, the responsibility of such companies is very important. We have strong partnerships with a lot of companies because they can help us to educate by advertising. The goal is to educate individuals about oral health. Each person is responsible unto himself to understand the importance maintaining oral hygiene. If you understand that, it is good. And for that, it is not only the dentists and dental assistants but for all people to understand oral health.

DTI: Okay. Now, in Pakistan, the number of dental graduates who have emerged in the last 4-5 years and the students who are yet to graduate in the upcoming future, has heavily increased. We used to have some 20-25 colleges just 10 years ago, now we have more than 45 dental colleges. So you can understand the number of dentists who will emerge. A question on the minds of most young dentists is; are they eligible for obtaining funding from FDI to undertake projects and if yes, how do they go about it?

PH: We work very closely alongside young dentists through the dental association. Therefore young dentists must in turn be working alongside their dental association. We have an official young dental association for young dentists worldwide. For example for WOHD, the young dental association of students and young dentists and members of FDI must work together for promotion. Because when it comes to the youth, we need a different approach. Because young people use social media, thus social media is extremely important.

DTI: Just one last question. Obviously, national dental associations are always there, ensuring the pathways of communication with the FDI. But there are also some private companies or corporations who would like to work with the FDI to promote public awareness. What is your personal opinion on this? Should it work this way?

PH: For me, it is very clear what we have to do. We can give exclusivity to the dental associations and dentists. But promoting oral health is the responsibility of everybody, especially relevant companies. The responsibility of FDI is to advocate these companies to make good products and after that to promote oral hygiene using these products. We create partnerships at FDI. We have partnership conditions are ethics and quality. If you have ethics and quality, we can work together to promote oral health and to promote products. FDI is happy to work with many companies worldwide to promote oral hygiene.

DTI: Thank you very much for your time sir. One last thing, if you could please give a message for WOHD specific for Pakistan that would be great?

PH: The most important thing is to be proud to be a dentist, and to hold the tremendous responsibility of improving the well-being and quality of life of Pakistanis. You have to promote oral health and dentistry in Pakistan. Good luck.

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