Commonwealth Dental Association
Working for Oral Health in the Commonwealth
CDA BULLETIN

The Newsletter of the Commonwealth Dental Association
CDA is supported by The Commonwealth Foundation

From the Editor

D Y D Samarawickrama

Dentists may well be the first health care workers to come across persons who have experienced abuse, crueltyand neglect of one kind or another. However, they are not qualified to diagnose these conditions,but should have sufficient awareness and knowledge to alert the appropriate authorities, if they have come across a suspected victim of abuse, cruelty and neglect.

There are many groups of persons who have experienced abuse and neglect, although the most widely acknowledged group is children. Child abuse, cruelty and neglect are heinous crimes, considering how vulnerable they are. The effects of these are more than bruises and broken bones. Although those two are visible, other types such as emotional abuse, cruelty and neglect not so, but can leave deep and long lasting scars on the victims. Their abusers are often persons in a position of trust: members of the family, relatives, teachers, care workers and religious persons.

Therefore, it is important to be aware of common types of abuse and neglect and learn what can be done as a dentist. The earlier the victims get help, the more one can do and make a lasting impact on a child's life.

Domestic abuse, also called domestic violence, battering or intimate partner violence is another serious crime. It can take many forms: emotional, sexual and physical abuse and threats of abuse. Although women suffer more often,men can be victims also. Sometimes, domestic abuse begins during pregnancy, putting the health of the victim and the baby at risk. The dangers often continue after child birth. Of concern is that even with the victims being adults, these forms of abuse are not easy to identify at first. Again, dentists may well be the first to notice tell tale signs.

With people in many countries living longer, there are more elderly persons needing care and attention. In their dependant state, they are also more vulnerable to abuse and neglect. Elder abuse can take many forms: physical, psychological, sexual and material. In this instance too, dentists who are sensitive to the welfare of the elderly can play an important role in detecting and preventing this form of abuse.

Therefore, it is quite timely that the Barbados Dental Association, in conjunction with the Commonwealth Dental

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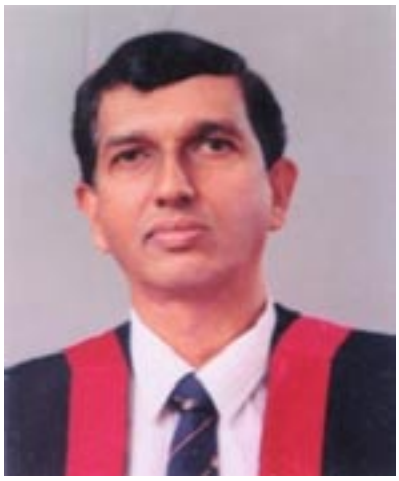
President's Message



Hilary Cooray

"Women as agents for change" was the theme of the Commonwealth for 2011. A service for Commonwealth Day was held at Westminster Abbey on Monday March 14th, in the presence of Her Majesty the Queen, the Head of the Commonwealth and HRHPrince Philip, the Dukeof Edinburgh. The importance of women in different spheres of activity was highlighted in the numerous presentations that were made.The service

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Association,is hosting a meeting/ workshop on the theme "Education, Abuse, Neglect and the Oral Care Practitioners" in Barbados from 22nd to 25th November 2011. Further details of this event can be found elsewhere in this Bulletin.

DYD Samarawickrama
Editor

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was followed by a reception at Marlborough House.

Of course, in the field of Dentistry, where women professionals are playing leading roles, they too should bring about change for improvements in oral health care.

The annual Commonwealth Health Ministers' Meeting (CHMM) was held on May 15th, on the theme "Non-Communicable Diseases - a priority for the Commonwealth". This was a follow-up to the 2009 Commonwealth Heads of Government Meeting, which released a statement on action to combat non-communicable diseases.

There are known links between oral health and non-communicable diseases. The effect of periodontal disease on systemic diseases is now being widely investigated. A number of studies have been done on the role of periodontal disease as a risk factor for cardiovascular disease, stroke, diabetes, chronic obstructive pulmonary disease (COPD), pneumonia and metabolic syndrome; also periodontitis during pregnancy and its effects on low birth weight. Dental caries may not have a direct impact on non-communicable diseases, but it has an effect on good overall health.

Dental pain has an effect on nutrition, discomfort and thereby difficulty in speaking during social interactions. It also has its detrimental effects on learning, mental development and physical activity which contribute to good general health.

The onus of prevention of oral diseases such as periodontal disease, dental caries and oral cancer is the responsibility of oral healthcare professionals. It is not only for the prevention of non-communicable diseases but also for good health in total. The role of the oral health care worker in Oral Health Education, Health Promotion and Prevention of Disease is of significant importance.

In November this year, the Barbados Dental Association, in collaboration with the CDA, is organising a workshop on Education, Abuse, Neglect and Oral Care Practitioners. Members, especially from the Caribbean, are encouraged to attend this event.

Hilay Cooray
President

FINANCIAL REPORT for 2010-2011

Dr Anthony S Kravitz OBE
CDA Treasurer

In many respects the last year has been financially successful, as the outturn was a larger financial surplus than I had predicted in my budget report to the Executive Committee in July 2010.

Subscriptions remained steady – and came in almost exactly according to budget (figure 1). All those associations who had subscribed in the previous year did so again. But, as I wrote last year, the loss of support from one of our largest association members (Canada) in 2009, was a big blow. Additionally, in these straitened times, almost all our individual subscribers ("CDA Friends"), many of whom have sent us donations for years, seem to have deserted us. However, we were able to welcome the New Zealand Dental Association, who joined us for the first time.

Thankfully our main sponsor, the Commonwealth Foundation (CF) continued to give us excellent financial support, underpinning our administrative activities to a large extent and giving us "seed funding" for our event in Lagos, Nigeria. Unfortunately, we have not had a good pledge from the CF for our forthcoming year, which I refer to below.

I was mindful of the pressure on us from the CF to raise a higher proportion of our annual income than hitherto from subscriptions and sponsorship. Therefore, it was disappointing not to obtain any sponsorship in the year.

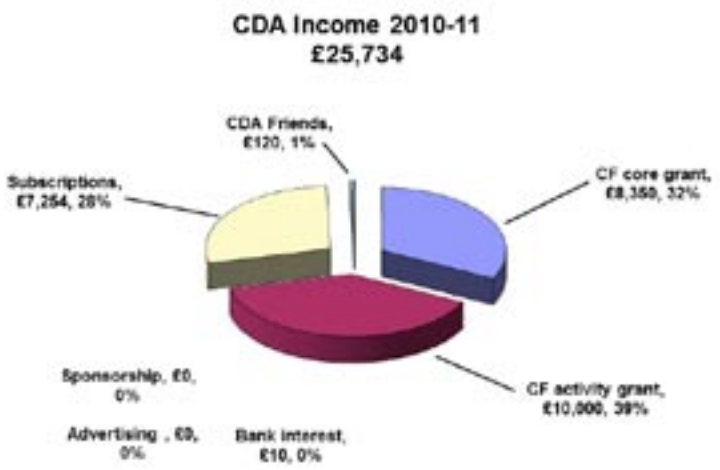
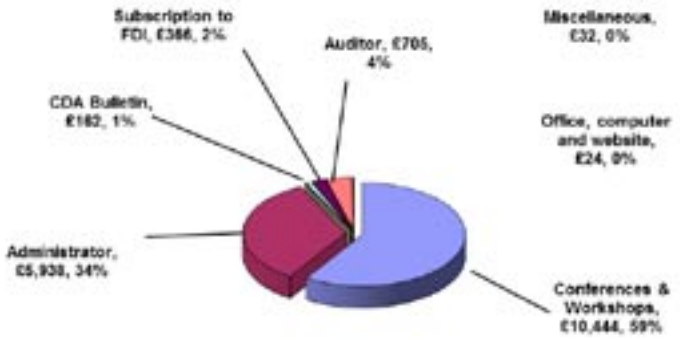


Figure 1

One of the major calls on our expenses is administration costs. Ulrike Matthesius of the British Dental Association carries out our day to day administration, for which the BDA charges us a flat rate. The British Dental Association have continued to be very generous to us and continue to charge us a very reasonable amount, probably less than their actual costs. Therefore, our administration costs are also running at about half of what they were 5 years ago. As they were mainly covered by the CF grant, administrative costs continue to form only a small part of our outgoings (Figure 2).



CDA Expenditure 2010-11
£17,672

Figure 2

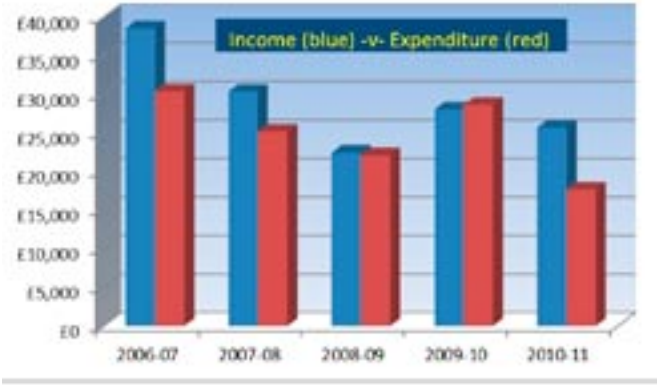


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Figure 3

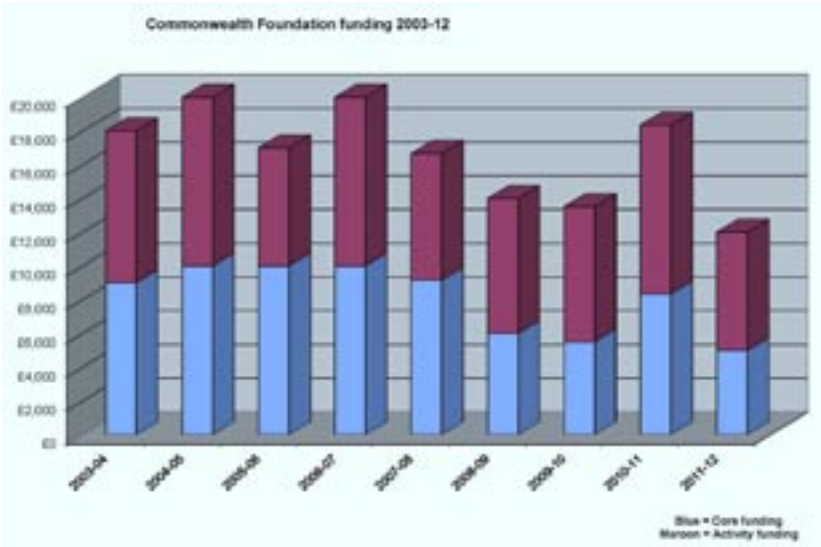

Figure 4

As usual, our main expense has been our activity – the reason, after all, why we exist (figure 3). The one main conference we held was in Lagos in November 2010, but this cost us less than we had budgeted for as attendance from outside Nigeria was very limited and so cost us less than planned. This was very disappointing as it was our first activity in West Africa for a long time. We continue to attend the annual Health Ministers' Meeting (CHMM) in Geneva; our costs are mainly for travel and accommodation for our President and one other. But, it must be recorded that Hilary Cooray has been subsidising some of his travel costs from his own pocket. We are currently reviewing our attendance at CHMM, whether this represents value for money for the CDA.

The successful outturn (figure 3) meant that at the end of June our reserves represented a full year's turnover.

However, we are faced with a very active year, in 2011-12, with two big CDA meetings, in Barbados in November 2011 and Malaysia in May 2012. Our budget for these two events is £20,000 and the financial support from the Foundation has been offered at a very disappointing £7,000 (figure 4). Indeed, the support from the Foundation has been steadily falling for a few years, with the exception of last year. We are negotiating with a sponsor to make up almost half of the shortfall, but I anticipate that otherwise our deficit in 2011-12 may be as much as £6,000 – almost wiping out the surplus for 2010-11.

REPORTS FROM THE REGIONS

Contemporary Issues in Australian Dentistry

Prof. Bill O'Reilly
CDA President Elect

Access to Dental Treatment

1. Cost is one of the barriers to Australians accessing proper dental care and the NDTIS report also highlights that health benefit card holders are more likely than non-card holders to avoid or delay dental care due to cost.

The introduction of a Dental Access program as put forward by the Australian Dental Association, supported with targeted funding and an improved effort on promoting individuals to look after their teeth would deliver quality dental and oral health services to those most disadvantaged in the community.

The current impasse (needs to be explained a bit more) between the Federal government's and the Senate's dental agenda must be resolved urgently. Like the government, the ADA has repeatedly called for changes to the Chronic Disease Dental Scheme (CDDS) so that eligibility is limited to those most in need.

Changes to the workforce mix in the delivery of dental treatment

2. The Draft National Health Workforce Innovation and Reform Strategic Framework for Action has been released and the framework as it currently stands implies that substitution of workers with a less qualified and therefore less expensive worker will be more cost effective and help solve some of the workforce issues.

The ADA supports attempts by governments to collaborate and introduce system-wide health workforce innovation and reform; however, it wishes to point out the uniqueness of dentistry and reinforce that what is applicable in medicine is not necessarily transferable to dental practice.

Over eighty per cent of all dental services are provided in a private practice setting usually consisting of one or two practitioners. These small professional business ventures must operate in a way as to meet overheads while providing an income to the practitioner and salary to employed staff such as dental assistants, receptionist and in some cases, a dental hygienist. These entities have evolved over time into very efficient decentralised team-based providers of high quality dental care services.

The ADA would caution that there is significant risk to quality and safety outcomes for patients if workforce substitution becomes an accepted solution to workforce supply.

It should be noted that rather than there being a dental workforce shortfall, there is more importantly a mal-distribution of the dental workforce with problems in rural and remote areas, academia, and for people requiring access to public dental care.

Cost of Compliance

3. A study conducted by Access Economics in 2006, commissioned by the Australian Dental Association, examined the incremental and gross costs of compliance for dental practices. Incremental compliance costs refer only to a practice's administrative processes and resources that are devoted to activities they would not normally do if the regulation did not exist. Australia wide, the mean incremental cost of compliance was $14,000 per annum (per practice setting) in 2005. This creates an estimated total cost of around $66.1 million per annum across Australia. The majority of this estimated incremental cost is due to the direct costs associated with business regulation (41%), environmental regulation (34%), and infection control (19%).

It was found that the mean core gross cost of regulatory compliance is $64,200 for each dental practice in Australia. The estimated gross cost is made up of infection control (40%), business regulation (30%), and continuing professional development (11%).

West-Africa

Prof Adeyemi O. Olusile,
CDA Vice-President for West Africa

The West African sub-region has been a hive of activity since the New Year:

1.The Faculty of Dentistry, Obafemi Awolowo University had its 9th Annual Scientific Conference at the Conference Centre of the University in Ile-Ife on 17thMarch 2011. The Theme of the Conference was "The Role of the Media in Oral Health Delivery". A guest lecture was delivered by a seasoned Journalist in Nigeria, Mr. Ray Ekpu of the Newswatch Communications Limited. There were scientific paper presentations on various aspects of dentistry and in attendance were the academics from most of the seven dental schools in Nigeria, private dentists and those in public services.

2.The Nigerian Dental Association had its Annual General Meeting in Abuja, the Federal Capital of Nigeria on the 9th and 10th June 2011. The theme of

the meeting was "Changing the Image of Dentistry in Nigeria". Dr. Aknitade Dare, a dentist who is a Professor of Radiology gave the Guest Lecture. There were some other lectures around this theme, including one given bya representative from Unilever Nigeria Plc. entitled "Public Perception of Dentistry in Nigeria". The meeting attracted officers of the Federal Ministry of Health and dentists from all over Nigeria.In addition to the lectures, matters of the Association were discussed and a number of resolutions adopted.

3.The Ghanaian Dental Association had its Annual General Conference in Accra, Ghana from June 23rd to 25th. The theme of the Conference was "Comprehensive Oral Health Care – Challenges and Solutions". The Chairman of the Opening Ceremony was the Minister of Health of Ghana and the keynote address was given by the CEO of Korle-Bu Teaching Hospital in Ghana. Eminent scholars and specialists were invited to speak on different aspects of the theme.

4.The Faculty of Dental Sciences, University of Lagos had its 5th Annual Scientific Conference on July 6th 2011. The theme was"Evolving Lifestyle Changes: Impact on Oral Health" and the sub-theme "New Trends in Oral Rehabilitation". An Alumnus of the School, Prof. Nii-Otu Nartey, and the CEO of Korle-Bu Teaching Hospital in Ghana delivered the keynote address. Eminent scholars and specialists were invited to speak on different aspects of the theme and the sub-theme.

5.An event that every dentist in Nigeria is looking forward to is the 3rd Conference of the African and Middle East Region, of the International Association for Dental Research, in conjunction with the Nigerian Dental Association. The conference is scheduled to take place from 27th to 30th September 2011 in Abuja. The theme is "Building Capacity for Improved Oral Health Delivery". Experienced researchers have been invited from allover the world to speak at the conference to provide first hand information on new developments and current and future trends in dentistry. Scientists, specialists and general practitioners from all over Africa and the Middle East will exchange and deepen their knowledge.

More information can be obtained on www.iadrnigeria2011.org and info@iadrnigeria2011.org

Report of the Commonwealth Health Ministers (CHMM) Meeting in Geneva, 15 May 2011

Theme: "Non-Communicable Diseases (NCDs) – A Priority for the Commonwealth"

Dr Anthony Kravitz, CDA Hon.Treasurer and Dr Hilary Cooray, CDA President at the CHMM Meeting.

The CHMM takes place annually, in Geneva, immediately before the annual meeting of the World Health Organisation. In past years most Commonwealth countries sent their most senior health minister to the CHMM, although those with a federal system (such as Canada and Australia) did not always send the federal minister.

However, fewer and fewer countries are now sending their health ministers. This year, none of the big developed countries were represented by health ministers and several smaller countries also followed suit. These countries send senior officials instead.

The CDA is one of the organisations invited by the Commonwealth Secretariat (ComSec) to send one or two observers. The objectives of our attendance are:

- The information we can gain
- The opportunity to highlight dentistry, particularly the CDA, to important people in Commonwealth governments
- The networking we can do.

This report is about the 2011 main meeting, which is on one day only (Sunday).There were pre-meetings on the Saturday, which included a meeting of the Commonwealth Health Professions' Alliance (CHPA).This writer attended on the Sunday only, but the CDA President was present for both days – and indeed made a presentation at one of the pre-meetings.

I was fortunate to have an (ad hoc) Sunday breakfast with HE Mr Kamalesh Sharma, the Commonwealth Secretary-General. I was able to explain to him the work and financing of the CDA and also what good oral health brings to general health and well-being.

The conference opening remarks were made in a short speech from Mr Sharma. The meeting was chaired by the Minister of Health for Bangladesh. He addressed his remarks to the increasing influence of NCDs on the costs of healthcare across the world.

- The Keynote address was by Prof Jean-Claude Mbanya, President of the International Diabetes Federation. He spoke of

the increase in NCDs across the whole world, causing 36m deaths per annum, 2 in 3 deaths, but this figure increases to 4 out of 5 in low and middle income countries. The equivalent of the population of North America will develop diabetes each year. There is a tidal wave of preventable diseases.

There is an international NCD Alliance - Diabetes, Cancer, Heart (CVD) and Chronic Lung Disease. Dentistry was not mentioned and so I guess that alliance does not include the FDI.

• The next presentation was – "A technical overview of NCDs in the Commonwealth": The four risk factors were described - tobacco, poor diet, excessive alcohol and physical inactivity. No mention of oral disease. NCDs are an enormous public health problem, with millions of premature deaths (80% of mortality is from lower and middle income groups- as related to low or high income countries). Almost 6m people die from tobacco use per annum.

Approximately 30% of populations are insufficiently active, leading to over 40% being overweight in the Americas and Europe. Worldwide, over 30% have raised blood pressure and between 8 and 12% have diagnosed diabetes and unknown number undiagnosed. Obesity amongst children is rising, and was over 40m in 2008.

There will be a UN high-level Meeting on NCDs in September 2011.

• There followed very interesting presentations by Kenya and New Zealand on "Experiences on prevention and control of NCDs"

During the late morning I was able to discuss the contribution that oral health care can make towards preventing NCDs, with the Ministers of Health from Barbados and Trinidad and Tobago. I pointed out that oral health had not been mentioned once during the morning, despite dental caries and periodontal disease being the most widespread NCDs in the world, and also poor periodontal health being a major risk factor for CVD. I also pointed out the rapid increase in the numbers with oral cancer, across the world.

Later, in the plenary meeting, the Minister for Trinidad departed from her written script and specifically mentioned the use of oral care in prevention - and the Chief Medical Officer (who was accompanying her) turned around and gave us the thumbs up! This was the only mention of dentistry the whole morning!

Unfortunately, for the lunch break, the Ministers were separated off from the rest of us – thereby losing us the networking opportunities we previously had in earlier years. We were provided with a working lunch, as the food was followed by a "facilitated discussion" on "Women as Agents for Change for Health". It would seem that the ComSec seem determined to reduce the opportunities to waylay those ministers attending, in the breaks such as lunch.

The afternoon discussions were dominated by arguments about the theme for CHMM 2012 and discussions on the "Statement from CHMM to the Commonwealth Heads of Government Meeting (CHOGM)", for which all the observers (including us) were asked to leave for a short while. Unfortunately these discussions were so prolonged that all the observers left before their conclusion and any further networking opportunities were lost.

So did the CDA achieve the objectives outlined above? I am afraid that, in my opinion, the CHMM is now failing on all three counts. There was little information given that was of direct benefit to our members – except that (with the single exception of Trinidad), oral health does not appear on the horizon of the important opinion formers in the Commonwealth. We do not appear on their agendas and our attendance at CHMM did little to improve that this year. We will need to review very carefully with ComSec and our sister organisations in the CHPA, our future attendance.

Dr. Anthony Kravitz
CDA Treasurer

Dental Digests

Knowledge, attitudes, practices and training needs of Kentucky dentists regarding violence against women
Skelton J, Herren C, Cunningham LL Jr., West KP Gen Dent 55 581 – 586 (2007)

Dentists are uniquely placed to detect signs of abuse during routine dental examinations. This study examined the knowledge, attitudes, practices and training needs of dentists in Kentucky, USA regarding domestic violence against women. Of 1892 questionnaires sent, 790 (42%) were returned. Only 7% of the dentists had any training while 82% expressed a desire to have more training. Of significance was that 42% indicated that they were legally not required to report suspected cases to the authorities.

The role of the dentist in recognising older abuse
Wiseman M J Can Dent Assoc 74, 16 – 20 (2008)

Dentists are ideally placed to identify and signal suspected elder abuse as they examine the head and neck region and see their patients twice a year in general. This paper provides the dentist with tools to identify abuse and a decision tree to manage and monitor suspected abused elder.

SPECIAL FEATURE

Minimal Intervention Dentistry: Altraumatic Restorative Treatment in the Management of Dental Caries

Dr. M. A. Sede, Dept of Restorative Dentistry, University of Benin, Benin City, Nigeria.

This paper is based on a lecture given by Dr. Sede at the CDA – NDA Workshop on The Use of Restorative Materials in Resource Limited Settings, held at Lagos, Nigeria in November 2010.

Introduction

GV Black did extensive research on dental amalgam and published "Operative Dentistry Volumes 1 & 2". The basis of Operative Dentistry was surgical excision of dental caries and extension for prevention.

Consensus Statement (2007)

General Assembly of the World Congress of Minimally Invasive Dentistry (MID), members of the Western, Central, and Eastern (US) Caries Management by Risk Assessment (CAMBRA) Coalitions, ADEA Cariology Special Interest Group, all recognize the 2002 FDI Policy Statement as the current clinical standard for caries management.

Definition & Aim

MID is an approach in the management of dental caries with the aim of minimising the loss of tooth structure as a result of disease or by iatrogenic intervention thereby preserving "TEETH FOR LIFE". MID adopts a philosophy that integrates prevention, re-mineralization and minimal intervention in the placement and replacement of restorations (Dawson & Makinson, 1992).

How can the goal "Teeth for Life" be achieved?

This can be achieved by preventing the "Repeat Restoration Cycle" (Elderton 1990) through adequate diagnosis, optimum prevention, tailor-made recalls, minimally invasive operative interventions and repair rather than replacement of restorations.

Is it possible to stop the "Restoration Cycle"?

The answer is YES, through the application of the knowledge of the caries process, remineralisation of enamel and dentine and utilisation of adhesive systems and materials.

Principles of MID

- Remineralisation of early lesion
- Reduction of cariogenic bacteria to reduce the risk of further demineralisation and cavitation
- Minimum surgical intervention in cavitated lesions
- Repair rather replacement of defective lesions and disease control

(Tyas, Anusavice, Frencken & Mount.2000)

Dental Caries

This is a highly dynamic process. It is driven by micro-organisms in plaque bio-film and results in the loss of minerals. Demineralisation results from an unfavourable oral environment that needs to be changed. Factors facilitating tooth re-mineralisation are: pH > 5.5, Calcium ions, Phosphate ions and Fluoride ions.

Management of Enamel Carious Lesions

Disturbance of Plaque bio-film using fluoride toothpaste: Professional flossing with fluoride gel is associated with a 30-39% reduction in dentine lesions in 13 - year old children after 3 years (Gisselsson et al., 1999). Fluoride varnish plus tooth brushing has led to a 19 - 25% reduction in dentine lesions in 5 year old children after 2 years (Petersson et al., 1998)

Evidence-based Caries reduction with fluoride toothpaste (Cochrane review): There are 70 studies on Fluoride toothpaste. The reduction in DMFS increment was 24%. This is strong evidence. (Marino et al., 2006)

Caries reduction with fluoride mouth rinse (Cochrane review): There are 34 studies on Fluoride mouth rinse. Reduction in DMFS increment was 26%. This is strong evidence. (Marino et al., 2006)

Management of Enamel carious lesions: non-invasive measures: Using Casein Phosphopeptide-amorphous calcium phosphate (CPP - ACP). It is a product of the protein found in cow milk. CPP - ACP products: Tooth mousse / MI Paste (GC Japan); Recaldent chewing gum; CPP - ACP incorporated in GIC (Mazzaoui, 2003). One method is to use Tooth Mousse / MI Paste.

Management of enamel carious lesions is also influenced by saliva quality and quantity. Reduction in the intake of cariogenic substances and use of sugar substitutes are other methods.

Caries reduction with sugar substitute (Systematic review): Two trials showed no effect; 7 clinical trials showed good effect. Anti - cariogenic effect of chewing Sorbitol, Xylitol or Sorbitol / Xylitol gum. Is explained by the salivary stimulation, lack of sucrose and inability of bacteria to metabolize polyols into acids. Thus, sugar-free chewing gum has a caries reducing effect (Mickenautsch et al., 2007).

Dental Caries

- "Surgical" approach - Invasive operative intervention and extension for prevention: No
- "Biological" approach - Maximum prevention and minimally invasive operative intervention: **YES**

Atraumatic Restorative Treatment (ART)

ART is one of the Minimal Intervention approaches in Minimal Intervention Dentistry (FDI report, 2000). ART approach evolved in response to the unavailability of restorative care in population groups with limited resources (Frencken et. al., 1996). It is based on using hand instruments and restorative materials. ART is practised in both developed and developing countries. (Burke et. al, 2005; Bulut & Sharif 2004; Kikwilu et al., 2009 & Jordan et al., 2010)

Acceptance of ART philosophy

WHO adopted the ART approach at the World Health Day in Geneva in 1994 while FDI adopted the ART approach at the General Assembly Meeting in Vienna in 2002. ART is an approach where carious tooth tissues are removed with hand instruments and the resultant cavity and adjoining pits and fissures are restored and sealed with adhesive dental material, usually a glass-ionomer. (Frencken et al.1996). In one procedure, the restorative and preventive components are carried out.

Preventive Component

This involves the use of sealants in the prevention of pits and fissure caries. Two approaches are recognised: composite resin (with bonding) and glass-ionomer (high viscosity Type II) applied under finger pressure (ART approach).

Composite resin vs. High viscosity Glass-ionomer: caries-preventive effect of high-viscosity glass ionomer sealant, placed according to ART procedure is between 3.1 and 4.5 times higher than that of composite resin sealants after 3-5 years (Beiruti, Frencken, van't Hof, Taifour & van Palenstein Helderman 2006). In patients with fracture of GIC sealants, the GIC may appear clinically absent; it still provides a seal in the fissure.

Steps in the application of fissure sealants (Frencken et al., 1996)

• Clean the occlusal surface using a probe to eliminate debris etc

• Clean the occlusal surface with a moist cotton pellet

• Apply conditioner (20% polyacrylic acid) on the occlusal surface for 10-15 seconds

• Wash with water and dry with cotton pellet

• Apply the Glass ionomer

• Apply finger pressure to the glass ionomer

• Remove excess glass ionomer after bite registration

• Burnish and protect with varnish, or Vaseline.

• Preventive component: fissure sealants.

Restorative Component Indications

Indicated in situations where the dentine lesions is accessible, or can be made so using hand instruments. (Tyas, Anusavice, Frencken & Mount. 2000).

Contra-indications

In the presence of swelling or fistula near the carious tooth, the pulp of the tooth is exposed; teeth have been painful for a long time and there may be chronic inflammation of the pulp; there is an obvious carious cavity, but the opening is inaccessible to hand instruments; especially in proximal surfaces (Manual for the atraumatic restorative treatment: an approach to control dental caries. Frencken et al., 1997)

Cavity Design

There is no preconceived cavity design. The shape of the carious lesion defines the extent of the cavity- (minimal intervention). Remove only degraded enamel and infected dentine. Both the cavity and the pits and fissures are filled and sealed (maximum prevention).

Steps in restoration- creating a cavity

• Remove plaque and debris from the occlusal cavity

• Create access into the carious lesion

• Use the hatchet to enlarge the access

• Remove infected dentine using an excavator

• Further opening of the cavity maybe indicated

• Wash, dry and isolate the cavity

Steps in restoration

• Condition the cavity, pits and fissures, wash and dry

• Mix and insert glass-ionomer when the mixture has a glossy appearance

• Coat the index finger with Vaseline and press the glass-ionomer into the cavity, pits and fissures (Press-finger technique)

• Remove excess GIC and do bite registration

• Bite correction using an excavator and coat with Vaseline.

When dentine caries is sealed in-situ, what happens?

Complete versus partial removal of soft dentine from cavity floor: There is an Increase in radiographic opacity of radiolucent zone suggested mineral gain; arrest of lesion progression; bacteria inside cavity are not harmful once they are isolated from the environment. Complete dentine caries removal does not seem to be essential to control caries progression. (Oliveira et al.2006).

Complete versus partial removal of soft dentine from cavity floor: The partial removal of carious dentine and sealing of the cavity for a period of 36-45 months prompted pulpal defence reactions and arrest of the carious lesion (Maltz et al., 2007).

Treatment of deep carious lesions by complete or partial removal: A critical review

Several additional studies have demonstrated that cariogenic bacteria, once isolated from their source of nutrition by a restoration of sufficient integrity, either die or remain dormant and thus pose no risk to the health of the

dentition (Thompson et al, 2008).

Advantages

- Minimal cavity preparation
- Pits and fissures are also sealed
- No need for local anaesthesia
- Anxiety is minimized
- Does not require not electricity and expensive devices
- Materials are inexpensive
- Procedure is cheap
- Eliminates in inequality in access to restorative dental care

Survival of ART restorations

Atraumatic restorative treatment versus amalgam Restoration longevity: a systematic review.

In the permanent dentition, the longevity of ART restorations is equal to or greater than that of equivalent amalgam restorations for up to 6.3 years and is site-dependent. No difference was observed in primary teeth. Mickenautach, Yengopal & Banerjee. 2010).

Ten-year survival of ART restorations in permanent posterior teeth

The 10-year survival of single- and multiple-surface ART restorations assessed using the ART criteria were 65.2% and 30.6% respectively. Using the USPHS criteria, the 10-year survival of single- and multiple-surface ART restorations were 86.5% and 57.6%, respectively. (Zanata, Fagundes, Freitas, Lauris & Navarro. 2010)

The Atraumatic Restorative Treatment (ART) approach for managing dental caries: a meta-analysis cconcludes that single-surface ART restorations using high-viscosity glass-ionomer in both primary and permanent dentition show high survival rates and meets the American Dental Association (ADA) standard for quality restorations. (van 't Hof MA, Frencken JE, van Palenstin Helderman WH and Holmgren CJ.. Int Dent J, 2006;56:345-351)

For a successful ART restoration, a clinician needs:

Knowledge of caries process, knowledge of chemistry and handling characteristics of restorative materials, excellent restorative materials, sharp instruments, clinical skills and diligence. Attending an ART course is an advantage.

Conclusion

Extend prevention and think Atraumatic Restorative Treatment without extension for prevention to stop the Repeat Restoration Cycle and tooth extractions.

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DENTAL DIGEST

The Dentist's role in recognizing childhood abuses: study on the dental health of children victims of abuse and witnesses to violence.

Montecchi PP,Di Trani M, Sarzi Amade D, Bufacchi C, Montecchi F, Polimemi A Eur J Paediatr Dent 10,185 – 187 (2009)

Aim of this study was to verify the hypothesis that dental neglect is often associated with other forms of neglect; therefore, it could represent an important sign in identifying childhood abuse and neglect. The study compared a control group with a group of children with psychological disorder. Results indicated that the abused children had a significantly higher dental plaque index, a higher gingival inflammation, a higher number of untreated decays, more evidence of neglect. In addition, the abused children were less cooperative during dental visits. The data support the view that that the abused children were more neglected by their care givers.

FACT BOX

Birth defects

- Left lip and palate are the most common types of congenital birth defects.
- Risk factors are genetic predisposition, poor nutrition, smoking, alcohol and obesity during pregnancy.
- Average incidence rates vary for different ethnic groups.
- Incidence rates for 100,000 live births for some groups are as follows: African Americans 50; Caucasians 152; Asians 225.
- If properly treated, complete rehabilitation is possible.
- Necessary facilities and trained personnel are not available in many less developed countries.

CDA Administration

General Matters:
For queries of a general nature and membership please contact the CDA Administrator,
Ms Ulrike Matthesius at:
Administrator@cdauk.com

CDA Secretary Matters:
please contact the Executive Secretary, Dr Sam Thorpe at:
Sam.Thorpe@cdauk.com

Financial Matters:
For subscriptions, invoices and other financial matters, contact the CDA Treasurer,
Dr Anthony Kravitz at:
Anthony.Kravitz@cdauk.com

Communications:
For website and contacts database updates, contact:
Mr David Campion at:
David.Campion@cdauk.com

Four Day Workshop in Barbados

The Commonwealth Dental Association in conjunction with the Barbados Dental Association will be hosting a meeting/workshop in Barbados at the Accra Beach Hotel and Spa from Tuesday November 22ndto Friday 25th2011. The theme of the meeting is "Education, Abuse, Neglect and the Oral Care Practitioners".

Barbados is one of the most sought after destinations for tourists and is an ideal location for hosting this meeting, with the venue located on its south coast on one of the island's most popular beaches. This is a beautiful time of the year to visit the island.

The Programme

The "Education" part of the programme will include presentations by Noam Tamir, CEO and Chairman of "Smile-on Ltd" and Professor Stephen Lambert-Humble, Dean of Postgraduate Dentistry for Kent, Surrey and Sussex (KSS Deanery). It will also include an on-line lecture demonstration featuring Dr Raj Rattan and is designed to inform attendees of the best practise in approaching continuing professional education. Such methods of disseminating education are now a reality that will be of great benefit to colleagues who live in isolated areas such as the Caribbean. These benefits are especially important when attaining higher degrees, without being away from home and practice for long periods.

There is an extensive list of lectures within the "Abuse and Neglect workshop" including lecturers from the legal fraternity, the child-care board, psychology department, forensic dentists and many others who have been invited to participate in this interactive event. These lecturers will provide an insight into the dilemma that faces the dental profession in recognising abuse/neglect. This topic is relatively new to the dental profession and it is expected to generate much discussion. Delegates will leave with some practical hands-on experience in identifying bite marks and the protocols that should be followed in such cases.

Further details, including a copy of the full programme, can be obtained from August 1st 2011 at: www.caribbeandentalprogram.com

Registration

The convention registration fee, which is expected to be around £500, will cover all lectures, coffee breaks, lunches, afternoon breaks and social events over 4 days. Delegates who do not want full registration can register daily, but will be entitled to attend only that day's academic programme, inclusive of breaks.

The Accra Beach Hotel & Spar

The hotel has a total of 224 rooms and is located on one of the finest beaches in Barbados. There are ample lecture room facilities.

The hotel facilities include free wireless internet service, an outdoor pool with pool bar, a fitness centre, and a boardwalk overlooking the beach. Each room has air-conditioning, an overhead fan, a safety deposit box, coffee maker and cable television. There are many restaurants in the area for those who would prefer to eat out. One of the world's heritage sites (the Garrison) is approximately one mile away.

Delegates requiring more information can go on-line to: http://www.accrabeachhotel.com/main.html

Delegates are asked to call, text or email for reservations, but must quote "**the dental convention group code 190016**" to receive special convention rates of:
BB$400.00 (£133)/night single
BB$440.00 (£147)/night double
occupancy, bed and breakfast. Any delegate requiring special services must request them when booking their accommodation.

There is some funding available from the Commonwealth Foundation (through the CDA) for up to 5 male and 5 female dentists from Commonwealth countries & dependencies in the Caribbean (excluding Barbados) to assist with the bulk of their travel costs, to pay for their accommodation for up to 3 nights and their registration fees. This financial support will be restricted to 1 dentist from any one country on the basis of "first come first served"
For further information email:
Dr Anthony Kravitz at
treasurer@cdauk.com
and copy to:
administator@cdauk.com

Accra Beach Hotel, Barbados

CDA/MDA/FDI World Dental Federation Joint International Scientific Convention and Trade Exhibition 2012

Sarawak will host one of the largest dental conventions in the region, the upcoming CDA/MDA/FDI World Dental Federation Joint International Scientific Convention and Trade Exhibition 2012. The conference which is held in conjunction with Malaysian Dental Association (MDA) 69th annual general meeting will be held from **May 25 to 28 at the Borneo Convention Centre Kuching.**

Expected to draw more than 3,000 delegates from all corners of the world, the upcoming conference will be held amidst multiculturalism and ethnicity in the city capital of Kuching.

With the theme "Dentistry- Bridging Technologies Past, Present and Future", the objective of the conference is to bridge technologies and sharing of ideas among dental practitioners worldwide. The event provides delegates with a professional, educational and thought-provoking series of lectures and seminars presented by an exciting list of speakers. The headline stage will boast many celebrity speakers presenting various topics in esthetic dentistry, Prosthodontics, implant dentistry, orthodontics, endodontics, oral and maxillofacial surgery and pediatric dentistry. They are from the USA, Taiwan, Portugal, Switzerland, UK, France, Canada and Malaysia. Among prominent speakers to watch out for are:-

• Dr. David Garber who is a dual trained clinician and professor in the Department of Periodontics as well as in the Department of Oral Rehabilitation at the Medical College of Georgia. His specialty is Aesthetic Dentistry.
• Dr Chris Chang who is currently practicing in Taiwan; he received his PhD in bone physiology and Certificate in Orthodontics from Indiana University in 1996. His specialty is Orthodontics and he has been actively involved in the design of orthodontic bone screws and their application on managing impacted teeth.
• Dr. L. Stephen Buchanan who is a diplomate of the American Board of Endodontics and a fellow of the International and American Colleges of Dentistry. He also serves as an assistant clinical professor at the University of Southern California School Of Dentistry and at the University of California, Los Angeles School of Dentistry. His specialty is endodontic and implants surgery.

Malaysian Dental Association Eastern Zone (MDAEZ) has appointed two prestigious hotels in Kuching city as their official hotel partners namely: Pullman Hotel and Resorts as official platinum hotel partner and Riverside Majestic Hotel as official gold partner. These hotels will offer a choice accommodation for the delegates from various countries.

There will also be a trade exhibition held during the conference and MDA is offering 200 booths for local and foreign exhibitors to display their services and products.

Those interested in attending the convention and exhibition can visit the official website at http://mdaez-convention.com.

There may be some partial funding available to members of NDAs which are members of the CDA to attend this convention. Further details can be obtained from the CDA.

This news item is based on a press release by:

UCSI Communications Sdn Bhd, Lot 2498, Block 16, KCLD Jalan Tun Jugah, 93350 Kuching, Sarawak, Malaysia Tel: +60 82 455 255 Fax: +60 82 455 573; Website: www.ucsicommunications.com

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Seventh CDA Triennial Meeting 2012 – Cape Town, South Africa

The next CDA Triennial General Meeting will take place in Cape Town, South Africa, on Saturday 3 November 2012. The venue will be the Cape Town International Convention Centre (CTICC), near the Waterfront, the foremost social, leisure, accommodation and conference district in Cape Town.

The CDA meeting will be held as part of SADA's main annual conference.

The educational programme for the event is currently in development and will be circulated to CDA member associations at the beginning of 2012.

The CDA Business Meeting will consider changes to the CDA's Constitution to move from triennial to biennial meetings. It will also elect the officers for the next term of office.

We invite members to put the date in their diary and look forward to seeing you there in November 2012.

CDA WEBSITE

The CDA website provides a facility for the dissemination of information to all the Commonwealth dental associations and includes access to the former CDA Newsletters and subsequent Bulletins.

The website also contains articles of relevance to the CDA, a Who's Who of the current Executive Committee and, importantly, contact information for CDA and its officers.

Whereas previously the CDA had a large number of Newsletters and Bulletins printed and posted to Commonwealth Associations, the cost of printing and distributing has been saved by only making the Bulletin available on the web and by email.

The printing costs saved are now used to further the CDA's other objectives and compensate for the increasing difficulty of attracting support grants in the current financial climate.

The CDA Executive wishes to remind associations that the CDA website is being used for information and announcements so they should make a point of visiting it from time to time. If they wish to be notified by E-mail of any new information put on to the website then they should send CDA the E-mail address of the person to be notified. The E-mail should be sent to:

webmaster@cdauk.org

The CDA website address is:

www.cdauk.com

CDA Contacts

Please use the folllowing E-mail addresses for formally contacting CDA:

Secretary@cdauk.com
Treasurer@cdauk.com
Membership@cdauk.com
Bulletin@cdauk.com
Administrator@cdauk.com
Webmaster@cdauk.com

CONTACT INFORMATION

CDA uses electronic information as its primary means for communication so it is important that it has an up to date record of E-mail addresses.

People do occasionally change their E-mail address so please keep us up to date with yours if you change it.

Please circulate this Bulletin to your colleagues.

It can also be found on the CDA website at:

www.cdauk.com

This issue has been timed to include the details for the Barbados Workshop

Bulletin Editor:
Prof D Y D Samarawickrama

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