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

Message from the President

Greetings to you all!

As we look forward to our 6th Triennial Meeting in Singapore in September 2009, it is important that all dentists in the Commonwealth reflect carefully on the extent to which we have participated in meeting the Millennium Development Goals. Even though one or two of the goals might not appear to be closely related to what we do daily, I strongly believe that as responsible citizens of our respective countries, we should contribute indirectly. It is with this background information in mind that I kindly request all Presidents of National Dental Associations to initiate the process of discussing this matter in their respective associations. Hopefully, we shall in due course get an opportunity to share our experiences with our colleagues within the Commonwealth.

The other issue which has been of concern to me is the fact that we are not sharing adequately information emanating from our various activities in different regions of the Commonwealth. For example, if there is something unique to a given region which has been initiated for the sake of improving the delivery of dental care, it should be forwarded to the regional Vice-Presidents in the form of a written report on its onward transmission for publication in the CDA Bulletin. This way, we shall be kept informed of the activities in the dental associations which are members of CDA.

Finally, I wish to appeal to all our members who will be attending FDI meeting in Singapore to attend our 6th Triennial meeting. It will give us an opportunity to interact with you and appreciate the challenges facing each one of you as you work tirelessly to serve our members and the general public.

Prof. Jacob T Kaimenyi *PhD*
President

Editorial

From the Editor

It is that time of the year when the sun only makes an occasional appearance, the days get shorter and we reach for our warm clothes. Mind you, those of you dear readers in the southern hemisphere will be shedding your "winter woollies", looking forward to enjoying the summer and reaching for the sun tan lotion. And the rest of you in the tropics will look forward to more of the same warm weather broken up with some timely rain. However, whether it is winter or summer, all of us have been affected by the financial Tsunami. With banks running out of money to lend, financial markets in turmoil, pension funds depleted and growing unemployment, it is a stark reminder of the limits of wealth. The economic downturn is even harder for less developed nations to deal with. At times like these, health and education budgets are particularly likely to be under scrutiny.

It is all the more important, therefore, for us to work together whether we are in the developed or the less developed parts of the world; whether we are in education, finance or health care. It is my belief that only a concerted effort can get us out of the mess we are currently in.

In the meantime, we have to continue with our work to improve oral health of the people we are here to serve. This issue quite appropriately contains a report on the financial health of the CDA. There are two reports from Botswana on continuing education programmes. A report from Sri Lanka highlights the issue of brain drain and outlines some strategies to retain skilled health workers in their home countries.

The main article in this issue deals with an important subject: tobacco, health and disease. It is recommended reading for every health care worker.

CDA is looking forward to working with other organisations such as Bridge2Aid to promote oral health. The triennial meeting of the CDA is scheduled to be held in Singapore next year.

In meantime, the Bulletin brings you Compliments of the Season and Best Wishes for a Successful and Peaceful 2009.

DYD Samarwickrama

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CDA FINANCIAL REPORT

Dr Anthony S Kravitz OBE
CDA Treasurer

Dr Anthony Kravitz

Financial Report for 2007-08

The year was again successful financially and we ended with a surplus of funds. However, much of this came from a reduced expenditure (see below). This has enabled me to build our reserves for a "rainy day" – which looks like being during the 2008-09 year.

Our turnover for the financial year was just over £30,000 – a big reduction on the previous year (£8,000). However, the grant we received from the Commonwealth Foundation was over £3,000 less, accounting for some of this shrinkage. We are also finding external commercial sponsorship harder to find and we received £5,000 less than the previous year. We do continue to be sponsored with regular contributions from Dr Mike Knowles, for which we are very grateful.

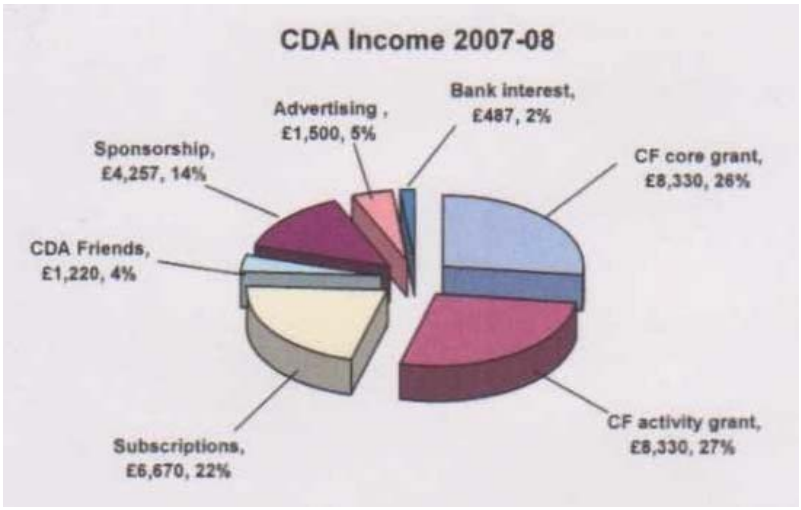
Despite the small increase in our subscription rate – agreed at the 2006 Triennial – now working through, currently subscriptions and contributions from CDA Friends are static and only form a small percentage of our income. This is very concerning, as without the support of our members we cannot continue to exist. It needs to be discussed at next year's Triennial meeting.

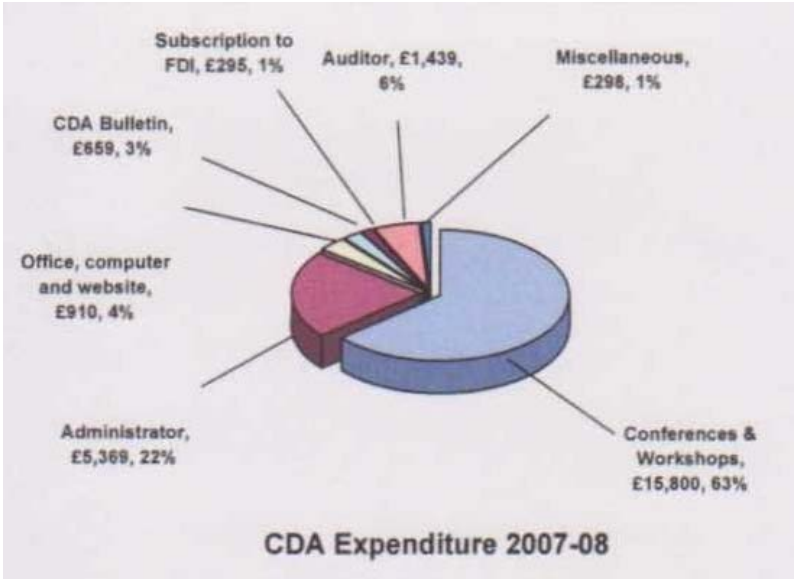
The very sad death of our Administrator, Julia Campion, shortly after the start of our financial year meant that for several months much of the work running the Association was undertaken by two of the honorary officers – who by definition had to work unpaid. This meant that our expenses were reduced and were completely covered by funding from the Commonwealth Foundation, for which we are very grateful. These officers have continued to bear some of the administrative load and so our new Administrator (Ulrike Matthesius), will cost us a smaller annual amount.

Our Auditor's fees are considerably higher this year as a result of the additional work necessary following our mid-year disruption. However, because of the new financial systems we now use, we are advised that the fees should be considerably lower in future years.

Of course we exist to carry out activities and the cost of these naturally formed over half our expenses in the year. Fortunately the grant from the Foundation and sponsorship meant that we undertook these at nil cost to our reserves.

Our small surplus of funds this year has been transferred to these reserves. Whilst the reserves are currently standing at almost the equivalent of our annual turnover, I am afraid they will deplete during the current and subsequent financial years, unless we can find urgently sponsors for a forthcoming workshop in Tanzania and our Triennial meeting in Singapore – both in 2009.





Meeting Reports from Botswana

**Dr. Clement Luhanga,
CDA Vice-President,
Southern Africa Region**

Aesthetic Dentistry

On the 18th October 2008, the Botswana Dental Association (BODEA) hosted a continuing education programme for its members. The theme was Aesthetic Dentistry and wholly sponsored by *3MESPE* Company. The main presenters were from University of Pretoria and *3MESPE* itself.

Dr. Paul Brandt, Senior Lecturer and Researcher in the Department of Dental Materials presented new ideas and innovative information on modern day composite materials, their indications and correct methods of usage with a view to obtaining optimal benefits with a reduced rate of failures.

The lecture on traditional composites was very informative. *Filtek* which is the first direct posterior composite to achieve less than 1%shrinkage, has set new standards. The more traditional composites which are methacrylate based, have posed a big problem to dental practitioners due to their high percentage of shrinkage causing decreased marginal integrity, unwarranted enamel fractures, postoperative sensitivity and leakage.

3MESPE through their research have now brought a new era in dentistry through this silorane chemistry. The advantages of Silorane over traditional composites are:

1. Excellent marginal integrity
2. Reduced enamel fracture
3. Reduced postoperative sensitivity
4. Reduced risk of secondary caries
5. Increased working time of 9 minutes
6. Easy and fast to polish
7. No slumping

Disadvantages

1. Limited shades available
2. Uses own self-etch and primer and bonding system.

Important points when using composites to be borne in mind are:

1. Round all sharp margins to avoid fractures
2. Buccal chamfer or palatal butt joint in anteriors
3. Packing must be done in incremental layers of 2mm
4. Correct use of bonding agents and preceded by correct etching technique
5. Use of translucent shades for incisal edge.

Following presentations on composite, Dr. Christine Strydom, Manager of *3MESPE* Products Division presented a good overview of the use and application of glass ionomer cements GIC in dentistry which are as follows:

- For geriatric patients
- Atraumatic Restorative Technique - ART
- For management of caries in children
- Core build up
- Luting, lining and fissure sealing.

The unique properties of G1C make them very useful in dentistry:

1. Excellent biocompatibility
2. Reduced micro-leakage
3. Easy handling
4. Fluoride release

BODEA wishes to thank *3MESPE* for hosting this programme and Dr. P. Brand and Dr. C. Strydon for their wonderful presentations. Last but not least, *Megadent Dental* and *3MESPE* are thanked for their support.

One day Continuing Education Course

In fulfilment of Botswana Dental Association (BODEA) policy implementing continuing education programmes for its oral health team, a one day course was held for 70 delegates mainly Dental Surgery Assistants (DSA) and Receptionists. The course was sponsored by Colgate Palmolive, South Africa and the lecturers were from the University of Tswane Science and Technology in Pretoria, South Africa. The topics presented were:

1. Teamwork and motivation
2 Health care waste management in dentistry
3 Tooth surfaces charting
4 Child abuse: The Responsibility of the Dental Team
5 Halitosis

The morning began with some outstanding lectures by Dr. Elize Prinsloo covering four topics as follows:-

Teamwork and motivation

Teamwork is extremely important in dentistry as members of the dental team work very closely together. Knowledge of the strong/weak points of each member makes it easier to determine the duties and responsibilities of staff. People who feel that they are part of a team have greater loyalty and their work ethics are also better. The bonus of teamwork is that staff knows that there is a support system in place and this leads to motivation of personnel. Taking turns to be the leader of the team is educational and makes personnel realize what the duties of other team members are. Motivated staff is a pleasure to work with and it rubs off on the patients as well. This creates a Snowball effect which is great for the marketing of the practice also.

Continued on Page 4

Health care waste management in dentistry

Knowledge of health care waste management is essential for personal protection and environmental protection. Every DSA should know how to dispose of "general", "medical" and "hazardous" waste in the correct way. The "Cradle to the Grave" concept is very important and means that you are responsible for waste from the moment it is generated till the final destruction of it – an incineration report has to be filed for each bag of waste collected. In general one should remember to REDUCE, RE-USE and RECYCLE as possible to protect the environment for future generations.

Tooth surfaces and charting

Assisting during the charting of the teeth is one of the most important responsibilities of the DSA. A clear understanding of tooth surfaces and knowledge of a charting guide is essential to properly assist the dentist. They should not shy away from performing duties due to a lack of knowledge – (this unfortunately often happens due to a lack of enthusiasm) – as continuous and self education are always options that remain open.

Child abuse – the responsibility of the dental team

The DSA is in an excellent position to notice signs and symptoms of child abuse as they work closely with patients. All DSAs should constantly be vigilant and look for signs of abuse and to report anything suspicious to the dentist. Suspect behaviour as well as suspect injuries should be reported to the local Child Line or relevant authorities. Child abuse is increasing at an alarming rate and we can no longer shy away from our responsibility to report suspect cases.

3MESPE presentation on dental materials

Kim Cave spoke on: glass ionomers, adhesives, composites, impression taking and cementations. The closure included aspects of personal motivation.

Then Maggi Oosthuizen spoke on halitosis i.e. problem of bad breath.

Halitosis

It can be accepted that the majority of adults will at least once develop bad breath and this has become a challenge to the dental professionals who have to deal with it at some stage. Recent studies show that volatile sulphur compound VSC in the mouth is the main cause of bad breath causing over 85% of these cases (an indication that bad breath originates from oral cavity).

Indications that bad breath originates from oral cavity are:

a. The odour comes mainly from the mouth not from the nose

b. The odour decreases when using a potent breath rinse

c. The odour increases as soon as the patient starts talking

d. The odour decreases as soon as good oral hygiene cleansing has been implemented.

e. The odour increases dramatically when the mouth is dry.

The participants concluded that the meeting was very educational.
The marketing of the courses was done by Prof Elize Prinsloo.

Dental Digest 1

Is physical therpy effective for temperomandibular disorder?

A revier of 30 studies has shown that active excdrcises and manual mobilisations may be effective. In addition, the following have also been found to be effective: mid-laser therapy; relaxation techniques and biofeedback;elec tromyography; postural training.

A systematic review of the effectiveness of excercise, manual therapy, electrotherapy, relaxation training and biofeedback in the mangement of temperomandibular disorder. Medlicott MS, Harris SR. Phys Ther 86: 955 -973 (2006)

PEOPLE

Professor Kofo Savage

Dean, School of Dental Sciences, College of Medicine, University of Lagos was elected to the FDI Council at the World Dental Congress held at Stockholm, Sweden recently. Following her graduation from the University of Lagos, she had her postgraduate training both in Nigeria and the United Kingdom. She is a visiting professor to several African universities. She is also an external examiner to the Universities of Ibadan and Benin in Nigeria and the University of Ghana. She publishes widely and has co-authored two books in dentistry. She is married with two children.

Professor D.Y.D. Samarawickrama has been elected the President of the British Association of Teachers of Conservative Dentistry. He is also the winner of the DDU Dentist Teacher of the Year (UK & Ireland) Award 2008. This prestigious award is keenly contested by all dental academics and is sponsored by the Dental Defence Union, the British Dental Association and Dentsply UK.

A Case Study on Successful Retention Strategies

Dr. Suresh Shanmuganathan,
BDS(SL), MS(Col), FDSRCS(Eng), MSurgDentRCS(Ed), FIAOMS
Sri Lanka

Introduction

To address the issue on successful retention of Health Workers, one has to highlight the issues around health workers' migration, which are as follows:

• More lucrative employment overseas and better living standards.

• Unequal distribution of facilities like educational facilities for children, sanitation in the different regions of the country, which pushes the workers to migrate primarily to urban areas from rural areas or else to overseas; similarly workers from urban areas to greener pastures.

In the past, Sri Lanka has not adequately explored the avenues of rendering services of highly skilled professionals in the field of health and is in the process of developing strategies to achieve a satisfactory outcome with wider range of benefits to all concerned parties.

Country experiences on efforts to better manage the migration of health workers – the Knowledge Economy

• Foreign employment is the second largest foreign income generating avenue in Sri Lanka and more than 50% of its income comes through unskilled labour exportation, mainly from housemaids employed in the Middle East.

• Sri Lanka's earnings from skilled jobs comprising of professional (intellectual labour) and technically skilled people, has played a lesser role so far and the professionals have mainly contributed to the 'brain drain' only.

• While appreciating the valued financial contributions made by unskilled workers, unskilled labour exportation from Sri Lanka would lead to several consequences including issues of social destabilization.

• Skilled worker exportation has its own benefits, while eliminating the negative aspects of unskilled labour exportation. It will safeguard the welfare of the employee as employers are expected to fulfil standard obligations in skilled worker exportation. The revenue generation is several times higher and the knowledge and experience gained by the worker would be beneficial for the development of the country by sharing and exchanging the knowledge gained.

• In addition to financial benefits, it is important to make necessary arrangements for health workers to improve and update their knowledge and skills regarding the new management protocols and procedural techniques. This would be immensely useful to improve attitudes, to learn about employment issues, patient care and to gain experience by working at centres in developed countries.

The following strategies have been identified by the professional medical and dental associations in Sri Lanka with the concurrence of Government of Sri Lanka to counter the problem around health worker migration.

Retention Strategies in Sri Lanka

Establishment of a Foreign Placement Coordinating Centre (FPCC) to promote, secure and coordinate the overseas placements without disrupting the local healthcare system, while improving our existing system.

• Establishment of links with training centres - FPCC will work in collaboration with Ministry of Foreign Affairs to mobilize overseas missions to arrange permanent training positions at recognized overseas centres. This will ensure fixed number of training positions every year and more links will be established through government mediation. This would bring knowledge, skills of modern medicine and facilitate sharing experience in medicine, research and collaboration.

• Promotion of medical tourism, so that health workers trained abroad through the programme would be able to contribute towards the development of the field.

• Revenue generation through promotion of ethical research and collaboration at national and international level.

Conclusions

These measures would not only improve the training and career prospects of health workers, but reduce the brain-drain as well.

Sri Lanka is also embarking on programmes to train adequate number of health workers with the appropriate skills to cater to the private heath care system in addition to the public health care systems to respond to societal health needs.

From a paper submitted to the Commonwealth Asia Symposium on Migration of Health Workers, 17th – 18th November, 2008 New Delhi, India

ACKNOWLEDGEMENTS

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The CDA is very grateful for the continued support of Dr Michael Knowles, Integrated Dental Holdings, other sponsors and Corporate and Individual Friends of CDA.

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Tobacco, Health and Disease

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Professor of Oral Medicine and Experimental Oral Pathology, King's College, University of London,
Director, WHO Collaborating Centre for Oral Cancer, UK

Introduction

There are about 60 varieties of nicotiana species and over 100 varieties of tobacco are used to prepare commercial products. The majority come from n. tabacum species. Every year, the use of tobacco products causes a heavy toll of deaths and considerable human disease worldwide.

Tobacco is used in a variety of ways, mostly are smoked but many populations use smokeless tobacco, which comes in two main forms: snuff (finely ground or cut tobacco leaves that can be dry or moist, portion packed in sachets) and chewing tobacco (loose leaf, in pouches of tobacco leaves, plug or twist form) .

Different tobacco products used amongst populations are shown in Table 1:

Smoked	Smokeless (Oral)
Cigarettes	Chewing tobacco (twist/roll)
Cigars	Moist snuff
Local hand rolled proucts (bidis, cheroots)	Snus (Scandinavia) Betel quid (SE Asia)
Pipes	Snus (Scandinavia)
Water pipes	Pan Masala, Gurka, Mishri, Zarda, gudakhu (SE Asia)
	Shammah, Toombak (N Africa)
Smokeless (nasal)	Nass (Central Asia)
Dry snuff	Naswar (Afganistan, Pakistan)
	Chino, Iq' milk

Table 1: Tobacco products

Smoking has been identified as a major risk factor of many cancers, heart disease, peripheral vascular disease and chronic pulmonary obstructive disease (COBD).

The most serious disease caused by smoking is cancer and there are several target organs in the body which includes lung, oral cavity, pharynx, larynx, pancreas, urinary bladder, renal pelvis, urethra, nasal cavities and sinus, oesophagus, stomach, liver, kidney, uterine cervix and bone marrow cancers. Furthermore, smokeless tobacco is known to cause cancer of the oral cavity and pancreas.

There are many oral disorders caused by tobacco and these are listed in Table 2 of which periodontal disease and mouth cancer appear to be the most important.

Aesthetic and social impacts	Severe gum disease
	Periodontal attachment loss
Stained teeth	Tooth loss
Bad breath (halitosis)	Implant failure
Reduced sense of taste and smell	Delayed wound healing
	White and red patches
Oral pigmentation	Mouth cancer

Table 2: effects of tobacco on oral health

Periodontal diseases

Cigarette smoking is an important risk factor for periodontal disease and account for a high proportion of disease activity in the population. Some studies also suggest that smoking increases the risk of caries. Most published studies indicated that cigarette smokers are also more likely to have missing teeth and experience greater rates of tooth loss due to periodontal disease than non smokers. The hazards ratio for tooth loss was estimated at 2.1 among Japanese men who smoked cigarette compared with non smokers. The odds ratio for periodontal disease is also significantly related to frequency of smoking, rising from 1.5 for smokers between 1-19 per day to 2.81 for smokers 20 per day and more.

Oral Cancer

Oral and pharyngeal cancer group together is the sixth most common cancer in the world. There is a clear link between social deprivation and oral cancer. Evidence from around the world confirmed that risk of mouth cancer increases significantly amongst smokers compared to non smokers. It has been estimated that oral cancer risk is 3.4 three times higher in smokers compared with non smokers and 1.4 times higher among former smokers. These risks are also increased or energised by alcohol consumption and use of betel quick (areca nut).

Carcinogenic agents in tobacco

There are over 60 carcinogens present in tobacco smoke and today 28 carcinogens have been identified in tobacco used orally. These include benzo (a) pyrine, volatile aldehides, nitrosamines, inorganic compounds and radio nuclides. Although the dose of each carcinogen per cigarette/ chewing quid/portion of snuff is quite small, the cumulative dose over a lifetime is substantial.

Individual susceptibility to cancer depends on carcinogen uptake, how the ensign systems would metabolically activate tobacco ingredients and then pathways available for detoxification of these activated products by a phase II enzyme. Only a small proportion of smokers would however get cancer in a target organ. At present, we cannot predict which smokers are susceptible.

Precancer

In addition to squamous cell carcinoma, tobacco also causes oral potentially malignant disorders (OMPD's) in the mouth. These include leukoplakia, erythoplakia, erytholeukoplakia. Some populations in the world smoke tobacco with the lighted end of the cigarette or cigar inside the mouth and in these people, palatal lesions varying from white, red to brown are noted. These are referred to as reverse smokers' palate. Oral lesions caused by smokeless tobacco seem to be geographically located at sites where tobacco is placed. One would encounter leukoplakia of the buccal mucosa or the sulcus in the Asian tobacco chewers, lower lip keratosis amongst Sudanese toombak users and oral lesions on the maxillary labial sulcus among snuff dippers in Sweden. It is known that a proportion of these may transform to cancer and the detection of these lesions and thereby high risk subjects provide high opportunities to intervene at an early stage to prevent malignant transformation.

Prevention

Both in tobacco smoking and use of oral smokeless tobacco, nicotine remains the main determinant of addiction. Most smokers want to quit. Coordinated national strategies for tobacco prevention, cessation and control are essential in each country. Community based intervention like mass media, higher prices, smoke free environment aim to increase tobacco cessation by providing cessation services and availability of pharmacotherapy is likely to increase their chances of success.

Recommendations for intervention by health organisations to control oral cancer have been published.

Effective smoking cessation treatments are available and every patient who uses tobacco should be referred one or more of these treatments. Evidence based treatment methods that have been researched are outlined in Table 3. Advice and support from several health professionals could increase people's success in treating smoking. Individual counselling and intensive treatment is better than brief advice. Nicotine replacement therapy NRT aims to reduce cravings and withdrawal symptoms associated with stopping smoking by replacing cigarettes with therapeutic nicotine.

	Type of Therapy	O d d s ratio
1	Nursing intervention	1.28
2	Physician's advice	
	Brief advice	1.66
	Intensive advice	1.84
3	Dentists' advice	1.44
4	Counselling	1.56
5	NRT	1.58
6	Clonidine	1.89
7	Bupropion	1.94
8	Varenicline	2.33
9	Acupuncture	1.36

Table 3: Evidence-based treatment methods

The use of NRT increases chance of stopping smoking by approximately 50-70%. NRT is available in skin patches, chewing gum, lozenges, tablets, inhalers and nasal spray. Those receiving intensive treatment along with NRT are about 4 times more likely to quit and remain quit. Stopping smoking has been shown to reduce lifetime risk of developing oral and other cancers.

Most adult smokers would like to quit, and as revealed here effective therapies are available. Adverse health consequences of smoking and oral tobacco could be avoided by improving awareness and by providing services that are accessible to people at risk.

Prevention of smoking onset by public education and support for smoking cessation through health care providers could contribute to saving lives.

CDA Administrator

Ulrike Matthesius

Ulrike Matthesius was appointed to the post of CDA Administrator in April 2008. She has worked at the British Dental Association for over 10 years and for much of this time has been involved with international issues. She combines her CDA role with her existing one at the BDA.

She can be contacted:

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CDA Administration Arrangements

General Matters:
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Please contact the Executive Secretary Dr Sam Thorpe at:
secretary@cdauk.com

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

Communications:
For website and membership database queries, contact:
Mr David Campion at:
webmaster@cdauk.com

Forthcoming Events

Caribbean Dental Program at Grand Barbados Beach

The venue for the convention

It is with great pleasure that Caribbean Dental Program invites you to attend its 2009 convention due to be hosted at Grand Barbados Beach resort from 16th to 19th April inclusive. It is hoped that you will be able to attend and that you will also inform all dental personnel whom you know about the event.

The event is not restricted solely to dentists as lectures have been included to educate and update medical doctors, medical staff, dental surgery assistants, hygienists, reception staff, dental technicians and members of the public who have an interest in all the new techniques that will be of great benefit to the general public.

Barbados is one of the most sought after destinations and we are very fortunate to be hosting this meeting at one of our luxury hotels which is centrally located in Carlisle Bay and within two minutes of our city (Bridgetown) and also within walking distance of the historic garrison and George Washington House where the former president stayed on his only visit outside of the USA.

We are hoping to commence on-line registration on 15th December when all arrangements are in place.

Information can also be accessed at:
www.caribbeandentalprogram.com

Dr. Victor Eastmond

Invitation to a Workshop in Tanzania

The CDA and the Tanzanian Dental Association are teaming up with Bridge2Aid for our next workshop. *Training of Rural Clinical Officers in Urgent Oral Treatment, a Challenge to the Oral Health Professions* will be held in Mwanza from Tuesday February 24th to Thursday February 26th 2009.

The programme will include sessions on the training programme structure, resources, techniques, evaluation and supervision. Participants will then visit a local health centre for a demonstration of the training model. Written course material will be supplied to participants, also and there will be a small social programme, including informal dinners.

There will be WHO and FDI input to the international problem and discussions about the system in Tanzania and their strategy. This workshop will be especially attractive to countries which wish to set up oral health outreach programmes.

The workshop will be restricted to 15 participants, who will be selected on a "first-come-first-served" basis. There is some funding available from the CDA **for dentists from developing countries**, to assist with the bulk of their travel costs and also to pay for their accommodation. This financial support will be restricted, in the first instance, to one dentist from any one developing country. **Funded participants must have support from their relevant dental association.**

If you would like to attend this workshop, please get in touch with Ulrike Matthesius, the CDA Administrator, at:
administrator@cdauk.com
by January 5th 2009 (when the first allocations of funding will be made).

If all available CDA funds are not taken up initially, further requests for financial support from a dental association with an already supported participant will be considered. So, **it is important for all potential participants to apply as early as possible and for the dental association to indicate an order of priority**.

CDA Triennial Meeting

The next CDA Triennial Meeting will be held in Singapore on 5 September 2009 at the Suntech Singapore International Convention and Exhibition Centre, on the fringes of the FDI Annual World Dental Congress.
There will be a workshop on an infection control topic in the morning, with the business meeting and the election of officers in the afternoon.
The event will close with a reception.
Details of the event, as well as requests for the nomination of officers, will be circulated via email to national dental associations early in 2009.
For more information, please contact Ulrike Matthesius on:

administrator@cdauk.org

Dental Digest 2

Association between periodontal disease and pregnancy outcomes

More than 7000 from seventeen studies were studied. More than a thusand of these with periodontal disease delivered a preterm and/or low birth weight baby ($p<0.0001$).However, the better the quality of the research study, the lower the strength of the association. Therefore, larger, well designed studies are needed to confirm this possible association.

Preterm low birthweight and maternal periodontal status; a meta-analysis Vergnes JN, Sixou M. Am J Obstet Gynecol 196: 135.

Dental Digest 3

Controlling pain after oral surgery

Twenty one trials involving nearly 2000 patients who had undergone third molar surgery were analysed. Of these, 1133 patients took paracetamol and 835 the placebo. Paracetamol provided a statistically significant benefit for pain relief at both 4 hours and 6 hours. In addition, a higher dose of 1000 mg. gave a greater benefit for pain relief than a dose of < 1000 mg.

Paracetamol for pain relief after surgical removal of lower wisdom teeth. Well k, Hooper L, Afzal Z, et al. Cochrane Dataase Syst Rev 3: (2007)

The Atraumatic Restorative Technique ART for treating root caries in the elderly

One hundred and three elderly persons had 162 root restorations placed of which 78 were done using the ART technique. The rest were done conventionally. The material used for both groups was glass ionomer cement. After 12 months, 66% of the ART and conventional restorations were sound. There was no statistically significant deifference between the two types.

ART and conventional root restorations in elders after 12 months. Lo EC, Luo Y, Tan HP, Dyson JE, Corbett EF. J Dent Res 85: 929-932 (2006)

Long term stability after orthodontic treatment

Thirty eight studies involving the treatment of crowding were analysed. Although the treatment was successful, crowding of lower anterior teeth recurred post-retention. There is a need for well designed studies to address this issue.

Long term stability of orthodontic teatment and patient satisfaction. Bondemark L, Holm AK, Hansen K et al. Angle Orthod 77: 181 – 191 (2007)

CDA Website

The CDA website provides a facility for disseminating information to all the Commonwealth Dental Associations including access to the former Newsletters and subsequent Bulletins.

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

Whereas, previously, 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, apart from a very limited number of copies that are printed and posted and some which are directly E-mailed to CDA Associations.

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

The CDA website is available at

www.cdauk.com

David Campion *- Webmaster*