Are your patients’ dentures truly clean?

Even visibly clean dentures can have hidden dangers. The denture surface contains pores in which microorganisms can multiply and thrive. Up to 80% of patients use toothpaste to clean their dentures.2 As dentures are approximately 10x softer than enamel, the abrasive nature of toothpaste can create scratches, which may lead to increased microbial colonisation, resulting in gum irritation or denture malodour for your patients. These inadequate cleaning methods can cause the appearance of your specially made and well-fitting dentures to deteriorate and affect your patients’ denture wearing experience and satisfaction.

Corega® Extradent denture cleanser – specially designed for dentures

• Corega® Extradent cleanser offers patients the dual benefits of mechanical and chemical cleansing†

• Corega® Extradent cleanser is proven to penetrate the biofilm2 and kill microorganisms even within hard-to-reach denture surface pores5

• Corega® Extradent cleanser is non-abrasive†, unlike toothpaste, and does not create scratches, which can lead to increased microbial colonisation

Offer your patients proven daily protection with Corega® Extradent denture cleanser

Brushing with Corega™ Extradent was associated with significant (p<0.005) reduction in depth of abrasion compared with a regular toothpaste2
d

By Dr David Muscat

Dear colleagues,

At the FDI General Assembly in Poznan this year, the FDI redefined Oral Health. This definition lays the foundation for the future developments of standardised assessment and measurement tools.

Oral Health is multi-faceted and includes the ability to speak, smile, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and without pain, discomfort and disease of the craniofacial complex.

Oral Health:
• Is a fundamental component of health and physical and mental well being
• Reflects physiological, social and psychological attributes essential to the quality of life
• Is influenced by individuals changing experiences, perceptions, expectations and ability to adapt to circumstances.

In 2017 the FDI will focus on the development of a standard measurement instrument that can be applied across countries and across settings.

At our last EGM a subcommittee was set up to look into the issue of foreign dental schools opening in Malta. The DAM has had meetings with the Health authorities regarding the Draft Dental clinics regulations. There will be further Medical Emergencies courses. There will also be a course on 3D radiography.

The DAM Christmas party will be held on 7th December at The Hilton.

A Happy Christmas to you all!

Best regards,

David
Dr David Muscat B.D.S. (LON) Editor / President, P.R.O. D.A.M.

References:

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Editors are responsible for the claims made in their ads and the opinion of the advertisers and editors of articles in the issue are not necessarily the opinion of the DAM.
OptraGate®
The latex-free lip and cheek retractor

The gentle solution for a better view

• Efficient treatment and easier relative isolation
• Enlarged operating field and easy access to cavity
• Increased comfort for patients
• Attractive colours for enhanced patient compliance among children

The Dental Probe December 2016 – Issue 60
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www.ivoclarvivadent.com

INTERVIEW WITH DR GLAZER

HOW DID THE IDEA FOR A SCULPTING INSTRUMENT WITH FOAM TIPS ORIGINATE?
My two partners, Dr. Dominic Viscomi and Brian Viscomi, and I were fooling around with foam to sculpt a direct resin veneer and we discovered that it would not stick to any composite and left no marks when moving the composite. Brian then went on to design a handle and a way to hold the foam on the handle.

HOW DID YOU SCULPT STICKY COMPOSITE RESINS IN THE PAST? WHAT WERE THE DISADVANTAGES?
In the past all we had were metal instruments and then over time other instruments evolved with tips of rubber, silicone, teflon or even gold but none worked well. These types of instruments would leave indentations and a rough appearance to the composite surface.

We also have had composite warmers and vibrating/oscillating instruments that all tried to make the composites more fluid to allow for better placement. Sometimes we would use a fine sable brush to move and shape the composite resins but these brushes would leave striations on the composite surface and we had to make them disposable since there was no effective way to sterilize them between patients.

IN WHAT WAY HAS OPTRACULPT PAD CHANGED YOUR WORK WITH COMPOSITE RESINS?
OptraSculpt Pad has made it remarkably easy to work with any composite since it is an ideal modelling instrument for shaping and contouring all composites. You can work faster and achieve a great esthetic result in less than half the time using any other instrument. A real bonus is how the OptraSculpt Pad leaves the surface in a state that requires very little finishing and polishing.

WHAT IS SO SPECIAL ABOUT OPTRACULPT PAD?
In addition to what I mentioned above, the fact that there are disposable tips in varying sizes makes it suitable for many types of restorations. And, the reference scales on the handle are quite valuable when doing direct anterior restorations.

WHAT ARE THE ADVANTAGES OF OPTRACULPT PAD COMPARED WITH OTHER COMPOSITE MODELLING INSTRUMENTS?
• Moves composite easily and leaves no marks
• You can place and spread the composite without any pull-back, stickiness (i.e. sticking to the instrument) or leaving any indentations
• Surface requires only minimal finishing and polishing, which saves time and money!
• No other instrument to my knowledge has a reference scale which indicates the average size of the anterior teeth and their natural inclination toward the midline.

IN YOUR OPINION, WHAT KIND OF INFLUENCE DOES OPTRACULPT PAD HAVE ON THE TREATMENT PROCEDURE INVOLVING COMPOSITE RESIN FILLING MATERIALS?
There is no doubt that the profession is rapidly moving towards more direct composite restorations in part due to the economy, and in a great part, due to the esthetic nature of composite restorations. OptraSculpt Pad will be a genuine asset to the profession in composite placement.

WHAT KIND OF ADVICE WOULD YOU GIVE TO YOUR COLLEAGUES FOR USING OPTRACULPT PAD?
Once you try the OptraSculpt Pad you will never use a metal instrument on resin again for sculpting and contouring. This is a no-brainer when it comes to time savings and achieving a highly esthetic result.
A STUDY OF THE RELATIONSHIP BETWEEN VENOUS DISEASE AND DIABETES MELLITUS IN MALTA

Schembri Leonard, Schembri Maria – Mater Dei Hospital – Malta

INTRODUCTION
The aim of this study was to assess the prevalence of Venous Disease in Diabetics compared with the general population in Malta (European Health Interview Survey EHIS 2008). Data was collected prospectively by one vascular surgeon in a tertiary referral hospital over a period of 5 years (N=5620). Diabetes was ascertained from patient histories within the same database. Diabetic patients in the population under study were compared to the diabetic population in the EHIS by gender and age group. The Odds Ratio for Venous Disease in patients with Diabetes was obtained for each group.

RESULTS
Significant p value findings in <30 age group who have both Venous Disease and Diabetes Mellitus whereas the rest of the EHIS population do not.

CRITERIA
Inclusion:
Patients diagnosed with Venous Disease and venous leg ulcers over 18 years of age.

Exclusion:
• Patients with autoimmune disease
• mixed aetiology disease
• haematological disorders
• Hansen’s disease
• peripheral vascular disease
• bowel disease
• crural disease
• malignancy
• donor graft from the affected lower limb
• and incomplete data

TOTAL POPULATION OF PATIENTS WITH:

<table>
<thead>
<tr>
<th>VENOUS DISEASE</th>
<th>VENOUS DISEASE &amp; DIABETES MELLITUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1409</td>
<td>184</td>
</tr>
<tr>
<td>178 (excluded)</td>
<td>41</td>
</tr>
<tr>
<td>1230</td>
<td>143</td>
</tr>
<tr>
<td>100%</td>
<td>8.6%</td>
</tr>
</tbody>
</table>

FINDINGS
After calculating the Odds Ratio for the two populations, an overall p value <0.001 was only found in the <30 age group as explained in the table below. This was driving the difference in the two groups.

<table>
<thead>
<tr>
<th>AGE GROUPS</th>
<th>VENOUS DISEASE &amp; DIABETES MELLITUS</th>
<th>EUROPEAN HEALTH INTERVIEW SURVEY 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30</td>
<td>8.48</td>
<td>0.009</td>
</tr>
<tr>
<td>31 – 40</td>
<td>0.76</td>
<td>0.731</td>
</tr>
<tr>
<td>41 – 50</td>
<td>1.60</td>
<td>0.227</td>
</tr>
<tr>
<td>51 – 60</td>
<td>0.91</td>
<td>0.715</td>
</tr>
<tr>
<td>61 – 70</td>
<td>0.91</td>
<td>0.621</td>
</tr>
<tr>
<td>&gt;70</td>
<td>1.05</td>
<td>0.723</td>
</tr>
</tbody>
</table>

CONCLUSION
There is a significant difference when the total populations in both groups were examined for both gender and age (p=0.001). The difference became insignificant when age groups were considered separately (p=0.05).

ACKNOWLEDGEMENTS
Barbara D., Bartolo J., Cauchi A., Micallef S., Muscat Simintiu O., Sammut J., Schembri O., Wubbels M. And special thanks to Dr Neville Calleja and Prof Kevin Cassar.
Continually protect your patients from dentine hypersensitivity

Create an even harder reparative hydroxyapatite-like layer

With twice-daily brushing, it can:

- Create an even harder reparative hydroxyapatite-like layer
- Repair & Protect

Sensodyne

- Sensitivity relief can start from week 18, and is still making progress.
- Forms a protective layer over the sensitive area of the teeth.
- Brush twice a day for lasting sensitivity protection.*

References:
1. Parkinson CR
2. Greenspan DC et al.
4. Earl JS et al.
5. GSK Data on File, ML498.
6. GSK Data on File, RH01897.
7. GSK Data on File, ML589.
9. Saude para o povo by Centro Popular de Saude.

OBJECTIVES OF PROPOLIS TREATMENT

1. To avoid the development of ulcer pain when administered as prophylaxis.
2. To relieve the patient from pain within 24 hours (or thereafter) if the mouth ulcer/s are already present.
3. To help heal the patient’s mouth ulcers.
4. To avoid admitting the patient to hospital with mouth ulcers, thereby saving thousands of euros for one admission alone.
5. To avoid separating the child or young teen from his/her immediate family and friends.

BEFORE THE ADMINISTRATION OF PROPOLIS

It is necessary to ask the parents whether the child (refer to footnote) is allergic to bees or their products. If s/he is, then they would be allergic to propolis if they do not know, then you would have to check whether the child is allergic to bees or their products. (Refer to ADMINISTRATION OF PROPOLIS TINCTURE 50%, point number 3). However, it is better to commence treatment on day one of the radiotherapy/chemotherapy.

GENERAL NOTES ABOUT PROPOLIS

1. Its general use

As described earlier, Propolis is produced by the honey bees. It is then manipulated with alcohol to produce a tincture. It can be used for quite a big range of illnesses. It is used both internally and externally. It can be used internally for: upper and lower respiratory tract infections, sinusitis, rhinitis, tonsillitis, cough, colds, bronchitis and pharyngitis. It is used externally for: wounds, furuncles, eczema, whitlow, burns, warts, gingivitis, mouth ulcers, athlete’s foot and onychomycosis.
Propolis Tincture 50% and its Specific Use for Mouth Ulcers Following Chemotherapy

Continues from page 8.

2. Different forms of propolis

Propolis can be manipulated in order to produce a tincture, pomade, a cream, an ointment, oil or different strength suspensions and tablets. It can also be taken raw. Propolis sweets are also available on the market. There is also a spray which is not available in Malta. There might be other forms which are not mentioned here. The tincture (which could come in different strengths) can be mixed with water to do it with a suspension or with honey. The tincture is alcohol based and the 50% tincture is the only one available in Malta.

3. Adults and mouth ulcers

Propolis is administered in tincture form to adults. Some 2 to 3 drops are usually put onto a cotton bud until the cotton bud is saturated with the propolis. It is dabbed onto the ulcer directly from once to four or five times daily. Ulcer pain normally disappears altogether within 24 to 36 hours. It is also a fact that the continuous use of propolis cures the mouth ulcers completely.

4. Why mix it with honey?

Adult patients have reported that the tincture burns for a short while when applied directly to the ulcer and that it is unpleasant to taste. To overcome these two minor problems it would be better to mix the tincture with honey when administering it to children. Honey makes it palatable and it will remove the sting or burning sensation experienced by adults.

5. A guide for health professionals – correct administration

As paediatric oncology patients might have more than one ulcer, then the attached table (Appendix 1) can be used to act as a guide to those administering it. This is done not to exceed the very safe daily drop allowance of the medication and also because the patient might have other ulcers in the throat and further down the throat which are not visible to the naked eye. The medication (propolis and honey) mixed with the saliva will reach most of these areas, whereas those ulcers which could be identified or are visible in the mouth, could have the medication applied directly with the forefinger or cotton bud by that of the health practitioner or parent.

It is imperative that the child is not given anything to drink or eat for at least half-an-hour after the administration of the treatment. An hour is preferable. This is done not to have the medication, which is meant to act locally (i.e. on the ulcers), flushed down the stomach by any liquids or solids.

There are two more points to remember. The first one is that the recommended daily dose (as described in appendix 1) may be administered in the one go or divided into two, that is, at twelve hourly intervals. The second point to remember is to have the mixed propolis and honey stored away in the refrigerator. This is to make it less viscous, consequently making it easier to apply. And as it takes the form of paste, it can remain on the ulcers for a slightly longer period of time, whereas it would not, if it had to be applied soon after it was mixed.

6. Other general information

Other than acting locally, the medication will also help combat any impending or likely infections, such as, upper and lower respiratory infections.

This is quite advantageous to the child undergoing radiotherapeutical/chemotherapeutical treatment because of his/her very low immune response to combat infections. Thus it also acts as a prophylaxis.

Throughout the child’s hospitalization, it would be better to invest heavily in educating the parents. Explain to the parents the complications which are likely to arise after aggressive chemotherapy (e.g. the continuous mouth ulcer pain), so that they will comply with the propolis treatment if the need arises and also because they would feel that they are being involved with the child’s treatment. Education and sharing of knowledge, which are synonymous with each other, among all the health professions is a must. Let us not forget that our main objective is the child.

ADMINISTRATION OF PROPOLIS TINCTURE (50%) FOR DIFFERENT FORMS OF TREATMENT IN THE MOUTH CAVITY, PHARYNX AND FURTHER DOWN THE GASTROINTESTINAL TRACT

1. For preventative treatment: mix 5 drops/day in 20mls of lukewarm water/milk and instruct the patient to swish and gargle with this solution. After swishing and gargling encourage him/her to swallow the solution. Please refer to point number 4f below as well.

Note that when the mouth ulcers become visible and/or painful, then stop this treatment and go to step 2 below. It might pay off to prepare the right number of propolis drops with honey (if using honey – point number 4d below) and put it in the refrigerator some days beforehand so that it is less viscous.

2. For pain caused by the visible mouth ulcers: either (i) apply 2 to 3 drops onto a cotton bud (or until completely soaked) of the propolis tincture and then dab/apply it onto the ulcer from twice to four times daily. This may apply more frequently if the patient is still in pain after 36 hours. Or (ii) mix the right amount of propolis tincture (from appendix 1) with 20 to 30mls of lukewarm water/milk and inform the child/teen to swish and gargle this. May then swallow the solution. Please refer to point number 4f below as well. Or (iii) go to step number 4 below and mix with honey as explained.

3. For complete healing of the mouth ulcer/s: as all point number 2 above. However, continue applying the propolis tincture or solution until the mouth ulcer/s disappear/s. Please refer to point number 4f below as well.

4. For ulcer/s which are either in the mouth and/or the naso-pharynx and may be further down:

a. Refer to appendix 1: Table of 50% Propolis Tincture.

b. Identify the age group.

c. Identify the amount of drops which is across from the age group.

d. Mix the right number of drops either (a) with one teaspoon of honey (i.e. 1 to 2 ml of honey) in a small pot (e.g. pill cup) or (b) with 20 to 30mls of lukewarm water/milk. Please note that if you select the honey, then it would be better to refrigerate it the day before so that it becomes less viscous.

e. Administer this to the patient. Dab/apply some of it with a cotton bud onto the mouth ulcers first and the remainder may be introduced into the mouth with a teaspoon. Inform the child to swallow this.

f. Do not let the child eat or drink anything by mouth for at least half-an-hour after the treatment. One hour is better.

g. Encourage propolis lozenges. Inform the child/teen to suck these and not to crush them with his/her teeth. If following the steps above (i.e. points a to f), then do not forget to allow half-an-hour or one hour before encouraging these lozenges.

h. If the pain persists, then as a last resort, you may repeat the dose. This step may also be carried out when a patient is not given any propolis treatment, for some reason or other, and then presents him/herself with painful ulcers for the first time. This double bolus dose may be repeated for up to 3 days, however,

normal propolis treatment (as per table in appendix one) is to be resumed when all the patient is completely free of pain.

NOTES:

1. Use one teaspoon of honey with the number of drops above.

2. The doses mentioned above can be administered for either 5, 7, 10 or 15 days or until all the ulcers disappear. It all depends on the severity of the ulcers.

3. When one encounters 5.2 drops/day, 6 drops can be administered and not 5 drops. This medication is fairly safe if all the steps mentioned in this paper are followed to the letter.

4. The adult daily dose is from 26 to 36 drops and the prophylactic dose is 10 drops daily.

<table>
<thead>
<tr>
<th>AGE</th>
<th>DAILY DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 6 months</td>
<td>2.4 drops</td>
</tr>
<tr>
<td>6 months – 1 year</td>
<td>3.6 drops</td>
</tr>
<tr>
<td>1 - 1½ years</td>
<td>4.4 drops</td>
</tr>
<tr>
<td>1½ - 2 years</td>
<td>5.2 drops</td>
</tr>
<tr>
<td>2½ - 3 years</td>
<td>6.8 drops</td>
</tr>
<tr>
<td>3½ - 4 years</td>
<td>6.4 drops</td>
</tr>
<tr>
<td>4½ - 5 years</td>
<td>7.2 drops</td>
</tr>
<tr>
<td>5 - 6 years</td>
<td>8 drops</td>
</tr>
<tr>
<td>6 - 7 years</td>
<td>8.8 drops</td>
</tr>
<tr>
<td>7 - 8 years</td>
<td>9.6 drops</td>
</tr>
<tr>
<td>8 - 9 years</td>
<td>10.4 drops</td>
</tr>
<tr>
<td>9 - 10 years</td>
<td>11.2 drops</td>
</tr>
<tr>
<td>10 - 11 years</td>
<td>12 drops</td>
</tr>
<tr>
<td>11 - 12 years</td>
<td>13.2 drops</td>
</tr>
<tr>
<td>12 - 13 years</td>
<td>14.4 drops</td>
</tr>
<tr>
<td>13 - 14 years</td>
<td>15.6 drops</td>
</tr>
<tr>
<td>14 - 15 years</td>
<td>16.8 drops</td>
</tr>
<tr>
<td>15 - 16 years</td>
<td>18 drops</td>
</tr>
<tr>
<td>16 - 17 years</td>
<td>19.2 drops</td>
</tr>
<tr>
<td>17 - 18 years</td>
<td>20.4 drops</td>
</tr>
<tr>
<td>18 years and over</td>
<td>10 drops (prophylactic dose)</td>
</tr>
</tbody>
</table>
Representatives of CED Member and Observer organisations met in The Hague, The Netherlands on 20-21 May 2016 for the first General Meeting under the chairmanship of CED President Dr. Marco Landi. The meeting was hosted by the Royal Dutch Dental Association in the context of the Dutch EU Council Presidency. It started with a welcome address by Dr. Hendrik van Drie, acting President of the Royal Dutch Dental Association.

SPECIALIST DENTISTS
A dentist is qualified to carry out all acts performed by specialists and must not be forbidden to perform any activities of specialists. This was the statement unanimously adopted by the General Meeting on 20 May. The main difference between a dentist and a specialist is that the specialist is more likely to perform the activities related to the specialty in question on a daily basis.

SUGAR
Sugar is a leading cause of tooth decay, particularly among children and the elderly. European dentists are very much concerned with the increasing consumption of sugar by EU citizens and have unanimously adopted a resolution to raise awareness to decision-makers to the pain and suffering caused by this preventable disease. Reducing the frequency and amount of sugar consumption are crucial for the prevention of both dental and systemic diseases. The CED believes that action is required to help EU citizens to improve their food choices.

NEW RULES FOR DENTAL AMALGAM
The impact of the Commission’s proposal for a regulation on mercury was also discussed by delegates.

The Commission proposes that dental amalgam should be restricted to encapsulated form and the mandatory use of amalgam separators from 1 January 2019.

“The proposal takes into account the opinions of both scientific committees SCHER and SCENIHR. I believe that it is well-considered, proportionate and balanced.

“We would now like to see Member States more engaged in tackling oral diseases, by setting national objectives for dental caries prevention and investing in oral health promotion programmes”, says Dr Susie Sanderson, Board Member and Chair of CED Working Group on Amalgam & Other Restorative Materials.

Further information:

FUTURE OF DENTISTRY
European dentists also raised concerns on the future of dentistry.

CED President Dr Marco Landi explains: “I am concerned with the commercial drivers affecting patients’ rights to receive dental healthcare in their best interests. The CED will be dedicating more resources to look into this issue”.

The Council of European Dentists (CED) is a European not-for-profit association which represents over 340,000 practising dentists through 32 national dental associations and chambers from 30 European countries.

Its key objectives are to promote high standards of oral healthcare and effective patient-safety centred professional practice across Europe, including through regular contacts with other European organisations and EU institutions.

For more information contact:
CED Brussels Office
Tel: + 32 2 736 34 29
ced@eudental.eu
http://www.eudental.eu

RESULTS OF CED GENERAL MEETING IN THE HAGUE
Press Release – 25 May 2016

NEW!}

TePe EasyPick™
Interdental cleaning made easy.
The efficient solution for cleaning between the teeth. For a clean and fresh feeling.
OF CONDUCT FOR DENTISTS

1. PUT PATIENTS’ HEALTH INTERESTS FIRST

Recall of minimum EU law: individual patients may seek healthcare in a Member State other than the Member State of affiliation (Recital 11 & 29 of Patients Directive).

2. RESPECT THE RIGHT OF PATIENTS TO BE CARE OF BY THE DENTIST OF THEIR CHOICE

Recall of minimum EU law: “Member States shall ensure that the healthcare providers on their territory apply the same scale of fees for healthcare for patients from other Member States, as for domestic patients in a comparable medical situation, or that they charge a price calculated according to objective, non-discriminatory criteria if there is no comparable price for domestic patients.” (Article 4(4) of Patients Directive)

3. PROVIDE CARE WITH RESPECT, DIGNITY AND WITHOUT DISCRIMINATION

Recall of minimum EU law: “Member States shall ensure that the use of commercial communications which are part of, or constitute, an information society service provided by a member of a regulated profession is permitted subject to compliance with the professional rules regarding, in particular, the independence, dignity and honour of the profession, professional secrecy and fairness towards clients and other members of the profession.” (Article 8, Electronic Commerce Directive).

Recall of minimum EU law: “1. Member States shall ensure that the use of commercial communications which are part of, or constitute, an information society service provided by a member of a regulated profession is permitted subject to compliance with the professional rules regarding, in particular, the independence, dignity and honour of the profession, professional secrecy and fairness towards clients and other members of the profession.” (Article 8, Electronic Commerce Directive).

Recall of minimum EU law: “Professionals benefiting from the recognition of professional qualifications shall have a knowledge of languages necessary for practising the profession in the host Member State.” (Article 53 of RPQ Directive).

5. COMMUNICATE EFFECTIVELY WITH PATIENTS

5.1 Use a language that you are comfortable with patients

Recall of minimum EU law: “A commercial practice that misleads consumers is unfair and, therefore, prohibited, and there is no need to show that it is contrary to the requirements of professional diligence (EU case-law C-435/11).

5.2 Provide the patient with information allowing direct access to the activity of the company, organisation or person, in particular a domain name or an electronic-mail address,

- Communications relating to the goods, services or image of the company, organisation or person compiled in an independent manner, particularly when this is without financial consideration;” (Article 2(f), Electronic Commerce Directive)

5.3 “This concept therefore covers (…) professional cards mentioning the title and specialisation of the service provided.” (DG Internal Market in The role of European Code of Conduct, 2007)

Recall of minimum EU law: “1. Member States shall ensure that the use of commercial communications which are part of, or constitute, an information society service provided by a member of a regulated profession is permitted subject to compliance with the professional rules regarding, in particular, the independence, dignity and honour of the profession, professional secrecy and fairness towards clients and other members of the profession.” (Article 8, Electronic Commerce Directive).

Recall of minimum EU law: “1. Unfair commercial practices shall be prohibited. 2. A commercial practice shall be unfair if: (a) it is contrary to the requirements of professional diligence; and (b) it materially distorts or is likely to materially distort the economic behaviour with regard to the product of the average consumer whom it reaches or to whom it is addressed, or of the average member of the group when a commercial practice is directed to a particular group of consumers.” (Article 5, Directive 2005/29 on Unfair commercial practices).

A commercial practice that misleads consumers is unfair and, therefore, prohibited, and there is no need to show that it is contrary to the requirements of professional diligence (EU case-law C-435/11).

5.3 “This concept therefore covers (…) professional cards mentioning the title and specialisation of the service provided.” (DG Internal Market in The role of European Code of Conduct, 2007)

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Recall of minimum EU law: “In order to remove barriers to the development of cross-border services within the Community which members of the regulated professions might offer on the Internet, it is necessary that compliance be guaranteed at Community level with professional rules aiming, in particular, to protect consumers or public health; codes of conduct at Community level would be the best means of determining the rules on professional ethics applicable to commercial communication; the drawing up, or where appropriate, the adaptation of such rules should be encouraged without prejudice to the autonomy of professional bodies and associations.” (Recital 32, Electronic-Commerce Directive).

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FEDCAR’S EUROPEAN CODE OF CONDUCT FOR DENTISTS

Continues from page 15.

Recall of minimum EU law: “The Member State of treatment shall ensure that (…) there are transparent complaints procedures and mechanisms in place for patients, in order for them to seek remedies in accordance with the legislation of the Member State of treatment if they suffer harm arising from the healthcare they receive;” (Article 4(2)(c) of Patients Directive).

6. OBTAIN VALID CONSENT FROM THE PATIENT
6.1 Obtain valid consent before starting treatment, explaining all the relevant options with associated benefits, risks and costs.

6.2 Make sure that patients (or their representatives) understand the decisions they are being asked to make.

6.3 Make sure that the patient’s consent remains valid at each stage of investigation or treatment.

Recall of minimum EU law: “The Member State of treatment shall ensure that: (b) healthcare providers provide relevant information to help individual patients to make an informed choice, including on treatment options, on the availability, quality and safety of the healthcare they provide in the Member State of treatment and that they also provide clear invoices and clear information on prices, as well as on their authorisation or registration status, their insurance cover or other means of personal or collective protection with regard to professional liability. To the extent that healthcare providers already provide patients resident in the Member State of treatment with relevant information on these subjects, this Directive does not oblige healthcare providers to provide more extensive information to patients from other Member States;” (Article 4(2)(b) of Patients Directive).

7. ACCEPT RESPONSIBILITY FOR THE CARE PROVIDED BY AUTHORIZED DENTAL PERSONNEL
7.1 Accept responsibility for the care provided by authorized dental personnel.

Recall of minimum EU law: “The Member State of treatment shall ensure that: (b) healthcare providers provide relevant information to help individual patients to make an informed choice, including on treatment options, on the availability, quality and safety of the healthcare they provide in the Member State of treatment and that they also provide clear invoices and clear information on prices, as well as on their authorisation or registration status, their insurance cover or other means of personal or collective protection with regard to professional liability. To the extent that healthcare providers already provide patients resident in the Member State of treatment with relevant information on these subjects, this Directive does not oblige healthcare providers to provide more extensive information to patients from other Member States;” (Article 4(2)(b) of Patients Directive).

8. ESTABLISH FEES WITH TACT AND MODERATION IN THE INTEREST OF THE PATIENT AND NATIONAL HEALTH SYSTEM

9. DECIDE IN INDEPENDENCE AND WITH IMPARTIALITY ABOUT THE TREATMENT AND SERVICES NEEDED FOR THE PATIENT’S ORAL HEALTH.

Recall of minimum EU law: “(…) this Directive includes also liberal professions, which are, according to this Directive, those practised on the basis of relevant professional qualifications in a personal, responsible and professionally independent capacity by those providing intellectual and conceptual services in the interest of the client and the public. The exercise of the profession might be subject in the Member States, in conformity with the Treaty, to specific legal constraints based on national legislation and on the statutory provisions laid down autonomously, within that framework, by the respective professional representative bodies, safeguarding and developing their professionalism and quality of service and the confidentiality of relations with the client.” (RCP Directive, Recital 4)

10. MAINTAIN A SAFE AND HEALTHY OFFICE ENVIRONMENT

11. WORK WITH COLLEAGUES IN A WAY THAT IS IN PATIENTS’ BEST INTERESTS

12. PROTECT THE CONFIDENTIALITY OF THE PERSONAL AND HEALTH INFORMATION OF PATIENTS

12.1 Protect the confidentiality of personal and health patients’ information and only use it for the purpose for which it was given. Only release a patient’s information without their permission in exceptional circumstances. Recall of minimum EU law: “(…) the processing of data concerning health or sex life. (…) Paragraph 1 shall not apply where processing of the data is required for the purposes of preventive medicine, medical diagnosis, the provision of care or treatment or the management of health-care services, and where those data are processed by a health professional subject under national law or rules established by national competent bodies to the obligation of professional secrecy or by another person also subject to an equivalent obligation of secrecy.” (Data Protection Directive, Article 9(3)).

12.2 Ensure that patients can have access to their records. Recall of minimum EU law: “(…) the Member State of treatment shall ensure that: in order to ensure continuity of care, patients who have received treatment are entitled to a written or electronic medical record of such treatment, and access to at least a copy of this record in conformity with and subject to national measures implementing Union provisions on the protection of personal data, in particular Directives 95/46/EC and 2002/58/EC.” (Article 42(f)(f) of Patients Directive).

Continues on page 25.
Our Mission
The Sector of Oral Medicine “V. Margiotta” is an Italian leader in patient care, teaching, and research involving diagnosis and nonsurgical management of diseases of the oral cavity, including:
- Mesiall disease (from infections to potential malignant lesions)
- Oral cancer and complications of cancer therapy
- Salivary dysfunction
- Oral complications of systemic illnesses
- Oral care for patients with special needs
- Osteonecrosis of the jaw related to drugs

Epidemiology of MRONJ

In cancer patients, the cumulative incidence of MRONJ ranges from 6.7% to 6.7%.

From Diagnosis to Dental Management

Olga Di Fede, DDS, PhD, MS
Sector of Oral Medicine “V. Margiotta”
University of Palermo

Epidemiology of MRONJ

Malden andoppel derived an incidence of 0.004% (0.4 cases per 10,000 patient-years of exposure to alendronate) from 11 cases of MRONJ reported in a population of 10,000 patients living in southeast Scotland.

Avascular necrosis of the jaw

Osteonecrosis of the jaw (ONJ) 2003
Osteonecrosis of the jaw: a review

“...growing number of patients referred for evaluation and management of “refractory osteomyelitis” of varying duration...”

Bisphosphonates related osteonecrosis of the jaw (BRONJ) 2007
American Association of Oral and Maxillofacial Surgeons Position Paper on Bisphosphonate-Related Osteonecrosis of the Jaws

Conclusion:
"Patients may be considered to have BRONJ if all of the following 3 characteristics are present:
1. Current or previous treatment with a bisphosphonate:
2. Exposed, necrotic bone in the maxillofacial region that has persisted for more than 8 weeks:
3. Bone history of radiation therapy to the jaws.”
Continues from page 16.

12.3 Keep patients’ information secure at all times, whether your records are held on paper or electronically. (mHEALTH initiative, draft General Data Protection Regulation).

13. ENSURE THAT THE DENTAL TEAM MAY RAISE CONCERNS IF PATIENTS OR COLLEAGUES ARE AT RISK

13.1 Act promptly if patient’s or colleague’s health is at risk and take measures to protect them.

13.2 Make sure if you employ, manage or lead a team that you encourage and support a culture where staff can raise concerns openly and without fear of reprisal.

13.3 Make sure if you employ, manage or lead a team that there is an effective procedure in place for raising concerns, that the procedure is readily available to all staff and that it is followed at all times. Recall of minimum EU law: healthcare professionals are encouraged to report to the manufacturer or to their competent authority in accordance with national guidance, any serious incident in respect of devices made available on the Union market (current Guidelines on a medical devices vigilance system; Article 6 of the draft proposal of Regulation on Medical Devices). Likewise, they are encouraged to report adverse drug reaction (Regulation 1027/2012 & Directive 2012/26 on pharmacovigilance).

14. PARTICIPATE IN THE PERMANENT CARE AND ON-CALL DUTY THAT ARE ORGANIZED IN YOUR COUNTRY OF PRACTICE

15. BE TRUTHFUL AND OBEY ALL APPLICABLE LAWS OF THE COUNTRY WHERE HIS PRACTICE TAKES PLACE, AS A TRAINEE OR A FULLY QUALIFIED PROFESSIONAL, WHETHER ON A AD HOC OR ON A PERMANENT BASIS

Recall of minimum EU law: ‘Where a service provider moves, he shall be subject to professional rules of a profession, statutory or administrative nature which are directly linked to professional qualifications, such as the definition of the profession, the use of titles and serious professional malpractice which is directly and specifically linked to consumer protection and safety, as well as disciplinary provisions which are applicable in the host Member State to professionals who pursue the same profession in that Member State.’ (Article 5 of RPQ Directive).

“The service provider should be subject to the application of disciplinary rules of the host Member State having a direct and specific link with the professional qualifications, such as the definition of the profession, the scope of activities covered by a profession or reserved to it, the use of titles and serious professional malpractice which is directly and specifically linked to consumer protection and safety.” (Recital 8 of RQP Directive).

Recall of minimum EU law: Where a dentist moves, he shall be subject to the pro-fessional rule for calculating fees or the rule prohibiting unprofessional advertising provided they are compatible with the Single Market’s requirements (case-law C-475/11, para.35-46).

Recall of minimum EU law: “Nationals of a Member State who practice their profession in another Member State are bound to observe the rules that govern the practice in that Member State of the profession in question. Where the professions of doctor, dentist and veterinary surgeon are concerned, those rules are in particular those inspired by concern to protect the health of humans and animals as efficiently and fully as possible.” (case-law C-351/09).

Recall of minimum EU law: When completing a professional traineeship in a host Member State or in a third country, the dental trainee is subject to guidelines on the recognition and on the organisation of the professional traineeship, in particular on the registration of his supervisor (Article 55a RPQ Directive).

16. MAINTAIN, DEVELOP AND WORK WITHIN HIS PROFESSIONAL KNOWLEDGE AND SKILLS

16.1 Continuing professional development (CPD) activity is not mandatory in all EU countries.

16.2 You must however make sure that you know how much continuing professional development (CPD) activity is required for you to maintain your registration in your country of establishment and that you carry it out within the required time.

17. MAKE SURE HIS PERSONAL BEHAVIOUR MAINTAINS PATIENTS’ CONFIDENCE IN HIS PERSON AND THE DENTAL PROFESSION

17.1 Maintain appropriate and dignified boundaries in relationships with patients.

17.2 Ensure that your conduct, both at work and in your personal life, justifies patients’ trust in you and the public’s trust in the dental profession.

17.3 Protect patients and colleagues from risks posed by your health, conduct or performance.

18. IN CASE OF PROFESSIONAL MOBILITY, INFORM THE HOME COMPETENT AUTHORITY AND LAINE WITH THE HOST COMPETENT AUTHORITY

18.1 Co-operate with any relevant formal or informal (e.g. European Certificate of Current Professional Status) inquiry and give full and truthful information.

Continues on page 36.
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- Most competitive premium available for Professional Indemnity cover in Malta & Gozo;
- Widest cover available;
- Various Limits of Indemnity to choose from;
- Optional extensions to choose from including:
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  - Retroactive Cover
  - Botox & Dermal fillers extension
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- Your cover still reflects your present operation, example if you are performing Botox &/or Dermal fillers you have availed yourself of the relative extension.

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MIB YOUR INSURANCE SOLUTION
Dental materials have advanced greatly over the past years. In particular, composite materials have been improved and enhanced in many aspects. A composite material consists of two main components—the resin phase and the reinforcing filler. The resin conveys advantages such as the ability to be moulded and shaped freely at ambient temperatures, coupled with the fact that setting through polymerisation can be achieved in a controlled fashion and in a conveniently short time. The filler on the other hand conveys properties such as hardness, strength and a lower value for the coefficient of thermal expansion.

In addition to all these advantages, a high proportion of filler content will significantly decrease the value of thermal expansion. This means that the composite materials one can select for a specific clinical scenario is quite extensive. Another key advantage is that composite materials adhere to tooth structure.

Nowadays, and it has been for quite a while, the key word in dentistry is conservation and minimal invasiveness. The idea is to cut at little tooth tissue as possible, while restoring what has been lost in a way that preserves the natural function and appearance of the tooth. This can be achieved by restoring defects in anterior teeth can be challenging. To achieve the same tooth structure, morphology and texture can be quite a task. To ensure maintenance of results, periodontal maintenance is always necessary (6).

All of the above and much more were highlighted during the SEDOC (Societá Italiana di OdontoiatriaConservativa) conference titled ‘Fundamentals and new trends in Esthetic Restorative Dentistry’ on the 12th and 13th February 2016. We attended this conference as part of the KAI EU training programme in Rome organised by the DAM. A series of inspirational lectures were given by renowned speakers all of whom presented their own personal takes on several different restorative and conservative techniques.

Overall, their motivation and the effort and energy with which they practiced their profession, as well as their plentiful experience and knowledge was really an eye-opener and probably also to all those who were present.

REFERENCES:


Vannini L. Anatomic stratification technique. Presented at the 26th Annual AADSc Scientific Session; Cooperate, TX; April 27, 2010.


MRONJ: FROM DIAGNOSIS TO DENTAL MANAGEMENT

Continues from page 23.

Dental treatments

Non-surgical treatments

Surgical treatments

Dental procedures are classified as follows:
- Contraindicated: the risk of osteonecrosis of the jaw associated with the procedure is high and the benefits for the patient are insubstantial
- Possible: low risk without specific contraindications, but the benefits of the treatment have to be outweighed case by case
- Indicated: none or low risk, or, in turn, when the benefits derived from the treatment far exceed the risk of osteonecrosis of the jaw.

Endodontic treatment

Root canal therapy is a safe procedure and may reduce the onset of ONJ.

Endodontic therapy has not been identified as a significant risk factor for promoting ONJ and is therefore considered the favored alternative to extraction when possible or when we are confident in a successful therapy.

Endodontic treatment protocol

- Chlorhexidine mouthwash prior to the start of the treatment
- Anesthetic agents with vasoconstrictors should be avoided.
- Working under aseptic conditions is mandatory — rubber dam
- Patency of the apical foramen should be avoided.
- Techniques which lower risk of overfilling and overextension of the filling material are recommended.

Orthodontic treatments

No studies have directly attributed orthodontic treatment to increased ONJ risk.

Recommendation:
- In patient with high level of osteoclastic inhibition avoid orthodontic treatment
- Monitor for slower than expected tooth movement
- Slower tooth movement can continue for years after the drug is discontinued
- Evaluate the presence of early signs of MRONJ during all treatment

Dental treatment warning score for cancer patients

...and for non-cancer patients

Orthodontic treatments

No studies have directly attributed orthodontic treatment to increased ONJ risk.

Recommendation:
- In patient with high level of osteoclastic inhibition avoid orthodontic treatment
- Monitor for slower than expected tooth movement
- Slower tooth movement can continue for years after the drug is discontinued
- Evaluate the presence of early signs of MRONJ during all treatment

Dental treatments

Restorative dentistry

There are no evidences of ONJ cases related to restorative dentistry.

This procedures are always possible and indicated when need to prevent more invasive dental procedures.

It’s important to avoid any damage to the gingival tissues during the placement of a rubber dam clamp.

Removable prosthetic therapy

The primary goal (to reduce ONJ risk) must be to minimize the pressure of the dental prostheses on the mucosa, reducing the force per unit area while providing retention and stability.
- Ill-fitting dentures could cause breaches to the defective underlying mucosa
- The patient should be recalled every 2 1/2 months and advised on keeping the prosthesis out of the mouth for at least 12 hours daily.

Fixed prosthetic therapy

- Care must be taken to the maintenance of biologic width.
- When dental treatment will violate the integrity of the oral epithelium, patients exposed to MRONJ-related medication are ideally at risk for ONJ.
- Thus, at risk patients should be treated so as to preserve the mucosa that overlies the BP-containing bone.

Periodontal non-surgical treatment

STRATEGIC TREATMENT

- An adequate protocol of home oral hygiene is the pre-requisite to the administration of MRONJ-related medication
- Patients at risk of MRONJ should receive appropriate forms of non-surgical therapy combined with a reevaluation of 4 to 8 weeks.
- Follow up should be scheduled every 4 months for cancer patients and every 6 months for osteoporotic patients.
MRONJ: FROM DIAGNOSIS TO DENTAL MANAGEMENT

Continues from page 31.

**Dental treatments**

<table>
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<tr>
<th>Dental treatments</th>
<th>Non-surgical treatments</th>
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<td>Surgical treatments</td>
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**Dental implants**

While implant placement should be avoided in cancer patients, it is a potential option in non-cancer patients. The risk of MRONJ needs to be explained to the patient and is advisable to achieve the informed consent:

- Risk factors for MRONJ should be explained to the patient.
- Prophylactic treatment may be considered in high-risk patients.
- Regular follow-up appointments are recommended to monitor for early signs of MRONJ.

**Pre-operative stage:**

- **Drug holiday:** Planning to be discussed with the prescriber.
- **Pre-medications:**
  - Oral medications
  - Intravenous medications
  - Topical medications

**Pre-operative medical therapy**

- **Antibiotic administration:**
  - Metronidazole 500 mg per os 3 hours before starting 3 days pre-operatively.
  - Clindamycin 300 mg per os 3 hours before starting 3 days pre-operatively.

**Gastrointestinal probiotics**

- Oral administration of lactobacillus and probiotics 3 days pre-operatively.

**Clinical procedures:**

1. One minute mouthwash with 0.2% Chlorhexidine (CHX) in adult and pediatric patients.
2. Anesthesia administered using 3% mepivacaine hydrochloride without adrenaline.
3. Evacuation of a full-thickness mucoperiosteal flap to expose the surgical area.
4. Tenotomy and suture with gauze gently performed.
5. If necessary, osseous and/or subperiosteal osteotomies were done with an ultrasonic surgical device.
6. Debridement and irrigation with saline solution of the post-operative socket.
7. Careful closure and suture of the soft tissue with absorbable sutures.
8. Suture of the flaps to achieve a tension-free soft tissue closure.

**Experience of dental surgery protocols**

- **SPD-M:**
  - Prevention and Research on Medication-related Osteonecrosis of the Jaws
  - Non-cancer patients
- **P.R.O.M.F.**
  - Preliminary stage:
    - Assessment of the patient's category: Cancer patients
  - Radiological investigation for dental implant placement
  - In presence of poor oral hygiene, provide plaque and tartar removal.

**Peri-implantitis捍卫**

- All patients at high risk of MRONJ development should avoid dental procedures.
- Surgical procedures cannot be avoided, peri-implantitis and endodontic surgical procedures are indicated to treat significant ongoing infections.
- Surgical procedures should be guided by the same recommendations applied to dentoalveolar surgery.
- Medical therapy
  - Drug holiday
  - Suture of the flaps to achieve a tension-free soft tissue closure

**Preventive strategies**

- **Pre-operative medical therapy:**
  - Antibiotic administration
  - Gastrointestinal probiotics

**Continues on page 34.**
MRONJ: FROM DIAGNOSIS TO DENTAL MANAGEMENT

Continues from page 33.

P.R.O.Ma.F. protocol
Post-operative medical therapy
Antibiotic prophylaxis

- Amoxicillin/Clavulanate potassium: 1g pr. as 3 daily for 6 days
- Metronidazole*: 500 mg pr. as 3 daily for 7 days
- In patients reporting peridontal allergy: Biseomycin: 500mg pr. as 3 daily for 7 days

Chlorhexidine 0.2% mouthwash: 2 x daily 15 days
Gastrointestinal probiotics: x daily 15 days
Chloramidine 0.5% gel: 3 daily for 10 days
Amiwo-oids and sodium hyaluronate gel: 1 daily for 10 days

* Use if at risk, otherwise non-steroidal is suggested.

Clinical case
Exposure of the surgical area, through the excision of a full-thickness mucoperiosteal flap

Suture of the flaps to achieve a tension-free soft tissue closure

Clinical case
Tooth extraction and evaluation and debridement of the post-extraction sockets

Remove the suture at seven days

Dental extraction and platelet concentrates

The use of autologous platelet concentrates as an adjunct to oral surgery procedures may have a beneficial effect, improving bone and soft tissue healing.

The three types most used are:

- PRP (Platelet-Rich Plasma): plasma rich in growth factors
- ANPC: platelet-rich fibrin
- All are characterized by a concentration of platelets higher than in systemic blood, which develops an extracellular release of multiple bioactive factors (VWF, PDGF, TGF-β, CTGF).

Clinical case

Follow up visit at 11 months

Panoramic radiography (detail) 11 months

Conclusions

- Although MRONJ epidemiology and pathogenesis remain unclear, significant improvement have been made to improve risk reduction strategies
- Effective surgical procedure can be safely carried out in some centres
- Specific surgical protocols must be applied when surgical procedures are mandatory to treat significant ongoing inflammatory-process

Conclusions

- Patients must be aware of the risk of MRONJ related to surgical procedures
- Any invasive surgical procedure in patients at risk of MRONJ should be combined with broad-spectrum antibiotic prophylaxis
- “Drug holiday” should be discussed with prescribers
- A tension-free soft tissue closure should be achieved every time a flap is necessary

Doct Ora!l
The increasing awareness of the risk for MRONJ among health professionals

The protection of inappropriate dental screening and the initiation of MRONJ-related medications

The development of evidence-based guidelines and online patient regard directly to oral procedures

Safe procedure
Counselling
MRONJ Cases
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FEDCAR’S EUROPEAN CODE OF CONDUCT FOR DENTISTS

Continues from page 25.

18.2 Inform the Dental Authority to which you are registered or to which you intend to register if you are subject to criminal proceedings or a regulatory finding is made against you anywhere within the EU.

Recall of minimum EU law: “Moreover, for the first provision of services or if there is a material change in the situation substantiated by the documents, Member States may require that the declaration be accompanied by the following documents (...) for professions in the security sector, in the health sector and professions related to the education of minors, including in childcare and early childhood education, where the Member State so requires for its own nationals, an attestation confirming the absence of temporary or final suspensions from exercising the profession or of criminal convictions;” (Article 7(2)(e) of RPQ Directive).

ANNEX I - COPY OF FORMER FEDCAR’S ETHICAL PRINCIPLES ADOPTED IN NOVEMBER 2008 (UNDER THE FORMER NAME OF CODE)

CODE Ethical Principles

C.O.D.E. is the Conference of Orders and Assimilated Bodies of Dental Practitioners in Europe bringing together European competent authorities responsible for the regulation, the registration and the supervision of dental practitioners. In November 2008, CODE members agreed to set core ethical principles.

Why?
- In the context of increased mobility of practitioners, some general principles are necessary both for professionals and patients crossing borders
- The European Commission is promoting the development of codes of conduct at European level.

What?
The objective of this CODE initiative is not to harmonise national rules. It does not intend to replace national Ethics codes that must be respected by all dental practitioners working in a specific country.

CODE Members commit to respect these core ethical principles and ensure that their national Codes of Ethics do not conflict with these common principles.

The core principles

- CODE Members represent European authorities that are responsible for implementing national codes of ethics. They consider they have a role to play in the process of establishing common principles of good conduct for dental practitioners at European level.

Recall of minimum EU law: “The competent authorities of a Member State shall inform the competent authorities of all other Member States about a dentist, a specialist dentist or any other professional exercising activities that have patient safety implications where the professional is pursuing a profession regulated in that Member State” (RPQ Directive, Article 56a).

“Moreover, for the first provision of services or if there is a material change in the situation substantiated by the documents, Member States may require that the declaration be accompanied by the following documents: (…) for professions in the security sector, in the health sector and professions related to the education of minors, including in childcare and early childhood education, where the Member State so requires for its own nationals, an attestation confirming the absence of temporary or final suspensions from exercising the profession or of criminal convictions;” (Article 7(2)(e) of RPQ Directive).

“The competent authorities of the home and the host Member States shall exchange information regarding disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive.” (Article 56a of RPQ Directive).

The objective of this CODE initiative is not to harmonise national rules. It does not intend to replace national Ethics codes that must be respected by all dental practitioners working in a specific country.

CODE Members commit to respect these core ethical principles and ensure that their national Codes of Ethics do not conflict with these common principles.

These are the core ethical principles for those that practice dentistry in the EU, according to the definition provided by the directive 2005/36/EC: “dental practitioners are generally able to gain access to and pursue the activities of prevention, diagnosis and treatment of anomalies and diseases affecting the teeth, mouth, jaws and adjoining tissue (…)” (article 36.3).
As a dental practitioner, you must:
1. Put patients’ interests first and act to protect them
2. Respect patients’ dignity
3. Give appropriate information to patients and respect their choices
4. Protect the confidentiality of patients’ information
5. Cooperate with the appropriate national authorities and other healthcare colleagues in the interest of patients
6. Maintain your professional knowledge and competence
7. Be trustworthy
8. If you intend to treat patients in any member state you must inform the competent authority in that country.

ANNEX II - EXTRACTS FROM DIRECTIVE 2000/31/EC ON CERTAIN LEGAL ASPECTS OF INFORMATION SOCIETY SERVICES, IN PARTICULAR ELECTRONIC COMMERCE, IN THE INTERNAL MARKET (DIRECTIVE ON ELECTRONIC COMMERCE)

Note that this Directive applies to health professions.

(Rectal 3) In order to remove barriers to the development of cross-border services within the Community which members of the regulated professions might offer on the Internet, it is necessary that compliance be guaranteed at Community level with professional rules aiming, in particular, to protect consumers or public health; codes of conduct at Community level would be the best means of determining the rules on professional ethics applicable to commercial communication; the drawing-up or, where appropriate, the adoption of such rules should be encouraged without prejudice to the autonomy of professional bodies and associations.

(49) Member States and the Commission are to encourage the drawing-up of codes of conduct; this is not to impair the voluntary nature of such codes and the possibility for interested parties of deciding freely whether to adhere to such codes.

Article 8 – Regulated professions

1. Member States shall ensure that the use of commercial communications which are part of, or constitute, an information society service provided by a member of a regulated profession is permitted subject to compliance with the professional rules regarding, in particular, the independence, dignity and honour of the profession, professional secrecy and fair-play towards clients and other members of the profession.

2. Without prejudice to the autonomy of professional bodies and associations, Member States and the Commission shall encourage professional associations and bodies to establish codes of conduct at Community level in order to determine the types of information that can be given for the purposes of commercial communication in conformity with the rules referred to in paragraph 1.

3. When drawing up proposals for Community initiatives which may become necessary to ensure the proper functioning of the Internal Market with regard to the information referred to in paragraph 2, the Commission shall take due account of codes of conduct applicable at Community level and shall act in close cooperation with the relevant professional associations and bodies.

4. This Directive shall apply in addition to Community Directives concerning access to, and the exercise of, activities of the regulated professions.

GLOSSARY


Health initiative refers to: The Green Paper on mobile Health (“mHealth”) published on 10 April 2014 along with a public consultation on the merits of mHealth and on the needs to enhance its regulation.

Draft General Data Protection Regulation: Proposal for a Regulation updating and modernising the protection of personal data.

SALIENT POINTS FROM ‘DENTAL PHOTOGRAPHY’ ITI LECTURE BY DR EDWARD SAMMUT

1. A mobile phone never produces an image of sufficient quality for publication or for reference purposes.
2. Prime lenses have a fixed focal length. They have a high resolving power.
3. One should always buy a filter. This in addition protects the lens.
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