Editorial

By Dr David Muscat

Dear colleagues,

It has been quite an eventful year. We have seen a draft of clinic standards which are to be introduced as from next year. In 2016 there will be mandatory CPD with accreditation. The DAM is working on these issues.

The DAM has also taken an active role in trying to stem the tooth whitening clinics run by beauticians.

We have also embarked upon a KA1 scheme where with the use of EU funds which we have obtained we will be sending some dentists to Italy for a week of postgraduate experience in top dental clinics in Rome.

We have our Christmas party on 4 December at the Quarterdeck bar at the Hilton on Friday 4 December. In April 2016 we are planning a hands-on endodontic course.

The cover picture is a painting by Dr Noel Manche, a very talented committee member.

I would like to thank the DAM committee for all their hard work through the year. Sadly Dr Lino Said has decided to call it a day. His organization of DAM events has been spectacular and he will be sorely missed. His position on the committee has been filled by Dr Audrey Camilleri who had been co-opted at the last AGM. Hope to see you at the Christmas party where there will be a grand raffle for charity.

I wish you all a Merry Christmas and a Happy new Year.

Best regards,

David

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

References:
Harnessing the proven power of sodium bicarbonate to help stop bleeding gums

parodontax® toothpaste is unlike any other toothpaste. Its unique formulation contains 67% sodium bicarbonate. This gives parodontax® toothpaste a mode of action which helps disrupt the sticky polysaccharide matrix holding plaque to the teeth. The result – more plaque is removed with brushing.

See the benefit after just 60 seconds
After just 60 seconds of brushing with toothpaste with 67% sodium bicarbonate, patients start to gain the benefit, with a 23% greater plaque reduction compared with a non-sodium bicarbonate toothpaste.

parodontax® toothpaste reduces bleeding significantly more than a non-sodium bicarbonate toothpaste
You should see bleeding on probing, something needs to be done. Recommend parodontax® toothpaste as part of your advice to patients for their ongoing oral care routine to combat bleeding gums and help keep those gums healthy.

parodontax® toothpaste even helps in areas hard to reach with a toothbrush
When your patients brush their teeth, those hard-to-reach areas are where plaque builds up the most. So, it is comforting to know that parodontax® toothpaste shows the greatest advantage in plaque reduction in these hard-to-reach areas.

References:

Why save baby teeth?
- Maintenance of arch length and occlusion
- Maintenance of healthy oral environment
- Maintenance of function
- Prevention of pain
- Prevention of sepsis
- Prevention of damage to permanent successor
- Prevention of extraction
- Building up of awareness

12 year old with impacted UL5 due to extraction of ULE at age 7

Space loss and impacted 15

15 year old boy with impacted lower 5’s due to ext of lower E’s when 5 yrs old


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THE IMPORTANCE OF RESTORING CARIOUS PRIMARY TEETH

Continues from page 5.

Space loss and impaction LL5 due to early extraction of LLD

Space Loss

Dental treatment under GA

Oro tracheal intubation

Pre op

Post op

Continues on page 9.

CURAPROX

- Full-effect CHX
- Alcohol free
- Minimum brown discoloration
- No follow-up treatment needed

CURASEPT ADS

CURASEPT

Oral Rinse

Protects oral mucosa

SWISS PREMIUM ORAL CARE

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Non-stick effect for efficient contouring

Ivoclar Vivadent has developed the innovative modelling instrument OptraSculpt® Pad in order to meet the demand for efficient processing of highly-esthetic composites.

Despite the excellent mechanical properties of composite materials, their contouring remains a very demanding task for dentists even today. Highly esthetic composites, in particular, sometimes demonstrate a very adhesive consistency due to their filler composition, and they are thus more difficult to shape.

OptraSculpt® Pad is a contouring instrument with special foam pad attachments, which is designed for the efficient, non-stick forming and shaping of composites. It is especially suitable for the contouring of class III, IV and V restorations as well as of direct veneers.

Non-stick shaping and contouring

The non-stick attachments of OptraSculpt Pad enable composite materials to be shaped and contoured with ease, without leaving any unwanted marks. Thus, composite restorations with smooth and even surfaces are fabricated with utmost efficiency.

Smooth and even surfaces

Due to the special material of the pads, natural-looking restorations are easily accomplished in only a few steps. The highly flexible synthetic foam pads optimally adjust to the anatomical contours and allow smooth modelling.

Professional esthetic results

The reference scales on the instrument handle assist in the creation of esthetic and anatomically-correct restorations. The markings allow the clinical situation to be compared with the ideal average tooth width proportions and angular alignments in the upper anterior dentition.

OptraSculpt® Pad is also optimally suitable for applying and modelling lab composites. Therefore, the efficient processing of composites is equally supported in dental labs.

Non-stick shaping and contouring with a metal spatula

Shaping and contouring with OptraSculpt Pad

Shaping and contouring with a metal spatula

Result achieved with OptraSculpt Pad

Result achieved with a metal

Reference scale 1

Reference scale 2

Children treated under GA

Age range

2013

2014

2015

Why don’t we treat?

• Parents are afraid of GA
• Hospital experience might create more fear
• Increase in cost
• Teeth will fall out anyway – SO WHY BOTHER?

Why do we choose GA?

• Better quality of care if patient is frigid and restless
• All treatment done in one appointment – several apples might increase anxiety
• Reduce parental anxiety by giving information leaflet
• Provide parent with a detailed treatment plan with costs

For further information, please visit www.ivoclarvivadent.com
**ENHANCING CLEANING AND SHAPING IN CLINICAL ENDODONTICS**

Spyros Floratos DMD, Endodontic Specialist
Adjunct Assistant Professor, Department of Endodontics, University of Pennsylvania USA

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**Prepared vs Unprepared Root Canal Walls**

- 43% of the MB
- 33% of the DB
- 49% of the P

Canal walls WERE NOT instrumented

- Red: Unprepared Canal Wall
- Green: Prepared Canal Wall

**Factors**

- Anatomy
- Disinfection
- Obturation

**THE APICAL REGION**

- Dentin
- Cementum

**Control of Endodontic Infection**

- Median diameter of Mandibular canals
- 1 mm from radiographic apex

- Central incisor: 0.37 mm
- Lateral incisor: 0.37 mm
- Canine: 0.33 mm
- Premolar: 0.35 mm
- MB (molar): 0.40 mm
- ML (molar): 0.38 mm
- D (molar): 0.46 mm

Wu et al, 2000

Continues on page 12.
TePe Gingival Gel with Chlorhexidine and Fluoride

This antibacterial gel combines the advantages of chlorhexidine (0.2%) and fluoride (0.32% NaF) for double protection of gums and teeth. Chlorhexidine has an antiplaque and antigingivitis effect, while fluoride prevents cavities and protects sensitive root surfaces. TePe Gingival Gel contains no abrasives and no alcohol. The mint flavour and smooth formula enable pleasant and easy use with an interdental brush.

Areas of use:
- Gingivitis
- Periodontitis
- Peri-implant mucositis
- Peri-implantitis
- High caries activity

Local application of chlorhexidine with an interdental brush has been shown to have a positive effect on gingival inflammation.


Enhancing Cleaning and Shaping in Clinical Endodontics

Continues from page 14.

Mineral Apical Preparation #30-35

Insufficient Working Width

Biological apical size

preops 12/2012

#47 percussion (+) palpation (+)

#46 percussion (-) palpation (-)

postop

Minimal Diameter

Apical Preparation

NiTi Rotary files

Cleaning untouched areas

STEPS of Mechanical Instrumentation

1. Glide path

2. C&S NiTi Rotary / Scout, ISO

3. Apical Preparation

4. Cleaning

continues from page 14.

Continues on page 18.

Are you ready for a better way to relieve tooth sensitivity?

That sharp, stabbing feeling of sensitivity is something you may no longer need to endure.

Announcing the arrival of a toothpaste so revolutionary, so different, it addresses the cause of sensitivity, not just the signs.

And with direct application, it can give instant sensitivity relief.

Colgate® Sensitive Pro-Relief™ is the only toothpaste to contain the advanced PRO-ARGIN® technology. This breakthrough formula works by instantly plugging the channels leading to the tooth centre.

Brush twice a day for lasting sensitivity relief.

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ENHANCING CLEANING AND SHAPING IN CLINICAL ENDO DONTICS

Continues from page 16.

THE CHALLENGE

- The canal area to be cleaned
- Less cleaned
- Cleaning
- ORIGINAL ROOT CANAL ANATOMY

3D APICAL CLEANING - IDEAL

THE SOLUTION

XP ENDO

- Room temperature Mathesenic Phase
  - M25/00 M-Phase

- 35°C Full Austhenic transformation
  - A-Phase

XP ENDO

- MB1
- MB2
- DB

Inserting the files inside the root canals

Continues on page 22.
THE DAM TOOTHWEAR HANDS-ON COURSE

It is ideal for the dentist to use materials that do not need to be polished, particularly posterior restorations as this is time consuming and may damage adjacent enamel.

When treating tooth wear one must relate to the remaining lifespan of the patient as the teeth will wear again.

BRUXISM

The bruxist has big masseter muscles. There is a notch under the angle of the mandible. The tongue has ridges. The cheeks have extra keratin called linea alba. The teeth show signs of damage but in the true bruxist the teeth are not sensitive. There are sharp edges and bits ping off. There are cracks in the posterior teeth. Amalgams look polished. Split teeth may be lost.

The treatment for a bruxist is to catch early and prevent from getting worse.

A protective splint is indicated. A soft splint will increase muscle activity. One may make a bilaminar splint-hard on the outside and soft on the inside.

An acrylic chrome splint can be made to stop damage to the teeth. It stops the damage but not the bruxism. The cause of bruxism is nothing to do with the tooth. One can use botox to reduce bulging muscles, and this can be done 3 times a year, usually in women.

One may use an inhibitory reflex to switch muscles off.

At chairside one may make an acrylic splint. Place Vaseline on the upper anterior centrals, your nurse can mix trim or ortho resin, and a ball of trim coated in Vaseline may be squashed flat in a ‘button shape’, which is then flattened with your putty spatula into an anterior bite platform which is 1.5mm thick and flat. The Anterior bite platform ABR is called NTI in America. This covers the front 2 central incisors.

The way the anterior splint is thought to work is that the impulse is transmitted to the foramen ovale and sensory nerve cortex, and then to the brain stem which then activates inhibitory nerves which stop the muscles.

To prevent swallowing or inhalation, one can make an Essex retainer or soft guard over it. So one has an ABR with an Essex. (please note this is not a Lucy jig).

EROSION

This results in rounding, matt, smooth surfaces. There is differentiated wear, sensitivity and acid damage. This is dietary or gastric. The dentine wears down ten times faster than enamel.

To restore eroded teeth one can use PTFE tape. Get the patient to bite onto the filling with the tape over it. The result will be a filling that is smooth, polished, set with no oxygen inhibition. Do not put cusps on these cases.

Dentine bonds sometimes break down after a year because placing etch on the dentine activates the collagenases enzymes in the dentine. There are MMPs in the body- the ones in dentine do not usually work and are ‘asleep’- the acid activates them and they break down the collagen you have bonded to. Thus it is best not to etch dentine with phosphoric acid. Use a self etching primer system. It is less strong but a better long term dentine bond. 2% chlorhexidine can be used to scrub the dentine for 1 minute dry and then use the dentine bond.

ARTICANE INJECTION

Use one twentieth of a cartridge. Use a short needle. Go down 5 mm papillae at right angles to the surface- do not touch the periosteum to start with and then go to bone level. Use both sides of the tooth if there are two roots.

ATTITION AND EROSION

Do not add composite in increments. You need to wrap over and bond to enamel. Use single increment. Bond while you still have enamel.

Incisal edge is finished to 30 degrees. Will shrink onto tooth. You can do this on 3 to 3 or 4 to 4. Get the patient back into central relation. Use ICP if you can. Otherwise use centric relation.

Put condyles in the right place.

DAHL APPLIANCE

The idea is to intrude one tooth and allow the others to extrude. This is an occlusal adaptation.

It is described as a ‘Relativ Axial tooth movement’. It was in fact described before Dahl.

COMPOSITE VENEERS

In the lab these can be made to a knife edge. The impression trays for veneers should go in along the path of insertion as otherwise you will get tearing of the alginate between the teeth.

New materials have less tear strength than materials used in the 90s. They were hydrophobic so modern materials have surfactants which reduce their tear strength. Dentistry have added an additional cross linking agent.

For bite registration one can use a clear silicone.

With articulating paper one can see centric stops on functional cusps.

THE MICHIGAN SPLINT

This is a device for joint pain. It deals with occlusal problems, headaches and neckaches. It is expensive and difficult to adjust. One requires 20 mins of discussion deprogramming so one can manipulate into CR. Take a CR record and a facebow reading for the lab.

All teeth should be in centric relation. Anterior guidance to create posterior discclusion.

With articulating paper one can see centric stops on functional cusps.

THE CRACKED TOOTH SYNDROME

The tooth will be cold sensitive not hot sensitive. There is nothing on the periapical radiograph. The tooth is vital. One should transilluminate. Etch buccally and lingually and place composite all round 1mm thick. If the patient bites and there is pain then this is pulpitis as the fracture is to the pulp. If they bite but there is no pain then all is ok. Patient may talk with a lisp.

Complete occlusal coverage does not cause pain.
Enhancing cleaning and shaper in clinical endodontics

Clinical Protocol

Recommended speed: 800-1000 rpm
Torque: 1 Ncm
- XP should be used only after canal preparation to at least #25.
- In multirooted teeth, start with the largest canal.
- Work along the entire length of the canal for approximately one minute/canal.
- The access cavity should be filled with irrigant only after the XP is in the canal.

Fix the canal working length by using the plastic tube to adjust the rubber stop.
Cool the XP-endo finisher inside the tube using a cold spray.

Avoid to place the tip against the furcation.

Inserting the files inside the root canals
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.1 Up to 80% of patients use toothpaste to clean their dentures.2,3 As dentures are approximately 10x softer than enamel,4 the abrasive nature of toothpaste can create scratches, which may lead to increased microbial colonisation,5 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 biofilm† and kill microorganisms even within hard-to-reach denture surface pores.

- 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 toothpaste.

Help your patients eat, speak and smile with confidence with the Corega® denture adhesives and Corega® Extradent denture cleansing tablets.

References:
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Together with the Dentists Association of Malta, MIB have set up a scheme exclusively for the members of DAM.

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- Widest cover available;
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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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– Michelle Hurlbutt, RDH, MSDH

Experience Breakthrough Innovation: Philips Sonicare AirFloss

Patients who just won’t floss will love the new Philips Sonicare AirFloss. Its innovative microburst technology delivers a quick burst of air and microdroplets for a gentle yet powerful clean in-between.

Effective: Sonicare AirFloss helps reduce gingivitis by up to 75% and the number of bleeding sites by up to 86% in 4 weeks.

Easy to use: Reported easier to use by 86% of patients surveyed.

Preferred: After 1 month, 98% of patients who flossed inconsistently used Sonicare AirFloss at least 4 times per week.

Ask your Dentist for more information. Available from all leading Pharmacies in Malta & Gozo.

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Continues on page 30.

Sonicare AirFloss helps reduce gingivitis by up to 75% and the number of bleeding sites by up to 86% in 4 weeks.
ENHANCING CLEANING AND SHAPING IN CLINICAL ENDODONTICS

Continues from page 29.

Bioceramic Perforation repair on MB canal

Bioceramic Apical Plug

Bioceramic Sealer - Cases

Bioceramic Sealer - Cases

failed apicoectomy

Root end filling

Root end filling

Root end filling

Bioceramic Sealer - Cases

Root end filling

Root end filling

TotalFill Bioceramics

TotalFill Bioceramics

TotalFill Bioceramics
ENDODONTIC TIPS

By Spyros Floratos DMD, Endodontic Specialist. Summarised by Dr David Muscat.

It is important to remove the roof of the pulp chamber and fish out all the dentinal chips, if necessary using ultrasonic tips.

It is ideal to use X42 magnification.

The law of colour change – the colour of the Pulpal floor is always darker than the walls.

The law of orifice location states that the orifices of the root canal are always located at the junction of the walls and the floor. The grey colour if the floor of the chamber. Necrotic pulp peri radicular periodontitis.

Infection is pulpitis-bacterial proliferation and growth over a certain threshold then a periradicular lesion develops. Bacteria are produced and an immune reaction occurs to defend against infection.

Bacteria may be in three forms - live bacteria in canal; bacteria in canal walls; bacteria which penetrated into dentinal tissues. As you go apically bacteria go deeper into dentinal tubules. One cannot remove mechanically but chemically. One needs sodium hypochlorite to penetrate. Biofilms have to be removed. There will always be a part of a root canal that will not be touched by instruments. 43% of MB, 33% of DP and 49% of Cal walls were not removed in a study by Peters IEJ2003.

STEPS OF MECHANICAL INSTRUMENTATION a. glide path-open path to the apical foramen. b. conical shaping. c. apical preparation to a biological (Apical)size. d. Cleaning untouched areas as the shape is oval.

To achieve success one must know the anatomy of the last 3mm of canal. In most cases the canal exists on the side. Thus we fill to 1mm short of radiographic apex. What is the diameter of the apical constriction?

A number 40 is the first file that will remove the radiographic apex. What is the diameter of the apical constriction?

A number 40 is the first file that will remove the radiographic apex. Thus we fill to 1mm short of the side. The grey colour if the floor of the chamber. Necrotic pulp peri radicular periodontitis.

Infection is pulpitis-bacterial proliferation and growth over a certain threshold then a periradicular lesion develops. Bacteria are produced and an immune reaction occurs to defend against infection.

Biofilms are aggregates of bacteria that are stuck onto the canal walls. They are one thousand times more resistant to sodium hypochlorite.

Rotary files should ideally be flexible; there should be a number of them and they should not break. You need to work to apical size 30-35. A progressively reduced taper required-biology not technology.

Mechanical properties of Nickel Titanium 25/0.02 tap file is at the tip of the file the diameter is 25 microns. When the taper of the file increases, the flexibility decreases. Nickel titanium has cyclic fatigue-file will break round a bend (so always go up and down and do not keep still), and torsional fatigue-the tip locks, as there will be flute deformation. With your rotary instrument, go in 4 strokes up and down, take it out, wipe with gauze and inspect for flute deformation.

RACE FILES are removers with alternate cutting edges of a non-threading flute design. The flutes are interrupted by a straight part every 3mm so there is no locking within the canal. The possibility of fatigue is limited. The file scrapes not cuts. Race files also have an electro chemical polished surface. Microgrooves cause microcracks and electropolishing eliminates this. Also the file is more resistant to corrosion by sodium hypochlorite.

A microgap at the apex is the most common finding of a failure of an endodontic instrument. The correct working width is important not just working length. A biological instrument to the correct apical size.

The solution has to do with the nature of the nickel titanium alloy. This occurs in two phases. The Austenite phase is super elastic it has a shape memory and goes back. The Martensite phase has no shape memory and can stay deformed. Ideally one needs a file that takes the temperature of the canal and becomes austenite again. The XP Endo finisher expands-finishes and is used after the 30-35 sizes. The file can touch all the canal wall 3D and reaches the untouched areas. A size 25 has a zero taper and is straight at room temperature in the Martensite. At 35 degrees in the canal there is an Austenite transformation. When spinning in the canal the XP Endo finisher has a total of 3mm expansion. When using it one faces the cusp and the stopper is adjusted to the working length.

The protocol is a speed of 800-1000rpm with a torque of 1Ncm. In a multi-rooted tooth start with the largest canal. Work along the entire length of the canal for approximately 1 minute per canal. The access cavity should be filled with irrigant only after the endo finisher has been in the canal.

TOTAL FILL BC SEALER is a bioceramic -a new cement and philosophy over the last 4 years. The 65 studies have shown that it does not shrink; it is dimensionally stable; better working time than MTA; hydrophilic; and has a property of bonding on the dentine surface that MTA does not. It also stimulates the formation of new dentine. It has good sealing ability and high antibacterial properties.

Totalfill comes in a jar – putting mix viscous for perforation repairs, surgery; pulp capping and use in open apex. Alternatively it comes as a syringe which is a sealer. Or else a box putty and syringe. The sealers do not dissolve and fill the space between gg and wall. The sealer is introduced to a third of the canal.

The gg pushes sealant in a different concept. Use a lentulo to fill canal with sealer. Place 2mm short of WL. Sealant placed on master core. GP inserted into canal gently all the way to length. Cut upper part of master core and compact it. A single cone concept. 20. The gp is used as a plugger to push the sealer.

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IS IT RIGHT TO ‘RAISE THE BITE’?

By Dr Matthew Cachia
BChD, MFDS RCSED

The Dental Probe December 2015 – Issue 56

Why open your articulator?
- Tooth wear
  - Erosion
  - Attrition
  - Abrasion
  - Attrition
- Tooth loss + lack of posterior support causes attrition of anterior teeth. (being used for chewing rather than cutting)

Tooth wear
- Caused when the physiologic rate of tooth loss is excessive and there is now a risk that the patient will not have enough enamel in old age.
- 0.2mm loss of enamel per decade of life can be considered as acceptable physiologic wear.

Category III patients
- Raising the OVD in these cases is pointless as there is no available space for restorative materials and there is no increase in the freeway space. Tooth wear is often slow progress
- These cases are best treated by crown lengthening and full veneer crowns or overdentures in extreme cases.

Case 1.
- 26 year old female
- PC: Thinning out upper incisors, recently noticed chipping of enamel. Worried she may lose her teeth and unhappy about the uneven appearance of her incisor edges.

Turner and Missirian Classification of toothwear patients (1984)
- Category I patients: Excessive tooth wear with a loss in the VGO
- Category II patients: Excessive wear with no apparent loss in the VGO
- Category III patients: Excessive wear with no loss in the VGO

Category I patients
- Rapid loss of tooth tissue with no time for dento-alveolar compensation
- Important to identify the cause before treatment
- Erosion is commonly a strong factor
- Simple to treat
- Plenty of space for restorative materials

Category II patients
- Forward positioning of the mandible gives the impression that there is no loss of VGO
- Intermediate difficulty
- Treatment by distalization, intrusion, extension or raising the OVD uniformly
- Use temporary restorative materials first if possible as major changes to the occlusal scheme may not be tolerated by the patient

Category III patient
- Denture alveolar compensation is very obvious (freeway space is normal)
- The alveolar bone often looks thin around the shortened teeth

Treatment options
- Monitor
- Classic Gold appliance to gain anterior space then build up anterior teeth to the desired height
- Direct composite build ups of the anterior teeth placed high
- Indirect composite restorations placed high in CR

Category II patient

Continues on page 36.
IS IT RIGHT TO ‘RAISE THE BITE’?

Continues from page 35.

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Continues on page 38.

IS IT RIGHT TO ‘RAISE THE BITE’?

Continues from page 35.

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The NEW GUM® HYDRAL™ range quickly and effectively relieves dry mouth all day, every day.

Chewing, swallowing and speaking difficulties are significantly decreased, taste is less affected and burning sensations in mouth are decreased*.

Gentle formulation specifically designed for the sensitive oral mucosa.

*10-days In Home Use Test performed on GUM® HYDRAL™ range in 02.2014 on 51 dry mouth sufferers aged 20 to 69, to determine the perceived efficacy and the overall acceptability of GUM® HYDRAL™ gel, spray and mouthrinse.
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S W I S S + M A D E

ALL-NEW
TORNADO
30 WATTS