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The Dental Probe

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Editorial

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DENTAL ASSOCIATION OF MALTA
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By Dr David Muscat

Dear colleagues,

The DAM organised a lecture on 'Temporomandibular Joint Disorders: A comprehensive approach to diagnosis and management' by Mr Ross Ellidge, Maxillo Facial surgeon on Wednesday 31 May at Xara Palace, kindly sponsored by Pro Health. The lecture provided an overview of TMJ disorders. The diagnostic focus was on the sub-classification of TMDs and identification of common pathologies including degenerative joint diseases, internal derangement and myalgia. The importance of a functional overlay was discussed and its implications on pain perception. A stepwise approach to management was described including bite raising appliances and physiotherapy, TMJ arthroscopy and arthrocentesis. Intra-articular medicaments such as steroids and hyaluronic acid were also described as well as intramuscular botolunim toxin, open arthroplasty and total alloplastic joint replacements. Mr Elledge also described his research on extended TMJ replacements (eTMJRs) and the evidence base for a treatment algorithm, including identifying when to refer.

The wedding season has kicked in and several of our younger members are tying the knot since Covid restrictions have been lifted. Drs Lara Camilleri, Chantelle Abela, Rebecca Schembri Higgins and Andrea Agius have all got married recently.

Another CPCD course is being organised by the Dental Association of Malta at The Hilton. No further permits for CPCD units will be issued by the Occupational Health and Safety authority unless this course is successfully completed.

On 22 June Bart Enterprises organised an IPS e Max system lecture at Salini Resort with opinion leader Maria Spanopoulou.

On Friday 7 July at The Palace Sliema, Marletta Enterprises is organising half day lectures presented by Dr Dominic O'Hooley with the participation of Dr Nicholas Busuttil Dougall. These lectures are on Osteoimmunity meeting true host bone regeneration. The latest theories on why Beta Tri Calcium Phosphate and Calcium Sulphate are ideal graft materials will be outlined. The use of EthOss in different clinic scenarios will be described as well as advanced techniques. Further Medical emergencies courses are also planned.

In October the DAM is planning a lecture on new irrigation protocols for endodontics by Dr Maria Xuereb.

Dr Edith Vassallo, The Congress President of the 35th Annual Meeting of The European Society of Head and Neck Radiology has invited member dentists and maxillofacial surgeons of the Dental Association of Malta to attend a designated session on 'Dental/ Maxillofacial' on Saturday October 7th between 11am and 12:30pm. This will involve the following presentations:

- How do I assess the OPG?
  – M. Suuronen Espoo/FL
- Cystic Lesions of the mandible and maxilla: A systematic approach
  – C. Greenall, Cardiff/UK
- Incidental Findings in the jaw on CT: what should we know about teeth?
  – C. Czerny, Vienna/AT
- Imaging of TMJ
  – I. Sepulveda, Concepcion/CL

A fee of 150 euro is payable.

We mourn the loss of Dr Stephen Borg Cardona on Thursday 11th May. May he rest in peace.

The cover picture is The Customs House Valetta by the artist Jacqui Agius.

David

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

IDS 2023

Prof. Arthur R. G. Cortes, DDS, MSc, PhD

In mid-April of 2023 there was the celebration of 100 years of the International Dental Show. This took place, as usual, in Cologne Germany, at the IDS 2023.

Usually, the products that come to the Dental Market in the World, are initially exposed for the first time at the IDS. For this year, several trends and categories were highlighted by the event companies, such as Virtual Reality, Artificial Intelligence, and Computer-aided Design and Computer-aided manufacturing (CAD-CAM).

Several Maltese Dentists were at the event, representing the country. The University of Malta was also represented by Professor Arthur Cortes, and two PhD students whose theses are focused on Digital Dentistry: Dr. Anne-Marie Agius and Dr. Juliana No-Cortes. The three academics participated in several meetings with multiple companies, and presented their research and their new book "Digital Dentistry: A Step-by-step guide and Case Atlas". Prof Cortes also emphasised the importance not only for dental clinicians but also for students and technologists to participate on events such as this one, since being up-to-date in regard to dental technology is becoming increasingly important in our careers.

Prof. Arthur Cortes, Dr Anne-Marie Agius and Dr Juliana-No Cortes, at IDS 2023

Dental Continuing Professional Development

Summary by Dr David Muscat

Dr Ann Meli Attard

A three year Dental CPD research project was carried out as part of the Dental Association of Malta's CPD initiatives and as part of Dr Ann Meli Attard's MClinDent with Kings College Dental Institute London.

The results of this project were subsequently published as a series of two articles by Dr Ann Meli Attard, Dr Adam Bartolo and Prof Brian Millar in the European Journal of Dental of Dental Education and will support the Dental Association of Malta and other European Countries with scientific basis for planning the future of Dental CPD. This is a summary of the first article.

CPD is mandatory in most EU countries but in Malta it is still voluntary. There is a move towards mandatory CPD across all member states. However in Malta the EU Directive on CPD has not been transposed into Maltese Law.

It is important to determine as to whether CPD is truly effective in so much as improving the quality of care, treatment outcomes as well as public safety.

The minimum compulsory CPD hours have been imposed by regulatory bodies and some are arbitrary.

In Malta the Dental Association of Malta recognised the need for further research on the matter.

CPD can be defined as a lifelong learning process, designed to assist professionals in maintaining and updating their knowledge in the profession with the primary scope of improving the quality of care, treatment and safety of the public.

There is a move towards the harmonisation of CPD across member states and this will enhance mobilisation and trust in Dental surgeons.

Dental CPD is voluntary in nine EU countries of which seven are member states and Malta is one of those member states. The EU Directive 2005/36/EC article 22(b) states;

'Member States shall, in accordance with the procedure specific to each member state, ensure by encouraging CPD, that professionals are able to update their knowledge ,skills and competencies in order to maintain a safe and effective practice and keep abreast of professional developments.

In certain countries CPD has become a requirement for recertification. However the core topics as well as the number of hours may not necessarily be what is required.

Continues on page 7.

Dental Continuing Professional Development

Continues from page 5.

The most common CPD providers are professional Dental Associations and University Dental schools.

CPD is divided into 'verifiable' and' non verifiable .'

VERIFIABLE CPD

This is defined as CPD that 'has concise educational aims and objectives, clear anticipated outcomes and identified quality control mechanisms.'. It must be supported by documentary evidence of attendance. Examples. Lectures, courses, conferences.

NON VERIFIABLE CPD

This does not satisfy the requirements of Verifiable CPD but serves to advance the individuals professional development such as reading journals, background research etc.

CPD PROGRAMME

This should be tailor made for the needs of individual practitioners which is directly related to the needs of the public.

Each profession designs its own CPD programme and sets minimum CPD compulsory hours.

Difficulties arise in determining the needs as well as the minimum hours and the differences between EU countries.

It is important the CPD in fact is shown to actually make a difference to the dentist's skills and knowledge. This in turn enhances patients ' confidence and trust .The dentists who attended the CPD courses must be shown to then implement the learning and this must be translated into better care and safety.

It has been shown that dental CPD increases job satisfaction and makes for better work environment.

80% of European Dentists are in favour of mandatory CPD. The correct methods of evaluation are important.

The DentCPD project recommended:
1. Pre and Post Event test with identical questions.(testing short term retention of knowledge)
2. Feedback form
3. A further questionnaire 6 weeks later to evaluate long term retention of knowledge and a change in behaviour.

The CPD provider has to evaluate the CPD programme at as many levels as possible using the Kirkpatrick Framework of evaluation.

The Kirkpatrick levels of evaluation
1. Participation
2. Reaction to the programme
3. Evaluation of knowledge acquisition
4. Application of acquired knowledge
5. Healthcare outcomes of the CPD event.

Whilst dentists prefer formal lecture, research has shown that a hands on practical course has the most positive impact on practice.

The 'core' topics are 'core compulsory' and 'core recommended.'

Core Compulsory should be:
1. Medical emergencies
2. Infection control
3. Management of medically compromised patient
4. Radiation protection

Core Recommended:
1. Health and safety
2. Pain management
3. Safeguarding children and vulnerable adults

All topics must be 'underpinned by evidence based dentistry.'

In the UK core recommended topics also include:
1. Oral cancer early detection
2. Legal and ethical issues
3. Complaint handling

GDC GUIDELINES

1. Medical Emergencies – a minimum of ten hours in a five year cycle (two hours per year)
2. Disinfection and decontamination (min. 5 hours every 5 years)
3. Radiography and radiation protection (min. 5 hours in every 5 year cycle

The Dental Association of Malta embarked upon a three year dental CPD Pilot Project in Malta so as to develop guidelines and recommendations on how to establish and evaluate a customised and evidence-based CPD programme for local regulatory bodies and CPD providers. The DAM added 'Primary Dental Care – Fundamental Principles' to the list of the DentCPD project.

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The Malta CPD Project

Summary by Dr David Muscat

A three year Dental CPD research project was carried out as part of the Dental Association of Malta's initiatives and as part of Dr Ann Meli Attard's MClinDent with Kings College Dental Institute London.

The results of this project were subsequently published as a series of two articles by Dr Ann Meli Attard, Dr Adam Bartolo and Prof Brian Millar in the European Journal of Dental Education and will support the Dental Association of Malta and the dental profession in Malta and other European Countries with scientific basis for planning the future of Dental CPD. This is a summary of the second article .

The aim of this project was to measure the effectiveness and success of a new CPD programme so as to determine strategy, guidelines and recommendations to establish a dental CPD programme in Malta.

In this case the Dental Association of Malta was the CPD provider.

PHASE 1:

Analysis of a survey sent out to 135 DAM members

PHASE 2:

Evaluations of 8 verifiable CPD events using pre and post event feedback forms and tests so as to gauge short term knowledge retention as well as satisfaction regarding the event by the participants.

The objective of the study was to use Malta as the target population under study to represent all EU countries that still do not have mandatory CPD as part of their natural legislation.

This was conducted via a two phase CPD pilot project.

1. Selection of CPD provider
2. Literature review
3. CPD project design

The CPD events were as follows:

- Restorative
- Local anaesthesia
- Endodontics
- Law and Ethics
- Decontamination and Infection control
- Medical Emergencies and Basic Life Support
- Radiology

The CPD events showed a statistically significant improvement in short term knowledge retention in each subject. The lowest baseline scores were in Medical Emergencies and Infection Control.

A 'baseline score' is defined as the knowledge of the delegate before the CPD event.

The satisfaction level of the attendees was 90—100 %.

The dentists stated that online CPD is the barrier to learning as it is the least popular method.

Over 70 % said that they would recommend CPD events in the Pilot Project to colleagues.

The results of the survey show essentially the following:

1. All lectures should be held on Wednesday evenings
2. All hands on courses CPD popular months – February and March. The least popular CPD months are July, August and December.
3. 60% of dentists are in favour of mandatory CPD in Malta .
4. 70% of dentists said they would be happy if a system was set up for regular CPD.
5. 75% of dentists believe that mandatory CPD would improve the standard of dentistry in Malta

It is pertinent to note that currently in Malta there are no private CPD providers who stand to gain financially if CPD in Malta becomes mandatory.

The authors recommended that Verifiable CPD should be in a five year cycle set at 50 hours in Malta compared to the 75 hours recommended by the GDC.

They also recommended that 'Primary Dental Care' should be considered as a Core verifiable CPD subject as quality of care should be given importance in patient safety.

This not only reflects the lack of local resources and CPD providers but aims on focusing on the high quality of CPD events that are properly evaluated as opposed to a high quantity of CPD events that are of poor quality and poorly or not even evaluated.

This will help instil more confidence in CPD and harmonisation across EU states thus encouraging mobility of the dental workforce and enhancing patient trust in the dental profession.

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Approaches to the surgical removal of Ameloblastoma

Mr Thomas Martin Grixti – MDS 5th Year Student
Faculty of Dental Surgery, University of Malta

Introduction

- This report follows the management of a patient who was diagnosed with a unicystic ameloblastoma – basaloid variant, in the left posterior mandible.
- Following the diagnosis through clinical, radiographical and histological examinations, a partial mandibulectomy was planned with wide resective margins..
- The patient did not consent for an autogenous bone graft. A prefabricated fixation plate was thus left in situ for long term.
- Evidence from the literature on surgical approaches, reconstructive techniques and long-term management was discussed.

Aims and Objectives

1. To explore methods of achieving complete resection of the odontogenic tumor and reducing risk of tumour recurrence.
2. To explore the criteria pertaining to long-term functional resolution.

Case Report

- 37 year-old male
- Patient is fit and healthy
- Extraoral examination: Unilateral left mandibular swelling
- Intraoral examination: Buccolingual swelling of body of mandible. No tooth mobility.
- Investigations: OPG, incisional biopsy (soft tissue fragments collected through marsupialization – January 2019).

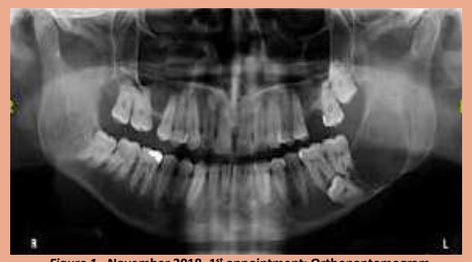

Figure 1 **- November 2018. 1st appointment; Orthopantomogram.**

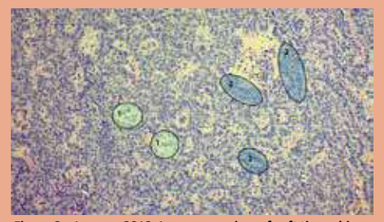

Figure 2 **– January 2019. Low power view of soft tissue biopsy.**

1 - Tumour stroma with inflammatory cells
2 - Sheets of basaloid cells with peripheral palisading and occasional reverse nuclear polarity

Treatment:

- Radical ablative resection with 1cm safety margins through both intra and extraoral incisions.
- Pre-op medical CT and MRI for 3D analysis and plate fabrication. (April 2019)
- Post-op histology confirmed complete tumour resection.

Post-op complications:

- Salivary leakage from Parotid gland. Healed spontaneously.
- Fixation plate failure after a 9-month review. [Figure 3]

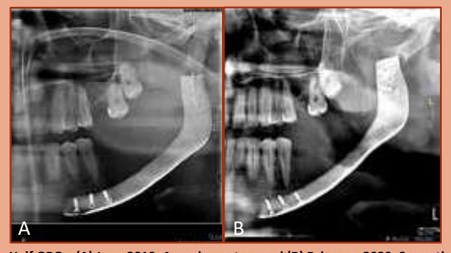

Figure 3 **– Half OPGs; (A) June 2019, 4 weeks post op and (B) February 2020, 9 months post-op**
Note the plate displacement in (B) compared to (A)

Discussion

Resection:

- Determining the objectives for a successful tumour resection.
- Importance of accurate diagnosis and its impact on the surgical approach of choice in treating ameloblastoma.[1]
- Conservative vs Radical approaches, comparing each method's potential risk of recurrence for ameloblastoma.[2]
- Adjuncts to the surgical removal of ameloblastoma, such as Carnoy's solution.

Reconstruction:

- Transitioning from fixation to reconstruction; why and how
- Immediate vs Delayed reconstruction with bone grafts.
- Autogenous sites for bone grafting in mandibular spaces.
- Vascularised vs non-vascularised bone grafts.

Conclusions

- Importance of digital planning for fabricating surgical guides and custom metal plates in surgery planning
- Radical techniques reduce the risk of recurrence in unicystic ameloblastoma.[2]
- Long-term functionality is best achieved through bone grafting, showing better results in delayed reconstruction.[3]
- Patient involvement in treatment planning has a profound impact on the treatment outcomes.

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THE RELEVANCE OF DIRECT INTRAORAL DIGITAL SCANS IN TODAY'S DENTAL PRACTICE

By Dr James Frederick Attard BChD

The widespread use of CAD/CAM for dental applications might seem to have happened fairly recently, but the concept of acquiring a digital dental impression was first documented in 1973[1,2] ; 50 years ago!

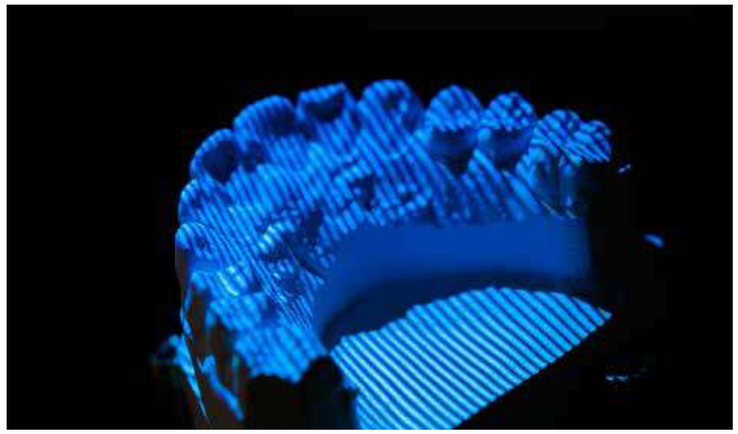
The first commercially available CAD/CAM units arrived in 1987.[2] Even though the novel polyvinyl siloxane (PVS) materials of the 80s rendered CAD/CAM imperfect by comparison, the concept of digitalisation was always regarded as state-of-the-art. By 2005 the quality of direct intraoral digitisation was on par with conventional impression taking.[3]

A survey carried out in 2021 showed that 53% of dentists used an intraoral scanner (IOS) in their practice4, with the aim of improving clinical efficacy, with 58% of the respondents having had their scanner for less than 4 years. 4 The commonest reason for not using an IOS within this group was the level of financial investment required.[4]

Most modern IOS collect information on tooth, dental arch anatomy and implant positioning (via an implant scan body) by projecting a beam of structured light onto the surface which is being scanned.

The structured light distorts as it hits the uneven surfaces of the dental arch; the distorted reflection is captured by high resolution cameras inside the IOS body.

The data collected by the cameras is then processed by reconstruction software, first into a polygonal mesh of point clouds and then into the final 3D model.[5]



ADVANTAGES OF OPTICAL IMPRESSIONS:

PATIENT COMFORT

The high level of patient comfort that this non-contact method of record capturing offers is the first of many advantages that IOS offer and one which is highly appreciated by patients. Those with very strong gag reflexes or children who might not tolerate conventional impression taking techniques with bulky impression trays and materials tend to respond much better to direct digital impression taking.[6]

EFFICIENCY

Optical impressions reduce overall working times (and therefore costs) when compared to conventional impressions.[6] The actual scanning procedure is probably not faster than taking an alginate impression; the increased efficiency can be appreciated when considering all the steps required from taking the actual impression to landing a plaster model on the technologist's lab bench.

- Casting is not required
- No wasted space to store plaster study models
- Avoid cost of physical model preparation and delivery to dental lab
- Offers immediacy
  - Scan can be sent to the lab via email to be vetted within minutes; scan can be retaken without having to ask the patient to return to the dental office if the technologist is not satisfied with the first scan
  - Scan can be used to start surgical planning immediately

SIMPLIFIED CLINICAL PROCEDURES

If the clinician is not completely satisfied with a scan the defective areas can be re-scanned and improved, no need to start all over. Multiple implant cases can be planned more easily by merging the digital models with radiographic scans whilst severe undercuts which could distort a conventional impression will not be an issue.

BETTER COMMUNICATION WITH THE DENTAL TECHNOLOGIST

The technologist and clinician can discuss the scan without having to be physically in the same room.

BETTER COMMUNICATION WITH THE PATIENTS AND TREATMENT MONITORING

The optical impression together with the powerful 3D rendering software which is readily available allow the clinician to offer more predictable treatment explain more effectively with 3D renders. Besides showing the patient how committed the practice is to invest in the latest technology, visuals make the patient feel more involved in the treatment. This positive impact tends to motivate the patient to be more compliant. All the patient's scans can be kept over a longer span of time without sacrificing physical space at the dental office.

Scans can also be found much quicker when compared to scavenging for plaster models inside a cabinet, allowing for better treatment monitoring and enhanced patient education and communication. If a physical model is required, it can be 3D printed at any time.[7]

Optical impression taking does not come without its drawbacks; IOS are surely not the miraculous solution that their sleek looks and cool adverts suggest. There is a learning curve for the clinician and an integration process for the practice.

Older clinicians with less aptitude and experience with technological innovations could find these devices complex.[6]

Scanners from different manufacturers vary, making one arguably better or more suited to specific functions over another. Licence agreements determine the intended use of that particular scanner. Despite these differences, difficulty in detecting deep infra-gingival margin preparations seems to be a common struggle.

The structured light emitted by the scanner does not penetrate well infragingivally and the scanner fails to detect the margin's finishing line correctly. This is also true in case of bleeding. The light emitted is not capable of physically displacing gum and blood as is the case with a conventional PVS wash impression.

This shortcoming can be addressed by using retraction cord and haemostatic agents and ensuring optimal health of the soft tissues by motivating the patient to maintain high levels of oral hygiene and providing precise provisional restorations.[6] Scanning perfect single tooth preparations is usually very straight forward and accurate, but wet, shiny or very dark areas can present a challenge. Keeping the scanning area relatively dry should be enough for modern scanners to produce an accurate scan. Alternatively, a thin layer of scanning spray can be used to homogenise shiny and dark areas.[7]

Other challenging areas of capture are mobile soft tissue, usually including the cheeks, lips, tongue and flabby edentulous ridges.

The rendering software of an IOS is constantly stitching hundreds of 3D images together; the software identifies common points on different images, overlaps and stitches them in place, producing a larger continuous scan, much like pieces of a jigsaw puzzle fitting together.

During a scan multiple passes are made over the same areas; this tends to improve the quality of the scan by 'stitching' further images of the area.

If though, during a repass, soft tissues assume a different position, the new scan will differ from the earlier one and create distortion. One way to help reduce this is by using retractors to reflect unwanted soft tissues away from the dental arch and stabilise soft tissues such as frenula.[7]

Digitalisation is at the heart of modern dentistry. Conventional methods of impression taking will probably live on for a while longer – as the exception rather than the norm, according to recent trends.[4]

As more dental offices are investing in digital scanning technology; it is only a matter of time till IOS become standard equipment in every practice.

One must choose wisely by carefully taking into consideration the annual management costs, fees and software limitations which differ with each product, ultimately choosing a scanner with best cost benefit.

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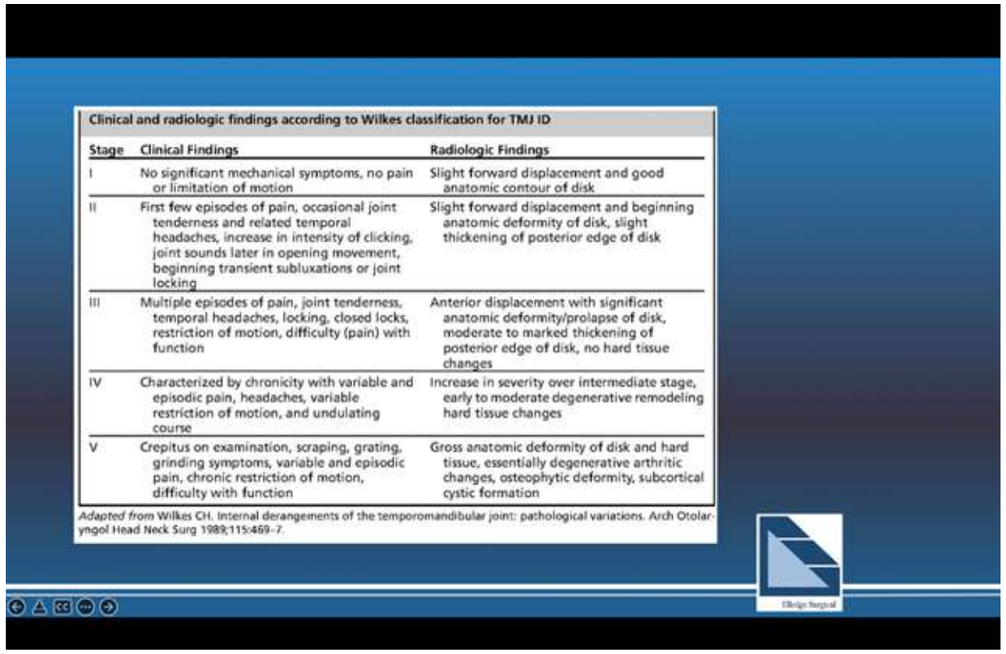
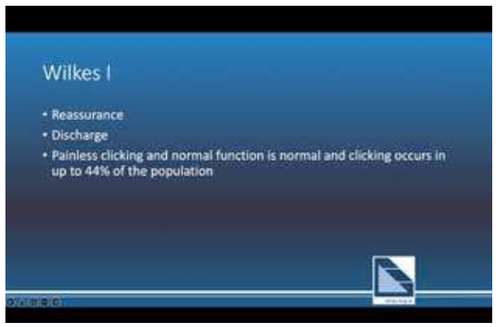
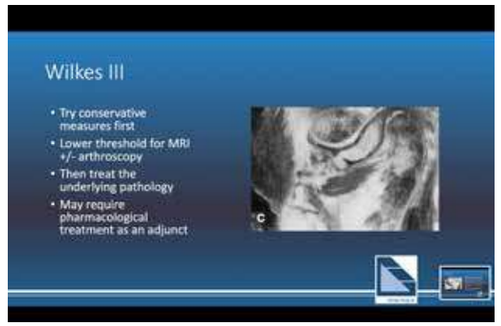
LECTURE ON TMJ BY **ROSS ELLEDGE**

CONSULTANT ORAL AND MAXILLO FACIAL SURGEON

At Xara Lodge Resort On
Wednesday 31st May
Sponsored by Prehealth







LAUNCH OF 3SHAPE TRIOS 5 INTRA ORAL SCANNER

THE PHOENICIAN SUITE AT THE WESTIN DRAGONARA RESORT, ST JULIANS

Synopsis of Presentation by Dr Konstantinos Sergis,
Prosthodontist and 3Shape Key Opinion Leader

Wednesday evening, 19th of April 2023, in Westin Dragonara hotel took place the "Launch of the 3Shape Trios 5 Intra Oral Scanner" -organized by Bart Enterprises Ltd - with the participation of more than 30 dental professionals.

Mr Etienne Barthet, at this introductory lecture, presented in detail the features of 3Shape Trios 5 and the new Trios-Share set-up which is available for clinicians.

Invited speaker was Dr Konstantinos Sergis, Prosthodontist based in Athens and 3Shape KOL in Greece, lecturing about "Inside Trios 5. Digital Mode ON!"

In his introduction, Dr Sergis mentioned the importance of a smooth transition from analog to digital dentistry, and how this goal can be achieved in daily dentistry. Explained in detail were concepts like model-free monolithic restorations -which are widely used in digital dentistry-, the various options of materials that exist in the market now and the digital protocols that clinicians and lab technicians should respect for offering a high standard of digital care to the patients, efficiently and with predictability in all the applications of dentistry.

At the second part of the lecture, Dr Sergis scanned live with Trios5 a 3D-printed model with pmma provisionals on, in order to show the importance of additional digital

scannings. Pre- preparation scan, preparation scan, antagonist scan and bite scans, include all the information needed to be sent to technicians, in order to design an accurate and predictable rehabilitation.

Applications like Smile Design and Patient Monitoring, besides engaging the patient, offer a higher level of communication among specialists team and lab as well. Use of tools of Trios software like Trim and Lock, replicate accurately the conditioned tissues especially in implantology and aesthetic dentistry, which is a competitive advantage of digital workflow comparing to analog, as Dr Sergis mentioned.

At the closing part of his lecture, Dr Sergis analyzed complex cases with immediate loading and full digital protocols, from design of surgical guides till provisional restorations and final prostheses, having always a prosthetically driven mindset which is the key of success and predictability of digital dentistry.

He mentioned the importance of "Final Design" of each case and how can a clinician transfer that, through mock-ups, prototypes and provisionals to the patient, verifying each step for achieving a successful result.

SHADE TAKING

A lecture by Dr Ann Meli Attard
Summarised by Dr David Muscat

Colour is dependent on:
- Light source
- Modified by object
- Interpreted by receiving apparatus

Colour is determined by
- Value-brightness
- Hue-wavelength
- Chroma-saturation (how much of that hue is in that colour)

Refer: Munsells colour sphere. Shades have opalescence (how light is passing through a tooth).

Fluorescence – the ability of a surface to emit light. This can be used to diagnose caries.

If you are in a room where any of the colours are removed from the room you will not see that colour.

Bluish hues best for shade taking. Daylight is not consistent. Best is Northern daylight at midday with high energy in the blue end of the spectrum.

Artificial light -bulbs have a colour temperature of 5500 K and a colour rendering index of 90% or higher.

Replicate by:
1. Barrisol lights- no shadows
2. Check specifications dental chair light
3. Use CED colour corrected light

Types of shade guide:
1. Vita
2. Digital spectrophotometer
3. Custom shade guide- made with composite

The shade guide has to be set up according to the value from light to dark .The Vita shade guide is in value order. A chroma is a saturation of the hue.
If you are unsure of a shade -convert to a black and white picture.

SETTING UP CLINIC

Use neutral colours on walls, floors, furniture. Colour corrected lights selected. Use grey patient bibs allowing the eye to rest during shade matching without the risk of after image production.

Patient at appointment:
1. Wear a grey top
2. No make up

THE CLINICIAN

9.8% males and 0.1% female dentist in the USA are colour blind, It may be worth doing an ISHIHARA colour blindness test. Over the age of 60, blue and purple vision is affected.

Chronic disease – diabetes/ glaucoma Medication. Anti epileptic drugs. Tiredness – avoid taking shade at end of the day

THE PATIENT

- Take shade at the start of the appointment when teeth are hydrated.
- Clean teeth.
- Remove make up and jewellery
- Wear a neutral top – grey
- A non-surgical periodontal appointment must be scheduled ahead of shade taking
- A clean mouth is an aesthetic mouth.
- Re: tooth whitening – delay composites for 3 weeks so as to allow the oxygen to dissipate and for shade regression to take place.

PAYMENT FORM

Please cut out this section and send with a cheque for 75 euro payable to **Dental Association of Malta** for your 2023 DAM membership – the best 75 euro investment ever!

Please note that membership renewals received after 1st July 2023 will incur an additional 25 euro administrative fee.

TO:

The Treasurer, Dr Noel Manche,
The Dental Association Of Malta,
Federation Of Professional Associations,
Sliema Road,
Gzira.

NAME:

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ADDRESS:

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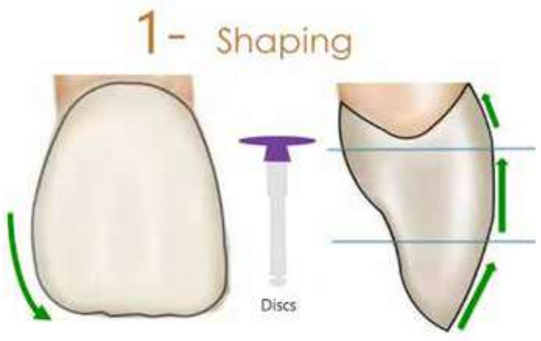
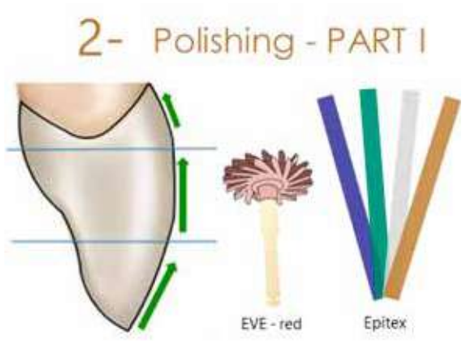
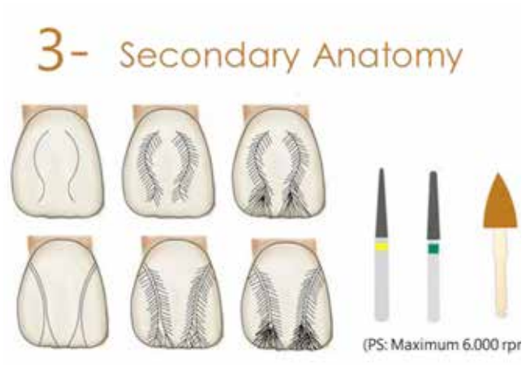
A Guide to Finishing and Polishing







THE GC CAMPUS EVENT

On 28th April 2023, a hands-on event was held at Cherubino Ltd. This GC Course was run by Dr Ann Meli Attard KOL of GC.

The aims of the course were to describe and teach the injection moulding technique and describe the G-aenial injectable material.

Accurate shade selection was also covered as well as the management of the discoloured tooth. Composite layering was also described and an introduction to the basis uses of the Optiglaze colour kit.

A silicone key was fabricated with Exaclear and the IMP procedure was carried out on non prepped teeth, teeth with a corrugated bevel and on veneered teeth.

The course is a great adjunct to the general practitioners armamentarium in his/her practice. A valuable kit and burs were also given free to the participating dentists

Further similar courses are envisaged due to the great interest that has been shown for these courses. A truly excellent course.

THE KA1 ZIRCONZAHN PROJECT

By Dr David Muscat

There have been three groups of dentists who have attended a weeks course in Zirconzahn in northern Italy.

Zirconzahn was founded by Master Dental Technician Enrico Steger. He is behind Prettau Zirconia. This is pre-coloured Zirconia which is used in the manufacture of implants. By using this material one can avoid micro cracks and hence obtain better results for patients.

Zirconium has produced excellent milling machines used worldwide- these ensure excellent detail and a good fit for the prosthesis that we make for our patients such as dentures and bridges etc..

Our course was held at the main education centre in Gais, South Tyrol.

At the course we were taught about the in house Zirconia,resins , CAD CAM systems as well as the implant prosthetic components available for more than 140 implant systems - this made us more aware of the diverse armamentarium a dentist has at his/her disposal. This will translate into better planning and treatment outcomes in our clinics.

The standard and quality of training as well as the systems we were taught to use were world class- in fact the company prides itself on 'the most expensive,for the clients you value.'

Since we were taught in small groups we were all given individual training and attention. The training centre laboratory was in the same building as the accommodation in a type of boot camp with discipline and a non nonsense approach with no wifi or tv or alcohol allowed - just chessboards .

Our group was lucky enough to have a personal trainer who would take our group on physical training ,mainly cycling in the shadow of the dolomites at 6am every morning. At 7am the group had breakfast and a quick shower for a prompt start at 8am in the laboratory. This regimented approach every day ensured we were all on time with our various tasks. Character building is also a feature of this course.

Appreciating your surroundings and using earth,water ,fire and air - the essential elements is drummed into you in an almost philosophical matter and you are left feeling a sense of duty and vocation which you take away from the week.

We were taught minimal preparation techniques for crowns and veneers- this will ensure that we do not cut more tooth substance than we need to when we carry out these preparations for our patients.

The use of CAD CAM systems was taught - this is using computer scanners rather than taking physical impressions on our patents - this means use of less materials and is better for the environment with much less material wastage.

Inn addition using technology means there is more accuracy and less margin for error as there are less stages were errors may be introduced.

We were also taught the chemistry and science of the bonding of Zirconia and this will translate into a better understanding of materials we use at the chairside and why we carry out procedures in a certain way based on sound scientific principles.

Teaching us the the fabrication of aesthetic mock ups allows ups to plan our patients treatments using the computer rather than having to build up models in wax.

This makes it easier for the technician /patient /dentist all round, and it is also much quicker and probably less expensive for the patient. The patient can have a digitally produced resin mock up which he/she can wear prior to producing the permanent prosthesis. We were shown in detail how to use the milling machines.

We were also taught how to produce a hard occlusal splint using CAD CAM - these prosthesis are used for our patients with a lot of wear.

In dental practices nowadays using CAD CAM machines and milling machines and using the software one may produce in house crowns. This is certainly an advantage for the dentist and patient as one maybe able to fit the crown made for ones patient within hours of it being prepared ,without the need of a dental technician .Tthis saves everybody's time. Truly excellent.

We were also taught how to use a digital articulator - in the past one had to pour plaster to transfer measurements on a facebow using positions that were arbitrary as were the results.

Using a digital articulator one may reproduce mandibular movements and this makes it possible to determine the exact occlusion . a digital workflow to create a final scan and a temporary prosthesis for a full mouth rehabilitation was also taught and demonstrated- this will stand in good stead for our complex cases in out clinics. One may use these temporary prosthesis so that the patient can get used to it prior to embarking on the final one.

An innovative Zirconium planefinder was also described- this is used to detect the natural; head position and occlusal plane angle . this can be used instead of the traditional facebow. The plane system is more accurate and transfers the register of the maxillary position, midline and occlusal plane to the PS1 3D articulator.

All in all we were exposed to the latest world class digital technology techniques which we will implement in our clinics to improve the quality of work and quality of life for our patients. By writing articles n the various topics and publishing them we are also disseminating the knowledge to our colleagues. The benefits to patients are immense. Treatments are more predictable. Service is more efficient. The time, effort and cost invested in this course will reap great dividends. The course certainly contributed towards our professional development.

In Gais, after a days work in the laboratory we had to walk to the next village to get our dinner - this exercise did us a great deal of good and increased the degree of camaraderie.

After the course we travelled to Munich where we had a cultural tour as part of the experience. We also practised our chess in the evenings.

This course was very well organised by Dr Noel Manche and Dr Nicholas Busuttil Dougall who had the correct inkling in choosing such an excellent training programme and venue.

Digital Technology in dentistry is clearly the future and we need to embrace it, and this was a golden opportunity to do so in a wonderful environment in the Dolomites- one of the nicest places in the World I have been to. Being at one with nature allows for a better learning experience.

UPDATES FOLLOWING COUNCIL OF EUROPEAN DENTISTS MEETING IN STOCKHOLM MAY 2023

By Audrey Camilleri
International Liaison Officer,
Dental Association of Malta

In May 2023 I represented Dental Association of Malta at the Council of European Dentists Meeting together with representatives of the Council of European Dentists (CED) Member, Affiliate Member and Observer associations. The meeting was held in Stockholm

1. CORPORATE DENTISTRY

In Europe there are more and more non dentists owning a dental practice and there are more dental chains – more young dentists are working for dental chains and these chains usually have more money to advertise.

2. WHO GLOBAL ORAL HEALTH STATUS REPORT

Several members highlighted the need to examine further how the data in the report was collected and analysed. While the members agree that the report offers a commendable highlight of the situation of oral health, it is of concern that some of the numbers do not match the existing scientific data and reality on the ground in some countries. It was agreed that a letter from CED and ERO will be sent to WHO to discuss this topic.

3. CED FINANCES

For 2024, the CED Board recommends a 5% increase of the members' fees. Together with the downsizing of the Brussels office, this would lead to expected benefit of €42.325 which would allow to strengthen the existing CED reserves.

The treasurer highlighted that several other measures have also been taken to reduce future costs – for example by finding a new hotel venue for the November 2024 General Meeting in Brussels

4. WG EDUCATION AND PROFESSIONAL QUALIFICATIONS

The Board Liaison informed the GM that the CED published after its General Meeting in November a statement on the recognition of dental qualifications emphasising that the qualifications obtained outside the European Union must be complete and in accordance with the applicable European requirements before a dentist may start practising dentistry for the first time in the European Union. The WG also developed and sent a questionnaire on the recognition of qualifications of third country nationals to its members. The results of the survey were presented to the General Meeting and the WG is planning to use them to prepare a CED position on the issue for when the European Commission releases its proposal on this topic in Q3 2023.

Katalin Nagy highlighted that during its last meeting, the WG members decided that the CED should get in contact with Directorate General GROW and schedule a meeting to discuss the results of the study and get their perspective on the Commission's plans to update the Annex and reiterate our position on the issue.

The WG plans to also get involved in the relevant parts of the WHO global strategy on oral health, from an education perspective.

5. WG PATIENT SAFETY, INFECTION CONTROL AND WASTE MANAGEMENT

The Chair updated the GM on the ongoing work on the CED White Paper on dentistry and waste.

The purpose of the document is to:

1) help ensure that the dental profession engages in the discussion on waste management in a proactive and timely manner, and that it can respond to new legislative and regulatory initiatives that may impose restrictions and conditions to the dental office,

2) help ensure that the dental profession clearly communicates its commitment to following environmental standards on waste/ has a say in the establishment of future environmental standards and requirements in relation to waste.

The WG launched a questionnaire on national vaccination policies for dentists and other dental professionals in Europe in 2022-2023. The questionnaire was also discussed with WG Oral Health and was disseminated to all CED members.

The summary of results was briefly outlined in the slides of Chair Tzoutzas to the GM.

Ioannis Tzoutzas also highlighted ongoing and existing EU legislation of relevance to the dental profession and the priorities of the WG.

He also encouraged members to share any information and updates on the WG priority topics for the existing online platform for articles and other documents of interest.

6. NIOM AND NORCE PRESENTATIONS ON DENTAL MATERIALS

The General Meeting was addressed by Dr Frode Staxrud (Senior Scientist, Nordic Institute of Dental Materials) and by Dr Lars Björkman (Research Director, Norwegian Dental Biomaterials Adverse Reaction Unit). They highlighted key issues of concern and interest to the dental profession. Examples included the topic of cobalt, as well as the overall issue of adverse reactions reporting.

The speakers highlighted the importance of improving reporting systems from patients but mainly from dentists, helping to track side effect and adverse reactions to specific dental materials. They also recommended that dentists should continue using tried and tested materials, as opposed to those sold for purely commercial goals.

THE MUTUUS PROJECT

Summarised by Dr David Muscat

The Mutuus Project is a feasibility study to extend social protectionism schemes provided by social partners.

The Project recalls two key issues of current European Social Policy namely the idea of mutuality and the social dialogue mechanism.

A Social Protection Floors function is created by embracing mutuality, social dialogue as well as bilateralism.

This rationale has been transposed into a feasibility study with three documents.

1. A new social contract for social Protection systems.
2. Definitions of Professional Self employed
3. Extension of social Protection to Pillar of Feasibility Study

National Social Protection floors should comprise:

1. Access to healthcare, including maternity leave
2. Basic income security for children, having access to nutrition, education and care.
3. Basic income security for persons in active age who are unable to earn sufficient income if sick, unemployed, disabled or pregnant.
4. Basic income security for older persons.

A new social contract depends on security, shared risk and opportunity.

Society can put a floor on income below which nobody can fall.

There should be access to a basic healthcare package and a minimum state pension to prevent destitution in old age.

Sick leave, unemployment insurance and access to reskilling should be provided through a social contract.

There is an impact of demographic change such as an increase in single person households, mobility to cities, brain-drain and migration flows.

This demographic change as well as the Green Paper on ageing deepen the debate on the impact of ageing.

More than 110 million Europeans are at risk from poverty.

In a revised version of the 20 Nov 2013 (Directive 2013/55/EU) 'liberal professions are defined as activities practised on the basis of relevant professional qualifications in a personal ,responsible and professionally independent capacity by those providing intellectual and conceptual service in the interest of the client and public.'

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THE MUTUUS PROJECT

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THE BEST DEFINITION OF SELF EMPLOYMENT

'The operational independence from both the customer/client/patient and any supervisory body/function other than that required by law, of the self-employed person who is providing this particular service.'

Professional self employed are individuals who earn a wage or salary but who derive their income from the exercise of their profession or business on their own account and at their own risk.

Bilateral-ism is considered by the Mutuus Project as a model to be taken into account to study the extension of social protection to the professional self employed. Historical drivers of social protection systems emerged from those of Bismarck and Beveridge.

There were also Scandinavian models introduced in Denmark in 1891 and Sweden in 2013.

Eurostat uses the following list of social protection functions:

- Sickness
- Health
- Disability
- Old age
- Survivorship
- Family/children
- Unemployment
- Housing
- Social Exclusion

At EU level the Social Protection committee is advising the Employment and Social Affairs Council (EPSCO). The SPC has been established by Council decision under article 160 of the treaty on the functioning of the EU.

It encompasses pensions, healthcare and long-term care as well as social protection and social exclusion. It is composed of two delegates from each member state and the commission.

It has organised four mutual learning workshops. These workshops identified good practice, mapped current gaps, identified possible avenues of reform and listed recommendations. Each workshop focuses on one of the key dimensions of the Recommendations access to social protection.

The Mutuus Partnership is studying a scheme for social protection additional to professional self employed as those working on their own account in professional activities of intellectual character.

The idea is to extend the current protection system in force for the liberal Professions. The analytical starting point is the Confprofessioni in Italy which is the social partner providing:

1. Healthcare contribution for medical fees
2. Yearly check up and rehabilitation resulting from work accidents
3. Income benefit for temporary sickness
4. Coverage of medical expenses due to maternity and a coverage for work accidents.

The insurance benefits and related work premiums are managed by either private insurance companies or directly provided by bilateral bodies. Currently Italian Bilateral Bodies provide coverage for 76,000 recipients. The scheme is limited to three years (2021-2023).

The self employed pay 0.26% of their income for 2021 and 0.51% for 2022 and 2023.3.21Teh ISCRO is considered as a new start for social protection schemes for the self employed. A case study for the social dialogue of the Mutuus Project is being carried out within the committee on an extension of social security to the PSE.

Lenten Talks 2023

This year the Lenten talks were given by Father Mark sultana, DAM Spiritual Director and were held at the tal- Virtu Seminary on Sunday 19th March. These talks were kindly organised by Dr Lino Said.

THE FEDCAR CONFERENCE

PARIS, 2 DECEMBER, 2022

Dr David Muscat BDS (LON)
Medical Council of Malta member

Dr David Muscat attended the Fedcar Conference in Paris on 2 December 2022 at the offices of The French Order

LATEST EU DEVELOPMENTS

The EU has adopted a specific Temporary Protection Directive to grant Ukrainian Citizens a Temporary Residence Permit.

Temporary Protection will be valid for one year and can be extended for up to three additional years if the EU decides so.

The ENIC-NARIC Networks are the result of an ongoing collaboration between the national information centres on academic recognition of qualifications of 55 countries.

GLOBAL HEALTH

There is a global health strategy to strengthen the EU's role in health. This is a non-binding document.

Communication, scheduled for the end of 2022 will aim to provide guidelines for better international cooperation in healthcare, with a focus on the reduction of inequalities in access to healthcare services. This is linked to the WHO.

EUROPEAN CARE STRATEGY

The strategy invites member states to develop a national action plan to improve the availability, accessibility and quality of long- term care.

MY HEALTH @EU PROGRAMME

All members states will have to integrate in this programme which is a European infrastructure for sharing health data for primary care. This is already developed in some countries; it is focused on health data exchange between patients and health professionals across member states. The aim is to give ~European citizens travelling or living abroad, access to the same healthcare as they would have in their home country. This will be implemented progressively until the end of 2025.

THE DIGITAL ECONOMY AND SOCIETY INDEX

This provides a country score ranging from 0 to 1 based on five indicators namely, connectivity, human capital, internet use, degree of digitalisation of businesses and public services. The EU hopes to implement this by 2025.

PHASING OUT OF AMALGAM

The Commission should assess and report on the feasibility of a phase out of the use of dental amalgam in the long term and preferably by 2030,taking into account the national plans required by this Regulation and whilst fully respecting Member states competence for the organisation and delivery of health services and Medical Care (Recital 21)

Regulation EU 2017/852 covers the full cycle of mercury. Article 10 of Regulation (EU) 2017/852 sets restrictions -on the use, patients and waste. Member states must publish action plans to phase out the use of dental amalgam by 1st July 2019. Dentists can only use pre encapsulated amalgam staring from 1st January 2019.

Article 19 sets an updating of the phasing-out of the use of mercury. A phase out does not refer to a complete ban. Certain exceptions that relate to specific categories of patients or medical specificities could be maintained.

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THE FEDCAR CONFERENCE

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There are three categories on member states depending on their amalgam use.

REPORT EC 2020

1. Dental amalgam remains the largest use of mercury in the EU.
2. Use is decreasing but not fast enough to reach complete phase out by 2030.
3. Only France and Hungary have quantified in 2019 dental amalgam use in their action plans.
4. Alternatives-lack of comprehensive studies. Additional research required.

ADEE PRESENTATION

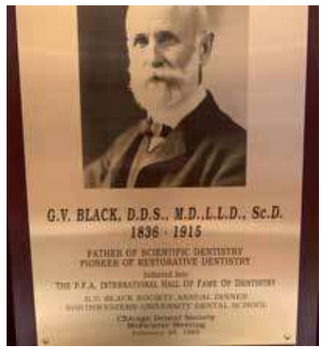
Pr Pal Barkvol President of ADEE as well as FEDCA Rare writing to the EU commissioners calling for an update the free movement of health professionals in the internal market.

They are calling for a re-evaluation of the minimum dental training programme organised by Directive 2005/36 on the recognition of professional qualifications (-the Directive).

The training programme is 40 years old. The listed topics are outdated and does not take into account neither the considerable advances in educational theory nor the curricular developments of recent decades. There is a necessary change of dental education for the next ten years. A need for quality assurance and more inter-professional education.

A competency-based training is today being prepared.

ADEE IS THE ASSOCIATION OF DENTAL EDUCATION IN EUROPE



Patients have been going to no EU countries for dental treatment and these have been exposed to different treatment methods and our dentists are having difficulty giving 'first aid' to these patients.

Dentists must work side by side with other health workers. The education of health care workers must be more closely linked to inter professional programmes. The government must reduce factors that cause disease -such as sugar.

Inter-professional education and collaborative care is a community of practice. One moves horizontally rather than vertically forward. One must start early to be effective. It is multidisciplinary. In Norway patients in nursing homes lose their teeth after a year or two in the homes so nurses need to know about oral health. Bio-Materials are very important - and this is an important research area.

In line with WHO recommendations new research should be focused on public health programmes, population-based intervention, digital technology, teamwork, minimal invasive interventions, alternative filling materials, sustainable professional practice and an economic analysis to identify cost effective prevention.

Dental Training should be a minimum of five years or 300 ECTS credits. 5000 hours – full time theoretical and clinical practice and that this is provided by a University or equivalent level.

A lot of diseases manifest themselves in the oral cavity first.

DENTAL SPECIALITIES

If there are 13 specialities what will there be left for the GP Dentists are professional health workers and not cosmetic dentists

There are 145 dental schools that are members of ADEE. Inspections are voluntary. Substandard Dental schools do not apply.

EDSA PRESENTATION BY CHARLOTTE CARTER, EUROPEAN ASSOCIATION OF DENTAL STUDENTS

EDSA is the European Dental Students Association. The Association represents 180 schools in 33 countries and has 70,000 students.

The Association offers opportunities beyond borders. There is protection of the integrity of students in the dental and healthcare fields. Students network. Students opinions are respected. Students are encouraged to take up Erasmus projects.

WHO PLAN ON ORAL HEALTH BY DR. VARENNE, DENTAL OFFICER ORAL HEALTH PROGRAMME WHO GENEVA

What is next in 2023 - There is a global strategy on oral health and a draft oral health plan. There are global targets and core indicators.

Continues on page 37.

THE FEDCAR CONFERENCE

Continues from page 34.

A Global action Plan cannot be imposed. WHO responded to a request and engaged experts. WHO works for everybody so there tends to be a universal approach so it has to be adapted to a range of countries with different cultures. The situation is different from one country to another. Countries with high incomes have more dentists. e.g. in Brazil there are many dentists but there is not good access to oral care.

PRESENTATION BY PORTUGAL - STATE OF THE NATIONAL REFORM OF THE DENTAL TRAINING BY DR. MIGUEL PAVAO, PRESIDENT OF OMD

A survey was carried out amongst dental students. Many said that they were never asked to carry out a self-assessment. In clinical training 26.4per cent declared that after qualifying they declared they did not feel ready for the labour market. Many said they did not fulfil all the recommended treatments for clinical endodontics.

ACCREDITATION OF DENTAL EDUCATION IN EUROPE BY DR CEDRIC GROLLEAU ONCD

This is a non-binding recommendation for programmes that are shared with universities. The EU wants there to be a development of co-operation between Universities.

NEW DEVELOPMENTS ON PRIVATE DENTAL SCHOOLS BY DR. BAUDOUI MAUREI VICE-PRESIDENT ONCD

The degrees from these dental schools are not sufficient and there are some schools where students only attend at the weekend and the rest is done on-line. These schools cut and paste the curriculum of other EU universities.

The competent authorities are presented with the correct paperwork but cannot really verify the level of training especially clinical training. Some of these schools would have an agreement with a private clinic to allow students to practice.

FITNESS TO PRACTICE

Different countries have different approaches to this. The main reasons would be serious mental illness, mental or physical impairment, long absence from the profession, use of alcohol, drugs or substances with a similar effect, significant lack of professional insight, irresponsible activity, significant breaches of duty according to the health and professional regulations. In Italy some dentists were suspended for not observing COVID 19 regulations.

In France a lack of skill as well as pathological conditions may be the reasons -alcohol-drugs, psychological. Usually a Council receives a complaint from a patient or a report by another colleague.

In France even for registration, a health and skills background check is done if there is any doubt. Fitness to practice may also be a question of hygiene. There have also been students with bipolar disorders. These experience difficulty and may be dangerous.

IMPLEMENTATION OF DIRECTIVE 2005/36 RECOGNITION OF PROFESSIONAL QUALIFICATIONS

Croatia registered the highest percentage of non-EU dentists. Migration of dentists is most important in Romania, Spain and Portugal. It is important for all EU countries to work within Annex V as there are many Italian dentists who have been trained in former Yugoslavia. One has to check the training of the candidates to see if they have been well prepared.

There is risk as qualifications may not be good. It is good to have rules that can be applied. Universities have data on the training received. There are specific dates and months and how much practical training. If Universities are not meeting these criteria they should be closed. Some of these Private Universities have a cap on the number of students that can be trained but in some, there is an unlimited number.

Recently the CED passed a resolution on the importance of checking the qualifications of dentists from non-EU Countries. FEDCAR members will look at this resolution and will either endorse it or FEDCAR will issue its own statement. This will be done by the end of December 2022.

HOLDING COMPANIES RELATING TO DENTISTRY

Different EU countries have different rules. Some holdings group together health professionals. Liberal Societies have legal or professional persons.

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THE FEDCAR CONFERENCE

Continues from page 37.

Some countries have rules which state that half of the capital of these companies must be held by health professionals. In France dentists are saying that this should not be open to non-health professionals. Some health care centres are run by non-professionals and are badly managed and are only interested in making money. We do not want financial concerns to become more important than health.

In Italy in 2016 a law was proclaimed that superseded a 1936 law that restricted this type of company. A government had suspended this law so now these companies have more freedom. Now there is a mixed company with doctors and dentists and other types of professionals.

An inter-professional company had to have its share capital held by health professionals. Dentists are liberal professionals and have to follow specific requirements.

Unfortunately, a treatment plan is signed off by a company. The problem arises when the practitioner makes a diagnosis but offers treatment in the interests of the company with money as the main incentive. There are pressures from owners to reach their targets. In Denmark these companies would have a Corporate Responsible Dentist.

Most countries have not opened such companies where there are non-members of the health professions.

In Portugal there are big dental groups. Clinics must be registered with Health Authorities and they have to identify a Clinical Director but the director does not control marketing and finances. These companies should be at least 51% controlled by dentists. There is an open market.

In France, if an employee works in a health centre it is the responsibility of the health centre and one instigates procedures against the practice. Employees are responsible for their staff. In Italy there is a law on company liability (1934) which states that the Health Centre has to have a Technical director who is responsible for the Health Centre Organisation.

Corporate Dentistry is a growing trend. It is a fragmented market. In Finland 20 % of the market in 2018 and 6% of the Market in Norway in 2018.

Italy is strict regarding the advertising by these companies. One cannot offer free consultations, special prices or loyalty schemes. In Romania, Syrian refugee dentists are employed. They are trapped as they have to pay a high price to use the clinics.

They cannot exercise as independent dentists and are in a difficult situation.

Syrians have had their degrees recognised in Romania. The Syrians have to pay equipment and installation fees and they have to work on Sundays and they pay double fees.

In France Syrian dental degrees have NOT been recognised - they are employed as health workers.

Luxembourg has many dentists who have come from a third country and registered in France. There are many Portuguese dentists in Luxembourg. They cater for some Portuguese residents who only speak Portuguese.

Croatia has reported that Turkish Dental clinic chains are being opened in Macedonia and Bosnia and are trying to open in Italy, Slovenia and Croatia.

3D PRINTING CENTRES

Croatia has reported that there are certain centres run and programmed by non-dentists and who do not know anything about dentistry who are printing the supra-structure for dental prosthesis.

This is an important element in the chain and dentists should steer well away from these centres who entice dentists with much lower prices.

UNBEATABLE TOGETHER!

Primary care of X-tra quality

- **Unbeatably durable:** Fully withstands masticatory forces, excellent physical properties[1]
- **Unbeatably simple:** Universal shade with chameleon effect, 4 mm bulk fill
- **Unbeatably quick:** Exposure time of only 10 seconds, reduced working time in combination with Futurabond U (universal adhesive in hygienic *SingleDose* packaging)

More than 13 million restorations worldwide![2]

[1] Tiba A et al., Journal of American Dental Association, 144(10), 1182-1183,2013.
[2] based on sales figures

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VOCO THE DENTALISTS