2014 • Volume 1 • Issue 4

CDA Award Winners
Recognizing Excellence
P. 11

Dr. Paul Kavanagh
Honouring War Veterans
P. 30

Point of Care
Gingival Graft Failure or Loss
P. 39

CDA *essentials*

The Canadian Dental Association Magazine

Early Childhood Caries

Call to Action

Page 33

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CASE STUDY 3

Cases finish as scheduled.

ISSUE

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SOLUTION

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Help reduce no-shows and cancellations.

ISSUE

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RESULTS

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Janet Tamo
B.Sc., D.D.S.

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CDA essentials

2014 • Volume 1 • Issue 4

CDA MISSION STATEMENT

The Canadian Dental Association (CDA) is the national voice for dentistry, dedicated to the advancement and leadership of a unified profession and to the promotion of optimal oral health, an essential component of general health.

CDA*essentials* is the official print publication of CDA, providing dialogue between the national association and the dental community. It is dedicated to keeping dentists informed about news, issues and clinically relevant information.

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"...we demonstrate respect and help perpetuate the memory of their invaluable contribution."

Page 30

"We see kids that are suffering daily with pain..."

Page 33

CDA at Work

9 **Help Spread the Word: First Visit by Age 1**

11 **CDA Award Winners: Recognizing Excellence**

14 **U.S. Army Dental Command Hosts CDA at its Headquarters**

17 **Unlicensed Dental Products: Protect Yourself and Your Patients**

News and Events

19 **More Children Eligible for Free Dental Care in Ontario**

20 **The Royal Canadian Dental Corps after World War II: The Korean Conflict, the Suez Canal and NATO in Europe**

22 **The Good, The Bad and The Great Doldrums**

25 **New President for Ontario Dental Association**

25 **Alberta Adds Esthetic Therapies to Dentists' Scope of Practice**

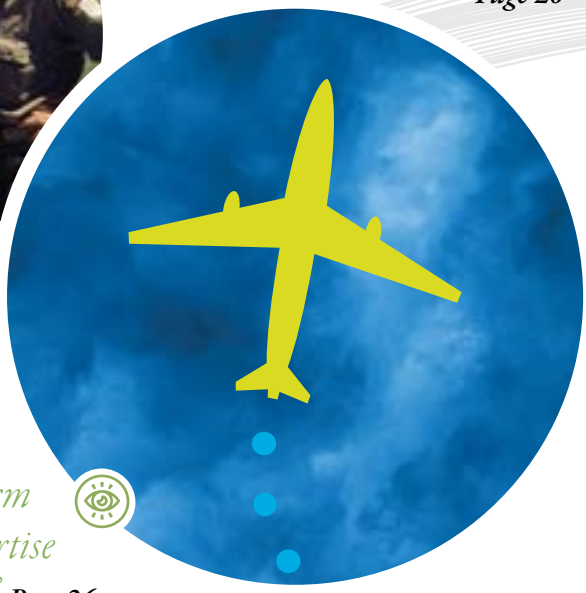
CONTENTS

"...dental service provided in Korea under difficult conditions enhanced the reputation of the Corps."

Page 20

2014 CDA Award Winners

Page 11



"...both airline pilots and dentists perform complex procedures that require expertise and team participation." **Page 26**

Issues and People

26 **Optimizing Patient Safety: Can We Learn from the Airline Industry?**

30 **Dr. Paul Kavanagh: Honouring War Veterans**

33 **Early Childhood Caries: A Call to Action**

Supporting Your Practice

37 **Effect of Preheating on Microhardness and Viscosity of 4 Resin Composites**

39 **Managing Patients with Gingival Graft Failure or Loss**

46 **Discover Oasis Discussions**

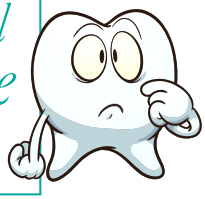
Classifieds

42 **Offices and Practices, Positions Available, For Sale, Advertisers' Index**

Dental Bite

Each year, about 19,000 Canadian children under the age of 6 undergo day surgery because of early childhood caries.

Source: Canadian Institute for Health Information. *Treatment of Preventable Dental Cavities in Preschoolers: A Focus on Day Surgery Under General Anesthesia.* 2013



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[1] Strategic Data Marketing, 2014 (Multipurpose/Dual Cure and Light Cure Adhesives-in units). [2] Winner of the 2012 Red Dot Design Award.

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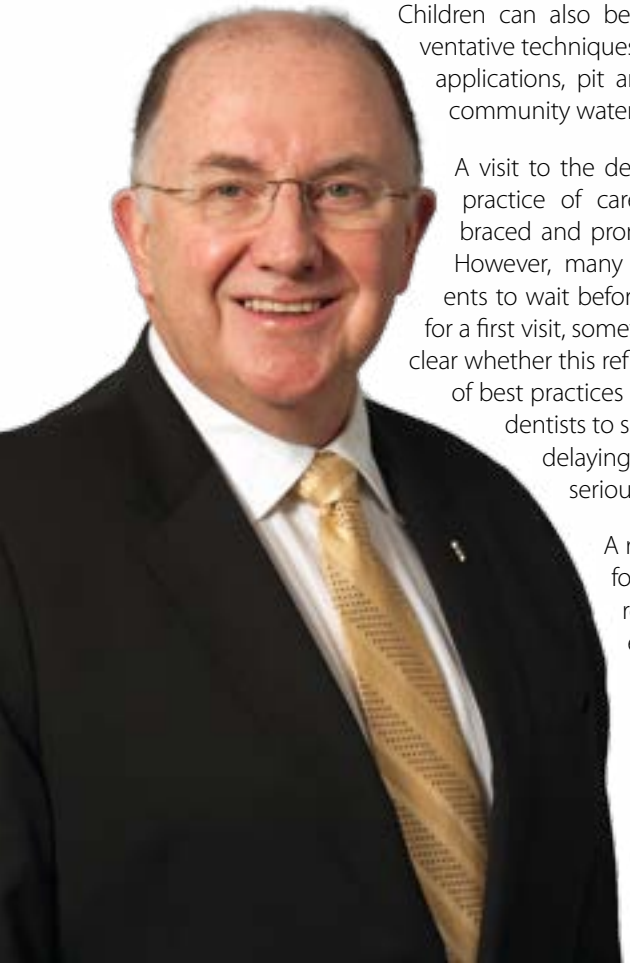
Help Spread the Word: First Visit by Age 1

CANADIAN DENTAL ASSOCIATION

I had the privilege of participating in a round table discussion in Toronto in May, on the state of maternal and child health in Canada. The event was hosted by the Honourable Rona Ambrose, Minister of Health, and Dr. Margaret Chan, director-general of the World Health Organization.

It was a great opportunity to deliver one of Canadian dentistry's key messages: good oral health is essential to a child's well-being. We know that toothache and infections in primary teeth can result in lost sleep, poor growth and behavioural problems. The negative impacts can also extend to a child's self-esteem and their ability to communicate and socialize.

Minimizing a child's risk of developing dental caries can be accomplished, in large part, by encouraging good oral health habits at an early age, such as daily brushing and healthy food choices. Children can also benefit from proven preventative techniques such as topical fluoride applications, pit and fissure sealants, and community water fluoridation.



A visit to the dentist by age 1 is a best practice of care that should be embraced and promoted by every dentist. However, many dental offices tell parents to wait before bringing their child in for a first visit, sometimes until age 3. It's not clear whether this reflects a lack of awareness of best practices or a reluctance by some dentists to see younger patients. But delaying that first visit can have serious consequences.

A recent Canadian Institute for Health Information report showed that early childhood caries accounts for approximately one-third of all day surgeries performed on preschoolers between ages 1 to 5. This statistic did not go unnoticed at the round table discussions—it highlighted the prevalence of a preventable health problem and raised the alarm about the most common chronic disease of childhood.

This is why CDA supports a first visit to the dentist by age 1 as a best practice to reduce early childhood caries and start children on the path toward a lifetime of good oral health.

A child's first visit to the dentist is an important milestone and should be celebrated. It's our opportunity to educate parents and caregivers about best practices, good dental habits and how to integrate oral care routines into their daily schedules. By performing a personalized caries risk assessment for a child, we can help parents understand the known risk factors for early childhood caries and how they might be mitigated.

Parents and caregivers have an essential role in ensuring their children achieve optimal oral health. They may need our advice about how to take care of their child's teeth, including tips on how to effectively brush teeth and gums, information on tooth-friendly snacks and drinks, or a reminder to avoid sending their child to bed with a bottle.

Other health care providers also have an important part to play in reducing early childhood caries. The round table discussion provided an opportunity to encourage other health professionals to look in their pediatric patient's mouths, talk to parents about good oral health care habits and encourage a visit to the dentist by age 1.

Finally, explaining the broader connections between oral health and systemic health to parents and caregivers can be a persuasive reminder that a healthy mouth is more than just a great smile.

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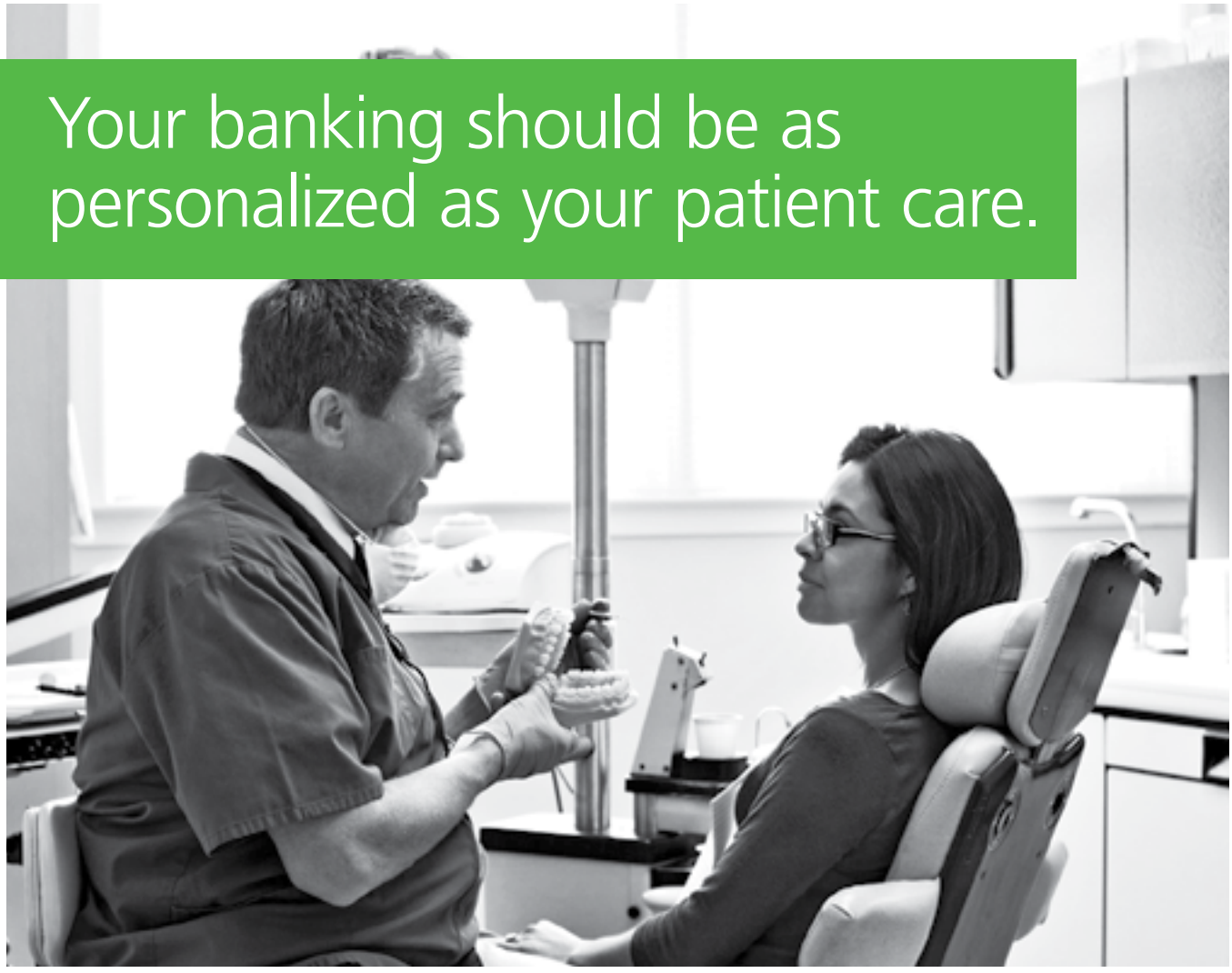

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CDA AWARD WINNERS: RECOGNIZING EXCELLENCE

Exceptional individuals were recognized for their contributions to the dental profession, the dental community or the oral health of Canadians at the annual CDA award ceremonies held in Ottawa in April.

Medal of Honour

The Medal of Honour is the highest award conferred by CDA. It is given to a dentist in recognition of a lifetime of outstanding service and professional achievement to the benefit of the dental profession, the dental community and society at large, and to whom significant change can be attributed. The breadth and scope of achievement are significant factors in granting this award, as are the individual's contributions to the goals and objectives of CDA. This year's recipient was ***Dr. George Zarb*** *of Toronto.*

Dr. George Zarb is internationally recognized as one of the most respected clinical scholars in prosthodontics. Following a long and distinguished academic career, he retired in 2005 as professor and head of prosthodontics in the faculty of dentistry at the University of Toronto. He is the recipient of numerous national and international awards and honours, including 6 honorary doctorates, as well as Honorary Fellowships from the Royal College of Dental Surgeons of England and the Royal College of Surgeons in Ireland. He has the distinction of receiving the Academy of Osseointegration's Brånemark Osseointegration Award, the Gold Medal of the American Prosthodontic Society and being the only recipient of all three awards given by the Greater New York Academy of Prosthodontics. In 2008, he was made a member of the Order of Canada, and in 2009 he received the National Order of Merit from the President of Malta. In 2012, he was awarded the Queen Elizabeth II Diamond Jubilee Medal.

> *"It is a career highlight—nothing tops this sort of recognition from the professional constituency I chose to devote my entire career to," Dr. Zarb said of his award. "I am very grateful to CDA for this."*

Honorary Membership

The Honorary Membership award is given to an individual (dentist or non-dentist) who has made an outstanding contribution to the dental profession, the dental community or the oral health of Canadians over a sustained period of time at the academic, corporate, specialty society, council, commission or committee level. An outstanding contribution at the national level is a principle consideration. The breadth and scope of achievement is a significant factor in determining this award. The CDA Honorary Membership was presented this year to ***Dr. William MacInnis*** *of Halifax.*

Dr. William (Bill) MacInnis has held many prominent positions provincially, nationally and internationally, including dean of the faculty of dentistry at Dalhousie University, registrar of the Dental Board of Nova Scotia, president of the Association of Canadian Faculties of Dentistry, and president of the International College of Dentists. He has also written a book on dental law in Canada and served in the Canadian Forces, where he retired as Lieutenant Colonel and then later served in the honorary capacity of Colonel Commandant of the Dental Corps. He has been a mentor, teacher, advisor and friend to a multitude of colleagues and students. His honesty and passion for quality education have been the hallmarks of his career.

> *"The profession of dentistry has been very kind to me. It has provided me with a richness of experience beyond my dreams," said Dr. MacInnis. "At the same time, I am fully aware that I could not have been able to succeed without the trust, generosity and kindness that my friends, family and colleagues have provided me with over the years."*

Distinguished Service Award

The Distinguished Service Award is given to recognize outstanding contributions to the dental profession, the dental community or the oral health of Canadians at large, in a given year or for outstanding service over a number of years. It may also recognize outstanding contributions at the academic, corporate, specialty society, council, commission or committee level. The Distinguished Service Award was presented to 3 recipients: ***Dr. Walter Dobrovolsky*** *of Edmonton,* ***Dr. Louis Dubé*** *of Sherbrooke, Quebec, and* ***Ms. Susan Matheson*** *of Ottawa.*

Dr. Walter Dobrovolsky has passionately advocated for his profession, his patients and his specialty, oral and maxillofacial surgery (OMFS), for over 35 years. He has worked tirelessly to obtain government funding for patient programs, including the Alberta Health Oral and Maxillofacial Devices and Services Program for patients requiring dental services due to severe oral/facial conditions. He also played a key role in the Alberta government funding of total prosthetic replacement of the temporomandibular joint (TMJ) and the development of a national, hospital-based OMFS procedure list. Through his involvement at Alberta Health Services, he was instrumental in getting dentists to access electronic health records. He has been recognized with a Distinguished Service Award from the Canadian Association of Oral and Maxillofacial Surgeons and has the distinction of being only the second Canadian to be inducted into the American Society of TMJ Surgeons.

"No success is possible without mentorship, support and help," said Dr. Dobrovolsky. "I'd like to thank all of my educators and mentors who instilled in me a love of learning and scientific curiosity."

For many years, Dr. Louis Dubé has played a pivotal role at CDA, serving as president from 2003–04 and as a committee member for a host of initiatives. As a member of CDA's Advocacy Committee, a position he has held since 2007, Dr. Dubé's work has led to improvements in many oral health care programs, including the Veterans Affairs Canada program and Health Canada's Non-Insured Health Benefits program. He has also served as CDA's French language spokesperson, providing a critical link to Members of Parliament and media outlets in Quebec. His professional dedication and generosity have earned him the admiration of colleagues across the country.

"I am really honoured that CDA nominated me for this prestigious award. I take this opportunity to say merci beaucoup to the CDA staff—for everything that you did for me and for the profession," said Dr. Dubé.

For the past 25 years, Susan Matheson has been committed to her work at the Commission on Dental Accreditation of Canada (CDAC), where she is the director. Ms. Matheson is at the heart of CDAC operations, working with staff and a host of volunteers while handling its rigorous processes with grace and an unrelenting work ethic. While both staff and volunteers appreciate Ms. Matheson for her intelligence, integrity and perseverance, it is her positive outlook and caring personality that make them feel fortunate to count her as a colleague. In 2000, Ms. Matheson received the Outstanding Alumnus Award from the faculty of dentistry at Dalhousie University.

"Many of you who have been involved in the Commission know that it doesn't function on its own," said Ms. Matheson. "I really do think this award is about recognizing the Commission, our volunteers, our board members, and most importantly, the Commission staff."

Award of Merit

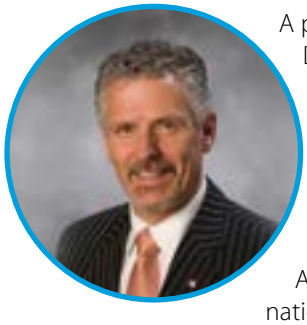
The Award of Merit recognizes an individual who has served in an outstanding capacity in the governing or service of CDA over a sustained period of time, or who has made similar outstanding contributions to the dental profession, the dental community, or the oral health of Canadians and/or society at large. This year, there were 3 recipients of the award: ***Dr. Dennis Bedard*** *of Edmonton,* ***Dr. Colin Jack*** *of Souris, Prince Edward Island, and* ***Dr. Grahame Usher*** *of Halifax.*

In addition to his many notable career achievements, including associate professor in the department of pediatric dentistry at the University of Alberta and past-president of the Alberta Academy of Pediatric Dentistry and the Alberta Society of Dental Specialists, Dr. Dennis Bedard, has dedicated his life to providing disadvantaged communities with dental care, both in Canada's far north and overseas. Through his volunteer organization, Dentistry for All, Dr. Bedard has led many outreach programs to Guatemala, the Phillippines and Nicaragua, touching the lives of thousands of grateful patients.

"This year was our twentieth year of providing dental services to those less fortunate than ourselves," said Dr. Bedard. "I would be remiss if I did not mention my wife Bev—without her, these missions would not be quite as successful. I owe all my success in life to her."

Dr. Colin Jack provides dental care to families in Souris, Prince Edward Island, and has also served in various positions at the Dental Association of PEI and the Health Agency Board of PEI. He has always been motivated by a commitment to do the right thing for his patients, his community and his profession. While serving on the CDA Board of Directors he was a champion for dental students, supporting the importance of their role within organized dentistry, and advocated for a united dental community.

"To be honoured by one's peers is a profound thing, and to be included in the group that is receiving the awards this year is a very great honour," said Dr. Jack. "One of the rewards of getting involved in organized dentistry is simply the wonderful people you meet and become friends with—the experience has enriched my life greatly."



A practising endodontist in Halifax, Dr. Grahame Usher has earned many achievements at the provincial and national levels in organized dentistry. Provincially, his accomplishments include serving as president of the Specialist Society of Nova Scotia and president of the Nova Scotia Dental Association. His involvement at the national level includes serving on the CDA Board of Directors and his current positions as member of the CDA Code of Ethics Working Group and member of the Board of Directors of the Canadian Dental Specialties Association. He is recognized for planning the memorable 2011 CDA convention in Halifax with his trademark energy and enthusiasm. Dr. Robert MacGregor, CDA past-president, accepted the award on Dr. Usher's behalf.

"I've had the great fortune to work with Grahame over the years. I can tell you first hand he is a tremendous person and worker, with a tremendous wit," said Dr. MacGregor.

U.S. ARMY DENTAL COMMAND HOSTS CDA

at its Headquarters

(top) Recently promoted Major General Thomas R. Tempel, now Chief of the U.S. Army Dental Corps, with Dr. Peter Doig, CDA past-president, and his wife, Terrie.

(bottom) Dr. Doig (second from left) with the Dental Command staff at Fort Sam Houston, Texas.

In March, the U.S. Army Dental Command invited Dr. Peter Doig, CDA president at the time, for a tour of its headquarters in Fort Sam Houston, Texas. Dr. Doig had an opportunity to witness first-hand the local U.S. Army dental clinics in action, toured the on-site dental laboratory and visited the Specialty Care Center, where military personnel receive dental treatment.

"This visit was an opportunity to acknowledge the importance of the close ties between the Royal Canadian Dental Corps (RCDC) and the U.S. Army Dental Corps," says Dr. Doig. "Recognizing the dental commands in both countries as integral members of the profession is an important part of supporting them in fulfilling their mission."

The strong relationship between the RCDC and the U.S. Army Dental Corps was formed through a history of training together and shared deployments.

The U.S. Army Dental Corps provides military dentists with a wide variety of training, including oral and maxillofacial surgery, endodontics, periodontics, prosthodontics, orthodontics and a one- and two-year advanced general dentistry residency. Fort Sam Houston is home to around 15,000 active duty officers and enlisted soldiers, reserve components, National Guard, and student personnel.

> *This visit was an opportunity to acknowledge the importance of the close ties between the Royal Canadian Dental Corps and the U.S. Army Dental Corps.*

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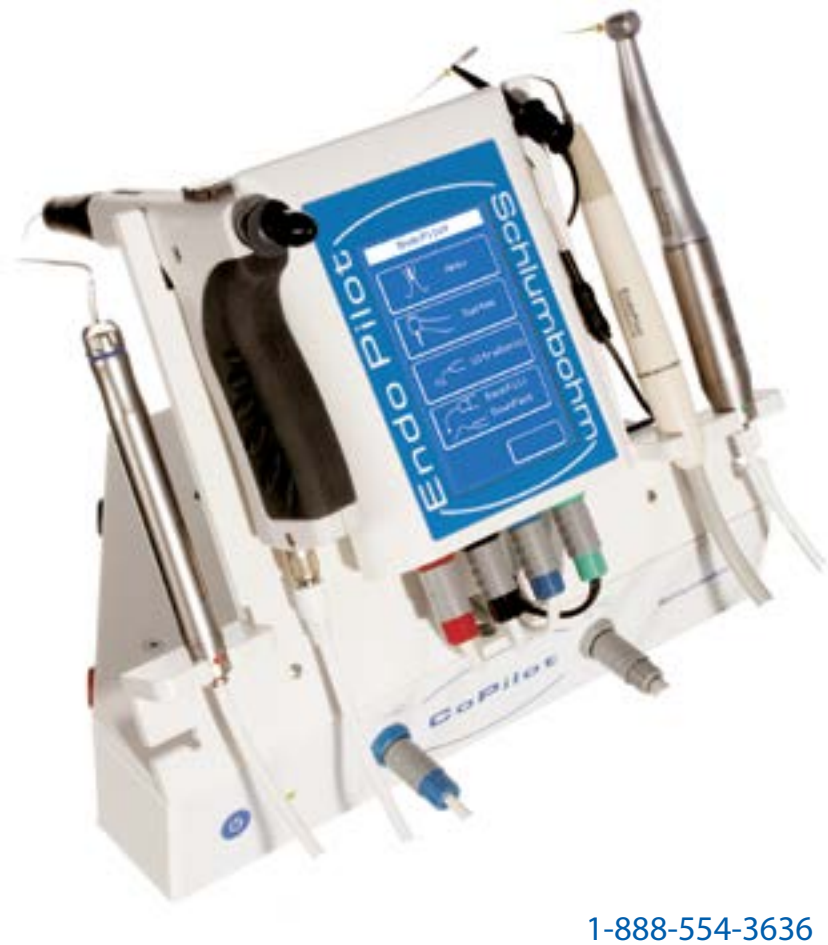

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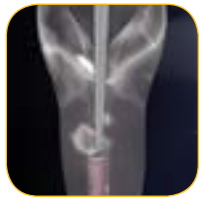

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Unlicensed Dental Products: PROTECT YOURSELF AND YOUR PATIENTS

In May, the Dental Industry Association of Canada (DIAC) hosted a summit in Toronto, bringing together representatives in the dental industry and profession to discuss how to prevent noncompliant dental products from making their way into the mouths of Canadian patients. CDA participated in this event and talked to Peter Jugoon, DIAC past-president, about this issue.

DIAC
Dental Industry Association of Canada
Association Canadienne de l'Industrie Dentaire

Peter Jugoon

The long-standing problem of sales in unlicensed dental materials hasn't diminished in Canada, according to Mr. Jugoon. He admits that it's difficult to estimate the scale of the issue, because sales of noncompliant products can't be tracked. But there are indications that the problem persists.

"One measure of how many noncompliant products are coming into the Canadian dental marketplace is the number of flyers in circulation that feature products offered by distributors who we know are not authorized to sell those products," he says. "Based on this measure, it looks like the problem isn't going away."

Dental products, such as dental equipment and materials, are considered noncompliant if 2 requirements are not met:

- The product does not meet Health Canada's licensing requirements. Manufacturers of dental products are responsible for obtaining a Medical Device License from Health Canada before their product can be sold.
- The product is imported or distributed by an unauthorized dealer—one that does not hold an Establishment Licence from Health Canada.

However, there are signs of improvement for some types of noncompliant products. "Grey market products are those that are diverted from the manufacturer's intended market, usually developing countries, and find their way into the Canadian market even if the distributor is not authorized to sell that product in Canada," Mr. Jugoon explains. For these illegal products, the shipping, handling and storage conditions may have an impact on the product's quality. "I think that the diverted product sector is flat, or even decreasing, because manufacturers have been working to rebrand and relabel for different countries."

Sales of counterfeit products, on the other hand, may be on the rise. "What's scary about counterfeit products is that it's difficult to tell what is or isn't a legitimate product," he says. "Many times these products are being used without the dentist realizing it, and ultimately we don't know what is going into patients' mouths."

Mr. Jugoon stresses the importance of educating everyone in the dental office—especially those responsible for purchasing—about the existence of noncompliant dental products and the risks associated with their use.

Have Concerns About a Product?

- Search for a valid product license through Health Canada's online database, Medical Devices Active Licence Listing (MDALL): **hc-sc.gc.ca/dhp-mps/md-im/licen/mdlic-eng.php**
- Search for a company's valid establishment license through Health Canada's online database, Medical Devices Establishment Licence Listing (MDEL): **http://webprod5.hc-sc.gc.ca/el-le/prepare-search-recherche-mdel-lepim.do?lang=eng**
- Examine packaging for defaced product logos and packaging, repackaged products, missing or defaced lot numbers and expiry dates, and labelling that isn't provided in both English and French.

For more information on the regulatory requirements of instruments, equipment and materials used by Canadian dentists, consult the *CDA Guidance Document Pertaining to Devices for Use in Dental Health Care:* **jcda.ca/uploads/pdf/ccsa/Medical_Devices-EN.pdf.**

Have you had an experience with noncompliant products?

To better understand the impact of this issue in Canada, we want to hear your stories. Send your story, anonymously if you wish, to: **publications@cda-adc.ca.** Or call our toll-free line at 1-855-71-**OASIS** (6-2747).

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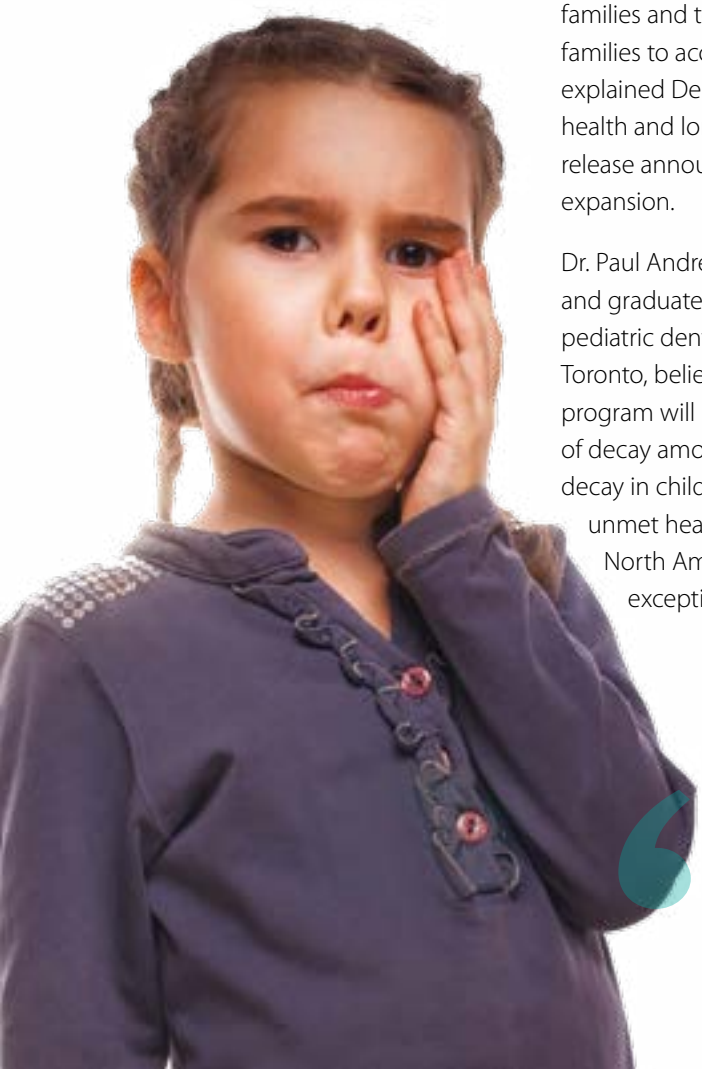
More Children Eligible for FREE DENTAL CARE IN ONTARIO

Paul Andrews

As of April 2014, an additional 70,000 Ontario children from low-income families are eligible for free dental care under the Healthy Smiles Ontario (HSO) program. Oral health services covered by the program include cleanings, diagnostic services and basic treatments.



"Good oral health is an important component of good overall health. That's why we have taken important steps to increase access to free dental services for more kids in low-income families and to make it easier for families to access oral health services," explained Deb Matthews, minister of health and long-term care, in a news release announcing the program expansion.

Dr. Paul Andrews, assistant professor and graduate clinic director in pediatric dentistry at the University of Toronto, believes the improved HSO program will help reduce the burden of decay among children. "Dental decay in children is the number one unmet health care need across North America, and Ontario is no exception," he says.

The program expansion is part of the province's poverty reduction strategy, which states "breaking the cycle of poverty requires providing children with services that support their future health and well-being." An estimated 300,000 children received dental care through Ontario's dental programs between April 2012 and April 2013.

"Children suffering from severe dental decay tend to be poorly nourished, to sleep less, to grow more slowly, to perform less well in school and to have a lower self esteem than their peers with good oral health," notes Dr. Andrews. "Achieving good oral health will go a long way in providing every child the opportunity, regardless of their background or circumstances, to reach their full potential."

> *... breaking the cycle of poverty requires providing children with services that support their future health and wellbeing.*

The Royal Canadian Dental Corps after World War II:

THE KOREAN CONFLICT, THE SUEZ CANAL AND NATO IN EUROPE

Canada's military dental services have looked after the oral health needs of Canada's troops in both World Wars, Korea, Afghanistan and many other peacemaking, peacekeeping, humanitarian and forensic operations. In the lead-up to the 100th anniversary of the Royal Canadian Dental Corps (RCDC) in 2015, this article is the third in a series that will bring to light the history of the RCDC over the last century, celebrating the heritage, accomplishments and dedication of the dental services personnel of the Canadian Armed Forces (CAF).

CDA*essentials* is honoured to publish a regular series of articles, leading up to the celebration of RCDC's 100th anniversary.

Korea (1950–57)

In August 1950, the Canadian government decided that Canada would participate in the United Nations police action in Korea. The participation of the RCDC in the Korean War was of significant importance to the development of the Corps. During this action, both the Canadian Forces and the Dental Corps more than doubled in size. The high standard of dental service provided in Korea under difficult conditions enhanced the reputation of the Corps with the soldiers and officers of the CAF and our Allies.

The first dental detachment arrived in Pusan on November 7, 1950 and the last detachment departed Korea on July 1,1957. During these 7 years, 43 officers and 85 non-commissioned members served in Korea with great distinction, continuing the tradition of a high standard of mobile dental service to Canadian troops in the field. This was in addition to the immense task of preparing the troops at home for military service, many of whom were WWII veterans who had not had any dental care for several years or were new volunteers "in dreadful dental condition." The commanding officer of the dental detachment at the staging area in Fort Lewis, Washington, reported that many members of the Princess Patricia's Canadian Light Infantry who had departed for Korea were edentulous, which he considered a "scandalous" situation.

Captain W.O. Mulligan described service in Korea: "Everything was under canvas except the dental clinic itself. The dental clinic was in 'B' echelon where the canteen was located; troops were glad to get back for 'shopping' plus a few fillings." RCDC mobile clinics were often as far forward as the 'A' echelon and it was never very difficult for the front line troops to travel back for treatment. The dental detachment had a well equipped laboratory that could provide a wide range of services, from partial dentures to bridgework, while the dental clinics of our Allies were part of the Mobile Army Surgical Hospital (MASH), well back from the front lines.

> *The high standard of dental service provided in Korea under difficult conditions enhanced the reputation of the Corps with the soldiers and officers of the CAF and our Allies.*

UNEF – Suez Canal (1956–67)

As the Korea operation was coming to an end, hostilities between Egypt and Israel in 1956 threatened to disrupt the freedom of navigation through the Suez Canal, forcing the United Nations to deploy a police force. The RCDC, as part of the Canadian contribution to the campaign, would be called upon once more to assist in providing dental support to this operation, entitled United Nation Emergency Force (UNEF) Middle East. This mission ran from 1956 to 1967.

NATO in Europe

Following WWII, 27 Canadian Field Dental Detachment supported Canada's contribution to the North Atlantic Treaty Organization (NATO). Eighty-seven officers and 141 non-commissioned members served with the dental unit, providing service to brigade personnel and their families. 35 Field Dental Unit had clinics in Metz and Marville in France, and in Zweibrüchen and Baden-Soellingen in Germany. In 1967, all NATO bases in France were closed, and 35 Field Dental Unit moved to Lahr, Germany.

In 1983, 35 Field Dental Unit, now renamed 35 Dental Unit, operated dental clinics in Lahr and in Baden-Soellingen, Germany. The clinic in Lahr also had a fleet of mobile dental clinics. After Canada withdrew these formations from Germany in 1994, dental detachments remained at Supreme Headquarters Allied Powers Europe (SHAPE) in Casteau, Belgium, and in Geilenkirchen, Germany, where they continue to provide dental care today to Canadian military members and their families

CDA is playing a central role in commemorating the 100th anniversary of the RCDC in May 2015, reflecting CDA's role in establishing a military dental service in Canada and the close partnership between CDA and RCDC since that time.

❶ Military exercise in Germany, 1965

❷ (L. to r.) Major Ross Covey, Major Garth Evans and Captain Maurice Gourdeau in Korea, 1951

❸ Canadian Korea Medal

❹ United Nations Service Medal for Korea

THE GOOD, THE BAD AND THE GREAT DOLDRUMS

While most Canadians consider the 2008 global economic crisis to be behind us, many dental practices are still feeling its effects. With the growth in full-time equivalent (FTE) dentists exceeding that in dental demand in some provinces, financial recovery could be slow. Dr. James Armstrong, CDA Board member for British Columbia, takes stock of the situation in Canada, with a particular focus on the impact in his home province.

James Armstrong

BSc, MBA, DMD, FACD

Dr. Armstrong is chair of the British Columbia Dental Association (BCDA) Economics Committee, editorial consultant for jcda.ca on business and economics matters, co-organizer for the Certificate in Dental Practice Management and adjunct professor at Sauder School of Business, UBC.

Hope springs eternal for fishermen/women, skiers, and chairs of economic committees everywhere. The good news is that in 2012 the average dentist in British Columbia (BC) reduced their expenses by 3.7%. The bad news is that gross and net incomes fell 3.8% and 3.4% respectively in 2012. This is the first drop in net incomes since 2003 during the SARS crisis when patients avoided dental offices for fear of infection.

During balance sheet recessions (where there is a hangover of debt that must be worked out) world economies take an average of 5 to 7 years to return to any semblance of normalcy. Throughout 2013, as the Eurozone flirted with deflation and the US Congress seemed determined to "play chicken" with its economic recovery (and everyone else's), there was a great deal of uncertainty as to where we are headed, more than you would expect 6 years out from 2007–08.

Not all BC dental practices had their net income drop in 2012; however, the gap between incomes increased from an already high level. For every winning dental practice last year, more saw incomes decrease. There are a lot of key questions, the obvious one being, what is happening in 2013 and 2014? Is this drop in incomes a breather (the effects of a recession are delayed in dental practices—we tend to lag behind other services), or are stagnant incomes the new normal?

All econometric forecasting suffers from the same structural problem: it takes time to correlate financial data—so on average, the data you are using to forecast the future is 2 years old. I am waiting with baited breath to see the 2013 results for BC dental practices, which we will not get until the fall of 2014.

Practices with increased incomes in 2012 had two things in common:

- They are good managers of their dental practices.
- They create value for their patients (some charge below fee guide, some at fee guide, and some above).

Economics committees across Canada will likely face a challenge trying to stimulate demand for dentistry for the next 5 to 10 years, a lifetime in economic forecasting.

> *...many economists expect slow, uncertain and sluggish growth to be the new normal for the next decade for the economies of the G7 countries, including Canada.*

If the number of dentists is growing rapidly, this overwhelms growth in the total marketplace, and the average practice shrinks. There are various factors at play in BC.

Market growth

BC's economy is growing at a miniscule 1% per year, yet our growth in full-time equivalent (FTE) dentists is growing at up to 3.8% per year. The pie is growing slowly, but there are more slices being cut, hence, thinner slices. Combined with the trend of mature practitioners delaying retirement (in some cases by 10 or more years), it suggests declining population to dentist ratios in BC for the next decade.

Greater competition

BC is one of the most competitive marketplaces in all of North America, not just Canada. We have the lowest "dollar pool" of all Canadian dentists (**Fig 1**). If the increase in FTEs continues over the next 10 years, as we have forecast, there will be constant downward pressure on net incomes.

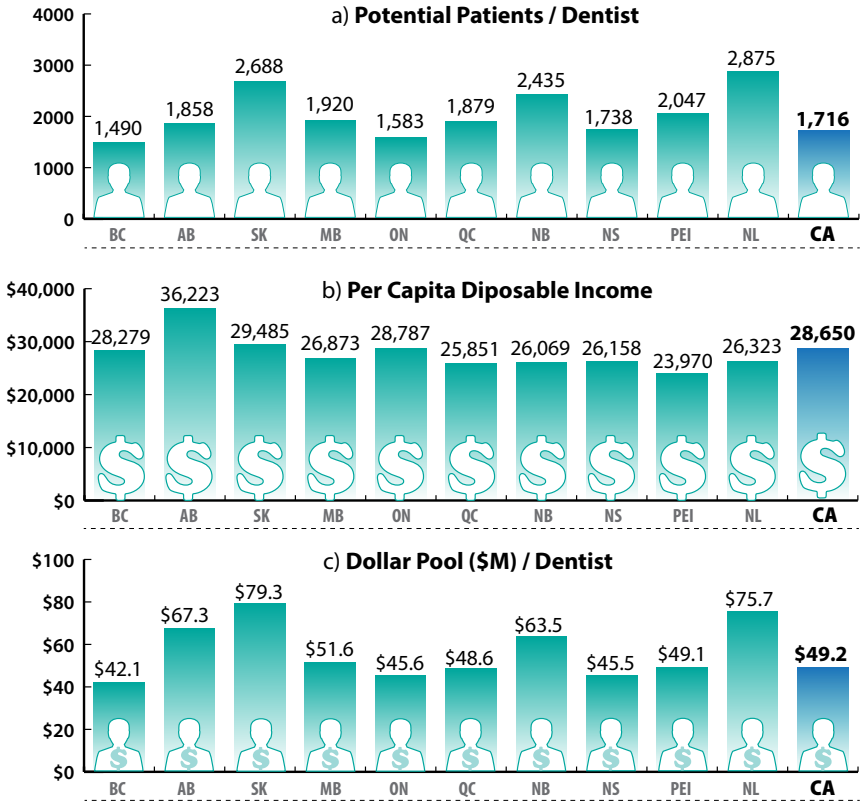


Figure 1: a) Potential patients per dentist ratios **b)** per capita disposable income **c)** dollar pool per dentist ratios. Sources: RKH Economic Consultants Ltd; Statistics Canada Tables 384-00123 and 051-0001; *Canada Health Care Providers, 2000 to 2009,* Canadian Institute of Health Information, October 2011

However, there is always a silver lining to every cloud. The three quartiles of dentists who are not operating like the most efficient quartile have the ability, through better management skills, to run more efficiently. Even if the gross incomes of these practices continue to drop they can maintain or increase their net income. This means taking a hard look at expenses. Relying on what happened in the last 10 years to continue in the next 10 years is a very risky strategy going forward. The good news is there are many places to get the management assistance needed to run your practice more efficiently. One course that I am familiar with is offered at UBC *(See: dentistry.ubc.ca/Education/CDE/CertificateInDentalPracticeManagement.asp).*

In BC, it looks like the decreasing population to dentist ratio will persist for the next 5 to 10 years, and many economists expect slow, uncertain and sluggish growth to be the new normal for the next decade for the economies of the G7 countries, including Canada.

Spending on dentistry/demand

Per capita spending on dentistry in BC is one of the highest, if not the highest, in Canada. In 2012 there was a drop of 2.6%, representing out of pocket costs or employment benefits. There is downward pressure on dental benefits from employers which will further decrease per capita dental spending going forward.

If we are right about stagnating total demand, and stagnating or decreased dental incomes then every dentist needs to ask some or all of the following questions:

- What is a safe debt level to carry both personally and in your practice if it takes longer to pay debt off?
- If you are a young practitioner, how much do you want to pay for a practice that may have diminishing cash flow going forward from the historical cash flow? The flip side question to the mature dentist: how much can you realistically expect from your practice sale if the net present value (NPV) of your practice is going to decrease? How does this affect your retirement plans?

This article outlines the magnitude of the issues facing economics committees across Canada. However, dentistry is a caring and rewarding profession. I wish you the best in 2014, and hope the world economies get back on track again so our next column is more fun to write!

The opinions and/or perspectives raised in this article are not an official position of the BCDA.

A version of this article originally appeared in the January/February 2014 edition of *the bridge*— the member publication of the BCDA. CDA thanks the BCDA for granting permission to re-publish this article.

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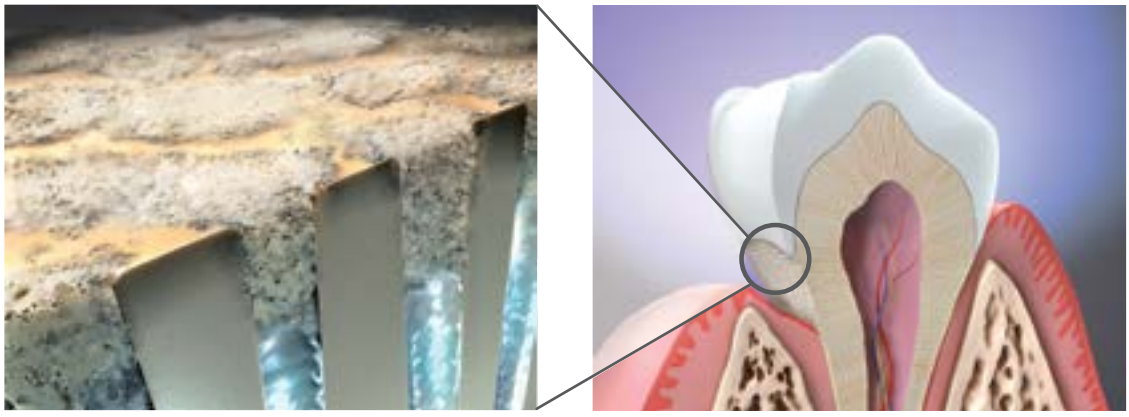

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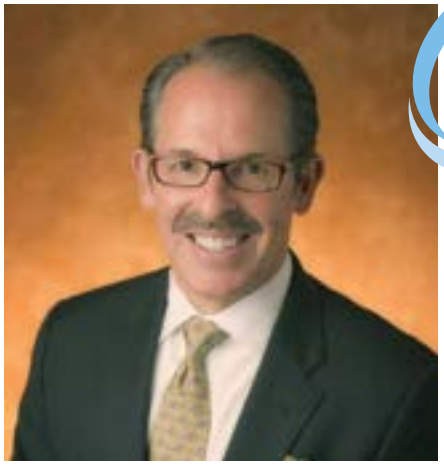

DR. GERALD SMITH

Ontario Dental Association

New President for Ontario Dental Association

Dr. Gerald Smith of Thunder Bay, Ontario, was elected president of the Ontario Dental Association for 2014–15.

A 1987 graduate of the University of Toronto faculty of dentistry, Dr. Smith is a fellow of the Pierre Fauchard Academy, the International College of Dentists and the American College of Dentists. Dr. Smith is a staff dentist at the Thunder Bay Regional Health Sciences Centre.

"I am excited to be a part of an organization that has served me very well throughout my career," says Dr. Smith. "I have been a member of the ODA for 27 years and every year has rewarded me with continuing knowledge, peer-support and overall the best possible environment to practice dentistry in my community.

Alberta Adds Esthetic Therapies
to Dentists' Scope of Practice

Dr. Gary Fong

The Alberta Dental Association and College (ADA&C) has a new standard of practice that allows dentists and dental specialists to provide esthetic therapies and adjunctive procedures. The expanded scope of practice makes Alberta only the second province, after British Columbia, where dentists can use Schedule 1 drugs, which include neuromodulators like botulinum toxin type A, or BOTOX®, and the only province where they can use dermal fillers. The new standard of practice came into effect in February 2014.

Dr. Gary Fong, ADA&C past-president, says introducing the new standard of practice was "a good way to increase the ability of our members to treat the oral maxillofacial complex." According to Dr. Fong, the new treatment modalities enhance treatment for headaches caused by temporomandibular disorders (TMD), migraines or bruxism. In addition, patients can receive cosmetic treatments to complement everyday dental procedures.

Dentists or dental specialists must apply to the ADA&C to be certified before administering neuromodulators, dermal fillers and other esthetic agents.

From the ADA&C Standard of Practice:

Facial Esthetic Therapies and Adjunctive Procedures in Dental Practice

The new ADA&C standard of practice describes the requirements "for administration by dentists and dental specialists of Schedule 1 drugs such as neuromodulators (e.g. Botulinum Toxin Type A), dermal fillers, other agents (injected and/or topical), and adjunctive non-surgical and/or surgical therapies used to provide comprehensive therapeutic and esthetic oral and maxillofacial treatment for the restoration of a patient's appearance in form and function or to enhance their appearance, or both."

Visit **oasisdiscussions.ca/2014/04/08/btx** to hear an interview with Dr. Fong.

Optimizing Patient Safety

Can We Learn from the Airline Industry?

Richard D. Speers

DDS

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Acknowledgement: Dr. McCulloch is supported by the Canada Research Chair Program (Tier 1).

The views expressed are those of the authors and do not necessarily reflect the opinions or official policies of the Canadian Dental Association.

This article has been peer reviewed.

High Reliability Organizations (HROs) operate in challenging environments where the consequences of errors are high but the probability of making an error is extremely low. Every day, these organizations encounter situations with considerable potential for adverse outcomes but they generally provide positive results and commit relatively few errors.[1] Airlines and medical care systems are examples of complex organizations in which the consequences of errors are high. In the United States, 45,000–98,000 Americans die annually from preventable medical errors[2] while in Canada up to 23,750 preventable deaths per year have been linked to adverse events.[3] Accordingly, medical care delivery systems in North America may not qualify as HROs.

In medical care delivery, errors made by highly trained professionals are frequently attributed to system failures; errors are less often associated with unacceptable performances by individuals.[4] In dentistry, there has been limited analysis of treatment errors and adverse outcomes; we are essentially a "data-free zone." In one analysis,[5] dentists were responsible for 18% of reported errors on the wrong body part and 41% of reported errors due to wrong procedure/wrong treatment. Further, dentists ranked second among a group of health care professionals in committing errors relating to identification of wrong body part or wrong procedure/wrong treatment.

One approach for estimating the incidence of adverse outcomes in dentistry is to consider legal actions confronting dentists. For example, in Ontario between 2001 and 2010, files opened by the Professional Liability Program of the Royal College of Dental Surgeons of Ontario (RCDSO) rose by 75% (from 875 to 1528 cases per year).[6,7] This increase may be explained by operator limitations, unrealistic expectations of patients, procedural risks and simply the increased numbers of practising dentists. In view of these findings and recent analyses of adverse outcomes in medical care delivery, dentists should proactively investigate adverse outcomes and their prevention. As health care professionals who perform treatments with inherent risk, one of the most important duties of dentists is to optimize patient safety. In this context we can learn from the medical profession, which has consulted extensively with the airline industry to improve patient safety.[8]

Lessons from the airline industry

There is increasing interest in functional similarities between the aviation flight deck and the medical operating room.[9-11] In the air or in an operating room, the lives and welfare of humans are the responsibility of the air crew or the operating room team, respectively. In the context of dental practice, we note that both airline pilots and dentists perform complex procedures that require expertise and team participation.

Several airline crashes in the 1970s were attributed to communication failures, inadequate team work by crew members, interruptions of established protocols and hierarchical airline culture. Detailed analyses of these crashes demonstrated a chain of minor individual mistakes that collectively led to catastrophic events.[12] While communication failures have been cited as contributing factors in 43% of adverse outcomes after surgery,[13] surgeons rarely investigate their failures since failures impact only one person at a time.[14] This lack of investigation of failures may have slowed the development of approaches for improving patient safety.

The causes of airline crashes and errors in general are consistent with Reason's model of accident trajectory,[15] which suggests that defences are not foolproof (**Fig. 1**). In this model, defences are likened to parallel arrays of rotating slices of Swiss cheese: the holes in the slices represent weaknesses in individual parts of the defence system. When a critical number of holes (i.e., risk factors) align, a trajectory for accident opportunity is created. Subsequently, a hazard may pass through the defensive holes and lead to an error and possibly, an accident.

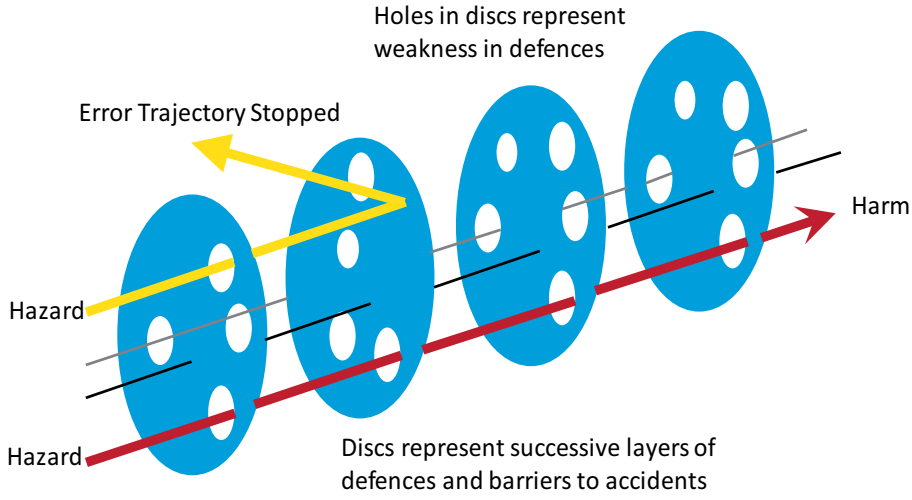

Figure 1: *Conceptual diagram illustrating concepts developed by Reason[15] of accident trajectory. In this model, defences are not foolproof and are similar to the illustrated arrays of parallel discs. When a critical number of holes are aligned, a trajectory for accident opportunity is created and a hazard may pass through the defensive holes, thereby leading to an accident. The holes represent weakness in defences. Latent Failures include organizational influences, poor training and pre-conditions such as fatigue. Active Failures include unsafe actions.*

Crew resource management and the dental office

In response to the large number of airline crashes in the 1970s that were attributed to human factors, Crew Resource Management (CRM) was developed in conjunction with NASA and the National Transportation Safety Board.[16,17] CRM is typically defined as an approach that uses available information, equipment and personnel to realize safe and efficient flight operations. CRM encompasses team training as well as simulation, interactive group briefings, measurement and improvement of crew performance. At the first level, CRM advocates for error avoidance. At the second level, potential errors are identified by the team before they are committed. At the third level, mitigation of the consequences of error occurs.

CRM involves implementing cultural change within the workplace. Success or failure is portrayed as a team, rather than an individual, issue. While there is no single, standardized team training program for health care, all programs should stress several key approaches. In the dental office, team training should minimize the potential for error by implementing pre-treatment briefings. Dentists need to minimize hierarchy in their operatories by creating an atmosphere in which all personnel feel comfortable speaking up when they suspect a problem. A team member may see something the dentist is oblivious to, such as undetected caries or a tooth that is about to receive inappropriate treatment. Dental team members should be encouraged to cross-check each other's actions, offer assistance when needed, and address errors in a non-judgmental fashion. The creation of backup systems, cross-checking and confirmation are essential components of an effective team strategy to enhance patient safety in the dental office (**Table 1**).

In contrast to medical care, dental services are generally delivered in small, independent clinics. Unlike a surgeon in a hospital operating room, dentists define their own hours of operation and work with the same staff members on a routine basis. Indeed, the relative constancy of dental office staff can facilitate team training and obviate oversights in treatment. Oversights are associated with human factors that include complacency, fatigue, poor communication, and lack of a proper description of possible complications. These factors could be addressed by implementation of CRM protocols, as illustrated by the following example. A comparative analysis of duty hours showed that airline crews are much more likely to recognize fatigue as a risk factor than are surgeons.[18] Can dentistry be that different? We suggest that since human error is inevitable, management techniques are needed to help identify and trap error before it develops into unexpected, adverse outcomes. One approach is the application of risk analysis, which increases situational awareness of potential error and emphasizes early error detection.[19]

Table 1: Skills needed for Crew Resource Management (CRM) development in dental offices.*

Communication	*Teamwork*	*Task Management*
Effective Briefing - Set an open tone - Outline the plan - Allocate tasks	**Leadership** - Balance authority and assertiveness - Use all available resources - Set high standards	**Planning and Conduct** - Plan and stay ahead - Maintain situational awareness - Change plan if needed
Interpersonal Skills - Share information - Suggest solutions - Speak assertively when required	**Followership** - Actively monitor and participate - Back up and support - Prompt others appropriately	**Workload Management** - Recognize overload in self and others - Avoid distraction - Take time
Methods - Listen actively - Confirm understanding - Share assessments	**Team Relations** - Adopt a friendly and relaxed tone - Manage conflicts - Adapt to others' needs	**Decisions** - Identify problems accurately - Involve others - Evaluate and re-evaluate

* Adapted from: Dahlström and colleagues.[23] The factors listed above illustrate important conceptual elements to enable integration of communication, teamwork and task management to avoid accidents and improve patient safety.

The way ahead

Dentists, like other highly trained professionals, will commit errors, which together with ever-increasing expectations of dental patients[20] are reflected in the growing numbers of complaints against dentists. The application of CRM protocols can reduce the frequency of errors and improve patient safety in medical practice.[4,19] The use of a checklist has been adopted by anaesthesia and surgical teams in many hospitals[21] and is now starting to be embraced by the dental profession, as illustrated by the RCDSO guidelines regarding implant therapy.[22] The implementation of checklists is a positive step for improving patient safety and treatment outcomes. In a related preventive approach, ongoing analysis of adverse outcomes enables practitioners to learn from one another. The RCDSO and other oral health organizations that aim to protect the well-being of the public publish practice alerts, complainant reviews and analyses of litigations against dentists. A review of a complaint is not undertaken to vilify a specific practitioner. Instead, cases are presented to illustrate common causes of complaints and how they might be mitigated in the future.

Conclusion

Current trends emphasize implementation of approaches in which professionals and institutions employ better communication, practice standardization, teamwork, self-reporting and cultural changes. These elements of improved practice typify CRM and if appropriately applied to dental practice could lead to improved patient safety and better treatment outcomes. CRM could be a vital step in health care delivery becoming an HRO.

References

Complete list of references available at: jcda.ca/article/e37

Canadian veterans made an enormous contribution, serving our country and the entire world. It's our turn to serve them.

Dr. Paul Kavanagh

HONOURING WAR VETERANS

Coming from a military family, Dr. Paul Kavanagh was raised to respect the sacrifices of those who serve our country. With Operation Veteran, he wishes to honour our veterans and share our past with schoolchildren.

When visiting the Canadian War Museum in Ottawa in 2009, Dr. Paul Kavanagh witnessed a heartbreaking incident—a dignified veteran trembling of embarrassment when he realized he could not afford soup and coffee at the museum's cafeteria. Dr. Kavanagh discreetly paid for the man's meal. "He was in tears; I had to do something," he remembers. The idea for Operation Veteran was born.

A few weeks after the poignant encounter, Dr. Kavanagh, a periodondist practising in Laval, Quebec, went back to the museum to meet with its director general. Together, they established the principles for the Operation Veteran initiative. Thanks to the generosity of private donors and the fundraising efforts of schoolchildren from across the country, veterans now receive a complimentary meal when visiting the museum. More than 5000 war heroes have benefited from the program to date.

Lest we forget

Another focus of Operation Veteran is education. Every year, schools that help fund the initiative are invited to participate in Remembrance Day activities. Students have the opportunity to attend the wreath-laying ceremony and discuss with veterans as they tour the Canadian War Museum. "It's that one-on-one interaction that adds the personal element," explains Dr. Kavanagh. "I believe that if young people know our history and respect our veterans, they will value and take care of our country."

Through online teaching modules, schoolchildren can also discover lesser-known aspects of the military such as diplomacy and peacekeeping. Another outreach tool of Operation Veteran is a 3-day educational program which includes workshops, lectures and museum tours.

Operation Veteran will be launching its latest addition in September 2014, just in time to celebrate the First World War centenary. *Supply Line* will offer a hands-on opportunity for students to learn about life at war. With the support of the Canadian War Museum, trunks from the Great War will travel to schools throughout the country. Their contents—authentic and reproduction materials including uniforms, gas rattles and masks, helmets, ration biscuits, letters exchanged between those on the frontline and their loved ones, and other wartime mementoes—will prompt schoolchildren to imagine themselves in the shoes of those who fought a century ago. Each trunk will come with a study guide developed specifically for the kids' age group—elementary or high school students.

"Canadian veterans made an enormous contribution, serving our country and the entire world. It's our turn to serve them," says Dr. Kavanagh. "By providing meals to our veterans and offering educational programs so young people can better understand our military history, we demonstrate respect and help perpetuate the memory of their invaluable contribution."

In recognition of his tremendous services to the veteran community, Dr. Kavanagh received the Queen Elizabeth II Diamond Jubilee Medal and Royal Canadian Legion Certificate of Merit in 2012, and the Minister of Veterans Affairs Commendation in 2013—a distinction rarely awarded to non-veterans.

Operation Veteran

① Dr. Paul Kavanagh, the catalyst for Operation Veteran Initiative

② A student partakes in the opportunity to interact with a war veteran

③ Two students view war memorabilia from the Canadian War Museum

Geneviève C. Gagnon is CDA writer/editor.

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Early Childhood Caries
A CALL TO ACTION

Dr. Ross Anderson, head of the pediatric dentistry division at Dalhousie University's faculty of dentistry and chief of dentistry at the IWK Health Centre in Halifax, spoke with CDA about the prevalence of early childhood caries, also known as "the silent epidemic," and what dentists can do to help.

Ross D. Anderson
DDS, Dip Paed, MSc, FRCD(C)

For the full audio interview and the list of references, visit **oasisdiscussions.ca/2014/04/01/ecc-3**

From your perspective, what is the most important issue in the area of child and infant oral health today in Canada?

As a pediatric dentist, I have to tell you that there's a silent epidemic of the most common chronic infectious disease in childhood—early childhood caries and severe early childhood caries. We have an inability in dentistry to be able to cope with this presently.

How big an issue is this in Canada? What does the evidence say and is it a growing issue?

Anecdotally, we've known about the problem for a long time. In 2007, the Centers for Disease Control and Prevention reported that this disease was increasing.[1]

More recently, in Canada there have been two pivotal publications. The first was a paper by the surgeon-in-chief at The Hospital for Sick Children on access target times for pediatric surgeries in Canada.[2] The article showed that for Canadian children, pediatric dentistry was the most common surgical procedure out of all pediatric surgeries, and we had the longest wait times and the poorest access to service.

The second publication, by the Canadian Institute for Health Information, was on day surgery for preventable treatment of childhood cavities.[3] The shocking thing about this paper is it showed that 30% of all day surgical time in public facilities for infants and children was devoted to treatment of early childhood caries and severe early childhood caries. You just need to stop and think: 30% of all day surgical time—that's a huge part of a public health resource. And the study noted that it's really just the tip of the iceberg because the data doesn't capture the general practice dentists who treat kids in their office, pediatric dentists doing this work, and people working in private surgical facilities. So it's a huge issue in Canada that's recently been recognized.

What is the significance for us as a profession— and as a society—if we don't come up with creative solutions for this silent epidemic?

I think that children are one of the most vulnerable segments of our population. We all know the relationship of oral health to general health—for example, the association of oral health with cardiac disease or low-birth-weight infants. But in pediatrics we've known the effects of poor oral health for a long time. We see kids that are suffering daily with pain, suffering

> *We see kids that are suffering daily with pain, suffering with either chronic infections or acute exacerbation, kids with swollen faces who can't eat or sleep well.*

with either chronic infections or acute exacerbation, kids with swollen faces who can't eat or sleep well. And there's also evidence that chronic pain during a critical window of development can affect their growth and development.

CDA BEST PRACTICE

First visit to the dentist by age 1, or within 6 months of eruption of first tooth.

Do you have a call to action for individual dentists and dental teams? What role can they play?

As an educator who's been teaching the value of infant oral health care for quite awhile now, I must say it's frustrating when I hear about parents who have phoned 2 to 3 dental offices to try to make an appointment for their one-year-old child, but they're turned away. And it's also disconcerting for my medical colleagues who I've trained to do oral health assessments and risk assessments; they identify an infant who is at high risk and yet they can't get them into a dental office.

My challenge to general dentists is to realize that they're part of a bigger system of primary care providers. That if you're a family dentist, family includes womb to tomb—that means infants and babies. General practitioners have a tremendous advantage in educating pregnant moms, in assessing families at risk and putting in place preventive measures like frequent fluoride varnish application and motivational interviewing.

We can't prevent every case of early childhood caries or severe early childhood caries, but we have to measure our successes. If counselling and fluoride varnish applications can reduce the number of cavities, you may have reduced the burden of illness, you may have kept a kid out of hospital.

This interview has been condensed and edited.

The views expressed are those of the author and do not necessarily reflect the opinions or official policies of the Canadian Dental Association.

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1 Than a manual toothbrush. M. Ward, K. Argosino, W. Jenkins, J. Milleman, M. Nelson, S. Souza. Comparison of gingivitis and plaque reduction over time by Philips Sonicare FlexCare Platinum and a manual toothbrush. Data on file, 2013.

2 Defenbaugh J, Liu T, Souza S, Ward M, Jenkins W, Colgan P. Comparison of Plaque Removal by Sonicare FlexCare Platinum and Oral-B Professional Care 5000 with Smart Guide. Data on file, 2013. Single use study.


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*The following is an abstract of a research article published in the 'Clinical Review' section of **jcda.ca**—CDA's online, open access scholarly publication that features articles indexed in Medline, Journal Citation Reports and Science Citation Index.*

Effect of Preheating on Microhardness and Viscosity of 4 RESIN COMPOSITES

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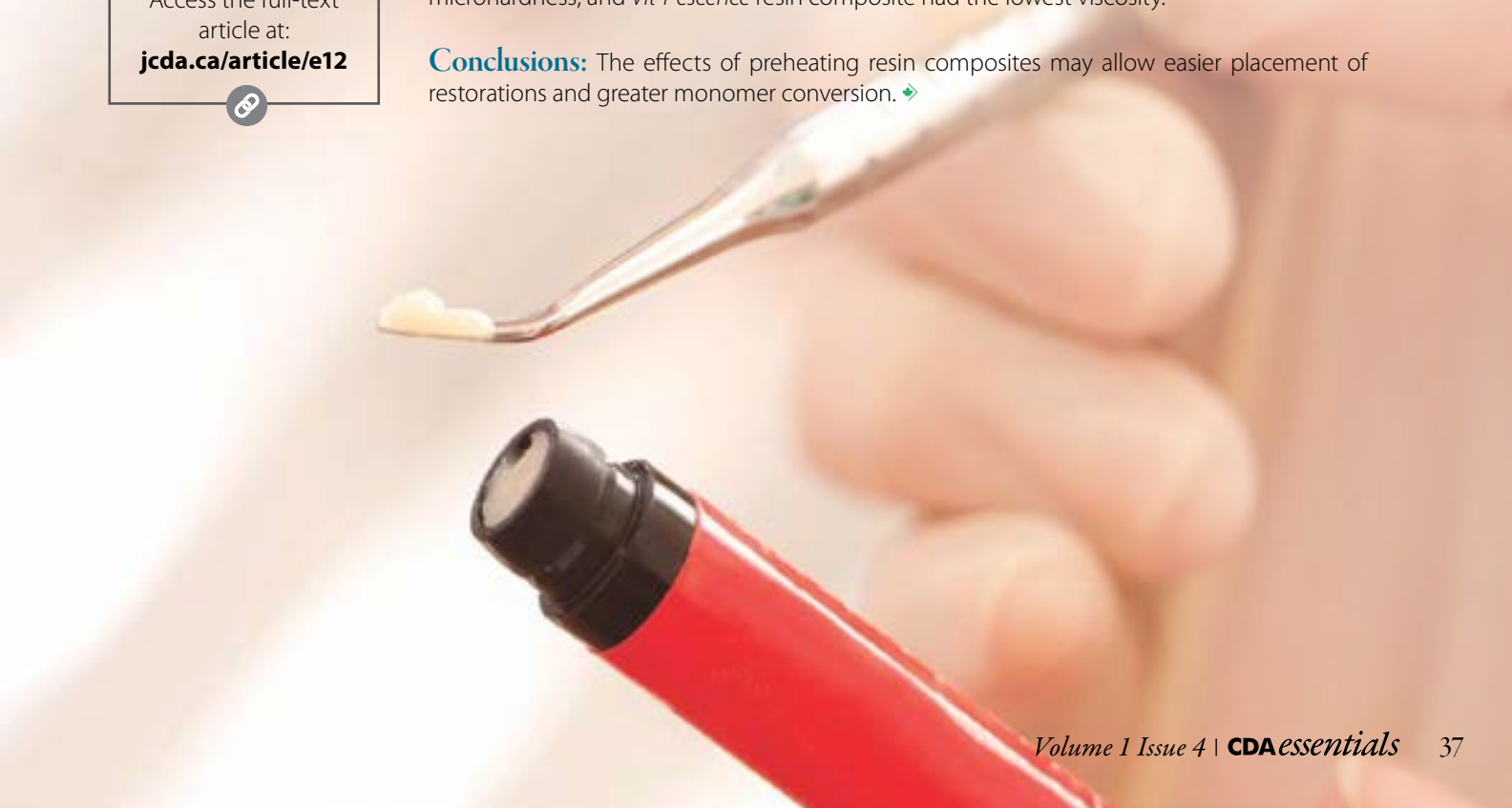
Abstract

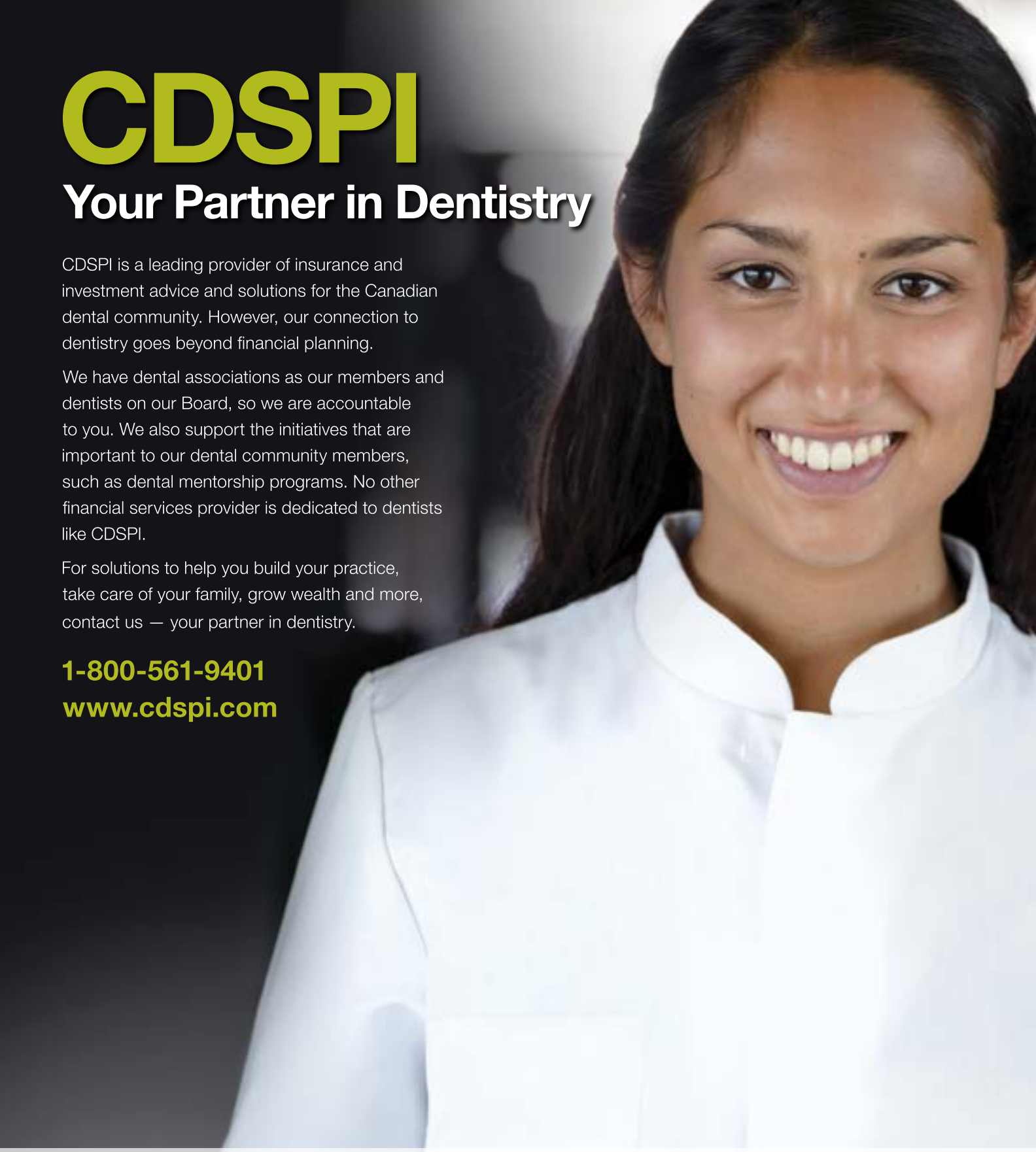
Objectives: This study was undertaken to determine the effect of temperature on the microhardness and viscosity of 4 resin composite materials (*Filtek LS, Filtek Supreme Ultra, Tetric Ceram HB, Vit-l-escence*).

Methods: To investigate microhardness, samples of each of the 4 composite materials, prepared by standard insertion of resin into prefabricated moulds, were divided into 2 groups (n=10 per group). On the first group, the resin composite materials were inserted into the moulds at room temperature and cured. On the second group, the resin composite materials were pre-heated in a heating device, inserted into the moulds and immediately cured. Microhardness after curing (both immediately and after 24 hours of storage) was determined (using a 300 g load applied for 10 seconds) and averaged for 5 randomly selected points on the top and bottom surfaces of each sample. To investigate viscosity, 0.5 g samples of room temperature or preheated resin composite (n=15 per group) were placed under a 454 g load for 45 seconds before light-curing (40 seconds). After curing, each sample was photographed and the surface area calculated. Data were analyzed by *t* tests or one-way analysis of variance and Tukey's test.

Results: Preheating the resin composites increased the microhardness and decreased the viscosity of the samples. *Filtek Supreme Ultra* resin composite had the highest mean microhardness, and *Vit-l-escence* resin composite had the lowest viscosity.

Conclusions: The effects of preheating resin composites may allow easier placement of restorations and greater monomer conversion.





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13-104 06/14

Oasis Point of Care

Managing Patients with GINGIVAL GRAFT FAILURE OR LOSS

Terrie Logue

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The author has no declared financial interests.

This article has been peer reviewed.

As periodontists, we perform gingival augmentation procedures regularly. On occasion, a treated patient contacts their family dentist following this type of procedure with concerns about the surgical site. Family dentists are also involved in follow-up care, sometimes in the early stages of post-operative healing. The following is intended to help guide the dentist through concerns they or the patient may have during a follow-up visit.

Presentation

Population

- Individuals with a recent history of gingival augmentation surgery
- Immunocompromised patients and those with delayed wound healing may be at higher risk

Signs

- Dislodged or removed surgical dressing
- Redness of surgical (recipient) site or tissue sloughing
- Approximating vestibular tissue may appear "necrotic"
- Persistent root exposure likely noted

Symptoms

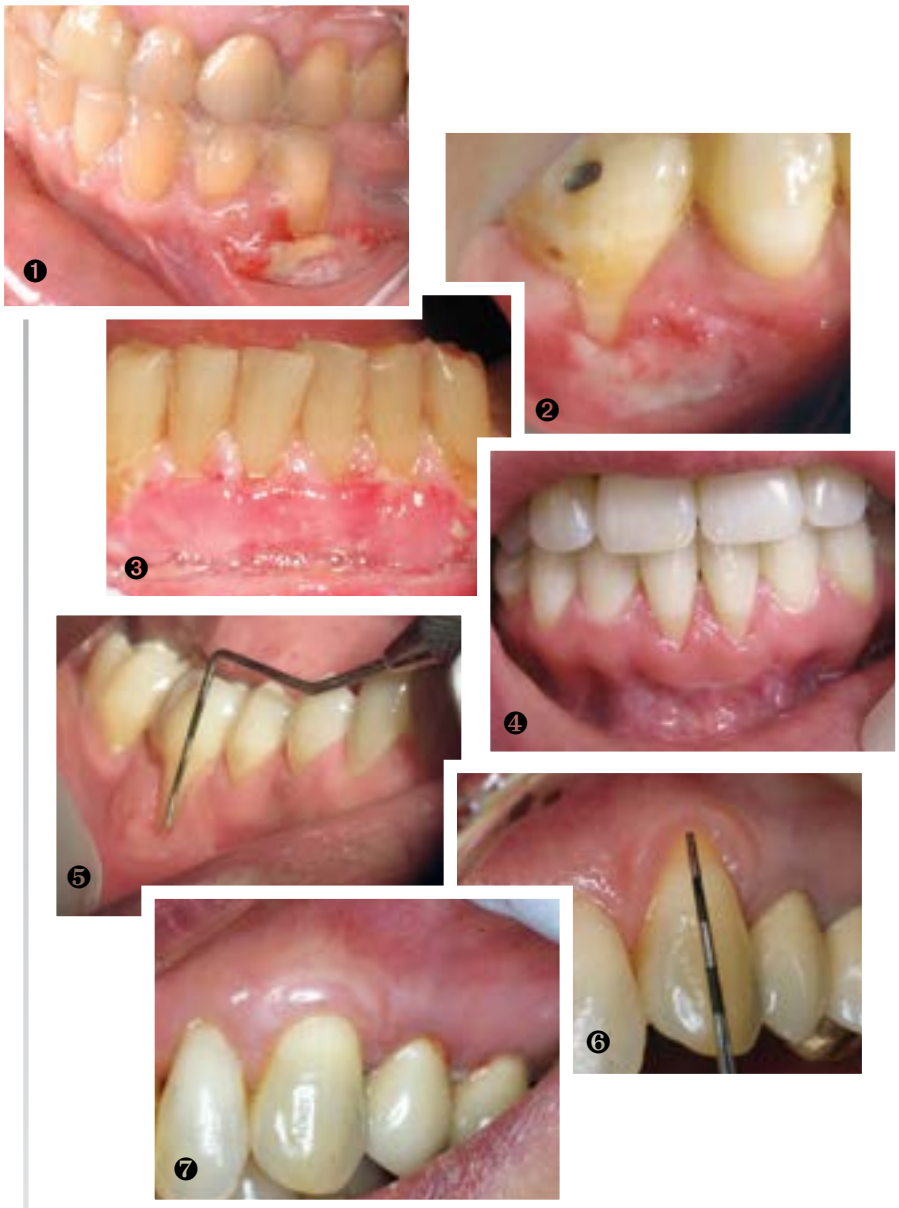
- Patient may experience pain, described as a constant dull ache or sharper pain during mastication or speaking (movement of oral and peri-oral tissues).
- Patient experiences anxiety over procedure and perceived lack of success.

Investigation

1. Perform complete extraoral (head and neck) and intraoral (teeth and soft tissue) exams to rule out postoperative infection. Evidence of postoperative pain, bruising, swelling or even infection does not indicate a gingival graft failure/loss.
2. Examine the surgical site:
   - Is there evidence of tissue on the periodontal dressing?
   - Is there trauma to the site as reported by patient?
   - Is there evidence of new tissue covering the periosteum, apical to the tooth or teeth that received the graft?

Dental Emergency Scenario

This article was originally created for the JCDA Oasis searchable database. Visit Oasis Help at **jcdaoasis.ca** to access this and other point of care clinical consults.



1. Normal post-operative healing of a free gingival graft. Note "whitish" colour that patients perceive as "lost graft." (Photo courtesy of Dr. Peter Halford)
2. Normal post-operative healing of a free gingival graft at 7 days. Whitish areas are sloughing epithelium. (Photo courtesy of Dr. Peter Halford)
3. Normal post-operative healing of a free gingival graft at 7 days. The whitish tissue is normal healing and is related to epithelial sloughing. There is remaining exposed root surface as the goal of the free gingival graft is to augment the keratinized gingiva.
4. Healed free gingival graft 6 weeks post-operative. Healing is successful, but there is still root exposure.
5. At 3 months post-operative, there is still exposed root but marked evidence of keratinized tissue. This indicates a successful free gingival graft.
6. Gingival recession, before connective tissue graft.
7. Healing of gingival graft, 3 months postoperation.

3. Ascertain which grafting procedure was completed:
   - A free gingival graft (FGG) is placed with the goal of increasing the zone of attached gingiva.
   - A connective tissue graft (CTG) is placed with the goal of both increasing the zone of attached gingiva and achieving root coverage of a previously exposed root surface.

Diagnosis

Infection

- Severe swelling of localized facial tissues and intraoral site approximating the surgical site
- Localized lymphadenopathy
- Evidence of pus/exudate in the graft recipient site (may be liberated from site with gentle pressure)

Surgical Site

- Dislodged or removed dressing may have evidence of tissue on it. In many instances, this may just be the sloughed epithelium and the remaining connective tissue will have remained/survived at the site (**Figs. 1, 2** and **3**).
- Most grafting procedures can withstand minor traumas. However, significant traumas (i.e., blow to the face, direct injury to the site with utensil/toothbrush), particularly if occurring in the first 24–48 hours postoperation, can cause graft necrosis.
- Clinical evidence of soft tissue covering periosteum is indicative of graft survival, even in the presence of persistent root exposure.

Graft Type

- A successful FGG will show remaining root surface but evidence of healing tissue apical to the exposed root (**Figs. 4** and **5**).
- A successful CTG will have evidence of tissue covering the previously exposed root (**Figs. 6** and **7**).

Treatment

Common Initial Treatments

Early Stage (<14 Days Postoperation)

1. Reassure the patient.
2. Prescribe antibiotic if there is evidence of infection: usually amoxicillin 500 mg, t.i.d. for 3 days is sufficient. Confirm if previous antibiotic has been prescribed and consider alternative drug.
3. Pain management: Prescribe anti-inflammatory medication (ibuprofen 400–600 mg t.i.d. or q.i.d. for 4–5 days) or acetaminophen-codeine-caffeine (one tablet q. 4–6h. p.r.n. for 3–4 days).
4. Advise the patient to perform minimal or no mechanical brushing of the site.
5. Start or continue to use antibacterial mouth rinse for 7–10 days (chlorhexidine 0.12%).
6. Contact a periodontist, if required, to advise about your and the patient's concerns.
7. Follow up in 21–28 days.

Later Stage (4–6 Weeks Postoperation)

1. Assess root coverage for CTG (may achieve partial coverage of exposed root surface)
2. Measure the zone of keratinized gingiva for FGG and CTG
3. If there is no evidence of root coverage (CTG) or of a zone of keratinized gingiva (FGG), retreatment will likely be required. In this instance, **contact a periodontist**. Success or failure of graft will be determined by the periodontist or the operating surgeon. Failure happens in less than 2% of cases. ◆

Suggested Resources

1. Parameter on mucogingival conditions. American Academy of Periodontology. *J Periodontol.* 2000; 71(5 Suppl):861-2.

2. Greenwell H, Fiorellini J, Giannobile W, Offenbacher S, Salkin L, Townsend C, et al. Oral reconstructive and corrective considerations in periodontal therapy. *J Periodontol.* 2005;76(9):1588-600.

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US Small Cap Fund (Trimark)	1.25%	21.3%	18.0%	22.3%	6.6%
Income Funds					
Bond and Mortgage Fund (Fiera Capital)	0.99%	2.0%	2.0%	2.1%	2.9%
Bond Fund (PH&N)†	0.65%	5.0%	4.2%	5.0%	5.2%
Fixed Income Fund (MFS)†	0.97%	4.8%	4.0%	4.3%	4.6%
Cash and Equivalent Fund					
Money Market Fund (Fiera Capital)	0.67%	0.5%	0.4%	0.3%	1.5%
Growth and Income Funds					
Balanced Fund (PH&N)	1.20%	18.0%	7.5%	8.0%	4.9%
Balanced Value Fund (MFS)†	0.95%	17.7%	8.9%	8.6%	5.6%
Corporate Class Funds					
Canadian Bond Fund Corporate Class (CI)†	1.10%	4.8%	4.0%	4.5%	n/a
Canadian Equity Fund Corporate Class (CI)†	1.65%	23.2%	9.2%	11.1%	n/a
Corporate Bond Fund Corporate Class (CI)†	1.25%	8.8%	7.1%	8.2%	n/a
Income and Growth Fund Corporate Class (CI)†	1.45%	18.7%	9.3%	10.9%	n/a
Short-Term Fund Corporate Class (CI)†	0.75%	2.5%	1.5%	1.0%	1.8%
MANAGED RISK PORTFOLIOS (WRAP FUNDS)					
Index Fund Portfolios					
Aggressive Index Portfolio (BlackRock®)†	0.85%	19.6%	9.2%	10.0%	6.3%
Conservative Index Portfolio (BlackRock®)†	0.85%	11.6%	6.7%	7.6%	5.1%
Moderate Index Portfolio (BlackRock®)†	0.85%	15.6%	7.9%	8.9%	5.8%
Income/Equity Fund Portfolios					
Aggressive Growth Portfolio (CI)†	1.65%	23.5%	11.5%	11.5%	5.8%
Balanced Portfolio (CI)†	1.65%	15.9%	8.9%	9.5%	6.5%
Conservative Growth Portfolio (CI)†	1.65%	18.2%	9.8%	10.3%	6.0%
Income Portfolio (CI)†	1.65%	10.3%	7.1%	8.4%	6.1%
Income Plus Portfolio (CI)†	1.65%	12.8%	7.5%	8.6%	6.1%
Moderate Growth Portfolio (CI)†	1.65%	20.6%	10.6%	10.8%	6.0%

Figures indicate annual compound rate of return. All fees have been deducted.
As a result, performance results may differ from those published by the fund managers.
Figures are historical rates based on past performance and are not necessarily indicative of future performance.
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† Returns shown are for the underlying funds in which CDSPI funds invest.

†† Returns shown are the total net returns for the funds which track the indices.

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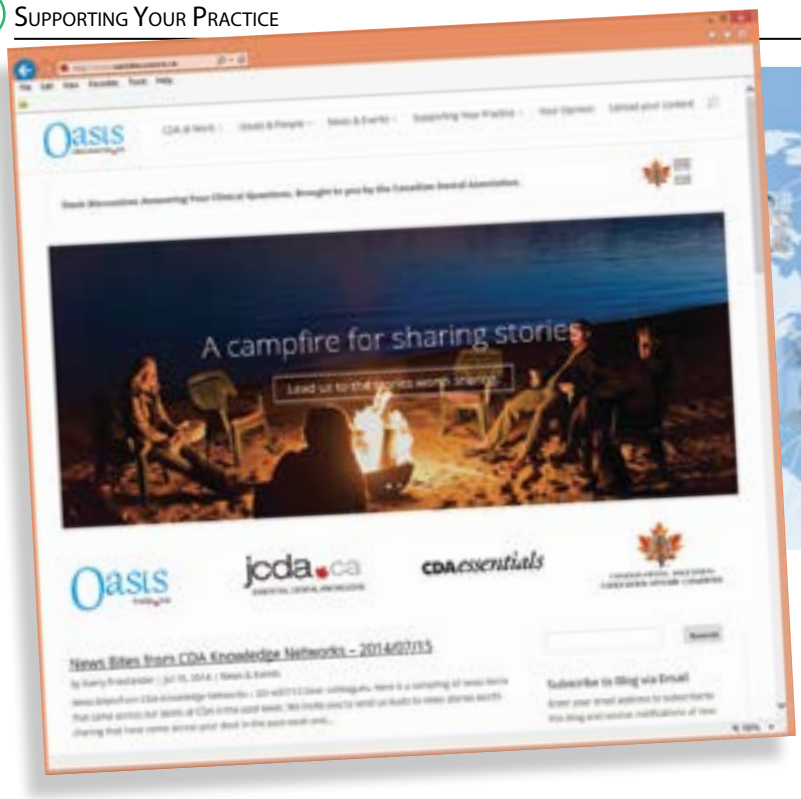


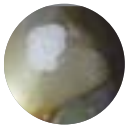
Oasis Discussions is a website that answers your clinical questions, discusses issues related to the profession, voices dentists' experiences, touches on the business of dentistry and showcases innovations in the dental industry.

The **Oasis Discussions** website has a new look! The following posts generated the most views on the site in June:

Which to choose: complete vs. incomplete caries removal? A systematic review
by JCDA Oasis Team
oasisdiscussions.ca/2014/06/02/ci

How do all-ceramic crowns fracture?
by JCDA Oasis Team
oasisdiscussions.ca/2014/06/17/acc

What are the indications for third molar extraction?
by JCDA Oasis Team
oasisdiscussions.ca/2014/06/13/3mo



How does one decide whether a crack/craze line on an asymptomatic tooth should be attempted to be removed, either with a restoration or a crown?
by Dr. Mary Dabuleanu
oasisdiscussions.ca/2014/06/05/ct

How do I manage oroantral communication? Key points
by Dr. Archie Morrison
oasisdiscussions.ca/2013/03/19/oc-2

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