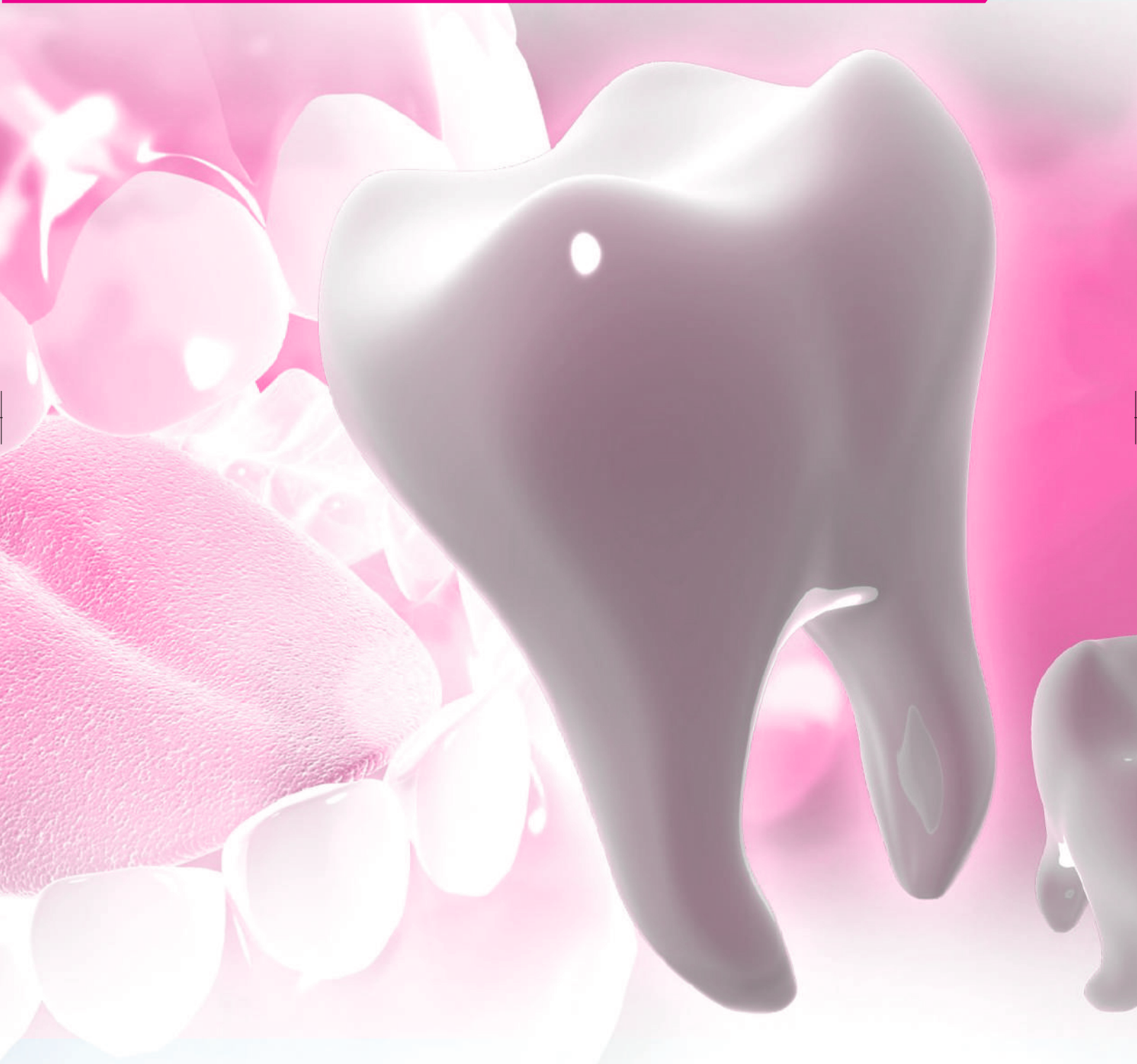




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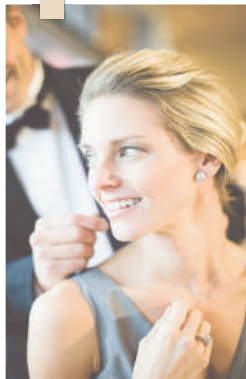
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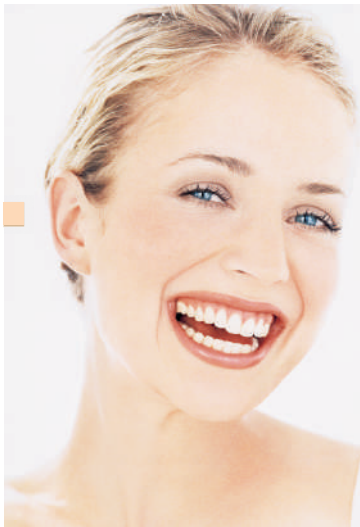
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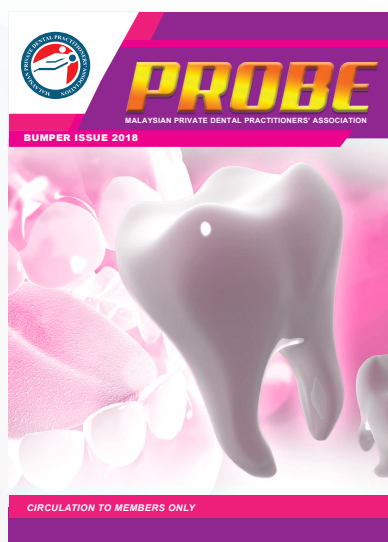
SECRETARIAT

Malaysian Private Dental Practitioners' Association
Suite 525, Block A3, Leisure Commerce Square,
No.9, Jalan PJS 8/9, 46150 Petaling Jaya. Selangor.

☎ Tel : 03-7874 0606 / Fax : 03-7874 0607

✉ Email : mpdpa1@gmail.com

🌐 Website : www.mpdpa.com



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President's Message



Dear Friends & Members.

It is indeed a great honour and privilege to serve as your President. I am humbled and will continue to create greater awareness and recognition for the MPDPA.

- We have organised many events. The 4th MPDPA ASEAN DSA Congress & Trade Exhibition 2018 was held recently. With the Tremendous Support from GP's who registered their DSA's and also support from the GOVT SECTOR, we achieved Great Success. None of this would have been possible without the tireless efforts and commitment from the Organising Chairperson Dr Foo Gaik Kee and the Committee Members. THANK YOU

We will be organising and conducting GP Lecture Series on Orthodontics, Periodontics & Prosthodontics, in the near vicinity. The Calendar will be sent by email to all of you.

Of Great importance is the Dental Bill which I know is on everyone's mind. We shall endeavour to raise our Grievances to the Minister of Health and the Committee is working on this. We are optimistic of getting the meeting and our views heard and look forward to a positive outcome. The MPDPA also paid a courtesy call to the New Principle Director of the Oral Health Division, Dr. Normah bte Taharim and extended our Congratulations on her appointment.

We regret that the MDA has decided to go ahead and form a Private Practitioners Wing, despite MPDPA's presence in the dental circuit of Malaysia. We will continue to champion issues affecting the Private Practitioners and seek solutions.

We wish to note that MPDPA's representative to the MDA's council was not taken into the council as per the MDA's constitution despite numerous reminders.

The Previous committee had exhausted all resources to resolve the issue and this was discussed at MPDPA AGM. The floor gave the mandate to seek clarification from the Registrar of Societies on the legitimacy of our request. The ROS then wrote to the MDA requesting them to abide by the constitution resulting in MPDPA's representative being taken into the MDA council.

At the recent MDA AGM the MDA committee sought to admonish MPDPA for writing to ROS. The disciplinary committee, under the able chairmanship of Dr. Paul Lee found that there was no necessity to pursue this matter.

MDA was not happy that the disciplinary board chaired by Dr. Paul Lee did not find MPDPA guilty to tarnish MDA. We just sought clarification from the ROS. MPDPA was removed from MDA council, as the MDA had formed MDAPPS, which is not registered with ROS and therefore Illegal. No one knows, when MDAPPS was formed. MDA does not want us to be privy of what is going on in their association.

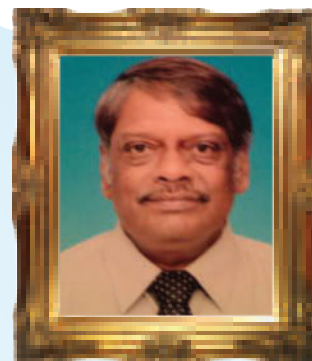
In Conclusion, I urge all the members old & young to give the association your full support and rekindle our GLORY DAYS. I need all of you to work alongside me to make this happen. Long live MPDPA! Long Live MPDPA! Long Live MPDPA!

I would also like to take this Opportunity to thank COLGATE, PUREEN, GSK, MaryKay and GC for their contributions towards the DSA congress 2018

Thanking you.

Dr Mahendran Ponnudurai.
President of Malaysian Private Dental Practitioners Association 2017 - 2019

Publication Secretary's Message



Greetings from the MPDPA.

Yet another issue of the Probe beckons,,this time, mindful of the need to preserve our environment it will be as a soft copy, an e-Probe.

The DSAs' seminar was held recently,about 150 dental surgery assistants from all over the country participated,enhancing their knowledge and skills so as to assist their dental surgeons even better. A couple of Evening Lecture Series were held on Periodontology and Orthodontics,there will be more to come.

Significantly,our newsletter can be a Forum for all of us to express our views on matters involving our practise and profession. Do go ahead and gives us your feedback on the numerous issues we face in our day to day clinical journey. Send an email to : mpdpa1@gmail.com or call us at 03-78740606.

We note the demise of Dr Lim Chee Shin,one of our founders.We salute his contributions to our profession and to fellow practitioners.

Looking forward to better participation in our future events from all of you. For your professional indemnity needs do contact the secretariat.

Till our next issue, wishing all of you, Great Dentistry.
Yours Sincerely,

A handwritten signature in black ink, appearing to read 'S. R Sothy', written over a horizontal line.

Assoc. Prof. Dr. S. R Sothy
(Publication Secretary MPDPA 2017-2019)

Important Facts For GPs To Know

MPDPA representatives, President Dr.P Mahendren, Dr.Vijendran, Dr.Foo Gaik See, paid a courtesy call to Dr Normah bte Taharim on 28th June 2018, who is the Principal Director of the Oral Health Division, Ministry of Health. We had a short & fruitful discussion on matters concerning Private Practitioners. MPDPA Executive Council took this as our duty as we represent the private dental practitioners.

1. The inspection of Dental Clinic by the Oral Health Division.

Licensing ,especially of Autoclave and Dental Compressors.As long as you have registered online with the JKKP,it will be accepted As regards the autoclaves, you can do the spore test once every two weeks and keep a record and present it during the inspection. Those with old compressors which are in good condition and without certificate must get the supplier to test it and give you a letter stating it is in good condition,having passed the safety test .You can then submit it to JKKP to get your license.

2.Advertising

Facebook advertising,loyalty cards ,packaged based treatment offers, may not be in line with our code of ethics.

3. Under the new Dental Act in case of any infringement to the practice of Dentistry,there is no need for a complainant to give their name,just giving the relevant information is sufficient.

4. A fee schedule for dental procedures is being drawn up. MPDPA is not represented here. At least two of our committee members should be included.

5. New Dental graduates will in future sit for the **Professional Qualifying Exams**. For those in the local universities, it is included in their syllabus and they should pass it. Graduates from overseas have to sit for this exam also and this will be implemented within the next five years.

6.Professional Indemnity Insurance

This will be compulsory for all practising dental surgeons starting next year 2019.

Government dental surgeons wanting to do locum in the private sector will have to show proof of having Indemnity insurance before being given permission by their respective Heads of Departments. MPDPA is in a collaboration with ZURICH, an insurance company of international repute,to provide indemnity insurance to all dental practitioners at a reasonable cost.

Please call 03 78740606 for more details.

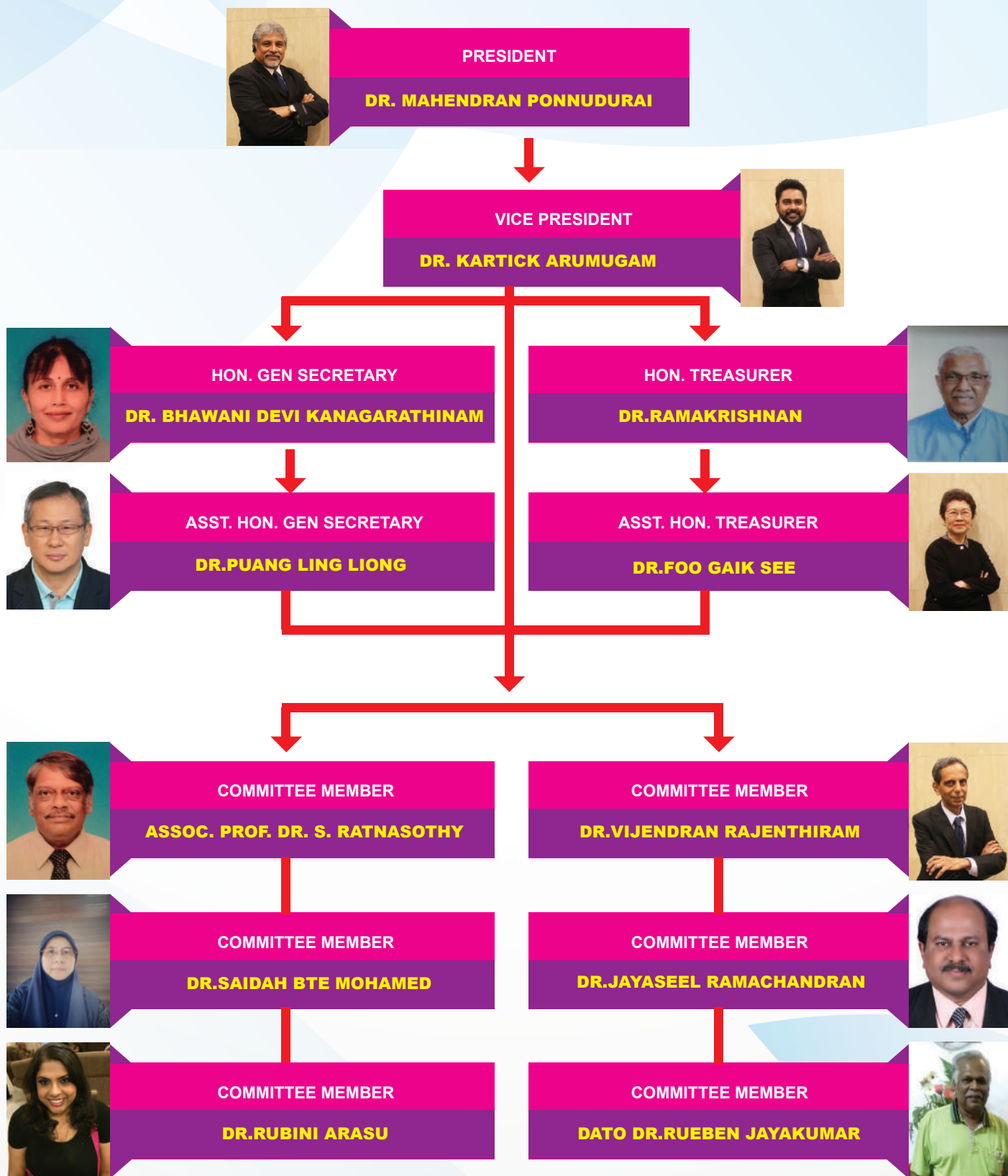
7.Discussions are on going to lower the required **CPD points** from the current figure of 30.

Please wait for the official announcement.

The meeting was conducted in a cordial and harmonious manner and we were assured that the Principal Director, Dr.Nomah, will meet up with us should the need arise.

Dr Mahendran
President MPDPA 2017-2019

MPDPA ORGANIZATION CHART 2017/18





Biological Restoration: A Simple Method for Reconstruction of Severely Damaged Primary Anterior Teeth

Shanthi M¹, Thimma Reddy BV², Bahruddin³, Sekhar S⁴, Sothy R⁵

¹ Senior Lecturer, Department of Paediatric Dentistry, MAHSA University College, Malaysia

² Professor and Head of Department, Department of Paediatric and Preventive Dentistry, MAHSA University College, Malaysia

³ Senior Specialist, Paediatric Dentistry, Hospital Serdang, Malaysia

⁴ Senior Lecturer, Department of Oral & Maxillofacial Pathology, MAHSA University College, Malaysia

⁵ Associate Professor and Head of Department, Department of Family Dentistry, MAHSA University College, Malaysia

ABSTRACT

Restoration of primary maxillary incisors, severely destroyed by trauma or caries is a commonly faced problem in a paediatric dental clinic. Most cases are observed in children with early childhood caries or trauma. In the past, the only option is to extract the affected teeth and replace them with prosthetic substitutes. The availability of natural crown and root would allow the use of biologic restorations to preserve the integrity of patient's natural dentition. This article describes a case in which biological restoration using tooth was placed in primary anterior tooth, with severely damaged crown due to trauma. The restored tooth demonstrated good retention and aesthetic results over a one year period. Hence, a biological restoration seems to be a successful and cost-effective alternative approach for treating such cases.

Key Words: Biologic restoration, Early childhood, Natural teeth

Please cite this article as: Shanthi M, et al. Biological restoration: a simple method for reconstruction of severely damaged primary anterior teeth. Malaysian Dental Journal 2013; 35(Suppl. APDC): 1-5.

INTRODUCTION

Anterior teeth fracture, as a result of traumatic injuries, frequently occurs in dentistry and presents a special challenge to paediatric dentist. Premature loss of primary incisors may affect the speech by interfering with the pronunciation of consonants and labial sounds, decreased masticatory efficiency, abnormal tongue habits and potential subsequent malocclusion.

The child may also suffer from psychological problems if aesthetics is hampered.¹ Because of reduced coronal tooth structure, direct adhesive restorative procedures do not always give satisfactory results. In the past, the most expedient treatment was to remove the involved teeth. This treatment was justified on the basis that the permanent teeth would eventually replace the extracted ones. However, the importance of

preserving the integrity of primary dentition until the appropriate exfoliation time is well recognized.

The consequences of premature loss of primary teeth are well known namely the loss of vertical dimension of occlusion, tongue thrusting and mouth breathing habits, which can be sources of future malocclusion. In cases of severe loss of tooth structure intra canal posts became mandatory.

The various root canal posts used in paediatric dentistry are orthodontic thread in the shape of alpha or gamma,² the metallic posts with macro retention,³ composites posts,⁴ biological restoration¹ and the fibreglass post.⁵ Recent development in restorative materials, placement techniques, and adhesive protocols facilitates these restorations. However these procedures turn out to be expensive, technique sensitive and also require expertise of the operator.

The expression “biological restoration” was coined by Santos and Bianchi,⁶ in 1991. A biological restoration⁷ meets up to the aesthetic and structural standards of natural teeth.

Proper reconstruction of extensively damaged teeth can be achieved through the fragment reattachment procedure known as “Biological Restoration.” They provide natural posts and crowns which can fit into the treated root stumps of the individual and replace the coronal portion aesthetically.

The first paper reporting the use of fragments of extracted teeth as dental restorative materials was published in 1964 by Chosak and Eidelman.⁸ Thereafter, several other reports have demonstrated the advantages of this technique, such as favourable aesthetics, resulting from enamel's natural surface smoothness, anatomic contouring and colour match, functional and masticatory effectiveness, preservation of sound tooth structure, prevention of physiological wear, and no need of complex material resources.^{9,10} This case report shows success of placing biological restoration in child with severely mutilated primary anterior tooth.

CASE REPORT

A 4yrs old female child presented along with parents to department of paediatric dentistry, three hours after sustaining a complicated crown fracture of her maxillary left central incisor during playing activity (Figure 1). Medical history was non contributory. General physical examination shows child appears to be panic. Extra –oral examination reveals no lacerations or bruises on face. Intra-oral examination reveals complete set of primary dentition with left maxillary central incisor crown split into two fragments intervening coronal pulp tissue.

Radiographic observation did not reveal sign of root fractures as the surrounding structures of root had sound integrity. The child's parents were informed about the various treatment options. Parents were impressed with biological restoration as it is cost effective, retaining portion of natural tooth. In addition, it was made clear to the parent's advantages as well as disadvantages of the technique and the post and the crown would be obtain from natural, extracted teeth that had been

previously sterilized by autoclaving in accordance with bio security standards. Consent was obtained using natural tooth restoration. Booster dose of Tetanus Toxin was given.



Figure 1. Initial view of fracture left maxillary central incisor

Phase 1

Child was premeditated due to anticipated negative taking her age into consideration. Under local anaesthesia, fractured mobile fragment of crown and intervening pulp tissue was removed (Figure 2).

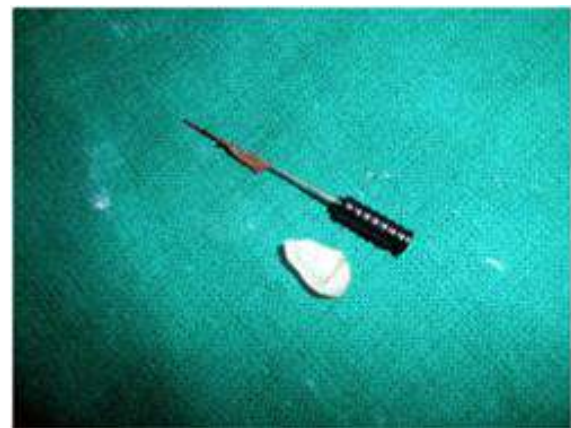


Figure 2. Extirpated pulp with removal of fractured fragment

Endodontic preparation

Endodontic treatment of fractured teeth was carried using Ni-Ti files and reamers and after complete sterilization of canal, obturated with zinc oxide eugenol cement.

Phase 2

Preparation of biological post

The patient was asymptomatic on the second visit. The obturating material at coronal one

third of root (4mm) is removed, for preparation of core to take biological posts (Figure 3). A 1 mm thick layer of glass ionomer cement was condensed over the remaining zinc oxide eugenol filling to prevent interference in the polymerization of composite resin restoration.



Figure 3. Intra-oral photograph showing condensation of GIC over Zinc-oxide eugenol cement



Figure 4. Primary tooth selected for the procedure and shaped to function as post

Tooth selected from tooth bank was reshaped with a crown preparation kit and the roots shaped to function as posts. The apical third was removed and the remaining stump was filled with flowable composite material. Tooth prepared for use as biological restoration was then autoclaved for 15 min at 121°C before cementation. The tooth was then tried for fit and adjustments in the prepared root canal (Figure 4). The finally prepared

crown and root were cemented using dual cure resin modified GIC. Finishing and polishing was done to give natural appearance like adjacent tooth (Figure 5).

Follow-Up

After a period of follow ups for 3,6,9 months biological restoration is satisfactory without any discoloration, marginal breakdown, and loss of restoration.



Figure 5. Final aesthetic result

DISCUSSION

The principle goal of paediatric restorative dentistry is to restore the damaged teeth to its normal function as well as to retain its aesthetic. In the past, the only treatment option for pulpally involved primary teeth would have been to extract the teeth and replace them with prosthetic substitutes, until the permanent teeth erupted. However, the availability of natural crowns and roots would allow the use of biologic restorations to preserve the integrity of patient's natural dentition.

Fragment re-attachment using natural teeth is a technique known as biological restoration. Although the technique is simple, it requires professional expertise to prepare and adapt the natural crowns and intra-canal posts.¹¹ Biological restorations not only mimic the missing part of the oral structures, but are also bio-functional.¹²

The advantages of using biological restorations are the length of each appointment is reduced because natural teeth are prepared previously; the technique eliminates laboratory processing and is economical. The technique is simple, allows the preservation of sound tooth structure and provides excellent aesthetics

compared to composite resins and stainless steel crowns, especially regarding translucency.

Clinical chair time for fragment bonding procedures is relatively short, which is very advantageous when treating paediatric patients.^{13,14} Resin composite restorations do not present these advantages and can allow staining and plaque formation on their surfaces.

Disadvantages of the biological restoration technique include the difficulty in obtaining teeth with the required coronal dimensions and characteristics, problems inherent to indirect restorations and matching fragment colour with tooth remnant colour. Also, having fragments from other people's teeth in their mouth is not a pleasant idea for some patients and many of them refuse to receive this treatment. However, all these factors are not contraindications of the technique.

It is important that the parents are informed that the tooth fragments used for biological restoration are previously submitted to a rigorous sterilization process that completely eliminates any risk of contamination or disease transmission to the child receiving the fragment.

Presently, secure methods of sterilization and storage are available to ensure the safety of teeth or tooth fragments coming from tooth banks.^{15,16} Several materials have been used for bonding dental fragments to cavities, e.g., adhesive systems, composite resins, glass ionomer cements and dual-cure resin cements.

The association between "Biological Crowns and Posts" offers excellent aesthetic, functional, and psychosocial results, which justifies the use of this technique to achieve the morpho functional recovery of extensively damaged teeth. In the present case, the use of biologic restoration with the natural roots and crown resulted in clinical success as well as recovered function and aesthetics.

The biologic restoration is a promising alternative to prosthodontic restoration for primary teeth severely destroyed due to trauma or caries. Also, the technique eliminates high costs associated with other restorative techniques for deciduous anterior teeth, and provides highly functional and aesthetic outcomes.

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Corresponding Author:

Dr. M. Shanthi
MAHSA University College
Level 6, Block E, PBD
Kuala Lumpur
Malaysia
Tel: 60166542489
Email: shanthineha2012@gmail.com



Natal Teeth – A Case Report

Shanthi M¹, Ravi Chandra PV², Reddy S³, Sothy R⁴

¹ Senior Lecturer, Department of Paediatric Dentistry, MAHSA University College, Malaysia

² Professor and Head of Department, Department of Conservative and Endodontics, MAHSA University College, Malaysia

³ Senior Lecturer, Department of Paediatric and Preventive Dentistry, MAHSA University College, Malaysia

⁴ Associate Professor and Head of Department, Department of Family Dentistry, MAHSA University College, Malaysia

ABSTRACT

Teeth that are present in newborn infant are called "natal teeth". In some cases, the infant is born without teeth, but eruption may occur in the first four weeks following delivery. These types of teeth are called "neonatal teeth". They are most commonly the mandibular central incisors, which are the teeth that usually erupt first. The incidence of natal and neonatal teeth is difficult to determine, and reports vary widely, most certainly under reported because in some cultures great fear and negativity was associated with natal teeth. One re-view of 359 recorded cases suggests an incidence of 1 in at least 3,000 births. Natal teeth are more common than neonatal teeth with a ratio of 3:1. Natal teeth might cause discomfort to a nursing mother and present a risk of aspiration and swallowing by the infant if they are loose. Also, they may cause irritation and trauma to the infant's soft tissues. Under these circumstances, natal teeth need to be extracted. In this article, a case report of infant with two natal teeth is presented. The teeth were present in the mandibular incisor region and excessively mobile. Because the teeth caused problems in the nursing process and ran a risk of aspiration, they were removed and histopathologically examined.

Key Words: Natal tooth, Neonatal tooth, Hypoplasia

Please cite this article as: Shanthi M, et al. Natal teeth – a case report. Malaysian Dental Journal 2013; 35(Suppl. APDC): 33-36.

INTRODUCTION

In 1950, Massler and Savara¹ introduced the now commonly used terms "natal teeth" for teeth present at birth and "neonatal teeth" for teeth that erupt within the first 30 days of life. These terms only define the time of eruption and give no consideration to anatomy, histology or whether the tooth is a component of primary dentition or supernumerary teeth.^{2,3} Various terms such as congenital teeth, fetal teeth, pre-deciduous teeth, precociously erupted teeth (Mayhall and Bodenhoff), premature teeth, dentitia praecox and dens connatalis have been used to describe these teeth in the past. The normal eruption of the primary teeth typically begins at six months of age.⁴

Natal teeth are present at birth and are usually a benign problem.⁵ However, natal teeth

might interfere with breastfeeding and, if loose and mobile, might be swallowed or aspirated during nursing.⁶

The presence of natal and neonatal teeth is definitely a disturbance of biological chronology whose aetiology is still unknown.⁷ It has been related to several factors, such as superficial position of the germ,^{8,9} osteoblastic activity inside the germ area related to the remodelling phenomenon,¹⁰ transmission of a dominant autosomal gene^{11,12} (hereditary), eruption accelerated by febrile states¹³ or hormonal stimulation, malnutrition and hypovitaminosis.

Natal teeth may also be associated with cleft lip, cleft palate¹⁴ and cyclopia. Most of the time, natal teeth are not related to a medical condition. However, sometimes they may be associated with Ellis-van Creveld Syndrome,¹⁵

Hallermann-Streiff syndrome,¹⁶ Jadassohn-Lewandowski Syndrome, Soto syndrome.⁷

Studies showed that the incidence of occurrence of natal and neonatal teeth is 85% in mandibular incisors and usually in pairs, 11% in maxillary incisors, 3% in mandibular canines and molars and only 1% in maxillary posterior regions. Natal and neonatal cuspids are extremely rare. More than 90% of natal and neonatal teeth are

prematurely erupted whereas less than 10% are supernumerary. With respect to gender, there was no difference in prevalence between males and females. However, a predilection for females was cited by Kates et al¹⁷ (1984) reporting a 66% proportion for females against a 31% proportion for males. A case report is presented in this article where an infant was born with two natal teeth.



Figure 1. Infant with natal teeth



were diagnosed as “natal teeth” since it was present in the infant's mouth at the time of the delivery. It was decided to extract the mobile natal teeth for two reasons: a) to prevent aspiration and b) to ensure proper feed for the baby.

CASE REPORT

A 12 days old female infant was brought to department of paediatric dentistry by her parents with the chief complaint of teeth in her lower jaw. Mother also complained that child exhibits pain during suckling and could not nurse properly (Figure 1 & 2). There was no familial history of any similar oral manifestation. Medical history revealed that the infant was delivered naturally following a 40-week pregnancy. There was no evidence of systemic disease, congenital anomalies or syndromes. Intra-oral examination revealed calcified teeth-like structures, whitish yellow in colour and exhibit grade II mobility are present corresponded to those of teeth 71 and 81.

The structures were smaller in overall dimensions as compared to the corresponding primary teeth. The baby seemed to be uncomfortable and mouth was kept open during feeding and hence was spoon fed. Examination of the rest of intra oral mucosa revealed no other lesions.

Due to lack of co-operation from the baby, intraoral radiographs could not be taken. The teeth



Figure 2. Extracted natal teeth

Extraction was done with minimal blood loss and haemostasis was readily achieved and teeth were send for histological examination. The removed natal teeth had dimensions of 5 mm to 4 mm and the root development had been

incomplete. It also had a hypoplastic appearance (Figure 2).

Histological report suggests normal enamel with enamel lamellae and dentin with dentinal tubules with prominent terminal branching with large vascular pulp (Figure 4). There was no evidence of root formation. The features were suggestive of natal teeth. After 2 days of extraction infant was re-evaluated, recovery was satisfactory and feeding was normal.

DISCUSSION

Normally primary teeth begin to erupt at age of six months¹⁸ which is a milestone both in terms of functional and psychological changes in the child's life and in emotional terms for the parents. The expectations about the eruption of the first teeth are greater and even more when the teeth appear early in the oral cavity. In rare cases, the chronology to tooth eruption is significantly altered and the first teeth are present at birth or will emerge shortly after birth.

On the basis of clinical characteristics, these teeth were then classified into: Mature—when they are fully developed in shape and comparable in morphology to the primary teeth; immature—when their structure and development are incomplete. Hebling (1997)¹⁹ recently classified natal teeth into 4 clinical categories:

1. Shell-shaped crown poorly fixed to the alveolus by gingival tissue and absence of a root;
2. solid crown poorly fixed to the alveolus by gingival tissue and little or no root;
3. eruption of the incisal margin of the crown through gingival tissue;
4. oedema of gingival tissue with an un erupted but palpable.

Clinically, the natal teeth are small or of normal size, conical or of normal shape. They may reveal an immature appearance with enamel hypoplasia and small root formation.

Natal teeth may exhibit a brown yellowish or whitish opaque color. They are attached to a pad of soft tissue above the alveolar ridge. The dimensions of the crown of these teeth are smaller than those of the primary teeth under normal conditions. There is some fear that a natal tooth could come loose, and the baby could aspirate (inhale) it. However, this appears to be rare.

Most frequent difficulty is during feeding including Riga-Fede disease²⁰ where the presence of natal or neonatal teeth in association with nursing or suckling leads to ulceration on the ventral surface of tongue. Prolonged gingival irritation from natal or neonatal teeth may cause localized inflammation of the gingiva or fibrous hyperplasia.

Histologically, the majority of natal teeth have dysplastic or hypomineralized enamel, irregular dentin and osteo dentin in the cervical portions, and interglobular dentin in the coronal regions.²¹ The incisal edge might lack enamel. Both Hertwig's sheath and cementum might be absent. There is often an increase in the number of dilated blood vessels in the pulpal tissue. Root formation is often incomplete.

Differential diagnosis may include bohn's nodules and epulis might be confused with natal teeth. Bohn's nodules are usually multiple and found along the buccal and lingual aspects of the mandibular and maxillary ridges.²² These remnants of mucus gland tissue are firm with whitish rice-like appearance, asymptomatic, do not interfere with feeding and are spontaneously shed within several weeks.

Epulis are tumour-like growths of the gum that might be either sessile or pedunculated, and are reactive rather than neoplastic lesions. Other differential diagnoses include lymphangioma and hamartoma of the alveolar ridge.

A dental roentgenogram is always indicated to differentiate the premature eruption of a primary deciduous teeth from a supernumerary tooth.^{5,6}

Difficulty in obtaining a radiographic appraisal of the region, due to the child's age, prevented immediate confirmation of whether the tooth in question belonged to the normal series or was supernumerary. However, with subsequent patient follow-up and eruption of the remaining teeth, made possible to confirm that the teeth belong to normal complement of primary dentition.

Regarding management of natal teeth, no intervention is necessary if teeth is asymptomatic and does not interfere with breastfeeding. Teeth extraction if indicated should be planned carefully due to its several complications like post extraction haemorrhage and premature loss of primary teeth may cause consequent malocclusion in permanent dentition.

Consultation with a paediatric dentist is strongly recommended. Extraction of the teeth should be followed by curettage of the socket if necessary to prevent continued development of the cells of the dental papilla.²³ Failure to curette the socket might result in the eruption of odontogenic remnants and necessitate future treatment.²⁴

Paediatricians are usually, the first who find natal teeth and early consultation with paediatric dentist can prevent complications.

Although their occurrence is rare, it is still possible to encounter natal teeth in daily practice. In these cases, it is important to make the appropriate decision, taking into consideration the adverse effects these teeth may have for both the infant and the mother.

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Corresponding Author:

Dr. M. Shanthi
MAHSA University College
Level 6, Block E, PBD
Kuala Lumpur
Malaysia
Tel: 60166542489
Email: shanthineha2012@gmail.com



CASE REPORT

TOE WALK IN NOONAN SYNDROME- A CASE REPORT

¹Padmanabha Kumar, G., ²Soma Sekhar Goud, E.V., ^{3,*}Shanthi, M. and ⁴Ratnasothy, S.

¹Senior Lecturer, Dept of Oral and Maxillofacial Surgery, MAHSA University

²Senior Lecturer, Dept of Oral Maxillofacial Pathology and Microbiology, MAHSA University

³Senior Lecturer, Dept of Paediatric Dentistry, MAHSA University

⁴Associate Professor, Dept of Family Dentistry, MAHSA University

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ABSTRACT

Noonan syndrome (NS) is a rare genetic disorder, which may occur as sporadic or inherited as autosomal dominant or recessive trait. It is a multifactorial condition that is characterized by a series of congenital malformations including facial anomalies, post-natal growth development, webbing of neck, pulmonary stenosis and undescended testicles in boys. NS can be confirmed genetically by the presence of any of the known mutations. However, despite identification of fourteen causative genes, the absence of a known mutation will not exclude the diagnosis, as there are more undiscovered genes that cause NS. Thus, the diagnosis of NS is still based on clinical features. The present report describes a case of this syndrome without cardiac abnormalities but with characteristic bilateral toe walking.

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INTRODUCTION

The eponym "Noonan syndrome" (NS) was first recognized by a paediatric cardiologist Dr Jacqueline Noonan in 1962 (Opitz, 1985). Though it is an autosomal dominant disorder there is evidence for a rare autosomal recessive form. It can occur in both genders with normal number of chromosomes. The estimated prevalence of this genetic disorder is 1 in 1000 to 1 in 2500 live births (Noonan and Ehmke, 1963). Germ line mutations (Carta, 2006) in genes in Ras/MAPK pathway which is a critical pathway for cell growth to cell death have been linked to NS in 61% of cases. In 2001 Tartaglia *et al.* (2001) discovered PTPN11, the first gene for NS which encodes SPH-2, a non-membranous protein tyrosine phosphatase with largely positive regulatory roles in signal transduction for many cytokines, hormones and many growth factors. PTPN 11 mutations account for more than 50% of NS cases. Gene mutations can also occur in KRAS, SOS1, RAF1, SHOC2, NRAS genes.

The characteristic features are short distinctive facial features, chest deformity, and congenital heart diseases. Though the diagnosis is based solely on clinical findings, establishing the diagnosis can be very difficult in adulthood due to great variability in expression and the phenotype becomes less pronounced with increasing age. But definitive diagnosis can be made by one major sign or two minor signs or 2 minor signs or 3 major signs. (Table 1) This is a case report of a 10-year-old Asian boy with NS showing multiple congenital anomalies but without cardiac and karyotyping abnormalities who was referred by a general dental practitioner for management.

Case presentation

We present a case of 10-year-old Asian boy, reported along parents with chief complaints of pain and bleeding gums since 10 days. History revealed that the child had delayed milestones, learning disability, speech problems and had undergone orchiectomy for left testis 5yrs back and surgery for webbed neck three years ago. Family history was non-contributory and child is third in birth order and was born full term. Other siblings, two sisters were normal.

*Corresponding author: Shanthi, M.

Senior Lecturer, Dept of Paediatric Dentistry, MAHSA University.

Table 1. Scoring system for diagnosis of NS

Present changes	A=major	B=minor
Face	Typical face dysmorphology	Suggestive face dysmorphology
Heart	Pulmonary valve stenosis, cardiomyopathy	Other defect
Body height	<P3*	<P10*
Thorax	Pectuscarinatum/excavatum	Broad thorax
Family history	First degree relative with definite NS	First degree relative with suggestive NS
Others	Other Mental retardation, cryptorchidism and lymphatic dysplasia	Milder forms of these changes

* P3 and P10-related measures height by age (normal range P3-P97)

Table 2. Comparison of values of the patient with average 10 year old Asian boys

No	Distance	Average values of 10 year old Asian boy (mm)	Patient's values (mm)
1.	Inner canthal distance	29.16±3.31	30
2.	Outer canthal distance	78.86±7.7	96
3.	Inter pupillary distance	51.03±2.69	55
4.	Inter mammary distance	130±3	140

Table 3. Differential diagnosis for NS

S. No	foetal alcohol syndrome	turner syndrome,	cardio-facio cutaneous syndrome,	costello syndrome,	leopard syndrome
	•Characteristic facial anomalies, growth retardation (intrauterine growth restriction and failure to have catch-up growth) •CNS involvement (cognitive impairment, learning disabilities, or behavioural abnormalities)	•Dysmorphicfacies, short stature and widely-spaced nipples but differs in that patients have an abnormal karyotype (45XO). •Only females are affected, patients have left-sided heart abnormalities, renal pathology and developmental delay	•Hypertelorism, down-slanting palpebral fissures. •Micrognathia, low-set ears, pulmonic valve stenosis, and keratosis pilaris	•Cardiac abnormalities, ECG anomalies, decreased growth velocity in the post-natal period caused by low growth hormone levels. •Feeding difficulties, misalignment of the teeth, and issues with vision. •Associated with Chiari I malformation, macrosomia	•Also referred to as Noonan Syndrome with Multiple Lentiginos (NSML). •Patients classically have lentiginosis, ECG abnormalities, ocular hypertelorism, pulmonic stenosis, abnormal genitalia, •Retardation of growth, and sensorineural- deafness

On General physical examination, child had difficulty in sustaining attention, hyperactivity, and impulsive behavior which is suggestive of attention deficit/hyperactivity disorder. Gait abnormality characterized by an absence of normal heel-to-floor contact (heel strike) by both feet i.e. toe walking was found (Fig.1).



Picture 1. Characteristic toe walk

Other characteristic findings are short stature, short and scared neck with low hairline at the back of the neck, prominent right clavicular head, depressed sternum, and prominent floating rib on right side, small soft clavicles bilaterally. (Fig.2) Right testicle was absent.



Picture 2. Front back lateral view

Child mental age was 4-5 yrs lesser compare to his age. Other like child's inner and outer canthal distance and inter pupillary and mammillary distance were measured (Table 2). Extra-oral examination revealed facial asymmetry due to facial hemiatrophy on left side, hyper telorism with downward slanting of palpebral fissures and strabismus, eye brow were arched and diamond shaped, nasal tip is bulbous with deviated nasal septum, broad philtrum, ears are asymmetrical in length and are low set, posteriorly located with thick bilobed helixes.

(Fig-3) Lips are incompetent with proclined permanent maxillary central incisor. Lymph nodes were not palpable and for TMJ, no abnormality was detected. Hypo plastic jaws on left side were seen. Intra-oral examination shows mixed dentition with narrow, high arched palate, irregularly placed upper anterior teeth, and anterior deep bite, with heavy calculus deposits. Dental caries in retained primary and permanent teeth (16, 54,64,65, 75,74,84,46) were seen. Unerupted maxillary lateral incisor, retroclined maxillary left permanent incisor and midline shift of teeth towards left side of jaw were seen.



Picture 3. Thick bilobed helixes



Picture 4. PA chest OPG

Patient also had hyper-sensitive palate causing gag reflex. As the syndrome has a wide spectrum of disorders, child had undergone the following investigations like hematological, bio-chemical, radiographic analysis, ultra sound of abdomen, MRI pelvis, audiometry, cytogenic studies, ECG, HCG stimulation test. The complete treatment plan for full mouth rehabilitation that includes oral prophylaxis, extractions, and restorations of decayed teeth was discussed with the parents. As the child was not able to follow verbal commands, treating the child under nitrous oxide conscious sedation was discussed. Paediatrician's consent was obtained prior to procedure and all necessary treatments were done in two visits. The patient was periodically followed up during the subsequent follow-ups. Opinion was obtained from department of orthodontics regarding malocclusion which will be treated in later stages.

DISCUSSION

NS could be considered as brachial arch development syndrome with characteristic ocular, facial, cardiac and dental anomalies.

NS is also called as webbed neck syndrome. An obvious and evident webbing of the neck is generally present in only one fourth of the cases, while an apparent neck shortening with redundant skin on the neck and low posterior hairline are more commonly noted. The classic features of NS changes with age. In the new born, typical features include tall forehead. During infancy the head is relatively large with tall and prominent forehead. During childhood, the face may appear coarse or myopathic. Facial contour becomes more triangular with age, as the face lengthens. During adolescence and young adulthood neck is longer with accentuated webbing or prominent trapezius. In older individuals, the nasolabial folds are prominent and the skin appears thin and transparent. Growth retardation (Mendez and Opitz, 1985; Sharland *et al.*, 1992; Ranke *et al.*, 1988) is an important feature of Noonan syndrome, and short stature is found in 50-70% of cases in previously reported series. Short stature may be due to partial skeletal dysplasia as they are found to have disproportionably large trunk than legs, similar to what is seen with Turner syndrome. Early delay in motor milestones could probably be explained by the presence of hypotonia and hyper extensibility in the younger child. The characteristic bilateral toe walking shows prominent foetal pads on toes, which may be due to muscle spasticity and muscle dystrophy. Both the inner and outer canthal distance and inter-pupillary distance was increased which can also see in other syndromes like LEOPARD, apert syndrome. Inter-mammillary distance is also increased which shows wide chest with large distance between the nipples. These features may be more obvious in early childhood, but tend to become much less noticeable in adulthood.

The variety of clinical manifestations of this syndrome indicates that a multidisciplinary approach is necessary for diagnosis, treatment, and follow-up of these patients. In the present case, the child's haematological and bio-chemical investigations showed no abnormality. Cytogenetic studies shows male karyotype (46, XY) without numerical or structural chromosomal abnormality and was important in distinguishing between Turner and NS. Chest X-ray shows both the lung fields are clear, normal heart size and rib cage except right clavicle joint is more bulbous. (Fig. 4) 2D echocardiography shows structurally and functionally normal heart. Cervical spine and thoracic lumbar spine shows vertebral anomalies like scoliosis at thoraco-lumbar junction concave to right, block vertebrae, disc spaces are narrowed without paraspinal mass and blocked vertebrae. Ultrasonography of abdomen shows no abnormality, except right testes could not be localized. HCG stimulation test shows normal hormonal response. In MRI pelvis right testis is not visualized in the inguinal region or in the line of descent of testis. Audiometry values are normal. Orthopantomograph (OPG) shows mixed dentition stages of tooth development. Taurodontism, with mandibular first molars and open apices was noted. Other findings are nasal polyp in right nostril with deviated nasal septum towards left and reduced ramus height with antegonial notch on left side of the mandible. (Fig. 4) There are several disorders that resemble NS phenotypically like LEOPARD, Foetal alcohol syndrome, Turner syndrome, Cardio-facial cutaneous syndrome, Costello syndrome (Judith Allanson, 2010). (Table3)

Majority of children with NS will grow up and function normally in the adult world. However, they may require special care and counseling. New medical problems may not be expected in adulthood. However, males who were born with undescended testes may have fertility problem. There is no evidence for gynecological or child bearing complications in females with NS. Adults with NS do not require special medical care.

Conclusion

Noonan syndrome is a genetic condition with characteristic phenotypic anomalies, but a wide range of clinical expression. Multidisciplinary treatment is the key to success in managing children with NS and the paediatric dentists play an important role to lead the health team. The children with NS usually have a wide array of health problems making it important for all specialties to be aware of the child's special care needs.

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CLINICAL CASE REPORT

Maxillary Obturator With Oral Rehabilitation

INTRODUCTION :

Oral rehabilitation of a middle aged patient with a history of fungal infection of the palatal mucosa which was surgically treated ,resulting in a palatal defect 20 yrs back.

A female patient aged 46 years reported to the clinic with palatal defect, with a History of Present Illness.

20 years ago, female patient aged 26 years had reported to the clinic with a swelling on the left side of the face, with facial palsy.

On intra oral examination, there was an ulcer on the Left side of the palate, measuring approximately 1-1.5Cm in size.

Further investigation revealed involvement of both sphenoidal and ethmoidal sinuses and displaced nasal septum.

Biopsy revealed it was a fungal lesion.

Surgery - Cadwel Luc surgery was done. Further, a post surgical template was given.

After 20 years, patient reported with poor oral hygiene and associated caries and acute gingivitis.

Removable Acrylic Prosthesis, complaining of carious teeth and impaired function.

Diagnosis & Treatment plan:

Patient with unilateral maxillofacial defect with acrylic articulator.

OBSERVATIONS:

On Extraoral examination - Difficulty in speaking, limited mouth opening and post facial burns.

On intraoral examination - Poor oral hygiene, Grossly carious 16,22,23,24,25,26,27,38.

Clinical Procedure:

Oral prophylaxis and curettage to be done.

Grossly decayed teeth to be marked for extraction.

Carious teeth with pulpal involvement to be marked for endodontic treatment.

Diagnostic cast to be surveyed, treatment plan to formulated for a cast partial frame.

Due to limited mouth opening, a conventional cast partial with clasps could not be planned.

A cast partial frame with PRECISION ATTACHMENT RHEIN83, with a hollow bulb is planned to be rehabilitate the maxillofacial defect.

Treatment (16/8/14-20/9/14):

Treatment commenced on 16/8/2014.

Scaling and curettage was done.

All root stumps and grossly decayed teeth beyond recovery (16, 22, 23, 24, 25, 26, 27, 38) were extracted.

Carious teeth with pulpal involvement (17, 15, 14, 13, 12, 11, 21, 36, 37, 44) were endodontically treated.

Endodontically treated teeth were then prepared to receive PFM crown/bridge.

Primary impressions were made with alginate for temporization

Final impressions were made with PVS, jaw relations were recorded.

Wax modulation included:

(i) Crown/Bridge

(ii) Rhein 83 OT cap precision attachment in rel. to 16, 21

Cast metal frame was fabricated

The maxillofacial defect was rehabilitated with a hollow bulb obturator, to aid in phonetics.

Treatment ended on 29/9/2014.

Conclusion:

This clinical procedure was chosen to rehabilitate a patient , with a defect and associated dental caries in multiple teeth .and the patient's financial limitations and increased retention was needed.

Advantages of Rhein83 Attachments being of Superior design ,Economic,Easily castable components, and a Wide range of options.

Review of literature of palatal :

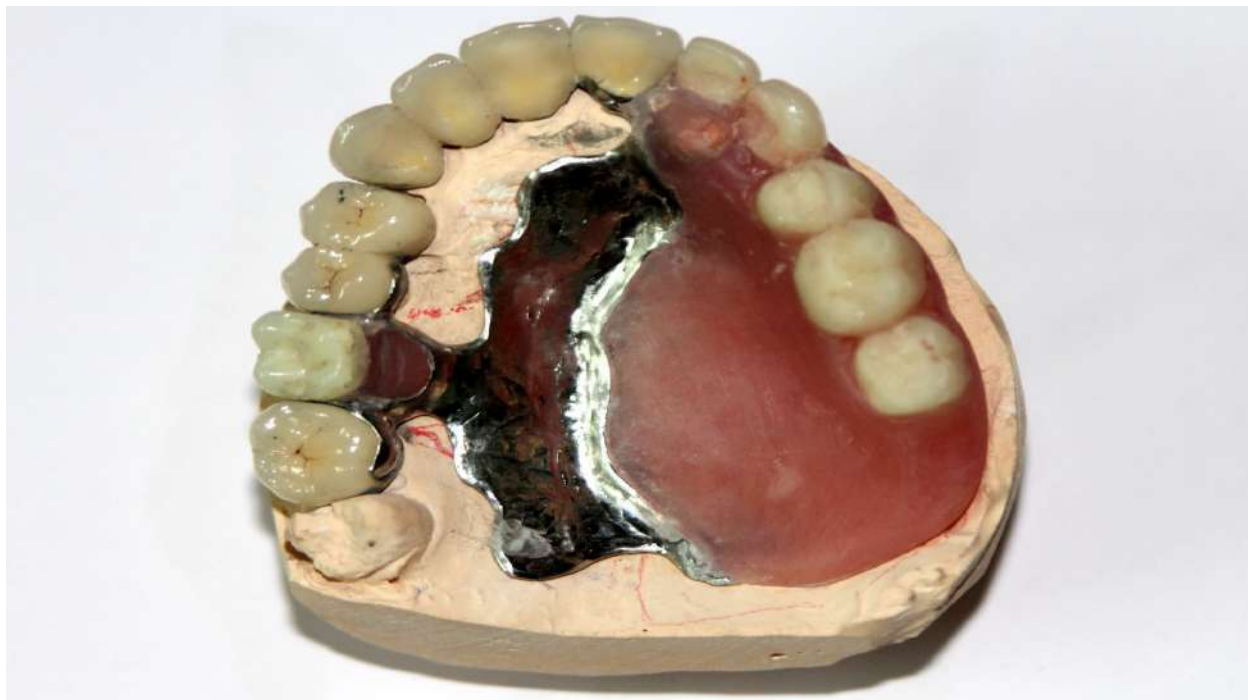
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Author:

Dr.VIKAS .B.V.J. M.D.S,
PROSTHODONTIST.
Email : occlusion_vikas@yahoo.com
+91 9849014710

Dr. AYESHA SAMEERA . M.D.S,
ORAL PATHOLOGIST.

Closure of Midline Diastema using Direct Composite Layering Technique: A Case Report

Sivaashinii Maniyarasu

Department of Family Dentistry, Faculty of Dentistry, MAHSA University

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1. Introduction

Spacing between teeth is a part of the normal dentition. However, spacings more than 0.5mm are considered to be esthetically displeasing by some people. Most patients often complain about the compromised esthetics due to the presence of maxillary anterior spacing or a midline diastema. It has been reported that the maxilla has a higher prevalence of a midline diastema than the mandible [1].

Several factors predispose a patient towards this condition. Apart from hereditary and racial predisposing factors, abnormal frenal attachments, ugly duckling stage in mixed dentition, microdontia (peg laterals), presence of a mesiodens, congenitally missing teeth, abnormal pressure habits from a tongue thrust or digit sucking, and trauma leading to tooth loss in the incisor region may be the causes of a midline diastema occurrence [2]. In a deciduous dentition, the presence of a midline diastema is transient and is actually a healthy sign as it provides adequate amount of space for the succedaneous teeth to erupt [2].

Direct composite resin restoration in diastema closure cases gives the dentist and the patient complete control in the formation of a natural smile [3]. Recent esthetic composite resin materials have similar physical and mechanical properties to that of the natural tooth and possess and appearance like natural dentin and enamel [4]. An expanded range of shades and varying opacities are offered by these recent composite materials compared

to the earlier brands of composite resin which only provided “body” shades and appeared dull and dense [4-5].

This case report describes direct midline diastema closure using a composite layering technique.

2. Case Report

A 37 year old, Indian, male patient reported to the Department of Family Dentistry, Faculty of Dentistry, MAHSA University with a chief complaint of spacing in the upper front tooth region. The patient claims to have had the spacing since he was younger. No positive systemic conditions were revealed. On intraoral examination, presence of spacing in between the maxillary central incisors, approximately 5mm, was noted due to the presence of a high labial frenal attachment. No dental caries were seen clinically. Taking into consideration the conservative, economical and esthetic factors, a direct composite build up was advocated.

Firstly, shade selection of the composite in relation to the teeth was done. Kerr’s Neofill nano composite shade A3 and A3.5 were selected to be used together to simulate the natural tooth color appearance. Then, retention grooves were created on the proximal surfaces of the maxillary central incisors followed by cleaning of the teeth with pumice and water. The teeth were then dried and cotton roll isolation was done. The mesial aspect of the teeth were etched with Eco-Etch etching gel containing 37% phosphoric acid for 15 seconds, rinsed and dried. Following etching, Tetric N-Bond bonding agent was applied and gently air-dried to leave a uniform layer and then light cured for 20 seconds. Composite shade A3.5 was first used at the cervical region of the teeth and shade A3 was then blended to it as incremental build up was done towards the incisal region. A mylar strip was placed in between the two mesial restoration to create natural interdental space. The composite resin was light cured with each incremental layers. The final restoration was finished on the labial and palatal aspect with a slow speed white

stone diamond bur and interdental areas were finished with the interdental strips (Super-Snap Polystrips). Finishing and polishing was done until ideal contour and appearance of the teeth was achieved.

Oral hygiene instructions were given to the patient. The patient was also motivated to follow up for recall appointments at 6 months interval.



Figure 1 : Pre-operative photograph showing the midline diastema.



Figure 2 : Post-operative photograph showing the closure of midline diastema by direct composite restoration.

3. Discussion

The direct composite restoration for closure of a midline diastema can be done in a single visit. Study models or diagnostic wax ups are usually not necessary. Due to the entire procedure being done only clinically, extra laboratory fees are not required such as in the case of placing a porcelain crown, for example. Also, in the event of an unforeseen fracture, they can be repaired easily compared to the costly and time-consuming repairs or remakes for porcelain alternatives [6]. Composite resins are also non-damaging to the opposing dentition as compared to porcelain or ceramic materials [7].

Several disadvantages are also present with the use of direct composite resin restorations. Most composite materials possess less fractural toughness, shear and compressive strength and are not ideally suitable for ultra-high-stress areas found in certain clinical situations [8, 9]. In cases of a Class III malocclusion with an edge to edge incisor relationship, bruxism or nail biting habit, the direct composite restoration's longevity may be compromised [5, 10].

In conclusion, direct composite resin restorations are functionally and esthetically stable in addition to being cost and time effective for the treatment of a midline diastema.

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Title:

Is single implant-retained mandibular overdentures clinically viable treatment option?

Author:

Pravinkumar G. Patil BDS, MDS, Affiliate-fellow AAMP(USA), MFDS RCPS(Glasg)

Prosthodontist and Implantologist

Sr Lecturer, School of Dentistry,

International Medical University, Kuala Lumpur

+601135022042, pravinandsmita@yahoo.co.in

Two implant-retained mandibular overdentures (TIMO) for edentulous mandible is a minimal standard care of treatment as per the expert consensus.¹ This consensus is made due the fact of enormous evidences found in several clinical studies suggesting that the TIMO significantly improve the quality of life of edentulous patients as compared to conventional complete dentures.



Fig. 1. Two free standing implants with attachments retaining mandibular overdenture.

The concept of single implant-retained mandibular overdentures (SIMO) was introduced by Cordioli² in 1993 and later he and his colleagues also published the first 5-year results in 1997 with implant success rates of 100%.³

Benefits of the SIMO can be listed as:

1. Reduced cost: The approximate ratio of the cost of the treatment of the SIMO versus TIMO is 1:1.7⁴
2. No nerve and vessel injury: Chances of Inferior alveolar nerve and vessels injury are minimized.
3. Less surgical time⁵
4. Less post-surgical maintenance time⁵
5. Less time to modify mandibular denture⁵
6. Less chances of surgical complications.
7. Simplicity: The treatment becomes simple because single implant eliminates the need to place (2) implants parallel to each other and at the same horizontal level.



Fig. 2. Single median implant with attachment retaining mandibular overdenture.

Walton et al⁵ studied total 86 patients for their satisfaction and prosthetic outcomes after treating the dentures with 1 or 2 implants with conventional loading protocols and

concluded that the SIMO is a satisfactory treatment alternative against the standard treatment care of TIMO. The SIMO system has the similar biomechanical effects to that of TIMO in terms of lateral forces to the abutment and denture base movements under molar functional loads.⁶ Liu et al⁷ carried out 3D finite element analysis to evaluate the strain distribution in peri-implant bone, stress in the abutments and denture stability of mandibular overdentures anchored by different numbers of implants under different loading conditions, through the and concluded that the number of implants does not significantly affect the strain pattern. In recent years, the clinicians are frequently using immediate loading protocols for both fixed and removable implant supported restorations simply due to the fact that it saves treatment-time and treatment-cost and patient can enjoy immediate esthetic and functional experience. Additionally, with complete overdenture, it may help reducing the postoperative pain and discomfort, since the soft tissue of the surgical wound is not loaded with the denture during healing.⁸ In 2007, Liddelow and Henry⁴ reported on a 100% implant-survival rate of immediately loaded implants after 36 months of observation when implants with oxidized surfaces were used. Recently (2018) de Souza Batista et al⁹ carried out a systematic review and meta-analysis to verify the clinical viability of SIMO. Total 9 prospective randomized clinical trials (RCTs) were reviewed for final analysis. They found that total of 205 implants were placed in patients with a mean age of 64.1 years; the cumulative survival rate was 96.6% over a mean follow-up period of 37.3 months. They further concluded that the SIMO with a complete denture as the opposing arch may be considered an alternative treatment for completely edentulous patients. However, this study also confirmed the need for more RCTs on this topic.

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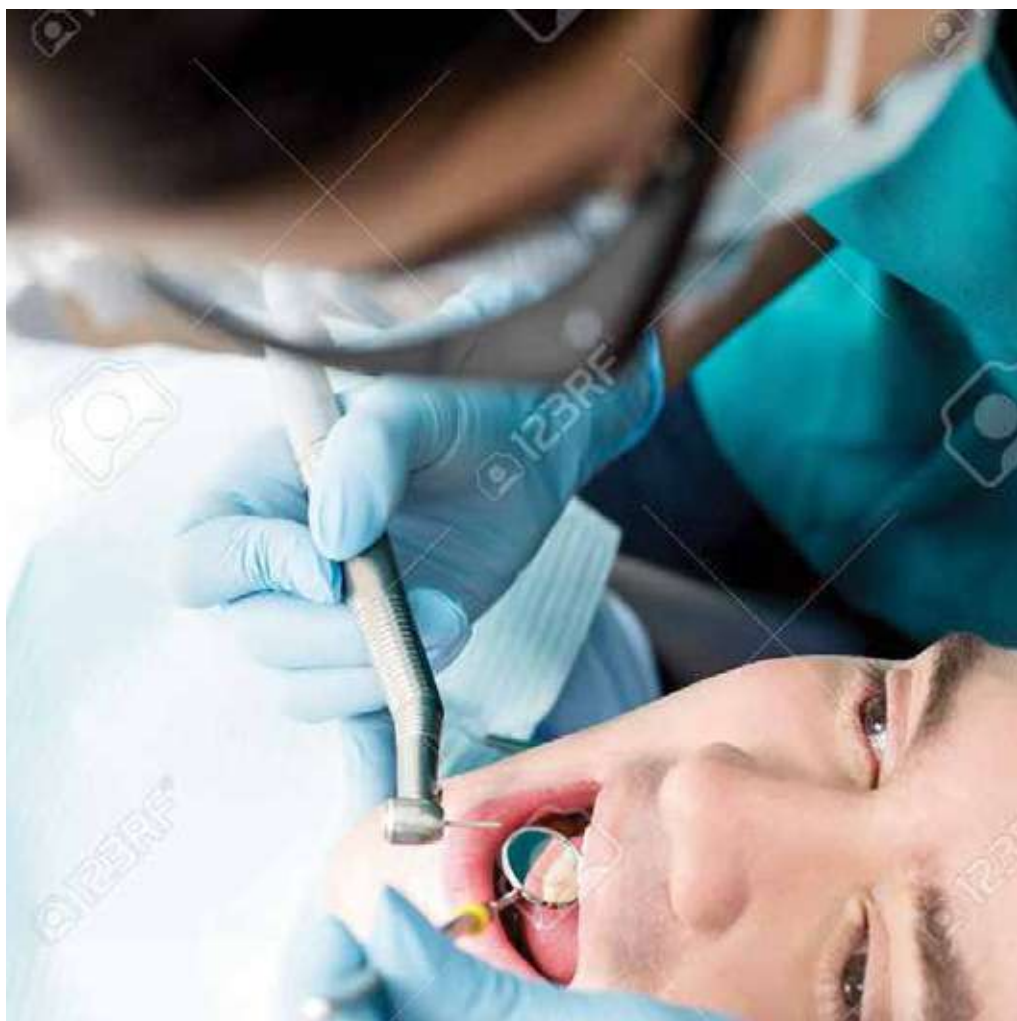
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Professional Indemnity Insurance For Dental Practitioners

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This scheme is comprehensive and has taken account of the current trends and responsibilities of the dental practitioner and also the latest legal developments (Private Healthcare Facilities & Services Act).

We have also thought of the retiring practitioners for whom we are offering continued cover. This means as a retired practitioner, you need not worry about impending issues which may arise out of work done prior to your retirement. Hence, you can have peace of mind even after your retirement.

We have also introduced cover for Malaysian Dental Council disciplinary hearings, not usually provided by commercial Insurers.

Being an exclusive scheme for dental practitioners, the inevitable need for locums is recognized and it is incorporated as a special feature at request. Also amongst the highlights of the scheme is the indemnity cover for Government Dentists practicing as locums in private practices.

Apart from the enhanced coverage, we trust that you will be comfortable with the scheme as it is underwritten by Zurich General Insurance Malaysia Berhad, one of the world's leading insurance groups.

The scheme is managed by Medical Risk & Claims Management Services, a specialty services company offering medical risk management services. MRCM Services has been actively involved in the development and further enhancement of the pioneer locally underwritten Professional Indemnity Scheme for General Medical Practitioners which was first introduced in 1994. As scheme managers, MRCM Services has managed to maintain the premiums at affordable rates without any abrupt increases since its introduction.

MRCM Services has a highly qualified consultant on board to provide valuable advice and expertise. Dr. KM Ponnusamy MBBS (Belgaum) LLB (Hons) (London) CLP (Mal) has two decades of experience in medical risk management and is currently practicing as a medico-legal consultant. He has investigated and reviewed over 1,000 medico-legal claims as a specialty adjuster for insurance companies. He has represented the medical profession in the Preliminary Investigation Committee (PIC) hearings at the Malaysian Medical and Dental Council apart having been a member of the Medicine Advertising Board, the Poisons Board, Drug Control Authority and a host of others associated with medical risk management. He continues to be a member of the National Patient Safety Council at Ministry of Health and Member of the Ethics Committee of Malaysia Medical Association and Pharma Ethics Committee.

The Professional Indemnity Insurance, which when we began in 1994, was only for the General Medical Practitioners being the FIRST ever in the country. Having successfully managed the scheme for a decade, we decided to extend the scheme to General Dental Practitioners and the Pharmacists in 2004. Again they were the FIRST in the country for these Professionals.

After more than a decade, we are EXTENDING the scheme to all DENTAL Professionals, Generalist, as well as Specialists AND also to a range of Medical Specialists apart from the General Practitioners whom we have been catering for since 1994. Our track record on Our Products, Services, and Claims Management speaks for itself.

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i) General Practice	1,000,000	700	
ii) General Practice with specialized procedures	2,000,000	1,270	
iii) Specialist Practice	2,000,000	1,700	
3. Full Indemnity Cover (covers your practice both in public and private sectors, doing general dentistry)	1,000,000 2,000,000	950 1,250	
Private Dental Practitioners			
1. General Dental Practice	1,000,000 2,000,000	1,200 1,400	
2. General Dental Practitioners, practising accredited specialised procedures.	2,500,000	1,700	
3. Dental Specialists (Private sector) (except Maxillo-Facial surgery which can be considered upon request)	2,000,000 3,000,000	2,200 2,700	

* The Premium is subject to an additional 0% GST and Stamp Duty RM10.

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Lecture series



PERIODONTAL THERAPY: THE ROAD TO SUCCESSFUL PRACTICE



Prof Dr. Betsy Thomas

**M.D.S (Perio) , Consultant Oral
Implantologist**

Prof Dr . Betsy is a periodontist with over 21 years of experience in handling research and imparting teaching & training to undergraduate and post graduate students. She completed her undergraduate (1985) and post graduate education (1995) from Manipal dental college .She was the recipient of Manipal research incentive award in 2010 for research and scientific publications. She obtained fellowship in oral implantology in 2011. She has authored more than 45 research papers in national and international journals. . Currently working as professor and head. Department of periodontology. MAHSA University.

ABSTRACT-Management of the periodontal diseases is a fundamental part of general dental practice. Indeed, it may be considered the foundation of general practice because unless diseases of the periodontal tissues are controlled, all other dental care will ultimately fail . This presentation discusses opportunities and challenges which the general practitioner face and hopes to provide useful information that can be put to practice.

Lecture series



MPDPA -EVENING LECTURE SERIES 1

PERIODONTAL THERAPY: THE ROAD TO SUCCESSFUL PRACTICE

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Lecture series



MPDPA - ELS 4

ORTHODONTICS FOR DENTAL PRACTITIONERS

DATE : 26. 8. 2018
DAY : SUNDAY
TIME : 1.30 PM - 5.45 PM
VENUE : MPDPA SECRETARIAT,
SUITE 525, LEVEL 5, BLOCK A3,
LEISURE COMMERCE SQUARE,
NO.9, JLN PJS 8/9, 46150, PJ,
SELANGOR

MEMBER : RM 30
NON-MEMBER : RM 30
STUDENT : RM 30
LIMITED PAX : 35



**DR.
PUVANENDRAN
BALASINGHAM**

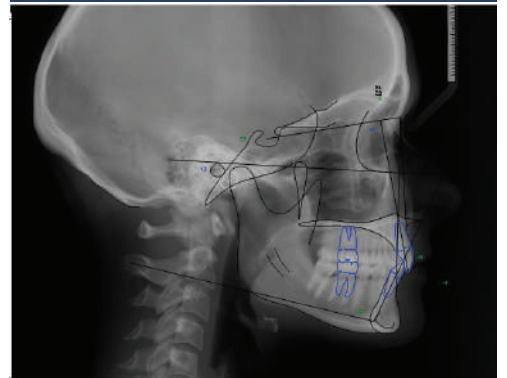
Dr Puva is an orthodontist with more than 14 years of experience in clinical practice. He completed his BDS (2004) at University of Malaya and MClintDent (2011) at Edinburgh Postgraduate Dental Institute in United Kingdom. He was awarded as a distinction student during his postgraduate study. He obtained his membership in Orthodontics (MOrth) RCSEd in 2011. He is currently working as a consultant orthodontist in Klinik Pergigian Seremban 2.

ABSTRACT

Orthodontics is an integral part of Dentistry. As a general practitioner, dental surgeon should be able to treat simple to moderate orthodontic cases. Diagnosis is the basis for an ideal orthodontic treatment outcome. Preventive, interceptive and corrective orthodontics should be practiced for a stable goal which is Aesthetics and Functions.

PROGRAMME

1.30pm - 2pm - Registration
2pm - 3.30pm - Lecture 1
3.30pm - 4pm - Tea Break
4pm - 5.30pm - Lecture 2
5.30pm - 5.45pm - Q&A and End



CONTACT US

Assoc.Prof Dr. Ratnasothy :
016-6701125
Dr. P. Mahendran:
012-2038343
Tel:03-78740606
Email: mpdpa1@gmail.com
MPDPA Account No :
MBB-564128430729

SYMPOSIUM INVITATION

MPDPA Evening Lecture Series 2

"Successful Non-Surgical Periodontal Therapy"

Featured speaker

Prof Dr Peter Galgut

*Practising Clinical Periodontist, Post Graduate Lecturer, and
Emeritus Senior Research Fellow, Eastman Dental Institute, London University
Ph.D., M.Phil., M.Sc., BDS, MRD.RCS, LDS RCS, FDS, MFGDP (UK), DDF.Hom. FHEA CUEW*

► **Time**
1500 - 1800

► **Date**
Sunday, 29 April 2018

► **Venue**
Pullman Hotel Bangsar,
Kuala Lumpur

PROGRAMME

► **Registration**
1430 - 1500

► **Lecture 1**
1500 - 1600

► **Tea Break**
1600 - 1630

► **Lecture 2**
1630 - 1730

► **Q&A session and closing**
1730 - 1800

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"Successful Non-Surgical Periodontal Therapy"

Traditionally it has been accepted the dental plaque causes gingivitis and periodontal disease with bone loss. However, many clinicians have observed people who have mouths with substantial amounts of dental plaque who have either no gingivitis or periodontitis, or have only superficial gingivitis with no periodontal pocket formation, or they have gingivitis and periodontitis. On the other hand there are those patients who seem to keep their mouths reasonably clean, but who always have some gingivitis and periodontal pocketing that does not heal, even with treatment.

Increasingly it is recognised that the dental plaque (now called microbial dental biofilm) model in the aetiology of periodontal diseases is too simplistic. Increasingly it is recognised that the aetiology and pathogenesis of periodontal diseases is multifactorial and this is affecting the way in which we manage these conditions. Yes, mechanical root surface debridement remains the primary and most important form of treatment to remove contaminating material from root surfaces but increasingly we are enhancing the effects of mechanical cleaning by relying on both topical and systemic pharmacological agents such as antimicrobials and host modulators like Gengigel to help eliminate residual infection and promote healing.

This presentation summarises emerging concepts in the aetiology and pathogenesis of periodontal diseases, and new treatment strategies for managing periodontal diseases more effectively to achieve better treatment outcomes for our patients.

Dr Peter Galgut

The Speaker:



Dr Peter Galgut

Dentist of the Year 2010
Dentist of the Year 2013

Ph.D., M.Phil., M.Sc., MRD.
RCS., B.D.S., LDS, RCS.,
DGDp, RCS., FDS, MFHom.
(Dent), FHEA., CUEW

Dr Peter Galgut is a practicing a Periodontist in North West London (England) and a World renowned Lecturer. His practice website is at www.periodontal.co.uk. He has published over 120 research papers and he has written a text book on Periodontics (Periodontics: Current Concepts and Treatment Strategies: ISBN 1-85317-981-7). He has also recently added a section to his website offering help and advice in the management of periodontal conditions for colleagues who do not have a local periodontist which can be found on his website:- www.periodontal.co.uk/professional-services/

In 2010 and again in 2013, Peter was the winner of both of the most prestigious national awards by the British Dental Health Foundation: Dentist of the Year (South) (Equivalent to England), and UK National Dentist of the Year.

Peter is still a practicing clinician, and he accepts referrals for periodontal and related oral soft tissue problems at his practice in the Garden Dental Surgery.

In addition, he continues to give lectures and seminars and hands on workshops throughout the UK and abroad, and as a qualified Expert Witness prepares dento-legal reports in cases where patients have claimed that inadequate periodontal treatment has been provided by their dentist or hygienists

MPDPA & ORAL HEALTH DIVISION of THE MINISTRY of HEALTH

The MPDPA committee, led by its President, Dr P.Mahendran, paid a courtesy call on Dr Nomah bte Taharim, who recently became the Principal Director of the Oral Health Division, of the Ministry of Health. We had a short discussion with her on a few issues, among them were,

1. The inspection of dental clinics by the OHD. Licensing, especially of Autoclaves.

In the case of practitioners having old autoclaves then the spore test can be tabulated weekly, to prove its capability.

2. Advertising

Facebook advertising, loyalty cards, packaged based treatment offers may not be in line with our code of ethics.

3. Under the new Dental Act. in case of any infringements to the practise of Dentistry, there is no need for a complainant just the relevant information is enough. Perhaps, something for us to be wary of.

4. A fee schedule for dental procedures is being drawn up, MPDPA is not represented here. At least two of our committee members should be included.

5. There are indications that the required CPD points will be lower than the current 30 points, Let us wait for the official announcement.

6. New Dental graduates will in future sit for a Professional Qualifying Exam, This will be implemented within the next 5 years, The meeting with the assurance that there will be future meetings to discuss issues as they come up.



4th MPDPA ASEAN DSA CONGRESS & TRADE EXHIBITION 2018

The 4th MPDPA ASEAN DSA Congress and Trade Exhibition

Date: 29th July, 2018

Venue : the Royal Selangor Club, City Centre, Kuala Lumpur.

Theme : " Excellence in Dental Assisting."

Speakers & Topics:

1. BASIC LIFE SUPPORT

Assoc . Prof Dr S. R. Sothy, Mahsa Univ.

2. MANAGEMENT OF DENTAL MATERIALS -GIC & IMPRESSION MATERIAL

Mr. Ramanathan Govindan, Country Manager, GC Asia Dental Pte. Ltd.

3. FRONT DESK MANAGEMENT

Dr Lo Sue Ann , Colgate .

4. CONFIDENTIALITY AND PRIVACY OF PATIENTS ' RECORDS & RESTRICTION IN ACCESSIBILITY

Dato Sri Jahaberdeen Mohamed Yunoos

125 DSAs attended and there was a Cement and Impression Mixing Competition conducted by GC. Mary Kay (M) Sdn Bhd conducted Grooming Sessions with the DSAs.

A lucky draw was held and our dental trade sponsors and individual supporters contributed to the prizes.

MPDPA takes this opportunity to thank all the speakers, dental trade exhibitors (Pureen , Colgate, GC, GSK and Mary Kay), all well wishers, the MPDPA Executive Committee for their support and contributions.

Dr Foo Gaik See

Organising Chairperson





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