MALAYSIAN PRIVATE DENTAL PRACTITIONERS' ASSOCIATION

PROBE

2022 EDITION










BE PROUD OF YOUR MOUTH

WORLD ORAL HEALTH DAY

~20th March 2022

" WE BELIEVE IN PROVIDING THE BEST POSSIBLE SERVICES FOR ALL OF OUR CLIENTS, TO ENSURE THAT THEY ARE HAPPY AND SATISFIED. WE'RE EXTREMELY FLEXIBLE, AND WORK WITH EACH CLIENT IN ORDER TO FIND A SOLUTION THAT WORKS FOR THEIR SPECIFIC NEEDS AND FINANCIAL SITUATION. FEEL FREE TO CONTACT US WITH ANY QUESTIONS REGARDING YOUR FINANCING NEEDS ".

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- Latest Income Tax or EPF Statement
- Latest Employment Confirmation Letter
- Copy of Staff ID (For selected package employers only)
- Certificate of registration with MDC

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REGISTRATION FEES : RM 625

(VOUCHER WORTH: RM 300)

** Kindly register with MPDPA.
Contact person : Dr. Jayaseel 012 670 0864 / Dr. Mahendran 012 203 8343

** All payments will be directed to MIDS organisers directly.
** Offer valid until 15th April 2022.


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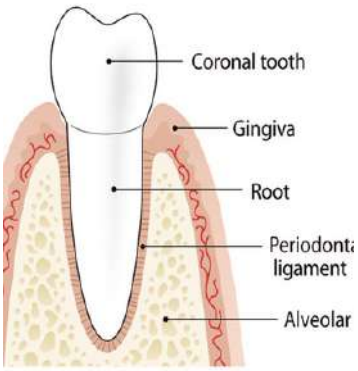

CONTACT US

Malaysian Private Dental Practitioners' Association
Suite 525, Block A3, Leisure Commerce Square,
9, Jalan PJS 8/9, 46150 Petaling Jaya, Selangor.

03- 7729 7515 / Fax : 03 - 7726 7515

Email : mpdpa1@gmail.com

Malaysian Private Dental Practitioners Association

mpdpa_1

www.mpdpa.org.my

PRESIDENT'S MESSAGE...

I am honoured to be elected to the MPDPA Presidency for 2021/2023.
My Committee and I will strive to improve on the welfare and benefits for of our members.

I would like to take this opportunity to acknowledge and commend Dr P. Mahendran's many achievements during his tenure as President. His and the MPDPA Committee's efforts in initiating the Early Vaccination Drive for MPDPA members and their staff, purchasing nitrile gloves at a discounted rate, the complimentary zoom webinars that took place during the lockdown, the Food Bank Donation Drive in collaboration with various NGOs, Bank Islam and Chubb Insurance collaborations and finally the one-day seminar on 28th Nov 2021 on Risk Management with Assoc.Prof.Dr.S.Ratnasothy, a talk and demonstration on Basic Life Support by Assoc. Prof. Dr. Abdul Ali Bin Raja Mohamed and an Open Forum Discussion with Dr.Haznita Zainal Abidin, Deputy Director, Legislation & Enforcement Unit, Oral Health Programme, Ministry of Health, Malaysia with the intention to provide an opportunity and platform for Private Dental Practitioners to address and seek clarifications in regards to issues they are encountering with the Dental Regulations and their enforcement.

My Committee and I have kick-started the year with a Fundraising Project among our generous members and friends of the Association during the recent 'Darurat Banjir' which became a national crisis.

As my team and I continue to build and grow this prestigious Association, we are currently working on a membership drive to invite Associate members and Dental students ("budding dentists") from Dental Institutions in Malaysia to join us.

MPDPA is also currently in discussion with Dr Shield (JA Assure Sdn Bhd) for a Professional Dental Indemnity Insurance scheme, in discussions with MDIA and IDAM to organise a Joint Scientific CPD Conference as well as planning many other CPD Programmes. From 2023 onwards, it will be mandatory for every dentist to collect CPD Points and to have Professional Indemnity Coverage. We hope these efforts will benefit our members.

With the recent passing of the Dental Act 2018 and Dental Regulation 586, it has left Private Practitioners confused in the many 'grey areas'. MPDPA has therefore taken the initiative to invite Prof Dato' Dr Ishak bin Abdul Razak, Pro Chancellor of MAHSA University to share an Open Forum on this matter, tentatively scheduled for June 2022.

In summary, all of MPDPA's efforts would not be possible without the continuous support from my Committee, Members of this Association and the Dental Traders who have been our pillar of support. I do hope to get more support and participation from all Private Practitioners in the near future, so that united we can stand with one voice.

I wish all of you a very good Year of the Tiger as we continue to battle through the difficulties brought on by Covid 19.

Dr. Jayaseel Ramachandran
MPDPA President
2021-2023

PUBLICATION SECRETARY'S MESSAGE....

Greetings Friends!

Yet another copy of E-Probe delivered to you!
What better way to keep you updated with MPDPA than via this platform.

The pandemic has kept us apart. Most of us have been going through a rough patch. Financially, emotionally and socially, it has affected us personally and our practices as well. But, this experience has taught us resilience. To be able to stand up taller and stronger and to fight our way forward.

Just like all of you, MPDPA took these challenges in it's stride. We took the opportunity to connect with our members and the community in need. Interpersonal relationships and communication skills with our members were restored once again by the formation of "The MPDPA Members WhatsApp Group". This has tremendously improved the efficiency of the Council members in reaching out and communicating with our members.

Also, so as not to burden our members financially, various complimentary webinars were organised during the lockdown to keep our members occupied and abreast with the advancements in dentistry. The Committee would like to thank all our guest speakers who have contributed their time and effort in these webinars.

We had reached out to the community in need through our various CSR Projects in hopes of providing those in need with some temporary aid and relief until they were able to get back on their feet again. This includes donations to various Health Care Facilities and reputable Non-Governmental Organisations, participating hands-on in the Food Bank Donation Drive and the recent Darurat Banjir by providing flood-aid assistance. We salute our members and friends of the Association who have contributed generously to these projects.

As we continue to hustle our way through 2022, we look forward to rebuilding our relationship with our fellow dental traders and friends of the Association through various collaborative efforts and events. Most definitely we look forward to meeting all of you!

Together, let's bring MPDPA back into the limelight once again!

Stay well, keep safe till our next issue!

Dr.Puang Ling Liong
MPDPA Publication Secretary
2021-2023

MPDPA COMMITTEE 2021- 2023

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VICE PRESIDENT
DR. JASPALL SINGH

HON. GEN. SECRETARY
DR. K. BHAWANI DEVI

HON. TREASURER
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DR.PATRICIA MURUGASU

COMMITTEE MEMBER
DR.T. DAVEINTHIRAN

COMMITTEE MEMBER
DR.K. SHARMILA

MEMBERSHIP DRIVE 2022

ORDINARY MEMBER

All registered qualified dental practitioners in private practice in Malaysia are eligible for ordinary membership.

One time Registration Fees : RM 150
Annually : RM 100 / every year

ASSOCIATE MEMBER

- All registered qualified Dental Practitioners in Malaysia not in private practice are eligible for Associate Membership.
- Associate Members shall be entitled to all the benefits and privileges of Ordinary Members, except that they shall not be eligible to hold office or to vote.
-Open to Expats & Foreign Dentists practicing in Malaysia with TPC (Temp.Practicing Certificate)

One time Registration Fees : RM 130
Annually : RM 80 / every year

DENTAL STUDENT MEMBERSHIP.

Annually : RM 30 / yearly.

REFER A FRIEND OR A COLLEAGUE TODAY !!

MPDPA

MALAYSIAN PRIVATE DENTAL PRACTITIONERS' ASSOCIATION

6TH MPDPA ASEAN DSA CONGRESS & TRADE EXHIBITION

POSTPONED TO AUGUST 2023 !
** A New Date & Venue will be announced later.

SUNDAY, 14th AUG 2022

8.00 AM - 5.00 PM

DORSETT KUALA LUMPUR HOTEL

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MAIN SPONSOR :

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CERTIFICATE OF PARTICIPATION

3 CPD POINTS

COVID 19 VACCINATION DRIVE

The Council Members worked alongside CKAPS to ensure Early (Covid 19) Vaccination for all of our Members and their staff.
200 MPDPA members and their clinic staff benefited from this vaccination drive.

UNVACCINATED PATIENTS.
TO TREAT OR NOT TO TREAT ?

According to the Code of Professional Conduct endorsed by the Malaysian Dental Council,
Referring to Part A: Obligations & Responsibilities:

1.1(c) A decision not to provide dental treatment to an individual because the individual has any communicable disease for which acceptable methods of protection are available, based solely upon that fact, is unethical.

1.1(d) A dental practitioner may refuse to treat a patient if:

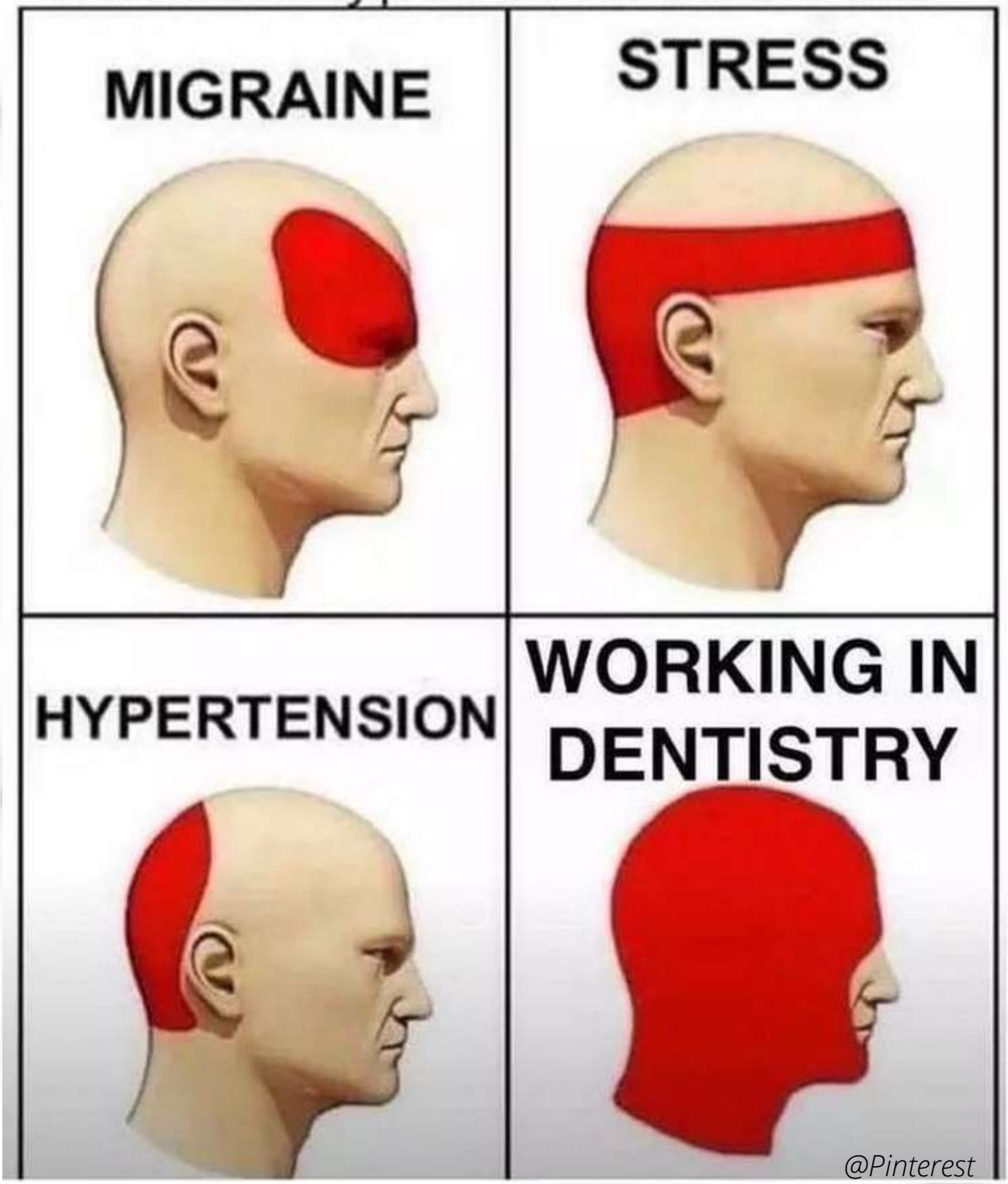
- **it is beyond his capacity to manage the patient's problems**
- **he is unable to manage the patient**
- **it is in the patient's best interest**

AND

According to The Private Healthcare Facilities and Services Act 1998 [Act 586], subsection 38(1) on Emergency treatment and services, states that ;
Every licensed and registered private healthcare facility or service shall at all times be capable of instituting, making available, essential life saving measures and implementing emergency procedures on any person requiring such treatment or services. Non-compliance to the above subsection is an offence under the Act 586.

The above information has been shared with us by Dr. Haznita Zainal Abidin, Timbalan Pengarah, Program Kesihatan Pergigian, Cawangan Perundangan dan Penguatkuasaan Kesihatan Pergigian.

Different types of head aches



DIABETES AND PERIODONTAL DISEASE (GUM DISEASE)

Professor Dr Dasan Swaminathan,
BDS(Mysore), MSc(Bristol), FDSRCS(Eng), FDSRCPS(Glasgow) FADI, FICD, FICCDE.
Professor of Periodontology
Faculty of Dentistry
Lincoln University College
Petaling Jaya.

Diabetes mellitus is emerging as a global epidemic, the complications of which have significant impact on quality of life, longevity and healthcare costs. It is estimated that 346 million people currently suffer from diabetes worldwide and the World Health Organization (WHO) predicts that this will increase to 439 million, almost 10% of adults, by 2030 (WHO 2011).

The escalating human and economic burden across both the developed and developing world necessitates a multidisciplinary approach, including adjunctive measures in managing diabetes and its complications. The onset of diabetes is caused by pancreatic beta-cell dysfunction / damage leading to increased presence of glucose in the blood circulation.

Inflammatory periodontal (gum) disease is the most common chronic inflammatory condition of adults worldwide. The destructive form of periodontal disease called periodontitis affects approximately 50% of adults and more than 60% of over 65-year old, with severe periodontitis impacting 10–15% of populations. The primary cause of periodontal disease is bacterial plaque biofilm, which if not removed by maintaining oral hygiene, will accumulate in the gum margins and interdental areas of the dentition leading to the destruction of the attachment apparatus of the teeth. This destruction of the attachment apparatus, namely the gingiva, periodontal ligament, cementum and the supporting alveolar bone, is known as chronic periodontitis. If periodontitis is not treated, it will eventually lead to tooth loss.

You may have periodontal disease if you notice :
·Red, bleeding or swollen gums
·Discharge (exudate) from the gingival tissues
·Foul taste
·Longer- looking teeth
·Loose teeth
·Increasing spaces between your teeth

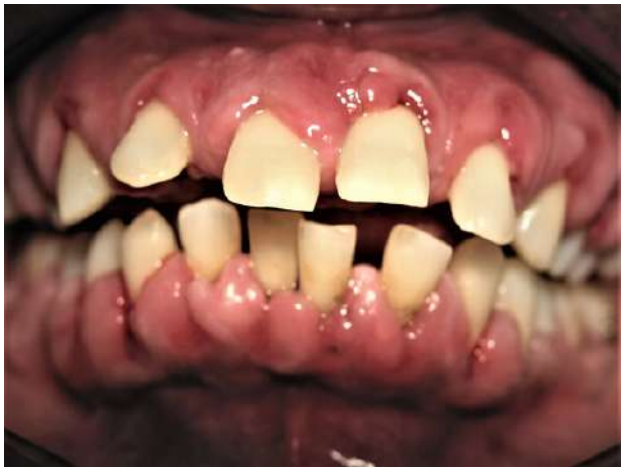
The two-way relationship between periodontal disease and diabetes

Diabetes that is not well controlled leads to higher blood sugar (glucose) levels in the mouth fluids. This promotes the growth of bacteria that can cause gum disease. On the other hand, infections from untreated periodontal disease can cause the blood sugar to rise and make it harder to control diabetes.

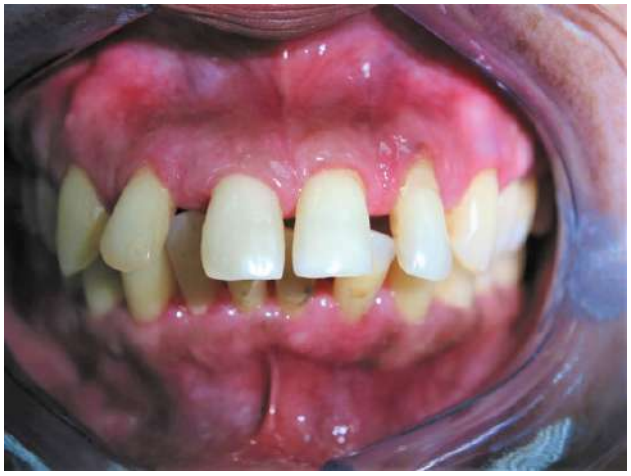
Severe gum disease (periodontitis) can negatively affect your blood sugar control and increase your chances of suffering from other common long-term complications of diabetes. The inflammation, which occurs in the gums, escapes into the bloodstream and upsets the body's defence system which in turn affects blood sugar control.
Diabetes is a systemic contributing factor to gum disease and does not directly cause gum disease like periodontitis. However, diabetes can alter the response of the periodontal tissues to bacterial plaque biofilm, speeding up the destruction of the soft and hard tissues of the attachment apparatus of the tooth and delaying healing after treatment.

Oral bacterial pathogens in diabetes

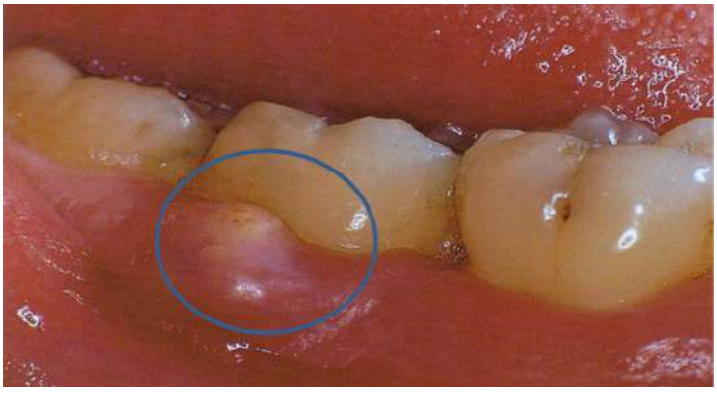
The increased glucose in the gingival fluid and blood of diabetic patients could change the environment of the oral microflora by inducing qualitative changes in the bacteria which contribute to the severity of periodontal disease.
The glucose in the oral tissues and gingival fluid also provides nutrition to the oral microorganisms leading to an increased rate of multiplication. This increased presence of the bacteria in the gum tissues will accelerate the destruction of the periodontal tissues, especially without intervention.



Appearance of the gums in a 52 year old Type 2 diabetic before treatment. Her oral hygiene is very poor leading to gum swelling, soggy appearance of the gums, redness and increased exudate from gum tissues.



Appearance of the gums 3 months after gum treatment. Although the oral hygiene is not satisfactory, the inflammation of the gums shows some resolution. The gum has taken a pinkish hue and firmer appearance.



The appearance of the gums on the lower right molar in a 57 year old male patient with poorly controlled type 2 diabetes.
Periodontal abscess associated with the molar tooth which requires immediate attention. Periodontal abscesses can occur in patients with poor glycemic control due to the presence of glucose in the periodontal tissues providing nutrition to the bacteria.

Clinical images adapted from Prof Dasan's collection.

Patients with diabetes attending oral healthcare clinics for the first time.

Patients who have just been diagnosed with diabetes, whether Type 1, Type 2 or gestational should be informed that they are at higher risk of periodontal disease and should get a dental check-up as soon as possible.

Diabetics attending oral health clinics for the first time should preferably schedule their appointments in the mornings. They should take their diabetic medications before their scheduled dental appointment and they should inform the oral healthcare professional of the medications that they are taking. Do not take more or less of your medications prescribed by your healthcare provider.

If you have been told by your dentist that you have gum disease, you should follow up with necessary treatment as advised. This may require several appointments. Like diabetes, gum disease is a chronic condition and requires lifelong maintenance.

Patients with diabetes should also be evaluated for other potential oral complications, including dry mouth, burning mouth and candida infections.

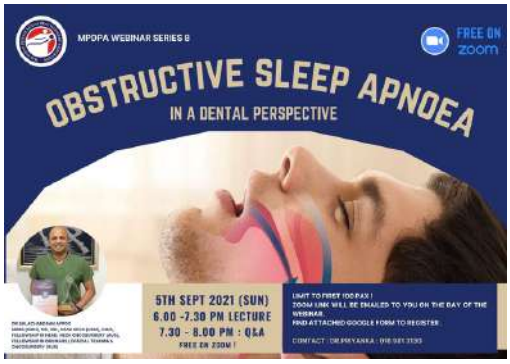
For children and adolescents diagnosed with diabetes, an annual oral screening for early signs of periodontal involvement is recommended starting at the age of 6 years.

If you do not have diabetes, but your dentist has identified some risk factors for diabetes including signs of worsening gum disease, it is important to get a medical check-up as advised. Your medical doctor can order blood tests to see if you have diabetes and can provide proper advice and care based on the results. Remember to inform your dentist about the outcome of your visit to the medical doctor.

The immune response of an individual with diabetes (especially when poorly controlled) and periodontal disease will be adversely affected. This may pose an increased risk of succumbing to infections such as Covid-19 and also for a more severe toll on the individual.

It is important to keep your mouth and your whole body as healthy as possible with proper oral hygiene, regular oral health and medical care.

WEBINARS


MPDPA WEBINAR SERIES 8
FREE ON zoom
OBSTRUCTIVE SLEEP APNOEA
IN A DENTAL PERSPECTIVE
5TH SEPT 2021 (SUN)
6.00 -7.30 PM LECTURE
7.30 - 8.00 PM : Q&A
FREE ON ZOOM !


FREE ON zoom
MPDPA WEBINAR SERIES 4
8pm
SUNDAY
4th
JULY 2021
' BEYOND THE ORBICULARIS ORIS ' -
FACIAL THERAPEUTICS & COSMETIC ENHANCEMENT USING NEUROTOXINS & DERMAL FILLERS
BY DENTAL PRACTITIONERS


THE MALAYSIAN PRIVATE DENTAL PRACTITIONERS' ASSOCIATION
MPDPA WEBINAR SERIES 6
PAIN MANAGEMENT & STRESS IN YOUR PRACTISE WITH CLINICAL HYPNOTHERAPY
6pm
25th
JULY 2021
Meeting ID : 894 5532 5863
Password : mpdpa
*Please dial in early. Zoom Room will be open from 5.30pm onwards.
*Entry to Zoom is based on first come first serve - as we are at full capacity for this webinar.
*Please do not log in-log out repeatedly as you will deprive someone else from joining the webinar.
*Ensure your name registered in google form is THE SAME as your name appearing on Zoom
*E-certificate will only be given to participants with full participation.

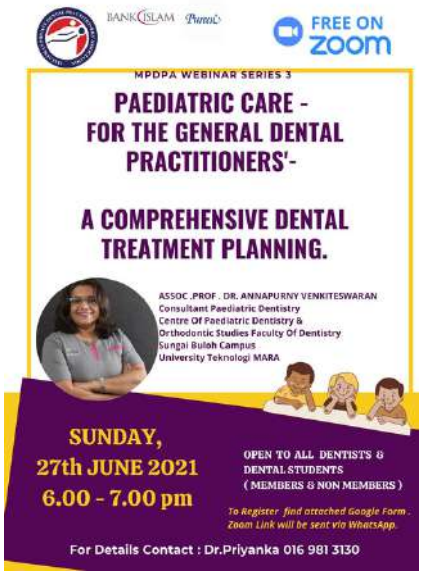

THE MALAYSIAN PRIVATE DENTAL PRACTITIONERS' ASSOCIATION
MPDPA WEBINAR SERIES 9
A POTPOURRI OF ORTHODONTICS
8pm
SATURDAY
18th
DEC 2021
Meeting ID : 858 0509 2883
Password : mpdpa
*Please dial in early. Zoom Room will be open from 7.30pm onwards.
*Entry to Zoom is based on first come first serve - as we are at full capacity for this webinar.
*Please do not log in-log out repeatedly as you will deprive someone else from joining the webinar.
*E-certificate will be emailed to participants with full participation only!

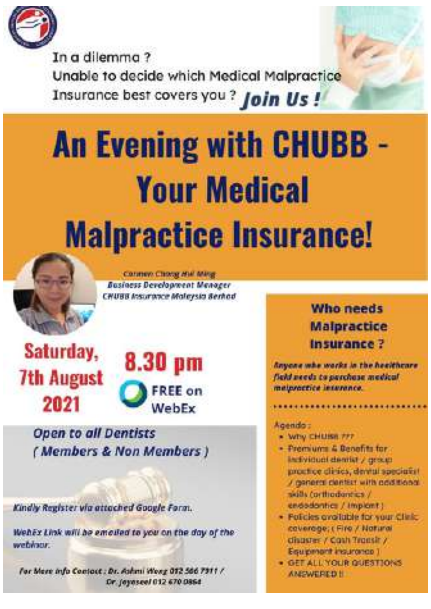

THE MALAYSIAN PRIVATE DENTAL PRACTITIONERS' ASSOCIATION
PANORAMIC X-RAY EVERYTHING A DENTAL PRACTITIONER NEEDS TO KNOW
6pm
SUNDAY
13th
JUNE 2021
Meeting ID : 815 0071 2988
Password : MPDPA
** Please dial in using a computer device ; desktop or laptop for better visibility of the slide presentation.


THE MALAYSIAN PRIVATE DENTAL PRACTITIONERS' ASSOCIATION
TROUBLESHOOTING : DAY TO DAY IMPLANT PRACTICE.
6pm
SUNDAY
18th
JULY 2021
Meeting ID : 835 7122 0585
Password : mpdpa

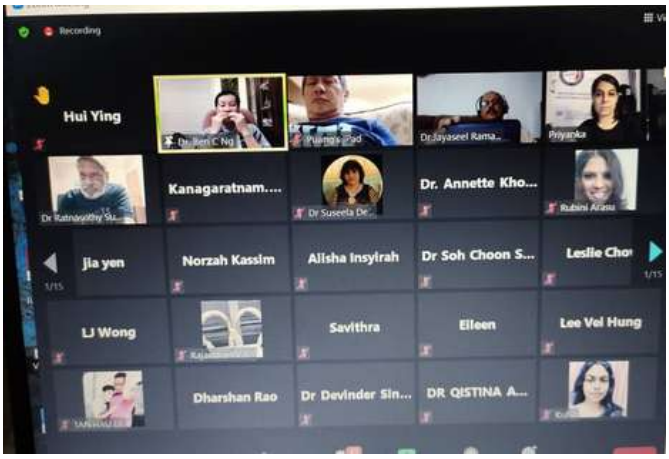

THE MALAYSIAN PRIVATE DENTAL PRACTITIONERS' ASSOCIATION
PRACTICE SAFE DENTISTRY & KNOW YOUR LIMITS !
5pm
30th
MAY 2021
Meeting ID : 875 2011 9154
Password : mpdpa


Meeting ID : 833 0497 9523
Password : mpdpa
Common Mishaps Of Oral Surgery - In General Dental Practise.
6pm SUNDAY 1st AUG 2021
Please ensure you Log in with your FULL NAME ONLY !
Failing to do so- organisers have the right not to admit you / remove you anytime during the webinar.
Zoom Room will be open from 5.30pm onwards - please dial in early as entry is based on first come-first serve.
Your attendance for E -Certificate will be taken upon entry to the Zoom Room.
E Certificate will be issued via email to participants with FULL Participation only.


FREE ON zoom
MPDPA WEBINAR SERIES 3
PAEDIATRIC CARE - FOR THE GENERAL DENTAL PRACTITIONERS'-
A COMPREHENSIVE DENTAL TREATMENT PLANNING.
ASSOC. PROF. DR. ANNAPURNY VENKITESWARAN
Consultant Paediatric Dentistry
Centre Of Paediatric Dentistry & Orthodontic Studies Faculty Of Dentistry
Sungai Buloh Campus
University Teknologi MARA
SUNDAY, 27th JUNE 2021
6.00 - 7.00 pm
OPEN TO ALL DENTISTS & DENTAL STUDENTS (MEMBERS & NON MEMBERS)
To Register find attached Google Form . Zoom Link will be sent via WhatsApp.
For Details Contact : Dr.Priyanka 016 981 3130


In a dilemma ?
Unable to decide which Medical Malpractice Insurance best covers you ? Join Us !
An Evening with CHUBB - Your Medical Malpractice Insurance!
Carmen Chong Bik Ming
Business Development Manager
CHUBB Insurance Malaysia Berhad
Saturday, 7th August 2021
8.30 pm
FREE on WebEx
Open to all Dentists (Members & Non Members)
Kindly Register via attached Google Form.
WebEx Link will be emailed to you on the day of the webinar.
For More Info Contact : Dr. Ashni Wong 012 586 7911 / Dr. Jeyaseel 012 670 0864
Who needs Malpractice Insurance ?
Anyone who works in the healthcare field needs to purchase medical malpractice insurance.
Agenda :
Why CHUBB ???
Premiums & Benefits for individual dentist / group practice clinics, dental specialist / general dentist with additional skills (orthodontics / endodontics / implant)
Policies available for your Clinic coverage (Fire / Natural disaster / Cash Transit / Equipment Insurance)
GET ALL YOUR QUESTIONS ANSWERED !!

The Complimentary WEBINARS during the Lockdown...



Since physical seminars were not allowed during the Movement Control Order (MCOs), a series of multi - disciplinary *virtual* webinars were organised for members, non -members and dental students' to participate.

Mr. Peter Mabbutt
Clinical Hypnotherapist
Pain Management & Stress In Your Practice with Clinical Hypnotherapy

Dr. Ben C. Ng
On Beyond The Orbicularis Oris
Facial Therapeutics & Cosmetic Enhancement Using Neurotoxins and Dermal Fillers by Dental Practitioners.

Assoc. Prof.Dr.G.Padmanabha Kumar
Oral & Maxillofacial Surgeon
On Common Mishaps In Oral Surgery in General Dental Practice.

Dr. Balachandran Appoo
ENT Surgeon,
On Obstructive Sleep Apnoea, A Dental Perspective

GP SEMINAR ...

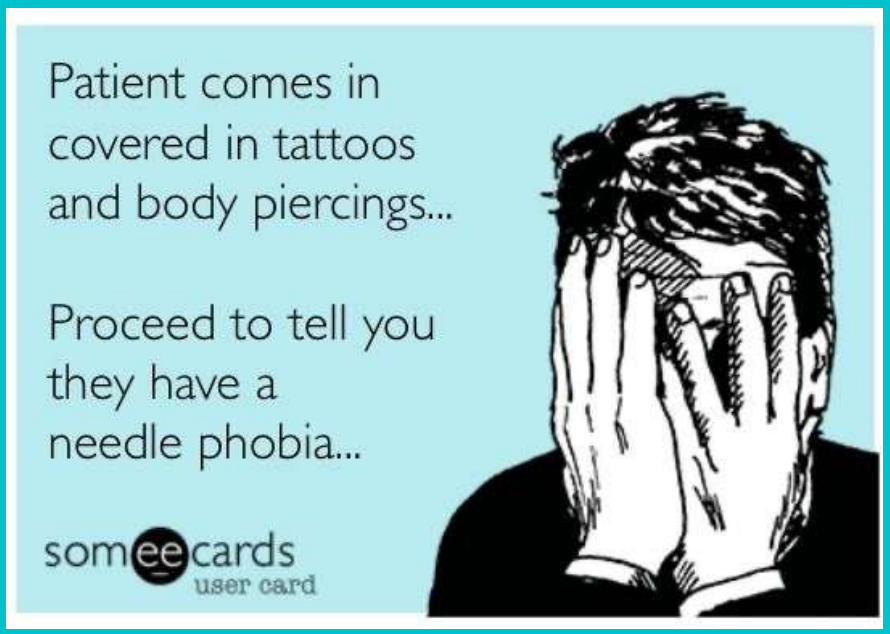
A one-day seminar was held on 28th Nov 2021 on Risk Management and Basic Life Support and an Open Forum Discussion with Dr.Haznita Zainal Abidin, Deputy Director, Legislation & Enforcement Unit, Oral Health Programme, Ministry of Health, Malaysia with the intention to provide an opportunity and platform for Private Dental Practitioners to address and seek clarifications in regards to issues they are encountering with the Dental Regulations and their enforcement.

Our Guest Speakers (From Left to Right) Assoc Prof.Dr.S.Ratnasothy, Assoc. Prof. Dr. Abdul Ali Bin Raja Mohamed and Dr. Haznita Zainal Abidin.

Participants in a hands on CPR session.


Dental Advice
The appointment time you scheduled is a commitment, not a suggestion.
Kara_RDH


Dental Appointment Tip
A heart attack, knee replacement surgery and diabetes diagnoses are all considered changes in your medical history!
Kara_RDH


Patient comes in covered in tattoos and body piercings...
Proceed to tell you they have a needle phobia...
someecards
user card

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INTRAORAL PROJECTIONS - BITE-WING AND PERIAPICAL IMAGING

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FF (OMP) [Forensic Odontology] (RCPA).

In the year 2000, the American Dental Association recognised Oral and Maxillofacial Radiology as a specialty in the USA. This specialty of dentistry and discipline of radiology is concerned with the production and interpretation of images and data produced by all modalities of radiant energy that are used for the diagnosis and management of diseases, disorders and conditions of the oral and maxillofacial region. Under the new Malaysian Dental Act (2018) Oral and Maxillofacial Radiology is also categorised as one of the 12 dental specialties recognised by the Malaysian Dental Council.

Radiography/imaging provides an image of the internal anatomy that is not visible on clinical examination. To interpret a radiograph/image the clinician must use his or her knowledge of normal anatomy to mentally reconstruct a three-dimensional image of the anatomic structures using information from one or more two-dimensional views. It is therefore an unravelling process to see what is happening in the body. The major objectives in sequence are ascertaining the absence and presence of diseases, determining the nature and extent of diseases, and providing information for differential interpretation and subsequently diagnoses of diseases when attaching history, clinical and histopathological findings from the patient. Therefore, radiology has a king-pin role in dentistry as images are not only involved for diagnoses, but are also needed during many endodontic and surgical treatment procedures.

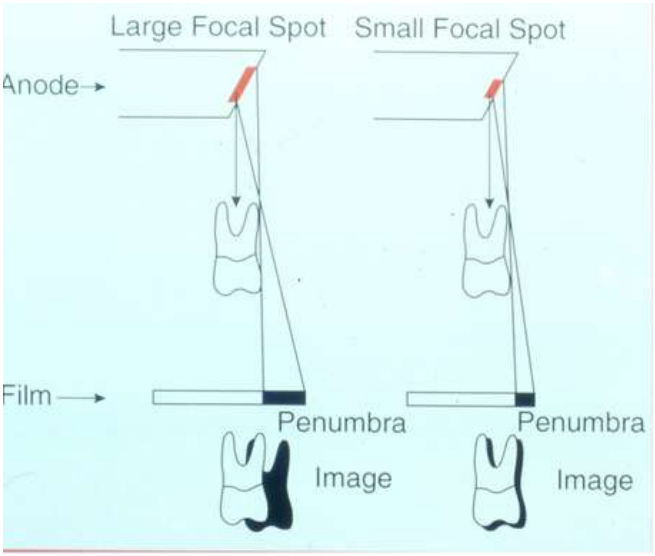
The majority of dental practitioners undertake their own radiographic/imaging work and make their own interpretations. This being so, the public has the right to expect the same standard in this area as they receive in any other dental work. In 5.1.2011, the Ministry of Health has under the Atomic Energy Licensing Act (304) agreed to allow certified Dental Surgery Assistants (DSA) to acquire intraoral images under the supervision of a practising dental surgeon. This benefit is also extended to Dental Nurses who have undergone post-basic training in radiology.

Due to the introduction of digital imaging, the terminology "radiography" which was the making of film records using radiation (x-rays) has been replaced by imaging. Images are acquired using receptors / detectors / sensors. These are charge-coupled devices (CCD), complementary metal oxide (CMOS) and photo-stimulable phosphor plates (PSP)which are then viewed on the monitor. It is often stated in radiology that what the brain does not know, the eye cannot see. Therefore, a person who interprets the images must have sound knowledge of imaging procedures, good knowledge of anatomy and pathology and also the ability to manipulate and interpret images. Interpreting the imaged records intelligently for the benefit of the patient is termed radiology.

Image quality is a concern of any dentist acquiring images. This refers to the exactness in detail with which an anatomical structure/region is represented on the radiograph/image. The image quality depends on image sharpness, spatial resolution, contrast resolution and any distortions including elongations and foreshortening. Sharpness is defined as being able to determine the edge between two areas of differing radio-density (e.g. enamel and dentine at DEJ). Spatial resolution is dependent on the pixel size and is the ability to differentiate between two different structures placed very close together on the image. Gray scale resolution is dependent on BITs (binary digits) of the sensor and displays the final difference between the various black, white and grey shadows in the image. Therefore, the best images are with the optimal sharpness and resolution and without any distortion of structures.

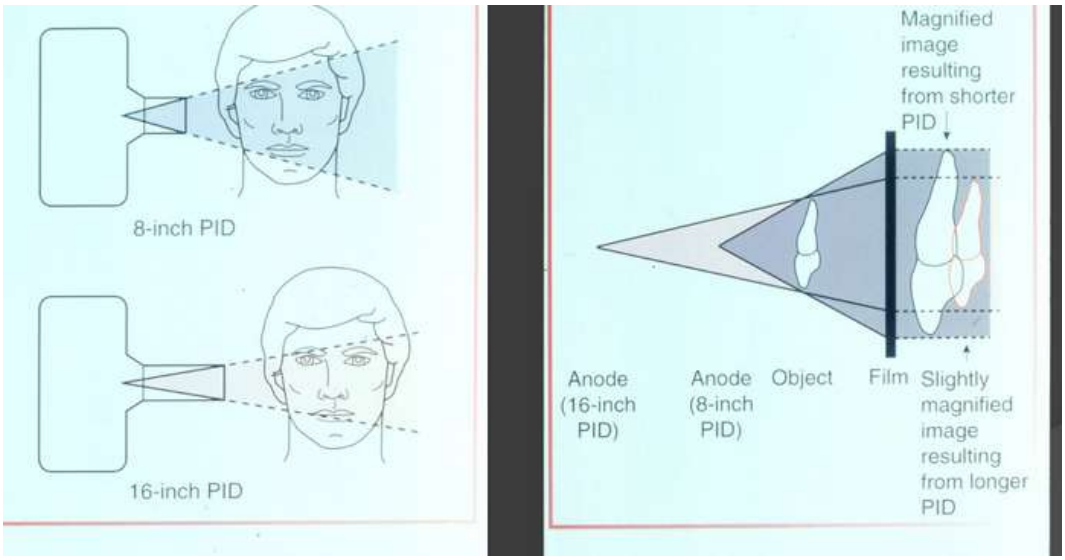
The following principles of projection geometry are important for ideal intraoral radiography/imaging:

1.The focal spot should be as small as possible.



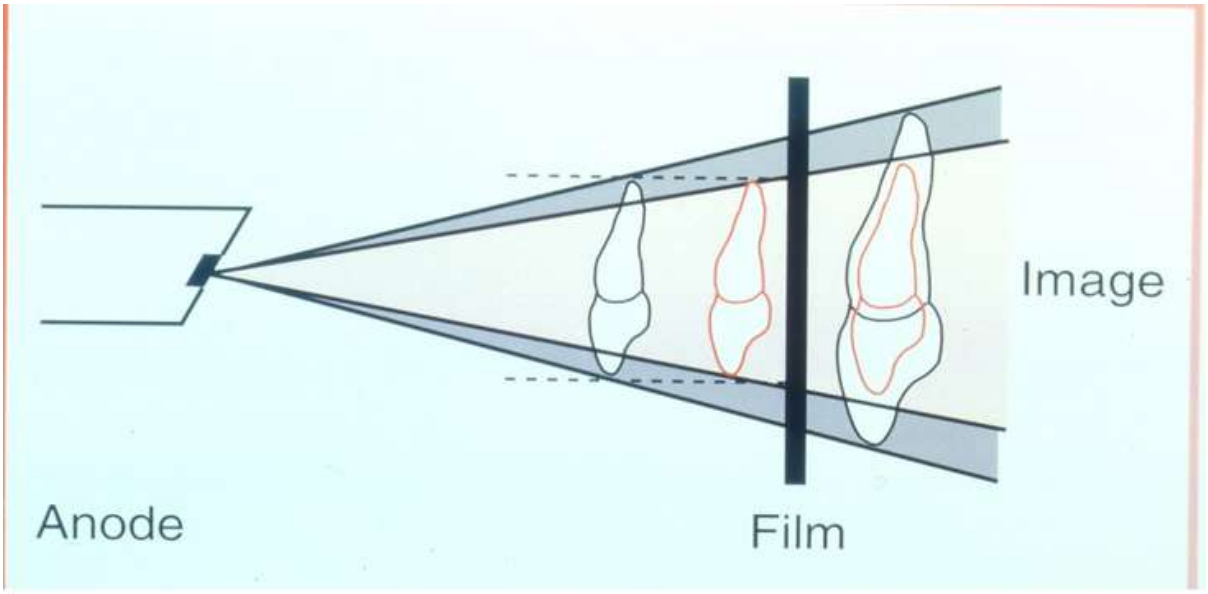
The larger the focal spot area, the wider the zone of blurriness and this is called the penumbra effect. The effective focal spot sizes in dental x-ray machines range from 0.4 to 0.7 mm.

2.The source - receptor distance should be as long as possible.



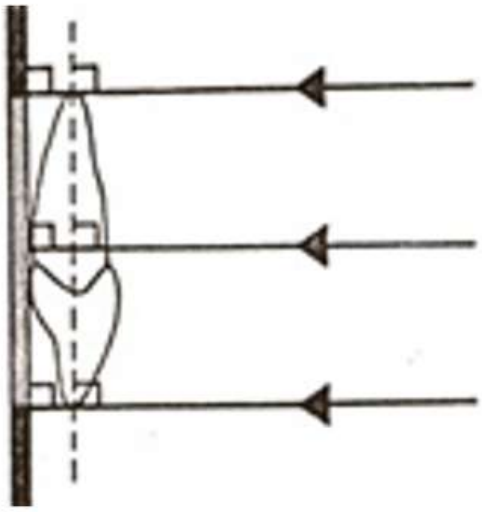
To prevent the magnification of structures in the image, a parallel, non-diverging, X-ray is required. This is achieved usually by having a larger X-ray source and skin distance. The ideal would be source-receptor distance of at least 16 inches. Less than 8 inches, then this technique is not suitable as there is magnification of structures and wider exposure of the patient to X-rays.

3.The structure (object)- receptor distance should be as small as possible.



Less magnification when object is closer to the receptor.

4.The receptor should be parallel to the long axis of the object.



Parallel X-ray beam meeting both the object and film at right angles

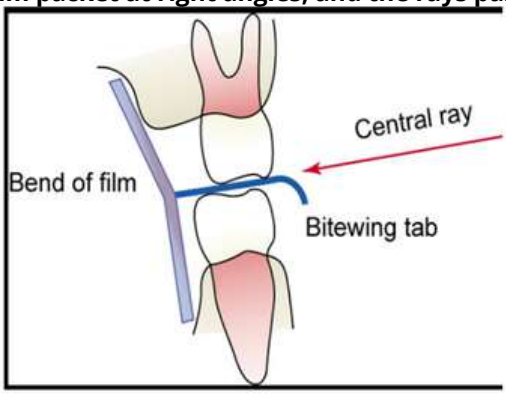
5. The central beam should be perpendicular to the object and the receptor.

BITEWING IMAGING (RADIOGRAPHY)

Bitewing radiography takes the name from the original technique which required the patient to bite on a small wing (tab) attached to an intraoral film packet. Digital image receptors can be used and the clinical indications are the same. An individual film is designed to show the crowns of the premolar and molar teeth on one side of the jaws.

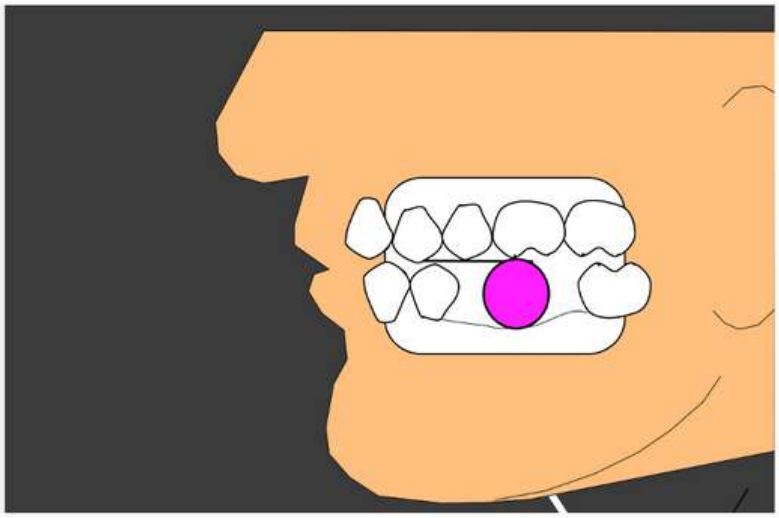
Main indications:
-Detection and assessment of interproximal dental caries.
-Detection and assessment of the extent of occlusal caries.
-Monitoring the progression of dental caries.
-Assessment of existing restorations, discolored tooth with suspicion of secondary caries.
-Assessment of periodontal status; calculus deposits; chronic resorption of the alveolar bone.
-Pulp chamber shape and size; pulp stones.
-Occlusal relationship of teeth may be considered.

The vertical angulation is always set at (+) 5-80 (the tubehead is pointing downward). Make sure the patient's head is positioned properly before attempting the cone alignment. This angulation is used to compensate for the slight bend of the upper portion of the film and the tilt of the maxillary teeth-curve of Monson (also to prevent overlap of the cusps onto the occlusal surface. In the horizontal plane the X-ray cone should be aimed so that the beam meets the teeth and the film packet at right angles, and the rays passes directly through all the contact areas.

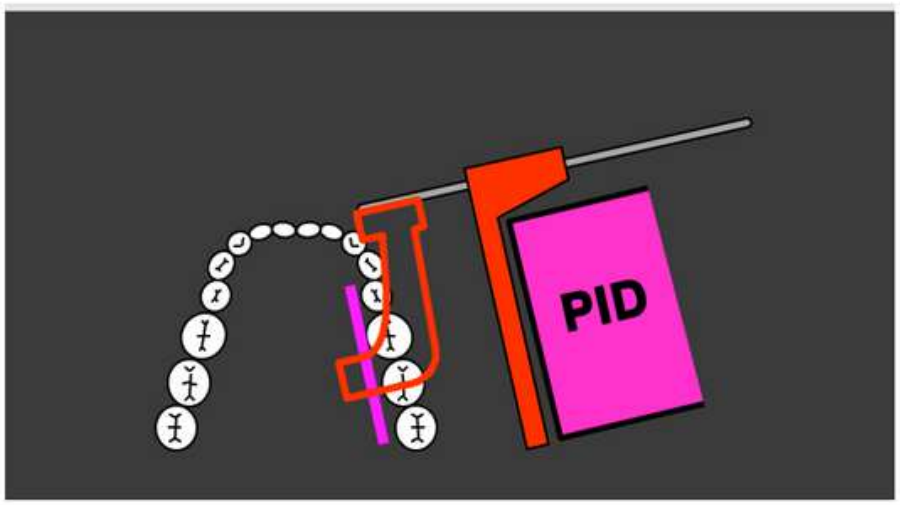


Two posterior bitewing views are recommended for each quadrant- a premolar and a molar.

The film packet is held firmly by the occluding opposing teeth and cannot be displaced by the tongue. Position of the X-ray tube-head is determined by the holder, thus is less operator dependent, ensuring that the X-ray beam is always at right angles to the film packet. In the case of an edentulous area, place a cotton roll to replace the lost teeth.

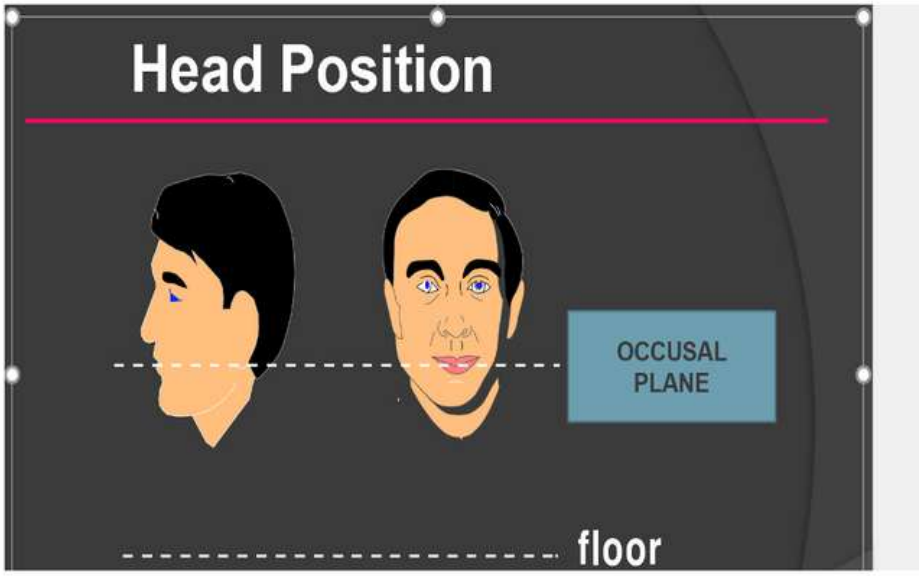


Several simple film and receptor holders have been produced. They can eliminate many of the disadvantages of the arbitrary tab method. The choice of holder is a matter of personal preference. The 3 parts of the holder are :
- a mechanism for holding the receptor/film packet parallel to the teeth.
- a bite-platform that replaces the wing.
- an X-ray beam aiming device (locator).

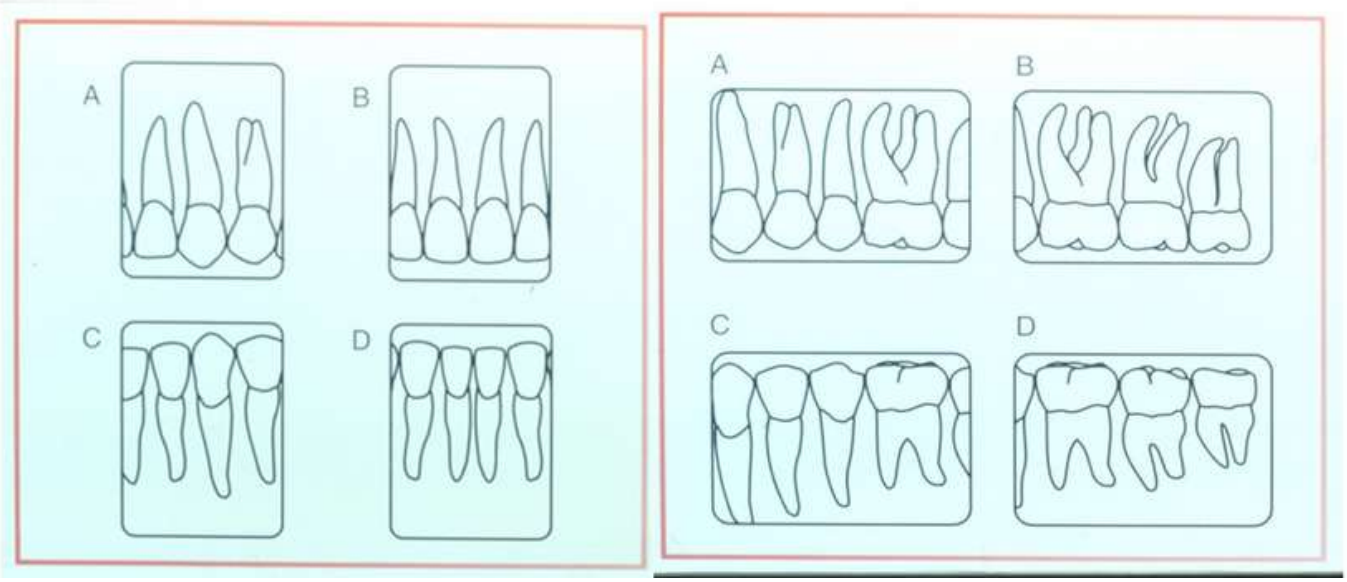


PERIAPICAL IMAGING

Describes intraoral techniques designed to show individual teeth and tissues around the apices. Each image receptor usually shows two to four teeth and provides detailed information about the teeth and the surrounding alveolar bone. The receptor is inside the oral cavity and the X-ray beam at various angles from a position outside the mouth.



Head position when acquiring intraoral images.



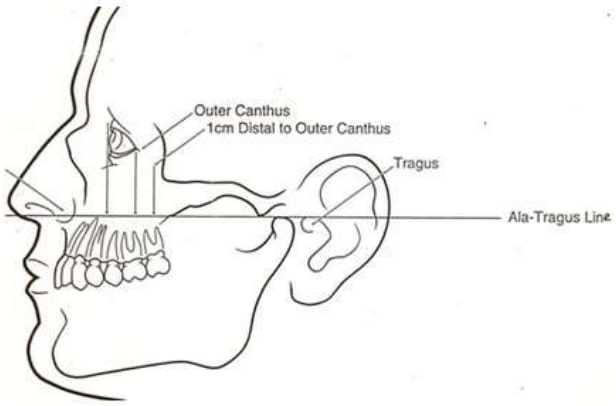
Anterior teeth are recorded vertical and posterior teeth are horizontal.

MAIN INDICATIONS FOR PERIAPICAL IMAGING :

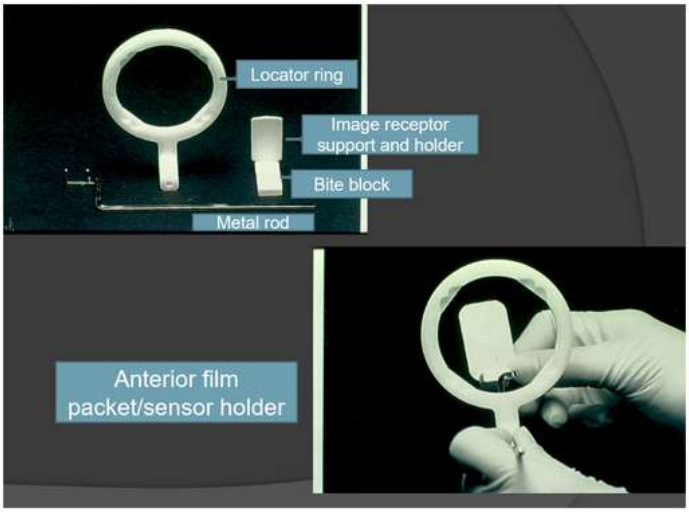
1) Presence of relevant signs and symptoms indicating periapical pathology
2) Assessment of the periodontal status.
3) After trauma to the teeth and associated alveolar bone.
4) Assessment of the presence and position of unerupted teeth.
5) Assessment of root morphology before extractions.
6) During endodontics.
7) Preoperative assessment and postoperative appraisal of apical surgery.
8) Detailed evaluation of apical cysts and other lesions within the alveolar bone.
9) Evaluation of implants postoperatively.
10) Presence of deep caries / restoration that approximates the pulp detected from bitewing images will require periapical imaging.

The anatomy of the oral cavity (palate and alveolar bone) do not always allow the ideal positioning requirements (as mentioned above). To overcome the problems of image distortions two techniques have been developed:
1) The paralleling technique
2) The bisecting angle technique

The paralleling technique-
Always remember the root tips of the maxillary teeth are not beyond the ala-tragus line.

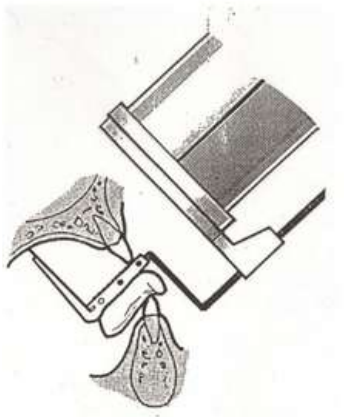
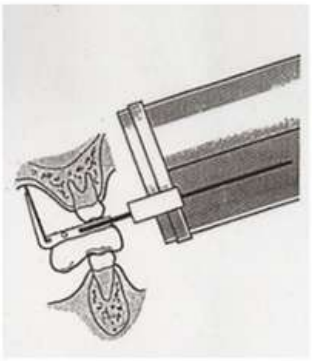


RECEPTOR HOLDERS



Holders have been developed for this technique. The components are different for the anterior and posterior teeth.

a)A metal supporting indicator rod.
b)A bite block or platform; a mechanism for holding the receptor which ensures parallel positioning of the sensor.
c) A locator (sometimes called beam aiming device).
Rectangular collimation will have the added benefit of radiation reduction of the beam size on the patient. This is done by attaching an adapter on the rim of the cone or using a locator with a rectangular aperture (rather than circular aperture).

ANTERIOR TEETH	POSTERIOR TEETH
	

It is evident that the X-ray beam is directed at 90 degrees to the teeth and receptors while the teeth and sensor are parallel to each other. Specialised holders may be available for solid-state sensors as these sensors are thicker when compared to films and PSPs.
The anatomy of the palate and the shape of the arches, means that the tooth and the receptor cannot both be parallel and in contact with each other. The receptor must be positioned some distance from the tooth. This however fulfils four of the best principles of projection geometry for ideal intraoral radiography/imaging.

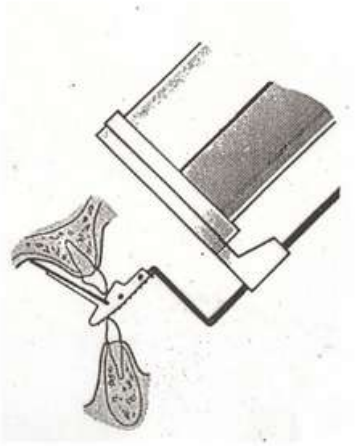
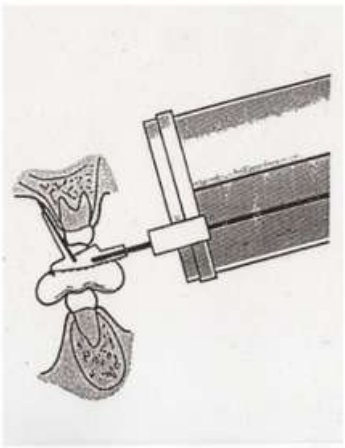
The Bisecting Angle Technique

1) The receptor is placed in the holder and positioned in the mouth parallel to the long axis of the tooth under investigation .

2) The X-ray tubehead is then aimed at right angles (vertically and horizontally) to both the tooth and the film packet.

3) By using a film holder with fixed receptor and X-ray tubehead positions, the technique is reproducible.

4) This positioning has the potential to satisfy four of the five ideal requirements mentioned earlier.

ANTERIOR TEETH	POSTERIOR TEETH
	

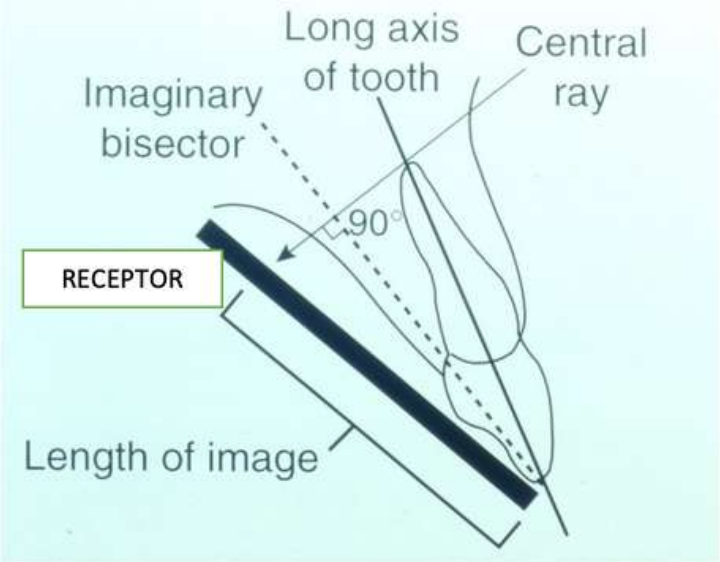
It is evident that there is a raised platform on the bite block. The principle involved ensures the morphologies of the teeth are reproduced accurately as images without any geometric distortions.

The bisecting angle technique is performed accurately by:

1) The receptor being placed as close to the tooth under investigation as possible without bending the receptor.

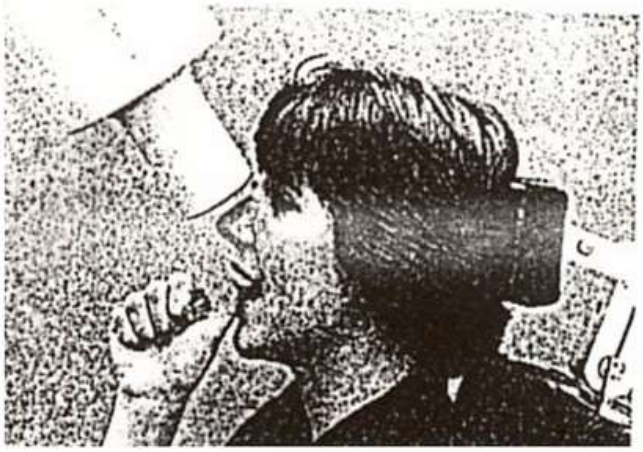
2) The X-ray tube-head being positioned with the central ray of the X-ray beam aimed at right angles to the imaginary bisecting line. This is automatically possible due to the raised platform of the bite block.

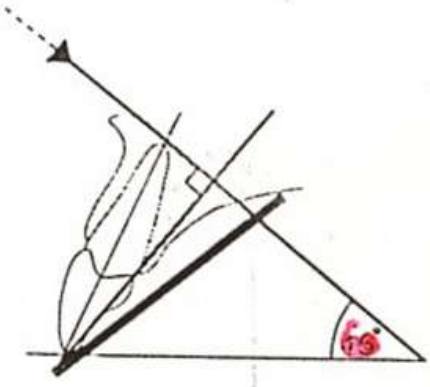
3) Using the geometrical principle of similar triangles, the actual length of the tooth in the mouth will then be equal to the length of the image of the tooth on the receptor, provided the two triangles have equal angles and a common side. It is called the rule of isometry (isometry is defined as equality of measurement).



Central ray of the X-ray beam is exposed at 90 degrees to the imaginary line.

Before the use of receptor holders, dentists used to get their patients to stabilise the film using their fingers.
This is actually the bisecting technique, and it is discouraged nowadays as the finger of the patient is unnecessarily exposed to X-ray radiation.





This finger holding technique can be employed when the patient is experiencing gagging sensation with holders. The finger needs to be disinfected.

Paralleling technique

ADVANTAGES

1) Geometrically accurate radiographic images with little magnification when compared to the bisecting angle technique.

2) The shadow of the zygomatic bone appears above the apices of the molar teeth.

3) The periodontal bone levels are well represented.

4) The periapical tissues are accurately shown with minimal foreshortening and elongation.

5) The crowns of the teeth are well shown enabling the detection of approximal caries.

6) The horizontal and vertical angulations of the X-ray tubehead are automatically determined by the positioning devices.

7) The X-ray beam is aimed correctly at the centre of the receptor-all areas of the receptor are irradiated and there is no coning off or cone cutting.

8) Reproducible images are possible during different visits,

DISADVANTAGES

1) Positioning of the film in the posterior area can be uncomfortable - gagging.

2) Positioning of the holders within the mouth can be difficult for inexperienced operators.

3) The anatomy of the mouth sometimes makes the technique impossible - e.g. a shallow, flat palate.

4) The apices of the teeth can sometimes appear very near the edge of the receptor.

5) Positioning the holders in the lower third molar regions can be very difficult.

6) The holders need to be autoclavable or disposable

Bisecting angle technique

ADVANTAGES

1) If the vertical and horizontal angulations are assessed correctly, the image of the tooth will be the same length as the tooth itself and should be adequate (but not ideal) for most diagnostic purposes.

2) Comfortable for the patient when used without holders.

DISADVANTAGES

1) The many variables involved in the technique can result in the image of anatomical structures being distorted.

2) Incorrect vertical angulation will result in foreshortening or elongation of the image.

3) The periodontal bone levels are poorly represented.

4) The shadow of the zygomatic bone frequently overlies the roots of the upper molars.

5) The horizontal and vertical angles have to be assessed for every patient and considerable skill is required (when holders are not used).

6) It is not possible to obtain reproducible views – if holders are not used.

7) Coning off or cone cutting may result if the central ray is not aimed at the centre of the film (when holders are not used).

8) Incorrect horizontal angulation will result in overlapping of the crowns and roots.

9) The crowns of the teeth can be distorted thus preventing the detection of approximal caries.

10) The buccal roots of the maxillary premolars and molars are foreshortened.

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3)Robert P. Langlais & Craig S. Miller. Exercises in Oral Radiology Interpretation. 2017. (5th Edn)
4)Olaf E. Langland & Robert P Langlais. Principles of Dental Imaging. 1997.

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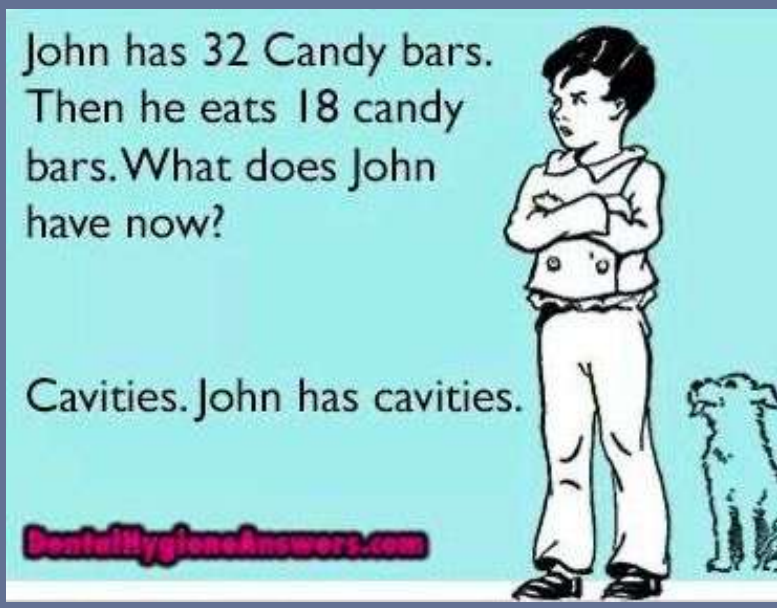
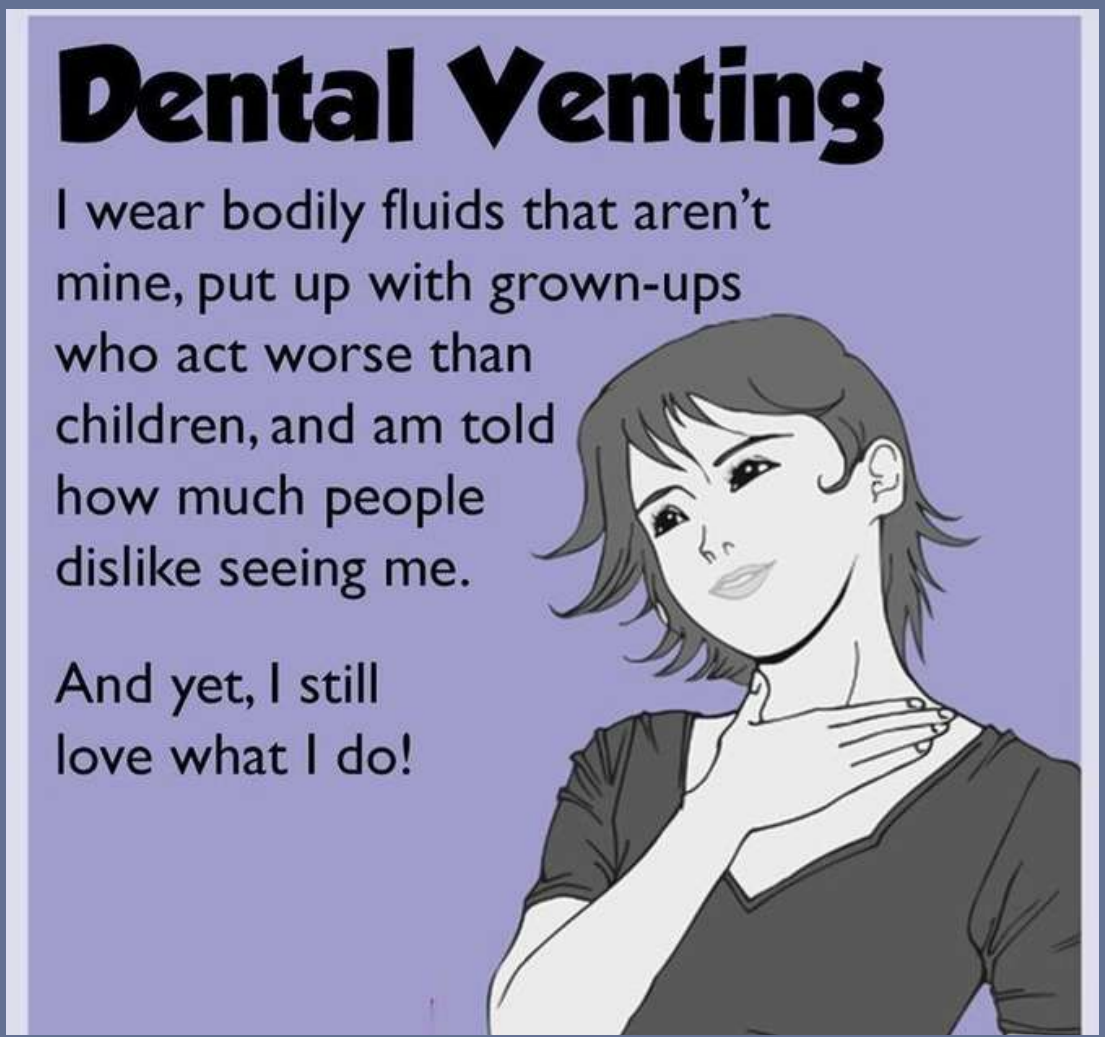
Dental Sarcasm
Patient: I'm in a hurry, so can you be fast?
Hygienist: Sure, which ten teeth would you like me to clean?
Kara_RDH


John has 32 Candy bars. Then he eats 18 candy bars. What does John have now?
Cavities. John has cavities.


Dental Venting
I wear bodily fluids that aren't mine, put up with grown-ups who act worse than children, and am told how much people dislike seeing me.
And yet, I still love what I do!

@Pinterest

The Elusive Periodontal Disease.

Professor Dr Dasan Swaminathan,
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Professor of Periodontology
Faculty of Dentistry
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Petaling Jaya.

"My gums are red, puffy and bleed when I brush my teeth and I am afraid to brush my teeth". This is a common complaint from patients visiting the dentist. Gums should never bleed even when you brush or use dental floss. If your gums bleed even sometimes, something is wrong. Gums should never be red or swollen.

The adult population especially in developing countries suffer from some form of periodontal disease or more commonly known as "gum disease" and periodontal disease is the main cause of tooth loss in these adults. As periodontal disease is now the main cause of tooth loss when compared to dental caries, oral healthcare professionals are now spending more time treating this disease than before. I tend to term periodontal disease as elusive because a person with this disease will not have any pain to alert him to come running to the oral healthcare professional seeking treatment. When this person does visit the oral healthcare professional, the disease may have progressed into deeper tissues of the periodontium and become irreversible.

There is evidence to indicate that this disease has been around since the dawn of time. Skull remnants of prehistoric man indicated some form of bone loss around the dentition and also tooth loss which could have been due to this disease. Mankind has not been spared the ravages of this disease ever since and despite much research and money spent to study this disease, mankind remains afflicted and tooth loss due to the disease continues at an increased pace. The modern era is characterized by longevity and better health but unfortunately many adults continue to suffer from periodontal disease leading to early loss of teeth thus jeopardizing their quality of life.

The tooth is attached to the alveolar bone by the attachment apparatus which consists of the gingiva, root cementum, periodontal ligament and the alveolar bone. The periodontal ligament acts as a "shock absorber" to cater for the high masticatory load that is produced during chewing. Periodontal disease causes the destruction of the attachment apparatus of the tooth as it progresses and the destruction of this attachment apparatus can eventually lead to loss of the tooth.

Every day a sticky, almost invisible film forms on the tooth surfaces. As it matures without removal by proper oral hygiene, it becomes what is called plaque, or now termed as plaque biofilm or oral biofilm and this biofilm is the primary etiology of periodontal disease. If you do not remove this plaque biofilm, it will be contaminated by bacteria which are found in abundance in the oral cavity. It is said that there are more than 650 species of bacteria present in our mouths and some of these bacteria can lead to periodontal disease, if they multiply outside the normal range. Plaque biofilm can be seen particularly at the gingival margins. The bacteria within the plaque biofilm produces toxins (poisons) that make the gums red, swollen and bleed easily. This inflammation is the start of periodontal disease! Byproducts and toxins produced by the bacterial plaque biofilm not only cause inflammation of the gingival tissue but also destruction of the alveolar bone, which holds the roots of our teeth. This destructive process is also aided by our own immune system. When sufficient bone has been lost, the tooth loosens and when deprived of most of the periodontal ligament and supporting alveolar bone, the tooth becomes so loose that it either falls out or has to be extracted. Our immune system which has a role in targeting the bacteria within the plaque biofilm can also contribute to the destruction of the tooth-supporting tissue, which again can lead to eventual tooth loss. There are several local and systemic contributing factors which can lead to the initiation and progression of the disease.

Symptoms of gum disease will be bleeding gums, migration of teeth, receding gums, mouth malodor or halitosis, taste disturbances and tooth loss as the disease progresses. Signs of gum disease will include inflamed gingiva, the space between the neck of the tooth and soft tissue known as the sulcus becoming deeper resulting in a term called periodontal pocketing which will harbor multiple anaerobic bacteria causing the destruction of the supporting structures of the tooth especially the alveolar bone in which the root of the teeth is embedded. There will be radiographic changes indicating the destruction of alveolar bone. Periodontal disease in the early stages, only involving the supra-gingival area is called chronic gingivitis and when it proceeds to the roots of teeth via periodontal pocketing (sub-gingival areas or below the gums) and affects the supporting structures of teeth, the periodontal ligament and alveolar bone, it is called chronic periodontitis. Gingivitis is reversible if early treatment is sought but periodontitis is irreversible and can only be prevented from causing further damage by periodontal treatment. It is unfortunate that what is lost due to the disease especially bone is hard to regain even with sophisticated dental treatment that is now available. Periodontal disease is a chronic condition and may take several weeks or months to become noticeable.

As mentioned before on the elusive nature of periodontal disease, it is almost painless in the early stages and this will prevent many individuals from seeking dental help and intervention. You may not notice the gradual onset of puffiness of your gingiva or pay attention to occasional bleeding when brushing. Four out of five teenagers and adults have some form of periodontal disease and most do not even know it. That is why people lose more teeth from periodontal disease than from all other causes combined. But the good news is that most periodontal disease can be prevented or if already begun, it can be treated. This is particularly true if it is recognized in its early stages and is still within the gingival connective tissue.

A few people are very resistant to periodontal disease. Some are highly susceptible. However, most people have a varying resistance to the disease at different times in their lives. For example, a person's immune system may be normal for years and then when this immunity is reduced, it can cause the “resting” periodontal disease stage to flare up. No one knows why our resistance to the disease varies from individual to individual or why it varies in the same person at different times. Periodontal disease thus can have an active phase when the disease can progress rapidly and a “quite phase” when the disease practically “hibernates” for a certain period of time!Some experts in the field of Periodontology feel that the immune system of the host plays a major role in these cyclic changes in the progression of the disease.

Periodontal disease in Children.

Children who have deciduous / permanent teeth in their mouth are not susceptible to periodontal disease as compared to adults. However, children can suffer from gingivitis due to poor oral hygiene. Usually gingivitis in children will not progress to periodontal disease. This may be due to the better immune response in children to the bacterial infection in plaque biofilm. The disease entity is mainly confined to the gingival soft tissue but with any genetic disorders causing the child to be immune- compromised, gingivitis can progress into the deeper tissues to become periodontitis. Certain genetic disorders such as Down’s syndrome and Papillon Leferve syndrome can cause severe periodontal destruction in children. Aggressive periodontitis which has a hereditary predisposition can occur in young adults even when their oral hygiene and plaque biofilm control are very good. These young adults will lose their teeth especially their molars rapidly as the disease progresses.

The relationship between periodontal disease and Systemic Disorders.

The relationship between periodontal disease and several systemic disorders is worrying oral healthcare professionals especially due to the fact that periodontal disease is rampant in the adult population worldwide. Smoking is a contributory factor in the development of periodontal disease. The vasoconstriction caused by smoking on the gingival blood vessels may play a role in the disease process.

Ongoing research and scientific papers over the last decade have linked periodontal disease to systemic conditions such as diabetes mellitus, artherosclerosis and cardiovascular diseases, strokes, osteoarthritis, respiratory tract and lung infections, obesity, renal disorders and pregnancy. These systemic conditions are considered as host-mediating factors which can contribute to the progression of periodontal disease. Research has now shown that diabetics are more susceptible to gum disease and gum disease in turn has been implicated in poorer glycemic control in these individuals. Even some cancers are linked to periodontal disease and recently Alzheimer's disease has also been mentioned. The exact mechanism whereby this association occurs is still debatable but it has been suggested that the byproducts of periodontal pathogens and the host immune response to this bacterial infection may play a contributory role in associating periodontal disease with the systemic conditions mentioned. Research is ongoing to determine the association between periodontal disease and systemic disorders. The findings from research thus far have made the prevention and management of periodontal disease even more important for our patients.

Management of periodontal disease.

Periodontal disease is very unpredictable. We think that the disease is caused by a group of bacteria present in our mouths and not by any one particular microorganism. Thus it is difficult to develop a vaccine for the disease as several species of microorganisms may be involved in the initiation and progression of the disease. The main clinical parameters that we assess are the plaque and gingival bleeding scores and periodontal pocket depths before we can embark on any non-surgical or surgical interventions. This will give us information on the stage of disease progression. Radiographic evaluation of the hard tissues can also be done to evaluate, among other findings the alveolar bone levels.

The management of periodontal disease will consist of removing the bacterial plaque biofilm from the mouth along with any deposits in the supra-gingival and sub-gingival parts of the teeth and making the roots of the teeth as clean and deposit-free as possible. This procedure is known as scaling and root planing / debridement. The main concept of carrying out scaling and root planing / debridement is to reduce the bacterial load in the mouth by removing deposits that are contaminated by bacteria. The local contributing factors such as overhanging restorations, ill-fitting prostheses, carious lesions and malocclusion can act as traps for bacterial plaque biofilm and have to be addressed. The systemic host-mediating factors may require referral to our medical colleagues, if the patient is not under medical care and we as oral health professionals should always have a good rapport with our medical colleagues in the management of patients with systemic conditions. To maintain this lowered level of bacterial load, it is imperative to give your patients proper oral hygiene instructions tailored to individual patients' needs. Oral hygiene education has now become an important aspect and integral part of periodontal therapy and should be reinforced at every visit and reviews. Surgical intervention is only carried out when periodontal disease is still persistent and refractory in areas of the dentition and the oral hygiene of the patient has improved to an acceptable level.

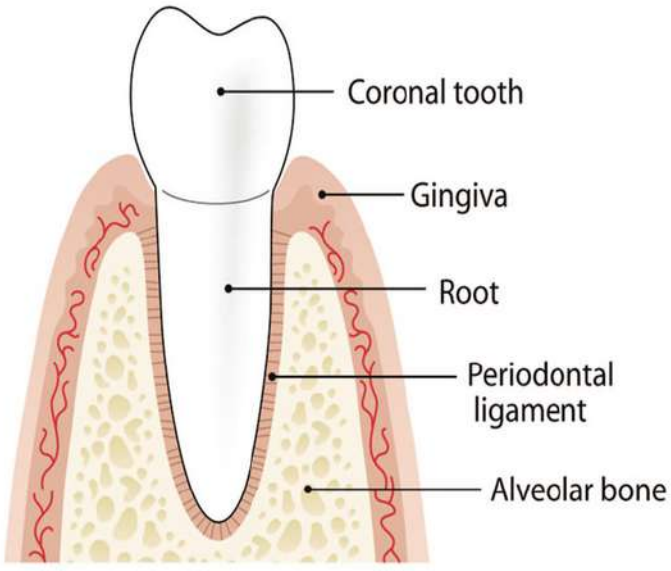
Mouth rinses such as chlorhexidine, which is categorized as a "gold standard" antibacterial agent and has excellent antibacterial effect can be used as an adjunct to mechanical oral hygiene such as tooth brushing and flossing. These mouth rinses are especially useful in individuals with poor manual dexterity as in patients who have had a stroke. It is also useful in patients who are in intensive care, mentally and physically challenged whereby care-givers can maintain oral hygiene with these antimicrobial agents and in patients who have undergone periodontal and maxillofacial surgery to look after their oral hygiene during the post-surgical phase. I would strongly recommend the usage of chlorhexidine in all the above mentioned situations and also in individuals who are susceptible to gum disease and who have issues maintaining their mechanical plaque control, on the advice of their oral healthcare professionals.

The association of periodontal disease and Covid-19.

The management of periodontal disease is even more important during this Covid-19 pandemic that we are facing. Periodontal disease is an inflammatory disease and the added burden of dealing with another inflammatory condition as in the Covid-19 viral invasion will be challenging for one's immune system. A situation of concern is when a Covid-19 patient is on a ventilator in the intensive care unit and the patient's oral hygiene becomes the lowest priority in the management of this very ill patient. There will be an accumulation of bacterial plaque biofilm in the patient's oral cavity leading to progression of infection and further destruction of the periodontal tissues. This will be an additional burden on the patient's immune response, already challenged by a highly very pathogenic virus infection. It has been reported that patients on ventilators are susceptible to bacterial pneumonia due to the tracking of accumulated periodontal pathogens from the oral cavity along the ventilator tubings. Patients on ventilators for Covid-19 which is a respiratory viral infection will be further compromised with this spread of bacterial infection into the respiratory system.
It is thus recommended that oral healthcare professionals should also be involved in the overall management of patients afflicted by Covid-19 along with the frontline caregivers. The use of chemical plaque biofilm control agents such as chlorhexidine will benefit patients in intensive care units in the management of their oral hygiene. It is also imperative that we deal with any inflammatory conditions including periodontal disease during this pandemic era to enable our immune systems to cope.

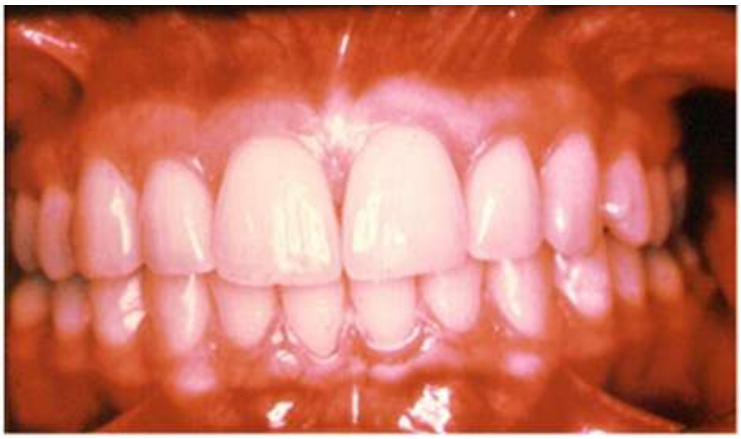
Conclusion.

It can be concluded that periodontal disease has been around for a long time and it will continue to be active for years to come. The prevention of the disease is literally in our hands and together with oral healthcare professionals, we can try and identify the disease early and prevent it from causing damage to the tooth supporting tissue, thus preventing tooth loss and improving our quality of life. We should make regular visits to oral healthcare professionals and we should treat oral health as an important aspect of our lives. It is our responsibility to look after our oral hygiene well by regular brushing, flossing, use of antimicrobial mouth rinses when required and importantly regular visits for dental checkups as well as following instructions and treatment given by oral healthcare professionals. As mentioned, the involvement of oral healthcare professionals in the care of patients afflicted by Covid-19 is recommended.

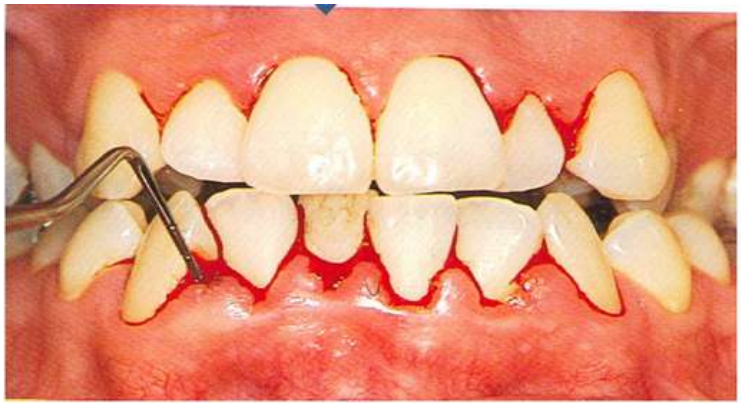


The Attachment Apparatus of the tooth

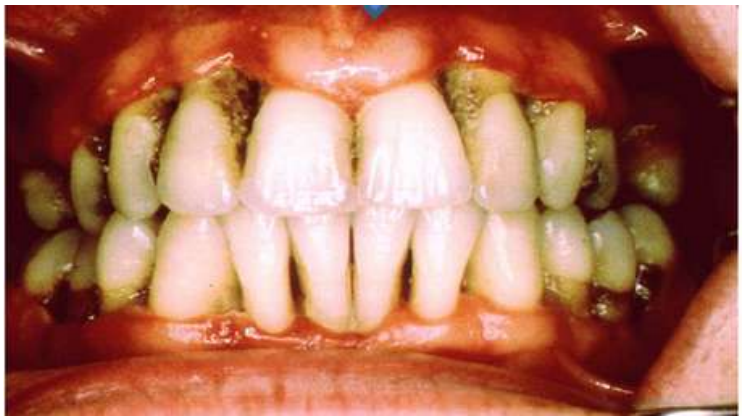
NORMAL GINGIVA



CHRONIC GINGIVITIS



CHRONIC ADVANCED PERIODONTITIS (UNTREATED)



2021 CSR PROJECT.

MPDPA has taken part in various CSR Projects. This includes the Foodbank Donation Drive in conjunction with the *Bendera Putih (White Flag)* Movement and *Darurat Banjir, a* Flood-Relief Fundraising Drive. We also made monetary contributions to the Yayasan Kasih Hospice Malaysia to provide aid for cancer patients and to the Tara Foundation to equip school children with tables and chairs.
All this was made possible by donations collected in cash and kind from our members, friends and family of the Association.

FOOD BANK DONATION DRIVE

In collaboration with the SUKA Society, The Meatless Malaysian Group, The Rotary Club of Kajang and our personal contributions, we distributed over 300 food boxes to 155 local and foreign recipients in the B40 group, 150 refugee families and 4 welfare homes in need.


MPDPA &
SUKA Society
12/7/2021
@mpdpa
PIC•COLLAGE


Delivery to Flat
Sri Sarawak, KL.
9/8/2021
@mpdpa
PIC•COLLAGE


@mpdpa


suka
....with SUKA Society.
46 packs to refugees of Afghan
community in Ampang.
51 Rohingyas in Ampang 30 in
Setapak & 23 in Seri Kembangan
@mpdpa
PIC•COLLAGE


AREAS WE HAVE PROVIDED ....
TEMERLOH
SEMENYIH
KUANTAN
AMPANG
PUCHONG
SERDANG
KUALA LUMPUR
BATU CAVES
SALAK SELATAN
ALOR SETAR
BANDAR RINCHING
BANGI
KOTA BHARU
KLANG
SERI
KEMBANGAN
SETAPAK
KAYU ARA
KAJANG
KG KERINCHI
MELAKA
KUBANG
KERIAN
BATU PAHAT
PASIR MAS


PACKING
@mpdpa
PIC•COLLAG


For 5 families in Bandar
Baru Bangi Lama
19/7/2021
@mpdpa
PIC•COLLAGE


Kajang, Kubang
Kerian, & Kota
Bharu, 14/7/2021
@mpdpa
PIC•COLLAGE


Distribution to Rumah
Kongsi Taman Andalas,
Klang. Daily wage
foreign-workers who
have lost their jobs
during this EMCO.
17/7/2021
@mpdpa
PIC•COLLAGE


Taman West
Country & Kg.
Kemumin.
16/7/2021
@mpdpa
PIC•COLLAGE

Children who have lost their parents to CoVid ..

Collaboration with the "Meatless Malaysian" : deliveries to B40 families.

The differently able community were not left out....

Persatuan Kebajikan Chen Ai OKU - 10/8/21

FOOD BANK DONATION DRIVE

If you can't feed a hundred people, then at least feed one! ~ Mother Theresa.

Daily wagers who have lost their income this season ...

DARURAT BANJIR

A flood relief fundraising drive was organised to raise funds among members and friends of MPDPA to provide aid to the flood victims.

Since it was challenging for us to physically reach out to these affected areas, we decided to collaborate with various NGOs sharing the same aim and intention. This includes, The Gurdwara Sahib Petaling Jaya, The Malaysian Hindu Sangam Serdang Council, and The Sai Baba Organisation together with the Soroptimist International Club Of Bangsar, The Rotary Club of Kajang, The Persatuan Penganut Sri Vishwa Guru Tabovanam Malaysia alongside the Adun Office of Sentosa, Klang.

Items that were purchased and donated to these victims were toothbrushes, toothpastes, hygiene care products, dry food items, baby bottle sterilisers, mattresses, gas cylinders, bedding items, and kitchen utensils.

Our donations reached out to victims in Karak, Ampang, Taman Sri Nanding, Hulu Langat, Klang and its surrounding areas.

DARURAT BANJIR

Delivery of hygiene products, food steamer (for babies) and baby bottle sterilisers to Rumah Asnaf Qaseh Ibu, Ampang.

Delivery done on our behalf by The Sai Baba Organisation together with the Soroptimist International Club Of Bangsar .

DARURAT BANJIR

In collaboration with various NGOs.

Purchase and distribution of mattresses and gas cylinders by The Rotary Club of Kajang.

DARURAT BANJIR

Joint efforts with The Persatuan Penganut Sri Vishwa Guru Tabovanam Malaysia together with the Adun Office of Sentosa, Klang. Post Flood Recovery victims receiving their kitchen utensils and a food box each.

AGM 2021

5th Dec 2021 at
The Royal Selangor Club,
Bukit Kiara Kuala Lumpur.

MPDPA Past & Present President.

Members present at the AGM.

Fun & Fellowship following the AGM.

A LETTER OF GRATITUDE...

Dear MPDPA Members,

Apologies for being unable to attend the MPDPA AGM 2021. It would help greatly if this message be recorded as a vote of thanks to Dr. Mahendran.

We are highly appreciative of the proactivity and achievements of the MPDPA during Dr.Mahendran's two terms.

a) The finances of the Association had improved many-fold and become very robust.
b) Communication and personal touch with members have returned in good measure with abundance.
c) Members had benefited from policies and action-oriented measures during the Covid19 crisis.
d) President Mahendran has put in supreme effort, time and energy in raising the status of MPDPA.
e) President has improved the image of the MPDPA and even encouraged charity donations to the needy.

It would be highly appreciated and duly acknowledged if the floor could officially record a vote of appreciation and thanks to Dr.Mahendran for the drive, hard work, input and communication he injected to raise the position and standing of the MPDPA among our dental peers.

From
Dr. Wong Foot Meow
MPDPA Past President (2002-2003).

ESTABLISHED DENTAL CLINICS FOR SALE

ESTABLISHED CLINIC FOR SALE
Located in Plaza Mont Kiara.
Next to 163 Retail Park and 1Mont Kiara.
Strategic location, surrounded by condos and offices.
Owner retiring.
Only seriously interested, pls call 012-9122891 between 5-9pm.

FOR SALE.
Established Dental Specialist Clinic located in Section 13, Shah Alam.
Great location, plentiful parking.
Vicinity of Giant Hypermarket, Aeon Mall, Hospital Management & Science University (MSU), Shah Alam Stadium, Bkt. Jelutong.
Good market. Ready clients.
Well designed layout and interior deco. Lock, stock & barrel.
Only serious buyer call 0192390239.
Owner retiring.


MALAYSIAN PRIVATE DENTAL PRACTITIONERS' ASSOCIATION
Thank you!