2014

# ICDigest

journal of the european section
international college of dentists

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making a difference by doing things 'anybody can do'

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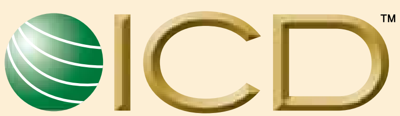


INTERNATIONAL COLLEGE OF DENTISTS

### Mission

The International College of Dentists is a leading honorary dental organisation dedicated to the recognition of outstanding professional achievement and meritorious service and the continued progress of the profession of dentistry for the benefit of all mankind.

### Motto

Recognising Service as well as the Opportunity to Serve.

### Objectives

- To provide a universal forum for the cultivation of cordial relations within the profession.
- To foster the growth and diffusion of dental knowledge.
- To recognise distinguished service to the profession and to the public worldwide.
- To promote post-graduate study and research in the field of oral health.
- To contribute to the advancement of the profession of dentistry internationally.
- To encourage and support projects of a humanitarian nature.
- To uphold the highest standard of professional competence and personal ethics.
- To assist in preserving the highest public perception of the profession.
- To perpetuate the history of the profession and maintain its dignity and stature.

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## ICDigest 2014 Volume 58

The ICDigest is published annually and is the official publication of the European Section of the International College of Dentists. All statements of opinion and supposed facts are published with the authority of the contributors under whose names the articles are published and are not necessarily to be regarded as the opinion or a policy of the European Section of the International College of Dentists. Therefore, the College, its officers, employees and editors accept no liability or responsibility whatsoever for the consequences of any inaccurate or misleading statements made by the contributors to the publication.
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Published May 2014.

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ISSN X1565-964

# Bringing out the Best

As governments carefully pronounce the financial crisis a thing of the past, our ICD European Section continues to plot a cautious but optimistic course to the future. As in economics, expansion is a key theme in many of our current ICD topics: expansion of our geographic boundaries, e.g. towards Eastern Europe; expansion of our humanitarian horizon – this ICDigest shares welcome updates on ongoing projects, and impulses for new initiatives; expansion of our acceptable age of induction; and expansion of our economic basis and resources by growth and development; issues deserving of our full attention and wise deliberation.

But expanding our arena simply to play to the galleries, or add a trophy to our wall, is futile and utterly unworthy of our mission. It is a temptation that we, in this modern era of individualisation, may need to resist. More than ever before, it is by bonding together, honouring commitments, bringing out the best in ourselves, individually and collectively, and those around us, that we as the ICD European Section will achieve our objectives, remembering that it is what we do when no one is looking that reveals our true natures.

The best is often brought out not by complex strategies, but a firm decision to take a first, modest step. Small gestures can lead to great events. Note how the interview in this ICDigest with our new Chairman of the Projects & Funding Committee, Gil Alcoforado, splendidly illustrates this universal truth in our humanitarian effort. His sharing of a video in a conversation, which ultimately improved the lives and dental health of thousands of children in Portugal, serves as a hopeful and inspirational reminder of what we can do to expand our influence in order to benefit others.

Another theme that, unavoidably, comes to mind is modernisation. The ICD European Section remains committed and on course to keep our organisation future-proof. Our website is currently undergoing a makeover, giving it a new and crisp look & feel. We trust that once it goes live, you will enjoy its innovative functionality. Our annual journal, which is traditionally printed to the highest standards, will be made compatible for iPad reading and electronic distribution, potentially enabling significant cost savings.

Dear Fellows, our European Section is a vibrant organisation, very much alive with the values and principles we cherish. The potential for service, philanthropy and excellence in our profession is virtually endless. It is my hope this 2014 ICDigest will expand your vision and spark your imagination of what you may achieve, once you decide to take the first step to bring out the best.

**Walter van Driel**
Editor

***Achieving objectives in silence reveals our true nature***

The 58th Annual European Section Meeting

# Looking Back on Copenhagen 2013

Organising an ICD meeting is somewhat like planning a big celebration. You want it to be a success, and for it to be so, you need good venues, an outstanding scientific agenda offering something for everyone, and a wonderful social programme. Once all that is taken care of, you hope that people will come and participate, because apart from all the practicalities involved, it is really the attendees that make the meeting a success. So therefore I wish to thank the 248 participants and spouses for making Copenhagen 2013 such a memorable event!

**Henrik Harmsen**
**Immediate Past President, ICD European Section**

## Early Birds

Officers and Regents arriving early in Copenhagen enjoyed an informal dinner together. Some of them played the traditional Pre-Congress Golf Tournament at the Royal Golf Course in Copenhagen the next day, concluded with a lovely – somewhat late – outdoor lunch.

## Regents Dinner at Geist

Copenhagen is renowned for its modern gastronomy. One of its delightful exponents, Restaurant Geist, challenged the palates of the officers, regents and guests with new and unfamiliar flavours. Like all the venues (except one), Geist was conveniently located within walking distance from the hotels.

## Welcome Reception at City Hall and Dinner at Tivoli

Buses are quite handy when you need to bring your guests to a venue 1.5 km away. The city hall, built in 1905 in beautiful national Romantic style, is always booked 3 years in advance. However, as an organiser you do not know until 2 months ahead whether you are accepted or not. Fortunately we were accepted, and the 248 participants enjoyed this very Danish tradition.

The tradition stipulates that foreign heads of state and other official visitors to Copenhagen are given an official reception at the City Hall, and everybody is offered the ▶

exact same menu: pancakes, coffee and wine.

Dinner was served at Paafuglen restaurant, right in the middle of Tivoli, the world's oldest amusement park dating from 1847 and founded by Georg Carstensen (note that his great-grandson is an ICD Fellow in Seattle, Washington!). For the first time the weather gods decided that a little rain was welcome.

## Scientific Day

Under our chosen theme Changing Paradigms in Dentistry, lectures included a demonstration by Francesco Martelli how lasers in periodontology can change the outcome of treatment. We learnt the importance and method of planning implants top-down in Ashok Sethi's lecture. Tif Qureshi showed us how minor orthodontics could reduce major invasive preparation of teeth to minor alterations and bleaching to produce great aesthetic results. David Winkler focused on ethics in aesthetics, and raised the question whether extensive tooth preparation in order to alter aesthetics were within the ethics of being a *lege artis* dentist in 2013. John Orloff shared interesting details that led to major failures in implantology, and Kwang Bum Park from Korea informed us about his contemporary company. As an experiment, the Open Forum was interspaced between the other lectures, and Miguel Pavao, Vicente Lozano and Hani Farr updated us on ICD Europe-supported projects.

## Accompanying Persons Tour

The tour went to the Louisiana Museum of Modern Art, beautifully situated on the coast north of Copenhagen, and from there to Kronborg Castle, where Shakespeare's Hamlet is set. It is the greatest renaissance castle north of the Alps and well worth another visit.

## Friday Evening

Our golf sponsors at www.secherfineart.com invited all participants to a tour of their gallery and served us ample bubbling wine. From there we went a few hundred metres to the Nyhavn Canal for a tour around Copenhagen harbour. The tour of course took us by the statue of the little mermaid and we ended up in one of the new landmarks: the new Copenhagen opera building, where we dined on the top floor overlooking most of the city.

## Saturday

Saturdays of all ICD annual meetings begin with the induction ceremony, and this year was no exception. For practical reasons the ceremony was held across the street from the conference hotel in the Odd Fellow Palace, which had generously allowed us to use their ballroom for the induction.

This was followed by an excellent serving of champagne, and then we just had to cross the street again to the Moltke Palace. Although the weather gods decided to pour heavy rain this time, we were able to escort the party safely across the street and celebrate our gala dinner. This was when the golf prizes were awarded, and it is my hope that the first prize wil wander on in years to come.

## Sunday Post-Congress Tour

The post-congress tour took us to the viking ships in Roskilde, followed by a short sailing trip on the Roskilde fjord with lunch being served on board. A few months later in December 2013, the ships were nearly destroyed in a flood, as water rose 2 meters above normal level and threatened to break the windows and pour into the building.
The congress ended at 16.15, when we said goodbye to the last guests in front of our hotel.

This congress was a first in that except for one mailed pre-congress information, all invitations were sent by email, and all registration was electronic, showing this procedure is convenient and effective for our annual meetings.

It was a great pleasure and honour for me to be your host in Copenhagen. I am thankful for having had this opportunity, and very much look forward to our upcoming meeting in Ljubjana, Slovenia. Best of luck, Ljubo! ■

# Henk Ruskamp Remembered

It was with great sadness that we learnt of the passing of Dutch Master Fellow Henk Ruskamp on Sunday 5 May 2013 at the venerable age of 89.

Henk's contributions to our College were innumerable and invaluable. He served as Regent of the Benelux District, where he and his wife Liet never failed to create a warm sense of togetherness, making sure during College events that Dutch and Belgian District members had an opportunity to meet in an atmosphere of cordial friendship and professional fellowship.

As the Treasurer of ICD Europe, Henk was much loved and respected for his wisdom and goodness, his practicality, and selfless outlook on life and the profession. Even though Henk was not spared his share of trials and tribulations, he never allowed them to dull his zest for life and indomitable optimism.

The following reflects the combined memories of Fellows Jan Pameijer and Pieter van Mens of their friend:

*On 5 May 2013, the day we in the Netherlands celebrate our liberation from German occupation by the allied forces, Henk Ruskamp quietly passed away.*

*Henk graduated from the University of Utrecht Dental School in 1950. Instead of having to complete the compulsory military service, Henk was allowed to teach at the Dental School of the University of Groningen. During his stay in Groningen he married Liet, whom he met through his older brother who, like Liet, was active in the resistance.*

*In 1952 they left Groningen for Delft, where Henk started a dental practice in an old house on one of the most beautiful canals, not far from where the famous painter Johannes Vermeer used to live.*
*It didn't take long for patients interested in quality dental care to find out that Henk Ruskamp was the dentist they should visit. The practice was limited to private patients, which in those days was somewhat unusual, socialised dentistry being most prevalent.*

*Dentistry is his passion, Liet used to say, and it certainly showed in his work. Henk attended many postgraduate courses, joined the Amsterdam Occlusal Study Club, was a founding member of the European Academy of Gnathology, and a member of many Dental Societies.*

*In addition to all these activities, Henk also found time for his old love, teaching. On the invitation of Prof. Frits Tempel, he joined the Amsterdam Academic Centre for Dentistry (ACTA) prosthetic dentistry department in 1968, starting as an instructor in the preclinic, then as an instructor and supervisor of clinical students in preparing full dental prostheses. In these roles, Henk manifested himself as we all knew him. His down-to-earth attitude and integrity, combined with his mild mannerism made him a highly respected and much beloved teacher.*

## *There is an old belief*
## *That on some distant shore*
## *Far from despair and grief*
## *Old friends shall meet once more*

*Henk was in every respect a pillar of a man, with a striking presence, and an excellent tutor. He had the unique talent to explain the subject at hand with perfect clarity, and horizontally, as it were – making the students his peers. He taught by demonstration, that was how he felt it should be. Always with a captivating smile, but leaving no doubt as to how it should be done.*

*He was exceptionally fraternal, always willing to provide explanations. There was no rigid allocation in who taught which students; the work at hand was done on a daily basis. An endearing characteristic of his was that if he ever disagreed with anything, it was never resolved over the backs of his students or by involving his superiors.*

*Henk was also a dedicated member of the European section of the International College of Dentists. For many years Henk served as treasurer, gracefully fulfilling the difficult task of collecting the dues with the help of the Regents of the various Districts. There were not many meetings he missed, and he was heavily involved in organising the Annual Meeting in Amsterdam in 1999.*

*In his private life Henk had his share of grief; the early death of their daughter, shortly followed by the passing away of his beloved Liet, were difficult to cope with. In the last decades of his life he was plagued with diminishing eyesight, for which he underwent surgery several times. The insertion of contact lenses, often followed by losing them, were a constant annoyance, though he never complained – grumbled at most.*

*Early December 2012 Henk was admitted to the hospital for abdominal surgery, from which he never fully recovered. The will to live was clearly present, but his body lacked the strength to recover. Henk is survived by his son Hylke.*

*Let us remember Henk the way he was, down to earth, honest, trustworthy, sincere, a true friend. And perhaps we may take comfort in the following lines:*

There is an old belief
That on some distant shore
Far from despair and grief
Old friends shall meet once more ■

## A different way of looking at preventative occlusal treatment through alignment and bonding

# Tooth Wear: the Dahl Principle

Simple anterior orthodontics may have been overlooked for many years as potentially one of the most important and useful areas in dentistry. This is illustrated by the suggestion that many dentists simply do not recognise that increased crowding in the anterior region over time can lead to, or is associated with, a collapse of lower intercanine width that may induce the loss of canine guidance and the development of group function with the potential issues this may cause.

**Tif Qureshi**

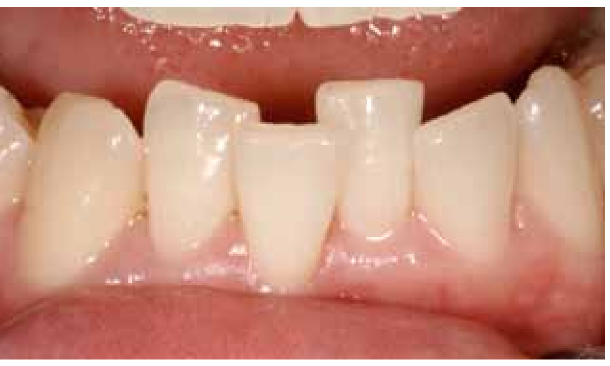


**Figure 1. Patient A before treatment showing intercanine collapse and crowding.**

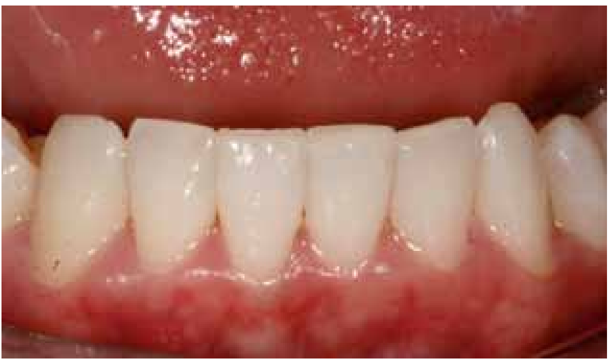


**Figure 2. Immediately after alignment and whitening.**

This loss of guidance can happen in a relatively short period of time as the canines lose their protective function once they tip inwards. It is likely a combination of factors that causes this, but data is limited; however, the phenomenon is clearly visible when examining patients on a daily basis.

If we think ahead when considering a case such as that featured in Figure 1, we see that several problems could develop over time.

Firstly, the crowding could worsen, leading to increased risk of periodontal disease. The likelihood of differential tooth wear is also increased as crowding progresses. Areas already worn down to dentine are likely to wear faster because of the softer substrate.

Exposed dentine is also likely to stain more as open tubules are more susceptible to ingress of particles that over time may cause intrinsic staining.
If the canines continue to tip inwards, there will be a loss of canine guidance that might well cause the transition to group function which could become traumatic if not monitored (and treated as needed). Many patients left untreated eventually need extensive work, up to and including full mouth dentistry.

If patients are in a situation where lower crowding is starting or has started, it is appropriate to align the lower teeth,

Figure 3. 6 years with retention post-treatment.

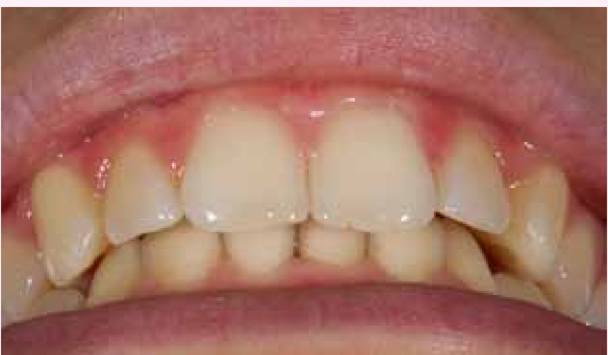


Figure 5. Following alignment and increase of intercanine width.

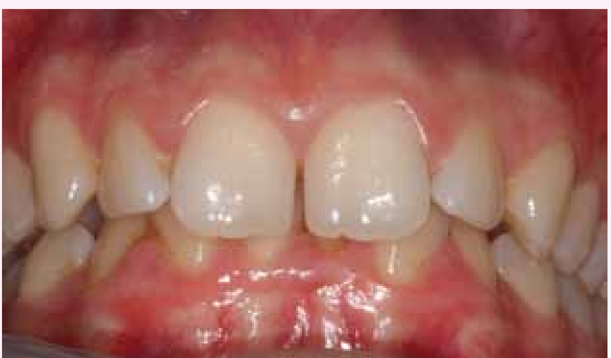


Figure 4. Patient B before treatment.

Figure 6. Patient C in occlusion with deep bite. Note posterior contacts.

upright the canines and then apply retention in an attempt to prevent relapse (Figures 2-3). Figures 4 and 5 show another case before and after alignment with a resulting increase of intercanine width.

If the edges are already worn, it is also possible to restore the tips to seal the exposed dentine and improve aesthetics. In cases with more extensive wear, this can be combined with the Dahl principle where space can be reclaimed by opening the anterior bite, disengaging the posterior teeth and allowing the posteriors to overerupt and the anteriors to intrude a little.

## The Dahl Principle

Modified Lucia jigs have been used as deprogrammers to help the mandible find centric relation (CR). Direct composites can also be used as an anterior deprogrammer. Resin composites – because of their resilience and ease of manipulation even in small thicknesses – are ideal materials to restore the palatal surface and the worn lower anterior incisal and canine edges.

Dahl (1975) suggested creating space to treat localised anterior tooth wear by separating the posterior teeth using an anterior bite plane for 4-6 months.

A combination of passive eruption of the posterior teeth and intrusion of the anterior teeth allowed the re-establishment of posterior occlusion while holding the anterior space. Dahl actually used a metal appliance to separate the posterior teeth, but we can now achieve the same result with adhesive anterior direct composites.
By identifying the difference between maximum intercuspal position and CR, using pressure to gently guide the mandible, the position of the direct composite can be set slightly posterior to maximum intercuspal position. This will create anterior contact on the incisal edge build-ups and possibly create premature contacts on the posterior teeth. These premature contacts can be equilibrated to improve the amount of contact, but the residual space will eventually close through passive eruption over a few months.

I have used this principle for over 15 years in over 500 patients with continued success. Importantly, the Dahl principle should not be used in aggressively worn full mouth cases.

During the "cosmetic boom" years, virtually every single veneer case I placed on the upper teeth had composite tip build-ups on six to eight lower anterior teeth to treat any wear and re-establish guidance before fitting the upper ceramics. I used up to 2.5 mm of composite anteriorly and this seemed to cause a combination of extrusion of the posteriors and possibly intrusion anteriorly. I rarely ever placed ceramic directly on lower teeth because I could improve aesthetics and function with non-invasive composites instead. Yes, they can wear but the usual life span for these was about five to eight years and most patients were quite satisfied with this when compared to tooth preparation and the cost of veneers.
It should be emphasised that the Dahl principle is really only reliable and useful when there is anterior tooth wear. For large posterior tooth wear cases, the patient required

**Figure 7. Patient in occlusion with Dahl composite added to lower anterior teeth. Note posteriors in contact at 3 months.**

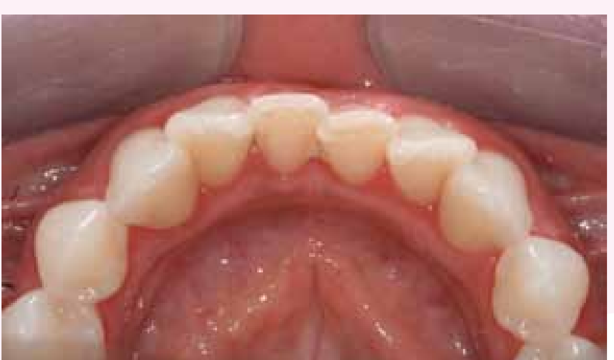


**Figure 8. Before occlusal view.**

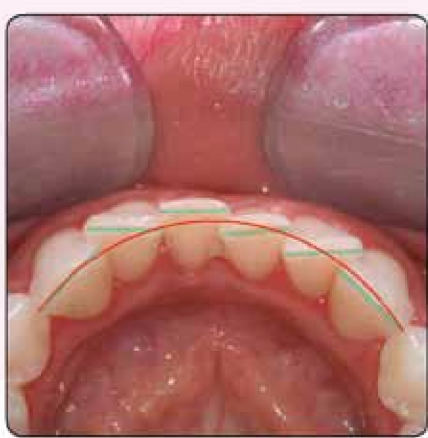
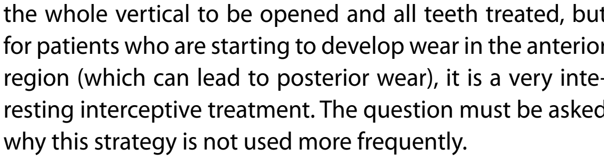


**Figure 9. Spacewize calculation shows 3.8 mm crowding.**



the whole vertical to be opened and all teeth treated, but for patients who are starting to develop wear in the anterior region (which can lead to posterior wear), it is a very interesting interceptive treatment. The question must be asked why this strategy is not used more frequently.

The following case illustrates its potential use when addressing a case of intercanine width loss.

## Case Report

A 43-year-old female (Patient C) presented complaining of "crooked front teeth". Her main concern was her lower teeth. She asked for them to be "straighter". She also complained of jaw joint pain and a "clicky" jaw.

Examination revealed mild to moderate crowding of the lower anteriors. Space calculation indicated 3.5 mm of crowding, which meant that 3.5 mm of space needed to be created to allow the teeth to align. Space calculations can be carried out by Hanchers technique, manually or using a digital space calculator, such as Spacewize. These space calculators are an excellent way for clinicians to visualise actual crowding and exactly where the teeth need to go as this becomes a perfect prescription for the lab setup.

The width of only one tooth needs to be measured as the programme will use this for calibration. The dentist then simply draws lines on the teeth by a single click that measures the mesial-distal width of each tooth being moved (known as the required space, or 'the teeth') and then the programme allows a curve to be intuitively set up that follows the line of the ideal curve (known as the available space or 'the curve').
The curve needs to be set through the landmark teeth – meaning teeth that are well-placed occlusally and aesthetically. This will prevent the teeth from flaring out and ensure correct occlusal control.

The programme then does the math and subtracts the required space from the available space. This figure represents the level of crowding and hence the amount of space that might need to be created by interproximal reduction (IPR), expansion or domino effect.

In this case, there was clearly also a deep bite emerging, reducing anterior and canine guidance.

Close anterior photos were examined and discussed with the patient. It was pointed out that the anterior teeth were all at different lengths. Before alignment, patients often do not see this. Their eyes are focused on the crowding and they do not realise that the irregular outline is equally due to differential wear. This discussion is very important because patients must be aware of the extra treatment that may be needed after alignment.

In my experience, most adults have some degree of differential wear. After alignment, teeth rarely need to be ground in order to level them off as this is clearly destructive and will only reduce guidance and increase posterior interferences over time. Instead, in most cases, the bite is built and opened anteriorly with composite and the Dahl effect is in-

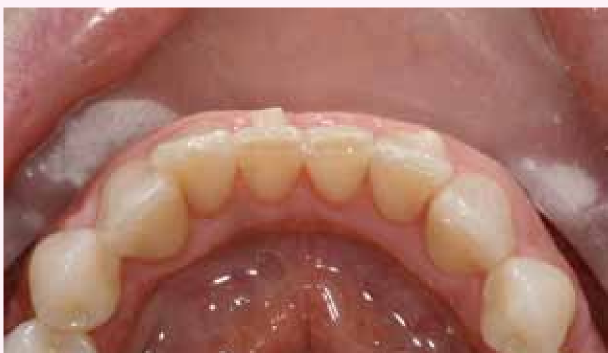


**Figure 10. Occlusal after eight weeks of alignment and start of bleaching.**

**Figure 12. Before close side view. Note differential wear.**

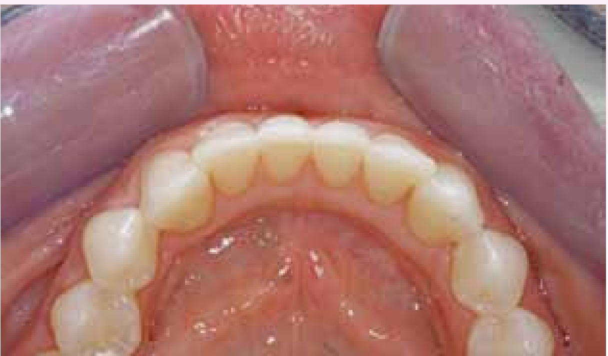


**Figure 11. After 12 weeks with bleaching complete and additive bonding in place.**

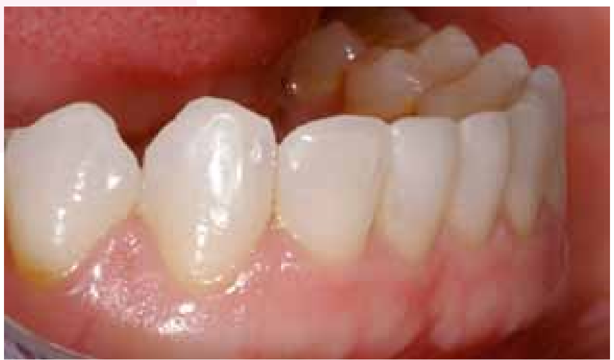


**Figure 13. Close side view after alignment with Inman Aligner, bleaching, and Dahl principle bonding.**

duced. Those who treat adults with orthodontics must be able to rebuild the tooth structure or co-plan with a restorative dentist in order to protect the patient's guidance.
The patient wanted an Inman Aligner as she wanted her teeth to align quickly; she also wanted to be able to remove the appliance for periods at work. We also quoted for eight composite tips to improve the aesthetics, treat the deep bite and induce the Dahl effect to establish better anterior and canine guidance.

## The Treatment

Her Inman Aligner treatment took 10 weeks with three sessions of IPR and no more than 0.13 mm of adjustment per tooth per appointment.

This staged IPR approach is far safer than performing all of it in one session, as less IPR is often needed than expected. It avoids excess space formation and the destruction of contact point anatomy, which is so often seen when IPR is done all at once. Anatomically respectful IPR should be performed by anyone creating space to move teeth.

The patient was also instructed to remove the aligner for at least four hours a day.

At seven weeks, the patient started whitening with Zoom! DayWhite (Philips Oral Healthcare) when not wearing the aligner. Whitening can be highly effective if the proper instructions are given to the patient. Dry teeth will whiten better, so we routinely instruct patients to swallow, then suck air over their teeth before the tray is inserted. In my experience over the last few years, this has made whitening far more predictable and the results have been consistently better.
A short-acting hydrogen peroxide gel that requires only 45-minute application each day is ideal. With sealed rubber trays, it does not matter if the teeth are still aligning. After eight weeks, they are usually 60-75% aligned. The tray will still fit at the end, but a new tray is made over the composites and wire retainer. Performing whitening in this way adds massive value and reduces chair time and, of course, can only be done with removable braces.

You cannot, and should not, use short-acting concentrated gels in rigid clear aligner trays as they are not sealed and the gel will come in contact with the gum line. Lower percentage bleaching materials are indicated.

At 12 weeks, the composite tips were placed in one session. It is quite possible to have your technician construct a wax-up of the proposed outline. It is also feasible to do this with articulated models and a wax-up. You can then use a putty stent to help you create an accurate outline.

Personally, I have always preferred to build free-hand. I try to visualise the original anatomy of the teeth before they were worn. The new initial contact position is slightly posterior to maximum intercuspal position. Very minimal feather preps were used to slightly roughen the bonding surface. The teeth were then etched, bonded and an initial outline of the load-bearing areas was built up with a nano-hybrid composite.

Figure 14. Before close view.

Figure 16. Before patient protrusive, edge to edge.

Figure 15. After close view.

Figure 17. After protrusive. Note how upper alignment has improved by simply aligning the lowers correctly.

A dentine shade, then an incisal enamel shade, was layered over. The composite was then polished back with fine burs and smoothed with Soflex discs and Pogo rubbers.

Eight composites were placed in this manner. They were built up using different amounts but in a way that aligned the incisal outline and that opened the bite on the anterior teeth. It was important that their contacts be fairly even but with more load on the canine and premolar and a long centric contact on the incisors. At this point, the patient's posterior teeth were discluded and a visible space was present.

The patient continued to wear her Inman Aligner and an impression was taken for a jig that would hold a stainless steel retainer to be fitted next time.
A bonded retainer was fitted to the lingual surface from canine to canine and the patient was instructed on the use of interdental brushes.

## The Results

The patient was seen after 3 weeks to ensure there were no premature posterior contacts. On return after a few months (Figure 4), it was noted that the posterior teeth were now in full contact again. Lateral excursion showed good predictable canine guidance and anterior guidance was now completely discluding the posteriors. Whether this has happened due to passive eruption, anterior intrusion or even some repositioning of the condyle can be argued. The point is that the patient's deep bite was reduced, her occlusal symptoms disappeared and the aesthetics had greatly improved. She had better canine and anterior guidance and, one year on, she has had no issues, chips or even stains.

A potentially difficult treatment plan was transformed into a simple non-invasive technique and the photographs show a pleasing result. The patient reported an improvement in symptoms. However, we always give the patient a bite guard to wear in case of periods of bruxism.

## Conclusion

We have all read articles showing similar cases that eventually end up with invasive preparation for ceramic restorations. Patients like this left untreated will in the long term become more worn and eventually may need full mouth or extensive treatments.
While I certainly cannot profess the Dahl principle to be the answer to all occlusally compromised cases, I suspect that with the recent trend towards non-invasive treatments and rapidly rising litigation, this kind of less destructive solution might become more popular.
The key is to pick up on likely candidates early and treat them with alignment and bonding or just bonding to help prevent wear in later life. If patients are aware of the benefits and of the problems they could avoid, there could be millions of potential candidates for this kind of treatment. ■

*Tif Qureshi is in private practice in the UK and is the Immediate Past President of the British Academy of Cosmetic Dentistry. He leads the Global Inman Aligner Training Programme.*

*Suggested reading available on the ICD European Section website: http://www.icd-europe.com/*

Failures in Implantology

# When Minor Details Matter

Dental implantology has evolved both as a dental specialty and a dental treatment carried out by general dental practitioners since Professor P.I. Brånemark installed the first dental implant in a human volunteer.

**John Orloff**

Very early in research, the focus in dental implantology was on survival rates and success rates, and different criteria have been developed over time.
Smith and Zarb suggested the following criteria in 1989, which have become the standard for evaluating implants:
- Immobile when tested clinically.
- No evidence of peri-implant radiolucency.
- Less than 0.2 mm annual bone loss after first year of service.
- No persistent pain, discomfort, or infection is attributable to the implant.
- The implant design does not preclude placement of a crown or prosthesis with an appearance that is satisfactory to the patient and dentist.

By these criteria, a success rate of 85% at the end of a 5-year observation period and 80% at the end of a 10-year period are minimum levels for success.

This set of criteria has been modified by Van Steenberghe et al at NIH 1997:
- Does not cause allergic, toxic or gross infectious reactions neither locally nor systemically.
- Offers anchorage to a functional prosthesis.
- Does not show signs of fracture or bending.
- Does not show any mobility when individually tested by tapping or rocking with a hand instrument, or, when tested with an electronic tapping device, does not reach improper values of rigidity.
- Does not show any signs of radiolucency on an intraoral radiograph using a parallel technique strictly perpendicular to the implant-bone surface.
- In order to determine the prognosis, marginal bone loss (on intraoral radiographs) and/or attachment loss (probing depth + recession) should not jeopardise the anchoring function of the implant or cause any discomfort to the patient before 20 years.

A Medline search in April 2013 for "dental AND implants" produced 14,243 hits (1,393 reviews), and 1,342 hits (181 reviews) when searching for "complications AND dental AND implants". When searching for "failure AND dental AND implants" the hit rate was 2,246 (260 reviews), indicating that complications and failures today represent a substantial proportion of research in dental implants and therefore must be an important aspect of dental practices dealing with these procedures.
Zarb and Smitt observed complications as early as 1990, stating that 'virtually all of the problems encountered were iatrogenic in nature.' This means that the key to minimising complications is to be found in the dental offices when carrying out the various procedures.
Moy found in 2005 that the overall failure rate in the maxilla was almost double of that in the mandible (8.16% in the maxilla and 4.93% in the mandible). He also found that age is a factor – 60-79-year-old patients have 2.2 x higher failure rates than patients younger than 40 years.
Up to the early 2000's, most research in dental implantology was based on 'survival rates' (the proportion of implants still in place at a certain time) and 'failure rates' (the proportion of implants lost at a certain time).
The more recent term 'success rate' (the subjective evaluation of a treatment outcome) is based on many different parameters, i.e. the patient's expectations, the provider's capabilities, measured in terms of relative proportion of the restoration to the contralateral tooth in single tooth restorations or general blending in the residual dentition.
Research of patient expectations is very limited. Dental implantology research (Zarb, 1990) and multicenter studies show different survival and success rates for different centres, but the specific effect of the provider's skills on the overall treatment outcome is often overlooked.
Figure 1 shows a clinical case, where the implant resto-

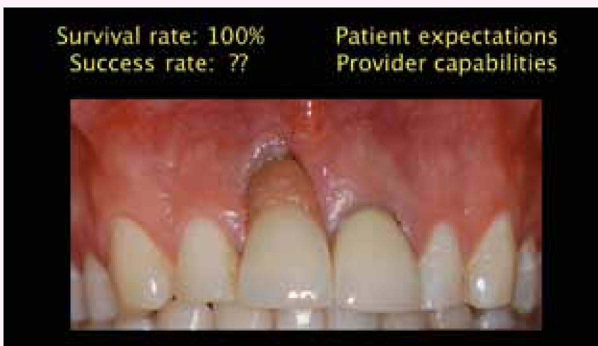



*Figure 1. A single tooth dental implant #11 still in place (100% survival rate) but with a debatable success rate.*

J Oral Rehabil. 2008 Jan;35 Suppl 1:72-9.
**Prosthetic treatment planning on the basis of scientific evidence.**
Pjetursson BE, Lang NP.

| Survival rate | 5 years | 10 years |
|---|---|---|
| conventional FDPs | 93.8 % | 89.2 % |
| cantelivler FDPs | 91.4 % | 80.3 % |
| implant-supported FDPs | 95.2 % | 86.7 % |
| combined tooth-implant supported FDPs | 95.5 % | 77.8 % |
| implant supported SC | 94.5 % | 89.4 % |
| resin-bonded bridges | 87.7 % | 65.0 % |

*Table 1. Data from Pjetursson et al, 2008.*

ration is still in place (age unknown) leading to a 100% survival rate, but the success rate is debatable. Is the patient satisfied? Does the crown part of the restoration blend in? Does the colour of the soft tissue match the surrounding tissues? Does the reconstruction allow access for optimal hygiene procedures? And other questions can be asked in order to determine the success rate. Is it 100%, 10% or 1%? It all depends on the factors included for evaluation.
Gehrke (2008) discussed the pink aesthetic score in terms of the dental observer specialisation based on Fürhauser's score from 2005. These scores are intelligent measurement scales, which unfortunately are somewhat too complicated for the general dental practitioner. If success rates are to be scored objectively in dental practice, they need to be easily accessible and easy to learn with low interexaminer variability.

## Survival Rates Used for Treatment Planning

Survival rates for different dental treatments are interesting for comparison purposes, but the major benefit from such research information is obviously in the planning phase and in the choice of treatments for patients.
One could claim that research data only shows averages from a patient population and not the complex situation for specific patients. But research data from large cohorts and well conducted studies can be used as guidelines in treatment planning for individual patients.
Pjetursson (2008) wrote a summary of a series of systematic reviews on survival and complication rates for various designs of fixed dental prostheses (FDP). Table 1 shows the 5-year and 10-year follow-up data. Interestingly, conventional FDPs and implant-supported single crowns (SC) have roughly the same survival rate over 5 and 10 years. Conventional FDPs show survival rates over 5 years and 10 years of 93.8% and 89.2% respectively, versus 94.5% and 89.4% respectively for implant-supported SCs. There is no significant difference in these data indicating that survival rates cannot be used for decision making between a small bridge or a single tooth implant. Other factors have to be taken into consideration - see below.
It is also of interest to note that combined tooth and implant-supported FDPs have a 5-year survival rate of 95.5%, dropping to 77.8% over 10 years. An even higher drop in survival rate is seen in resin-bonded bridges, dropping from 87.7% over 5 years to 65.0% over 10 years.

Jung (2012) analysed complications of implant-supported SCs and listed different findings from longitudinal studies with a mean follow-up of 5 years:

- 7.1% soft tissue complications, which as stated above can be difficult to quantify or compare between different studies.
- 5.2% bone loss > 2 mm, which according to Smith and Zarb 1989 is far from acceptable.
- 8.8% screw loosening, which is easily detectable in "flat" abutment/implant connections, but can be more difficult to detect and become more complicated (abutment fracture) in more tapered abutment/implant connections.
- 4.1% loss of retention, which means that the crown becomes loose due to cementation failure, occlusion etc.
- 3.5% fracture of veneering material, which is equal to fractures of tooth-supported ceramic crowns. The major reason is unsupported ceramic due to non-optimal framework design for supporting the ceramic.
- 7.1% aesthetic complications, which is even more complicated to set parameters for, even though Fürhausers and Gehrke have developed systematic data collection protocols.

This adds up to 23.5% technical complications over 5 years for an implant-supported SC!

**The author of this article has for several years had an interest in the 'reverse side' of success and survival rates: the complications and failures in dental implantology. His first presentation on this subject was in 2001 at The First Asian Friadent Implantology Symposium. Over the past 3 years, the author has videotaped all his dental implant operations for documentation and education purposes.**

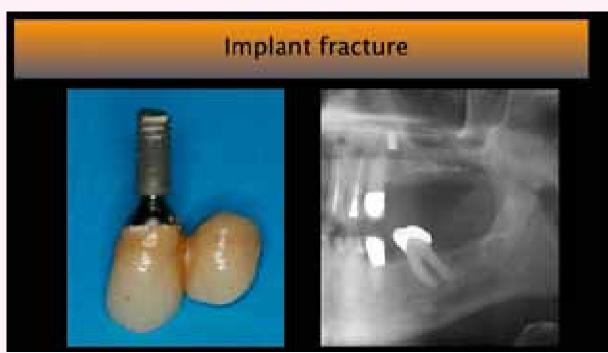



*Figure 2. Implant fracture due to loss of bone and overload.*

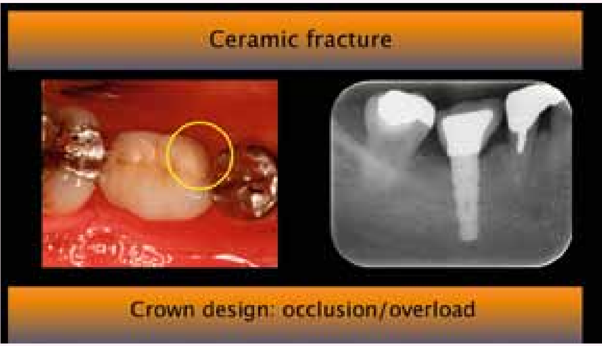



*Figure 3. Ceramic fracture/chipping due to overload and/or unsupportive design of metal coping.*

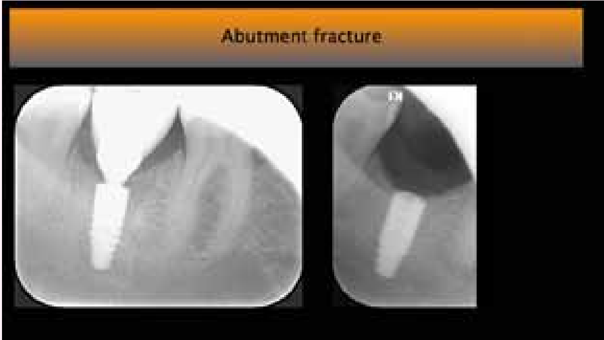



*Figure 4a. Abutment fracture.*

*Figure 4b. Abutment fracture due to overload in terms of occlusal forces, abutment strength and design.*

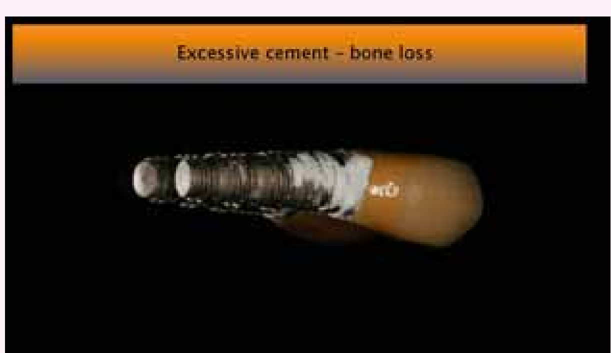



*Figure 5. Excessive cement due to bone loss prior to cementation and failed cementation procedure.*

*Figure 6. Misplaced implant – position "central incisor".*

Clin Oral Implants Res. 2012 Oct;23 Suppl 6:2-21.
**Systematic review of the survival rate and the incidence of biological, technical, and aesthetic complications of single crowns on implants reported in longitudinal studies with a mean follow-up of 5 years.**
Jung RE, Zembic A, Pjetursson BE, Zwahlen M, Thoma DS.

| Complications ISC | 5 years | 10 years |
|---|---|---|
| survival rate - Jung 2008 | 97.2 % | 95.2 % |
| survival rate - META Jung 2012 | 96.3 % | 89.4 % |
| soft tissue | 7.1 % | n.a. |
| bone loss > 2 mm | 5.2 % | n.a. |
| screw loosening | 8.8 % | n.a. |
| loss of retention | 4.1 % | n.a. |
| fracture of veneering material | 3.5 % | n.a. |
| aesthetic complications | 7.1 % | n.a. |
| **Technical complications** | 23.5 % | |

*Table 2. Data from Jung et al, 2012.*

Clin Oral Implants Res. 2012 Oct;23 Suppl 6:22-38.
**A systematic review of the survival and complication rates of implant-supported fixed dental prostheses (FDPs) after a mean observation period of at least 5 years.**
Pjetursson BE, Thoma D, Jung R, Zwahlen M, Zembic A

| Complications | 5 years | 10 years |
|---|---|---|
| fracture of veneering material | 13.5 % | |
| peri-implantitis + soft tissue complications | 8.5 % | |
| loss of access hole restoration | 5.4 % | |
| abutment screw loosening | 5.5 % | |
| biological + technical complications | 33.6 % | |

*Table 3. Data from Pjetursson et al, 2012.*

*Pjetursson (2012)12 examined fixed dental prostheses (FDPs) after a mean observation period of at least 5 years and found the following complications:*
*- 13.5% fracture of veneering material*
*- 8.5% peri-implantitis and soft tissue complications*
*- 5.4% loss of access hole restoration*
*- 5.5% abutment screw loosening*
*- 33.6% biological and technical complications.*

*Based on the 5-year complication rates in these 2 reviews, the practitioner can expect*
*- 23.5% technical complications in implant-supported single crowns and*
*- 33.6% biological and technical complications in FDPs.*

## Conclusion

In dental implantology, complications are substantial after 5 years. Longer follow-ups are currently not available in the literature, but will be presented within a few years.
Complications must be expected in 25%-33% of all implants (or patients). Such statistics have significant financial and personal impact on both the patient and the dentist, which must be considered before and during dental implantation procedures. ■

*Dr. John Orloff is a diplomat specialist in implantology of the Royal College of Surgeons London and owner of the Hausergardner clinic in Copenhagen, Denmark*

*References available on the ICD European Section website: http://www.icd-europe.com/*

## P&F Chairman Gil Alcoforado making a difference by doing things 'anybody can do'

# Overcoming Inertia

You can never do everything for everyone, but you can always do something for someone. This expression seems to perfectly characterise Portuguese-born ICD Fellow Gil Alcoforado, who, while still learning the mechanics of his new role as P&F Chairman of the European Section, is well-versed in the practice of humanitarian initiative. Driven by a desire to give something back for what life has given him, he has found that becoming involved in humanitarian work is exquisitely rewarding and actually quite easy. All it takes, he explains, is a decision to do something. Once you decide to move, things start moving around you to help achieve results you wouldn't have dreamed of at the start.

**Merryn Jongkees**

### Father Inspiring Tutor

His father, a very successful and highly respected dentist in Lisbon, Portugal, almost missed his son's birth in order to be inducted as an ICD member in 1955; that same son attended his first ICD meeting at the age of 6 – Gil Alcoforado recognises his father and the ICD as early and powerful influences in his life. His father, now at age 96, and having worked up to age 87, continues to be one of his greatest inspirations and tutors.

'I grew up watching my father's passion for the profession, and liking the smell of eugenol in his office. My father was one of the best practising dentists in Lisbon, I was told; he had excellent professional ethics and an uncompromising insistence on details. The family was not happy when they introduced ceramics in Portugal: for a full year he used the home bathroom to experiment with it, making sure he knew exactly how to use it before he took it to the office, where he had two lab technicians working for him.'

***The little drop of water I contribute to an ocean of need, is not lost; it means something to someone***

'He actually wanted me to be an engineer and work in the family business, but I went into medical school. When, after three years, the dental school opened and I entered, my family would have preferred me to finish medical school, but I loved periodontology from day one. I became my father's hygienist, working in his practice one day a week as I finished my dental studies. I was amazed at what I was able to achieve with simple skills, good root planing and oral hygiene instruction. This has been my life's passion ever since. When I finished my studies, I had no doubts that this is what I wanted to do.'

'Looking back, I see how much I owe my father for everything he has taught me. He was a perfect example. He instilled in me an attitude of never being satisfied – after surgery, he said, I should always look back and ask myself, what could I have done better? You have to do this immediately after you finish, or you lose the details. My dental assistant says I'm hard on myself and never pleased with what I've done, that everything went very well. But I will always find this or that which could have been improved. It's my way of not falling into habit and repetition, and the only way to improve. I tell my students and staff that if they ever hear from me that something is perfect, they need to ▶

send me home because I'm ready to retire. I got that from my father, and I'll always be grateful to him.'

### Early ICD Years

'I became a member of the ICD in 1985, somewhat against my father's wishes. I think his colleagues may have pushed for that a little bit. He was the Regent of the Portuguese District and a Past President. At that time I was the only periodontist in Portugal. Looking back, it was perhaps a bit early. But I realised it was something very special, and it spurred me to do something for the College. After a few years the Portuguese District asked me to become the Regent. Having had my father as Regent was, I would say, emotionally very important. Again, the responsibility went up.'

'I don't think age is a primary criterion for induction, but you must have something to look back on. We have a wonderful example in our current Vice-Regent, who has achieved so much in humanitarian work; he was inducted at even a younger age than I was. His works speak for him.'

Was it difficult having a prominent father and becoming an ICD Fellow while he was still active? 'Well, people always tend to compare, and yes, it was difficult. People had different feelings about my father, some loved and respected him, while others envied his success. I was in a different field from my father, and one he didn't very much believe in. When I started in periodontology, he was very worried and asked me, "Do you think you can support your daughters doing perio, without prosthetics? But I persisted. I chose periodontology because of the results I saw as a hygienist.' With a smile he adds, 'And he never did need to help me support my daughters.'

### Humanitarian Beginnings

It is this quiet but determined persistence, even when faced with opposition, which eventually brought Gil on a path of service to the people around him. It is a humbling experience to hear Gil Alcoforado describe his gratitude for what life and dentistry have given him. 'The profession has been very good to me, I have always done what I love to do. Whatever you do with love you do best, it comes naturally. I'm kind of a religious person, whenever I go to church, all I do is give thanks, because I have been blessed immensely – my marriage, my parents, my daughters, my work. I am a very fortunate man.'

During a period in his life that his health forced him to take rest, he decided it was time to put that gratitude into action. A friend and ICD member in the US, Dr. Steve Mackler, who has done tremendous humanitarian work, had invited Gil to join him in his efforts in the Amazon and Africa. While Gil was recovering from back surgery, and even unable to lift a book to read and therefore with much time to think, he knew it was time for him to do something. Even though Dr. Mackler had been a great inspiration to him, why, he asked himself, 'go to the Amazon or Africa, when there is so much that needs to be done right here in Portugal?'

***Once you decide to move, things start moving around you***

## Simple Prevention in a Non-Office Environment

'Close to Lisbon's affluent neighbourhood, perhaps 500 metres from the tennis club, is a district people used to call the End of the World; mostly refugees and foreigners lived there. It's the type of place with bullet holes in the walls. I wanted to do something for the children there, so I started giving oral hygiene instruction and fluoride application, things you can do in a non-office environment. I would usually give such treatments twice a year, but since this was a population at risk, I did it four times a year, just simple primary prevention. I didn't record any data or keep notes, but based on empiric information from the local system the number of emergencies has gone down over the years. These were just small things that anybody can do.'

The work accelerated dramatically after the ICD Maastricht meeting in 2010. His experience illustrates how small events can have great consequences. 'One presentation was on an oral hygiene campaign in schools in the Philippine jungle. Prof. Wim van Palenstein Helderman showed a fantastic video that hit home. When he finished I asked him for a copy, because I thought I had a very good use for it. It felt like I was carrying an incredibly powerful tool in my hands. I went home, and three days later I had in my office the VP of the National Assembly. I asked her, "Do you have six minutes, I could show you a short video that might interest you." I showed her the video, and she was impressed: seeing the children, the distribution system for toothbrushes, toothpaste, the President of the Fluoride Brigade, the Vice-President of the Fluoride Brigade, the kids do it all. She thought it was fantastic. I said, "Isn't this wonderful? Just imagine what we could do right here for our own children. There is just one problem: politicians won't go anywhere with this." "Why?" she asked. "Because the results won't show before four years so they can't use them politically." She was so angry with me, I thought she was going to hit me,' he recalls, visibly amused.

## *Transforming the impossible into reality – it happens!*

'She left, and three quarters of an hour later the telephone rings, it's the Mayor. He said, "I spoke with the Vice-President, I'm very interested in your ideas, can you meet me tomorrow?" "Well, I have consultations," I said, "but I'll cancel everything." So I went. To make a long story short, three weeks later I had a school allocated in that area, and we started giving oral hygiene instruction, daily brushing and dietary counselling to both the children and their parents. They said: "Show us results, if you show us results, we will give you more schools." We started with 174 children and were able to reduce plaque by 70% in 6 to 8 months. They were amazed; the next year they gave us 13 more schools. We now have more than 7000 children, implementing the same structure. And it all started with a little video at one of the ICD scientific sessions.'

## Unique Human Experience

Gil intends to use the ICD as a platform to spread similar initiatives. 'Many Fellows want to do something, but because of inertia and procrastination, they never make a start. If we can create a structure, a scaffold, give help and ideas, it can have a great multiplying effect. There is so much potential in the ICD European Section. In every Fellow lives a desire, all they need is a nudge to help them cross their barrier to move them into action. This should definitely become an even stronger focus of the ICD. We can bring in more new Fellows, but we may also lose them again. Once they get involved in ICD humanitarian work, I am sure we can help them to retain their commitment and enthusiasm; I know this from personal experience!'

Gil is visibly touched as he remembers people and experiences that have become dear to him. 'You know, it almost feels selfish, the satisfaction you get out of it. You contribute a drop of water in an ocean of need. You may think it makes no difference. But the drop of water I contribute means something to someone. Wouldn't it be wonderful to use the ICD as a catalyst to make initiatives like this happen in the lives of our Fellows and those they can reach out to? It's a unique human experience.' ■

Changing Paradigms in Implant Dentistry

# Backward Planning

Conceiving the end result before embarking on treatment is becoming easier. Both the patient and the clinician can now visualise their journey using technologies such as 3-dimensional imaging, stereo lithography and CAD/CAM. This article describes how changes in the field of implant dentistry impact the way we work and benefit our patients, and addresses a staged approach to treatment versus the immediate replacement of failing teeth.

**Ashok Sethi**

## Backward Planning (Forward Thinking) Staged Treatment

Conceiving the end result before embarking on treatment requires a number of stages, both technical and clinical. The key is to start off with a realistic diagnostic preview (Figure 1), and then transfer this information from one stage to the next and between the laboratory casts in the mouth.

*Figure 1. Diagnostic preview of the proposed aesthetic outcome and occlusal scheme.*

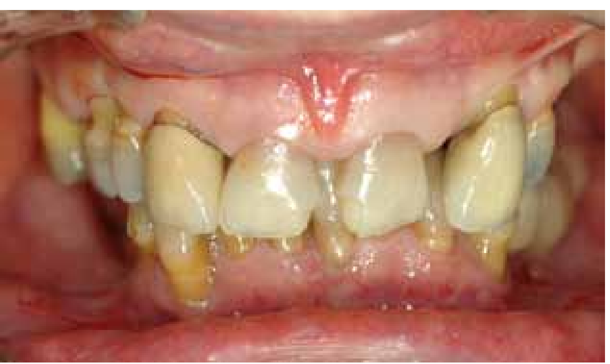


*Figure 2. Preoperative view of the patient showing mal-positioned teeth and overclosed intermaxillary relationship.*

3-dimensional imaging coupled with an interactive software programme (Simplant, Leuven, Belgium) greatly increases the accuracy and predictability with which the treatment can be completed (Sethi and Kaus, 2012). The following case depicts the management of a patient with failing teeth who required a change in the appearance as well as the occlusal scheme to improve aesthetic and functional outcome (Figures 3-8).

## Immediate Replacement of Failing Teeth

Staged treatment is highly predictable. However, recent observations and developments in surface technologies have made the immediate placement and functionality of implants equally predictable. This is a very attractive option for patients in view of the lower number of surgical appointments. Importantly, this enables patients to have failing teeth extracted and at the same time have the new teeth implanted, albeit with the provisional restoration.

The same process of diagnostic imaging and transfer of tooth position data can be carried out for a patient with failing teeth where there is a need for immediate replacement of these teeth with implants.

The positions and dimensions of the implants required for rehabilitation of the patient can be selected within the Simplant programme using Cone Beam CT (CBCT) data. This information can be transferred to a drill guide, enabling the placement of implants at the correct position and depth.

This is facilitated by the use of stereolithographic models created directly from CT scan data. This of course enables the fabrication of transitional restorations directly on the stereolithographic models. Abutments can be selected at the same time based on selected tooth positions.

The following case depicts the management of a patient

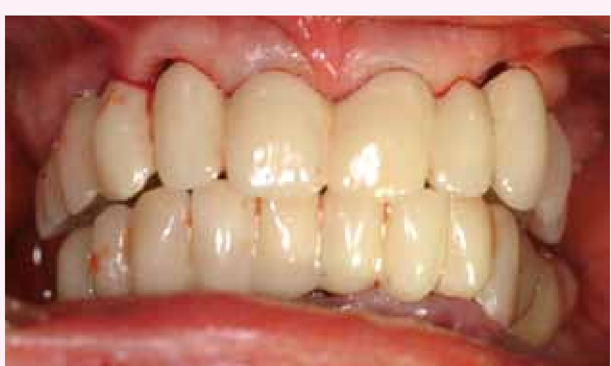


*Figure 3. Showing the transfer of information from the diagnostic preview to the mouth in the form of a provisional metal acrylic bridge supported by selected teeth. Note the change in tooth position and intermaxillary relationship.*

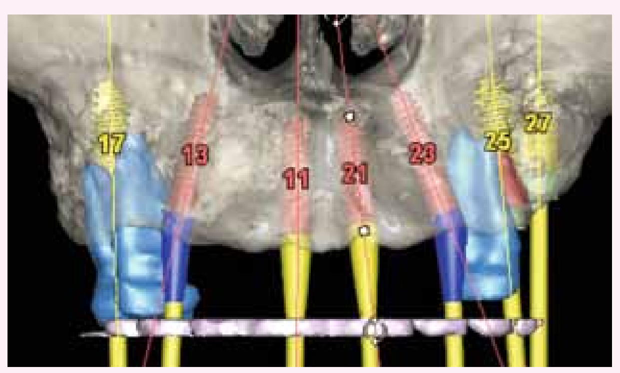



*Figure 4. Cone Beam CT scan. Interactive planning using the Simplant software showing the positioning of the implants within the available bone as well as the selection of the abutments, which lie within the prosthetic envelope.*

*Figure 5. Intraoperative view showing the implants inserted into preselected positions decided upon using the Cone Beam CT scan.*

*Figure 6. Transitional restoration made from data transferred from the diagnostic preview and the metal acrylic provisional. The transitional restoration is supported by the abutments. It is used to develop soft tissue contours for a natural emergence profile.*

*Figure 7. Intraoral view of the abutments on completion of soft tissue healing. The contours developed by the transitional restoration are visible. Please note that the abutments lie within the prosthetic envelope and are aligned to each other.*

*Figure 8. Definitive restoration. Note the naturally contoured soft tissue emergence profile.*

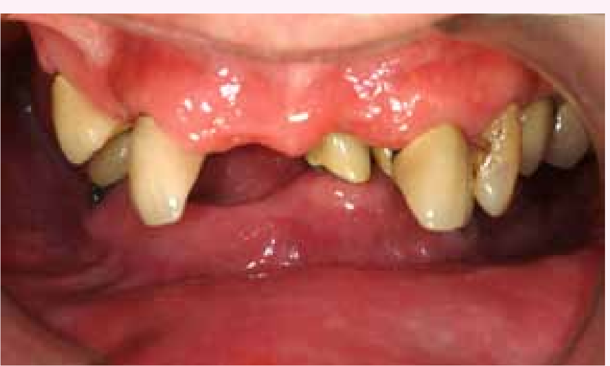


Figure 9. Case 2. Preoperative view of total overclosure with traumatic occlusion.

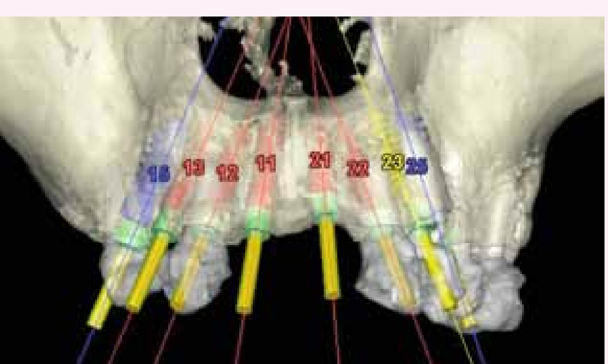



Figure 10. Interactive planning on the 3-dimensional image using the Simplant software. Each implant position can now be transferred to a stereolithographic model constructed from CT scan data. In addition a drill guide can be created from the same data, which will transfer the implant position from the planning directly to the mouth. The Expertease system permits precise positioning in terms of angulation as well as depth.

Figure 11. Stereolithographic model is visible which is a replica of the maxilla and is fabricated from the CT scan. Implant analogues have been inserted into this model and the abutments selected and customised as required. The transitional restoration based on the diagnostic preview (wax-up) is visible. This restoration will be supported by the abutments. The connection of the transitional restoration to the abutment is via a prefabricated acrylic sleeve, which is also visible in this image.

Figure 12. The implants have been inserted into the maxilla. The preselected abutments have been attached and are visible in perfect parallelism and alignment to each other. These have been transferred from the stereolithographic model.

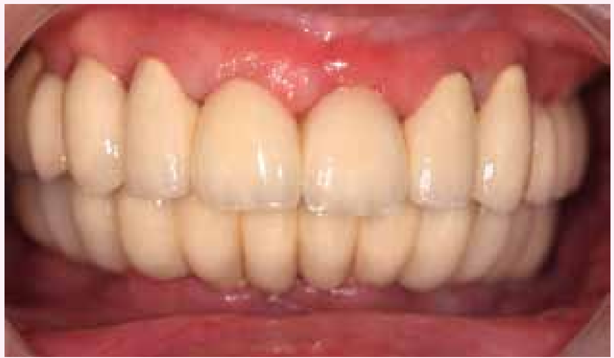


Figure 13. The definitive porcelain fused to precious metal alloy can be seen. Note the closing scheme, which has been transferred from the diagnostic preview.

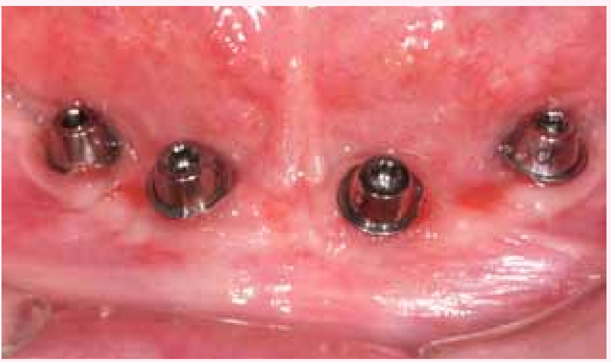


Figure 14. Four abutments, attached to implants in the interforaminal region can be seen. Impressions of these are taken using the open tray technique. Accuracy verified and master cast constructed.

*Figure 15. The master cast with abutment analogues is visible. This has been constructed from a verification jig. This will be scanned along with the diagnostic preview. Both the master cast as well as the diagnostic preview will be sent to the scanning centre.*

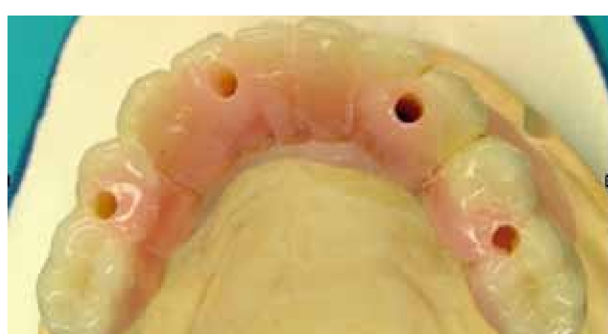


*Figure 16. The diagnostic preview will be sent to the scanning centre along with the master cast. The scanned data will then be used to construct the metal (chrome cobalt) framework.*

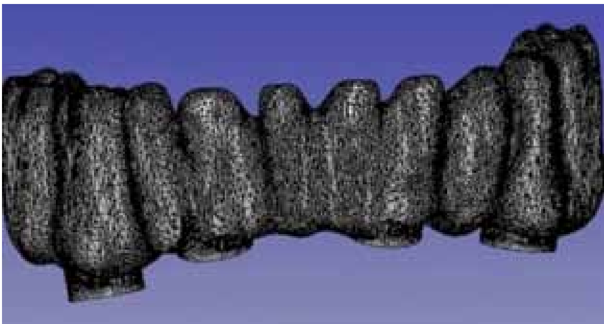


*Figure 17. The diagnostic preview scanned. The contour of the try-in has been digitally reduced to allow for space for the addition of the veneering material, which may be either porcelain, composite or acrylic.*

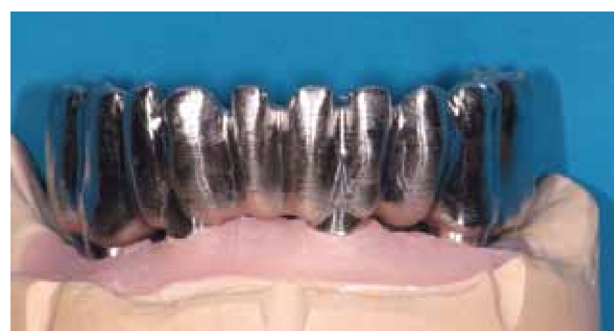


*Figure 18. The metalwork can be seen seated on the master cast. Provision has been made for the veneering of the porcelain.*

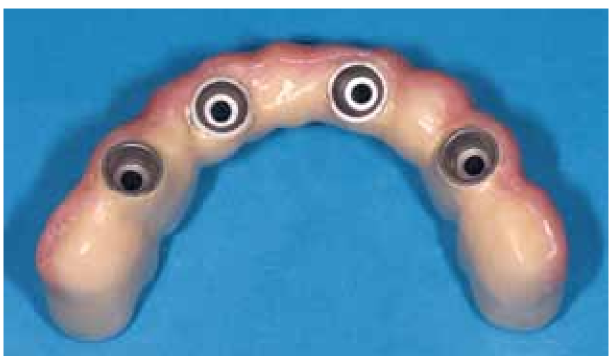


*Figure 19. The fit surface of the framework with the porcelain fused to it is visible.*

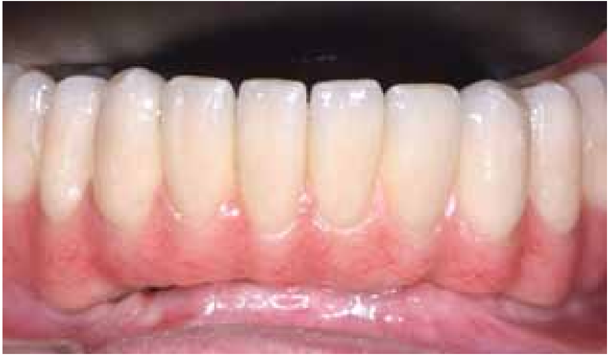


*Figure 20. The definitive screw-retained restoration is visible. The main advantage of CAD/CAM technology is that it allows for the fabrication of the metal framework, which is more likely to fit accurately than a conventionally cast framework.*

whose medical condition required minimisation of the number of interventions (Figures 9-13).

## CAD/CAM (Computer-Aided Design and Computer-Aided Manufacturing) Technology

The first stage is to construct an accurate cast of the abutments in the patient's mouth (Assif et al., 1996, Assif et al., 1999). The cast with the abutments can then be scanned using a digital scanner. At the same time the diagnostic preview (wax-up) indicating the position of the planned teeth must be scanned.

Once the desired tooth position and the abutment position and shape have been scanned, it is possible to fabricate a prosthetic framework by milling it from a number of materials. These may be titanium, zirconium oxide or a chrome cobalt alloy. Porcelain or acrylic can then be veneered onto the framework.

Figures 14-20 depict the fabrication of a framework using CAD/CAM technology, which enables a more accurate fit to be achieved than with a framework made by conventional casting technology (Takahashi and Gunne, 2003).

*Ashok Sethi is a specialist in surgical dentistry and prosthodontics in his Centre for Implantology and Reconstructive Dentistry in London. He is a founding member and past president of the Association of Dental Implantology UK.*

*Excellent news that all Fellows can now work to the same framework*

# European ICD sponsors WHO Publication

It was at a hastily arranged meeting of the Projects and Funding (P&F) Committee of the European Section of the ICD, during the lunch hour on the scientific day in Munich, that the liaison between ICD and WHO was first mooted. The P&F Committee had been formed by the amalgamation of the trustees of the Philip Dear Foundation with the Projects committee so that the decision making process for projects to fund and the finances involved became a seamless operation.

**Prof. Phillip Dowell**

Information about the need for funding the publication, the 5th Edition of Oral Health Surveys Basic Methods, was given to us by Committee member Prof. Ken Eaton. Ken is the Immediate Past President of the European Association of Dental Public Health (EADPH) specialist interest group in Periodontal Epidemiology and also current Chair of the Platform for Better Oral Health in Europe. He is and remains a great resource of information for our Section and updated us on the plight of WHO with regard to the financial aspects of funding the publication. It was therefore at this meeting that Prof. Eaton asked whether the Philip Dear Foundation of the European Section could sponsor the new publication to the amount of ten thousand US Dollars. The discussion of this possibility was wide ranging and the vote in favour was unanimous given certain assurances were granted by the WHO.

As Chair of the Committee I contacted Prof. Poul Erik Peterson, head of Oral Health at the WHO headquarters in Geneva and commenced a long protracted dialogue concerning this arrangement. The final outcome was that the WHO could give acknowledgment to the ICD for the funding but more importantly that the ICD could make the electronic version of this publication available on it's website, not only to the European Fellows, who had funded it, but to all its Fellows worldwide.

The International College of Dentists is placing more and more emphasis on projects of an educational or humanitarian nature and has large numbers of ongoing projects not only from the European Section but in sections and regions worldwide. In order to get funding from the Philip Dear Foundation applications must be made according to the recently revised application forms. The process demands a proper scientifically written protocol with an evidence-based approach and regular review periods with systematic reporting of data.

It is envisaged that the European application process will be shared with other sections and in particular used by the newly created Global Visionary Fund (GVF) set up by the International council specifically to fund projects in low and middle-income countries (see www.icd.org).

As stated in the newly published manual, the aims are to encourage national oral health survey planners to standardise measurements of oral diseases and conditions that are important for planning and evaluation of oral health programmes, as well as to ensure the comparability of data collected in a wide range of environments. It does this by applying the WHO global approach to chronic disease surveillance to an operational model for integration of oral health into chronic disease surveillance systems. Adoption of this approach will:

- Encourage systematic reporting of data on oral diseases and conditions.
- Ensure that the data collected are reliable and comparable within and between countries.
- Encourage collection of data on self-reported oral health and risk factors consistent with STEPS framework.
- Provide an option to countries that have a special interest in collecting data on major oral conditions associated with the human immunodeficiency virus (HIV AIDS).

The manual is divided into three sections.

Section 1 provides background information for survey planners on the methods and approaches relevant to collection of clinical data on oral health status.

Section 2 covers self-reporting of oral health and the risk factors assessed by means of questionnaires.

Section 3 describes survey activity such as data analysis and survey reporting.

It is excellent news that all Fellows can now work to the same framework and that our project reporting can, where necessary, be standardised in format.

As Ken Eaton stated, "a big thank you to the ICD for having the foresight to fund this publication which will be invaluable worldwide".

*Phillip Dowell is the former Chairman of the Project & Funding Committee. The new Chair is Gil Alcoforado, Regent for Portugal.*

*The new Chair of the P&F Committee is Gil Alcoforado, Regent for Portugal.*

# Project Smiles Door to Door

Today's older adults keep their natural teeth much longer than older adults of the past. Yet, with the natural teeth that remain, there is a risk of tooth decay and periodontal disease. These are the two most common mouth diseases throughout a person's life. If these conditions are not treated, the teeth become painful, loose, or broken, causing chewing problems, changes in appearance, and eventually affecting older adults' self-esteem.

**Miguel Pavåo**

Older adults remain at risk for caries that is untreated in approximately 30% of adults with teeth. They are at increased risk for root decay because their gingiva continue to recede, which exposes root surfaces. Some of their medications can cause dryness in the mouth, which allows caries to continue. About 50% of people over 75 years old have root cavities affecting at least one tooth in their mouth. About 25% of older adults have bone loss around the teeth because of advanced periodontal disease. Without early prevention, these conditions become difficult to treat.

In Europe, dental care is not a priority among older adults, even though the elderly population is increasing daily. It is estimated that in 2025 more than 20% of Europeans will be 65 or over, with a particularly rapid increase in the number of over-80s.

The Project Smiles Door to Door sponsored by BPI, Calouste Gulbenkian Foundation and the International College of Dentists (ICD), was the Winner of the 1st Contest, among 89 candidates, of the Social Innovation Centre of the Foundation Porto Social in 2012. The project took its first steps in the city of Porto, benefiting 1500 elderly people. Encouraged by its huge success, Mundo a Sorrir decided to implement the project in the remaining districts of Portugal.

In order to do this, we submitted the project to the "BPI Seniores 2013" prize, which is sponsored by one of the biggest and most prestigious private banks in Portugal. Our project was the first among 390 applications.

The goals of the project are to improve the oral health and quality of life of the elderly, provide training to geriatric social care workers, prevent oral cancer and encourage the involvement of local authorities/dental professionals in these matters.

Between now and 2015, our objective is to reach 17 districts of Portugal, 15,000 elderly people, 3,000 geriatric social care workers and 300 nursing homes/day centres. In terms of human resources allocated to the project, we have 5 dentists and one administrative assistant.

To date, 21 institutions were visited, 730 elderly people screened and 314 geriatric social care workers instructed. All geriatric social care workers completed a survey before and after training.

The outcomes show that 57.4% of the workers provide some sort of support to elderly people in their oral hygiene care. After the training, 88.8% of the elderly participants considered it a very useful initiative, 91% claimed to have

acquired new knowledge about oral health and 85.6% would like to receive additional training on oral health. Of the elderly people screened, 78.5% were female with a mean age of 79 years. When asked about their last visit to the dentist, 39.2% of the seniors said they "did not know" and/or "did not remember". It is also significant that 6.6% of seniors said that they hadn't been to the dentist "for more than 10 years". The most relevant difficulties were those resulting from the refusal of the elderly to cooperate with the dentists.

We found that the elderly population had deficits in their personal oral hygiene. It is therefore essential to continue a project dedicated to the senior population. With this project we aim to improve oral health and reduce the risk of infections and diseases associated with the use of dentures. This is done by screening and targeted interventions, such as the elimination of pain and adjustment of dentures, and educating health professionals who work in these institutions about oral health and increasing their awareness of its implications.

Portugal is one of the European countries with a high number of elderly people. Regrettably, the Portuguese Government doesn't include dental medicine in the National Program for Public Health. Projects like these are essential to bridge the gap in the coverage of our public health care service, not only for the elderly but also for other social groups. ■

# Europe Meets Asia

On the invitation of ICD Asia Philippine Section, Dr. Hani Farr attended the 47th Annual Convocation in Parañaque City on 26 January 2014 to present the ICD Europe humanitarian project in the island of Negros.

**Hani Farr**

A fully-functional dental clinic was set up in 2012 in the Gawad Kalinga (GK) (an NGO organisation) Hope Village that provides housing and social services to the poorest population. With the generous contribution of the ICD Europe Philip Dear Foundation, the first dental clinic was established in the GK Hope Village giving free dental treatments in addition to educational and preventive measures to GK inhabitants and the surrounding area. One of the main long-term objectives is to help create awareness of dental health and prophylaxis among the local population. In addition, a new focus on hygiene and preventive measures has been implemented in local schools in co-operation with the Dental College of Dentistry in Iloilo and local volunteer dentists.

My presentation to the Fellows in Manila about the GK Hope Village Dental Clinic received positive feedback. In particular, Dr. Faye Dizon, Head of Gawad Kalinga, expressed her great appreciation for such an inspiring project and intends to make it a platform for similar projects.

The importance of such preventive and educational projects for ICD Europe's ambitions to improve the standards of dental health and dental care worldwide was the subject of discussion in a conversation with the President to the ICD International Council, Dr. John Hinterman, who assured me of his support for such dental humanitarian projects.

Attending the ICD meeting in Manila significantly strengthened the relationship between ICD Asia and ICD Europe, focusing on a common aim of realising sustainable development projects with a particular focus on dental educational programmes and preventive care with long-term goals. These goals are:

- Reducing oral disease burden and disability, especially in poor, marginalised populations.
- Promoting healthy lifestyles and reducing risk factors.
- Developing oral health systems.
- Integrating oral health into national and community health programmes and promoting oral health.

### The Continuous Educational Programme of the Dental Clinic

At the request of GK Philippines, the Philip Dear Foundation is currently working on the framework for the sponsorship of a 2-year training programme to motivate a GK resident to become a professional dental technician.

The GK Hope Village project aims to support other interested GK villages by passing on the acquired know-how. The broad acceptance among the population, and measures leading the GK Hope Village Dental Clinic towards self-reliance, make it an exemplary model for similar projects in other GK villages in the long term. ■

# Conversation with Ljubo Marion, European Section President

# East Meets West

**Merryn Jongkees**

**The turbulence of recent years in Europe has not left our profession untouched. How do you see the role of the ICD as we move into a new era of modernisation, individualisation and tough choices?**
The economic crisis which affected all of Europe and especially its Mediterranean region impacted its public dental health sector too. Unemployment increased enormously in Southern states. People without health insurance had problems obtaining dental care, not so much for acute problems but for extensive perio or endo treatments and prosthetic restoration. Not to mention orthodontic treatments, which were always reserved for the more affluent individuals and societies. The crisis was felt not only by populations with low incomes and scarce insurance options, but also by the dental profession and members of dental teams. Incomes of many dental offices dropped and numerous dental laboratories were forced to close down, even in rich Germany.
The crisis is now abating in Western and Northern Europe but continues in the South and East, where dental health is and always was in "crisis". A simple comparison of DMF indices between developed and undeveloped countries says it all, not to mention other indices of oral health and organisations of public dental health services. I do not know if the ICD has done anything against problems arising from the economic crisis in Europe or even if ICD is obliged or able. This is more the arena of health politicians and EU policy in general. The commitments and obligations of ICD are numerous – advance the art and science of dentistry, raise its quality level, maintain high professional ethics, encourage and support humanitarian projects, to mention just some – and were meant originally for prosperous countries from where the dental elite members originated. By establishing Section XX, the College at Large opened up opportunities to spread ICD commitments to new countries, mostly to countries with a low level of dentistry.
Supported by the Philip Dear Foundation, ICD Section V has in recent years furthered the knowledge of orthodontics and endodontics in Ukraine, promoted oral hygiene and basic dental care for children in undeveloped regions of the Philippines, Cape Verde, Portugal, Mexico... but not in Eastern Europe, because there were no proposals from there.

*Membership requires a contribution to society*

**What is your perspective on the College's growth and development, in particular in Central and Eastern Europe, versus upholding our numbers of (active) fellows in existing Districts?**
I am glad ICD Europe has opened towards the Eastern part of Europe and has established District 14. A new spirit is inspiring dentists in Eastern Europe. Although they are few, they felt honoured to become members of this prestigious society. The District of Central and Eastern Europe is very picturesque and heterogeneous, with diverse historical, cultural, economic, national and religious backgrounds. The District consists of 36 members from 13 countries: Bulgaria, Croatia, Czech Republic, Georgia, Hungary, Moldova, Montenegro, Poland, Romania, Russia, Serbia, Slovenia, and Ukraine. They have in common that after the Second World War they were socialist states, unsatisfied with it, and over the last 20+ years embraced new capitalist systems. They were not prepared or mature enough for the freedom and obligations which are part of democracy. The results are rampant privatisation of common or formerly state-owned properties such as factories and companies; corruption is everywhere, especially in business and politics, average wages are low. Many privatised properties were not managed properly, companies bankrupted, owners stayed rich, employees lost jobs. The minority of the population is rich, the majority is poor, unemployment is high, the young see no prospects for the future, seniors are limited in their possibilities, new graduates leave the country to find success abroad. It is like the Wild West in the 19th century.
On the other hand, many were able to establish private companies and factories which do very well and are beneficial to employees and owners alike. Many of them are successful dental clinics.
Looking back, members of District 14 feel very honoured and proud when inducted into ICD but do not attend subsequent meetings as often as expected. The main reason is the high cost. For a couple, it is all together around 3,000

euros. Monthly salaries in Eastern universities and public dental health services are far below 1,000 euros. Also, they would like to acquire new knowledge as is expected from dental congresses. They do not have many opportunities to attend the professional conferences in Western Europe. Simply meeting dental colleagues, networking, visiting new places and cultures, with at times limited knowledge of English, is frustrating and just not worth it.

### The induction age discussion is ongoing. Where do you stand in this respect?

Dentistry is a very challenging and demanding profession and dentists need time to reach professional maturity and social dignity. Looking back, it took me more than 10 years to become confident in my professional decisions and performance. I would not set a time limit for membership, e.g. 5 years of practice and 30 years of age, but would assess strictly the criteria for membership. Membership not only requires professional expertise or economic ability, but first and foremost a contribution to society in terms of humane, empathic and ethical behaviour.

### What do you see as the ICD's current barriers and opportunities?

The ICD was established in 1928 as a closed type of organisation of the most prominent and notable dentists of its time, and so it continued till today. Members of this elite college included invited dentists known as excellent practitioners, opinion leaders, many of them also distinguished professors and mostly also very well situated. They gathered as a kind of club, similar to the Rotary club. ICD continues to be a closed worldwide society with very high and noble commitments. It is divided into Sections and subdivided into Districts. Each District organises annual closed meetings with high-quality lectures, invites new candidates, gathering at fine locations with a black tie dinner. The emphasis of group activity is not on obtaining new professional knowledge, as they get this information at specialist academies and associations, but on professional discussions, consensus, professional behaviour and ethics. The spirit of friendship during these meetings is uplifting and enjoyable.
Today we see three types of dentistry: of the Western world, of the Third world, and also dentistry in between. The differences between them are enormous. ICD Section XX was established to include dentists from the Third world and to balance the differences in the level of dentistry. This is a long-term commitment because the level of dentistry depends on the economic situation of countries, their social and cultural level, and on state health policies etc. So the ICD contribution should be only symbolic in terms of funding, and mostly for enabling dentists to provide preventive oral health measures and basic clinical activities, and for teaching, helping in missions and rural clinics. For instance, medical and dental students and graduates from the Ljubljana University Faculty of Medicine regularly offer assistance in Africa, providing medical and dental treatments in small rural settings. They and others like them should be supported by the ICD.

### Do you have specific ambitions or objectives for your term as President?

Presidents cannot make revolutionary changes in a one-year term, even if he or she has ideas for such an ambition. The policy of ICD Section V is determined by the Board twice a year, where seniority and tradition set the tone. President and Registrar simply implement the decisions of the Board. The President's main role is to organise the next annual meeting, recruit new inductees, ensure the Society's continuity, and maintain our focus on its values and objectives.

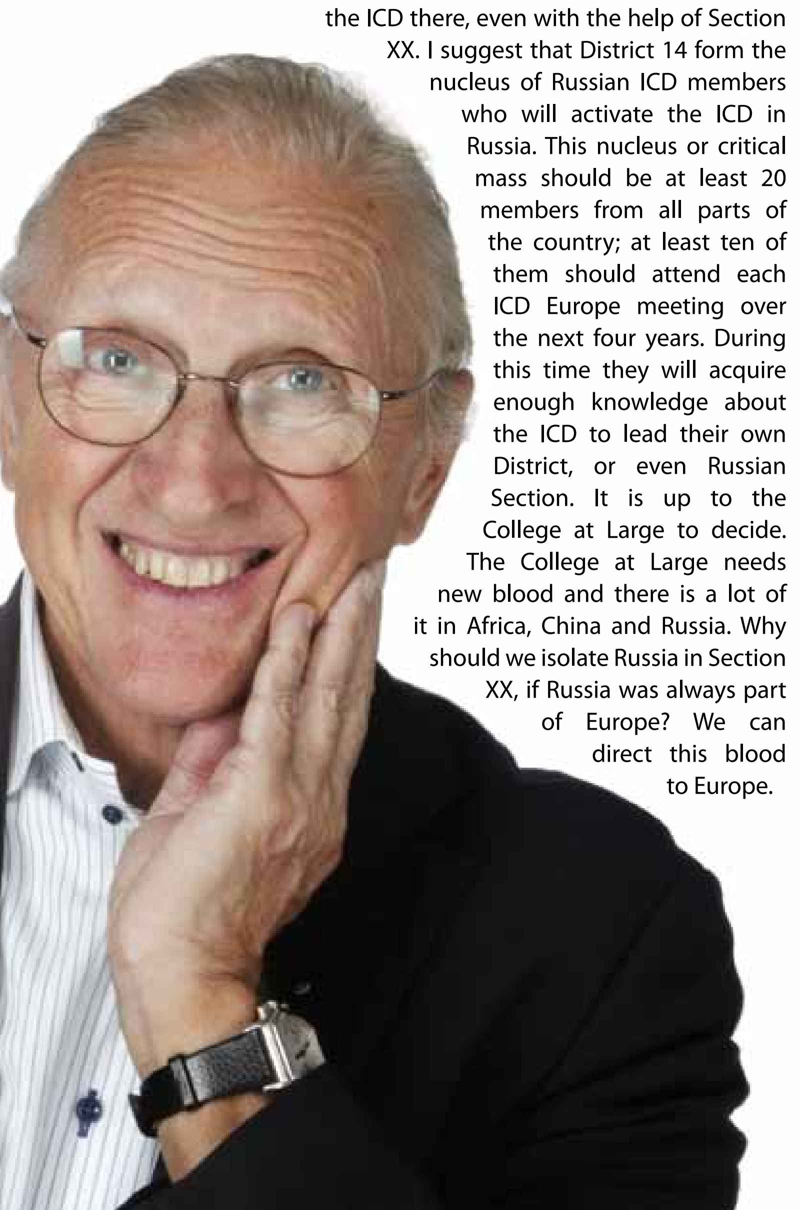
### As regent of District 14, how easy or difficult do you find it to bring together people across such diverse cultures and languages?

District 14 is too large and diverse to organise District meetings as other Districts do. The reasons are mostly economic. Attending local meetings would double their ICD expenses. Lack of local interaction is a reason why many members of District 14 do not know each other and do not feel they belong to their District; consequently, they do not pay their annual fees as regularly as expected. Members are supposed to attend the European Annual Meeting regularly, where they would meet other members from District 14. In practice, they mostly come just once; only a few of them regularly attend our Annual Meeting.
The main reason for not attending Annual Meetings for members from Eastern countries who are employed by the state is simply money. There are also many good and successful dentists in the East who do not attend meetings as expected either, even though they can afford it. They usually have a high workload and prefer to attend professional congresses, academies and courses where they gain new knowledge for their clinical work. When they want to relax, they prefer luxurious vacations. They do not feel our Annual Meetings add value.
Although there are no local meetings, some members meet at congresses and keep company there. They also invite ICD members as speakers to their meetings and courses. At the 19th Balkan Stomatologic Society congress in April 2014 in Belgrade, ICD members from Bulgaria, Greece, Hungary, Romania, Serbia and Slovenia were lecturing and socialising.
The active future of the ICD in the Eastern countries of Europe will be successful only with a substantial increase of members in each and every state or group of neighbour states who would organise local meetings, establish friendly contacts between members, and present the ICD to other colleagues as an honorary and a worthwhile society.
Until now our goal was to

increase the number of states in District 14; this number went up to 13 countries, with on average less than three members per country. Our next task is to increase this average to more than ten members per country, which will enable local meetings and group activities, and the establishment of new Districts and the appointment of new Regents.

### Russia represents a challenge in several ways. How do you feel our European Section should move forward there?

Russia is a large and unique country because of its history and the impact of drastic changes from the previous political system. There are currently only five ICD members in Russia, which is not enough to permanently activate the ICD there, even with the help of Section XX. I suggest that District 14 form the nucleus of Russian ICD members who will activate the ICD in Russia. This nucleus or critical mass should be at least 20 members from all parts of the country; at least ten of them should attend each ICD Europe meeting over the next four years. During this time they will acquire enough knowledge about the ICD to lead their own District, or even Russian Section. It is up to the College at Large to decide. The College at Large needs new blood and there is a lot of it in Africa, China and Russia. Why should we isolate Russia in Section XX, if Russia was always part of Europe? We can direct this blood to Europe.



### Many Fellows feel strongly about the ICD's humanitarian ideals. What is your message to our members who want to become involved but are unsure where to start?

I strongly encourage everybody who is prepared to give his knowledge and effort to help the underprivileged, the people in countries with a high incidence of oral pathology. There is so much we can do to help the poor people in this unjust world.

We should be aware that funding humanitarian assistance can at times be associated with a level of corruption locally, so a degree of caution is necessary. The fulfilment and satisfaction that come from such initiatives far outweigh any effort we ourselves put in.

### You are a long-time Fellow of our College. What has the ICD meant to you over the years, and how do you look back on your service?

I am happy and proud to be a member of the ICD and am grateful to Prof. Aris Petros Tripodakis, who proposed me for membership. All meetings I attended were wonderful experiences, visiting locations which we normally would not see. I met so many wonderful people, became good friends with many of them, we visit each other and I feel a special fraternal bond in the ICD which I have not found in other societies.

Looking back on my work as a Regent, I see that more work needs to be done, more members invited, with more communication with Fellows and, being the pragmatist I am, more annual fees collected…

### You will be our Ljubljana conference host this summer, our first Eastern European venue. What can attendees look forward to?

Ljubljana is prepared to welcome our ICD guests and express to them our hospitality. There will not be too many lectures, but enough to sense the quality of clinics and dental research from our District and to hear about ICD humanitarian work at Open forum. Actually my idea for the Open Forum was to present a comparison of Western and Eastern European dental health services, compare indices of oral health, organisation of dental services, review the problems of dental services in the East, and how ICD could contribute to improved oral health in Europe. This has proven to be somewhat ambitious, unfortunately, so the format of the Open forum will remain as is.

Apart from the science, you will have time to stroll the old city and food market, relax at places along the Ljubljanica river, enjoy the Roman and medieval history of Ljubljana and our art galleries and museums. Wine testing of Slovenian wines has been planned, plus a golf tournament and a trip to the coast and Lake Bled. Three evenings are devoted to amicable socialising, to music and good food.

I personally look forward very much to warmly greeting each of you, and renewing our friendship and professional associations as we participate in the wonderful scientific and social programmes we have organised for you. See you in Ljubljana! ■

# International College of Dentists

## European Section

### 59th Annual Meeting
### Ljubljana, Slovenia
### 26 – 29 June 2014

**Dear Friends, Fellows and Guests of ICD,**

***On behalf of the European Section of the International College of Dentists I have the pleasure of inviting you to the 59th Annual Meeting which will be held in Ljubljana, Slovenia in the last weekend of June 2014.***

Slovenia is not a large country, but at the hub of traffic routes from east to west and north to south, it has always played a role in European events greater than its size would suggest. Slovenia is a Central European state, on the sunny side of the Alps. The landscape embraces rolling countryside leading to the Pannonian plain to the east, rugged Karst bordering the Adriatic Sea to the southwest, and the Alps to the west and north. The Slovenian nation of only two millions today has survived mainly due to its culture, language and vitality. A bone flute, 30,000 years older than any other known in Europe, and Europe's oldest bone needle, testify the importance of culture and work here even in the prehistoric times.

Its capital Ljubljana has a picturesque unity, composed of an architectural heritage spanning Roman city Emona, through Renaissance and Baroque Ljubljana, to the Secession Art Nouveau and Modern Ljubljana, so strongly marked by the influence of the famous Slovenian architect, Jože Plečnik. Ljubljana is an university city. The roots of the University go back to the seventeenth century with Academia Operusorum, the fourth oldest Academy of Sciences in Europe. A Philharmonic Society dates back three centuries.

At the Meeting we would like to present you some lectures and research activities of fellows from the countries of ICD District Central and Eastern Europe and establish new contacts and friendships between members of European ICD Districts.

It is expected that the 59th Annual Meeting of European section ICD will be an exciting scientific meeting, and last but not least, we will offer you a social programme reflecting the warmth and hospitality of the Slovenians.

*Dr Ljubo Marion, dr dent med, prosthodontist*
*President-Elect, European Section, ICD*

## ICD European Section

Dr. Ljubo Marion
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email: ljubo.marion@mf.uni-lj.si

# SOCIAL AND SCIENTIFIC PROGRAMME

### Wednesday, 25 June 2014

**Pre-congress golf tournament,** G&CC Bled

### Thursday, 26 June 2014

**Reception of fellows and guests,** Lobby Grand Hotel Union

**Welcome party,** Tivoli Mansion Graphic Art Centre

### Friday, 27 June 2014

**Scientific day,** Grand Hotel Union

Morning session: Seven lectures by members from District 14

Afternoon session: ICD Open Forum

**Accompanying persons programme:**

Walking sightseeing tour of Ljubljana

**Dinner & fun,** Ljubljana Castle

### Saturday, 28 June 2014

**Induction Ceremony,** Opera Theatre

**Gala Dinner,** Grand Hotel Union

### Sunday, 29 June 2014

**Optional excursions** (minimum 20 persons):

**Postojna caves,**

**Idrija,** Mercury Mine Museum and Secret WW2 hospital Franja

## Accommodation

**Conference Hotel:** Grand Hotel Union (4 stars)
**Alternative Hotel:** Central Hotel (3 stars)

## Conference Hotel

Grand Hotel UNION

Miklošičeva 1, 1000 Ljubljana, Slovenija
T: +386 (0)1 308 12 70
F: +386 (0)1 308 10 15
E: hotel.union@gh-union.si

## Austria

The Regent of Austria Werner Lill reported their District currently has 39 members including 2 Life Members and 1 Master. All dues were paid, as confirmed by Treasurer Walter van Driel. They will have their local Meeting in January or February, and will have 2 Inductees for Ljubljana. The District is in good order.

## Benelux

The Regent of Benelux Walter van Driel reported that District 2 is in good order, with all dues paid. They currently have 37 active members, 4 Life Members and 1 Master, 2 resignations and 2 deceased. Normally they have their Regional Meeting in November, but this year that was not possible because of time constraints. He said in concluding his report that as indicated previously, they do not have an Inductee for Ljubljana; Of 5 potential candidates, only 2 are considering the invitation.

## Scandinavia

The Past President and Regent Henrik Harmsen reported that there are 37 Active Fellows in the Scandinavian District, 4 Life Members, no Masters or Honorary Fellows, and one request from a Past President for resignation, Terje Wahr-Hanssen, as announced by Registrar Argerios Pissiotis earlier. During this year they inducted one member from Finland and one member from Iceland; to his knowledge they are the first ICD members in their countries. They did not have a local Meeting this year, except if the Board were to accept that they had a somewhat expanded local Meeting with participants from all over Europe. Next year they are planning a local Meeting in Denmark. Everybody has paid their dues and the District is in good order, he said concluding his report.

## England Scotland and Wales

Shelagh Farrell, Regent of the District, reported that they have 57 Active Fellows, 2 Masters and 4 Life Members. They had a dinner in October, earlier than usual, during which Phillip Dowell discussed ongoing and future ICD activities. The Regent is contemplating adding a lecture before the dinner, which may bring more people in. She is pleased with the Fellows' current dues payment discipline, reflecting commitment to our organisation. During the last couple of years their numbers have remained fairly constant; they have not lost anyone this year and she is hoping to add to their ranks after our Ljubljana Meeting, she said concluding her report.

## France

The Regent of France Jen Louis Portugal reported that the District of France is composed of 47 Active Members, 5 Life Member – they recently lost their Master Fellow Peter Pré, Past President of the Section and former Regent of the District France, leaving them only 1 Master now – and they have two Inductees for Ljubljana. They asked 2 Fellows to resign for not paying their dues. Otherwise the District is in good order, and he along with Vice-Regent Demolon will organise a local Meeting in "Le Procope" including the new Inductees at the beginning of the next year, he said concluding his report.

## Germany

The Regent of Germany Matthias Bimler reported that they now have 49 Active Fellows, 3 Life Members and 1 Master; all fees have been paid. They will present 3 candidates in Ljubljana and are planning to have a Regional Meeting in Munich early 2014. The District is in good order but they have what can be termed a bank problem. He explained that Germany has a law against money laundering and he has as yet been unable to take over the ICD account. He indicated that he needs help from the Board on how to resolve this issue.

## Greece and Cyprus

Heraklis Goussias, Regent of Greece and Cyprus, said they have 37 active Fellows, 1 Master – Andreas Tsoutsos, who now celebrates 40 years of membership in the College and will be present for that reason in Ljubljana next June – and 7 Life Members. Most of the Fellows, not all unfortunately, have paid their dues. They will have 5 Inductees in Ljubljana, and a large group of participants is preparing to attend the Meeting. They had a Regional Meeting on the 14th of November in a new country club in the suburbs of Athens, which was well attended by 32 Fellows. The guest lecturer was Aris-Petros Tripodakis, who shared with them very interesting information about the history of the College and its mission. Concluding his report, Heraklis Goussias indicated they also had 2 resignations; otherwise the District is in relatively good order.

## Ireland

The President-Elect and Regent of Ireland Tom Feeney reported that the Irish District is in good health. They will have their annual social event in January next year and expect a good attendance. The District will have 2 Inductees for next year in Ljubljana, Ann O'Donoghue, who is a periodontist in Dublin, and Paula McHenry, a prosthodontist in Newry, Northern Ireland. The numbers are 42 Active Members, 2 Masters, 2 Life Members and one Honorary Fellow, totaling 47 Fellows in the Irish District and two upcoming Inductees in June, he said concluding his report.

## Israel, Malta and Baltic States

Dov Sydney, Regent of Israel, Malta and the Baltic States, reported they have 16 Active Members and 4 Life Members in the District, and 1 new Inductee for Ljubljana. Their student prize programme was cut back by one university sponsor for cost containment reasons, and the Regent urged participants in similar programmes to

ensure sponsors receive value back for their sponsorship. In concluding his report, Dov Sidney congratulated the UK District on Phillip Dowell's appointment as Vice-President of the College.

## Italy

The Vice-President of the Section and Regent for Italy Corrado Paganelli reported they have 49 Active Fellows, 7 Life Members and 1 Inductee for Ljubljana. The Italian District is in good order with all dues paid. They had their annual Regional Meeting in September, which was an open meeting for the first time.

## Portugal

The Regent of Portugal Gil Alcoforado reported they have 37 Active Fellows, 5 Life Members, 2 resignations because of retirement and 5 resignations of Fellows for not paying their fees. They are planning to have another meeting in March to welcome the new Inductees; they have three for Ljubljana. They expect to be in good order by the end of the year.

## Spain

The Regent of District 12 Spain Santiago Jane reported that the Spanish District has 29 Active Fellows and 2 Life Members. One new Inductee is proposed for Ljubljana. They have a new Vice-Regent, Vicente Lozano-de Luaces, well known for his humanitarian work in the name of ICD. As the new Regent of Spain, he said concluding his report, his goal for the next years is to attract members by spreading the name and the mission of the ICD to his Spanish colleagues.

## Switzerland

The Regent of Switzerland Christian Robin reported that the Swiss District is in good order. They have 29 active Fellows and 6 Life Members. He has one resignation by the end of the year, Francis Pribula, who is an American trained Orthodontist who retired. For Ljubljana he has one Inductee, possibly two. The Inductee he introduced comes from the south of Switzerland, an Associate Professor at the University of Zurich which gives him a good opportunity to open the College to the German speaking dentists of Switzerland. He thanked Henrik Harmsen for the beautiful Meeting in Copenhagen, having received very good feedback about the excellent organisation; the District is looking forward to the Meeting in Ljubljana.

## Eastern and Central Europe

The President and Regent of District 14 Eastern and Central Europe, Ljubo Marion, reported that District 14 now covers 12 countries with 35 active Fellows, expecting 16 more in Ljubljana. They did not have a Regional Meeting, but this year many of them will participate in the Meeting of the Balkan Stomatological Society (BaSS) in Belgrade next April. He was asked to present a keynote lecture and hopes to organise a small gathering of the ICD Fellows. They also meet in other European Meetings but not all together. He is considering appointing another Vice-Regent, he said concluding his report, because the number of members and countries is increasing.

# College at Large President Leon Aronson addresses the 2013 Inductees

Thank you, President Harmsen and Registrar Pissiotis for inviting my wife Barbara and me to your 58th Annual Meeting. I realise there are many parts in putting together a meeting such as this and we thank all of you who were involved. It is a great pleasure for us to be in this beautiful country and bring you greetings from the 12,000 Fellows from around the world.

We have been privileged to have attended your past meetings in Bilboa, Dublin and Stockholm and along the way we have made many wonderful friends. And we look forward to making more friends at this meeting.
We have always been impressed with the elegance, class and style of your convocation and especially enjoy the introduction of the new Fellows. Today's induction was no different.

We were at the meeting when you formed the Philip Dear Foundation. In fact, my wife was with some of the ladies when this was discussed and upon returning home, she told me that I should make a donation to this Foundation, which I did. I applaud you for how far this Foundation has come, and in such a short period of time, and all the good things that it is allowing Section V to do.

I also want to compliment you on the "ICDigest". It is a wonderful publication and I see that editor Walter van Driel is carrying on the fine work of your past editor, Dov Sydney.

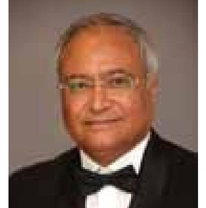
The European Section gained sectional status in 1955 and since that time you have had 9 international presidents and over 20 master fellows. It has been a pleasure working with your present and past Councilors; Peter Kotschky, Joe Lemasney, Frans Kroon, Phillip Dowell and Argirios Pissiotis and enjoying their friendship as well as your past treasurer, Jan van Hoeve and certainly the college editor and communications director, Dov Sydney. You have great leadership in your Section, and I am sure that some of you in this class will rise to that level. And congratulations on inducting your first Fellow from Finland and Iceland.

My remarks today are primarily directed to the new Inductees. Today, the new Inductees will become a part of the world's oldest and most honorary Dental Society. A Society that has its roots in Japan when doctors Ottofy and Okumura at a dinner in Tokyo in 1920 discussed the need for this type of organisation. I congratulate these Inductees on this high honour, and even though they are being inducted in this Section, I want them to realise that they are part of an active global organisation that is doing good things around the world, and they are now part of not only Section V's projects but also part of every project the International College of Dentists is involved in, regardless of where it is happening. And there are many.

Our objectives are many but can be summarised as follows:
1. We elevate the quality of dentistry around the world.
2. We increase the access to dental care around the world.
3. We develop, promote and recognise leadership around the world.
Our motto is: "Recognising service and the opportunity to serve". Today, you are being recognised and I hope that you will "seize the opportunity" to serve. It will make your fellowship much more meaningful.

Today, you are in this room with your family and friends but from this point forward, you will be part of something much bigger than yourself. You will be in many parts of the world because you will be part of all the International College of Dentists is involved with in our global setting.

# The European Section 2013 Inductees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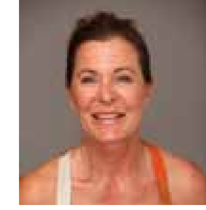
Peter Hotz

Katharina Schatz

Inga B Arnadottir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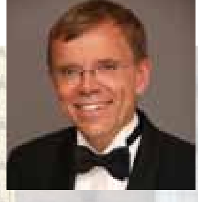
Per Bjørndal

Glen Happel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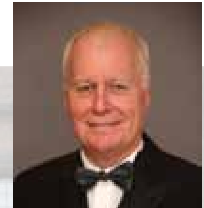
Mikkel Ro Larsen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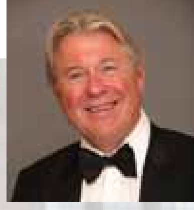
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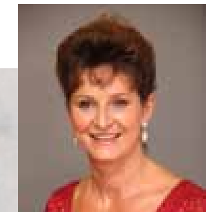
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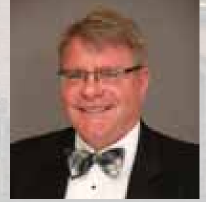
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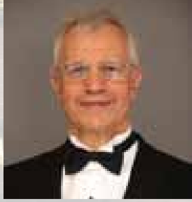
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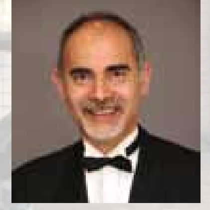
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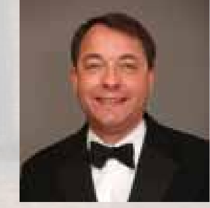
Jayseelan Padayachy

Rhiain Paul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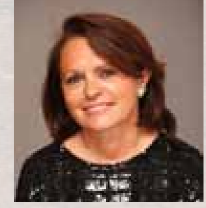
Martin Christiansen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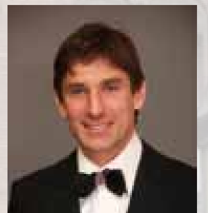
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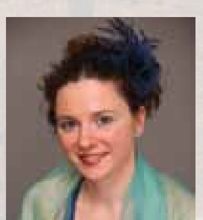
Dana Weigel

Declan Corcoran

Johnny Fearon

Nikolai John Attard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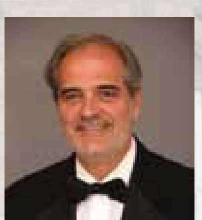
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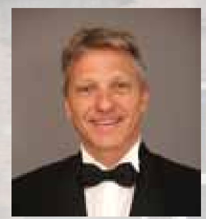
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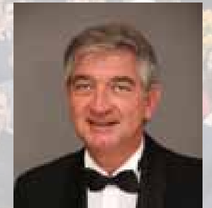
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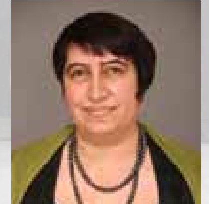
Danilo Avolio

Francesco Michelini

Georgy Bezvestnyy

Svitlana Demyanenko

Norina C. Forna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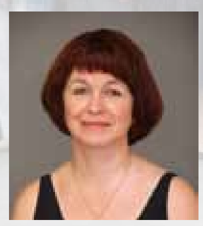
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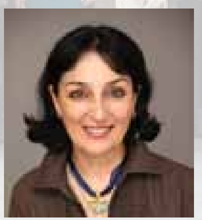
Marina Mamaladze

Maja Ovsenik

Ksenija Rener Sitar

Lyubov Smaglyuk

We, and now you, are truly international. We are made up of professors, researchers, dental practitioners, authors of textbooks and others who have made and will continue to make many contributions to our profession and to mankind. We are the most prestigious dental society in the world. Visit our website at www.icd.org and see all that is going on in your College, and be sure to visit project 55 on the website and you will be surprised by what you are now a part of by virtue of your Fellowship in the College.

So, what is happening today is more than the pin and plaque that you will receive. You did not 'join' this College. One cannot join this organisation. You were recognised by some of your peers who took note of your many accomplishments and nominated you for Fellowship, and it is encumbent upon you to recognise and nominate others who are worthy of this high honour.

You will begin receiving our annual publication, The Globe. Please read it carefully and you will become aware of all that your College is involved with. Dov Sydney does a magnificent job as the editor.

You and all of us are the trustees and guardians of what doctors Ottofy and Okumura started, and the bridge that others reinforced for us to cross. We must do our part to strengthen that bridge for others.

I would like to read a poem that addresses this point. It is entitled Bridges, the author is unknown.

*An old man traveling a lone highway*
*Came at the evening cold and gray*
*To a chasm vast and deep and wide*
*The old man crossed in the twilight dim*
*For the sullen stream had no fear for him*
*But he turned when safe on the other side*
*And built a bridge to span the tide*
*"Old man," cried a fellow pilgrim near*
*"you're wasting your time in building here"*
*Your journey will end with the closing day*
*You never again will pass this way*
*You have crossed the chasm deep and wide*
*Why build you this bridge at even-tide?"*
*The builder lifted his old gray head*
*"Good friend, in the path I have come," he said*
*"There followeth after me today*
*A youth whose feet must pass this way*
*This stream which has been as naught to me*
*To that fair-haired youth may pitfall be*
*He, too, must cross in the twilight dim*
*Good friend, I am building that bridge for him*

I repeat, we must do more than display our pin and plaque.

It is such an honour for my wife and daughter and I to be with you on this special occasion. Thank you very much for your generous and warm hospitality.

I want to close by modifying a famous quote made by USA President John F. Kennedy: "Ask not what the ICD can do for you, ask what you can do for the ICD."

Again, I congratulate the new Fellows. Enjoy this recognition of your accomplishments and this milestone in your professional career.

Thank you.

# European Section Officers and Regents

## First row from left to right

**Werner Lill,** Regent, Austria
**Tom Feeney,** President-Elect, European Section and Regent, Ireland
**Shelagh Farrell,** Regent, England, Scotland & Wales
**Ljubo Marion,** Incoming President, European Section, Regent District 14
**Leon Aronson,** Acting President, College at Large
**Henrik Harmsen,** Acting President for Copenhagen Meeting and Regent, Scandinavia
**Juan Salsench,** Regent, Spain
**Jean Louis Portugal,** Regent, France
**Gil Alves Alcoforado,** Regent, Portugal
**Argirios Pissiotis,** Registrar, European Section

## Second row from left to right

**Sheldon Dov Sydney,** International ICD editor and Regent, Israel, The Baltic States & Malta
**Phillip Dowell,** Vice-President, College at Large
**Matthias Bimler,** Regent, Germany
**Walter van Driel,** Editor, European Section and Regent, Benelux
**Ivar Hoff,** Vice-Regent, Scandinavia
**Christian Robin,** Regent, Switzerland
**Corrado Paganelli,** Vice-President, European Section and Regent, Italy

## Not shown in picture

**Heracles Goussias,** Regent, Greece and Cyprus

# Future Annual Meetings of the European Section
# International College of Dentists

**2014 Ljubljana,** Slovenia • 25-28 June

**2015 Dublin,** Ireland • 7-11 October
also hosting the International Council

**2016 Milan,** Italy • 23-26 June