dental SURGEON

A PUBLICATION OF **SINGAPORE DENTAL ASSOCIATION** MICA (P) 168/01/2008

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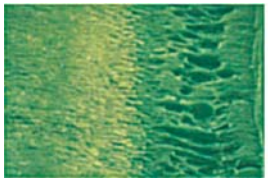
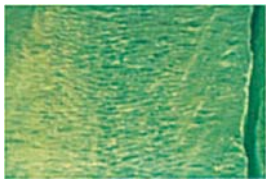
July 2008 ISSUE

Brace Your Patients For The APF Advantage

PREVENTS DEMINERALISATION, PROMOTES REMINERALISATION



Before Phos-Flur
(Microphotograph of enamel)



After Phos-Flur
(Microphotograph of enamel)

Active Ingredients:
0.044% w/v Sodium Fluoride
0.05% Acidulated Phosphate
Topical Solution

- Greater fluoride uptake to promote remineralisation & increase tooth resistance to acid attack
- Fights acid attack & demineralisation
- Prevents white spot lesions in orthodontic patients
- 100% alcohol-free and sugar-free mouth rinse
- Acidulated Phosphate Advanced Fluoride Formula for Orthodontic Patients
- Helps prevent early decay

Clinical References:

1. P. Keyes and H. R. Englander. Fluoride therapy in the treatment of dentomicrobial plaque diseases. J. Am. Soc. Prev. Dent. 5: 17-21, 1975
2. H. S. Horowitz and S. B. Heifetz. The current status of topical fluorides in preventive dentistry. J. Am. Dent. Assoc. 81:166-177, 1970
3. R. E. Hirschfield Control of decalcification by use of fluoride mouthrinse. J. Dent. Child. 45: 458-460, 1978
4. R. E. Corpron et al., In vivo remineralization of the artificial enamel lesions by a fluoride dentifrice or mouthrinse. Caries Res. 20; 48-55, 1986
5. Data on 2005-06 Professional Tracking Studies.

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CONTENTS

EDITOR'S note

It's more than halfway through 2008 and what have you done this year? Like many others, my New Year resolutions remain sorely unfulfilled.

But take heart, read on and perhaps be inspired to fill the remaining year by increasing your knowledge (pg 22), picking up a new sport (pg 16 & 19) , helping out at SDA (pg 8) , going for life-changing mission trips (pg 20 & 21) or even writing a opinion piece for this newsletter (pg 7) !

Ready. Set. Go!

Dr Charlene Goh

Thank you

Our contributors for this issue:

Dr Asha Karunakaran
Dr Raymond Ang
Dr Betrand Chew
Dr Oliver Hennedige
Dr Andrew Robinson
Dr Emmanuelle Lerat
Dr Alvin Lee
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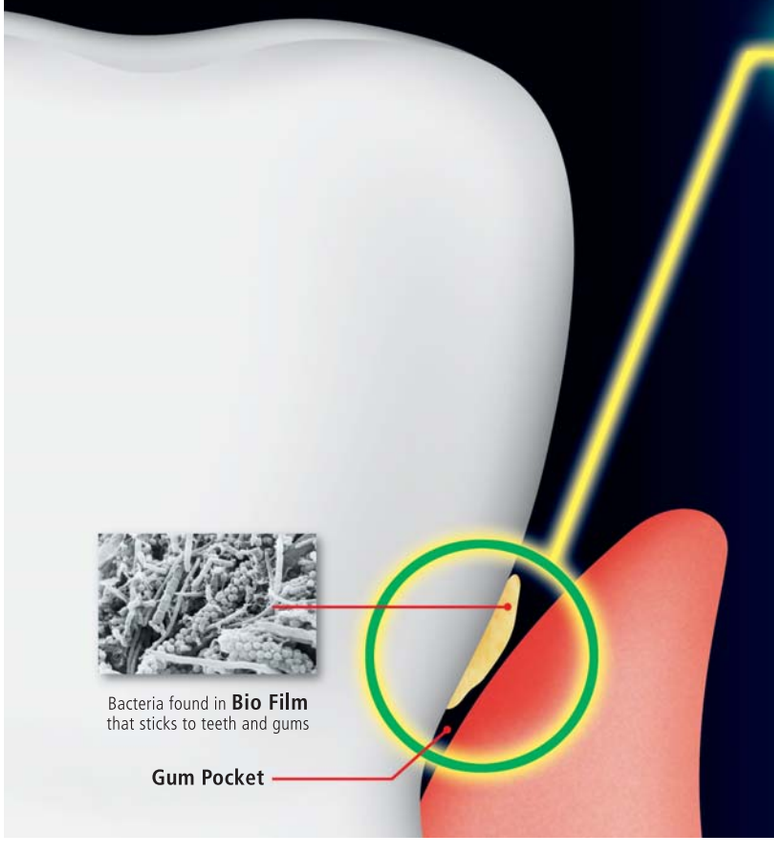
LION Japan

Japan's No.1 Oral Care Company

LION Discovery – IPMP Effectively Fights Gum Disease

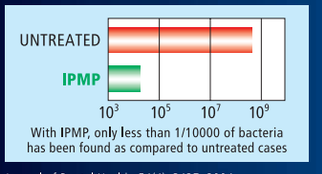


IPMP Attacks Nesting Bacteria at its Source

It's a fact, your teeth and gums are under constant attack. Bacteria, bits of food and saliva combine to form a nasty, germ-rich, tough-to-kill bio film that covers your teeth and gums. Left untreated, bio film can produce toxins, causing red and swollen gums, which can lead to gum pockets and gum disease.

After years of research, Lion Corporation, the number one oral care company in Japan, succeeded in creating a "GD Bio Film Model". This important development led to the discovery of the new anti-bacterial agent IPMP. IPMP effectively penetrates and quickly kills harmful bio film and is a significant weapon in fighting gum disease.

Antisepticizing power of IPMP against Bio Film



With IPMP, only less than 1/10000 of bacteria has been found as compared to untreated cases

Journal of Dental Health, 54(4), P437, 2004

Systema Toothpaste & Mouthwash contain **IPMP** along with **GK2** for **Double Impact Gum Protection**. Both these specially developed Systema advanced dental ingredients work together to fight gum disease.

For a complete oral care regimen, use Systema Toothpaste and Mouthwash in conjunction with Systema Toothbrush and Interdental Gel & Brush

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FORUM

Dear dentalSURGEON,

I like the contents of the "new" SDA Newsletter.

Articles on the registration of OHTs and the Nitec Programme are certainly timely and useful.

The article by Kelvin Chye on PR was thought provoking. I hope that there will be more such articles on practice management as it is hard to come by information on practice management in the Singapore context.

It is always good to read about our own members and their interesting accomplishments. Perhaps you can have more in-depth interviews with such personalities so that we can be inspired by "what makes them tick". I liked the layout of the article on Dr. Choo Teck Chuan. It is often more effective to have just one or two well-taken photos to illustrate an article than have many small pictures.

The most amusing and insightful photo was that of Council. I write insightful because it really made me appreciate the multiple portfolios that Council Members hold – testimony to their hard work and commitment! Association members certainly need to be reminded of that.

I imagine that for most people, the Newsletter is a "quick read". To make that an effortless "quick read", a logical consistent layout with clear font is essential. For example, having black font on a grey background as in parts of the Nitec story, made it difficult to read. This was also true of the little descriptions next to the photos of the contributors on page 1. Since you are acknowledging your contributors, it would be gracious to do this more prominently.

Lastly, I wonder why there was no picture of you in the Editor's Note column? If members don't know what you look like, how can they go up to you and say nice things about your work?

Dr Asha Karunakaran.

Our sincere thanks to those who responded to our call for feedback and letters. The editorial team is a little camera shy so we will continue to go incognito.

Dear dentalSURGEON,

What a fantastic issue you and your team have put together!

Not in my wildest dreams did I think dentists could come up with something like this.

The layout is incredible. You do us all very proud.

Thank you for undertaking this task. Looking forward to future issues.

Dr Peter Yu

Message from the Council

This is a gentle reminder to all valued members of SDA to please pay their annual subscriptions promptly in order to help our secretariat.
Your kind attention is drawn to Article V of the Constitution,the two relevant sections are reproduced below for your perusal.

Section 3(a)- Subscription shall be payable on 1st January each year
Section3 (c)-In the event that any member whose subscription remains unpaid for a period of six(6) months, and fourteen(14) days have lapsed after a written reminder has been given at the member's last known address,that member's rights and privileges as provided by the Association shall be automatically withdrawn and/or suspended until payment of all arrears of subscription and /or such other payments as may be prescribed by the Council,have been fully settled and paid up by that member.

We regret that as many subscriptions have been tardy,we shall follow the Constitution strictly from now on.
We also apologise sincerely to members who will be inconvenienced by such a move and seek their understanding.

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FEEDBACK/LETTERS
DON'T HOLD BACK!
Disagree with any of the articles? Or do you have something to add to the debate? YOUR opinions, feedback and suggestions are important to us. So please write to us. Please include your name and address. Letters may be edited for clarity and length

ADVERTISING/SPONSORSHIP ENQUIRIES
The dentalSURGEON is the official newsletter of the Singapore Dental Association and is mailed to all members thrice annually. To discover how you can use the newsletter to maximise your advertising budget, and reach a target audience, please contact us for more information at the above address.

A PERSONAL VIEW ON DENTAL EDUCATION

By DR OLIVER HENNEDIGE

Education is never static – especially in this fast changing world. What you have learnt during your undergraduate days in dental school may very well become inadequate by the time you are practicing dentistry for just a couple of years! I've used "inadequate" rather than "obsolete" because what you have learnt will still remain relevant but medical and dental advances may overtake you!

Methodology, material science and today with genetic engineering and stem cell research many things are set to change in the medical and dental fields. If a dentist does not keep up with what is happening in dentistry and has no interest in upgrading himself (the male gender used in this article denotes both male and female) he will sooner than later find that the treatment he offers is out of date. I shall not deal, in this article, with the ethical aspects of being outdated but will confine my writing to certain broad aspects of dental education.

Three factors are important in developing dentistry into a respected health profession. They are – entry qualification to the dental faculty; undergraduate education and continuing dental education or commonly known as professional development.

Firstly all candidates entering dentistry must have at least good 'A' level results with a science background or its equivalent. The need to begin with good students with the correct level of basic education and intellectual capacity will be necessary. In almost all dental faculties worldwide because of the great demand for dentistry the entry qualification remains high and competitive. However in recent years in the Asia Pacific region a disturbing trend for different reasons is appearing. In India and the Philippines, both are experiencing a dearth of suitable candidates. Fortunately in Singapore, bright students are still seeking dentistry as a profession.

Let me now touch on the second factor which is dental undergraduate training. Dental students should be given sufficient information and knowledge on the various disciplines in dentistry which should form the basic foundation for further advancement once they graduate.

They should be sufficiently competent by the time they graduate in the various aspects of dental treatment such as tooth extraction including removal of broken roots, endodontic treatment and a higher level of competency in all other dental disciplines especially in orthodontics and periodontics. Equipped with the knowledge and skill he will not only be able to offer better treatment options to his patients but will be able to confidently upgrade his skill and knowledge while he practices dentistry.

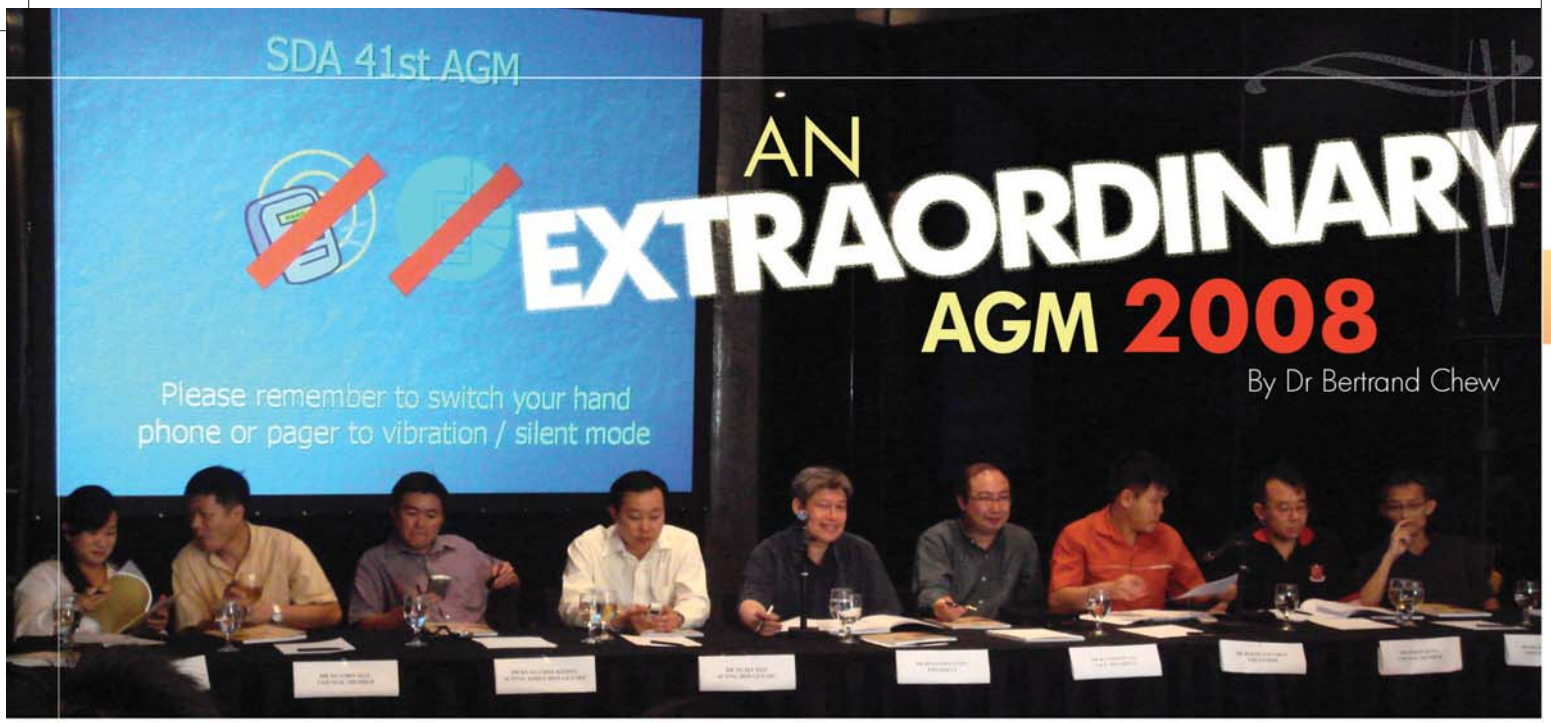
Finally, after graduating a dentist should continue to upgrade himself so that he should be able to handle a wide range of dental treatment modalities on his own without reference to dental specialists at a drop of a hat. By having better trained dentists, dental specialists' skills and expertise could be better utilized for the more difficult and unusual dental conditions which they have been trained for.

I'm pleased that in Singapore we have taken continuing dental education or professional development seriously by making it mandatory for dental practitioners to obtain a certain number of credit points in a fixed time frame. Attendance itself to earn points may not be sufficient. Our graduates should take the initiative as stated earlier to upgrade their skill and knowledge in practically all dental disciplines so as to obtain a broader outlook and keep themselves current on recent advances.

If we take this approach the benefits are:-

- Most treatment modalities will be provided by general dental practitioners with a truly holistic approach;
- Dental specialists who are presently very busy, may find themselves rightly addressing complex dental procedures for which they have been specially trained instead of straight forward procedures which should and could be handled by general dentists; and
- As more general dental practitioners gain competency the cost to the patient will certainly fall.

In my view, dental education with the right emphasis on upgrading general dental practitioners will not only provide a better service to the public but will utilize the skill and expertise of our dental specialists appropriately.



AN EXTRAORDINARY AGM 2008

By Dr Bertrand Chew

The SDA AGM was held at the Mercedes Center after a 2 year break. The event witnesses the completion of the council's 2-year term on the 27th April 2008.

The center just celebrated its 2nd anniversary and SDA is indeed fortunate to be the first organization to use the MAY-BACH room.

The event started off with the lunch hosted by Mercedes Center. Unfortunately, the required quorum was not achieved at the start of the AGM and accordingly, it was delayed for half an hour as provided for by the Constitution.

As usual, the AGM continued with the usual Q & A on the spending and the policies of the council. An additional agenda was submitted by Dr Seow Onn Choong on the sale of the SDA property , which has appreciated in value over the years.

However, no decision was made on this Agenda as the Constitution mandated a requirement of a two-third majority of all SDA members. The same applied for the Constitution Amendment agenda.

This year, the election at the AGM was unprecedented. Five appointments were vacant which included the key executive positions of President, Vice-President and Treasurer.

A member of the floor, Dr Tang Kok Weng proposed a resolution to hold an Extra-Ordinary General Meeting (EOGM) about 6 weeks later to elect the five positions. After some discussion, the motion was carried unanimously.

Dr Benjamin Long and Dr Raymond Ang would stay on as the care takers of their respective positions.

There was also a door gift at the end for all members who stayed on. *The SDA council would like to register their thanks to Mercedes (Cycle & Carriage) for hosting us.*

NOTE

SDA held its Special General Meeting(SGM) on the 8th of June as instructed by the house during the AGM on April 27th 2008 for the sole purpose of elections.

The election started at 1230hrs. However at 1500hrs, there were only 25 members. Under Article IX ,3c, the Special General Meeting did not meet the quorum.

As candidates for the other positions had been elected unopposed prior to the SGM leaving only 1 position for council member to be contested, this position will be filled by a co-opted member.

With that the following now forms the new council for year 2008-2010:

President:	Dr Lee Kim Chuan, Lewis
Vice President:	Dr Seow Onn Choong
Hon Gen Sec:	Dr Bertrand Chew Shen Hui
Asst Hon Gen Sec:	Dr Lim Lii
Treasurer:	Dr Teo Hiow Hoong
Council Members:	Dr Kuan Chee Keong
	Dr Edwin Heng
	Dr Micheal Mah
	Dr Seow Yian San

Let us welcome the new team to lead SDA for the next 2 yrs with important events like FDI 2009 and IDEM 2010!

MOH spotlight

By Dr Charlene Goh

In the previous issue, we interviewed Prof Tseng and he revealed to us his plans for increasing the awareness, availability and support of geriatric and pediatric dentistry.

Action came swiftly after and in late April, MOH released a press statement announcing that from 2008, the Ministry of Health has set aside a sum of $5 million for 6 fully sponsored scholarships per year to top performing dental officers to pursue a 3-year postgraduate programme in Paediatric Dentistry or Geriatric and Special Needs Dentistry at renowned overseas centres of excellence.

There are presently only 20 Paediatric dentists. There are none trained in Geriatrics and Special Needs Dentistry as this is a relatively new dental discipline with few schools internationally conducting courses in them. With sufficient core numbers, MOH intends to make it a specialty and be one of the first in the region to have experts in this field.

What does the scholarship cover?

- Salary and approved allowances
- Tuition fees
- Return economy class airfare
- Maintenance allowance
- Book allowance
- Travel insurance

Successful candidates are required to sign a service commitment to serve the Government of Singapore, or in any institution as directed by the Government of Singapore, for a period of 6 years.

Even though the dateline for applications was 15 May 2008, a second round of applications may be held if there are still vacancies for the scholarships. Look out for more news!

NITEC GRADUATION 2008

On 12th May 2008, the pioneer batch of NITEC dental assistants graduated. The ceremony held at the College of Medicine Building was a solemn affair attended by approximately 150 guests, consisting of family members, friends, sponsors Colgate and academic staff.

A speech was delivered by Chief Dental Officer Clinical A/P Patrick Tseng and Prof Chew Chong Lin, who initiated the programme, also imparted a few words of wisdom to the graduates.

5 top awards were given:

1st Lakhit Kaur
2nd Teo Kim Tho
3rd Zeng Xiu Qing
4th Lim Li Li
5th Lee Chen Ping.

Colgate sponsored $500 each for the top 5 trainees .Thank you,Colgate!

Our heartiest congratulations to the 28 graduates!

Better INFECTION CONTROL At a price?

By Dr Raymond Ang

Highlights of Complaint

1

• Dr. X sliced off part of the gum holding the problem wisdom tooth and patched up another "sensitive" tooth. He did not wear any glove again but much to my dismay, he told me to rinse my mouth from a plastic cup which was used by the previous patient. The cost of the gum treatment is Sing $30 and $20 for the "sensitive" tooth.

• On both visits to the clinic, I was given anesthetic injections. I am highly skeptical whether he used disposable needles during the injections and whether he sterilized the dental apparatus.

• The clinic is patronized by many patients. However on my first visit, Dr. X was operating on his own. There was only an old woman who came in to clean the waiting area and the toilet.

• During my second visit, his wife assisted him. My deepest fear now is that due to the lack of high hygiene standard during the practice, did I contract any undesirable disease, especially HIV?

• I appeal to your organization to send someone to visit and investigate how Dr. X conducts his clinic rather than summon him to give an explanation. Denture moulds would be found laying everywhere and some foul smell could also be detected.

2

• I also like to bring up to your attention the cleanliness and health hazard of his dentist practice in the clinic. The tools are never sterilized, the water cup smells of saliva and so is his hands and fingers and he never wear gloves or protective gears when doing his work.

• I am not a promiscuous person or frequent red light districts and if I do contract HIV virus, I can only attribute my death sentence to his unhygienic practice, in fact many of the patients I met told me they bring along their own bottle to rinse their mouth.

• He may charge cheaper than others, have an influx of patients but that does not mean giving sub¬standard services. The Association should look into such complaints received and make a thorough check of the clinic for blatant disregard for cleanliness, odd opening hours, inefficient services etc.

• Punitive measures should also be taken with a view of revoking practice licenses should such malpractices be rampant, otherwise if this persists, the dentist industry is going to see more deteriorating services in this profession.

In both of the complaints above, Infection Control and possible spread of infectious diseases are key issues that SDA Ethics Committee is concerned about.

Although in many complaints to SDA, SDC, MOH etc. are regarding other aspects of patient's treatment, patients often complain about the hygiene of the clinic as a "side issue". Please bear in mind that even if the complaint can be effectively mediated or resolved, SDA, SDC, MOH has an obligation to follow up on shortcomings regarding Infection Control or handling/disposal of Biohazards. MOH and Clinic Licensing Unit can still follow up on these issues even if the main complaint has been dropped.

Important issues regarding Infection Control & handling/disposal of Biohazards :

1)As professionals, we have a responsibility to our patients. Our patients have a right to expect that their best interest will be looked after when they visit our clinics. There is no excuse if we put patients at risk of infectious disease like AIDs, Hepatitis, SARs, etc. due to poor Infection Control.

2)As a Clinic owners or Dentists working in a Clinic, we also have a responsibility to protect our Dental Nurses or Clinic Assistants in the practice. We need proper protocols on handling Biohazards. Furthermore, we have a responsibility to the Community by observing proper disposal of Biohazards.

3)There are Guidelines from Ministry of Health (MOH), Ministry of Manpower (MOM), and National Environment Agency (NEA) governing issues of Infection Control and Biohazards handling/disposal. They can investigate complaints regarding these issues.

4)Having proper Infection Control and Biohazards Procedures can be expensive.
a) Clinic must have enough handpieces and scaler tips to change and autoclave after each patient.
b) Instruments and Trays should be changed, cleaned, pouched up and autoclaved after patients.
c) Disposable needles, blades, suction, cups, bibs, for patients
d) Disposable mask, gowns, caps and gloves for both Dentists and Dental Surgery Assistants for all treatment procedures.
e) Proper and effective disinfection and hand washing between patients.
f) Yellow Sharps disposal Box and licensed Contractor to dispose of Biohazards.
With the relentless increase in the cost of doing business, all these expenses add up. However, as responsible Dentists, we can never use increased costs as an excuse not to have the proper procedures.

5)Since 1st April 2008, according to MOH Guidelines, patients should be issued with Itemized Bills for all Dental Treatment. According to Singapore Medical Association (SMA) and a Straits Times article on 2nd June 2008, clinics should separate the patient charges. Treatment and Professional fees should be separated from Consumable charges, and Medication costs.

6)Many Government and Restructured Institutions like National Dental Centre (NDC) and Polyclinics are already charging patients separately for Consumables. Many large group practices like NTUC Denticare are also passing the costs of Infection Control to patients as a separate Consumable Charge.

Conclusions

1)Infection Control and Biohazards handling/disposal are extremely important in a Dental Clinic. As Professionals we have an obligation to protect our patients, our clinic staff and our community from spread of Infectious Diseases.

2)Proper Infection Control procedures are not cheap. With rising costs in Singapore, all these expenses do add up. However, increased costs can never be used as an excuse not to implement proper procedures and protocols.

SURVEY ON THE PROVISION OF DENTAL BENEFITS TO EMPLOYEES

The Singapore Dental Health Foundation (SDHF) commissioned the Research Centre of SHRI to conduct a survey of employees and HR managers in January this year.

One of the objectives of the survey was to study and understand both employees (mainly blue-collar workers) and HR professionals with respect to their awareness and desire for the provision of preventive dental care.

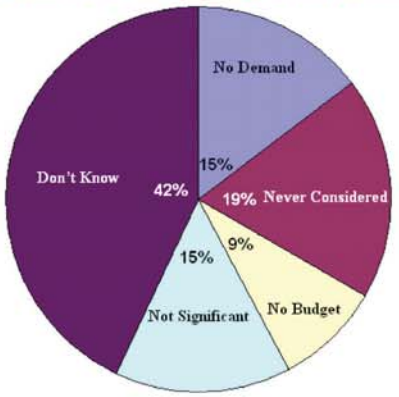
How the survey was done:

SHRI Research Centre sent out questionnaires to 1500 companies operating in Singapore including 500 Small and Medium Enterprises (SMEs). 200 other SMEs went through a face-to-face survey. Furthermore, 9 HR professionals from SMEs were interviewed. 337 organisations from a broad spectrum of industries participated in the survey. 45% of the respondents were employees (88% of which were blue-collar workers) and 55% of the respondents were HR professionals.

The following are just a few of the many statistics from the full Survey Report*

- An overwhelming 92% of the respondents agreed that preventive dental care is important to maintain general health
- Nearly 60% of the respondents were aware of possible links between poor oral health and conditions like diabetes & heart attack
- More than 90% of both HR personnel & employees stated that dental benefits are important to employees

Reasons for Not Providing Dental Benefits



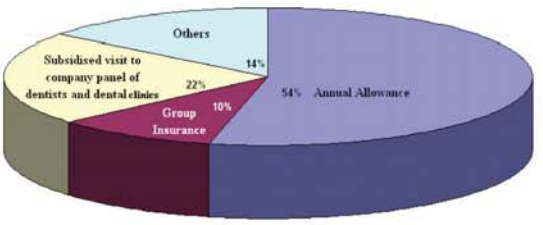
YET The prevalence of the provision of dental care benefits lags behind the provision of healthcare benefits to employees.

75% of respondents' reported their organisations provide medical benefits; only 54% respondents' organisations provide dental benefits.

- Only 9% quoted "No budget" as the reason for not providing dental benefits.

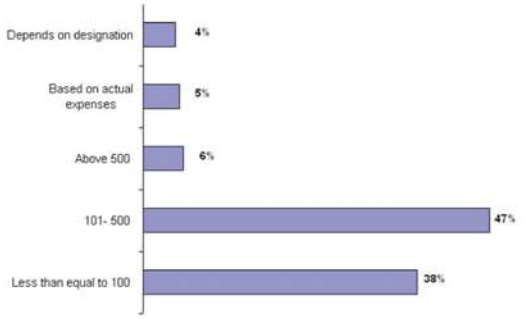
Nature of Dental Benefits Provided

The provision of dental benefits varies from annual allowance (54%), group insurance (10%) to subsidised visit to the company panel of dentists and dental clinics (22%).



With regard to the quantum of the allowance, nearly 38% of the respondents' organisations offering dental benefits pay SGD100 or less, per annum. 47% pay between SGD101 and SGD500.

Quantum of Annual Dental Allowance Provided



The most commonly covered dental services are extractions, dental cleaning, fillings and root canal treatment.

* The full Report of the Survey can be purchased from the Singapore Dental Health Foundationat $35 per copy for members. Please contact wennie.kok@sda.org.sg

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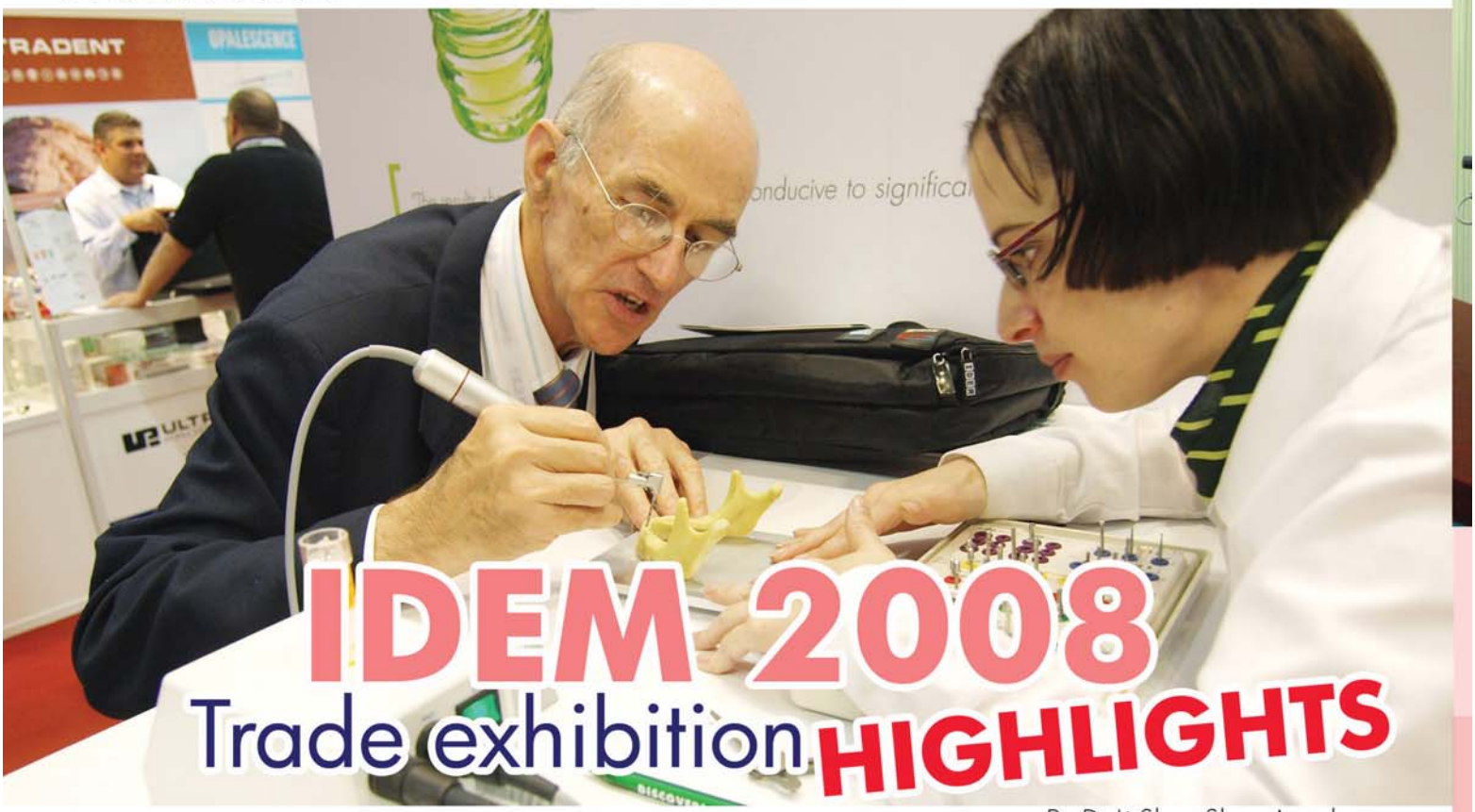


IDEM 2008
Trade exhibition HIGHLIGHTS

By Dr Li Shan Shan Angela

IDEM 2008 was held with resounding success and saw a record number of trade exhibitors and attending delegates. Jointly organized by SDA and Koelnmesse, the event got off to an exciting start with the Minister of Trade and Industry, Mr Lim Hng Kiang gracing the occasion.

The event featured comprehensive educational seminars, a massive trade exhibition and even included a dental public health screening (organized by SDHF). There was overwhelming interest in the Scientific Conference which focused on the theme "Scientific Basis of Clinical Practice". A comprehensive range of seminars conducted by internationally recognized speakers like Professor Steven Offenbacher and Professor Edward J Swift and many others covered the latest evidence based concepts in the practice of dentistry.

The trade show was also packed with latest innovations and product developments and the exhibition hall had to be increased to 10 000 sq metres to accommodate the 384 exhibitors from 34 countries. Altogether, the exhibition welcomed 6,370 trade visitors from 56 countries. In comparison to IDEM 2006, the trade fair saw a 20 percent increase in the number of exhibitors and a 12 percent increase in the number of visitors. The trade booths displayed a wide range of products from dental materials to clinical instruments and equipment to digital software. dentalSurgeon scouts out the exhibition to bring you the highlights.

Heine

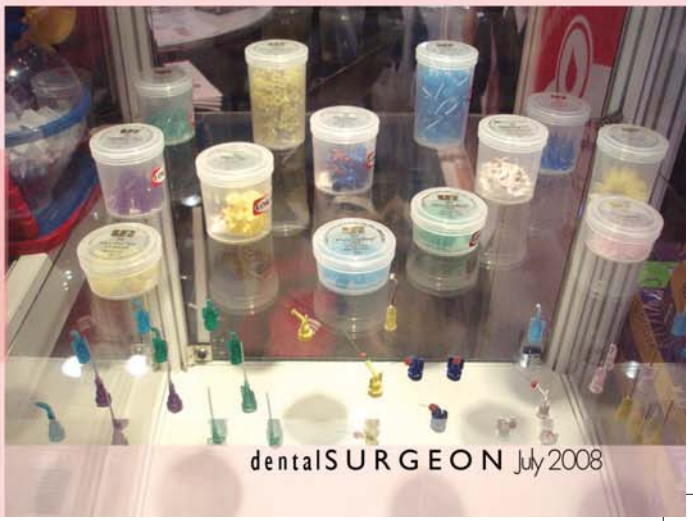
It is difficult to find a good pair of loupes and this was one of the best we saw at the exhibition. It is from a German-based company specialising in diagnostic instruments, including ophthalmoscopes, laryngoscopes and many others. The special optical design and multi-coating gave a clear, crisp image. Light and compact, it is easy to use and store.

Dental Art

Which dentist can resist such exquisite, detailed art work centred around the tooth? The intricate pieces would be able to brighten up any clinic.

Puppets

These delightful puppets will bring a smile to any defiant child and may possibly make treating children easier!



Navitip Tips

A popular tool among endodontists, these syringe tips come in various lengths and sizes and are small enough to deliver materials right to the apex.

DR JAIME CHAN
Dentist on land

By Dr Charlene Goh

Mention that you are a dentist by profession to any avid wakeboarder and 9 out of 10 will tell you that one of Singapore's top female wakeboarders is a dentist.

Dr Jaime Chan has won several wakeboarding competitions including the Singapore Wakeboard/Ski Federation Nationals Intermediate and Open Women's catergory 2002/03 and the Jet Pilot Women's Open in 2002/03.

We speak to this gung-ho athelete to find out more:

Q:How did you get into competitive wakeboarding?

I started out like anyone else, riding just for fun. I got more into wakeboarding after I graduated from University, before I started work. It was my friends who signed me up for my first competition!

Q: Don't you ever worry about injuries affecting your work?

Sometimes, but injuries to the upper body (especially hands) are rare in the sport. Besides, if I worried about it too much then I might as well cocoon myself in bubble wrap 24/7.

Q: Do you still compete and why?

I've stopped competing behind the boat but I just competed in the 1st Asian Cable Championships in Philippines. I've got bad knees from wakeboarding behind the boat (nothing wrong with the hands and fingers!) so cable skiing's friendlier on the knees.

Q: Any tips for beginners?

Start slow and don't do anything beyond your skill level. Always strive to improve by watching other better/ experienced riders, videos and even get someone to take videos and photos of yourself while riding. You'll learn a lot from yourself. Most importantly, enjoy the ride!

Q: Tongue in cheek, how does your hobby help you to be a better dentist?

Wakeboarding helps me relax, releases tension and makes me feel fresh on a Monday morning. It has strengthened my back muscles and improved my posture at work. It has also strengthened my forearms tremendously so I can extract teeth with more ease!

Lastly, it makes me want to work harder to earn more money so that I can wakeboard more!

Wakeboarding champion on water

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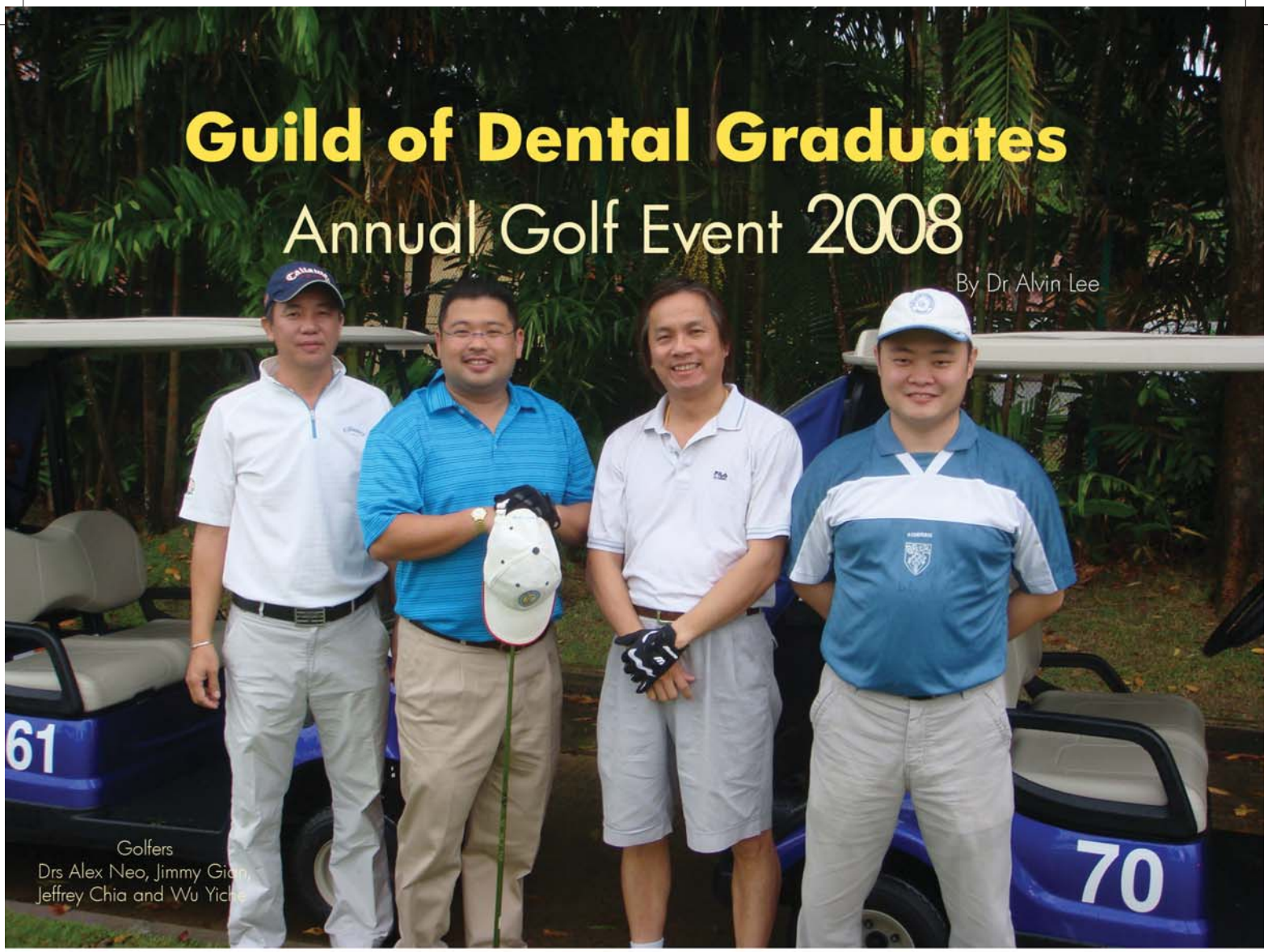
Guild of Dental Graduates
Annual Golf Event 2008

By Dr Alvin Lee



Golfers
Drs Alex Neo, Jimmy Gian, Jeffrey Chia and Wu Yiche

The Guild of Dental Graduates held its Annual Golf Event on 14th May 2008. Unlike previous years, this was not a charity event, but more of a gathering of sorts, for golfers and dentists to mingle and network. This year's event was kindly sponsored by the Office of Alumni Relations, Nobel Biocare, Fondaco, as well as ABN Amro.

The Golf Event held at the National Service Resort and Country Club (NSRCC) at Tanah Merah, was a huge success considering we had more golfers wanting to play than the number of slots available. However, on the day of the event, there was a heavy down pour throughout the morning and early afternoon. There was talk of cancelling the event altogether. Fortunately for us, the rain stopped at about 3pm allowing most of us to finish our game by about 7:30pm. The course, obviously well maintained, proved to be very enjoyable even after the heavy rain.

As with last year, a dinner buffet was specially arranged to be held at the country club shortly after the game. The winner of the event was Dr Chan Thian Sang who scored a nett of 69 whilst the runner-up, on count-back was Mr Lim Swee Kee with a score of 70.

This year, in addition to the champion and runner-up trophy, we had a Old vs Young competition as well. The winner of this year Old vs Young Trophy went to the Young team which comprised of the 6 lowest nett score from the golfers. The members include Drs Chin Yee Fatt, Wong Keng Mun, Tony Wong, Ho Kok Sen and Alvin Lee.

Prizes were given out during the buffet dinner held at the club and included a lucky draw which culminated in a top prize of a DVD player, sponsored by ABN Amro. This sought-after prize was won by Dr Chen May Lin. Congratulations to Dr Chen!

On behalf of GDG, I would like to express my sincere thanks to all those who helped in more ways than one to ensure the successful completion of this year's golf event. We hope that this event would be a regular fixture in all dental golf enthusiasts' calendars and we definitely hope to see you again next year.

BALI MISSION TRIP

By Dr Nijamuddeen A. Latiff

On March 19, 2008, I had the opportunity to join a group of 20 medical and dental personnel, led by Dr Myra Elliott to go to Bali to provide medical and dental treatment to the people of Ubud, Bali. The group comprised of 4 medical doctors, 8 dentists, 1 orthopedic surgeon, 3 oral maxillofacial surgeons, 1 anesthetist, 1 gynecologist and 2 nurses.

We departed from Changi Airport in the early hours of the morning and reached Ubud only in the late afternoon as we had to make a stopover at Jakarta International Airport. Upon reaching Ubud we headed to the local community hall to set up the equipment to begin treatment the following day.

On the morning of the 20th, we were all geared up to start treating the people of Ubud. As we reached the hall, there were already several people waiting. We immediately began treating the patients. The oral condition of the patients seen ranged from years of dental neglect to patients who simply needed a good scaling. For some patients, it was their first visit to the dentist. Their reasons for not visiting a dentist were inaccessibility to dental clinics and poor dental awareness. It was hard work with only a quick lunch break in between but we worked well as a team and this helped us to get through the day.

The next two days went by just as the first. A total of over 700 dental patients, over 800 patients seen by the medical doctors, 7 surgical procedures were carried out to remove lumps and bumps, 50 gynecological cases and 12 cases of cleft lip and palate were treated.

It was not a trip of all work and no play. One of the main organisers of the trip, Mr Subandi Salim made sure of that. Together with his wife, Mr Subandi Salim treated us to dinner at authentic Balinese restaurants. We enjoyed various traditional Balinese dance performances and fire dances. We were also brought to visit some beautiful temples and Ubud being famous for its art, was a hit for some of our art-loving members. The picturesque scenery of Ubud's hills was appreciated by all.

We returned to Singapore safely on March 23rd. Tired but thoroughly satisfied with the job well done, we returned to our everyday lives with a sense of accomplishment and new friendships forged.

10-17 May 2008

By Dr. Emmanuelle Lerat

Dental Humanitarian Mission providing dental care to 1300 Vietnamese in rural Đà Nang, located in central Vietnam

Mr. Khuu Tuong Cam and Drs. Kaan Sheung Kin and Lim led this humanitarian mission providing dental care in rural villages, located around Đà Nang, Viêt Nam. The team consisted of 14 dentists: 11 Singaporeans, 2 Malaysians and a Belgian, and a non-dental team leader.

The team arrived in Đà Nang – Viêt Nam on 10th of May 2008 where the Vietnamese Red Cross of the Province of Cam Le and Khue Thung welcomed the team with a lot of enthusiasm and professionalism.

Every day, ten heavy suitcases full of dental equipment and materials accompanied the dentists from one village to the next. The variety was impressive: three compressors to power the high and slow speed handpieces, amalgam capsules and an amalgamator, composites and light and self cured glass ionomers together with 3 portable light cure units, two modern ultrasonic scalers, and instruments for executing extractions including forceps, elevators and surgical instruments. Everything we required was there.

The working area was divided into six sections: dental screening (to pick up the conditions that need more urgent dental attention), scaling, operative dentistry, oral surgery, sterilization and pharmacy.

With compassion, the team took care of all, from children to the elderly as well as some land mine victims and mentally handicapped patients affected by Agent Orange - a Napalm gas used during the Vietnam War (1956 – 1975).

The older Vietnamese women needed much scaling because they chew betel nut which makes their mouths and teeth black. Whilst it seems to protect their teeth, it is also deemed to be responsible for a percentage of mouth cancer.

Many large cavities for children were treated. Some children were scared because they had never seen a dentist before, but we quickly learned to manage this by cheering them up with a balloons. The smiles on their faces at the end made our efforts worth-while.

The extractions were relatively easy, but minor surgical procedures were done in the more difficult cases.

Around 1200 to 1300 patients were treated through five long and intensive working days. We took turns to man each section with great team spirit. Despite being an "Ang Moh", I did not feel left out and got much support from my colleagues. The coordination between our team and the people from the Red Cross as well as the local administrators was good, ensuring that everything went smoothly.

This was my first charity mission and through this experience I realised that dentists have a universal bond: to protect, encourage, and take care of one another.

During the rest day, we enjoyed a visit to the city of Hue (located north of Đà Nang) and its beautiful Royal citadel. The peaceful walk through the Tu Duc's tomb compound in Hue gave us energy for the shopping in the city of Hoi An (located south of Đà Nang) that followed.

I felt very emotional during the thank you dinner held on the last day. To be thanked for a job we love to do, gave us immense satisfaction.

This amazing experience would not have been possible without all our sponsors, donors and well wishers as well as the Vietnamese Red Cross of the Province of Cam Le and Khue Thung and their volunteers. Special thanks also go to the SDA for its continued support.

Looking forward to the next trip...

HAND FOOT MOUTH DISEASE

PULL OUT AND KEEP

A Dental Perspective

By Dr Andrew Robinson

Introduction

It has been 50 years since the first description of an outbreak of a disease in Toronto, Canada, characterised by an acute onset of vesiculoulcerative lesions of the oral mucosa accompanied by a maculopapular rash involving the hands and feet. Hand, foot and mouth disease (HFMD) as it was later named, is caused by a group of viruses called the Enterovirus. The dental surgeon should be aware of this very common infectious disease presenting with oral manifestations which may occasionally be the initial sign of the disorder.

Epidemiology

The Enterovirus include the Poliovirus, Coxsackie virus Group A (23 serotypes), Coxsackie group B (6 serotypes), Echovirus (31 serotypes) and Enterovirus (68-71). HFMD in most instances is caused by Coxsackie A16 and Enterovirus 71 (EV71). It is usually a mild, self-limiting disease of childhood. Complications do occur, albeit rarely, and may result in sudden and rapid death, of particularly the very young, such cases being frequently associated with the EV71 strain.

HFMD is endemic throughout the year in Singapore but we have had significant outbreaks in past years. The epidemic years were in 2000, 2002, 2005 and 2006. There were 3526 cases from September to December 2000 and about 15000-16000 cases annually in the other epidemic years. Last year, they were 20000 cases of HFMD. We experienced an epidemic outbreak, in the first quarter of this year as well, peaking in the month of April. As of 7th June 2008, 14571 of HFMD have been notified. At the height of the epidemic there were 1466 cases of HFMD in a week. The number of cases appears to be declining with about 508 cases reported in the first week of June. About one third of this year's cases were attributed to the EV71 strain. The largest EV71 outbreak in Singapore was in 2000-2001, which resulted in the deaths of 7 children. This same strain was reportedly responsible for the deaths of 34 children in Sarawak in 1997, 78 deaths in Taiwan in 1998 and this year alone, it has resulted in the deaths of 22 in Fuyang City, China and 11 in Vietnam.

Transmission

HFMD is highly contagious especially in children and large outbreaks are reported in child-care centres and preschools. Indeed, an outbreak of HFMD in a dental hospital in UK was reported as far back as 1969, by the late Professor RA Cawson. Twenty dental staff and students were infected after a social gathering and some of the staff passed the infection to their family members as well.

The most infectious period is a few days before the onset of symptoms to about 1 week from the onset of the illness. However the virus may continue to be excreted in the stools and oropharynx for up to 6 weeks or more especially in infants and the immunocompromised. Transmission occurs primarily by the oral-faecal route and by direct contact with infected mucus, respiratory droplets, saliva, vesicular lesions and stools. Indirect transmission occurs by contact with contaminated objects.

Clinical Features

HFMD occurs mainly in children younger than 10 years of age although adults may be affected as well. After an incubation period of 3-5 days, the patients present with a brief prodrome of fever accompanied by anorexia and general malaise. The fever lasts for 2-3 days and is accompanied by pharyngitis, oral lesions and non-pruritic, non-painful vesicular lesions or erythematous spots typically on the plantar surfaces of the feet, the palmar surfaces of the hands and the phalanges. Other sites include the buttocks and diaper areas.

The classical triad of hand, foot and mouth lesions may not be present in all cases and occasionally oral lesions may be absent. Patients can also present with rhinitis and coughing. Symptoms usually resolve within a week. Rare complications include myocarditis, encephalitis and pneumonitis.

During the outbreak of HFMD in 2000-2001, it was noted that there were no significant clinical differences between EV71 and non-EV71 infections. Of note, the absence of mouth ulcers (although the numbers were small), vomiting, raised total WBC count and atypical physical findings were risk factors for fatalities during that epidemic.

Oral Lesions

These start initially as erythematous macules which become vesicular and ulcerate rapidly to form small localised, shallow ulcers anywhere on the oral mucosa but commonly on the tongue, buccal and palatal mucosae. The gingivae is not normally involved and there is absence of acute gingivitis. There may be just 1-2 small ulcers or multiple ulcers throughout the oral cavity. The ulcers may coalesce to form rather large grayish superficial ulcers surrounded by erythematous mucosa, typically on the posterior palate. The mouth lesions can interfere with feeding, speech and swallowing. Halitosis and a coated tongue are other presenting features.

Diagnosis

The diagnosis of HFMD is largely clinical. It occurs in epidemics or small outbreaks and a history of contact with an infected person together with the clinical features of a child with a sore mouth and red spots on the hand and feet, clinches the diagnosis.

Mouth lesions may be absent or occur as the sole presentation, at least initially. The differential diagnosis of the ulcers seen in HFMD include Primary herpetic gingivostomatitis (Primary HSV1), Herpangina, Recurrent aphthous stomatitis or Erythema multiforme. These conditions are summarised in the table.

Definitive diagnosis of, in particular, atypical cases can be made by viral isolation or more rapidly by PCR techniques from stools, oral ulcers or throat swabs.

Treatment

Treatment is symptomatic and includes the use of antipyretics, IV rehydration and tepid sponging. There are no effective antivirals for this condition. Complications should be sought for and managed in a hospital setting.

Soft, bland, diet (minced foods) with adequate fluids should be encouraged. Foods which are spicy, flavoured, very hot, dry with sharp edges (crackers, chips), citrus fruits and carbonated drinks should be avoided.

Good oral hygiene though difficult and uncomfortable needs to be maintained. This can include soft tooth brushes or using a finger wrapped with a clean, damp soft cloth to wipe the surfaces of teeth. Dentifrices may prove uncomfortable for patients with multiple ulcers. Toothbrushes and other oral aids used during the illness should be discarded.

If the child is old enough and knows how to expectorate, a

mild, warm diluted, antiseptic such as 0.12% chlorhexidine mouthwash or an antiinflammatory/ antiseptic mouthwash, Difflam C, can be used. Alternatively, the ulcers can be coated with Orabase, Difflam mouth gel, chlorhexidine gel (Elugel), or benzocaine/lignocaine gel. Additionally, oral discomfort can be relieved, as in chemotherapy or radiation induced oral mucositis, by using ice chips and allowing it to melt in the mouth.

Dental considerations

Few cases present initially to the dental surgeon, the occurrence of oral ulcers and fever, accompanied by rashes, possibly suggesting to patients that a medical rather than a dental consult may be more appropriate.

Dentists however, must always have a high index of suspicion for HFMD, especially during this epidemic period. Patients suspected of having the disease should be isolated and referred to their medical GP (HFMD is a legally notifiable disease).

The dental surgeon can instruct the patients on methods to maintain good oral hygiene and to relieve oral discomfort. All elective dental treatment should be postponed till perhaps after 2 incubation periods. It is unlikely that dental surgeons need to render dental treatment to patients with active HFMD, since the length of the illness is short. However, if urgent dental care is needed and taking into consideration the occurrence of viral shedding in clinically well patients, strict adherence to "Standard Precautions" are essential with particular emphasis on hand washing, minimising aerosol generation and the wearing of protective goggles, face shields and masks. All contaminated clothing, clinical and work surfaces should be cleaned with a suitable disinfectant. The virus is resistant to many disinfectants so it is important to use chlorinated (bleach) or iodized disinfectants.

Conclusions

Dental surgeons need to include HFMD in their differentials of patients presenting with acute, multiple oral ulceration. Prompt recognition of the disorder is essential. Strict adherence to the principles of asepsis and hand hygiene is imperative. Dentists who are themselves infected should take all preventive measures to prevent disease transmission including ceasing all clinical work until complete resolution of the illness or for at least one week after the onset of the illness.

DISEASE	CLINICAL FEATURES
Primary HSV 1 (Herpetic gingivostomatitis)	Painful pin-point oral ulcers, occurs in clusters, ulcers may coalesce, are pan-oral AND *accompanied by* Acute gingivitis (swollen, painful, haemorrhagic gingivae) Fever, malaise, anorexia, painful cervical lymphadenopathy Infants, children, young adults affected No cutaneous lesions unless autoinoculation occurs
Herpangina	Ulceration and erythema *only* on pharynx, soft palate No cutaneous lesions Fever, dysphagia, short mild illness Seen in infants, young children, outbreaks common
Recurrent aphthous stomatitis	Ovoid shaped ulcers, with intense red peri-ulcer halo, on non-keratinised mucosa, not preceded by blisters History of similar lesions, lesions recur No extraoral lesions or constitutional signs and symptoms First episode seen in teenagers and young adults
Erythema multiforme	Ragged superficial and varied oral ulceration towards anterior part of mouth *with* swollen blood crusted lips, gingivae spared "Iris' lesions on extremities, other mucosae involved (eyes, genital, nasal) May be preceded by Herpes infections or drug intake Typically in young adult males

The author acknowledges with thanks the helpful comments from A/Professor Paul Tambyah, Head of the Division of Infectious Disease, Faculty of Medicine, NUS in the preparation of this article.

THE STORY OF ANAESTHETIA

By Dr Kuan Chee Keong

Anaesthesia comes from the Greek word meaning 'lack of sensation'. During the early decades of the 19th century, many European poets and bohemians began experiment with nitrous oxide and used it to induce feelings of hilarity during parties, thus giving it the name 'laughing gas.' This eventually spread to America where a craze for 'laughing gas parties' soon caught on.

Crawford Long, a highly talented physician in Georgia experimented with ether as a substitute for nitrous oxide for recreational use. He soon found a use for ether in his treatment of patients but never published his works. Meanwhile an enterprising huckster named Gardner Colton proclaimed himself 'Professor' Colton, a 'traveling lecturer in chemistry' and began demonstrating the effects of nitrous oxide at fairs. His act impressed a local dentist in Connecticut, Horace Wells so deeply that he decided to try out nitrous oxide for himself. He had Colton render him unconscious with nitrous oxide while a colleague extracted one of his teeth. Wells soon moved to Boston and with a partner William Green Morton, constructed a 'laughing gas apparatus' consisting of a bellows and a tube with a wooden mouthpiece which was placed in the patient's mouth. Convinced that this apparatus would be perceived as a major breakthrough, Wells arranged for a public demonstration at the Massachusetts General Hospital. Unfortunately, the supply of nitrous oxide was insufficient and the young patient woke up shrieking in terror. The assembled doctors and students were outraged and Wells was dismissed in ignominy. He then set up a practice in New York and performed many successful operations using his apparatus. Despite testimonials from his patients, nobody in the medical and dental profession was willing to believe Wells' claims. Showing increasing signs of manic depression, Wells began taking nitrous oxide to console himself and was soon exhibiting symptoms of hopeless addiction.

When Wells had left Boston, his partner William Green Morton returned to Harvard and met Charles T. Jackson, his professor at Harvard University. Morton set about conceiving his plan for achieving lasting fame with nitrous oxide and confided in Jackson. Jackson was another oddity, in this cast of odd characters. He regarded himself as a genius who had been thwarted for world acclaim in several occasions. One of such occasions occurred during a trip across Atlantic in 1832 when he had become involved in a smoking room discussion about electricity. One fellow passenger had asked him whether a small pulse of electricity would transmit along a wire for any great distance and Jackson assured him it would. This passenger was Samuel Morse who went on to develop this idea and invented the electric telegraph, which he patented. After listening to Morton, Jackson suggested using ether instead of nitrous oxide. Four years earlier, Jackson had traveled through Georgia and had heard about Crawford Long's pioneer anaesthetic method.

Morton tested Jackson's ether suggestion – first on his son's goldfish, then on a hen and finally his pet spaniel. All proved successful and in September 1846, he anaesthesized a patient with ether and extracted a tooth. After fine-tuning his anaesthetic equipment, Morton demonstrated his method successfully at Massachusetts General Hospital, the same place where Wells failed miserably. The surgeons at Massachusetts General Hospital endorsed his claim to have discovered an effective modern anaesthetic and demanded to know the secret of his method. Morton realized that if he had told them that it was just ether, everyone would soon be using it and he would reap no profit. So Morton consulted Jackson who suggested mixing ether with some aromatic oils to mask its smell and naming it Letheon (after the mythical Greek river Lethe, through which the dead crossed to the underworld, whose water erased all memory of their earthly life). Morton then applied a patent on Letheon. However, Jackson was waiting for such an opportunity and he immediately contested Morton's application, claiming to be co-inventor. On legal advice, Morton was reluctantly forced to include Jackson as his co-inventor.

News of this great discovery soon swept around the world. The French Academy awarded a gift of 5000 francs to them but Morton refused to accept his share, still convinced that he was the sole discoverer and should be awarded the entire prize. It was at this time that Morton's erstwhile partner, the disgraced dentist Horace Wells, launched a claim of his own, insisting that he was in fact the discoverer of the first anaesthetic. This launched litigations and counter-litigations which even ended up before the Senate where it became to be known as the 'Gas War'. All this while, the original discoverer refused to join in the fray. Crawford Long continued to practice in the Georgia countryside, administering his anaesthetics when necessary and carefully recording its effect.

All three protagonists in the Gas War came to a bitter end. Wells moved on to chloroform addiction and became more erratic in his behaviour. In 1848, just two years after lodging his initial claim, he was jailed for attacking two prostitutes where he then committed suicide by slashing his wrist. Although the secret of Letheon was quickly exposed, Morton persisted in his legal battle to establish his priority of the inventor (with it the generous grant promised by the government) and was left financially ruined. Some supporters took pity on him and began raising a testimonial subscription for 'the founder of anaesthesia'. When Jackson got wind of this, he immediately contested Morton's claim to the title, threatening to scupper the entire subscription. Morton was in a carriage while traveling through Central Park in New York when he read Jackson's threat in the newspaper. He became so enraged that he suffered a fit of apoplexy and died.

The continuous litigation in which Jackson had involved himself only served to increase his paranoia. In 1852 Crawford Long was finally persuaded to publish a paper describing the use of ether as an anaesthetic and many now recognised he was the true pioneer. For years, Jackson alternated between fits of paranoia and long bouts of deceptively calm depression. Eventually in 1873, Jackson was confined to a lunatic asylum where he died seven years later.

The **Importance** of **Hand Care** for **Dental Healthcare Workers**

By Dr Phang Hui Jing

Working as a dental healthcare worker (e.g. dentists, nurses) requires repetitive and frequent hand washing which may increase skin dryness and roughness. There is also an increased risk of developing natural rubber latex allergy through the frequent use of natural rubber latex gloves.

It is important to protect against breaches of the skin barrier which can result from frequent use of skin cleansers and glove-wear, especially if you have an atopic background (e.g. eczema) where damage to the skin from irritants is more common. Hand-disinfectant agents and protective gloves need to be selected with great care and it is also important to use a suitable aqueous based emollient at the end of each clinical session

Tips on hand care from The British Dental Association

- Removal of rings, jewellery and watches before clinical session
- Wash and disinfect hands at the beginning and end of each session, as well as between each glove change
- Use cool/tepid water when washing, to keep hand temperature down
- Use hand-wash agents sparingly
- Rinse thoroughly to remove all traces of hand wash
- Pat skin dry rather than rubbing it
- Ensure hands are dry before putting on gloves
- Use well fitting, non-powdered gloves with low levels of natural rubber latex proteins and residual chemicals
- Minimize contact with other potential irritants/allergens in the surgery (e.g. acrylic powders/anti-microbial solutions)
- Regular use of an emollient hand cream to prevent the skin from drying, especially after every clinical session

The regular use of skin care preparations should therefore help to prevent both dry and rough skin among healthcare workers in clinical practice

TRIED & TESTED

Products tried and tested by
Drs Khin Ma Ma, Phang Hui Jing, Charlene Goh & Li Shan Shan Angela

Ahava Deep Sea Mineral
100ml tube for $30

A rich mineral hand cream from dead sea salt. The balance of the salts in Dead Sea water are magnesium, potassium, calcium chloride and bromides which are critical to our skin metabolism

What we liked: It had a nice smell and absorbed quickly. Dermatologist tested.

L'Occitane Shea Butter
150ml tube for $43

A very thick and moisturizing hand cream for dry hands. It contains 20% shea butter. Shea butter high level of essential fatty acids and natural antioxidant compounds provide good moisturizing capabilities and cellular restoration.

What we liked: Like all L'Occitane products it had a nice smell blended with jasmine and ylang-ylang essences.

Clinique Derma White
75 ml tube for $44

A penetrating, non greasy hand cream that forms a protective layer on hands. It helps to brighten hands and fades the appearance of dark spots and discolorations caused by UV exposure and environmental aggressors.

What we liked: The cream absorbed immediately into the skin leaving no residue at all. Dermatologist tested.
Fragrance free.

FDI supports efforts to promote fluoride for oral health

Ferney-Voltire, FRANCE, 16 June 2008 – A team of researchers, which includes Dr Habib Benzian of the FDI World Dental Federation, Dr Ann Goldman of the School of Public Health and Health Services at the George Washington University in Washington D.C., Dr Robert Yee and Dr Christopher Holmgren, both expert consultants to the FDI's World Dental Development & Health Promotion Committee, compared the relative affordability of fluoride toothpaste in 48 countries. This study is the first to attempt to quantify the affordability of toothpaste across the globe.

Fluoride toothpaste is prohibitively expensive for the world's poorest people, according to the study that was published in BioMed Central's open access journal "Globalization and Health". Researchers revealed that the poorest populations of developing countries have the least access to affordable toothpaste.

Fluoride toothpaste is the most widely used method of preventing dental decay, but currently only about 12.5% of the world benefits from it. The researchers believe that the low-use of fluoride toothpaste is largely due to its cost, which is prohibitive for poor populations in some parts of the world. The results showed that in different income groups in various countries, as the per capita income decreased, the proportion of income needed to purchase a year's supply of toothpaste increased; the poorest in each country being the hardest hit.

"Dental decay is the most common disease on the planet and the use of fluoride is a key approach in preventing it. Fluoride is on the list of essential medicines therefore all efforts should be made to make fluoride-containing products, such as toothpaste, universally available and affordable. The study has added new understanding of the challenges that poor populations worldwide are facing with regards to using an es

> "Fluoride toothpaste is the most widely used method of preventing dental decay, but currently only about 12.5% of the world benefits from it."

sential preventative product for their dental health", commented Dr Habib Benzian, FDI Development & Public Health Manager. "We are keen to work closely with the global manufacturers, governments and other stakeholders in this context" he added.

Supporting this research is a part of the FDI's ongoing efforts to promote the use of appropriate fluoride for better oral health. During 2006 and 2007, two expert consultations were held by the FDI, in partnership with the World Health Organization (WHO) and the International Association for Dental Research (IADR) to discuss and analyse the impact, delivery methods and advocacy strategies related to fluoride and oral health. Both conferences resulted in declarations that called for the promotion of oral health through fluoride.

ADDITIONAL INFORMATION

The article, "Global affordability of fluoride toothpaste", Ann S Goldman, Robert Yee, Christopher J Holmgren and Habib Benzian, is available online at the Globalization and Health's website at www.globalizationandhealth.com.
More information about the FDI, WHO and IADR consultations and conference declarations can be found on the FDI website at www.fdiworldental.org/public_health/3_2fluoride.html.

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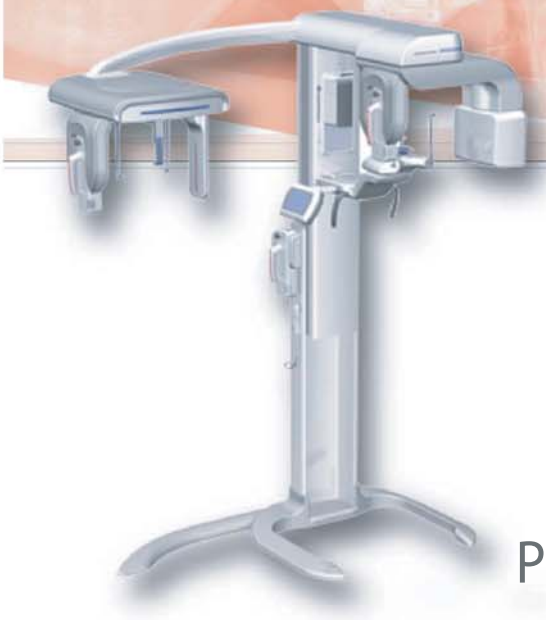

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Thestorybehindthe SDA logo

By Dr Tan Yinghan

The Singapore Dental Association began as part of the Malayan Dental Association which had its official inauguration at the General Hospital in Singapore in Sept 1938. By 1949, the Malayan Dental Association had 3 branches including one in Singapore, Penang and central Malaysia. When Singapore gained independence in 1965, the Singapore branch broke away to form the Singapore Dental Association in 1967. We spoke to Prof Yip Wing Kong, the founding Hon.Gen Secretary of SDA to find out more about the history of SDA and the story behind its logo.

Prof Yip had graduated from dental school in 1964 and was working as an assistant lecturer in the dental school. In 1965, he was appointed to be the Hon. Gen Secretary for SDA and together with Mr Chee Kah Keng (Chief laboratory technician of the Pathology and Histology lab then) as his assistant, they formed the backbone of the SDA administration then. There was no proper office then and they were based in the General Hospital.

With its recent separation from MDA, SDA needed a new crest to represent itself and a design competition was held. The design by Prof Yip was selected and it has become the present SDA logo.

The SDA crest features a lion and a tiger which represents the historical connection of Singapore and Malaysia and the Singapore colours red and white were chosen for the background. In the centre, Prof Yip designed a brown serpent wrapped around a bur to aptly represent dentistry. This was actually based on the traditional symbol of medicine: the rod of Asclepius. This is an ancient Greek symbol featuring a serpent wrapped around a staff and it is associated with the healing arts. In Greek mythology, Asclepius was a skilled physician who was eventually worshipped as the Greek god of medicine. Interestingly, the original Hippocratic Oath translated from Greek actually begins with the invocation "I swear by Apollo, Asclepius, Hygieia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment, the following Oath..." (Apollo, the father of Asclepius, was an important Greek deity and recognized as a god of medicine among many others; Hygieia and Panacea were daughters of Asclepius and symbolised cleanliness and healing.)

With a new crest, SDA then embarked on its mission to raise awareness about dentistry and improve image of the profession. Much effort was put in to differentiate between Division I and II dentists and to gain recognition of dentists as doctors on par with the medical profession. We have certainly come a long way since then and SDA now works towards global recognition through organizing international events like IDEM and FDI.

- Listerine fights germs throughout the entire mouth—areas where brushing and flossing can't reach
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  — **52%** greater plaque reductions vs brushing and flossing alone*[1]
  — **21%** greater reductions in gingivitis vs brushing and flossing alone*[1]
- Listerine is safe and appropriate for long-term daily use

Recommend Listerine, twice a day, every day, for whole-mouth health.

for Life

*Based on a home-use test among subjects with mild-to-moderate gingivitis.

Reference: 1. Sharma N, Charles CH, Lynch MC, et al. Adjunctive benefit of an essential oil-containing mouthrinse in reducing plaque and gingivitis in patients who brush and floss regularly: a six-month study. J Am Dent Assoc. 2004;135:496-504.

Long Lasting Relief From Hypersensitivity & Dental Caries

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Colgate® Gel-Kam® Gel builds protection against painful sensitivity of the teeth due to cold, heat, acids, sweets or contact.

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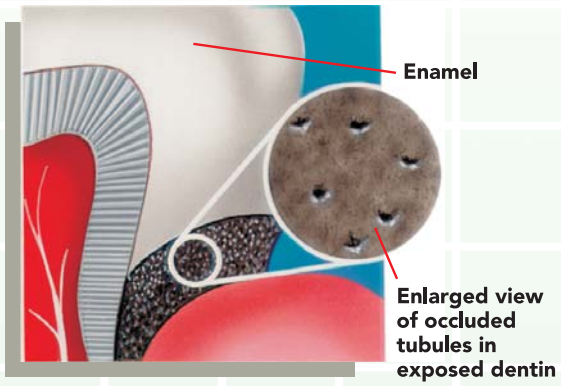

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Active Ingredients:

Gel : 0.4% stable stannous fluoride (SnF2)

Rinse : 0.63% stable stannous fluoride (SnF2) concentrate

Clinical References:

1. Miller S Et al - Arch Oral Biol 1994;39 (suppl) 151S. 2. Ellingsen J, Rolla G. Scand - J Dent Res. 1987; 15: 281 286. 3. Blong MA et al - Dent Hyg, 1965; 489-492.
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