

7th NORTHEAST REGIONAL DENTAL CONFERENCE 2011



MEGHALAYA BRANCH

Souvenir

"Learn, Excel & Enjoy"

7th NORTH EAST REGIONAL DENTAL CONFERENCE 2011



Meghalaya Branch

Souvenir
2011



INDIAN DENTAL ASSOCIATION

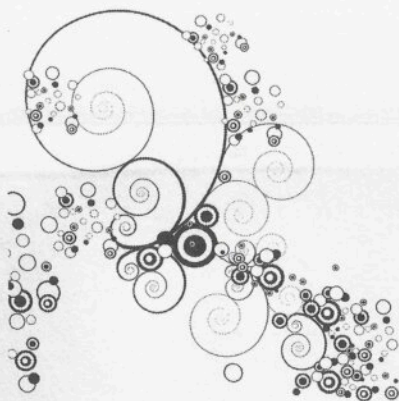
7th North East
Regional
Dental Conference
2011

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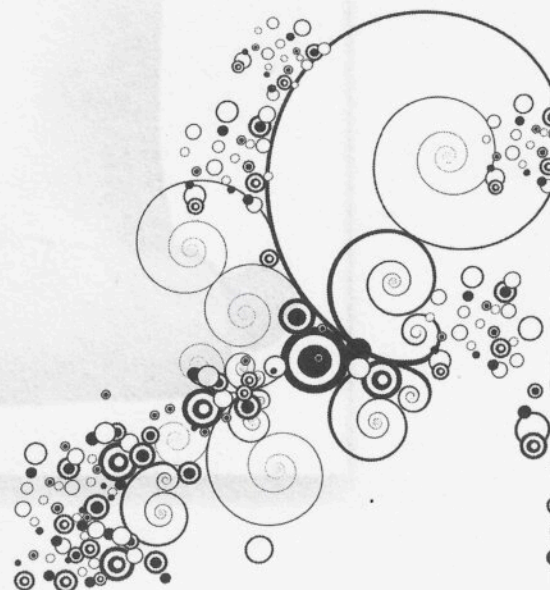
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Dr. P. Shakil Ahammed, IAS,
Commissioner & Secretary to the
Governor



सत्यमेव जयते

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GOVERNOR'S SECRETARY

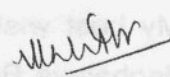
RAJ BHAVAN

SHILLONG - 793001

MESSAGE

His Excellency, Shri Ranjit S. Mooshahary, Governor of Meghalaya is happy to know that the Indian Dental Association, Meghalaya Branch is organizing the 7th North East Regional Dental Conference on 17th & 18th October 2011, at Shillong and a souvenir is being brought out to commemorate the occasion.

His Excellency, the Governor hopes that this conference will give opportunity to the practitioners and participants to share and disseminate knowledge, experience and research in the management of dentistry and hopes that this conference will benefit the people of the state and the North Eastern Region in general.


{Dr. P. Shakil Ahammed, IAS}

वीसेन्ट एच. पाला
VINCENT H. PALA



जल संसाधन एवं अल्पसंख्यक कार्य राज्य मंत्री
भारत सरकार

नई दिल्ली-110001

MINISTER OF STATE FOR
WATER RESOURCES AND MINORITY AFFAIRS
GOVERNMENT OF INDIA
NEW DELHI-110001

MESSAGE

I am glad to be apprised regarding the 7th Annual North East Dental Conference being held at Shillong on 17th and 18th October 2011. It is indeed a matter of pride that Indian Dental Association, Meghalaya Branch is organizing and hosting this prestigious event.

I am confident that the conference shall be well structured and deliberations during the two day interaction shall be meaningful and come up with improved and latest strategies for dissemination of improved oral health care in the North East. The approach of the conference may also like to emphasize on the oral health care issues of the rural masses including generation of awareness among them on the importance of oral health and dental care.

I am sure that your esteemed branch shall make all possible endeavours to attain the desired goal of the conference.

My best wishes remain with you, all distinguished members of IDA, Meghalaya Branch and delegates from the North Eastern States for optimal success of the event.

(VINCENT H. PALA)

Dr. Mukul Sangma
Chief Minister
MEGHALAYA



Office : 0364-2224282
PABX : 2200
Fax : 0364-2227913
(R) 2522752
September 15, 2011

MESSAGE

It gives me great pleasure to know that the Indian Dental Association (Meghalaya Branch) will be hosting the 7th North East Regional Dental Conference, 2011 in Shillong. It is inspiring to know that this Conference will include lectures on courses which I am sure will revolutionize dental practice in the North East Region.

With the advancement of Science and Technology, the face of dentistry is also changing and it is pertinent that Dentists are required to acquaint themselves with up-to-date dental materials so as to improve dental care in the region.

I hope that the deliberations and interactions by the participating members will address the problems and issues relating to dentistry and further enhance the knowledge which will serve to improve the services of the Dentists in the state in particular and the country in general.

I wish the Conference all success.

(Dr. Mukul Sangma)

Mr. R. Lyngdoh
Deputy Chief Minister
I/c Health & Family Welfare, Labour
Parliamentary Affairs, Home (Passport) &
Administrative Reforms



Ph. No. : 2224568 (O)
2640 (O)
2521353 (R)
9436111005 (M)



Date: 01.08.2011

MESSAGE

It is with immense pleasure to learn that the Indian Dental Association, Meghalaya Branch have bagged to host the prestigious 7th North East Regional Dental Conference in shilling to be held on the 17th and 18th of October, 2011 and to commemorate the occasion a Souvenir will be published for the event by the Association.

On this special event, I would congratulate the Meghalaya Branch of the Indian Dental Association for conducting awareness programme in many schools and villages. I would further emphasize upon the Indian Dental Association to create more awareness programmes by conducting dental awareness especially in the rural areas where most of the people are uneducated and lack in these kind of awareness.

As I extend my heartfelt gratitude to the Association for its service rendered to the people of our State, I hope that this Conference will be able to come out with solutions to various dental problem and other challenges and to bring forward improved and cheaper dental care to all sections of the society.

I wish the Conference a grand success.

(R. Lyngdoh)



MEGHALAYA MEDICAL SERVICES ASSOCIATION

Regd. No. SR/MMSA-19/77 of 1977
H.Q.Shillong

Date : 5th September 2011

MESSAGE

The Meghalaya Medical Services Association (MMSA) is extremely happy to know that the Indian Dental Association, Meghalaya State Branch is hosting the 7th North East Regional Dental Conference in Shillong on 17th and 18th October 2011 and a souvenir is being brought out to commemorate the occasion.

We hope that the outcome will bring about further improvements in the delivery of Oral Health Care Services to the people of the entire North East Region.

On this special occasion, we on behalf of the MMSA wish the members of the Indian Dental Association, North East Chapter all success for the Conference.

Thanking You

Yours Faithfully

(Dr. R. Nongbet)
President, MMSA

(Dr. A. War)
General Secretary, MMSA.

Dr. Ashok Dhoble,
Honorary Secretary General,
Indian Dental Association.
534, Indian Mutual Terrace, 2nd Floor,
Sandhurst Bridge,
Opera House,
Mumbai 400 007

| MESSAGE |

It is a pleasure to know the Meghalaya branch of IDA will host the North East Regional Dental Conference in Shillong on October 17th and 18th 2011.

Please accept our congratulations. Organizing a conference on such a large scale requires dedicated and painstaking work. We are sure that under your leadership, your team will do a fine job.

Many useful ideas will be generated during the conference, which will pave way towards attainment of the goal of improving the dental health of people in the region.

We are also very happy that you are compiling a souvenir to commemorate the occasion. Surely, the souvenir will provide valuable information to the readers.

Our best wishes for grand success of the conference.

Dated : Shillong the 09-08-2011

Dr. A. Das

*Director of Health Services (MI)
Meghalaya, Shillong.*

MESSAGE

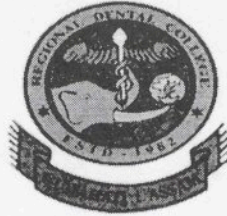
It is a great pleasure on my part to know that the Indian Dental Association, Meghalaya Branch is hosting the North East Regional Dental Conference at Shillong Club, Shillong on the 17th & 18th October, 2011.

I am glad to learn that the Indian Dental Association, Meghalaya Branch is publishing a Souvenir. As the Indian Dental Association believes in the importance of oral health for each and every individual and leads that effort of attaining that goal, I am sure it will continue to serve the interest of the public at large.

I wish the Indian Dental Association, Meghalaya Branch all the best in its future endeavors. I also take this opportunity to wish its members and to urge them to continue working for the health of the state and its people with sincerity and a sense of dedication.

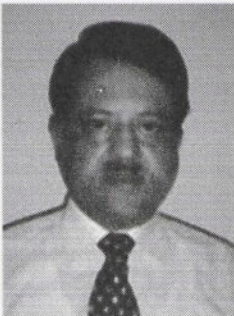
I wish the two day Conference a success.


(Dr. A. Das)



GOVERNMENT OF ASSAM
OFFICE OF THE PRINCIPAL, REGIONAL DENTAL COLLEGE,
P.O. INDRAPUR GUWAHATI - 781022

Dated Guwahati the 2nd September, 2011



Dr. A. K. Adhyapok BDS. MDS (Pedo), MDS (OMFS)
Principal,
Regional Dental College,
Guwahati 32

| MESSAGE |

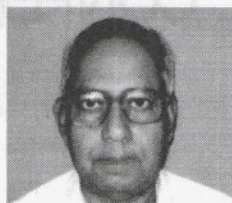
I am very happy to learn that the 7th North East Regional Dental Conference is being organized by the Indian Dental Association; Meghalaya Branch on 17th and 18th October, 2011 in Shillong. In this auspicious occasion the organizing Committee is going to publish its mouthpiece during this mega event. I hope this magazine will make interesting and useful reading both for the professional and common readers.

I am confident that the magazine will highlight the goal and achievement of young dentists.

I wish their endeavor will achieve a great success.

(A. K. Adhyapok)

Dr. B.R. Bhuyan
MBBS, BDS, MDS, FICD.
Retd. Principal Regional Dental College
Guwahati 781032



Res & Clinic :
M.R. Dewan Road
Silpukhuri, Guwahati 781003
Phone (0361) 2667059

Date : 24.08.11

MESSAGE

Thank you for asking me for a message to be published in the Souvenir being released on the occasion of the 7th North East Regional Dental Conference being organized and hosted by the Meghalaya State Branch of the IDA. It is most heartening for me to see that the Dental Association which was formed in 1969 with only eleven members drawn from different parts of North East is growing and its members, besides rendering professional services to the people in their individual capacity, are also collectively treating and counseling the masses regarding importance of Dental & Oral Health under the banner of IDA, organizing Dental Health Camps etc.

You are aware that because of very negligible number of qualified Dentists in this region earlier, I along with a few of my friends, took the initiative to form this Association. At that time, Meghalaya was in the verge of being declared as a State. Dr. P.C. Bhattacharya, from Shillong was one of the eleven member team. From 1965-66 to 1986-87, a handful of young boys and girls qualified as Dental Surgeon by studying in other States, under Govt. quota. After creation of the Regional Dental College at Guwahati, as a NEC Scheme, we could produce nearly one Thousand Dental Surgeons till now. These Dental Surgeons are now serving in all the Seven States of the region. It is also a matter of great pleasure for me to find that you are forming Branches of Indian Dental Association every State of this region.

I congratulate the Meghalaya Branch for inviting the 7th Regional Dental Conference and I am confident you will organize the programme in a much better way than the earlier ones.

I wish a grand success of the Conference.

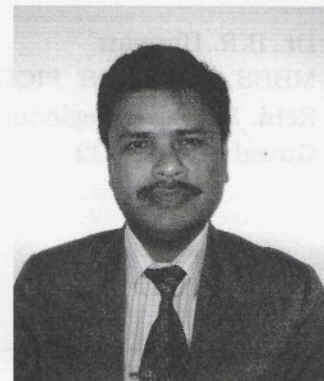
Yours Sincerely,

(B. R. Bhuyan)

Chairman,
Co-Ordination Committee,
North East Dental Forum.

NORTH EAST REGIONAL DENTAL CONFERENCE (An Annual Event) “SURGE AHEAD”

Dr. J. Barman,
Convener, Co-ordination Committee



The Indian Dental Association, a premier professional association of dentists was founded in 1945 by Dr. R. Ahmed, being the Founder President, along with four other Founder Members. IDA today, is the largest recognized organization of dentist in India, expanded its horizon to cover all the State and Union Territories representing more than 50,000 dental professionals. Time has been a witness to the evolution of the association and also to that of the dental profession over the years.

The Indian Dental Association has emerged in the North East Region of India by recommending Assam State Branch in 1969 with just 11 members. Most of the Dental surgeons serving and practising in the entire region later joined the Assam State Branch. As the time passes, Assam has been curved out to seven sisters. However, till recently, IDA, Assam State Branch functioned as a common forum for all the Dental Surgeons of this region. Gradually, the numbers of Dental surgeons has increased. The Regional Dental College, Guwahati, the only Dental College in the North East India, has played a great role in the growth and progress of dental education and dental health services in the entire region. We owe and acknowledge the efforts of its founders and the contribution of the institution to the nation. The increased numbers of dental graduates in the region, today facilitate organization of separate State branches of IDA in all the seven states. Besides, the Assam State Branch has four Local branches, namely Guwahati, Tinsukia, Silchar and Dibrugarh Local Branches under its aegis.

Dear colleagues, as I have already mentioned, Assam State Branch of IDA till few years back, was the common branch for the dental professionals of this region. Therefore, all the activities of the branch were meant for the benefit of its members and the public of the entire North East Region. Our pioneer members' organized Dental conferences on a few occasions with an accordance the concept of the IDA. Today, all the State branches in the region are actively organizing various activities including their own Annual State Dental Conferences. However, it was deemed necessary to form a common platform for all the dental professionals of the region to discuss the common problems and planning for the development and progress of the dental profession in this region to keep pace with the ever-changing World Dentistry.

Since last few years, our sister branches were putting all out efforts to form a common forum. In the best of my knowledge. The endeavours of the Mizoram State Branch in this regards should be appreciated. Finally our efforts paid off and we could reorganize a common Dental Conference on 27th and 28th November, 2010 at Shilpgram, Guwahati, and named it as the 6th NORTH EAST REGIONAL DENTAL CONFERENCE, accounting the efforts and contribution of our pioneer organizers. We also could form a Co- ordination of Committee of IDA Branches of North East Region in pursuance of the decision arrived in the meeting held in the same conference venue on 28th November, with Dr. B. R. Bhuyan in the chair and participation of representatives of all IDA State Branches in the North East, namely- Assam, Meghalaya, Manipur, Tripura, Nagaland and few doctors from Arunachal Pradesh. The meeting formulated the duties and responsibilities of the Committee and unanimously formed the following committee to function for the next three years.

Chairperson	: Dr. B.R. Bhuyan, Guwahati, Assam
Co-Chairperson	: Dr. Kamaljit Singh Sehdeva, Shillong, Meghalaya.
Convener	: Dr. J. Barman, Guwahati, Assam
Treasurer	: Dr. T. Bharali, Guwahati, Assam
Members	: All presidents and Secretaries of IDA, NE State Branch

Subsequently, the Co-ordination Committee has unanimously recommended few Guidelines for the smooth functioning of its activities.

Dear friends, time bring changes and we have to move with time. The North East Region of India has witnessed many changes over the years. Every change should be a change for the better tomorrow. The North East Regional Dental conference will provide a common forum for the Dental professionals of this region to stand united together and welcome the changes in the field of Dentistry for the progress and development of the Dental profession and to offer the best possible Dental and Oral health Care Services in the region.

Let the conference go ahead!

Long live North East Regional Dental Conference!



Dated : 20th September 2011

Dr. K. S. SehDave

Organizing Chairman

President IDA Meghalaya State Branch

Greetings form IDA Meghalaya State Branch!!

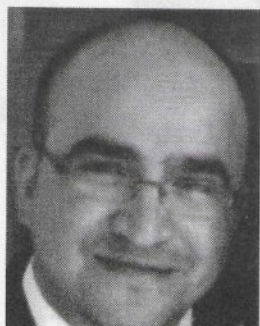
| MESSAGE |

It gives me immense pleasure to place my feelings as President IDA Meghalaya and Organizing Chairman of the 7th North East Regional Dental Conference at a time when our Branch is enjoying almost 6 years of its youth. Till this time IDA Meghalaya has grown many folds with almost 100 members in its organization. This, I feel is the right time to take our organization with the help of the North East Forum and reach out to the Dental fraternity of all the 8 North Eastern states so that the academic talents and scientific knowledge of our members will be exposed to the practice and academic standards as per international level.

On behalf of the Organizing Committee I welcome all the delegated to this Pine City of Shillong and wish you have a great time academically as well as with your friends and family.

Best Wishes

Dr. K. S. SehDave



Dr. Kyrpang Passah
Organizing Secretary
7th North East Regional Dental Conference

MESSAGE

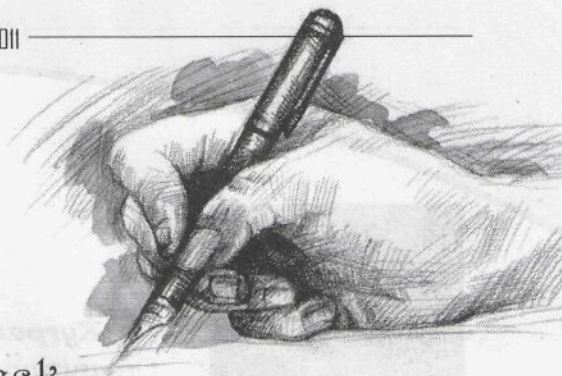
When Lt. Col. Dr.H. Darekar was posted in Shillong almost 6yrs ago, for us dentists of Meghalaya, he was in the right place and at the right time. It was his initiative and farsightedness that along with some likeminded dentists, he started the IDA Meghalaya branch on the 20th of July 2006 with just about 30 dentists. We had the approval of the IDA head office on the 17th of august 2006. Today we have grown to strength of almost a hundred members. The main objective of our association is to give organised service to the people. To realise this, we need to update our skills and knowledge on a regular basis. We do this through our Continuing Dental Educational programme (CDE) by having CDE programmes and hands on courses. We also have our Continuing Dental Health programmes (CDH) in the form of free dental checkups, camps and dental educative programmes in schools both rural and urban. These are done sometimes in collaboration with Colgate and other companies where we distribute free dental kits. We have also held camps with different organizations like the Cancer Society of Meghalaya, SOS village, schools for differently abled children and orphanages. Awareness programmes through media, both print and electronic have been carried out on various occasions.

With our newly acquired experience and the increasing strength of our numbers, we decided to bid for the chance to host the 7th North East Regional Dental Conference 2011 here in our home town. Needless to say, we were chosen to host this prestigious event which for us is a great privilege and a challenge. With a small man power (the majority of our dentists are government servants with rural postings) and without the back up of a dental college the word "Challenge" took on a new meaning. It has been possible only because of a group of hard working doctors who gave their heart and soul to make this conference work. I thank each and every one of you who had faith in me and supported me. It was certainly not a free ride or a bed of roses but we could overcome all the obstacles with mostly a lot of laughter and sometimes not. I am grateful to the forum for giving us this chance to prove ourselves but we do apologise for any short falls. I also thank all the various companies and the NEC for their generous support. Last but not the least I thank each and every one of you who helped this conference to be a grand success. I would like to end my note with our motto "learn ,excel and enjoy" for the conference.

Thank you
Khublei

Chi hajar Ngooh,
Mitela

DR. Kyrpang Passah



From the Editor's Desk

The day that we have been waiting for has finally dawned. The 7th North East Regional Dental Conference 2011, being held in our very own city, Shillong. I on behalf of Indian Dental Association, Meghalaya branch extend a warm welcome to each one of you. It is indeed our privilege to be able to organize such a prestigious event and play host to our esteem guests. I hope your visit to our city proves to be a fruitful one and you would carry back fond memories of this conference and our people.

In these changing times, when everyday there is something new to learn in every field, dentistry is no exception. But at the same time it is not always possible for us to attend conferences and seminars in and outside the country. North East Dental Conference being closer home and more convenient for us, is an ideal platform where we get to enhance our knowledge and excel in our profession, in the process serve our people better. It is also a place where we exchange ideas, discuss and catch up on old times with our friends and colleagues. Thus the motto of this conference "learn, excel, enjoy".

To commemorate the event, we are bringing out this souvenir. Apart from the usual articles that you read in a souvenir, I have included a special section called MIX BAG which is my collection of snippets, which I hope will help you unwind as you close the last page of the souvenir.

And finally as I end my editorial note, it would be incomplete on my part not to thank all my colleagues and good friends who have contributed articles and all those who have been associated with me in this souvenir. I also thank all the Guest speakers for coming to our city and the PG students for their participation.

Thank you

Khublei Shibun

Chi hajar nguh

Mitela

Dr. N. Py. Mawrie

Members of Co-ordination Committee of IDA Branch of N.E. Region of India

Chairperson :
Dr. B.R. Bhuyan
Gauhati, Assam



Co-Chairpeson :
Dr. K.S. SehDave
Shillong, Meghalaya



Convener :
Dr. J. Barman,
Gauhati, Assam



Treasurer :
Dr. T. Bharali,
Gauhati, Assam



7th North East Regional Dental Conference 2011

Organising Committee

Organising
Chairperson



Dr. K. S. SehDave

Organising
Secretary



Dr. Kyrpang Passah

Joint Secretary



Dr. Lumbor L. Mawson

RECEPTION

Chairperson

Dr. Neelakshi Choudhury



Convener

Dr. Patrick Pala



SCIENTIFIC PROGRAMME AWARDS / GIFTS

Chairperson
Dr. S. Pradhan



Convener

Dr. Hu Chi Shane Dhar



FINANCE

Chairperson
Dr. L.E. Lyngdoh



Convener

Dr. I. Tiewsoh



SOUVENIR

Chairperson
Dr. N. Py. Mawrie



Convener
Dr. V.G. Mawlong



REGISTRATION

Chairperson
Dr. E. Garod



Convener
Dr. A. Dutta



TRADE FAIR

Chairperson
Dr. M. Bhowmick



Convener
Dr. S. Dey



HOSPITALITY

Chairperson
Dr. R. Kharwanlang



Convener
Dr. Linda Marbaniang



CULTURAL / BANQUET

Chairperson
Dr. Freddy Nongkynrih



Convener
Dr. Nathaniel Kharumnuid



STUDENTS

Chairperson
Dr. Namsarang Momin



Convener
Dr. Nishwa Dhar



TRAVEL / ACCOMMODATION

Chairperson
Dr. Ronald Pyngrope



Convener
Dr. Rimeo Nongtdu



7th North East Regional Dental Conference 2011

SUB-COMMITTEE

ORGANISING

- Chairperson : Dr. K.S. SehDave
Organising Secretary : Dr. Kyrpang Passah
Joint Organising Secretary : Dr. Lumbor L. Mawsor

TREASURER / FINANCE

- Chairperson : Dr. Lana E. Lyngdoh
Convener : Dr. I. Tiewsoh
Members : Dr. Easter Sangma, Dr. Lariker Lyngdoh
Dr. W. Hynniewta, Dr. S. Marak

RECEPTION

- Chairperson : Dr. Neelakshi Choudhury
Convener : Dr. Patrick Pala
Members : Dr. Maya Pala, Dr. Lal Rochama (Mizoram)
Dr. Neisatuo Nero (Nagaland), Dr. Pranabendu Singha (Tripura)
Dr. A. Buklsuria (Dibrugarh), Dr. Pirrola Marak
Dr. Rupam Bhuyan (Tinsukia), Dr. Lala Wage (Arunachal Pradesh)

SCIENTIFIC PROGRAMME / AWARDS & GIFTS

- Chairperson : Dr. S. Pradhan
Convener : Dr. Shane Hu-Dhar
Members : Dr. Senful Kharkylliang, Dr. Danial Hu, Dr. Lariker Lyngdoh

SOUVENIR

- Chairman : Dr. N. Py. Mawrie
Convener : Dr. V. Mawlong
Members : Dr. D. Jyrwa, Dr. W Lyngdoh, Dr. B. Sanglyne.

STUDENTS

- Chairman : Dr. Namsarang Momin
Convener : Dr. Nishwa Dhar
Members : Dr. Ibanylla Malngiang, Dr. Dolvicia Swet, Dr. B. Kanti.

TRAVEL/ACCOMMODATION

Chairman : Dr. Ronald Pyngrope
Convener : Dr. Rimeo Nongtdu
Members : Dr. (Mrs.) S. Mawsor, Dr. H. Challam, Dr. Cornelious Sangma

REGISTRATION

Chairman : Dr. E. Garrod

Convener : Dr. A. Dutta

Members : Dr. P. Chakraborty, Dr. Woorhenlang Lanong
Dr. R.K. Ratan Kumar Singh (Manipur)

TRADE FAIRE

Chairman : Dr. M. Bhowmick
Convener : Dr. S. Dey
Members : Dr. G. Marak, Dr. W. Hynniewta
Dr. B. Purkayastha

HOSPITALITY

Chairman : Dr. Raplang Kharwanlang
Convener : Dr. Linda Marbaniang
Members : Dr. Livande Lyngdoh, Dr. D. Rumnong, Dr. D.N. Lamare
Dr. D. War

CULTURAL / BANQUET :

Chairman : Dr. Fredy Nongkynrih
Convener : Dr. Nathaniel Kharumnuid, Dr. D. Choudhury
Members : Dr. Dr. S. Dhar, Dr. L. War, Dr. Freddie Kharmawlong

GUIDE LINES FOR THE CO-ORDINATION COMMITTEE AND NORTH EAST REGIONAL DENTAL CONFERENCE

(Notified by the Convener of the Co-ordination Committee Dr. J. Barman on 1st March, 2011)

The 1st meeting of the Co-Ordination Committee of IDA Branches of North East Region held on 26th Feb/2011 in the Regional Dental College, Guwahati has unanimously recommended the following Guidelines for smooth functioning of its activities.

GUIDE LINES

The Committee will be known as **The Co-Ordination Committee of IDA Branches of North East Region of India.**

- 1) **Members of the Committee:** Representatives of the IDA State Branch of Assam, Meghalaya, Tripura, Nagaland, Mizoram, Manipur and Arunachal Pradesh shall constitute the Co-ordination Committee.
- 2) **Composition of the Committee:** The Committee consists of the following posts:

<u>Post</u>	-	<u>Tenure</u>
a) Chairperson	-	3 years
b) One Co-Chairperson	-	3 years
c) Convener	-	3 years
d) Treasurer	-	3 years
e) Members:		

- President of the above named State Branches office - 1 year
- Hon. Secretary of the above named State Branches in Office- limited by his/her office term.

- 3) The Chairperson, Co-Chairperson, the convener and Treasurer will be selected/elected by the joint meeting of the Association during the Annual Conference or in a specially convened meeting for the purpose, in case there is no conference in the relevant year.
- 4) The committee will function for three years; the representatives may be changed, following expiry of office of the President/Secretary of the Branch. However, the Chairperson, Co-Chairperson, Convener and Treasurer shall remain in office for three years with effect from Association year 2011.

- 5) **Fund:** Every State Branch shall contribute Rs. 1,000.00 per year. The Treasurer shall keep the accounts. He shall maintain a Register recording income and expenditure.
- 6) The Committee shall meet at least on three or more occasion in a year
- 7) **Objectives:** The primary objectives of the Committee are:
 - i. To discuss matters of all the Branches and take effective measures.
 - ii. To consider invitation offered for the conference by the constituent branches and decide the venue and dates of the conference.
 - iii. Offer constructive suggestions to the Host Branch for organizing the Annual North East Regional Dental Conference in a better way.
- 8) **Office:** The Committee shall ordinarily meet at Guwahati. However, it may be held in other States also, on invitation.
- 9) The Host Branch of the Conference shall furnish a copy of the statement of income and expenditure of the conference to the Co-ordination of Committee for record.
- 10) The change of President/secretary of any Branch should be communicated to the Convener. Full address and phone No. of the President/Secretary should be furnished to the convener.
- 11) The State Branch entrusted for organizing the conference shall form an Organizing Committee and the required Sub-Committees. Registered IDA members from other State Branches shall be included in the sub-Committee.
- 12) The inaugural meeting/open session shall be President by the Chairperson of the Co-ordination Committee. In his/her absence, the Co-Chairperson shall president over the meeting.
- 13) The invitation shall be issued jointly by the Organizing Committee along with the Convener of the Co-ordination Committee.
- 14) The valedictory/closing function shall be chaired by the president of the Organizing Committee.
- 15) The delegate for the conference fees shall be fixed with the approval of the Co- Ordination Committee.
- 16) Enrolment of delegates shall be done by the respective State Branches and fees collected shall be deposited to the Conference Bank Account opened for the purpose.
- 17) The Conference Committee will arrange accommodation of registered delegates at their (delegates') own cost.
- 18) The Conference Committee shall decide the name of the Chief Guest for the inaugural function. Besides the Chief Guest the Chairperson, Co-Chairperson and the Convener of the Co-ordination Committee, the Chairperson and Secretary of the Organizing Committee shall be invited to the dais.

Programme

17th OCTOBER 2011

8.00 AM- 8.30 AM	Flag Hoisting & Inauguration of Trade fair
8.30 AM- 9.00AM	Breakfast
9.00 AM- 10.00AM	Registration

HALL-1

PRE-CONFERENCE COURSE-2 (10.00 AM-4.00 PM)

TIMING	TOPIC	PRESENTER
10.00 AM-12.00 PM	Minimally Invasive Dentistry (Lecture)	Dr. Udatta kher
12.00PM-1.00PM	LUNCH	
1.00 PM-4.00 PM	Minimally Invasive Dentistry (Hands-on)	Dr. Udatta kher

HALL-2

PRE-CONFERENCE COURSE-3 (10.00 AM-4.00 PM)

TIMING	TOPIC	PRESENTER
10.00 AM-12.00 PM	MODERN ENDODONTICS (Lecture)	Dr. V. Gopikrishnan
12.00PM-1.00PM	LUNCH	
1.00 PM-4.00 PM	MODERN ENDODONTICS (Hands-on)	Dr. V. Gopikrishnan

HALL-1

17th OCTOBER 2011 (Evening) FREE PAPER PRESENTATION

6.30 PM-8.40 PM SESSION – I	I/C Dr S.Pradhan Dr Daniel Hu Dhar	Chairpersons Dr K Alex .Kithan Dr A.Saikia
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TIMING	TOPIC	PRESENTER
6.30 PM-6.40 PM	Conservative Management of Odontogenic Cyst – a Review	→ Dr Partho Sarati Chakroborty
6.40 PM-6.50 PM	Management of complex Odontoma by Surgical segmental mandibulectomy and Reconstruction with Titanium Reconstruction Plate-A Case Report	→ Dr Taggat Taggu
6.50 PM-7.00PM	Prosthodontic Rehabilitation of post Surgical Maxillary defects with hollow Obturator	→ Dr Ashish Meshram
7.00 PM- 7.10 PM	Central Ossifying Fibroma of Mandible	→ Dr Abishek Singh

HALL-1

7.20 PM- 7.50 PM SESSION – II	I/C Dr S.Pradhan & Dr Daniel Hu Dhar	Chairpersons- Dr Mitali Borah & Dr Nabanita Buruah
TIMING	TOPIC	PRESENTER
7.20 PM- 7.30 PM	Orthodontic Management of Cleft Lip & Palate	→ Dr Nichukholie Vupru
7.30 PM-7.40 PM	4 th Dimension in Orthodontic Treatment -Timing	→ Dr Arunima Goswami
7.40 PM-7.50 PM	Silver Lining in Non Extraction therapy	→ Dr Nilotpol Borah

HALL-2 SESSION-I (6.30 PM-7.20PM)

I/C Dr Shane Hu Dhar & Dr Namsrang Monin

Chairpersons- Dr J.Barman & Dr. K. Alex Khitan

TIMING	TOPIC	PRESENTER
6.30 PM-6.40 PM	Imaging Modalities for Pre operative assessment in dental Implant therapy	→ Dr Arvind Kr Singh
6.40 PM-6.50 PM	Bioceramics – Ideal materials for Implant	→ Dr Sonali Tholia
6.50 PM-7.00 PM	Rationale of Prosthetic Rehabilitation of patients following maxillofacial surgery	→ Dr Silpi Jalan
7.00 PM- 7.10 PM	Digital Impressions	→ Dr Indrani Das

HALL-2 SESSION-II (7.20 PM-7.50 PM)

CHAIRPERSONS: Manjula Das & Dr B.K Roy

TIMING	TOPIC	PRESENTER
7.20 PM- 7.30 PM	RME –Bio Mechanic & Clinical Implication	→ Dr Amarjeet Yanglem
7.30 PM-7.40 PM	A Review of Gagging problem in dentistry	→ Dr Purnima N Yaikhom
7.40PM-7.50 PM	Myofunctional Appliance	→ Dr Haj Sai

18th OCTOBER 2011**8.30 AM-9.30 AM Breakfast & Registration****SESSION I (9.00 AM-12.00 PM)**

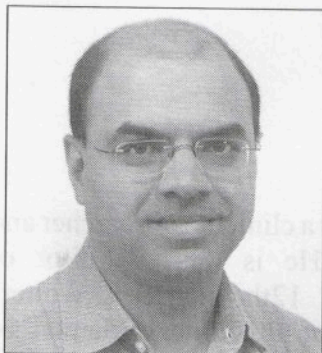
TIMING	TOPIC	PRESENTER	CHAIRPERSONS
9.30 AM-10.30 AM	Early Detection and Prevention of Pre-Cancerous Lesions	Dr. J.G.Roy	Dr Anjan Saikia Dr Sanbe Marak
10.30 AM-11.30 AM	Modern Endodontics	Dr. V. Gopikrishnan	Dr. A.C.Bhuyan Dr. K.S.Sehdave
11.30 AM – 12.30 AM	Basic Implantology	Dr. Udatta kher	Dr Chandana kalita Dr Mrinal Bhowmik
12.30 AM- 1.30 PM	LUNCH		

SESSION II (1.30 PM-3.30 PM)

TIMING	TOPIC	PRESENTER	CHAIRPERSONS
1.30 PM -2.30 PM	Management of Impactions in General Practice (Dentistry)	Dr A.K.Adhyapok	Dr B.R Bhuyan Dr K. Alex Kithan
2.30 PM -3.30 PM	Practice Management	Dr P.S Thaha (Dubai)	Dr Deity Jyrwa Dr Pirolla Marak
Free Paper Presentation			
3.30 PM-3.40 PM	Optical Coherence Tomography System – A new chairside imaging modality	Dr. Shefali Jain	Dr Ruby Kakati & Dr Asif Ahmed
3.40 PM-3.50 PM	Apexification with MTA as apical barrier.	Dr. Prakash Chavan	-do-
3.50 PM-4.00 PM	Recent advances in posterior composites	Dr S.L. Saatheesh	-do-
4.00 PM-4.10 PM	Mounbanks Dentistry	Dr Lalit Ch Baruah	-do-

PRE-CONFERENCE COURSES

PC - II



Dr. Udattha Kher graduated from G.D.C&H, Mumbai in 1990 and followed that up with masters in Oral Surgery from the same institute. He maintains two practices at Pali Hill and Lokhandwala complex, Mumbai. His main focus in practice is towards implantology, laser dentistry and restorative dentistry. He is an adjunct faculty in the 'Implantology Department' at SDM Dental College, Dharwad and at Manipal College of Dental Sciences for the 'Laser dentistry Certificate programme'. He is a Founder member of the 'Indian Academy of Laser Dentistry'. Dr. Kher also holds a 'Diploma in Laser Dentistry' from Aachen University, Germany. He devotes a considerable amount of time lecturing on various podiums, mentoring young dentists, and publishing articles for dental journals in the field of his speciality. He is the 'Study Club Director' for the Mumbai Seacoast Study Club of the 'International Team for Implantology'.

Topic : MINIMALLY INVASIVE DENTISTRY

Dentists are sad to say not a popular lot. For generations our profession has been haunted by the phantom of pain. Almost every patient who steps into our offices suffers from dental phobia. The anticipation of a painful procedure, the fear of injections, the sound of drills and the sight of blood wrecks havoc in the bravest minds. Another criticism is that most dental procedures are time consuming, requiring multiple appointments. Few have the patience and time for numerous visits to their dentist.

As dentists we face challenges too. We work in a highly sensitive and vascular part of the human body. All procedures are carried out in our operatories, with the patient being fully conscious. Patients are thus witness to every sight and sound around them.

It is not a surprise then that most patients find dentistry 'Unpleasant'.

It's time that we as dentists change this perception. Past generations of dentists had limitations in technology. Fortunately today, we benefit from advances in technology and materials that help us offer a more pleasant and predictable patient experience.

Several studies have indicated that procedures which are less invasive in nature have better prognosis and patient acceptance. Since we work on a tissue that does not have the ability to regenerate, it is extremely important that we are conservative in our treatment plan. After all, of what value is a 10 year success rate, in an aggressive and irreversible treatment, executed on a young patient? A slight shift in the philosophy of our practices, by being "Minimally Invasive", could bring about the desired change.

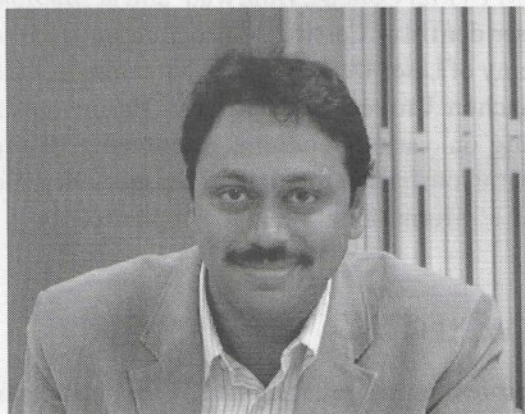
This presentation will showcase routine and specialized dental procedures, modified to increase patient acceptability with no compromise on scientific principles. Procedures such as, Reattachment, Diastema closures, Ultraconservative restorations, Fiber reinforced bridges, Indirect Composite resin restorations, Intracoronaral Bleaching, and Smile Designing will be discussed.

Hands on

Anterior Indirect Veneer preparation, impressioning, temporization and composite build up of the same

PRE-CONFERENCE COURSES

PC - III



Dr. V. Gopi Krishna, MDS, FISDR is a clinician, researcher and academican of national acclaim. He is the Co-Editor of Grossmans Endodontic Practice - 12th Edition (Wolters Kluwer - Lipincott) and Editor of Preclinical Manual of Conservative Dentistry (Elsevier).

He is also the Editor-in-Chief of the Pubmed indexed Journal of Conservative Dentistry (www.jcd.org.in) and is working as Professor, Dept. of Conservative Dentistry & Endodontics at Thai Moogambigai Dental College. He is the Founder - Director of the Root Canal Centre - an exclusive endodontic training and treatment centre at Chennai, which mentors more than 100 dentists every year in improving their endodontic

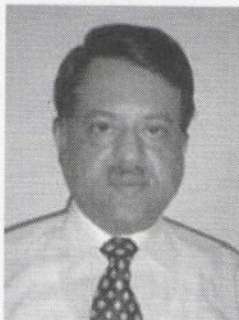
skills.

Topic : Efficient and Skilful Endodontics

Hands on

Endodontics and restorative

GUEST SPEAKERS



Dr. A. K. Adhyapok BDS. MDS (Pedo), MDS (OMFS)
Principal,
Regional Dental College,
Guwahati 32

Qualifications: BDS(from Trivandrum Dental College,1977) MDS in Pedodontics (Dental wing of King George Medical College of Lucknow,1979-80) MDS in Oral and Maxillofacial Surgery (from Trivandrum Dental College, 1981-83) Joined as a lecturer in Maxillofacial surgery from October 1983 to 1986.

Joined as an Assistant Professor of the above department from 1986 to 1994.

Worked as a professor from 1994 to 2010.

At present the Principal incharge from May 2010 in Regional Dental College.

Has a Stint of Surgical Training in Guy's Hospital London under WHO fellowship in 1994.

Life Member of Indian Association of Oral and Maxillofacial Surgeons in India.

Life Member of Indian Dental Association.

Member, International Association Oral and Maxillofacial Surgeons.

Had number of publications both in international and national journals conducted chairpersons of scientific sessions of national and international conferences.

**Topics : Removal of Impacted Mandibular third Molars
by General Dental Practitioners**

A thorough discussion of the subject for general dentists are undertaken in order to help them attempting removal of these teeth and their complications.



Dr. J.G. Roy, MDS

GUEST SPEAKERS



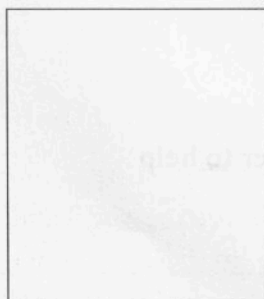
Dr. Udatta Kher, MDS (Expert on
Lasers and Implantology)
G.D.C&H, Mumbai

Topic : Basic Implantology



Dr. V. Gopi Krishna, MDS, FISDR

Topic: Modern Endodontics



Dr. P.S. Thaha, MDS,
Director of Thaha medical and dental centre,
Abu Dhabi, UAE

CANCER, TOBACCO AND THE INDIAN TOBACCO CONTROL ACT, 2003.

Dr. Judita Syiemlieh,

MBBS, Gua, DMRT, MD, Mum, PDCR

50% of Cancer deaths are preventable. According to WHO (country Office India) 2011, 53% deaths belong to deaths from Non Communicable Diseases (NCD), like Cardio vascular diseases, Chronic Respiratory diseases, Diabetes Mellitus, Cancer. There are 5.1 crores Diabetic, 2.9 crores suffers from cardio vascular diseases and 23 lak cancer patients at any point of time in India. The prominent offending factors are tobacco use in any form, unhealthy diet, lack of physical exercise and alcohol

Further, the WHO estimated that yearly tobacco kills 5 million worldwide, from cardiovascular diseases, chronic respiratory diseases and cancer. This does not include the 600, 000 others who died from second hand smoking, where a quarter are children. If the current trend continues the projected toll will rise by 17% in the next 10 years and 60% will be seen in the developing countries. In India 6 lak people died from cancer alone. All these deaths are preventable.

According to the ICMR the following is the fact on tobacco & cancer, (an Indian scenario):-

- ☐ One third of all cancers in India are tobacco related
- ☐ 90% of oral cancers are due to tobacco use
- ☐ 50% of all cancers in man are due to tobacco use
- ☐ 40% of all cancers in woman are due to tobacco use
- ☐ 90% of lung cancer deaths are caused due to smoking.

WHO since 1999, set up a world treaty to combat and reduce the amount of tobacco consumption and to prevent, preventable deaths due to its use. WHO set up the **WHO Framework Convention on Tobacco Control (WHO FCTC)**. The WHO FCTC directs all members' countries to set up their own tobacco control laws, latest by 2005. The Indian Parliament passed the Indian Tobacco Control Laws in 2003, which is known as Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production Supply and Distribution) Act 2003 or COTPA Act 2003 also known as Indian Tobacco Control Laws or Indian Tobacco Laws.

The following are the main points in the WHO FCTC. All signatories' members' countries shall formulate their laws, based on the broad points below:

- ☐ Protect public health policies from commercial and other vested interests of the tobacco industry.
- ☐ Adopt price and tax measures to reduce the demand for tobacco.
- ☐ Protect people from exposure to tobacco smoke.
- ☐ Regulate the contents of tobacco products.
- ☐ Regulate tobacco product disclosures.
- ☐ Regulate the packaging and labelling of tobacco products.
- ☐ Warn people about the dangers of tobacco.
- ☐ Ban tobacco advertising, promotion and sponsorship.
- ☐ Offer people help to end their addiction to tobacco.
- ☐ Control the illicit trade in tobacco products.
- ☐ Ban sales to and by minors.
- ☐ Support economically viable alternative to tobacco growing.

Below are the rationales and main sections of CIGARETTES AND OTHER TOBACCO PRODUCTS (Prohibition of Advertisement and Regulation of Trade and Commerce, Production Supply and Distribution) Act 2003 or COTPA Act 2003.

Salient features of the Act:

This Act was also known as COTPA Act, 2003; or Indian Tobacco Control Laws and was passed by the Parliament in 2003 with the aim to

- ☐ To enact a law on tobacco in the public interest to protect public health.
- ☐ Prohibits consumption of tobacco products & others which are injurious to health, in order to improve public health as enshrined in the constitution number 47.
- ☐ It is expedient to prohibit advertisement & to regulate trade & commerce, production, supply & distributions.

Main sections of the Act applicable to all Indians, state and central governments, public undertaking, business houses, and others public places etc:-

- ☐ Section 4- ban of smoking in public places.
- ☐ Section 5- ban of advertisement in any form
- ☐ Section 6a- ban of sale of tobacco products to below 18 years of age and by those below 18 years of age.
- ☐ Section 6b- ban of sale of tobacco products within 100 yards of educational institutions.
- ☐ Section 7- mandatory pictorial warning on all tobacco products. Tobacco products manufactured after May 31, 2009 without pictorial warnings will not be allowed for sale
- ☐ Section 12- power to entry and search
- ☐ Section 13 power to seize.
- ☐ Section 29 immunity from punishment of officers for action taken in good faith.

Section 4- ban of smoking in public places. 'public place' as defined in the act, means any place to which the public has access whether as of right or not and includes all places visited by general public. The owner or the head of the public place should display a board as prescribe by the Government of India. It should have a picture and the words as 'No smoking area, Smoking here is an offence' the board should be displayed in all prominent places of the building, steps, corridors, toilets etc. Failing which, the owner will be fined. Public who smoke in the public places will be fine (Details please refer to Smoke Free Rules, Steps to Compound Offence and Smoke Free Work Place-enclosed).

Section 5- ban of advertisement in any forms, including surrogate advertisements and indirect advertisements. Sellers of tobacco products shall not display their wares openly. Brand of tobacco products in papers or CD cannot be displayed. They should have a board written as 'Tobacco Kills and Smoking Kills' to be written on a white back ground board with magenta letters and to display prominently in front of their shop. Details please refer to COTPA Act 2003-enclosed.

Section 6a- ban of sale of tobacco products to below 18 years of age and by those below 18 years of age. This may require to discuss with the Labour Department etc

Section 6b- ban of sale of tobacco products within 100 yards of Educational Institutions. Education institutions should have a board as per section 4 as well as a board stated that 'selling of tobacco products within 100 yards of this school compound is prohibited'.

Section 7- mandatory pictorial warning on all tobacco products. Tobacco products, without tobacco warnings manufactured after 31 May, 2009, will not be allowed to sale. All tobacco products produced after the 31st may 2009 should have the mandatory pictorial warnings. Sellers selling products without pictorial warnings will be fine amounting to Rs.5000.00 in the first offence and Rs. 10,000.00 in the second offence. Their wares can be confiscated with effect from 30th July 2009. Drug Inspector, Food Inspector, Police Officer not below the rank of Sub Inspector and any other officers authorized by the Government has the power to enter, search and confiscated the tobacco products which are outside the ambience of the act.

It is the duty of every Indian to ensure the implementation of the act, the state government being the facilitator.

Initiatives taken by the government of Meghalaya:

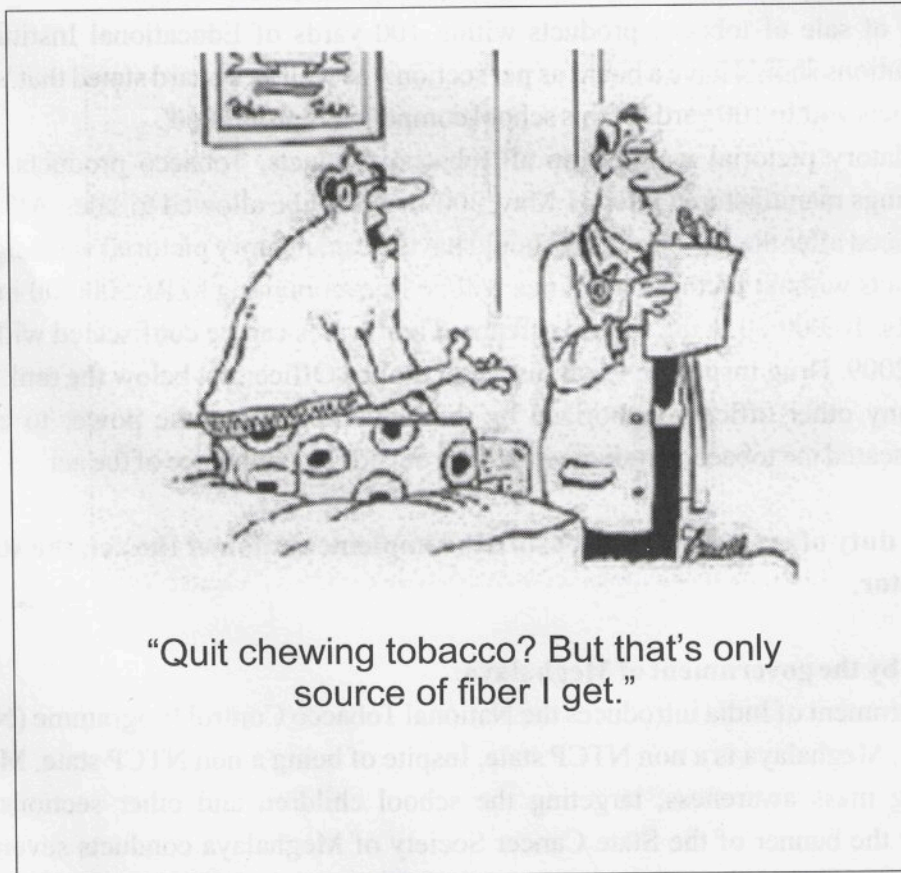
The government of India introduces the National Tobacco Control Programme (NTCP) in most of the states of India. Meghalaya is a non NTCP state. In spite of being a non NTCP state, Meghalaya is very active in creating mass awareness, targeting the school children and other sections of the society. Meghalaya under the banner of the State Cancer Society of Meghalaya conducts several cancer camps (Oral, Cervical, general), massive school programmes in different districts. Posters campaigns, producing pamphlets, hands out, posters and booklets are available for mass distribution.

Various NGOs, DMHOs, sections of the society invites the State Cancer Society of Meghalaya for different activities. The Dental Department situated at Civil Hospital Shillong, in collaboration with the other Dental Surgeons of other districts is the main supportive group to the various activities of the State Cancer Society of Meghalaya, besides others. We have detected 27 cancer cases in 2010-2011 from the various camps conducted, 90% are the cancers of the Oral cavity.

FOR FURTHER INFORMATION PLEASE CONTACT:

Dr. Judita Syiemlieh, DMRT, MD (Mum)

Specialist, Dept. of Radiation Oncology, Civil Hospital Shillong &
State Nodal Officer, National Tobacco Control Programme & Member Secretary of State
Cancer Society of Meghalaya at: Email:judita@rediifmail.com/0364-2500815/9436102572.



ATTACHMENT RETAINED REMOVABLE PROSTHESIS A CASE REPORT

Dr. Saurav Banerjee,
Dr. Arlingstone Khongshei,
Prof.(Dr.) Tapas Gupta,
Prof. (Dr.) Ardhendu Banerjee.

ABSTRACT

Conventional cast partial dentures are incompatible in modern dentistry where esthetics is of paramount importance while the complexity of the direct retainers acts as a food trap, gingival impingement leading to increased chance of dental caries in and around the abutment. The advent of attachment retained partial dentures in dentistry have solved many problems concerning with esthetics while its increased retention and stability leads to user friendly prosthesis. Key words precision, semiprecision, retention

INTRODUCTION

Conventional cast partial denture with clasp retention have been the cynosure of the last few decades. But they seem to be incompatible to today's world of modern dentistry where esthetics is of paramount concern to the patient, especially in the maxillary arch where visible labial or buccal clasp arms of the conventional cast partial denture can ruin an esthetic dental result while the retentive components seem to be a trap for food accumulation leading to increased chance of dental caries. The advent of resilient attachment seems to solve the puzzle with less components, effective and almost completely invisible retainers, long-lasting retention and stability. They can even be used in distal extension situation thus no need of any indirect retention or stress breaker is required in such cases.

Attachment is defined as a retainer consisting of a metal receptacle and a closely fitting part; the former (the female {matrix} component) is usually contained within the normal or expanded contours of the crown of the abutment tooth and the latter (the male {patix} component), is attached to a pontic or the denture framework [1]. They are divided into Precision and semiprecision attachment. Precision attachment are all prefabricated machined to very fine tolerance and have a very precise smooth action. Usually they are adjustable, some have replaceable parts, others have a variety of uses such as conversion from friction retention to snap retention [3,4]. In addition there are those that are either resilient or non resilient. Resilient attachments are designed to provide a defined amount and direction of movement of the RPD relative to the attachment, in theory permitting controlled movement of the RPD denture base tissue ward while minimizing the amount of unfavourable stress transfer to the abutment tooth. These types of attachments are considered "stress directors," [5] Resilient attachments are designed to provide either hingelike movement (movement in one plane) or

rotary movement (movement in multiple planes). Semiprecision attachments, due to the nature of their fabrication, are less precise in their tolerances and are manufactured from patterns made from either wax, nylon, or plastic, or they may be hand waxed by a dental laboratory technician [7].

In addition, attachments are classified in two other ways. If a semiprecision or precision attachment is located within the contours of the abutment tooth it is classified as intracoronal, and if it is located outside the contours of the abutment tooth it is categorized as extracoronal. This article represents the use of a semiprecision extracoronal attachment in a Kennedy Class III Mod 2 situation.

CASE REPORT

A 40 yr old patient reported to the Dept of Prosthetic Dentistry with esthetic problems. On intraoral examination tooth number #14,15,21,22,23,25 was found missing. Past dental history revealed that patient previously had a fixed restoration in the maxillary anterior region, with the loss of the tooth the FPD became non functional. A full veneer tooth preparation of #11 was evident which previously was a FPD abutment. Treatment option sorted out where

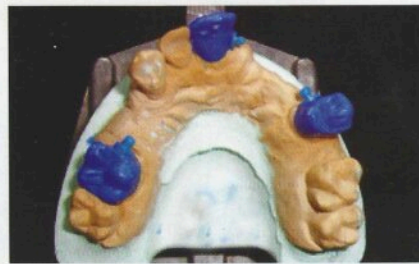
- 1) Implant supported prosthesis.
- 2) Conventional Cast partial denture with clasp retention
- 3) Conventional acrylic temporary removable denture
- 4) Attachment retained Cast partial denture

After clinical and radiological examination and explaining the pros and cons of the treatment options it was decided to rehabilitate the case with attachment retained cast partial denture. (Fig 1)



PROCEDURE

- 1) A primary impression was taken with irreversible hydrocolloid impression material and poured in dental stone to obtain the diagnostic cast.
- 2) Placement of three Ceka Sagix attachment was planned on the mesial surface of tooth no #11, 16 and 24. A 1.7 mm spherical male was planned to be placed in #11 while 2.2 mm spherical male was planned to be placed in #16 and 24
- 3) Space Requirements for 1.7mm were : 3.1mm vertical, 3.1mm diameter for 2.2mm: 4.1mm vertical, 4.2mm diameter
- 4) Tooth preparation steps were undertaken in tooth no #11, 16 and 24 and impression was taken with additional silicone impression material and was poured in die stone to get the first master cast.
- 5) The prepared tooth were waxed up in a conventional manner and the plastic male part of the attachment was attached to the mesial aspect of the wax patterns. (Fig 2,3)



- 6) To insert the cast plastic male the path of insertion should be determined correctly. A paralleling mandrel was attached to the surveyor and then the plastic males with the paralleling mandrel were incorporate into the wax-up of the prepared tooth. The path of all the three males were made parallel to each other. A lingual bracing arm is recommended for removable partial dentures. Casting was done in a hard dental alloy.
- 7) After casting and finishing the restoration with the male part were cemented with glass ionomer cement to the prepared tooth. (Fig 4)
- 8) In the next visit, an impression was taken with additional silicone impression material of the restorations with the male part. The impression of the male part was poured in cold cured acrylic resin while the rest part was poured in die stone. This ensured that the male part didn't break while the second master cast was being retrieved. (fig 5)
- 9) Processing the female. Place the pink duplicating dummies over the males and align them all parallel. Block out the undercuts and duplicate in refractory material.
- 10) Finish the cast frame without damaging the retentive ledge in the cavity for the female. Polish the access opening to a high shine. A try in of the framework was done. (Fig 6)
- 11) Jaw relationship record was made and arrangement of tooth were done.
- 12) After denture try in , press the pink processing female with the insertion tool into the frame to process the acrylic resin.
- 13) Replacing the processing female- To replace a female, use a pointed instrument to dislodge and remove. Use the insertion tool to insert a new female. 3 retention levels are available: yellow: normal retention white: reduced retention red: increased retention. The postoperative view of smile showed marked improvement.(Fig 7,8)
- 14) Recall visits were made at 1 week interval and regular oral hygiene instructions were explained to the patient.(Fig 9,10)



DISCUSSION

Preci sagix (Ceka) is sagittal ball attachment with segmented female for partial dentures and implant applications. Advantages includes patented snap mechanism, inexpensive, wide range of applications, easy replacement of parts, choice of working procedures, long-lasting retention. It has a audible snap for patient security and increased retention and a unique female contacts a greater surface area of the sphere for increased retention and stability.

Owall states that this type of denture has a long-life span and does not incur significant problems or repairs. He also has found that treatment failure occurs as a result of loss of abutment teeth or the fixed partial denture due to recurrent caries and periodontal disease [5].

Indications for use of semi precision attachments in RPD [7,8]

1. Presence of effective and almost completely invisible retainers.
2. Availability of RPD retainer where esthetics is of paramount concern.
3. Ability to provide adequate to excellent retention, irrespective of crown contour
4. Ability to reduce bulk of the RPD in direct retainer areas
5. Presence of increased stability to the RPD, as the attachment provides good resistance to horizontal or rotational displacing forces
6. Ability of attachments to minimize food stasis and impaction, gingival irritation around the complexly designed direct retainers
7. Ability to minimize stress on the abutments caused as the attachment-retained RPD is inserted and withdrawn, because, in a clasp-retained RPD, there is the potential for rocking and stressing of the abutment tooth as the direct retainer goes over the height of contour to reach its intended undercut area in its terminal position.
8. Ability to lower the heights of contour by placing cast restorations and attachments, since the presence of divergent abutment teeth with high survey lines (even after enameloplasty) necessitate extracoronal clasps placed high on the teeth, which may compromise the longevity of abutments and the RPD through application of excessive horizontal and torquing forces.

Contraindications are : Presence of insufficient vertical space (less than 4mm) for attachment use, presence of teeth with insufficient coronal bulk and inadequate root surface area unsupported by alveolar bone to be used as supporting abutments, Inability to repair or service an attachment-retained RPD, some attachments are costly [7,8].

CONCLUSION

Some diagnostic and treatment planning steps, laboratory procedures used in the rehabilitation of a patients with a semiprecision attachment-retained RPD are discussed. Long-term success with this type of restoration is multifactorial and reasonably predictable when the patient is adequately diagnosed, the treatment carefully planned, and follow-ups are made on a regular recall schedule.

REFERENCE

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2. Burns DR, Ward T. A review of attachments for removable partial denture design: Part 1. Classification and selection. *Int J Prosthodont* 1990;3:98-102.
3. Becerra G, MacEntee M. A classification of precision attachments. *J Prosthet Dent* 1987;58:322-327.
4. Preiskel HW. Precision Attachments in Prosthodontics. Vol 1: The applications of intracoronal and extracoronal attachments. Chicago: Quintessence, 1984.
5. Owall B. Precision attachment-retained removable partial dentures: 1. Technical long-term study. *Int J Prosthodont* 1991;4:249-257,
6. Cunningham DM. Indications and contraindications for precision attachments. *Dent Clin North Am* 1970;14:59S-601,
7. Renner RP, Semiprecision attachment-retained removable partial dentures. *Quintessence Dent Technol* 1994;137-44.

RAPID CANINE RETRACTION WITH DAD



Dr. Mitali Bora



Dr. Hu Chi Shane Dhar

Abstract:

Distraction Osteogenesis can be defined as the creation of new bone by the application of mechanical strain in the preexisting bone. In conventional orthodontics, canine retraction which is a common procedure especially in cases of maximum anchorage i.e. severe crowding, protruded anterior teeth, usually takes 6-9 months and also taxes the posterior anchorage. Utilizing the principles of distraction osteogenesis, methods have been developed for the rapid retraction of canines into the premolar extraction space where the canine retraction is completed within as little as 10 days to 3 weeks. This article describes the history and rationale of canine distraction and also includes a case report treated with DAD to better illustrate the principles and technique involved.

Introduction:

Distraction Osteogenesis can be defined as the creation of new bone by the application of mechanical strain in the preexisting bone. New bone is formed in the osteotomy gap by the stretching of the callus present in the osteotomy gap which is gradually widened with the help of various distraction devices. Distraction osteogenesis was first performed in 1905 by Codivilla¹ to lengthen a shortened femur but it was only after Ilizarov²⁻⁴, a Russian surgeon, developed his principles of distraction for limb lengthening that the procedure started to become widely popular. From being widely used in orthopedics for various procedures like limb lengthening, correction of skeletal deformities, etc., distraction osteogenesis has also been applied to the craniofacial skeleton especially in the mid face and lower jaw for the correction of congenital syndromes, where large movements need to be accomplished which are otherwise impossible or difficult by orthognathic surgery, in cases of temporomandibular joint ankylosis and other post traumatic growth disturbances, and so on⁵⁻⁸. One of the more recent innovative procedures utilizes the principles of distraction in the rapid retraction of canines during orthodontic treatment.

Rapid Canine Retraction using Distraction Osteogenesis:

In conventional orthodontic treatment, we often come across cases with severe crowding, bimaxillary protrusion cases, Class II div 1 cases with severely proclined upper incisors. Such cases often require extraction of premolars followed by maximum anchorage requirements and lengthy treatment times. Canine retraction which is often the first step for creating space or conserving anchorage often takes a long time to accomplish, about 6-9 months. The rate of bone formation limits the amount of tooth movement to a maximum of 1-1.5 mm a month, conventional orthodontics achieving space closure at an average of 1mm per month. Canine retraction is thus a slow procedure and also heavy on anchorage requirements. A recent method of rapid canine retraction utilizing the principles of distraction osteogenesis aims to reduce the treatment time as well as conserving anchorage.

At present, two different methods of canine distraction have been introduced; periodontal distraction and dentoalveolar distraction.

Periodontal Distraction: The first method to be introduced for rapid canine retraction, this procedure was developed by Liou and Huang⁹ from Taiwan. According to them, the process of osteogenesis in the periodontal ligament during orthodontic tooth movement is similar to osteogenesis in the midpalatal suture during rapid palatal expansion. Liou and Huang called this technique "dental distraction"¹¹ in which canine retraction could be accomplished in as little as three weeks. This procedure was demonstrated to not only cause rapid tooth movement but also minimal loss of anchorage was seen as well as minimal to no root resorption being present. The canines can be distracted rapidly because the tooth is being moved into the premolar extraction space that has not yet been filled with solid bone tissue. Anchorage loss was minimal because after initial tooth movement, there is a lag period which

persists for about 2-3 weeks before tooth movement starts again. In this procedure, canine retraction is completed while the molar is still in its lag phase or just initiating mesial movement. External root resorption occurs 2-3 weeks after orthodontic force application. Thus minimal root resorption is seen as the canine retraction is completed within the above time period.

Procedure for periodontal distraction: In the method described by Liou and Huang⁹, a custom, rigid intraoral tooth borne distractor is used to rapidly retract the canines. Before starting the distraction, fixed orthodontic appliances should preferably be in place. The molar and 2nd premolar is used as anchorage. Bands are fabricated on the molar and canine to which the distractor is soldered, the distractor lying in the buccal vestibular area. After the completion of first premolar extraction, the interseptal bone distal to the canine is undermined with a bur grooving both the buccal and lingual walls vertically and extending obliquely toward the base of the interseptal bone to weaken its resistance to tooth movement. After the corticotomy cuts are made, the intraoral distractor is then fixed to the molar and canine and is activated 0.5-1 mm a day till canine retraction is completed. Power chains are also applied lingually to prevent rotation of the canines as they are distracted.

Although the technique of periodontal ligament distraction described above sounds very attractive and promising, there are also certain shortcomings. Studies have shown that decreased vascular blood supply occurs in presence of very high force levels. High tensile forces that are inevitable in this procedure can lead to cell death in the vicinity of the stretched periodontal ligament fibers. Resorption of Sharpey's fibres, vascular invasion of cells into the periodontal membrane, resorption of alveolar bone, and reduction of alveolar bone thickness and height are also inevitable in the region of tension generated by the distractor appliance.

Dento Alveolar Distraction(DAD):

This technique of rapid canine retraction was first described by Haluk Iseri¹⁰ and Reha Kisnisci¹¹ from Turkey. In this method, the dentoalveolus itself is made to serve as a bone transport segment for posterior movement of the canine. Vertical osteotomies are performed around the root of the canine tooth followed by splitting of the spongy bone around it. Thus by creating a dentoalveolar segment which is then distracted posteriorly, this technique does not rely on stretching the periodontal ligament, which eliminates the stress accumulation and overloading of the periodontal ligament which was a disadvantage in periodontal ligament distraction.

To illustrate the surgical procedure and distraction protocol involved in DAD, a case report is given below where unilateral canine distraction is carried out according to the method given by Iseri and Kisnisci. In this patient, the maxillary left canine was distracted at a rate of 0.8mm per day for 9 days with the canine being retracted a total of 7.2 mm.

Case Report:

A 22 year old male patient reported to the dept. of Orthodontics, Regional Dental College, Guwahati, with the chief complaint of protruded anterior teeth (Fig1). Extraoral examination shows a Class II div I pattern with a mesoprosopic face type, convex facial profile. The upper anterior teeth are proclined with potentially incompetent lips. Intraoral exam shows Angle Class II div I malocclusion with a deep curve of spee in the lower arch, overjet of 11mm and a complete traumatic deep bite. The upper right canine and 1st premolar shows complete transposition as also seen in the OPG. Cephalometric evaluation shows the patient to be both skeletal and dental Class II.

In treatment planning, it was decided to extract the transposed upper right canine and replace it with the 1st premolar. In order to shorten the time taken to move a solitary canine distally which would otherwise take 6-9 months as well as preserve anchorage, it was decided to retract the upper left canine separately after 1st premolar extraction using a simple rigid, tooth borne, intraoral unidirectional distractor attached to the canine and 1st molar (Fig2a,b). After the canine distraction was completed, the distractor was removed and conventional fixed appliances were bonded in the upper and lower arches and orthodontic treatment continued. The procedure of dentoalveolar distraction (DAD) can be divided into two phases, a surgical and a distraction phase.

Surgical phase:

The surgical phase was carried out under local anesthesia supplemented with i.v sedation. A Horizontal crevicular incision was made extending from the middle of the lateral incisor to the mesial margin of the 1st molar with vertical incisions extending the crevicular incision to the vestibular area. A full thickness flap was then raised and using a small round carbide bur, corticomy holes were drilled mesial and distal to the canine and 3-5 mm above the canine apex. These holes were then joined using a thin, tapered fissure bur to create the corticomy cuts around the canine

(Fig2c). The 1st premolar was extracted and the buccal bone removed extending from the corticomy cut distal to the canine anteriorly to the 2nd premolar posteriorly. Osteotomes were then used to completely mobilize the alveolar segment that houses the canine by fracturing the cancellous bone off the lingual or palatal bone. Any bony interferences in the extraction socket between the canine and 2nd premolar were also eliminated and smoothed with the lingual/palatal cortical bone being preserved, to allow for the undisturbed distraction of the canine. The dentoalveolar transport segment created houses the canine along with the buccal cortical plate, the spongy bone covering the canine root, leaving the palatal cortical plate intact and the bone around the canine apex (Fig2c). The flap was then replaced and secured with sutures and antibiotics and anti-inflammatory drugs given for 5 days.

Distraction Phase: Immediately after the surgical phase, a rigid, tooth borne, unidirectional distractor which is soldered to stainless steel bands is cemented on to the molar and canine (Fig2b). The distractor is located as high up as possible in the buccal region with the guidance bar parallel to the occlusal plane to ensure minimal tipping of the canine. According to the principles of distraction osteogenesis, distraction was started after a latency period of 3 days. The distractor was activated by a single turn of 360 degrees per day to give a total activation of 0.8 mm per day. The active phase of distraction was continued for a total period of 9 days to retract the canine by 7.2 mm (Fig3). The distractor was then removed and conventional fixed appliances bonded in the upper and lower arches and leveling started. The distracted canine, 2nd premolar and 1st molar was ligated in figure of eight fashion and kept for at least 3 months during the consolidation phase.

Pre and post distraction periapical radiographs as well as orthopantomograms taken show no visible root resorption or root fracture of the canine (Fig4,5). No root ankylosis, endodontic or periodontal lesions were seen radiographically or clinically. New alveolar bone is also seen to form 12 months post distraction with restoration of gingival height and contour. Although pulp vitality tested with an electronic pulp tester showed no response immediately post distraction, a positive response was obtained 12 months post distraction. No color change was also observed in any of the teeth during and after distraction.

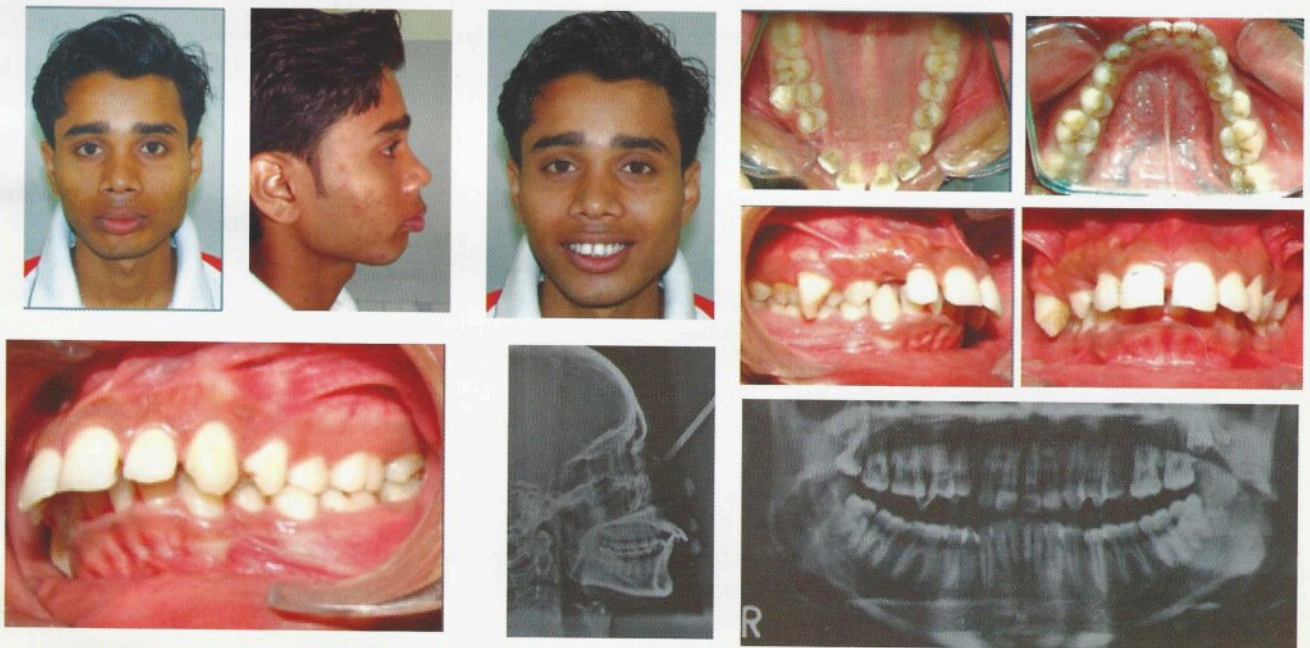


Fig 1: A 22 year old patient with a Class II div I malocclusion and transposition of upper right canine and premolar



Fig 2: Rigid unidirectional distractor soldered to bands on canine and 1st molar (a); distractor device cemented in place immediately after surgical phase (b); corticotomy cuts made around canine (c)



Fig 3: Pre distraction (left); immediately post distraction(middle); 12 months post distraction(right)

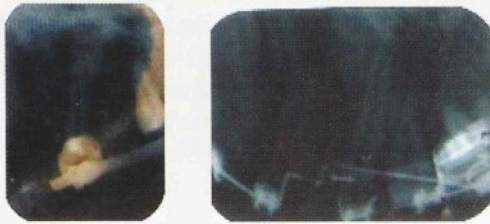
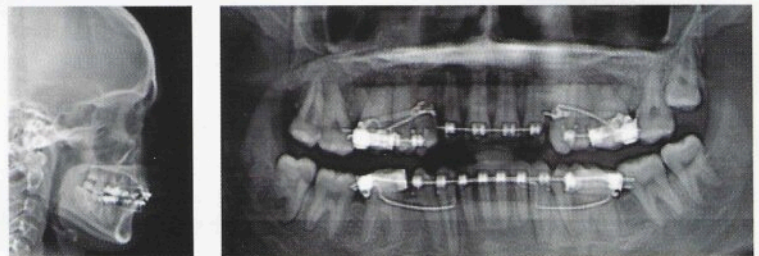


Fig 4: Periapical radiographs; pre distraction(a) and 12 months post distraction(b)

Fig 5: Lateral cephalogram and OPG, 12 months post distraction



Conclusion:

The technique of dentoalveolar distraction (DAD) for rapid canine movement is the fastest procedure recently developed for orthodontic tooth movement. This may improve treatment acceptance especially among adult patients where time is an important factor. Other situations where this procedure can be beneficial are in cases of severe crowding, Class II div I, bimaxillary protrusion cases, periodontally compromised patients, tooth ankylosis, teeth with root malformations. Orthodontic treatment duration is also reduced by 6-9 months with minimal anchorage loss without the need for any intra/extraoral anchorage devices.

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A B S T R A C T

THE FOURTH DIMENSION IN ORTHODONTIC TREATMENT : TIMING

One of the controversial issue in orthodontics is the "timing" of treatment of the various problems encountered in growing patients. Most often, the principal concern is the benefit of treatment in the deciduous, early mixed dentition stage of development when compared with treatment started in the late mixed dentition stage of development or in the permanent dentition. One reason for the controversy is that the accepted "cost" of an early treatment time is a two-phase protocol. Thus, risk/reward analysis becomes inevitable. Do the benefits of early intervention justify the cost of two-phase treatment?

This paper basically deals with the proper timing of instituting treatment for various orthodontic problems in order to achieve best possible results.

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BIOCERAMICS IDEAL MATERIAL FOR IMPLANTS

The uses of bioceramics have been revolutionizing the biomedical field in deployment as implants for humans. Many implant materials made of ceramics have been used for the past three decades. In the search to improve the biocompatibility and mechanical strength of implant materials, attention has been directed towards the potential use of ceramic/ceramic composites. The ceramic-based biomaterials have been accepted after biological evaluation through several in vivo and in vitro tests. In this review an attempt has been made to elicit the biomedical applications of bioceramics.

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Imaging Modalities for Preoperative Assessment in Dental Implant Therapy : An overview

The placement of dental implants requires meticulous planning and careful surgical procedures.

A combination of a limited bone volume and poor bone quality may lead to less predictable bone apposition and early implant failures. A thorough radiographic assessment is paramount for evaluating these factors and informing patients of their prospects for successful rehabilitation with dental implants.

Many imaging modalities have been reported to be useful including periapical, panoramic, lateral cephalometric and tomographic radiography, computed tomography, interactive computed tomography, and magnetic resonance imaging.

This paper reviews various imaging techniques, their applications and limitations in dental implant treatment planning.

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Management of complex odontoma by surgical segmental mandibulectomy and reconstruct with titanium reconstruction plate : A Case report

Odontoma : In true sense, the term refers to any tumour of odontogenic origin. This is the growth in which both epithelial and ectomesenchymal cells exhibit complete or incomplete differentiate of tooth formation structures. It is of two types; compound odontoma and complex odontoma. Here how complex odontoma management is done at Regional Dental College, Guwahati, Deptt. of Oral and Maxillofacial Surgery is present.

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Central Ossifying Fibroma Of Mandible - A Case Report

Introduction- Central cementifying fibroma is a rare non odontogenic tumor coming in the group of fibro osseous lesion, arising from periodontal ligament and is usually seen in tooth bearing area. It can affect both the mandible and the maxilla, particularly the mandible. This bone tumour consists of highly cellular, fibrous tissue that contains varying amounts of calcified tissue resembling bone, cementum or both.

Case report-A 52 yr lady, Biak Sangi, presented to our hospital with a bony hard swelling in the body and ascending ramus of the right side of the mandible which she reported to be slowly increasing since 15 yrs. The CT oral cavity and the OPG revealed a dense radio-opaque lesion in this region. A incisional biopsy was done through the interdental bony area & specimen after the histopathological examination revealed ossifying fibroma of mandible. The case was put under GA and hemimandibulectomy with reconstruction by a titanium reconstruction plate was done.

Discussion- The World Health Organization classifies central ossifying fibroma as a fibro-osseous neoplasm included among the non-odontogenic tumors derived from the mesenchymal blast cells of the periodontal ligament, with a potential to form fibrous tissue, cement and bone, or a combination of such elements. These are slow-growing lesions, and are more frequent in women between the third and fourth decades of life. Although the underlying cause is not known, there have been reports of past trauma in the area of the lesion. Due to the good delimitation of the tumor, surgical removal and curettage is the treatment of choice.

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Mountebanks in dentistry: A critical analysis from northeast Indian perspective

This paper will analyse the socio economical and professional impact of mountebanking of dentistry, measures to tackle with a statistical report of its prevalence in north east Indian states.

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RATIONALE OF PROSTHODONTIC REHABILITATION OF PATIENTS FOLLOWING MAXILLOFACIAL SURGERY

It is the God given rite of every human to appear and to function human. Few areas of dentistry offer more challenges to the technical skills and ingenuity or greater satisfaction, than the successful rehabilitation of function and esthetics of patients with acquired or congenital intraoral and extra oral defects.. Here, the prosthodontist contributes to facets of patient care from diagnosis and treatment to rehabilitation..In case of patients with palatal insufficiency, speech and deglutition becomes arduous, thereby requiring rehabilitation. Resected mandible. results in facial disfigurement, thus leading to psychological problems. Acceptable prosthodontic care for a patient with acquired maxillary defect includes cautious prosthesis designing, combined with routine maintenance and ample care to provide comfort, function, aesthetics and minimal changes to the remaining compromised structures. This paper aims at highlighting the importance of prosthodontic rehabilitation of post-surgical patients with the help of some clinical case presentation.

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A Review of Gagging Problems in Dentistry: Aetiology and Management

Gagging in dental patients can be disruptive to dental treatment and may be a barrier to patient care, preventing the provision of treatment and the wearing of prostheses. Some people have a pronounced gag reflex that can be a severe limitation to their ability to accept dental care and the clinician's ability to provide it. It can compromise all aspects of dentistry, from diagnostic procedures to active treatment and can be distressing for all concerned. Many techniques have been described that attempt to overcome the problem. Dentists will undoubtedly see patients with gagging problems and knowledge of a variety of management strategies is necessary to aid the delivery of dental care. This paper looks at the background to gagging problems and their management during dental treatment.

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ORTHODONTIC MANAGEMENT OF CLEFT LIP AND PALATE : CASE REPORTS

Clefts involving the lip, palate and alveolus are the most commonly seen congenital deformities and can occur individually or together in various combinations. Cleaving of the palate and alveolus lead to a series of distortions in dentofacial development resulting to malocclusion. The effected individual requires a series of prolonged treatment by a multidisciplinary team in which the orthodontist have a vital role to play. The timing and sequencing of orthodontic treatment is not carried out in isolation from other members of the team, but as a result of coordinated and collaborative decision. For a more systematic approach, orthodontic care may be divided into four distinct periods with specific recommended treatment objectives. The presentation emphasizes the importance of the timing and sequencing the treatment of cleft lip and palate and in prioritizing the treatment objectives within a particular specific time frame to achieve the optimum treatment results.

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Digital impressions

Impression making is the most important step in the fabrication of a good prosthesis. Precision and accuracy are critical to the marginal fit and overall excellence. The art of making impressions has undergone numerous changes over the years. We often face troubles while making an impression like tongue interference, increased salivary secretions, patient having severe gagging etc. With the advent of digital impression system this problems can be overcome. here a 3-D image is generated within 10 secs which is free from bubbles, voids, pulls and tears that are inherent in the conventional impressions. Digital impressions eliminate various errors, either by humans or with materials and techniques and hence produces good results. This paper highlights the different aspects of digital impressions.

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PROSTHODONTIC REHABILITATION OF POST SURGICAL MAXILLARY DEFECT WITH HOLLOW OBTURATOR: A CASE REPORT

Patients with acquired maxillofacial defects have had ablative cancer surgery or severe trauma. These two groups are similar in that in both situations a person who had relatively normal anatomy and physiologic function subsequently lost overnight. The need for the study of obturator design is evident because of (1) the increase in the number of partially edentulous patients undergoing partial resection of the maxilla, (2) the increase in the life expectancy after surgery, creating a need for definitive restorations, and (3) an ever-increasing percentage of younger patients in the maxillary resection patient population. This paper is a case report of patient of undergone surgical maxillectomy and subsequent prosthodontic treatment with hollow obturator.

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Conservative management of Odontogenic Cysts: a review

Odontogenic cysts of the jaws are usually treated by either enucleation or marsupialisation or combination of both. The major variables that decide treatment of cysts include their site & size and histological type. Cysts less than 3 cm in diameter can be treated by primary excision. Treatment of large lesions, exceeding 3 cm in diameter, however, is less clear. Many surgeons decompress the cyst to avoid the risk of infection, which often occurs when large cysts are excised. In addition to size, the histological type of cyst is vital in making decisions about treatment; for odontogenic keratocysts, for example, conservative treatment is recommended by some, while others favour an aggressive approach. If, however, one could stop or even reverse the growth of the cyst with a simple procedure as marsupialisation, regardless of histological type, it would be an alternative to radical operation and would also provide surgeons and patients with time for reflection before making further decisions about treatment.

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RME biomechanics and clinical implication

If the applied transverse forces are of sufficient magnitude to overcome the bioelastic strength of the sutural elements, orthopedic separation of the maxillary segments can occur. Biomechanical analyses of the maxillary expansion force strongly suggest that the stainless steel wires joining the teeth to any rapid maxillary expansion device should be of the largest diameter possible. Clinicians frequently correct absolute or relative maxillary-mandibular buccolingual discrepancies with rapid maxillary expansion. In this review the indications and contraindications of the procedure are outlined. The effects of expansion on the maxillary and mandibular structures as well as the implications of these changes on the clinical management of patients who can benefit from this procedure are discussed. Calculation of the required amount of maxillary molar expansion together with a suggested activation schedule for different ages is presented in this review.

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Myofunctional Appliances

Removable or Fixed Orthodontics appliances which use forces generated by the stretching of muscles, fascia and/or periodontium to alter skeletal or dental relationships are the myofunctional appliances. Myofunctional appliance can also be tooth borne or tissue borne. These appliances are used for the correction of Class II skeletal discrepancy, in mild Class III and for the correction of abnormal pressure habits. MFA are capable of producing orthopedic, dentoalveolar and muscular changes. If diagnosed at correct time, dentofacial equilibrium can be achieved with MFA without even going to the second phase of the treatment.

My presentation will include the basic criteria for indication, basic steps of appliance fabrication, mode of action, types of appliances and some clinical cases treated in our department.

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A Case Report of Fast Back Appliance in Treatment of Class II Malocclusion

(Silver lining non-extraction therapy)

Class-II malocclusion is the most frequent treatment problem in orthodontic patients. Distal movement of maxillary 1st molars is a common goal in the treatment of Class II molar relationship and in the resolution of tooth size/arch length discrepancy in the maxillary arch. In recent times a large number of appliances for the distalization of the upper molars have been developed Keles Slider, Kelies TPA, Distalix, First Class appliance, Veltri's Distalizer etc. The common goal for all these distalizing appliances is to provide a dental movement that is biomechanically controlled and generated by adequate forces, while keep undesirable contra-movements to a minimum.

The First Back Molar distalizer is one of the most effective appliances used in molar distalization nowadays. It was developed by Dr.C.Lanteri, his team and Filippo Francolini (technician) in the year 2000.

The Fast Back Expansor pack contains two springs with different forces of 200g and 300g for different orthodontic requirements. The lighter coil with 200 gms force is used when only the sixes are erupted and heavier coil with 300 gms are used when the sevens are also present, whether they are partially or totally erupted.

The Fast Back Expansor also has a self locking terminal stop which makes the appliance fully programmable and considerably increases its safety during use.

It also enables vestibular treatment to be initiated using any multibracket technique without having to wait for distalization to complete.

The advantages of Fast Back appliance are-

- 1) Easy to plan and assemble.
- 2) Reduced bulk.
- 3) Minimal patient discomfort.
- 4) Good aesthetics.
- 5) Continuous, constant force.
- 6) Reduced or minimum loss of anchorage.
- 7) Reduced or minimum contra-movements.
- 8) Easy, non-frequent activation.
- 9) It can be used in conjunction with fixed buccal appliances (brackets).
- 10) Bodily distalization occurs, no risks of undesired movements.

In this paper I would like to present a case report using fast-back appliance.

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Recent Advances In Posterior Composites

Restorative dentistry is a material based science. With the advent of newer and improved materials, the patient as well as the clinician has a wide range of options to choose from. The need for esthetic restorations in the posterior regions is also on the rise due to increased esthetic concern and patient awareness. The challenging factor in posterior composites is to maintain the balance between esthetics, without compromising on the strength of composites.

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Apexification with MTA as Apical Barrier

Introduction: In teeth with open apex caused by trauma, caries and other pulpal pathosis, the absence of the natural constriction at the end of the root canal presents a challenge and makes control of filling materials difficult.

Case description: An apexification case report of an 18 year old girl, with a history of trauma 10 years back in which clinical and radiographic signs of healing were achieved with MTA as an apical barrier in an immature open apex.

Discussion: Root canal treatment of teeth with open apex requires a root end closure technique to form a complete calcific barrier at the apex to allow for optimal filling of the canal and reinforcing the weakened root against the fracture both during and after apexification.

Conclusion: MTA is a newer material in dentistry and its application in endodontic therapy ranges from apexification to pulpotomy. It acts as an apical barrier in tooth with open apex cases and reduces the number of appointments to form a hard tissue barrier as in calcium hydroxide apexification.

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Optical Coherence Tomography (OCT)

Optical Coherence Tomography (OCT) is the first non invasive modality in dentistry capable of imaging both “hard” and “soft” tissue in the mouth at a very high resolution. The OCT Dental Imaging System will have a significant impact on the practice of dentistry. High resolution and detailed visual characterization dramatically enhance the diagnostic capability of the clinician to detect early stage disease. There are widespread clinical implications of OCT in restorative dentistry, periodontics and endodontic practice.

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Deptt. of Operative and Conservative
Dentistry

Presented by

Dr. Shefali Jain

Deptt. of Operative and Conservative
Dentistry
Regional Dental College, Guwahati

POSTER PRESENTERS

1. Ergonomics
- Dr. Indrani Das
2. Root Banking
- Dr. Ashim Choudhury & Dr. Kasturi Hazarika
3. Management of Mandibular Ameloblastoma by Surgical Segmental Mandibulectomy
- Dr. Tagat Taggu
4. Recent Advances in fix Dental Prosthesis
- Dr. Arvind Kumar Singh
5. Management of Vertical Root Fracture of 21 with clinical exposure of pulp
- Dr. Julia Okram
6. Clinical Management of Difficult Edentulous Situations
- Dr. Silpi Jalan

Our ida Activities...



INDIAN DENTAL ASSOCIATION
Meghalaya State Branch
Committed to Dental Excellence
Observing
WORLD ORAL HEALTH DAY
12 September, 2009

DENTAL AND ORAL HEALTH CHECK UP CAMP, NEPA
BY IDA MEGHALAYA STATE BRANCH
TO CELEBRATE COLGATE ORAL HEALTH MONTH
Date: 18.10.2009

THE 1ST MEGHALAYA STATE DENTAL CONFERENCE
Venue: Polo Towers, Shillong
Date: 17th Aug. 2010
Committed to Dental Excellence

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Our **ida** Activities...



INAUGURAL FUNCTION OF INDIAN DENTAL ASSOCIATION (IDA) MIZORAM STATE BRANCH CUM GENERAL CONFERENCE

Time : 6th September 2006 (Saturday)
Venue : Tourist Lodge, Aizawl, Mizoram
CHIEF GUEST : DR. N. PALLAI,
Director of Health Services, Govt. of Mizoram

Our ida Activities...

