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THE INFODENT INTERNATIONAL APP, A NEW CHALLENGE!

When I decided to come up with the Infodent International App I asked myself several questions: how to modify marketing and communication according to the changes constantly taking place? Do I just need a new App or do I need to look at the whole with a new perspective? How can this App be useful and relevant in the "mobile" life of my customers and potential customers of new generation, dealing differently with new technologies?
In fact, "mobile" is neither a marketing channel nor a type of marketing but its correct definition should be "mobile-augmented marketing". It should be integrated in all aspects of marketing, involving and often completely changing the way of doing business, from customer care, to sales, to communication, logistics etc. Performance indicators should be reviewed. The indicators to success were: time spent within the website or number of visited pages; now, **fast and repeated accesses are what make an APP valuable for the user.**

Mobile is not an evolution of the worldwide WEB and internet but a completely new way of relating, communicating and connecting, generated by large band connectivity without time limitations, using always more powerful and performing devices at much more affordable prices.
It is the new generation's primary way of connecting: a smartphone is useful and easy to use…it's the norm… **Pleasure** and **Speed** are the key words of its success. **No technology has a real boom unless it's simple, fast and versatile.**
Turned into a mass addiction, it's enough going around the street, by train or metro to see the epidemic of mobiles…as well as by car, unfortunately! The device is always there, while kissing, on the table at the restaurant, it's used for any kind of search: find the way, buy flight ticket, hotel booking…
Using a computer is something to do at home or in the office while mobile actions are made almost anywhere in public: check the prices of a retailer, tripAdvisor for a restaurant. People are constantly connected to their smartphones and on checking Google's data we realize how vast the phenomenon is: around 70% of people check the smartphone within 15 minutes from waking up, 90% keeps the phone with them day and night and the device is checked around 150 times a day…

In the pre-smartphone era each device took time away from another, now it adds up: smarphones are always present, next to us, while watching television, at the cinema, while listening to the radio. We share comments on TV shows through social networks: twitter, whatsapp, facebook, wechat, line, snapchat, telegram; creating an interconnected network of people all over the world: I send a photo and get a feedback in a few seconds!
The connected device has turned into a basic necessity; people are so much attracted by it that leaving their wallet at home is less frustrating than leaving the smartphone; not having our alter ego with us ruins our day as we are always more delegating different roles to it: appointments/agenda, find addresses/GPS, reminders, bookings, lovers and much more…

Mobile is not an evolution of the worldwide WEB and internet but a completely new way of relating, communicating and connecting

With all this in mind, Infodent International has worked hard, for two years, to present, for the first time at the IDS 2017, the Infodent International App - the most effective way to connect the dental industry worldwide. **Designed to connect manufacturers, distributors and dental professionals worldwide, our App is fast, easy to use and free**…just what our customers are looking for!
Our key words are FIND and MEET: you can click to search posts, distributors, manufacturers, dental professionals and trade shows close to you or around the world. You can personally meet new partners by posting what you are looking for and by exploring their profiles and their posts to check if they could be looking for you. You can show them your GPS position, how long is your stay and what you are looking for. You can check the dental trade shows calendar and interact by getting more information or by informing the market that you are participating, as well as checking who'll be attending! You need to invest money, time and efforts to find partners around the world: The Infodent App makes it easy, quick and cheap. **Visit our booth at IDS for all the details: B090 C091, Hall 4.1** - We can be your strategic turning point!

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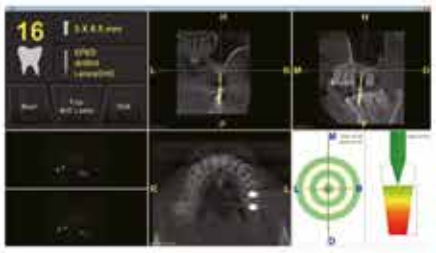

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Contents

We are excited to develop an innovation in our Infodent magazine. Starting from the upcoming issue our focuses are changing, nevertheless remaining loyal to our articles on the economic and medical markets as well as worldwide industry news.

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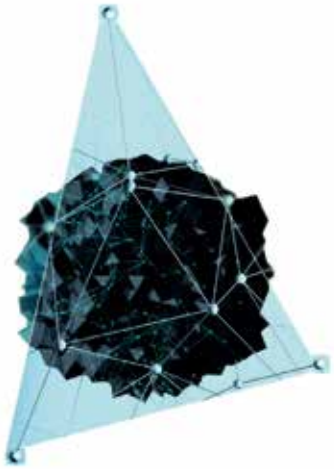

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IDS Product Highlights

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Showcasing new, innovative ROSI technology at IDS 2017 in Cologne, Midmark helps to make it even easier to ensure that only the highest quality water is converted into steam, penetrating even the most hard to reach areas of your instruments. An integrated reverse osmosis system makes light work of providing purified water to your steriliser, leaving you with more time to focus on what's important - your patients.

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Midmark is a fourth generation family-owned, global leader in the supply of steam sterilisers to dental practices all around the world.

With a family ethos maintained throughout our 101 years of business, Midmark truly cares about providing the best, high quality, but affordable instrument processing solutions for your practice, helping you make a positive difference in the treatment of your patients.

For a tailored demonstration to your requirements and budget, visit the Midmark booth in Hall 10.1, Booth G 059 at the IDS 2017 trade show, held in Cologne, Germany.

If you are unable to attend this year's show, but would like to find out more about our ROSI technology and the Midmark range of sterilisers, contact the Midmark team by calling +39 0522 875 166 or e-mailing newmed.sales@midmark.com. Alternatively, take a look at www.midmark.co.uk to view our full portfolio.

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AD Surgical

AD Surgical is an American company based in Sunnyvale, CA. We are introducing two innovative dental implant accessories at IDS 2017:

• Our patented Thermoplastic Surgical Guide (EZ Stent) can be fabricated within minutes using hot water alone. It provides accurate point of entry, angulation, and depth control during implant surgery.

• Our new Universal Drill Stopper Set (EZ Stopper) is the first and only system that allows users to customize a medical-grade silicone drill stopper in seconds. This provides precise depth control during dental implant placement. EZ Stopper is compatible with both freehand and guided surgery.

Both EZ Stent and EZ Stopper are compatible with all dental implant systems on the market. We are currently looking for dynamic international distributors for these two popular products. For demonstration and inquiry, please stop by our booth at US Pavilion Hall 4.2, booth M-052.

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The Wolf Black Label's LED coupling and 3 port spray assures clear visibility of the working field at all times. Very significantly, for an air-driven handpiece, the operational noise is quite low.

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MESTRA at IDS 2017 fair in Cologne

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Biotech Dental launchs DentoSmile transparent aligners on the international market

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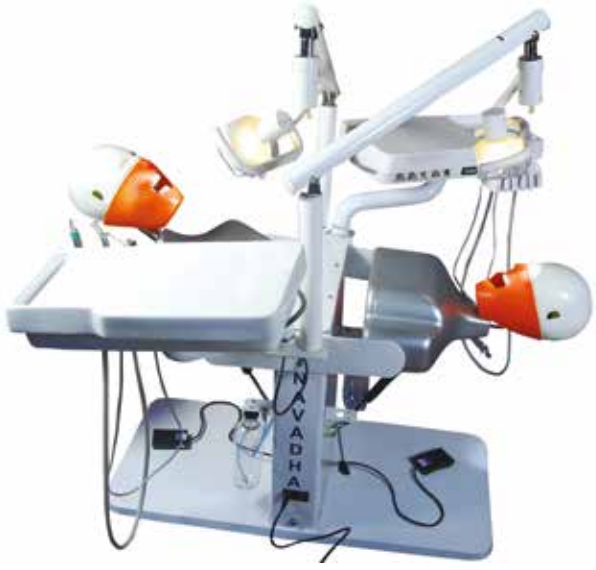

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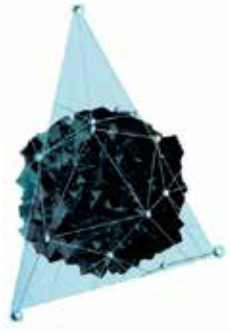

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PRE-CONGRESS COURSES
09:00 - 18:00 BAIRD
An. Agnini, Al. Agnini, A. Aloum, M. Esposito, E. Diaz Guzman, F. Mangano, S. Vaccari
09:00 - 12:00 Endodontics
09:00 - 12:00 Pedodontics
09:00 - 12:00 Interdisciplinary treatment
15:00 - 18:00 Surgery Session

HANDS ON COURSES
15:00 - 18:00 Hands on Veeners
15:00 - 18:00 Hands on Perimplantitis
15:00 - 18:45 Hands on Endodontics
15:00 - 18:45 Hands on Pain Management

FRIDAY, JUNE 16

09:00 - 12:30 3rd AIO - SIE Symposium
09:00 - 12:30 Perio Session (G. Zucchelli)

FRIDAY, JUNE 16

09:00 - 12:00 International Symposium
09:00 - 12:00 Prosthetics Session
15:00 - 18:30 Esthetic Session (L. Vanini)
15:00 - 18:30 Implantology Session (P. Malo)
15:00 - 18:00 4th AIO - SIDO Symposium

HANDS ON COURSES
15:00 - 18:00 Hands on Prosthetics

SATURDAY, JUNE 17

09:00 - 18:00 4th AIO - SIDO Symposium
R. Cocconi - D. Martin
08:45 - 18:00 Brasil vs Italy: the Esthetic Competition
M. Veneziani, V. Musella, F. Mangani, L. Vanini, P. Kano, L. Yoshinaga
09:00 - 18:00 Course in Communication for Dental Hygienists and Chairside Assistants


G. Zucchelli


L. Vanini


F. Mangani


P. Kano


L. Yoshinaga


R. Cocconi


D. Martin S.

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Training model for working with photocurable composite materials

Professor, Doctor of Medical Science
I.K. Lutskaya, Doctors of Medical Science N.V. Novak, V.V. Gorbachev

Belarusian Medical Academy of Postgraduate Education
Minsk, December 2016.

Photocurable composite materials are widely used in preventive dentistry clinics as they guarantee good adhesion and a high level of both durability and aesthetics of the restorations produced. The technique and correct execution of the procedures described in the instructions therefore require special training of the dentist and the dental assistant.

The following training stages represent the optimal scenario to achieve the required level of skill. The first stage is the acquisition of theoretical knowledge about the properties of the material, indications for and methods of its use. The next step is the use of a training model for the formation of manual skills. Then there can be work in the clinic as an assistant, and finally the treatment of patients in need of aesthetic restorations of their teeth; first modelling simple restorations, and then more complex ones.

We will use the photocurable composite material Competence universal (W+P Dental) as an example for the practical implementation of this kind of staggered method of familiarisation with working practices.

In accordance with the indications for the use of composite resin on training models a class III cavity in a central incisor with the creation of enamel bevelling is prepared ***(Fig. 1)***. (The stage of dental colour shade matching can be omitted). Filling begins with the application of a cement base considering the depth of the cavity.

The photocurable glass-ionomer cement Glass liner (W+P Dental), which does not require mixing, is introduced into the cavity and distributed along the bottom without overfilling beyond the conventional „dentine“ borders ***(Fig. 2)***. The material is photocured.

The next step – preparation for adhesion involves acid etching of the prepared enamel surface ***(Fig. 3)***.

After rinsing the surface, C-bond bonding agent is introduced. This is dispersed evenly under a light stream of air and then photocured ***(Fig. 4)***. The bond is characterised by its thixotropic property, i.e. it is easily distributed over the surface, taking on the desired shape, and therefore there is no need for additional procedures.

Before proceeding to the filling, a contour matrix is put in place which is retained by wedges. In the clinical setting the matrix guarantees a clean and dry working area.

The cured adhesive surface is covered with a layer of flowable composite (Competence Flow) without overfilling beyond its borders ***(Fig. 5)***. The material is photocured. Filling continues using Competence universal opaque composite.

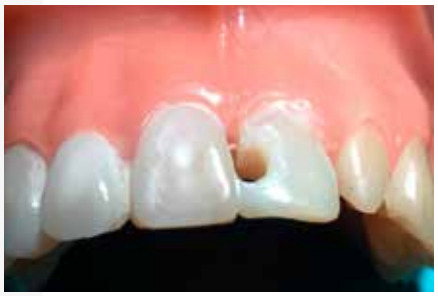

Fig. 1. *Prepared class III cavity*

Fig. 2. *Cement base is applied*

Fig. 3. *Acid etching of the tooth*

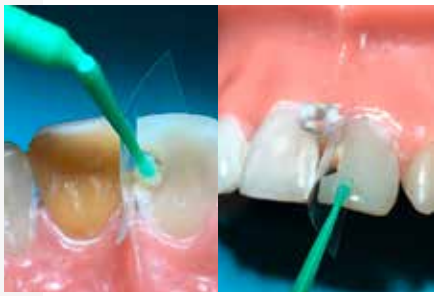

Fig. 4. *Application of adhesive bond to the palatal (a) and vestibular (b) surfaces*

Fig. 5. *Introduction of the flowable composite*

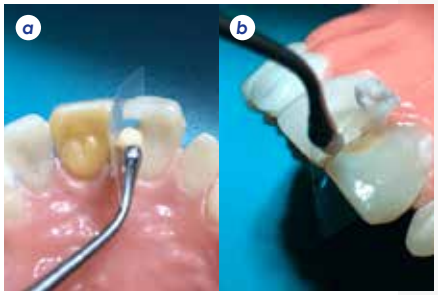

Fig. 6. *Filling of the cavity (a) and packing (b) with opaque material*

Fig. 7. *Modelling the opaque layer*

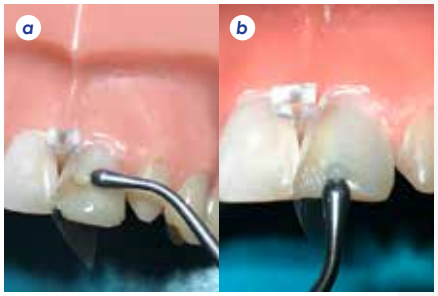

Fig. 8. *Application of enamel composite to the centre line (a) and the cutting edge (b)*

Fig.9. *Modelling the enamel layer*

Fig. 10. *Application of transparent composite*

To this end the plunger is depressed to squeeze out of the syringe the required amount of material onto a small carver. The plunger is returned to its original position and the syringe orifice is covered with a cap. The composite on the tool is introduced into the cavity and packed against one of the walls ***(Fig. 6)***.

To fill the corners of the defect the material is condensed using handheld tools. The layer, no more than 2.0 mm thick, polymerises for 60 seconds under halogen light. The cavity is filled layer by layer with opaque composite resin, corresponding to the lost dentine ***(Fig. 7)***.

Then the primary enamel tone is applied and distributed in a thin layer covering the opaque material, and is cured (20 seconds) using light from the halogen lamp ***(Fig. 8, 9)***.

Transparent composite is distributed over the primary enamel tone in such a way that the proximal surface is translucent to a width of 0.5 mm ***(Fig. 10, 11)***. Photopolymerisation is performed.

The filling is completed immediately; using a fine grain, conical diamond bur, the excess filling material is removed by moving the tool across the surface of the filling in a mesio-distal direction ***(Fig. 12)***.

Next, diamond grinders and ultra-fine grain burs, polishing heads and discs are used ***(Fig. 13)***. The work is carried out at a low speed and with water cooling.

The interdental gingival crevice is emphasized with a fine bur. The surface of the filling is polished until the appearance of a natural lustre using a paste applied to a brush. The tooth is rinsed with water, then dried. Photo recording of the restoration is performed ***(Fig. 14)***.

The next stage of the training (familiarisation with the work technique) is the use of the material in the clinic.

Here is an example of work with photocurable composite. Patient A., 42 years old, came in complaining of aesthetic dental defects. Tooth decay cavities are localised on the mesial surfaces of the upper central incisors. The teeth have changed colour ***(Fig. 15)***. The combination of defects and dentine pigmentation dictate the choice of restoration to be a full direct veneer.

Cleaning the plaque from the teeth is done mechanically using agents that do not contain fluorine or oil. Paste is applied to a special brush which rotates at a low speed at the tip of the dental treatment unit. Then the tooth is rinsed thoroughly with a stream of water.

Selection of the desired shade of filling material is done under natural light using special colour matching samples. The teeth should be wet when choosing the colour. In order to eliminate the subjective aspect in perception, the participation of at least three observers is required for the evaluation of tooth colour: the dentist, the assistant and the patient.

The colour match sample is placed next to the tooth being examined. The cutting edge, neck area, centre line and lateral surfaces of the tooth are compared with the colour match samples until there is a full colour match to the specific segment of the patient's tooth.

In the course of this work 3 syringes will be used:
1 opaque shade, 2 enamel shades (primary and transparent).
Then the size, shape and topography, including the odontometry and odontoscopy of symmetric incisors, is planned. The vertical and horizontal parameters of the prospective restoration are assessed visually. The identifying signs from one side are described and the individual characteristics of the tooth are defined.

The rectangular shape of the crown is visually assessed: the lateral surfaces are arranged practically parallel; the horizontal dimensions for the top, middle and bottom thirds are similar.

Assessment of the identifying signs of the teeth from the side showed a slight predominance in size of the distal crown angle. Evidence of crown curvature is poorly defined. The dento-gingival contour (upper limit of the crown of the tooth) is recorded as dome-shaped. The extent of the proximal contacts between the teeth is planned from the top of the interdental papilla to the cutting edge. The planning stage concludes with the selection of a slightly convex cutting edge.

Preparation of the teeth begins with the removal of poor quality fillings and reduction of enamel overhangs and dentine necrotomy. The boundaries of the veneer coating are designated by making small grooves no deeper than 0.5 mm with a small spherical bur. Horizontal scores are made using a marker bur: to a depth of 0.3 mm in the cervical area, 0.5-0.6 mm at the centre-line, 0.8 mm at the cutting edge. Then the vestibular enamel is ground off to the depth of the marker scores using a long cylindro-conical bur. The edges and the surface are made smooth with a fine-grained diamond bur, including in the gingival area with the „mosquito stinger", rinsed with a jet of water and dried ***(Fig. 16)***.

Then adhesive preparation is carried out on the enamel and dentine areas worked on in accordance with the instructions. Acid gel (Extra-gel) is applied to the surface area of the enamel, and 15 seconds later to the dentine surface ***(Fig. 17)***. After another 15 seconds the paste is rinsed off with water. After drying, the etched surfaces are covered with an adhesive (C-Bond), which is exposed to the light of the halogen lamp.

Fig. 11. *Modelling the cutting edge*

Fig. 12. *Treating the restoration with a bur*

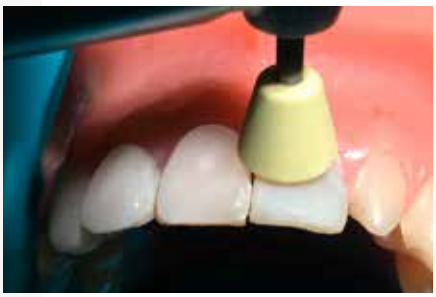

Fig. 13. *Polishing the vestibular surface*

Fig. 14.*Photo recording of the finished restoration*

Fig. 15. *Colour changes in the central incisors*

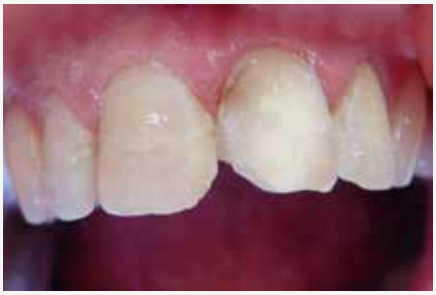

Fig. 16. *The prepared vestibular surfaces*

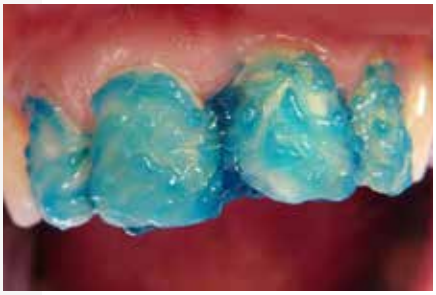

Fig. 17. *Acid etching of enamel and dentine*

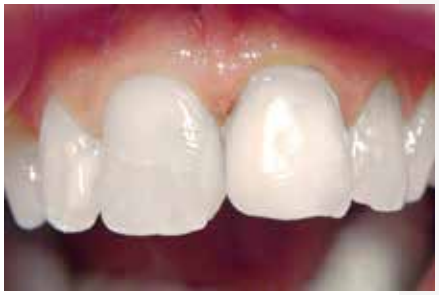

Fig. 18. *The opaque base of the restoration*

Fig. 19. *Modelling of the vestibular surface using enamel composite*

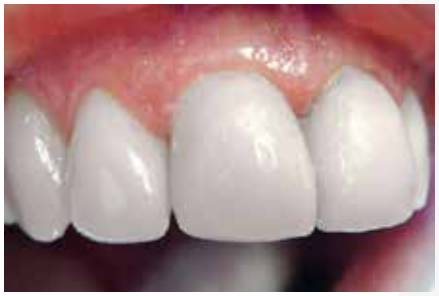

Fig. 20. *Modelling the gingival contour*

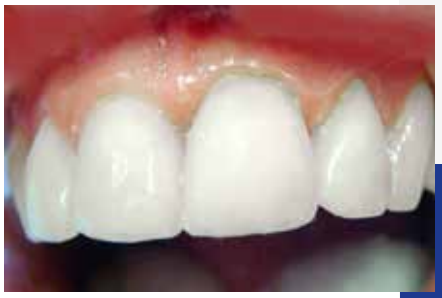

Fig. 21. *Modelling of the cutting edge*

Fig. 22. *The finished veneers*

Restoration begins with filling of the prepared cavities layer by layer using opaque composite (Competence universal) in accordance with the colour record form. Each layer is no more than 2.0 mm thick and is polymerised separately. Reconstitution of the contour of the geometrical shape of the dentine to designate the lateral and lower boundaries of the veneer is guaranteed by the sequence of procedures. The crown angle feature is modelled. Contacts between the teeth are formed throughout the extent of the middle and lower tiers ***(Fig. 18)***.

The main reference for the dentine contour is the border of the transparent enamel of the tooth. In this case, the enamel layer uniformly covers the vestibular surface and 0.5 mm is left around the perimeter of the tooth for the transparent layer ***(Fig. 19)***.

To recreate the dento-gingival contour on the central gingival part of the tooth, a portion of the enamel composite is applied and smoothed from the centre towards the periphery ***(Fig. 20)***. The gingival margin is covered with composite with some excess (in thickness), which is ground away in subsequent phases.

Modelling of the contact surfaces is completed by application and distribution of the transparent layer, taking into account the individual degree of enamel transparency. The cutting edge is modelled with this same shade, and the corners of the veneer are covered ***(Fig. 21)***. The composite resin hardens in layers (20 secs). The restoration is exposed to light for a final time.

After making the aesthetic restorations, the work is complete; the surface hybrid layer is removed and the relief is enhanced. Contouring of the veneer surfaces is done with cylindrical and conical diamond (red ring) burs. Then, diamond burs with a yellow ring and a diamond grit size of 15 microns are used. Then adjustments are made using ultra-fine finishing diamond burs (white ring) with a grit size of 8 microns and 30-bladed multi-fluted carbide finishing burs. The vestibular surface is polished with special heads and discs, avoiding significant pressure on the surface of the restoration.

The palatal surface of the veneer at the cutting edge is prepared using a pear-shaped, fine grain diamond bur. The gingival area is made smooth with a fine "mosquito stinger" bur. Finishing the side surfaces is done in strips.

In order to achieve shine on the restored surface, polishing heads, sponges and polishing pastes are used ***(Fig. 22)***.

The final stage of treatment is to treat the enamel surrounding the filling with fluoride preparations.

Conclusion

The use of photocurable composites at a preventive dentistry clinic involves strict observance of instructions for performing all procedures, which, in turn, requires prior study of how to work with up-to-date materials. The optimal sequence for the acquisition of manual skills is an initial study of the theoretical knowledge, acquaintance with the instructions, familiarisation with the procedures of forming aesthetic restorations on models, followed by continuation of the training as an assistant, and then making at first simple and then complex restorations in the preventive dentistry clinic.

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With over 20 years of experience in the dental imaging industry, Suni Medical Imaging has been at the forefront of developing state-of-the-art imaging technology for the dental community. With a robust suite of products, Suni is committed to providing practitioners with high-quality digital imaging tools that help maximize their diagnostic capabilities and increase workflow efficiency.

Suni Medical Imaging sells its sensors in over 90 countries around the globe, making Suni one of the most purchased digital sensor brand worldwide. And because every last one of their digital sensors is designed, developed, and manufactured right from our ISO-certified manufacturing facility in Silicon Valley, they're able to provide our customers witj unparalleled support and service.

It's latest introduction, the d'vinci, is moving digital imaging forward by offering a cost effective and versatile alternative to traditional radiography. Its ability to replace multiple wall mount systems and protect the operator and patient from radiation exposure give dentists an effective way to enhance their digital imaging capabilities.

The all new Suni IQ digital radiography system by Suni Medical Imaging continues its commitment to technological innovation and advanced digital sensor design. The Suni IQ epitomizes intuitive digital sensor technology. By combining high-performance with high-efficiency, Suni has achieved the perfect blend between superb image quality, enhanced durability, minimal radiation exposure, and comprehensive software. With the Suni IQ, Suni has created a complete digital radiography system designed to seamlessly integrate with your entire practice.

The SuniCam HD combines excellent image quality, powerful imaging tools, patient accessibility and ergonomic design, making it a powerful and versatile intraoral camera that will maximize your practice's imaging capabilities and workflow efficiency. The SuniCam HD is designed to seamlessly integrate into your practice, allowing you to capture incredible images to educate your patients simply and effectively. The Suni XQ mounted x-ray system is a versatile tool that combines high performance and reliability with ease of use and an ergonomic design to produce superior image quality on film phosphor plates or digital sensor.

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Since 1995, Suni Medical Imaging has been pioneering digital radiography, leading the industry with innovative, balanced and safe digital sensor technology.

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BULKFLEX is Deflex's new line of bulk injectable materials.
High quality thermoplastic polymers in bulk packaging allow for dispensing only the amount needed. Deflex continues to expand its product lines manufactured by Nuxen SRL. This began with the Deflex line of Premium injectable cartridges. This was followed by the arrival of CAD/CAM material. Today, taking advantage of the IDS as the most important dental trade show, we are announcing the launch of Deflex's bulk material line called BULKFLEX, for the manufacture of removable dentures.

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- Metal-free
- Minimal shrinkage
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Semi-flexible polyamide
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Nacera Hybrid by Doceram Medical Ceramics for multi-functional chairside and labside application

Long live aesthetics!

New hybrid ceramic withstands all kinds of requirements and stress

Simply more possibilities, visibly more aesthetics, and certainly more durability: Doceram Medical Ceramics' new Nacera Hybrid meets all the requirements of a modern, multi-functional composite for CAD/CAM technology—whether it is chairside or labside production! These highly compressed hybrid ceramic blanks, combining the best characteristics of ceramics and composite, not only guarantee long-term dental aesthetics with maximum levels of elasticity and stability but also universal processability and versatility. At the same time, Nacera Hybrid restorations can be repaired or adjusted by dentists at any time using their usual composite system. And with four new Nacera Blend Tissue Flow composites as part of the system, you can directly design customised gum portions or remodel them at a later stage.

With its unique compression strength of 480 to 500MPa, an extremely low elasticity module of 10GPa and a dentine-similar Vickers hardness (0.71GPa), **Nacera Hybrid** is currently the most stable, flexible and antagonist-friendly CAD/CAM restoration material on the market. Furthermore, with a bending strength of 170MPa, its homogeneous hybrid structure is in the ceramics range. The secret lies in its unique chemical composition with a sophisticated mixing ratio of 70% glass ceramics and 30% polymers and nano fillers—for chewing strength-absorbing, long-term treatments without any risk of chipping or fracture!

Best marks for maximum flexibility and compression strength

Whether its classic crowns and bridges, implant-based treatments, minimally invasive inlays and onlays or aesthetic table tops and veneers: Using millable **Nacera Hybrid** blocks and discs from the Dortmund manufacturer specialising in high-performance ceramics materials, it is possible to produce ultra-strong and ultra-stable posterior teeth restorations as well as cosmetic anterior teeth treatments with a reduced thickness. This universally applicable composite impresses with a very high level of translucence and an internal reflexion capability, precisely reproducing shade of colour, opalescence and fluorescence of the natural tooth to result in a genuine chameleon effect.
In order to achieve all common dental colours, blocks and discs are available in the colours A1, A2, A3, B1, D2, C2 and BL2. With dentists and dental technicians processing the same premium hybrid ceramics, chair- and labside restorations meet the same aesthetic benchmarks without differing colour results—for interdisciplinary one-stop solutions!

A further chairside benefit: Dentists can repair or refinish **Nacera Hybrid** restorations directly in the mouth using a composite material of their choice. With individual crowns being reproducible in every detail, defective treatments are also easy and quick to replace—a great benefit for patients with craniomandibular dysfunctions (CMD).

Versatile repair and adjustment options using composite!

Using our four new flowable **Nacera Blend Tissue** composites, it is possible to complete hybrid-ceramic treatments directly from the syringe with red aesthetics and apply customised characterisations—chair- as well as labside. Gingiva-coloured flow materials are also suitable for subsequent corrections or remodelling of gum-coloured restoration portions and for underpinning provisional and definitive implant work following a loss of soft tissue or bone material!
In a first step, this innovative hybrid ceramics, which can be worked precisely and crack-free in all common milling machines, is available in two block sizes (15.5 x 38.8mm and 18 x 15mm) for dental surgeries and in two disc sizes (98.3 x 15mm and 98.3 x 20mm) for dental laboratories, complemented by the **Nacera Blend Tissue** gingiva set with four colours. In a second step, Doceram Medical Ceramics will introduce two more **Nacera Blend Enamel** and eight **Accent** colours—for even more customisation options for aesthetic anterior teeth!

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In most countries where no dental scanning facilities are available, dentists have to resort to sending their patients to local hospitals for a conventional (full body) CT scan, which exposes up to twenty times more radiation to the patient. When CT Dent opened its independent Dental Scanning centers, the reaction from dentists was extremely positive and welcomed. Today, all CT Dent centers use the latest Cone Beam CT imaging technology, delivering high-resolution 3D volumetric images, providing dental surgeons with the most accurate Imaging data for the most sophisticated bone structure and tooth orientation procedures.
The advantages of sending patients to CT Dent scanning centers are:
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2. Patients no longer have to queue at Hospitals or General Imaging centers.
3. CT Dent clinics offer great hospitality and fast service to clients.
4. The process is less the 20 min.
5. CT Dent consistently offers the lowest prices for dental imaging within every markets it serves since it CT Dent focuses purely on dental imaging.
6. Radiology centers and hospitals do not specialize in Dental imaging, meaning the equipment is not specifically designed for dental use.

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Denterprise's Intraoral Sensor and Handheld X-ray Generator A Key Part of Bone Healing Studies on the International Space Station

ORMOND BEACH, Fla. (February 15, 2017) - The great thing about dental science and technology is that it's always touching a wide range of medical research and applications. With the recent launch of the Falcon-9 Space-X cargo trip to ISS, the excitement was in the air at Denterprise International, Inc. (DII), its related business units, Indiana University School of Medicine, CASIS, and NASA. The joint effort to understand bone healing in space is instrumental research that can be applied to further human exploration of our galaxy as well as at home on earth.

Similar to the rocket used for the February 18, 2017 cargo mission to ISS, this is a Space-X Falcon 9 v1.1 rocket soars after lift off from Cape Canaveral Air Force Station in Florida.

With a solid approach to dental device manufacturing practices, government clearance processes, and maintaining relationships in the scientific and academic community, Denterprise continues to play an important role in bringing emerging technology into the dental industry, as well as contributing to other parts of the medical science community. A key part of the success of this relationship is directly related to the practice of making sure dental devices meet the highest standards for the industry at large. Joyce St. Germain, head of Denterprise's 510(k) FDA division states, "Being a trusted adviser and having helped many companies get medical device clearance through the FDA; it was exciting to have cleared our own dental imaging sensor and see it used for monumental bone healing research in spaceflight."

510k FDA Consulting helped facilitate the sensor through FDA clearance with great efficiency and in faster than usual times. "We strive to make sure that our dental imaging technology is prepared with the highest level of standards, benchmarks, and safety. This is indicated by the fact that our FDA clearance was expeditious and moved through the process properly," says Claude Berthoin, Denterprise CEO and Founder. "Because we put a lot of emphasis on the importance of due diligence in dental imaging product development and delivery," continues Berthoin "it enables us to stay close to research and emerging medical science applications, thus ultimately contributing to the advancement of health science at home and beyond."

The bone healing study, headed by Dr. Melissa Kacena at Indiana University's School of Medicine, will focus on the healing of laboratory mice. The mice, also part of the cargo to ISS, will be observed on the space station with data being sent back to researchers on earth, for analysis and further studies. "The Denterprise sensor is a highly cost effective and powerful tool for our research. We usually capture the image we need with minimal dosage from the mini x-ray generator and we get great image quality," says Dr. Melissa Kacena of Indiana University School of Medicine. Low exposure, with high resolution diagnostic clarity, is a key differentiator of Denterprise's sensors and x-ray generators. "We look at the alignment of the bones, the position of the surgical hardware, and the location of the fractures while the test subjects heal", continues Dr. Kacena, "so the clarity produced by the DII sensor and the ease of use of the mini handheld generator really contribute to this study."

For more information on 510(k) FDA Consulting and understanding the clearance process for medical devices, contact:

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Interview of Dr. Majd Naji and Cefla

Who is Dr. Majd Naji?

Dr. Majd Naji is a cosmetic dentist dedicated to the highest levels of excellence in the art and science of cosmetic dentistry in accordance with the code of ethics upon which Liberty Dental Clinic was founded, he is a professional member of American Academy of Cosmetic Dentistry with over 19 years of experience in creating smile makeovers, educating and introducing patients to the latest developments in the dental cosmetic field utilizing the safest, least invasive and most advanced treatment methods to produce the best most natural-looking results. Dr. Majd is recognized both locally and internationally in which celebrities from the music, movie and political domains from all over the world come to Dubai for his care.

Dr. Mohammed Naji

Dr. Majd tell us about your relation with Cefla?

My relation with Cefla started more than 13 years ago when I bought my first Anthos chair. And even though it was their simplest model the A3 but it was still it was the best decision I ever made. Then things evolved between us and now my whole clinic in all branches is fully equipped from Cefla, including their top of the range products like the S380 Stern Weber chair and the sky view CBCT from Myray. And finally things got even bigger and better that I've become the brand ambassador of Cefla in Middle East and North Africa and I'm very proud to represent them in all of our dental conferences around the world and it was a great pleasure to visit their factory in Emule and witness their accuracy and high level of perfection in manufacturing their products.

Tell us about Liberty dental clinic.

Liberty Dental Clinic was established in 1998, the clinic has been awarded to be the Best Dental Clinic in UAE according to "GV Pedia", the official publisher for "The Best in the World". Liberty Dental Clinic is about creating a signature smile that re-designs an individual's smile to suit their face and enhance their appearance. Every discipline of dentistry required in the treatment process is founded under the comfort of one roof with a team of more than 24 dentists between specialists and consultants in the fields of: Cosmetic Dentistry, Prosthodontics Dentistry, Laser Dentistry, Oral Maxillofacial Surgery and Implantology, Periodontics, Orthodontics, Endodontics, Paedodontics, Restorative and Conservative Dentistry. The clinic is equipped with latest technologies to serve our patients such as: 3D CBCT scan and lasers. Such technologies serve in providing accurate diagnosis and facilitate painless treatments. Moreover, the advanced 3D scanner and computerized milling machines available enable dentists to fabricate restorations within the same treatment session. The clinic is associated with a high quality laboratory equipped with latest computerized technologies.

We heard about your upcoming reality show, tell us more about that.

The "Smile Masters": show is the first of it's kind reality show in the Middle East. This show portrays Dr. Majd Naji's personal life with his wife Dr. Deema Basim, and his brother Dr. Mohammed Naji. In which this trio constantly change people's lives and smiles through a series of events in Dubai the city of dreams and glamour.

Tell us about the future plans between cefla and yourself.

We recently signed an extension of our deal for another year, and I will be present in the IDS conference in Cologne at their stand to see their latest innovations in the world of dentistry and to support their upcoming events.

What would you like to tell the readers of our magazine?

I am very happy and honored to be featured on your magazine, especially that it has a great name in the medical field and it's highly followed by the most prestigious dentists from all around the world.

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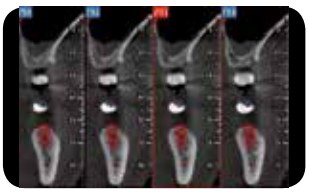

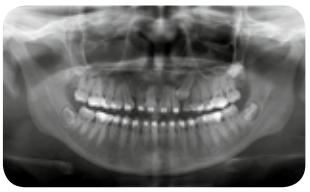

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Current Issues of Concern for the European Dentists

From Dr. Marco Landi, President of the Council of European Dentists (CED), elected in November 2015 by the CED General Meeting for a term of three years.

Currently there are a lot of topics on the agenda of the CED. I would like to share with you the topics we are working on and which vary from the future of the dental profession to the debate triggered off by the European Commission on the future of regulated professions, concerns about initiatives in European standardization of healthcare services, new EU Regulation on Mercury laying down the future of dental amalgam and the new Regulation on Medical Devices which has been adopted recently.

1. The Future of dental profession

Dental profession is facing some serious challenges. Driven by financial interests other players are trying to enter the booming market of healthcare services. The European Commission has the deregulation of professional rules at the top of its agenda. These developments can change the face of dentistry radically. We need to come up with our vision of dentistry in the future, defending independence and patients' interests. The CED is dedicating more resources to look into this issue and is preparing a risk assessment on the current challenges that dentistry faces today from the point of view of the professionals.

Dr. Marco Landi, President of the Council of European Dentists

2. Evaluation of regulated professions/deregulation by the European Commission

The CED continues to see the initiatives from the European Commission on this file with great concern. We see a shift in the way the Commission is working and on how economic instruments will now have an impact on national health systems.

2.1 First, the **Single Market Strategy** saying that the Commission will issue periodic guidance identifying concrete reform needs to individual Member States to improve access to and the exercise of regulated professions at national level and across the EU. These reforms are being addressed in the context of **the European Semester process and country specific recommendation.** Our impression is that the recommendations related to health mainly address the need to ensure cost-effectiveness and sustainability of health systems (fiscal dimension), whereas issues of access to, effectiveness and high quality services do not receive deserved attention.

2.2 Second, the Commission published a roadmap on **Guidance on reforms needs for Member States in regulation of professions** and an inception impact assessment for a **future proposal for a Directive on proportionality test.**
Professional regulation is regarded by the European Commission as an obstacle to the internal market.

In addition, there are several infringement procedures regarding tariffs and fees of liberal professions – in Germany Architects and Engineers. A recent ruling of the European Court of Justice considers that fixed prices set in Germany for prescription-only medicinal products are contrary to the EU law. The Court did not acknowledge that overriding reasons of public health justify such fixed prices.
The CED believes that a merely economic approach is not appropriate. Professional regulation guarantees a certain level of quality of services for the benefit of the patients.

3. Dental hygienists

There is a discussion on future of dental hygienists at European level. Member States were asked to review the qualification requirements imposed on regulated professions and the scope of reserved activities (process from 2014 - 2016). The objective is to remove unjustified regulatory barriers and to simplify access to regulated professions. In some countries these reforms are already in place (Spain, Portugal, Poland and Slovenia). Healthcare professions were in the second cluster of sectors and the profession of dental hygienists was selected to be discussed in further detail at EU level. The same for Opticians, Psychologists and related professions and Physiotherapists. **In the Commission's report Member States were invited to reflect on whether they should:**

3.1. Offer more autonomy to dental hygienists (abolish the requirement for dentist referral to see a dental hygienists when applicable or allow dental hygienists direct access to patients);

3.2. Enlarge the scope of activities reserved to dental hygienists if proved to be cost-effective and safe for the patient.

3.3. Reduce or increase training requirements – this should be seen in conjunction with the level of autonomy of dental hygienists and to guarantee the quality of the service provided.

3.4. Ease potential barriers to mobility by: i) improving clarity and transparency of regulatory measures to professionals, ii) aligning training requirements with the scope of reserved activities and the level of responsibilities of dental hygienists, and iii) **granting dental hygienists partial access, especially for dental hygienists moving to a country which does not regulate the profession of dental hygienist or the activities in dental hygiene belong to the remit of another dental profession.**
The Evaluation meeting last year showed great differences between EU-Member States.

4. Standardisation of healthcare services

We see that **the political environment is to develop more standards**, since they are seen as key elements for innovation and progress in the Single Market, for European competitiveness, jobs and growth. These initiatives come from the European Standardisation Committee (CEN). CEN continues to push for further standards in healthcare delivery (besides the standard on aesthetic surgery services). They have created a **Healthcare Services Focus Group** and developed a **European strategy on standardisation of healthcare services** to find a common framework for any new proposals in this field. The CED looks with great concern at the developments in this area and cooperates closely with its partners to make sure that European standardization initiatives do not harm the delivery of healthcare, quality of healthcare services and high level of patient safety.

They have created a Healthcare Services Focus Group and developed a European strategy on standardisation of healthcare services to find a common framework for any new proposals in this field.

5. Amalgam

In February the European Commission published a proposal for the implementation of UN-convention of Minamata to reduce the use of mercury including dental amalgam – mandatory separators and encapsulate amalgam.
During the legislative process the European Parliament favoured a phase-out of dental amalgam by the end of 2022, which goes beyond the requirements of Minamata convention.

Currently, the EU institutions are in negotiation discussions and the CED hopes for a positive outcome. The CED believes that amalgam should be kept in the toolbox given that the alternative filling materials present also some problems and concerns.

6. Medical devices

The CED considers that a high level of health and patient safety protection is required when it comes to medical devices. This can be guaranteed with a strong, safe and effective regulatory framework.
In May this year, the European Parliament and the EU Council agreed on a final text of the new Medical Devices Regulation.
One issue remains of concern to the CED: **classification of nanomaterials.** The current provision on nanomaterials is quite ambiguous and the text of the Regulation does not provide any explanation for further interpretation.
As you can see there are many developments at European level which CED is following closely and taking all possible efforts to make the voice of the European dentists heard.

Presentation of the CED - The Council of European Dentists (CED) represents over 340,000 practising dentists from 30 European countries; our

members are dental associations and dental chambers with regulatory competences, meaning that our positions are informed both by interests of the dentists (many of whom work as small businesses) and of the regulators acting in the public interest.
The CED was established more than 50 years ago, in 1961, to provide expert advice to the European Commission on matters related to dentistry, and this relationship remains central to our work. For this reason we are partners and members in different Joint Actions and Groups led by the Commission.

Our key objectives are to safeguard public health, to promote high standards of oral healthcare and dentistry and effective patient-safety centred professional practice. The CED's core activities are financed exclusively from membership fees. We are registered in the Joint Transparency Register. www.cedentists.eu/

Source: European Trade Press Conference for IDS 2017, 6 December 2016. Speaking notes from Dr. Marco Landi (CED).

Promote Innovations, Retain Amalgam as Dental Material

From Dr. Peter Engel, President of the German Dental Association

Every two years, the International Dental Show, IDS, is a barometer for the global dental market. This is where the innovations will be presented today that the dentists and dental technicians will be working in the practices and laboratories of tomorrow. Dentistry is dependent on the support of the dental industry in the form of innovations and developments. In the face of an ageing population, our aim must be to preserve oral health as long as possible. Comprehensive dental care, novel therapies and progressive care structures – combined with high-quality technical and durable medical products – are necessary to achieve this aim.

Apart from innovations, don't neglect the basics

Despite the necessary pursuit for innovations, we mustn't however neglect the "basics". Care that is affordable and available to all people forms the basics of dentistry. This is why amalgam - contrary to the current demands of the European Parliament - should continue to be available as a filling material. It is reliable, cheap, easy to process and very durable. Worldwide there is no other filling material that has been examined as frequently and as intensively as a possible health risk. It is not still counted as being part of the standard care by the legal national health insurance companies without good reason.

In February, the European Commission presented an acceptable proposal for a new EU mercury guideline, which is to be used to implement the UN agreement passed in 2013 in Minamata. The aim of the agreement is to reduce the worldwide consumption of mercury. In the course of the legislation process, especially the European Parliament is demanding that amalgam should be done away with in the near future, in spite of all of the above-mentioned advantages. According to the will of the responsible parliamentary committee, amalgam should be gradually discontinued by the end of 2022 ("phase-out"). From then onwards, the material should only be used in exceptional cases that are necessary due to medical reasons. This goes far beyond the provisions of the Minamata Convention, which merely foresees a reduction of the use of amalgam ("phase-down").
The following already applies in the dental area today: Amalgam fillings shouldn't be used for pregnant women or children, in the case of serious kidney diseases or proven allergies. Furthermore, amalgam separators have long since been legally prescribed for the recycling of amalgam in Germany - in contrast to other European states. Overall, the share of amalgam fillings continues to decline in Germany. However, it should still be used as a filling material,

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Dr. Peter Engel, President of the German Dental Association

because it cannot be completely replaced by other materials to-date and it allows many people to enjoy dental care and an optimum therapy. It remains to be seen as to whether the European Parliament will assert itself with its, in my opinion, excessive demand.

The young colleagues need innovations

However, there is also good news from the political scene: After 60 years, the draft bill of the new dental licensing regulation has finally been available since last month. That was long overdue. Fortunately, most of the demands of the German Dental Association have been included in the amendment. I hope that the colleagues-to-be will soon be licensed according to the requirements of modern dentistry and thus be able to partake in its innovations.

The opportunity to fully partake in innovations is especially important for the young generation. As the current Dental Practice InvestMonitor of the Institute of German Dentists (IDZ) documents, the founding a new, individual practice costs Euro 484,000 on average. This is a very large sum for young colleagues and signifies a major life-influencing decision. This is precisely why they have to be able to fall back on high-quality and durable equipment for the practice, like that presented here at IDS.

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Source: European Trade Press Conference for IDS 2017, 6 December 2016. Speaking notes from Dr. Peter Engel

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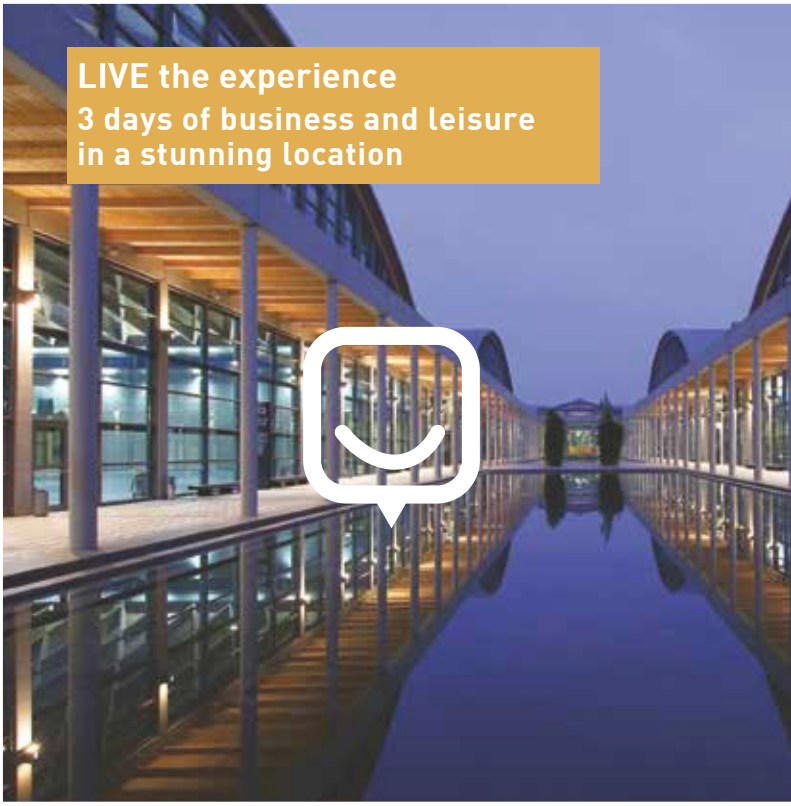

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3 days to get into the DIGITAL WORKFLOW

Italian Dental Industries Association

UNIDI - Italian Dental Industries Association associates the majority of Italian manufacturers of equipment and consumables for dentists and dental technicians – about a 100 high-calibre companies, which are able to guarantee safety and performance of their products. In fact, membership of UNIDI entails the compliance to specific standards and to current Italian and EU legislation.

The Italian Dental Industry employs more than 3,300 people, achieving an annual revenue of more than € 820 million. Exports represent about 60% of the total with peaks rising to 80% when considering specific product categories. The Italian Dental Industry has confirmed its position in the forefront of international markets on the strength of products that are appreciated throughout the world for the reliability of their components, their avant-garde technological solutions and pleasing design.

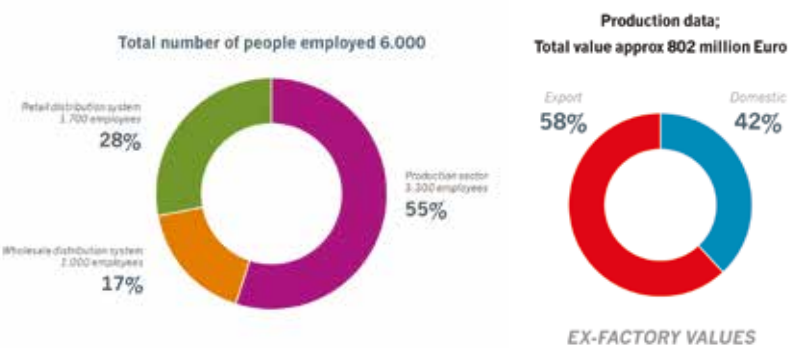
UNIDI was set up in 1969 and in 48 years of activity it has made an all-important contribution to the growth of the Italian Dental Industry. Today, it is one of the world leaders, among the first for volume of business, technological innovation and exports.

UNIDI promotes "made in Italy" through two important international events: Expodental Meeting in Rimini, the most relevant international trade-show for the dental sector in Italy; and **IDEA – International Dental Exhibition Africa**, the only international trade-show for dental professionals of all African Countries. Moreover, UNIDI carries out an intense foreign activity by attending several dental exhibitions in both emerging countries and developed markets. This activity is supported by ICE-Italian Trade Promotion Agency.

EXPODENTAL MEETING, the showcase of the Italian Dental Industry

In 2016 the exhibition and the comprehensive cultural and scientific program has attracted a huge number of dental professionals and buyers (16.000 visitors from 72 Countries), which created an increasing number of business opportunities and returns for the 244 Exhibitors; the beautiful location of Rimini Fiera turned out to be perfectly appropriate to welcome both national and international visitors.

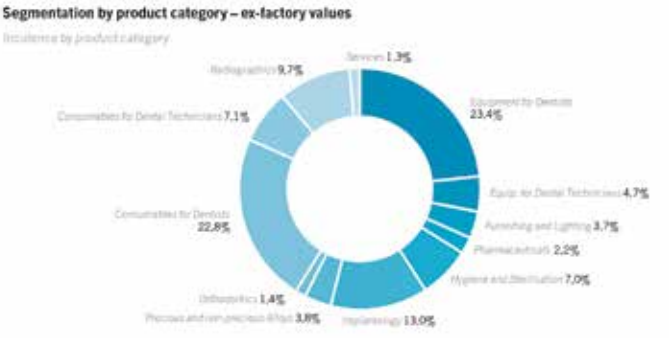
For 2017 the offer for exhibitors and visitors will be even more complete and appealing: not only a trade-show, but a comprehensive experience where manufacturers, distributors, agents, professionals, press and university from all over the world will have the opportunity to meet, with a special focus on education and updating.



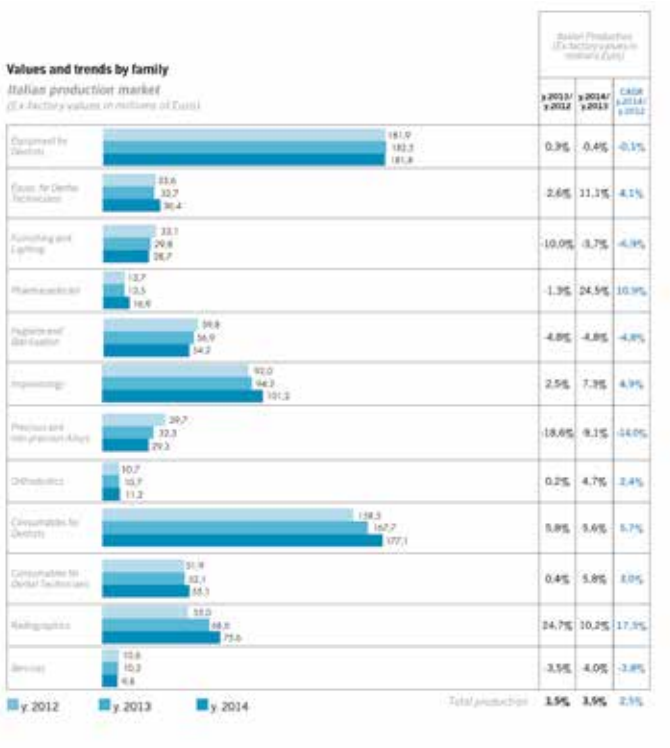
In fact, **a comprehensive cultural and scientific program** integrates the broad exhibition: over 20 scientific sessions for dentists, dental technicians and maxillo-facial surgeons, in partnership with the most important Universities and dental associations. There will be training opportunities

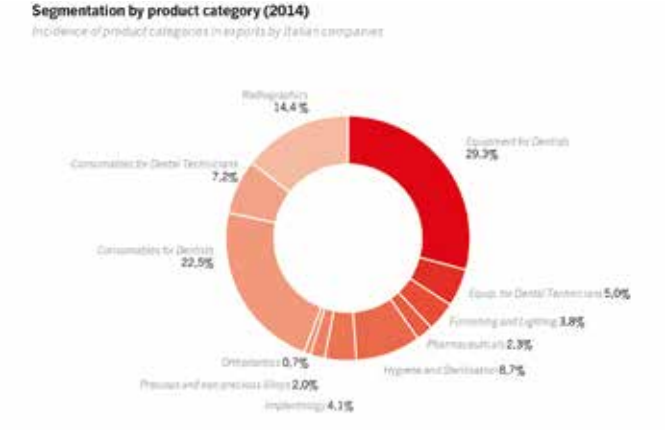
for dental hygienists and dental assistants as well. A panel of internationally renowned lecturers will hold their courses in the training rooms of Rimini Fiera from 18 to 20 May 2017.

However, what will really make the difference at the upcoming edition is the new pavilion called **EXPO3D: an entire area, totally dedicated to the digital workflow** from dental practice to dental lab. The Digital revolution is changing the world: compu-



Top Italian Dental Industries





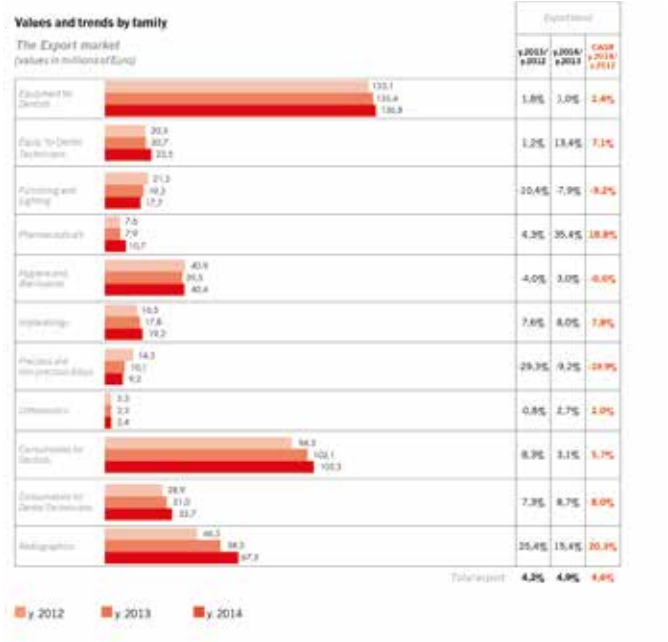
ters and Digital devices are making what were previously manual tasks easier, faster, cheaper and more predictable.

Even in Dentistry, Digital technologies are rapidly advancing: new technologies such as intra/ extra-oral scanners, cone beam computed tomography (CBCT) scanners, computer aided design / computer aided manufacturing (CAD/CAM) softwares and innovative fabrication procedures such as 3D printing and layered manufacturing are changing the way patients are treated.

The exposure of digital products and the intense scientific program focused on digital technologies aim at a broader disclosure and knowledge of digital dentistry, in order to promote professional growth within the dental sector. Besides the display of materials, equipment and machineries used within the digital workflow, a rich scientific program will take place, entirely focused on digital technologies, including events by professional Associations, scientific lectures by academic experts such as the Digital Group of S. Raffaele Institute and the Eastman Institute for Oral Health University of Rochester. Exhibiting Companies will also be part of the program by organizing their own workshops.

At last, Digital Dentistry Society - the first International Scientific Society exclusively dealing with these new technologies - will explain the complete digital workflow in dentistry, through its main phases: starting from the image acquisition - through CBCT, Intraoral Scanner, Dental laboratory scanner - all the way through the use of CAD/CAM software to the final manufacturing phase (Milling, Prototyping, Additive Printing).

Finally, in 2017 the cooperation with ICE/ITA (Italian Trade Agency) will be even more intense, in order to make Expodental Meeting more and more international. In fact, last year the international participation has increased by 72%, with 563 new foreign visitors from 71 Countries and a large delegation with more than 60 buyers; next year no less than 100 delegates will meet the Italian companies in Rimini. Besides, with its immense offer of beautiful landscapes, restaurants serving the best in local cuisine, culture, shopping, wellbeing and entertainment, Rimini is the place where business meets leisure, making your stay a truly unforgettable experience.



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As UNIDI reports "The Italian Dental Industry has achieved a highly competitive position on international markets, performing as a leader in the dental culture. Italian production is appreciated everywhere for the reliability of its components, its avant-garde technological solutions and design.

The Italian Dental Industry generates a turnover of more than 720 million euro, two-thirds of this figure representing equipment and instruments, and one-third consumables. Exports represent about 60% of the total amount, with peaks rising to 80% for some products. Furthermore the industry employs more than 3.300 people from manufacturing to the consumers area."

We are proud to connect these top companies with Infodent International network of distributors in 189 Countries, because we are always looking for the satisfaction of all our partners and in Italy we trust.

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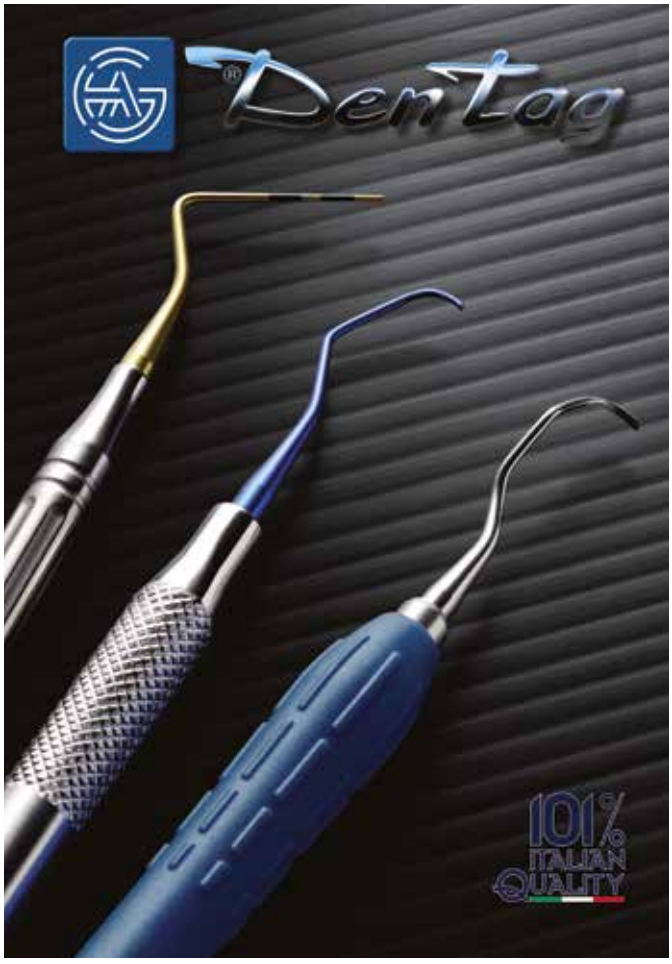
Now we would like to give you a brief introduction of DenTag

Renowned throughout the world for its traditional craftsmanship and superlative quality of its knives and scissors, the small town of Maniago, in northeastern Italy, is the home of **DenTag**.

The Company was established in the early 1950s by a team of expert artisan knife-makers and, as may readily be imagined, knives and scissors were their very first products. Soon thereafter, the ambition and vision of the founders pushed the company towards another direction, diverting its attention to the manufacture of high-quality surgical and dental instruments.
The raw materials – stainless steel, aluminum and titanium – are carefully selected. Hardening and sharpening techniques for which craftsmen of Maniago have been famous for generations have been applied in their precise manufacturing of instruments.

During the years, **DenTag** establishes many contacts with universities and final users, to adapt and modify its own production to continuous changing requests of a demanding market. The result was an increasing expansion through the Italian and foreign market, so at the end of the '80s the company moved to a new and bigger plant. The success of **DenTag** is due to its continuous and steady investments in research and quality. During the years, digital control machineries were introduced and many manufacturing processes automated. Moreover, computer – aided design was introduced, and the entire production cycle is computer controlled, even the packaging process and the final LASER marking phase.

Despite this, at **DenTag** final testing and control procedures are made by expert craftsman, trained within the company, as cer-



tain phases are particularly important and delicate in terms of quality. Today, **DenTag** offers a varied amount of new items, with different aesthetic features, and it is known for its high quality level, which is able to satisfy the most demanding customers.
DenTag has obtained UNI EN ISO 9001 Q.S., and UNI EN ISO 13485 Medical Devices certifications, and it is recognised by FDA "Food and Drug Administration" for products exported to the United States. Thanks to its focus on quality, **DenTag** today produces surgical and dental instruments for several companies in Italy and abroad, as well as a range bearing its own brand.

Given the highly-specialized nature of its products, **DenTag** receives requests for new instruments – on a nearly daily basis. For this reason, research specifically focuses on the manufacture of instruments that are innovative in every way – in their shape, the materials used, and in the surface finish.

We are firmly convinced that quality will have an increasing important and predominant role, in a market which is becoming more and more globalized, and we will continue to achieve this goal. We are firmly convinced that, during this third millennium, the concept of total and real quality is destined to become increasingly vital, especially in light of the extraordinary level of globalization that is rapidly becoming the dominating factor in the market. We will continue to achieve this goal with versatility and continuous research into innovative production technologies. It will be the basis for expansion of **DenTag** in this field.

Following it we introduce our new line of instruments "EVO"

DenTag always produces surgical and dental instruments... using stainless steel.
Over the years, we have produced, for us and others, innumerable variations of instruments. We have also started the production of tools in aluminum, titanium and with inserts in hard metals but always working in the field of metals. We believe, in our little experience, to have built a recognized standard of quality and reliability.
However, we always pay attention to changes and trends in the market that evolves rapidly and sometimes suddenly.

Cyclically we receive requests for instruments lighter but at the same time as reliable as those made of stainless steel. Not being able to change the material used for the tips, to lighten the devices, we can only works on the handles. That is why we started to manufacture an entirely new line of light material handles.

Clearly this solution is already used by others before us so that, in the design, we started to study the state of art, trying to take advantage and, if possible, improve the positivity and correcting any errors, if we found.

The result of this search is the EVO family of instruments with handles which has, we think for the first time, several positivity together:

• **Material:** Lightweight (11 g) and resistant to stress. Use turns out to be easy, for sure grip and non-fatiguing. Tested and used in the food field, then completely non-toxic and free of potentially harmful substances. Autoclavable without change of shape and color.

• **Form:** 10.5 mm Diameter of the handle and the center of 9.0 mm to minimize the problems to carpal tunnel data from prolonged use in time. Longitudinal notches to increase the grip and the sensibility.

• **Construction:** We have inserted during molding of the handle, two stainless steel bushes suitably shaped, in which the tips are then introduced. With this procedure will eliminate the presence of an internal longitudinal metal bar with obvious reduction in weight. The tips are not glued to the material and so there is no risk of potentially harmful substances are released.

• **Aesthetics:** Profile simple, easy to wash and clean. Without deep grooves or notches that may cause accumulation of germs and bacteria. Since plastic is possible to color in various shades aesthetically pleasing and with advantages for the immediate recognition of the instrument.

It is known that simple dental instruments such as curettes or double probes may injure the operator's hand or lacerate the glove (with the opposite working points). The possibility of injury is during use, handling or passing the instrument between Assistant-Dentist-Assistant while performing the procedures on the patient.

Directive 2010/32/EU - prevention from sharp injuries in the hospital and healthcare sector, also it states that it's necessary to prevent workers' injuries caused by all medical sharps and pointed devices.
Instruments with a handle 100, 105 mm are too short and the tips, even if they are turned contrary than working one, very often touch on the back of his hand.
Instead, what it can do as an additional preventive action is to choose, when buying or replacing, one instrument with a long handle.
The longer instruments can be wrapped exactly like the other and, in the event that the dentist use cassettes or trays for sterilization of small size, it will be sufficient to put the instruments in the direction of the longer side
That's another reasons to choose new **DenTag** "EVO" family of instruments.

As always we are respecting our quality standards and, we are proud of, 101% Italian quality.

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Using MillBox means: One click unlocks full manipulation of restorations: Rotation, Positioning, Changing Support Pin positions and or adding additional support. New graphical user interface with full support for touch screen displays. Users guided throughout the intuitive process in preparation for milling. The wide range of restoration types, together with the variety of materials can cover all needs of the laboratory. MillBox uses different colors to highlight potential areas that may need extra focus during milling (undercuts or un-reachable areas). MillBox will also indicate when there is an issue with how the user is positioning / rotating parts. Specially designed for professionals who require simple and efficient tools, can provide high performance in less time and get the work you want through fewer steps. MillBox users are always up to date thanks to the continuing evolution of the software. Several features have been introduced or improved during the past year, the software has become even more accessible than ever. Among other new features introduced, the Cavity Fit feature has been introduced. Sometimes, after a long process, the milled object may not have a good fit due to design issues or material. In MillBox, without changing any cutting strategies, you can adjust fit on the prep with a simple click. These parameters can be used then as default every time a similar item is imported. Five new types of Stabilizers have been introduced in MillBox, each of them with its own structure that can adapt to the type of the object that you are looking to support. MillBox allows the simultaneous opening of different working sessions. In the Windows taskbar, a "Progress Bar" is shown indicating the progress of the calculation. If an error occurs, this bar turns red to alert the user. All materials that are currently being used in the dental industry are fully supported by MillBox. We also offer the option to change the display color of the material used. We can utilize and display "shaded" and "multilayered" materials. The restorations specifically placed in the materials during the design phase, can automatically be imported into MillBox while preserving the position between the CAD & CAM. The new optional "Make&Mill" module has been introduced with the aim to take advantage of the use of two different manufacturing technologies, additive and subtractive, inside a single software. The user can import the STL of an object to be Laser Sintered at a reduced cost and afterwards transfer the indexed part over into a milling machine so that only designated key areas will be milled when they require a more precise finish like in the case of interfaces on a bar. Furthermore in MillBox you can import any type of dental restoration from any open CAD source. Using 3Shape®, DentalWings® and Exocad® software, the recognition of the type and morphology is completely automated. Automatic features will be applied to each imported object such as nesting, support pins, margin line detection , offset and orientation. MillBox now more than ever, is the most suitable partner to improve your workflow, increasing the quality and range of your products. CIMsystem relies on its strong expertise in the manufacturing and dental industry to fully support customers. Starting from the initial assessment of their needs, down to the implementation and customization of the right solution, the company delivers high-quality, innovative, and powerful technical tools, with training from qualified technicians providing excellent after-sales service and support. CIMsystem engineers are pleased to welcome you at IDS 2017, Hall 3.1 Booth J 19. For more specific information please visit our websites: **www.cimsystem.com; www.sum3ddental.com.**

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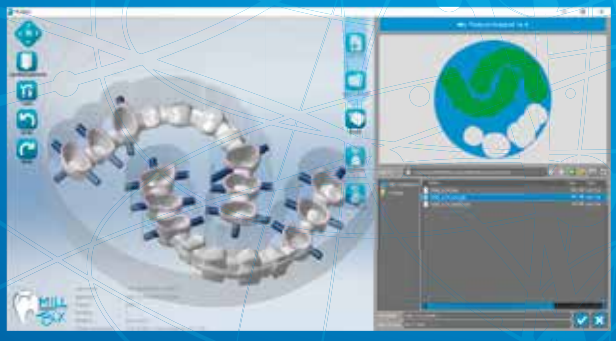


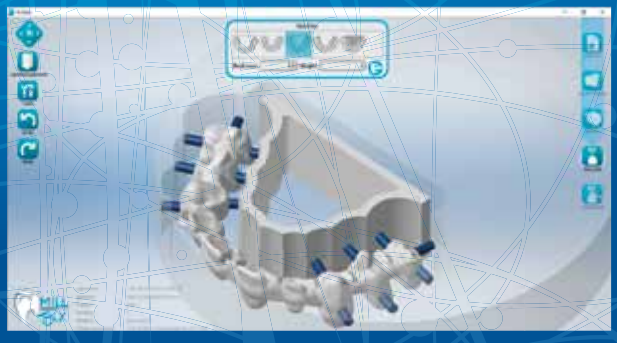

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ADEE members

are European university dental schools, specialist societies or other national dental bodies concerned with or related to dental education

ADEE is organizing the meeting in London 8-9 May together with ADEA for Shaping the future of Dental Education.
Dental education is working towards harmonization and cooperation in a global perspective.
So the next event in 2017 will be a workshop on:
- key challenges impacting the future of dental education in various parts of the world.
- opportunities for global collaboration to address these challenges.
- future trends and opportunities to work together to address/optimise them.
- best practices that can be used on local, regional and global levels.
- plan and mechanisms for continuing communication between meetings.
- global response to improve oral health through dental education.

At King's College London, Guys Campus, on Monday and Tuesday, May 8–9, 2017 experts will work to develop a consensus or position paper on the selected themes.
- Global Networking: the how and why for dental educators.
- Inter-professional Education: an imperative for dental education.
- The impact of new technological and scientific discoveries on traditional dental education.
- Assessment in a global context.

The annual congress will be held as usual on 23-26 August in Vilnius and will be about learning together to improve oral health and quality of life. The format of the meeting is constantly evolving to adapt to different formats of education perspectives and new interesting research in order to:
-Keep abreast of developments and new techniques in Dental Education.
- Brush up on industry's ongoing developments that enhance the developments of the needed competences by Europe's future dentists.
- See what's happening in research and development within the field of Dental Education and related sciences.
- Exciting programme full of interesting events.
- Some of the best key note speakers on Dental Education in the world.
- Attend workshops and unique forums such as the FREEStage and the Special Interest Groups, which seek to highlight the recents trends in modern Dental Education.
- Network and socialise with like-minded professionals.

The actual president of ADEE is Corrado Paganelli by the University of Brescia (IT)
The executive committee of ADEE is planning the best practice examples that can be proposed to Schools applying for the LEADER project for quality improvement programme

www.adee.org/leader/index.html

Dental Tech: a long road dedicated to implantology

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Dental Tech operates in compliance with the rigorous requirements of European Directive 93/42/EEC, is certified by TUV Product service CE 0123 for medical products, and our quality management system is ISO certified in accordance with UNI EN ISO 9001:2008 EN ISO 13485:2012+AC:2012

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Tongue Stars 2 (TS2) System for Rapid Open Bite Closure

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Abstract: The aim is to discuss a new system to treat severe skeletal open bite malocclusion using a new, miniaturized tongue star 2 device. Methods: Clinical applications of the first generation of the tongue star devices with nine rounded protrusions, initially manufactured as one-piece, were evaluated over a 2-year period in the private orthodontic clinic of the author. Improvements were noted and implemented to develop a second generation tongue star 2 (TS2). The new TS2 was made in Italy by SIA Orthodontic Manufacturer as a four-piece unit including a body with 6 tie-wing undercuts for crossbite elastics, brazed to the bonding pad for greater flexibility, and 80-gauge mesh for higher bond strength against lingual shearing forces. For each orthodontic patient, 12 TS2s were bonded, including six tongue stars positioned on the palatal aspects of the gingival middle-third of the upper six anterior teeth from canine to canine, and six tongue stars were placed on the lingual middle-third of the lower anteriors from canine to canine. TS2s were the central device of a 4-component system to treat severe anterior, and lateral tongue positioning. The second component of the system included tongue stars bonded at the same time as a Siamese twin, Active self-ligating appliance that employed the third component of new initial NiTi iArch wires for light force control. These specialized archwires with a higher vertical dimension than horizontal dimension (for example .018 X .014") acted closer to the center of resistance of the root for earlier moments of incisor torque, and were incorporated with curve of Spee for the lower arches, and reverse compensating curve on the upper arches to further facilitate incisor re-eruption. The fourth component of the system included a vertical box elastic from the upper lateral incisors to the lower canines (1/4", 4.5oz) that was additionally applied on the labial aspects for light incisor re-eruption in conjunction with the TS2s. Clinical Results: TS2s were found to be highly effective in restricting anterior tongue positioning for rapid open bite closure (ROC). No clinically significant root resorption was noted that appeared to be related to the light forces applied. Conclusion: Tongue stars are recommended for rapid open bite closure since they cause the tongue to be retracted during treatment to permit anterior dental re-eruption.

Introduction to Multi-directional Forces of Anterior Tongue Positioning (Tongue thrusting):

The tongue affects the alignment of the dentition because it has one of the strongest sets of muscles in the human body capable of reflex.1 Malocclusions involving open bites are classified as two types, anterior open bite located in the area of the anterior canine-to-canine area, and lateral open bites located at the premolars and molars. In open bite malocclusions the tongue attempts to seal the oral cavity for effective swallowing (suction-effect) in an unnatural, anterior position. In addition, the tongue thrusts both superiorly and inferiorly. This results in progressive opening of the bite preventing eruption of the upper and lower incisors. It is significant that both the upper and lower incisors are not only intruded, but also proclined often by the unnatural anterior tongue position between the incisors. Several factors have been associated with open bites.

Etiology of open bite includes:

1) Primary anterior, superior and inferior tongue positioning in conjunction with lateral tongue thrusting
2) Allergies, asthma, nasal obstruction from for example nasal septum deviation as a result of chronically inflamed turbinates, chronically enlarged tonsils and adenoids etc.
3) Primary, habitual mouthbreathing (or 2°), associated often with anterior, superior and inferior tongue positioning
4) Skeletal downward and backward growth of the mandible (dolicocephalics)
5) Muscle hypoactivity (an extreme pathological example is observed in muscular dystrophy patients)
6) Dental delay of incisor eruption and over-eruption of the molars
7) Habits such as thumb-sucking, finger-sucking, blanket sucking over-retention of soothers after age 6

Several appliances have been developed to control the anterior tongue positioning including the traditional cemented tongue-cribs soldered to molar bands, and bondable tongue habit-breakers type brackets on the palatal of the upper incisors. These were often bulky, uncomfortable and cumbersome for patients. The purpose of this clinical study was to develop and test a small bondable type device to be effective and efficient in application in an attempt to prevent and control anterior tongue positioning. The second objective was to develop an overall System using the tongue device to for rapid open bite closure.

What is a Tongue Stars 2? *Methods*

The first tongue star was developed in 2014 with 9-reminder protrusions rounded at the tips to prevent anterior tongue positioning. It was manufactured as a one-piece bracket and tested clinically for 2 years by the author in his private orthodontic clinic in Toronto, Canada. This first generation tongue star was found to be effective in controlling the tongue for rapid open bite correction. As a result, new modifications were then implemented by the author to improve the first generation tongue star (TS1). The second generation TS2 was made in Italy, by SIA Orthodontic Manufacturer, in Italy as a four-piece unit including:

1) Bracket body with 9 rounded protrusions and 6 new, tie-wing

undercuts
2) Braze (for flexibility) to
3) Bonding pad
4) Separate 80-guage mesh for greater shear resistance and bond strength

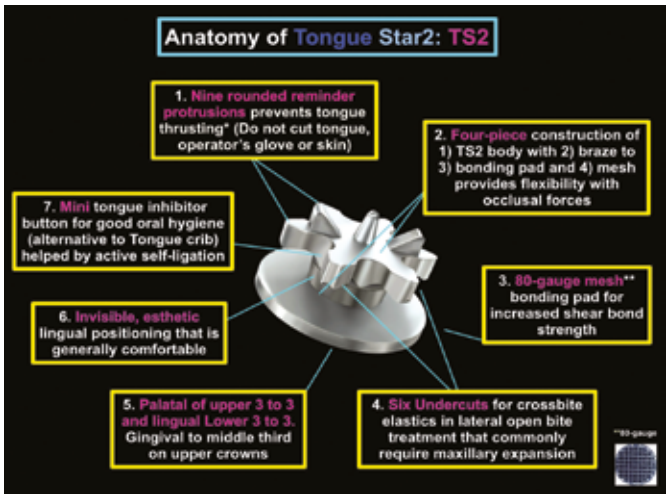


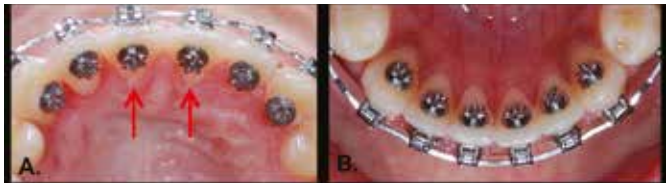
Fig. 1 Anatomy of TS2: The seven characteristic features of the second generation tongue star 2 (TS2) are shown.

The separate application of 80-gauge bonding mesh is used to improve bond strength during shearing forces on the lingual. TS2s are miniaturized in size similar to bondable buttons to be comfortable for patients and to facilitate oral hygiene. In addition, tie-wing like undercuts are designed into 6 of the 9 protrusions to secure the placement of crossbite elastics. This is required commonly in lateral open bite treatment that is associated with severe skeletal maxillary constriction (Figs. 2A,B).

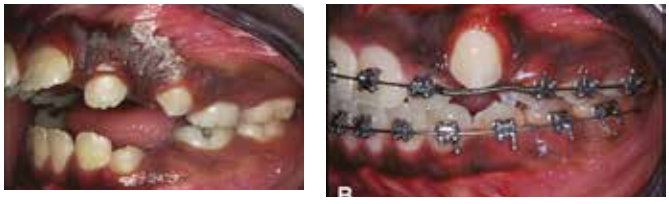
Where to Place Tongue Stars 2?
Clinically,TS2s are bonded on the middle-third regions of the upper and lower canine-to-canine regions (Figs. 3A,B). The TS2 position recommended for the upper anteriors is just gingival to the middle third to prepare for the corrected upper incisors to approach contact with the lower incisors during rapid open bite closure. This provides a total of 12 TS2s on the day of first bonding of a full Siamese twin, active self-ligating appliance recommended with new .018" X .014" NiTi, iArch wires (SIA Orthodontic Manufacturer). In addition, for each open bite treatment, TS2s are applied in conjunction with anterior box elastics (1/4", 4.5 oz. see below Fig. 6B) from the labial aspects of the upper lateral incisors to the lower canines to facilitate a rapid open bite closure (Figs 4A,B). This completes a System composed of four-components for rapid open bite closure.

Why Apply Tongue Stars 2? *Results*
Normal swallowing takes place approximately 600 times/day or more (including during chewing and speaking) the tongue is generally positioned in the palate. However, in anterior open bites the tongue fills the open bite space through anterior tongue

Figs 2A, B. Lateral open bites commonly associated with skeletal maxillary constriction frequently have an ENT etiology, producing secondary mouthbreathing and a chronic imbalance between a lower tongue position and buccinator muscle activity (facial muscles).



Figs 3A, B. The recommended positions of the tongues stars are mildly more gingival for the upper incisors in 3A.



Figs 4A,B. Tongue Stars 2 with anterior box elastic, and active self-ligating brackets shown, and found to be a highly effective and efficient system for rapid open bite correction (ROC) of severe skeletal anterior and lateral open bites.

positioning (previously referred to as tongue thrusting). TS2s are applied for both Rapid Open Bite Closure (ROC) and for Rapid Lateral Open Bite Closure (Figs 4A,B). They are used in conjunction with active self-ligating appliances due to the low resistance shown in vitro to permit free and controlled movement of the upper and lower anteriors. Once the incisors begin to develop a positive overbite relationship the tongue generally begins to retract posteriorly into a more natural tongue position assuming the etiology of the open bite has been additionally controlled (for example nasal obstruction).

When to Place Tongue Stars 2?
TS2s are recommended at all ages including for both early interceptive treatment in children (Figs. 5A-F) and in adults. The ideal recommended time of placement is at the time of placement of active self-ligating brackets (that are regularly positioned on the labial aspects). TS2s and active self-ligating brackets work ideally and synergistically with specialized iArch wires that have a higher vertical dimension than horizontal dimension (for example .018 X .014") to be closer to the center of resistance for earlier incisor moments of torque and control required for open bite correction. The archwires incorporate curve of Spee for the lower arches and reverse compensating curve on the upper arches to further facilitate incisor re-intrusion. TS2 incisor re-extrusion is further facilitated by the alignment of the anterior teeth, where a labial box elastic can be placed that also restrains the tongue

Figs 5A,B. A 9-year old girl demonstrates that the anterior tongue positioning is additionally directed inferiorly resulting in the proclination of the lower incisors. This indicates that need for the TS2s to be placed in the lower arch.
Fig. 5C,D. The radiographs reveal that anterior tongue positioning (C) is often associated with nasal obstruction related to enlarged and chronically inflamed turbinate's (D), secondary mouthbreathing, and molar over-eruption.
Figs 5E,F. Lip harmony and balance are shown following rapid open bite closure using the four-component System of TS2s, anterior box elastics, active self-ligating brackets, and specialized archwires for torque control.

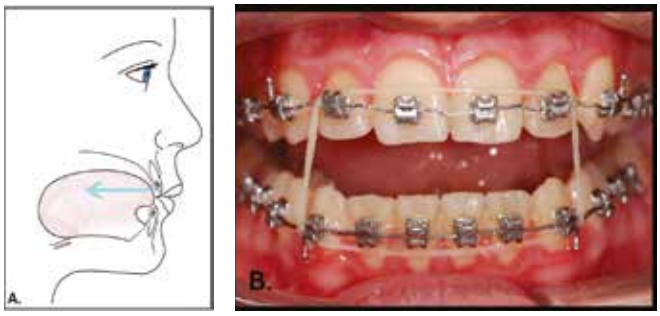


Fig 6A. The retraction reflex mechanism shown with TS2s.
Fig. 6B. Application of anterior box elastics and active SL.

(please see below Fig. 6B). No clinically significant root resorption was found with the use of this light force system that reduces the unnatural and multi-directional anterior, superior, inferior and lateral tongue forces.

How do Tongue Stars 2 work?

The basic mechanism of action is that the TS2s produces a negative conditioning reflex response for anterior tongue positioning.2 This is similar to a hot-stove effect (Fig. 6A). However, due to the rounded ends of the 9 protrusions the tongue is not lacerated, nor is the operator's glove or skin. The feeling against the finger is one of coarse sandpaper as simply a reminder for the tongue to stay retracted away from the open bite. This permits the TS2s to work effectively in conjunction with the anterior box elastics (5/16", 4.5oz) for rapid open bite closure (ROC) shown in Fig. 6B. In lateral open bite patients where the TS2s are placed at the premolars and molars crossbite elastics are applied, that are generally heavy 1/4", 4.5oz, to further prevent lateral tongue positioning while maxillary expansion is completed simultaneously. In addition, it is important that the patient is instructed to exercise swallowing with the tongue in the roof of the mouth from the day of TS2 placement.

Special Procedures with TS2s and Over-correction of open bites

As anterior open bites are corrected it is important to observe the gingival protrusions of the TS2s for the possible need of reduction with a high-speed to prevent dental interferences. The objective is to over-correct the open bite to be greater than 30% overbite for long-term retention. The reason is that open bites are often associated with patients growing with the mandible in a downward and backward direction. It is additionally recommended that upper and lower brackets from canine-to-canine be bonded 1mm toward the gingival than the customary average height positions to facilitate open bite closure. This is particularly important at the upper lateral incisors that are the smallest of the incisor teeth and affected most by the unnatural, anterior tongue positioning forces.

Conclusions: Advantages of Tongue Stars 2 Applications

A System of 4 components was developed and tested to produce rapid open bite closure. This included the use of new tongue stars, anterior box elastics with active self-ligating brackets with new iArches to provide freedom of movement of the system including the upper and lower archwires with its proven low resistance, in vitro. The summary is:

1) Metal TS2s are highly effective and efficient chairside for rapid open bite closure (ROC)
2) Efficiency is gained by ready-made, bondable TS2s, that do not wear, are miniaturized for patient comfort and facilitate oral hygiene
1) TS2s are placed on all 12 anterior dental units from the upper canine to canine, and lower canine-to canine
since the tongue was observed and found to be positioned anteriorly, superiorly and inferiorly.

TS2 are applied in conjunction with anterior box elastics (5/16", 4.5oz) and ideally with new, low profile active self-ligating brackets with NiTi clips for light, continuous forces for the periodontal membrane, completely frost-coated for esthetics, and with progressively lower forces from molars to incisors. Active self-ligating brackets make use of reduced resistance found in vitro and active seating of iArch wires for earlier moments of torque that are closer to the center of resistance of the incisors to improve control (future publication).

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Dr. John C. Voudouris maintains teaching positions at the University of Toronto, as Associate in Orthodontics, Discipline of Orthodontics for 31 years teaching functional appliances, and at New York University, as Visiting Scholar, Division of Biological Sciences for 18 years, teaching Active self-ligation. He is a full member of the Edward H. Angle East Society, and the recipient of the prestigious American Association of Orthodontist's Milo Hellman Research Award for condylar growth modifications and glenoid fossa remodeling with Herbst appliances applying electromyographic, cephalometric, and histological investigations

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Activabone®

Second generation bone pastes and the "C" factor. Interview with Mauro Fiorini, R&D Director at Bioteck SpA.

Bone deficit, whether it is caused by trauma, pathology or degeneration, significantly reduces the quality of life of those affected by it. Its correct treatment, based on the most modern techniques of Regenerative Medicine associated with biomaterials and latest generation medical devices, represents the therapeutic approach that is most capable of guaranteeing the repair of lesioned bone tissue or the regeneration of missing tissue, not only restoring the structure, but also favoring full functional recovery. Nowadays the market demands increasingly higher performing bone grafts, for both practical as well as biological and biomechanical use, without losing sight of their economic competitiveness, in a period of close attention to cost and a significant decline in resources also in the healthcare sector.
Dr. Mauro Fiorini, R&D Director at Bioteck SpA, as the invited speaker at the recent World Biomaterials Congress 2016, held in Montreal (Canada) last May, to an audience of international surgeons and researchers, presented Exur-Teck®, the new Bioteck-patented technological platform, at the basis of the innovative line of Activabone® bone substitutes, focusing mainly on the chemical-physical, biochemical and biological characterization.

Here, in the form of an interview, are the highlights of the presentation, to learn more about the properties of the new Activabone® bone pastes.

Dr. Fiorini, what are the characteristics of the ideal bone substitute?
Based on their origin, bone substitutes can be classified as homologous, heterologous and synthetic. Ideally, a bone substitute should have the structural characteristics and biological properties to guarantee full clinical success. Biologically it should recruit cells and bone precursors (for example mesenchymal stem cells and osteoblasts), and provide a bioactive effect on the neo-osteogenesis process (osteopromotion). The three-dimensional structure should act as scaffolding for adhesion and penetration inside cells and blood vessels and the deposition of new bone matrix (osteoconduction), to then be completely remodeled into new vital patient tissue. The most highly performing bone substitutes include bone pastes, which are now broadly used as they are practical to manage, they adapt easily to the implant site and can count on osseointegration kinetics and accelerated remodeling.

Let us take a look at the benefits for the operator. Over the last years you have worked intensely on improving the rheological properties of bone pastes. With what results?
We have worked intensely on this, with considerable investments and great efforts made by the entire company. Bone pastes represent a highly valid alternative to traditional bone grafts, however the carriers often feature rheological properties that are unsuited to assuring good bone paste handling or withstanding leaching during grafting in a bloody environment. This is why we have developed Activabone®, a line of second generation heterologous bone pastes, featuring extraordinary balance between rheological and biological properties for use in Orthopedics, Neurosurgery and Oro-Maxillo-Facial surgery. Activabone® is created through the association of Exur® - medical-grade polymeric hydrogel (hydrogel) developed and patented by Bioteck R&D - with DBM, equine origin bone granules or chips. The innovative Exur-Teck® technology makes it possible to produce composite biomaterials with variable textures, malleability and rheological properties (specifically, injectable, malleable, moldable and pre-shaped bone pastes), by virtue of the adjustable visco-elasticity of the gelified component.
The innovative hydrogel has the specific function of creating

bone substitutes with a formula that provides the end user with easier manageability and application than the traditional and more commonly used form (powder, granules, chips) of the equine corpuscular component.

How is it possible to vary and optimize the viscosity of these bone pastes? Can you explain what the "C" factor is?
The inherent innovation of this new technology consists in adding to the polymers a specific amount of a molecule with a visco-modulating function, Ascorbic Acid (AA, Vitamin C), for the purpose of obtaining a hydrogel of the required density and viscosity, exploiting its capacity to modulate cross-linking of the polymer chains during Beta-ray sterilization of the bone pastes that it is mixed in.

What are the operative and clinical advantages?
By suitably modifying the dose of AA, it is possible to obtain extremely versatile and functional sterile ready-to-use bone substitutes, having specific controlled biological, bio-mechanical properties, texture, malleability and adhesiveness, so as to adapt perfectly to the specific geometry of the bone defects of any dimension or shape, as well as with the ability to be shaped extemporaneously in the operating room with the aid of a scalpel or scissors.

Does the use of this innovative hydrogel pose any restrictions of use?
No, quite the opposite: it provides the Bioteck materials with access to multiple fields of application, at the same time offering new opportunities for surgeons and especially for patients. With this technology it is possible to obtain extremely fluid or dense injectable bone pastes, depending on the specific indications for use: or also malleable pastes, or in the form of "crunch", that can also retain and incorporate very structured granules and chips, so as to respond to the most diverse surgical needs.

Lastly, a reflection on Bioteck research in relation to the broader Italian panorama.
«We invest in activities aimed at optimization, development and brand new research. And we invest heavily, more than 10% of our turnover. This has provided us with visibility, not only nationally, but internationally as well, as we export our products to approximately 60 countries around the world. Doing research from scratch also means not availing of any public funding , primarily from the Community, considering that the EU is, on the other hand, more interested in research projects that already possess good sales visibility».

Cutting-edge solutions for regenerative medicine
Bioteck devices are used in orthopedics, dentistry, maxillofacial surgery and in neurosurgery.
In dentistry and maxillofacial surgery, Bioteck devices are used in all guided bone regeneration procedures such as horizontal and vertical bone augmentation, maxillary sinus lift, preservation of alveolar pocket, peri-implant regeneration procedures and the correction of periodontal defects.
They also allow the surgeon to rebuild aesthetic profiles, correct anatomical defects and position dental implants and correct gingival defects in complete safety and with the certainty of excellent results.
It is most commonly used in orthopedics to resolve cases of substance loss (periprosthetic deficit, pseudoarthrosis, etc.) but also in reconstruction, arthrodesis and in specific applications such as, for example, femoral and tibial osteotomies in addition and distal realignments of the patellar ligament.
On top of these we also have guided tissue repair with membranes and pastes. Application in neurosurgery is, on the other hand, localized to the skull where they are used as tissue replacements (reinforcement or coverage of dural grafts) or in cases of bone substance loss (closing cranium holes) and on the spine for interbody fusion procedures.

Communicating innovation: the Bioteck Academy
The ideal allocation of Bioteck research is at the Bioteck Academy, the natural location of aggregation where all of the top resources contribute to the company's development on a daily basis. Fostering the circulation and dissemination of knowledge on tissue regeneration, applied in the fields of dentistry, maxillofacial surgery, orthopedics and neurosurgery.
Thanks to interaction with Italian and foreign university researchers and the collaboration of top clinics, the Bioteck Academy has developed a culture of sharing scientific knowledge aimed at the dissemination of the best techniques and practices in the various areas of regenerative surgery.
bioteckacademy.com offers doctors and researchers with an access portal that provides a privileged view of the evolving world of regenerative medicine, including a constantly updated bibliography, downloadable scientific articles and many case studies of talented colleagues.

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• RealGUIDE™ PRO: 3D diagnosis and implants planning
• RealGUIDE™ DESIGN: surgical guides modelling, teeth and bone segmentation revolutionary tools, bone regeneration functions
• RealGUIDE™ APP: easily view, plan, share and manage the digital treatment with the tip of the fingers, thanks to the beautiful and simple APP design

The new RealGUIDE software suite involves, through the cloud, all the figures in the digital dentistry world: the radiologist can perform a full diagnosis (also thanks to the new **RealBODY™ 3D engine**) and prepare the exam for the dentist that can easily share it with his laboratory to integrate the prosthetic planning and optical scans to the project. Starting from the complete virtual patient (including bone, gums thickness and ideal teeth positions) the doctor can plan the implants on the tablet and share the project with other colleagues and the Patient as well. The final project can be sent back to the laboratory for the surgical guide modelling in the DESIGN module, as well as the provisional prosthesis modelling with any CAD/CAM system, thanks to the open project data exported in STL format from the 3DIEMME suite. The licensing system, mainly based on a subscription service model, is innovative and totally suited to the customers needs, giving the chance to everybody to enter the digital dentistry world without huge software investments.

Main functions of the RealGUIDE™ APP:
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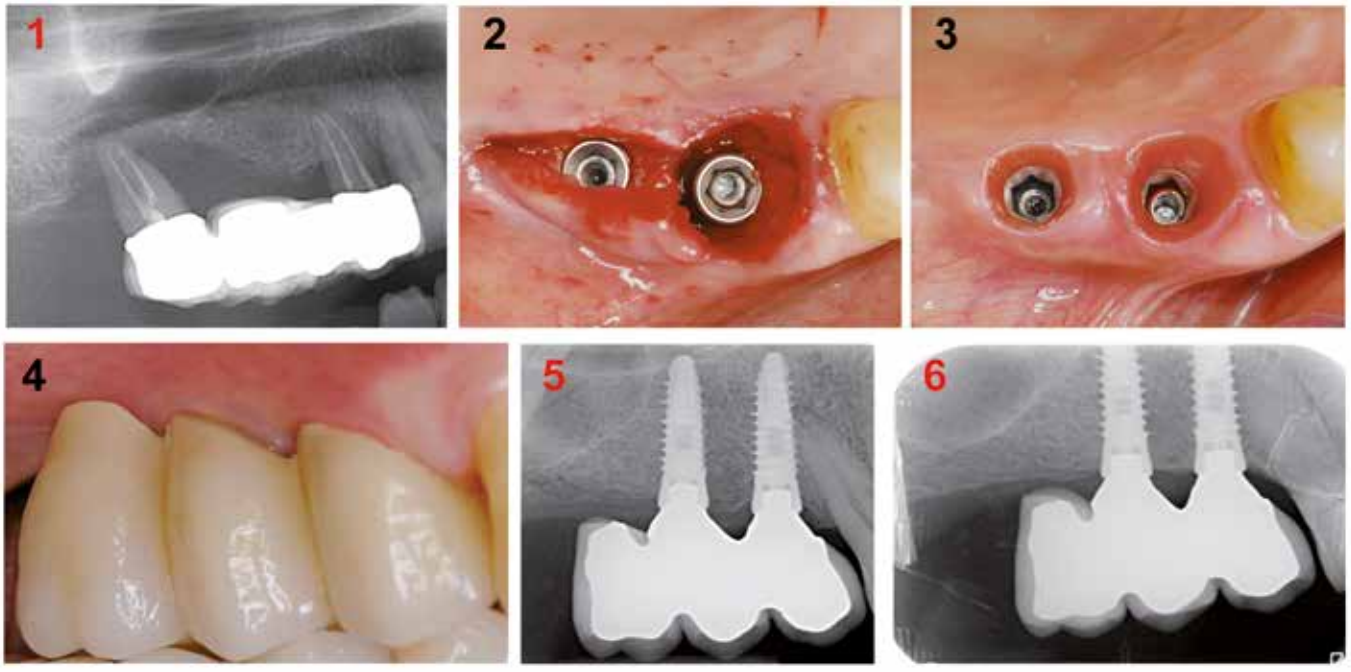
Study about aesthetical and functional predictable implantology in the daily practice: two implants with immediate loading protocol, one of which on post-extractive site. Retrospective at 7 years.

The purpose of this study is to evaluate the prognosis of a rehabilitation with fixed prosthesis, supported by two implants, one post-extraction and the one not, with immediate loading protocol [6] in terms of aesthetical and functional predictable implantology. [7]
Another goal is to see if, by simplifying therapy and shortening treatment time, you can get a long-term success.
The post-estraction implant placement and provisionalization is a daily routine challenge for every dentist. Many authors claim that the best solution is probably the delayed implant placement [2], while others recommend exactly the opposite.
The solution lives in an accurate examination of the tooth site that needs to be extracted.
If the initial anatomic conditions are favorable, the differences between the two methods are minimal, but, by an esthetic point of view, the immediate implant placement and prosthesis is the optimal choice. In this way the interpapillary and alveolar-gingival fibers preserve the interproximal bone level, when the interdental peri-implant tissues are provided with an immediate provisional prosthesis. The goal is to show that, with the proper use of the implant protocols and guidelines, it is possible to arrive at an aesthetic and functional implantation.[6][7]
The analyzed case shows all the optimal parameters for an immediate treatment, then the probability to obtain an ideal esthetic is high.

Introduction and presentation of the case.
Female patient, aged 60 years, in good health and with a history of periodontitis [1]. The clinical examination, OPT (Figure 1) in 2010 and the periodontal screening, allows to make a diagnosis of "advanced periodontal disease" as regards the elements 14 and 16. Both elements of the bridge, show a grade 3 mobility. The element 16 also has a vertical mobility. After a precise and targeted dialogue with the patient about his expectations, in agreement, we decide to perform a treatment plan restricted to the first quadrant, proceeding with the extraction of both elements, not curable, and adopting the technique of immediate loading. The element 14 shows the following screening: 335 vestibularly and 533 palatine. The tooth is extracted during the planned therapy and after a careful dissection of the periodontal fibers. Adopting the technique of immediate loading it becomes necessary to use root-form fixtures with an optimal stability[3], with "platform switching" principles and able to gradually compact bone, according to the clinical needs. In this respect was chosen an implant to be able to ensure that primary stability both in the post-estractive site (implant 14) and not (implant 15).[4]
The fixtures chosen are two implants with internal hexagon connection, measuring 4mm in diameter and 13mm in length (Figure 5). (BIOCOIN by IDENT srl - Italy)
The selected implant morphology shows an wide thread along the implant body and microthreads on collar that engage at the level of the cortical bone.
Considering the poor quality of bone in the posterior region of the maxilla, the implant site in position 15 was undersized, so taking advantage by the shape of fixtures that enables gradual condensation of bone and guarantees high primary and secondary stability also the presence of compromised bone.
It is relevant notice that the self-tapping feature of implant system used allows an easy insertion of fixtures, ensuring a com-



plete contact between the implant surface and the bone and creating an effective osteo-connection, first step of a correct osteo-integration.
After surgery, it was taken the impression copy. In lab are two armed provisional prepared and screwed [5]. After 6 hours it provides to load the implants.
The standard internal hexagon connection (Figure 2) grants a sealed and stable connection, easing the housing of the fixing cylinders of provisional elements.
After 4 months the implants are correctly osteointegrated and the peri-implant tissues are stable and mature (Figure 4). We decide to finalise the case, using a mono-fusion technique, of which fitting and passivation are been controlled (Figure 5). It runs a rough ceramics test to verify the occlusion and hygienic maintainance of the prosthesis, prior to delivery. It performs intraoral radiography control. Between screwed or cemented prosthesis it decide for that screwed [5], so as to be more easy, in case of need, a reoperation on the prosthesis (Figure 4).
Follow up after 7 years, in February 2017. The bone level on the implant collar is intact. No sign of distress. The surgery was monitored by X-ray (Figure 6) in 2017 and today it notices an excellent maintenance of bone level with thick and keratinazed soft tissue, evidence that the "platform switch" system and the smooth top collar of fixtures (only machined), interfacing with the soft tissue, allow a minimal bone resorption, so granting a marginal hard and soft tissue stability (Figure 6).

Conclusion

Key factors for an aesthetical and functional predictable implantology, in the daily routine, are:

– a careful choice of the case and an accurate dialogue with the patient about his expectations and the possible implantologic solutions,
– if necessary, a treatment plan for any periodontal disease, or problems about soft tissues and bone,
– a proper implant-prosthetic project and the choice of type of load,
– the evaluation of an adequate implant morphology, with "platform switch" principles, a good stability, an easy positioning together with the possibility of a gradual bone compacting,
– a good operator experience with a proper practice and professional and educational background,
– observe the surgical protocols and guidelines, as described in the literature.

In conclusion analyzing the clinical case in all the parameters discussed above, with the proper use of the implant protocols and guidelines, already reported in the literature and if appropriate for an immediate loading treatment, the probability to obtain an ideal aesthetic and functional is high and predictable.

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Medical aesthetics

Facial wrinkle treatment in dental practices with plasma gel

Aesthetics - a business, gaining more and more importance in peoples' daily life and society. It is therefore not surprising that even dentistry practices have to take account of this demand. In order to remain competitive, it is not only of great importance to be able to offer individual treatment concepts and a modern practice equipped with the latest technology. Decisive factors for success are additional services in the field of holistic aesthetics. Nowadays, dermal fillers are frequently demanded by clients.

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The production of plasma gel is carried out by medical staff, who after taking the blood, processes it into gel.

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The effect

As a training institute we have tested various systems at home and abroad. Meanwhile, we use a worldwide recognized user protocol for the manufacturing of plasma gel. Therefore we have shifted our focus from the PRP (platelet-rich plasma) to the concentrated growth factors (CGF) (Massimo et al/2006). Unlike with other protocols, here specifically thrombocytes and CD34+ stem cells are taken, which later are added to the plasma gel. The effect is caused by the thrombocytes: As soon as the biphasic platelets get activated by thrombin, they release growth factors which are significant for cellular proliferation and collagen synthesis (Rodella et al/2011).
The injection of plasma gel affects the skin in two ways: an instant effect due to the addition of the filler - as well as rejuvenating the skin (Dong et al/1995).

The production

Specific centrifuge tubes, made of borosilicate glass manufactured by the company Silfradent, deliver high-quality results and do without citrate as an anticoagulant. Studies have clearly proven the increased yield of growth factors with the use of sodium heparin ((G Valacchi and V Bocci/1999).
The first step is to centrifuge the tubes filled with the blood. The latest technology in this field is the MEDIFUGE MF 200, offered by the company Silfradent. By centrifuging at different times and speeds, particles of various sizes can be separated. This technique is called differential centrifugation and differs from conventional methods. In the next step, parts of the plasma are transformed into a filler gel. For this process we use a device for denaturation (A.P.A.G.) by the brand Silfradent. The preset programs simplify the usage. Furthermore it is built with anti-static and anti-magnetic materials.

The injections

A vital factor for a visual skin aging is the facial volume loss, reduction of fat tissue and muscles. With a deflated support system, skin starts to sag. Modern wrinkle treatments no longer only inject single wrinkles - a three-dimensionale recontouring of the face ensures an optical balance. Anatomists have defined so-called "sweet spots": facial areas, when being injected, have the greatest impact. Injections in deep compartments prevent a migration of the plasma gel in surrounding tissues and a lifting effect occurs, while blunt cannulas are used superficial to volumize.

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The software features a range of modules designed to fit specific needs: the implant module for the design of abutments, the virtual verticulator for check of dynamic occlusion, the bars module for the design of simple and advanced bars, and the provisional module for temporary crowns and bridges.

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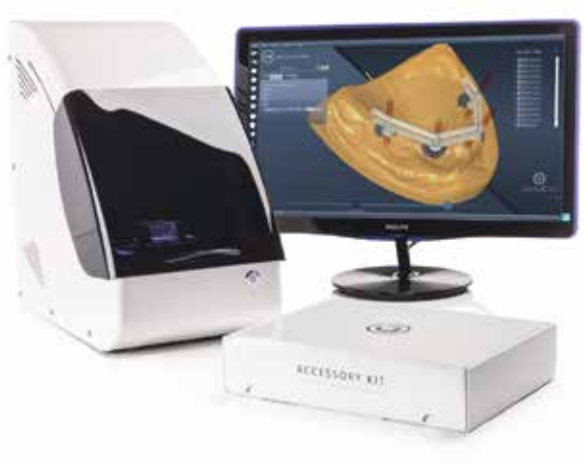

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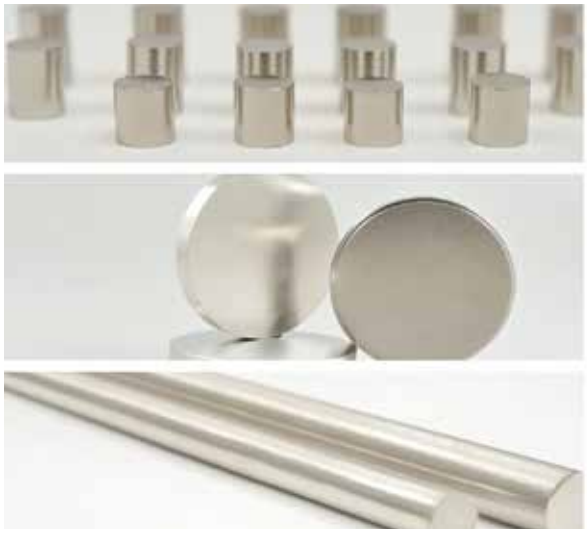

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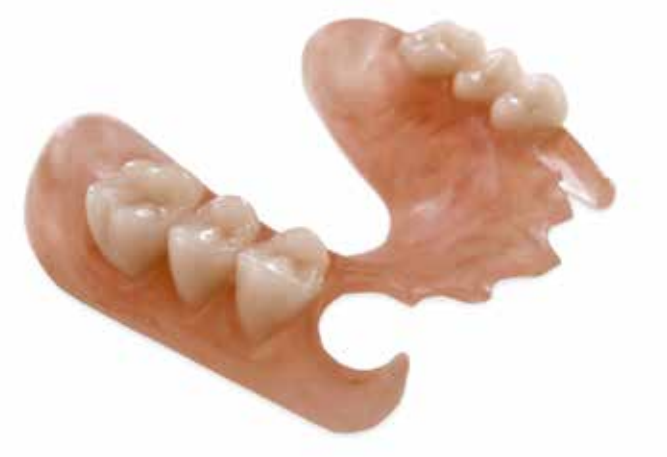

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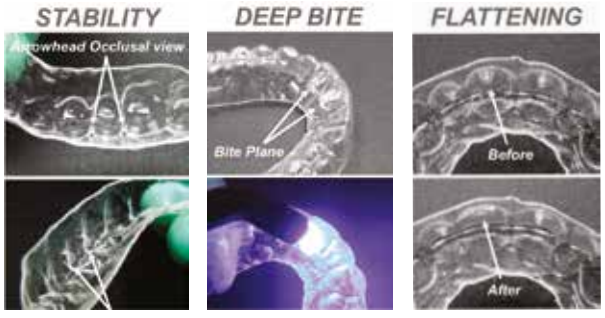
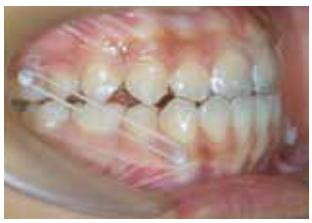
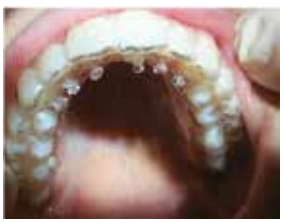




ELASTIC TRACTIONS of 2nd and 3rd classes



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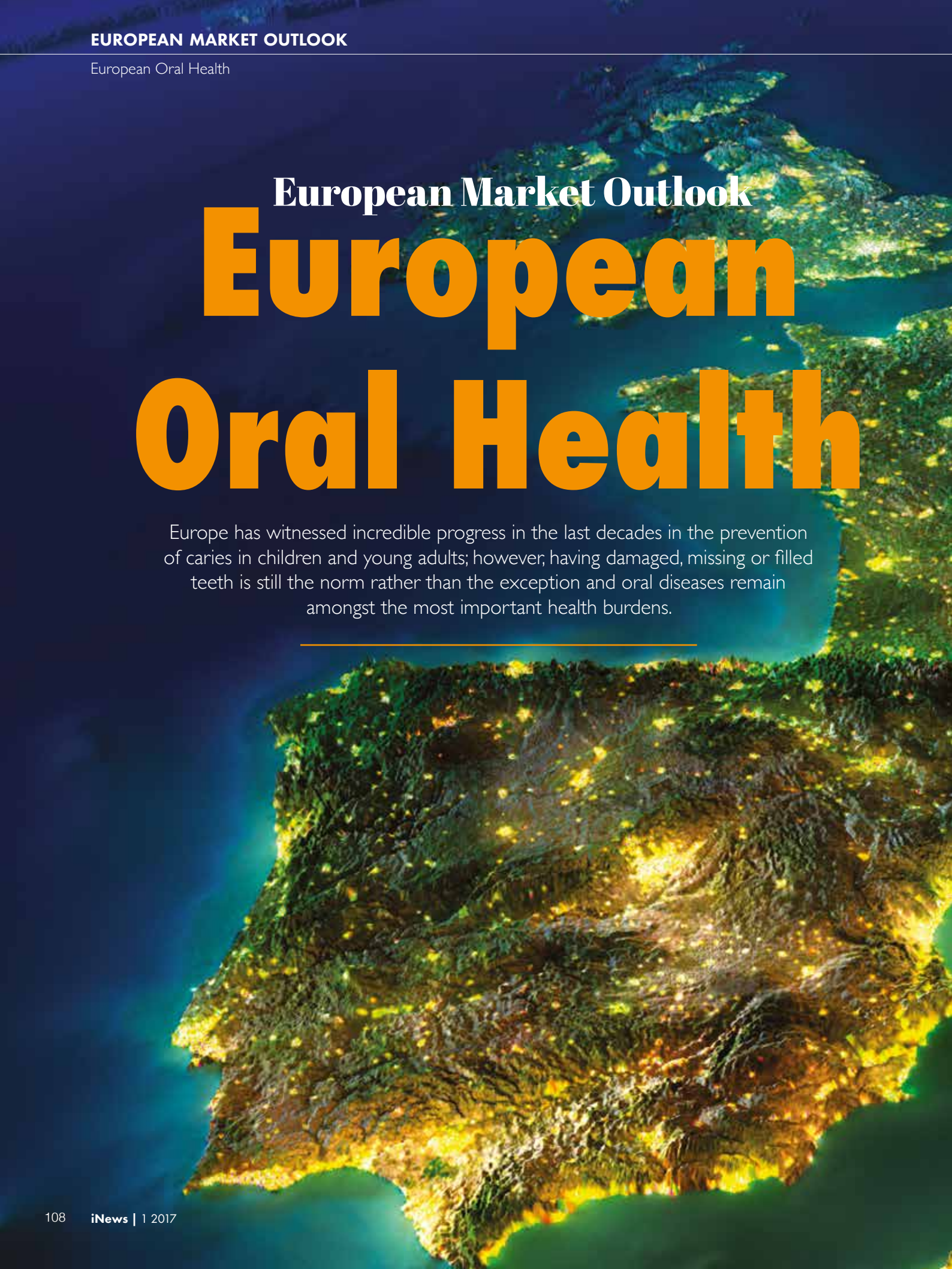
European Market Outlook

European Oral Health

Europe has witnessed incredible progress in the last decades in the prevention of caries in children and young adults; however, having damaged, missing or filled teeth is still the norm rather than the exception and oral diseases remain amongst the most important health burdens.



In fact, Europe still fails to realize that oral health is about much more than having good teeth. It is an integral part of general health, and it impacts not only on quality of life but also on society and health systems through the associated economic costs.

As the WHO has noted, oral diseases have several risk factors in common with the four main categories of chronic diseases (cardiovascular diseases, cancers, chronic respiratory diseases and diabetes), including poor nutrition, smoking and alcohol abuse. Inadequate oral hygiene is also a risk factor.

Nevertheless, there is a distinct lack of policy emphasis placed on oral diseases' prevention and oral health promotion within Europe. This is compounded by the lack of routinely available and comparable epidemiological and economic data which describe the current situation in Europe. Robust data would be of supreme importance in the planning, implementation and evaluation of community preventive activities and oral health promotion; **as a result, there are thus challenges in indentifying best-practice initiatives and allocating resources to where they are most needed.**

The economic cost of traditional curative dental care is substantial for many high-income countries, in which 5 to 10% of public health spending is devoted to oral health. That is why it is important to promote awareness raising campaigns and ensure that citizens in Europe and throughout the world adopt a preventative approach, indispensable for their health.

Europe still fails to realize that oral health is about much more than having good teeth.

Although, overall, the oral health of Europeans is satisfactory, there are still categories of the population that are at risk; thus prevention and the dental care system seem unsatisfactory. **Member States should make an effort in reducing the impact on public health of morbidity and incapacity for work related to oral diseases.** To this end, several are the objectives:

• to improve the performance of health systems through better organization;
• to improve the quality of health information by facilitating cooperation between Member States;
• to promote the development of relevant medico-social policies, with priority being given to reducing inequalities in the area of healthcare;
• To further integrate oral health into national or community health programs.

Access to oral healthcare services remains a major public health burden among vulnerable and low income groups and oral health inequalities are increasing across Member States in terms of access to appropriate oral care; as low-income populations most in need of dental care face higher hurdles compared to high-income groups. Over half of the EU Member States do not place policy emphasis on reducing health inequalities; **inequalities such as age, gender, socio-economic and education level.** A far lower percentage of the population appear to attend the dentist in socially and economically less well developed EU Member States, where there is little or no publically funded dentistry, than in those which provide publically subsidized oral healthcare. However, even in well developed EU Member States, socio-economic inequalities, as well as inequalities in age and education level, still persist.

There are scarce best practice principals in prevention and oral health promotion; as such the need to define and encourage good practice sharing among EU Member States. A more progressive health promotion approach that recognizes the importance of tackling the underlying social, political and environmental determinants of oral health is required.

On this regard, limited and fragmented data and knowledge base is a main issue. Lack of routinely available and comparable EU oral health data (and public health data) and research knowledge poses an obstacle to assessing the current situation. Epidemiological data relating to tooth decay and periodontal diseases are particularly unreliable. The oral health needs of the most disadvantaged groups, such as individuals with special needs, institutionalized persons and the homeless, are not clearly identified. Across Europe, there is a lack of suitably trained advisors with the ability to develop oral health epidemiological studies and needs assessments and assist in oral health strategy and policy development.

Demographic change within Europe presents a formidable challenge for oral health, since decreasing loss of teeth within the elderly population is expected to increase treatment needs significantly in the coming years.

The State of Teeth in Europe

Dental Caries - there has been incredible progress in the last decades in the prevention of caries in children and young adults especially in Western Europe and some improvement in Eastern European Member States.

Despite a global decline, the disease still remains a problem for many groups of people in Eastern Europe, and for those from socio-economically deprived groups in all European Union Member States.

Current negative trends in periodontal health and oral cancer:

- Periodontal health - Epidemiologic data are of very poor quality, and are absent from several European Member States. **There is a perception that periodontal health may be deteriorating within the population of the EU. It has been suggested that**

over 50% of the European population may suffer from periodontitis and over 10% have severe disease. Prevalence increases up to 70-85% of the population aged 60-65 years of age. This is principally due to a larger number of people that are retaining some of their teeth in old age, and an increase in the prevalence of diabetes. Studies show that periodontal diseases are associated with individuals' income and socio-economic status.

- Oral cancer – is the eighth most common cancer worldwide. **In the EU, lip and oral cavity cancer is the 12th most common cancer in men.** Highest prevalence rates are found in Spain and Hungary. **Trends are now showing an increasing incidence in women, and young adults.** Mortality rates have continued to increase in several Eastern European Member States.

A survey published by Eurobarometer has revealed that **only a minority of Europeans still have all their natural teeth (41%) and while almost a third of those who have lost some of their natural teeth wear a removable denture, the vast majority of Europeans experience almost no difficulties or embarrassment concerning their teeth.** Nevertheless, beyond this European average, there are fairly marked differences between the Member States. The respondents stating that they still have all their natural teeth live mainly in the Scandinavian countries (Sweden, Denmark and Finland), in Ireland and in the countries in the extreme south-east of the European Union (Cyprus, Malta and Greece). While inhabitants of eastern European Union countries (Hungary, Estonia, Poland, Slovakia and Latvia) seem the most disadvantaged in this respect (only between 19% and 29% have all their natural teeth). Fairly logically, the youngest respondents have the most natural teeth, with 84% of those in the 15-24 age groups, compared only to 13% of respondents aged 55 or over. The most advantaged socio-economic categories (those who studied the longest, as well as students and managers and other employees) are also categories in which respondents are more likely to have all their natural teeth.

Europeans as whole visit a dentist regularly, since 57% last went to see a dentist (for their teeth, denture or gums) less than one year ago; only a minority (9%) last visited their dentist five or more years ago and 2% have never visited a dentist. The respondents the most likely to have visited a dentist during the past twelve months tend to be inhabitants of northern European Union countries: the Netherlands (83%), Denmark (78%), Germany and Luxembourg (77%), followed by Slovakia (73%) and Sweden (71%). It should be borne in mind that in some of these countries, it is compulsory for inhabitants to go to their dentist once a year or even every six months in order to continue to benefit from medical insurance cover for their teeth. On the other hand, the inhabitants of several countries in the east of the European Union are the least likely to have visited a dentist during the past year: Romania (34%), Hungary (35%), Latvia (41%), Poland (44%), Estonia and Bulgaria (45%), Lithuania (46%) and Greece (49%). It is also the case of Spain.

Moreover, 79% of them prefer to go to a dental practice or a private clinic if they need dental care, while 14% go to a clinic run by the city or government. The countries in which respondents traditionally opt for a dental practice or a private clinic include five of the six EU founding states: Germany (99%), Luxembourg (98%), the Netherlands and France (97%), followed by Belgium (94%). It is also the choice of the vast majority of respondents in Denmark (96%). On the other hand, only 31% of respondents in the United Kingdom, 46% in Finland, 50% in Hungary, 51% in Sweden and 60% in Poland chose that option. In these countries, citizens very often opt for a clinic managed by the city or government. These differences undoubtedly reflect specific national policies and how the healthcare systems are structured.

The countries in which respondents traditionally opt for a dental practice or a private clinic include five of the six EU founding states

The standard of living of the people interviewed does appear to have some influence on their choice: the most advantaged citizens, such as managers, as well as self-employed people and employees, are more likely than unemployed people, pensioners and house-persons to choose a dental practice or a private clinic.

Most Europeans seem to consult a dentist for preventative reasons and not for emergency treatment: 50% of the people interviewed say that the last time they visited a dentist was for a check-up, an examination or cleaning. A third went for routine treatment (33%) and only one in five went for emergency treatment (17%), mostly Cyprus, (45%), Bulgaria and Romania (40%) and Slovenia (33%).

The fact of belonging to a more advantaged social category also plays a role: the Europeans who studied the longest are the most likely to have visited a dentist for a check-up. Similarly, senior executives, students, employees and self-employed people are more likely to visit a dentist for a check-up than the other categories (unemployed people, pensioners, house-persons and manual workers).

Finally, a relative majority of Europeans consider that if they do not go to see a dentist it is mainly because they do not have serious dental problems. However, apart from this most frequently mentioned reason, respondents who say that they do not go to see a dentist mention the high costs of consulting a

dentist and dental treatment rather than problems of accessibility.
While men and women have a similar perception of the cost of visiting a dentist and dental treatment, the older the respondents are the more the cost of dental treatment seems to be a real obstacle to consulting a dentist. The least advantaged categories (unemployed people, manual workers, housepersons and pensioners) and those who studied the least are more likely to mention cost as their reason for not consulting a dentist. Logically, the same applies to the people who have difficulties in paying their bills 'most of the time' since they obviously have to make a choice.

What was the main reason you did not visit a dentist in the last two years?

- Your dental problem is not serious enough - 33%
- You have no teeth or you have false teeth - 16%
- It is too expensive - 15%
- You are afraid or you don't like dentists or dental hygienists - 10%
- You are too busy - 7%
- You don't want to spend money on dental care - 3%
- Dental office too far away - 1%
- Physical problems preventing you from going - 1%

Studies have shown how in some industrialized countries the mouth is the most expensive part of the body to treat.

In fact, the vast majority of Europeans (88%) consider that it would be possible for them to see a dentist when needed within a distance of 30 minutes from their home or place of work. Similarly, the availability of dental professionals does not seem to be an issue for Europeans since 89% of inhabitants of small and medium-sized towns declared that they could find a dentist within thirty minutes of their home or place of work; this confidence is shared by 87% of inhabitants of rural villages and large cities. These results suggest that territorial coverage in this area is equally satisfactory in both privileged areas and more disadvantaged areas. **In the same way, the vast majority of Europeans (92%) have access to a dentist in case of need.** Of course the most privileged people are the most likely to answer in the affirmative. Thus, 95% of senior executives and 94% of employees say that they have access to a dental practice in case of need, compared with 89% of unemployed people. The area where the respondent lives does not seem to be discriminating.

Economic Impact of Oral Diseases in Europe

Oral health-related costs are still on the rise despite the fact that oral diseases are highly preventable, remaining a major public health issue for high-income countries, where expenditure on treatment often exceeds that for other diseases, including cancer, heart disease, stroke and dementia. This is disturbing, given that much of the oral disease burden in high-income countries is due to dental caries and its complications and this is preventable through the use of fluoride and other cost-effective measures. There is strong evidence that the benefits of preventing tooth decay exceed the costs of treatment. For example, savings in dental expenditure have been demonstrated in Member States such as Denmark and Sweden, which have invested heavily in the provision of preventative oral health services, with a significant reduction in the prevalence of oral disease.

Furthermore, lack of economic and statistical data among the EU countries, the challenge in estimating the expenditure on the provision of oral healthcare as well as in quantifying out-of pocket and indirect costs lead to an underestimation of the true costs of oral healthcare provision, thus limiting the ability to assess the impact of existing public health measures and invest in the most effective initiatives:

- Studies have shown how in some industrialized countries the mouth is the most expensive part of the body to treat. In 2015, the EU spent around 84 billion Euro on oral health and if trends continue, this figure could be as high as Euro 93 billion in 2020.

- Delivering oral health services is costly, accounting for 5% of total health expenditure and 16% of private health expenditure across OECD countries (average estimates, varying year by year).

-Out-of-pocket expenditure is an important, and often underestimated, aspect of oral healthcare delivery, varying according to the structure of the oral healthcare system within the different EU Member States. There may be a significant impact on low income groups especially in Member States where oral health services are mainly provided by private practitioners such as Spain, where patients usually pay the total cost, creating access problems for low-income groups. In Denmark, oral healthcare is free of charge for all children under the age of eighteen and adults pay for treatment from private dental practitioners through a system of government subsidies. In Member States such as France and Germany, prevention and treatment are covered within the basic package of public health insurance, but a share of the cost is borne by patients.

-High indirect costs arise from the social burdens of poor oral health and its interaction with systemic diseases and conditions including diabetes, heart and circulatory diseases and the effects of poly-pharmacy on oral health and vice-versa.

-Dental Industry – The total sales value over all dental products, consumables and equipment within Europe (except Sweden, Hungary, Denmark and Bulgaria) reached a total value of around 6.501 million Euros in 2015, showing a small but constant growth since 2010. Among the leaders in the dental industry market are Germany, Italy, France and Great Britain.

Country	% of GNP spent on Oral Health in 2010**	Spend on oral healthcare services (Billion Euro)			
		2010	2012	2015	2020
Austria	0,52	1,60	1,67	1,77	1,95
Belgium	0,5	1,95	2,03	2,15	2,38
Bulgaria	0,18	0,07	0,07	0,07	0,08
Cyprus	0,3	0,06	0,06	0,06	0,07
C. Repub.	0,3	0,44	0,46	0,48	0,53
Denmark	0,33	0,86	0,89	0,95	1,05
Estonia	0,39	0,06	0,06	0,06	0,07
Finland	0.4	0,79	0,82	0,87	0,96
France	0,45	9,58	9,96	10,57	11,67
Germany	0,8	21,28	22,70	24,09	26,60
Greece	1,1	2,63	2,74	2,91	3,21
Hungary	0,16	0,16	0,17	0,18	0,19
Ireland	0,6	0,84	0,87	0,92	1,02
Italy	0,82	13,73	14,28	15,16	16,74
Latvia	0,24	0,05	0,05	0,05	0,06
Lithuania	0,19	0,06	0,06	0,06	0,07
Luxembourg	0,29	0,09	0,09	0,10	0,11
Malta	0,4	0,03	0,03	0,03	0,03
Netherlands	0,5	3,16	3,28	3,48	3,85
Poland	0,2	0,74	0,77	0,81	0,90
Portugal	0,4	0,72	0,75	0,80	0,88
Romania	0,18	0,23	0,24	0,26	0,28
Slovak Rep.	0,15	0,11	0,11	0,12	0,13
Slovenia	0,36	0,14	0,14	0,15	0,16
Spain	0,4	4,54	4,72	5,01	5,53
Sweden	0,68	2,59	2,70	2,86	3,16
UK	0,5	9,27	9,65	10,24	11,31
TOTAL (billion)		**Euro 76**	**Euro 79**	**Euro 84**	**Euro 93**

Notes and explanation

** % GNP spent on the provision of oral healthcare services in 2010 (unpublished CECDO data 2012). The % GNP estimates for several former Eastern Bloc Member States may not include private expenditure. Data for Spain, the Czech Republic and Bulgaria are estimates.

A predicted annual 2% increase in expenditure on oral health was utilized to calculate predicted expenditures up to 2020.

It is important to note that these figures are estimates, as it is extremely difficult to collect data for Member States in which there is very little public or insurance funding of oral health. *Source: http://www.oralhealthplatform.eu/wp-content/uploads/2015/09/Report-the-State-of-Oral-Health-in-Europe.pdf*

Workforce in the European Union (EU)/European Economic Area (EEA)

The EU has a surface area of 4 413 844 km², 505 701 172 inhabitants *(January 2013, provisional)* and 24 official languages. The EEA is the area in which the Agreement on the EEA provides for the free movement of persons, goods, services and capital within the European Single Market. The EEA agreement specifies that membership is open to member states of either the European Union (EU) or European Free Trade Association (EFTA).

The EU Member States (28) are as follows:

Austria (AT)	(FR) Lithuania (LT)	Spain (ES) Czech Republic (CZ)
Estonia (EE)	Slovakia (SK)	Hungary (HU)
Italy (IT)	Croatia (HR)	Netherlands (NL)
Portugal (PT)	Germany (DE)	Sweden (SE)
Belgium (BE)	Luxembourg (LU)	Denmark (DK)
Finland (FI)	Slovenia (SI)	Ireland (IE)
Latvia (LV)	Cyprus (CY)	Poland (PL)
Romania (RO)	Greece (EL)	United Kingdom* (UK)
Bulgaria (BG)	Malta (MT)	
France		

**EU member, voted in a 2016 referendum to leave the Eu (at a date to be determined). The future status of UK inclusion in the EEA remains unclear.*

Total dental workforce recorded - 1.12 million workers. Adding the workers not recorded, such as cleaners, managers and those working in the dental trade, it is more than likely that over 1.50 million people directly derive their employment from dentistry.

Number of registered dentists	**442,027**
Number of active* dentists	**between 345,000 - 360,000** *(estimated)*
Number of auxiliaries	**681,850**
Workforce total	**1,123,877**

**The difference between the number of registered dentists in a country and the "active dentists" should represent those dentists who are retired or no longer undertake any form of dentistry including administrative dentistry. Some countries are unable to assess how many of these dentists are "active", so accurate figures for the number of such dentists are difficult to assess.*

Dentists - Despite the continued increase in the numbers across the EU, the geographical distribution remains uneven, with people in rural areas often having large distances to travel to the nearest dental practice.

Dental Hygienists - 33,000 (estimates) - present in most countries. There are varying rules within the different countries relating to the degree of supervision and duties of hygienists. Many countries allow their hygienists to diagnose and treatment plan.

Dental Technicians - 150,000 (estimates) - recognized in all countries. They normally provide services only to dentists, although in most countries they are permitted to repair dental appliances directly for patients, provided they do not take impressions or otherwise work in the mouth. Dental laboratories amount to over 50,000.

Clinical Dental Technicians/Denturists - only in 5 countries (Denmark, Finland, the Netherlands, the UK and Switzerland in some cantons) they are allowed to provide oral health services – specifically full (complete) or partial dentures - directly to the public. This means that they are trained to work inside the mouths of patients.

Dental Assistants - 400,000 (estimates) - the development is not as great in some countries (Belgium, Greece and Portugal) where most dentists work without the help of another person at the chair-side, and Cyprus, France, Lithuania and Poland less than half of dentists work with such help.
Dental Therapists - provide limited clinical conservation and exodontia services. They are recognized in few countries (Sweden, Switzerland and the United Kingdom) and Orthodontic Auxiliaries (Sweden and the UK). There are different rules about the duties they may perform and the degree of supervision they may need.

Dentists - Based on a sum of the available data from "Eurostat Statistics Explained", **there were just over 345 thousand practicing dentists in the EU in 2014. Greece had the highest number of dentists per 100 000 inhabitants at 126 (licensed to practice) per 100 000 inhabitants.** This was considerably higher than in any of the other EU Member States, as Bulgaria and Cyprus (both with 98) and Estonia (92) had the next highest ratios for practicing dentists. By contrast, there were fewer than 50 practicing dentists per 100 000 inhabitants in Slovakia (professionally active dentists), Malta and Poland.
The number of practicing dentists per 100 000 inhabitants remained relatively unchanged in most of the EU Member States between 2009 and 2014; there were, however, seven Member States where this ratio increased by at least 10 additional dentists per 100 000 inhabitants. The largest change (both in absolute and relative terms) was recorded in Lithuania, with an additional 21 dentists per 100 000 inhabitants (+ 30 %), while there were also relatively large gains in Romania (+ 29 %), Hungary (+ 28 %), Italy (+ 24 % of professionally active), Spain (+ 23 % of dentists licensed to practice) and Bulgaria (+ 13 %). By contrast, there were three Member States where the number of dentists per 100 000 inhabitants fell between 2009 and 2014. The biggest reductions (– 4 % in both cases) were

No. of Dentists and Graduates in Dentistry, 2014

EU Members	No. of dentists 2014	Dentists per 100 000 inhabitants	Graduates 2009	Graduates 2014
Belgium	8108	72	156	219
Bulgaria	7054	98	232	270
C. Repub.	7906	75	407	343
Denmark (2013)	4295	76	177	154
Germany	69089	85	1819	2314
Estonia	1215	92	29	25
Ireland (licensed to practice)	2758	60	72	81
Greece	13746	126	271	202 (2013)
Spain (licensed to practice)	33286	72	1289	1785
France	42281	64	717	1191 (2013)
Croatia	3327	79	119	134
Italy (professionally active)	39075	64	977	345
Cyprus	839	98	0	0
Latvia	1400	70	34	40
Lithuania	2669	91	147	170
Luxembourg (excluding stomatologists and maxillofacial surgeons)	476	86	0	0
Hungary	6203	63	219	378
Malta	201	47	6	4
Netherlands (professionally active)	8750	52	248	177
Austria	4893	57	134	106 (2013)
Poland	13088	34	941	915
Portugal (licensed to practice)	9125	88	755	642
Romania	14846	75	1060	1534
Slovenia	1365	66	35	53
Slovakia (professionally active)	2642	49	44	94
Finland	4234	78	72	130
Sweden (2013)	7747	81	196	242
UK	34638	54	1085	1195

EFTA Members	No. of dentists 2014	Dentists per 100 000 inhabitants	Graduates 2009	Graduates 2014
Iceland	274	84	6	6 (2013)
Liechtenstein	51	137	0	0
Norway	4450	87	130	118
Switzerland	4217	51	120	96

	No. of dentists 2014	Dentists per 100 000 inhabitants	Graduates 2009	Graduates 2014
Montenegro	25	4	-	-
FYR of Macedonia (professionally active)	1762	85	0	0
Albania	-	-	58	261 (2013)
Serbia (professionally active)	2310	32	518	386 (2013)
Turkey (professionally active)	22996	30	927	1567

Source:
http://ec.europa.eu/eurostat/statisticsexplained/images/0/0b/Practising_dentists%2C_pharmacists_and_physiotherapists%2C_2014.png
Note: For dentists, Eurostat collects data for three concepts:
-'practicing', in other words, healthcare professionals providing services directly to patients; Dentists who are working in administration, research or other posts that exclude direct contact with the patients and clients are excluded from the definition of those who are practicing, as are those who are unemployed, retired, or working abroad.
-'professionally active', in other words, 'practicing' professionals plus health care professionals for whom their medical education is a prerequisite for the execution of their job;
-'licensed', in other words, health care professionals who are registered and entitled to practice as healthcare professionals.
In this Table preference is given to the concept of 'practicing' healthcare professionals. For some Member States data are not available for this concept and therefore data are presented for one of the alternative concepts instead (notes indicate these exceptions in each figure).

The number of practicing dentists per 100 000 inhabitants remained relatively unchanged in most of the EU Member States between 2009 and 2014

recorded in Greece and Denmark. France also presented a 4 % reduction although a break in the time series needs to be taken into account.

Graduates **-** In 2014, there were close to 13,000 dentistry graduates in the EU-28. **The EU's most populated Member State, Germany, had the highest number of dentistry graduates (2,314) among the EU Member States in 2014, while there were more than 1,000 dentistry graduates in Spain, Romania, the United Kingdom and France (2013 data).** Relative to population numbers, Romania recorded the highest number of dentistry graduates in 2014 at 7.7 graduates per 100 000 inhabitants. Portugal (6.2 graduates per 100 000 inhabitants) and Lithuania (5.8 graduates per 100 000 inhabitants) also recorded relatively high ratios and all three of these Member States also reported that their number of dentistry graduates per 100 000 inhabitants rose during the period 2004–14. The majority of the EU Member States for which data are available had between 1.5 and 3.5 dentistry graduates per 100 000 inhabitants, although Austria (2013 data), the Netherlands, Malta and Italy were below this range. In Cyprus, Luxembourg as well as in Liechtenstein there were no available degrees in dentistry.

According to EU statistics on income and living conditions some 5.4 % of the EU-28's population reported they had unmet needs for dental care due to financial reasons in 2014; this figure was slightly more than double the corresponding share of the population reporting they had finance-related unmet medical needs. This difference may, at least in part, be due to national social security systems covering less people or a lower proportion of the total cost of dental care, resulting in some individuals having to pay a relatively high share of their dental expenses out of their own pockets (or through private health insurance).
'Dental tourism' is an area that has seen particularly rapid growth in several EU Member States in recent years, for example, in Hungary, as relatively low prices, increased pa-

tient mobility and greater consumer confidence have led some to consider the option of having dental treatment abroad. This pattern may be expected to develop in the coming years: Directive 2011/24/EU of the European Parliament and of the Council, on the application of patients' rights in cross-border healthcare was implemented in 2013 and provides patients with increased rights and promotes cooperation among health systems.

An increasing number of health professionals are seeking jobs in other EU Member States. Aside from the expected benefits for the individuals concerned, their movement can help rectify labor market imbalances between countries. Directive 2005/36/EC on the recognition of professional qualifications provides a Europe-wide legal framework enabling Member States to recognize each other's qualifications. A range of health professionals — including dentists— enjoy automatic recognition, in other words, if they are a certified practitioner in their home country then they are automatically entitled to practice anywhere else in the EU. The directive also provides a set of minimum requirements for each professional activity, including: the need for a compulsory university degree in order to be a dental practitioner; and a minimum study/training period of four years for dental practitioners.

Sources:

- Extracts from "The State of Oral Health in Europe" commissioned by the Platform for Better Oral Health in Europe: http://www.oralhealthplatform.eu/wp-content/uploads/2015/09/Report-the-State-of-Oral-Health-in-Europe.pdf
- "EU Manual of Dental Practice": http://www.cedentists.eu/library/eu-manual.html
The EU Manual of Dental Practice, commissioned by the Council of European Dentists (CED), was first published in 1997 and last updated in 2015.
- Extracts from Eurobarometer Survey: http://ec.europa.eu/public_opinion/archives/ebs/ebs_330_en.pdf
- http://ec.europa.eu/eurostat/statistics-explained/images/0/0b/Practising_dentists%2C_pharmacists_and_physiotherapists%2C_2014.png
- The Association of Dental Dealers in Europe (ADDE) - is a trade organization working actively in the dental industry. Today ADDE represents the interests of a total of more than 960 dental dealer organizations: http://www.adde.info/en–

An increasing number of health professionals are seeking jobs in other EU Member States.

EU Oral Health Systems *In Brief*

Oral health is defined by the WHO as a part of human health and it is essential to generate health and well-being.

There are nevertheless substantial differences between oral healthcare provision systems and general healthcare. Chief among these is the fact that dental care has much less tradition of third-party involvement of any kind in funding, whether by insurance or government, than does general healthcare. In the European Union (EU), oral healthcare is mostly available through private practice. Although entitlement to state or insurance-funded healthcare is a constitutional right in some countries and a stated principle in others, in oral health it is not as much guaranteed as it is in general healthcare. Most European countries are now increasing co-payments or decreasing the level of dental care coverage. Private provision among small group practices that may enter into a service contract with a third-party payer (an insurance company or the National Health Service) is a growing phenomenon. Let us take a look at some of the systems:

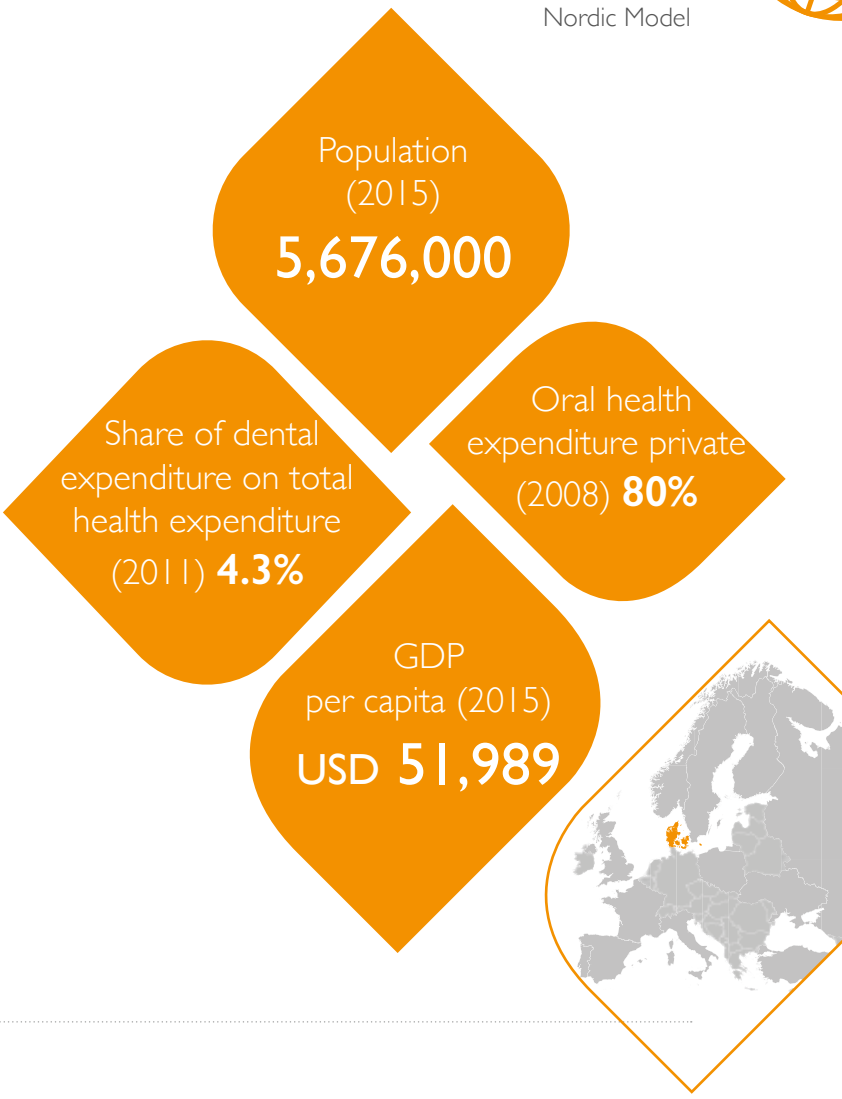
NORDIC MODEL
Found in Denmark, Finland, Norway and Sweden

- Large public dental service financed by national or local taxation with free services for under 18 year-olds and some adults
- Central guidance and supervision
- Private sector generally treats adults many of whom receive co-payment from the state
- Well developed team dentistry with wide use of Dental Hygienists and Nurses (Chair-side Assistants)
- Clinical Dental Technicians/Denturists, who provide removable prostheses directly to patients, are found in Denmark and Finland
- Over 90% of those under 18 years and 60% - 90% of adults attend regularly for oral healthcare

Denmark

Highly decentralized National Health Service, largely funded by general taxation. **Oral healthcare is provided for children and young people (0-17) and only partly subsidized by the government for adults (approximately 17 -20%).**
While the government pays approximately 85% of the national costs of healthcare, 15% comes from individuals through co-payments for treatment. **For dental care this ratio is reversed since the national cost of caring for adults' dental health is 20% government-funded, with the remaining 80% paid by patients.**

Number of registered dentists (2013)	7,900 (Percentage female 58%)
Active dentists (2013)	Between 4,295 - 5,161
Active dental offices (2015)	1,930
Population to (active) dentist ratio	1,086 (2013)
Members of Danish Dental Association (DDA)	81% - Dentists are advised to hold a membership even though not mandatory
Technicians (2015)	1,200
Dental labs (dentists' & commercial labs, 2015)	130
No. of Dental Dealers (2015)	37

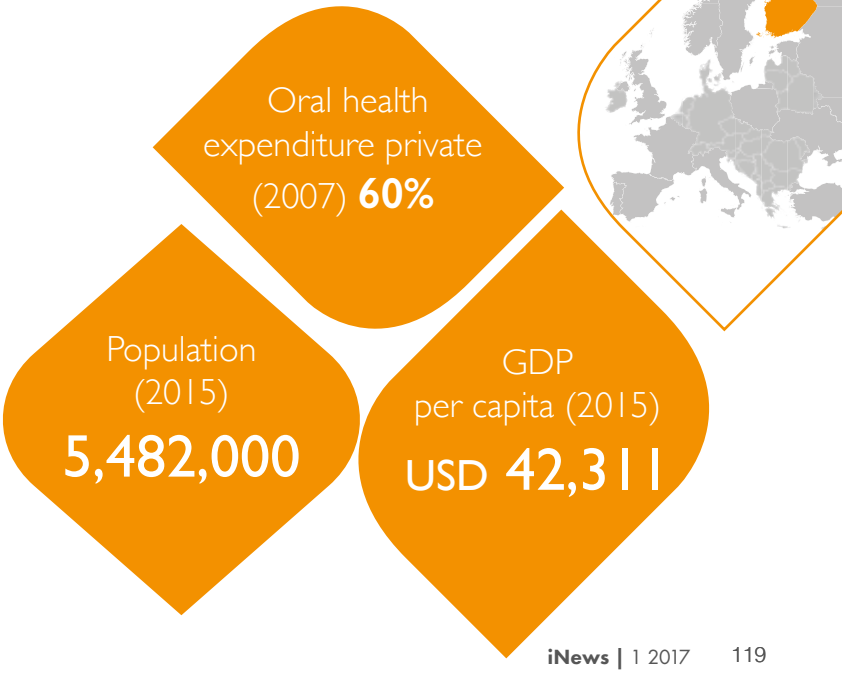


Finland

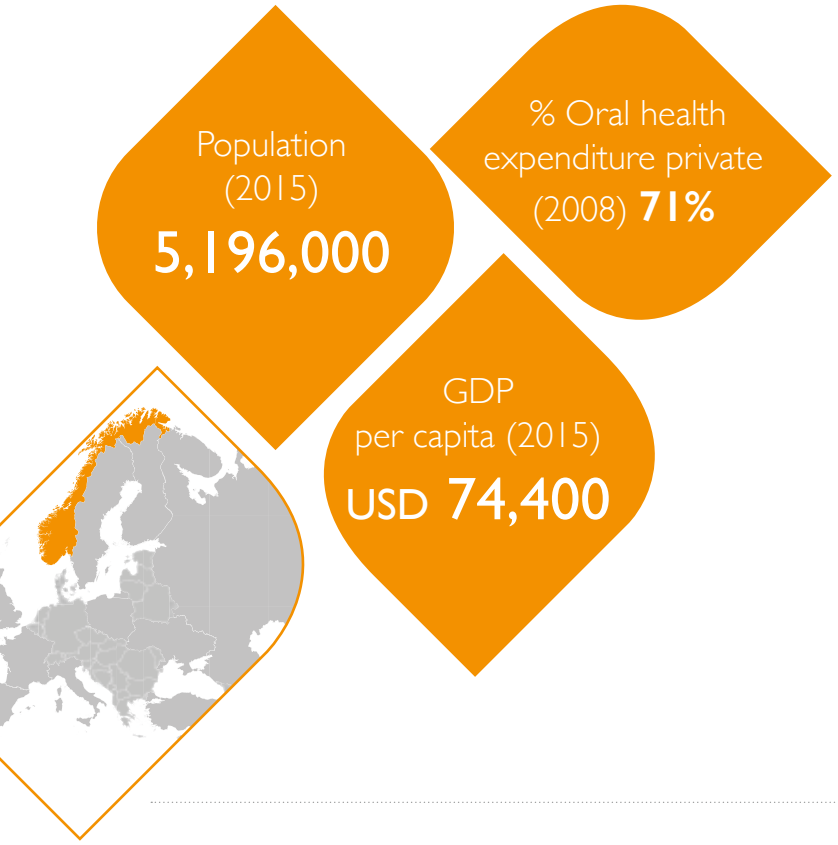
Healthcare is funded largely through general taxation, with an additional special tax for health which is paid by everyone including those who have retired. **Dental services are delivered either through the system of public health centers, or by private dentists, denturists and dental laboratories. About 36 % of dental care is state-funded (half by the municipalities, half by central government) and 56% is paid for directly by households. Oral health services are provided in both the public and private sectors with about half of dentists in each sector.** About three quarters of the population receives oral healthcare regularly (in any two-year period) and oral examinations would normally be undertaken every 1-2 years.

Number of registered dentists (2013)	5,925 (Percentage female 58%)
Active dentists (2013) (The register does not distinguish between working or retired persons)	Between 4,234 - 4,500
Population to (active) dentist ratio (2013)	1,208
Members of Finnish Dental Association	98% (representing private and public health dentists)
Technicians (2015)	450
No. of Dental Dealers	35

** All figures are approximate, varying year by year, taken and/or compared from different sources.*



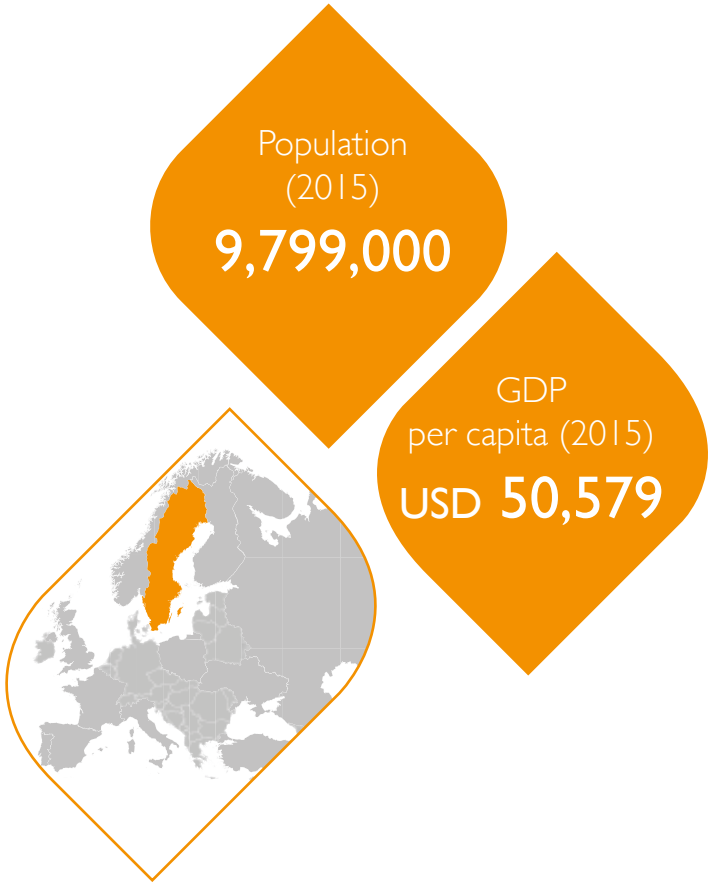
Norway



General health services are funded through a form of national insurance, the Folketrygden. Benefits include pensions, full salary for long term sickness, unemployment benefit and healthcare. **But, only priority groups receive dental healthcare free of charge from the Public Dental Health Service. Adults must pay the full cost for dental care. Children and juveniles 0-18 year also receive free dental care.** About 80% of adults see a dentist every 12 months and more than 90% within 2 years, the majority from general practitioners in private practice paying full cost of treatment.

Number of registered dentists (2013)	5,350 (Percentage female 47%, estimated)
Active dentists (2013)	Between 4,450 - 4,576
Active dental offices (2015)	1,930
Population to (active) dentist ratio	1,107
Members of NDA (Norwegian Dental Association)	90% of active dentists are members. It represents private and public service dentists
Technicians (2013)	703

Sweden



Most healthcare is provided through a national social insurance system, which also provides sick pay, child benefits, disability allowances and pensions. General healthcare is paid for through general taxation, plus a small fee for each visit to a doctor. **In total, around 81% of healthcare costs, including dentistry are funded by government.**
80% of dental care is carried out by dentists within the Public Dental Service (PDS); but there are also private practitioners (PP) who provide care that is financed by the county/region. In any one-year period, approximately 60% of the whole adult population access dentistry.

Number of registered dentists (2010)	14,454 (Percentage female 52%)
Active dentists (2010)	Between 7,528 - 7,747
Population to (active) dentist ratio (2010)	1,251
Membership of the Swedish Dental Association (SDA)	95%
Technicians (2008)	1,500 (estimated by SDA, for "active" technicians)

** All figures are approximate, varying year by year, taken and/or compared from different sources.*

SOUTHERN EUROPEAN MODEL
Found in Italy, Portugal and Spain

- Predominantly private provision of oral healthcare without Government involvement
- Very limited number of public clinics
- Limited number of insurance schemes
- Limited provision of free treatment for under 18 year olds
- Some team dentistry
- Low rate of regular attendance for oral health care in Portugal and Spain (30-40% per year)

Italy

GDP per capita (2015) USD **29,957**

Oral health expenditure private (2007) **95%**

Population (2015) **60,802,000**

Share of dental expenditure on total health expenditure (2011) **6.5%**

The comprehensive public health system provides universal health coverage through public taxation with small co-payments by patients limited to specific classes of pharmaceuticals, specialist visits and diagnostic services, with various exemptions (medical conditions and income levels).
Each Italian region determines the size and type of public dental services provided, included in the so called LEA ("Livelli Essenziali di Assistenza", basic assistance levels). LEA generally provides government funded primary care (restorative treatment and only occasionally prosthetics and implants, with co-payment by the patient). As such, dentistry should be considered as private sector treatment as only 5% of dental care is provided within the National Health Service (NHS) completely free, in public or semi-public facilities (some with co-payments), while 85% of patients have to pay totally out-of-pocket for their dental treatment. Theoretically, everyone is eligible to use the NHS but in reality it is mostly used by the lower or middle class, who cannot afford private care.
Patients do not have problems of access to private dentists but they do have access problems in the public sector with under-provision or waiting lists. The private health sector is increasing in importance and number of structures, due to the faster service and higher quality offered, as well as a consequence of the possibility to be treated under co-payment schemes allowing patients to receive care in private structures contracted by the National Health System. According to a 2010 ANDI study based on ISTAT data, 39.7% Italians visited a dentist at least once a year, compared to 11.5% who never visited. Only about 27% of children between 3 and 5 years have access to completely free dental care and even less in the 6 to 10 years group (12%) and between 11 and 13 years (10%).

Number of registered dentists (2015)	60,600 (Percentage female 34%)
Active dentists (2013)	Between 39,075 - 45,896
Active dental offices	41,000
Population to (active) dentist ratio (2015)	1,003
Members of Dental Associations (ANDI and AIO)	52%
Technicians (2015)	26,000
Dental labs (dentists' & commercial labs)	12,800
No. of Dental Dealers	326

** All figures are approximate, varying year by year, taken and/or compared from different sources.*

GDP per capita (2015) **USD 19,222**

Population (2015) **10,349,000**

Portugal

The Portuguese National Health System (NHS) was introduced in 1979 to provide universal insurance coverage to the Portuguese population irrespective of income. The Constitution was amended in 1989 to the effect that the NHS would not be totally free, but would continue to follow a free "tendency" according to the individual ability to pay. Taking into account the economic and social conditions of the user and chronically ill patients, about 40% of the population is exempt of any extra co-payment when using the NHS. While the rest of the population pays a co-payment for each appointment or treatment provided. Finance is mainly through taxation but some services are still provided within the social insurance scheme. **Oral healthcare is provided almost entirely by the private sector. Public Dental Services are available in only a few hospitals and the type of treatment offered is limited to major conditions that require hospital admittance, e.g. major surgery, oncology etc. A handful of Public Health centers provide simple restorative treatments and extractions. Approximately 50% of the population has no access to dental care, due to financial reasons, amongst others.**

The *Portuguese Public Oral Health Program* (PPOHP) –From 2008 a new complementary public strategy to control oral diseases was introduced. For the first time ever, some vulnerable selected groups (low income over 65 years old, pregnant women, patients with Human Immunodeficiency Virus, 3-16 years old children and adolescents) have access to oral health promotion, prevention and treatment of oral diseases integrated in a public program. The patients can choose from a list of private enrolled dentists.

Dentists, stomatologists* & odontologists*	Between 9,125 - 9,886
Population to (active) dentist ratio (2013) Active dentists, stomatologists & odontologist	1,153
Membership of the OMD (Ordem dos Médicos Dentistas)	100%
Technicians	4000-5000

**Odontologists - the former group of "technicians", designated as odontologists, are recognized only in Portugal. They are no longer being trained. Their qualification is insufficient to be recognized as dentists. // Stomatologists - medical practitioners with an additional of dental training. Portugal EU membership has caused a growth of the number of Médicos Dentistas (dentists with specific dental university education) and a dramatic reduction of the number of stomatologists.*
All figures are approximate, varying year by year, taken and/or compared from different sources.

Spain

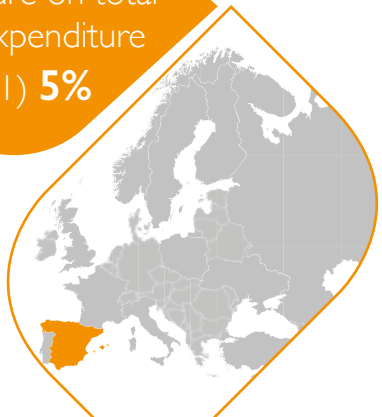
Spain has a National Health System which is mainly financed by the deductions on the workers income. These deductions are proportional to the income amounts. **The population has the right to all primary healthcare but dental, psychiatric and cosmetic services are excluded. Each region has a small Public Dental Service available to all sections of the population delivering free urgent treatments, for example extractions and prescription of antibiotics.** Patients attending the public dental service pay nothing for their care. Less than 5% of registered dentists work in the service. **As such, almost all oral healthcare in Spain is provided by private practitioners and patients usually pay the total cost.** Only around 27-30% of Spaniards visit a dentist within a year, most tend to go only when they have dental problems

GDP per capita (2015) **USD 25,831**

Oral health expenditure private (2007) **85%**

Share of dental expenditure on total health expenditure (2011) **5%**

Population (2015) **46,420,000**



Active Dentists (estimated)	Between 29,000 – 33,286
Active dental offices (2015)	21,000
Population to (active) dentist ratio (2014)	1,394
Membership of the Dental Association (Consejo General de Colegios Oficiales de odontólogos y estomatólogos de España)	100%
Technicians (2015)	14,500
Dental labs (dentists' & commercial labs, 2015)	4,200
No. of Dental Dealers (2015)	350

** All figures are approximate, varying year by year, taken and/or compared from different sources.*

BISMARKIAN MODEL
Found in Austria, Belgium, France, Germany, Luxembourg, the Netherlands and Switzerland

- Based on statutory sickness insurance paid for by employers and employees
- Costs of oral healthcare totally or partially reimbursed by the insurance scheme
- Fees negotiated between insurance agencies and dental associations
- Very little Government involvement
- Very small public dental service
- Apart from in Germany and the Netherlands, little use of team dentistry
- No dental hygienists in Austria, Belgium, France and Luxembourg
- Dental nurses (chair-side assistants) relatively uncommon in Belgium, France and Luxembourg

Austria

GDP per capita (2015) **USD 43,775**

Oral health expenditure private (2007) **40%**

Population (2015) **8,611,000**

Share of dental expenditure on total health expenditure (2011) **5%**

The Austrian healthcare system is based on compulsory social insurance. Entitlement to receive funded healthcare is through membership of health insurance organizations (or sickness funds). These are provided by public compulsory and private supplementary insurance.

Approximately 99% of the population is covered by the compulsory insurance schemes which include cover for specified dental treatments. Premiums are paid by employers and employees (each 50%). Children are covered by the social sickness insurance of their parents and have the same rights. The type of treatment covered by the social sickness fund is the same throughout Austria; there are regional differences in the percentage the patient has to pay. Oral health services are provided mainly in general (private/liberal) practice, both in the public and private sectors.

Compulsory insurance schemes do not cover all types of dental treatment: 41 conservative and surgical items and 11 removable orthodontic and prosthodontic treatments are fully covered by the sickness insurance. Crowns and bridges, implants, fixed orthodontic appliances and other complex or cosmetic treatments have to be paid in full by the patients.

Active dentists	Between 4,421- 4, 893
Active dental offices (2015)	3,850
Population to (active) dentist ratio (2015)	1,977
Members of Dental Association/Austrian Dental Chamber	100%
Technicians (2015)	2,800
Dental labs (dentists' & commercial labs, 2015)	720
No. of Dental Dealers (2015)	57

** All figures are approximate, varying year by year, taken and/or compared from different sources.*

Bismarkian Model

Belgium

Population (2015) **11,286,000**

GDP per capita (2015) **USD 40,324**

Share of dental expenditure on total health expenditure (2011) **2.2%**

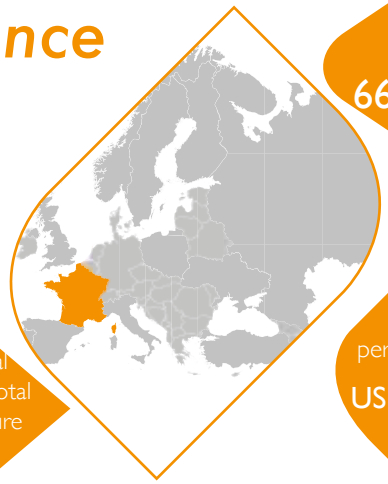
Oral health expenditure private (2011) **40%**

** All figures are approximate, varying year by year, taken and/or compared from different sources.*

Number of registered dentists (2015)	8,879 (Percentage female 48%)
Active dentists	Between 7,800 - 8,108
Active dental offices (2015)	4,290
Population to (active) dentist ratio (2015)	1,436
Members of Dental Associations	about 74% (4 dental associations recognized by the social security system)
Technicians (2015)	1,340
Dental labs (dentists' & commercial labs, 2015)	650
No. of dental dealers (2015)	48

The system is based on a compulsory social insurance system. Working adults, both salaried and self-employed, make compulsory payment through deductions from their wages or incomes which contribute to the health and social services, provided by the National Health Insurance scheme. Employers also contribute additional sums for their employees. Self-employed people are only obliged to pay an insurance premium related to high risk healthcare (major surgery, hospitalization etc.). **Dental care is classified as low risk healthcare. Approximately 85% of the population is covered for all risk (low and high) healthcare.** Patients are reimbursed at 75% of the nationally agreed fees for restorative care, removable dentures, minor oral surgery and limited preventive care. Restorations for children aged 0-12 years, including fissure sealants, have almost total reimbursement. Periodontal treatments, fixed prostheses and oral implants are not covered. There is only a low level of reimbursement for orthodontic treatment and only for children who start orthodontic treatment before the age of 15 years. Only approximately half of the population attends a dentist regularly.

France



Population (2015) **66,808,000**

GDP per capita (2015) **USD 36,205**

Share of dental expenditure on total health expenditure (2011) **4.5%**

A mandatory insurance system called "Sécurité Sociale" (National Health Insurance) covers the entire population living legally in France. The social insurance system is established by law and is divided into 3 major branches, the Sick Funds (Assurance Maladie), Pensions and Family. These are managed independently of the state. The Assurance Maladie is financed by compulsory contributions from individual incomes and taxes on the employers. **This obligatory insurance gives individuals the right to be totally or partially reimbursed for their health expenses for themselves and their dependants. Co-payments complete the cost of healthcare.** Patients can claim the reimbursement of a part of the cost for conservative and surgical treatments (70%); prevention and examination at the age of 6, 9, 12, 15 and 18 (100%); orthodontics and prosthodontics treatments (approx. 35% for prosthetics and 5% for orthodontics). Many items of treatment are not covered by health insurance and private insurances are largely contracted by the French people. About two-thirds of the population visits a dentist at least once a year.

Number of registered dentists (2015)	46,104 (Percentage female 40%)
Number of active dentists	Between 41,495 - 42,281
Active dental offices (2015)	27,500
Population to (active) dentist ratio (2015)	1,605
Members of CNSD Members of ADF	36% (the Professional Union) 65% (the French Dental Association)
Technicians (2015)	18,000
Dental labs (dentists' & commercial labs, 2015)	3,800
No. of dental dealers (2015)	105

Bismarkian Model

Germany

Health insurance is mandatory for all citizens and permanent residents of Germany. It is provided by state-approved, not-for profit health insurance funds or "sickness funds" in the Statutory Health Insurance system (SHI), or by substitutive Private Health Insurance (PHI).

All employed citizens (and other groups such as pensioners) earning less than Euro 54,900 per year (as of 2015) are mandatorily covered by SHI, and their dependents (nonearning spouses and children) are covered free of charge. Individuals whose gross wages exceed the threshold (over Euro 54,900) can remain in the publicly financed scheme on a voluntary basis (and 75% do) or opt out and purchase substitutive PHI. For self-employed persons and certain groups of professionals (e.g. civil servants) membership of a private insurance scheme is mandatory. Statutory Health Insurance, which provides a standardized level of coverage, is funded by a combination of employee contributions, employer contributions (almost half each) and government subsidies on a scale determined by income level.

About 86% of the population receives their primary coverage through SHI and 11% through substitutive PHI.

Membership of a statutory sick fund entitles all adults and children to receive oral care from the statutory health insurance system. General clinic procedures are totally covered by the insurance, dental prostheses and orthodontics are subject to co-payments. Implants are not covered.

Persons aged less than 18 are entitled to full compensation for all medically necessary conservative and surgical dental treatment as well as necessary orthodontist care. They are also entitled to receive certain prophylactic treatments free of charge.

With this system Germany reaches the impressive percentage of 70% of the adult population and 75% of the children using the dental system in a typical year.

** All figures are approximate, varying year by year, taken and/or compared from different sources.*

Population (2015) **81,413,000**

GDP per capita (2015) **USD 41,313**

Share of dental expenditure on total health expenditure (2011) **7.6%**

Number of registered dentists (2013)	88,882 (Percentage female 42%)
Active dentists	69,089 - 70,740
Active dental offices (2015)	47,805
Population to (active) dentist ratio (2013)	1,163
Members of Dental Association	100% - The national federation of Chambers is known as the Bundeszahnärztekammer (BZÄK) and all dentists must be a member of the local Chamber.
Technicians (2015)	68,000
Dental labs (dentists' & commercial labs, 2015)	17,493
No. of dental dealers (2015)	167

Luxembourg

There is one scheme for general healthcare, the Caisse Nationale de Santé (CNS), which is made up of several sick funds. It is funded by contributions from employers (50%) and employees (50%), as well as the government. **Medical (and dental) insurance is obligatory and covers 99.9% of the population.**

Everybody is entitled to dental care partly paid for by the CNS and all dentists must work within it. Every dentist must charge the fees specified by the fund, unless a fee is not stated, and patients obtain (variable) reimbursement. Items not listed in the scale of fees may be charge at any reasonable rate. 100% of care is provided in general (private) practice and there is no reported difficulty for access to care for patients.

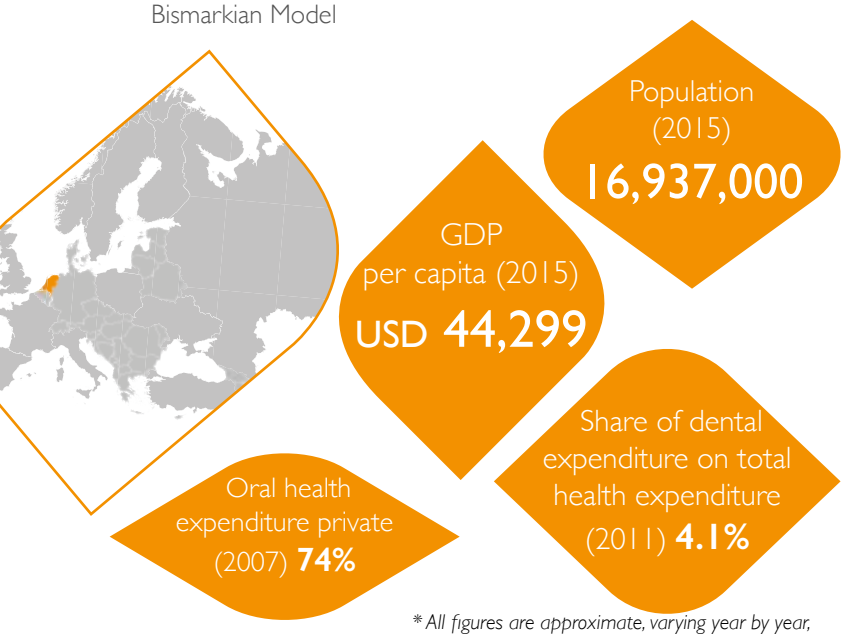
GDP per capita (2015) **USD 101,450**

Population (2015) **569,700**

Number of registered dentists (2013)	512 (Percentage female 40%)
Active Dentists	Between 452- 476
Population to (active) dentist ratio (2013)	1,188
Membership of Dental Association	90% (voluntary membership)
Technicians (2013)	82

Bismarkian Model

The Netherlands

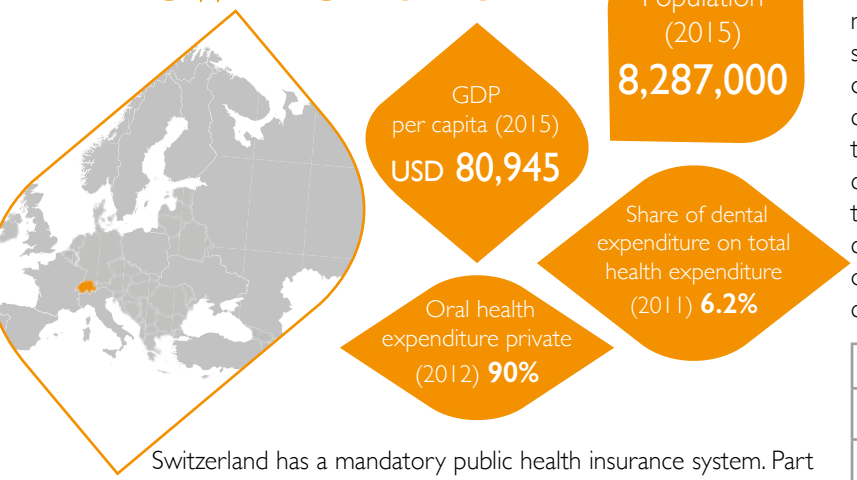


** All figures are approximate, varying year by year, taken and/or compared from different sources.*

Since 2006 the Netherlands have a new health system. A government-regulated compulsory health insurance is provided to the Dutch population by private insurances. This insurance package is the same for everyone and includes the basic, mostly curative, healthcare. All other healthcare can be additionally insured or paid for privately. Healthcare insurers have a duty to accept applications from every individual seeking the basic insurance. Approximately 69% of the population is registered in the public system. **The basic oral care insurance package covers all preventive and curative care for individuals up to 21 years old; full set of dentures and care for subjects with specific conditions like physical or mental handicapped. All other treatments including all preventive and curative dental care for grown-ups and all orthodontic care can be additionally insured or paid for privately. Although dental treatment is provided under the private system, there is a national scale of maximum fees.**

Number of registered dentists (2013)	10,780 (Percentage female 35%)
Number of active dentists	Between 8,750 - 8,773
Active dental offices (2015)	5,600
Population to (active) dentist ratio (2013)	1,914
Membership of the Dutch Dental Association (KNMT)	76% (not compulsory)
Technicians (2015)	3,200
Dental labs (dentists' & commercial labs, 2015)	880
No. of dental dealers (2015)	29

Switzerland



Switzerland has a mandatory public health insurance system. Part of the financing comes from the fees paid to the private insurance companies (Kassen), other part comes from Federal taxes and a third part comes from the out of pocket contributions. The system is compulsory for everyone. Patients, except those on low income, pay a basic annual fee of approx. CHF 3,000 (€2,449). For those on low incomes the fee is reduced by up to 100% (approximately 30% of the population). The Kassen are not allowed to make profits from the basic statutory insurance, but can benefit from any additional coverage, such as dental care. Apart from a minority of dentists employed by hospitals or the school dental service, most oral healthcare is provided by independent private practitioners and paid for directly by individual patients. Unless dental treatment is necessary because of an accident, the medical insurance system only subsidizes the cost when a patient has a prescribed disease and only 10-15% of care is eligible. More specifically: oral conditions caused by another severe and not avoidable disease of the masticator system; oral conditions caused by another severe condition and its sequel; oral conditions which must be treated in the overall treatment of another severe disease; oral conditions caused by accidents. As such, most dental care is paid directly out of pocket for private services. About 90% of the population access dentistry in a 2-year period.

Number of registered dentists (2013)	4,850 (Percentage female 28%)
Number of active dentists	Between 4,217 - 4,800
Active dental offices (2015)	4,200
Population to (active) dentist ratio (2013)	1,679
Membership of the Société Suisse des Médecines-Dentistes (SSO)	90%
No. of dental dealers (2015)	10
Technicians	2,200
Dental labs (dentists' & commercial labs, 2015)	1,100

BEVERIDGIAN OR HYBRID MODEL
Unique to the United Kingdom

- Mixture of publicly and privately funded oral healthcare
- Publicly funded either in relatively small number of public service clinics or in private clinics where the owners contract with the state
- Free of charge to all under 18 years of age and "special groups"
- Widespread and increasing use of team dentistry
- Growing numbers of dental hygienists, dental therapists, dental nurses
- Also clinical dental technicians and orthodontic nurses all are registered

The United Kingdom

The National Health Service (NHS), providing healthcare to all, is financed mainly by general taxation (approx. 90%) with the balance coming from charges to patients for prescriptions, dental & optical care.

Oral healthcare is available from the NHS or privately. The effect of an increased expenditure by patients in the private sector and the high proportion paid by them as dental charges when obtaining treatment in the NHS, means that **patients in the UK are funding 54% of all spending on oral healthcare, with 46% being publicly funded.** About 75% of private oral healthcare expenditure is made up by out-of-pocket payments and 25% by private dental insurance.

Access to a NHS general practitioner (GDP) is, in principle, available to all. NHS charges are about half or less of that which is paid privately. In many parts of the UK, access to NHS dental care is difficult, therefore "Access Centres" staffed by salaried GDPs and Public Health Dentists (PHDs) offering clinical services at NHS charges are available.

Children under 18 years old, pregnant and nursing mothers; individuals on welfare benefits; individuals under 19 years old in full time education are entitled to free oral care within the NHS.

The vast majority of GDPs treat patients both within the NHS and privately.

Individuals are entitled to immediate access to urgent oral healthcare when required and also have the right – subject to a set of co-payments – to all clinically necessary treatments such as preventive treatment, white fillings, dentures, root canal treatment, crowns and bridges. **Nevertheless, they may choose to receive a mix of private and NHS treatment within the same episode of dental care (known as "mixing"). Often basic treatment is carried out within the NHS and more advanced treatment, involving the use of more expensive materials, privately.**

About 60% of adults and 70% of children (0-18 years) see GDPs for continuing care annually.

** All figures are approximate, varying year by year, taken and/or compared from different sources.*

GDP per capita (2015) **USD 43,876**

Oral health expenditure private (2012) **55%**

Share of dental expenditure on total health expenditure (2011) **6%**

Population (2015) **65,138,000**

Number of registered dentists (2015)	39,258 (Percentage female 45%)
Active Dentists (estimated, 2014)	Between 33,000 – 34,638
Active dental offices (2015)	11,800
Population to (active) dentist ratio (2015)	1,630
Membership of the British Dental Association (BDA)	57% (active dentists)
Technicians	7,656
Dental labs (dentists' & commercial labs, 2015)	2,080
No. of dental dealers (2015)	60

Among main sources:
-Extracts from the "EU Manual of Dental Practice". For full and detailed report: http://www.cedentists.eu/library/eu-manual.html
The EU Manual of Dental Practice, commissioned by the Council of European Dentists (CED), was first published in 1997 and last updated in 2015. The CED is a European not-for-profit association which represents over 340,000 dentists across Europe. Established in 1961 is now composed of 32 national dental associations from 30 European countries. http://www.cedentists.eu/
- The Association of Dental Dealers in Europe (ADDE) - is a trade organization working actively in the dental industry. Today ADDE represents the interests of a total of more than 960 dental dealer organizations: http://www.adde.info/en

Do's and Dont's in German Business Culture

What are the hidden rules of etiquette foreigners need to watch out for while doing business in Germany? Below are some top tips for keeping on the right side of your German colleagues.

Anyone who has spent some time in a German workplace will tell you that quite a few stereotypes about Teutonic business culture do ring true.

Order, structure, precision and thoroughness permeate work life here, which is why foreigners in business environments could be forgiven for suspecting their German colleagues have a secret set of rules - and are following them to the letter.

Here are just a few of the main German business customs to look out for…of course, these rules are for traditional office and business environments, but they could be embarrassingly out of place in, say, an urban start-up run by twenty-something. If in doubt, use the golden rule: do as those around you do!

Be on Time

Being late in Germany is a cardinal sin. Seriously. Turning up even five or ten minutes after the arranged time – especially for a first meeting – is considered personally insulting and can create a disastrous first impression. Repeated unpunctuality robs the business partner of his credibility. Unexcused lateness should be avoided at all costs, as it could send your German business partner into a wide-eyed panic. Casual deviations from the timetable can be seen as an affront, and in the worst case even the end of the business relationship. Minimize reputation damage by calling ahead with watertight excuse if you're going to be held up. Fortunately, this works both ways; you are perfectly entitled to demand flawless punctuality from the Germans and be just as irritated if they are not on time.

Use Titles and Surnames

German workers tend to stick to roles rigidly and rarely step out of strict office hierarchies. Stay in line and do not forget to address your contact with titles and surname, unless they invite you to go informal, which should be seen as a personal honor, "Doctor Schmidt" is the correct way of addressing your business partner, rather than just "Jürgen" or "Anne." If you find yourself hosting, introduce your highest ranking guest to everyone else taking care to use full names and job positions.

If in Doubt, Shake Hands

As well as shaking hands in greeting, Germans also shake hands with everyone in a room before and after a business meeting or conference. If you have to leave early, shake everyone's hand again, starting with the most senior person present and working down. The German handshake is firm and brief, said to convey confidence and reliability. A weak handshake will suggest you are unsure of your abilities. Don't forget to make direct eye contact upon greeting and goodbye.

Your First Meeting with your Business Partner

Formal clothing is expected for a business meeting with a German. With women just as much as men, a conservative choice of business dress will definitely count more in your favor than against you. Men are advised to avoid flashy ties and women should keep make-up and jewellery simple and low-key.

Business, not Personal

Existing, trusting, human relationships don't matter as much when it comes to starting or closing on a business venture. A longstanding relationship with your future business partner certainly is helpful, but this pre-business connection will not matter a jot if the business could be done better elsewhere.

Don't expect your German colleagues to be natural sharers, and don't take it personally if they seem distant, even after some time. Keep small talk light and non-specific, as most prefer to keep the details of their home life or political and religious views

out of the office. Never discuss your or anybody else's income – a taboo in Germany.

Knock First

Earn German colleagues' respect by respecting their privacy. If you find yourself faced with a closed door, especially to a private office, always knock before entering. Equally, never call a German colleague at home unless it's really an emergency – of catastrophic proportions.

Keep your Distance

Unlike some Asian countries and North America, Germans prefer to keep a fair amount of personal distance. Observe the personal space of others and avoid patting shoulders, arms or generally any physical contact beyond that all-important handshake. Business cards are exchanged at the first meeting, although less formally than in Asia, for example. But make sure the business card looks neat and clean, as this also falls into the category of the German desire for Ordnung.

Say What you Mean

Pragmatism and candor are just as important in German business practice. In negotiations, Germans tend to be direct and frank about what they want, leaving you in no uncertain terms as to their position on the subject. Polite sensitivity for difficult subjects is pretty rare, while euphemism and sarcasm are simply things that exist in other countries. However, this icy directness is also expected from you. Small talk is merely a formality, and may be entered into the timetable as such, for it affects the efficiency of discussions if it runs over. The time would be better spent on discovering facts and listening to topical presentations. Be prepared to be shown a barrage of figures, graphs, tables and pie charts!

Plan Ahead

Germans tend to keep full, relatively inflexible calendars, so be sure to schedule meetings well in advance. Surprises are generally frowned upon, so don't expect to be able to change or cancel an appointment at short notice without annoying your German associates. Last minute cancellations are an even worse sin than being late.

Communication

German is the official business language, but it's hard to find people whose English isn't sufficient. It's one of the requirements for senior jobs, so Germans have no problem conducting business

in English. They take a lot of pride in it and make sure it doesn't go unnoticed. E-mails, letters, and missed phone calls should be answered as soon as possible, or the initial sender will assume you were either uninterested or suffering deep personal emergency, which might even be followed up by inquiries about your well-being. Many German companies have a rule of responding within 24 or 48 hours, and as with every other rule they adhere to, they expect the same in return.

Guten Appetit

If attending a business lunch or other meal, wait for the host to initiate most things – drinking wine, eating and conversation. Make sure to wish everyone Guten Appetit ("enjoy your meal") before digging in. When toasting with Prost! or Zum Who! Look other guests in the eyes when clinking glasses. Tips are generally between 5 and 10%. The process is to be presented with the bill and to tell the waiters how much money they will get in total, including tip: in other words, you get a bill for 95 Euros and tell the waiter you are giving him 100. Hopefully, the meal will follow the German toast Erst mach' dein' Sach dann trin' und lach! (First, take care of business, then drink and laugh!)

Gifts

Whereas in other regions, such as in Asian countries, gifts and flatteries help develop a relationship and foster business, the giving of such in Germany is unusual and is regarded rather somberly. You're a lot better off taking someone out to a good dinner.

Private Dealings

Private and public spheres of German life are generally distinct and timetabled, meaning private invitations from business partners are rare unless you have known them for years. Contacting anybody less than a very familiar German business partner outside business hours is not well received, although call-screening and other technology make the attempt close to impossible. Should you be lucky enough to get an invitation to the home of your business partner, flowers for the lady of the house and a bottle of wine are generally the accepted norms. Even though these invitations may be private, the rules of Ordnung and punctuality still apply, and deviations will be met with an equally confused and uncomprehending reaction!

Sources:

-Extracts from Germany Trade and Invest website "Markets Germany" Issue 1 / January 2016: https://www.gtai.de/GTAI/Content/EN/Meta/Press/Markets/Markets-germany/2016/Issue-2016-01/download-markets-germany-2016-01.pdf?v=2

-Extracts from: https://www.thelocal.de/galleries/others/1773

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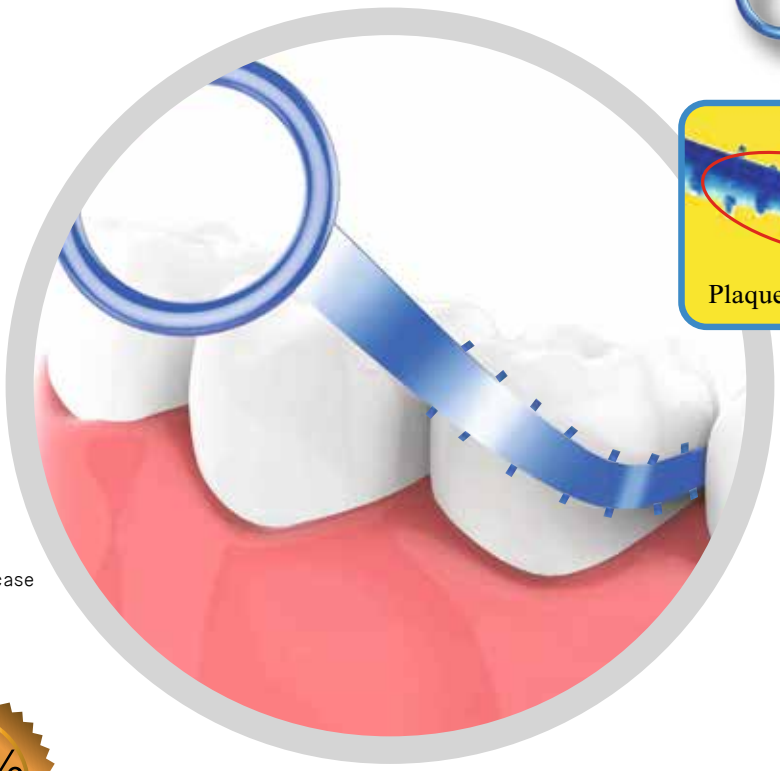

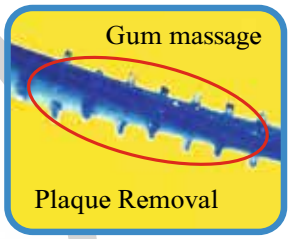

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International Dental Show 2017: Diversified supporting programme

Speakers Corner with a wide spectrum of themes - renowned employers introduce themselves - know-how tours - partners: the International Dental Show 2017

The latest products and services of the dental industry are the focus of the International Dental Show (IDS) from 21 to 25 March 2017 in Cologne. IDS offers exhibitors and visitors from all over the world an ideal platform to exchange knowledge and experiences, network and initiate business transactions - rounded off by a diversified supporting programme, which addresses all target groups and promotional groups. The events of long-standing partners also contribute towards this: The German Dental Association (BZÄK) is once again offering dentists comprehensive consulting and information, the Association of German Dental Technicians (VDZI) is distinguishing aspiring young talents from the dental technology trade for the 16th time and the Federal Association for Dental Alumni in Germany (BdZA) is also represented this year again in the form of the Generation Lounge.

The "Speakers Corner" has been established for many years: From 21 to 24 March lectures by international experts offer well-founded knowledge and the basis for expert discussions. New treatment methods play just as much a role as the theme practice organisation. All legal aspects of everyday practice life are addressed. Many lectures deal with the digitalisation of the industry: 3D print, Cloud computing, dental photography, CAD/CAM applications and networked collaboration are some of the keywords that are particularly moving the industry in 2017.

The event is being held for the first time on a spacious surface in the lit-flood Passage between Halls 4 and 5.

The complete programme can be found under our event search.

IDS as a career kick-start

The IDS Career Day will be held for the second time on 25 March, also in the passage between Halls 4 and 5. Here, among others Dentsply, Sirona, Ivoclar Vivadent as well as VITA Zahnfabrik H. Rauter GmbH & Co. KG will be presenting their offerings in the section of professional training, further development and career promotion in the scope of lectures and individual consulting. This enables university graduates, trainees from the fields of dentistry and dental 2/3 technology as well as pupils and school leavers, who want to find out about attractive training and career opportunities in the dental sector, to gain a first impression of the various spheres of activity of the participating companies. In addition, the "Career Day" offers fully-trained persons or career changers information about further training options and career opportunities in the dental sector.

Dentists at a glance

The German Dental Association (BZÄK), together with its partner organisations, will offer information and discussion rounds on various different topics relevant to dentists at their stand. The stand in Hall 11.2, Aisle O/P, Stand 50/59 that is following this year's motto: "Politics, Practice, Partner - Living dentistry together," will not only play host to the German Dental Association (BZÄK), but also the Institute of German Dentists (IDZ), the Centre for Dental Quality (ZZQ), Zahnärztliche Mitteilun-

gen (zm) trade magazine, the Relief Organization of German Dentists for Leprosy and Disaster Areas (HDZ), the Federal Association of Dental Students in Germany (BdZM), the Federal Association of Dental Alumni in Germany (BdZA), the Dentista Association, Campaign Toothfriendly (AZEV), the Association for Dental Hygiene (VfZ) and the Young Dentists Worldwide (YDW).
Moreover, the BZÄK will once more organize the "Aid organisations" coordinating conference at IDS, which is taking place on 24 March 2017 and which aims to allow representatives of dental aid organisations to share their experiences and network.

Presentation of the 16th Gysi Prize
The coveted gold, silver and bronze medals and certificates will be awarded to the prize winners of the 16th Gysi Prize competition in a festive awards ceremony on March 23. The renowned young talents competition organised by the Association of German Dental Technicians (VDZI) honours trainees in the dental technician trade. The winning entries from the three groups will be on display for the duration of the fair at the passageway between Halls 10 and 11. Furthermore, the VDZI is presenting information on the latest developments for dental technicians at its exhibition stand in Hall 11.2, Aisle S, Stand 10/12.

Generation Lounge
The Federal Association for Dental Alumni in Germany (BdZA) is represented at the IDS again with its Generation Lounge in Passage 4/5. Here, primarily themes such as career planning, practice change-overs and the networking between experienced colleagues and young graduates.

Exchanging experiences beyond the exhibition halls
The so-called "Know-how Tours" are also taking place again in 2017: To round off 3/3 the second and third day of the fair, a small group of interested people will view modern Cologne dentist surgeries in the scope of exclusive tours and thus receive the opportunity for a professional exchange with famous colleagues.

About IDS
IDS (International Dental Show) takes place in Cologne every two years and is organised by the GFDI Gesellschaft zur Förderung der Dental-Industrie mbH, the commercial enterprise of the Association of German Dental Manufacturers (VDDI) and is staged by Koelnmesse GmbH, Cologne.

100 years of VDDI
The VDDI celebrated its 100th anniversary in 2016. It was founded as the Association of German Dental Manufacturers on 24 June 1916 and organised the first Dental Show in 1923. In 1928 the VDDF organised the first International Dental Show. Today, the VDDI has 200 member companies with 20,000 employees. The overall turnover is more than Euro 5 billion with an export share of 62 percent.

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North American companies back at IDS, Cologne with record breaking numbers

January, 2017 Chicago/Cologne
When it comes to dental innovation and dental export promotion, U.S. companies take top rank in the global marketplace. This year, the North American dental industry is back in Cologne with virtually all major players and many new-to-market companies underlining the strong condence the industry consistently places in the powerhouse called IDS Cologne which will take place from March 21-25, 2017.

Attendees will have access to products from well over 200 North American suppliers (198 U.S, 15 Canada, 4 Mexico) who will show everything from Abrasives, Dental Materials, Dental Chairs, Implants, Filling Materials, Orthodontics to Lighting and Laser Devices. This year 125 exhibitors and co-exhibitors will display their products in 3 USA pavilions in IDS halls 4.2, 2.2 and 5.1. U.S. and Canadian manufacturers and service providers can also be found as independent exhibitors in each of the ve multi-level IDS halls.

The powerful North American presence at IDS re ects a strong, international demand for high quality and reasonably priced products. The U.S. Pavilions are organized by Koelnmesse, Inc. based in Chicago with the sup- port of the Dental Trade Alliance (DTA).

A comprehensive directory listing all U.S. Exhibitors will be available at all IDS info counters and around the USA pavilions, as well as online. Exhibitors can be searched by products or hall location. The directory also serves as a follow-up tool to reach exhibitors after IDS has concluded.

International dealers and dentists with interest in North American products are encouraged to visit the USA pavilions in halls 4.2., 2.2 and 5.1.

For more information please contact:
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17

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Bulmedica - Buldental 2017 - 51st International Specialized Exhibition for human and dental medicine

(Sofia - Bulgaria)

Organized by: Inter Expo Center Sofia, Bulgaria

Tel: +359 2 9655 220 / +359 2 9655 279
Fax: +359 2 9655 231
Email: iec@iec.bg

Project Manager: Gabriela Lubenova
Email: glubenova@iec.bg
Tel: +359 2 4013 279
Fax: +359 2 9655 231/ +359 2 4013 231
Venue: Inter Expo Center
Add: 147,Tsarigradsko shose blvd

www.bulmedica.bg/en

18

18-20/05/2017

Expodental Meeting 2017

(Rimini - Italy)

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Phone: +39 02 70061222 - Fax: +39 02 70006546
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Phone: +39 02 700 61223
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Fabio Catellani
Email: sales@expodental.it

Phone: +39 02 700 61229
www.unidi.it

22

22-25/05/2017

APDC 2017 - The 39th Asia Pacific Dental Congress

(Macao - Macao)

Organizer:
Kenes MP Asia Pte Ltd
Pico Building, 20 Kallang Rd., Singapore 339411, Singapore
Phone: +65 6292 0723
Email: Singapore@kenes.com

Website: www.kenes-group.com
International Exhibitors: Mr Onur Bucak
Phone: +90 212 299 9984
Fax: +90 212 299 9977
Email: obucak@kenes.com

Hong Kong Exhibitors: Ms Dorothy Liu
Phone: +852 2528 5327
Fax: +852 2529 0755
Email: dorothy.liu@hkda.org
Venue:
Hong Kong Convention and Exhibition Centre

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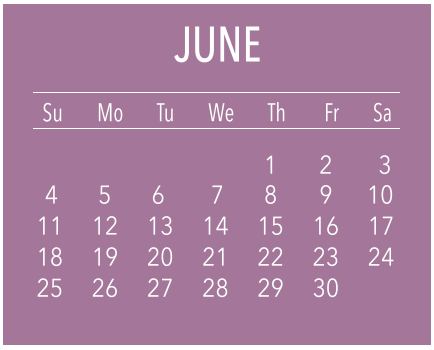

2017
June

2

02-04/06/2017

SIDEX 2017 - The 14th Seoul International Dental Exhibition & Scientific Congress

(Seoul - Korea, South)

Organized by:
Seoul Dental Association (SDA)

Managed by:
SIDEX Organizing Committee
81-7 Songjeong-dong Seongdong-gu
Seoul 133-837, Korea
Phone: +82 2 498 9146 - Fax: +82 2 498 9147
E-mail: sda@sda.or.kr
Website: www.sidex.or.kr

Exhibition Venue: COEX
(Seoul Convertion and Exhibition Center)

eng.sidex.or.kr

9

09-12/06/2017

SINO-DENTAL 2017

The 22nd China International Dental Exhibition and Scientific Conference

(Beijing - China)

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Commission
Add: Rm. 703,B3 Wudongdalou,
No.9 Chegongzhuang Street
Beijing, 100044 - P.R.China
Phone: +86 10 88393917 - Fax:+86 10 88393924
Email: info@sinodent.com.cn
Website: www.sinodent.com.cn+
Contact person: Ms Carol Kang
Email: kangle@ihecc.org
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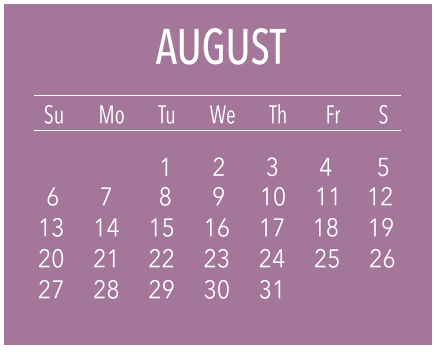

29

29/08-01/09/2017

FDI 2017 - Annual World Dental Congress - Accompanied by World Dental Exhibition

Infodent's Booth:

Hall: 7 booth: A21- A22

(Madrid - Spain)

Organised by:
Exactus Sp.j.
PL 90-418 Lodz
Al. Kosciuszki 17
Phone:+48 4263 22866
Fax: +48 4263 22859
Email: exhibition@fdi2016poznan.org

Venue:
IFEMA - Feria de Madrid
Avda. del Partenón, 5.
28042 - Madrid (Spain)
Phone: +34 91 722 5000

North Convention Center:
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Exhibition Area- Halls 3, 5, 7

Worldwide Upcoming Events

2017 September

14

14-16/09/2017

CEDE 2017 - The 26th Central European Dental Exhibition

(Poznan - Poland)

Organized by: EXACTUS
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90-418 Lodz
Phone: +48 42 632 28 66
Fax: +48 42 632 28 59
Email: info@exactus.pl, cede@cede.pl, info@cede.pl
Website: www.exactus.pl
Venue: Poznan International Fair grounds
Add: Glogowska Str. 14
60-734 Poznan
Poland
www.cede.pl

15

15-17/09/2017

IDEC 2017 - Indonesia Dental Exhibition & Conference

(Jakarta - Indonesia)

Organised by: Koelnmesse Pte Ltd
Jl. Cikatomas 1 no 7
Kebayoran Baru
Jakarta Selatan - Indonesia
Email:
Corrine Zhang: c.zhang@koelnmesse.con.sg
Dian Ariestya: dian@api-event.com
Drg. Monica Dewi R.: monic@pdgi.or.id

Venue:
Jakarta Convention Center

www.indonesiadentalexpo.com

25

25-28/09/2017

Dental Expo Moscow 2017 - 42th Moscow International Dental Forum & Exhibition

(Moscow - Russia)

Organised by: Dental Expo
B.Yakimanka 38A, 1 staircase, 2 floor
(Metro "Oktyabrskaya", "Polyanka")
Moscow
Russia
Phone: +7 495 921 4069
Fax: +7 495 921 4069
Email: info@dental-expo.com
Director of Moscow exhibitions: Ms Natalia Khokhlova
Email: rus@dental-expo.com

General manager: Mr Ilya Brodetski
Email: brodetski@dental-expo.com

Venue: Fairgrounds Crocus Expo, Pav. 2, Halls 5, 7, 8
Moscow, Russia

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15	16	17	18	19	20	21
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29	30	31				

2017 October

5

05-07/10/2017

EAO 2017 - European Association of Osseointegration Congress

(Madrid - Spain)

EAO Congress organisation and scientific secretariat office

c/o Colloquium
13-15 rue de Nancy
75010 Paris - France
Phone: +33 1 44 64 15 15
Fax: +33 1 44 64 15 16

E-mail: eaocongress@clq-group.com
Website: www.eao.org

www.eao-congress.com

12

12-14/10/2017

Dental World 2017 - 17th edition

(Budapest - Hungary)

Event Organizer Hungary Ltd.
Hungary 1012 Budapest, Kuny Domokos utca 9
Phone: +36 1 202 2994 - Fax: +36 1 202 2993

Email: info@dental.hu
Website: www.dentalworld.hu

Venue:
HUNGEXPO Budapest Fair Center
Add: 1101 Bp, Albertirsai Ã°t 10
Budapest - Hungary

www.dentalworld.hu

12

12-14/10/2017

Pragodent 2017 - The 25th Annual of International Dental Fair

(Prague - Czech Republic)
Organised by: INCHEBA EXPO PRAHA, spol. s r.o.
Vystaviste 67, 17090 Praha 7

Email: info@incheba.cz
Website: www.incheba.cz

Contacts
Project Manager: Ing. Marcela Benesova
Phone: +420 220 103 491
Fax: +420 220 103 492
Email: m.benesova@incheba.cz

Venue: Incheba Expo Praha

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2017 October

25

25-28/10/2017

DenTech China 2017 - The 21st International Exhibition and Symposium on Dental Equipmant Technology and Products

(Shanghai - China)

UBM China (Shanghai)
9F, CIROS Plaza, No 388 Nanjing West Road,
Huangpu - Shanghai, 200003 - China
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Phone: +86 21 61573953 // +86 21 61573953
Email: sandra.shen@ubm.com
Griffin Ge - Marketing Supervisor: Griffin Ge
Phone: +86 21 61573952 // +86 21 61573952
Email: griffin.ge@ubm.com
Sales Manager Assistant: Vivian Zhou
Phone: +86 21 61573954 // +86 21 61573954
Email: jc.zhou@ubm.com
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27-29/10/2017

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2017 November

26

26-29/11/2017

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(New York City - USA)

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(Madrid - Spain)

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www.ifema.es
infoifema@ifema.es

April

13

13-15/04/2018

IDEM Singapore 2018 - International Dental Exhibition and Meeting

(Singapore - Singapore)

Organised by: Koelnmesse Pte Ltd
152 Beach Road
#25-05 Gateway East
Singapore 189721

Contact
Wyatt Lee (Project Manager)
Phone: +65 6500 6700
Email: w.lee@koelnmesse.com.sg

Venue: Suntec Singapore Convention & Exhibition Centre
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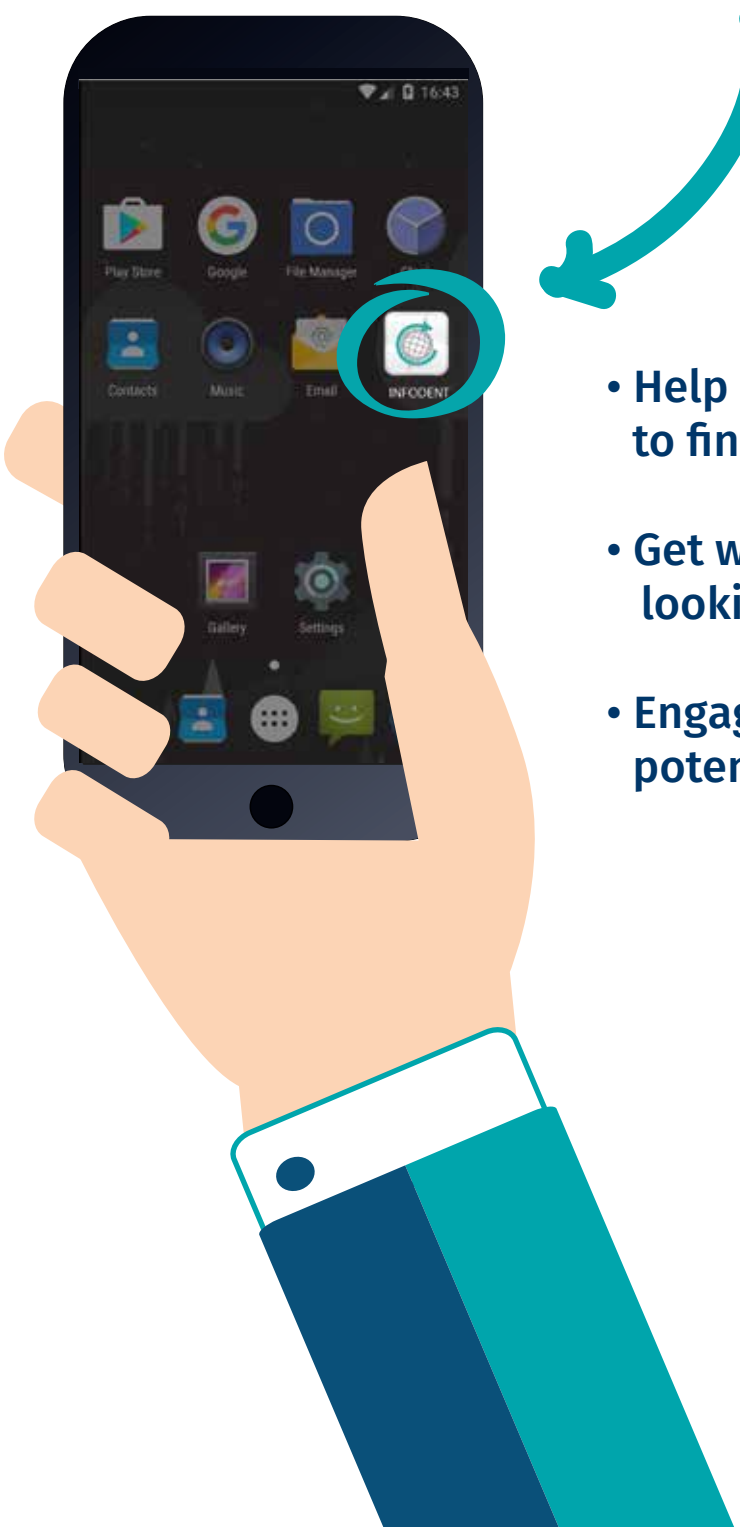

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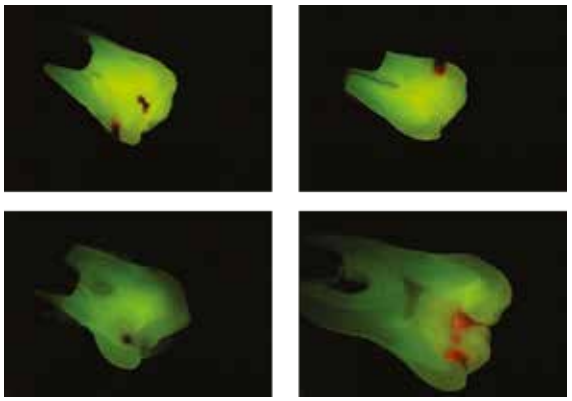

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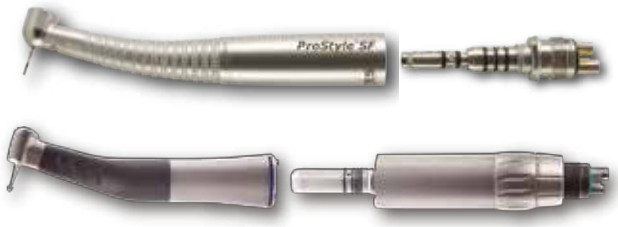

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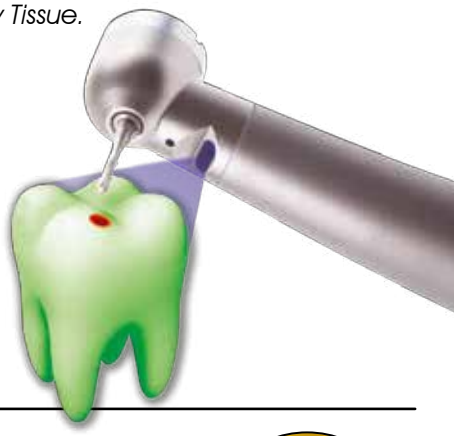

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