Mukherjee admits oral health challenges, calls for revolution

FDI Worlddental Daily

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An interview with GSK’s David A. Ross and FDI President Dr Tin Chun Wong

At yesterday’s opening ceremony of the FDI Annual World Dental Congress here in Greater Noida, the President of India, Pranab Mukherjee, called for a revolution in oral health comparable to the changes in agriculture and rural development his country experienced. The Seventy-eight-year-old, who attended yesterday’s ceremony at the India Expo Centre and Mart as guest of honour, said that his government is well aware of the poor standards of oral health in the country. Several programmes and projects conducted by his government and organisations like the Indian Dental Association (IDA) are underway to raise awareness of the importance of good oral health and hygiene among different segments of the Indian population, with the FDI AWDC being one of them.

Mukherjee, who has served as head of state since mid-2012, when he was elected in a landslide win against leftist rival candidate Purno Agitok Sangma, accepted the invitation from the IDA in Mumbai to attend the international event for dentistry, which has been organised in partnership with the Geneva-based dental federation. According to the FDI, the event has received significant interest, with more than 10,000 registrations from dental professionals in India alone.

“We are delighted to have selected India as the venue for this year’s Annual World Dental Congress and to have had the pleasure of working with our colleagues at the Indian Dental Association to secure a memo-
dition to council and committee meet-
ings on various issues, scientific pre-
sentations will continue today with topics focusing on financial manage-
ment, tobacco control, management of caries and prevention of dental im-
plant failure, among other things. Over 100 speakers from India and abroad are presenting at the event. Dental innovations are on display on the ground floor, where over 200 dealers and manufacturers are showcas-
ing their latest product developments and solutions, some of which have been made available to the Indian market for the first time.

For information and news about this year’s event in Greater Noida, please visit the Dental Tribune website at www.dental-tribune.com or scan the QR code at the bottom left corner of this page.

Mr Ross, what was the incentive for your company to seek endorsement for the new training modules by the FDI?

David A. Ross, Global Head of Sales Force Effectiveness at GSK Consumer Healthcare, and FDI President Dr Tin Chun Wong on Thursday morning to discuss briefly the part-
cernship and its long-term implica-
tions.

Worldental Daily: Mr Ross, what was the incentive for your company to seek endorsement for the new training modules by the FDI? David A. Ross: At GSK, we put a massive amount of weight behind the science of our consumer brands. This element, however, should drive A as a first, GlaxoSmithKline (GSK; Booths A131–A142) recently announced that it has recently announced that it has developed sales representatives training modules that will be regu-
larly reviewed and upgraded with the help of the FDI World Dental Fed-
eration. Worldental Daily had the opportunity to sit down with GSK’s Executive Producer: Gernot Meyer

About the Publisher

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not only customers but also our experts, who represent the scientific credibility and patient benefits that those brands deliver. What we want to ensure with this programme is that our representatives are up to date with the latest knowledge. Around two years ago, we started discussions with the FDI, asking whether they could help us to raise the standards of education that are expected of our representatives, so that they can represent all of that scientific knowledge when they are in front of a dentist. We thus developed these modules, which will allow us to train our representatives to standards set by the FDI.

What areas do these modules cover, and how do they correspond to the FDI’s mission to achieve good oral health worldwide?

David A. Ross: The training modules we are developing with the FDI really look to building a GSK representative’s knowledge of disease, anatomy, physiology, disease processes and therapy in oral health. This knowledge will allow them to establish good communication with the dentist and discuss a range of oral health matters, including caries, dentine hypersensitivity and gingivitis, all the common conditions dentists need to treat every day.

What are the long-term implications of this programme, and what are the requirements for it to continue?

David A. Ross: Initially, we set up the programme to run for three years with the FDI. Every year, they will review our training materials and upgrade them to certify that our representatives reach the required standard. We envision this programme continuing year after year.

It is quite exciting. There is a great deal of development in dentistry and we need to ensure that our sales force not only understands what we do at GSK, but also has a wider understanding of the greater context of dentistry. In order to talk to a dentist, they need to be able to discuss a whole range of subjects. 

Dr Tin Chun Wong: GSK has the products dentists want to use to treat their patients for improving their oral health. Sales representatives, therefore, need to be well versed in the science and the manner in which dentistry is delivered through these products. As we truly represent over one million dentists worldwide through our member associations, we are very aware of the cultural differences, the different needs and demands, as well as oral health care necessities, in various countries and regions. Through the programme, we can pass this particular knowledge on to GSK’s representatives, allowing them to better help our members provide optimal oral health care.

Thank you very much for the interview.

Dr Tin Chun Wong: I know that GSK runs extensive research projects in terms of oral health, which allow continued product development. Often, however, dentists and dental health care workers are not aware of the specific performance of each product. By dealing with trained representatives, dental professionals can communicate their needs to them better, so that the representatives know what dental professionals want and what patients want, and can help dental professionals establish the best means by which to achieve good oral health. Therefore, if you ask what the outcome will be, it’s optimal oral health for the world’s population.
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Made in Finland
New report to help integrate a CP-oriented healthcare culture in professional dental training

By Prof Nermin Yamalik and Dr Ward Van Dijk, co-Chairs, FDI Task Team on Collaborative Practice

FDI has just issued its eagerly-awaited preliminary report ‘Optimal Oral Health through Inter-Professional Education and Collaborative Practice’. It is the result of work carried out by a special Task Team set up in 2013 and draws inspiration from FDI Vision 2020 and several subsequent expert consultations.

According to the World Health Organization (WHO), collaborative practice (CP) happens when multiple health workers from different professional backgrounds work together with patients, families, carers and communities to deliver the highest quality care. It can mean intra-professional collaboration, for example among members of the oral healthcare team, and inter-professional collaboration between different medical professions.

In support of CP, Inter-professional Education (IPE) is an essential tool for enabling students from two or more professions in health and social care to learn together during all or part of their professional training, and thereby integrate a CP-oriented healthcare culture.

CP and IPE are not end goals. They are a response to a new healthcare environment characterized by changes in disease patterns, access to care issues, and the challenge of catering to the requirements of ageing populations. They are strategies to improve access to care, enhance efficiency and quality, and reduce costs.

For example, a recent report by the American Dental Association and published in the American Journal of Public Health has estimated that screenings by dentists for the most common chronic medical diseases could save the American health care system as much as US$102.6 billion annually, with healthier outcomes for patients. In practical terms, the CP should encourage a move from cure to patient-centred care.

Although dentists have already made great strides forward, the new CP report will undoubtedly have repercussions for the profession. FDI is of the view that, on issues of collaboration to advance oral health and contribute to the improvement of general health and quality of life, dentists, as front-line medical professionals in the prevention, early detection and treatment of oral and systemic diseases, should play a leadership role.

The profession should therefore be part of the political dialogue at a national and global level and recognized as a driving force behind the development of CP competencies and implementation of any CP model.

A review of CP literature indicates that collaborative practice models, introduced within a variety of contexts, have the primary objective of improving different aspects of healthcare delivery: increasing access and quality, lowering costs, and improving practice productivity and efficiency as well as clinical outcomes and patient satisfaction.

The recently-issued FDI report has assembled examples of collaborative practice from around the world, reproduced without comment or value judgment: there is no one-size-fits-all solution, and models are appropriate or not according to national context.

Together, this material should serve to expand the dialogue on intra- and inter-professional collaborative practice and inter-professional education, and facilitate the policy and advocacy work undertaken by National Dental Associations (NDAs) for the planning of the future oral health workforce (OHW). It will thereby enhance the ability of the dental profession to lead change rather than have solutions imposed.

The work FDI is undertaking in collaborative practice will secure the role and relevance of the dental profession within the healthcare system not only now, but also in years to come.
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Prof. Francisco Ramos-Gomez: Unfortunately, there are only very prevalence few reports that include data from children aged 1 to 5, as most of the surveillance studies that have been conducted worldwide begin with a six-year old molar, which is an age that is already very late considering how early ECC can occur in a child’s life. However, we expect the prevalence of ECC to be over 60 per cent in some areas of the world.

According to reports, the majority of dentists in India are unfamiliar with the concept and implementation of the “Age One Visit” to prevent early childhood caries. Could you please explain why prevention of the disease is pivotal?

ECC is transmitted from the parent or caregiver to the child, and if left untreated, can lead to infection and severe pain. As a consequence, children can experience difficulties in eating and speaking, which will have an effect on their readiness for school and their overall quality of life. Most dentists, unfortunately, tend not to see children before they have reached the age of five or six. They do not realise that poor oral health and malnutrition, especially during pregnancy, can lead to disruption in the formation of enamel, among other things.

You need to have skilled paediatric and general dentists. A lot of general dentists who are exposed to these conditions do not have the means or the experience to deal with oral diseases in children at this early age.

What in your opinion are the most important oral health challenges that prenatal women and infants are confronted with?

There are several challenges that mothers and their children have to deal with including those posed by a poor diet and malnutrition. Many infants, particularly in developing countries, are exposed to high amounts of sugars, to name just an example. There is also a general lack of good oral health hygiene during and prior to when the first tooth is erupting in the mouth. Fluoride is something I have to mention here as well, because many dental providers do not recommend the use of fluoridated toothpaste at a young age, which really goes against new guidelines put up by organisations like the American Dental Association, the American Academy of Pediatrics, the American Academy of Pediatric Dentistry, and others, who recommend the use of fluoridated toothpaste as soon as the first tooth is in the mouth. Water fluoridation has been one of the most effective public health strategies for caries reduction in the last 68 years. Therefore, it is essential to have a whole campaign about the need and the effectiveness of daily use and consumption of fluoridated water.
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Besides fluoridation, what tools are currently available for dentists to help prevent diseases like ECC?

The concept of early risk assessment was proposed in the US almost 20 years ago. In 2003, the American Academy of Pediatrics finally endorsed the use of caries risk assessment. Cariology Management by Risk Assessment, also called CAMBRA, has three main domains. First, you have all the risk factors and second, you look at the protective factors present. Finally, you have the clinical findings. You try to balance the risk factors, with the goal of improving the clinical findings, by introducing as many protective factors as possible.

By age 1, we look into the mouth to ensure that the child has no signs of early childhood caries, which is generally characterised by very chunky white lesions around the tooth. These are the first signs of disease progression in these young kids. Then we start treating the white spot lesions with combination therapy, including fluoride varnish application, for example. It has shown to be very effective, as long as there is parental engagement to some extent. You really have to address changing the behaviour of the caregiver or the parent. They then bring these changes to their children. We actually spend a lot of time teaching and learning about parental engagement and how we can convey the value of good oral health to these families at a very early stage. They might have had a bad experience with their dentist in the past, but we need to show them that this is a 100 per cent preventable disease.

Adults have control of what they do at home, like reducing the child's consumption of unhealthy snacks and sugary foods like juice or sugar liquid substances, throughout the day and the night.

The one recommendation we usually struggle the most with is to emphasise the need for brushing or removing the plaque, especially at night, and exposing the child to fluoride toothpaste. This should generally be the last thing touching the teeth before they go to bed.

With this in mind, what are the prospects for such a concept to be implemented in countries like India, where oral health awareness is relatively low?

We need interprofessional collaboration between medicine, dentistry and related areas like nursing. I already spoke about interprofessional collaboration. Does this imply characterisation of early childhood caries, which is generally characterised by very chunky white lesions around the tooth. These are the first signs of disease progression in these young kids. Then we start treating the white spot lesions with combination therapy, including fluoride varnish application, for example. It has shown to be very effective, as long as there is parental engagement to some extent. You really have to address changing the behaviour of the caregiver or the parent. They then bring these changes to their children. We actually spend a lot of time teaching and learning about parental engagement and how we can convey the value of good oral health to these families at a very early stage. They might have had a bad experience with their dentist in the past, but we need to show them that this is a 100 per cent preventable disease.

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Secular trends are phenomena in physical maturation that are not cyclical or seasonal but develop over a relatively long period. An analysis of these patterns is of interest because they help us to understand the relationship between human development and the environment, as well as physiological aspects of intergenerational relationships in growth.

More importantly, secular trends can serve as indicators of developments in public health as it changes over time. To give an example: the average age of menarche was 17.5 years during the 1800s and since then has decreased progressively at a rate of two to three months per decade. In 2006, a study on Irish females found that the average age of menarche was 12.53 years.

In addition to skeletal development, secular changes have been reported with regard to body weight, body mass index and other physiological aspects of the human body, such as the dental arch or facial dimensions and other orofacial structures. They can be attributed to several factors, including changes in genetic pattern, socio-economic status, as well as nutrition, health and climatic conditions.

Unlike skeletal development, however, dental maturation remains relatively unaffected by other maturation phenomena. The secular changes observed in dental development, which includes dental maturation and emergence, are reflections of these minor changes that have been occurring over several years.

While dental maturation is the development of the anatomical components of a tooth, a process that starts with the initiation of crown formation in utero and continues until closure of the root apex in the early twenties, dental emergence is the eruption of a tooth into its relative position in the arch.

There is evidence that secular trends exist for both of these processes. For example, research has demonstrated delayed dental maturation in the remains of eighteenth-century children compared with dental records of children living in modern England. By analysing the maturation of a permanent tooth, Nadler also found that children living in the 1990s showed advanced maturation compared with children born two decades earlier.
A similar trend was observed in dental emergence in a study that found advanced emergence in Japanese children from the 1980s compared with children in 1934. Detected mostly in the permanent dentition, and to a minimal extent in the primary dentition, this finding was verified by research involving children in Finland, Germany and Hong Kong.

Dental development is a sequential process that varies substantially between the sexes and between populations with different ethnicities. For example, many studies have reported advanced dental development in females compared with males, a finding that is prevalent in all population groups. Similarly, advanced dental emergence has been observed in African-American children compared with Chinese and Japanese children.

Various secular trends have also been found in maxillary and mandibular dentition. There is widespread agreement that the latter is more advanced in dental maturation, as well as emergence, since mandibular teeth are the first to erupt in the oral cavity in both the primary and permanent dentition.

Nadler reported advanced dental maturation based on evaluation of only the growth pattern of a mandibular canine. The reason for this approach comes from an earlier study that found a correlation between the maturation of mandibular canines and ossification centres in the hand. This study also concluded that a strong relationship exists between dental and skeletal development. The use of a single tooth type to analyse secular trends has been criticised by several authors for ignoring that each tooth type exhibits different patterns of maturation. It has been suggested that all developing teeth must be included in the analysis in order to confirm a secular change. In our own study of 5- and 6-year-old children in Hong Kong, we found accelerated maturation of permanent teeth in children born in 2001 compared with children born in 1981. However, this trend was observed only in the maxillary dentition. As agreed by other investigators, in both year cohorts, females showed advanced development compared with males.

With such strong evidence, we need to bring the applicability of common dental atlas charts, such as those developed by Schour and Massler, whose tables and charts are based on institutionalised American Caucasian children in the 1920s, to the current population into question. A recent study conducted in London tested the applicability of old and modern dental charts and found that the older charts were inaccurate. However, most clinical textbooks in dentistry still reproduce these charts, mainly because few other population-specific dental charts exist.

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There is a need for evidence-based dental charts created from modern and healthy samples identified by sex and ethnicity. Once created, they could not only serve as an eminent tool in forensic dentistry for estimating the age of subjects with undocumented birth records, but also provide insight on current dental development standards that could be utilised for appropriate time-related management of dental conditions.

A list of references is available from the publisher.

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