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Intended for dental professional communication only.
Greetings from the Malaysian Dental Association and welcome to our MDA News October – December 2015 issue. I wish to take this opportunity to wish our Hindu dental colleagues, Happy Deepavali and our Christian dental colleagues, Happy Christmas. Indeed, the Christmas celebration signifies the coming of the end of year 2015. I must say that within a period of just three months since our last issue of MDA News, our Council Members have been kept busy with their official duties be it locally and abroad. Please do take some time to read our reports to keep abreast with current issues and happenings in the world of dentistry. In this issue, we wish to highlight another very prominent figure, a living local dental legend in our time, Dato’ Dr A. Ratnanesan. We wish to share with all of you his passions, struggles and achievement for the Malaysian dental profession and his significant role at the international arena.

I also wish to extend my heartiest congratulations to Dr. Noor Aliyah Bt Ismail on her recent appointment as our Principal Director of Oral Health, Ministry of Health Malaysia. On the international front, Dr. Patrick Hescot is now the new President of FDI World Dental Federation. He began his two-year mandate on 24th September, following an inauguration ceremony during the meeting of the FDI General Assembly, the federation’s governing body, in Bangkok. Again, as in previous issues, we also wish to make our MDA News educational for our members by including some scientific articles prepared locally.

So...Year 2016 is just around the corner. A friendly reminder and invitation to all members regarding the upcoming 23rd Malaysian Dental Association Scientific Convention and Trade Exhibition (SCATE) 2016 at Putra World Trade Centre from 15th – 17th January 2016. Registration is still open; please check out our MDA Homepage for further details on the programme arranged. Please do not hesitate to contact me at kjleong18@hotmail.com for comments or suggestions. Cheers!

Year 2015 is coming to an end & Year 2016 is soon unfolding.

HAPPY NEW YEAR 2016!!!

Thank you.

Dr Leong Kei Joe
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Renewal of EBSCO Service on MDA Website

AFTER prolonged deliberation on this issue by the council members, we have decided to renew our subscription with EBSCO for another year to enable our members to perform online search for dental journals at no extra cost. This decision was made even though the access rate by MDA members to this service was low and didn’t seem to justify the high price of the annual subscription fee of around US$16,000 or RM70,000 paid by MDA. The MDA Council felt that access to online journals for research purposes and continuing professional development is of utmost importance and hence we feel the need to publicise more on the availability of this valuable and beneficial service so that more members will be aware of it and start to utilise it.

Subscription Fee & Plan Revision of DPL

AS many of you are aware, for the year 2015 DPL has revised the subscription fee to RM2,085 from RM1,350 in 2014. We have just received notice from them in November 2015 that the fee may be revised again in 2016, and different plans for two specified areas, i.e. Orthodontic and Implantology, will be introduced. We have expressed our concern and dissatisfaction to them, and we are now awaiting their comment and final decision. In the meantime, MDA council is trying to source for other more affordable and reliable dental protection plans for our members. We shall keep our members informed on the progress of this matter.

2015 Dental Protection Fee
DPL Subscription Fee

RM1,350

RM2,085
Dental Act

THE Health Minister, YB Datuk Seri Dr S. Subramaniam has announced that the new Dental Bill will be tabled in October 2015, but it seems that it may not be possible until December 2015 or even March 2016. We have sent out an email blast last month to update our members on MDA’s stand on the Dental Bill. Please refer back and communicate with us if you have any question on that.

Other Matters

THE upcoming 23rd MDA Scientific Convention & Trade Exhibition will be held at the PWTC Kuala Lumpur on 15th – 17th January 2016. Please come and support this annual event and earn CPD points to prepare for the 30 compulsory CPD points for APC application once the new Dental bill comes into effect hopefully by next year.

A preliminary announcement to our MDA members that the council is working on the idea of starting a MDA cooperative project, aiming to supply reasonable dental products to all MDA members in view of the ever increasing price of the dental products. Please do not hesitate to give the council your view and feedback on this matter.
Dear Esteemed Members of the MDA,

In an extremely connected world that we live in, it is vital for us to always be well informed and up to date especially in our contactability. With this noble aspiration in mind, we sincerely urge all members of the MDA to make sure that your contact details are always current:

- EMAIL ADDRESS
- MOBILE HANDPHONE NUMBER
- CURRENT MAILING ADDRESS

This is to enable the MDA to always be able to keep you up to date with the latest information on important issues that affect the dental profession, seminars and talks, conventions both local and international. For Dental Protection Limited members, it is extremely important to keep your contact information always current so that your membership will always be up to date and you will always be covered. There have been several cases where members were hit with patient complaints during the period where they were inadvertently overdue in their subscriptions.

**IF YOU HAVE ANY DOUBT ABOUT YOUR CONTACT DETAILS, PLEASE EMAIL THEM WITH YOUR NAME TO THE MDA AT:**

mdaassoca@mda.org.my

or call 603-20951495
MDA NEWS 2016 WILL BE GOING GREEN

REQUEST FORM FOR CONTINUATION OF POSTAL DELIVERY OF MDA NEWS IN HARD COPY

Dear Esteemed Members,

Please kindly be informed that beginning of year 2016, our MDA News will be going e-copy and readily viewable online and downloadable from the members site. As such, members who wish to continue to receive their usual hard copies through postal delivery, please kindly fill in the details below and post the completed reply form back to our office at the address stated below.

YES! I would like to continue to receive my hard copy of MDA News

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54-2, Second Floor, Medan Setia 2, Plaza Damansara, Bukit Damansara, 50490 Kuala Lumpur, Malaysia.
During the month of Ramadhan, MDA Eastern Zone organised an Oral Health Education session for the medical staff of Queen Elizabeth Hospital II, Kota Kinabalu, that emphasises on the importance of oral health care during the fasting month. This event took place on the 24th June 2015 and the speaker was Dr Abd Rashid bin Hassan.

This educational talk provided an understanding on Dental Anatomy, basic science on oral dental health and the impact of fasting month on the overall dental environment, especially dehydration and accumulation of plaque and calculus.

Participants were also informed that dental treatment does not break the fasting practice, as shown by the Prophet using Siwak or Sugi during the month of Ramadhan, and that routine oral-dental should be continued during the holy month. About 40 staff members attended the talk together with Madam Nechfina, Head of CME programme from the Department of Pathology.
3rd Sabah Dental Congress 2015

Following the success of the 5th Borneo Dental Congress in March 2015, Malaysian Dental Association Eastern Zone (MDAEZ) is most delighted to organise another dental congress in Kota Kinabalu, Sabah. The 3rd Sabah Dental Congress was successfully held in Promenade Hotel, Kota Kinabalu from 10th – 11th October 2015 with the theme “Dentistry beyond ABC”. A total of 138 dental practitioners and professionals mainly from Sabah and Sarawak, and some from Brunei and Australia congregated at the congress.

The event is preceded by a pre-congress hands-on workshop, “Effortless Aesthetic and Fibre-Reinforced Composite Workshop” sponsored by GC and Kaldera in the evening of 9th October 2015 at Promenade Hotel. It was also the official launching of the GC latest products – Gaenial Anterior and Posterior and everX Posterior composite resin. This time, we offered complimentary pre-congress hands-on workshop to the first 50 delegates who registered with us. Due to the overwhelming responses from the delegates, the organising committee later increased the seat up to 75 seats.

The congress was officially launched by the Minister of Tourism, Culture and Environment, Sabah, Y.B. Datuk Seri Panglima Haji Masidi Manjun. We brought in various renowned experts from different fields to give talks and lectures, very much befitting of our theme “Dentistry beyond ABC”, beyond Art… Basic… and Conventional dentistry that we have been practising for decades. Among our notable speakers were Dr Firdaus Hanapiah who shared on implantology and dental tourism, Dr Rashid Tahir from Singapore on Paediatrics Dentistry, Dr Ha Kien Oon’s lecture on current facial aesthetics served as an eye-opener to most delegates, Prof Dr Prabhakaran on the CBCT technology and Dr Eason Soo on post endodontic treatments including post and core build up.

The 3rd Sabah Dental Congress 2015 Trade Exhibition was officiated by the Deputy Director of Dental Health Services Sabah, Dr Misliah binti Ahmad together with the chairman of the Malaysian Dental Association Eastern Zone, Dr Abdul Rashid Hassan with the ribbon-cutting ceremony. A total number of 60 traders with 30 booths from 29 companies showed their supports by participating in this dental trade exhibition. The 3rd Sabah Dental Congress 2015 team would like to extend our utmost gratitude towards the main event sponsor – GSK, workshop sponsors – GC and Kaldera, speaker sponsor – Coltene and congress bag sponsor – Advantech Dental Laboratory, and all others participating traders for their undivided support to the event.
Apart from the scientific programmes and exhibition, the 3rd SDC informal night in the evening added fun and laughter to the event. There were almost 80 delegates attended the informal night including our Guest of Honour – Y.B. Datuk Seri Panglima Haji Masidi Manjun, the Deputy Director of Dental Health Services Sabah – Dr Misliah binti Ahmad, the Director of Queen Elizabeth 1 Hospital, Kota Kinabalu – Dr Heric Corray, our invited speakers – Dr Firdaus Hanapijah and Prof Dr Phrabhakaran, MDAEZ EXCOs and also delegates of the congress. The dinner was hosted by the Minister of Tourism, Culture and Environment Sabah, Y.B. Datuk Seri Panglima Haji Masidi Manjun.

The 3rd SDC ended with a closing speech by the Organising Chairperson, Dr Alex Lo Shen En, thanking everyone for making the congress a success. The best trader was also selected among all the participating dental traders and this time, NTC walked away with a free dental trader booth during the 6th Borneo Dental Congress 2016. The congress also promoted the upcoming 6th Borneo Dental Congress which will be held in Imperial Hotel, Kuching, Sarawak from 11th – 13th March 2016.
Once again, a success was marked in the history of MDAEZ. Continuing dental education should be practiced by all dental practitioners for the benefits of the people and MDAEZ will continue to lead our dental community especially in the region of Sabah and Sarawak with more of such constructive events in the years to come. The next in line of MDAEZ project is the 6th Borneo Dental Congress, Scientific Convention and Trade Exhibition, cum 7th AGM on 11th – 13th March 2016 in Imperial Hotel, Sarawak. See you in Kuching!
New World Health Organization Guideline: 5 Teaspoons Of Sugar or Less A Day

In the FDI AWDC 2014 in New Delhi, the statement from Malaysia pertaining to prevention of early childhood caries was adopted in the FDI Policy Statement ‘Perinatal and Infant Oral Health’:

“There should be a concerted, integrated effort of parents, schools, health ministries and other stakeholders to decrease the intake of sugar in all its forms.”

Following this effort by Malaysia, the FDI AWDC September 2015 in Bangkok organised a World Oral Health Forum on ‘New WHO Guideline on Sugar Intake for Adults and Children’. The new guideline for sugar intake for adults and children is that the energy contribution of free sugar in all its forms should be reduced from the current 15-20% to 5% or less of total energy needs. The rest should come from proteins and fats. This translates practically as a rule of thumb to about 5 teaspoons of free sugar in all forms per person per day. [Note that 1 teaspoon of sugar is 4gm. One 3-in-1 white coffee contains 16gm to 20gm sugar which is 4 to 5 teaspoons of sugar.]

The problem that immediately arises is how to do it because the whole world has been addicted to sugar for the last 100 years and ever more so, resulting in not only an increase in caries but also obesity and diabetes, and all the accompanying diseases that follow. This global health emergency must be tackled...but how? Success will mean the saving of billions if not trillions of healthcare dollars that have to be spent if we do nothing.
It has been shown that the most effective measures are taxes on sugar and laws that regulate the addition of sugar to all processed foods and drinks, and clear labelling and warnings. The Malaysian participant proposed recruiting all mums to hold off all free sugars from their children and to get selected heads of states to do a 5-minute video to thumbs-down free sugars. Our chefs and home cooks will have to be convinced to hold off the sugar.

Another Feather In Malaysia’s Cap
This year in Bangkok, the Malaysian delegation represented by this writer debated on and assisted with the passing of the following policy statement of the FDI World Dental Federation:

“The new dentist should be able to carry out any kind of dental practice without harm to patients using modern, appropriate, effective and currently accepted methods of treatment.”

The passing of this statement clearly protects the professional rights of the dentist to practise any kind of dental practice which translates into a continuing hunger and eagerness to develop a lifelong learning ethos towards continuing professional development. For the public, it will mean easier access to every form of dental treatment and therefore, reasonable and affordable prices.

“Strong links exist between the responsibilities and the rights of dentists, including the right of professional autonomy, self-regulation and clinical freedom. These professional rights exist not only for the benefit of the dentists, but also enable dentists to provide quality and ethical oral health care for all members of the community, and to meet their professional responsibilities and commitments. When these professional rights are under threat, there may be a significant risk to the maintenance of professional standards.” FDI Policy Statement (http://www.fdiworldental.org/media/11175/Basic-responsibilities-and-rights-of-dentists-2007.pdf).

The Malaysian delegation also proposed a special task force to study dental facial aesthetics in the field of dentistry since the dental doctor is well placed due to their training in facial and lip aesthetics together with their detailed knowledge of facial and oral anatomy. This is vital to the continuing growth of medical and dental tourism as facial aesthetics, therapeutics, rejuvenation and enhancement is one of the fastest growth sectors in healthcare tourism. Neighbours like Singapore and Thailand are already well ahead in this sector.
The FDI World Dental Federation

The Fédération Dentaire Internationale or World Dental Federation is the United Nations of dentists throughout the world. With a membership of almost 200 nations and representing most of the one million dentists of the world, the leaders of dentistry meet once a year at different locations of the world to keep everyone abreast of the cutting edge advances in dentistry and also to deliberate extensively in putting forth authoritative policy statements on all the different aspects of the practice of dentistry. All these are to accomplish their stated mission:

“To be the worldwide, authoritative and independent voice of the dental profession. To promote optimal oral and general health for all peoples.”

FDI Policy Statements are extremely important because they become the official stands of this world body on the issues that impact the world of dentistry and ultimately, the oral health of the world since the statements represent the collective wisdom of top members of the profession from almost 200 countries and a million dentists. It goes without saying that a good command of English is essential to be able to participate effectively and influentially at such international forums. Many national policies of governments are and will be based on these FDI policy statements.

References:
This project was a collaboration by Majlis Keselamatan dan Tindakan Wanita Parlimen P174, Queen Elizabeth Hospital, Klinik Kesihatan Pergigian Penampang and MDAEZ. It was held at Penampang Library, Penampang, Sabah, on the 7th June 2015. A total attendance of 150 patients was recorded. The Health Awareness Programme was officiated by the District Officer of Penampang, Sabah. The Dental Team, headed by Dr. Florence Linus had given a free treatment and check-up to at least 80 patients. So far, no positive oral cancer case was detected. The team was awarded with 3 CPD points by the MDC.

MDAEZ wish to thank Dato’ Dr. Khairiyah Abdul Mutalib, Principal Director of Oral Health Division, Ministry of Health Malaysia, Dr. Misliah Ahmad, Sabah Deputy State Health Director (Dental) and Dr. Rokiah Aziz, Penampang Divisional Dental Official for their kind assistance and cooperation.
Dato’ Dr Ratnanesan Arumugam is an iconic figure in the dentistry world. His career is nothing short of illustrious, chalking up numerous recognition and conferment locally and internationally over the years. For the records, the 71 year old has presided over MDA for seven terms. He has worked tirelessly to bring out the best in the dental profession and MDA is privileged to sit down for a talk with Dato’ Dr Ratna about his exemplary work.

Lifelong Dedication to the Dental Profession

Interviewee:
Dato’ Dr Ratnanesan Arumugam

Interviewed by:
Gwen Ong
Paul & Marigold
Can you tell us briefly about your background?

I was born in Kuala Lipis, Pahang. We were a family of nine but two of my brothers passed on when they were two and three. My father was a civil servant. He suffered a heart attack and passed away when I was six years old. My mother was four months pregnant at that time. It was a tragic time for the family. We moved to Seremban where an uncle hosted us while another uncle got us registered at the local school. I started at the King George V School in Seremban in January 1952. I was always one of the top students despite being a sickly child.

I’m married to Datin Dr T.Yogeswari, who is a retired Government Dentist. We have three sons – Dr Avnesh, a Healthcare Consultant and CEO of Energesse in Sydney, Australia, Ashok Rudy, a Chartered Marketer and Ashvin, a Certified Public Accountant with Petronas Lubricants International. Currently, I’m attached to the Pantai Medical Centre in Kuala Lumpur as a Consultant Oral & Maxillofacial Surgeon.

Let’s go back in history; how did you get into dentistry?

My ambition was to do medicine. When I was in Form One, my uncle had promised to send me to Australia to study medicine but unfortunately, he met with an accident one night and perished. I was devastated. His untimely passing shattered all my dreams. During that time, a few of my friends had obtained admission to the prestigious Federation Military College (FMC) at Port Dickson (now called the Royal Military College). I was interested in following suit. However, my mother and grandmother were concerned because of my poor health. I was adamant on going because we had no godfathers to assist us. The FMC, a unique institution, provided food, lodging, excellent education and a subsistence allowance to go with it. I struggled with the tough discipline but survived and made lifelong friends there.

Upon reaching Form Six, University of Malaya had begun its course in Medicine and the other option was the University of Singapore. Before the Higher School Certificate Examination was due, I went on a camping trip to Penang with my friends. On my return journey, I fell ill. I returned home. The General Hospital in Seremban diagnosed my condition as malaria. I recovered and returned to the college a month before the exams. Despite my best effort, I missed out narrowly to secure a medical seat. I was offered Dentistry at the University of Singapore instead. This was how fate played a dominant role in my foray into dentistry.

What do you remember most about your days as a dental student?

When I went to Singapore, my health got better. I was in my element. Professor J.A. Jansen recognised my strength and potential. He put me in charge of Year One. I was actively involved in many activities and I must pay tribute to the leadership training I obtained at the Federation Military College. I became the President of the Dental Society, the Administrative Secretary of the University of Singapore Students’ Union, and the first dental student to be President of the King Edward VII Hall (medical hostel). Through Professor Jansen’s guidance, a few friends and I, initiated and founded the Asia Pacific Dental Students Association. The inaugural meeting was held in August 1968 in Tokyo, Japan when I was a final year student. Despite my many digressions, I graduated with a distinction in January 1969!

How did your career in dentistry take off?

After graduation, I returned to my hometown, Seremban. I began service under the Ministry of Health on 1st March 1969. I was posted as a Dental House Officer to the General Hospital Seremban. I have always been interested in the academia. I wanted to specialise. The hospital practice inspired me. It was there that I learnt the important basics in Clinical Oral Surgery and General Dentistry. The state dental specialist, the late Dr Tan Cheng Keat was my mentor. Confident in me, he left me to be on my own a lot of the time. After my housemanship, I was posted as the Dental Officer in Mentakab. I was in charge of the whole Temerloh district, which is the largest district in West Malaysia! Subsequently, I was posted to Tampin before being posted back to Seremban General Hospital.

In 1975, I had the privilege of being selected by the Ministry of Health to further my studies in the United Kingdom under a two-year Colombo Plan Scholarship. I was truly motivated. I obtained three post-graduate Fellowships from the Royal Colleges of Glasgow, Edinburgh and Ireland (in Oral Surgery) within 13 months. Thanks to my previous training and positive referrals. I felt rewarded in my choice of entering dentistry. However, as a result of my success, I was recalled to Malaysia. I was appointed as the State Dental Specialist in Kangar, Perlis, where I served for four years.

Following my appointment in Perlis, the restive me successfully obtained the Master in Dental Surgery (in Oral Surgery) from my Alma Mater, the University of Singapore. In my last two years in Kangar, I was
concurrently acting State Dental Consultant in Alor Setar, Kedah. I was then promoted to be the Consultant Dental Surgeon Pahang based in the General Hospital Kuantan. I served in this capacity for two years before entering private practice in Kuala Lumpur. I truly enjoyed my stint with the Ministry of Health.

For my services to the State and Nation, I was awarded with:

- Bintang Ahli Mahkota Perlis by His Highness, the Raja of Perlis in 1979.
- Bintang Kesatria Mangku Negara by His Highness, the King of Malaysia in 1991.
- Darjah Indera Mahkota Pahang by His Highness, the Sultan of Pahang, which carries the title of Dato’ in 1996.

You’re known to have helped raise the standards of dentistry in Malaysia. What were some of the initiatives that you were committed to?

I was always interested in continuing education. After resigning from the government service, I came to Kuala Lumpur and realised that continuing professional development, in particular continuing education programmes in dentistry were severely lacking. This was back in 1982. In 1983, I became President of the Malaysian Private Dental Practitioners Society (MPDPS) – for a period of three terms. In this capacity, I organised ambitious programmes in continuing education and continuing professional development.

I was determined to improve the image of the profession, particularly in the eyes of the community we serve and our medical colleagues. In the hospitals I served, I interacted with all the other medical consultants and was recognised for my role as a specialist in the maxillofacial region. I repeatedly emphasised that “Dentistry is a speciality of Medicine” and that “Oral Health was an integral part of Total/General Health”. In April 1985, we in the MPDPS organised the first implant course with about 150 participants. I was the organising chairman and with the support of my colleagues produced an outstanding workshop, which was a raving success. It set the stage for crucial development in Implant Dentistry and management of Oral and Maxillofacial conditions.

With my passion to advance dentistry in the profession, I liaised with the Royal College of Surgeons of England (UK) to establish a partnership with the Malaysian Dental Association to conduct a Diploma in General Practice (UK). I was in charge of this collaboration from 1994 to 2002. We produced over 30 Diploma graduates. This qualification is registerable with the Malaysian Dental Council.
The conduct of the Post-Graduate Programmes earned me:

- Honorary Diploma in General Dental Practice from the Royal College of Surgeons of England on 8th February 1997.
- Fellowship of the Faculty of General Dental Practitioners (UK) ad eundem on 10th March 2001 from the Royal College of Surgeons of England.

You’ve worked in many associations in Malaysia and internationally. Can you share what your experiences were like?

I served the Malaysian Dental Association (MDA) in various capacities from 1986, and as President of the MDA for a record seven terms. I’ve always been a hands-on man. I took my passion for the MDA to another level.

I secured the invitation to host the Inaugural Congress of the Commonwealth Dental Association (CDA) in April 1991. It was not an easy task with our limited resources. I held the Presidency of the CDA for three years from 1994 to 1997. Our aim in the MDA was to secure the Asia Pacific Dental Congresses for Malaysia repeatedly. This was to enhance the credibility and stature of the dental profession in the country and to promote Malaysia as well. I was fortunate I had been elected a member of the Executive of the Asia Pacific Dental Federation. This facilitated our efforts.

In 1995, I was elected into the council of the FDI World Dental Federation. Our effort to host our ultimate dream – the FDI World Dental Congress, which was initiated in 1988, took a new turn with my entry into the Council of the FDI. This resulted in us securing the FDI World Dental Congress in Kuala Lumpur in September 2001. It garnered a record number of participants – over 15,000. This included dental surgeons, various categories of auxiliary dental personnel and visitors to our International Trade Exhibition. It was a tremendous feat and a milestone for organised dentistry in Malaysia.

Fortuitously, I had been elected President-Elect of the FDI in 1999 in Mexico City and assumed the highest office of Presidency of the FDI at the World Dental Congress in Kuala Lumpur. It was the highest honour for me in particular and the dental profession in the country as it was a “first” for a developing country to be so recognised. It is pertinent to note that the Inauguration of the Commonwealth Dental Association in April 1991 and the launching of the FDI World Dental Congress were done by none other than...
the Prime Minister of the day, YAB Tun Dr Mahathir Mohamad (he was YAB Datuk Seri at that point of time).

Though I had served the Asia Pacific Dental Federation in various capacities, I had not held the mantel of the organisation. On securing the bid to host the Asia Pacific Dental Congress in 2013, I was delighted when the MDA Council elected me to be the Chairman of the Organising Committee. The Congress held in June 2013 was another hallmark achievement for the MDA with a record participation of 7,000 – a significant achievement for a regional congress. And I assumed the Presidency of the federation.

What are some of the key principles you have upheld throughout your career?

I have experienced many frustrations and absorbed numerous brickbats in my career. I took it all philosophically. The values I believe in most are honesty, integrity, unselfishness and commitment. This applies to my work in raising and uplifting the profession, and in my private life. I have given my life to Organised Dentistry in Malaysia. One does not look for rewards to achieve a higher purpose. One just perseveres and gives one’s best in all undertakings. One’s conscience will confirm that sincerity is the key.

In your opinion, how has the industry changed over the years?

The practice of dentistry has changed drastically and dynamically with technological advances in the last few decades. The materials and methods are far superior commensurate with the advances to provide quality oral healthcare to the communities we serve. However, there is a price to be paid. With the state-of-the-art developments – materials and technology including equipment, being produced overseas (minimal by local manufacturers), these developments are proving to be expensive. The consumers have to bear the brunt. Whilst it is appreciated by those who can afford these services, what about the average man on the street? These concerns are real and need to be addressed in appropriate fora and by the authorities. For, our main objective is to serve the community at large.

How do you think we can improve to raise the standards of the profession further?

My advice to my colleagues is to be adequately and appropriately trained before embarking on any complicated procedures. Though qualified dental
surgeons can perform a wide range of procedures, it must be within their capabilities and training. Otherwise, they stand the risk of incurring the wrath of the Malaysian Dental Council – for the Council is the custodian to ensure the regulation and practice of the dental profession as enshrined in the Dental Act. They have to protect themselves by updating their skills and knowledge continuously if they’re in active practice. Failure to do so would be deemed to be an abnegation of their professional responsibilities. We are today most fortunate that every dentist in the country has adequate access to continuing professional development programmes which are conducted regularly by the various institutions and organisations including the Malaysian Dental Association and the Oral Health Division of the Ministry of Health. This is most commendable.

What do you hope to see in the future?

Dentistry itself is one of the most demanding professions. Ideally, there should be more dental hospitals established and group practices encouraged. This will facilitate the general practitioners and the dental specialists to plan their work schedule and attendance of relevant continuing education programmes. It will enable members of the team to consult their colleagues for cross referrals and discussions, and work on rotation. This will significantly ease the pressure on the practising dental surgeons.

Dental hospitals and group practices must have state-of-the-art facilities and be on the cutting-edge of dentistry, keeping abreast with all modern developments. These group practices will provide better oral healthcare and services to the community at large.

The specialist and general practitioners, to increase their motivation and commitment, should subscribe to becoming stakeholders of these practices. These dental hospitals and group practices will also provide employment opportunities to the young graduates and encourage them to undertake post-graduate training. In this manner, we can provide more comprehensive care to our rakyat. God Bless.
ANNOUNCEMENT
TO MEMBERS OF MDA

GREAT NEWS! FREEBIES FOR YOU!

They say that there is no such thing as a free lunch in this world, maybe that’s true…but for MDA members, tons of free journals and books are waiting for you. Yes, reputable journals like JADA, BDJ, AJODO, EJED, QI, QDT, Compendium etc. are now at your fingertips via EBSCO Host upon logging in as a member to MDA website. You can also have access to important but hard to find dental volumes like Ronald Goldstein’s Esthetics in Dentistry Vol. 1 & 2, Ingle’s Endodontics etc. Most articles and chapters are in full text and downloadable as PDF for you to read at any place, any time using any device. Gone are those days which you have to cough up thousands and waiting for weeks for your favourite journals to arrive at your doorstep.

Bad news is the contract between the MDA and EBSCO costs RM70,000 a year and we may need to discontinue the service if the response of members is lukewarm.

Do not let that happen!

The MDA has made the efforts, now it’s your turn to make our efforts worthwhile.

Dr Neoh Leong Seng
CPD Chairperson
Malaysian Dental Association

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How to:
Log in to mda.org.my as MDA member and click on EBSCO Host.
This campaign was officially launched by The Principle Director of Oral Health Services, Ministry Of Health at The Royale Chulan Damansara Hotel on the 29th October 2015.

Around 80 people gathered at the launching arena and the speech text was read by Dr N. Jegarajan, The Director of Oral Health Regulation and Practice Division, MOH.

The objective of the campaign was to help Malaysians care for their oral health to better enjoy life, and achieve its vision of elevating oral health standards amongst Malaysians. Also, it is to reinforce the importance of practising good oral hygiene so that society can smile confidently and be at social best. The most important is to educate Malaysians in making clear decisions to meet their specialised oral healthcare needs – sensitive teeth, gum care and denture care.

The MDA has actively participated in this campaign and the roles and responsibilities of MDA among others are:

1. Nationwide Free Dental Check-ups
   Recruit and facilitate free dental check-ups with private dentist practitioner’s clinic.

2. Mobile Dental Clinics in public
   Select and appoint dentists and nurses to provide free dental check-ups at selected hyper/supermarket (one dentist and one nurse per location). Update of oral health status and dental check-up was done in several commercial area mostly in Giant Supermarket and Mydin Hypermall outlets.
3. Media Launch Engagement

Speech in media launch and post media interview.

The MDA had given a guideline to participating dental clinics to join in the campaign by facilitating the free dental check-ups starting from 7th November to 30th December 2015, GSK will provide the following to assist in addressing your patient’s specialised oral health needs:

- Nation of Health Smiles’ Poster
- Patient samples (Sensodyne, Polident and Paradontox trial sample)
- Educational leaflet
- Tracking form

The participating clinic will Display ‘Nation of Healthy Smile’ Poster prominently in the clinic throughout the campaign. All dental check-ups are to be given free of charge, however further treatment (restorations, scaling, etc.) should be borne by the patient. There will be ‘Nation of Healthy Smiles’ microsite and hotline number made available to public to help patient to locate the clinics.

During the press conference, the media was introduced to the Smile-o-graph Kiosk where a photo was taken and the smile indicator percentage was awarded. All photos were scanned and the code for a free dental check-up in the participating clinic was given. It was a very enlightening machine and the public were eager to participate in this campaign.

Also present at the media launch were Stacy Wallace, General Manager of Glaxo Smith Kline (GSK), MDA President-Elect Dr Chow Kai Foo, MDA CSR Chairperson Dr Abd Rashid bin Hassan and MDA Council member Dr Nurul Syakirin.
Surgical removal of impacted wisdom teeth becomes a routine treatment in our daily dentistry practice. In the United States, all oral and maxillofacial surgeons and many general dentists advocate prophylactic removal of wisdom teeth. (Friedman J.W., 2007) However, the management of the condition sometimes can be quite complex.

According to Santosh P. (2015), a tooth is considered impacted when the tooth is completely or partially un-erupted and is positioned against another tooth, bone or soft tissue so that its further eruption is unlikely, described according to its anatomic position.

**Classification**

Few classifications exist to describe the different types of impaction of the wisdom teeth. This includes:

- **Direction**
  - Mesially impacted
  - Distally impacted
  - Vertically impacted
  - Horizontally impacted

- **Nature of overlying tissue**
  - Soft tissue impaction
  - Partial bony impaction
  - Full bony impaction

- **Winter's Line (Figure 1)**
  - White line – occlusal surfaces of the erupted 1st and 2nd molars and extended over the 3rd molar
  - Amber line – bone level, indicate the amount of bone need to remove
  - Red line – imaginary line drawn perpendicular from the amber line to an imaginary point of application of an elevator

- **Pell and Gregory Classification (Figure 2)**
  - Class I, II, III – Relation between the impacted wisdom teeth to the ramus and 2nd molar
  - Class A, B, C – Relative depth of impacted wisdom teeth in the bone
Assessment

Careful pre-operative assessment is always critical and essential. It is important to determine whether to refer the case for specialist management or the need for further investigation. For example, 3D imaging and inform patient with predicted complications based on the investigation.

Clinical assessment is important to determine the patient fitness to undergo the procedure either under local anaesthesia or general anaesthesia. The surgery site needs to be assessed in terms of patient’s mouth opening, any gag reflex, visible carious on the opposing or adjacent teeth, periodontal problem, and types of impaction.

Dental imaging is an essential tool for routine diagnosis and surgical management in dealing with wisdom teeth. It is important for the pre-operative neurosensory risk assessment. Orthopantomography (OPG) is a standard imaging for every surgical removal of wisdom teeth cases. It provides the overview of the structures related to the surgical site, namely, the position and morphology of the impacted wisdom teeth, adjacent 2nd molar, opposing 3rd molar and inferior alveolar canal in relationship with the apical portion of the wisdom teeth.

Literature suggested a few specific signs observed in the OPG are reliable in assessing the intimate relationship between the impacted wisdom teeth and inferior alveolar canal.

These signs include:

- Darkening of the apical root of 3rd molar
- Abrupt narrowing of the root
- Interruption and loss of white line
- Displacement of the canal by the apical root of 3rd molar
- Abrupt narrowing of one/both of the white lines

In these cases, 3-D imaging is warrant. Cone-Beam Computed Tomography (CBCT) becoming the gold standard in assessing the relationship between the wisdom teeth and inferior alveolar canal. CBCT not only display a better 3-dimension images of wisdom teeth and their surrounding structures, furthermore, it also offers less radiation exposure and cheaper compared with traditional CT.

Indication of Removal


- Evidence of pathological changes such as periodontal disease, non-restorable carious lesions, infections, cysts, tumours, and damages to adjacent teeth.
2. Faculty of Dental Surgery, The Royal College of Surgeons of England (September, 1997)

- Overt/previous history of infection including pericoronitis
- Unrestorable caries
- Non-treatable pulpal and/or periapical pathology
- Cellulitis, abscess and osteomyelitis
- Periodontal disease
- Orthodontic abnormalities
- Prophylactic removal in the presence of specific medical and surgical conditions
- Facilitation of restorative treatment including provision of prosthesis
- Internal/external resorption of tooth/adjacent teeth
- Pain directly related to a third molar
- Tooth in line of bony fracture or impeding trauma management
- Fracture of tooth
- Disease follicle including cyst/tumour
- Tooth/teeth impeding orthognathic surgery/reconstructive jaw surgery
- Tooth involved in/within field of tumour resection
- Satisfactory tooth for use as donor for transplantation

**Treatment options**

1. No treatment
2. Retention with subsequent clinical and radiographic surveillance and hygiene maintenance
3. Removal of opposing 3rd molar
4. Removal of adjacent 2nd molar
5. Surgical removal of 3rd molar
6. Coronectomy

**Possible complications**

1. Minor complications
- Post-operative wound infection
- Post-operative bleeding
Retained apical root
Damage of the adjacent teeth, dental restoration and gingiva may occur during the procedure
Temporomandibular joint (TMJ) pain

1. Pericoronitis
2. Caries
3. Periodontal disease
4. Resorption of the adjacent teeth
5. Disease of tooth follicle
Basic Medical Skill: How to Perform a Successful Venipuncture?

Written by:
Dr. Daniel Lim, BDS (Malaya),
Prof. Dr. Ngeow Wei Cheong, BDS (Mal),
FFDRCSIreland (O.S), FDSRCS (Eng), MDSc (Mal), PhD (Sheffield), FAMM

Corresponding author:
Dr. Daniel Lim,
Department of Oro-Maxillofacial Surgical and Medical Sciences,
Faculty of Dentistry,
University of Malaya

Introduction

Venipuncture is one of the most common procedures performed daily in a medical facility. It is the introduction of a needle into a vein to obtain a blood sample for haematological, biochemical, or bacteriological analysis. It is also known as phlebotomy, venesection or taking/drawing blood. This procedure is becoming more significant in dental setting. This is a skill to acquire especially for use in guided bone regeneration (GBR) procedure. The collected blood can either be mixed with bone graft or centrifuged to obtain platelet-rich plasma (PRP), which potentially improve the outcome of GBR.

Venipuncture is usually performed on the upper limbs. There are a few potential sites on the upper limbs for venipuncture, beginning from the most distal site, the dorsum of hand, wrist, forearm and antecubital fossa.

Dorsum of hand is preferred by some practitioners as the veins are quite superficial and easily accessible. On the other hand, the veins are relatively smaller and it is more painful for the patient. Venipuncture of the wrist can be performed either on the dorsal or lateral aspects. Veins of the dorsal wrist though may be visible, they are quite mobile. The ventral aspect of wrist is not recommended as the arteries, nerves and tendons are relatively superficial and pose more risk for venipuncture. The dorsal aspect of forearm can also be used for venipuncture. Although the veins are larger than those in the wrist and dorsum of the hand, they are not as superficial. This makes venipuncture more difficult.

Antecubital fossa is one of the more preferred sites for
withdrawing blood. The veins in this region are larger than other sites on the arm, not as mobile as those found on dorsum of hand, and relatively safe, especially on the lateral aspect of the fossa.

In this article, we shall will give a refresher course on venipuncture of the cubital fossa, which is relatively easier to perform.

Anatomy of Cubital Fossa

Cubital fossa is a triangular area bounded by lateral border of pronator teres muscle, medial border of brachioradialis muscle and an imaginary line connecting medial and lateral epicondyle of the humerus. The floor of the fossa is formed by the brachialis and supinator muscles overlying the capsule of the elbow joint. Contents of the cubital fossa are median nerve, brachial artery and its terminal branches (radial and ulnar arteries), biceps tendon and bicipital aponeurosis, radial and posterior interosseous nerves. Lying on the roof of the fossa, superficially, are the median and lateral cutaneous nerves as well as median cubital veins which join cephalic and basilica veins. There are variations to the anatomy of the superficial veins. These superficial structures are not considered as the content of the fossa. Vessels and nerves that pass this region are shown in the following diagram (Figure 1).

Armamentarium for venipuncture

1. Personal protective equipment (e.g. non-sterile gloves, mask, protective plastic apron)
2. A kidney dish
3. A clean clinical tray
4. Skin disinfectant – alcohol swab
5. Clean tourniquet (buckle-closure, Velcro strap, blood pressure cuff or surgical gloves)
6. Hypodermic needle 22 Gauge (blue)
7. Syringe 5ml or 10ml
8. Sterile gauze
9. Plaster

Figure 1. Arteries, veins and nerve of the upper arm. Copyright © Dr. Daniel Lim
Steps in Venipuncture

1. Perform hand hygiene

2. Identify the site for venipuncture, preferably cubital fossa as it is easier to perform. Palpate to identify acceptable vein for venipuncture. Veins are easier to be identified when they are dilated or when venous blood pooled within the vessels. Warming of the arm with hot pack or hanging the hand down can be done to achieve this.

3. Apply tourniquet about 2-3 inches above the elbow crease. Pressure of the tourniquet should be just enough to slow venous flow without affecting the arterial flow. This results in blood pooling within the veins, distending them and rendering them more visible and easily located. Various types of tourniquet are available; for example, buckle-closure, Velcro strap, blood pressure cuff or surgical gloves (readily available in any dental clinic). If a blood pressure cuff is used (as shown in diagram), ensure that cuff is inflated between systolic and diastolic readings, i.e. 90-100mm Hg. Patient can be asked to open and close his or her hand into a fist to facilitate more blood pooling in the vein. A light tapping on the area will help in venodilation.

4. Disinfect the skin over the area of planned venipuncture with alcohol swab. Do not touch the site once it has been disinfected.

5. Use a 22 Gauge (blue) hypodermic needle and a 5ml or 10ml syringe to withdraw blood. Insert needle at about 30° to the skin surface with the bevel facing upward. The thumb of the opposite hand can be placed a few inches distal to the penetration site to anchor the vein and tense the skin to facilitate needle penetration. Alternatively, a winged needle (Butterfly) may be used to withdraw blood. This type of needle can be connected directly into a blood specimen bottle or multiple bottles, which is good when quite an amount of blood for PRP is needed.
Steps in Venipuncture

6. Prior to removing the needle, undo the tourniquet (your assistant may help to undo the tourniquet). With one hand withdrawing the needle, another hand is ready with gauze to be applied over the site of penetration.

7. A firm direct finger pressure is maintained for about 3-5 minutes. This is to prevent haematoma formation. Bending of the elbow does not provide adequate pressure, therefore may result in haematoma formation.

8. Be careful when handling all used needles and syringes. Dispose all used needles and syringes into the sharps bin.

9. Perform hand hygiene

Avoid the following during venipuncture:
1. Hard, sclerosed or fibrosed veins
2. Arm with arteriovenous fistula
3. Arm affected by stroke
4. Arm from the same side as mastectomy
5. Veins with haematoma. If unavoidable, withdraw blood from a site distal to the haematoma.

Conclusion
Venipuncture should be confidently performed by dental practitioners especially those performing guided bone regeneration procedures. Although the process of venepuncture may seem easy, it requires routine practice as practice makes perfect.

References:
2. National clinical policy and procedural guideline for nurses and midwives undertaking venepuncture in adults
The Ability to Give Pain Free Local Analgesia to a Child is an Important Factor in Managing a Child’s Behaviour

Written by:
Dr Leong Kei Joe
BSc(Dental Science) (Ina), DDS (Ina),
MFDS RCS (England), PostGradDip
Clinical Dental Science (London),
MClinDent (Paediatric Dentistry)
(London), FICD (USA)
Paediatric Dental Specialist
Department of Paediatric Dental Surgery
Queen Elizabeth Hospital, Kota Kinabalu, Sabah
Sabah Women and Children Hospital, Likas, Sabah

Introduction

Local analgesia is commonly used in paediatric dentistry as one of the methods in providing operative pain control as in restorations and surgical procedures such as extractions. In fact, the use of local analgesia falls into the spectrum of patient management that varies from simple behaviour management (such as tell-show-do) to full intubation general anaesthesia.

The ability to achieve a pain-free dental procedure through the administration of local analgesia in paediatric dentistry is of paramount importance in gaining the child’s confidence and in establishing a good rapport with the child. Unfortunately, the introduction of local analgesia in children could be very challenging for the dental profession as fear-related behaviour has long been recognised as the most difficult aspect of patient management and can be a barrier to good care. It is interesting to note that administering local analgesia may not only provoke anxiety in patients, but may also induce stress to the operator.

Children’s Perception of Pain

The International Associations for the Study of Pain defines pain as “…an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage”. It also stated that “pain is a subjective experience” and that “each individual learns the application of the word through experiences related to injury early in life”. As such, pain has sensory, emotional, cognitive and behavioural components that are interrelated with environmental, development, socio-cultural and contextual factors.

Infants up to about 2 years of age are unable to distinguish between pressure and pain. After the age of approximately 2 and up to the age of 10, children begin to have some understanding of ‘hurt’ and begin to distinguish it from pressure or ‘a heavy push’. Children over the age of 10 years are much more likely to be able to think abstractly and participate more actively in the decision to use of local analgesia, sedation, or general anaesthesia.

The Need To Be Able To Administer Pain-Free Local Analgesia

It is generally agreed that one of the most important aspects of child behaviour guidance is the control of pain. Painful procedures cause fear and anxiety; fear and anxiety intensify pain. This circle of cause and effect is central to the management of all patients. Therefore, good behaviour management, including administering pain-free local analgesia at each visit to reduce discomfort to a minimum and to control painful situations, reduces anxiety, which in turn
reduces the perceived intensity of pain, which further reduces the experience of anxiety\(^1\). A mail survey of 198 dentists who treated children was carried out to assess their beliefs about pain control in school-aged children and examine the relationship of those beliefs to pain management behaviours was carried in Seattle, United States of America. This survey showed that two out of three dentists always use local analgesia when doing restorations or extractions and also provide more local analgesia at the child’s request\(^4\).

Investigators had found that injection is the dental procedure that produces the greatest negative response in children and that responses become increasingly negative over a series of four to five injections. Thus, dentists should anticipate the need for continued efforts to help the child cope with dental injections\(^5\). Administering local analgesia to a child, especially if this would be the child’s first experience, should be performed with minimal discomfort and, if possible, pain-free. This is of utmost importance, as we greatly need to gain a good rapport, help the child to build up their confidence and therefore change their perception for the better towards dental treatment.
Most acclimatisation procedures, such as prophylaxis and application of fissure sealants, do not require the use of local analgesia. The use of local analgesia becomes indispensable when procedures become more invasive, such as in pulpotomy and extractions. The use of local analgesia in these situations acts not only as pain control but also as a mean of behaviour management. If administration of local analgesia is unsuccessful, then other means of behaviour management have to be employed, such as inhalation sedation or general anaesthesia.

Methods Of Delivering Pain-Free Local Analgesia

The child who requires dental treatment is, frequently, not capable of cooperative behaviour. The challenge facing clinicians is to provide an environment that allows technically complex dental treatment, starting with the injection of local analgesia, to be delivered without inflicting adverse psychological or physical harm to the child or others. The administration of pain-free local analgesia depends upon a number of factors that are within the control of the operator. These factors relate to:

1. Equipment

   Needles should be sharp and the finest available gauge should be used, usually 30 gauge. The type of cartridge used should be one that allows depression of the rubber bung at a constant rate with a constant force. New techniques for obtaining local analgesia could be used as substitutes to conventional techniques for obtaining local analgesia. These techniques include electronic anaesthesia, intraoral lidocaine patch, computerised local anaesthesia and Syrijet. The advantage of the electronically / computer controlled delivery of local analgesia is that it replaces the use of the conventional dental syringe which most children find it “scary” and in the hands of a skilful operator, this could be “hidden” within the palm of the operator.

2. Materials

   Local analgesia with adrenaline has a lower pH, compared to those without adrenaline, and may affect the discomfort of the injection. It had been suggested that initial injection using plain local analgesia followed by vasoconstrictor containing solution as the definitive local analgesia would provide minimal sensation. Although lignocaine has been the most commonly used local analgesia in dentistry, it has been claimed that amide articaine may be more superior as it exhibits excellent diffusion. This property of amide articaine provides sufficient infiltration to anaesthetise the palate following buccal infiltration.

3. Techniques

   Some of the techniques that can be used to reduce discomfort during administration of local analgesia are as follows:

   (a) Initial application of topical anaesthesia to reduce sensation during insertion of the needle. The author usually leaves the topical anaesthesia on the mucosa for about 3-4 minutes.

   (b) Injection of local analgesia should always be made slowly. A small drop of local analgesia is dispensed just beneath the mucosa, followed by brief pause before introducing the needle a little bit deeper. This is performed repeatedly until full anaesthesia is achieved.

   (c) Stretching the mucosa in the quadrant that required administration of local analgesia to ease insertion of needle.
(d) Direct injection into the palatal mucosa (and even lingual attached mucosa) is painful and can be avoided by infiltration technique on the buccal/labial aspect of the intra-papillary, followed by further advancement of the needle palatally.

(e) Inferior alveolar nerve block and intraligamental injection can be uncomfortable for a child. This is further complicated by the fact that infiltration technique is not successful in the posterior permanent dentition. This can be overcome by performing a small-dose buccal infiltration, followed by a papillary injection and finally by the intraligamental injection. Lingual gingival anaesthesia is obtained via the periodontal ligament by directing the needle through the interdental space.

(f) Non-pharmacological and pharmacological approach could be used in reducing pain and anxiety associated with dental procedures. Non-pharmacological methods may include Tell-Show-Do, desensitisation, modelling, reframing, distraction, and hypnosis. One method that has been used successfully by the author is to do “counting” (saying 1, 2, 3, 4, 5... and so on) during administration of local analgesia. The child is informed earlier on “how long” the “counting” would be and this enables the child to be mentally prepared “when” the procedure will stop for a short break before operator resumes again. Pharmacological management involves a broad spectrum of agents administered in a variety of ways (such as oral, parenteral, and inhalation routes). Inhalation sedation using nitrous oxide provides some degree of analgesia and its use had been shown to be reliable, efficient and safe adjunct to local analgesia in both healthy children and adults undergoing ambulatory oral surgery procedures.

(g) Distracting techniques may be applied and could be useful during injection. One such technique is by applying gentle pressure on the lip between finger and thumb to distract the child. Another distracting technique that had been proven to be useful in children aged 3 to 7 years old was by instructing the child to perform repeated deep breathing and blowing out air prior to and during administration of local analgesia.

CONCLUSION

When pain-free reliable local analgesia is achieved in children, confidence is gained from both the child and the operator, and a sound basis for a satisfactory professional relationship is established.
Bringing Dentistry to Greater Heights

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Malaysian Dental Association Eastern Zone
Dr Sim Wen Sann 016-8566189
Dr Chong Ro Mann 017-7809798
6bdc.mdaez@gmail.com

Keynote Speaker:
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