



Bahrain Dental Society

N E W S L E T T E R

Official Publication of Bahrain Dental Society

Volume 1, Issue 2

April 2005

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Editorial



Dr. GHASSAN DHAIF
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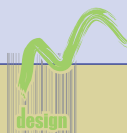
Training and Education.. New Graduates Dilemma?!!

New graduates are faced with rather exhaustive and lengthy training in Bahrain. Upon completion of dental school curriculum. before embarking on general dental practice either at Ministry of Health (MOH) or private sector. This two years training is equivalent to vocational training (VT) applied on UK graduates.

This usually reinforces the acquired knowledge and improve the clinical skills of the trainees. Furthermore, it exposes the trainee to the various clinical specialties and provides one - to - one opportunity. Therefore, the end- results are satisfactory for both parties (the trainee and the society). However, the program is still deficient in many aspects namely; MOH is a service body and not designed or suitable for training, lack of facilities including extra-dental chairs, available manpower, exhaustive and busy specialists, lack of incentives ... etc. These deficiencies are hindrance to provide an optimal atmosphere for training. Several attempts were made in the past to upgrade and modify this program which partly have succeeded in the improvement of the training. Recently, the option

of joining MGDS (Membership of General Dental Surgery) program tailored for MOH, Bahrain offered a glimpse of hope for those who are pursuing high dental training in general dentistry as well as acquiring an international degree from a recognized and reputable body (The Royal College of Surgeons of Edinburgh). This scenario of training and recognition seems to be theoretically promising albiet being conducted locally with the same deficiencies mentioned earlier for the new graduates. In fact, the responsibility applicable here is by far more and mandates utilization of those who are having the stamina and gesture of training. Furthermore, it should be regulated and supervised by a high caliber consultants. Again, alot of attempts were made to monitor and adjust the program to upgrade it, but my concern is that the motives to educate and train by the specialists as well as the available system does not encourage development.

Unfortunately, MOH did not take the initiative to assess the merits of the program, its success and the level of trainees satisfaction in order to ensure success and continuity. It is quite easy and practical to retrieve any encountered obstacle of an independent body to supervise and evaluate the progress of the program.



Guest's Corner



*Dr. Aqeel Al-Mosawi
Consultant Endodontist*

What do we mean by success? I dare to pose this question to every colleague. Is it your degrees? Your reputation? Your income? Your established practice? Or your professional self-satisfaction? Let us review some definitions. A dental student defined success as reaching the level of knowledge and skills that earns respect from our peers, and a level of service to our patients that earns admiration from our communities. Here is another good one "the ability to stand up with compassion, love and care, and complete honesty, to provide the best for your family, patients, students and colleagues".

Your definition might be different, yet we all want a favorable and desirable outcome in whatever action we take, don't we? I strongly believe that success in dentistry, like in life in general, is the point where we achieve a balance in life, allowing us to enjoy

Your success: Redefined

and nurture our loved ones, our friends and our profession.

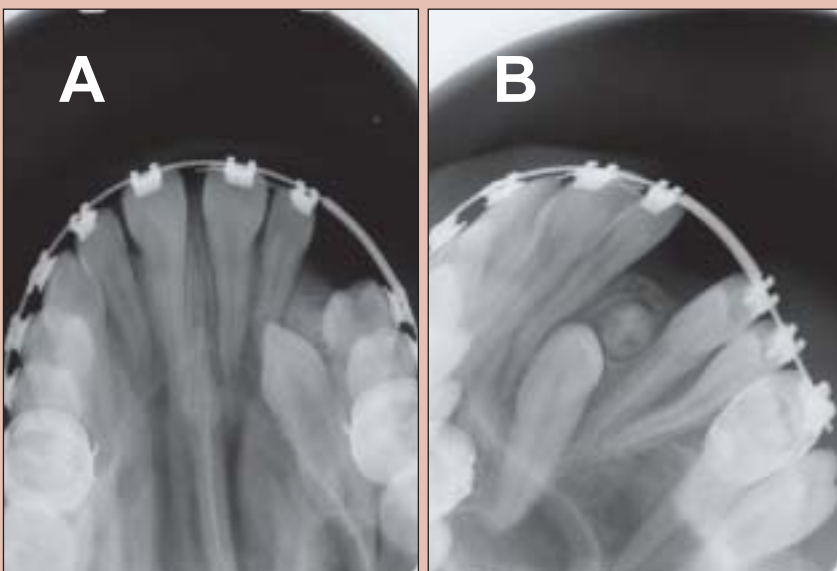
From a psychological point of view, according to John Gray author of "How to Get What You Want and Want What You Have". A balanced person is the one who has a healthy relationship with his/her God, parents, spouse (lover), dependants (children), self, family, friends, peer, community, and the world. I could add another important one for professionals that is the relationship with clients (patients in our case). All these relationships are vital, and one can't replace another. They provide us with the love we need and help us give unconditional love, and thus, give us the complete sense of a human being. Now answer the following questions before you can define your success.

1. In action not only in belief, how is your relationship with God? Do you contribute to God?
2. Other than being their pride, or dining with them, do you help your parents in anyway?
3. Do have a designated time in the week to spend with your lover, fiancé or your spouse alone?
4. Do you spend quality time with your children? Like doing homework or out-door activity.
5. Do you know the difference

- between self-love and selfishness?
6. Are you a good family member?
7. Do you have soul-mate friends?
8. Are you liked by your colleagues? Do you do volunteer work to the dental society?
9. Do you do volunteer work to the community? Are you a member in any of the local political societies?
10. Do you contribute to a noble cause (regional, Arabic, Islamic, or global)
11. Do you have disputes with any of your patients, colleagues or staff?
12. Have you read a non-dental book lately?

It is hard to generalize; nevertheless, one may say that professionals seek to get their self-satisfaction, self-worth and happiness from career accomplishments at the expense of other vital relationships. I find it very difficult to sympathize with a colleague, who finds no time to spend with his/her family and children, no time to do sport, or no time to read a book. Dentistry is no doubt a very stressful job. When unmanaged, stress may lead to undesirable habits such as social isolation, obesity, smoking, or alcoholism. While the dental school has trained you how to start your professional life, no one will train you how to end it, but yourself.

DENTAL CONANDRUM



Dr. Abbas Al-Fardan
*Consultant Orthodontist
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Naim Health Centre
Ministry of Health*



Those are maxillary occlusal radiographs (A Standard Central, B Left Oblique) and both were taken with tube at vertical angle of 60° With occlusal plane

Questions

1. Using the vertical parallax principle, what is the position of the impacted upper left canine tooth and why?
2. What is the most likely cause behind the impaction? and what is the outlines of your management to this case?

Answer in page 5 →



UNUSUAL SEQUELE OF HORIZONTAL ROOT FRACTURE: CASE REPORT

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 Ministry of Health

INTRODUCTION

Horizontal root fractures are not common and may be difficult to diagnose. The diagnosis of this type of fracture becomes difficult or misdiagnosed if the central beam's direction is not parallel to the fracture line, if the fracture runs in an oblique direction or if there is no separation of the broken segments of the root¹. It accounts for about 7% of the total traumatic injuries to permanent teeth and mostly affect central incisors^{2,3}. Root fractures in the apical third are best diagnosed with occlusal film exposure whereas the bisecting exposures are best for detecting root fractures in cervical third according to Andreasen⁴. There is a good chance for a tooth with horizontal root fracture to retain its vitality which could be due to that the fractured area provides avenue of escape for fluid pressure in the pulp and possible collateral circulation from PDL to assist in maintaining vitality. However, if pulpal necrosis occurs, it usually affects the coronal segment while the apical part remains vital^{5,6}. Therefore, the current recommendation is to do endodontic treatment for the coronal segment only if there is no sign of necrosis in the apical segment irrelevant to location of the horizontal root fracture. It is widely agreed that if the fracture is located at the apical third and if pathosis exists in relation to it, surgical removal of the apical segment after endodontic treatment of the coronal segment will be needed.

CASE REPORT

A-22-year-old male attended endodontic clinic complaining of discolored upper front tooth with a history of trauma to the upper left central incisor before 2 years. The tooth was asymptomatic except for slight tenderness on percussion. Radiographic examination revealed horizontal root fracture in the apical third with large radiolucency that involved apical segment (Figure1). Treatment plan was discussed with the patient which included endodontic treatment of the coronal segment and surgical removal of the apical third and apical retrograde filling

of the coronal segment.

The endodontic treatment of the coronal segment was performed (Figure2,3) and the patient was scheduled for apical surgery. However, the patient disappeared for about two years and came back for surgery. Periapical radiograph was taken showing almost complete disappearance of the radiolucency and no signs or symptoms clinically (Figure4).

DISCUSSION

This unusual result could be due to that the source of pathosis was mainly from the necrotic pulp in the coronal segment which extended apically to involve the apical third, which still retained its vitality. The other possibility might be the number of microbial population and their virulence was much less than the host immunity. This reflected on the complete resolution and healing.

The result of this single case may change the recommendations of surgical removal of the involved apical third and allow monitoring period to look for healing. We recommend long term study based on big number of cases.



Figure 1



Figure 2



Figure 3



Figure 4

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PROFILE



Dr. Leena Al-Sheerawi

Education:-

Part II MOrth RCSed September, 2004
September, 2004
MSc. GKT Dental Institute - University of London
September, 2004
Part I MOrth RCSed March, 2002
Licensure exam August, 1999
BDS. Cairo University, Egypt, 1997

General dental Practitioner
Dr. Munem Haffadh Orthodontic Clinic 1999-2000
General Dental Practitioner

Ministry of Health 1997-1999
Trainee Dentist (Internship Period)

United Arab Emirates: 1996
Sharja Dental Centre
Trainee Student.

Professional experience:-

United Kingdom-London: 2001-2004
Guy's Hospital
Specialist Trainee in Orthodontics

Ministry of Health, 2000-2001
General Dental Practitioner

Al-Mansoori Dental Clinic, 2000

Research work:-

Ministry of Health (1999): "Dental Anxiety and DMF score among Bahraini Patients"

Guys Hospital-UK (2003) "The Relationship Between Dyslexia, Awareness and orthodontics in Training Personnel"

ABSTRACT

The ability to conceptualise movement in three dimensions is fundamental to orthodontic treatment planning. Left and right discrimination is an important component of thinking in three dimensions and if errors are made in distinguishing left and right, this can seriously compromise dental/orthodontic treatment. The aims of this study were to (1) devise/design and examine a test for dyslexia examination for use in dentistry and to (2) explore the presence of difficulties in distinguishing between left and right in clinical situations, and the relationship between this and dyslexia in undergraduate and postgraduate dental students.

One hundred and five students (84 dental undergraduates and 21 postgraduate students of orthodontics) completed two tests to assess the likelihood that they were dyslexic (a culture free Intelligence test and a Symbol-Digit task). The participants also undertook a task involving a series of left-right discriminations in an analogue clinical situation. Postgraduate respondents completed an anonymous questionnaire concerning errors that they had made in clinical situation. Postgraduate respondents completed an anonymous questionnaire concerning

errors that they had made in clinical treatment. Thirty-five respondents (33%) were identified as having scores suggestive of dyslexia from the psychometric tests. When respondents were asked if they believed they were dyslexic, 8 respondents indicated that they were dyslexic. Agreement between the identification of dyslexia by psychometric tests and by self-report was low ($\kappa = 0.05$).

Individuals who were identified as having scores suggestive of dyslexia on the psychometric tests performed less well on the task of left-right discrimination, in comparison to those not so identified (Mean score for 'Test dyslexic' group 11.83, SD= 3.51; Mean score for 'Test non-dyslexic' group 13.87, SD=4.02; $t=2.26$ $p<0.05$). No difference in performance on the task of left-right discrimination was found between individuals identified themselves as dyslexic and those who did not (Mean score for 'Self report dyslexic' group 14.76, SD=3.92; Mean score for 'Self report non-dyslexic' group 13.92; $t=0.05$ ns) For postgraduate students no relationship was found between identification as dyslexic (either by test or self-report) and the occurrence of clinical mistakes.

Dental Conundrum Answer

- 1- Palatal. Tip of $\underline{L2}$ was against root canal shadow of $\underline{L2}$ at central occlusal film and moved with tube distally at left oblique occlusal (SLOB Rule).
- 2- The radiograph show well circumscribed radio-opaque mass occlusal to $\underline{L2}$ which goes more with the impression of complex odontome, this obstructed the eruption path of the $\underline{L2}$.

The management in this case involves surgical removal of the odontome and encourage $\underline{L2}$ to erupt spontaneously in young children or orthodontic traction in older children or adult.

Orthodontic Treatment of Partial Hypodontia: Case Report

Dr. Leena Al Sheerawi

Introduction

Congenital absence of teeth results from disturbances during the initial stages of formation of a tooth i.e. at the stage of initiation and proliferation. The remaining teeth that have successfully developed and erupted are usually small in size. As primary teeth give rise to the permanent teeth bud, there will be not permanent tooth if the primary predecessor was missing. However, it is possible that the primary teeth are present and all the permanent teeth to be absent. Therefore, retained or infraoccluded deciduous teeth may be present.

Severity of these cases depends on the number of the permanent teeth missing. It has been reported by Bailit (1975) that hypodontia and microdontia are polygenically determined. Hypodontia occurs more in females than males with a ratio of 3:2 (Egermark-Erikson and Lind, 1971). This confirmed that hypodontia is polygenically determined.

Incidence and prevalence

The prevalence of missing permanent teeth is around 6% of the population excluding the third molars (Brook, 1974). However, hypodontia in deciduous teeth has a less prevalence than the permanent teeth (0.1% - 0.9%). The frequency of missing teeth is the same in upper and lower jaws with the second mandibular premolar to be the most frequent absent after the third molars, followed by the maxillary lateral incisor and the maxillary second premolar. Hypodontia of maxillary central incisor or canine or first permanent molar is very rare and may present in cases with sever hypodontia. Maxillary lateral incisor is absent in 2% of the population (Zilberman et al., 1990).

Hypodontia could be syndromic i.e. it is associated with syndromes such as Down's, ectodermal dysplasia, and Cleft lip and palate. It has been shown that Hypodontia occurs in one third of children affected with isolated cleft palate; the upper and lower second premolars are most often affected (Ranta, 1982). Ranta (1983) studied the OPT of 416 children with isolated clefts between the age of 6 and 12 years old. They have found the following:

1. 33.7% late development of maxillary second premolars
 2. 26.9% late development of mandibular second premolars
 3. 11.1% hypodontia in the upper jaw.
 4. 9.3% hypodontia in the lower jaw.
- These reported figures indicate a marked increase in late development and hypodontia in cleft palate children.
5. It was also found that when one

second premolar was absent the mean delay in formation of the contralateral tooth was over one year. Thus, there is a correlation between hypodontia and delayed formation of the upper and lower second premolars.

6. Asymmetrically developing pairs of second premolars were found in about 3% of non-cleft children and this increased twofold in a random sample of cleft palate children, and six fold in the cleft palate group with one or more congenitally absent second premolars.

This study indicates that hypodontia, delay in mineralization, and asymmetry of the stages of formation of the contralateral second premolars results from the same etiological factors, and that delayed formation of second premolars is a milder expression of hypodontia.

In another study Wisth et al., 1974 have found that premolars can form as late as 9 years of age. However, the author of this paper have seen few hypodontic cases where the premolars starts forming at 14 years of age.

Treatment aims

1. Restore normal alignment with upper and lower midlines coincident whether spaces were closed or opened.
2. Replace missing teeth and bone.
3. Improve patient appearance, speech, and masticatory efficiency.

Factors affecting decision making: open or close spaces

1. Skeletal relationship and arch length:
 - a. In crowded arches space closure may facilitate teeth alignment especially in cases such as CI II buccal segment and increased overjet. Class I cases with crowding may also benefit from space closure.
 - b. In high maxillary mandibular plane angle, space closure is the right choice as distal movement of buccal segments should be avoided. But if distal movement of the buccal segment is required and is a must then a high pull head gear should be used to minimise the tendency to extrude molars.
 - c. Class I and III with no crowding lend themselves to space opening procedures.
 - d. Mild increase in overjet that does not concern the patient with any tooth-arch size discrepancy may give the operator the choice of space opening.

2. Occlusion:

It has been proved that space closure in CI I cases with the movement of the canine more mesially will not interfere with a normal canine protected occlusion, but it is advisable to grind the palatal cusp of the first premolar which

assumes the canine position so that the function will not be disturbed (McNeill and Joondelph, 1973). It has also been recommended to grind the canine cusp to avoid any interference with the lower dentition.

3. Inclination of teeth:

Residual spaces and tipped teeth are disliked. Effort should be made to avoid these problems.

4. Tooth morphology:

It is important that the tooth to be moved to close the space available is similar in size to that it is replacing. According to Ashler and Lewis (1986) the size of the crown of a tooth is determined in its vertical dimension by the relationship of its incisal edge to that of its neighbours and the height of its gingival margins. For example, where the central incisor is lost, the repositioned upper lateral incisor has a less apically positioned gingival margin. Thus, the clinical crown height of the lateral incisor should be increased by gingivoplasty prior to crowning since it is possible to compensate for the difference in height simply by lengthening the crown.

5. Tooth colour:

Shade imbalance between the canine and central incisors should be taken into consideration prior to space closure in case of missing lateral incisors.

Treatment options:

1. No treatment or simple improvement with composite resin
This treatment can be used for minimal spacing, unwilling or unsuitable patients to receive treatment, or in closing small diastemas.

2. Space closure:

- * Interceptive consideration
- * Autotransplantation
- * Space closure with implants

3. Space opening:

This option is simply by maintaining the space or creating the necessary space for prosthetic replacement of the missing tooth.

* Restorative management:

- a. Composite build ups
- b. Bonded Resin Bridges:
Zacchrisson (1984) have developed an acid-etch composite retained temporary bridge which allows physiological movement of the abutment teeth within the periodontal ligament. An acrylic pontic is held in place with braided rectangular wire and wide gauge multistrand wire and attached with composite to the palatal surfaces of the adjacent teeth.
- c. Conventional Bridge Work
- d. Partial Denture

e. Over dentures

4. Space modification:

Space is required in both horizontal and vertical dimensions if a functional and aesthetic restoration is to be achieved.

Conclusion

The choices here involves the appreciation of the distinction between the permanent results, with approximation of teeth and close the space of the missing tooth or the use of a restoration to replace the missing tooth which will lead to a further restorative treatment in the future. Each case has a different approach in treatment plan which makes it difficult to decide one way for treatment of hypodontic cases.

Case report

A 13-year 8 month-old Caucasian female was referred by her general dental practitioner complaining of the crooked appearance of her top front teeth. She presented with Class II division 1 incisor relationship on a Class I skeletal base with an increased Frankfort-mandibular planes angle and increased lower anterior facial height. The upper centreline was 2mm to the right of the facial midline and the lower centreline was 2mm to the left of the facial midline. Her lips were incompetent.

Intraoral examination revealed that she is still in the mixed dentition stage. As upper right, lower right and left second deciduous molar are still present. Upper right and left second permanent molars and all third molars are not present intraorally. All the remaining permanent teeth are erupted. There was caries in the occlusal surface of the lower left first permanent molar, otherwise the oral hygiene was good and the remainder of the dentition are healthy. The lower arch had severe crowding anteriorly with normally inclined lower incisors and the canines are mesially angulated. The upper labial segment was moderately crowded with normally inclined upper incisors except for the upper left central incisor where it is proclined. Both upper canines are distally angulated. The buccal segments in both arches are well aligned.

In occlusion the incisor relationship was Class II division 1 with a 6mm overjet to the proclined upper central incisor and an increased and complete overbite. The upper centreline was 2mm shifted to the left side, whilst the lower coincident with the facial midline. The molar relationship was half-unit Class II bilaterally. The lower right canine and the lower left canine are in crossbite with their correspondents.

The panoramic radiograph showed absence of lower right and left second premolars and all third molars. It also showed the presence of unerupted upper

second permanent molars and upper right second premolar. The lateral cephalogram indicated a skeletal I base this was confirmed by Witts analysis. The increased Maxillary-mandibular planes angle (34°) reinforced the finding of increased Frankfort-mandibular planes angle. The upper incisors were normally inclined at 109° , while the lower incisors were slightly retroclined at 88° in relation to the increased Maxillary-mandibular planes angle ($120-34^\circ$). The resultant interincisal angle was 133° . Table 1 shows the cephalometric values before and after treatment.

The classification of treatment need for this malocclusion was 4h, the weighted PAR score prior to treatment was 24.

The aims of treatment were to:

- * Maintain the facial profile
- * Alleviate the crowding
- * Correct the upper centreline shift
- * Reduce the overbite, thus, establish an optimal edge-centroid relationship
- * Correct the incisor and molar relationship to Class I

The treatment plan is outlined below:

- * Oral hygiene and dietary advice
- * Filling of the carious lower left first permanent molar
- * Extraction of all deciduous second molars, and upper right and left second premolars.
- * Upper and lower fixed appliance using the pre-adjusted edgewise appliance system (MBT Versatile+ prescription)
- * Upper and lower Hawley retainers

Extraction of the retained lower deciduous second molars forced on us due to the congenitally missing lower second premolars. Extraction of the upper second premolars all together with the upper left retained deciduous molar with provide the space needed for aligning the upper arch and reducing the overjet. The combination of this extraction is in fact will provide us with class I molar relationship after treatment; as the lower deciduous second molars provide the lower arch with the Leeway space which then changes the molar relationship from $1/2$ unit class II to Class I pre-treatment. Accordingly, the extraction pattern should follow that for a class I case.

The total treatment time was 20 months. Treatment commenced with restoration of the lower left first permanent molar and extraction ULE, UR5, LLE and LRE. Upper Nance appliance was fitted to increase anchorage in the upper arch. Upper and lower pre-adjusted edgewise appliance MBT Versatile+ bracket prescription and Roth bands prescription were placed. Upper and lower 0.014" Nickel Titanium was legated. Four months into treatment the UL5 was extracted under local anaesthesia. Nine months into

treatment, upper and lower 0.017" x 0.025" stainless steel was placed and starts class III elastic on the right side and class II elastics on the left (blue intermaxillary elastics) to correct the centre line discrepancy. Space closure with intramaxillary elastics was started using E-links. Fourteen months into treatment, both centrelines are coincident with the facial midline; so the intermaxillary elastics were stopped while still continue using intramaxillary elastics for space closure. Finishing required the use of upper and lower 0.019" x 0.025" TMA wire with 15° labial crown torque in the upper labial segment. Eighteen months into treatment lateral cephalogram and OPG were taken. Upper and lower arches were debonded after twenty months. Upper and lower Hawley retainers were fitted.

Case assessment:

The majority of the aims and objectives of treatment have been achieved. The patient has a class I incisor and molar relationship with the overjet within the normal limits. The centrelines are coincident with each other and with the facial midline. Lip competence has been achieved with the upper incisors under the control of the lower lip. The patient proved to be co-operative and treatment progressed well. The buccal segments are well interdigitated which increased the stability.

Superimposition of the lateral cephalograms (Fig) indicated an almost vertical growth pattern; this might be regarded to the use of intermaxillary elastics. The upper incisor angulation remained within the normal limits; however the lower incisor angulation was increased by 8° but still within the normal limits. This proclination in the lower incisors is an effect of the intermaxillary elastics as well. The resultant interincisal angle has decreased by 4° to 129° , and the edge-centroid relationship appears satisfactory from the tracings. The upper and lower intercanine width has changed by 1mm which is acceptable due to the fact that this is an extraction case.

At the end of treatment the patient exhibit canine and incisal guidance occlusion on lateral excursion and protrusion of the mandible respectively. There was no non-working side interferences.

The posttreatment PAR score of 2 showed a reduction of 22 points and an improvement of 91.66% which corresponds to greatly improved nomogram score.



Figure 1
Pre-op



Figure 2
Post-op

VARIABLE	PRE-TREATMENT	POST-TREATMENT	CHANGE
SNA	79°	78°	-1°
SNB	77°	76°	-1°
ANB	2°	2°	0°
Upper incisors to Maxillary plane	109°	106°	-2°
Lower incisors to mandibular plane	88°	96°	+8°
Inter-incisal angle	133°	129°	-4°
Lower incisor to A-Po Line	+1 mm	+2 mm	+1 mm
Lower face height percentage	57.89%	58.33%	+0.44%
Maxillary-mandibular plane angle	34°	34°	0°





ANTIBIOTIC PROPHYLAXIS FOR CARDIAC PATIENTS UNDERGOING DENTAL PROCEDURES

Compiled by: Dr. Amina Al Jishi

Regimen*

Standard general prophylaxis

Amoxicillin

Adults: 2 g

Children: 50 mg per kg

Taken orally one hour before the procedure

Patient is unable to take oral medications

Ampicillin

Adults: 2 g

Children: 50 mg per kg

Given IM or IV within 30 minutes before the procedure

Patient is allergic to penicillin

Clindamycin (Cleocin)

Adults: 600 mg

Children: 20 mg per kg

Taken orally one hour before the procedure

or

Cefadroxil (Duricef)

or cephalexin

(Biocef, Keflex) \ddot{U}

Adults: 2 g

Children: 50 mg per kg

Taken orally one hour before the procedure

or

Azithromycin (Zithromax)

or clarithromycin

(Biaxin)

Adults: 500 mg

Children: 15 mg per kg

Taken orally one hour before the procedure

Patient is allergic to penicillin and is unable to take oral medication

Clindamycin

Adults: 600 mg

Children: 20 mg per kg

Given IV within 30 minutes before the procedure

or

Cefazolin (Ancef, Kefzol)

Adults: 1 g

Children: 25 mg per kg

Given IM or IV within 30 minutes before the procedure

IM=intramuscularly; IV=intravenously.

*—The total pediatric dose should not exceed the adult dose.

\ddot{U} —Cephalosporins should not be used in patients with an immediate-type hypersensitivity reaction (urticaria, angioedema or anaphylaxis) to penicillins.



أخبار الجمعية

سمو الشيخ حمدان بن راشد آل
مكتوم نائب حاكم دبي، وزير
المالية والصناعة، رئيس دائرة
الصحة والخدمات
الطبية يلتقي مع الدكتور
محمد حسن الجشي رئيس
الجمعية خلال استقباله الوفود
المشاركة في مؤتمر إيديك ٢٠٠٥



شارك رئيس الجمعية الدكتور محمد حسن الجشي في عدة مؤتمرات ولقاءات داخل وخارج المملكة منها:

١. اللقاء السنوي للجمعية السعودية لطب الأسنان في الرياض من الفترة ١١-١٣ يناير ٢٠٠٥.
٢. مؤتمر الإتحاد العربي لأطباء الأسنان في السودان ٢٢-٢٤ فبراير ٢٠٠٥.
٣. مؤتمر إيديك واجتماع اللجنة العلمية العربية الآسيوية في دبي ١-٤ مارس ٢٠٠٥.

تهدف إلى ترابط جميع فئات المجتمع (كفالة يتيم، تبرع للصدقات الخيرية، صدقة جارية).

٣. تنظيم حفل عشاء فاخر ضمن برنامج ليالي الخليج الذي يقام في فندق الخليج وذلك يوم الثلاثاء الموافق ١٢/٤/٢٠٠٥م، وقد شارك فيها عدد كبير من أطباء الأسنان.

٤. أقامت اللجنة في منتجع البندر يوم عائلي لأطباء الأسنان وقد تخلله مسابقات وتقديم هدايا للأطفال.

اللجنة التثقيفية:

قامت اللجنة بعدة حملات توعية حول صحة الفم والأسنان وذلك بالتعاون مع بعض الأندية الثقافية ومع قسم التثقيف الصحي بوزارة الصحة ومنها:

١. المشاركة في نشاط اليوم الصحي للمخيمين ضمن المخيم الترفيهي الثالث للمحافظة الجنوبية وذلك يوم الخميس الموافق ٣ فبراير ٢٠٠٥م.
٢. المشاركة في اليوم الترفيهي لصحة اليتامى المكفولين من قبل جمعية النور للبر في مؤسسة سنابل الخير بالبحرق وذلك يوم الخميس الموافق ٢٤/٣/٢٠٠٥م.
٣. المشاركة في يوم الفرح العائلي والذي أقيم بالتعاون مع قسم التثقيف الصحي بوزارة الصحة وذلك يوم الجمعة الموافق ١/٤/٢٠٠٥م.
٤. المشاركة في نشاط اليوم الصحي الذي أقامه مركز السنابس الثقافى بالتعاون مع جمعية التمريض البحرينية بمناسبة أسبوع الصحة العالمية وذلك يومي الخميس والجمعة الموافق ٢٨-٢٩/٤/٢٠٠٥م.



اللجنة الاجتماعية:

أقامت اللجنة عدة نشاطات بهدف توطيد العلاقات الاجتماعية بين أطباء الفم والأسنان وعائلاتهم وقد كان من ضمن هذه الأنشطة ما يلي:

١. المشاركة في مارثون سير المسح الوطني لصحة الفم والأسنان لعام ٢٠٠٥م، الذي أقامته خدمات صحة الفم والأسنان بوزارة الصحة بالتعاون مع مؤسسة الشباب والرياضة وذلك يوم الخميس الموافق ٢٤/٢/٢٠٠٥م.
٢. حث أطباء الفم والأسنان على المساهمة في الأعمال الخيرية والتي

الصناديق الخيرية وذلك بالتعاون مع العيادات الخاصة والتي قدمت ولا تزال تقدم هذه الخدمة المجانية وهي:

- ١- عيادة د. علي مطر.
- ٢- عيادة د. ابتسام الدلال.
- ٣- عيادة د. زكية سلمان.
- ٤- عيادة د. ليلى مسيب.
- ٥- عيادة د. أمل السمك.
- ٦- عيادة د. سنية رسلان.
- ٧- عيادة د. منعم حفاظ.
- ٨- عيادة د. عقيل الموسوي.
- ٩- عيادة د. هيثم الجشي.
- ١٠- عيادة د. فاضل العلوي.
- ١١- عيادة د. طلال العلوي.



مشاركة اللجنة التثقيفية ضمن المخيم الترفيهي الثالث للمحافظة الجنوبية

لجنة عاجل محتاجاً:

استمرت اللجنة في تقديم علاج مجاني للمحتاجين وذلك عن طريق



تكريم المحاضرين والشركات الراعية لندوة العلاقة بين داء السكري وأمراض الفم والأسنان والفكين

وزارة الصحة لأطباء الفم والأسنان (شهر مارس)، حيث شارك في تقديم محاضراتها كل من الدكتور غسان ضيف، الدكتور ياسر أحمد، الدكتورة يمامة الجادر، الدكتورة هناء الخان، الدكتورة فتحية العريض و الدكتورة هالة السيد.

٢. ندوة العلاقة بين داء السكري وأمراض الفم والأسنان والفكين وذلك يوم السبت الموافق ٣٠ ابريل ٢٠٠٥م في قاعة المؤتمرات بفندق الخليج، وذلك بمشاركة كل من الدكتور فيصل المحروس، الدكتورة شهلاء عبدالغفار، الدكتور رشاد العلوي، الدكتور طلال العلوي، الصيدلاني محمد شلبياية و الصيدلاني أحمد محسن.

لجنة شؤون المهنة

عقدت لجنة شؤون المهنة عدة اجتماعات لمناقشة العديد من الموضوعات التي تمس المهنة وأطباء الأسنان في القطاعين العام والخاص ومن أهمها مشروع قانون خاص بشأن مزاوله مهنة طب الأسنان.

اللجنة العلمية:

أقامت اللجنة عدة نشاطات علمية خلال الفترة الماضية من العام الحالي وقد تضمنت التالي:

١. دورة لمراجعة امتحان التراخيص (مزاوله المهنة) الذي تقيمه

تحت رعاية
د. ندى حفاظ
وزيرة الصحة - مملكة البحرين

Under the auspices of
Dr. Nada Haffadh
Minister of Health - Kingdom of Bahrain



مؤتمر و معرض جمعية أطباء الفم و الأسنان البحرينية الرابع
٦ - ٨ ديسمبر ٢٠٠٥
(فندق الخليج)

The 4th Conference & Exhibition of Bahrain Dental Society
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