Bahrain Dental Society
N E W S L E T T E R

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Editorial

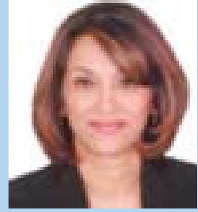
New Era!!?!

Dr. Ghassan A. Dhaif
Chief Editor

I would like to take this opportunity to congratulate the executive committee of Bahrain Dental Society who has taken a leading step of producing the Newsletter for the society. This is a golden opportunity for the dentists in Bahrain to use this as a tool and a core for developing it to a formal international refereed journal. As a matter of fact, this is our mission, but it requires effort and unity of the dental body. As we stand we are not yet ready for it, but this is achievable if everybody contribute positively.

Our colleagues in the Saudi Dental society have taken this step long time ago and are producing an excellent reputable international journal which publishes high standard scientific papers. Furthermore, all the clubs in the SDS are producing a high caliber newsletter. This should be a model for us we will try to seek their help throughout. It is obvious from this example that the continuity of the production is solely the result of the unity of the dental body and their contribution. Therefore, I cordially request all the dentists in Bahrain to participate in this new event and to positively criticize, where appropriate in order to ensure the continuity of the newsletter.

بسم الله الرحمن الرحيم



يؤمن العاملون في الحقل الطبي أن صحة الإنسان تبدأ من فمه فالفم هو خط الدفاع الأول عن صحة الإنسان، لذا تولي وزارة الصحة خدمات الفم والأسنان اهتماما كبيرا يوازي الخدمات الصحية الأخرى كما نؤمن نحن بالشراكة الفعالة مع مؤسسات المجتمع لتحقيق الأهداف المرسومة في هذا الإطار، وعليه فعلاقة وزارة الصحة وجمعية أطباء الفم والأسنان تزداد رسوخا يوما بعد يوم.

لقد كان ولا زال لجمعية أطباء الفم والأسنان دور فعال في تقديم مقترحات هامة لتنظيم ممارسة مهنة طب الأسنان والاستثمار الطبي كما لعبت دور محوري عبر ممثليها في صياغة كادر أطباء الأسنان الجديد الذي نأمل أن يرى النور قريبا.

هذا بالإضافة إلى الأدوار التي تلعبها الجمعية في الارتقاء بمستوى أطباء الأسنان والممارسين للمهن الأخرى المساعدة على الصعيدين العلمي والمهني الذي تأتي في سياقه إصدار هذه النشرة الإخبارية التي نأمل أن تكون أداة للتواصل بين المتهنين لمهنة طب الأسنان كما نرجو أن تلعب دورا فعالا في تطوير المستويين العلمي والمهني لأطباء وفنيي ومساعدي الأسنان.

ختاما نتمنى للقائمين على هذه النشرة كل التوفيق في إنجاز الأهداف التي من أجلها أصدرت هذه النشرة.

والسلام عليكم ورحمة الله وبركاته

الدكتورة ندى عباس حفاظ
وزيرة الصحة

بسم الله الرحمن الرحيم

لقد تحقق حلم جمعية أطباء الفم والأسنان البحرينية في إصدار العدد الأول من النشرة الخاصة بها والذي يصادف الاحتفال بمرور عشر سنوات على تأسيس الجمعية، وذلك بفضل تعاون الجميع وعلى رأسهم الدكتور غسان ضيف رئيس اللجنة العلمية.

إن هذه النشرة حلم وإنجاز كبير نفتخر به جميعاً، والتي نأمل أن تستمر في الصدور آملين أن يوفقنا الله في تحويلها إلى مجلة علمية دورية، ومن هنا ندعو الجميع إلى التعاون مع هيئة التحرير بتزويد النشرة بالمقالات العلمية وكافة الأنشطة الأخرى آملين أن يوفقنا الله ويحقق ما نصبو إليه من مشاريع أخرى نأمل أن تتحقق بفضل تعاون سعادة وزيرة الصحة التي حققت الكثير في فترة وجيزة وكان أهمها توظيف الأطباء بعقود دائمة وكذلك إنجاز الكادر الطبي وتقديمه إلى الحكومة الموقرة والذي يجمع لأول مرة أطباء البشري وأطباء الأسنان في كادر واحد مماثل لما معمول به في دول مجلس التعاون.

أكرر شكري للجميع على تعاونهم وأرجو أن تستمر الإنجازات وذلك لخدمة المهنة والأطباء والمجتمع.

د. محمد حسن الجشي
رئيس جمعية أطباء الفم والأسنان البحرينية

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PREVENTION AND TECHNOLOGY ARE THEY IN A CROSS DIVIDE?

Dr. Abbas Al-Fardan
Head of Oral &
Dental Health Services

I believe that we are blessed that we are practicing a profession the sole care of which is managing a preventable diseases and therefore prevention logically should be in the faith and practice of all practicing dentists. In order to keep oral cavity in good health and avoid their consequences of fighting with oral diseases in their different stages that might end with loosing teeth (extracting them). This notion was appreciated by several history greats and no one represent this better than profit Mohammed (PBUH) when he praised his closest poet (Al-Nabeghah Aljodi): "He lived 180 years and he didn't loose a tooth" .

On the other side, technology is invading dentistry in a rampant pace providing tremendous amount of therapeutic modalities and techniques, however those were geared largely to advance restorative and periodontal therapies and replacement of missing teeth which unfortunately might send a massage to dentists and to the public that it is ok for dental disease to propagates because technology advancement will be there to sort any resulting problem.

This was manifested to me through few worrying signs:

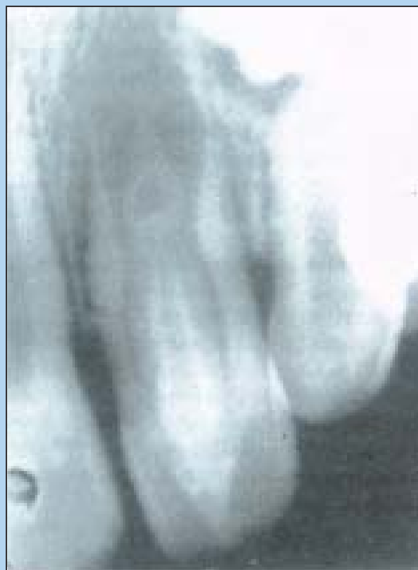
1. We had 19300 teeth extracted in Bahrain in 2003 and 19812 teeth and in 2004 "that was inside Ministry of Health clinics only"
2. Majority of dentists nowadays feeling pride and proud of themselves building their capacities in mastering advanced endodontic procedures, and different systems of implants "i.e. being promotive agents to treat non-vital teeth and replace extracted teeth" while we spend negligible amount of time if any learning and practicing prevention and oral health promotion on both individual and community levels. This direction was designed purposely by commercial componies and dental suppliers who exsist to sell expensive products that get upgraded and replaced frequently and unfortunately professional and scientific societies and dentists were victimized by this strategy and thus now we see plenty of courses in implant, advanced endodontics and advanced periodontics are organised, where we hardly get aware of any scientific activity organized to develop oral health promotion and prevention skills of the dentists .

I believe that the dental society should adopt a supportive role to the oral health services (MOH) in seeding, planning, propagating and implementing a nation wide strategy to develop a robust system for prevention and primary dental care in both government and private sectors using the scandavain countries as a bench mark, " in those countries graduating dental students travel abroad to learn how to extract teeth to complete oral surgery requirements as they cant find teeth to extract locally" and this can be attained through:

1. Active involvement of young dental graduates in the preventive and promotive programs of MOH.
2. Develop dental public health strategy aiming to motivate the community to adopt prevention as a practicing behavior.
3. Analyzing risk factors related to oral health and work collectively in counteracting them.
4. Bahrain Dental Society should use a balanced approach in designing their scientific program and provide fair share of activities to prevention and dental public health.
5. Direct Primary dental care to prevention in expense of curative & prosthetic care.

Finally I hope this newsletter by adopting articles like this will propagate endless motion toward prevention that can utilize technology on its side rather then portraying it in a cross divide.

DENTAL CONANDRUM



Dr. Moh'd A. Salman
Consultant Endodontist
Naim Health Centre
Ministry of Health

Question

1. What is the diagnosis?
2. Why pulp necrosis often occurs in these cases?
3. How it is diagnosed?

Answer in page 5

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PROFILE

Maria Abdull Al-Jowder
B.D.D. - M.Sc.

QUALIFICATIONS

Bachelor Degree of Dentistry from King Saud University June 1994. Riyadh- Kingdom of Saudi Arabia. G.P.A: 4.33 OUT OF 5.0 Master of Science in Dental Sciences from McGill University February 2004. Montreal-Canada. G.P.A: 3.72 OUT OF 4.0

Oral Health of Patients Suffering from Chronic obstructive Pulmonary Disease and Its Relationship with the Exacerbation Events

ABSTRACT

Chronic obstructive pulmonary disease (COPD) represents the fourth common cause of death among elders. The prevalence, incidence, and mortality of COPD increase with age. Smoking is the risk factor responsible for the majority of deaths caused by COPD. Smoking is also an important risk factor for periodontal disease which is one of two main oral diseases of the oral cavity in addition to dental caries. Therefore, smoking is a potential confounder for the association between periodontal disease and COPD. Patients suffering from COPD are experiencing exacerbation events. Exacerbation is a worsening episode of COPD symptoms, and the numbers of exacerbation the patient encounter is related to the severity of the disease.

Patients suffering from severe COPD encounter frequent episodes of exacerbations. The anatomical continuity between the oral cavity and the lung makes it a potential reservoir for respiratory pathogens that could be aspirated and cause the exacerbations. The objective of this pilot study was to determine the association between the oral health, oral hygiene in particular and the frequency of exacerbations. The study included 55 patients with severe COPD. Data were collected using various questionnaires and examinations. The results showed that poor oral hygiene was correlated significantly with the increase in number of exacerbations. There was a trend towards bad oral health in patients with high frequency of exacerbations however it was not significantly different between the two groups of low and high frequency of exacerbations. The results of bivariate and multiple logistic regression showed no statistical significant association between oral hygiene status and the frequency of exacerbations.

أبو ناصر في عيادة الأسنان

آهْ ضِرسِي صَرَخْ ولْدِي، أوقفزْ مِن نومه يعَافرْ
صارْ ايْعالجْ همَّه ساهِرْ، صار مِثْوَلوِلْ أوصايِرْ
الساعَة سَبْع الصبحْ آنا واقفْ إبطابُورْ قاطِرْ
هذا سَجِّلني يصيحْ، إضْروسِي والله ماني قادِرْ
ذاب قلبي يومْ شِفته جارِي امْورَّمْ الساطِرْ
المُهِم شِفنا الطبيبْ أوقعد فوقْ الكرسي ناصرْ
قَالْ هذا السِكْسْ أولازِم مِنْ عِلاج العَصَبْ صايِرْ
هَاكْ هذا الدَوَا أوقامْ أوفتحْ بَابه لأجْل أغادِرْ
رِحْنا إنعيمْ أوسألنا عن مواعيدِ أودفاتِرْ
قالوا إنتَ مِتفائِلْ. قِلِتْ جيفه! إشلونْ! وَآصِرْ
قِلِتْ ماكُوا غَيرْ أبُو لِقْلوسْ، أولكنْ ماني قادِرْ
ألفْ أوخَمسِمْيَة دراهِمْ، قال أبوالبيزات سَاخِرْ
وَيْلِي وَيْلِي صاحْ ناصِرْ {الوجعْ في الضِرسْ كافرْ}
والله بلوى وابْتلينا في عِلاج الوَلَد ناصِرْ
صَحْصِحُوا يا ناسْ أوديرُوا البَالْ في لأوْلاد، أوحاذِرْ

قِلِتْ وين آروح نِصْ اللَّيلْ والدنيَا اثماطِرْ
وآنا همِّي في عِلاجه مِنْ يشُوفه الصبُح باجِرْ
شَكله مُو طابورْ مَرضى إتقولْ إجْيوشْ أوعساكِرْ
أوذاكْ ياكاتب إرحَمني، زوجَتي تِكْسِرْ الخاطِر
يشتَكي والشكوى لله، والله لا يبلِي الشاطِرْ
تَكْ تَكْ الدكتورْ أو أفْ أفْ، مِن غدى إبحلْجَه يناظرْ
لازم إنحولَهْ أوعلاجَه عندْ أخصائِي الدخَاتِرْ
والولد مازالْ يصْرَخْ، دَمعَه فُوقْ الخَد مَاطِرْ
عَنْ عِلاج العَصَبْ تِسألْ؟ قِلِتْ: أيْوَهْ الولَدْ قاصِرْ
قالوا مَوعِدْنا بَعَدْ سِنْتَيْنْ، أولرَبَكْ كُونْ شاكِرْ
وَيشْ إسوي،إلِي مالهْ غيرْ ربهْ عَونْ أونَاصِرْ
ولاَ شيْلهْ! أوشَيْلهْ إبعشرينْ.إذا ما حَصَلْ كاسِرْ
قِلِتْ يالله تِوكَّلْنا، وانكسَرْ ضِرسَه يَغَافِرْ
عمليَّة، أوأخذْ أجرَهْ أربَعينْ، أوكانْ ناكِرْ
لا يصيبْ الضِرسْ سُوسَه {ترى السُوسة سيفْ باترْ}

حسن الملا

رابطة فنيي صحة الفم والأسنان البحرينية
Bahrain Dental Hygienist Association

Before eighteen years ago most of the Hygienist were dreaming and wishing to have an association or society, to encourage ourselves to be more creative, and fighting to improve our's skills. Unfortunately, no body stand with us neither Dental Department In neither the Ministry of Health nor other Hygienists, because every body felt disappointed and there is no clear policy from the dental section about the future of Dental Hygienist program.

After political curative in the Kingdom of Bahrain by the King Hamad bin Salman AlKhalifa, and giving license to many association to be held, and getting support from the Bahrain Dental Society and encouragement from the head of Dental Section, we get chance to see the light. We wish to get full support from them in the future.

First our program for our public society was implemented after three months exactly, it was last Sep8, 2004 and covered by Bahrain TV, National news papers and it is mainly supported by Lions Club Riffa. The workshop was held at (Al-A'Ali Complex) by the name - HAPPY SMILE DAY.

A. Shaheed Ali
President of Bahrain Dental Hygienist Association

The Bahrain Dental Hygienist Association (BDHA) is established on June 02, 2004 at Noaim Health center, supporting from Bahrain Dental Society (BDS). A 34 Hygienists met together and voted for the election of the Board of Trustee, after internal committee credit.

There were four authorized persons of voting trustees, three of them from BDS and one from the internal committee.

1) Dr. M. Al-Jishi	President of BDS
2) Dr. A. Al- Fardan	Head of Dental Dep. Assist. president of BDS
3) Dr. Y. Ahmed	Fund custodian of BDS
4) Mrs. Zainab Meftah	DH & Chief of internal committee credit.

Two hygienists' run for the position of President of BDHA, Mr. A.Shaheed Ali and Mrs. Maimona Marhon.

Four Hygienists run for the Member Board of Trustee, Mr. Ebrahim Yahia, Mr. Hussam Sheplaq, Mrs.Elaham Al-Orayedh, and Mrs. Naema Abdullah.

One hygienist win by recommendation for the Fund Custodian for BDHA Mrs. Zahra Ashoor, and one Hygienist, also, win by recommendation for the Assistant President of BDHA Mrs. Warada Al-Koheji.

The result was as follows:

1) Mr. A.Shaheed Ali	President of BDHA
2) Mrs.Warda Al-Koheji	Assist. President of BDHA
3) Mrs.Elham Al-Orayedh	Member board of Trustee of BDHA
4) Mrs.Nacema Abdullah	Member board of Trustee of BDHA
5) Mrs. Zahra Ashoor	Fund custodian of BDHA

After that Dr. Al-Jeshi congratulated the elected team of Board of Trustee, and stated that it is very important to work as a team and establish committees such as, scientific committee, social committee, educational committee, etc..

After that Mr.A.Shaheed thanked all his colleagues and promised that he will try to put alot of efforts to serve the BDHA for the service of public society.

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الأعضاء المؤسسون لجمعية أطباء الفم والأسنان البحرينية

أعضاء مجلس إدارة جمعية أطباء الفم والأسنان البحرينية للدورة الانتخابية السادسة

تسلم مجلس الإدارة الحالي مهامه بعد انتخابه من قبل الأعضاء بالجمعية وذلك في يوم الثلاثاء الموافق ١٠/٠٢/٢٠٠٤م، ويتكون مجلس الإدارة من الأعضاء التالية أسماءهم:

١. الدكتور محمد حسن الجشي	رئيساً
٢. الدكتور عباس الفردان	نائب الرئيس - رئيس لجنة شؤون المهنة
٣. الدكتور طلال العلوي	أمين السر - رئيس لجنة عالج محتاجاً
٤. الدكتور ياسر أحمد	الأمين المالي - رئيس لجنة تنمية الموارد
٥. الدكتور غسان ضيف	رئيس اللجنة العلمية
٦. الدكتورة شهلاء عبدالغفار	رئيسة اللجنة التثقيفية
٧. الدكتور هيثم محمد حسن الجشي	رئيس اللجنة الاجتماعية

Dental Conandrum Answer

1. Dens invaginatus.
2. As it allows entry of irritants into this area which is separated from pulpal tissue by only thin layer of enamel & dentine & presents a predisposition for development of caries and also sometimes channels may exist between invagination & the pulp.
3. In most cases it is detected by chance on the radiograph. Clinically, an unusual crown morpholog (eg. dilated, peg-shaped) or deep foramen coccum are important hints.

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Gorlin-Goltz syndrome: Case Report

Taha Al-Dairy[a], Ghassan Dhaif[b]
a). Dental intern b). Consultant

Gorlin-Goltz syndrome was first described by Mikultcz Radecki in the late 1800's(5), but it was delineated in (1950-1960) by Gorlin and Goltz.(2). It is known by various names including Gorlin-Goltz syndrome, Bifid Basal Cell Nevus Syndrome, Basel Cell Nevus Syndrome and Nevoid Basel Cell Carcinoma Syndrome (NBCCS).

Etiology:
It is inherited as an autosomal dominant trait where a mutation within the tumor suppressor gene has occurred on chromosome band 9q23.1-q31(3), that leads to inactivation of genetic material with consequence cancer predisposition(5).

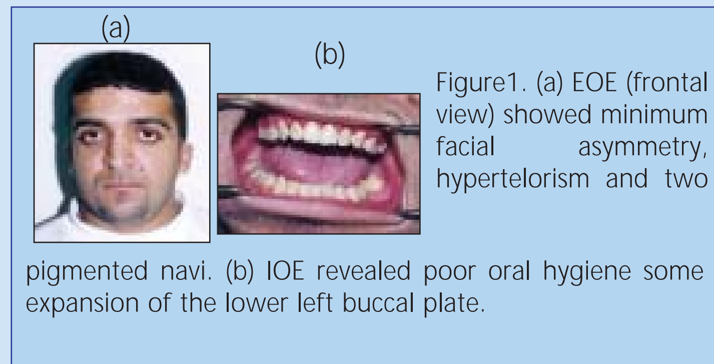
Diagnostic Criteria (2):

Major features:
- Multiple or single Basal Cell Carcinomas (BCC) appearing before age 20 years.
- Odontogenic keratocysts, (OKC).
- Palmar or plantar pits (>3).
- Bilamellar calcification of the falx cerebri.
- Positive family history of NBCCS.

Minor features:
- Congenital skeletal anomaly (ie, bifid ribs, vertebral anomalies).
- Macrocephaly (>97% with frontal bossing).
- Cardiac or ovarian fibroma.
- Medulloblastoma, lymphomesenteric cysts.
- Congenital malformations (ie, cleft lip/palate, polydactyly, eye anomaly).

Case Report:
A 19 years old Bahraini male was referred from local Health Center to Oral & Maxillofacial Surgery department at Salmaniya Medical Complex (SMC-Bahrain) with a painful swelling on the left side of mandible. He was complaining of severe and persistent night pain for the last two days in lower left side, with no history of swelling and negative reaction to hot, cold and sweet application. He consulted his dentist, and extraction of an infected tooth was done under local anesthesia. One week later, the patient developed moderate continuous pain and consulted his dentist again. X-rays were taken and the radiographic findings necisstates an immediate referral. Extraoral examination showed minimum facial asymmetry, hard non-movable swelling in the left side of mandible. The swelling was not warm, not tender and there was no lymphoadenopathy. Macrocephaly, frontal bossing, hypertelorism and two pigmented navi (BCC) were also noted (Figure 1a).

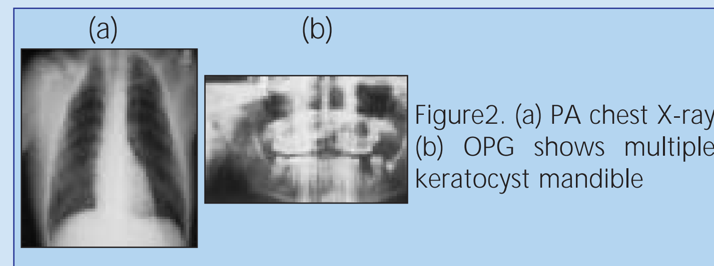
Intraoral Examination revealed poor oral hygiene, upper left 1st molar and lower right 1st molar had dental caries. The gums at upper right second molar area were tender to palpation, and no pathological periodontal pockets were present. Expansion of the lower left buccal plate was noted (Figure1b).



(a) (b)
Figure1. (a) EOE (frontal view) showed minimum facial asymmetry, hypertelorism and two pigmented navi. (b) IOE revealed poor oral hygiene some expansion of the lower left buccal plate.

1. OPG findings were:
- Multilocular radiolucent lesion on the left side of mandible with scalloped outline. The lesion starts mesial to lower 2nd molar to distal of 3rd molar and pushing the inferior dental nerve inferiorly but the inferior border of mandible was intact.
- 1cm unilocular radiolucent lesion on right side of mandible between lower 1st & 2nd molars roots.
- Retained root on lower left first molar area.

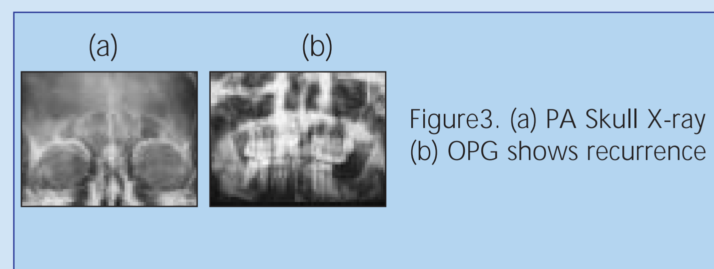
2- Posteroanterior chest and PA skull radiographs did not reveal any abnormalities (Figure 2b).



(a) (b)
Figure2. (a) PA chest X-ray (b) OPG shows multiple keratocyst mandible

Under general anesthesia, retained root was removed then extraction of lower left 2nd&3rd molar was done. Surgical enucleation and curettage of the lesion on left side of mandible was done. The lesion was sent for histopathological examination. The right lesion was planed to be operated separately in another operation.

After three months follow-up appointment, recurrence lesion was noted.



(a) (b)
Figure3. (a) PA Skull X-ray (b) OPG shows recurrence

Another surgery was planed for bilateral enucleation of right and left lesions, during operative procedure, sign of recurrence was clear in left side while the right lesion was more extensive than pre operative radiograph suggests as the lower right 1st molar was involved so extraction was necessary.

Patient was kept under follow-up appointment for further evaluation and assessment.

Histopathological Finding:

Microscopically, the cyst was lined by stratified squamous epithelium and keratin flakes were present in some areas of the lumen. The fibrocollagenous wall shows focal chronic inflammatory cell infiltration and bony spicule.

All clinical, radigrphical and histopathological findings were consistent with Nevoid Basal Cell Carcinoma Syndrome.

Discussion:

NBCCS patients are usually diagnosed in the 2nd and 3rd decade of life with OKC &/or BCC(2). This late diagnosis is a result of asymptomatic syndrome features, also because the syndrome signs need time to become well developed, before patient notice them, and seek a medical care.

Nowadays, prenatal diagnosis is possible at 10-12 weeks of pregnancy by genetic analysis of individual family members to identify unborn carriers of the defective gene(1).

Our patient was diagnosed of having NBCCS after presenting to our clinic complaining of painful swelling on the left side of his mandible. The swelling turned out to be OKC, which is the first sign of NBCCS syndrome in 78% of patients.

OKC is characterized by its aggressiveness and high recurrent rate, it may recur in unilateral or bilateral and in one or both jaws. The peak of it's recurrence is after 5 years of surgical enucleation and curettage (2).

Radiographic examination is very important in diagnosis of NBCCS. Plain radiogragh (O.P.G, PA of chest, PA of skull, pelvis) is so helpful when are combined with cranial MRI or axial CT. Also echocardiography is useful in children affected by NBCCS to exclude the cardiac fibroma(3). The sensitivity of NBCCS patient to the ionizing radiation should be considered. It is contraindicated to treat BCC with radiotherapy because the ionizing radiation encourages the development of skin cancers including BCC(2).

OKC is different clinically and histologically in syndomic and non-syndomic patients. The age of onset of OKC in syndromic patients is earlier and effect female more than male but there is no difference in the site of occurance(8). Histologically, in syndomic patient, there are more satellite cysts, solid islands of epithelial proliferation and odontogenic epithelial rests within the fibrous capsule than do isolated OKC in non syndomic patient(1), and also the type of keratin is different. These histological differences explain the high recurrent rate in syndromic patients that ranged from 30% to 60%.

In this case, the histopathologist report did not mention the presence of satellite cysts or different histological pictures that present in isolated OKC in non syndromic patient.

Our patient had two major criteria and two minor criteria of NBCCS and that was enough to establish NBCCS diagnosis, and as the oral & maxillofacial surgeon was part of the team treating NBCCS patient, we should think for advance treatment techniques to treat the medical problem that undergo our specialty(i.e OKC and cleft lip&palate).

OKC and cleft lip & palate occur 80%, 5%(9) respectively in NBCCS patient. The treatment options for OKC can be classified in two categories, radical and conservative surgery.

Conservative options are:

1- Enucleation and curettage, (some surgeons use the carnoy`s solution)
2- Recently, by start with marspilization in order to decrease cyst volume, enhance new bone formation, free the cyst from vital anatomical structure and increase the thickness of cyst wall, so the encleation of the cyst become easier and reduce the recurrence rate . This technique called decompression and cystectomy.

Radical surgery options include:

1- Bone Resection and bone transplantation.
2- Encleation with peripheral osteotomy for lateral cortical wall(4).

A team consisting of an oncologist, dermatologist, oral & maxillofacial surgeon, neurologist, cardiologist, orthopedic surgeon and geneticist, is necessary to provide an optimum health care to NBCCS patients.

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