Manitoba Dental Association

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BULLETIN

VOLUME 28, ISSUE 2 SUMMER 2009

POINTS OF INTEREST:

- Implant Program Protocol
- Congratulations to the 2009 Graduates
- First Dental Visit
- Provision of care in Northern regions
- Highlights from Tooth Fairy Saturday

INSIDE THIS ISSUE:

Congratulations to Dr. Tana Gilmartin on receiving the Mayor's Volunteer Service award for her volunteerism at Saul Sair Health Centre at Siloam Mission.

A unique dental program in Canada, Saul Sair Health Centre at Siloam Mission provides all dental treatment free of charge. The health centre functions mainly because of compassionate individuals who donate their time to serve Winnipeg's less fortunate.

Since the summer of 2007, Dr. Tana Gilmartin has been volunteering with this program and donates her time weekly to serve the inner-city population. For the many patients who walk though our doors, her compassion is unrelenting. Her services have been provided for hundreds of people with dignity and respect.

Dr. Gilmartin's active participation in our community has made Winnipeg's inner city better for us all. Without her support, the dental program would not be as successful as it is today. She is an advocate for those that are often disregarded and is an outstanding mentor within her profession and her community. Congratulations to Dr. Tana Gilmartin for The Mayor's Volunteer Service Award.

Sandy Mutchmor
President, MDA

President's Message...

I believe that someone once said that, "The only constant is change". As I write this message, it is well into June and there still doesn't really seem to have been much change towards spring. There is however, lots of change going on in organized Dentistry.

At the national level, much has been going on at the CDA. Lately, there have been some struggles with the different projects that the CDA has been involved in, resulting in an inability to budget to continue to function at the same level. Many meetings over the last months/years have brought about changes that will see a whole new corporate membership model and the ability to have some of the CDA's past functions carried out at the provincial level. Now, where a corporate membership exists, joining the Provincial Dental Association will also include membership in the Canadian Dental Association. Also, where a corporate member exists, dentists will not be able to join CDA directly. It is believed that this will help strengthen both the CDA and the Provincial Associations by increasing membership for both groups while reducing or eliminating duplication in services. Instead of competing against each other for members, they can now work together to supply the complete package of services in a more efficient manner. It is hoped that this will eventually also allow a reduction in membership fees.

"There is lots of change going on in organized Dentistry."

While I'm on the subject of the CDA, I should also mention another change with a more local connection. After six years as the MDA's voting delegate to the CDA General Assembly, Dr. Jim Bonar has decided to step down. Jim has done a tremendous job representing our views and has also been involved serving on other CDA committees along the way. So next time you see Jim, I'm sure a pat on the back and a "thank you" are in order.

Here in Manitoba, the biggest changes will arise out of Bill 18, the Regulated Health Professions Act. This is the umbrella legislation that seeks to standardize how the health professions are regulated. It has already passed second reading and proceeded to a legislative committee to whom I was able to make a presentation on our behalf to voice some of the concerns that our profession has. It was another new and interesting experience for me.

In the end, there will be some drastic changes to our 125-year–old association. The regulatory side of the MDA will have to be split from the membership services to produce the "College of Dentists of Manitoba". This will run separately and will mean that we will have to have a separate Board of Directors to run any continued membership services association. As the legislation is a watershed event for the MDA, much consultation, deliberation and strategic planning must take place. A Task Force is being set up with a draft Terms of Reference to begin overseeing the transition.

One of the main non-regulatory services that the MDA has provided to the public is an alternative dispute resolution mechanism to address the personal, primarily financial, issues between them and members of the dental profession. The Board recognizes that this has great benefit to both the public and the profession. We believe that this is a service that we do want to continue, and as a part of an overall regulatory review, steps are underway to consider options for what this should look like in the future.

Another key service provided by the MDA has been the annual fee guide. The fee guide benefits patients by facilitating the processing and payment of third party payer claims. Currently, all governmental and non-governmental third party payers in the province accept the MDA fee guide. A few vary the fees, but all rely on the relative valuation between the services. It would be financially and administratively costly, if not impossible, for each of the over 400 dental offices in the province to produce a unique price list without an information base on which to rely. In the future, it is possible that we may no longer be able to provide this guide.

Lately it seems that there is always something new at the Faculty of Dentistry as well. This time it's that the fall of 2009 will see the start of the first class under the new admissions policy which guarantees that at least twenty-five of the twenty-nine students accepted will be local Manitobans. The hope is that this will help increase the number of graduates that stay and practice here in the province. We will all be watching to see how this turns out.

They say, "A change is as good as a rest". However, with a whole lot of changes, I doubt there will be much rest at the MDA office.

I hope you all have a great summer! That is, if the weather ever changes.

Sandy Mutchmor, D.M.D.
President
Manitoba Dental Association

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08-185 05/09

Registrar's Column...

Marcel Van Woensel
Registrar, MDA

"The name of the dental regulatory authority in Manitoba will change from the Manitoba Dental Association to the College of Dentists of Manitoba ."

The universe is change… life is understanding.

Marcus Aurelius

The art of progress is to preserve order amid change and to preserve change amid order.

Alfred North Whitehead

Bill 18, *The Regulated Health Professions Act* (*The Act*), has completed the legislative committee hearings and is moving to third reading at the Manitoba Legislature. Although it will not affect the high standards and day-to-day operations of dentists and dental assistants in clinical practice, it will require fundamental changes to the regulatory structure for dentistry and dental assisting.

The legislation brings all 21 health professions under one statute. It develops a unified and consistent approach to regulation among the professions as well as clarifying the provincial government's relationship with the regulatory authorities. Each profession will then have regulations approved by the Province to govern their members. Bylaws confirmed by a member vote will focus on governance, registration, professional conduct, facility accreditation and Code of Ethics. Bylaws for registration and licensing fees will not require a member vote.

Several name changes will occur because of the new legislation. The name of the dental regulatory authority in Manitoba will change from the Manitoba Dental Association to the College of Dentists of Manitoba. The Board of Directors will be renamed the Council of the College. The Peer Review Committee will be Complaints Investigation Committee and the Inquiry Committee. Appeals of a Complaints Investigation Committee will be reviewed by an Appeal Panel of the Council of the College rather than an Appeals Committee of the Peer Review Committee.

A regulatory authority cannot produce a fee guide.

The new *Act* clarifies and expands the investigation and informal resolution powers of the Complaints Investigation Committee. It also allows this Committee to order a member to pay investigation costs in certain circumstances.

The new *Act* also allows for a College to perform office and facility audits to ensure continuing competency.

Health care provided by health professionals will now be regulated through reserved acts instead of through exclusive scopes of practice. Reserved acts are services or procedures that are done in the course of providing health care and that present a demonstrable risk of harm to persons if they are not performed correctly and competently. Only certain regulated health professions and qualified, skilled members of those professions are allowed to perform reserved acts. In some cases, the new *Act* permits the delegation of a reserved act to a person who is not a member of a regulated health profession but who is competent to perform the act. The reserved acts for a health profession will be established by Provincial regulations.

The Minister of Health has powers which include launching an inquiry, issuing a directive or appointing an administrator for a College when it is in the public interest.

It may be some time before regulations are developed to replace *The Dental Association Act*. A review of policies, practices and bylaws of the MDA has been ongoing for over a year to make the transition as simple and seamless as possible. Activities and terms of reference for existing committees are being reviewed to align with expectations of *The Act*. New committees are being formed to manage additional obligations. Potential options for assessing continuing competence and assuring quality are being investigated by the Taskforce on Office Assessment.

A new committee – The Taskforce on the Future of Organized Dentistry in Manitoba – will investigate how all the functions of a profession (regulatory and non-regulatory) can be met in the province. It will also consider the impact of reserved acts and the position of dentistry and dental assisting will take to ensure public safety.

For your interest, the Bill can be reviewed at http://web2.gov.mb.ca/bills/39-3/pdf/b018.pdf.

Enjoy the summer.

Marcel Van Woensel
Registrar, Manitoba Dental Association

Review Committee
Implant Program Protocol
March, 2009

The Implant Program is for those individuals who have a diagnosis of cleft lip/palate or a skeletal dental dysplasia, enrolled in the Manitoba Centre for Craniofacial Difference Program, or for those patients who, through resection for benign disease or because of severe debilitating facial trauma, are unable to wear conventional prosthetic devices. Patients with pre-existing facial trauma or benign resection prior to the commencement of this program are not eligible for the program. All implant cases must be pre-determined by the Sub-Committee.

Principles:

Treatment must be performed by:

certified specialist member in oral and maxillofacial surgery;

certified specialist member in prosthodontics;

academic affiliate member with practice restricted to oral and maxillofacial surgery who has been assessed by his/her supervisor as meeting Manitoba's standards of practice in this area of dentistry;

academic affiliate member with practice restricted to prosthodontics who has been assessed by his/her supervisor as meeting Manitoba's standard of practice in this area of dentistry.

All cases must be treatment planned by the aforementioned members and submitted to the Review Committee, which is a Sub-Committee of the Hospital Dental Services Committee of the Manitoba Dental Association.

The structure of the Sub-Committee will be:

Chair, MDA, HDSC

2 Oral & Maxillofacial Surgeons

1 Prosthodontist

The Dental Director Cleft/Dysplasia Program

An Appointee of the Minister of Health.

The Sub-Committee will meet 4 times a year: 30 April; 30 June; 30 September; and 15 December. Submitted cases must be received 2 weeks in advance of those dates to be reviewed or they will be held over until the next quarterly review date.

Patients who will have their cases submitted for consideration under the cleft/dysplasia category must be registered with the Craniofacial Difference Program.

The Dysplasia, Trauma and Resection Implant Programs being introduced have a funding level that allows for treatment that restores basic function with minimal implants and removable prosthesis.

For patients with a diagnosis of Cleft Lip/Palate funding will be for a maximum of 2 implants in the affected maxillary quadrant for unilateral cleft and a maximum of 4 implants in the maxilla in the case of a bilateral cleft. For cleft patients, funding would usually include fixed prosthetics.

For patients under the dysplasia or resection /trauma groups, there will be a limit to the number of implants required to a maximum of 4 per arch to allow a patient to wear a removable denture.

Payment is for initial treatment and will not cover maintenance costs.

Information to be submitted by a Prosthodontist or Oral & Maxillofacial Surgeon to the Sub-Committee on behalf of a patient must include: name, date of birth, relevant dental/medical history, casts, radiographs and a treatment plan.

The program will cover the initial surgical fee, fixture costs and minimum prosthetic fees necessary for basic function. Should a patient select a treatment plan that is more extensive than this, the program may pay up to the maximum of the treatment deemed suitable by the Sub-Committee once the practitioner presents information that the alternate treatment plan has been completed.

Any appeal for a case not accepted will be considered by an Ad Hoc Committee comprised of the Chair, MDA, HDSC along with 2 Oral & Maxillofacial Surgeons and a Prosthodontist who did not serve on the Sub-Committee making the initial decision. An appeal may be made only for a case that was not accepted for treatment. An assessment as to level of funding by the Sub-Committee will not be a reason for an appeal.

Patient compliance is a requirement for remaining part of the program.

The Sub-Committee meets on an ad hoc basis.

Once an application for coverage has been approved, notification will be sent to the treating dentists as well as a copy to the billing clerk of the Cleft/Dysplasia Dental Insurance Program and to Manitoba Health.

Billing:

Surgical fees for stage I and II will be made to Mb. Health, using a standard claim form and including a copy of the authorization note. Fees will be paid according to MDA fee code fees.

Prosthodontic fees will be submitted to the cleft/dysplasia dental program and will be paid, according to MDA fee code fees to a maximum of

$3000 per maxillary implant in the cleft patient inclusive of lab fees

$6000 in the case of 2 abutments and a removable prosthesis inclusive of lab fees

$8500 in the case of 4 abutments and a removable prosthesis inclusive of lab fees.

---------- **REMINDER** ----------

Manitoba Cleft/Dysplasia Coverage

Just a reminder that individuals with operated clefts, or with significant oral-facial dysplasias who are registered in the plan, are covered for most dental procedures by this provincial program.

For more information call Sheryl at 787-2207

Coronal Leakage: An Endodontist Perspective

Dr. Robert Kaufman

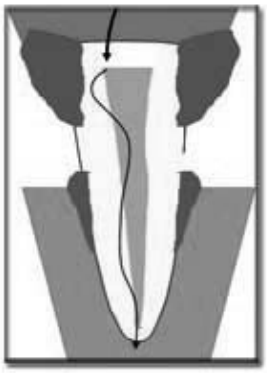
SPECIAL POINTS OF INTEREST

- Coronal microleakage
- Dentin bonding
- Bonding systems
- Bonding RCT teeth
- Orifice barriers
- Access openings
- Posts—overview
- Restoring RCT teeth
- Fibre posts
- Post length
- Restoration trivia

In vitro/In vivo

The use of orifice barriers as a precursor to or a concomitant component of restoring an access opening separately or doing a core buildup in conjunction with obturation has long been understood to be an integral component of endodontic success.

Coronal microleakage is a potential cause of endodontic failure *(Saunders and Saunders 1994).* The quality of the coronal restoration has a significant impact on the health of the periradicular health of root filled teeth *(Tronstad et al, 2000, Hommez et al 2002, Siquiera et al 2005).* A study of 775 endodontically treated teeth in 508 patients showed higher survival rate if restored within 2 weeks *(Willershausen et al 2005).*



Once root canal treatment is completed, immediate restoration of the tooth is recommended whenever possible *(Heling et al 2002).*

Swanson& Madison 1987—dye leakage to apex—3 days
Torabinejad et al 1990/Khayat et al. 1993—bacteria to apex—30days
Trope et al. 1985– Endotoxins to apex—20days

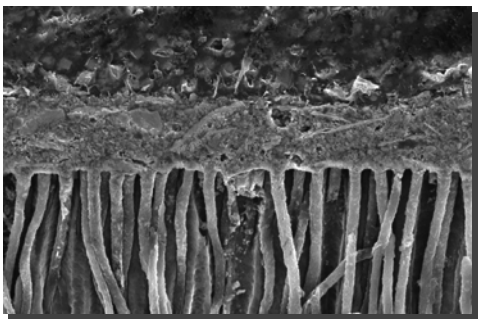
Bonded permanent restorations (regardless of the restorative material) should be used whenever possible to minimize microleakage *(Urange et al 1999, Howdle et al 2002).*

Dentin bonding

Acid-etching demineralizes dentin and exposes the superficial collagen matrix - a hydrophilic primer penetrates the collagen matrix - the volatile liquid in the primer evaporates - an adhesive resin co-polymerizes with the resin in the collagen matrix. The layer between the restorative material and the dentin consists of collagen fibres surrounded by resin and is referred to as the HYBRID LAYER. Dentinal tubules are not major contributors to retention. The collagen matrix in the intertubular dentin is more important to retention than the tubules and dentinal tubules account for only about 15% of retention.

Dentin and Enamel Bonding Systems

Etch and Rinse—4th generation—etch, rinse, primer, air dry, adhesive, polymerize.
3 steps



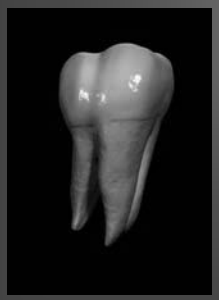
5th generation—etch, rinse, combined primer and adhesive, polymerize, 2 steps.

Self Etching—6th generation—acidic primer, air dry, adhesive, polymerize. 2 steps

7th—generation—acidic primer and adhesive combined, polymerize. 1 step

In general—3 step adhesives work the best and area most durable *(Inoue et al. 2001, van Meerbeek et al 2003, Tay et al. 2003, Fabianelli et al. 2003, de Munck et al. 2003, Armsrtong et al. 2003, Chersoni et al. 2005, Breaschi et al. 2008.* **Dental bonding agents lose bond strength over time** *(Takahashi et al. 2000, de Munck et al. 2005, Shirai et al. 2005).* **The three step etch and rinse adhesives remain the gold standard in terms of durability. Any kind of simplification in the clinical application procedure results in loss of bonding effectiveness.**

Use a resin modified glass ionomer material (most materials have little or no effect on GIC)



Bonding Systems

(exceptional track record)

- Optibond FL (Kerr): 3–step etch and rinse adhesive *(van Dijken & Pallesen Dent Mater 2008)*

4th generation

High bond strength

Stable bond over time—annual failure rate 3.1%

13 years of clinical data

20 years of clinical results

Works in wet, moist and dry preparation

Compatible with self or dual cure composites

Least technique sensitive of any adhesive

- Photobond (Kuraray): 3—step etch and rinse adhesive

4th generation

High bond strength

Fairly stable bond over time, annual failure rate 2%

13 years of clinical data

20 years of clinical results

Will work with wet, moist or dry preparation

Compatible with self or dual cure composites

Probably one of the least technique-sensitive of any adhesive

- Clearfill SE Bond (Kuraray): 2—step self etch adhesive

Composites *(Feltzer et al. 87, 88, Carvalho et al. 96, Braga et al 02, de Munck et al 05)*

The biggest disadvantage of composite resins is they shrink during polymerization (2-6%) and the contraction forces from polymerization shrinkage often exceed the bond strengths of dentinal adhesives. This may lead to stress, fractures, debonding and microleakage.

Solution

Incremental filling. Self or dual cure core materials: slow setting composites place less stress on the bond. The obvious answer is development of composites that shrink less—3M's new Filtek-Silorane composite, <1%)

Bonding in Endodontically Treated Teeth

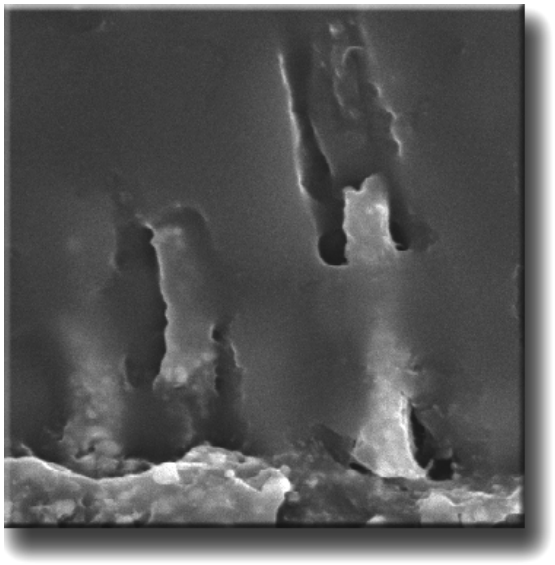
Eugenol—ZOE sealers and most temporary cements leave behind an oily debris which interferes with polymerization and bonding of resin *(Woody et al. 1992, Watanabe et al. 1997, Peutzfeldt et a. 1999)*. NaOCl breaks down to oxygen a and sodium chloride and hydrogen peroxide (RC Prep, Glyde) form an oxygen rich surface which interferes with polymerization and bonding of resin *(Morris et al. 2001, Lai et al 2001, Ari et al. 2003, Ozturk et al. 2004, Santos et al. 2006)*. The oxygen rich layer left behind by NaOCl can be reversed by a reducing agent like sodium ascorbate or ascorbic acid *(Morris et al. 2001, Lai et al. 2001, Yui et al. 2002)*.

10% sodium ascorbate for one minute restores the original bond strengths *(Weston et al. 2007)*. A final rinse of EDTA reversed the effects of NaOCl on bonding *(Doyle et al. 2006)*. ***Chlorhexidine*** has no effect on bond strength *(Perdigao et al. 1994, Erdemir et al. 2004, Santos et al. 2006)*.

Orifice Barriers

- Tetric Chroma (Vivadent)
- Permaflow Purple (Ultradent)
- Flow-it clear (Pentron)
- Effective bonding needs a clean surface

Danville Microetcher



Orifice Barriers, **clinical procedures**

- Countersink the orifices
- Clean the chamber
- Acid-etch for 15 seconds and rinse
- Apply a 4th generation primer and adhesive
- Apply a clear or colored flowable composite over the pulp floor
- Or use 6th generation system if non-eugenol sealer has been used (self etching systems incorporate the eugenol in the hybrid layer)
- Or use a resin modified glass ionomer material (Most materials have little or no effect on GIC)

Restoration of an access opening

Considerations; Bond to dentin, metal or porcelain.

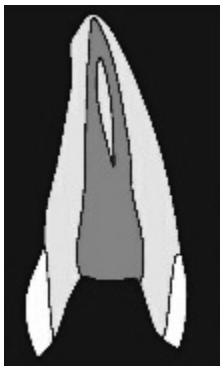
The access cavity has been abraded, and is clean and ready to restore.

- Porcelain: Apply 10% hydrofluoric acid to the porcelain for 1minute resulting in a frosty appearance.
- Acid etch the dentin for 15 seconds.
- Apply silane to the porcelain.
- Apply primer and bonding.
- Apply clear flowable composite.
- Apply dual or self cure core.
- Apply an opaquer, colour modifier ie. A3 Kerr
- Apply top layer ie. Tetric Ceram A3 or LuxaCore, or Ceramage OD A 3.5 (Shofu), or Filtek Supreme XT A2E (3M)

Article to review—Schwartz and Fransman. J Endod. 2005 Mar; 31(3):151-65.

Restoration of endodontically treat teeth

Cuspal coverage is the most important restorative factor in the survival of endodontically treated teeth *(Sorensen & Martinoff 1984, Cheung & Chan 2003, Salehrabi & Rotstein 2004).* Endodontically treated teeth with cuspal coverage had six times greater rate of survival *(Aquilino & Caplan 2002).* The five year survival rate of teeth w/o cuspal coverage was 36% *(Nagasiri & Chitmongkolsuk 2005).*



In vitro failure modes of fibre, metal and ceramic post/core systems. (Fokkinga et al. Int J Prosthodont. 2004 Jul-Aug;17(4):476-82.

298 papers were selected from literature between 1984 and 2003. Metal posts had the highest failure loads, ceramic the lowest. Significantly more favourable failures occurred with prefabricated Fibre-Reinforced Composite (FRC) post systems than with prefabricated and custom-cast metal post systems.

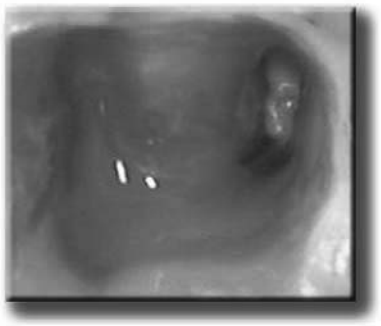
Clinical Studies of Fibre Posts; a lit review

Since 1990, 5 randomized controlled trials on fibre posts have been published in peer reviewed journals, but a meta-analysis is not applicable. Two trials indicate that FRC posts outperform metal posts, but this evidence is not considered conclusive. The placement of an FRC post protects against failure, especially under conditions of extensive coronal destruction. The most common type of failure with fibre-reinforced composite posts is debonding.

Posts—Overview

Important post principles

- Retention and resistance form
- Preservation of tooth structure
- Ferrule (collet)
- Failure mode
- Retrievability



Ferrule *(latin: viriola— small bracelet) is a ring or cap usually of metal put around a slender shaft to strengthen it or prevent splitting. When the supra-marginal dentin of a root-filled tooth is engaged by a crown, it may create a stronger tooth/restoration complex: the ferrule effect. (Stankiewicz & Wilson, Dent Update. 2008 May;35(4):222-8.*

It provides primarily resistance form and enhances longevity. A ferrule with 1 mm vertical height doubles the resistance to fracture *(Sorenson et al. 1990).* Maximum beneficial effect from a ferrule occurs with 1.5—2 mm of vertical tooth structure *(Stankiewicz et al. 2002, Zhi-Yue et al. 2003).*

The lingual surface is the most important in upper anterior teeth (Ng et al. 2006).

Tobjorner & Fransson, Int J Prosthdodont, 2004 May-Jun; 17(3):369-76. Fibre posts may be at risk for early failure, however, there is less risk of catastrophic failure. Metal posts demonstrate longer service with fewer problems with post fracture and or loss of retention, however, there are more non-restorable failures.

Post placement and root canal treatment are the major etiologic factors for root fractures *(Fuss et al. 2001).* ***Most fractured teeth: second maxillary premolars and mesial roots of mandibular molars (Tamse et al. 1999)***

Advantages of Fibre Posts

Can be used in aesthetically demanding areas. Their elastic modulus more closely approaches that of dentin—better distribution of forces of occlusion. More favorable failures occur than with custom cast metal post systems and there is growing evidence that they improve fracture resistance of pulpless teeth *(Rosentritt et al. 2004, Cavalho et al. 2005, Goncalves et al. 2006, Schmitter et al. 2006, Salameh et al. 2007, D'Arcangelo et al. 2008, Salameh et al. 2008).*

Most fractured teeth: second maxillary premolars and mesial roots of mandibular molars

Cast versus Fibre Posts

Cast Post	Fiber Post
Non-salvageable root fractures	More benign fracture type
Can compromise aesthetic result	Can be used in aesthetically demanding situation
Extra session required for insertion	Can be placed after finishing RCT
Strong	Lower strength value
Long record of clinical performance	More followup studies needed

No monoblock with current materials

There is evidence that fibre posts rely on mechanical (frictional) retention rather than bonding, just like metal posts *(Manocci et al. 2003, Goracci et al. 2004, 2005, Perdigao et al. 2004, Pirani et al. 2005, Sadek et al. 2006).* Gaps can be demonstrated between the resin and dentin *(Manocci et al. 2003, Goracci et al. 2005, Pirani et al. 2005)* and low bond strengths are demonstrated between fibre posts and root canal walls *(Goracci et al. 2004, Perdigao et al. 2004).*

Fibre posts will undergo a process of cement failure during cyclic loading, as do metal posts *(Baldissara et al.2006).* Configuration factor—C factor—ratio of bonded to unbonded free surfaces—C factor in root canal system is unfavourable *(Feltzer et al. 1987, 1988, Carvalho et al. 1996).* Higher ratio results in greater stress of the dentin bond. Class V highest—incisal edges lowest 5:1 vs. 1:5. Bouillaget noted that bond strengths in intact canals were lower than bonding onto flat dentin surfaces *(Dent Mater 2003 May; 19(3):199-205).*

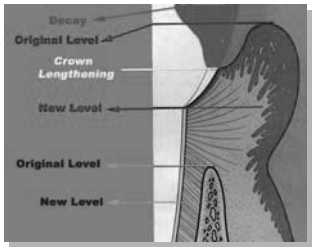
And yet

Long-term retrospective study of the clinical performance of fibre posts

Retrospective study of 3 types of fibre posts (n=985) after a service period of 7-11 years.

Results: A total of 79 failures were recorded (7-11% failure rate).

- 39 endodontic failures
- 1 root fracture
- 1 fibre post fracture
- 21 due to post debonding
- 17 crown dislodgements



The mechanical failures were always related to the lack of coronal tooth structure.
(Ferrari et al. Am J Dent. 2007 Oct;20(5):287-91.

The choice of the total etch technique using dual curing adhesive systems and cements represents the most predictable method for luting fibre posts.

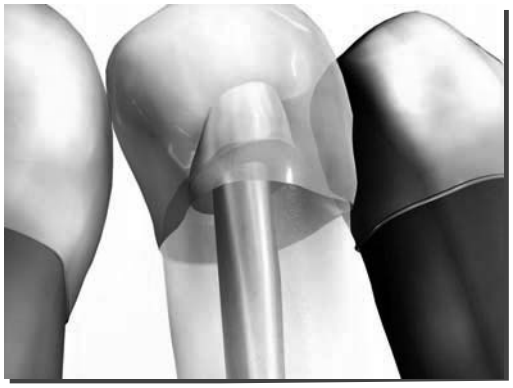
Technique

- Removal of gutta-percha—heat and then passive refinement of space with drill
- Acid etching with phosphoric acid—15 seconds
- Rinse and air dry
- Primer (dentin)
- Bonding (dentin and post)
- Composite in post space (needle tube)
- Post placement
- Build-up of composite (light cure if necessary)

Post Length

2/3 length of the canal—or at least equal to the length of the crown (97% success)

Post should extend apically beyond crest of bone –least risk to remaining tooth structure by occlusal forces *(Goodacre & Spolnik 1995, Sorensen & Martinoff 1984, Hunter et al. 1989).*



Restoration Trivia
Placement of fibre posts can improve fracture resistance in pulpless maxillary premolars, even under full coverage crowns *(Salameh et al. 2007).* The use of fibre posts in endodontically treated maxillary incisors with different types of full-coverage crowns increased their resistance to fracture *(Salameh et al. 2008).* ***Fibre post restorations seemed to significantly increase mean maximum load values for maxillary central incisors prepared for veneers (D'Arcangelo et al. 2008).***

Placing a post through an existing crown

- Crown retention will be increased
- Resistance to fracture may be increased, provided no additional radicular dentin is removed
- Choose a post that fits the canal preparation
- Extend it several mm apical to the crest of bone
  Use them routinely in front teeth and bicuspids

GIC or RMGIC

- Weak tensile strength and lowered resistance to fracture—brittle
- Low retention to metal posts
- Not strong enough to be used as a bulk material
- Suitable to block out undercuts after removing restoration
- Hygroscopic expansion can cause fracture of ceramic crowns

Post surface treatment for improving adhesiveness
> Silanization and/or adhesive application—improvement in bond strength between silanized fibre posts and composite cores *(Goracci et al, 2005, Aksommuang et al. 2006)*
> Acid etching, sandblasting and silica coating—air abrasion improved retention of glass fibre posts (*Balbosh & Kerr 2006).*
> Alternate etching techniques—pretreatment of fibre posts with hydrogen peroxide and silane improves the bond to composite *(Monticelli et al. 2006)*
Post treatment with 24% H_20_2 for 10 minutes followed by silane application, appears to be an effective and inexpensive method that can improve the clinical performance of both the methacrylate based and epoxy resin based fibre posts. (Vano et al. 2006).

This article is a Synopsis of a lecture given by Dr. Marga Ree at the New Jersey Association of Endodontists meeting on Feb. 7, 2009. Special thanks to Dr. Ken Serota for the transcription and layout.

CANADIAN DENTAL ASSOCIATION REPORT

The CDA Board of Directors held a meeting in conjunction with the Annual General Meeting of the CDA from April 23 to 25 in Ottawa. The BOD again met in Niagara-on-the-Lake for its annual planning session from June 11 to 13. The BOD meeting agendas have been realigned to CDA's three strategic priorities, a strong profession, a united community and a healthy public and to its list of services to the profession.

A Strong Profession

The BOD has approved revised terms of reference for the Dental Issues Group (DIG). The DIG identifies issues of concern in dentistry and coordinates collection fo information on issues. It acts as an emergency response to public inquiries. Dig also advises the elected officials and staff on issues management. The DIG is made up of the EDs of the provincial dental associations (PDAs) and the ED of the CDA.

The CDA BOD approved criteria to select and advance a candidate for election to the World Dental Federation (FDI) at the April BOD meeting. At the June BOD meeting the BOD selected Dr. Jack Cottrell as its candidate.

A United Community

The BOD reaffirmed its support for the new membership and governance model as recommended by the Presidents and CEOs of Corporate Members. At the April 25th AGM of the CDA the AGM unanimously approved the new membership model. Implementation will take place in April 2011 subject to approval of a new Memorandum of Understanding and approval of new bylaws at the November interim AGM. The current MOU on membership will be extended to 2011.

The BOD discussed the future of CDA conventions. The CDA will continue with its current convention partnership protocol. Discussions are underway for the partnering with the Order of Dentists of Quebec in 2010, the Nova Scotia Dental Association in 2011 and the College of Dental Surgeons of Saskatchewan in 2012.

The Presidents and CEOs meetings will be renamed the Dentistry Leader's Forum.

A Healthy Public

The BOD received a status report on Seniors Oral Health and noted that progress has been made. The DIG will be asked to gather and post CE information on Seniors Oral Health. There was a consultative forum on the Canadian Health Measures Survey on April 24th. The Strategic Priority Team on Healthy Public will review the CDA's direction on this issue and propose any necessary changes.

Services to the Profession

The CDA approved the Terms of Reference for the CSI Advisory Group. Members of the group have been appointed and will begin their work presently. I-TRANS has been designated as a no cost member benefit under the new membership model. Enrolments and transactions continue to grow.

The BOD received updates of the Dentistry Canada Fund (DCF). The BOD of DCF will be seeking input from the Corporate Members on the future of the charity.

The CDA approved a dissolution of the Trusts related to Life and Disability plans. The 21 year lifespan of the Trusts expire at the end of 2009 and could have caused a significant tax liability. The BOD also approved the transfer of the insurance plans from the CDA to CDSPI to allow for more efficiency in the management of the plans.

Following the AGM the BOD welcomed Dr. Randy Croutze, Alberta, and Dr. Alistair Nicoll, British Columbia, to the BOD, and congratulated Dr. Robert MacGregor on his election to Vice President.

The new membership model of the CDA is the most significant change to the CDA in its history. The new model will bring all the members of the ODA to the CDA and require all CDA members to also be members of their respective PDA to obtain the services of the CDA. This will provide mutual support and protection to all the PDAs and the CDA.

As always the CDA continues to work in the best interests of the dentists of Canada.

Peter J. Doig, DMD

CDA Board Representative


Your Company, Your Choice
CDSPI truly is *your* company.
Your associations – the Manitoba Dental Association and the Canadian Dental Association – are our members. And the insurance and investment programs we administer as member benefits on their behalf are designed specifically with dentists in mind.
What's more, the licensed advisors at CDSPI Advisory Services Inc. supporting those programs serve dental professionals exclusively. So they understand your insurance and investment needs – and how to meet them – better than anyone else.
Excellent reasons to make your financial services company – CDSPI – your first and only choice.
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CANADIAN DENTAL ASSOCIATION
CDSPI
08-183 01/09

Grad Breakfast 2009

The 2009 Grad Breakfast for the graduating Dentistry students was held at the Canad Inns, Club Regent, Winnipeg, on Thursday, May 28, 2009.

Congratulations

to the 2009 graduates of the

University of Manitoba Faculty of Dentistry

BAE, Daniel S.
BASCHAK, Tatiana E.
BERGEN, Jeffrey A.
BRASKO, Andrej
COULTER, Kristopher R.
DO, Kiet T.
DYKUN, Ashley
GODLEWSKI, Joanna I.
HUANG, Yi-Chen C.
HUMINICKI, Amanda C.
HUMPHREYS, Courtney C.
KHAN, Sukaina
KIM, James T.
KLUS, Bradley A.
KSIAZKIEWICZ, Natalia I.
LACAP, Perry
LESKAUSKAS, Vaidotas
LITTLE, Marcia N.
MOHAMMAD, Omar N.
NGUYEN, Monica
ONG, Christopher W.
PALTA, Rakhi
SAAD, Radwa
SCHERLE, Kurt M.
SEREBNITSKI, Alexander
SHAAR, Lina
SHARMA, Rohit
STEIN, Zachary D.
THORSTEINSON, Michelle C.
VAN JAARSVELDT, Lindi
WILLIAMSON, Lauren E.
YAKIWCHUK, Benjamin N.
ZETTLER, P. Anton

Congratulations
to the graduating 2009 Intra-Oral Dental Assistants

Red River College

ABRAHAM, Nicole
ANGALA, Julianne
ARCHER, Chantale
BABYNCHUK, Rena
BANFIELD, Kaloni
BARANOWSKI, Lindsay
BELL, Jessica
BENNETT, Laura
BONNETEAU, Brittany
BROWN, Breanna
CRANFORD, Charlen
CRUZ, Cerizza
EGAN, Sara
GAJ, Patrycja
GUTIERREZ, Marilou
HART, Megan
HARTLE, Megan
HOLLOWAY-DATZKIW, Lisa
IBALIO, Samantha
KAZUBEK, Andrea
KROPLA, Kelsey
KUYEBI, Gloria
KWOK, Allison
LECLAIR, Leah
LENTON, Lynne
LOUGHEED, Laura
MARTINSON, Kristin
MASON, Sheila
McCULLOCH, Melissa
MICHALUK, Darby
MOORE, Brenna
PAGSULINGAN, Lina
PANTELUK, Melissa
PAWLUK, Tannel
PERHAR, Jaspal
PONTES, Amanda
PRINCE, Anna-Marie
REBENCHUK, Tara
REIMER, Daisanne
REMOQUILLO, Mary
ROTHER, Tiffany
SAMPSON, Kyra
SANTOS, Jennie-Vi
SANTOS, Larissa
TREMORIN, Lisa
VYSHNESVSKA, Iryna
WILSON, Erin

CDI College

GRANDE, Richard
KLIPPENSTEIN, Lauren
LAMBERT, Geraldine
MALABANAN, Zorina
McCORRISTON, Amanda
McKINNEY, Ashley
PARK, Sunghee
ROMEO COQUETE, Crystal
SICOTTE, Andrea
TAN, Mary Anne
TOBIAS, Annaliza
TRUTER Cornelia
VOYTKIV, Halyna
VUONG, Enza

University College of the North (formerly Keewatin Community)

BERNARD, Michelle
BOUVIER, Shandie
CARTMAN, Amy
CHEGWIN, Abby
FLEMING, Candace
JAMES, Melissa
KERELUIK, Patricia
KOCHAN, Nicole
LEBEL, Allicia
LITTLE, Richelle
OSTASH, Melanie
PASIOWETZ, Leanne
SCHEMENAUER, Danielle
SINCLAIR, Elsie
SLEPICKA, Mandy
WOUTERS, Kelsey
ZELLER, Jenna

ManitobaDentist.ca

Have you considered placing your classified job wanted ads on the MDA website?

The Manitoba Dental Association will place free of charge to Manitoba dentists job wanted ads for associates, dental hygienists and dental assistants on our website. We will also run ads for practice sales. The ad will run for two weeks. At the end of the two weeks if you want to run the ad again just contact the MDA office.

You can email you ad to: office@manitobadentist.ca

First Dental Visit

Manitoba Dental Association's commitment to improving the oral health of young children

There is emerging evidence that the prevalence of caries in the North American preschool population is increasing, despite all the recent advancements in dental prevention that have benefited school-aged children.[1] The presence of caries in the primary teeth of children < 72 months of age (< 6 years) is called Early Childhood Caries (ECC).[2] Recent epidemiological research reveals that ECC is prevalent in several Manitoba communities and is not only an issue for First Nations children.[3-5] Further, far too many children in this province undergo dental surgery each year[6] because of an aggressive subtype of ECC, called Severe Early Childhood Caries (S-ECC).[2] While theoretically preventable ECC remains a significant public health problem that can have both immediate and long-term consequences.[7] Reducing the incidence of ECC is important as children who experience caries during early childhood years are significantly more likely to suffer from decay along the continuum of childhood.[8-10]

The contributing factors towards ECC are complex and multifactorial.[11] Therefore, there is no magic bullet or "one-size fits all" approach to prevention. However, the combined efforts of topical fluorides (e.g. fluoride varnish), parental education and counseling, improved dietary and hygiene practices, and early access to preventive dental care are beneficial.

The Canadian Dental Association (CDA) and the American Academy of Pediatric Dentistry (AAPD) both recommend a first visit by 12 months of age.[12,13] The rationale for this recommendation is based primarily on the argument that it establishes a preventive practice for the caregiver with long-term benefits for the child. In essence, it develops a "Dental Home" for the child. A "Dental Home" refers to an ongoing relationship between the dentist and the child, beginning no later than 12 months of age, where the child's access to comprehensive and coordinated oral health care and prevention is the central focus and specifically tailored to meet the child's needs.[14] This strategy may be an effective method to ensure children remain cavity free[15], as age is a significant determinant of ECC.[4,16]

However, a recent survey of Manitoba dentists revealed that only 58% of participants were aware of the CDA's recommendation for a first visit.[17] Further, only 1/3 of respondents indicated that they were aware of the standardized case definition for ECC.[17] Many practitioners are not currently seeing very young children in their offices as infants and preschoolers comprised less than ten percent of the respondents' practices and of those who saw preschool children in their practices, less than a half (48.6%) saw children before one year of age.[17] Fortunately, these values rose steadily with increasing age groups as 73.7% reported seeing 12 to 23 month olds, 89.6% saw 24 to 35 month olds, and 97.5% saw children aged ≥ 36 months.[17]

While pediatric dentists are specially trained to screen infants in their practices, their small numbers cannot meet the demand for "Dental Homes" of the entire preschool population across Manitoba. General dentists can and must play a key role in improving young children's dental health and must appreciate the benefits of early examinations so that they can begin to undertake their crucial role in preventing ECC.

Your Manitoba Dental Association (MDA) is currently working with its First Dental Visit Committee to develop a new voluntary First Dental Visit program to reach young children across the province to prevent ECC, promote good early childhood oral health, and develop "Dental Homes" for young children. Why does your MDA feel this is necessary? Part of this committee's activities is in response to the fact that a significant number of dentists in Manitoba, along with the general public, are still unaware of the recommendation of a first visit by 12 months of age. Over the next eight months, the First Visit Committee will be working and unveiling plans for this new initiative. A formal kick-off to the First Dental Visit program will take place at the 2010 MDA convention with the anticipated launch date being April 2010. Throughout the upcoming months, we plan on providing you with regular updates to prepare and equip you to see young children in your practices. This will include tips on how to examine an infant or young child (e.g. "knee-to-knee" technique), what to discuss with parents and caregivers (e.g. anticipatory guidance on dietary practices and oral hygiene), understanding the contributing factors behind ECC, and overcoming practitioner reservations and anxiety about caring for young children. Promotional and educational resources will also be developed so that dentists can provide appropriate anticipatory guidance to parents and caregivers of young children.

Naturally, some members may not wish to participate as their offices may not be suited for children. However, it is our intent to inform members about these new recommendations for a first visit by 12 months of age and remind those who choose not to participate that you do have a professional responsibility to ensure that these young children are connected with other colleagues who are willing to open their offices and establish these "Dental Homes".

Your First Dental Visit Committee:

Dr. Robert Diamond

Dr. Charles Lekic

Dr. Robert Schroth*

Dr. Leon Stein

Dr. Lanny Jacob

Rafi Mohammed

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Ref Type: Electronic Citation

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FACULTY CORNER

FACULTY OF DENTISTRY
SCHOOL OF DENTAL HYGIENE
UNIVERSITY OF MANITOBA
Traditions of Excellence, Horizons of Change

Global economic storm hits home
Stakeholder support now more important than ever

Over the last two years, the Faculty of Dentistry has undertaken significant changes to improve our student educational experience. We have also made great strides in reconnecting with alumni and the practicing community, and offering more value to all of our stakeholders. I hope you have felt a part of this positive change and that you know how much we appreciate your support and how important you are to our overall education and training program.

Much as we would like to have hoped, the University of Manitoba and our Faculty of Dentistry has not been spared its share of the economic storm that continues to cast a pall over the global community.

This sad reality was driven home following a series of budget meetings at our Fort Garry Campus which confirmed that tough financial times have beset upon virtually all Faculties of the institution. The process also identified some of the many factors that forced our arrival to this most unfortunate destination. Indeed, it has been a perfect storm of circumstance that leaves us all in what can only be described as a precarious position.

For dentistry, our dilemma is the result of many factors, both internal and external in their origins. To briefly elaborate, over the years our revenue streams have been slowly but steadily decreasing, spurred in no small way by the 10-year tuition freeze that has not allowed us to keep up with the times. Although the freeze was recently lifted, it will be subject to a cap of 4.5%. As most of you know, this will still keep our tuitions far, far below the status quo in North American dental schools and will continue to compound our problem so long as it remains in place.

In fact, we have witnessed a steady decline of per student government support to the point where we lag seriously far behind many if not most dental schools in the United States and Canada. Most recently, the provincial government provided the University with an operating increase of 4.5% rather than the 11% requested.

This, compounded with our aging infrastructure, deferred maintenance and accreditation requirements, have made it just that much more challenging for our Faculty to maintain our high level of education, research and outreach going forward.

Externally, the implosion of the global economy has come about at a less than opportune time and is already having ripple effects. The collapse of the financial markets pounded the University of Manitoba pension plan and the funding shortfalls need to be absorbed by the overall operations budget.

Economic hard-times have also beset many of our industry partners and suppliers as well as our alumni, further limiting our access to potential resources. Next year is predicted to be even worse.

To address this serious and unprecedented situation, our Faculty is taking significant steps that we believe will go a long way to stem the swelling tide of financial hardships that appear to be headed our way. We are pursuing an aggressive two-year financial plan designed to reduce our expenditures by 7.5%. The major features of this plan include the following:

- we will not fill many positions becoming open through retirement, leaves, and resignations for a two-year period
- we fully expect to maintain the quality of our existing programs and student services through hard work and reallocation of existing academic and support staff personnel to cover duties/responsibilities of any open positions
- all new initiatives associated with the “Drive for Top Five” will be funded through new external dollars and internal reallocation where appropriate
- to the fullest extent possible, we will redirect human resources rather than eliminating positions taking advantage of opportunities to do things differently
- we will reduce expenditures associated with meetings/events and examine ways to further cut operations costs
- our operations will be streamlined and we will continue to look for and identify new efficiencies in all aspects of our programs

In short, we will take this opportunity to make some long overdue changes that will put our house in order in a way that insulates us from future economic downturns. This will be accomplished through an iterative process involving our entire administrative team with feedback from our academic/support staff and students. Some of the changes will result in advantages and efficiencies that make us stronger and better than before.

In mid-March, I convened a meeting of all faculty and staff to outline our current situation, brief them on our plan to respond and, perhaps most importantly, to ask for their assistance, their cooperation, their ideas and their understanding. So far, the response has been encouraging and continues to show the commitment of our team.

FACULTY CORNER

….. Cont'd from page 16

FACULTY OF DENTISTRY
SCHOOL OF DENTAL HYGIENE
UNIVERSITY OF MANITOBA
Traditions of Excellence, Horizons of Change

This is also the request that I come to you with today. To see our way through this most challenging of times, we need your help. We need your ideas, your contributions, your leadership and your involvement to be part of the solution to this complex and difficult problem.

Who better to take a leadership role in preserving and maintaining the future of the dental Faculty in Manitoba than those who came before and witnessed first-hand what a profound impact this institution can have on those who have traveled through and the positive effect it has on our community and for society in general. You know, first-hand, what a gigantic task it is to run a dental Faculty and the sacrifices that are demanded of its students, the resources that it must command to deliver a premier education, the significant and tangible value that it delivers to all.

Our graduates continue to be among the best of the best. Academically accomplished in a challenging and difficult field, our alumni have also taken on the challenges of the business world, only to succeed with a quiet dignity and grace that stands in silent tribute to this institution. It is because of this that we look to you in our time of need.

I believe we are fortunate to be part of a wonderful profession that is still doing well in these tough economic times and I am privileged to be able to ask for your help at a time when we need your support the most. Please consider donating to the "Excellence in Education Fund" or "Drive for Top Five General Fund" so that we may continue to deliver our top quality educational programs and pursue our quest to be one of the best dental schools in North America.

I am confident that with your guidance, input and direction, we can overcome this latest hurdle and stand as a shining example to this university and the community at large. We can demonstrate how to stare down adversity and face this challenge with confidence and strength of conviction that will serve as the model for others to follow. For anyone who has been thinking of supporting the Faculty financially, this would be the most important time to come forward. I hope you will take me up on my invitation as I would be delighted to hear from you.

Grazie!
Dr. Anthony M. Iacopino
Dean of Dentistry, University of Manitoba

More Dentists for Manitoba

Faculty of Dentistry ensures local student access

In a move to increase the number of dentists in Manitoba, the Faculty of Dentistry is taking steps to attract more local students into its program. Effective as of the 2009 admissions cycle, the first-year class in dentistry will feature a minimum of 25 students from Manitoba. First-year classes usually consist of 29 students. It's the first time the faculty has set a minimum number for local applicants. "We hope this will open up additional opportunities for Manitoba students and get more of them thinking about applying to the dental college," said Dr. Anthony M. Iacopino, Dean of Dentistry. "We believe that this will go a long way to ensure that there are more practitioners for all parts of the province."

The Faculty of Dentistry is the only oral health academy in the province and routinely receives well over 300 applications each year from students looking to be part of the first-year class. While the majority of the applicants come from Canada and the United States, students apply from all around the world. In spite of the high demand, Manitoba students usually make up the majority of the first-year class by meeting and surpassing the very high entrance requirements demanded by the program. Students must spent at least two years in a pre-dentistry program (usually science) and must then pass a rigorous screening process before being allowed into the four-year program to attain a Doctor of Dental Medicine (D.M.D.) degree. "History has shown that the caliber of students from Manitoba has been exceptional," Dean Iacopino said. "Our experience has also shown that students from Manitoba very often stay in Manitoba."

Dentistry, like most other health-care professions in Canada, is always struggling to maintain and increase the numbers in its professional ranks. It is estimated that there are 475 dentists in Manitoba in 2009, a significant majority of these practice in Winnipeg. A Manitoba Job Futures profile notes the current dental labour force is older than average and expects strong employment prospects for new practitioners due to pending retirements. Dentists in Manitoba can earn between $60,000 and $150,000 per year in private practice, or as professors, researchers or administrators. "We are confident that allowing more local students into our program will prove to be a benefit for all Manitobans," Dean Iacopino said.

The Federal Budget and Your Financial Plan

By **Evan Parubets**

The recent federal budget provided some important opportunities for investors. Below are just a few examples.

1. The increases in personal income tax brackets allow you to earn more income at a lower marginal tax rate — including income earned from investments. For the 2009 tax year, the upper income threshold for the 15 per cent federal tax bracket is $40,726 (previously $38,832) and the upper limit for the 22 per cent tax bracket is $81,452 (previously $77,664). With the increases in the brackets, you can earn an additional $5,600 of income that is taxable at the lower rates. (Income over $81,452 is taxed at the 26 per cent rate and the 29 per cent bracket begins at $126,264.)

Income splitting with your spouse can help you keep your income from moving into the next (higher) tax bracket. For example, if you loan your lower income spouse money to buy investments, the investment returns will be taxed at your spouse's lower marginal tax rate. The income splitting achieved could provide more disposable income for your household.

Your spouse may also be able to deduct the interest costs of the loan against his or her investment income *if the loan rate is equal to or higher than the prescribed interest rate*, which is set at just 1 per cent until June 30, 2009 — an all-time low! The loan can *continue indefinitely at the 1 per cent rate* if the agreement is signed before June 30th, and your spouse never has to repay the loan principal, just the annual interest due on the loan within 30 days of the end of each calendar year (January 30). However, both the original amount you loan to your spouse and the interest payments your spouse makes must actually change hands. The loan arrangements must also be properly documented with a promissory note or other form of loan agreement.

2. Your small business can also earn more income at a lower tax rate in 2009. An additional $100,000 of small business income will be eligible for the reduced 11 per cent federal tax rate. In 2009, up to $500,000 (previously $400,000) of small business income qualifies for the lower rate.

When you are looking for places to invest your corporation's money, consider that a non-registered investment account provides the opportunity to invest in highly liquid assets, such as money market funds that are redeemable the next business day. You can even arrange for payouts from your corporation's investment account to be deposited directly into your company's bank account.

3. The increase in the basic personal amount — the amount of income that can be earned tax free — also provides an income splitting opportunity. In 2009, the basic personal amount increases to $10,320 (previously $10,100). If you are self-employed you can hire your children and your spouse to work for your business if there are services needed by your business that they are able to perform. They won't pay tax on income they earn that is up to $10,320 (each). (Their salaries, if reasonable and comparable to what you would pay an unrelated person to perform the same services, are deductible expenses which can reduce your income and your marginal tax rate.)

4. You can save an extra $5,000 in your RRSP for use under the Home Buyers' Plan. The new withdrawal limit under the plan is $25,000, up from $20,000. Establishing a spousal RRSP could help you and your spouse to save for a larger home down payment. The Home Buyers' Plan allows individuals who qualify to withdraw $25,000 tax free from their RRSP to purchase a home. Therefore, a couple can withdraw a total of $50,000. If one spouse isn't working or has a lower-paying job, the other spouse can establish a spousal RRSP to save faster for the down payment. (The contributing spouse must have sufficient RRSP contribution room.)

5. The time-limited home renovation tax credit provides an incentive for you to invest in your home. If you are a homeowner, you can claim a portion of home renovation expenses for work performed or goods acquired between January 28, 2009 and January 31, 2010. Eligible expenses that are over $1,000 and no more than $10,000 can qualify for the credit. The maximum credit is $1,350 ($9,000 x 15%).

To obtain more budget information, visit www.fin.gc.ca. For help maximizing the budget incentives, consult your tax advisor and financial planner. You can contact a certified financial planner at CDSPI Advisory Services Inc. at **1-877-293-9455**, **ext. 5023**. Insurance and investment plans are member benefits of the MDA and CDA and the plans are administered by CDSPI.

Evan Parubets is a certified financial planner and an investment planning advisor at CDSPI Advisory Services Inc.

By

Evan Parubets

CFP, CIM, FMA, FCSI

CDSPI Advisory Services Inc.

Dental Program at Saul Sair Health Centre

Saul Sair Health Centre was developed mainly in order to meet the diverse needs mainly of the homeless population in Winnipeg but also of other subgroups in the inner city: the chronically addicted, street-involved people, the mentally ill and others who frequent the services of Siloam Mission. The dental program at Saul Sair Health Centre provides basic and emergency dental care. Primarily, the dental centre is a walk-in service with some scheduled appointments as necessary. Patients of the dental program very often find us by accessing other Siloam services or are referred by neighboring agencies, such as Booth Centre and Union Gospel Mission. Many transition from using our services to accessing outside services as their lives become more stable.

The dental program hours of operation vary from week to week depending on how many volunteer professionals are available. Saul Sair Health Centre is open Monday through Friday from 8:30am-12:30pm. Patients are seen on a first-come, first-serve basis and are treated with basic and emergency care. Care is offered without discrimination, at no charge, and with dignity and respect.

For more information, please contact Kari Enns, Director of Saul Sair Health Centre, 204.943.0658 or kari.enns@siloam.ca.

Mount Carmel Clinic's Dental Program

Mount Carmel Clinic is a non profit-organization providing services mainly to residents of North End. Our mission is to create and promote healthy inner city communities. Recognizing that it is difficult for some individuals and families to afford dental care, we focus our service to provide care for individuals that tend to be marginalized in society, these people would include; North End community members, immigrants, refugees and street involved individuals. Our dental services are provided at low cost to those who meet our eligibility guidelines. No person is refused service because of inability to pay.

The Mount Carmel Clinic dental program provides basic and emergency dental care. Appointments are scheduled with a limited emergency walk-in service. Care is offered in an environment of dignity and respect with an understanding of the barriers and life circumstances of individuals and families.

Our dental program hours of operation are:

Monday, Wednesday and Friday 8:45am to 5:00pm

Tuesday and Thursday 8:45am to 8:00pm

For additional information, please contact Lori Black, Dental Program Manager, 204.791-3374 or email

PROVISION of CARE in NORTHERN and REMOTE AREAS

At our faculty's 50th anniversary celebration I was seated near Manitoba's Minister for healthy living Kerri Irvin-Ross. I soon realized that access to oral health care for those living in remote and northern communities was a topic of major concern to her. I knew of course that access to care in these communities has long been an issue for organized dentistry and further that care in the community is far less expensive to Canadian Taxpayers than travel to, and care in an established dental center. I volunteered to see what I could find out.

After a few emails and phone calls I found that there are currently two programs at work in Manitoba and both could benefit from some Dentist support.

The University of Manitoba's Faculty of Dentistry runs an outreach program that started in the 70's and continues today under the banner of the Centre for Community Oral Health (CCOH). This program offers both employment (full or part time) and independent contractor arrangements. The clinics provide a full slate of dental services with on site specialist's available in some sites and referral services available in the remainder. Certified dental assistants, dental equipment instruments and supplies are all provided. All travel, accommodation, and a daily meal allowance are arranged and funded by the program. Trip duration is from 1 week to 5 weeks and the remuneration for independent contractors starts at $800/day.

The Government of Canada has a long standing program to provide care in remote communities and contracts with dentists licensed in Manitoba to travel to First Nations communities in northern Manitoba. The more dentists are willing to go, the more it helps improve the northern residents' otherwise limited access to dental services. Work consists of basic dentistry such as direct restorations and extractions although endodontics, prosthodontics, crowns and prevention are part of the treatment mix.

Access to oral surgeons, endodontists and pediatric dentists is available by referral. The requirement is for a week at a time, Monday to Friday. Scheduling is flexible allowing dentists to work full or part-time, as many or as few weeks per month as you wish. Travel is usually by air with departure from Winnipeg, however other departure points can be considered. Accommodation in the communities is provided. Payment is a per diem that currently starts at $925 a day including travel days. Dental supplies, in-community dental assistant and other costs are reimbursed.

If you have some free time, travelling north for a week or more at a time can be a good way to supplement your income, start a new phase of your career, meet some great people, and get satisfaction from providing truly needed care.

Dr. Thomas D. Breneman

Contact Info:

Dr. Terry Hupman
Regional Dental Officer
Manitoba Region
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Winnipeg, MB
R3C 4W1
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Fax: (204) 984-5798
E-mail: terry_hupman@hc-sc.gc.ca

Dr. Doug Brothwell
Director
Centre for Community Oral Health
Faculty of Dentistry, University of Manitoba
Tel: (204) 789-3892
E-Mail: brothwel@cc.umanitoba.ca

Clinical Dentists / Geriatric Dentistry

2 Full-time continuing positions
(or equivalent combination of part-time positions)

The Centre for Community Oral Health (CCOH), Faculty of Dentistry is a not-for-profit organization that administers dental programs catering to underserved populations on behalf of the University of Manitoba. We are looking for self-motivated, community minded dental professionals to join our Geriatric Dentistry programs.

Reporting to the CCOH Director, successful candidates will provide a wide range of clinical dental services within various personal care home (long-term care) facilities, and community clinics in accordance with existing professional and program standards.

These positions encompass providing dental care to elderly patients within the long term care environment, supervision of dental students on externship rotation, as well as opportunity to be involved in research, health promotion, and policy initiatives. Clinical settings include institutional clinics, mobile clinics, and community clinics in Winnipeg. Remuneration options include salary, per diem rate, or percentage of fees generated. Employment or independent contractor agreements are possible.

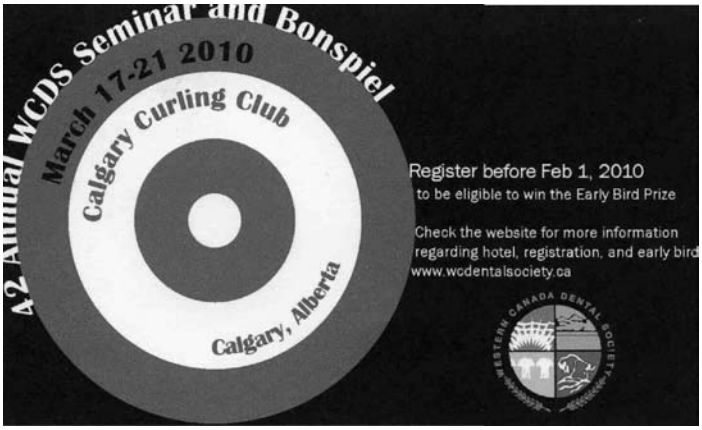
Applicants eligible for Manitoba licensure should reply in confidence to:

Dr. Doug Brothwell,
Director, Centre for Community Oral Health
University of Manitoba, Faculty of Dentistry
P128-780 Bannatyne Ave
Winnipeg, MB R3E 0W2
Tel: (204)789-3892 Fax: (204) 789-3991
E-mail: brothwel@cc.umanitoba.ca

Verification of NIHB Patients

Please ensure to verify the identity of eligible registered First Nations and recognized Inuit accessing dental care in your office. You or your staff should view the Certificate of Indian Status card for First Nations or the Health card for Inuit. This verification should occur at each appointment. You may wish to retain a photocopy of the card in your files for future verification should a discrepancy ever arise related to services for First Nations or Inuit patients. You may also wish to view a second piece of identification. It is the dental office's responsibility to confirm the identity of each patient being treated. The NIHB Program cannot cover any dental services provided to anyone who is ineligible to receive benefits.

Dr. Terry Hupman
First Nations and Inuit Health
Health Canada



OPEN WIDE RETURNS IN 2009

The Manitoba Dental Association extends an invitation to all dentists, dental hygienists, and dental assistants to participate in "Open Wide 2009", Saturday, October 24th, 2009 at the University Of Manitoba Faculty Of Dentistry.

The event will focus on encouraging people who are not currently seeing a dentist and are in need of immediate dental care to attend. It will also be of particular importance to families who, due to financial limitations, have been postponing necessary care for themselves and their children.

"The Open Wide event, which was last held in 2006, is being held again to provide the dental profession with the opportunity to give back to the community. Dentists and their staff recognize that there are hundreds of individuals who cannot access dental care because of limiting socio-economic factors," said Dr. Tom Colina, Open Wide 2006 Chairperson. "A wide range of dental services will be offered including cleanings, filling, extraction, and simple denture repairs," said Dr. Colina. He added that by holding this event the MDA hopes to raise the awareness about the importance of proper dental care.

Dr. Jerry Baluta, Open Wide 2009 Chairperson, would encourage dental offices to support this worthwhile initiative by volunteering for this event.

"Open Wide" is joint initiative with the Faculty of Dentistry.

MDA Directory Amendments

For changes to the MDA Directory please contact:

April Delaney at the MDA office - (204) 988-5300 Ext. 2

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Winnipeg, MB R3B 3H6
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(204) 471-9246

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Winnipeg, MB R3A 3H3
(204) 979-2345

Dr. Stephen Bongard
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Dr. Kristopher Coulter
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Dr. Randy Dawson
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Dr. Munjot Dosanjh
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Dr. Lindi van Jaarsveldt
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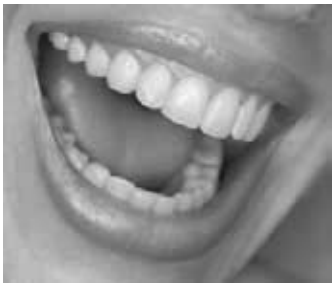

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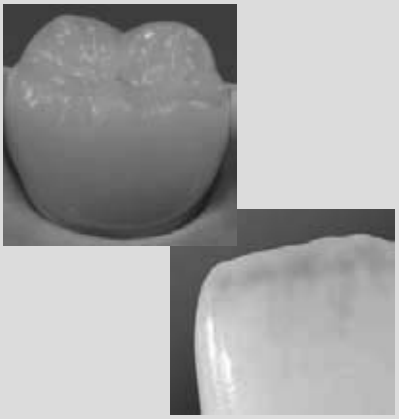

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Please contact: Dr. I. R. Battel (204) 489-4507

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