2021 | EDITION

MALAYSIAN PRIVATE DENTAL PRACTITIONERS' ASSOCIATION

probe

BANK ISLAM

" We believe in providing the best possible services for all of our clients, to ensure that they are happy and satisfied. We're extremely flexible, and work with each client in order to find a solution that works for their specific needs and financial situation. Feel free to contact us with any questions regarding your financing needs ".

Features

- **Financing amount up to RM300,000**
- **Financing tenure up to 10 years**
- **Takaful protection (optional)**

Required Documents

- Copy of MyKad
- Latest 3 months' salary slip
- Latest 3 months' Bank (salary) statements
- Latest Income Tax or EPF Statement
- Latest Employment Confirmation Letter
- Copy of Staff ID (For selected package employers only)
- Certificate of registration with MDC

Scan to apply and view the monthly instalment table

Visit a branch near you today.

BANK ISLAM

Assuring Trust. Delivering Value.

603 26 900 900 ▪ www.bankislam.com
facebook.com/bankislam

Bank Islam Malaysia Berhad ▪ 198301002944 (98127-X)

Snap n' Apply

Want to apply for financing?

- Snap a picture of this brochure
- Send NAME<space>LOCATION<space>FINANCING AMOUNT via WhatsApp to 03 2088 8286.

RANCANG KEWANGAN ANDA DENGAN LEBIH BIJAK DAN NIKMATI KADAR PEMBIAYAAN KOMPETITIF DARIPADA BANK ISLAM

Nikmati kadar kompetitif untuk Pembiayaan Peribadi-i Bank Islam.
Mohonlah hari ini!
Layari laman web www.bankislam.com atau
layarihttps://ezxcess.bankislam.com.my/eformv2.aspx
untuk info lanjut.
Terima kasih !

NOW AVAILABLE ON SHOPEE !

GENGIGEL®
HYALURONIC ACID

A FOUNDATION FOR DENTAL OUTCOME

Synergistic effect on periodontal management -

- › Reduces inflammation and bleeding of gums. [1]
- › Accelerates tissue proliferation and healing of gum injury[2]
- › Maintains healthy gingival tissue.[2]

- › Indicated across Gingivitis to Periodontal management continuum.[12]
- › Obtained by biotechnological synthesis.[2]
- › Biomimetic Hyaluronic Acid.[12]
- › Contains xylitol and does not cause caries. Suitable for diabetic
- › Safe to use in young children, pregnant women and elderly patients.[1]
- › Medical device Class B certified and approved by EU and FDA.[12,13,14]

GENGIGEL®
Gel 1ml Sachets (0.2% HA)
Pack of 100 sachets

GENGIGEL®
Hydrogel Mouthrinse 150ml (0.025% HA)

GENGIGEL®
Gel 20ml Spray (0.01% HA)

GENGIGEL®
Gel 20ml Tube (0.2% HA)

GENGIGEL®
PROF FLUID 500ml (0.1% HA)

GENGIGEL®
PROF SYRINGES
Pack of 4 X 1ml Syringes (0.8% HA)

References
1. 1. Periodontal status and provision of periodontal services in Malaysia Trends and way forward. Mohd-Dom TN, et al. MJPHM. 2013;13(2): 39-47.; 2. Hyaluronic Acid: A Boon in Periodontal Therapy. Parveen D, et al. N Am J Med Sci. 2013;5(5):309-315. 3. The clinical application of hyaluronic acid in gingivitis therapy. Pistorius A, Martin M, Willershausen B et al. Quintessence Int 2006;36:531-538. 4. A promising mediator for periodontal regeneration. Bansal J, Kedige SD, Anand S. Hyaluronic acid: Indian J Dent Res 2010;21:575-578. 5. A model for the role of hyaluronic acid and fibrin in the early events during the inflammatory response and wound healing. Weiger PH, Fuller GM, Le-Rouzi RD. J Theor Biol 1986;119(2):219-234. 6. Potential role of high molecular weight hyaluronan in the anti-Candida activity of human oral epithelial cells. Sakai A, Ashitua S, Itano N et al; Med Mycol Feb 2007;45(1):73-79. 7. Hyaluronic acid and periodontitis. Sulaiman S, Drishell I; Acta Medica (Hradec Kralove) 2007;50:225-259. 8. Stimulation of Osteoinduction in Bone Wound Healing by High-Molecular Hyaluronic Acid Sakai T, Watanabe C, 1995;16:9-15. 9. Gengigel Product Monograph. 10. Application of Gengigel in the Treatment of Gingival Inflammation M. Popovska, R. Klevid, S. Angelovski, Z.Balazalloska, E. Stefanovska, L. Kanurkova; Balk J Stom, 2012; 16:43-45. 11. Hyaluronic Acid as an Adjunct After Scaling and Root Planing , Sigrun Eick, Antonio Renatus, DMD, Melanie Heinicke, Wolfgang Pfister, Professor, Stefan-Ioan Stratul, Professor, Holger Jentsch, Journal of Periodontology; 2012 DOI: 10.1902/jop.2012.120269. 12. Gengigel Product Insert 13. Gengigel Medical Device (MDA) Registration Certification. 14. Gengigel Food Drug Administration Certification.

Afta® med

REPAIR, HEAL AND PROTECT

Real oral ulcer remedy that makes all the difference through its TRIPLE EFFICACY-

- › Anti inflammatory and pain reduction[6]
- › Wound healing and tissue generation[6]
- › Protective barrier and adherence[6]

- › Biomimetic HA from biotechnological synthesis. [5]
- › Does not contain alcohol and sugar. [5]
- › Iso salivary pH. [5]
- › Palatable taste, no artificial preservatives. [5]
- › Vegan-friendly. [5]
- › Safe to use in children and elderly patients.[2]
- › Suitable for immunocompromised patients. [5]
- › Available in Spray and Gel Formulations. [5]
- › Medical device Class B certified and approved by EU & FDA.[10,11,12]

Aftamed®
Classic Gel Tube 8ml (aniseed & mint)
Junior Gel Tube 8 ml (peppermint)

Aftamed®
Spray 20ml

Reference
1. Number VI Recurrent aphthous stomatitis, Jurge S, Kuffer R, Scully C, Porter SR. Recurrent aphthous stomatitis. Oral Dis. 2006;12:1-21. 2. Healthline. What causes mouth ulcers? 25 possible conditions. Available at: http://www.healthline.com/symptomhouch-ulcers. Accessed 4 November, 2015. 3. BetterHealth Channel. Mouth ulcers. Available at: https://www.betterhealth.vic. 4. Recurrent aphthous stomatitis, Powell L, et al. J Oral Maxillofac Pathol 2011;15:252-256. 5. Aftamed Factbook, Biopiax Limited. 6. Hyaluronic Acid: A Boon in Periodontal Therapy Parveen D, et al. N Am J Med Sci. 2013;5(5): 309-315. 7. In vitro" evaluation of barrier properties of polymeric formulations, Prof. Paola Perugini, Department of Drug Sciences, University Pavia, July 2013. 8. The efficacy of topical hyaluronic acid in the management of recurrent aphthous ulceration. A. Nolan, C. Baillie, J. Badminton, M. Rudralingham, R. A. Seymour, J Oral Pathol Med 2008; 38: 461-465. 9. The efficacy of topical hyaluronic acid in the management of oral lichen planus, A. Nolan, J. Badminton, J. Maguire, R. A. Seymour, J Oral Pathol Med (2008) 38: 299-303. 10. Aftamed Product Insert 11. Aftamed Medical Device (MDA) Registration Certification. 12. Aftamed Food Drug Administration Certification.

pharmaniaga
passion for patients

Please consult your healthcare professional for further information

PHARMANIAGA MARKETING SDN BHD (118284-D)
No. 7, Lorong Keluli 1B, Kawasan Perindustrian Bukit Raja Selatan, Seksyen 7, 40000 Shah Alam, Selangor Darul Ehsan, Malaysia.
Tel : 603-3342 9999 Fax : 603-3344 2222 Customer Care Line : 1-800-888-313
Email : customercare@pharmaniaga.com Website : www.pharmaniaga.com

INSIDE..

EXCLUSIVELY
From Our Members ...

OUR PASSIONATE DENTIST .

"Lockdown Diaries"

CONTACT US

Malaysian Private Dental Practitioners' Association
Suite 525, Block A3, Leisure Commerce Square,
9, Jalan PJS 8/9, 46150 Petaling Jaya, Selangor.

03- 7874 0606 / Fax : 03 - 7874 0607

Email : mpdpa1@gmail.com

Malaysian Private Dental Practitioners Association

www.mpdpa.org.my

COVER DESIGN

ACRYLIC PAINTING (2021)
BY : DR. RUBINI ARASU @ RubyCanvas

PROBE 2021; PREPARED & COMPILED
BY DR.RUBINI ARASU, DR.JAYASEEL RAMACHANDRAN & DR.FOO GAIK SEE

PRESIDENT'S MESSAGE ...

I am deeply honoured and I thank each and everyone of you who has supported, guided and put your faith in me to represent this esteemed Association. It is humbling and indeed a privilege to serve our members of caliber, who have dedicated their lives to perform ethical work and play such an essential role in the profession.

I am very fortunate to have such dedicated and committed Committee Members who have been helping me keep this Association strong despite the unprecedented times we faced and continue to face now. I am truly grateful to them. Special thanks to Dr. Rubini Arasu , Dr.Jayaseel Ramachandran & Dr. Foo Gaik See for volunteering their time and effort to put together yet another successful E-Probe!

What better way to find all your "Dental Gossip " in one place!

The year 2020 was a great challenge for us ! MPDPA had to put our planned activities and events on hold as the safety of our members was our priority. Nonetheless, we did not remain idle, and instead we arranged a meeting with the Honourable Health Minister, Dato Seri Dr.Adham Baba, together with the Oral Health Division team to find a solution to a fair Dental Regulation for all Private Practitioners . We have been affected economically by the pandemic. Most of us have been facing financial challenges in keeping our practices afloat. MPDPA has thus collaborated with Bank Islam to provide financial aid and assistance with special privilege financial rates for our members. The rising cost of PPEs and gloves especially has raised concerns among our members as well. We have thus addressed this issue to the necessary department and hoping for a favourable response soon.

Our annual Clinical Appointment Diary distribution took place as usual and we are highly appreciative for all the support we had received from our Dental Specialists, Traders, Members and Non Members who have supported it in their own way. Our Membership count has also increased over the term.

2021 has just begun and seems gloomy. Nonetheless, MPDPA remains positive and confident that with the roll-out of the Covid 19 Vaccine Immunisation Programme, we should be able to lead a *"Near-Normal "* Life soon and hopefully our practices, patient flow and the businesses of our fellow traders improve.

May we continue to support each other in times like this. "Kita Jaga Kita".

Stay safe , stay healthy and See you all soon My Dear Friends!

Dr. Mahendran Ponnudurai
2019-2021

MPDPA COMMITTEE 2019- 2021

PRESIDENT
DR. MAHENDRAN PONNUDURAI

VICE PRESIDENT
DR. JAYASEEL RAMACHANDRAN

HON. GEN. SECRETARY
DR. K. BHAWANI DEVI

HON. TREASURER
DR. RUBINI ARASU

ASST. HON. GEN. SECRETARY
DR. PUANG LING LIONG

ASST. HON. TREASURER
DR. JASPALL SINGH

PUBLICATION SECRETARY
DR. VIJENDRAN RAJENTHIRAM

COMMITTEE MEMBER
ASSOC. PROF. DR.S.RATNASOTHY

COMMITTEE MEMBER
DR.FOO GAIK SEE

COMMITTEE MEMBER
DR.T. DAVEINTHIRAN

COMMITTEE MEMBER
DR.K. RAMAKRISHNAN

COMMITTEE MEMBER
DR. ASHMI WONG LIRN JIING

Your safety is our priority!!
In view of the current Covid 19 outbreak,
the 6th MPDPA ASEAN DSA CONGRESS & TRADE EXHIBITION
has been postponed to Sunday, 14th August 2022.

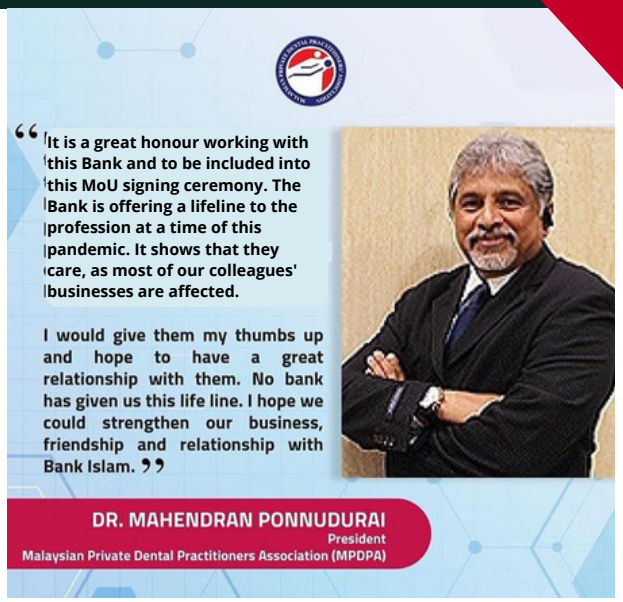
BANK ISLAM

MOU SIGNING CEREMONY

BETWEEN
MPDPA AND BANK ISLAM MALAYSIA BERHAD.
7th Sept. 2020 | EQ Hotel Kuala Lumpur.

At MPDPA, we go the extra mile to help our members with a business & personal financial solution!Be it to refinance or purchase a practice! Our collaborative effort with Bank Islam is to make the entire process as effortless and hassle-free as possible, so you can focus on what's really important - your business!

With years of experience in the industry, Bank Islam will be by your side the entire time. Get in touch and discover the easy way to handle your finances today.



UPDATE on our Meetings with The Honourable Minister Of Health & Oral Health Division, MOH.

In the recent past, MPDPA held meetings with the Oral Health Division and subsequently with the Honourable Minister of Health, Dato Seri Dr.Adham Baba.

We have brought up issues involving Private Dental Practitioners and Dentistry in Malaysia. The Oral Health Division has countered all the issues brought up with their own views and any change did not seem possible. However, when we met the Health Minister ,Dato Sri Adham Baba he was of the opinion that these issues should be addressed.He preferred a meeting of relevant dental organisations ,to discuss these matters and reach a common understanding. The pandemic then came in and this meeting will have to be postponed.

Some of the issues MPDPA brought up include :
A single APC for the whole country.
The right for all dental graduates to practise all disciplines of Dentistry.
The inclusion of Dental Therapists into the Dental Act 2018.
The offences and penalties imposed under the Dental Act.
The need for more Private Practitioners in the Malaysian Dental Council.

At a recent Annual General Meeting of the Malaysian Dental Association, the members had passed a resolution calling for the Dental Act 2018 to be reviewed.The Minister was also urged not to approve the Dental Regulations until the Dental Act was reviewed by the concerned stake holders.

Also highlighted to the Minister, was the methods of inspection employed by the Enforcement Division of the OHD. The inspection should be professional and cordial with the aim of encouraging and promoting good practises of Dentistry in our country.

With regards to Dental Radiology ,there was a plan to impose CPD points to be collected in Dental Radiology, as a requirement to renew the X-Ray license.However, this was opposed by the Private Practitioners present and this move is now being reviewed.

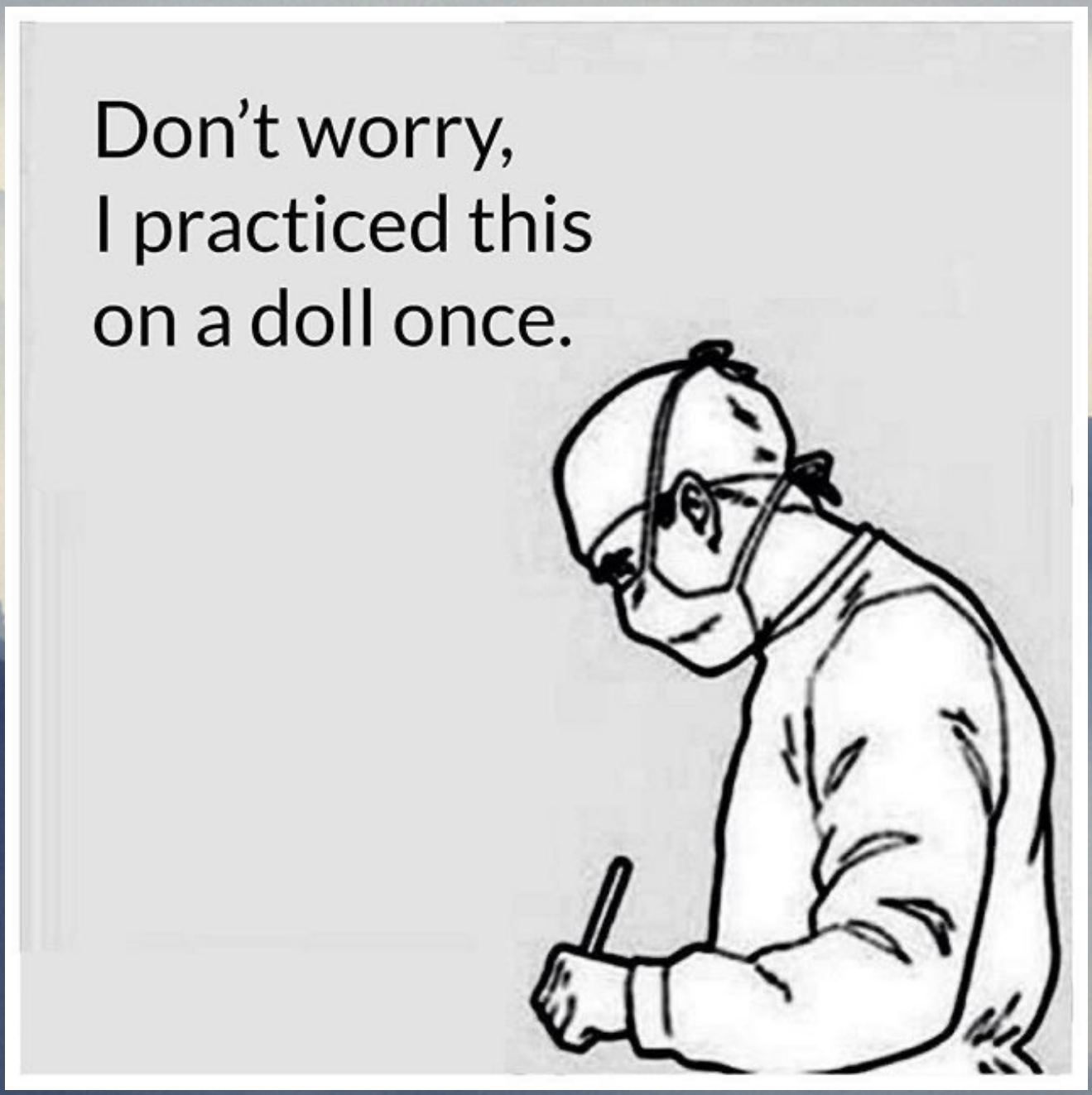
We look forward now to the meeting as proposed by the Minister of Health.

A DIFFERENT kind of AGM..

In view of the Conditional Movement Controlled Order in December 2020, the MPDPA's 52nd AGM was held Live & Virtually.

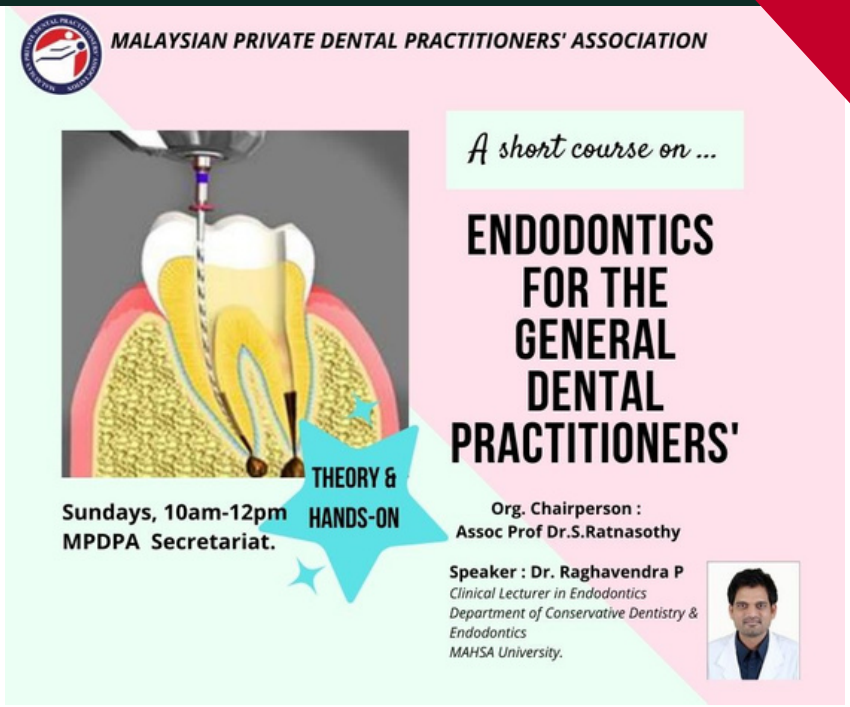
It was a fruitful session as we had our local and outstation members participating virtually for the first time.

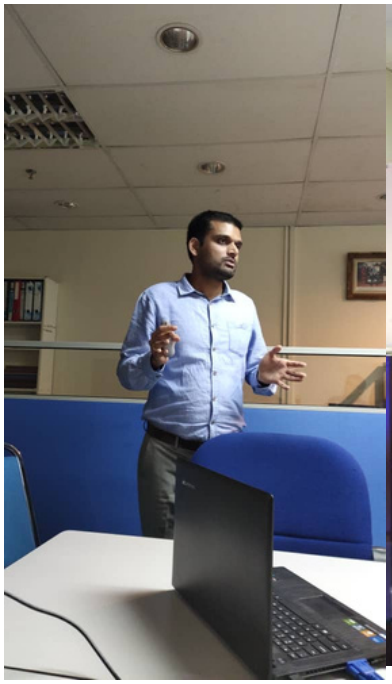
Among the matters that were discussed : concerns with the Enforcement Body (Ckaps, Ukaps) , Dental Regulations, Constituition Ammendments & etc..


Don’t worry,
I practiced this
on a doll once.

CPD COURSE

Early this year, MPDPA organised a short 4 days- Over The Weekend - CPD Course on : Endodontics For General Dental Practitioners.
Our Invited Guest Lecturer was :
Dr. Raghavendra P., Endodontist from MAHSA University.
Unfortunately due to MCO, the Hands-On session had to be postponed.





In The Pipeline for 2021....

MPDPA will be working with COLTENE to organise a CPD Course inclusive of Theory & Practical Hands- On Session On Endodontics for our General Dental Practitioners'

Due to the extended MCO that occured throughout 2020, our planned CPD Sessions had to be postponed to 2021.

STAY TUNE THIS 2021 FOR :

BASIC LIFE SUPPORT COURSE FOR PRIVATE PRACTITIONERS. (A CERTIFICATE COURSE)

IMPLANTS FOR THE GENERAL DENTAL PRACTITIONERS. THEORY & HANDS - ON.

.....& MANY MORE IN THE WORKS

Hopefully!


What Does Your Toothbrush Say About You?
You enjoy life's simple pleasures.
stressed out, are we?
You're frugal to a fault.
You're a multi-tasker
You're a kid at heart.
Speed Demon.
You're a vampire, or you have gingivitis.
Easy on the anchovies, partner.
You're just trying to stay alive in prison.
MENDENHALL

Some of my clinical Oral Surgery cases that I would like to share .....

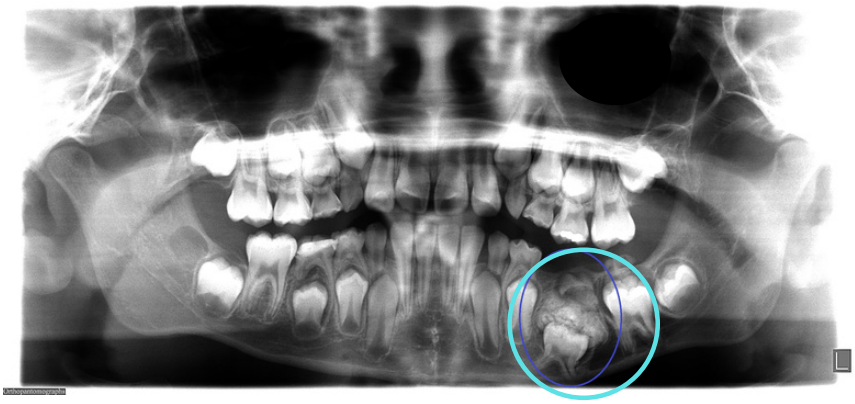
Dr. Giam Ewe Hock ,BDS, FRDSRCS, Msc Oral Maxillo-Facial Surgeon &
Dr. Ashmi Wong Lirn Jiing, BDS.
Klinik Pergigian Giam & Irda, Sandakan, Sabah.

Case 1 : ODONTOME

Odontome is a benign tumour linked to tooth development, specifically it is a dental hamartoma, meaning that it is composed of normal dental tissue that has grown in an irregular way. It includes both odontogenic hard and soft tissue.
As with normal tooth development, odontomas stop growing once mature which makes them benign. Usually associated with one or more unerupted teeth.

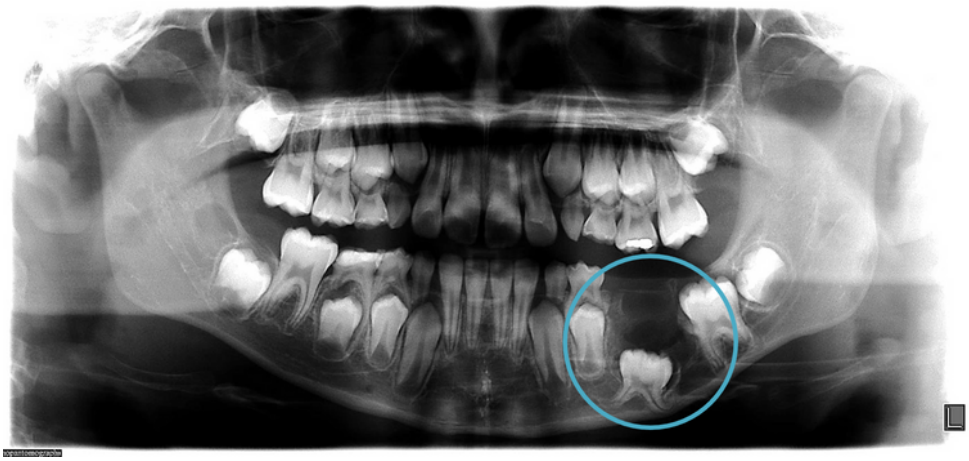
CLINICAL CASE :
8 yr old boy complains that his teeth are not like his cousins.
He told his mom and mom decided to come in for a check up.

OPG Findings on the Left side of the jaw : Impacted 75, missing 36, a stunted follicle growth of 35 with multiple overlying odontomes that will need to be sacrificed.

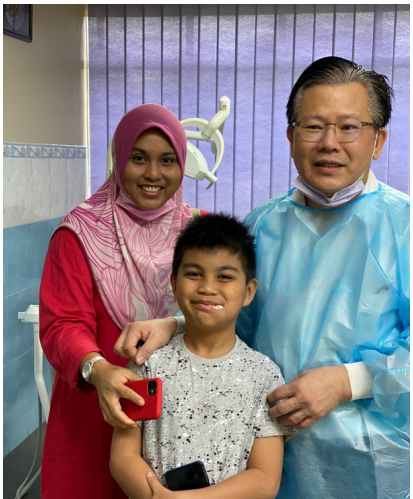


29 Dec 2019, Surgical removal of multiple odontomes were done under local anaesthesia. Due to his young age a micro saw is employed to cut open a buccal window large enough to expose the huge odontomes in its entirety. Piezotome is used to loosen it atraumatically. The entire process is delivered in less than 20 minutes which was the goal.

Post Op OPG was done :



Patient is healthy and under regular monitoring for the eruption of 75 till date.



Dr. Giam Ewe Hock ,BDS, FRDSRCS, Msc Oral Maxillo-Facial Surgeon &
Dr. Ashmi Wong Lirn Jiing, BDS.
Klinik Pergigian Giam & Irda, Sandakan, Sabah.

Case 2 : RADICULAR CYST

Radicular cyst is defined as a cyst arising from residual epithelial (Cell rest of Malassez) in the periodontal ligament as a consequence of inflammation, usually following the death of the dental pulp.

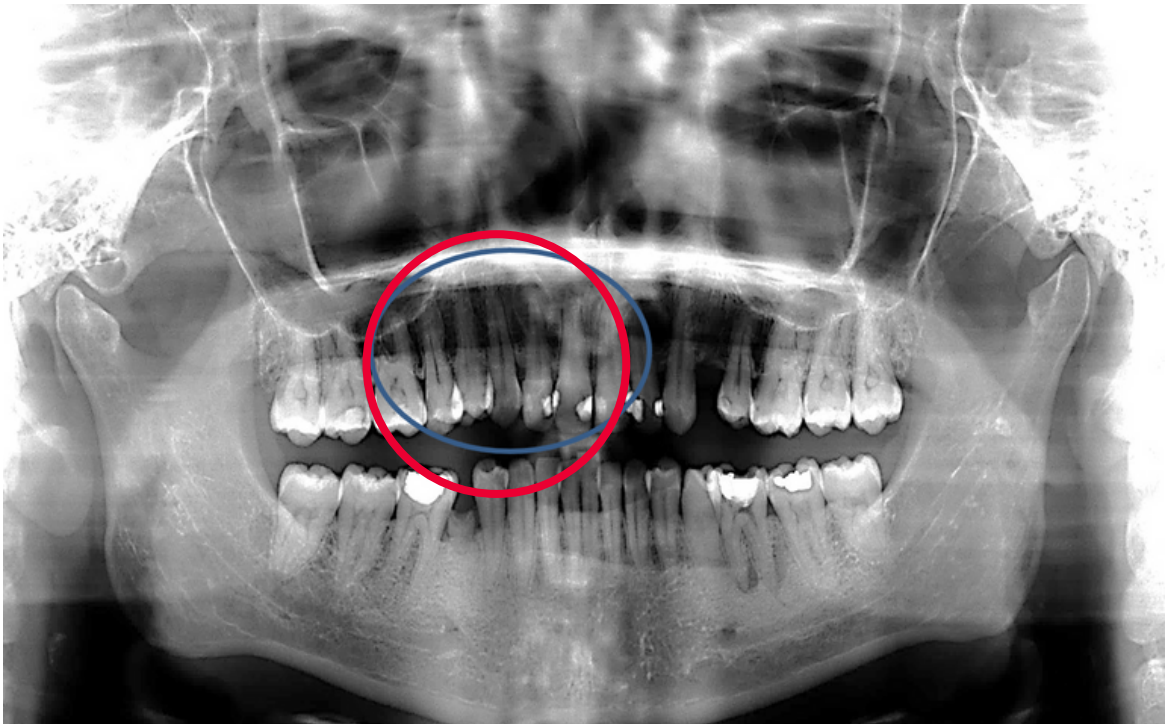
CLINICAL CASE :

34 yr old lady, complained of toothache since June 2016 on 11,12 & 21,22.
Root Canal was advised then, but patient declined treatment and finally came back in Dec 2019 ready to attend to her pain!
Nonetheless ,her main concern was she felt uncomfortable with her front teeth.

Electric Pulp Testing was done on both her visits.
Both visits : 11 12 21 22 were Negative & 13 remained Positive.

OPG was ordered.

Noted to have cystic -like lesions on her upper anterior teeth.



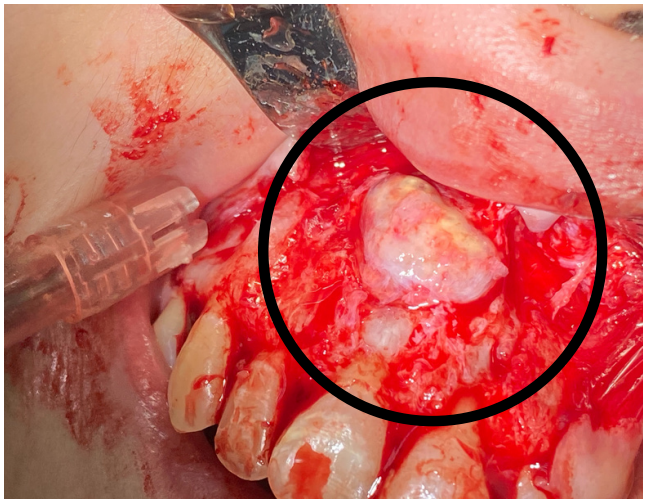
Root canal treatment on 11 12 21 22 was initiated in Dec 2019.

In Feb 2020, noted that 11 and 12 canal remained wet at every visit. Intra oral x-rays were taken and noted her cyst was not reducing!

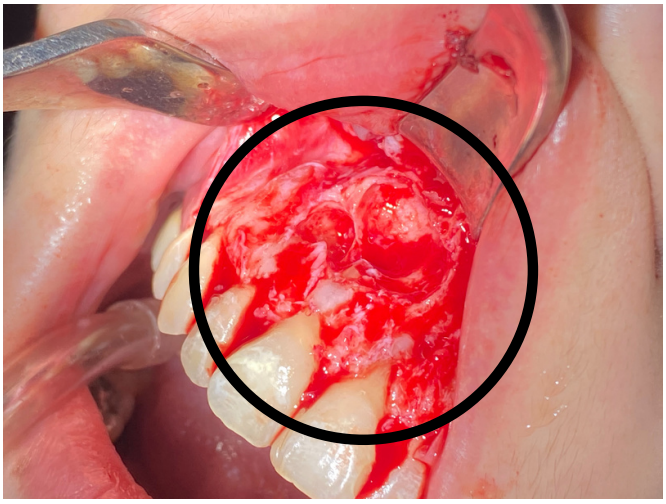
A bony like swelling remained palpable over 11.
11& 12 canal that remained wet : ? contained cystic fluid.

A surgical intervention was initiated, whereby enucleation of the cyst was done under local anaesthesia.
Root canal treatment of all involved teeth were also completed succesfully.

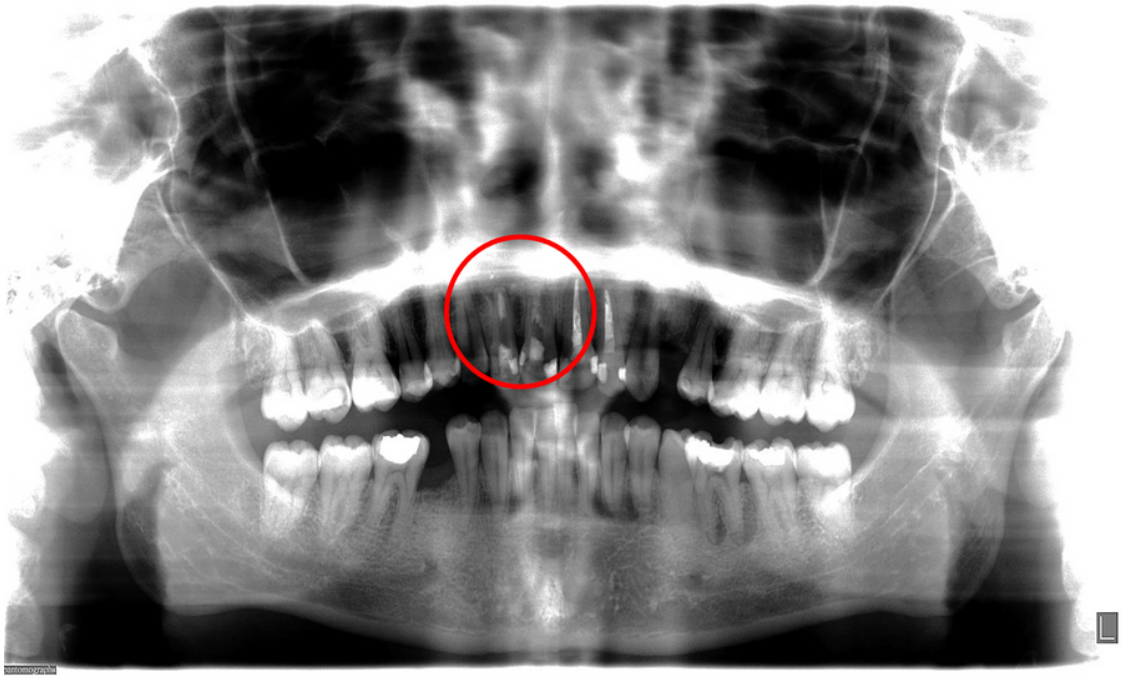
Patient routinely comes in for periodic monitoring (still in progress).
Patient is good otherwise.



Cystic Lesion noted & Enucleated under local anaesthesia.



Post -cyst enucleation.



Post Op OPG : No cyst present

THANK YOU !

GENERAL GUIDELINES TO FOLLOW IF YOU OR YOUR HEALTH CARE PERSONNEL IS SUSPECTED OR TESTED COV- 19 POSITIVE.

PERSON OF INTEREST

TESTS DONE :

RT - PCR

The testing Laboratory will notify through the SIMKA lab information system.

SIMKA : Sistem Informasi Makmal Kesihatan Awam

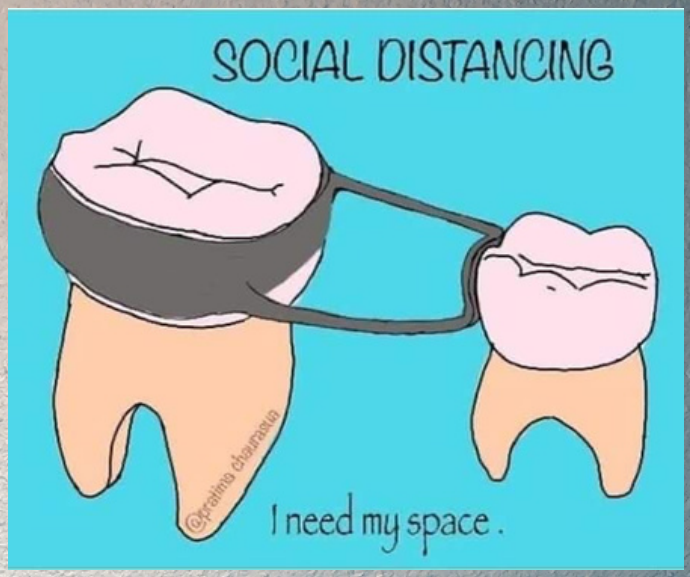
RAPID ANTIGEN

The clinic performing the test will have to notify it through SIMKA and its routine notification system.

For notification purpose, a Practitioner could email the nearest Pejabat Kesihatan Daerah with the Person of Interest's details using a scanned standard notification form.

Pejabat Kesihatan Daerah will do contact tracing, risk assessment and advise you on subsequent disinfection and closure of your clinic (if needed).

The above information has been shared with us by The Crisis Preparedness and Response Centre (CPRC) Kebangsaan (Sektor Pengurusan Bencana, Wabak, Krisis & Kecemasan Bahagian Kawalan Penyakit), Kementerian Kesihatan Malaysia



STAY UP- TO-DATE WITH THE GENERAL COVID 19 PRACTICING GUIDELINES for HEALTH CARE WORKERS at :

www.mpdpa.org.my or http://covid-19.moh.gov.my/garis-panduan/garis-panduan-kkm.

Downloadable & Printable copies available on our website!

"In meetings, Philosophy might work.

On the field, **PRACTICALITY** works! "

Amit Kalantri

Use of Dental Practicality Index in Managing Third Molar (Radix Entomolaris) with Endo -Perio Lesion

Abhishek Parolia and Vivian Tan Jia Hui

Corresponding Author :
Dr. Abhishek Parolia
BDS, MDS, MFDSRCPS (Glasgow), MFDSRCS (Edinburgh), PhD
Head,Division of Clinical Dentistry
School of Dentistry International Medical University, Kuala Lumpur, Malaysia.
abhishek_parolia@imu.edu.my

Abstract

Treatment planning and decision making have always been a challenge for clinicians and through understanding of various factors affecting the outcome is very crucial in formulating the treatment plan. Therefore, the importance of dental practicality index in assessing the practicality of saving the tooth and decisions making has been highlighted in this case report along with various strategies to successfully manage the third molar (radix entomolaris) with endo-perio lesion.

Introduction

Treatment planning has been shown to be one of the most important skills for budding clinicians to develop to prepare them for clinical practice [1]. It can be challenging and requires the clinician to consider many inter related factors to devise a coherent treatment plan. Ali *et al*. (2017) in their study observed undergraduate dental students less confident in formulating a comprehensive treatment plan and knowing when to refer a case [2].

Treatment planning guidance has been published; however, these have often been considered either too time consuming or too complex to be of practical benefit, resulting in a poor uptake amongst clinicians. Alternative treatment planning tools have limited the guidance to one aspect of dental treatment and as a result do not provide the holistic approach necessary for comprehensive treatment planning [3-6].

Dawood & Patel (2017) introduced Dental Practicality Index (DPI) that aims to provide the clinician with a tooth restorability index which takes into account the structural integrity, periodontal status and endodontic status and weights these factors in relation to the status of the tooth within the dentition as a whole, as well as any relevant medical or dental history and the patient's unique dental needs [7]. Applicable to everyday clinical practice, the DPI encourages clinicians to plan treatment methodically and holistically and help improve confidence in assessing which treatments are within the clinician's competency and when additional training or referral to another clinician may be required to complete the treatment. Tifooni *et al.* (2019) validated effectiveness of the DPI in predicting the outcome of root canal re-treatments and recommended further research, including the prospective assessment of a wider range of cases undertaken by a larger group of examiners [8].

Al-Nuami *et al.* (2020) examined the effectiveness of the Dental Practicality Index (DPI) in predicting the survival of root canal retreated posterior teeth and concluded that the DPI can potentially be used in decision making specially in identifying teeth with failed root canal treatment with varied residual volume of coronal tooth structure [9].

Case Report

A 55-year-old female presented to the clinic with a concern of pain on biting and loose gum in her right lower back tooth for past one month.
- Pain is dull and nagging in nature.
- Clinical examination showed an occlusal amalgam restoration on tooth 48 with tenderness on percussion.
- Periodontal probing showed a 5 mm deep pocket with no tooth mobility.
- Pulp sensibility tests were performed on tooth 48 and results were indicative of pulpal necrosis.
- Intraoral periapical radiograph showed presence of periapical radiolucency around the roots of tooth 48 suggestive of periapical lesion. An additional root in mandibular molar could also be observed suggesting radix entomolaris. After obtaining the detailed history and findings of investigating procedures, a diagnosis of endo-perio lesion due to endodontic cause was made and comprehensive treatment plan was formulated using the DPI.

Based on the practicality of structural integrity, restorative, endodontic, periodontal treatment needs and the local factor such as patient's ability to maintain their dentition and general factors including the impact of treatment in the wider context of their social/ dental/medical history, the DPI score for this patient was calculated.

The DPI score three for this patient provided an indication for a reasonably good outcome if the treatment is carried out following all protocols and guidelines.
In general, third molars are advised for extractions due to many reasons but in this case, it was decided to save the third molar due to missing tooth 46, as removal of tooth 48 will compromise the masticatory efficiency of the patient. Additionally, patient's willingness to save the tooth, accessibility to the tooth, presence of opposing tooth in a desired occlusion and clinician's skills to manage this tooth were taken into consideration. Therefore, multi-visits root canal therapy with nonsurgical periodontal therapy such as scaling, and root planning followed by a full coverage restoration with a porcelain-fused-to-metal (PFM) crown were proposed to the patient.

First Visit

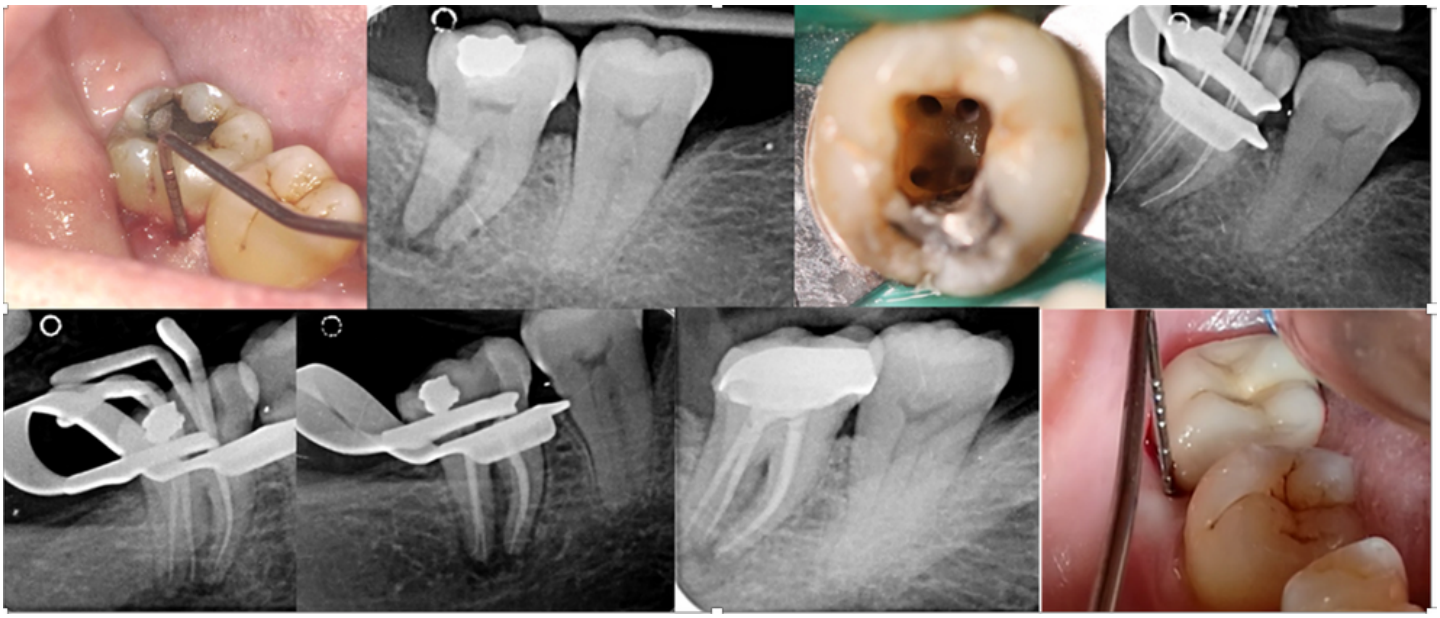
After obtaining the written consent, the treatment was carried out.
- The tooth was isolated using the rubber dam.
- Access cavity was prepared using endo access burs (Dentsply Maillefer, Ballagues, Switzerland)), - Pulp chamber roof was completely removed, all four canals were identified using DG16 probe namely mesiobuccal (MB), mesiolingual (ML) and distalbuccal (DB) and distopalatal (DP) canals. Stainless steel K-files size 8 and 10 were used to check the patency of the root canals.
-3% sodium hypochlorite (Clorox®, Oakland, California, USA) was used to irrigate the canals.
-Working lengths of the canals were electronically determined using Propex II apex locator (Dentsply-Maillefer, Ballaigues, Switzerland) and reconfirmed by intaoral periapical radiograph using the mesial shift technique.
- A glide path was established using the rotary proglider (Dentsply-Maillefer, Ballaigues, Switzerland) up to the full working length in all four canals.
- Ledermix, an intracanal medicament was placed into the root canals and the cavity was temporarily restored with Intermediate Restorative Material (IRM).
- Nonsurgical periodontal therapy, scaling and root planning were carried out in this same visit.

Second Visit

- Shaping and cleaning of all four canals were carried out using ProTaper NEXT rotary files (Dentsply-Maillefer, Ballaigues, Switzerland) up to size X2(25/0.06).
- Canals were thoroughly irrigated using 1 ml of 3% sodium hypochlorite (Clorox®, Oakland, California, USA) solution in between each sequential instrumentation followed by recapitulation with a small-sized K-file (Dentsply-Maillefer, Ballaigues, Switzerland).
- Non-setting calcium hydroxide (Voco GmbH, Germany) as an intracanal medicament was placed into the canals prior to temporization using IRM.

Third visit

The tooth was isolated and temporary restoration was removed, sign of healing such as reduction of periodontal pocket depth, absence of symptoms, tenderness, foul odour, and any exudate from the root canals were observed.
- All four canals were irrigated with 5ml of 3% sodium hypochlorite (Clorox®, Oakland, California, USA), 5ml of saline and 5ml of 17% EDTA (Calasept®, Nordiska Dental, Ängelholm, Skåne Country, Sweden) for 1 minute with agitation using endoactivator (Dentsply, Weybridge, Surrey, UK) to remove the smear layer.
- Canals were then dried with ProTaper paper points (Dentsply-Maillefer, Ballaigues, Switzerland) and matched cones (ProTaper NEXT gutta percha X2) (Dentsply-Maillefer, Ballaigues, Switzerland) were inserted into the root canals up to the working length, a periapical radiograph was taken to confirm the extension of the cones.
- Thereafter, all four root canals were obturated using matched gutta percha cones and AH Plus (Dentsply-Maillefer, Ballaigues, Switzerland) root canal sealer using warm vertical compaction technique.
- Excess gutta percha was removed up the level of cementoenamel junction using touch and heat.
- The pulp chamber was cleaned, etched with 37% phosphoric acid and an adhesive was applied and cured.
- The access cavity was then restored using Smart Dentine Replacement (SDR) (Dentsply-Maillefer, Ballaigues, Switzerland) as a bulk fill material and Ceram.x One Universal (Dentsply-Maillefer, Ballaigues, Switzerland) composite resin.
- The patient was recalled for follow up after one month to assess the clinical signs and symptoms such as absence of tenderness to percussion or palpation, swelling, locally deep periodontal probing defect, tooth mobility and condition of coronal seal. An intraoral radiograph was taken to assess the reduction/absence of periapical lesion.
- Thereafter, the tooth preparation was done followed by impression taking with Aquasil Monophase Polyvinyl Siloxane (PVS) (Dentsply-Maillefer, Ballaigues, Switzerland) impression material.
- After two weeks, the PFM crown was cemented with resin cement and post cementation radiograph was taken.



Endodontic management of third molar (radix entomolaris) with endo-perio lesion.
Periodontal probe going deep in the pocket on the buccal aspect of tooth 48, intraoral periapical radiograph showing periapical lesion, prepared access cavity showing four canals, conformation of working length, selection of primary gutta-percha cones, completion of root canal therapy, follow up radiograph showing healing of periapical lesion/presence of full coverage restoration and healing of gingival tissue with the PFM crown on tooth 48.

Discussion

Root canal treatment involving the third molar always poses a challenge due to internal morphological variations and position of the tooth at the most posterior region of the oral cavity. Generally, in third molar teeth root canal therapy are not advised and extraction is often recommended. However, in this case root canal treatment was advised based on DPI score and after considering other factors such as occlusion with the opposing tooth and comparatively easier accessibility. This conservative management was aimed to preserve the tooth in the dental arch which can contribute to the masticatory function.

A DPI score three was given after assessing the structural integrity (needing simple indirect restoration), periodontal treatment need (probing depth 3.5-5mm (BPE 3), root surface debridement indicated), endodontic treatment need (simple root canal system and radiographically easily identifiable root canals) and context (local/general): isolated dental problems where adjacent teeth are healthy) [7].

Based on their needs the scores are given from "0' if no intervention is required, '1' if simple treatment is required and '2' if the treatment needed is more complex. A score of '6' suggests that treatment would not generally be considered practical. After scoring each category, the sum of scores is then used to determine the DPI score. A DPI score ≥6 indicates that attempting to restore the tooth may not be advisable and other treatment options should be considered and discussed with the patient.

Clinicians shall always consider the following factors before making any choice :
· Is the tooth restorable?
· Will the margins of the potential restoration invade the biologic width?
· Is the crown root ratio favourable?
· Will crown-lengthening surgery, if necessary or even possible, expose a furcation or disturb the attachment height of adjacent teeth?
· Does the site have adequate bone to support the tooth?
· Will the remaining tooth structure be strong enough to resist fracture when occlusally loaded?
· Is the tooth necessary to keep for the patient to masticate effectively and will its loss result in the need for replacement?
· Cost involved, general health of the patient, risk involved in the procedures, expected outcome
· Clinical experience and armamentarium

Accessibility to the third molar region is one of the common challenges faced in performing the root canal therapy of third molar. Mouth props can be used to support the jaw and maintain a sufficient mouth opening for instrumentation. Miniature contra-angled head of the handpiece of the endo motor allowed better visibility and access. ProTaper Next rotary files were used as they have short handles that allowed better access to hard-to-reach areas. Use of operative microscope (OPMI pico from ZEISS) in this case greatly enhanced the visibility of the field of treatment area.

Before commencing any root canal treatment, meticulous study of the root canal anatomy is of prime importance to fully understand the endodontic implications [10]. In fact, these anatomical variations are the commonest cause of endodontic treatment failure resulting from problems like ledge formation, instruments separation, canal blockage and tear-drop transportation at the apex or perforation [11]. For this case, the tooth had four canals with moderately curved mesiobuccal and mesiolingual root canals.

The angulation was measured using VixWin dental imaging X-ray software using the Schneider method. There are various classifications of root canal curvature like Schneider, Dobo-Nagy, radius-based, curvature and shape-based curvature or according to anatomic location [12-14]. According to Schneider's classification, the curvature was considered as moderately curved as in this case. Clinicians shall prepare the coronal third of the root canal before handling mid-canal or apical curvature to avoid any iatrogenic error [12,13]. Therefore, coronal preflaring with Protaper Next XA file was done. Proglider was used to create a glide path that enabled the subsequent passive access of ProTaper NEXT shaping files upto the full working length according to manufacturer's instructions to prevent any procedural error.

For third molars, it had been infamous of its high degree of variability of crown and root morphology hence third molar shall be handled with extreme cautions. Radix Entomolaris is one of the major variants observed in human permanent mandibular molars [15]. A thorough and in depth understanding of all the variations in third molars are essential in achieving the success of treatment. Increased width of mesial root outline, crossing of translucent lines defining the pulpal space and periodontal ligament and unclear outlines of the root canals in the radiograph can be an indication for radix entomolaris.

A flight tight seal along the radicular portion of the root canal with a good quality coronal seal have been proven to prevent the recontamination of the root canal space and thereby affecting the outcome of root canal therapy [16]. Therefore, much attention has been given to coronal seal after root canal treatment. The American Association of Endodontics has indicated that posterior teeth with root canal treatment should receive cuspal coverage restorations depending on the number of walls remaining. In this case, upon completion of root canal treatment, crown preparation was done and a porcelain-fused-to-metal crown with good margins adaptation and proximal contact was issued as the final restoration of the tooth.

The diagnosis of endo-perio lesion can be made by performing the visual examination, understanding the pain characteristics, palpation, percussion test, periodontal examination, pulp sensibility tests, radiographic examination, sinus tracing and bite test if necessary. the endo-perio lesion has been classified in many ways but to make it more relevant for clinicians, three treatment modalities such as tooth needing endodontic treatment/ periodontal treatment/combined treatment shall be adopted. When the lesion is endodontic origin then the endodontic procedure shall be carried out. In case of a periodontal lesion, the nonsurgical periodontal therapy shall be considered first followed by surgical periodontal therapy if required. In case of a combined lesion, endodontic treatment shall always be carried out first along with nonsurgical periodontal therapy such as scaling and root planning if required. The healing of the lesion shall be assessed and based on the clinical and radiographic outcomes, further surgical periodontal therapy shall be taken into consideration [17].

Conclusion

The clinician shall be aware of dental practicality index that can be very useful in decision making and treatment planning. A thorough understanding of morphological variations, factors affecting the outcome, step by step approach to make an accurate diagnosis and evidence based protocols are the keys to achieve higher and predictable endodontic success.

References

1. Ali K, Tredwin C, Kay EJ, Slade A, Pooler J. Preparedness of dental graduates for foundation training: a qualitative study. British dental journal. 2014;217(3):145-9.

2. Ali K, Slade A, Kay E, Zahra D, Tredwin C. Preparedness of undergraduate dental students in the United Kingdom: a national study. British Dental Journal. 2017;222(6):472-7.

3. Curry M (2009) The utilization of case difficulty assessment when determining endodontic referral. Master's Dissertation, Chapel Hill, University of North Carolina.

4. Curtis EK, Simon DC. Endodontic case difficulty assessment: the team approach. General Dentistry 1999;47:340-344.

5. Falcon HC, Richardson P, Shaw MJ, Bulman JS, Smith BG. Developing an index of restorative dental treatment need. British dental journal. 2001;190(9):479-86.

6. McDonald AV, Setchell DJ. Developing a tooth restorability index. Dental Update. 2005 ;32(6):343-8.

7. Dawood A, Patel S. The Dental Practicality Index–assessing the restorability of teeth. British Dental Journal. 2017;222(10):755.

8. Tifooni A, Al-Nuaimi N, Dawood A, Mannocci F, Patel S. Validation of the effectiveness of the Dental Practicality Index in predicting the outcome of root canal retreatments. International endodontic journal. 2019 ;52(10):1403-9.

9. Al-Nuaimi , Ciapryna S, Chia M, Patel S, Mannocci F. A prospective study on the effect of coronal tooth structure loss on the 4-year clinical survival of root canal retreated teeth, and retrospective validation of the Dental Practicality Index. International Endodontic Journal. 2020 May 8.

10. Ahmed HM. Management of third molar teeth from an endodontic perspective. Eur J GenDent 2012; 1:148-60.

11. Balani P, Niazi F, Rashid H. A brief overview of the methods used to determine the curvature of root canals. J Res Dent 2015; 3:57-63.

12. Peter OA. Current challenges and concepts in the preparation of root canal system: A review. J Endod 2004; 30:559-67.

13. De Moor RJ, Deroose CA, Calberson FL. The radix entomolaris in mandibular first molars: An endodontic challenge. Int Endod J 2004; 37:789-99.

14. Mounce R. Negotiating challenging mid root curvature: Rounding the bend. Dent Today 2007; 26:108.

15. Bhatia S, Kohli S, Parolia A, Yap NH, Lai CT, Tan EH. Prevalence of radix molar in mandibular permanent molars: an observational study in Malaysian population. Oral Health Dent Manag. 2015;14:32-6.

16. Machtou P. Apical seal versus coronal seal. Endod Pract 2006;2:19-26.

17. Parolia A , Gait TC, Porto IC, Mala K. Endo-perio lesion: A dilemma from 19th until 21st century. J Interdiscip Dent. 2013;3(1):2.

DON'T TRY TO SOLVE SERIOUS MATTERS IN THE MIDDLE OF THE NIGHT ...

PHILLIPS K. DICK

Dr Lahari A Telang,
Research Coordinator,
Assoc. Prof. and Head of Dept. of Oral Medicine and Radiology,
Penang International Dental College.

Aerosol Generating Procedures AGPs: A summary of best clinical evidence.

The COVID 19 pandemic has created a disruption among the public, media, policy makers and health care professionals alike. The practice of dentistry was almost brought to a grinding halt as it came under stringent scrutiny for a profession with high risk in transmitting the virus during aerosol generating dental procedures and also proximity between doctor, assistant and the patient.

The dental operatory environment which was once considered a safe place for us dentists has now suddenly transformed into one of the most contaminated and dangerous areas. So much so that dentistry as a profession was topping the list of "most dangerous jobs" based on risk of infection1. The risk of air borne contamination in dentistry is considered high owing to the unique characteristics of dental equipment that work at high speeds and produce aerosols. Many studies were conducted in the light of the pandemic to define the best possible clinical practices in order to reduce this risk and yet maintain dental services operation and available to all.

Current evidence suggests three main pathways for virus transmission in dental settings:
(1) direct transmission through inhalation of cough, sneeze, or droplets containing the virus;
(2) transmission via eye, nasal, or oral mucous membranes; and
(3) contact transmission through contaminated surfaces.

All these transmission pathways are facilitated and possibly amplified by aerosols that are generated by most dental procedures.
The following dental procedures are classified as Aerosol Generating Procedures (AGPs)4,5:

- **Use of high-speed hand pieces for direct and indirect restorative procedures,**
- **Ultrasonic scalers**
- **High pressure 3:1 air syringe,**
- **Polishing teeth,**
- **Use of air-driven surgical handpieces,**
- **Air abrasion, slow-speed polishing ,**
- **Access opening of teeth for drainage ,**
- **Definitive cementation of crown or bridge,**
- **Surgical tooth extraction ,**
- **Implant placement,**

Intraoral radiography, can evoke gag reflex leading to coughing or sneezing that results in aerosols.

Airborne contamination caused by the use of dental hand pieces in the operative environment was mapped with the help of biological tracers and it was found that "no surface of the operative environment was free from the tracer after the use of the air turbine". The maximum distance of tracer detection was 360 centimeters for air turbine, 300 cm for contra-angle hand piece, and 240 cm for ultrasonic scaler. The operator and the assistant were therefore both exposed to these contaminants. This study concluded that attention should be paid to minimise or avoid the use of rotary and ultrasonic instruments when concerns for the airborne spreading of pandemic disease agents are present.

Another report which studied dental aerosol microbial composition and spatial distribution concluded that contamination caused by droplets and droplet nuclei is only of concern during dental treatment and tends to concentrate around the head of the patient to about at 1.5 m from the oral cavity. Both human and water-derived bacteria were found throughout the treatment room. These results stress the importance of infection control measures on surfaces in close proximity to the head of the patient. Adequate air ventilation and a low level of contamination of DUWLs (Dental unit water Lines) likely lead to lower levels of microbial contamination of the air in dental clinics.

There has also been an influx of Extra-oral scavenging(EOS) devices in the market, which aim to reduce risk of particulate spread. EOS devices have an effective filtration mechanism consisting of multiple layers of filters including High Efficiency Particulate Air (HEPA) filters. The efficacy of one such commercially available EOS device on contamination reduction during dental aerosol generating procedures (AGPs) was studied and it was found that EOSs resulted in 20% reduction in frequency and 75% reduction in mean intensity of contamination of operatory sites. There was a 33% and 76% reduction in mean intensity contamination for clinician and assistant, respectively. This could be attributed to the scavenging action of the EOS changing the airflow dynamics in the immediate area, thereby reducing exposure of the clinician and assistant.
Use of rubber dam and four-handed dentistry resulted in further reduction of contamination. Ultrasonic scaling procedures were associated with a lower frequency and mean intensity of splatter than that observed with air turbine procedures, which was lowered further with the use of EOSs. The frequency of contamination was less in the open clinic compared to the closed surgery; suggesting that general ventilation is important, to reduce the concentration of aerosols in the air, for example by keeping windows open. An example of one such EOS is given in figure 1.

Figure1: AGPs carried out in a specially designated isolation cubicle, with a custom made air purifying unit-suction type with HEPA filters (Japan Air Solution (M) Sdn Bhd).

Respiratory pathogens, including SARS-CoV-2, can colonise the oropharynx where the oral biofilm acts as a reservoir. Routine dental procedures such as drilling, scaling and polishing have the potential to aerosolise saliva and blood, causing airborne contamination. These particles can be absorbed across the respiratory mucosa and conjunctiva and penetrate the lungs, which can result in airborne transmission of SARS-CoV-2.10. Aerosol particles are smaller than 50 µm in diameter and remain airborne for prolonged periods. In contrast, splatter consists of a mixture of air, water or solid matter greater than 50 µm in diameter and can behave in a ballistic nature. The use of pre-procedural mouth rinse with preferably Chlorhexidine is suggested as one of the most effective strategies for the reduction of aerosol-related bacterial load in dental practice.

Based on a recent Cochrane review, there is clinical evidence to show that High volume evacuation along with usage of rubber dam helps in reducing levels of contamination in the aerosols generated during dental procedures.

To summarize, the key points for maximizing risk mitigation during AGPs is as follows:

- **Full PPE for both operator and assistant**
- **The routine use of four-handed dentistry**
- **Usage of High volume suction**
- **The routine use of rubber dam for isolation where possible**
- **Use of pre-procedural rinse antiseptic mouth rinse (chlorhexidine)**
- **The use of an EOS device can further mitigate the magnitude and concentration of splatter.**
- **Adequate air ventilation in both open clinics and closed surgeries**
- **Layering of routing Infection control protocols with special attention to surface decontamination and dental unit water lines.**

Safer Aerosol-Free Emergent Dentistry (SAFER Dentistry) is suggested as one approach to dental services during and emerging from the pandemic. The concept's starting point is the identification of the most common patient needs.
The next step is to replace common treatments addressing the most frequent needs with alternative interventions involving a lower infection risk because they do not generate aerosols. They comprise the following:
1. Examination/diagnosis via in-person teledentistry: when performed in person, this includes antiseptic mouthrinse and visual and/or tactile inspection without intraoral radiography for diagnosis.
2. Acute pain, swelling, or infection depending on the diagnosis, pulp devitalization/temporary filling (pulpitis), antibiotic therapy (acute inflammation), and/or local anesthesia and tooth extraction.
3. Toothache due to caries without pulpal involvement: silver-diamine-fluoride application (SDF), glass-ionomer sealants/Atraumatic Restorative Treatment (ART), fluoride varnish/gel, and/or tooth brushing with high fluoride-containing toothpaste (HFT, 5,000 ppm fluoride).
4. Acute periodontitis: hand scaling and metronidazole/amoxicillin combination for 1 week.
5. Denture repair/reline, lost crown or orthodontic bracket, or orthodontic wire: denture repair with soft re-line, crow and bracket re-cementation, and wire adjustment, repair, or removal as well as removal of stitches from previous surgery. The interventions of SAFER Dentistry are effective and realistic, even for resource-poor settings.

To sum in all up: The dental team has a vital role to play in reducing the transmission of infection in the dental care setting. With aerosols being a mode of transmission, it is only prudent that we take it upon us as a community to help curb the spread of the disease, whilst facilitating dental service providers to remain operational and generate income even under pandemic conditions.

or ELSE... SAMAN RM 10,000!!

???

ARE YOU AWARE ?

Compulsory requirements that should be incorporated on your dispensing medication envelope.

1.Name and address of your clinic.
2.Patient's Name & Registration Number based on your record book.
3.Date of drug dispensed / sold.
4.Complete instructions on how to take the medication.
5.Name of the drug and strength (mg) /
Generic name of the medicines / Name of the active ingredient.
6.Drug expiry date.
7.Details of the drug supplier / manufacturer
(Name of company & address)
8.Label "CONTROLLED MEDICINE" (for controlled drugs only).

ABC DENTAL SURGERY
123, JALAN DE, 56000 KUALA LUMPUR. TEL : 0123456789

NAMA : _____ RN : _____
TARIKH : _____

AMBIL : ☐ BIJI ☐ KALI SEHARI ☐ PAGI ☐ TENGAH HARI
☐ SELEPAS MAKAN ☐ PETANG. ☐ MALAM
☐ BILA PERLU SAHAJA

NAMA UBAT : PARACETAMOL 500 mg. EXPIRY DATE : _____

XYZ-MED SDN.BHD. JALAN MOP,47000 PETALING JAYA, SELANGOR

UBAT TERKAWAL / CONTROLLED MEDICINE

For more information : http://www.myhealth.gov.my

LOCKDOWN DIARIES ..

The year 2020, had definitely caught us by surprise.
No flying cars but viruses in the air!

To some, the MCO Lockdown was a nightmare!
But to some ,they made the best out of it!

We approached our members to share their personal views &
" MCO (Lockdown) Experience" with us!
And this is their story .....

" LEPAK SAHAJA ! "

" I Learned To Cook At 57 ! "

" Digital Dinosaur Awakening "

" My clinic was shutdown for 15 days ! "

I spent my time learning how to animate power point slides. To those of you who do presentations, especially in Zoom, the physical absence of the presenter can be mitigated with the use of animation. It's an easy enough skill to learn, even for baby boomers. It was also an opportunity to rediscover the joys of reading. I also discovered that the accompanying beer and chips, while also a joy, does not help one's diet. But the most important thing the lockdown afforded was the ***time to appreciate my good lady, extended family and count my blessings!***

- Past President Dr. Shashitharan Sadacharan.

Firstly, one should never take anything for granted.
Always be prepared for a rainy day!
The initial MCO days were difficult as I worked lesser hours.

The reduced patient flow resulted in loss of income thus I learned to be thrifty with my spendings. Despite ensuring and enforcing strict SOP measures for my staff to follow, their "personal after-work activities" affected my practice drastically. Resulting in my clinic to be shutdown for 15 days!
I learned not to take chances with the patients' declaration of medical health. Be very alert. Always be suspicious.
The efficacy & accuracy of the gadgets that we use to monitor temperature of patients is so pathetic! Clinic budget has increased due to greater usage of sanitisation / gloves / face shield accessories.
On a personal gain, I enjoyed & appreciated the family time I never had before. I have also learned to be a better home gardener and started growing my own vegetables.
As an elderly, I worry everyday for the safety of myself and my family.

- Anonymous Member -

As I reflect back on the year, it has been very challenging in the form of people's health and safety, government SOPs and business continuity. The pandemic led us into a new era with a new norm, where we need to be agile by adopting digital technologies to ensure my business was not held back at times like this. Besides that, my lifestyle changed as well. I had to work from home mostly , which granted me more time for taking care of my own health and wellness which I have neglected before. Despite the challenges, I am grateful for the opportunities and blessings I have and I personally wish 2021 will be a better year for everyone to start with!

- Ms. Shwu Hwa- GSK Representative.

MARCH 2020, APRIL 2020 ,MAY 2020.

1. Business down.
2. Had >300 WhatsApp messages daily! Made many new group chat friends. I only know the Administrators, the rest were total strangers.
3. Made it a point to call the elderly to show my concern. They were glad to have someone to talk to.
4. Forced to learn to cook.
5. **Digital Dinosaur Awakening.** I learned to use Zoom Webinars.
6. **Tasted "Trial Retirement"—lepak sahaja!** Movies and Korean dramas overload. Read and did a lot of things I never had time to do.

JULY, AUG, SEPT, OCT, NOV, DEC 2020 :

Got hooked onto App Games.
Limited to "Thousand Flowers", challenging to score with friends.
At my age, it was as "AN EXPERIENCE ! "

Miss my overseas travels, meals with family and friends, shopping mall trips but

I had loads of ME time.

- Dr. Foo Gaik See.

I have two nurses in my clinic.
When one of them was tested
Positive for Covid 19, the other staff and myself
immediately tested ourselves with
the RTK Antigen Swab Test.
We both tested negative.

I immediately closed my clinic for 14 days and all three of us went into strict home quarantine.
Unfortunately, 4 days later, my second staff (who had tested negative) developed fever and sore throat and was tested positive!
Both of my staff had dutifully informed MOH , and have been closely monitored by them.
My clinic was sanitised.
I have completed the mandatory second RTK Antigen test on my 9th day (Results : Negative) and my clinic remains close till 1/2/2021.

Both my staff were very lax in maintaining SOP protocols after office hours as they come from large families.

It is important that clinic staff follow SOP protocol even after working hours.
Adhering to SOP in the clinic alone is not enough !!

Every one of us are responsible for our actions. Our staff too must be held accountable.
Regretfully, this is a lesson learnt the hard way.

- Anonymous Member-

We are fortunate to be in a profession that allows us to work despite the on-going pandemic. Opening our clinic is purely our decision, and I am lucky enough to have good employees who were willing to work with me during this difficult times.Nothing much had changed during the lockdown. We still continued to see our regular patients who came for their dental treatment while we adhered to the necessary SOPs.
Their dental visit may have been the only reason they were allowed to get out from their quarantine homes and gave them the liberty to cross borders as well. We also managed to complete some 'pending' long-standing and complex multidisciplinary cases that had been held back by patients who had been busy , but now, they seem to have the time during this pandemic!

We have invested in Digital Dentistry and Artificial Intelligence heavily in our clinic. With very little technology support from our local vendors, and irresponsible suppliers and technicians we had lost a lot of money previously over the years. From this experience, it had thus taught me to focus on positive things. Even while in a crisis like now! It doesn't make our problems less critical but it does make the situation easier to bear.

I believe, every cloud has a silver lining. There may be something good you can make out of a bad situation.

My personal gain is I started picking up cooking as an additional skill. I learnt to cook at the age of 57! Since dining out was not allowed and we had limited hours for food delivery, I started cooking daily for my family especially during the fasting month with the help of my new digital cooking gadget called Thermomix. With that I also managed to maintain my weight by carefully watching what I cook and eat.

Just like everything else in life, nothing lasts forever ; including COVID-19.
Hope to see you all in the future .

Dr. Kamsiah G Haider BDS,
MDSc Prosthodontist in Private Practice
TTDI, KUALA LUMPUR

Financially, I had to go through an increase in operating cost with the use of daily PPEs and sanitisers now. There has been a drastic reduction in my patient flow and demand for cosmetic dentistry has tremendously reduced too! Coming from a small town, it wasn't easy to implement changes in my practice. Thankfully, my patients have learnt to accept the " New Norm" such as strictly adhering to appointment based visits only, strict sanitisation prior to entering the premise and only minors and disabled patients are allowed to be accompanied.

- Anonymous, Outstation Member.

I would like to share my MCO 1.0 experiences through these illustrations I have created...

Dr.Rubini Arasu

The Bat.
How it all started..

Signs & Symptoms.
The slightest flu-like symptoms that gets us all confused & paranoid.

"Duduk Diam-Diam Di Rumah" as advised by our Honourable Prime Minister.
Who would have thought staying at home could be so difficult !

Mouth Mask : An Accessory now.
Never leave home without your mobile phone, wallet, keys, and now this !

Shortage of Hand Sanitisers that caused a panic.
Thanks to YouTube I have learnt to DIY a Hand Sanitiser!

FRONT LINERS -
most -used daily- word.

The Great Global Toiler Paper Crisis that occurred during this Viral Pandemic.
Something I am still trying to understand...

The Nationwide Gardenia Bread Crisis!
I had to cross districts to buy a loaf of bread!

RoadBlock Policemen who are still confused to-date!

- got caught in a standstill roadblock for 5 hours with no way out.
- was once held up by the police because he did not know the significance of our APC and how its a relevant travel document for us to commute to work.
- these numerous roadblocks has taught me to navigate and discover new toll free routes.

The government subsidies we looked forward to.
Something better than nothing for the Private Sector.

**These illustrations were handpainted on a recycled paper coaster.

REFLECTIONS ON THE COVID-19 PANDEMIC AND THE LESSONS LEARNT.

Dr. Wong Foot Meow BDS (Mal), FDSRCPS (Glasg), AM (Mal), FICD, NSR, Senior Private Dental Practitioner

An unprecedented event, the COVID-19 pandemic outbreak changed the world as we know it irrevocably. Almost a year on, we find ourselves still adapting and learning to navigate our way through its lingering effects.

Working with the various challenges that continue to threaten the safety and wellbeing of patients, staff, our practice and bottom lines. Notwithstanding, this *pandemic does have its silver lining.*

It has given us the opportunity to pause, reflect, gain fortitude, and activate innate skills within ourselves.
More importantly, ***it taught us not take things for granted.***

Four elements, **in particular, stand out :**

1 CHANGES IN WORKSTYLE & DAILY ROUTINE

All Private Dental Practitioners (PDP), without exception, must now strictly adhere to the Ministry of Health (MOH) Standard Operating Procedures (SOP) for both staff and patients.

The 3Cs	The 3Ws
Avoid: Crowded places Confined spaces, and Close conversation	**Practice:** Frequent hand Washing, Wear a face mask Warn: avoid large social gatherings and refrain from flouting the SOPs

Taking to heart the Ministry of Health's stand that "we are all in this together" – the 'MDC Guidelines on Infection Control' has been rigidly applied in our daily practice as well as 'Dental Practice and Guidelines on Safety and Health' in conjunction with dental laboratories.

Examples of new protocols imposed include:
a.Advanced dental bookings;
b.Registration via the MySejahtera app and temperature screening on entry;
c.Compulsory staff and patient history screenings;
d.To enforce the 1m physical distancing rule, patients are required to attend alone, unless company is required e.g. children under 18;
e.For added safety, patients are requested to wait in their vehicles until their turn; and
f. Already strict dental asepsis protocols have been reinforced and made known to patients.

Separately, we have had to invest in HEPA filters and COVID-19 sanitiser machines which disinfects the ambient air and fixtures continuously throughout the day.

LESSON LEARNT :

We have been forced to re-evaluate our approach to the health and safety of patients and staff alike:
- Our dental staff are reminded always that we play an equal role in containing the pandemic and keeping each other safe.
- Patients, dentist and nurses alike must wear masks at all times.
- In the clinic setting, staff are required to change masks regularly. Special gowns and face shields are worn at all times.

These simple rules have brought us 'back to basics', re-emphasising the core values that every PDP should practice. It also motivated us to be empathetic and take an open-minded approach to problem solving. We have learnt to be more 'appreciative' in these adverse circumstances of our staff's contribution, sacrifices and patients compliance/cooperation.

ACQUIRE & DEVELOP SKILLS TO FACE CHALLENGES AHEAD FOR A POSITIVE OUTCOME.

" CREATE A SAFE BUBBLE IN YOUR PRACTICE ! "

Knowledge plus a healthy and positive work culture make for a wholesome work environment. This helps to reduces fear and anxiety in these uncertain times.

Every staff must be reminded that they have a role to play in containment of the virus.

Through discipline and strict compliance with MOH and MDC Guidelines, we must create a 'safe bubble' within the practice.

Staff should be actively encouraged to minimise social and public outings to keep our 'safe bubble' uncompromised.

Management can also take the initiative to keep staff appraised of the latest COVID-19 studies e.g. the risks of eating out vs take-out.

Now, either bringing home-cooked food or ordering in has become the norm for our staff to minimise their risk of infection. Unexpectedly, such new habits can bring the team closer.

LESSON LEARNT :

Whilst the MOH/MDC has yet to start visits by health officials or uniformed authorities, we must continue to work together and run our practices at the highest standards.

The pandemic has forced clinical culture to evolve but in a good way – staff and patients need to trust us. At all times, we should find out how our staff are faring and remind them of the need to be vigilant.

The job market has now become very fluid, and we now have enquiries for jobs where previously nurses were hard to come by. It is perhaps an ideal time to recruit new talent for PDP (that require them) and use this time to train them up when the economy recovers.

3 HOW THE PANDEMIC'S RESTRICTIVE AND ADVERSE OUTCOMES AFFECTED US.

Professionally, we find that patients are increasingly 'stressed', resulting in more cases of bruxism, cracked teeth and prosthesis.

More patients visit dentist as an escape from anxiety and will have to be counselled on proper self-care and to stick to healthy daily routines, healthy eating, ergonomics, healthy emotions, and mental health.

Whilst PDPs are considered an 'essential service' and can continue working, even during the MCO, we too feel the 'stress' of the pandemic.

We encounter police roadblocks, see less patients, are forced into shorter working hours and face hours of clinical inactivity.

STRESSED PATIENTS

POLICE ROAD BLOCKS !

SHORTER WORKING HOURS !

LOSS OF FREEDOM

LESSON LEARNT :

With the economy struggling and community freedoms deeply curtailed, this adversity we have faced over the pandemic has made us better professionals.

a. Socially. The MCO resulted in "loss of freedom" secondary to the uncertainty about advancement of the disease with deep feelings of helplessness especially in those separated from their loved ones.

However, this has allowed our practice to become closer – invested in each other's safety and preserving our 'safe bubble'. Staff and PDP are of one mind in providing good service whilst keeping ourselves safe.

Personally. A wise man once said :

> ***"We sacrifice our health to make money. Then we* sacrifice money to recuperate our health. We become so anxious about the future that we do not enjoy the present; the result being that we do not live in the present or the future; we live as if we will never die, and then died having never really lived. Yes, all these people are living for tomorrow."**

Whilst many PDP do not have the luxury of work-from-home, the clinical downtime could very well be a boon.

It allows us time to take stock of the practice, do inventory, review work flows that may not necessarily be possible when the practice is busy.

It also gives us time to re-train our staff or upgrade our skills via online courses and for those of us so inclined, sit down and write that article (or perhaps a book).

4 ARE THERE ANY LESSON TO BE LEARNT AND HAS ANY GOOD COME OUT OF THIS CRISIS?

DENTAL CLINICS SAW MORE THAN 50% DECLINE IN PATIENTS !

" HOW WILL THEY COPE IN MONTHS AHEAD ?? "

We are now into the 11th month of the various movement control orders (MCO) and the 4th wave of COVID-19 in Malaysia.

Until our community is fully vaccinated, the pandemic will continue to shape the future of the dental profession.

Dentistry as a Service.

Many PDPs have had to shift to an 'urgent dental care' model – operating at less than 30% on an initial emergency basis.

News portal estimate that dental clinics saw a more than 50% decline in patients between March and December 2020.

This has had a huge impact on the ability of practices to deliver care and maintain their bottom line. Especially with Government and MOH efforts fully focused on breaking the chain of infection, most private practices have had very little support over the course of the pandemic.

Even now with MCO 2.0, many now face real questions on how they will cope in the months ahead.

Investment in ventilation is an obvious way forward. Most courses of treatment involve aerosol generating procedures.

If we understand and accept the precautionary principle that this may put patients or staff at risk, we accept the obligation to provide support.

Although access to the vaccine eventually could reduce these challenges, such investments are prudent to future-proof our practice.

Government Support.
The private sector now accounts for 50% of the population's dental expenditure. PDPs during the pandemic had limited access to credit and had to go it alone while trying to provide vital dental service to patients.

Even as the Malaysian Government continue to make rules for healthcare to keep our community safe, government incentives and support needs to follow.

Private dentistry must not be ignored if the MOH is going to develop comprehensive plans to maintain good dental care standards for Malaysians across the board.

Go Digital. I had to do a virtual dental conference lecture in October 2020, and had to learn from scratch how to handle one!

Like it or not, we will have to adapt to the brave new world of remote triage. Remote consultations and triaging will clearly form part of the response to any future pandemic.

However, MCMC and dental associations need long-term planning and collaboration to ensure effective digital integration among dentists.

In the West, dentists with access to electronic prescribing and summary care records have significantly increased quality of time available for direct patient care instead of wasting time on mountains of paperwork.

The Malaysian Government and MOH should also consider similar initiatives and provide an appropriate, integrated digital infrastructure for Malaysian dentistry.

Stay Up-to-Date. Fortunately, there was no lack of communication as far as the dental profession is concerned. The various dental associations were highly proactive. PDP could reopen, and patients were clear on what levels of service they could access.

Certain dentists surveyed expressed dissatisfaction on PPE availability, quality of guidance and even financial support in the early days of the pandemic.

However, this has improved and augurs well as the crisis drags on. This experience will be fundamental in the event of any (future) pandemic.

A Logical Approach. The Malaysian Government has assured dentists (as front liners), that they will be given priority to the COVID-19 vaccine.

A rapid rollout of a COVID-19 vaccine will be a game changer, and Government advisors have recommended that all health professionals should be near the front of the queue.

We have seen what during the MCO what life is like without dentistry, and for much of the population now seeking routine care the situation has improved. The problems encountered in the past should not be revisited.

TO CONCLUDE ....

it is envisaged that PDPs will find it challenging in the coming year, at least until the economy recovers.

More than ever, PDPs must be ready to innovate, re-evaluate how we practice, implement new and better clinic management and infection control procedures.

For others, it may be a good time to go back to dental management basics;
– balancing income and expenditure to pull through this difficult period without sacrificing the quality of Malaysian PDP's dental care.

At this juncture, knowledge-sharing and understanding of the transmission of the virus is key to the betterment of our future health and financial status.

Together, we can and will overcome the pandemic to find our equilibrium in the 'new normal' of practice.

THANK YOU !

Probing Into Their Passion ....

Oft -times *the talent and passion*
of our members go unnoticed.
In this edition of Probe, I take great pride in introducing my classmate, Dr Chua Hock Khoon.
This article is all about having another passion besides Dentistry-- Philately.
He tells a fascinating historical tale of each stamped envelope. I am enthralled with the history of the era unravelled by the stamps.

Introduction by :
Dr. Foo Gaik See, Class 1976, University Singapore.

Picture above was taken during my role as a Jury for Malaysia 2014 World Youth and 29th Asian International Stamp Exhibition at KLCC.

Dr.Chua Hock Khoon
Senior Dental Practitioner, Penang
B.D.S. Singapore (1976)

I started stamp collecting at the pre-school age of six. My father was working as a clerk in a firm within walking distance from our *attap* house. Sometimes my father would bring me to his office to let me learn some basic English from a part time English typist. I got fascinated with those small colourful papers on envelopes thrown in waste paper baskets in the office. These "postage stamps" were soaked out from the envelopes and kept in boxes. Later my father bought a small stamp album for me, paving the way to proper stamp collecting which continues to date.

In my school days I made first day covers for local issues, exchanged stamps with friends and subscribed to stamp magazines. Unfortunately, my hobby stalled during my years in university.

" I CAME ACROSS SOME TOPICS WHERE OUR HISTORY BOOKS NEGLECTED, OMITTED AND EVEN PURPOSELY AVOIDED ! "

When I came back to Penang in 1980 and started my own dental practice I had more opportunities in purchasing stamps from dealers and attending exhibitions organised by Pos Malaysia and other local philatelic societies. These were really eye-opening! Instead of collecting stamps aimlessly I decided to focus on a topic which I was most interested in.

One day I was offered two philatelic Last Day Covers of Japanese Occupation by a local stamp dealer. These covers were considered "elementary" by today's standard. But I was very excited. I was born six years after Japanese surrendered and was intrigued since young by stories of lives of people during Japanese Occupation, told vividly by my grandmother. These covers were the records of that era of hardship and terror! Since then I started to build a collection of commercial covers and postcards, meaning these items were commercially posted and not intentionally made for the purpose of philately. Thus the Postal History collection of "Japanese Occupation of Malaya" started to expand.

Postal history is the history of mails and the organisation of the posts to handle them. A postal history collection tells the story of the history of the carriage of the mails, and the organization required to collect, convey and deliver the items put into the post.

Cultural, political and social activity of the period chosen can be learned from these covers and postcards, by studying the stamps used, postal markings, instructional notations and even the contents. One important aspect of postal history of this period are the censor marks. Every letter is opened, read and resealed by censor board before reaching the recipient's hand. From the collections of this period of three years and eight months, I came upon some topics where our history books neglected, omitted and even purposely avoided. Do you know Thai Occupation of the four northern Malayan states, Indian National Army and Indian Independence League, and the Thai-Burma Railway or the Death Railway? The covers and postcards provide solid evidence to these historical events and paint lively pictures to their forgotten tragic moments.

My knowledge was acquired and expanded by reading relevant books, learning from senior collectors, and joining stamp societies, both local and overseas. In monthly gatherings at local society, we display our collection in local stamp clubs involving discussion and exchanging knowledge. We have our own journals and club auctions where members can acquire favourite items and dispose off duplicates. Philatelic fraternity is thus cultivated, especially if you find somebody having the same area of interest. The internet era gives us much opportunity and access to philatelic knowledge and we can communicate more easily with fellow collectors.

" I EARNED A GOLD MEDAL IN 1997 AT THE INTERNATIONAL PHILATELIC EXHIBITION AT NORWEX IN OSLO & SINGAPORE WORLD STAMP CHAMPIONSHIP 2004 "

Collections can be set up and used for purely personal leisure or for competitions. Sometimes, of course, they serve the two functions. I find both ways of collecting are equally commendable, affording much interest and satisfaction.

In 1992 I entered KL'92, competitive stamp exhibition at national level, then ASEAN-PEX'94 which was regional, and finally International Philatelic Exhibition at NORWEX 97 in Oslo where I got a Gold medal. I achieved another Gold Medal at SINGAPORE WORLD STAMP CHAMPIONSHIP 2004.

" Editor of The Stamp Messenger Journal "

From 1993 to 2015 I was the President of Penang Philatelic Society and the editor of its journal, The Stamp Messenger. Several stamp exhibitions and public forums were organised in relation to Malaysia Day and Penang Heritage Day. Most notable was ASEAN-PEX'94 which involved six ASEAN countries. I was also a jury in national and international stamp exhibitions.

The age of internet has influenced the pattern of communication and the younger generation has too much distraction in the multimedia. That has raised the concern of continuation and promotion of this century's old hobby. But I also noticed the growing number of young intellectuals and professionals who show interests in stamp collecting.

Hope the king of hobbies and the hobby of kings be cherished and continues !

Stamp Exhibition codenamed "50 Years of Malaysia Stamp and Post Card Exhibition" at Whiteaways Arcade Penang, Sponsored by MCMC, represented by Senior Officer Mr. Toh Swee Hoe.

8c Pahang stamp with brown single frame overprint used on cover from Kajang 5.4.2602 (4th May 1942) to Tojo-to (Penang). Cover opened and sealed by censor with boxed censor chop 檢閱

Penang was once renamed "Tojo-to" during Japanese Occupation. The Japanese landed on Penang on 19 Dec. 1941 and the Military Administration proclaimed in early March 2602 (1942) that Penang shall be called "Tojo-to", after the Japanese Premier General Tojo Hideki and "to" means island. Presumably the authorities in Tokyo did not approve of the change, the name was reverted to "Penang". It was reported in a decree published in May 2602.

Postal Service Between Penang and Syburi (Kedah)

On 18 October 1943, Kelantan, Trengganu, Kedah and Perlis were ceded by Japan to Siam. Except for Trengganu, the year appearing on cancellations was changed to conform to the *Buddhist Calendar*. Thus 1945 became 2488. Kedah was renamed **Syburi**.

Registered cover from Bukit Mertajam 7/23/2605 (23 July 1945) to Kulim, Receiving an arrival post mark of **KULIM-SYBURI** and manuscript **2/8** (2 Aug 1945) Cover was opened, censored & resealed with official seal paper of Malai Military Administration Post Office

" Kedah was previously known as Syburi "

The Indian National Army or Azad Hind Fauj was formed by the Indian Independence League which was directed by the Japanese to liberate India from outside. In July 1943 Subhas Chandra Bose became the President of the Indian National League and leader of a reconstituted 13,000-strong Indian National Army. The SWARAJ INSTITUDE (Indian Youth Training School) and later the AZAD SCHOOL had their premises at Penang Free School, Green Lane, Penang.

12/28/2602 (28 Dec 1942) Cover from SWARAJ INSTITUDE to Medan (Sumatra)

Battle of Imphal (March-July 1944).

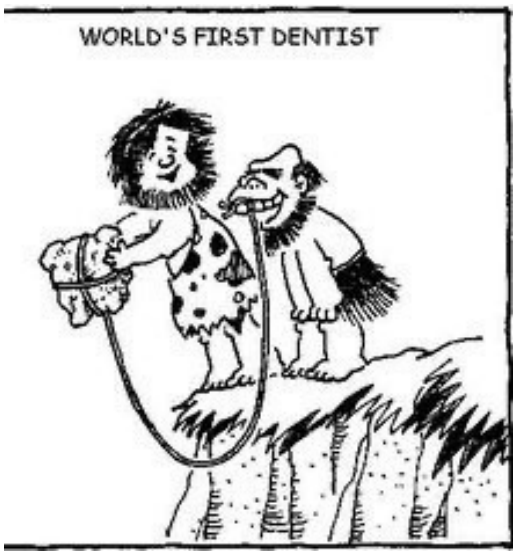
The Indian National Army, comprising of surrendered British Indian soldiers and local Indians, joined the Japanese Fifteenth Army in an attempt to invade and liberate British colony of India from Burma (today Myanmar).

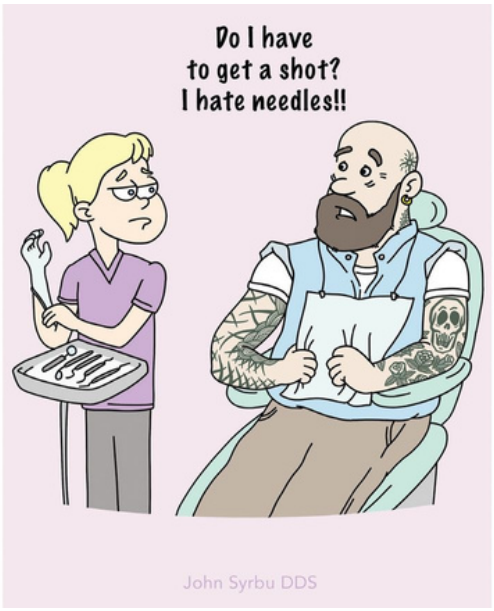
The Battle of Imphal took place in the region around Imphal, the capital city of Manipur in northeast India. But the joined armies were driven back to Burma with heavy loses.

THANK YOU !

LAUGHTER...

is like a windshield wiper, it doesn't stop the rain, but allows us to keep going.





FROM OUR VICE PRESIDENT'S KITCHEN.

..another hidden talent !

KERALA CLAY POT KAMPUNG CHICKEN CURRY

Ingredients

1. Chicken – 1 kg
2. Onion – 2 medium (sliced into thin pieces)
3. Tomato – 1 medium (diced)
4. Potato – 1 medium (diced into medium sized pieces)
5. Chicken Masala Powder (home made) – 2 tbsp
6. Coriander Powder – 1 tbsp
7. Kashmiri Chilli Powder – 1 tsp (Alter according to your Spice Tolerance)
8. Garlic Paste – 1 tsp
9. Ginger Paste – 1 tsp
10. Thin Coconut Milk 1 cup
11. Curry Leaves – A sprig
12. Cilantro (Malliyella)– A few (optional)
13. Coconut Oil – 3tbsp
14. Mustard Seeds –1/4 tsp
15. Water – As required
16. Salt – to taste

Chicken Marination :

1. Chicken Masala Powder – 2 tbsp
2. Turmeric Powder – 1/2 tsp
3. Kashmiri Chilly Powder – 1 tsp (Alter according to your Spice Tolerance)
4. Ginger Paste – 1 tsp
5. Garlic Paste – 1 tsp
6. Black Pepper Powder – 1/2 tsp
7. Yogurt- 2 tbsp
8. Salt – to taste

Method of preparation

1.Clean and cut the chicken into medium sized pieces and marinate it with the above ingredients. Refrigerate it for an hour.

2.Heat a Clay pot or non stick pan and add coconut oil. Splutter mustard seeds and sauté the sliced onions and curry leaves till the onions become light brown.

3.Next reduce heat, add chilli powder, coriander powder, chicken masala powder, ginger paste, garlic paste and saute for 2minutes.

4.Add the chopped tomato pieces along with little salt and saute well till the tomatoes are pulpy and mashed.

5. Add the potato and chicken pieces to the Clay pot and add 1 cup of water. Throw in the cilantro leaves

6. Reduce heat and simmer, covering the pan until the chicken is tender and cooked. This may take around 25-30 minutes depending on the chicken pieces used. Stir the chicken curry occasionally while it gets cooked.

7. Finally reduce heat, add coconut milk and stir gently. Simmer for another 2-3 minutes and remove the curry from stove top.

I hope you enjoy cooking as much as I do ! - Dr Jayaseel

Together, let's END this!

Dear Members,
We welcome any engaging articles, any personal experience you would love to share or something you are passionate about (besides Dentistry) and would love to share it with our readers.
Please do so !

Contact us : mpdpa1@gmail.com, for our next edition!