

9^{es} JOURNÉES ANNUELLES DE SANTÉ DENTAIRE PUBLIQUE,

Québec, jeudi, le 17 novembre 2005

OBJECTIFS DE LA PRÉSENTATION

POUR LES « AIDS » :

FOURNIR DES EXEMPLES DE PRATIQUES CLINIQUES
PRÉVENTIVES (PCP) QUI CONCERNENT LES « AIDS »

POUR LES DENTISTES :

PROPOSER UNE PLANIFICATION STRATÉGIQUE
DES ACTIVITÉS À RÉALISER EN VUE DE
PROMOUVOIR L'UTILISATION EFFICACE DES PCP'S

Cette présentation a été effectuée le 17 novembre 2005, au cours de la journée « Intégrer les pratiques préventives en santé dentaire dans les programmes clientèles : un apport considérable à la santé globale » dans le cadre des Journées annuelles de santé publique (JASP) 2005. L'ensemble des présentations est disponible sur le site des JASP, à l'adresse <http://www.inspq.qc.ca/jasp/archives/>.

OBJECTIFS DE LA PRÉSENTATION

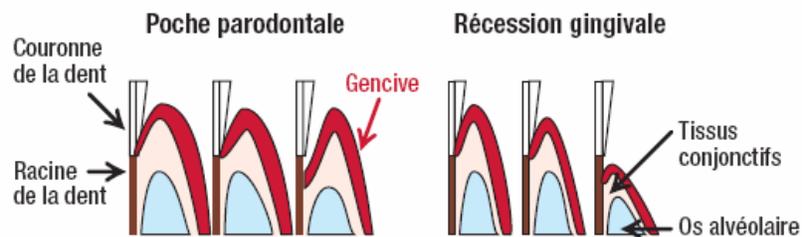
POUR LES « AIDS » :

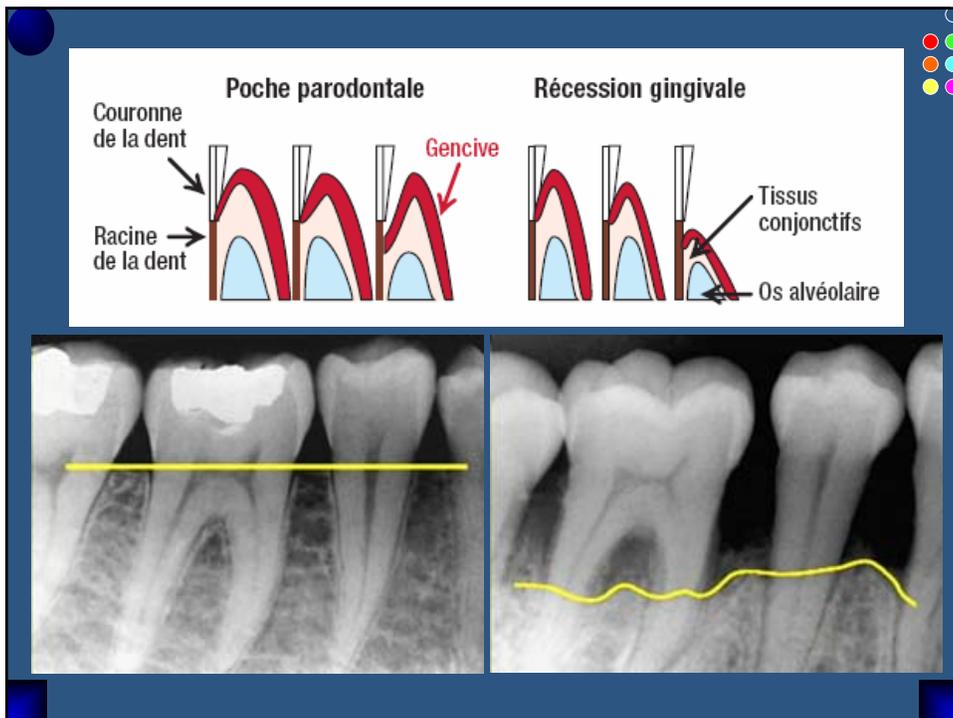
FOURNIR DES EXEMPLES DE PRATIQUES CLINIQUES PRÉVENTIVES (PCP) QUI CONCERNENT LES « AIDS »

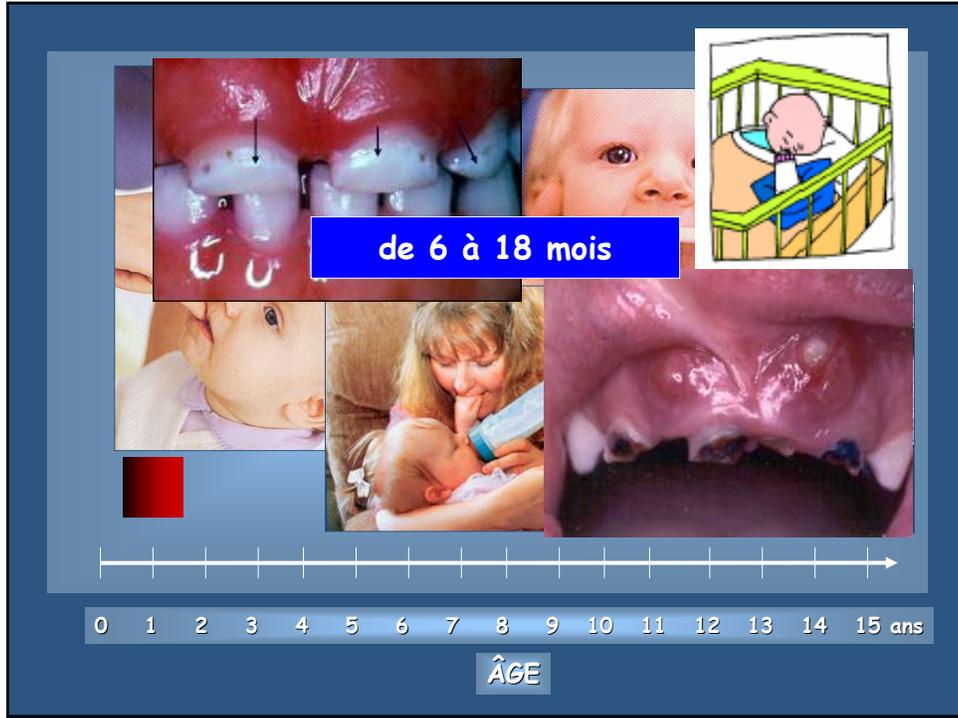
POUR LES DENTISTES :

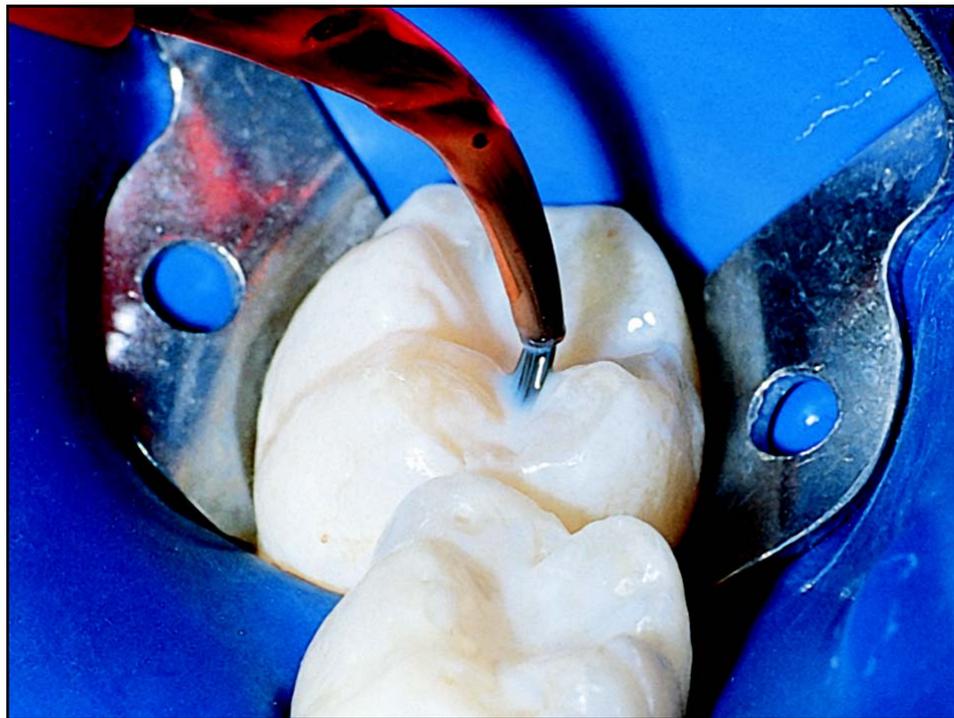
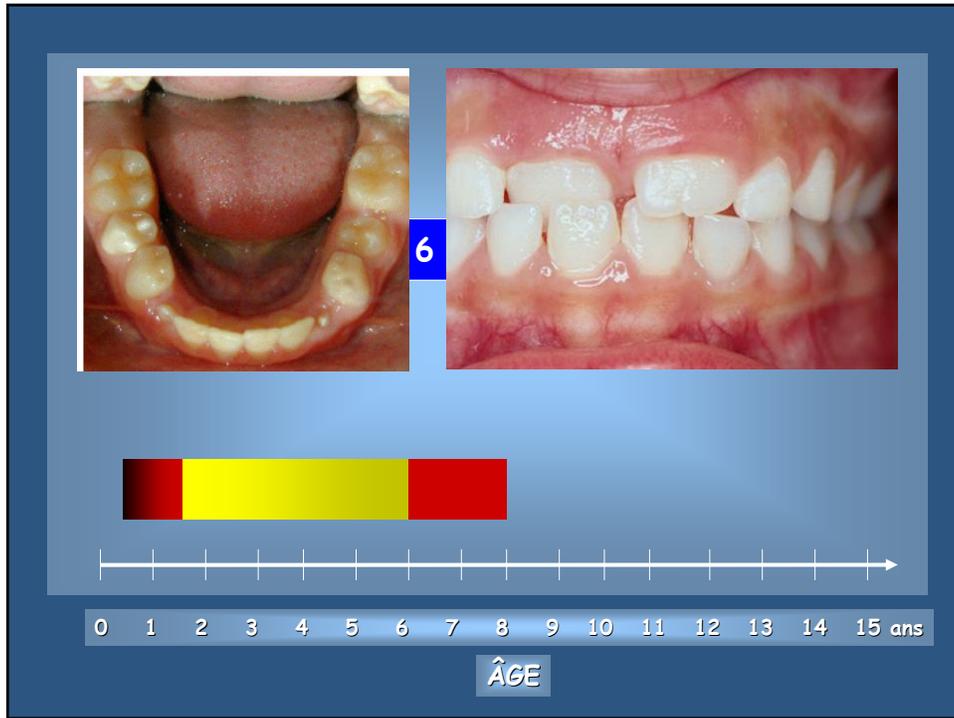
PROPOSER UNE PLANIFICATION STRATÉGIQUE DES ACTIVITÉS À RÉALISER EN VUE DE PROMOUVOIR L'UTILISATION EFFICACE DES PCP'S

PARODONTITE









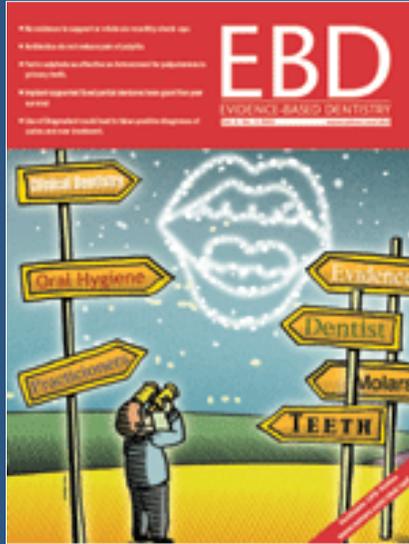


... ET
L'ÉVIDENCE
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QUI LES
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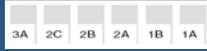
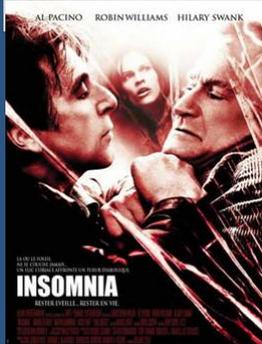
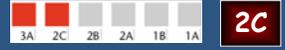


Table 1. Oxford Centre for Evidence-based Medicine levels of evidence (May 2001).

Level	Therapy/prevention/aetiology/harm	Prognosis	Diagnosis	Differential diagnosis/symptom prevalence study	Economic and decision analyses
4	Case-series (and poor-quality cohort and case-controlled studies)	Case-series (and poor-quality prognostic cohort studies)	Case-controlled study, poor or non-independent reference standard	Case-series or superseded reference standards	Analysis with no sensitivity analyses
5	Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"				

Note: Users can add a (-) to denote a study in a particular level that fails to provide a conclusive answer because of either: a single result with a wide CI (such that, for example, an absolute risk reduction (ARR) in an RCT is not statistically significant but whose CI fails to exclude clinically important benefit or harm); or an SR with troublesome (and statistically significant) heterogeneity; or the evidence is inconclusive, and therefore can only generate grade d recommendations.

SR, systematic review; RCT, randomised controlled trial; CDR, clinical decision rule algorithms or scoring systems that lead to a prognostic estimation or a diagnostic category.

*SpPin: An 'Absolute SpPin' is a diagnostic finding whose Specificity is so high that a Positive result rules-in the diagnosis.

*SnNout: An 'Absolute SnNout' is a diagnostic finding whose Sensitivity is so high that a Negative result rules-out the diagnosis.

*By homogeneity we mean a systematic review free of worrisome variations (heterogeneity) in the direction and degree of results between individual studies. Not all systematic reviews with statistically significant heterogeneity need be worrisome, and not all worrisome heterogeneity need be statistically significant. As noted above, studies displaying worrisome heterogeneity should be tagged (-) along with their designated level.

*Validating studies test the quality of a specific diagnostic test, based on prior evidence. An exploratory study collects information and trawls the data (eg, using a regression analysis) to find which factors are significant.

*Good reference standards are independent of the test, and applied blindly or objectively applied to all patients. Poor reference standards are haphazardly applied, but still independent of the test. Use of a nonindependent reference standard (where the test is included in the reference, or where the testing affects the reference) implies a level 4 study.

*Good follow-up in a differential diagnosis study is > 80%, with adequate time for alternative diagnoses to emerge (eg, 1-6 months acute, 1-5 years chronic).

*Met when all patients died before the treatment became available, but some now survive on it or when some patients died before the treatment became available, but none now die on it.

*Better-value treatments are clearly as good but cheaper, or better at the same or reduced cost. Worse-value treatments are as good and more expensive, or worse and equally or more expensive.

*5:1:1-sample validation is achieved by collecting all the information in a single tranche, then artificially dividing this into "derivation" and "validation" samples.

*Validating studies test the quality of a specific diagnostic test, based on prior evidence. An exploratory study collects information and trawls the data (eg, using a regression analysis) to find which factors are significant.

*Poor-quality cohort studies are ones that failed to clearly define comparison groups and/or failed to measure exposures and outcomes in the same (preferably blinded), objective way in both exposed and nonexposed individuals and/or failed to identify or appropriately control known confounders and/or failed to carry out a sufficiently long and complete follow-up of patients. Poor-quality case-control studies failed to define clearly comparison groups and/or failed to measure exposures and outcomes in the same (preferably blinded), objective way in both cases and controls and/or failed to identify or appropriately control known confounders.

*By poor-quality prognostic cohort study, we mean one in which sampling was biased in favour of patients who already had the target outcome, or the measurement of outcomes was accomplished in < 80% of study patients, or outcomes were determined in an unblinded, non-objective way, or there was no correction for confounding factors.

Richards, D. Not all evidence is created equal - so what is good evidence? *Evid Based Dent.* 2003; 4(1):17-18.

Bebermeyer, RD. Targeted supervised toothbrushing reduces caries increment. *Evid Based Dent.* 2003; 4(3): 50.

Clinical Guideline on Management of the developing Dentition and Occlusion in Pediatric Dentistry. American Academy of Pediatric Dentistry (AAPD). 2005.



Complete Summary

GUIDELINE TITLE

Clinical guideline on management of the developing dentition and occlusion in pediatric dentistry.

BIBLIOGRAPHIC SOURCE(S)

American Academy of Pediatric Dentistry (AAPD). Clinical guideline on management of the developing dentition and occlusion in pediatric dentistry. Chicago (IL): American Academy of Pediatric Dentistry (AAPD); 2005. 18 p. [133 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: American Academy of Pediatric Dentistry. Clinical guideline on management of the developing dentition in pediatric dentistry. Chicago (IL): American Academy of Pediatric Dentistry; 2001. 4 p.

www.guideline.gov/summary/pdf.aspx?doc_id=7494&stat=1&string=



La revue scientifique «Evidence-Based Dentistry » constitue un outil précieux dans la démarche entreprise par le réseau de santé dentaire publique au regard du dossier des pratiques cliniques préventives.



No.	Nom PCP	Cible	Evidence Scientif.	Univ. Sélective	%	Candidats / Commentaires
1.	Fluoration eau	Carie	Oui	U	100%	+ efficace, équitable, efficiente



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1.	Fluoration eau	Carie	Oui	U	100%	+ efficace, équitable, efficiente
2.	Suppl. de fluorure	Carie	Oui	S	7/25 %	Respect posologie, fluorose

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1.	Fluoration eau	Carie	Oui	U	100%	+ efficace, équitable, efficiente
2.	Suppl. de fluorure	Carie	Oui	S	7/25 %	Respect posologie, fluorose
3.	Brossage des dents	Carie + Paro	Non, mais...	U	100%	D.I. /carie, D.S. /gingivite

Abstract

Objectives To determine whether parachutes are effective in preventing major trauma related to gravitational challenge.

Design Systematic review of randomised controlled trials.

Data sources: Medline, Web of Science, Embase, and the Cochrane Library databases; appropriate internet sites and citation lists.

Study selection: Studies showing the effects of using a parachute during free fall.

Main outcome measure Death or major trauma, defined as an injury severity score > 15.

Results We were unable to identify any randomised controlled trials of parachute intervention.

Conclusions As with many interventions intended to prevent ill health, the effectiveness of parachutes has not been subjected to rigorous evaluation by using randomised controlled trials. Advocates of evidence based medicine have criticised the adoption of interventions evaluated by using only observational data. We think that everyone might benefit if the most radical protagonists of evidence based medicine organised and participated in a double blind, randomised, placebo controlled, crossover trial of the parachute.

<http://bmj.bmjournals.com/cgi/reprint/327/7429/1459?jkey=69d5013d2bf5f4edab5386f56a72ee52201ab3c9>

A call to (broken) arms

Only two options exist. The first is that we accept that, under exceptional circumstances, common sense might be applied when considering the potential risks and benefits of interventions. The second is that we continue our quest for the holy grail of exclusively evidence based interventions and preclude parachute use outside the context of a properly conducted trial. The dependency we have created in our population may make recruitment of the unenlightened masses to such a trial difficult. If so, we feel assured that those who advocate evidence based medicine and criticise use of interventions that lack an evidence base will not hesitate to demonstrate their commitment by volunteering for a double blind, randomised, placebo controlled, crossover trial.



La revue scientifique «Evidence-Based Dentistry » constitue un outil précieux dans la démarche entreprise par le réseau de santé dentaire publique au regard du dossier des pratiques cliniques préventives.



Il est souhaitable que la littérature scientifique supporte une pratique clinique préventive de façon adéquate, mais la qualité de l'évidence scientifique disponible ne fait pas toujours foi de tout.

Couleurs disponibles :

Repose-pouce à picots souples
Tête inclinée
Confort accru

Picots en caoutchouc proéminents au verso du manche
Large repose-pouce
Contrôle accru

Brossage hautement efficace et confort exceptionnel en une seule brosse à dents.

Toothbrush Development Timeline	
3000 B.C.	Egyptians use small branches with frayed ends to clean teeth
1400's	Chinese invent bristle toothbrush, made of Siberian wild boar hair fixed to a bamboo or bone handle
1600's	European travelers to China bring back toothbrush, replace wild boar hair with softer horse hair
1885	Companies began to mass produce manual toothbrushes
1938	First nylon bristles introduced
1950	Nylon bristles were made softer
1960	1 st electric toothbrush introduced in the U.S.
1987	1 st rotary action electric toothbrush for home use introduced
2000	Low-price power toothbrushes grow power brush market

3A 2C 2B 2A 1B 1A

In patient with orthodontic appliances are powered toothbrushes more effective than manual brushes in controlling plaque and gingivitis?

Practice point

- This study probably does not alter the Cochrane review finding that some types of powered toothbrushes have a small advantage over manual ones.

No difference in effectiveness of powered and manual toothbrushes?

Heanue M, Deacon SA, Deery C, et al. Manual Versus Powered Toothbrushing for Oral Health (Cochrane Review). The Cochrane Library 2003; Issue 1. Oxford: Update Software.

Thomas, D. No difference in effectiveness of powered and manual toothbrushes ? Evid Based Dent. 2003; 4(2):27.

Hickman J, Millett DT, Sander L, Brown E, Love J. Powered vs manual tooth brushing in fixed appliance patients: a short term randomised clinical trial. Angle Orthod 2002; 72:135-140

The Antimicrobial Action of Fluoride and its Role in Caries Inhibition

C. VAN LOVEREN

Department of Cariology & Endodontics, Academic Center for Dentistry Amsterdam (ACTA), Leisvanger 2, 1066 EA Amsterdam, The Netherlands

Despite a considerable amount of literature on the effects of fluoride in dental plaque, several questions remain unanswered, such as: Does the inhibiting effect of fluoride on dental plaque metabolism contribute to caries prevention? Does adaptation of plaque to fluoride affect its composition?

Single applications of fluoride directly to dental plaque reduced acid production, while fluoride delivered from specially treated enamel reduced the acid production in covering layers of oral bacteria in vivo. The effect of both treatments were only of short duration and may not be relevant to caries prevention in vivo. In contrast, daily application of fluoride resulted in a reduction of the acidogenicity of dental plaque even 8-12 h after the treatment. Such a reduction is likely to contribute to caries prevention. It is to be realized that with proper fluoride application, even the fluoride obtained from phosphate precipitates, enamel becomes available and an antimicrobial effect becomes operative. Field studies are done on the antimicrobial effect of fluoride exposure normally used in home care, in specially existing programs in schools, or in measures applied periodically over the months.

Adaptation of Streptococcus mutans to fluoride has been suggested to reduce the cariogenic potential of the cells. In vitro-derived fluoride resistance strains were also reported in vivo, and the ability of oral bacteria to adapt to fluoride, evidence of adaptation in dental plaque of normal plaque reacting as a reduced cariogenic potential has not yet been demonstrated.

J Dent Res 69(Spec Issue):676-81, February, 1990

Introduction

Demineralization and remineralization are the processes which determine the condition of tooth surfaces after eruption. Demineralization is caused by acids which are produced by bacteria in dental plaque. A microbial contribution to remineralization is not generally accepted, although remineralization will be enhanced by an elevated plaque pH resulting from the degradation of nitrogenous substrates (such as urea and amino acids) by bacterial enzymes (Kleinberg, 1967; Hara and Hara, 1974; Kleinberg et al., 1977; Sissons and Carron, 1988).

Fluoride is known to inhibit the energy and biosynthetic metabolism of bacteria (Bibby and Van Kesteren, 1946; Kalkar et al., 1977; Mitz and Fishback, 1982), but these antimicrobial effects of fluoride in caries prevention are often regarded as of little or no importance as compared with the direct interaction of fluoride with the hard tissue during caries development and progression (Chesson et al., 1988). However, it has to be realized *in vivo* evidence that fluoride has an antimicrobial effect in relation to the overall effect of fluoride on the dental plaque.

In vivo studies with oral lactic acid and streptococci have demonstrated adaptation of these organisms to fluoride resistance (Green and Dodd, 1975; Williams, 1984; Hara, 1986, 1989; Van Looven et al., 1990). However, it has been stated that data on adaptation *in vivo* are scarce. It has been stated

Presented at a Joint IADR/IGPCA International Symposium on Fluorides: Mechanisms of Action and Recommendations for Use, held March 21-24, 1989, Calgary, Calgary Conference Centre, Post Mountain, Calgary.

676

that, due to fluoride adaptation, the inhibition of acid production is unlikely to be important as a caries-preventive action of fluoride (Van der Hoeven and Franken, 1984). On the other hand, it has been proposed that the cariogenicity of plaque adapted to fluoride will be reduced (Loesche, 1982).

In this paper several topics will be reviewed and discussed concerning the effect of fluoride in dental plaque:

- (a) the inhibitory effect of both enamel-derived or topically applied fluoride on acid production in dental plaque;
- (b) the effect of plaque on the retention of fluoride in enamel;
- (c) the relevance of the inhibition of plaque acid production by fluoride for caries prevention; and
- (d) development of fluoride resistance and the consequences of that for plaque cariogenicity.

Effects of fluoride derived from enamel

In their review, Jansen and Edgar (1977) regarded plaque as a depot of fluoride available for incorporation into the enamel, rather than enamel fluoride as a source for plaque fluoride. This conclusion was based on the work of Grist et al. (1969), who found no evidence of fluoride uptake into dental plaque from shark enamel (Durogostine). Fluorapatite is not the only mineral which can be considered as a source for fluoride. Application of fluoride may result in the deposition of CaF₂ and any other soluble or slowly incorporated fluoride in the enamel (Shroedel, 1979; Mathberg et al., 1980; Dijkman et al., 1982). Subsequent dissolution of the soluble fluoride leads to a release of fluoride into the plaque (Dijkman et al., 1983; Balta and Ogawa, 1988).

In vitro experiments showed decreased acid production in suspensions of oral lactobacilli and oral streptococci in contact with fluoridated enamel or fluorapatite (Zwerner, 1957; Briner and Francis, 1962; Loomis and Loomis, 1962; Harper and Loesche, 1966). Removing the soluble fluoride from enamel suspensions treated with a fluoride liquid (Fluor Protector, Vivaldin, Schries, Lachemont) before incubation with a suspension of oral streptococci abolished almost completely the inhibitory effect of enamel fluoride on the acid production (Van Looven et al., 1984). Loomis et al. (1964) showed no difference in final pH in determining 5-minute lysis either covering enamel treated with Duraphat, a NaF varnish (Woolin Pharma GmbH at Co., 3400 Schwabing, FRG), but subsequently rinsed with water for 6 h for removal of absorbed fluoride and CaF₂, or covering non-fluoridated enamel. Incorporation of the eluted *in vivo* experiments is hampered by the buffering effect on pH which accompanies the dissolution of enamel. This buffering will support bacterial metabolism but, because less mineral dissolved in the presence of fluoride, acid production will be reduced. This inhibitory effect was not distinguished from the action of fluoride on bacterial metabolism. Therefore, these studies were not conclusive as to whether, or to what extent, fluoride itself caused the antimicrobial effect.

Inhibition of the metabolism in the cell suspensions in contact with fluoridated enamel was not permanent and disappeared rapidly (Griener, 1975; Van Looven et al., 1984).

« ... daily fluoride treatments should be performed shortly before the cariogenic challenges in order for an optimal optimal caries-preventive effect to be obtained.

To serve an optimal antimicrobial effect of fluoride, daily fluoride treatments should be performed shortly before the cariogenic challenges.»

Van Looven C. The antimicrobial action of fluoride and its role in caries inhibition, J Dent Res, 1990 Feb;69 Spec No:676-81.

preservation and restoration of tooth structure

Graham J. Mount, W.R. Hume

KJ Health



Notes

Brush teeth before or after eating.

Frequency of sugar intake is the major cause of caries.

First daily clean

The first oral hygiene routine should be carried out in the morning either before or after breakfast. The object is removal of plaque rather than the elimination of food debris so cleaning immediately before eating is just as effective as cleaning after a meal.

Tableau 4.1
Répartition des enfants âgés d'environ 5 mois, 17 mois et 29 mois selon certains comportements parentaux à l'égard de leur santé buccodentaire, Québec, 1998, 1999 et 2000

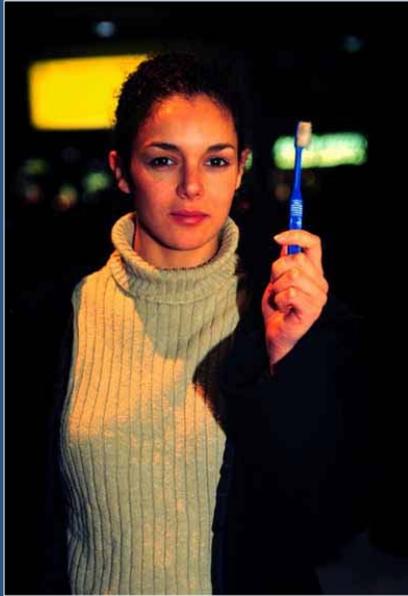
	5 mois		17 mois		29 mois	
	Oui	Non	Oui	Non	Oui	Non
	%					
L'utilisation du biberon	90,6	9,4	71,5	28,5	28,6	71,4
Pour endormir l'enfant au moment de la ou des siestes le jour ou la nuit	13,7	86,3	59,1	40,9	24,5	75,5
Pendant le sommeil de l'enfant au moment de la ou des siestes le jour ou la nuit	..	..	19,2	80,8	10,2	89,8
En période d'éveil ¹	...	...	42,9	57,1	16,8	83,2
Les collations sucrées						
Au moins deux collations par jour, au cours de la semaine précédant l'entrevue	...	...	..	..	25,7	74,3
L'utilisation d'une suce	..	..	45,5	54,5	23,4	76,6
Le brossage des dents	4,3	95,7	84,4	15,6	99,2	0,8 **
Au moins deux fois, le jour précédant l'entrevue	...	...	28,8	71,2	47,7	52,3
Brossage par un adulte	...	...	44,6	55,4	26,6	73,4
Brossage avec un dentifrice	...	...	44,3	55,7	90,4	9,6
La prise de suppléments de fluorure (seul ou en association avec des vitamines ou des minéraux)	1,7 *	98,3	14,9	85,1	7,6	92,4

1. En période d'éveil (ex. : pendant le jeu, devant la télévision, en se promenant, etc.)
* Coefficient de variation entre 15 % et 25 %; interpréter avec prudence.
** Coefficient de variation supérieur à 25 %; estimation imprécise fournie à titre indicatif seulement.
Source : Institut de la statistique du Québec, ÉLDEQ 1998-2002.

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	Oui	Non	Oui	Non	Oui	Non
	%					
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1.	Fluoration eau	Carie	Oui	U	100%	+ efficace, équitable, efficiente
2.	Suppl. de fluorure	Carie	Oui	S	7/25 %	Respect posologie, fluorose
3.	Brossage des dents	Carie + Paro	Non, mais...	U	100%	D.I. /carie, D.S. /gingivite
4.	Soie dentaire	Carie + Paro	Non, mais...	U	100%	D.I./carie, D.S./gingivite

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1.	Fluoration eau	Carie	Oui	U	100%	+ efficace, équitable, efficiente
2.	Suppl. de fluorure	Carie	Oui	S	?/25 %	Respect posologie, fluorose
3.	Brossage des dents	Carie + Paro	Non, mais...	U	100%	D.I. /carie, D.S. /gingivite
4.	Soie dentaire	Carie + Paro	Non, mais...	U	100%	D.I./carie, D.S./gingivite
5.	Brossage + Dent. Fluoré	Carie	Oui	U	100%	Facteur 1 baisse carie/monde

Consequently we still do not know whether toothpastes with higher fluoride concentrations would be preferable and, if so, whether they should be used generally or only by individuals at high risk of caries. The same uncertainty holds for the low-fluoride toothpastes. For infants and toddlers we need to balance the risk of developing carious lesions with the risk of dental fluorosis, and more evidence is still required with regard to optimal fluoride concentrations for children of different ages and with different levels of exposure to fluoride from other sources. Even the effect-modification by the daily frequency of brushing with fluoridated toothpaste needs to be studied in more detail. We know for sure that two times a day is better than once, but the marginal utility of each of the additional daily brushing times is not known. There is still a need for good quality RCT examining different aspects of fluoridated toothpastes.

Conclusions Supported by more than half a century of research, the benefits of fluoride toothpastes are firmly established. Taken together, the trials are of relatively high quality, and provide clear evidence that fluoride toothpastes are efficacious in preventing caries.

Practice point

- Fluoride toothpaste prevents caries and has a greater effect in people with more disease.

Hausen, H. Fluoride toothpaste prevents caries. Evid Based Dent. 2003; 4(2):28.

Indications: Formule au fluorure de sodium 1,1% comme dentifrice préventif de la carie pour les adultes et les enfants.

Mode d'emploi quotidien: (sauf directive contraire de votre professionnel des soins dentaires)

1. Enfants de 6 ans et plus et adultes: appliquer un mince ruban de PreviDent 5000 Plus sur la brosse. Bien brosser durant deux minutes, de préférence au coucher (ou selon les directives).
2. Après l'utilisation –Adultes: recracher. Éviter de manger, de boire ou de se rincer la bouche durant 30 minutes. Enfants: recracher et bien se rincer la bouche. Cette crème dentifrice peut remplacer votre dentifrice habituel sur recommandation de votre professionnel des soins dentaires.

Ingrédient actif: fluorure de sodium 1,1%

Ingrédients non-médicamenteux: (en ordre alphabétique): arôme, benzoate de sodium, dioxyde de silicone, eau, FD et C bleu n°1, gomme xanthane, polyéthylène glycol, pyrophosphate de tétrapotassium, saccharine de sodium, sorbitol, sulfate-lauryl sodique.

Précautions: NE PAS AVALER. Comme pour tous les médicaments, garder hors de la portée des enfants. Conserver à une température ambiante contrôlée (20-25°C).

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Colgate DIN 02210754 **Spearmint**

PreviDent® 5000 Plus™
 brand of **1.1% SODIUM FLUORIDE** Dental Cream

5000 ppm Fluoride Plus Cleaning System **NET WT. 51 g**

Indications: Formule au fluorure de sodium 1,1% comme dentifrice préventif de la carie pour les adultes et les enfants.

Mode d'emploi quotidien: (sauf directive contraire de votre professionnel des soins dentaires)

1. Enfants de 6 ans et plus et adultes: appliquer un mince ruban de PreviDent 5000 Plus sur la brosse. Bien brosser durant deux minutes, de préférence au coucher (ou selon les directives).
2. Après l'utilisation –Adultes: recracher. Éviter de manger, de boire ou de se rincer la bouche durant 30 minutes. Enfants: recracher et bien se rincer la bouche. Cette crème dentifrice peut remplacer votre dentifrice habituel sur recommandation de votre professionnel des soins dentaires.

Ingrédient actif: fluorure de sodium 1,1%

Ingrédients non-médicamenteux: (en ordre alphabétique): arôme, benzoate de sodium, dioxyde de silicone, eau, FD et C bleu n°1, gomme xanthane, polyéthylène glycol, pyrophosphate de tétrapotassium, saccharine de sodium, sorbitol, sulfate-lauryl sodique.

Précautions: NE PAS AVALER. Comme pour tous les médicaments, garder hors de la portée des enfants. Conserver à une température ambiante contrôlée (20-25°C).

Manufactured by/Fabriqué par: COLGATE ORAL PHARMACEUTICALS, INC. a subsidiary of/une filiale de Colgate-Palmolive Co. * Trademark reg'd Colgate-Palmolive Canada Inc.
 Distributed by/Distribué par: TransCanada Dental Ltd, Mississauga ON L5L 5Y7 Made in U.S.A./ Fabriqué aux É.-U. * Marque déposée de Colgate-Palmolive Canada

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 Please call us at: Appelez-nous à:
 1-800-999-2345
 N-F-T-L-Y-8-30-15-EST/PM

Colgate DIN 02210754 **Spearmint**

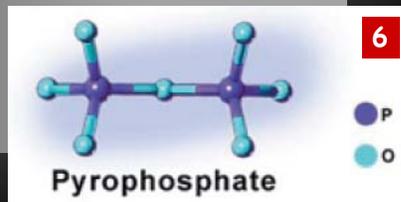
PreviDent® 5000 Plus™
 brand of **1.1% SODIUM FLUORIDE** Dental Cream

5000 ppm Fluoride Plus Cleaning System **NET WT. 51 g**

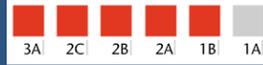
No.	Nom PCP	Cible	Evidence Scientif.	Univ. Sélective	%	Candidats / Commentaires
1.	Fluoration eau	Carie	Oui	U	100%	+ efficace, équitable, efficiente
2.	Suppl. de fluorure	Carie	Oui	S	?/25 %	Respect posologie, fluorose
3.	Brossage des dents	Carie + Paro	Non, mais...	U	100%	D.I. /carie, D.S. /gingivite
4.	Soie dentaire	Carie + Paro	Non, mais...	U	100%	D.I./carie, D.S./gingivite
5.	Brossage + Dent. Fluoré	Carie	Oui	U	100%	Facteur 1 baisse carie/monde
6.	Bross. + Dent. Pyrophosphate	Paro	Oui	S	[16,90 %]	*** Durée en bouche du Tx

FLUOR 5

Fluorure de sodium 0,243 % p/p, pyrophosphate de tétrasodium 2,16 % p/p, pyrophosphate tétrapotassique 4,42 % p/p, pyrophosphate disodique 1,65 % p/p



Is unsupervised use of a 0.3% triclosan/2% copolymer dentifrice effective in slowing the progression of periodontal disease in a normal adult population?



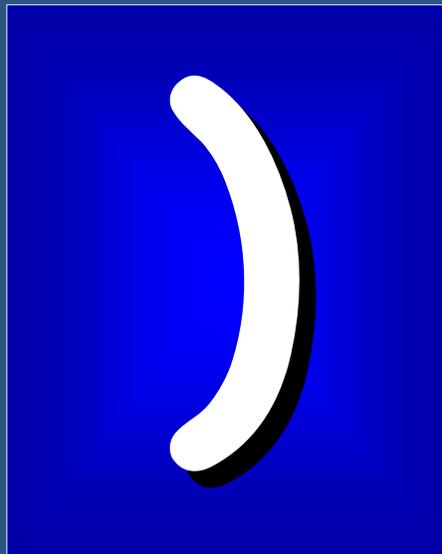
Triclosan-containing dentifrice may slow periodontal disease progression

Conclusions In a normal adult population, unsupervised use of a triclosan/copolymer dentifrice tended to slow progression of periodontal disease, and for patients with periodontal disease tended to reduce PPD.

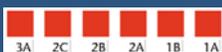
How might one apply these data to patient care? The NNT for subjects was around 100. In other words, 100 patients would need to be treated with the test toothpaste for one patient to benefit, compared with use of control toothpaste. Since the test toothpaste certainly reduces periodontal risk, if the costs of the toothpastes are similar, why not use it, as no harms have been reported? On the other hand, if the test toothpaste was significantly more expensive, then one might question its value compared with professional care.

Niederman, R. Triclosan-containing dentifrice may slow periodontal disease progression. *Evid Based Dent.* 2004; 5(4): 107.

Cullinan MP, Westerman B, Hamlet SM, Palmer JE, Faddy MJ, Seymour GJ. The effect of a triclosan-containing dentifrice on the progression of periodontal disease in an adult population. *J Clin Periodontol* 2003; 30:414-419



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5.	Brossage + Dent. Fluoré	Carie	Oui	U	100%	Facteur 1 baisse carie/monde
6.	Bross. + Dent. Pyrophosphate	Paro	Oui	S	[16,90 %]	*** Durée en bouche du Tx
7.	Appl. topique FI prof.	Carie	Oui	S	?/25%	Carie active ou risque élevé



For the prevention of caries in children is there is a beneficial effect of adding topical fluoride therapy (TFT) in the form of mouthrinse, gel or varnish to fluoride toothpaste?

Topical fluorides provide additional benefit when used with fluoride toothpaste

Conclusions Topical fluorides (mouthrinses, gels, or varnishes) used in addition to fluoride toothpaste achieve a modest reduction in caries compared to toothpaste used alone. No conclusions about any adverse effects could be reached, because data were scarcely reported in the trials.



Monopoli, M. Topical fluorides provide additional benefit when used with fluoride toothpaste. *Evid Based Dent.* 2004; 5(2):38.

Marinho VCC, Higgins JPT, Sheiham A, Logan S. *Combinations of topical fluoride (toothpastes, mouthrinses, gels, varnishes) versus single topical fluoride for preventing dental caries in children and adolescents (Cochrane Review).* In: *The Cochrane Library, Issue 1, 2004.* Chichester, UK: John Wiley & Sons, Ltd.

Are topical fluoride treatments (TFT; toothpastes, mouthrinses, gels or varnishes) effective in reducing dental caries in children and adolescents?

Benefits of topical fluorides firmly established

Table 2. Pooled estimate of treatment effect between different types of TFT from placebo controlled trials.

TFT	Preventive fraction	95% Confidence interval
Varnish	40%	9–72%
Gel	21%	14–28%
Rinse	26%	22–29%
Toothpaste	24%	21–28%
Overall	26%	23–29%

Practice point

- Children and adolescents benefit from topical fluorides irrespective of water fluoridation or other sources of fluoride exposure.

Hausen, H. Benefits of topical fluorides firmly established. Evid Based Dent. 2004; 5(2):36-37.



Conclusions There is some evidence that the use of topical fluoride or fluoride-containing bonding materials during orthodontic treatment reduces the occurrence and severity of white spot lesions, but there is little evidence regarding which method or combination of methods is most effective for fluoride delivery. Based on current best practice in other areas of dentistry for which there is evidence, we recommend that patients with fixed braces rinse daily with a 0.05% sodium fluoride mouthrinse. More high-quality, clinical research is required into the different modes of delivering fluoride to the orthodontic patient.

Practice point

- Local fluoride delivery during orthodontic treatment reduces white spot lesions, but more evidence is needed on the best delivery method.

Is fluoride gel effective at preventing caries in low caries-risk children?



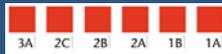
Fluoride gel inhibits caries in children who have low caries-risk but this may not be clinically relevant

Practice point

- Although this study provides evidence of a significant beneficial effect of fluoride gel treatment in the permanent teeth of young children at low risk of caries, the clinical relevance is considered low based on the large NNTs obtained from the trial.

Marinho, V. Fluoride gel inhibits caries in children who have low caries-risk but this may not be clinically relevant. *Evid Based Dent.* 2004; 5(4): 95.

van Rijkom HM, Truin GJ, van't Hof MA. Caries-inhibiting effect of professional fluoride gel application in low-caries children initially aged 4.5–6.5 years. *Caries Res* 2004; 38:115–123



UN RAPPEL

For the prevention of caries in children is there is a beneficial effect of adding topical fluoride therapy (TFT) in the form of mouthrinse, gel or varnish to fluoride toothpaste?

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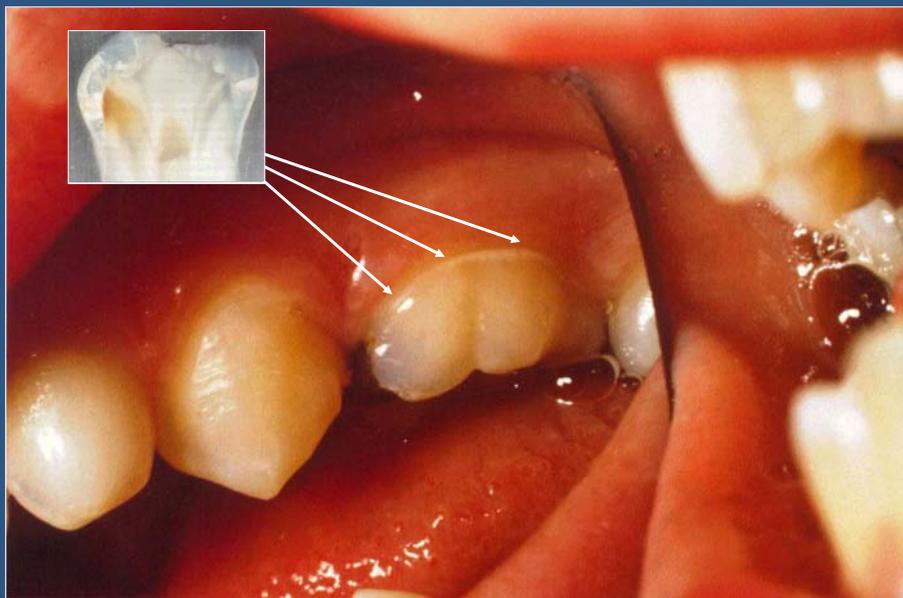
USAGE PROFESSIONNEL

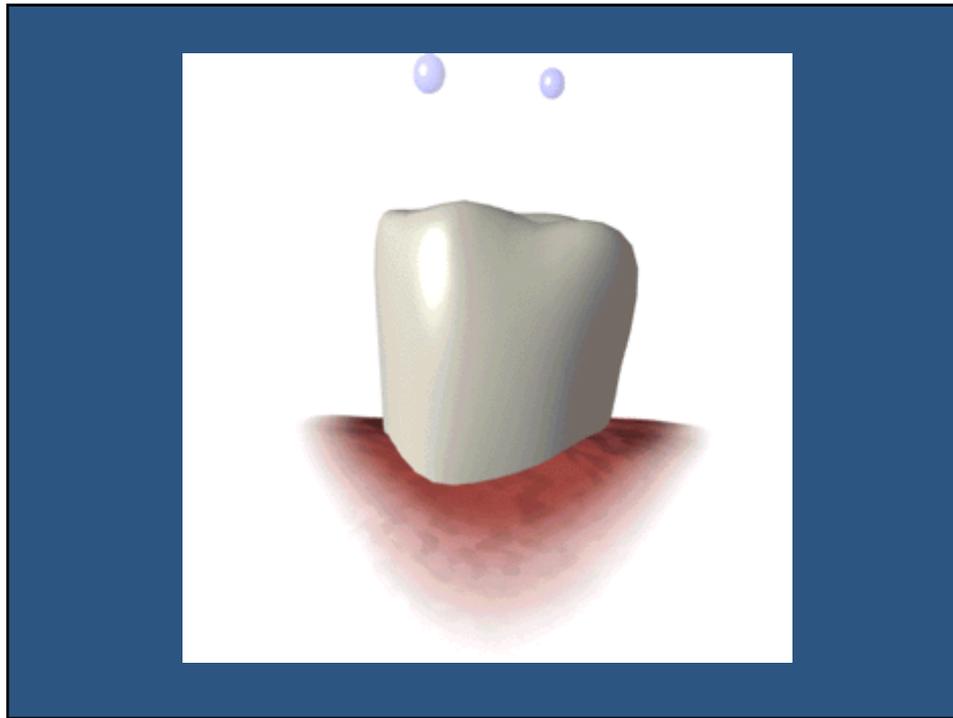
Pâtes NaF	[4,000, 20,000 ppm]
Gels fluorés : SnF ₂ et APF	[4,000, 12,300 ppm]
Solutions fluorées : NaF, SnF ₂ et APF	[9,200, 19,500 ppm]
Vernis fluoré	12,300 ppm

USAGE À LA MAISON

Gels fluorés SnF ₂ , APF et NaF	[1,000, 5,000 ppm]
Rince-bouche fluoré 0,2 %	920 ppm
Rince-bouche fluoré 0,05 %	230 ppm
Dentifrice fluoré Prevident	5,000 ppm
Dentifrice régulier NaF	1,100 ppm

Newbrun, E. Current regulations and recommendations concerning water fluoridation, fluoride supplements, and topical fluoride agents. J Dent Res. 1992; 71(5): 1255-65.





No.	Nom PCP	Cible	Evidence Scientif.	Univ. Sélective	%	Candidats / Commentaires
1.	Fluoration eau	Carie	Oui	U	100%	+ efficace, équitable, efficiente
2.	Suppl. de fluorure	Carie	Oui	S	?/25 %	Respect posologie, fluorose
3.	Brossage des dents	Carie + Paro	Non, mais...	U	100%	D.I. /carie, D.S. /gingivite
4.	Soie dentaire	Carie + Paro	Non, mais...	U	100%	D.I./carie, D.S./gingivite
5.	Brossage + Dent. Fluoré	Carie	Oui	U	100%	Facteur 1 baisse carie/monde
6.	Bross. + Dent. Pyrophosphate	Paro	Oui	S	[16,90 %]	*** Durée en bouche du Tx
7.	Appl. topique Fl prof.	Carie	Oui	S	?/25%	Carie active ou risque élevé
8.	Bouteille au DODO	Carie	Non/Oui	?	?	Principale cause ECC

No.	Nom PCP	Cible	Evidence Scientif.	Univ. Sélective	%	Candidats / Commentaires
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9.	Prophylaxie profess.	Carie + Paro	Oui/Non	S	?	Raisons non spécifiées

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8.	Bouteille au DODO	Carie	Non/Oui	?	?	Principale cause ECC
9.	Prophylaxie profess.	Carie + Paro	Oui/Non	S	?	Raisons non spécifiées
10.	Counselling tabac	Cancer buccal	Oui	U,S	100%	Ajouter parodontopathies

LE COUNSELLING TABAGIQUE EN CABINET DENTAIRE



**SAVOIR,
SAVOIR FAIRE,
SAVOIR ÊTRE**

No.	Nom PCP	Cible	Evidence Scientif.	Univ. Sélective	%	Candidats / Commentaires
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7.	Appl. topique Fl prof.	Carie	Oui	S	7/25%	Carie active ou risque élevé
8.	Bouteille au DODO	Carie	Non/Oui	?	?	Principale cause ECC
9.	Prophylaxie profess.	Carie + Paro	Oui/Non	S	?	Raisons non spécifiées
10.	Counselling tabac	Cancer buccal	Oui	U,S	100%	Ajouter parodontopathies
11.	R-B Fluoré	Carie	Oui	S	?	Caries actives + risque élevé

FONDÉ SUR L'ÉVIDENCE SCIENTIFIQUE

RINCE-BOUCHE FLUORÉ

Conclusions This review shows that the supervised regular use of fluoride mouthrinse at two main strengths and rinsing frequencies is associated with a reduction in caries increment in children. There is a need for complete reporting of side-effects and acceptability data in fluoride mouthrinse trials.

Practice points

- Fluoride rinses reduce caries.
- Fluoride rinses are more effective in high caries areas.
- Background fluoride use has little influence on the preventive effect of fluoride rinses.

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6.	Bross. + Dent. Pyrophosphate	Paro	Oui	S	[16,90 %]	*** Durée en bouche du Tx
7.	Appl. topique Fl prof.	Carie	Oui	S	?/25%	Carie active ou risque élevé
8.	Bouteille au DODO	Carie	Non/Oui	?	?	Principale cause ECC
9.	Prophylaxie profess.	Carie + Paro	Oui/Non	S	?	Raisons non spécifiées
10.	Counselling tabac	Cancer buccal	Oui	U,S	100%	Ajouter parodontopathies
11.	R-B Fluoré	Carie	Oui	S	?	Caries actives + risque élevé
12.	Scellants dentaires	Carie	Oui	S	50 %	Prochaine grande étape

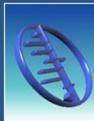
Are pit and fissure sealants effective in preventing decay in children and adolescents who are at risk of caries?



Sealants recommended to prevent caries

Practice points

- Sealants based on resins are effective for prevention of caries on occlusal surfaces of permanent molars.
- More research is needed to clarify the effectiveness of glass ionomer sealants in caries prevention.



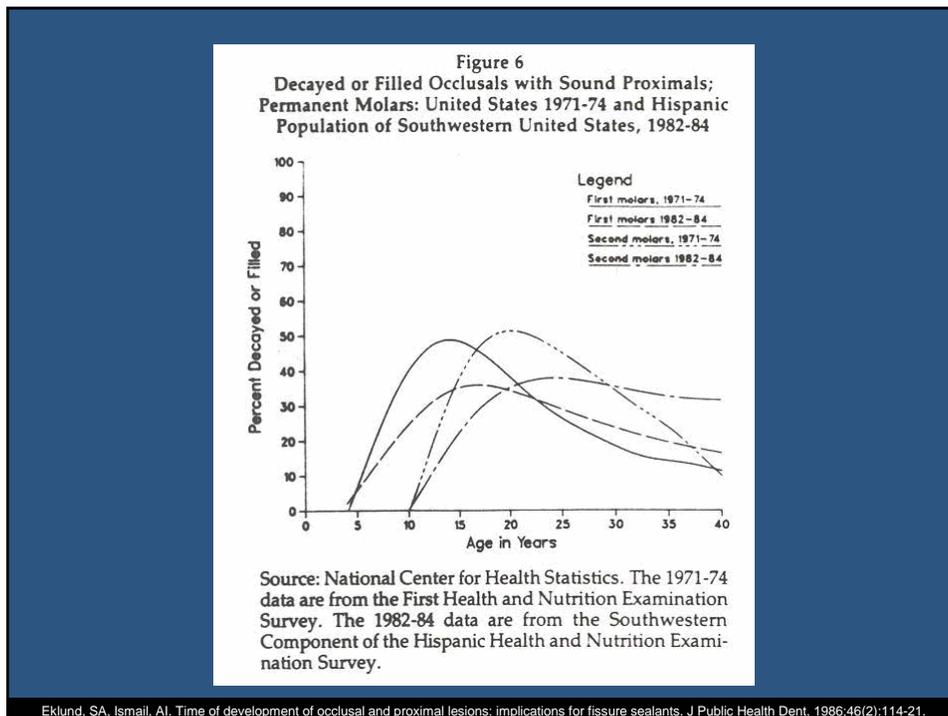
Uribe, S. Sealants recommended to prevent caries. Evid Based Dent. 2004; 5(4):93-94.

Mejare I, Lingstrom P, Petersson LG, Holm AK, Twetman S, Kallestall C, et al. Caries-preventive effect of fissure sealants: a systematic review. Acta Odontol Scand 2003; 61:321-330.

Ahovuo-Saloranta A, Hiiri A, Nordblad A, Worthington H, Mäkelä M. Pit and fissure sealants for preventing dental decay in the permanent teeth of children and adolescents (Cochrane Review). In the Cochrane Library. Chichester: John Wiley; 2004, Issue 3.

ÂGE	NHANES 1971-74			HHANES 1982-84		
	Occl M-1	Proximal	Occl / Prox sain	Occl M-1	Proximal	Occl / Prox sain
5	1	0	1	0	0	0
6	6	0	6	3	0	3
7	12	1	11	8	0	8
8	29	1	28	14	0	14
9	40	4	36	24	1	23
10	47	4	43	28	2	26
11	50	7	43	37	4	33
12	56	7	49	41	4	37
13	62	14	48	49	7	42
14	63	12	51	42	5	37
15	62	12	50	50	9	41
16	66	21	45	51	10	41
17	65	22	43	58	13	45
18	69	23	46	43	10	33
19	66	27	39	47	13	34
20	68	27	41	42	13	29
21	65	31	34	43	14	29
22	64	36	28	43	16	27
23	64	31	33	42	14	28
24	65	38	27	57	22	35
25	62	36	26	45	18	27

Source : Eklund, S.A., Ismail, A.I. Time of development of occlusal and proximal lesions: implications for fissure sealants. J Public Health Dent. 1986 Spring;46(2):114-21.



ÂGE	NHANES 1971-74			HHANES 1982-84		
	Occl M-1	Proximal	Occl / Prox sain	Occl M-1	Proximal	Occl / Prox sain
5	1	0	1	0	0	0
6	6	0	6	3	0	3
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13	62	14	48	49	7	42
14	63	12	51	42	5	37
15	62	12	50	50	9	41
16	66	21	45	51	10	41
17	65	22	43	58	13	45
18	69	23	46	43	10	33
19	66	27	39	47	13	34
20	68	27	41	42	13	29
21	65	31	34	43	14	29
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Source : Eklund, S.A., Ismail, A.I. Time of development of occlusal and proximal lesions: implications for fissure sealants. J Public Health Dent. 1986 Spring;46(2):114-21.



Carvalho JC, Ekstrand KR, Thylstrup A. Dental plaque and caries on occlusal surfaces of first permanent molars in relation to stage of eruption. *J Dent Res*. 1989; 68(5): 773-9.

Carvalho JC, Ekstrand KR, Thylstrup A. Results after 1 year of non-operative occlusal caries treatment of erupting permanent first molars. *Community Dent Oral Epidemiol*. 1991; 19(1): 23-8.

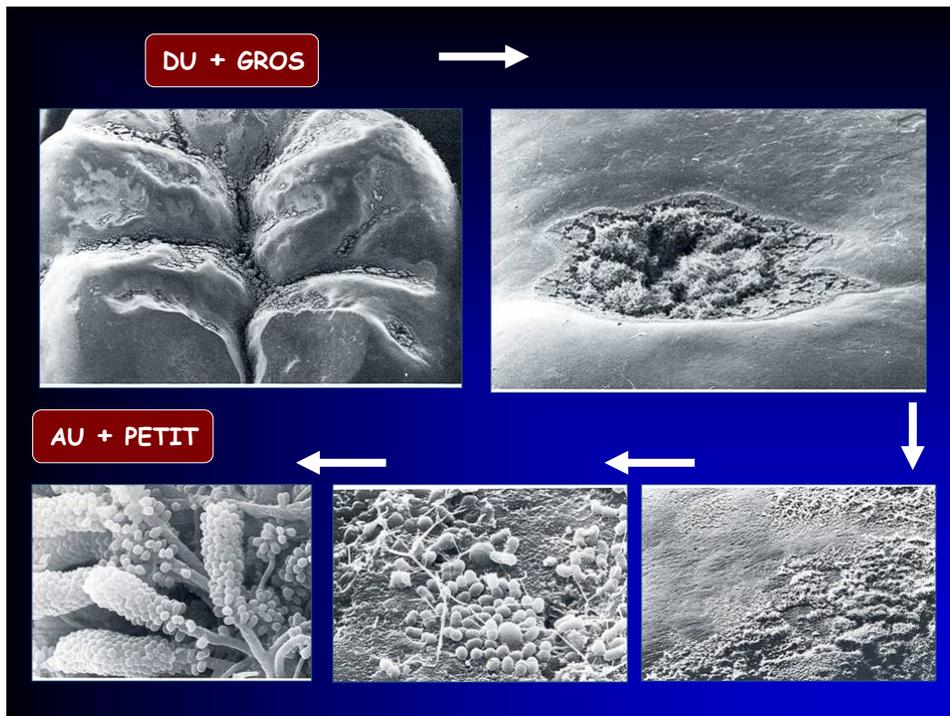
Carvalho JC, Thylstrup A, Ekstrand KR. Results after 3 years of non-operative occlusal caries treatment of erupting permanent first molars. *Community Dent Oral Epidemiol*. 1992; 20(4): 187-92.

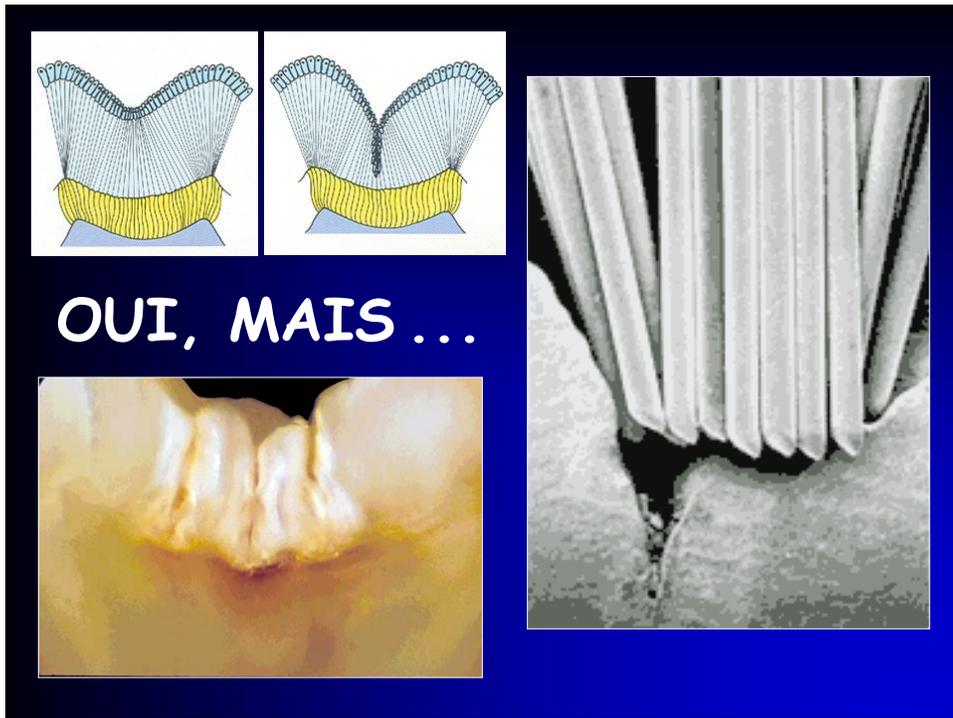
Thylstrup A, Vinther D, Christiansen J. Promoting changes in clinical practice. Treatment time and outcome studies in a Danish public child dental health clinic. *Community Dent Oral Epidemiol*. 1997; 25(1): 126-34.

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Ekstrand KR, Christiansen J, Christiansen ME. Time and duration of eruption of first and second permanent molars: a longitudinal investigation. *Community Dent Oral Epidemiol*. 2003; 31(5): 344-50.

www.nexodent.dk/referenc.html





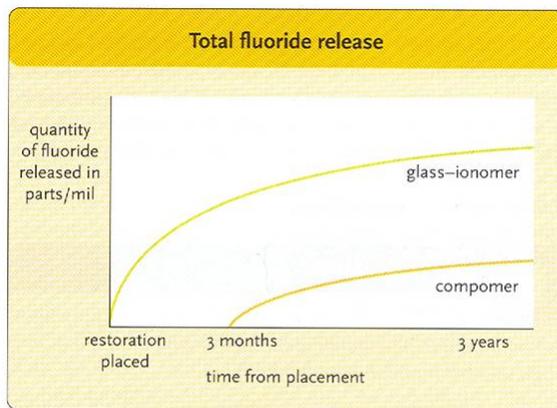
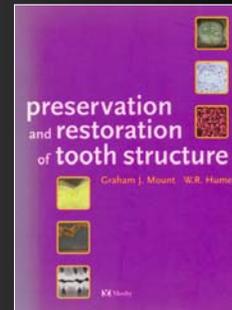


Fig. 8.21 Total fluoride release. A graph showing total fluoride release over time for the average glass-ionomer compared with a compomer which does not begin to release fluoride for the first 3 months after placement. The amount released thereafter is insignificant, and remains so.



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8.	Bouteille au DODO	Carie	Non/Oui	?	?	Principale cause ECC
9.	Prophylaxie profess.	Carie + Paro	Oui/Non	S	?	Raisons non spécifiées
10.	Counselling tabac	Cancer buccal	Oui	U,S	100%	Ajouter parodontopathies
11.	R-B Fluoré	Carie	Oui	S	?	Caries actives + risque élevé
12.	Scellants dentaires	Carie	Oui	S	50 %	Prochaine grande étape
13.	Détartrage professionnel	Paro	Oui	S	[16,90%]	Facteur étiologique reconnu

How effective is mechanical nonsurgical pocket therapy?



Conclusive support for mechanical nonsurgical pocket therapy in the treatment of periodontal disease

Despite the lack of evidence supporting the effect or efficacy of mechanical nonsurgical periodontal therapy, clinical experience tells us that this is the best single therapy option available. Until such time as there is sound evidence of efficiency, we must continue to use the information we have from clinical research, together with our best clinical judgment (with all its inherent biases) as to when, where, and in whom mechanical therapy is required.

Matthews, D. Conclusive support for mechanical nonsurgical pocket therapy in the treatment of periodontal disease. *Evid Based Dent.* 2005;6(3):68-9.

Albucasis. *La Chirurgie*. Translated by L. LeClere. Paris: Baillière, 1861.
Hirschfeld L, Wasserman B. A long-term survey of tooth loss in 600 treated periodontal patients. *J Periodontol* 1978; 49:225-237.

Suvan JE. *Effectiveness of mechanical nonsurgical pocket therapy. Periodontol* 2000 2005; 37:48-71

What are the benefits and harms of routine scaling and polishing for periodontal health and do these change with different time intervals?



Insufficient evidence to understand effect of routine scaling and polishing

Commentary

Seldom has a Cochrane review addressed a question with such relevance to dental practice. It is therefore disappointing, although understandable, that the review finds the available evidence to be inadequate for any conclusions to be drawn.



If practitioners draw the likely conclusion that there is no support for any recall regimen based on fixed intervals between scale and polishing that does not include an evaluation of clinical outcomes, then the most important implication of the review will have been successfully transferred. It will then be on their shoulders to complete the transfer into their practices.

Badre, J. Insufficient evidence to understand effect of routine scaling and polishing. *Evid Based Dent.* 2005;6(1):5-6.

Beirne P, Forgie A, Worthington HV, Clarkson JE. *Routine scale and polish for periodontal health in adults (Cochrane Review)*. In *the Cochrane Library*. 2005; Issue 1, Chichester: John Wiley

No.	Nom PCP	Cible	Evidence Scientif.	Univ. Sélective	%	Candidats / Commentaires
1.	Fluoration eau	Carie	Oui	U	100%	+ efficace, équitable, efficiente
2.	Suppl. de fluorure	Carie	Oui	S	?/25 %	Respect posologie, fluorose
3.	Brossage des dents	Carie + Paro	Non, mais...	U	100%	D.I. /carie, D.S. /gingivite
4.	Soie dentaire	Carie + Paro	Non, mais...	U	100%	D.I./carie, D.S./gingivite
5.	Brossage + Dent. Fluoré	Carie	Oui	U	100%	Facteur 1 baisse carie/monde
6.	Bross. + Dent. Pyrophosphate	Paro	Oui	S	[16,90 %]	*** Durée en bouche du Tx
7.	Appl. topique Fl prof.	Carie	Oui	S	?/25%	Carie active ou risque élevé
8.	Bouteille au DODO	Carie	Non/Oui	?	?	Principale cause ECC
9.	Prophylaxie profess.	Carie + Paro	Oui/Non	S	?	Raisons non spécifiées
10.	Counselling tabac	Cancer buccal	Oui	U,S	100%	Ajouter parodontopathies
11.	R-B Fluoré	Carie	Oui	S	?	Caries actives + risque élevé
12.	Scellants dentaires	Carie	Oui	S	50 %	Prochaine grande étape
13.	Détartrage professionnel	Paro	Oui	S	[16,90%]	Facteur étiologique reconnu
14.	R-B chlorhexidine	Paro	Oui	S	?	Difficultés brossage / OM.



In susceptible teenagers is chlorhexidine varnish more effective than a fluoride varnish in preventing caries?

Table 1. Mean DMFS at baseline and 3 years.

Treatment	Baseline (n)	End of study (n)	Mean baseline caries DMFS (SD)	Mean caries increment at 3 years DMFS (SD)
Fluoride varnish	90	84	2.11 (3.38)	2.81 (3.69)
Chlorhexidine/thymol varnish	90	82	2.57 (3.95)	3.08 (3.71)

DMFS, decayed, missing and filled surfaces; SD, standard deviation.

Practice point

- This study does not provide compelling evidence that a 1% chlorhexidine plus 1% thymol varnish offers any advantage over a 0.1% fluoride varnish for approximal dental caries prevention.

No difference between topical chlorhexidine and fluoride varnishes in preventing caries?

Banting, D. No difference between topical chlorhexidine and fluoride varnishes in preventing caries ? Evid Based Dent. 2003; 4(1):12.

Petersson LG, Magnusson K, Andersson H, Almquist B, Twetman S. Effect of quarterly treatments with a chlorhexidine and a fluoride varnish on approximal caries. Caries Res 2000; 34:140-143

Conclusions

From this review of this literature, it is apparent that, CHX and FI (specifically NaF) can be combined without losing their individual properties. For certain high-risk groups these formulations may be essential to oral health

Table 3
Practical Recommendations for Combined Use of Fluoride and Chlorhexidine

1. When toothpaste containing sodium lauryl sulphate is used, CHX rinse should be used a minimum of 30 minutes before or after brushing with the toothpaste.
2. When toothpaste containing sodium fluoride and no sodium lauryl sulphate is used, brushing can immediately follow the CHX rinse.
3. When two mouthrinses are used together, use the CHX first followed by the NaF rinse. The NaF rinse can be used immediately after the CHX rinse. Brushing with regular toothpaste containing sodium lauryl sulphate is again recommended only after a minimum of 30 minutes.

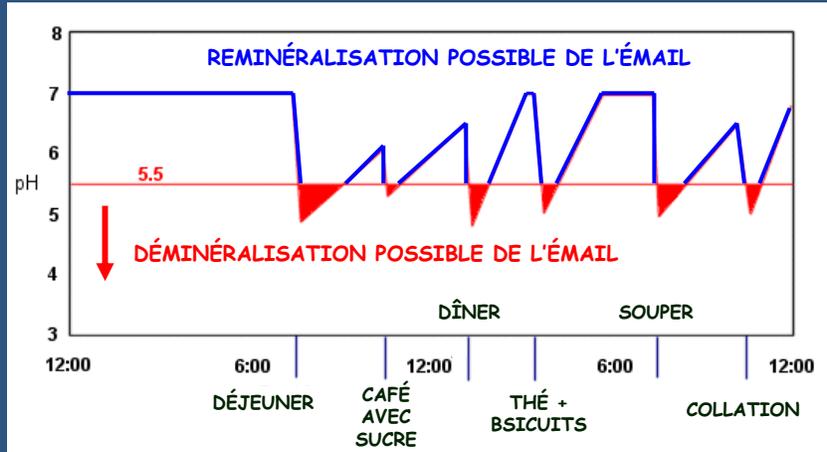
Donnelly, L., Craig, HS. A rationale for combining chlorhexidine and fluoride. Oral Health. 2000; 11 : 31 -37.

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6.	Bross. + Dent. Pyrophosphate	Paro	Oui	S	[16,90 %]	*** Durée en bouche du Tx
7.	Appl. topique FI prof.	Carie	Oui	S	?/25%	Carie active ou risque élevé
8.	Bouteille au DODO	Carie	Non/Oui	?	?	Principale cause ECC
9.	Prophylaxie profess.	Carie + Paro	Oui/Non	S	?	Raisons non spécifiées
10.	Counselling tabac	Cancer buccal	Oui	U,S	100%	Ajouter parodontopathies
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14.	R-B chlorhexidine	Paro	Oui	S	?	Difficultés brossage / OM.
15.	R-B Listerine ^{MC}	Paro	Oui	S	?	Gingivite sévère



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15.	R-B Listerine ^{MC}	Paro	Oui	S	?	Gingivite sévère
16.	Counselling alim. (sucre)	Carie	Non/Oui	S	?/25%	Risque élevé/Importance moindre

FRÉQUENCE DES ATTAQUES CARIÉUSES SUR UNE PÉRIODE DE 24 HEURES



1



versus



2



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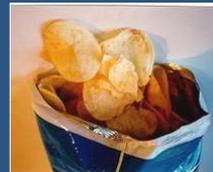


LE FROMAGE
NE FAIT QU'UNE
BOUCHÉE
DE LA CARIE

3



4



Can dietary measures assist in the prevention of dental caries?

Dietary factors and dental caries

Conclusions The review clearly demonstrates the need for well-designed randomised clinical studies, with adequate control groups and high compliance, looking at the effect of dietary measures on dental caries.

Looking at the broader context today, the role of good nutrition in improving the health of the population cannot be disputed.



Stillman-Lowe, C. Dietary factors and dental caries. *Evid Based Dent.* 2005; 6(1):7-8.

UN RAPPEL

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4.	Soie dentaire	Carie + Paro	Non, mais...	U	100%	D.I./carie, D.S./gingivite
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7.	Appl. topique Fl prof.	Carie	Oui	S	2/25%	Carie active ou risque élevé
8.	Bouteille au DODO	Carie	Non/Oui	?	?	Principale cause ECC
9.	Prophylaxie profess.	Carie + Paro	Oui/Non	S	?	Raisons non spécifiées
10.	Counselling tabac	Cancer buccal	Oui	U,S	100%	Ajouter parodontopathies
11.	R-B Fluoré	Carie	Oui	S	?	Caries actives + risque élevé
12.	Scellants dentaires	Carie	Oui	S	50 %	Prochaine grande étape
13.	Détartrage professionnel	Paro	Oui	S	[16,90%]	Facteur étiologique reconnu
14.	R-B chlorhexidine	Paro	Oui	S	?	Difficultés brossage / OM .
15.	R-B Listerine ^{MC}	Paro	Oui	S	?	Gingivite sévère
16.	Counselling alim. (sucre)	Carie	Non/Oui	S	2/25%	Risque élevé/Importance moindre
17.	Dépistage examen clinique	Cancer buc.	Non/Oui	S	> 65 ans	Risque élevé seulement

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16.	Counselling alim. (sucre)	Carie	Non/Oui	S	?/25%	Risque élevé/Importance moindre
17.	Dépistage examen clinique	Cancer buc.	Non/Oui	S	> 65 ans	Risque élevé seulement
18.	Dépistage par MD (gencives)	Paro	Non	S	?	Régions sans DMD

Comment dépister une parodontite ?

	A l'anamnèse	A l'examen objectif	Niveau de signification clinique
1. Saignement des gencives au moment du brossage des dents ou de l'utilisation de la soie dentaire	★ X		Signe de gingivite
2. Apparence des gencives (rougeur, œdème)		X	Signe de gingivite
3. Halitose (mauvaise haleine)	X	X	Signe évocateur de parodontite
4. Mauvaise hygiène buccale		X	Signe évocateur de parodontite
5. Sensibilité des gencives	X		Signe évocateur de parodontite
6. Sensibilité des dents au chaud et au froid	X		Signe évocateur de parodontite
7. Édentation partielle	X	X	Signe évocateur de parodontite
8. Antécédents familiaux d'édentation	X		Signe évocateur de parodontite (maladie héréditaire ?)
9. Tendance à faire des ulcères buccaux	X		Signe évocateur de parodontite (maladie générale ?)
10. Âge*	X		Signe évocateur de parodontite
11. Tartre	★	X	En cause dans les parodontites
12. Récession gingivale	★	X	Signe de parodontite
13. Pus autour de la dent		X	Signe de parodontite
14. Destruction des papilles interdentaires	★	X	Signe de parodontite avancée
15. Mobilité accrue ou excessive des dents	X	X	Signe de parodontite avancée

* Les signes cliniques associés aux parodontites tendent à augmenter avec l'âge et deviennent plus évidents à partir de la trentaine.



Picard, D. Pourquoi et comment dépister la plus fréquente des infections buccales ? Le médecin du Québec, 2004; 39 (7) : 51 – 57.
www.fmoq.org/Documents/MedecinDuQuebec/051-57Picard0704.pdf

Environ la moitié de la population québécoise âgée de 35 à 44 ans montre des signes évidents d'une maladie parodontale. À l'échelle mondiale, la prévalence et la sévérité des maladies parodontales tendent à augmenter avec l'âge.

Environ un adulte québécois sur cinq souffrira un jour d'une parodontite sévère pouvant même impliquer la perte de dents.

Environ le tiers des québécois âgés entre 35 et 44 ans n'ont pas consulté de dentiste au cours de la dernière année. Ce pourcentage augmente avec l'âge pour atteindre environ les deux tiers de la population, après l'âge de 65 ans.

Noninflammatory destructive periodontal disease (NDPD)
ROY C. PAGE & EDWARD C. STURDIVANT

Page, RC, Sturdivant, EC. Noninflammatory destructive periodontal disease (NDPD). *Periodontol* 2000. 2002; 30: 24-39.

The present paper questions the validity of the concept that *all* forms of destructive periodontal disease are infectious, and that they are *all* characterized by chronic inflammation, pocket formation and progressive deepening, and loss of attachment and alveolar bone. We suggest the existence of at least one form of severe destructive periodontal disease that is not recognized in the recent classifications. In this form of periodontal disease, loss of attachment, resorption of alveolar bone and tooth loss occur, but gingival inflammation and pocket formation and deepening are not prominent features; antimicrobial therapy is not effective in arresting or slowing the progress of the disease and bacteria may not be the primary cause.

Roy C. Page, D.D.S., Ph.D., Professor of Periodontics, Director RCDRC, Associate Dean, School of Dentistry, and Professor of Pathology, School of Medicine, University of Washington

School of Dentistry, University of Washington, Seattle, Washington 98195, USA. roypage@u.washington.edu

Analysis of the plaque flora fails to reveal the presence of expected putative periodontal pathogens such as *Porphyromonas gingivalis*, *Bacteroides forsythus*, *Actinobacillus actinomycetem-comitans*, and *Treponema denticola* or enteric species. Furthermore, serum antibody analyses fail to reveal evidence of prior infection by these organisms, e.g. titers of serum antibody reactive with antigens of these bacteria are not elevated. The evidence suggests that this form of periodontal disease is non-infectious. Almost without exception, these individuals do not respond to scaling and root planing or other currently used antimicrobial periodontal therapies.

In summary, over a period of more than 30 years of practice, we have encountered a large number of cases of destructive periodontal disease that do not fit the diagnostic criteria of any form of periodontal disease described in the classifications published since the 1970s. The primary diagnostic features of the disease include progressive gingival recession and loss of periodontal attachment and alveolar bone, the absence of gingival inflammation and microbial deposits and periodontal pocket formation, and failure of the disease to respond to traditional antimicrobial periodontal treatments. In addition, the disease appears to be noninfectious. To distinguish the disease from various forms of periodontitis, we suggest the name Non-inflammatory Destructive Periodontal Disease.

Page, RC, Sturdivant, EC. Noninflammatory destructive periodontal disease (NDPD). *Periodontol* 2000, 2002; 30: 24-39.



La revue scientifique «Evidence-Based Dentistry » constitue un outil précieux dans la démarche entreprise par le réseau de santé dentaire publique au regard du dossier des pratiques préventives.



Il est souhaitable que la littérature scientifique supporte une pratique clinique préventive de façon adéquate, mais la qualité de l'évidence scientifique disponible ne fait pas toujours foi de tout.



L'évidence scientifique concernant les PCP's efficaces à prévenir les parodontopathies est moins concluante qu'au regard de la prévention de la carie dentaire; Par conséquent, les cibles d'interventions sont plus difficiles à cerner.



Index of Orthodontic Treatment Need (IOTN)

A. Très grand besoin de traitement

1. Surplomb horizontal > 9 mm.
2. Hypodontie importante avec conséquences restauratrices qui requiert également un traitement orthodontique (plus de 1 dent dans au moins 1 quadrant)
3. Éruption d'une dent permanente (sauf M-3) empêchée en raison d'un chevauchement, d'une dent en déplacement, d'une dent surnuméraire, d'une dent primaire ankylosée ou pour toute autre cause pathologique
4. Surplomb horizontal négatif > 3,5 mm. avec difficultés masticatoires et d'élocution
5. Fissure palatine et bec de lièvre
6. Dent primaire ankylosée



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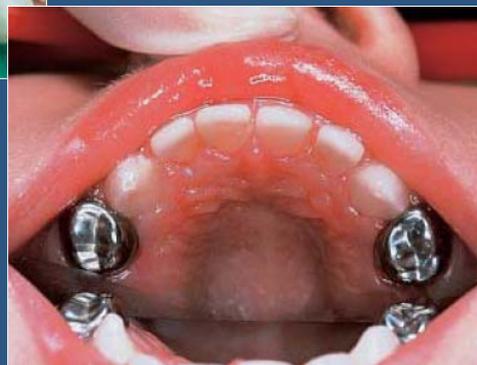


Les scellants dentaires, le rince-bouche fluoré et le dentifrice antitartre sont probablement 3 PCP qui méritent une plus grande utilisation.

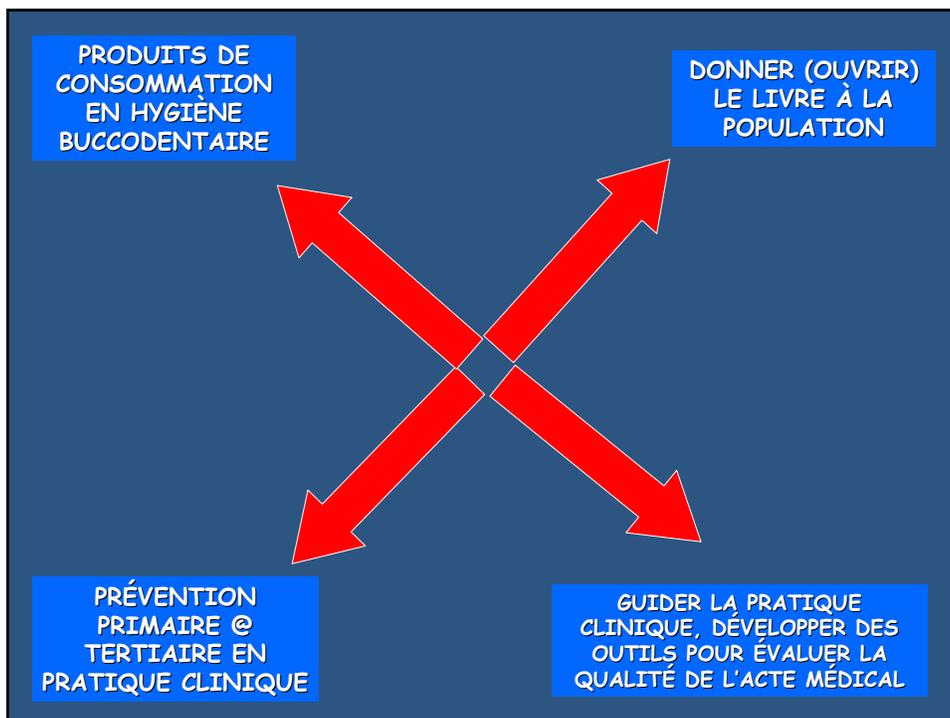


COURONNES EN
ACIER INOXYDABLE

ÉMISSION ENJEUX



**RIEN N'ADHÈRE À LA
SURFACE D'UNE
COURONNE EN ACCIER
INOXYDABLE ...
...OU PRESQUE**



ACTIONS POSSIBLES - LES CIBLES

1. FACULTÉS DE MÉDECINE DENTAIRE - INFLUENCER LES PROGRAMMES DE FORMATION SOUS-GRADUÉ
2. L'ORDRE DES DENTISTES DU QUÉBEC - LIGNES DIRECTRICES, GUIDE PRATIQUE ET AL.
3. L'ORDRE DES PHARMACIENS - OU AUTRE PORTE D'ENTRÉE POUR REJOINDRE LES PHARMACIENS
4. L'ASSOCIATION DENTAIRE CANADIENNE - LA CHRONIQUE «POINT DE SERVICE»
5. LE MSSS
6. LES DENTISTES CLINIENS
7. LES MÉDECINS CLINIENS
8. LA POPULATION, EN GÉNÉRAL

ACTIONS POSSIBLES - LES ACTIONS POSSIBLES

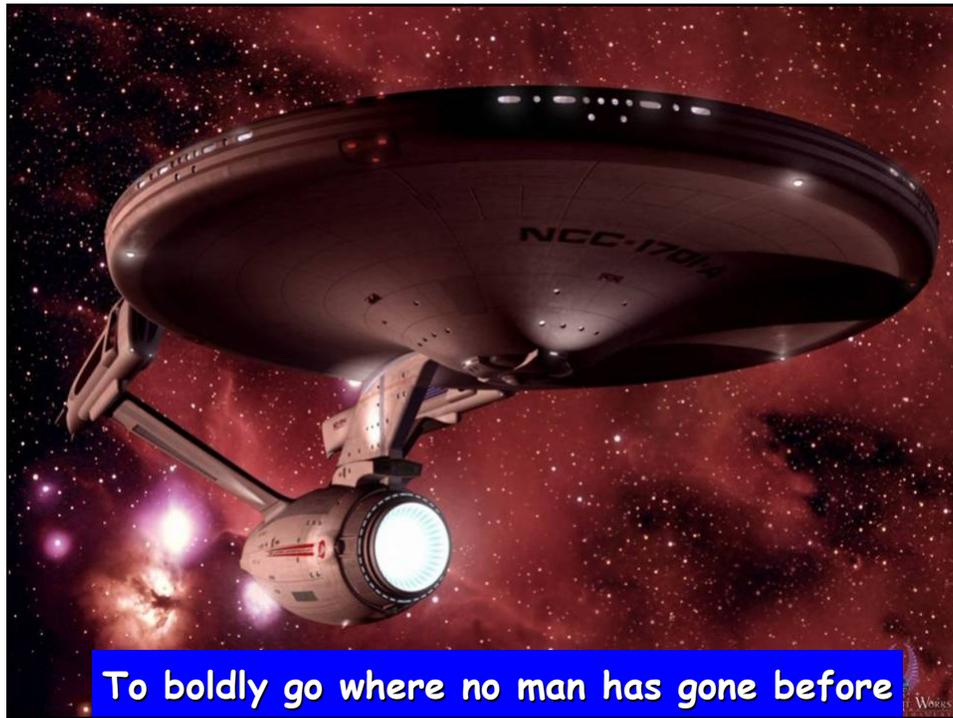
1. ÉTABLIR DES CONTACTS AVEC LES PRINCIPAUX « AIDS » : MÉDECINS, PHARMACIENS ET AUTRES (CENTRES D'ÉDUCATION À LA SANTÉ DES CSSS)
2. RECRUTER DES RÉPONDANTS AU NIVEAU DES « AIDS »
3. RECUEILLIR L'OPINION DE DENTISTES RÉPUTÉS CONCERNANT LES PCP RETENUES
4. ADRESSER UN QUESTIONNAIRE AUX FACULTÉS DE MÉDECINE DENTAIRE POUR :
(1) CONNAÎTRE LEUR OPINION AU REGARD DE CHACUNE DES PCP RETENUES ET
(2) POUR SAVOIR SI ELLES SONT ENSEIGNÉES ET, SI OUI, COMMENT ? ET
(3) COMMENT LES ÉLÈVES SONT ÉVALUÉS À CE SUJET
5. DOCUMENTER, SI POSSIBLE, L'UTILISATION DES PCP ET SURVEILLER L'ÉVOLUTION DE LEUR UTILISATION DANS LE TEMPS (CONN.-SURVEILLANCE)
6. SUGGÉRER L'INTRODUCTION DE L'OUTIL « PORTFOLIO » EN ÉDUCATION CONTINUE ET AU NIVEAU DE L'INSPECTION PROFESSIONNELLE
7. RÉDIGER DES LIGNES DIRECTRICES ET DE GUIDES DE PRATIQUES - ODQ
8. DÉVELOPPER UN PROJET « COLLECTIF » DE CHRONIQUE DANS LE JOURNAL DENTAIRE PUBLIQUE RÉSERVÉ À LA SANTÉ DENTAIRE PUBLIQUE
9. UTILISER LA CHRONIQUE « POINT DE SERVICE » DU JOURNAL DE L'ADC, AU BESOIN, POUR FAIRE LA PROMOTION D'UNE PCP
10. DÉVELOPPER UN SITE INTERNET : (1) FOURNIR «LE LIVRE» ET (2) DÉVELOPPER DES MODULES D'AUTO-APPRENTISSAGE ET AL.
11. DÉVELOPPER OU ORGANISER, AU BESOIN, UNE FORMATION CONTINUE
12. DEMANDER UNE ACTION OU L'APPUI GOUVERNEMENTALE AU BESOIN.

OUTILS À DÉVELOPPER ?

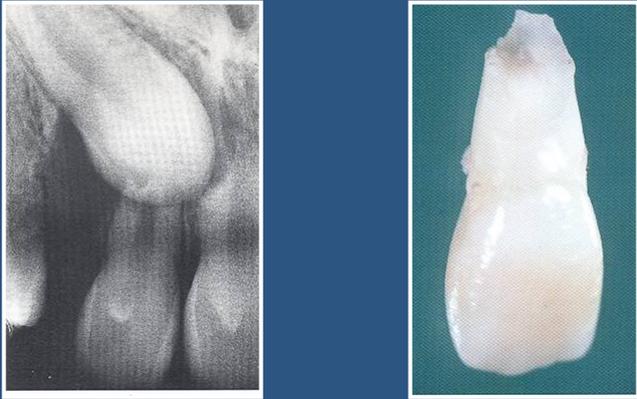


PRATIQUE CLINIQUES
PRÉVENTIVES EN PRÉVENTION
PRIMAIRE, SECONDAIRE ET
TERTIAIRE





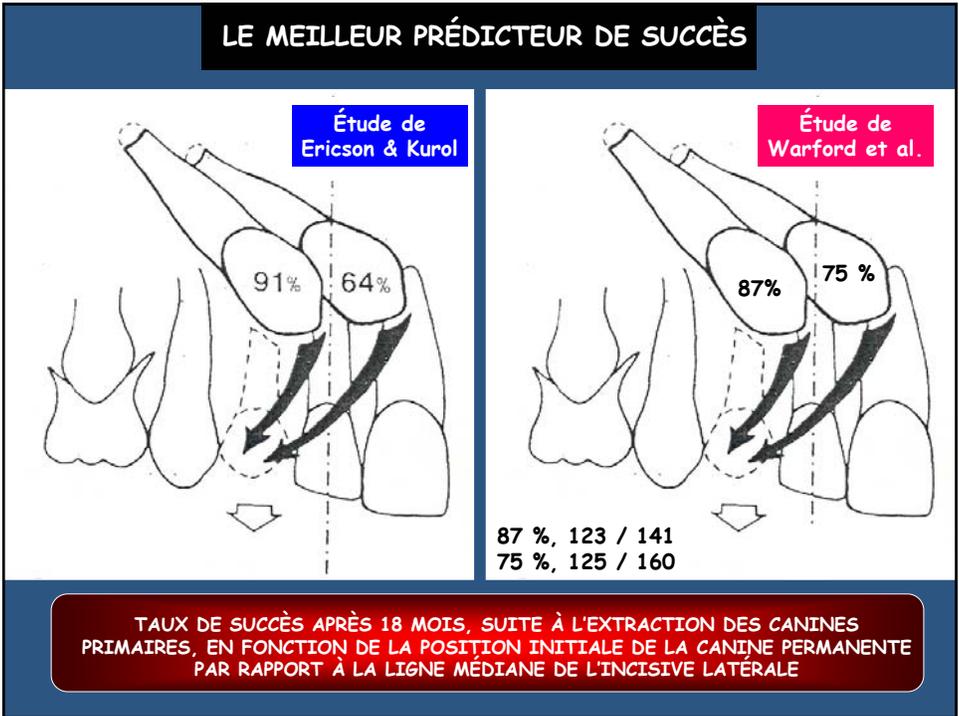
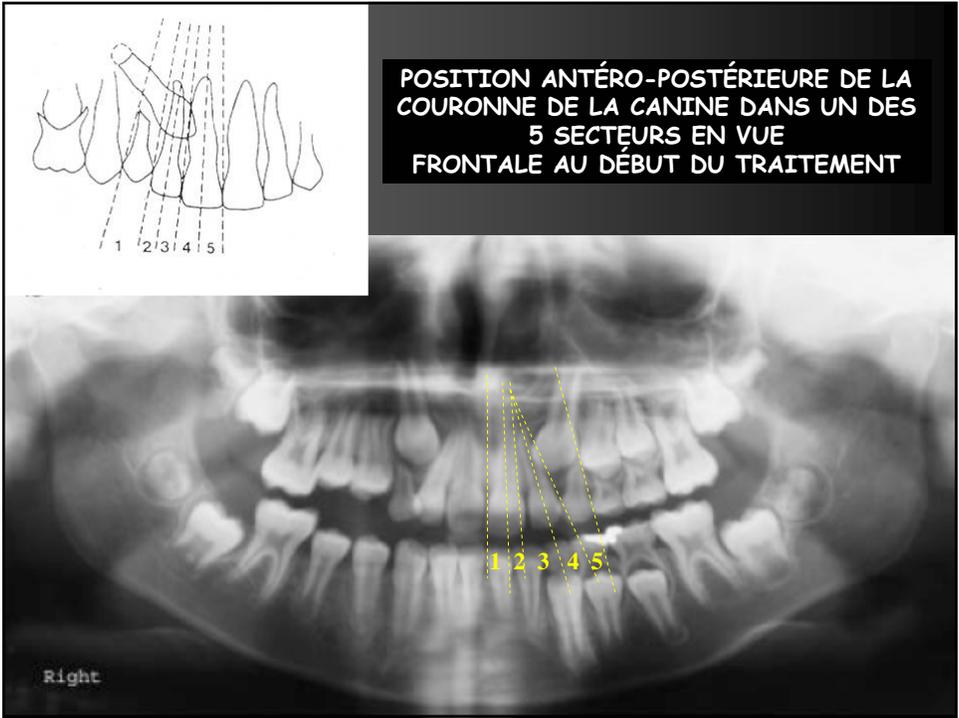
COMPLICATIONS POSSIBLES



RÉSORPTION DE LA RACINE DE L'INCISIVE LATÉRALE ET ESPACE INSUFFISANT POUR LA CANINE PERMANENTE SUR L'ARCADE DENTAIRE

Andreasen, JO, Petersen, JK, Laskin, DM. Textbook and color atlas of tooth impactions. Diagnosis, treatment and prevention. Munksgaard. 1997. Page 135.

The slide has a dark blue background. At the top center, there is a pink rectangular box containing the text 'COMPLICATIONS POSSIBLES'. Below this, there are two side-by-side images. The left image is a black and white radiograph showing a tooth with a significant resorption of its root. The right image is a clinical photograph of a tooth with a large, irregular resorption defect on its root. At the bottom of the slide, there is a white text box containing the title 'RÉSORPTION DE LA RACINE DE L'INCISIVE LATÉRALE ET ESPACE INSUFFISANT POUR LA CANINE PERMANENTE SUR L'ARCADE DENTAIRE' and a citation: 'Andreasen, JO, Petersen, JK, Laskin, DM. Textbook and color atlas of tooth impactions. Diagnosis, treatment and prevention. Munksgaard. 1997. Page 135.'

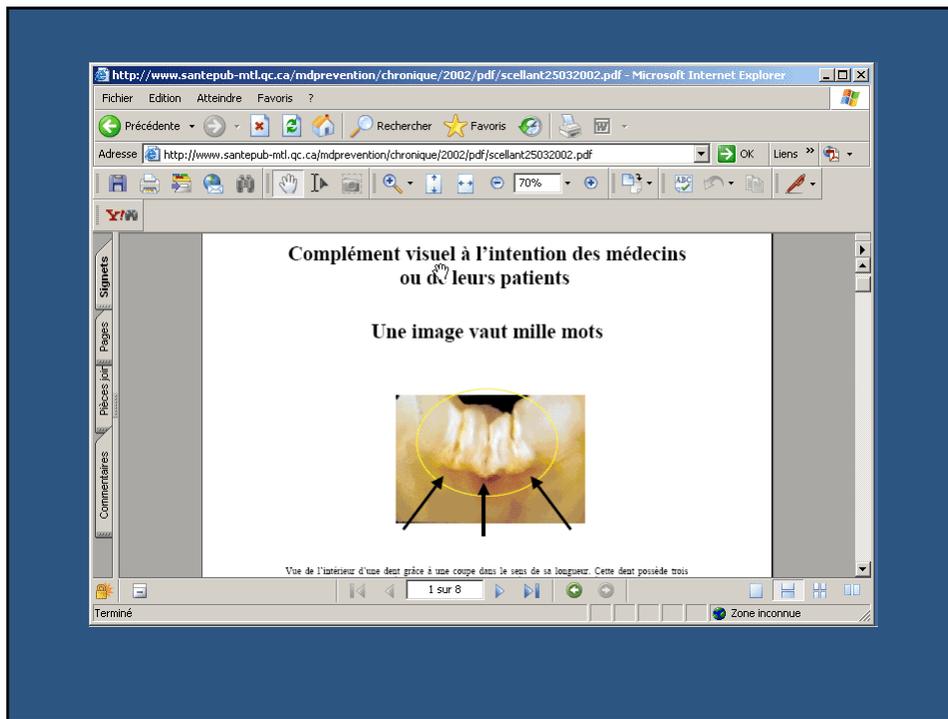


Preventive Measures:	Table 6. Protocol for the Prevention of Progression of Erosion
<p>1. Diminish the frequency and severity of the acid challenge.</p> <ul style="list-style-type: none"> * Decrease amount and frequency of acidic foods or drinks. * Acidic drinks should be drunk quickly rather than sipped. The use of a straw would reduce the erosive potential of soft drinks. * If undiagnosed or poorly controlled gastroesophageal reflux is suspected, refer to a physician. * In the case of bulimia, a physician or psychologist referral is appropriate. * A patient with alcoholism should be assisted in seeking treatment in rehabilitation programs. 	
<p>2. Enhance the defense mechanisms of the body (increase salivary flow and pellicle formation).</p> <ul style="list-style-type: none"> * Saliva provides buffering capacity that resists acid attacks. This buffering capacity increases with salivary flow rate. * Saliva is also supersaturated with calcium and phosphorus, which inhibits demineralization of tooth structure. 	
<p>3. Enhance acid resistance, remineralization and rehardening of the tooth surfaces.</p> <ul style="list-style-type: none"> * Have the patient use daily topical fluoride at home. * Apply fluoride in the office 2-4 times a year. A fluoride varnish is recommended. 	
<p>4. Improve chemical protection.</p> <ul style="list-style-type: none"> * Neutralize acids in the mouth by dissolving sugar-free antacid tablets 5 times a day, particularly after an intrinsic or extrinsic acid challenge. * Dietary components such as hard cheese (provides calcium and phosphate) can be held in the mouth after acidic challenge (e.g., hold cheese in mouth for a few minutes after eating a fruit salad).⁶³ 	
<p>5. Decrease abrasive forces.</p> <ul style="list-style-type: none"> * Use soft toothbrushes and dentifrices low in abrasiveness in a gentle manner. * Do not brush teeth immediately after an acidic challenge to the mouth, as the teeth will abrade easily. * Rinsing with water is better than brushing immediately after an acidic challenge. 	
<p>6. Provide mechanical protection.</p> <ul style="list-style-type: none"> * Consider application of composites and direct bonding where appropriate to protect exposed dentin. * Construction of an occlusal guard is recommended if a bruxism habit is present. 	
<p>7. Monitor stability</p> <ul style="list-style-type: none"> * Use casts or photos to document tooth wear status. * Regular recall examinations should be done to review diet, oral hygiene methods, compliance with medications, topical fluoride and splint usage. 	



Fig 1. A standard panoramic radiograph that has been scanned and digitized to enhance the reader's visualization of the atherosclerotic process. The patient is a 53-year-old man with calcified carotid plaques visible in the right neck below the hyoid bone and in the left neck overlying the hyoid bone (arrows).

Cohen, SN et al. Carotid calcification on panoramic radiographs: an important marker for vascular risk. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod.* 2002; 94(4): 510-4.



Formation continue

LA BOUCHE RÉVÈLE LES SECRETS DU CORPS

Pourquoi et comment dépister la plus fréquente des infections buccales ?

par Daniel Picard

REVUE LE MÉDECIN DU QUÉBEC

www.fmq.org/Documents/MedecinDuQuebec/051-57Picard0704.pdf

PRINCIPE MARKETING SOUS-JACENT : FACILITER LA TRANSACTION

T A B L E A U I I I

Rôle du médecin en matière de maladies parodontales

- S'enquérir de l'existence d'un problème de santé lié à la cavité buccale
- Vérifier la présence de facteurs de risque importants
- Connaître la date de la dernière consultation dentaire
- Vérifier le niveau d'hygiène buccale de son patient
- Rechercher la présence de signes cliniques d'une maladie parodontale si la situation le laisse croire
- Au besoin, recommander une consultation dentaire
- Inscire les coordonnées du dentiste traitant aux fins de communication éventuelle

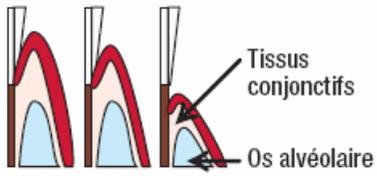
Picard, D. Pourquoi et comment dépister la plus fréquente des infections buccales ? Le médecin du Québec. 2004; 39 (7) : 51-57.

www.fmq.org/Documents/MedecinDuQuebec/051-57Picard0704.pdf





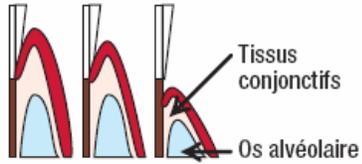
Récession gingivale



RÉCESSION GINGIVALE

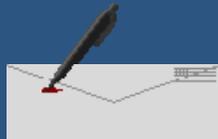


Récession gingivale



**RÉCESSION GINGIVALE
AVEC DESTRUCTION
DES PAPILLES
INTERDENTAIRES**

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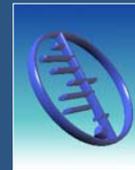
What is the most effective intervention for maintaining healthy tissue around dental implants?



Evidence is limited about effective interventions for maintaining healthy peri-implant tissues

Practice points

- There is only a little reliable evidence about what are the most effective interventions for maintaining health around peri-implant tissues: more research is required.
- There was no evidence that powered brushes were better than manual brushing but there was weak evidence to support adjunctive use of Listerine mouthwash.



Seymour, R. Evidence is limited about effective interventions for maintaining healthy peri-implants tissues. *Evid Based Dent.* 2003; 4(1):13.

Esposito M, Worthington HV, Coulthard P, Jokstad A. *Interventions for replacing missing teeth: maintaining and re-establishing healthy tissues around dental implants (Cochrane Review).* *The Cochrane Library* 2002; 2002; Issue 3. Oxford: Update Software