JIDA-KOCHI

JOURNAL OF INDIAN DENTAL ASSOCIATION - KOCHI

(AN OFFICIAL PUBLICATION OF INDIAN DENTAL ASSOCIATION, KOCHI BRANCH)

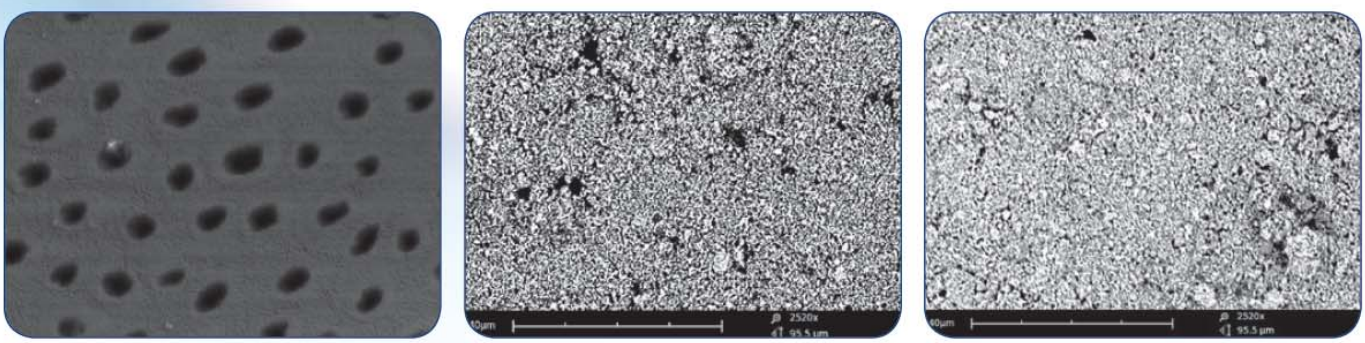
JANUARY-MARCH 2012 (VOL. 1) www.idakochi.org

Sensodyne Rapid Relief – Instant relief from dentine hypersensitivity

How does Sensodyne Rapid Relief work?

The strontium acetate formulation forms a deep occlusive plug within the dentinal tubules[1,2]

The robust occlusion formed by Sensodyne Rapid Relief is still maintained after an acid challenge[2]



Unoccluded dentine

After treatment and a 30-second acid challenge

After treatment and a 10-minute acid challenge

In vitro study of dentinal tubule patency following an acid challenge (immersion in grapefruit juice, pH 3.3) applied after dabbing and massaging for 60 seconds with Sensodyne Rapid Relief. Adapted from Parkinson and Willson 2010.

Sensodyne Rapid Relief – Instant and long-lasting relief from sensitivity

- Clinically proven relief.[3,4] Works in just 60 seconds*[3]
- Proven long-lasting relief with twice-daily brushing[4]
- Creates deep, acid-resistant occlusion[1,2]
- Contains fluoride

*When used as directed on pack

1. Banfield N and Addy *M. J Clin Periodontol* 2004; 31: 325–335.
2. Parkinson C and Willson *R. J Clin Dent* 2011; 22 (1) 6-10.
3. Mason S *et al. J Clin Dent* 2010; 21 (2):42-8.
4. Hughes N *et al. J Clin Dent* 2010;21(2):49–55.

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INDIAN DENTAL ASSOCIATION, KOCHI

JANUARY-MARCH 2012
(VOL. 1)

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Edited By: Dr. Pramod John
Published By: Hon. Secretary, IDA, Kochi
For **Indian Dental Association**, Kochi Branch.

Message from the Honorary Secretary General
Indian Dental Association

Dear friends in IDA, Kochi,

I am very happy to know that the Kochi branch of Indian Dental Association is bringing out a journal for the year 2012.

A journal is an effective medium to disseminate important news and information about the activities and achievements of the branch and of its individual members.

It is also a platform to apprise dental professionals of the events organised by your branch.

Of course, a journal also contains knowledge on scientific and research-related matters, which provides the readers with deep insight into the field of dentistry.

Bringing out a journal calls for a great deal of patient, painstaking efforts with zeal and commitment and is always a team effort.

I am sure the team from the Kochi branch will produce a fine journal.

Wishing all-round success to them.

I look forward to get a copy of the journal.

Dr. Ashok Dhoble,
Honorary Secretary General,
Indian Dental Association.

Message from the State President
Indian Dental Association, Kerala State

Dear friends in IDA, Kochi,

It is satisfying to note that IDA Kochi branch, the guiding force for IDA in yester years, is in action under Dr. Vinod Mathew, and Dr. Arun Babu. I know much is expected from these two experienced leaders by the members to regain the past glory of this prestigious branch. Journal- JIDA KOCHI- is a platform for scientific updating, interaction and it is a perfect bond between members.

Here let me remind the members that a powerful IDA is the need of the hour and I appeal to put all efforts to make this organization a true voice of Dentist to meet the challenges the profession.

Wish you all the best and a perfect IDA Year ahead.

Thanking You,

Dr. M. Raveendranath
President
IDA Kerala

PRESIDENT'S MESSAGE (President, IDA Kochi)

Dear Friends,

Thank you for the opportunity to speak to you as president of our association. Having served in various capacities within our local branch, I am humbled to share this privilege and experience. As a member for many years, I have witnessed the association's steady growth, thanks to the efforts of its leaders and the support of all members.

I would like to express my recognition for the excellent work and tireless efforts of our Immediate Past President Dr. Noorudeen towards keeping the high standards of IDA Kochi. I am also impressed with the outstanding events organized by Dr. Arun Babu and Dr. Jaykumar which added greater momentum to our branch activities.

This is our First Issue in the Journal Format for IDA, Kochi and I hope, this new beginning is better realized in the coming years as a full grown scientific journal from God's own country! I congratulate the Editor Dr. Pramod John and other members who have helped us realize this dream. I am certain in the future; JIDA Kochi will get better and gain more recognition in the dental circle.

The year began with a wonderful Installation ceremony at Mercy Hotel and the IDA-FDI CDE Program at IMA House, Kochi. Since then, we have moved slowly but steadily, utilizing energy to conduct programs throughout the year, in the interest of our members. Keeping the engine of innovation moving is an enormous task. But it is imperative that we come up with changes as participation in programs is the key to the success. Definitely, we will have our regular programs such as the monthly and the executive committee meetings throughout the year.

In order to cater specific interests, we will organize sports activities, ladies' night, family get together, picnic, Continuing Dental Education Programs, movie club, students' programs and a host of community dental health welfare activities in this year. I have my sincere gratitude to all those who have helped move IDA Kochi in the path of progress.

The revenue from membership dues is not sufficient to support a wide range of activities. Fortunately, the efforts of our Secretary and Treasurer have resulted in giving us sufficient funds to portray the usual schedule of events of our branch. We will bring good programs where everyone has a chance to relax and be part of the entertainment. We will try to be optimistic, innovative and proactive. We will try to uphold the ethics and values of our noble profession. We hope, you support us and our sponsors by being part of these activities.

In order to bring participation and to empower our members, we have taken a historical decision in making our Christmas New year program as a Free Entry program for all our members and their family. It is indeed a humongous task on office bearers to find the much needed sponsorship. But we hope, our efforts are given its due value with your participation.

The very individuals who designed and built this IDA Kochi, and those who are making efforts to rise above limitations, are fully remembered, their activities and their deeds are thanked from the bottom of the heart and enthusiastic young aspirants are welcomed into our association. We are all very proud of our profession and together, the association and its members can achieve great things for it and our patients.

My very best regards for a wonderful New IDA Year!

Dr. Vinod Mathew
President, IDA Kochi

Secretary's Message (Secretary, IDA Kochi)

There are some important qualities that one must possess to achieve, and these are the sense of purpose, the awareness of what one wants to achieve, and a burning desire to possess it. We the members of IDA Kochi should not underestimate the power of a smile, a creative idea, a listening ear, an honest compliment, a healthy criticism or positive suggestions, all of which have the potential to make IDA KOCHI-BETTER ITSELF to become the BEST.

IDA Kochi is the oldest and most vibrant among the branches. The members always stand apart, and these dedicated and enterprising members of all age groups have been the greatest asset of this association. The vision to have an association as conceived by Dr. M. K James became fruitful over the years, and we, the young office bearers of 2012 always need the blessings of all the senior members and their guidance. This will drive us ahead into the future. Let me take this opportunity to remind our members that, everything that we enjoy today is because of the commitment of our senior members and hence we should start from here, with their support and bring up an association as dreamt by our seniors, empowering ourselves, our patients and our supporters.

Dear members, I take this opportunity to bring to your attention the colorful, exotic and ravishing installation ceremony we had at Hotel Mercy, where the crowd present gave us the inspiration to gather momentum to move ahead. For those who missed, it was one of the most joyous occasion where Dr Noorudeen, the outgoing president of 2010-11 collared and installed Dr Vinod Mathew to the post of President, IDA Kochi for the year 2011–12, after which our newly elected President, Dr. Vinod Mathew installed his team members to their respective posts. Mr. Benny Behnan, MLA was the chief guest of the day with presidents and secretaries of various other branches attending the meeting and appreciating our members for the gala ceremony.

The overwhelming support of each and every member of IDA Kochi is so much appreciated. We are a team and not just the leaders in IDA Kochi. We ensure that we will stay focused to develop IDA KOCHI and certainly will have powerful commitment to the continued growth of the organization towards our betterment and for a social cause.

Our president Dr. Vinod Mathew and his team greatly appreciate the IDA members with all humility for showing full faith in the newly elected team and we sincerely would do the best within our capabilities to uphold the spirits and interests of Indian Dental Association.

"Four things support the world: the learning of the wise, the justice of the great, the prayers of the good, and the valor of the brave". As a team we are brave to do justice with the prayers to perform better. Talent wins games, but teamwork and intelligence win championships. We will strive to make our branch as a CHAMPION for the cause of dental surgeons of our branch, our society and to our sponsors.

I request the esteemed members to spare some precious minutes of yours and take a look into our web portal **www.idakochi.org.** Please offer your suggestions to make it better. Surf on it and you will find more about the activities of your branch. We offer to publish your articles on-line after clearance from the executive committee. Please use this facility as well.

It is **YOU** who make things happen and we are here as the new team of office bearers to support you.

With the change in the helms, we are bound to see some changes too. And I hope all our members will get to see and feel how our branch is heading into a powerful new brand "IDA Kochi". We are improving the standard of our programs, the ambience and the venues are carefully selected, the food will definitely be yummy, and programs will be impressive. We at IDA Kochi promise you that we won't disappoint you. We want you to be part of all our activities and support our sponsors who support us and we also solicit your co-operation in the work the office bearers are doing and you can also contribute in the activities of the IDA, Kochi through your participation in various programs. The humble request is to be part of every activity as per your time and convenience, especially the monthly meetings and CDE programs.

Wishing you all a great IDA year, ahead!!

Dr. Arun Babu
Secretary, IDA Kochi

FROM THE EDITOR'S DESK

The month of January marks the beginning of a New Year. It is the rime when most of us make New Year resolutions and soon we forget them. What is needed to tenaciously cling on to the resolutions that we have taken is a great quality – the will power. The greatest achievers in this world, though they went through failures and disappointments in their initial period of life, they had their strong will power to guide them. Overthrowing the British rule in this country by a frail person, Mahatma Gandhi, may not be believable for the generations of today. Now there are changing values in the society and corruption, nepotism and selfishness are the watchwords of today. Do we have the will power to bring in a change around us? When we see garbage dumped all over, do we refrain from throwing our household garbage on the streets? When we see corruption around us, do we refrain from paying or accepting bribes or favors? Is it possible to take up challenges and accomplish them and do we have the willingness? All of us can not be Mahatma Gandhi or Anna Hazare. At least can we inculcate some of the values of life that they have taught us? Shall we dream for a happy and prosperous year ahead? Shall we all strive to make this world a better place to live? Shall we forget the bitterness of the past and look at life with a smile?

Wishing all the members of IDA, Kochi a peaceful and wonderful year ahead filled with happiness and prosperity".

Jai Hind, Jai IDA

Dr. Pramod John
Editor, JIDA Kochi

KIND ATTENTION PLEASE...

Requesting all the readers to offer your constructive criticisms and suggestions to improve the quality of the journal, JIDA Kochi which is the rechristened version of BIDA, Kochi, our quarterly news bulletin. However, BIDA will continue to be published as a news portal of IDA, Kochi for the browsers of the internet. JIDA, Kochi will also be available as an e-journal. Readers can contribute articles or any creative work. You can also inform us any major happenings in your life so that we can include them in our forthcoming issues. This can be birth of a child, weddings, accomplishments, achievements or recognition in any areas.

Mail to: pramodjohn@hotmail.com

KNOW YOUR PRESIDENT

Dr. Vinod Mathew is one of the youngest Presidents of IDA, Kochi. He is activevely involved in various activities of the branch and served IDA in various capacities. He is energetic and dynamic. His vision for the branch activities are examples for the other IDA branches to follow. Our members will be curious to know about our President and here is a candid interview with our President.

1. **Where did you have your basic and specialty dental education?**

   Graduation at Annamalai University and my postgraduate diploma at the university of Vienna, Austria

2. **What are your goals for IDA, Kochi in your term as the President?**

   Bring innovative changes, work to improve participation and quality of programs and bring out a worthy journal for our members. I am looking forward to see a "Rise" in the conduct, ambience and quality of our programs encouraging our members to find time to participate in them.

3. **What is your greatest asset?**

   Probably my attitude is one the greatest asset! Attitude to be simple but dedicated and committed in what I am searching for, being positive, with the inclination to imbibe ideas, cohere with the group and work in unison.

4. **Do you have a role model? If yes, who is that?**

   I don't think I have. But I try to imbibe certain things from various individuals what I feel is strikingly different and impressive.

5. **What is your motto in life?**

   Be yourself and do your share to this world

6. **What is your favorite quote?**

   It is a quote by Mother Teresa

   People are often unreasonable, illogical and self centered; **Forgive them anyway.**

   If you are kind, people may accuse you of selfish, ulterior motives; **Be kind anyway.**

   If you are successful, you will win some false friends and some trueenemies; **Succeed anyway.**

   If you are honest and frank, people may cheat you; **Be honest and frank anyway.**

   What you spend years building, someone could destroy overnight; **Build anyway.**

   If you find serenity and happiness, they may be jealous; **Be happy anyway.**

   The good you do today, people will often forget tomorrow; **Do good anyway.**

   Give the world the best you have, and it may never be enough; **Give the world the best you've got anyway.**

   You see, in the final analysis, **it is between you and your God**; It was never between you and them anyway.

7. **What is your favorite holiday destination?**

   I have wonderful memories of Vienna and hence I would prefer being there again and again.

8. **If not a dentist, what would you have become?**

   Would love to try my hands on Journalism

9. **You are performer and you want to make things happen. How do you get inspiration for that?**

   I never had the courage to walk onto a stage. I have never dreamt of being in front of a mike. I was indeed a shy-guy. Well, over the time, I happened to be in situations where I had to do something or the other. Well, the desire to succeed made me strive and god willingly, I haven't been that bad I guess.

10. **What do you think is the force behind your success?**

    Readiness and attitude to be dedicated and committed in what I wish to do along with wonderful support from family and friends

11. **How do you maintain your physique and what is your fitness mantra?**

    I have been a sports freak all my life except the last two years. I can easily sacrifice dentistry for a game of shuttle badminton or for jogging. I have always been a sports enthusiast and that helped me to be outdoors in various games and sports….

12. **What is your typical day's diet?**

    A glass of coffee with couple of slices of bread and butter is my breakfast. Well , I love an egg to that…..and used to have the same till I turned 30, and with Cholesterol levels breathing at my neck, I had my first sacrifice in life- and that was , cutting down on my breakfast.

    My lunch and dinner are very much typical Malayali food and hence there isn't anything so special to be mentioned here.

13. **What are your hobbies?**

    I love driving and I do drive really long whenever I have a chance. Driving and music are my passion.

14. **Who is your favorite leader?**

    Mother Theresa.

15. **How do you summarize yourself in one sentence?**

    I am a reliable person who stands to my conscience.

16. **What is your vision for 2012?**

    My vision for myself is to be more organized and meticulous with time for myself and family.

    My vision for IDA Kochi is to make sure there is more participation in our programs and with time, bring an understanding in our members that being in IDA Kochi is really helping them to build a better professional career, attain the best social security, public protection, and also giving them social gatherings and entertainments which are qualitatively a cut above the rest with their peers.

17. **Have you prepared a list of New Year Resolutions? Would you like to share them with the readers?**

    I feel, my life is a bit disorganized with the kind of involvement I have in various things. I wish to make myself in order, into a better schedule and be more relaxed and productive in the coming year.

    I also wish to find more time for family and learn to enjoy little things in life and concentrate more on health.

FROM THE SECRETARY'S DESK...

RECENT ACTIVITIES

It was on November 20th,2011 the new team of IDA Kochi office bearers under the leadership of Dr. Vinod Mathew got installed at Hotel Mercy by the then President Dr. Noorudeen A M. It was a colorful ceremony with Mr. Benny Behnan MLA as the chief guest and Dr. Shibu Rajagopal, the IDA Kerala State Secretary as the Guest of Honor. The ceremony was attended by a large number of our members and your presence has been a great inspiration for the new team.

The Price of Life Project: IDA Kochi with Rotary Knights are contributing to the Isolation Ward of the Government Hospital Ernakulum in the year 2012 as we understand the price of Life for all remains the same and we need to support those who are in real need of our help. IDA Kochi along with Rotary Knights already contributed a water purifier to the CDH Representative Dr. Civy V Pulayath to install it in the Government Hospital on the 20th of November 2011. The same has been already installed in the Isolation ward.

The First Executive committee meeting of our branch was on the 24th of November at Avenue Regent Hotel and most of our executive members attended the meeting and the grand buffet which followed it.

The FDI IDA CDE program was held on the 26th and 27th of November at IMA House, Kochi. IDA Kochi office was instrumental in organizing the program in an ostentatious fashion.

Started on 1st December 1988, World AIDS Day is about raising money, increasing awareness, fighting prejudice and improving education. World AIDS Day is important for reminding people that HIV has not gone away, and that there are many things still to be done.

The red ribbon is an international symbol of AIDS awareness that is worn by people all year round and particularly around World AIDS Day to demonstrate care and concern about HIV and AIDS, and to remind others of the need for their support and commitment.

The IDA Kochi Executive committee team members all wore the red ribbon on this day while at work and also had the special World Aids Day Posture put up in their clinic to increase the awareness among the people and also contributed to the aids help centre.

World Aids Day Theme

The theme for World AIDS Day 2011 is 'Getting to Zero'. After 30 years of the global fight against HIV/AIDS, this year the global community has committed to focusing on achieving 3 targets:

"Zero new HIV infections. Zero discrimination. Zero AIDS-related deaths".

In 2010, there were 2.7 million new HIV infections and 1.8 million people died from AIDS. Moreover, in 2011 people living with HIV were still subject to restrictions on their travel and/or stay in 47 countries, territories and areas. These have to change…..and we all have to be part of the process!

The red ribbon is an international symbol of AIDS awareness that is worn by people all year round and particularly around World AIDS Day to demonstrate care and concern about HIV and AIDS, and to remind others of the need for their support and commitment.

The IDA Kochi Executive committee team members all wore the red ribbon on this day while at work and also had the special World Aids Day Posture put up in their clinic to increase the awareness among the people.

As an initiative to support the UN and our society, International Day of Disabled Persons (3rd December) were celebrated by our branch. The President, Secretary and the Treasurer along with a few executive committee members contributed to the Home for the disable persons and also distributed Oral Health Care Kits.

An innovative move made this year by our president, but surely a move which has scintillated many minds in the IDA. We have already been for a couple of movies this year- The infamous or unpopular Santhosh Pandit movie and the famous Vidya Balans movie. Well, I guess, you have got the movies right!!

The second ECM was held on 8th December 2011 at Hotel Excellency and various important decisions were made during this meeting.

Medicine Bank- IDA Kochi had its inauguration of the Medicine Bank to support the patients at our Free Dental Clinic during our Second Executive committee meeting on the 8th December 2011 at Hotel Excellency.

IDA Kochi conducted the first phase of the Elaborate Dental Assistant Training program on the 18th of December, Sunday at Hotel Excellency from 09:30 am to 4:30 pm. Each participant was presented with a Certificate of Attendance. Faculties: Dr. Noorudeen A M, Dr. Aji Kumar, Dr. Civy Pulayath, Dr. Sunil Alexander, and Mr. Sudhin (corporate trainee).

Clinic With A Heart
FREE DENTAL CARE DAY

Our Free Dental Clinic at Chalikkavattom had a great facelift during Dr. Noorudeen's term as president and this year, the FDC is working on all first and third Sundays of every month. Dr. Saji K K is in charge of the FDC.

Monthly Meeting

The December Monthly Meeting was held on 22nd at 8:15 PM at Hotel Excellency. We had two speakers for the day to talk on Customer Service and

Practice Management- Ms. Sapna Mary George spoke about the importance of customer service in the health care industry and certain guide lines for developing and implementing continuous quality improvement programs at the Dental Clinics and Dr. Civy V Pulayath, spoke extensively on various tips and tricks to improve Clinic practice.

DENTAL
CONFERENCE & EXHIBITION

Kerala State Dental Conference, Trivandrum was a perfect gift to the dental fraternity by the Trivandrum branch. The grand opening ceremony, the banquet and the trade fair really stood out. For those who were present, this would certainly be a great conference. We congratulate the IDA Trivandrum branch for their herculean efforts to pleasantly surprise all those who attended this conference. It was a bit sad to note there were only a few dental surgeons from Kochi to attend KSDC. (5th to 8th of January 2012)

The 3rd Executive Committee Meeting was on the 15th of January 2012 and was organized in a boat. The meeting discussed various unethical advertisements made by dental surgeons. Various other important decisions were also made during the meeting. Dr. Balu Soman and Dr. Mathew Varghese. An interesting part of the meeting was there were only men. All the men had a break from the daily routine as the boat was cruising through the serene backwaters with the setting sun at the backdrop. The ambience was excellent. We expect more of such exotic and innovative meetings in the future.

Following the 3rd ECM on the 15th of January, the DJ party gave the much needed relaxation and entertainment to the executive committee members as the boat was cruising through the serene backwaters with the setting sun at the backdrop. Thanks to the hosts Dr. Balu Soman and Dr. Mathew Varghese. We expect more of such exotic and innovative meetings in the future.

The CDH representative has organized various **CDH activities**. The NOHP of IDA Kochi has started and has covered the following schools.

1. Georgian Accademy
2. Mahatma Gandhi Public School, Ambadimala
3. Govt High School, Kadungamangalam
4. Lower Primary School, Thiruvamkulam
5. Bhavans Munshi Vidhyasram,Hillpalace
6. Toc-H School, Tripunithura
7. St.George High School, Vennikulam
8. Mahatma Gandhi memorial high School, Puthencruz
9. SNDP School, Mamala
10. KCLPS, Chithrapuzha

Dental Awareness Classes with lecture, demonstration, magic, audiovisual aids etc were given.

Our Sports activities took front seat with the IDA Kochi Premier League Cricket Matches starting with a friendly match between IDA Kochi members at the Sacred Heart College Ground, Thevara on the 22nd of January – Sunday morning at 7:30am.

2012
CONTINUING EDUCATION
PROGRAM

The First CDE Program of IDA Kochi was on the 27th of January at Lotus Club from 7:30pm to 10pm. The topic was Advanced Periodontics by Dr. Siby T Chennankara. There were 28 participants and everyone appreciated the program for its carefully selected contents. Colgate was the sponsor.

Our IDA Kochi website has had complete revamp with instant updating of all the activities of our branch. Membership application forms, Image and Hope details, and all recent future activities are present with pictures. The secretary's office has really made the site a fantastic place to look for all necessary information. We request you to kindly visit www.idakochi.org

IDA Kochi Free Denture Project: Dr. Aby Simon and Dr. Vinod Mathew have delivered free dentures to two patients from our FDC and IDA Kochi congratulates their effort (January 2012).

Teacher Training Program

IDA Kochi had its first Teacher Training Program for the year at St. Josephs Teacher Training College for Women, Ernakulum on the 31st of January with Dr. Civy V Pulayath and Dr. Vinod Mathew speaking on Dental Awareness and Dental Diseases.

World Cancer Day Observation

CDH Chairman and team members visited the cancer care and palliative care centre,vazhakkulam,Muvattupuzha and spend time with inmates. Dental health packs were distributed. A water filter was sponsored by Dr.Civy.

WORLD AIDS DAY- IDA Kochi- December 1st 2011

Started on 1st December 1988, World AIDS Day is about raising money, increasing awareness, fighting prejudice and improving education. World AIDS Day is important for reminding people that HIV has not gone away, and that there are many things still to be done.

International Day of Disabled Persons- 3rd December 2011

The International Day of the Disabled Persons was celebrated by our branch on 3rd December 2011.. The President, Secretary and the Treasurer along with a few executive committee members took part in the activities. They visited the Help Centre and the Home For Disabled Persons to distribute free oral health care kits.

CHRISTMAS NEW YEAR CELEBRATIONS X'mas and New Year Celebrations were held on 22nd January 2012. Thanking all the IDA members who made this a grand success.

FORTHCOMING ACTIVITIES

DENTAL ASSISTANT TRAINING PROGRAM 2011-12

I D A KOCHI will have a comprehensive Staff Training Program Phase II

*The **Second Phase** of this program will be held at Ernakulum North. The programme will help in engaging the participants to Prosthodontics and fFixed and removable orthodontics. This will be held in a hall near North Railway station and at Poly Dental Clinic. We intend to conduct this in early February.*

Speakers: Dr. Ajikumar, Dr. Afzal V A , Dr Sajil , Dr. Jose Julian.

I D A KOCHI will have a comprehensive Staff Training Program Phase III

*The **Third phase** will be organized at Dentcare Dental Lab, Muvattupuzha in the month of January, 2011 (the exact dates will be announced later), where the assistants are given an opportunity to observe the lab, the procedures there and a general class as to the work being carried out there. We hope this programme will improve the knowledge, understanding and perspective of Dental assistants to be more efficient in the work they handle. This would in turn help in improving the productivity and standard of the clinics. IDA Kochi along with Dentcare Dental Lab will arrange the transportation of the participants to and fro from the lab. IDA – Dentcare Certificate will be issued in the Third Phase of the programme to the attending participants.*

IDA Directory IDA Kochi will bring out a directory of its members this year. In this endeavor we need your help and we request each of you to fill up the Know Your Member form, paste your passport size photograph and send the same to the President of IDA Kochi – Dr. Vinod Mathew – Kattukarans Dental Clinic, 1st Floor Varappan Bldg, Banerji Road, Cochin 18, Kerala. Please call Dr. Vinod Mathew 9447055598. A detachable form is attached in this issue of JIDA, Kochi. Please fill this form and send it to Dr. Vinod Mathew.

Ship Cruise We intend to organize a trip abroad or a cruise ship trip this year approximately during the month of February or March. Those who are interested may call Dr. Vinod Mathew and give your names. As soon as a final decision is made, we will be able to get back to you with the dates, the number of days of the trip, the total expenses etc. We already have around ten members ready for the trip.

Monthly Meetings On Sundays To entertain our Lady members and those who are not able to attend the monthly meetings as they are held on Thursday Evenings, a couple of our Monthly meetings will be held on Sunday.

CDE Desk- Dr. Afzal V A – Proposed CDE Programs for 2012

1. Advanced Periodontics- Dr. Siby T Chennankara- 27th January 2012- Lotus Club
2. Tips and Tricks in Prosthodontics – Dr. Eldho Koshy – 23rd February 2012- Lotus Club
3. Rotary Endodontics- Dr. Raj Kumar- March 11th – Presidency Hotel from 9:30am- Lecture and Hands on Program, with live demonstration. Members wishing to attend Hands on program requested to bring Extracted tooth with access opening – molar or premolar, endomotors
4. Post and Core, impression materials and techniques, crown preparation and cementation - Dental Avenue- April 8th- Faculty - Dr. Sujit Bopardikar – a full day program supported by Dental Avenue and Colgate with live demonstration and hands on program….details soon…

CDH Desk- Dr. Civy V Pulayath - Proposed CDH Programs for 2012

1. Kudumbasree - Ayalkoottam - Asha - ICDS Dental Awareness program
2. "What After BDS" Program for Dental College Students
3. Awareness posters against advertisements and undercuts
4. School Dental Health Program
5. Free Dental Clinic and Free Denture Program
6. Dentist's Day Celebrations
7. Oral Hygiene Day
8. Support to Geriatric Homes, Special Schools, Isolation Ward Government Hospital
9. Blood Bank IDA
10. Medicine Bank IDA

Well, the year has started on a good note and hope we will be able to end on a high… Welcoming you all to the MONTHLY MEETING on the 22nd and X' MAS & NEW YEAR PARTY on Jan 22nd

Thanks and Regards

Dr. Arun Babu (Hon. Secretary IDA Kochi)

HUMOUR

"what is the difference between stress,tension & panic?

Stress is when wife is pregnant, Tension is when girlfriend is pregnant & Panic is when both are pregnant"

A man & wife entered a dentist's office. The Wife said, "I want a tooth pulled. I don't want gas or Novocain because I'm in a terrible hurry. Just pull the tooth as quickly as possible." You're a brave woman said the dentist. Now, Show me which tooth it is. The wife turns to her husband and says, "Open your mouth and show the dentist which tooth it is, dear."

IMPORTANT EXECUTIVE COMMITTEE MEETING DECISIONS

IDA Kochi executive committee had proposed a **hike the membership fee** for our branch. There were two suggestions which were put forward during the Presidenthip of Dr. Noorudeen. The resolution from the executive was taken up in the Annual General Body meeting, but since we had very less attendance for the AGM, it was decided to inform this to the members and then to schedule an EOGM to decide on the same.

The proposals were: Annual Membership Renewal Fee of Rs.500/- for Life Members, Rs.1250/- for other members and Rs.3000/- for new membership. If a couple is joining together Rs.5500/- OR Annual Membership Renewal Fee of Rs.750/- for Life Members, Rs.1500/- for other members and Rs.3000/- for new membership. If a couple is joining together Rs.5500/-

We will inform you in due course with regard to the EOGM for this matter.

For the net savvy members, there is IDA, Kochi web portal which can be accessed by logging on to www.idakochi.org which highlights all the activities of your branch. There are also several links and photo gallery. You can also download the applications such as IDA Membership Forms. Efforts are being made to make the IDA, Kochi publications JIDA-Kochi and BIDA-Kochi to be made available online. IDA, Kochi members are urged to make use of these.

IMAGE NEWS

Members of IDA Kochi having Dental Clinic are requested to join IMAGE and do the biological waste disposal through them. If not they might be subjected to corporation harassment and fine for which IDA Kochi will not be able to help. **Contact:** Dr. Ajit P. Mob: 9447465009

OBITUARY

Father in law of Dr. George Kottam, Mr. Antony George passed away and the funeral was held Little Flower Church Elamkulam.

Dr. Aby Simon's father Mr. T. A. Simon passed away. Funeral was held at Jerusalem Marthoma Church Elamkulam.

HUMOR ZONE

A man walks into the dentist's office and after the dentist examines him, he says, "that tooth has to come out. I'm going to give you a shot of Novocain and I'll be back in a few minutes."

The man grabs the dentist's arm, "no way. I hate needles I'm not having any shot!"

So the dentist says, "okay, we'll have to go with the gas."

The man replies, "absolutely not. It makes me very sick for a couple of days. I'm not having gas."

So the dentist steps out and comes back with a glass of water, "here," he says. "Take this pill."

The man asks "What is it?"

The doc replies, "Viagra."

The man looks surprised, "will that kill the pain?" he asks.

"No," replies the dentist, "but it will give you something to hang on to while I pull your tooth!"

Patient: Doctor, I am very nervous. You know, this is my first extraction.

Young dentist: Don't worry, it's my first extraction too.

WHAT EACH KISS MEANS

- Kiss on the Forehead: We're cute together .
- Kiss on the Cheek: We're friends.
- Kiss on the Hand: I adore you.
- Kiss on the Neck: I want you, now.
- Kiss on the Shoulder: Your perfect.
- Kiss on the Lips: I LOVE YOU...

WHAT EACH GESTURE MEANS

- Holding Hands: We definitely like each other.
- Holding you tight pressed against each other: I want you.
- Looking into each other's Eyes: I like you, for who you are.
- Playing with Hair: Let's fool around.
- Arms around the Waist: I like you too much to let go.
- Laughing while Kissing: I am completely comfortable with you.

THE OLD FISHERMAN

Mary Bartels Bray

Our house was directly across the street from the clinic entrance of Johns Hopkins Hospital in Baltimore. We lived downstairs and rented the upstairs rooms to out-patients at the clinic.

One summer evening as I was fixing supper, there was a knock at the door. I opened it to see a truly awful looking man. “Why, he’s hardly taller than my eight-year-old,” I thought as I stared at the stooped, shriveled body. But the appalling thing was his face ... lopsided from swelling, red and raw. Yet his voice was pleasant as he said, “Good evening. I’ve come to see if you’ve a room for just one night. I came for a treatment this morning from the eastern shore, and there’s no bus ‘til morning.”

He told me he’d been hunting for a room since noon but with no success. No one seemed to have a room. “I guess it’s my face ... I know it looks terrible, but my doctor says with a few more treatments...”

For a moment I hesitated, but his next words convinced me. “I could sleep in this rocking chair on the porch. My bus leaves early in the morning.”

I told him we would find him a bed, but to rest on the porch. I went inside and finished getting supper. When we were ready, I asked the old man if he would join us. “No thank you. I have plenty.” And he held up a brown paper bag.

When I had finished the dishes, I went out on the porch to talk with him for a few minutes. It didn’t take long time to see that this old man had an oversized heart crowded into that tiny body. He told me he fished for a living to support his daughter, her five children, and her husband, who was hopelessly crippled from a back injury.

He didn’t tell it by way of complaint. In fact, every other sentence was preface with a thanks to God for a blessing. He was grateful that no pain accompanied his disease, which was apparently a form of skin cancer. He thanked God for giving him the strength to keep going.

At bedtime, we put a camp cot in the children’s room for him. When I got up in the morning, the bed linens were neatly folded and the little man was out on the porch. He refused breakfast. But just before he left for his bus, haltingly, as if asking a great favor, he said, “Could I please come back and stay the next time I have a treatment? I won’t put you out a bit. I can sleep fine in a chair.”

He paused a moment and then added, “Your children made me feel at home. Grownups are bothered by my face, but children don’t seem to mind.”

I told him he was welcome to come again.On his next trip he arrived a little after seven in the morning. As a gift, he brought a big fish and a quart of the largest oysters I had ever seen. He said he had shucked them that morning before he left so that they’d be nice and fresh. I knew his bus left at 4:00 a.m. and I wondered what time he had to get up in order to do this for us.

During the years he came to stay overnight with us, there was never a time that he did not bring us fish or oysters or vegetables from his garden. Other times we received packages in the mail, always by special delivery ... fish and oysters packed in a box with fresh young spinach or kale ... every leaf carefully washed. Knowing that he must walk three miles to mail these, and knowing how little money he had made the gifts doubly precious.

When I received these little remembrances, I often thought of a comment our next-door neighbor made after he left that first morning. “Did you keep that awful looking man last night? I turned him away! You can lose roomers by putting up such people!”

Maybe we did lose roomers once or twice. But oh! If only they could have known him, perhaps their illness’ would have been easier to bear. I know our family will always be grateful to have known him. From him, we learned what it was to accept the bad without complaint and the good with gratitude to God.

Recently I was visiting a friend who has a greenhouse. As she showed me her flowers, we came to the most beautiful one of all ... a golden chrysanthemum, bursting with blooms. But to my great surprise, it was growing in an old dented, rusty bucket.

I thought to myself, “If this were my plant, I’d put it in the loveliest container I had!” My friend changed my mind.”I ran short of pots,” she explained,” and knowing how beautiful this one would be, I thought it wouldn’t mind starting out in this old pail. It’s just for a little while, until I can put it out in the garden.”

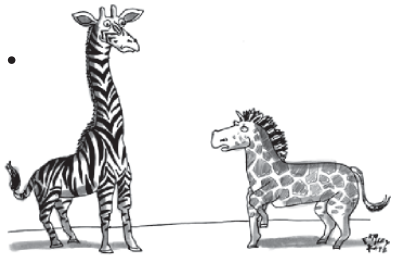
She must have wondered why I laughed so delightedly, but I was imagining such a scene in heaven. “Here’s an especially beautiful one,” God might have said when he came to the soul of the sweet old fisherman. “He won’t mind starting in this small body.”

All this happened long ago ... and now, in God’s garden, how tall this lovely soul must stand.

TIPS FOR BETTER PRACTICE…

Exceptional Dental Practice Management

They don't care how much you know, until they know how much you care!!!



"Great—now everybody at work is going to know."

First things first, understand your patient. What do they want? What do they care about? Is it the perception others have of them, or their own comfort and health? What is their understanding of oral health? What can they afford, and what are they willing to spend? How can you show them what they need in a way to make them want it, and how can you show them how to afford it? This all starts in the pre-clinical interview, so don't cut corners here. It's very tempting to rush the pre-clinical interview if you're running behind, or if the patient seems like an impatient person who wants to control the way the appointment is going to go. But, don't do it, take your time and get in there with them. Find a way to get past their defenses and get them to open up. You go first, tell them why you do what you do in your office, before to try to tell them why they should buy it.

Once you have a good idea of what is important to your patient and you've gathered all your clinical information, sit down and discuss the patient's treatment plan. First listen as a dental professional and make sure you understand the rationale for the treatment. Then put yourself in as close to your patient's frame of mind as you can and ask the questions you think they would ask.

Finally, come up with 3 treatment plans; good, better and best. (Sears used to do that years ago and who really wanted to go home with the good blouse if they could pay a little more and get the best quality one?) Also, find out if there is any treatment the your absolutely won't suggest or provide. Now you're ready to put your treatment plan presentation.

Print out the following: Review of findings, photos, x-rays, information about conditions or procedures (Click and Print is a great software package for this), and a copy of the treatment plan and fees. Place it all in a presentation folder that has a slot for the doctor's business card.

When the patient arrives, be sure to have a small glass or bottle of water available for them. I say small for a reason, you don't want them jumping up in the middle of your presentation to use the restroom, but you do want to show them you're considerate of them. Next, start by reviewing what they've told you are their goals for their oral health. Let them know that you want to help them achieve that. In other words, go through your best treatment options and let them know exactly why it is the best choice. For instance, if a patient is missing a tooth, you will likely have your good option as precision partial, your better option as fixed bridge and your best option as implant if they are a good candidate. If they aren't a candidate for implant, everything moves down a notch and you start with clasp retained partial, then precision, then bridge. Explain the pros and cons of each treatment *honestly*. Don't fall into an annoying salesman technique of bashing the good option in favor of the best, just give them the facts and help them if they have questions or misconceptions.

As it becomes time to decide, you may realize that you've now led your patient to truly desire the best option, but they don't see how they can afford it. This is where you must know what options your practice will offer in terms of financing. For patients who you have with very little experience, who don't have a reliable reference behind them, or who just seem like a credit risk for you to take on, I'd suggest Care Credit or another lending program.

If you offer in house financing, work with them on that. I love it when I can offer them a payment plan that takes them through a phased treatment plan. In other words, we may be working with them to maximize their insurance so we may be phasing their treatment over 2-3 years. If I can break up their payments to span that time period, everyone wins and the patient gets the best treatment available to them without undue financial hardship. If you are creative and you have a reasonable patient, the finances can be worked out to the benefit of the dentist and the patient equally.

Once the treatment is accepted and the financial plan is achieved, it's time to schedule the treatment. I don't like to schedule everything immediately, even though it feels great to get it on the books. That is because life happens and if you have 10 appointments scheduled, chances are patient will get home and notice that they have a hair appointment that can never be moved. (funny how hair appointments trump dental appointments every time, but to be honest, mine do, too). Now you have to start moving all the subsequent appointments, too, and that's a pain. I like to set up the first phase, or quadrant, and then midway through those appointments, set up the next.

It's important if you are phasing treatment over the span of a few years, to make a note to call the patient to set up the next phase in the last quarter of the year preceding. So, if a patient is going to start phase two in 2012, I'm going to have a note on the schedule in November, 2011 to call and set it up.

Finally, as the patient care facilitator, you need to be available to the patient to answer any questions they may have. Make sure they know that. Make sure they know that you are available to speak to their spouse, adult children, or whomever they release you to give information to (make sure you have a signed information release waiver).

Presenting treatment is interesting, sometimes challenging, and almost always rewarding. Helping people understand their oral health needs and then assisting them in making the possibilities and desires a reality are fulfilling ways to spend the day.

BRIDGING THE GAPS – FULL MOUTH REHABILITATION: A CASE REPORT

Dr. Jayasree Mohnan
Co-author: Dr. N. Mohan, Professor and Head, Department of Prosthodontics

KEY WORDS

Full mouth rehabilitation, metal fused to ceramic crowns, occlusal analysis, severe attrition

ABSTRACT

Full mouth fixed rehabilitation is one of the greatest challenge in prosthodontics. Apprehensions involved in the reconstruction of debilitated dentitions are heighted by widely divergent views concerning the appropriate procedure for a successful treatment. When it comes to comprehensive, full-mouth rehabilitation cases, dentists don't plan to fail, but they may fail to plan. Dedicating time for developing a treatment plan that includes the proper sequence of diagnosis and evaluation, as well as how to utilize them to get the best possible final desired outcomes for the case can make proceeding with clinical protocol more predictable. This clinical report describes the prosthodontics rehabilitation of a patient with severely worn dentition resulting in an end – to – end relationship. Maxillary and mandibular fixed restorations were constructed with canine – protective occlusion.

INTRODUCTION

Full mouth Rehabilitation has received considerable clinical interest from modern dental practices as a means of delivering ceramic restoration, implants, removable partial denture and so on. With increasing life expectancy and changing lifestyle, more people are trying to keep their natural dentition as they grow old. So people demand for preservation of natural teeth and rehabilitation of missing ones. Wearing of tooth is either natural or artificial. Rehabilitation has proved a fascination to mankind since the dawn of history the principal reason is that the other parts of the body repair themselves to a degree and therefore the influence of life event are eliminated as individual gets older. But it is not so in case of teeth which biologically speaking are almost inert and certainly in a gross sense are incapable of repair. Hence rehabilitating these patients always demand a lot from prosthodontics. Rehabilitation -Restoration of functional and structural integrity of dental arches is done by the use of inlays, crowns, partial dentures and implants.

When it comes to comprehensive, full-mouth rehabilitation cases, dentists do not plan to fail, but they may fail to plan. Dedicating time to developing a treatment plan that includes the proper sequence of diagnostic and evaluative tasks as well as how to utilize them to the best advantage to achieve the final desired outcomes for the case and can make proceeding with clinical protocol more predictable.

Imperative to the process is recognizing the importance of anterior guidance, incisal edge position, diagnostic models, and suitable treatment modalities that will satisfy patient expectations. Envisioning and determining the final restorations prior to undertaking any preparation design is also essential.

TREATMENT OBJECTIVES

The first objective is preservation of remaining tooth structure. Second one is optimize oral function, health, occlusal stability, esthetics and comfort for patient. Third one is to provide an ordered pattern of occlusal contact and articulation. Fourth and the last is it should be cost effective and short treatment time.

INDICATION

Full mouth rehabilitation is indicated for the following 1) Mutilated dentition i.e fractured, broken tooth due to caries or trauma. 2) Severely worn dentition due to parafunctional habits, with age, & professional hazards. 3) Developmental anomalies like amelogenesis imperfecta, dentinogenesis imperfect, hypocalcification and fluorosis. 4) Discoloured dentition due to medication and 5) multiple faulty FPD.

TREATMENT PROTOCOL

Many schools of thought exist for the treatment procedure for full mouth rehabilitation and they are based on individual author's discretion on occlusion and treatment procedure. But this can be broadly divided into two 1} one stage procedure, 2} twin stage procedure in which the posterior are rehabilitated first and then only the anterior are given. Each one has its own merits and demerits. But the protocol common for both these procedures can be divided into seven phases which are as follows:

1) Stabilization,
2) Reassessment I,
3) Preliminary restorative phase
4) Reassessment II
5) Definitive restorative phase
6) Reassessment III
7) Maintenance

Stabilisation: This phase starts from the time the patient reports in your clinic. In this the pain and discomfort for which the patient has reported is first relieved. The causative aetiology is identified and eliminated or controlled. And measures are taken to protect the remaining tissues.

Reassessment I: The patient condition is assessed after stabilisation. Patient is educated on the further course of treatment and his interest in the same is assessed.

Preliminary restorative phase: This is a very important phase as the most critical decision of the rehabilitation is taken in this phase. The vertical dimension of occlusion is assessed and increased hypothetically on mounted diagnostic cast in centric relation. Diagnostic wax up is done, the goal of the diagnostic wax-up is to recreate the patient's new bite and smile in wax so that this can then be transferred to the temporary restorations. Creating excellent temporary restorations is a key step in the full mouth rehabilitation because they allow the patient to evaluate the smile, bite and jaw position and determine if any changes need to be made before the final restorations are made. Reversible interventional modalities like occlusal splint, overlay RPD, fixed provisional or direct composite restoration are also given. And these are observed for a period of 6 to 12 weeks.

Reassessment II: The patient is then assessed for response to the preliminary therapy. The temperomandibular joint and the muscles of mastication are assessed for pain or instability. If the vertical dimension is altered then patient's adaptation to this is assessed.

Definitive restorative phase: The teeth are prepared conventionally or conservatively according to the situation and the impression taken of the prepared tooth. The provisional are given till the permanent are ready.

Maintenance: Patient with extensive fixed restoration should be recalled every 6 months to be assessed for soft tissue, root caries and periodontal status for abutment teeth. Occlusal dysfunction should also be assessed at each recall appointment to examine any occlusal wear facet in canine because wear in this area in a canine guided occlusion leads to excursive interfering contact of posterior teeth.

CASE REPORT

A male patient, aged 48-year, presented with a chief complain of severely worn teeth ***{fig I}*** and inability to chew food, at the Department of Prosthodontics, Vinayaka Mission Dental college, Salem (India)**.** The patient gave the history of gastric regurgitation. The patient dental history indicated periodic dental examination, oral prophylaxis, restoration and extraction. The patient denied any symptoms of temperomandibular joint disorder or myofacial pain dysfunction.

Clinical findings:

- *Extraoral* - The patient had no facial asymmetry, or muscle tenderness. Mandibular range of motion was within normal limits. The temperomandibular joint, and the muscles of mastication were asymptomatic.
- *Intraoral* – The maxillary & mandibular arch the following teeth missing 14,16,17,27,34, 36,37, and 46. Generalized attrition, abrasion, and erosion were noted. Composite restorations were present in 11,12,21,22 for class III caries. Amalgam restoration were present in maxillary 18, 26, 28, and all mandibular teeth.Teeth 35 to 43 and 15 had undergone root canal treatment .
- *Occlusal finding:* - The patient presented with a *bilateral* class I molar and canine relationship. The patient demonstrated a slide from centric relation to maximum intercuspation. The patient's lateral excursion showed a canine guided occlusion. Lower incisal edges glide along the palatal surface of maxillary anterior during protrusion. Due to attrition the vertical dimension was diminished {Category I – Turner & Missirian classification}.There was a high smile line with moderate display of gingiva. Maxillary and mandibular midline was 1.5 mm right to the midfacial vertical line.
- Radio-graphical finding: - the patient radiographs showed a trabecular bone to be finely woven pattern. The crown root ratio of lower anterior were unfavorable.

Treatment procedure:

1. The patient received oral prophylaxis, periodontal therapy, and oral hygiene instruction.
2. Odontoplasty was done on mandibular and maxillary teeth with uneven and sharp cusp.
3. The viability of the endodontically treated and restored teeth was assessed.
4. Maxillary and mandibular diagnostic cast are obtained using irreversible hydrocolloid.
5. Maxillary cast is mounted using {Quick mount} face bow on a Whipmix articulator in centric relation record.
6. The vertical pin of the Whipmix is set so that there is approximately 2mm of space between the teeth that contact first in centric relation.
7. A permissive occlusal splint is constructed on lower teeth in heat cure acrylic.
8. Occlusal splint was inserted and adjusted to provide a mutually protected occlusion
9. Another set of diagnostic cast are made. Maxillary cast was mounted using a ear piece face bow {Whipmix Quick mount face bow} onto a Whipmix articulator and mandibular cast are mounted using cen-

tric and two lateral interocclusal-aluwax record {Aluwax Dental Products Michigan, USA}.

10. Pankey - Mann Schuyler analysis gives the acceptable occlusal plane. Mandibular posterior occlusal plane was analysed using the Broadrick occlusal plane analyzer ***{fig iii}***. On analysis it was found all mandibular teeth followed the curve of spee. Maxillary right premolar was supraerupted due to absence of opposing teeth, which required occlusal correction.
11. Customized anterior guide table is fabricated with centric, protrusive & lateral record from acrylic resin to preserve the natural anterior guidance.
12. Mock preparation was done on articulated maxillary and mandibular cast and diagnostic wax patterns are developed in it. ***{fig iv}***
13. Tooth preparations for full coverage metal ceramic crowns were completed for the entire dentition ***{fig v}***. A final full – arch impression was made using polyvinyl siloxane {Aquasil, Dentsply Detrey, Germany} impression material with double-mix, double impression technique, the cast were poured in die stone { Kalrock ; Kalabhai Pvt. Ltd Mumbai. India}.
14. This assembly was mounted on a Whipmix articulator using a face bow {quick mount facebow} and centric inter-occlusal record made in Aluwax at previously determined vertical dimension.
15. Provisional restorations were made from the diagnostic wax-up template with autopolymerising acrylic resin, and esthetic and occlusion were evaluated. Provisional crowns were cemented with zinc oxide non-eugenol {Rely X, 3M ESPE, Germany} provisional cement.
16. Articulator was programmed with centric and two laterotrusive records. ***{fig vi}*** First posterior waxup is done to achieve a standard effective cusp angle of 25°. Then anterior wax up is done to achieve an incisal guidance, which produce a standard amount of disocclusion. ***{fig vii}***
17. All the wax pattern were cast and metal units were tried – in and adjusted for proximal contact and occlusion.***{fig viii}*** Definite restorations with porcelain fused to metal crowns exhibiting a vital and a natural appearance with proper contour, shade and optimal incisal translucency were designed. ***{fig ix}*** Permanent was done glass ionomer type I { GC Corp, Tokyo} luting cement.***{fig x}***
18. Oral hygiene instructions were reviewed, emphasizing brushing habits and use of floss threader and dental floss.

DISCUSSION

Every patient has unique treatment requirements. Proper diagnosis and treatment plan are an important aspect for full mouth rehabilitation. Planning is done with occlusal analysis, diagnostic waxup and correct programming of semi adjustable articulator. The treatment goal was to provide proper restorative treatment – to restore to worn out surfaces to enhance mastication and to improve the esthetic appearance. The final prosthesis with mutually protective occlusion was esthetically pleasing with good marginal fit.

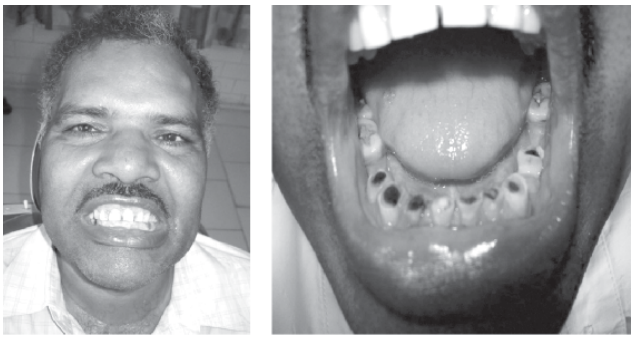


Fig I - Pre operative photograph

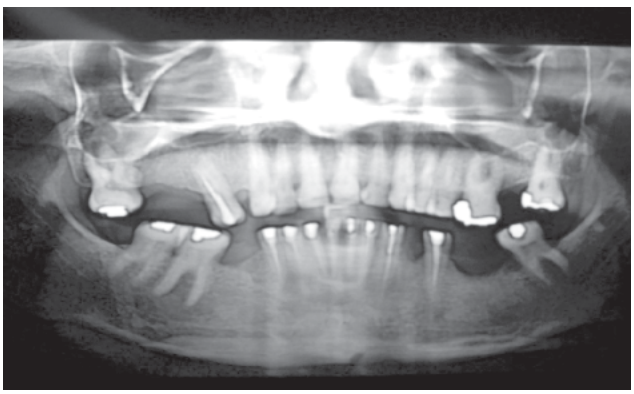


Fig II -OPG

Fig III - Occlusal analysis by Broadrick occlusal plane analyser

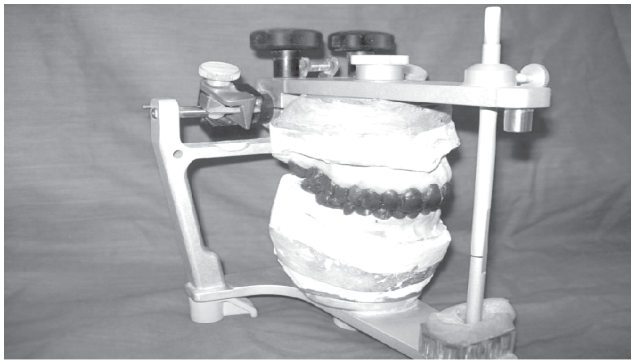


Fig IV - Mock Wax-up

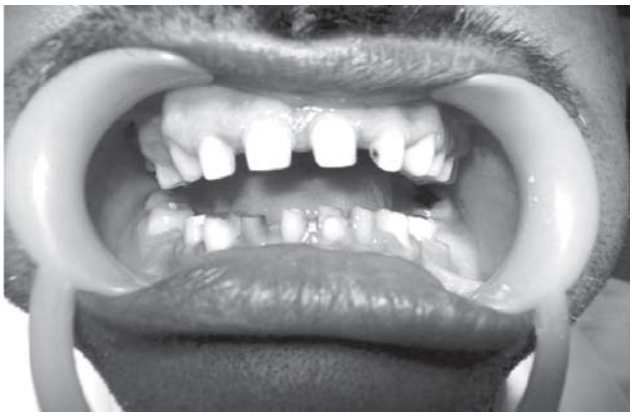


Fig V - Prepared teeth

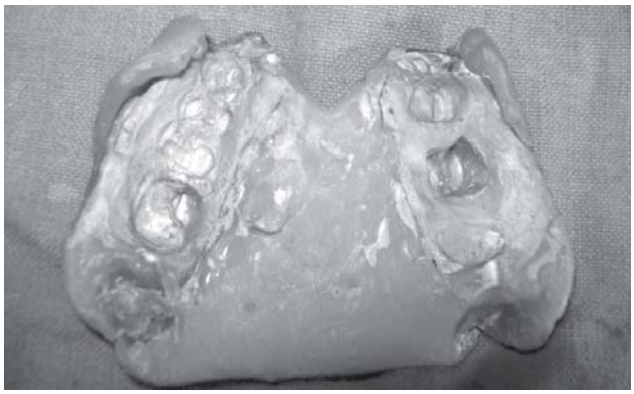


Fig VI – Interocclusal record

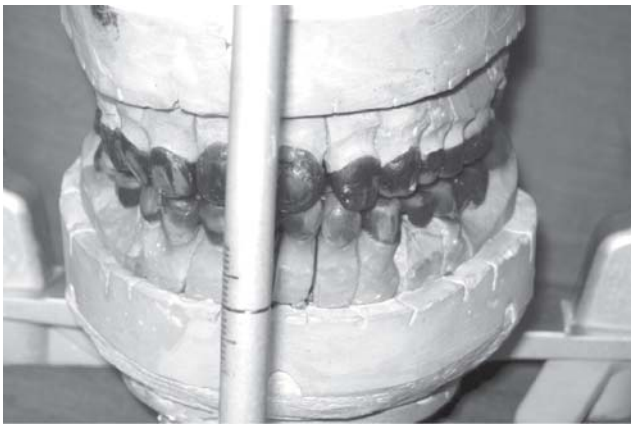


Fig VII - Die prepared and wax-up done

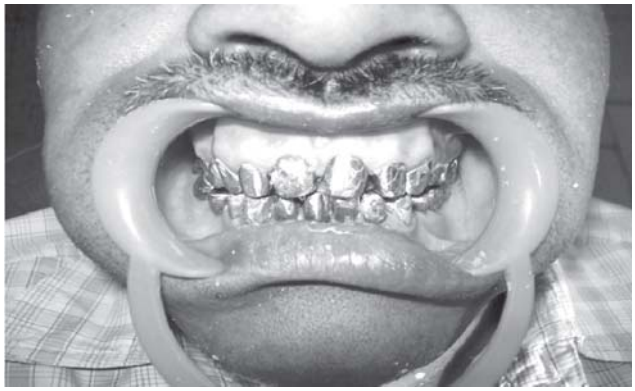


Fig VIII - Metal try-in

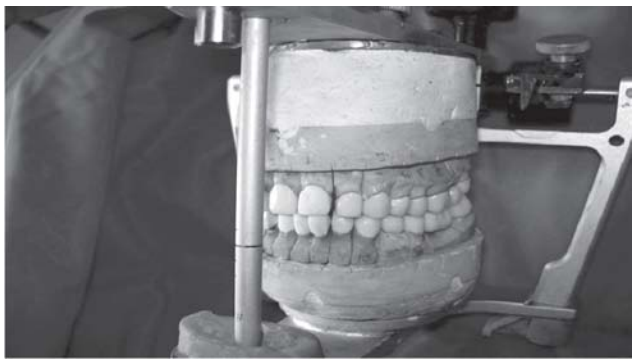


Fig IX - Ceramic build up

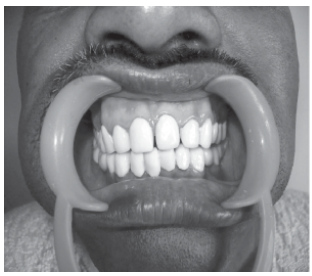


Fig X - Post operative photographs

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Every tooth in a man's head is more valuable than a diamond. ~ Miguel de Cervantes, Don Quixote, 1605

If suffering brought wisdom, the dentist's office would be full of luminous ideas. ~ Mason Cooley

Some tortures are physical, And some are mental, But the one that is both, Is dental. ~ Ogden Nash

Dentist: a prestidigitator who, putting metal into your mouth, pulls coin out of your pocket. ~ Ambrose Bierce

My health plan doesn't cover dental, so I enrolled my teeth as 32 dependents, each needing a complete physical once a year. ~ Robert Brault

You know, sometimes a man just can't satisfy all of a woman's desires, which is why God invented dental floss.

Adam and Eve had many advantages, but the principal one was that they escaped teething. ~ Mark Twain

I'm always amazed to hear of air crash victims so badly mutilated that they have to be identified by their dental records. What I can't understand is, if they don't know who you are, how do they know who your dentist is? ~ Paul Merton

Tooth decay was a perennial national problem that meant a mouthful of silver for patients and for dentists a pocketful of gold. ~ Claudia Wallis

There are two things in life that a sage must preserve at every sacrifice, the coats of his stomach and the enamel of his teeth. Some evils admit of consolations, but there are no comforters for dyspepsia and the toothache. ~ Henry Lytton Bulwer

A man loses his illusions first, his teeth second, and his follies last. ~ Helen Rowland

All this fuss about sleeping together, for physical pleasure I'd sooner go to my dentist any day ~ Evelyn Waugh

I told my dentist my teeth are going yellow. He told me to wear a brown tie. ~ Rodney Dangerfield

I was never afraid of anything in the world except the dentist ~ Taylor Caldwell

GLIMPSES OF ACTIVITIES OF IDA, KOCHI

An emotional Dr.Noorudeen at the Installation Ceremony, November 2011

The outgoing president Noorudeen administering oath to the incoming President Dr. Vinod Mathew

The first presidential address by Dr. Vinod Mathew

"The Jubilant Trio" (President Dr. Vinod Mathew, Secretary Dr. Arun Babu and Treasurer Dr. Jayakumar

The new team of IDA, Kochi under the Presidentship of Dr. Vinod Mathew

Chief guest Sri Benny Behnan addressing the gathering at the Installation Ceremony

The guests at the Installation Ceremony

The family of IDA Kochi members at the Installation Ceremony

"THE HAPPY SMILE" – A patient who received free denture at the Denture Camp

ECM on a boat January 2012

"THE ANTICIPATION"EC Members ready for the cruise

"SHADY DEALS" Meeting behind the "shade" for sponsorship

Dr. Vivy Pulayath in Action A CDH Activity

The Cricketers IDA Kochi

"LISTEN WHEN THE ELDERS SPEAK" Dr.K.L. Baby making a point in the Executive Committee Meeting

"OH, WHAT A FEELING…AND THE PANDIT MANIA" Scene from Movie Club

Staff training program - Dr. Ajikumar

Staff training program - Rotarian Shameen

Staff training program - Dr. Noorudeen

Staff training program - Dr. Sunil Alexander

Staff training program - Dr. Civy V. Pulayath

State Executive Committee Meeting

Monthly Meeting - Dr. Eldo Koshy

Participants - CDE Program

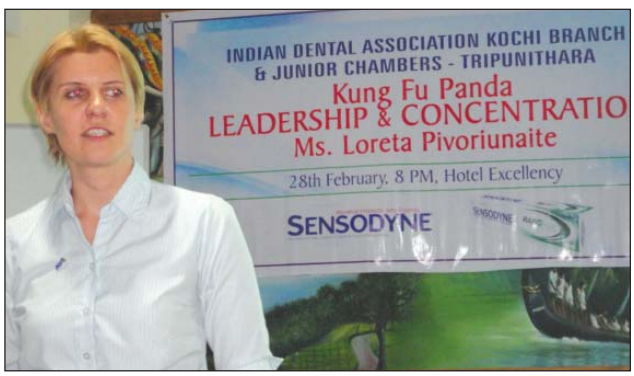
Head Office Training Program - Dr. Ajith Shaligram

Monthly Meeting Mrs. Sapna Vinod

CDE Program - Dr. Raj Kumar

ECM

Monthly Meeting - Dr. Eldo Koshy



International Training Program with Ms. Loreta Pivoriunaite

International Training Program with Ms. Loreta Pivoriunaite

Monthly Meeting Dr. Eldo Koshy

Secretary's Address at Dentists' Day

Dr. Civy's class at Dentists' Day

Dr. Preethy - X'Mas & New Year Celebrations

X'Mas & New Year Celebrations

X'Mas & New Year Celebrations

FDI - IDA Meet

Participants - Monthly Meeting

Little Wonders

Inauguration ceremony Dentists' Day

CDH Chairmans address at Dentists' Day

State Presidents address Dentists' Day

Dentists' Day 2012 Mercy Hotel

Training Centre program - Dr. Ajith Shaligram

Memento to Dr. Raj Kumar from Dr. Mathew Varghese - CDE Program

Media Awards at Dentists Day

Media Awards at Dentists Day

Sri. Salim Kumar, Chief Guest at Dentists' Day

Rotary Knights and IDA Kochi contributing water purifier to Isolation ward for General Hospital

Ms. Simy with IDA Office Bearers

Dr. Siby Chennankara at Monthly Meeting

Kungfu Panda concentration and leadership skills program by International Trainer Ms. Loreta Pivornaite

Dental Assistants' Training Programme

The Foreign Hand FDI-IDA Meet, held in Kochi

FDI-IDA CDE Programme

ACUTE LEUKEMIA PRESENTING AS GINGIVAL ENLARGEMENT

Dr. N. Mohan

Co-author Dr. Jayashree Mohan, Professor and Head of the Department, Department of Oral Medicine and Radiology, VMS Dental College, Salem – 636 308

ABSTRACT

Oral Manifestations may be the presenting feature in some cases of Acute Leukemia. The recognition and referral of these cases is important for a practicing dental surgeon. Leukemia is a Neoplastic disease characterized by an excessive proliferation of immature white blood cells and their precursors. A patient with Acute Myeloblastic Leukemia presenting to the dental surgeon with a gingival enlargement is presented here. The nature of the gingival enlargement in Leukemia is discussed along with other oral manifestations in leukemia.

KEY WORDS

Acute Leukemia, Oral Manifestations, Gingival enlargement, Diagnosis by dental surgeon.

INTRODUCTION

The leukemias are malignant neoplasms of the Hematopoietic stem cells characterized by diffuse replacement of the bone marrow by neoplastic cells. Leukemia may be classified[1] depending on the course of the disease as:-

- Acute Leukemia
- Chronic Leukemia

Depending of type of cell involved as:-

- Myeloid
- Lymphoid
- Monocytic

Thus four Major type of leukemia may be noted:-

- Acute Lymphoblastic Leukemia (ALL)
- Acute Myeloid Leukemia(AML)
- Chronic Lymphocytic Leukemia(CLL)
- Chronic Myelogenic leukemia(CML)[1]

Acute Lymphoblastic leukemia(ALL) is commonly seen in children and young adults and Acute Myeloblastic leukemia(AML) is more common in adults. [1,2,14]

Acute Myelocytic Leukemia (AML) is divided into seven subtypes based on the morphology of the cell as follows:

M1 – Myeloblastic leukemia without maturation,

M2 – Myeloblastic leukemia with maturation,

M3 – Hypergranular promyelocytic leukemia,

M4 – Myelomonocytic leukemia,

M5 – Monocytic leukemia,

M6 – Erythroleukemia,

M7 – Acute megakaryocytic leukemia.

Various etiologic factors have been suggested in leukemia including Genetic factors, Ionising radiation, Oncogenes, Exposure to chemicals and Viruses like HTLV1, HTLV2 and Epstein Barr virus.

Clinical Features of AML: Acute Lymphoblastic Leukemia is the most common Leukemia in children (Usually 3 to 5 years of age), while Acute Myeloblastic Leukemia is the most common type in adults[3]. Anaemia, fatigue and shortness of breath may be the presenting feature. Spontaneous bleeding, petechiae and expistaxis due to thrombocytopenia. Fever, generalized lymphadenopathy, abdominal pain with hepatic and splenic enlargement due to leukemic infiltration are also seen.

Oral manifestations:

Gingival enlargement and bleeding [4,5,6,7,8]

Mucosal ulcerations

Candidal infections

Pallor of mucosa with ecchymosis

Rapid periodontal destruction

Cervical lymphadenopathy

CASE REPORT

A 20 year old female patient presented with a complaint of sudden enlargement of the gums of 2 weeks duration. She also had difficulty in swallowing and mastication. (Fig.1) History revealed that she was feeling weak and extremely tired since 2 weeks and was having an abnormally increased menstrual flow. Clinical examination revealed multiple enlarged, firm, lymph nodes in the submandibular and cervical regions. Intra oral examination showed the presence of generalized gingival enlargement. (Fig.2, 3) The interdental papillae were swollen and bulbous, reddish and severe in canine region. A few petechial haemorragic spots were noted in the soft palate region.

Blood investigations revealed a leukocytosis (17,250 cells/cmm), Anemia and a platelet count of 36,000 cells/cmm). A peripheral smear study revealed a marked increase in the WBCs with large round to oval cells and moderate cytoplasm, oval nuclei with 2 -4 nucleoli. Many mature

lymphocytes were seen but no mature neutrophil was identified. Further investigations were done after the patient was referred to the Pathology Department. Special stains showed Periodic Acid Schiff Negative and Sudan Black B positive cells. (Fig.6) Leishman's stain showed myeloblast cells.(Fig.7) A Bone marrow biopsy after the patient was hospitalized confirmed the diagnosis of Acute Myeloblastic Leukemia (AML) – M1.

Despite the starting of Induction chemotherapy the gingival enlargement increased rapidly and became bluish-red, boggy and bled spontaneously. Ulceration and necrosis was also noted after a few days during the treatment. (Fig. 3 and 4) Gingival biopsy was not performed because of the low platelet count. The patient did not respond to chemotherapy and died within 3 months of Diagnosis.

DISCUSSION

Oral pathoses tend to be frequent signs or symptoms in patients with undiagnosed leukemia. In patients with Acute lymphocytic leukemia, approximately 89% have oral problems. Almost two-thirds of oral changes play a major role in diagnosis of Acute Leukemia in some patients. Patients should be questioned about their general health, past episodes of symptoms, systemic signs of myelosuppression, ecchymosis A differential count showed the Blast cells to be 78%. (Table -1.)

elsewhere, menhorragia, unrelenting pharyngitis, fever, malaise and weight loss. Sudden onset of generalized gingival enlargement without local factors and very high WBC count should give the suspicion of Leukemic gingival enlargement and reference to a Heamatologist or pathologist should be done without further delay.[3,8,13]

ORAL CHANGES IN LEUKEMIA

Apart from gingival enlargement, mucosal ulcerations, bleeding, petechial haemorrhages, mucosal pallor, herpetic infections, candidiasis and soft tissue growths are the other manifestations seen in leukemias. Localized tumors consisting of leukemic cells, called Chloromas are seen rarely in the orofacial region.[1,14]

GINGIVAL ENLARGEMENT IN LEUKEMIA[5,6,8,10]

In leukemic enlargement the gingiva differs clinically from that of non-leukemic individuals. It is a peculiar bluish red colour, markedly sponge-

like and friable and bleeds persistently upon the slightest provocation or even spontaneously. Clinical changes that occur in acute and subacute leukemia include a diffuse, cyanotic bluish red discolouration of the entire gingival mucosa (Surface becomes shiny)), a diffuse edematous enlargement obliterating the details of normal surface markings, a rounding and tenseness of the gingival margins, blunting of the interdental papillae and varying degrees of gingival inflammation with ulceration, necrosis and pseudeomembrane formation. There is considerable variation in the gingival and periodontal changes observed in acute and subacute leukemias.

Formation of lesions of the gingival is unrelated to sex, age and WBC count. Gingival lesions are particularly prone to infectious complications in patients with poor oral hygiene.[6] A gingival biopsy may indicate the presence leukemic infiltration in the tissues and help in the diagnosis of Leukemia.[10] In diagnosed cases of leukemia, a biopsy may indicate the extent to which leukemic infiltration is responsible for the enlargement. The absence of leukemic cells in gingival biopsy does not rule out the possibility of leukemia. However a biopsy may not be possible in all the cases because of bleeding diathesis and decreased immune function. Gingival fine needle aspiration cytology (FNAC) has been suggested as a substitute for biopsy. FNAC can be a simple, non-traumatic and useful diagnostic procedure for screening for leukemic infiltration in gingival tissues in Acute Leukemia patients.[11]

Of major importance in dental practice is the propencity for a haemorrhagic diathesis due to inability of platelets to be produced in the neoplastic bone marrow (Myelophthisic Thrombocytopaenia).[9]

CONCLUSION

Oral changes may be the presenting symptoms in some cases of Acute Leukemia. Recognition of Gingival enlargement and other signs of Acute Leukemia by the dental surgeon can help in the early diagnosis and referral of the patient with leukemia.

Table -1 ***Hematological findings***

Haemoglobin (Hb)	**8.2 gms%**
Total WBC Count	**17,250 cells/ Cu mm.**
Neutrophils	**5%**
Lymphocytes	**92%**
Monocytes	**01%**
Eosinophils	**02%**
Platelet count	**36,000 cells/ Cu mm.**

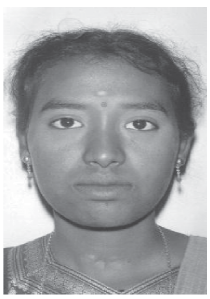


Fig. 1

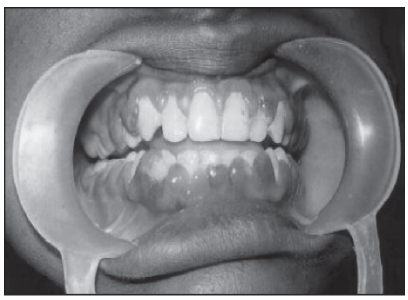


Fig.2 Gingival enlargement at presentation

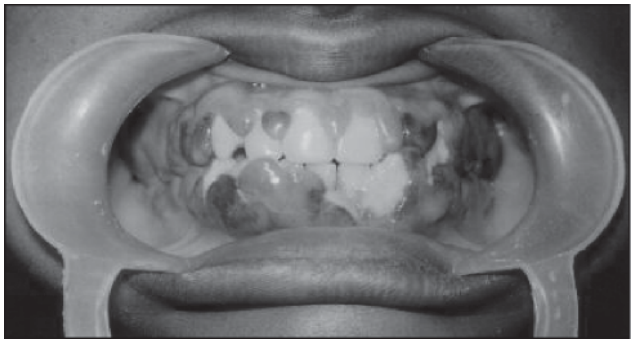


Fig.3 After 1 week

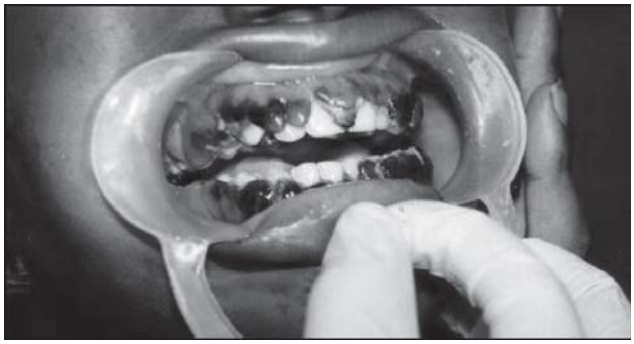


Fig.4 After 3 weeks

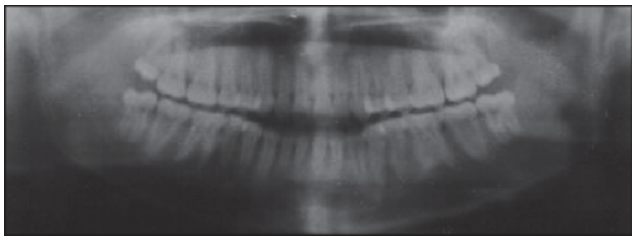


Fig.5 Panoramic radiograph of the patient

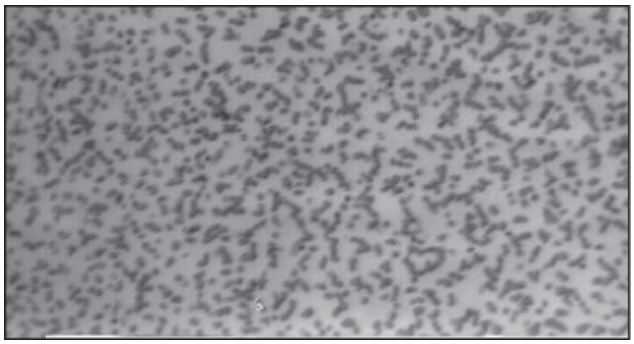


Fig.6 Leishman's stain showing myeloblast cells

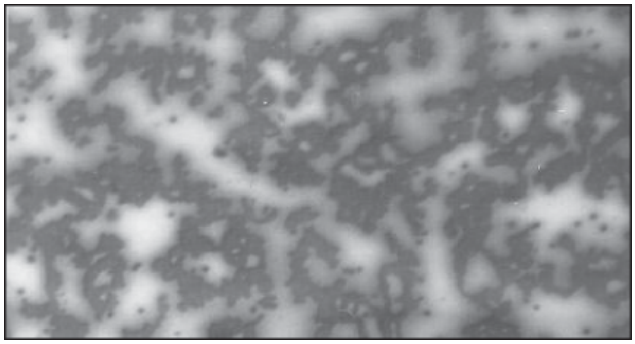


Fig.7 Sudan Black B positive cells

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Your charge as a dentist is to be a professional. If you are going to call yourself a *professional*, if you want to be recognized as a professional, and if you want to be a professional, then you must conduct yourself as one. Otherwise you run the risk of assuming the title without accepting the obligations.

Have you ever thought why a patient complains about your attitude? Or why they discuss your nature of treatment modalities based on the treatment charges? Or why you become so unpopular among your old patients or why you are unpopular among your peers? Some of these questions, in the truest sense in hindsight will help you to introspect yourself to what and how others perceive you. And it is important that perceptions of patients and your peers remain clean so as to genuinely consider yourself as a professional!

On receiving your degree in dentistry, you officially became a participant in a profession. Do not assume that a participant is necessarily a professional. Strive to become a dental professional in the truest sense of the term. What does this really mean? A professional respects patients for their unique needs and values. A professional places patients' interests first and foremost, with only rare, legitimate exceptions. A professional always considers patients' values and relevant personal preferences. A professional has integrity. A professional is honest. A professional is competent. A professional strives to improve personally and to effect improvement in the profession. A professional actively supports professional organizations. A professional is concerned about conduct and perceptions of conduct. A professional is *ethical*.

The term "professional," refers to one who practices a *learned* profession, i.e., one who has special knowledge and skills used to benefit the public, regardless of personal gain. This separates the learned professions from those self-proclaimed "professions" that essentially exchange goods and services.

Becoming a professional is a lifelong process of consistent behavior affirming the principles of your beliefs. Your conduct in a professional capacity ultimately establishes your status as a professional. Strive to be a true professional, and by so doing, make a significant contribution to dentistry, society, and most importantly, the patients you serve.

The ACD Test
For Ethical Decisions

Assess

Is it true?
Is it accurate?
Is it fair?
Is it quality?
Is it legal?

Communicate

Have you listened?
Have you informed the patient?
Have you explained outcomes?
Have you presented alternatives?

Decide

Is now the best time?
Is it within your ability?
Is it in the best interests of the patient?
Is it what you would want for **yourself**?

The ACD Test for Ethical Decisions prompts questions that should be considered when deliberating an ethical dilemma.

Core values represent a guide for ethical behavior. The core values that follow are from the American College of Dentists, and are the foundation from which its principles are derived. These values collectively reflect the character, charter, and mission of the College (in alphabetical order):

Autonomy—Patients have the right to determine what should be done with their own bodies. Because patients are moral entities they are capable of autonomous decision-making. Respect for patient autonomy affirms this dynamic in the doctor-patient relationship and forms the foundation for informed consent, for protecting patient confidentiality, and for upholding veracity. The patient's right to self-determination is not, however, absolute. The dentist must also weigh benefits and harms and inform the patient of contemporary standards of oral health care.

Beneficence—Beneficence, often cited as a fundamental principle of ethics, is the obligation to benefit others or to seek their good. While balancing harms and benefits, the dentist seeks to minimize harms and maximize benefits for the patient. The dentist refrains from harming the patient by referring to those with specialized expertise when the dentist's own skills are insufficient.

Compassion—Compassion requires caring and the ability to identify with the patient's overall well-being. Relieving pain and suffering is a common attribute of dental practice. Acts of kindness and a sympathetic ear for the patient are all qualities of a caring, compassionate dentist.

Competence—The competent dentist is able to diagnose and treat the patient's oral health needs and to refer when

it is in the patient's best interest. Maintaining competence requires continual self-assessment about the outcome of patient care and involves a commitment to lifelong learning. Competence is the just expectation of the patient.

Integrity—Integrity requires the dentist to behave with honor and decency. The dentist who practices with a sense of integrity affirms the core values and recognizes when words, actions or intentions are in conflict with one's values and conscience. Professional integrity commits the dentist to upholding the profession's Codes of Ethics and to safeguarding, influencing and promoting the highest professional standards.

Justice—Justice is often associated with fairness or giving to each his or her own due. Issues of fairness are pervasive in dental practice and range from elemental procedural issues such as who shall receive treatment first, to complex questions of who shall receive treatment at all. The just dentist must be aware of these complexities when balancing the distribution of benefits and burdens in practice

Professionalism—Self-governance is a hallmark of a profession and dentistry will thrive as long as its members are committed to actively support and promote the profession and its service to the public. The commitment to promoting oral health initiatives and protecting the public requires that the profession works together for the collective best interest of society.

Tolerance—Dentists are challenged to practice within an increasingly complex cultural and ethnically diverse community. Conventional attitudes regarding pain, appropriate function, and esthetics may be confounded by these differences. Tolerance to diversity requires dentists to recognize that these differences exist and challenges dentists to understand how these differences may affect patient choices and treatment.

Veracity—Veracity, often known as honesty or truth telling, is the bedrock of a trusting doctor-patient relationship. The dentist relies on the honesty of the patient to gather the facts necessary to form a proper diagnosis. The patient relies on the dentist to be truthful so that truly informed decision-making can occur. Honesty in dealing with the public, colleagues and self are equally important.

Requesting all Dental Clinics, Dental Hospitals & Dental Surgeons to uphold this noble profession, complying with the Dental Ethics, creating a level playing field, bringing awareness rather than campaigning so as to bring cohesiveness among the dental fraternity and disseminating proper relevant Oral and dental care information and treatment to the society.

*Compiled & Written by **Dr. Vinod Mathew** in the Interest of this Noble Profession*

Dental Update

Newly Identified Oral Bacterium Linked to Heart Disease and Meningitis

A novel bacterium, thought to be a common inhabitant of the oral cavity, has the potential to cause serious disease if it enters the bloodstream, according to a study in the International Journal of Systematic and Evolutionary Microbiology. Its identification will allow scientists to work out how it causes disease and evaluate the risk that it poses.

The bacterium was identified by researchers at the Institute of Medical Microbiology of the University of Zurich and has been named Streptococcus tigurinus after the region of Zurich where it was first recognised. S. tigurinus was isolated from blood of patients suffering from endocarditis, meningitis and spondylodiscitis (inflammation of the spine). It bears a close resemblance to other Streptococcus strains that colonise the mouth. Bleeding gums represent a possible route of entry for oral bacteria into the bloodstream.

The similarity of S. tigurinus to other related bacteria has meant that it has existed up until now without being identified. Its recent identification is clinically important, explained Dr Andrea Zbinden who led the study. "Accurate identification of this bacterium is essential to be able to track its spread. Further research must now be done to understand the strategies S. tigurinus uses to successfully cause disease. This will allow infected

patients to be treated quickly and with the right drug."

Irreversible Damage To Teeth Caused By Sports And Energy Drinks

A recent study published in the May/June 2012 issue of General Dentistry, the peer-reviewed clinical journal of the Academy of General Dentistry, found that an alarming increase in the consumption of sports and energy drinks, especially among adolescents, is causing irreversible damage to teeth - specifically, the high acidity levels in the drinks erode tooth enamel, the glossy outer layer of the tooth.

"Young adults consume these drinks assuming that they will improve their sports performance and energy levels and that they are 'better' for them than

Continued on page 38

THREE GENERATIONS OF HEREDITARY GINGIVAL FIBROMATOSIS: CASE REPORT

Angel Jacob* and Maya Rajan Peter**
*Associate Professor ** Post Graduate Student, Dept of Periodontics, Amrita School of Dentistry

ABSTRACT:
Hereditary Gingival Fibromatosis (HGF) is traditionally considered an autosomal dominant disease. It is characterized by a slowly progressive, benign enlargement of the keratinized oral gingival tissues. Gingival tissues surrounding both the maxillary and the mandibular dentition may be affected. As a result, the teeth become buried to various degrees, beneath the redundant hyperplasic tissues, which results in both aesthetic and functional problems. Although genetic factors appear to play a significant role in many types of gingival fibromatosis, the under lying genes responsible for these disorders are unknown. Here we report a case of hereditary gingival fibromatosis seen through three generations, daughter, mother and grandmother. We discuss our patient's clinical findings, histopathological evaluation, analysis and treatment plan.

Key-words: Hereditary, Gingival Fibromatosis, Heat shock proteins, Syndrome

Key Messages: The mental trauma of the patient with HGF has to be taken into consideration due to the rapid recurrence rate after treatment. Other associated co morbidities have to be looked into further to see whether any syndromes are associated with the gingival fibromatosis. This should be an area of active research trying to find out the exact cause and the remedies that can be formulated based on stem cell therapy and molecular biology research.

INTRODUCTION

Gingival enlargement is the overgrowth of the gingiva characterized by an expansion and accumulation of the connective tissue with occasional presence of increased number of cells.[1] It is caused by several factors, such as inflammation, leukemia, drugs, and inheritance.

Hereditary Gingival Fibromatosis (HGF) is traditionally considered an autosomal dominant disease. It is characterized by a slowly progressive, benign enlargement of the keratinized oral gingival tissues. Gingival tissues surrounding both the maxillary and the mandibular dentition may be affected. As a result, the teeth become buried to various degrees, beneath the redundant hyperplasic tissues, which results in both aesthetic and functional problems. The gingival enlargement usually begins at the time of eruption of the permanent dentition but can develop with the eruption of the deciduous dentition and rarely is present at birth[2,3]. The presence of teeth seems to be necessary for HGF to occur because the condition disappears or recedes with the loss of the teeth. Although HGF most commonly presents as an isolated clinical finding, it is also known to occur as part of a number of syndromes.[4] Syndromic gingival fibromatosis has been associated with ancillary features such as hypertrichosis, mental retardation, epilepsy, progressive sensorineural hearing loss and abnormalities of the extremities, particularly of the fingers and toes. The relationship between isolated hereditary and syndromic presentations of gingival fibromatosis is unclear. The most common effects are diastemas, malpositioning of teeth, prolonged retention of primary dentition, delayed eruption, cross bites and open bites, prominent lips, and open lip posture. Although the gingival enlargement does not directly affect the alveolar bone, the gingival swelling may increase the bacterial plaque accumulation, inducing periodontitis and bone resorption and halitosis.

In addition to Mendelian and syndromic forms, gingival fibromatosis is also known to be induced by certain classes of drugs, including phenytoin, calcium channel blockers and cyclosporin.[5] Although these drugs differ in their primary target tissues, they share similarities with respect to their pharmacological mechanisms of action at the cellular level and they may act similarly on a common secondary tissue, such as gingival connective tissue.

This differential potential to develop gingival fibromatosis after exposure to these drugs may have a genetic basis that determines whether an individual is a responder or not. Although genetic factors appear to play a significant role in many types of gingival fibromatosis, the under lying genes responsible for these disorders are unknown.

The gingival tissues are usually pink and non haemorrhagic, and have a firm, fibrotic consistency. Histopathologically, the bulbous increased connective tissue is relatively a vascular and has densely arranged collagen fibre bundles, numerous fibroblasts and mild chronic in-

flammatory cells. The overlying epithelium is thickened and acanthotic and has elongated rete ridges.

Here we report a case of hereditary gingival fibromatosis seen through three generations, daughter, mother and grandmother. We discuss our patient's clinical findings, histopathological evaluation, analysis and treatment plan.

CASE HISTORY

An eleven year old girl was referred from the department of Pediatric dentistry with complaints of enlargement of the maxillary and mandibular gingiva. She has no physical abnormalities, no associated syndromes and her mental status was also normal. She has no history of intake of any anti epileptic, antihypertensive or immunosuppressive medications that could contribute to the gingival enlargement. The enlargement started since the age of two when her deciduous teeth started erupting. She has a history of two previous surgeries at the age of 4 and at the age of 6. The gingival enlargement recurred within 2 months of surgery.

Intraoral examination revealed moderate to severe gingival overgrowth of a firm, dense and fibrotic consistency that involved both the maxillary and mandibular arches. The gingiva covered three fourths of the crows of the anterior teeth and almost full crown of the erupting premolars. Figure 1

An orthopantomogram revealed a normal mixed dentition. Figure 2

FAMILY HISTORY

Family history revealed that her grandmother was affected by similar condition that involved all her teeth. The enlargement disappeared when she lost her teeth except on one remaining central incisor Figure 5. Her siblings and parents did not have a history of a similar condition.

The patient's mother was affected by the similar condition and had gingivectomy and orthognathic surgery done to correct her prognathic mandible Figure 6. Both the mother and grand mother did not give a history of any drug intake that can cause gingival fibromatosis.

HISTOPATHOLOGICAL FINDINGS

The attached gingiva excised from the buccal and interdental areas during surgery was immediately fixed in 10% buffered formaldehyde solution and sent for histopathologic examination. The specimen was processed and then embedded in paraffin wax. Multiple 5mm serial sections were prepared, stained with hematoxylin and eosin, and viewed under a binoculor light microscope with flat – field objective lenses at 10x and 40x magnifications.

The microscopic evaluation of these sections revealed hyper parakeratinized squamous epithelium, which was hyperplastic with elongated rete ridges. The underlying connective tissue was moderately fibrous with bundles of collagen fibres and the inflammatory component was minimal suggestive of a fibrotic gingival enlargement. Figure 3

TREATMENT

The patient initially underwent phase 1 periodontal therapy that comprised of scaling and root planning and oral hygiene instructions.

Surgical phase involved gingivectomy using electro cautery in the mandibular arch and in the maxillary arch an internal bevel gingivectomy. There are no signs of recurrence after one year. Figure 4

DISCUSSION

Gingival fibromatosis can occur in isolation or associated with various syndromes like Rutherford syndrome, Zimmerman-Laband syndrome, Ramon syndrome, Murray-Puretic-Drescher syndrome, Prune belly syndrome, Cross syndrome, Jones syndrome and can also be associated with hypertrichosis.

Three different loci associated with the isolated form of HGF:Ttwo map to chromosome 2 (GINGF on 2p21-22 and GINGF3 on 2p22.3-p23.3. [6,7,8]Recent findings have identified a mutation in the SOS-1 gene that segregates the hereditary (GINGF) to a 3.8-cM region on 2p21, which do not overlap, and one maps to chromosome 5 (GINGF2 on 5q13-q22).[9] Of these loci, only the SOS1 (son of sevenless one) gene underlying the GINGF locus has been identified.[10]gingival fibromatosis phenotype. There is also an autosomal dominant or recessive form of inheritance.

Since in this case there is a history of familial occurance of gingival fibromatosis, it can be considered as hereditary gingival fibromatosis. The specific genetic basis for hereditary gingival fibromatosis should help elucidate the pathogenic mechanisms that cause gingival enlargement.

Tipton et al demonstrated that c-myc proto-oncogene expression specifically drives the elevated proliferation of HGF fibroblasts [11] Fibroblasts from HGF proliferate faster than those of normal gingiva. [12, 13, 14] and a greater percentage of cells are in G2/M and S phases of the cell cycle than normal cells. [15]

Highly proliferative HGF cells produced elevated levels of fatty acid synthase (FAS) and androgen receptors and it has been shown that FAS inhibition significantly reduces HGF proliferation, suggesting a role for the androgen-driven fatty acid biosynthesis in HGF fibroblast proliferation. [16] Testosterone also induces proliferation and interleukin- 6 (IL-6) production by HGF fibroblasts, indicating a role of sex hormones on HGF gingival enlargement.

Another relevant feature in HGF pathogenesis is the synthesis of collagen. There is 30% to 50% more total collagen than normal gingival fibroblasts. [17] Type I collagen with a normal stoichiometry of [a1(I)]2[a2(I)] is the major collagen type produced by HGF. The levels of

heat shock protein 47 (Hsp47), a specific molecular chaperone for type I collagen that binds to it, preventing premature folding and aggregation, is also increased significantly in cultured HGF fibroblasts compared to normal fibroblasts.[18] Hsp47 has also been reported to have an inhibitory effect on the degradation of procollagens in the endoplasmatic reticulum. Therefore, in HGF fibroblasts with enhanced type I collagen synthesis, an increase in the Hsp47 levels may be necessary to maintain the stoichiometry of the interaction between the two molecules. Hsp47 may play an important role in the post-translational processing of the overproduced type I procollagen chains, leading to the accumulation of collagen in HGF gingiva.

Increased synthesis of other extracellular matrix components, such as fibronectin and glycosaminoglycans, are also increased in HGF. [19] There is also diminished extracellular matrix degradation in HGF. Collagen turnover in gingival tissues is high, and degradation occurs by two main pathways: fibroblast phagocytosis and degradation in the extracellular space by members of the matrix metalloproteinase (MMP) family of proteases. [20] MMP-2 inhibition may contribute to an abnormal accumulation of glycosaminoglycans and fibronectin, substrates[21] in the HGF gingival tissues. Consequently, the reduction of the degradative capacity of HGF cells may contribute to the increased collagen content even in the absence of type I collagen overexpression. Proliferation and connective tissue metabolism are controlled by cytokines and growth factors. Recent studies reveal abnormally high levels of specific cytokines, including IL-6 and transforming growth factor beta 1 (TGF-b1), TGF-b2, and TGF-b3, in gingival enlargement from HGF. TGF-b1 is a key regulator of the biochemical mechanisms associated in the pathogenesis of gingival overgrowth induced by cyclosporin and in HGF. TGF-b1 enhances fibroblast proliferation, not only by increasing the G1/S transition and DNA synthesis but also by shortening the G1 phase of the cell cycle. [22] TGF-b1 also induces myofibroblast transdifferentiation via connective tissue growth factor (CTGF) pathway. [23,24]

Hence the biologic mechanisms underlying development of gingival enlargement in HGF have is through activation or selection of the resident tissue fibroblasts, phenotypically characterized by increased proliferation, low levels of extracellular matrix-degrading metalloproteinase synthesis (MMP-1 and MMP-2), and abnormally high collagen production. Furthermore, the autocrine stimulation by excessive amounts of TGF-b1 produced by HGF cells contributes to those phenotypes. Myofibroblasts may be important to HGF pathogenesis in those cases where lesional cells are characterized by elevated production of CTGF [3].

Further studies are needed to understand the genetic, molecular and cellular basis of gingival enlargement. The fact that HGF decreases in the rate of growth after puberty further stresses the role of sex hormones in the development if this disease. In this case, the recurrence rate has come down drastically as compared to its recurrence when the patient was 4 years and 6 years of age. In addition to its impact on the emotional aspect of the patient, the overgrown gingival tissues harbours plaque and calculus and can lead to periodontal infection and bone loss.

The best time for treatment is after puberty when the recurrence is low. But taking into aspect its impact on the emotional well being of the patient, and if it interferes with the normal eruption of the deciduous dentition, surgery can be done anytime and can be repeated when there is recurrence. Maintenance therapy with oral hygiene measures can ensure that the inflammatory component can be can be reduced.

Various treatment modalities include external or internal bevel gingivectomy, electrocautery, carbondioxide laser and apically positioned flap. Here we did a combination of external bevel gingivectomy and internal bevel gingivectomy in the maxillary arch and electrocutery in the mandibular arch. The intention was to evaluate different treatment modalities and it was found that none was superior to the other.

The patient is on constant follow up and now after 6 months she does not show signs of recurrence. Further investigations are needed in this patient to assess the genetic factors associated in the hereditary mode of transmission and if there are other associated genetic defects.

CONCLUSION

Hereditary gingival fibromatosis begins with eruption of teeth and disappears when the teeth is lost. It is best to perform gingivectomy after puberty but taking into account the patient's inability to perform oral hygiene measures and the emotional well being, surgery can be performed at any age and recurrence can be retreated. The genetic factors need to be looked into and other associated problems assessed and taken into consideration while treating a case of hereditary gingival fibromatosis.

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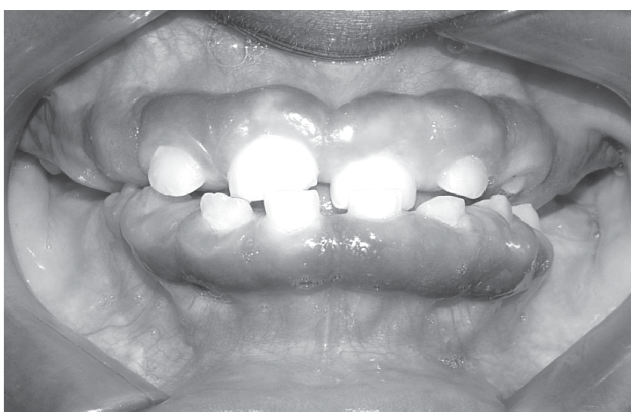


Fig. 1 Clinical photograph

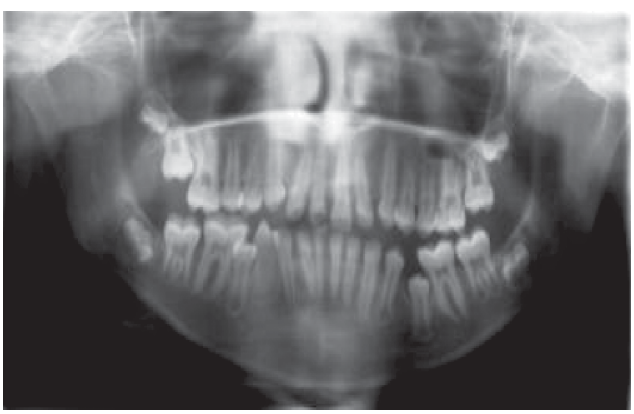


Fig. 2 Panoramic radiograph

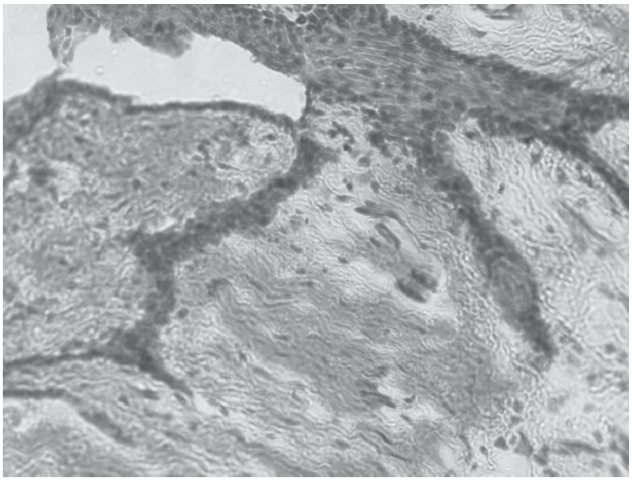


Fig. 3 Histopathology

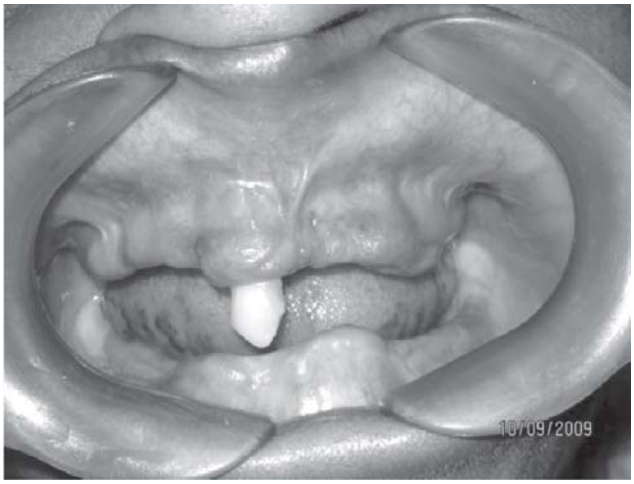


Fig. 5 Clinical photograph

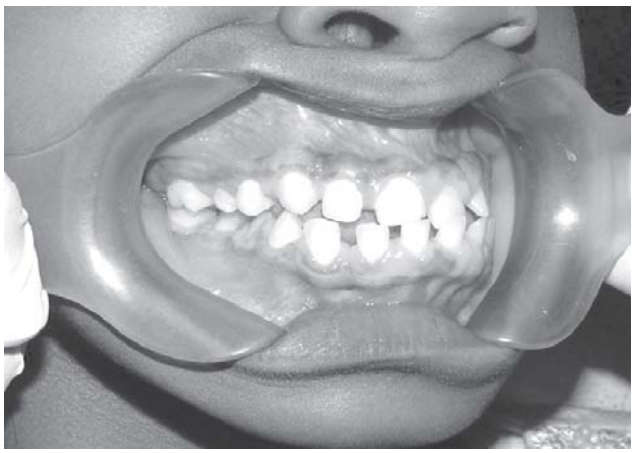


Fig. 4 Clinical photograph

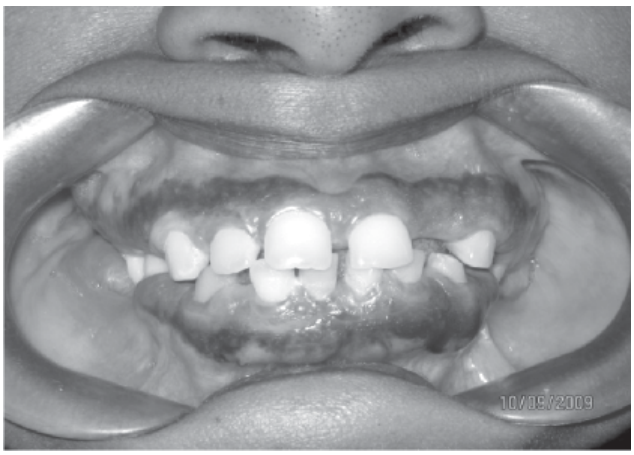


Fig. 6 Clinical photograph

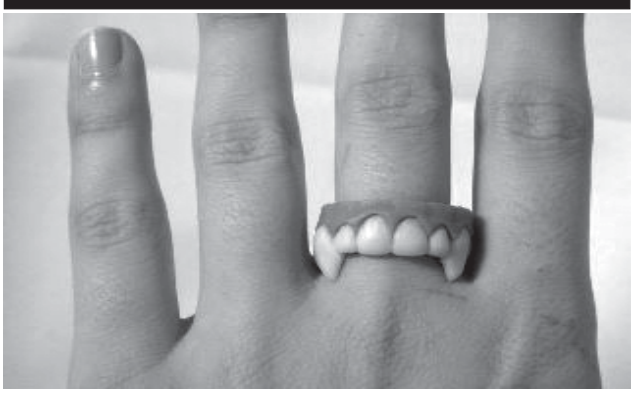
Continued from page 33

soda," says Poonam Jain, BDS, MS, MPH, lead author of the study. "Most of these patients are shocked to learn that these drinks are essentially bathing their teeth with acid."

The researchers found that damage to enamel was evident after only five days of exposure to sports or energy drinks, although energy drinks showed a significantly greater potential to damage teeth than sports drinks. In fact, the authors found that energy drinks caused twice as much damage to teeth as sports drinks.

With a reported 30 to 50 percent of U.S. teens consuming energy drinks, and as many as 62 percent consuming at least one sports drink per day, it is important to educate parents and young adults about the downside of these drinks. Damage caused to tooth enamel is irreversible, and without the protection of enamel, teeth become overly sensitive, prone to cavities, and more likely to decay. ●

INTERESTING PICTURE !



Oropharyngeal Candidiasis Associated with Use of Steroid Inhaler in Chronic Asthmatic Patient: A Case Report

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INTRODUCTION

Candidiasis or oral thrush is a fungal infection by any of the Candida species, of which *Candida albicans* is the most common. *Candida albicans* is a fungus that grows both as yeast and filamentous cells and is a causal agent of opportunistic oral and genital infections in humans. *Candida albicans* lives in 80% of the human population without causing harmful effect as a commensal, although overgrowth of the fungus results in candidiasis (candidosis), the term given for infection caused by *Candida albicans*. Most candidial infections are treatable and resulst in minimal complications such as redness, itching and discomfort, though complication may be severe or fatal if left untreated in certain populations.

In immunocompetent persons, candidiasis is usually a much localized infection of the skin or mucosal membranes, including the oral cavity (thrush), the pharynx or esophagus, the gastrointestinal tract, the urinary bladder, or the genitalia. A weakened or undeveloped immune system or metabolic illnesses such as diabetes mellitus or immunosuppressive therapy are significant predisposing factors for candidiasis. Diseases or conditions linked to candidiasis include HIV/AIDS, infectious mononucleosis, cancer treatments, steroids, stress, and nutritional deficiency.

The organisms are buried in the superficial layers of the epithelium and the treatment should be aimed at having the antifungal agent in contact with the affected areas (topical application). The antifungal drugs commonly used to treat candidiasis are clotrimazole, nystatin, fluconazole, and ketoconazole.

Bronchial asthma is a respiratory disorder which is associated with a high incidence, prevalence and mortality rate and the prevalence among the general population is increasing in the recent past. It is a very serious health problem for both children young adults and adults. Bronchial asthma is a chronic inflammatory disease of the airways characterized by air flow obstruction that is reversible, but not always completely. It may be acute life-threatening attack or chronic with mild to moderate or severe symptoms. The symptoms include wheezing, shortness of breath, chest tightness and coughing.

Management of bronchial asthma includes avoidance of allergens, hyposensitisation of allergens, oxygen administration, inhalation of bronchodilators or corticosteroids, and administration of systemic corticosteroids.

Although no oral lesions occur directly from asthma, indirect effects of asthma drug therapy can cause clinical lesions. Patients most prone to oral manifestations are chronic asthmatics who use corticosteroid inhalants. Repeated contact of steroid inhalant on the oral mucosa can result in the development of acute pseudomembraneous candidiasis (oral thrush) because of fungal overgrowth in an area of localized immunosuppression. This steroid-induced infection consists of *Candida albicans* colonies that appear as curdy white lesions located commonly on the soft palate and oropharynx. The lesions are usually asymptomatic but wiping the plaques reveals a red, raw or bleeding mucosal surface. Dysphonia, hoarseness of voice and pharyngeal discomfort may be concurrent and serve as additional signs of persistent steroid inhalant use.

CASE REPORT

A 55 years old male patient came to the department of Oral Medicine and Radiology, Amrita School of Dentistry, Cochin, on 22nd August 2011 with a complaint of roughness and peeling of tissue in the mouth since 2-3 months. His mouth was apparently normal till 3 months back. Then the mouth became rough to feel. He gives a history of bronchial asthma since 10 years. He was using bronchodilator inhaler for the past 7 years frequently and now changed to a steroid inhaler for the past 3 months. On intraoral examination, erosive areas on the tongue towards the tip were seen (Fig. 1). Diffuse erythematous lesions over the soft palate, uvula, palatoglossal folds and oropharynx with scrapable white patches were seen (Fig. 2). On gently rubbing these white patchy areas, erythematous area was visible.

Fig. 1 Tongue lesions

Fig. 2 Palatal lesions

CONCLUSION

Candida albicans is a common commensal of oral cavity

and overgrowth of the fungus results in candidiasis. The "DISEASE OF THE DISEASED" is an opportunistic infection. Repeated contact of steroid inhalant for the treatment of Bronchial asthma, on the oral mucosa can result in the development of acute pseudomembraneous candidiasis (oral thrush) because of fungal overgrowth in an area of localized immunosuppression. In this patient, candidiasis developed in the tongue, oropharyngeal and palatal regions.

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***Quatable quote*: "A patient judges a dentist by his feelings, not by his fillings".**

HUMOUR

So this is why there's no more "spit bowls" at the dentists' office?

Did you hear about the two little kids in a hospital who were lying next to each other? The first kid leans over and asked, "What are you in here for?"
The second kid said," I'm in here to get my tonsils out and I'm a little nervous."
The first kid said," You've got nothing to worry about, I had that done to me once. They put you to sleep and when you
wake up they give you lots of Jell-O and ice cream. It's a piece of cake!"
The second kid then asked, "What are you in here for?"
The first kid responded, "Well, I'm here for a circumcision."
The second kid said, "Whoa! I had that done when I was born. I couldn't walk for a year!"

I don't exercise at all.
If God had wanted me to touch my toes
He would have put them up higher on my body.

One of life's mysteries is how a two-pound box of candy can make a woman gain five pounds.

I'm in shape. Round is a shape.

The advantage of exercising everyday is that you die healthier.

What do you give a man who has everything? Antibiotics

ISSUE OF THIS ISSUE

RENAL DISORDERS AND DENTAL SIGNIFICANCE

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Is there any dental significance for renal disorders?

Some of the renal disorders such as chronic renal diseases and renal transplantation can often be associated with dental significance. These disorders can complicate dental treatment. The renal disorders are associated with the following features:

- Impaired excretion of drugs leading to retention of drugs and drug toxicity
- Hypertension
- Immunosuppression
- Anemia
- Neurological symptoms

Chronic renal failure and renal transplantation

Progressive and severe renal damage can occur due to chronic glomerulonephritis, chronic pyelonephritis, congenital renal anomalies, hypertension and diabetes mellitus. These can lead to chronic renal failure (CRF). CRF is clinically manifested as decreased glomerular filtration rate (GFR). The symptoms vary depending on the severity of the condition and in the initial stages of the disease, symptoms may not be present. Some of the clinically manifested features are excessive bleeding, anemia, infections due to immunosuppression, pruritis, hyperpigmentation, anorexia, nausea, vomiting, peptic ulcer, bleeding from the gastrointestinal tract, weakness, drowsiness, headache, sensory disturbances, tremors, hypertension, congestive heart failure (CHF), cardiomyopathy, excessive thirst, polyuria, increased serum urea and serum creatinine, elevated levels of lipids and uric acid, electrolyte disturbances, secondary hyperparathyroidism etc.

Dental significance

CRF in children can be associated with growth retardation and dental abnormalities. Concentration of urea in the saliva can lead to an ammoniacal odour to the breath. Uremic stomatitis is a condition that occurs due to elevated blood urea nitrogen (BUN). Uremic frost or white plaques may be seen in the skin or oral mucosa. Anemia may result in bale oral mucosa. Bone changes such as osteoporosis and osteolytic areas may be evident in radiographs. Secondary hyperparathyroidism can lead to giant cell lesions. As there can be renal toxicity due to impaired excretion of drugs, the dosage of drugs must be reduced. Antibiotics such as erythromycin and doxycycline may be given in normal dose, The dosage of penicillin and cloxacillin should be reduced. Due to defective platelet function, there can be bleeding after oral surgical procedures. Renal transplant patients are prone for oral infection because of immunosuppression. Immunosuppressive medications such as cyclosporine can lead to gingival enlargement.

Nephrotic syndrome

Nephrotic syndrome is characterized by massive proteinuria and hypoalbuminemia. There can be edema and hyperlipidemia. Loss of immunoglobulins can result in severe oral infections. The dental significance are the same as that of CRF and renal transplantation.

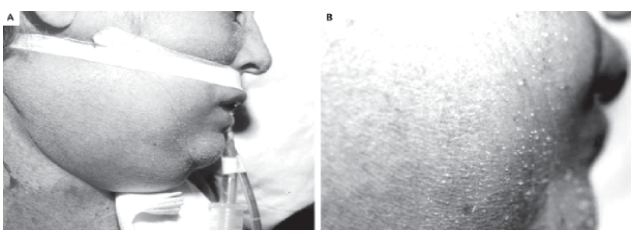

Fig. 1 Uremic deposits on skin

HUMOUR ZONE

Dentist to Patient: (begging) " Would you help me? Could you give out a few of your loudest, most painful screams?" Patient: Why? Doc, it isn't all that bad this time. Dentist: There are so many people in the waiting room right now and I don't want to miss the 4 o'clock football game.

A remarkable true story of a dying man's dream...

(Every issue of JIDA-Kochi will have a true and inspiring story of human interest)

RANDY PAUCHE: THE LAST LECTURE

Randy Pausch, the charismatic young college professor who chronicled his battle with pancreatic cancer in a remarkable speech widely-known as the "Last Lecture," has died at the age of 47. He was at home, surrounded by his wife, Jai, and his three children. Pausch's lecture and subsequent interview was one of the most powerful accounts of hope, grace and optimistism ABC News has ever featured, and drew a worldwide response. "I'd like to thank the millions of people who have offered their love, prayers and support," his wife Jai Pausch said in a statement. "Randy was so happy and proud that the lecture and book inspired parents to revisit their priorities, particularly their relationships with their children. The outpouring of cards and emails really sustained him." It all began with one, age-old question: What would you say if you knew you were going to die and had a chance to sum up everything that was most important to you? That question had been posed to the annual speaker of a lecture series at Carnegie Mellon University, where Pausch was a computer sciences professor. For Pausch, though, the question wasn't hypothetical.

Pausch, a father of three small children and husband of his young wife Jai, had been diagnosed with pancreatic cancer — and given six months to live. Friends and colleagues flew in from all around the country to attend his last lecture. And — almost as an afterthought — the lecture was videotaped and put on the Internet for the people who couldn't get there that day. That was all it took. Somehow amid the vast clamor of the Web and the bling-bling of million-dollar budgets, savvy marketing campaigns and millions of strange and bizarre videos, the voice of one earnest professor standing at a podium and talking about his childhood dreams cut through the noise. The lecture was so uplifting, so funny, so inspirational that it went viral. So far, 10 million people have downloaded it. And thousands have written in to say that his lecture changed their lives. If you had only six months to live, what would you do? How would you live your life? And how can all of us take heart from Pausch's inspiring message to live each day to its fullest? Pausch's answers to these questions, both in the lecture and in three separate interviews over a series of months with Diane Sawyer, are moving, funny, thought-provoking and extraordinary.

Pancreatic cancer is the fourth leading cause of cancer death in the United States, and unlike other cancers, during the last 30 years the medical community has seen very little advancement in prolonging the lives of pancreatic cancer patients. But instead of focusing on his death, Pausch spoke about his childhood dreams. "You may not agree with the list but I was there. ... Being in zero gravity, playing in the National Football League, authoring an article in the World Book Encyclopedia — I guess you can tell the nerds early. ... I wanted to be one of the guys who won the big stuffed animals in the amusement park." He went on to attain almost all of those dreams, but they didn't all come easy. In the lecture, he spoke of overcoming the obstacles that may seem insurmountable. Although he graduated magna cum laude from Brown University, he nearly didn't get in to Brown in the first place — he was wait listed. It was a brick wall that some might have walked away from. But Pausch had a novel way of looking at obstacles: "The brick walls are there for a reason," he said during his lecture. "The brick walls are not there to keep us out. The brick walls are there to give us a chance to show how badly we want something." He kept calling the college until it let him in.

Pausch maintained that his most formidable brick wall was a beautiful graduate student named Jai Glasgow. Pausch was 37, with a reputation as something of a ladies' man, when he met her at a lecture. Pausch was smitten, but she resisted. However, he refused to give up, and they eventually married and had three children.

Pausch spoke movingly of how he was trying to create memories for his three kids, Dylan, 6, Logan, 3, and

Chloe, 18 months, and why he couldn't allow himself to wallow in self pity. "I mean, the metaphor I've used is ... somebody's going to push my family off a cliff pretty soon, and I won't be there to catch them. And that breaks my heart. But I have some time to sew some nets to cushion the fall. So, I can curl up in a ball and cry, or I can get to work on the nets." Pausch was already a popular professor, and one of the foremost teachers in the field of virtual reality, when he proposed a class that would become legendary at CMU: It was called Building Virtual Worlds, a high-wire act that brought together students from many different disciplines, writers and computer programmers and artists who were forced to work together intensively in small groups. Pausch told Sawyer that while the course was ostensibly about designing virtual reality worlds, there was a stealth message as well: "How do you behave with integrity? How do you behave in a way that other people will respect you and want to keep working with you?" The result was so popular that it eventually spawned an entire program at the university. Together with drama professor Don Marinelli, Pausch started the Entertainment Technology Center, which over the years has become the go-to school for video gaming and Hollywood high tech.

At the ETC, students were encouraged to try the unconventional and the risky. As former student Phil Light said, "We went to him and said, 'We have these ideas, we have a couple of ideas. This idea here is very safe. This idea here is risky.' He said, 'Go for the risk. It's better to fail spectacularly to pass along and do something which is mediocre.'" Pausch said that over the years, he went from attaining his own childhood dreams to learning to enable the dreams of his students, which he maintained is every bit as satisfying. To enable dreams on a grand scale, Pausch began his latest venture, called **Alice**. Alice is a free computer application that teaches kids to program, while giving them the impression that they are simply creating animated stories. Created by a Carnegie Mellon team including Wanda Dann, Dennis Cosgrove and Caitlin Kelleher, Alice has already been downloaded more than a million times. The new version of Alice will feature characters from the popular computer game "The Sims."

After his diagnosis, Pausch devoted almost all of his time to his family, moving to a location near his wife's family, so that she would have some emotional support, and spent a lot of time with his three kids. He had tried to approach what he called his "engineering problem" as a scientist: He interviewed people who'd lost their parents and asked them what they would have wanted to have as keepsakes; what they wished their parents had told them before they died. Pausch said he wanted to make sure he gave his wife and children what they would need to remember him, and to know that he loved them.

He and his wife, Jai, consulted psychotherapist Michele Reiss and other experts to help them grapple with such issues as when to tell the children. Reiss says very young children "have no particular time orientation yet. So you can talk to a young child in terms of breakfast time, or lunchtime, or dinnertime, or nap time, but you can't talk about the day after tomorrow, or next week, or next month, much less three to six months from now." Therefore, the decision was made not to tell the children until their father was much sicker. The Pausch family had asked any viewers who might run into them to respect the experts' opinion and say nothing.

One of the things Pausch left behind for his kids: the lecture. He called it a message in a bottle. The lecture, along with private videos he made for their eyes alone, and a book he wrote called "The Last Lecture" would help give his children — at least one of whom is too young now to be able to have distinct memories of her father — a sense of how much he loved them. Sawyer asked Pausch about his children, in particular Chloe, the youngest. "I hope that her passion will take her to wherever she goes and the same for Dylan and Logan. I just hope that they have passion for things, and I'm sure they will. I'm sure their mother will instill that in them. And whatever they see of me in direct memories and indirect memories, uh, will send that signal. Because if they have passion for things, then I'm happy for whatever they have passion for."

Worldwide Impact

But if Pausch's lecture was written for an audience of only three, it has touched millions of others as well. People around the country told ABC News about the many ways his lecture had helped bring magic into their lives. Alfred Nicolosi of Salem, N.J., said the night he watched Pausch's lecture was the "same night when Randy's life turned mine around." Battling depression, cancer surgery and facing heart problems, Nicolosi cleaned up his life, literally. "I had never been a very organized person, but this was exceptional. I had allowed piles of boxes, groceries, laundry, books scattered everywhere. There was absolutely no order to my life, no way to find things, it was just lost. So immediately after seeing the lecture, I began to organize my house, and I felt like I was rediscovering my life in the process."

Peter Riebling, a lawyer from Vienna, Va., handed his 10-year-old daughter, Kimberly, a pencil and gave her free reign on her bedroom walls. "He told me to go draw on my walls, so at first I honestly thought he had gone crazy, because most parents wouldn't let their children draw on the walls, especially when they are brand new and painted and stuff. So I did start drawing on my walls

— and then I actually found it was extremely fun so I kept doing it," said Kimberly.

Diane Gregory from Las Vegas encouraged her teenage son Matt to express himself by hanging every piece of sports memorabilia he had collected on his walls. Matt jumped at the opportunity and with the tacks and double-sided tape went to work. Harry Wooten, a choir minister from Dallas, uses Pausch's message to touch his congregants through prayer and song. After battling breast cancer, Kaje Lane of Los Angeles says Pausch has inspired her to pursue singing — a passion she had put aside for many years. "I think so many people relate to Randy because every one of us has some sort of dream they want to make real, or some sort of passion that they want to tap into if they're not already thinking that way. … I think people are just drawn to that. It's very magnetic to see someone positive not just about the big things but the little things."

'Leave It All on the Field'

Even though he had enabled the dreams of so many others, we couldn't help but notice that there was one dream Pausch had never been able to fulfill — playing in the NFL. So ABC News made a couple of phone calls, and in October, Pausch took the field with the Pittsburgh Steelers. He was wearing the jersey of his favorite player: wide receiver Heinz Ward. Moments later he was catching balls thrown by Ward. He caught every pass — and even kicked a field goal, on his first attempt. "There was a definite sense," Pausch told Sawyer, "when I put that talk together, to use another football expression, you know, I wanted to leave it all on the field. … If I thought it was important, it's in there. I played in football games where you walk off the field and the scoreboard didn't end up the way you wanted. But you knew that you really did give it all. And the other team was too strong. Yeah, I'm not going to beat the cancer. I tried really hard … but sometimes you're just not going to beat the thing…I wanted to walk off the stage and say anything I thought was important, I had my hour."

After a bout earlier this year in the hospital to overcome kidney and congestive heart failure — side effects of his chemotherapy — Pausch returned home to his family. "His fate is, is our fate, but it's just sped up," said co-author Jeff Zaslow. "He's, you know, 47, and, and we don't know when we're gonna go, but we all have the same fate. We're all dying, just like Randy is … when we can see him, how he's, how he's traveling, it makes us think about how we're going to travel." Millions of people around the globe have been touched by his message of optimism. Last spring, Sawyer asked Pausch what was the best thing that had happened to him that day. He replied, "Well, first off, I'd say the day's not over yet. So there's always a chance that there will be a new best."

Lasting Legacy

Carnegie Mellon University will honor Pausch's commitment to collaboration by building the Randy Pausch Memorial Footbridge to connect a computer science center under construction with a nearby arts building. Announcing the project last September, Carnegie Mellon President Jared L. Cohon said, "Randy, there will be generations of students and faculty who will not know you, but they will cross that bridge and see your name and they'll ask those of us who did know you. And we will tell them." In a statement released by the university today, Cohon expressed the community's sadness at Pausch's passing.

"Randy had an enormous and lasting impact on Carnegie Mellon," Cohon said . "He was a brilliant researcher and gifted teacher. His love of teaching, his sense of fun and his brilliance came together in the Alice project, which teaches students computer programming while enabling them to do something fun — making animated movies and games. Carnegie Mellon — and the world — are better places for having had Randy Pausch in them."

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