

Sri Lanka Dental Journal



Volume 21

1991/92

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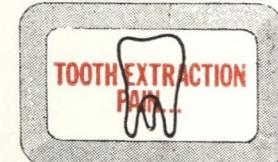
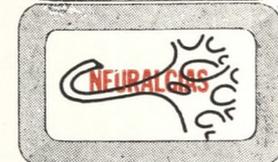
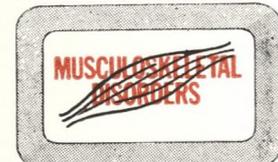
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SRI LANKA DENTAL JOURNAL

The Journal of the
Sri Lanka Dental
Association



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SRI LANKA DENTAL JOURNAL

Editor:

Dr. Kumar Warnakula

B.D.S. (Cey) D.G.D.P. (Col)

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University of Peradeniya
Peradeniya

Galle — Southern Branch
Department of Dental Surgery
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Galle

North-Western Branch —
Dental Unit
S.L.A.F., Katunayake

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South Asian Dental Associations Federation (SADAF) was officially formed at Lahore, Pakistan on 21st December 1991. Dental Associations of South Asian countries are eligible to become members of the SADAF, which has been formed with the objective of promoting greater understanding and mutual exchange among member nations and Dental Professionals.

South Asian countries have many similarities. They are all third world countries and are not technologically advanced. There are similarities in their cultures and socio-economic standards of its peoples.

The Dental Professions of the South Asian countries too have many common features.

The disease patterns in the countries of this region are similar. Hence mutual exchange of ideas in relation to treatment and preventive aspects of these diseases could take place among the member countries through scientific exchange of papers and workshops. Publication of a Journal of the Federation and other publications too could be beneficial in this aspect.

Research is another field on which mutual cooperation could take place among member countries. Through community research an Oral Health Care System appropriate to the economies of these nations could be devised.

Dental Professionals from the South Asian countries undergo Postgraduate training in Western countries. The cost of Postgraduate education in the Western countries is very high and often prohibitive by South Asian standards. Through mutual cooperation Postgraduate training facilities available among member nations could be utilised by Dental Professionals in these countries. Undergraduate student exchange programmes too could be carried out among these countries to promote the exchange of ideas.

The high cost of Dental equipment and materials manufactured by the developed countries too is a major problem which affects third world countries. Manufacturers of member nations could be encouraged to carry out sales promotion by participating at Trade Exhibitions during Congresses of the Federation.

A Congress of SADAF is expected to be held every year in one of the member countries in rotation during the Annual Sessions of the National Associations. The first South Asian Dental Congress will be held in Sri Lanka in December 1992.

The cooperation of members of our National Association is necessary to ensure the success of SADAF and the objectives which it is striving to achieve.

PRESIDENTIAL ADDRESS 1991

Origins, Development and the Future of Dentistry

Dr. H. W. M. Cooray

B. D. S. (Cey). M. C. G. D. P. (Sri Lanka)

Dr. Mrs. Ira Ratnayake, Past Presidents, Members of the Council, Members of the Sri Lanka Dental Association, distinguished guests, ladies and gentlemen.

I thank you Madam for all the compliments you have paid me. I thank my fellow members of the Sri Lanka Dental Association, for the trust you have placed in me, by electing me your 59th year President. I have no doubt, that this is the highest honour that the profession can bestow on any of its fellow members and in all humility I assure you I will try to be worthy of your confidence. When I joined the association in 1972, I never imagined I would be the youngest member to be inducted as its President. I am proud to say I have been a member for 19 years of which 14 years I have served as an office bearer.

Traditionally the newly inducted President makes the presidential address on the day of his induction and it has been the practice of each President to speak on his own field of interest at his induction. Having a special interest in the history of Medicine and Dentistry, the topic I

Presidential Address delivered by Dr. H. W. M. Cooray on his induction as President S. L. D. A. on 12th July 1991.

have chosen this evening is the "Origins, Development and the Future of Dentistry".

The History of Dentistry throughout the world is very closely linked to the History of Medicine and stretches back over centuries, being as old as the History of Medicine.

The earliest records that gave a reference to Dentistry is from the Babylonians in the year 5000 B. C. The civilisation of Babylonians who lived between the valley of the rivers Tigris and Euphrates is often referred to as the cradle of civilisation.

The period 3000 to 2000 B. C. has never ceased to exercise its influence even up to present day by their inventive genius of the system of weights, estimate of time, a double set of hours 60 minutes and 60 seconds. The first attempts at Dentistry seem to have originated here as with so many of the other arts and sciences. They would make use of a strange mixture of medical lore and religious exorcism, and call down in their prayers the wrath of the God "Ea" on the worm that causeth tooth ache. This belief was in existence up to recent times.

Chinese Dentistry

In the year 2700 B. C. further East at a later period of History, Dentistry

has been described by Huang Ti, the Chinese "Father of Medicine" who described in detail the parts of the gum and the jaws which should be punctured by silver and gold needles for relief of pain. Acupuncture constituted the remedy for most illnesses.

Egyptian Era 3000 to 1000 B. C.

The Egyptian era has left deeper traces in the memory of mankind than that of Babylonians. For thousands of years the majestic pyramids have kept fresh in the minds of countless races, the golden age of this land. Herodotus the Greek historian has stated that Egypt is the healthiest of the countries but filled with physicians of whom one treats only the diseases of the eye, another for the teeth, one for the abdomen or the internal organs. This is the earliest record of specialisation, for in the Babylonian and Chinese Medicine, it appears that the physicians treated all ailments of the body including those of the teeth and the mouth.

The discovery of two papyri rolls at Thebes by professor George Ebers has a bearing on Egyptian medical knowledge. These papyri were written about the middle of sixteenth century B. C. and are only compilations of older writings that in fact dates back to the times of the pyramids about 3000 B. C.

In Ebers papyrus are found therapeutic formulae for various diseases. Among them were eleven dental prescriptions for disorders of teeth, remedies for tooth ache and cures for gum boils. Investigations of Egyptian mummies have revealed certain techniques in substitution of teeth and fillings in teeth using gold.

The Indian system of Medicine called Ayurveda is documented in the Vedas compiled at least as early as 1000 B. C. The Ayurveda, Ayur (Life) Veda (Knowledge), was divided into eight branches or disciplines. One of them being Shalyatantra "the art of the surgeon". Sushruta known as the Surgeon of India who lived in the later part of the 4th century B. C. compiled a surgical compendium known as Sushruta Samhita.

In this he describes many surgical procedures and his instrumentation contained 101 blunt, 20 sharp, and 23 other instruments. In Sushruta Samhita there is a discourse on the medical treatment of the diseases of the mouth.

This chapter is entitled "Mukha Roga" The first paragraph of this chapter on diseases of the mouth deals with inflammation of the lip and its treatment. Diseases of the roots of the teeth are vividly described together with the methods of treatment. Treatment of Gum disease, epulis, and a Krimi Danta or worm eaten tooth is described in this chapter.

Ancient Concepts on Oral Hygiene

Sushruta Samhita contains a chapter on oral hygiene. It describes the time and method of cleaning one's teeth. The making of the chew-stick is elaborately explained. The types of wood to be used, its hardness and quality are all specified.

In this same chapter on oral hygiene is this interesting paragraph on betel chewing "A betel leaf prepared with cloves, camphor, nutmeg, lime and arecanut should be chewed after meals as it tends to cleanse the mouth, impart a sweet aroma to it, strengthen the voice, the tongue, the teeth, and the

jaws. A betel leaf prepared as before proves wholesome after a bath, after anointing, and after rising from sleep." Perhaps it is noteworthy to recognise and appreciate that it is an age old cultural and traditional practice and it needs special attention in our efforts in trying to discourage this in our society.

The Indian system of medicine is believed to have been brought to this country at the time of the arrival of Prince Wijeya with his band of 700 followers which comprised of medicine men, and all other craftsman included in a royal retinue.

In the period 377 to 307 B. C. King Pandukabhaya built the city of Anuradhapura with great emphasis on hygiene and sanitation. The Mahavamsa states that "with the Sacred Bo tree and Emperor Asoka's retinue came Brahmins, merchants, tradesman, goldsmiths, weavers and other craftsmen and the Indian Medicine of Ayurveda was well established here." Construction of temples, monasteries for the maintenance of Buddhist Sangha and construction of hospitals became meritorious deeds on the part of each king. Facilities like the medicinal bath (beheth oruwa) were available in them. There are references to specific instructions on dental hygiene. In one such reference the tablet of Mahinda IV at Mihintale says "The monks residing at this vihara shall rise at time of early dawn and having cleaned their teeth should put on and cover themselves in their yellow robe." The latest evidence in support of the practice of surgery in ancient Ceylon is from the excavation site of Alahana Pirivena of the Polonnaruwa era.

Surgical instruments unearthed at this site have been very well illustrated and explained by Prof. Arjuna Aluvihare and Prof. Prematillake in their paper presented at the National Archaeological Congress.

The Greek system of medicine which began in the 6th Century B. C. and continued to the end of 2nd Century A. D. appears on the horizon of history a heir to Egyptian tradition which was developed and improved by Hippocrates, Aristotle, Galen and others. Corpus Hippocraticum is a collection of works of Hippocrates "the Father of Medicine" contains the Hippocrates oath which is still a guidance to the healing professions. In one chapter it says when a person has a ulcer of long duration on the margin of the tongue, one should examine the teeth on that side to see if some of them present a sharp point. The Greeks possessed an instrument named odontogonon for extraction of teeth and were able to bind loose teeth together and to support artificial teeth by means of gold wire and gold bands. Trading links existed between the Greeks and Lanka which they called Taprobane.

Dentistry of the Romans

The earliest work in Latin is De Re Medic of Celsus which was prepared about A. D. 30. He described plastic surgery of the face and mouth. An account is given of the Roman Surgical instruments including dental forceps used in Dental Practice. Roman Law quoted by Cicero reads "If any one's teeth have been bound together with gold it shall be unlawful to bury with it."

The contribution of the Romans to the world of Medicine, Dentistry

and Law still lives through its vocabulary. For instance Dens Dentis (N) tooth, incidere to cut, hence incisors responsible for cutting up of food, canes meaning dog, and canine is so named due to its resemblance to a dog's tooth and its function. Caries, is dry rot. The words gingivae, alveolus, maxilla, lingua, labial are all derived from Latin. It is similar in the fields of Medicine, Law and many other sciences.

Arab Medicine

After the fall of the Roman Empire Western Europe passed into a period of material waste and intellectual decadence. The art of Dentistry and the centres of learning and research moved eastward once more. In the ninth century a Moslem Empire was established with its centre in Baghdad. Greek and Roman Scientific work was translated to Arabic. The name of Razes and Avicenna are prominent among them. Albucasis the great surgeon of the Arab race wrote extensively on Dentistry in his work "Al Tasrif." He was born in Cordova in Spain which was under the Arabs at that time. It is reported that Arab Medicine or Unani Medicine was introduced to Ceylon by the Arabs who settled in Beruwala in the 10th Century. This system is still being practiced and is now taught leading to a Bachelor's degree at the Institute of Indigenous Medicine of the University of Colombo.

Age of Progress

The period between 1600 to 1800 A. D. is the period of revival of science and technology. The foundation of modern Dentistry as it exists today was laid during this period. Dutchman Anton Van Leuwenhoek des-

cribed in detail the micro organisms he had seen in tartar covering the teeth thus establishing the first step in Microbiology. The English Anatomist John Hunter published the book "The Natural History of Human teeth". Frenchman Pierre Fauchard known as the "Father of modern scientific Dentistry" published the book *Le Chirurgere Dentiste* which described the entire field of modern Dentistry. In England a guild of Barber Surgeons was formed. E. H. Angle introduced the subject of Orthodontics the art of moving of malaligned teeth.

1800 to present Era

In the 18th Century, prior to the discovery of anesthesia, the prospect of pain made every one very reluctant to seek treatment. Both surgeon and dentist relied on operating as rapidly as possible with their patient under the influence of alcohol or opium.

One of the greatest improvements to dental treatment in the Nineteenth Century is the introduction of anaesthetic gases. In 1800 Sir Humphrey Davy an English chemist had relieved the pain of an infected tooth by inhaling nitrous oxide. He published a paper suggesting use of nitrous oxide in surgical operations.

In 1846 Horace Wells an American dentist used Nitrous oxide to render patients unconscious prior to extraction of teeth. William Morton at the same time was using ether to induce unconsciousness for surgery. The first major operation under ether was done by Robinson.

In 1847 Simpson used chloroform. In the nineteenth century a wide range of dental instruments was developed. Dentures of various types,

some made of ivory and at times teeth on wooden bases have been used. Springs were designed which joined the upper denture to a lower partial denture and were generally not removable which made them very difficult to clean.

Lack of hygiene was a real problem with all these early dentures, and the mouth emitted a characteristic stench. One contemporary dentist had admitted "No wonder the use of the fan became a social necessity.". Cleaning of ones teeth was thus developed as a habit and various forms of brushes and dentifrices were developed. The first tooth brush club was formed in England in 1912.

Dentistry in Ceylon

The British took over the rule of the maritime provinces from the Dutch in 1776 and annexed the Kandyan kingdom in 1815. With the introduction of the British system of Medicine, Dentistry was practiced initially by the British Army doctors who were here to look after their troops. The first qualified dentist to be registered under the Dental Registration Ordinance in Ceylon was Sperling Christoffelz.

He registered on 15th May 1915 and had the qualification L.R.C.P., M.R.C.S. (Eng), L.D.S. (Edin). The first dentist without medical qualification to be registered was Sidney William Garne. He was registered in 1916 and had the qualification L.D.S. (Edin). He was also a founder member of the Ceylon Dental Association. He established a General Dental Practice at the Bristol Hotel, Colombo, which was in existence up to late 1970's though it changed hands many times.

History of the Sri Lanka Dental Association

The Ceylon Dental Association was formed on 6th December 1932 by a group of 12 dentists practising at that time. Though it did not commence as a Ceylon branch of the British Dental Association the constitution had been based heavily on that of the British Dental Association. The crest of the Association was adopted at the time of the formation. It has two snakes coiled around the twigs embracing the anchor.

The basic motif was the staff of Aesculapius with a single snake coiled around it because it is believed that Western Medicine originated from him.

In the statue found in Ancient Greece Aesculapius is depicted with a wooden staff round which a snake was intertwined. The snake in Greek mythology was always associated with the art of healing and is probably related to the phenomenon of moulting which may have led to the belief that by shedding its skin the snake was capable of rejuvenation.

Through the initiation of Ceylon Dental Association, the Dental School was established in Colombo in 1938 and then moved to Peradeniya in 1954. The first batch of students were medical graduates who were to do dentistry as a speciality. In this group were Charles Batholemeuz, Sebastian de Jong de Silva, who later became the first Ceylonese to obtain the Fellowship in Dental Surgery of the Royal College of Surgeons, Michael Rodrigo Cruz who established a General Dental Practice in Barbter Street which is now being continued by his daughter Philomina and Dr. F. A. L. Fernando who was incharge of the Dental Institute for many years.

The Ceylon Medical Council was established in 1925 and since then the registration and control of doctors and dentists has been vested in it. The Dental Institute was established in its present locality in 1927, thus creating a Department of Dental Surgery in the hospital sector. The dental services of the public sector now has a cadre of 18 Consultants, 338 Dental Surgeons in 154 hospital Dental Clinics, 503 Dental Therapists and other auxillary staff under a Directress of Dental Services, Dr. (Mrs) Siromani Abayaratna, incidently the first lady to hold this post. In addition to this we have 26 Dental Surgeons on the staff of Faculty of Dental Sciences, 24 in the Armed Forces and approximately 100 in General Dental Practice.

In 1933 at a combined meeting of the Ceylon Branch of the British Medical Association (now the Sri Lanka Medical Association) and the Ceylon Dental Association Dr. S. L. Cramer proposed and Dr. E. M. Wijerama seconded that nationals of countries that do not recognise our qualifications should not be registered as Dental Surgeons in our country. This resolution was passed and then implemented. This evidences the solidarity and bon dage that existed between the Medical & Dental Professions, even at that time.

Past Presidents of the Association

Thirty two eminent men and women have held the office of President over the last 59 years. A few have held office more than once and only two Lady Presidents to date. The first being Mrs. Siromani Abayaratna followed by our out going President Mrs. Ira Ratnayake. I have had the

pleasure of working in association with both of them and I can say without any hesitation that the two of them were excellent Presidents, they had all male councils working with them and they had everyone of us dancing to their tunes. Dr. Ranjan Abeyasinghe has been one of the longest serving Presidents with a term of four years.

Fig. 1

Past Presidents

1939-41	Dr. S. W. Garne
1942-45	Dr. T S. R. Goonewardena
1946-47	Dr. A. A. Gomes
1948-51	Dr. V. Sinnathamby
1952	Dr. W. Balendra
1953-55	Prof. R. H. Mc Keag
1956-58	Dr. W. Balendra
1959	Dr. R. G. Jasinghe
1960	Dr. J. A. L. Nelson
1961	Dr. V. Sinnathamby
1962-64	Dr. G. P. D. Rajasooriya
1965	Dr. W. Balendra
1966	Dr. V. S. Karunagaran
1967	Dr. Prof. L. Tillekaratne
1968	Dr. J. A. L. Nelson
1969-70	Dr. Dixon de Silva
1971-72	Dr. A. Nagendra
1973-75	Dr. A. R. Abeyasinghe
1976	Dr. K. H. T. De Silva
1977	Dr. V. S. Karunagaran
1978	Dr. S. A. Silva
1979	Dr. W. G. Wimaladharma
1980	Dr. M. P. P. de Silva
1981	Dr. W. G. Wimaladharma
1982	Dr. L. S. W. Dassanayake
1983	Dr. Ranjan A. Abeyasinghe
1984	Dr. Neil Gunawardhana
1985	Dr. M. M. Mukthar
1986	Dr. Mrs Siromani Abayaratna
1987	Dr. Raja Jasinghe
1988	Dr. Reggie Goonatilleke
1989	Dr. K. D. G. Saparamadu
1990	Dr. Mrs. Ira Ratnayake

Past Secretaries of the Association

Twenty one dedicated men have held the burden of doing all the work behind the scenes. I would like to place on record the service of Dr. Lionel Dassanayake who was the secretary continuously for 10 long years. It is said that the President gets the credit when everything goes well and if anything goes wrong it is the secretary who gets the blame.

I hope the activities of our Association will progress well this year. So that nobody would blame our genial Honorary Secretary Dr. Nalin Jaytilake.

Fig. II

Past Secretaries

1937-44	Dr. A. A. Gomes
1945	Dr. W. Balendra
1946-51	Dr. G. P. D. Rajasooriya
1952	Dr. N. Sathasivam
1953	Prof. L. Tillekaratne
1954-55	Prof. S. B. Dissanayake
1956-58	Dr. M. P. P. D. Silva
1959	Dr. Balasubramaniam
1960-64	Dr. A. Nagendran
1965	Dr. Major F.R.I. Batholemeuz/ A. Nagendran
1966-69	Dr. Neil Gunawardhana
1970	Dr. P. A. Peiris
1971-74	Dr. L. S. W. Dassanayake
1975	Dr. P. A. Peiris
1976-80	Dr. L. S. W. Dassanayake
1981	Dr. M. Mukthar/ Rajitha Senaratne
1982	Dr. H. W. M. Cooray
1983	Dr. R. L. N. S. Rajapakse/ Siromani Abayaratna
1984-85	Dr. Mano Fernando
1987-88	Dr. A. Amunugama
1989	Dr. S. L. Perera/ Mano Fernando
1990	Dr. Mano Fernando

Past Treasurers of the Association

24 Men and women held the responsibility of the office of the Treasurer. A very onerous task of keeping true and accurate records of all the monies received and expended by the association. I have to mention the service rendered by Dr. M. M. Mukthar who held this post for 8 years.

Fig. III

Past Treasurers

1939-41	Dr. A. A. Gomes
1942	Dr. V. Sinnathamby
1943-44	Dr. G. D. P. Rajasooriya
1945	Dr. W. Balendra
1946	Dr. A. A. Gomes
1947-49	Dr. G. P. D. Rajasooriya
1950-53	Dr. N. Sathasivam
1954-55	Prof. S. B. Dissanayake
1956	Dr. M. P. P. De Silva
1957-60	Dr. G. M. Sinnathamby
1961-62	Major F. R. I. Batholemeuz
1963	Dr. Y. M. E. Fernando
1964	Dr. Ranjan Abeyasinghe
1965	Dr. Y. M. E. Fernando
1966-68	Dr. Ranjan Abeyasinghe
1969	Dr. S. A. Silva
1970	Dr. L. S. W. Dassanayake
1971-75	Dr. M. M. Mukthar
1976	Dr. H. W. M. Cooray
1977	Dr. V. Kugadas
1978-79	Dr. Mukthar
1980	Dr. Ravindraraj
1981-83	Dr. Mrs. S. Abayaratna
1984-87	Dr. H. W. M. Cooray
1988	Dr. Gamini De Silva
1989	Dr. S. Dharmatillake
1990	Dr. Ravi Gurusinghe

Fig. IV

Editors of Sri Lanka Dental Association

1970	Dr. Neil Gunawardhana	Vol. 1
1971	Dr. Neil Gunawardhana	Vol. 2
1972	Dr. Neil Gunawardhana	Vol. 3
1973	Dr. E. P. Fernando	Vol. 4
1974	Dr. P. A. Peiris	Vol. 5
1975	Dr. L. S. W. Dassanayake	Vol. 6
1976	Dr. S. A. Silva	Vol. 7
1977	Dr. H. W. M. Cooray	Vol. 8
1978	Dr. H. W. M. Cooray	Vol. 9
1979	Dr. Yvonne Dwight	Vol. 10
1980	Dr. Mrs. S. Abayaratna	Vol. 11
1981	Dr. Mrs. S. Abayaratna	Vol. 12
1982	Dr. D. Y. D. Samarawickrama	Vol. 13
1983	Dr. M. T. M. Jiffry	Vol. 14
1985	Dr. Raja Jasinghe	Vol. 15
1986	Dr. Ajith Ranasinghe	Vol. 16
1987	Dr. M. T. M. Jiffry	Vol. 17
1989	Dr. P. P. Tillaivasan	Vol. 18 & 19
1990	Dr. Kumar Warnakula	Vol. 20

The first issue of the Ceylon Dental Journal was published in 1970 with Dr. Neil Gunawardhana as its first editor. Since then it has been published annually without a break. In a recent survey Prof. A. Ekanayake has recorded 538 Publications on various subjects of Dentistry by the members of our profession in local and foreign journals.

The name of the Ceylon Dental Association was changed to Sri Lanka Dental Association in 1974 following the change of name of the country from Ceylon to Sri Lanka. The ceremonial induction of the president was started in 1978 with Dr. Srilal Silva as the first inducted president. It was in this year that we commenced our library with a purchase of the first set of books with a grant received from the Commonwealth Foundation.

This library is improving slowly but steadily. I must place on record the

contribution made by our Vice President Dr. Gamini de Silva in the development of the library and the office.

The Golden Jubilee Year of the Association was celebrated in 1982 with Dr. Lionel Dassanyake as the president and I had the privilege of being the honorary secretary. A series of events was held to mark the occasion. An International Congress, a Dental Exhibition, Dental Health Education Programmes in the mass media and a Dental Trade Exhibition were among them. The annual sessions of the association which was started during the Golden Jubilee year has been continued up to date.

The S. L. D. A. did not have an office of its own for the greater part of its existence. It was in the Golden Jubilee year that we moved into the office which was purchased at the Professional Centre of the O. P. A. with

funds from the Dance organised in 1979 of which I had the privilege of being the chairman for the Sri Lanka-India Dental Congress under the guidance of Dr. Srilal Silva as the President and Dr. Reggie Goonatileke as Vice President who contributed much for the success of this event. Realising the need for the extension of our activities to other parts of the country, the first branch was inaugurated in 1986 in Kandy through the initiation of Dr. Neil Gunawardhana. This was followed by a branch in Galle and we are hoping to inaugurate a branch in the North Western province on 27th of this month.

The Sri Lanka Dental Association as an advisory body is represented on the National Advisory Council of the Health Ministry, the Board of Management of the Faculty of Dental Science, the Formulary Committee, and the Food and Drugs Committee.

Our association has given grants to scientific workers to do research on oral health problems of our community.

The responsibility of organising the first S. L. D. A. Oration was undertaken by Dr. Neil Gunawardhane as President in 1985 and the honour of delivering the first Oration fell on Dr. Reggie Goonetilleke. Since then it has become an annual event.

Sri Lanka Dental Association is a Founder Member of the Organisation of Professional Associations of Sri Lanka. We have participated actively towards its development in many important ways. We have given it two Presidents and many office bearers who have contributed to its development in no small measure.

Sri Lanka Dental Association plays an active part in international dental

affairs. We became a member of Federation Dentaire Internationale in 1956, Asia Pacific Dental Federation in 1988 and a founder member of the Commonwealth Dental Association in 1991.

The importance of knowing the origins or the past is aptly described in these quotations.

"The longer you look back the further you can look forward."

Sir Winston Churchill

addressing the Royal College of Physicians of London March 1944

"To know nothing of History is to wonder through life naked and be wildered on an unfamiliar shore."

Sir Wilfred Fish

Having spoken on the origins and development and our present status. I would now like to consider wither our profession is heading.

Let us start with dental manpower. One of the main aspects that the profession should look into is the oral health manpower situation in the country. The present status is given in Table 1. The distribution of Dentists in Sri Lanka is also shown in this Table.

Health manpower planning is the process of estimating the number of persons with the given skills and attitudes they need, to achieve a pre-determined health target and health status objectives. Such planning also involves specifying who is going to do what, where, how, and with what resources, for what population groups, or individuals. This process requires continuous monitoring and evaluation.

The health status targets for the year 2000 have been determined by the

Table 1

	<i>Number</i>
Dental Surgeons in General Dental Practice	82
Dental Surgeons in Government Services	356
Dental Surgeons in Armed Services	26
Dental Surgeons in University Mercantile Establishments	32
	02
Retired Dental Surgeons (Part time practice) Est	40
Registered dentists (Act no 27 of 1947)	18
Total	<u>556</u>
School Dental Therapists	503

Ministry of Health for the programme "health for all by the year 2000". It is essential that the Ministry of Higher education, the Ministry of Health and the profession work in close co-operation when making major policy decisions on issues such as these. This year the intake of Dental students was increased from 75 to 110. It is unfortunate that a proper manpower study was not done nor the profession consulted when the Ministry of Higher Education made decisions of this nature.

The National Professional body must take the initiative in forming a committee consisting of all concerned groups for continuous assessment of this aspect.

Research has shown that the major dental diseases are preventable. This has brought about the concept of priority given to prevention through general and specific measures rather than to the treatment of dental disease. Due to recognition given to dentifrice companies (we have only one major firm) which through their marketing strategies has brought about a greater awareness on oral health in the community. Prevalance of Dental caries in 12 years old children in Sri Lanka is 1.9 according to data obtained

from the National Oral Health Survey done with Dr. Saparamadu as chief investigator. (Table 2) when compared to other international data (Table 3) it is low.

Table 2**Dental Caries**

<i>Age</i>	<i>DMFT</i>	<i>DMFT</i>
6 years		4.4
12 years	1.9	
35 years	9.2	
	NOHS 83/84	

Table 3**International Comparisons**

<i>Country</i>	<i>DMFT at 12 years</i>
Australia	2.8
Denmark	4.7
Netherlands	3.9
New Zealand	3.3
U.K.	3.0
U.S.A.	2.6
Sri Lanka	1.9

In our health status target for the year 2000 we are trying to keep this figure at this level. But look at our sugar consumption pattern. (Table 4) With economic development and increases in incomes, sugar consumption

is bound to increase which will result in more caries. The question is are we prepared for this increase in disease levels and what action are we taking to persuade our people to have control on the consumption of sugar, and adhere to other preventive measures?

Periodontal disease level is assessed by the Community Periodontal Index of Treatment Needs (C.P.I.T.N.). This table 5 from the National Oral health survey, shows that nearly 78% of the 12 year old population and 93% of the 35-44 year old have some form of periodontal disease.

However when treatment needs are assessed using the same index, the treatment needs of a great majority of patients could be met by simple procedures like oral hygiene instruc-

tions, prophylaxis i.e. scaling & polishing which could even be carried out by dental personnel of a lower grade of appropriately trained auxiliaries. Health planners are all out to cut down the rising cost of dental care in the face of dwindling availability of medical resources. Trained personnel are difficult to come by and the opening up of more universities and hospitals will not be the answer. The Profession may have to seriously consider the prospect of accepting a category of auxiliaries to carry out these function of repetitive work, like giving correct oral hygiene instructions, scaling and polishing. Oral hygiene means, in this context, personal plaque control which is training the person to actively participate in his own plaque control by proper brushing techniques. The words of Abraham Lincoln are

Table 4

Sugar Consumption Vs Income

<i>Income in Rs per month</i>	<i>Consumption ounce per month per person</i>
0 - 600	23
601 - 800	24
801 - 1000	26
1001 - 1500	30
1501 - 2500	37
2500 - 3000	36
> 3000	41

C F & S E Survey 79

Table 5

Community Periodontal Index of Treatment Needs C. P. I. T. N

<i>Age</i>	<i>% Needs</i>		
	<i>T N 1 Instruction</i>	<i>T N 2 Prophylaxis</i>	<i>T N 3 Complex Care</i>
12	87	97	0
35-44	93	92	10

NOHS 83/84

most appropriate in this connection "you cannot help men permanently by doing for them what they could and should do for themselves".

Oral Cancer

30 to 40% of all cancer in Sri Lanka are oral. In a programme involving the primary health care workers Prof. Warnakulasuriya has shown that they can be successfully trained for early detection of cancer and pre cancer. How far have we gone, on the implementation of this work into practice? These are simple affordable preventive programmes and must be given the full thrust by the health worker and be continuously monitored and assessed if the community is to benefit from such an exercise. The cancer control programme should take serious cognisance of this types of research and seek the advise of the dental profession to implement them.

Self reliance

The practice of Dentistry involves not only knowledge and skills. It has the component of materials and equipment. 100% of our materials and equipment are imported from the developed world at exorbitant prices with the kind of money we can hardly afford. The world has grouped into giant economic groupings like the European Economic Community, U. S. A. — Japan trade pacts, Asean, which are all to our disadvantage. It has been often alleged that developing countries are the dumping grounds for redundant old machinery and equipment. Whenever the West produces a new model of equipment the old models are shipped here and that too, equipment which was never intended to be used in a tropical developing economy like ours. To sum it up in the words of Dr.

Mahler former Director General of the World Health Organisation, I quote "Technology of the developed countries is being given to their colleagues in developing countries who have not the resources nor the environment to use them". This is where the concept of appropriate technology comes into play. We have to look for simple equipment appropriate for our country, we have the expertise to invent such equipment. We have the entrepreneurs and the finances for this type of ventures. The profession has to encourage this technology. It is time that members of the Dental trade consider ways and means to do research and start manufacture on an import substitution basis and perhaps for export at least few of the materials that we use in our daily practice.

As long as we continue to depend on imported materials and equipment comprehensive Dental Health Care will continue to remain a service for a few privileged or the affluent and only emergency dental care for the masses. The figure from the treatment in government hospitals shows that 80% of the treatment is by means of extractions. It is in General Practice of the private sector that the other range of Dentistry is being practiced and that is mainly for the higher income groups who can afford to pay for such services.

If we cannot reach self reliance individually it could be achieved to some extent collectively by establishing links and grouping ourselves with the countries of the South Asia Region.

A more pragmatic approach of building up co-operation among the professionals of our neighbouring countries of the South Asian Region would be a step in the right direction.

Co-operation could be achieved in the fields of exchange of materials and equipment at fair and reasonable prices and in the field of Post Graduate Dental Education. The neighbourly mistrust, internal conflicts, ideological differences are factors that stand in our way. But the common external economic threat, the poverty of our people, and historical background with common cultural heritage makes this prospect a simple practical and a attainable one. The idea to have a strategy for individual and collective self reliance among the South Asian countries is something to be pursued.

Sri Lanka has to come to terms with the idea of importing some materials and equipment from India, Pakistan and other regional neighbours. On our part we have to develop the industries to manufacture some of our needs and perhaps export some others.

Sri Lanka's Post Graduate Dental Education is very well recognised. Apart from India, Sri Lanka is the only country in South Asia that has an organised Post Graduate Dental Education programme. Our qualification M. S. (Dental Surgery) has reciprocal recognition of the Royal College of Surgeons of England, M. S. in Orthodontics, a Diploma in General Dental Practice and a M.Sc. in Community Dental Health are available for respective specialities. Why can't we be a centre of post graduate education for South Asian countries? It is certainly possible provided we have the will to do it.

Ethics of the Profession

Occasionally there are very abusive references in the local press regarding the ethics, fees and other malpractices. It is a problem that is recurring cons-

tantly and would be as old as the profession itself. As regards the fees for services rendered it is quite a necessity, for inspite of the dedicated service, the dental surgeon must subsist and his standard of living must certainly be equal to that of other professionals at least. But of course there must be a certain degree of integrity and resonableness in levying of charges which may be quite personal and specific to each individual.

Exploitation of any kind has to be condemned and we must be guided by certain ethical principles bearing in mind that the labourer is worthy of his hire and not an exorbitant hire. Hammurabi was right when in Mesopotamia he took the law into his own hands and gave a schedule of fees for medical and surgical practice in view of the abuses that were prevailing at that time. Our leaders may be compelled to follow King Hammurabi if we do not act with a sense of responsibility and decorum.

Hippocrates Oath is a guide for the medical profession and for other health professions. Even in the time of Hippocrates medical ethics was not law but something spontaneous on the part of the practitioners. It is the duty of every dental surgeon to use it as a guide and decide on the mode of giving the best of his services for the patient. If some of us are guilty of unethical practice our Association should have, not a Penal Committee but an Advisory Committee as a corrective measure. If this fails the Ceylon Medical Council would take action according to law.

International Affairs

On the arena of international affairs our members have performed extremely.

well. Last year we had the honour of our member Prof. Saman Warnakulasuriya winning the coveted Johnson and Johnson F. D. I. award for Community Research out of applications from the whole world.

Dr. Lakshman Samaranayake has published in England a book on Essentials of "Oral Microbiology" which is now a standard text book in many dental schools of the United Kingdom.

Dr. M. T. M. Jiffry, Head of Dept of Physiology Faculty of Medicine, Colombo has published the book "Fundamentals of Oral Physiology" which is very useful for the undergraduate Dental Students as well as the clinicians.

Such achievements from our members I am sure would be on the increase in the future. The Sri Lanka Dental Association has placed a bid to hold the 18th Asia Pacific Dental Congress in Sri Lanka in the year 1996. If it is awarded we are assured of having about 3000 foreign dentists coming to this country for the Congress. The decision on this would be made in New Zealand meeting due to be held in March 1992.

Promotion of Dental Science

The primary object of the Sri Lanka Dental Association is the promotion of Dental Science. Until recently when three Colleges in their specialities of Dental Surgery were established it was this association that was the only forum available to discuss matters relevant to their science and art. The annual scientific sessions have been conducted regularly. This is now spreading to the branch associations and our Kandy Branch has been having it annually for the last 4 years. These

would be organised in other branches as well. The possibility of having the annual session of the association occasionally in other cities like, Kandy Galle etc, may be a proposition worth considering for the future.

The Library of the Association needs development. We have been making great strides in this direction. Latest editions of books and journals have been purchased during the last few years. A section on video cassettes on continuing education programmes and a collection of slides would be of immense benefit for the membership.

Development of General Dental Practice

The profession has to keep pace with the latest developments in the rest of the world. In the field of restorative dentistry great strides have been taken in the direction of crown and bridge work and Implantology. As these are highly expensive procedures it would never be available to the whole community. But could be made available to the persons who could afford, through General Dental Practice. A centralised modern ceramic laboratory for crown and bridge work and for Implantology is an absolute necessity in the near future.

As the present emphasis is on prevention it is useful for the General Dental Practitioner to undertake programmes aimed at reorientation of the practitioner in the preventive approach.

Insurance schemes to pay for comprehensive dental care is lacking at the moment. The profession should take steps to initiate insurance schemes to provide comprehensive Dental Care to persons who are entitled to these benefits. A look into the welfare of the practitioner by way of organis-

ation of a pension scheme, retiring benefits and medical sickness insurance would certainly augur well for the entire profession.

Development of the Hospital Sector

The Dental Institute of Colombo was opened on 14th March 1927 with Dr. W. Balendra in charge thus establishing a Department of Dental Surgery in the Public Medical Services. 9591 patients were treated during the year.

The statistics of treatment carried out in 1989 is given in table 6. According to this pattern of treatment carried out has not changed for the better. If we are to reach the goals set out for the year 2000 major changes would have to take place in this sector. With the financial constraints looming over the health planners it is almost impossible to bring about appreciable improvements in the curative field. The only other alternative

is to improve the preventive services offered by the hospital Dental Surgeon. The Dental Surgeons in service are geared in general for an emergency treatment type of oral health care. It is of vital importance that the hospital dental surgeon be given reorientation programmes to make their approach to oral health care on a preventive orientation basis. The re-orientation of the hospital dentists on to a preventive approach could be done by taking them in batches for in service training programmes. At the same time the Faculty of Dental Sciences should take serious note of the skills needed by the future dental surgeon and train them accordingly.

The Chronic breakdown of Dental units, sterilisers and other equipment is another major problem in the state sector. Why not rationalise the import of equipment by having one standard model and make for all hospitals in the country so that their repairs and maintenance could be handled by

Table 6
Attendance in Hospital Dental Clinics, 1988-1989

<i>Activity</i>	<i>1988</i>		<i>1989</i>	
	<i>Number</i>	<i>%</i>	<i>Number</i>	<i>%</i>
1. Fillings (Total)	146,157	12.1	150,691	12.8
Temporary	80,355		83,078	
Permanent	65,802		67,613	
2. Extractions (Total)	957,555	79.3	925,902	78.7
Caries	779,254		732,659	
Periodontal diseases	147,500		149,604	
Other	30,801		43,639	
3. Scaling/Polishing	51,441	4.3	48,526	4.1
4. Surgical Interventions	51,706	4.3	51,638	4.4
Total	1,206,850	100.0	1,176,757	100.0

Source: Medical Statistics Unit.

not so highly skilled technicians? The improvement to backup technical service by the provision of dental laboratory service is another area that needs attention.

The rights and privileges of all dentists in public service are protected by the powerful trade union. But we must not forget to do our duty and obligation by the community.

Conclusion

In Conclusion it would appear that this Association has lived up to the high ideals expected of a national professional association. Today we are a very active group of professionals that is nationally and internationally recognised. Our membership is drawn from all sections of Dental Practice. We have General Dental Practitioners, Specialists and non specialists Dental Surgeons from the state sector Armed Services, University Teachers and the Administrators. We try to involve them in all our activities for the strength of our Association lies in the interest taken by all of them in our activities.

We the members of this Association represent the Dental Profession of this country. We are bound together in the

service of our community in a common knowledge and understanding of Dental Science. We have inherited an ancient tradition of healing, improving the quality of life and relieving the burden of suffering. The rewards of the healer are not in kind but in the goodwill of the community and a high position conferred upon those who are duty bound in improving the quality of life. Let us therefore keep in mind that there is always a place in the community for a concerned dedicated, understanding dental surgeon who with a touch of his gentle hand and dextrous fingers can relieve pain and suffering of his fellow human beings.

I am proud to declare that this Association has had and will continue to have men of such calibre. Utilising a crystallised wisdom and experience of our senior members and the enthusiasm and talent of our new colleagues we have confidence that we step into the last decade of the twentieth century and the 60th year of our Association with hope and courage to meet the challenges of tomorrow.

Finally, let me thank each and every one of you for your presence here today and for having listened to me so patiently.

Bilateral Dens Invaginatus, Irregular Calcified Mass and Residual Cyst in the Pre-maxilla of a Young Shri Lankan Girl

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S. Ali*

Introduction

It is most unusual to encounter multiple pathology in the maxillary anterior region. Dens invaginatus ('dens in dente') is a fairly common lesion in the maxillary lateral incisor region. Bilateral occurrence of dens invaginatus is quite common. (Conklin 1978). There has been several reports on the prevalence of dens invaginatus including those by Pindborg 1970, Shafer et al 1953 and Ulmanky & Hermel 1964. Complications of the dens invaginatus has also been documented (Kramer 1953). Those include the periapical pathology, periapical cyst formation and abscess formation. The maxillary anterior region is also the location for other irregular calcified masses such as compound composite odontomes and more rarely complex composite odontomes. These calcified masses prevent root development, prevent

eruption of teeth and also get involved in cyst formation in relation to the pre-maxilla. In addition odontogenic tumours that present with calcification need to be considered. These are the ameloblastic odontoma and ameloblastic fibro-odontoma. Further adenomatoid odontogenic tumour (AOT), calcified epithelium odontogenic tumour (CEOT), and calcified odontogenic cyst (COC), and periapical cementum dysplasia can also present with calcification in the maxillary incisor region. Residual Cyst from the desiduous teeth are uncommon (Pindborg 1970, Shafer et al 1983). When they do occur these cysts could be found in relation to the retained roots of desiduous teeth in the alveolar process where cysts develop.

An unusual case is presented here, that of a patient who had (a) bilateral dens invaginatus in relation to the maxillary lateral incisor teeth (b) periapical infection in relation to both affected lateral incisor teeth (c) an irregular calcified mass (complex composite odontome) in relation to the 2/ root area, and (d) a residual cyst

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located in the alveolar bone between the roots of upper left lateral incisor tooth and canine tooth arising from the retained deciduous upper left lateral incisor tooth root.

Case Report

A 22 year old healthy girl presented with a swelling in relation to the upper left lateral incisor tooth and upper right lateral incisor tooth. She complained of swelling for the last 5 years. There had been a history of recurrent swelling, pus discharges and healing. About 7 years ago when the patient was 15 years old she had some sensitivity in relation to 2/2. She gave a history of a fall 10 years ago when she was 12 years old. This had happened in school and there had been no bleeding or laceration at the time. The past medical history was uneventful and the family history showed that one of her sisters had a mesiodense supernumerary tooth. On examination all the teeth were present and there was no evidence of caries. There was a deep cingulum pit in relation to the 2/2 and when testing for vitality with an electric pulp tester 2/2 was found to be nonvital.

Radiographic Examination

The radiographic examination revealed radiolucencies in relation to the right and left maxillary lateral incisor teeth together with an irregular calcified mass or odontogenic malformation in relation to the root of the upper right lateral incisor tooth which showed an irregular radioopaque mass with a well defined radiolucent border surrounding the periphery of the calcified mass. The right and left maxillary lateral incisor teeth also showed periapical lesions in relation to both apices. The irregular calcified mass was interpreted as "a complex composite

odontome". The left lateral incisor showed dens invaginatus, widening of the pulp chamber, resorption of the apical end of the root, together with an associated periapical radiolucent area. The left anterior maxilla also showed a radiolucency about 1.0 cm in diameter between the roots of the upper left lateral incisor and the canine tooth. This radiolucent area extends from the mesial periodontal space of the upper left canine to the distal periodontal space of the upper left lateral incisor tooth. There seems to be a connection between the periapical radiolucency of 1/2 and the radiolucency of the residual cyst. The radiolucency was regular, with about 1.5 cm of bone separating the radiolucency from the maxillary alveolar crest. Close examination also revealed a radioopaque mass, seen with part of the radioopacity outside the radiolucency. (Fig. 1 & 2).

Treatment

Treatment commenced on 21.07.1991. It was decided to open the pulp chambers and root canals of 2/2 simultaneously and to place medicaments (Camphorated Paramonochlorophenol) inside the root canals. The patient was followed-up on a weekly basis for 4 consecutive weeks. The medicaments were changed at every visit. At the end of the 5th week as there was no tenderness, pain and pain on percussion the final root fillings were placed with gutta-percha. On the same day of the final fillings surgical apicectomy and apical curettage was undertaken in relation to the 2/2. The periapical area was debrided of chronic inflammatory tissue and washed with distilled water. The irregular calcified mass in relation to 2/1 was left undisturbed in view of the fact

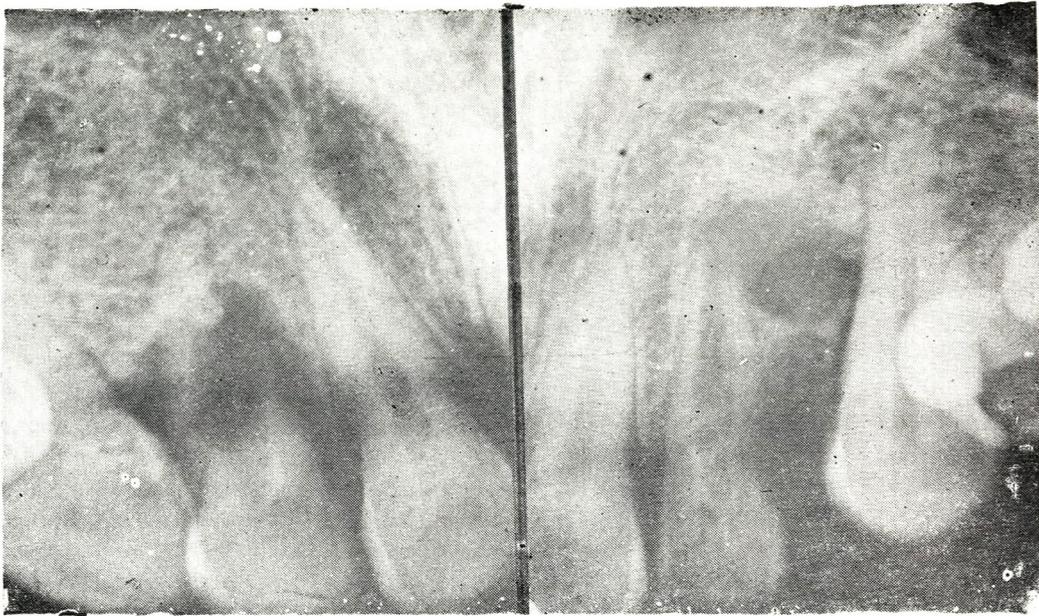


Fig. 1
Preoperative Radiograph taken in June 1991

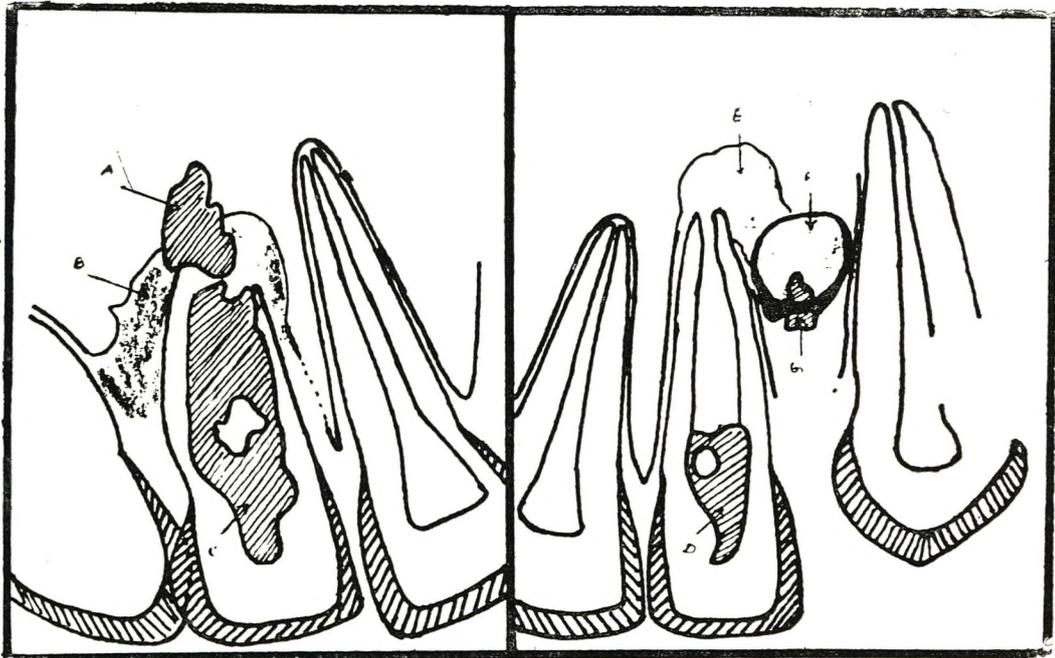


Fig. 2 Schematic Diagramme of Fig. 1
[A Complex Composite Odontome B Periapical infection 2/ C Dens invaginatus 2/
D Dens invaginatus 2/ E Periapical infection /2 F Residual Cyst from /B
G Residual piece of /B

that the mass was fairly well attached to the bone in the vicinity of the root of 2/. Disturbing the mass would have resulted in loosening of the 2/. In relation to the /2 the apical curettage was combined with enucleation of the residual cyst. The flap was repositioned and interrupted sutures were placed between the interdental papillae of the six anterior teeth. Unfortunately the periapical tissue obtained from the 2 teeth [and] the contents of the residual cyst was not sent for histopathological examination. The patient was kept under close follow-up examination on a monthly basis and the healing upto now has been uneventful. The postoperative radiographs (Fig. 3) were taken on 19.02.1992.

Discussion

This case is interesting because of the multiple pathological changes seen in the anterior maxilla.

The dens invaginatus in relation to 2/2 was endodontically treated. This was a difficult clinical decision to make in view of the nature of the invagination and the large periapical radiolucency. The invaginations were of the coronal variety, in relation to 2/, while the invagination expanded into the root area in relation to /2. The dens in dente is known to have tortuous root canals. These root canals are difficult to fill because it is not always possible to get a satisfactory apical seal. If the apex is hermetically sealed (with no leakage between the gutta-percha and

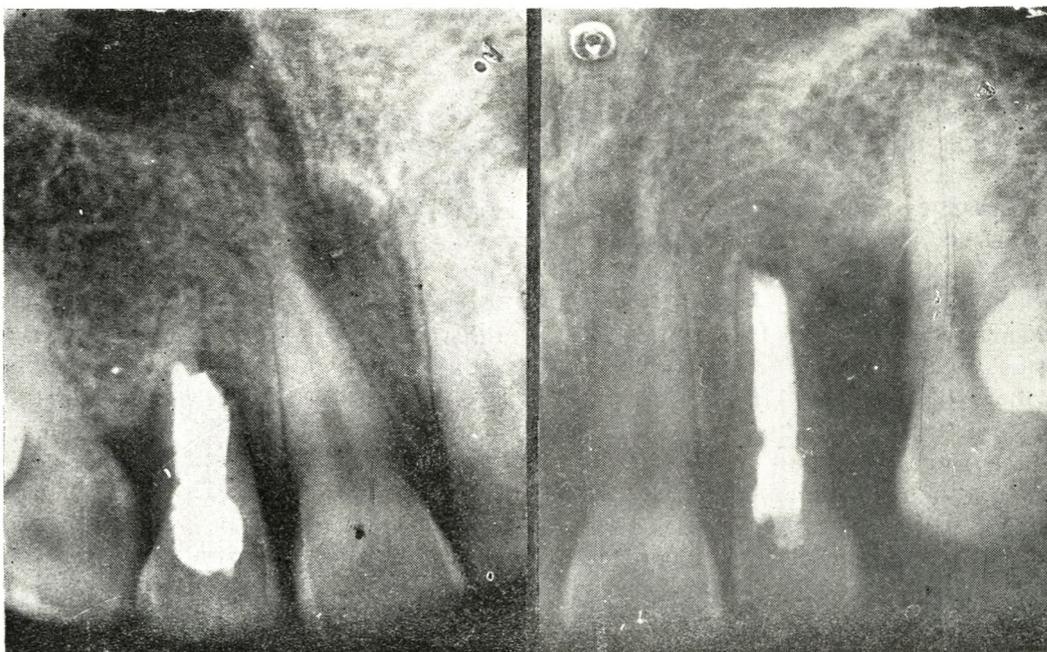


Fig. 3

Postoperative radiographs of the patient taken on 19.02.1992, seven months after the commencement of treatment. Note: both 2/2 are root filled. The periapical lesions of 2/2 have resolved. The irregular calcified mass in relation to the apex of 2/ is still in situ.

The residual cyst in between the roots of /2 and /3 shows evidence of satisfactory healing.

the margin of the root canal) in a normal single rooted tooth with a periapical radiolucency the radiolucent area would resolve both clinically and radiographically in about 9 months to 1 year when apicectomy is done. If an apicectomy procedure however is not done it will take longer, 1.5 – 2.0 years (Weine 1989). In this patient despite of the odontogenic malformation very satisfactory healing was obtained in relation to the apices of **2/2** with apicectomy and periapical curettage, in 8 months. This confirms the view of many Restorative Dentists, Endodontists and Oral Pathologists that even with gross abnormalities teeth can be saved if the Dental Practitioners are sufficiently motivated. There has been no residual infection over a 8 months period. It seems unlikely that satisfactory healing would have taken place if apicectomy had not been carried out. Retrograde amalgam filling for **2/2** was considered as an option, but was not done because both apices in relation to **2/2** had well condensed gutta-percha with no possibility for microleakage. The prevalence of dens invaginatus has been reported at 0.25% to 5.1% (Conklin 1978). Bilateral involvement of upper lateral incisor accounted for 2.2% of 5.1% in one study (Amos 1955) and 0.77% of 1.26% in another study (Shafer 1953).

The irregular calcified mass was left in-situ without disturbance as it was felt that removal of the mass would result in loosening of the upper right lateral incisor tooth which already had a compromised bony support. As such the calcified mass was not available for histopathological examination. The nature of the radioopacity indicated that the calcified mass was not active. Lesions such as benign cementoblastoma or periapical cemental dysplasia would have a different radiological appearance.

It could be argued that this irregular calcified mass is a complex composite odontome. The radioopacity is not quite correct for such a lesion either. Further, the distribution of the complex composite odontome is rather uncommon in the anterior maxilla. The distribution for complex composite odontome is as follows: posterior maxilla 59%, anterior maxilla 34% and maxillary premolar area 7% (Shafer et al 1983). It is also interesting to note that such multiple pathology in the premaxillary region with a propensity for the development of irregular calcified masses, additional pathology by way of adenomatoid odontogenic tumour formation and supernumerary tooth formation is common in the anterior maxilla. This further suggests that the premaxillary region of the jaw may be predisposed to disturbed odontogenesis. Yet, no logical explanation can be given for such predilection.

The residual cyst in the left maxilla also showed healing after enucleation and primary closure. This behaviour is quite inkeeping for healing after such procedures. It is reported that small cysts after enucleation heal with normal bone formation after a reasonable period of time from the time of the operation. The radiolucency in relation to the residual cyst (Fig.3) is now 8 months old.

It shows a disappearance of the cavity particularly in relation to the inferior surface. The overall radiolucency in relation to the lesion has also diminished. There is radiographic evidence that bone with a radio-opaque architecture is filling into the defect. With time bone trabeculae will gradually reappear. In the differential diagnosis of this residual cyst an odontogenic keratocyst may have to be considered, but the presence of a root fragment excludes such a possibility.

Acknowledgement

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Prevalence of Gingivitis amongst Pregnant Women in an Urban Population in Sri Lanka

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Introduction

Gingivitis amongst pregnant women is a common finding all over the world. However, there had not been any proper study done to ascertain the extent of the problem, degree of gingivitis, as well as the probable pre-disposing factors which contribute for this condition in a Sri Lankan sample. The only study reported in this area in Sri Lanka (Ratnayake, 1988) has been conducted at the De Soysa maternity Home. In the above mentioned study gingivitis has been assessed visually rather than according to any acceptable index, in 834 pregnant mothers attending the ante-natal clinic.

As early as before the turn of the century, observations showed that the clinical status of gingiva somehow or the other has been influenced by pregnancy (Lee, 1965). Numerous studies (Cohen, et al 1969; Loe & Silness, 1963; Hugoson, 1970; Maier & Orban, 1949; Ringsford et al, 1962; Arafat, 1974 and Samant et al 1976) showed an increase in the severity of gingivitis during the course of pregnancy and it has been ascribed to local as well as systemic factors. Thus according to some investi-

gators (Loe, 1965; Hugoson, 1970; Maier & Orban, 1949) the accentuated inflammatory response to bacterial irritation is secondary to an altered tissue metabolism of the gingiva during pregnancy. Others claim (Hugoson, 1970; Arafat, 1974) that the temporary aggravation of gingivitis is primarily due to systemic physiological changes that occur during pregnancy and the local irritants being only contributory factors.

Whatever the mechanism responsible for the onset of gingivitis amongst pregnant women, it is imperative to have an understanding of the occurrence of gingivitis amongst pregnant women in Sri Lanka. Such knowledge would be beneficial to implement appropriate oral health care programmes amongst pregnant women as well as to prevent the breakdown of subsequent tooth attachments in later life amongst them.

Therefore, in this study it is aimed to assess the prevalence of gingivitis amongst a sample of pregnant women from an urban area using a standardised gingivitis index.

Materials and Methods

Nugegoda area has been selected for this study since it is (i) a densely populated area, (ii) no previous similar studies had been conducted in this region,

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(iii) the population represents a true urban resident population and (iv) there are several polyclinics available where pregnant mothers attend for their antenatal care.

Study Sample

The whole population of the Nugegoda MOH area is about 95,000 and the Birth Rate is 22.2 per 1000.

Estimate of the expectant number of births for midyear 1991 = $(22.2/1000) \times 95,000 = 2,109$ for midyear 1991.

The estimated total number of expectant mothers under care for midyear 1991 = $1.4 \times 2,109 = 2,952$ for midyear 1991.

(* 1.4 is the correction factor for predicting expectant mothers).

Therefore, there are about 2,952 estimated expectant mothers for midyear 1991 under care in Nugegoda MOH area.

Assuming that women get pregnant evenly throughout the year, there should be approximately 246 pregnant mothers under care in the Nugegoda MOH area per month in the year 1991. The average daily attendance at each clinic ranged from 25 to 55. It was decided to examine all the pregnant mothers attending at each antenatal clinic (Nugegoda, Welikada and Obeyesekerapura).

All the pregnant mothers who were registered with the above named three centres have been informed through the relevant midwives about this project and their consent had been obtained.

Period of study

Prior permission has been obtained to conduct this study from June 20th

to August 30th, 1991, from the Regional Director of Health Services, Colombo and Medical Officer of Health, Nugegoda. The investigating team visited all the polyclinics functioned during this period in all the three centres.

Before the commencement of the study a pilot survey was carried out in the Nugegoda MOH region during the month of April 1991.

Method of Examination

The investigator got familiar with the diagnostic criteria used in examination, by seeing gingiva of pregnant mothers at antenatal clinics. The method of investigation was assessed by the Regional Dental Surgeon, Colombo, at the antenatal clinic Nugegoda to eliminate the examiner variability. The intra-examiner consistency was found to be greater than 80% at each examination.

The school dental nurse was trained by the investigator to interview and also to record the data on the prescribed form.

The *Gingival Index* as described by Loe & Silness has been used to assess the status of the gingiva of the pregnant mothers.

The examination of the gingiva of each subject was carried out by the investigator after drying the gingiva with a piece of sterile gauze. The periodontal probe was gently run twice through the gingival sulcus and waited for a few seconds to observe bleeding and the gingival scores recorded in the prescribed form.

All examinations were carried out in artificial light. Each subject was made to sit on a straight back chair. The

position of the chair was adjusted to receive maximum illumination from the artificial light and to avoid direct sunlight.

Results

During the period between 1st to 25th July, 1991, 248 pregnant women were examined. The period of gestation amongst these women varied between 3 to 6 months, their age range was found to be 18 - 48 years.

The mean GI value of all the subjects (N=248) was found to be 1.79 ± 0.18 (Table 1). The analysis of the course of the gingival changes in relation to the three trimesters of preg-

nancy showed a progressive increase in the GI (Table 2).

When the GI value was compared to the period of gestation expressed in months, there has been an increase upto the seventh month; thereafter, it decreased falling back to the level observed at the third month (Table 1).

The rate of change in the mean GI values were when compared in relation to the group of teeth, molars showed the highest whereas the incisors and premolars showed lower values (Table 3).

Only in one subject the presence of pregnancy epulis was observed.

Table 1
Mean Gingival scores of the patients in relation to months of pregnancy

<i>Period of gestation (month)</i>	<i>Number</i>	<i>Mean GI</i>	<i>S. D.</i>
3	32	1.73	± 0.22
4	30	1.76	± 0.18
5	36	1.77	± 0.16
6	34	1.78	± 0.19
7	40	1.91	± 0.18
8	38	1.80	± 0.16
9	38	1.73	± 0.15
Total	248	1.79	± 0.18

Table 2
Mean GI of pregnant women in relation to trimesters

<i>Trimester</i>	<i>Number</i>	<i>Mean GI</i>	<i>SD</i>
First	32	1.73	0.22
Second	100	1.78	0.17
Third	116	1.72	0.18

Table 3**Mean GI of groups of teeth in relation to months of pregnancy**

<i>Months</i>	<i>Incisors mean GI</i>	<i>S.D.</i>	<i>Premolars Mean GI</i>	<i>S. D.</i>	<i>Molars mean GI</i>	<i>S D.</i>
3	1.78	±0.12	1.66	±0.10	1.73	±0.18
4	1.71	±0.14	1.74	±0.18	1.81	±0.16
5	1.56	±0.18	1.80	±0.16	1.82	±0.14
6	1.76	±0.16	1.71	±0.22	1.80	±0.19
7	1.88	±0.13	1.89	±0.18	1.98	±0.22
8	1.69	±0.16	1.80	±0.14	1.78	±0.17
9	1.74	±0.18	1.69	±0.15	1.74	±0.16

Discussion

All pregnant women examined in the present investigation showed gingival changes which could be clinically described as inflammation of the gingiva. Gingivitis observed in the pregnant women in this study was found to be present from the third month of gestation with a gradual increase to the seventh month. This is in conformity with the observations of other workers that inflammatory gingival changes do occur during pregnancy and that the severity of gingivitis increases during the pregnancy. During the last month of pregnancy, the severity of gingivitis present tend to fall approximately to that of the third month. However, results of a study conducted by Loe showed two peaks occurring during the third and eighth months of pregnancy. The difference in peaks between the present study and that of Loe's may be due to the fact that a clear distinction cannot often be drawn between the different months of gestation because one interceptibly merges into the other. But in the seventh or eighth month the peaks in both are seen to occur during the third trimester. In this study, it was observed that gingival

index increased from the first trimester to the third trimester (Table 2). During the first trimester due to nausea and vomiting, most of the pregnant women avoid tooth brushing and they may resort to rinsing the mouth as their method of oral cleaning which would result in gingivitis. Or it may be an exaggerated response of the oral tissues to bacterial plaque due to the altered levels of sex hormones secreted during pregnancy.

The rise in the severity of gingivitis during the first trimester could be attributed to the rise in gonadotrophin levels in the blood. The increase thereafter may correspond with the plasma oestrogen concentration. The abrupt decrease in the secretion of these hormones shortly before parturition may account for the fall in gingival index during the last month of pregnancy.

The molars gave the highest score (Table 3) of gingival index which is in agreement with Loe's findings. The fact that the first molars were the first teeth to erupt and therefore exposed to the oral environment for a longer period may account for this high

value. On the otherhand it may be due to poor accessibility for brushing as they are placed posteriorly. The ginival index for the molars are found to increase steadily with a peak occuring during the seventh month and a fall thereafter. This too may be attributed to the rise and the fall in the levels of sex hormones during pregnancy. (Table 3)

There is no marked variation of the gingival index with regard to their age, seen amongst the pregnant women (probably because they may have been in different trimesters of pregnancy or it may be because equal numbers of pregnant women had not been represented in this age group. The GI scores observed in these pregnant women may be considered as being low when compared to the study conducted by Loe in Sri Lanke on Tea Estate labourers. The above study showed that the mean GI for 15 yrs. old subjects was found to be 1.34 and for 30 yrs and over to be 1.90. This cannot be taken; as a baseline value for Sri Lanka as the study was limited to tea estate labourers who on the whole may be considered to be having poor oral hygiene practices.

Since the gingival changes during pregagncy are inflammatory in nature scoring systems that are graded on the basis of inflammatory changes may be used to study the gingiva during pregnancy. The use of an index which depend on the degree of severity of inflammation when applied to each gingival area of the different groups of teeth appears to provide sufficiently detailed information on the location and quality of gingival changes. The lack of registration of pregnancy tumours is not a serious objection to the use of this index. As these

tumours are rare. In the present study only 1 out of 248 women presented with a pregnancy epulis. This is in agreement with other reported observation (below 1%).

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AIDS and its Dental Implications — A Review

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Acquired immune deficiency syndrome (AIDS) is defined as a disease indicative of a defect in cell mediated immunity occurring in a person with no known cause of immunodeficiency other than the presence of human immunodeficiency virus (HIV) (Farthing et al, 1988).

AIDS was first recognised in 1981 in U.S.A. as a disease affecting promiscuous male homosexuals. But it is thought to have originated in Central Africa and has now spread worldwide with 96500 cases being reported from 136 countries. (Macfarlane and Samaranayake, 1989). AIDS has now reached epidemic proportions in Africa where nearly 25% of adults are HIV positive in some areas. (Scully and Cawson 1987).

In Sri Lanka the first case of HIV disease was detected in 1987. Since then 59 cases of HIV disease have been detected in the country, of which 12 have been foreign nationals. Of the 47 Sri Lankan patients 17 had developed full blown AIDS while 30 were HIV antibody positive cases.

Aetiology

The major aetiological agent of AIDS is a retrovirus termed the human lymphotropic virus III (HTLV III) which is also known as the human immunodeficiency virus (HIV). It is believed that co-factors such as immunosuppressive drug therapy and genetic haplotype of

an individual may play a contributory role in the pathogenesis of the disease. (Macfarlane and Samaranayake, 1989).

The HIV has a particular affinity for a subgroup of T lymphocytes known as the helper-inducer (T4) cells. The virus infects and damages the T4 cells resulting not only a defect of cell mediated immunity, but a widespread immune defect reflecting the major influence these cells have on the entire immune system.

HIV is also neurotropic. Destruction of brain tissue results in the clinical manifestations of encephalopathy.

Infection with HIV results in the production of antibodies. But the presence of antibodies is not indicative of the elimination of the virus or of immunity to the disease. Therefore all HIV positive individuals are regarded as potentially infective. A few patients with AIDS have no detectable HIV antibody and the absence of HIV antibody does not necessarily exclude infection with HIV.

Some 20 – 60% of Individuals who are antibody positive are probably at risk of developing AIDS, and over 90% of patients with full blown AIDS, are seropositive. (Macfarlane and Samaranayake, 1989).

HIV has been detected in blood, plasma, semen, saliva, tears, breast milk and cerebrospinal fluid.

Clinical manifestations of HIV disease

A number of stages of disease activity has been identified in the natural history of AIDS.

1. Seroconversion illness or Acute HIV disease

Although majority of the patients remain asymptomatic during the initial stages of the infection, HIV disease may first present with a seroconversion illness.

Within a few weeks of infection with the virus the patient presents acutely unwell with fever, sore throat, head ache, arthralgia, lymphadenopathy and a maculo-papular rash. Usually the patient recovers spontaneously within a week.

2. Persistent generalised lymphadenopathy (PGL)

This is the most common syndrome of AIDS and is due to reactive hyperplasia of lymph nodes.

PGL is defined as

- a. Lymphadenopathy of at least three months duration involving two or more extra-inguinal sites.
- b. Absence of any current illness or drug use known to cause lymphadenopathy.
- c. Presence of reactive hyperplasia in a lymph node if biopsy is performed.

It is detectable in over one third of all cases particularly those that appear asymptomatic. It's absence in those with symptoms signifies a poor prognosis. (Ogden and Chisholm, 1988).

3. AIDS related complex (ARC)

Constitutional symptoms such as fatigue, night sweats and relatively

minor medical problems such as shingles and oral thrush precede the development of major opportunistic infections or tumours. At this stage the patient does not satisfy the Centre for Disease Control (CDC) criteria for AIDS, but is said to be suffering from ARC (Farthing et al, 1988).

Presence of two of the following clinical findings of HIV infection, plus two laboratory findings are suggestive of ARC.

The clinical findings are.

- a. Fatigue
- b. Night sweats
- c. Lymphadenopathy of more than 3 months duration
- d. Weight loss of more than 10% of total body weight
- e. Fever of more than 3 months duration
- f. Diarrhoea

The laboratory abnormalities are,

- a. Decreased T-helper cell count
- b. Increased serum globulin
- c. Anergy to skin testing
- d. Anaemia

4. Full blown syndrome of AIDS

The full blown syndrome may not develop for some months or years in a patient with ARC. It is characterised by opportunistic infections and/or malignant neoplasms. (Table 1). The most common of these opportunistic infections is *Pneumocystis carinii* pneumonia, while the most common neoplasm is Kaposi's sarcoma.

As HIV is neurotropic nearly 60% of all full blown AIDS patients may have clinical manifestations of encephalopathy which includes meningitis

Table 1

**Opportunistic infections, neoplasms and other features
of AIDS and AIDS - related diseases**

(1) Opportunistic infections: Pneumonia, sinusitis	Pneumocystis carinii Aspergillosis Candidosis Cryptococcosis Zygomycosis Strongyloidosis Toxoplasmosis Atypical mycobacterioses Cytomegalovirus Legionellosis Pseudomonas aeruginosa Staphylococcus aureus Streptococcus pneumoniae Haemophilus influenzae
Gastrointestinal	Cryptosporidiosis Isospora Giardiasis
Brain, meningeitis encephalitis	Polyoma JC virus Toxoplasma gondii Papovavirus
Mucocutaneous	Herpes simplex Herpes Zoster Human papillomavirus Atypical mycobacteria Candida albicans Staphylococcus aureus Histoplasmosis
Disseminated	Mycobacterium fortuitum Avium-intracellulare Cryptococcus neoformans Histoplasma capsulatum Cytomegalovirus Adenoviruses
(2) Neoplasms : Kaposi's sarcoma Lymphoma (especially of the central nervous system) Squamous cell carcinoma (of mouth, anus and rectum) Leukaemia	
(3) Other complications : Encephalopathy Idiopathic thrombocytopenic purpura Lupus erythematosus Seborrhoeic dermatitis	

(acute and chronic), dementia, paralysis, seizures or incontinence. (Porter et al, 1987).

AIDS in Africa is often characterised by a diarrhoea wasting syndrome known as 'Slim disease'. *Pneumocystis carinii* pneumonia is less common than in AIDS patients from the West.

Oral manifestations of AIDS

Oral manifestations are extremely common in patients with ARC and AIDS. Since these manifestations are often the presenting sign of the disease in some individuals it may prove valuable in the identification of hitherto undetected HIV infection.

Infections

a. Candidal infections:

Oral candidosis (thrush) is often the first opportunistic infection encountered in HIV disease. Its presence indicates that the disease has advanced to a stage where the development of AIDS if has not already occurred is certain to do so within the next 2 years.

Oral thrush is extremely uncommon in healthy young people and when it occurs other causes for candidal infection such as diabetes, anaemia, broad spectrum antibiotic therapy, use of oral steroid inhalers (for asthma) and other forms of immunosuppressive therapy (eg. cytotoxic drugs), should be excluded. Oesophageal candidosis could be present concurrently with oral thrush and can cause dysphagia. Angular cheilitis may also be present.

b. Herpetic infections:

Herpes simplex virus infections are commonly seen in ARC and AIDS patients. Both primary and reactivated herpes simplex infection can be ob-

served. Chronic mucocutaneous herpes simplex is a common problem seen in African patients.

Herpes zoster infection although less common may affect the face and less commonly the oral mucosa.

c. Hairy leukoplakia:

This condition is often seen in male homosexuals who develop AIDS. Hairy leukoplakia (HL) which is thought to be induced by Epstein Barr virus has not been described outside of HIV disease. (Farthing et al, 1988). HL which presents as white areas of thickening is exclusively described as occurring on the tongue usually the lateral border, and only 11 patients have been reported with HL involving mucosal surfaces other than the tongue. But the detection of a case of multifocal lesions of both hairy leukoplakia and Kaposi's sarcoma in a patient, with HL present in the epithelium covering Kaposi's sarcoma suggests that HL is more common and more widely distributed than is generally recognised. (Southam et al, 1992).

d. Gingivitis:

Recurrent periodontal disease which includes rapidly increasing pocket depths, rapid destruction of bone and halitosis is common in HIV disease.

Neoplasms

a. Kaposi's sarcoma:

This endothelial cell tumour is the characteristic neoplasm found in AIDS. It is often seen in homosexual AIDS patients, but rarely in intravenous drug abusers and never in haemophiliacs. (Ogden and Chisholm, 1988). Kaposi's sarcoma (KS) which is often an early oral manifestation of Aids presents as a red or purple macule or nodule usually in the palate.

Before AIDS, KS has been occasionally detected in elderly men of Jewish descent and more commonly in people from Central Africa.

The presence of KS in the mouth of a male who is not on immunosuppressive therapy is virtually pathognomonic of AIDS.

Epithelioid angiomatosis is a recently described vascular lesion which may be clinically and histologically similar to KS, but which is infective in origin. This condition which could successfully be treated with broad spectrum antibiotics has so far been reported in patients with AIDS or ARC, and most patients have been terminally ill at presentation. The lesions are usually cutaneous and multiple and in only 3 cases have oral lesions been present. But the presentation of a rare case in which epithelioid angiomatosis was limited to the oral cavity, and was associated with HIV infection but not with AIDS or ARC, suggests that epithelioid angiomatosis could be one of the earliest signs of HIV infection. (Speight et al, 1991)

b. Squamous cell carcinoma and other lymphomas may develop infrequently in oral cavities of HIV infected individuals.

Miscellaneous oral manifestations

Recurrent aphthous ulcerations, dental abscesses, intra oral warts and parotitis could occur less frequently.

Transmission of AIDS

Transmission of HIV occurs primarily through receptive anal intercourse and by administration of blood and blood products including plasma. Trauma in sexual intercourse is not necessary for the transmission of the virus, as artificial insemination of semen alone has been responsible for infection in hu-

mans and other primates. (Farthing et al, 1986). But there is no evidence yet of oral transmission via the orogenital route. (Scully and Cawson, 1987). There is also no evidence yet of transmission of HIV by saliva or by normal social contact (Scully et al, 1987), and the low infectivity of whole saliva has been reaffirmed by recent studies. (Samaranayake, 1991).

Susceptibility seems to play a role in transmission of HIV, since individuals who are not in high-risk groups but who are exposed to the virus appear to remain seronegative. (Macfarlane and Samaranayake, 1989). The major risk groups for AIDS and AIDS related diseases are,

1. Sexually promiscuous homosexual or bisexual men
2. Intravenous drug abusers
3. Haemophiliacs and other blood transfusion recipients
4. Heterosexual contacts of above groups or infected persons
5. Infants born to infected mothers

Children may acquire AIDS from exposure to blood or blood products, or occasionally in utero or intrapartum transmission from infected mothers.

AIDS also appears in patients who are not in any of the risk groups. HIV infection can be sexually transmitted from females to males and in Africa the disease appears to be transmitted mainly by promiscuous heterosexual activity. Female prostitutes in several countries have been shown to be HIV positive.

As contaminated blood and blood products form a well proven route of HIV transmission the possibility arises that health care workers (HCW's) are at an increased risk of contracting HIV

via occupational exposure to blood. But current data indicate that occupational exposure to blood of patients infected with HIV does not pose a serious threat to HCW's except in situations where accidental parenteral injuries have occurred. Further analysis of data concerning accidental needlestick inoculation or percutaneous/mucous exposure of HCW's indicates that single small parenteral inoculations from HIV positive individuals are associated with a very low risk (0.4%) of HIV infection, which means that seroconversion occurs in less than 1% of cases. (Samaranayake, 1990). Such a low accidental possibility of cross infection could be further minimised by HCW's exercising caution when performing invasive procedures and following universal infection control guidelines.

Studies also reveal that dental professionals run a low risk of contracting AIDS by virtue of their occupation. HIV transmission among dental professionals is unlikely in the absence of accidental percutaneous/mucosal injuries. (Samaranayake, 1990).

Prevention of HIV infection

The only reliable method of prevention is the avoidance of sexual promiscuity and high risk sexual practices such as unprotected intercourse, especially anal intercourse. Discouraging needle sharing among drug addicts is also important.

Although steps are being made towards a vaccine against HIV, an effective vaccine is not expected to be available within the next 5 years.

Prevention of infection for staff

The fact that a dentist knows that a patient belongs to a high risk group should encourage him/her to be more

careful during treatment, but logically no extra precautions are required as universal precautions should now be the norm in every dental practice, (Samaranayake, 1990).

Some authorities however advise additional precautions to be followed when treating high risk infective patients such as those infected with HIV.

1. Treatment at end of a session or day
2. Use rubber dam where possible
3. Use a 3 in 1 syringe with a sterilizable tip
4. Use autoclavable hand-pieces
5. Avoid use of aerosol producing instruments (eg. air turbine hand-pieces and ultrasonic scalers) as much as possible
6. Use disposable instruments where possible
7. Dental impressions should be taken with silicone based material, and impressions should be disinfected prior to casting models.
8. X-ray films should be protected in a sealed plastic bag when in patients mouth.

All surgery staff should be educated on the possible dangers of HIV infection, the modes transmission and the precautions necessary to prevent cross infection. Pregnant or immunocompromised staff should be relieved from the responsibility of treating positive patients.

Management

If as a result of the presence of signs of oral manifestations or as a result of the medical history a person is suspected to be infected with HIV,

the patient should be referred to the appropriate medical authorities for diagnosis and specialised management.

As there is no effective treatment for the underlying immune defect in AIDS or for HIV infection, alleviating the opportunistic infections or neoplasms by therapeutic measures are important, although unlikely to be life saving.

New therapies such as Thymic hormones, interferon and drugs acting against retroviruses such as ribavirin and azidothymidine (AZT) are being examined. AZT appears to show some promise in raising T4 levels, reducing HIV infection of mononuclear cells and producing clinical improvement.

Conclusion

As there is an increase in Aids cases in Sri Lanka, and the number is expected to rise significantly in the near future the dental practitioners should have a wide knowledge on AIDS in order to

1. Identify patients who could present to them with signs and symptoms of the disease, as often the oral manifestations are the first indication of HIV infection.
2. To carry out preventive measures in the dental surgeries to control the spread of infection with HIV.
3. To identify individuals at risk against AIDS or AIDS related diseases.

4. To advise patients on preventive measures and control of the disease.

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A Short History of Asian Pacific Dental Federation

Dr. H. W. M. Cooray

In 1955, on an invitation made by the Japanese Dental Association, Representatives from Japan, Philippines, Indonesia, Malaya, Thailand, South Vietnam, Hong Kong and Republic of China (Taiwan) met in Japan and decided to form the Asian Dental Congress. (The forerunner of Asian Pacific Dental Federation). The President of the Japanese Dental Association Dr. Yoshio Ogura was elected the President and Dr. B. B. Erana of Philippines as secretary. Professor Matsumiya of Tokyo Dental College was the person who by having discussions, with the individual national Dental associations, made way for this meeting. It was decided to call this meeting the 1st congress and to have the 2nd Congress in Philippines in three years time in 1958.

At the 2nd Congress the name was changed to "Asian Pacific Dental Federation". Korea was admitted a member at this meeting. The 3rd Congress was held 1961 again in Japan. At this meeting All India Dental Association was accepted as the 10th member of the Federation.

The Federation was recognised by the Federation Dentaire International through its affiliation in 1959. But it was in 1967 that a clear and a final recognition of A. P. D. F. as a regional organisation of F. D. I. was granted,

President, Sri Lanka Dental Association.

when during the 55th session of F. D. I held in Paris on 6th July 1967 the following resolution was passed. "Resolved that the application by the member associations for recognition of the Asian Pacific Dental Federation as the Asian Pacific Regional Organisation of the F. D. I. be approved".

The 4th Congress was held in Singapore in 1964 and was hosted by the Malayan Dental Association. The 5th Congress was held in South Korea in 1967. It was at this meeting that Australia became a member and New Zealand soon followed. The Dental Association of Thailand hosted the 6th Congress in 1970 which was under Royal Patronage.

The 7th A. P. D. C. was hosted by the Indonesian Dental Association in 1974 and the 8th in 1977 in Manila, Philippines. The 9th Congress in Kuala Lumpur held in 1979 was, the first time a Congress was held after a two years interval.

The 10th A. P. D. F. Congress hosted by the Singapore Dental Association was a great success with a attendance of 1780 delegates from 34 Countries. There was a trade exhibition covering 55,000 sq. ft with 168 Exhibitors. A joint A. P. D. F.—W. H. O. workshop was organised for the first time. Dr. Oliver Henedige was the President A. P. D. F. and the organising Chairman for this Congress. Burma became a member at this meeting.

In 1984 the Hong Kong Dental Association hosted the 11th A. P. D. C. Congress followed by Thailand hosting the 12th A. P. D. C. This was followed by India hosting the 13th Congress in 1988. The 14th Congress was hosted by the Korean Dental Association in 1989 and the 15th by New Zealand. The schedule for next Congresses are 16th A. P. D. C. by Malaysian Dental Association, 17th A. P. D. C. by Philippines Dental Association and 18th A. P. D. C. by Indian Dental Association. History was created when Sri Lanka Dental Association was awarded the bid to host the 19th Asia Pacific Dental Congress in Colombo. This Privilege has been given to us after being a member for only five years.

Sri Lanka Dental Association and the A. P. D. F./A. P. R. O.

The idea of Sri Lanka Dental Association joining this regional organisation emerged when Dr. Cooray and Dr. Saparamadu met Dr. Oliver Henedige, the Secretary General A. P. D. F /A. P. R. O at a ceremony where the Fellowship of International College of Dentists was being awarded to Dr. Saparamadu during the F. D. I. Congress in Belgrade in 1985. On inquiring why S. L. D. A is not a member he replied that it is because the S. L. D. A has not applied for membership, though records reveal that S. L. D. A. had been invited to become a founder member in 1955. Thereafter the treasurer S. L. D. A. at that time wrote to him officially, with Council approval, during the Presidency of Dr. Mrs. Siromani Abayaratne. We became an associate member in January 1987. In January 1988 when Dr. Raja Jasinghe represented the S. L. D. A. as the chief delegate at the 13th A. P. D. C. we were admitted as a full member.

At the very next 14th A. P. D. F Congress in Seoul which had a very representative delegation of twelve led by Dr. Reggie Goonetillake as President we placed the bid for the holding of the Congress in Colombo. An inspection team consisting of Dr. Jhee Heun Taiko, President A. P. D. F. and Dr. Oliver Henedige, Secretary General of A. P. D. F. visited Sri Lanka in 1991 to assertion of the convention facilities available here, Dr. Mrs. Ira Ratnayake was the president at the time.

We like to record with gratitude the assistances received by the Sri Lanka Convention Bureau who hosted the Inspection team at Hilton Hotel and for making all arrangements to facilitate this inspection and for the assistance given in preparation of bid document and in many other ways.

A very favourable report of this inspection team was placed at the delegates meeting in Milan. A Lot of canvassing and lobbying had to take place at the delegates meeting in Amsterdam & Milan (Dr. Cooray was the Chief delegate) meetings which proceeded the decisive 15th A. P. D. C. delegates meeting in New Zealand.

The Enthusiasm of the S. L. D. A. members to hold this Congress was seen when the largest ever delegation to attend an international Dental Congress totalling 24 was in attendance to receive the award of the 19th Asian Pacific Dental Congress to Sri Lanka Dental Association. To add to this success, was that Dr. Hilary Cooray who lead this delegation was elected a vice president of the Asian Pacific Dental Federation/Asian Pacific Regional Organisation. An Unique honour, as the first Sri Lankan to hold office in this 37 year old prestigious international Organisation.

Asia Pacific Dental Congress — New Zealand

A Report

The Asia Pacific Dental Federation held its 15th Congress at Auckland, New Zealand from 8th to 12th March 1992 at the Aotea Convention Centre. Sri Lanka Dental Association had a delegation of 24 persons including spouses & children. Our thanks to members who participated, namely:-

Dr Hilary Cooray	Dr Reggie Goonetilleka
Dr Gamini De Silva	Dr (Mrs) Siromani Abayaratna
Dr Sunil Fernando	Dr Lionel Dassanayake
Dr Nalin Jayatilake	Dr Mano Fernando
Dr Sunil Guneratne	Dr S Dharmatilleka
Dr Sarath Senaratne	Dr Asoka Ratnayake
Dr Jayantha Wijesooriya	Dr (Miss) Priya Samaranayake
Dr Raja Jasinghe	Dr (Mrs) Yvonne Dwight
Dr Srilal Silva	

The opening ceremony was held on Sunday 8th March at the spacious A. S. B. Theatre of the Aotea Centre at 7 p. m. followed by a reception. A Delegates Meeting and other Meetings of the Sub Committees were held in the morning prior to the opening ceremony.

The Scientific Programme that was held from 9th to 12th March included many current topics on the theme for each session. Among them were —

- (a) Treatment options — The multi disciplinary clinical approach
- (b) Achievable Aesthetics for the General Practitioners.
- (c) Management in a evolving profession.

There were many other alternate programmes and free communication that were held concurrently.

The Dental Trade Exhibition was spread out in 3 floors of the Aotea Centre. There were around one hundred dental trade exhibitors participating at this exhibition.

An extravaganza of social programmes were arranged. There were daily city tours and various other tours arranged for the accompanying persons. Evening cocktail parties were held daily which were sponsored by the future congress hosting member associations, trading organisations and other member associations. Pre and post Congress tours of 3 to 6 days duration were also arranged by the Official Travel Agent.

Delegates Meetings were held on 3 days at which the official delegates and observers were present. The following are some of the items taken up for discussion at the delegates meeting:-

(1) Amendments to the Constitution — There was a lengthy discussion on above but a decision could not be made and the matter was referred to the Constitution Sub Committee for a report.

(2) The Reports of Commissions on Dental Public Health, Dental Education and Oral Diseases were discussed.

(3) One country one vote proposal for the F. D. I. was discussed at length. It was decided to request the F. D. I. Council to study this proposal further.

(4) Future Congresses.

Under the Agenda item Future Congresses, the Secretary General announced that India would be given the Congress in 1995 and Sri Lanka Dental Association would host it in 1996.

(5) Election of Office Bearers — Out of the three Members of the SLDA who had been approved by the General Membership to seek election only Dr. Cooray contested a Post of Vice President and was elected.

During this Congress an informal meeting was held with the Members of the Japanese Dental Association who are the donors of the SLDA Research Fund. Those who took part in the discussion were Dr. Cooray, Dr. Sunil Fernando, Dr (Mrs) Siromani Abayaratna of SLDA, Prof. Morimoto and Dr. Tsurumaki of Japan and Dr. Pradeep of Thailand.

Another informal meeting was held regarding the proposed BDJ Study Tour to Sri Lanka. Mrs. Margaret Seward, President Elect B. D. A., Dr. Cooray, Dr. Sunil Fernando and Dr. Gamini De Silva took part in the discussions.

The closing session was held in the A. S. B. Theatre on 12th March at noon at which ceremony the new Office Bearers were installed.

The S. L. D. A. wishes to record its sincere thanks to M/s. Unilevers (Cey) Ltd. for the generous travel grant for all the delegates. Our thanks also to Air Lanka for the rebated air tickets given to the delegates.

Dr. Hilary W. M. Cooray
President
Sri Lanka Dental Association

NEWS AND VIEWS

We congratulate the following members on their achievements.

Dr. Premaratne Weerakoon was awarded the Deshabandu award by His Excellency the President of Sri Lanka on National Hero's Day of 1992.

Prof. A. N. I. Ekanayake, Head of the Department of Community Dentistry, Faculty of Dental Sciences, University of Peradeniya, was appointed Dean of the Faculty of Dental Sciences.

Dr. A. Ranjan Abeyasinghe a past President of the S. L. D. A. was appointed for a second term, as a member of the Peradeniya University Council by the University Grants Commission.

OBITUARY

Dr. H. E. Gomes, L. D. S. (Cey), H. D. D. (Sri Lanka)

Dr. Gomes, Edgar to all colleagues and friends, passed away on 1st March 1992 after a brief illness. He was in the third batch of dental students to qualify from the then University of Ceylon, in 1950.

Having qualified as a dental surgeon, he joined the public sector and started his professional career at the Dental Institute, Colombo. Later he joined the School Dental Service and was among the pioneer workers in his service. He was awarded a training course in the dental care of the school child in New Zealand in 1967. On his return to the country, he continued to be in this Service until his retirement in 1982. He was held in high esteem not only by his large subordinate staff in this service, but also by the school children who were under his professional care and supervision and their parents. He helped to build and expand the School Dental Service. His contribution was devoted and immense.

During the crucial days of 1958 when dental surgeons started their agitation for parity of salaries and conditions of service in par with their medical colleagues, Edgar was the secretary of the Government Dental Surgeons Association. As was always his nature, he served this cause and struggle too with devotion and zeal.

His devotion and dedication to the religion of his faith, the Anglican church, was of no small measure. Deeply respected by the large congregation of Holy Emmanuel church and the public of that faith in Moratuwa he was repeatedly elected a warden of that church and was also later nominated by the Bishop as a Bishop's Warden. He held this post for an aggregate of about 25 years with dignity and decorum. His peace loving nature and skilful mediation was well manifest during his tenure of office.

With his demise, the Sri Lanka Dental Association has lost a very keen member; the citizens of Moratuwa have lost a mature and very respected fellow citizen. I have lost a true and sincere friend.

He leaves behind his wife Vilma, two sons and two daughters.

May he rest in peace

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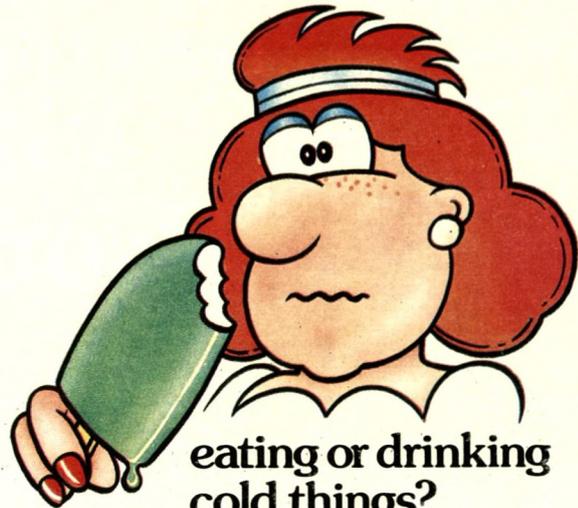
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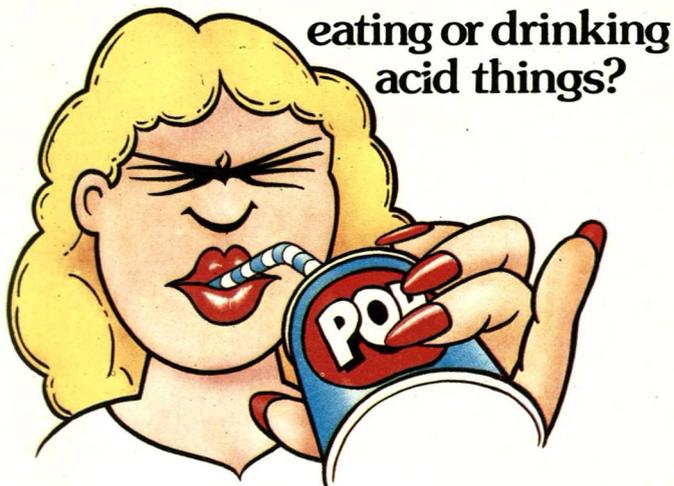
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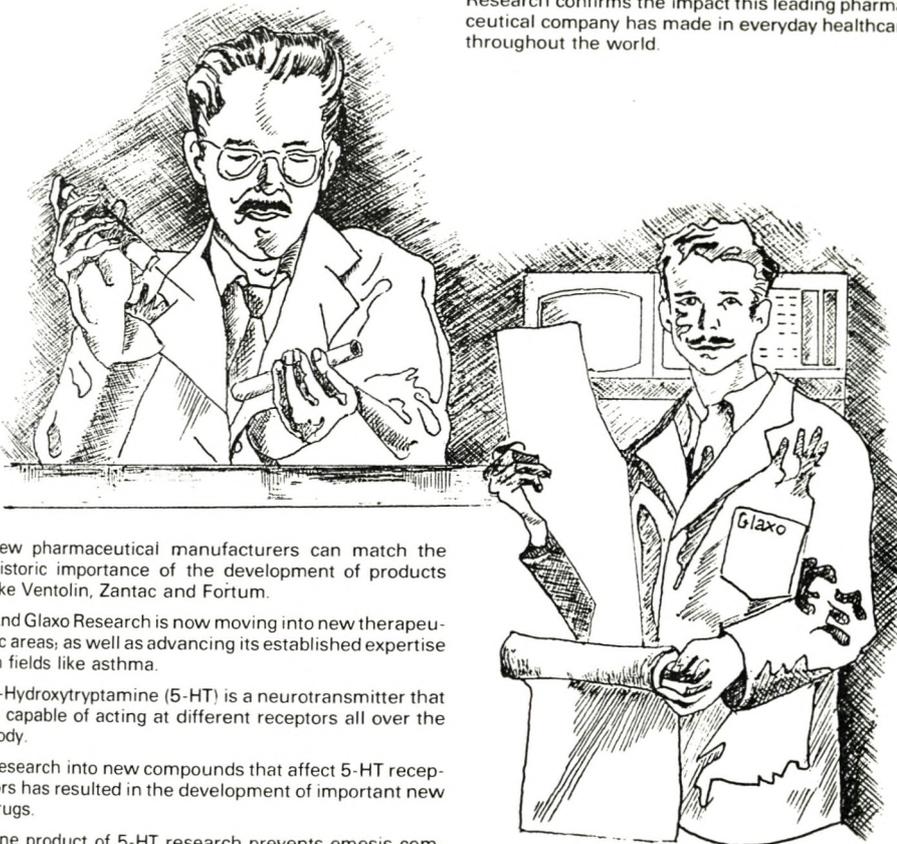
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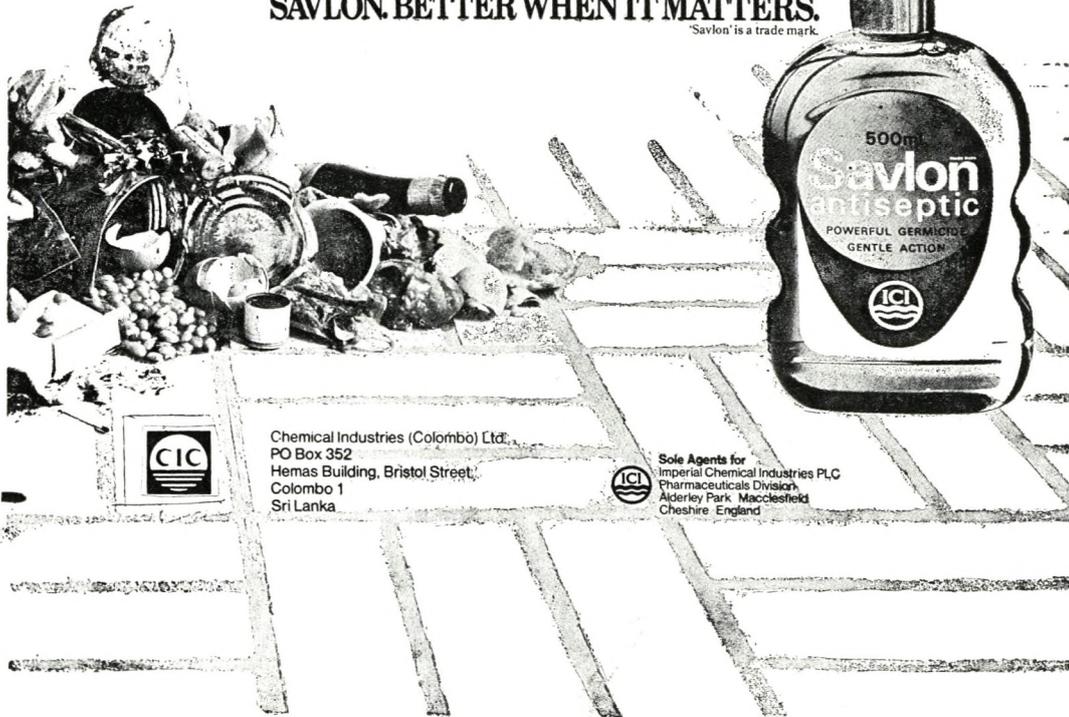
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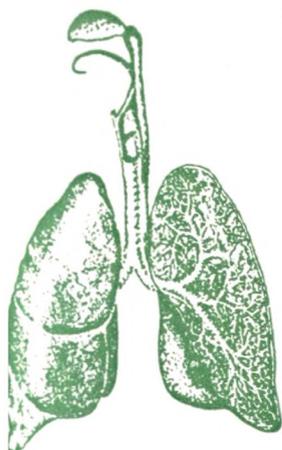


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