

## Budapest in the Spirit of Dental Research

35th annual meeting of the Central European (CED) and Scandinavian Division of the International Association of Dental Research in Budapest.

This is the 35th time that European scientists from all subdisciplines of dentistry have convened for a joint European annual meeting. The Hungarian capital was at its best on this late summer weekend. The time-honoured *Semmelweis University* proved to be a perfect venue for this top-level science-oriented meeting, even if the slightly fading charm of the functional utility building could certainly do with some refurbishment.

The meeting focused on taking stock of the current status across this broad and diverse field. The annual meeting particularly resonated with young researchers who use it as a perfect platform for presenting scientific results. This meeting has long been known among practitioners as an insiders' tip for innovative techniques and new methods. It is good practice for interested conference attendees to be able to choose a very individual program from wide-ranging topics.

Poster presentations, key issues and a multitude of symposia demonstrated the high research standards in many different ways. Be it implant surfaces, new adhesive techniques or key issues in periodontology - no discipline was omitted.

What this year's annual convention made very clear was the close integration with other medical fields and the growing need for dentists to boost their professional skills in treating medical issues.

This issue is easy to imagine from the example of the halitosis symposium which ran under the slogan: "How do you manage halitosis in your own dental surgery?" The symposium was split into three lectures.

It was the responsibility of Professor **Dr. Crispian SCULLY**, Emeritus at the Eastman Dental Institute for Oral Health Sciences, University College London to deal with the dental and clinical aspects of halitosis.

On the basis of his observation that the causes of halitosis are to be found in the oral cavity in 85 percent of cases, it was these cases which were focused upon in the lecture. These not only include infections just as much as periodontitis, they also include ulcerosa, neoplasias and "dry mouth". Only 15 percent of well-known cases stem from systemic phenomena, they also originate from causes within the respiratory tract or are a potential consequence of blood diseases. Not to be taken lightly - in his view - are diseases or inflammations in the nasal cavity. Thus

incorporated foreign bodies can have fatal consequences. It should not be forgotten either that halitosis frequently occurs in conjunction with psychogenic disease.

**Professor John GREENMAN** of the Centre for Research in Biosciences, University of the West of England, Bristol, United Kingdom, dealt with *the link between* biofilm and oral malodour.

John Greenman stated by confirming the figures presented by Scully and went a step further, referencing the thesis submitted by Rosenberg back in 2002: "The cause originates from the dorsoposterior surface of the tongue. That was where a high population of microorganisms was found in a tightly clinging layer, generally termed the tongue's biofilm! He recommends extensive oral hygiene along with chemical preventive therapy as the only therapy guaranteeing success.

**Karin Kislig** of the Clinic for Conservative Dentistry, Preventive and Paediatric Dentistry at Berne University closed by offering recommendations for implementing this discipline in dental practice.

Taking the standard of education and information which Swiss dentists enjoy as a basis, Karin Kislig started by asserting that in fairness this situation certainly cannot be termed the problem. There is a two-hour lecture forming part of student training, half a day of instruction is earmarked for prospective dental hygienists. During her lecture she presented a three-stage concept consisting of: communication, recognition and assistance. A fundamental requirement for including a corresponding protocol into running a surgery is the questions: How can the problem be communicated? How can halitosis be detected and treated? As far communication is concerned, the speaker urges that problems of malodour be systematically queried in the anamnesis form, right at the outset. It is also advisable to speak directly to the patient about oral malodour as the case requires. A further approach would be to assess the tongue and particularly its coating and to indicate any sign of the potential emergence of halitosis. A further diagnostic procedure would include using a halimeter to examine respiratory gases. But there is just one halimeter to 500 dentists in Germany. The fact that acquiring such a device does not necessarily make economic sense was not ignored either. This would make it possible to measure organoleptic values using relatively simple means. The odour of the exhaled air is tested at 5 defined distances and the distances are subdivided into 5 grades from immeasurable to extremely strong. The distances are between 10 cm and a meter. The drawback is that the measured values are neither reliable nor reproducible.

There is also a relatively simple method for measuring tongue coatings: the tongue is simply divided into sextants. There are three levels of

severity for this: no coatings, moderate and strong. Adding all six measured values produces the so-called "tongue coating index".

In Kislig's view an appropriate therapy should also include a detailed consultation on eating habits and an equally detailed oral hygiene briefing. In the first instance this has to include information on tongue cleaning. It is vital to indicate that patients have to allow for dealing with the disease within their daily routine. For, the problem is often such that the causes are not always clearly recognizable and often have multifactorial causes. Therefore symptomatic treatment often constitutes the only option.

A very lively discussion involving other top-level panellists rounded off the positive impression from this thoroughly successful event.