

DAY 1

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Orofacial myology in the 21st century

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The field of Orofacial Myology has been emerging for more than forty years. There have been many disciplines that have attempted to deal with malocclusion and the stability of changes made by dentistry and orthodontics, but the field of Orofacial Myology has now begun to be recognized as pivotal with regard to the need to also change muscle function. The fact that muscle can remodel bone with properly designed and prescribed exercises is making a difference in patients of all ages. Orofacial Myology deals with issues such as mouth breathing due to allergies, low muscle tone or just habit, tongue thrust, where teeth can be moved by improper rest postures of the tongue and lips creating anterior and posterior open bites and cross bites, thumb, finger and pacifier habits which create open bites and cross bites, poor speech production because of low, forward tongue posture and weak and underdeveloped muscles of the tongue, forward head posture from an open mouth rest posture, snoring and sleep apnea as a result of open mouth breathing and enlarged tonsils and adenoids, all of which produce total body dysfunction. Orofacial myology addresses these behaviors from an educational perspective, retraining muscles through a series of exercises designed to change the neural behavior of the client, adopting sensory motor techniques and involving families and caregivers to facilitate practice of the exercises. The discussion will cover a brief history of Orofacial Myology, the changes that have occurred in the field, before and after photographs showing the results of therapy and a perspective on where this field is heading.

Biography

Sandra R Coulson began her career as a public school Speech Therapist (1965). She taught in the Public School District, Tacoma, Washington for

five years, where she was the Chair of a Special Education Department dealing with children with special needs. She became a US Public Health Stroke Therapist; worked as itinerant Speech Therapist for Denver Public Schools; taught personal adjustment courses for the Community College of Denver and began a private practice in Orofacial Myology specializing in dental anomalies. She has been a member and leader in several organizations including: Chairman of the DADE Study Club, a large, Denver-based organization for the study of temporomandibular joint dysfunction; Board Member and President of the International Association of Orofacial Myology; Board Member of the National association of Women Business Owners and the President and Owner of the Coulson Institute of Orofacial Myology. She is a recognized expert in her field, speaker at international meetings and teaches courses internationally. She assumed the position of Clinical Professor of Orofacial Myology for the University of Behavioral Health Sciences in 2017. She is a sought-after speaker in her field and delivers many commencement addresses.

Roger Price is the Director of Professional Services at The Graduate School for Behavioral Health Sciences, a registered US University delivering live, interactive online Certification and Degrees in the fields of Orofacial Myology and Breathing Behavior Analysis. The University also offers a Masters Degree in Applied Breathing Sciences -as many chronic health disorders have their origins in dysfunctional behavior patterns created over time - resulting in symptoms and deficits. Roger Price is a much sought after speaker, both locally as well as internationally and is the recipient of the 2016 International Functionality Association Lifetime Award for his contribution to Form and Function. His presentations are entertaining, educational, sprinkled with anecdotes and humor, and are based both on scientific facts and good old common sense.

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Early malocclusion prevention in children

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Malocclusion is usually known as an inherited or congenital condition. However, in many cases it is caused in early childhood by prolonged use of a pacifier or bottle/breast feeding, thumb/foreign object sucking, injuries that result in the misalignment of the jaw, poor dental care that results in improperly fitting dental restorations or untreated carious lesions, primary teeth extractions without space maintainers, mouth breathing, potentially caused by allergies or airway obstruction by enlarged adenoids/tonsils or bad habits. The consequences of malocclusion in children are deplorable, leading to improper alignment of the teeth, alteration in the appearance of the face, self-esteem problems, frequent biting of the inner cheeks or tongue, discomfort when chewing or biting, speech problems, including the development of a lisp, mouth breathing resulting in adenoid and long face formation, trauma and caries susceptibility. It is therefore important that attention

be paid to the methods of early prevention of malocclusion in infants, thereby eliminating the future problems in the bud. The present report explores several best practices, used in infants to reduce the long-term complications of malocclusion.

Biography

Dr. Belfer Marina has completed her DMD at the age of 25 years from Tel Aviv University (School of dentistry) and postdoctoral studies from Jerusalem University (Pediatric Dentistry) and Russian University of People's Friendship (Orthodontics). She is an assistant professor of the department of Paediatric Dentistry and Orthodontics in RUDN University and has a dental practice in Moscow. She has published more than 25 papers in reputed journals and has translated several dental textbooks and lecturers into Russian. Dr. Belfer delivered many lectures in child dentistry and orthodontics all over the world.

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Implant-assisted overdentures: A paradigm relocation & simplification

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Completely edentulous patients often have problems with their complete dentures; a treatment modality of using two, four or six implants to support an overdenture has been proposed to improve the retention as well as the stability of the conventional denture, in addition to preserving the residual alveolar bone. Several worldwide research studies tested the impact of implant-assisted overdentures on satisfaction and quality of life and concluded that; individuals with implant-assisted overdentures were more satisfied and had a better oral health quality than others with conventional dentures. Implant-supported overdentures are indicated in clinical conditions requiring high values of retention and stability; such as cases of high muscle attachments. Implant-retained overdentures offered a simpler, cheaper and equally successful prosthetic solution compared to the fixed restorations in the rehabilitation

of maladapted edentulous mandibles. Moreover, they provide enhanced masticatory function, higher patients' satisfaction and quality of life than the conventional complete dentures.

Biography

Dr. Mostafa Helmy Mostafa Ahmed is studied PhD (Doctor Degree) in Implant prosthetic dentistry, Cairo University 2013. He completed his M.sc (Master degree) in Implant prosthetic dentistry, Cairo University since 2010. He is a Associate professor in prosthetic department at Cairo University & Lecturer in prosthetic department, Cairo University since 2010 till 2013. He is also the demonstrator in prosthetic department, Cairo University since 2007 till 2010. Resident in prosthetic department, Cairo University since 2004 till 2007. University: BA degree from the faculty of dentistry year 2002.

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Distraction osteogenesis versus orthognathic surgery

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Distraction osteogenesis (DO) initially developed by Ilizarov for limb lengthening has recently been applied to the correction of severe congenital or acquired craniofacial deformities as an early alternative to orthognathic surgery. Distraction osteogenesis involves the lengthening and reshaping of deformed bone by surgical fracture and gradual separation of bony segments. The surgeon lengthens and reshapes deformed bone by surgically fracturing the bone and slowly separating (distracting) the resultant segments with specially fabricated hardware. The bony fragments are held in place during the first week following surgical fracture to allow callus to form between the fragments. During the next several weeks, the fragments are gradually separated at a rate of 1 to 2 millimetres per day, up to a pre-determined length (e.g., 20 days for 20 millimetres or 5/8 inches). The bone segments are moved gradually to allow callus formation and adaptation of fibromuscular attachments. Once the desired length and shape is achieved, the hardware is left in place for an additional 6 weeks until the newly formed bone calcifies. The primary advantage claimed in connection with distraction osteogenesis is that it allows major reshaping of the facial bones without bone grafts or jaw wiring. Proponents claim that distraction osteogenesis may be safer than other methods of facial reconstruction, since it can involve less blood loss and a lower risk of infection. Orthognathic surgery is the surgical correction of skeletal anomalies or malformations involving the midface, mandible and maxilla. These malformations may be present at birth or may become evident as the patient grows and develops. Jaw malformations can cause chewing and eating difficulties, abnormal speech patterns, early loss of teeth, and disfigurement and dysfunction of the maxilla and mandible. Malocclusion may be caused by a deficiency or excess of bony tissue in one or both jaws, or by trauma to the

facial bones. In orthognathic surgery, an osteotomy is made in the affected jaw, and the bones are repositioned in a more physiologic alignment. Generally, the bones are held in their new positions with plates, screws and wires. The patient may also need arch bars placed on both jaws to add stability. Patients with deficient bone tissue may require grafts from their ribs, hips or skull. Alloplastic replacement of missing bone may also be required. Several studies have evaluated DO as a definitive mandibular advancement technique and it has been proved that advancements of between 6 and 10 mm resulted in no significant differences in stability be it distraction or orthognathic surgery. With the enthusiasm of successful results using midfacial and mandibular distraction, it has been asserted that the introduction of DO techniques would result in the elimination of traditional orthognathic surgery. However, this has not proved to be the case. In patients with syndromic craniosynostoses, DO can be applied at strategic times as part of a staged surgical treatment plan for the management of severe skeletal discrepancies. Distraction may be regarded as a useful additional technique to minimize skeletal deformities but definitive orthognathic surgery remains the treatment of choice to enable accurate occlusal correction and good facial balance.

Biography

Simon Chummar completed his BDS, MDS, from Royal College of Surgeons of Edinburgh, AO Fellow from United Kingdom. He is Scholar from International Bone Research Association, Germany. He is a specialist Implantologist and Oral and maxillofacial surgeon, at present he is working in a Dental department, NMC Specialty Hospital, UAE.

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