Article: Masterclass in Implantology: Hydraulic lift Sinus Floor Elevation revisited. Van Zyl and Todorovic, page 6

1. *Which of the following statement/s are incorrect regarding hydraulic lift sinus floor elevation:*

a. With the transcrestal osteotome technique, a limited SFE is possible and to achieve more than 3mm vertical lift is risky as the membrane may tear.
b. With the hydraulic lift SFE described a 40mm lift is achievable in a low trauma low risk technique with no sharp instruments or sharp bony splinters as can happen with the osteotomes.
c. A CBCT scan is mandatory to study the sinus floor anatomy.

2. *Which of the following statement/s are incorrect regarding hydraulic lift sinus floor elevation:*

a. Measure the available bone below sinus on the CBCT as this will determine what stopper will be used to approach to within 1mm of the sinus floor.
b. A slightly thickened Schneiderian membrane is much riskier to lift than one which is not visible on CBCT.
c. When performing a one stage procedure, at least 3-5 mm of bone is required for implant stability. The geometry of the implant used is important as an implant with a smooth 2-3mm neck, will not provide any mechanical stability in such limited bone.

3. *Which of the following statement/s are incorrect regarding hydraulic lift sinus floor elevation:*

a. It is an accepted fact that some shrinkage will occur during the maturation of the bone graft, one should therefore aim to lift the Schneiderian membrane at least 2mm above the apical aspect of implant to protect the implant.
b. Particulate bone graft material is used for sinus floor elevation, and this may be mixed with blood or saline.
c. The more loose the bone particles, the worse it will spread as it is introduced into the sinus.

4. *Which of the following statement/s are incorrect regarding hydraulic lift sinus floor elevation:*

a. With a SFE one should allow for longer healing as most of the implant surface will have no bone contact and this takes time to heal.
b. Whether a lateral window or transcrestal hydraulic technique is used, the healing time should be equal for both.
c. If the bone particles are not mixed with blood before pushing it into sinus, it will not form new bone.

5. *Which of the following statement/s are incorrect regarding hydraulic lift sinus floor elevation:*

a. The safe way to approach the implant osteotomy preparation is to use a drill stopper of 1mm less than what the bone was measured on the CBCT.
b. Proceed in 1mm increments till the hard bone of the sinus floor is sensed. Recommended speed for this is 3000-4000rpm to minimise heat build-up.
c. The implant should be placed with a low 15rpm, as the implant will increase the pressure on the particulate graft as it enters the sinus, and you do not want to overexert pressure on the Schneiderian membrane at the very end which may cause a tear.

Article: Deep shape in endodontics. Machtou et al, page 12

6. *According to the authors, MIE stands for:*

a Mandibular incisor extraction
b Minimally invasive endodontics
c Micro instrumentation endodontics

7. *According to Zahner, 2006, which is the most difficult zone to clean and disinfect:*

a The apical third
b The middle third
c The cervcial third

8. *Following Kerekes and Tronstad's (1979) studies, who were the first to advocate extensive reaming in the apical region to reduce the endodontic source of bacterial infection?*

a Rollison, Barnett and Stevens in 2002
b Dalton and colleagues in 1998
c Ørstavik, Kerekes and Molven in 1991

9. *What is the main drawback of larger apical preparations?*

a The increased risk of creating adverse iatrogenic errors
b Reduced apical periodontitis healing
c An increase in post-operative pain.

10. *In the Toronto study – phase four (de Chevigny et al, 2008), what was the healing rate of the Schilder shaping technique with warm vertical compaction of gutta percha compared with the standardised technique with lateral condensation?*

a 77% versus 87%.
b 87% versus 77%.
c 67% versus 77%.

Article: Update on research and clinical guidelines in dentistry 2026: Vol 2 Hartshorne and Kotzé, p46
(NB: More than one answer per question is applicable)

11. Which of the following key findings related to the survival rate of implants in patients with a history of periodontitis are TRUE?
a. The 5-year cumulative survival rate is 98,8%.
b. History of tooth loss due to periodontitis does not significantly increase risk of implant failure.
c. Implants placed with GBR had a lower risk of failure compared to those without GBR.
d. Regular supportive periodontal therapy significantly improved implant survival.

12. Which of the following are established dental therapies for obstructive sleep apnea (OSA)?
a. Mandibular advance devices
b. Orthodontic extractions.
c. Maxillomandibular advancement surgery.
d. Laser frenum release procedure.

13. Which of the following key findings related to sleep-disordered breathing (SDB) and orthodontics are TRUE?
a. Current evidence supports orthodontic interventions.
b. Craniofacial phenotypes can reliably identify the presence of SDB.
c. CBCT and Cephalometric airway analysis are not suitable for diagnosing SBD.
d. Patients at risk of SDB should be referred to a physician for definitive diagnosis.

14. Which of the following key findings related to Risk Stratification of Oral Epithelial Disorders (OED) are TRUE?
a. Leukoplakia is the most frequent potentially malignant OED.
b. The floor of the mouth is strongly associated with moderate to severe dysplasia.
c. Lesion heterogeneity is not strongly associated with moderate to severe dysplasia.
d. Potentially malignant oral disorders are not frequently found on the gingiva / alveolar mucosa.

15. Which of the following key findings related to the clinical effectiveness of bulk-fill composite resins are TRUE?
a. Longevity of bulk-fill restorations is generally lower than that of conventional incremental composite restorations.
b. Polymerization-induced stress remains a limitation for bulk-fill composite restorative materials.
c. Long-term success appears to depend more on the adhesive protocol and clinical technique than on the material itself.
d. Most failures were associated with adhesive bonding rather than material racture or tooth cracks.

Article: Complex crowding: clear aligners. Makki, page 20

16. What was the patient's molar and incisal relationship at the initial examination in the case report?
a. Class I molar, class II incisal
b. Class II molar, class III incisal
c. Class III molar, class I incisal
d. Class I molar, class I incisal

17. According to the author, which factor contributed to the patient's relapse following her previous orthodontic treatment?
a. Inadequate IPR during earlier treatment
b. Lack of a retainer after fixed orthodontics
c. Overuse of elastics in adolescence
d. Failure to extract premolars

18. How much interproximal reduction (IPR) was performed in this case, and between which teeth?
a. 1.0mm between LR3 and LL3
b. 0.25mm between UL1 and UR1
c. 0.5mm between UL3 and UR3
d. 0.75mm between LR2 and LR3

19. What was the reason for the patient choosing aligner treatment?
a. Discreet appearance
b. Removability
c. Improved comfort
d. All of the above

20. How many aligners were used for the maxillary and mandibular arches during treatment?
a. 20 upper, 36 lower
b. 31 upper, 45 lower
c. 40 upper, 20 lower
d. 45 upper, 31 lower