severely affected areas include the Bhaktapur, Dhading, Dolakha, Kathmandu, Katre, Lalitpur, Nuwakot, Ramechhap, Rasuwa, and Sindhupalchowk districts of Nepal’s Central Region, as well as the Gorkha District of its Western Region.

Have you received any correspondence from the dental community?

I am glad to have received many e-mails with best wishes and prayers from our dental friends around the world. It is so gratifying to know that many of them have pledged their support of the earthquake victims of Nepal. Some dental manufacturers have shown keen interest to help us in the rehabilitation of children who have been affected.

Despite an immediate response from India and Western countries, relief efforts seem to be insufficient, according to reports. What is your impression?

International communities have offered immediate support and we really appreciate their help. However, 59 of the most affected villages are in remote locations with mountainous terrain. The relief work, therefore, is hampered and support items cannot be delivered on time. Many people in these small villages are still waiting for basic items, such as food and shelter.

Regardless of the efforts by the Nepalese army, police and Red Cross Society, as well as national and international organisations, which are working 24/7, the manpower and supplies are still felt to be inadequate.

In your opinion, how will this disaster affect the infrastructure of your country in the long run?

Nepal’s development budget depends mainly on foreign aid. Rebuilding all the infrastructure affected by the earthquake will require an estimated US$200 billion. The government plans to meet this mainly through foreign and international funding. However, damaged infrastructure will definitely affect the economic growth of Nepal negatively.

When I will be able to start practising again depends on when all my staff are mentally ready for work. Daily life in Kathmandu is still very stressful, as there are frequent aftershocks and people are still terrified. Under these conditions, I do not expect people will come for general dental treatment, except in the case of an emergency.

What do you consider the most important to improve your situation, and how can the international dental community help?

More than 95 per cent of houses and infrastructure have been damaged in the affected villages, so the rehabilitation phase for the earthquake victims is going to be a great challenge for our country. I personally feel that in order to overcome this difficult time our country needs support from each individual and professional in Nepal. We have, therefore, started a humanitarian project, the Dental Community for Humanity—Nepal Earthquake Relief Project, under the umbrella of the Punyaarjan Foundation, a charitable and non-profit organisation dedicated to supporting people most in need.

This project aims to support poor children living in these remote villages in particular. I humbly appeal to the international dental community to support this cause. Please, with your donations and support, we can bring back the smiles of our poor children.

Thank you very much for taking the time and all the best for the future.
Owning a dental practice or group has always presented challenges, but the market-place has never been more crowded than it is now. With an ever-increasing level of choice for patients, it is more important than ever for dental businesses to stand out from the crowd. While we of course all know the value of providing a first-rate customer service, and that will always remain the most important factor, how many of us recognise the importance of creating and building a brand?

Generally, in dentistry, branding has not been regarded in the same way it is in the corporate world, where multi-national businesses expand on the strength of their brands. But now, with the growth of dental corporates and multi-practice groups, branding is becoming an increasingly important factor. That is not to say that branding is only the domain of the big players. Creating a brand which is unique and people can identify, talk about, recommend to others and remember is just as important for a single practice, and in some situations even more so, where there are other local competitors for existing and potential clients to choose from.

Effective branding is also important when looking to expand, franchise or sell one’s business. When dentists are adding another site to their existing portfolio, doing so under a brand will enable people to know who is moving into their area, and can help give confidence that this is an established dental business taking over their local site. One example being a business in North East England I act for, the Burgess & Hyder Dental Group, who now operate 11 clinics across the region under their brand. They are welcomed into each area as their brand is widely known, as is the quality associated with it.

Equally in franchising, the importance of a strong brand is crucial to enable a business to thrive in other areas relies on an existing strength of reputation. Through being part of that recognisable brand, patients will know that each site under that umbrella will offer the same levels of service and quality. Another of my clients, Damira Dental, has recently rebranded from Aspire Dental Care, and is pursuing a franchising model under its new and fresh identity. The business, which has 14 sites across the South of England, has amassed a strong reputation during its eight years in operation, and the strength of its service coupled with its branding will allow that to be replicated across the UK.

The creation of a brand identity, which can help support the expansion of a business, can also be of great importance when it comes to selling. It is much easier to market a business which is well known and has invested time and effort in standing out from the crowd. To a potential buyer, they are important factors in instilling the confidence to take on a site in a new territory.

In this day and age of dentistry being an increasingly competitive business, distinguishing oneself from the many other players has never been more important, and is something that must be given due consideration.

Amanda Maskery is one of the UK’s leading dental lawyers. She is Chair of the Association of Specialist Providers to Dentists (ASPD) in the UK and a Partner at Sintons law firm in Newcastle. She can be contacted at amanda.maskery@sintons.co.uk.
US to lower fluoride in drinking water after 50 years

WASHINGTON, USA: US health authorities have updated their guidelines for fluoride in drinking water and now recommend an optimal fluoride concentration of 0.7 mg/l. As Americans today have greater access to fluoride in the form of toothpaste and mouthrinse and owing to the increasing incidence of fluorosis due to excess fluoride, the Department of Health and Human Services sought to replace its previous recommendations that were issued in 1962.

Since the early 1960s, the practice of adding fluoride to public drinking water systems has grown steadily in the US. Nearly all water fluoridation systems in the US have used fluoride concentrations ranging from 0.8 to 1.2 mg/l. With the recent update, however, this will be reduced by 0.1–0.5 mg/l, and fluoride intake from drinking water alone will decline by approximately 25 per cent. The total fluoride intake will be reduced by about 14 per cent.

According to the department’s report issued on 27 April, the new optimal concentration of 0.7 mg/l was chosen to maintain caries prevention benefits, but reduce the risk of dental fluorosis.

Although a number of studies have found that community water fluoridation has led to a significant decline in the prevalence and severity of tooth decay, data from the 1999–2004 National Health and Nutrition Examination Survey and the 1986–1987 National Survey of Oral Health in US School Children indicate that over 20 per cent of people aged 6–49 have some form of dental fluorosis.

Today, nearly 75 per cent of Americans who are served by public water systems receive fluoridated water. In 2012, the Centers for Disease Control and Prevention estimated that approximately 200 million people in the US were served by 12,341 community water systems that added fluoride to water or purchased water with added fluoride from other systems.

Artificial fluoridation of drinking water remains controversial as a public health measure, as it has been suggested that excess fluoride may have adverse health effects. For instance, it has been associated with neurodevelopmental delays in children and with the development of attention deficit hyperactivity disorder only recently.

In contrast to fluoridation policy in the US, many western European countries, including Austria, Belgium, Finland, Germany, and Sweden, do not fluoridate their water supply. Other European countries, such as Ireland and the UK, currently add fluoride to drinking water at levels ranging from 0.2 to 1.2 mg/l.
Swiss study finds sonic toothbrushes vary greatly in efficacy

BERN, Switzerland: Sonic toothbrushes are increasingly used in daily dental care today, as they promise to reduce biofilm without any mechanical bristle contact owing to hydrodynamic effects. However, not every model is equally effective in cleaning teeth, a recent study by researchers at the University of Basel has found.

In order to inhibit damage to the gingiva and teeth, the biofilm formed by oral bacteria must be removed regularly.

Sonic toothbrushes claim to reduce the amount of biofilm—even in areas that are difficult to reach, such as the lateral tooth area and interdental spaces—without any mechanical bristle contact.

This is possible because of the high frequency movements of sonic toothbrushes, which are believed to cause hydrodynamic effects that remove adhesive bacteria. These effects result from acoustic sound waves, as well as the shearing forces and the surface tension forces of moving air bubbles in liquid media.

However, the Swiss researchers found that the effectiveness of different models of sonic toothbrushes varies greatly. The toothbrushes analysed in their study reduced the amount of biofilm by between 9–80 per cent.

In their in vitro study, the researchers cultivated an artificial biofilm on titanium plates. The biofilm contained three different strains of bacteria and was developed by dousing the titanium plates in a mixture of saliva and serum. Afterwards, the researchers tested the impact of four different commercially available sonic toothbrushes on the artificial biofilm. They varied the distance between the toothbrush bristles and the biofilm surface (0.2 and 4.0 mm), as well as the exposure time (2.4 and 6.0 seconds). Using fluorescence microscopy and special software, the researchers then quantified the remaining biofilm.

They found distinct variations regarding the efficiency of the sonic toothbrushes. The two high-quality products analysed were able to reduce the amount of biofilm on the titanium plates significantly, whereas two low-cost models had only little impact on the artificial biofilm. According to the researchers, the different exposure times and bristle distances did not influence the reduction of biofilm.

The study, which was co-financed by the research fund of the Swiss Dental Association, confirms the results of various international studies and proofs that sonic toothbrushes can reduce biofilm without actual bristle contact—although the cleaning efficacy depends greatly on the respective toothbrush model used.

The research fund of the Swiss Dental Association is financed through the membership fees of the association’s member dentists. It supports and fosters dental research, especially in the fields of prevention and dental practice.

The study, titled “Efficacy of various side-to-side toothbrushes for noncontact biofilm removal”, was published in the Clinical Oral Investigations journal in April 2014 and was recently reported in the 2/2015 issue of Dimensions, the journal of the Swiss Dental Hygienists.
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“Holding ConsEuro in London was a little bit of a risk”

An interview with Prof. Stephen Dunne, King’s College London Dental Institute

Can the outcome mainly be attributed to the London factor?

We chose one of the best conference centres in the world with the Queen Elizabeth II Centre right in the heart of London, it is fair to say that we also chose one of the most expensive ones. This made us very concerned when we planning this three years ago because at that time we were in an economic downturn. Trying to re-

Owing to the economic situation gradually improving over time, we exceeded our expectations with regard to sponsorships. We actually sold out the exhibition space several months ago. That has been very successful and helped us to cover the costs. We came above break-even on the first day, so I am much more relaxed today than I was yesterday morning. And it looks as though we might make a reasonable profit, which would then be shared different variables, King’s usually comes out very near the top, which I am very pleased about. The school attracts not only good teachers and researchers, but also equally good clinicians from across the world.

When I first joined the EFCD about ten years ago, there was very much an effort to compete with the International Association for Dental Research, so it was very focused on academics and researchers from the universities.

My view is that this was a mistake, as we really needed to provide a conference that has interest across the board, so it base. Should they be using these things and, if they are using them, which particular model? This was very much the rational when we were planning the programme.

We also ought to have a paperless conference. Our website and app have been very effective and when I read statements yesterday on our Twitter feed, participants commented that this was the most technologically advanced conference they have ever been to.

Technology has clearly expanded the scope of this conference. Does it also apply to clinical practice?

This is exactly what we are doing here now.

What other lessons will you take home from the conference?

Our conference proves that you can take a high-tech approach and still hopefully be profitable or at least break even. Technology is definitely here to stay; we just need to look at the evidence base. We also need to have training in the use of technology and need to look at clinicians and scientists to guide us in the selection of the particular devices that we should use.

Thank you very much for the interview.