Three cheers for Dr Crouch

An orthodontist has won a landmark victory, after taking on the Department of Health and fighting against an appeal, which would have given health bosses the right to terminate dental contracts without cause or notice.

The DH lodged the appeal earlier this year after Eddie Crouch, an orthodontist in Birmingham, won a Judicial Review, which said that primary care trusts (PCTs) were wrong to interpret a clause in the NHS dental contracts allowing them to terminate the contract without cause or notice.

The DH battled it out in the High Court, saying that health bosses needed such a power.

The Court of Appeal upheld the earlier ruling that the reasons by which a PCT can end a contract are set out in legislation and that a PCT must abide by legitimate termination reasons.

If the DH had won the appeal, primary care trusts would have had the power to end dentists’ contracts with as little as one day’s notice.

Dr Crouch said that it was ‘reassuring’ that ‘fairness was seen to be upheld’ and said it ‘should encourage others to challenge inappropriate powers that PCTs and the Department try to influence’.

Dr Crouch was forced to rely on financial support from fellow dentists to fight the case after he failed to come to an agreement with the British Dental Association (BDA) over a confidentiality document they wanted him to sign.

Mouthwash link with cancer

Mouthwashes containing alcohol can cause oral cancer and should be removed from supermarket shelves, a dental health study claims.

The news, which was revealed as Dental Tribune was going to press reports sufficient scientific evidence that such mouthwashes contribute to an increased risk of the disease.

The ethanol in mouthwash is thought to allow cancer-causing substances to permeate the lining of the mouth.

Michael McCullough, associate professor of oral medicine at the University of Melbourne, Australia, who led the study, said: ‘We see people with oral cancer who have no other risk factors than the use of mouthwash containing alcohol, so what we’ve done is review all the evidence.’

‘Since this article, further evidence has come out, too. We believe there should be warnings. If it was a facial cream that had the effect of reducing acne but had a four to fivefold increased risk of skin cancer, no-one would be recommending it.’

Professor McCullough, chair of the Australian Dental Association’s therapeutics committee, said the alcohol in mouthwash ‘increases the permeability’ of the mucous membrane to other carcinogens, such as nicotine.

A toxic breakdown product of alcohol called acetaldehyde that may accumulate in the oral cavity...
Mouthwash link with cancer

Dr Gregory, a former dental public health consultant for NHS Fife, is a fellow of the Faculty of Public Health, Royal College of Physicians and a member of the Faculty of Dental Surgery of the Royal College of Surgeons of England.

Dr Gregory said: ‘I am tremendously excited by this award, it is always a great privilege to be recognised for the work you do and this is a really fitting ending to a wonderful few months.’

New president for the BSDHT

Maria Harris is to be the new president of the British Society of Dental Hygiene and Therapy, for the last two years in her capacity as president-elect, to ensure a smooth and successful handover.

Ms Harris trained in the RAF Dental School training, I do not know. I think I speak for most colleagues because we offer different specialist services from each other therefore there is no need for petty rivalry.

Prof McCullough and co-author Dr Camile Farah, scientific adviser to the British Dental Association, said further research was needed to substantiate the claims.

‘Excessive consumption of alcohol and tobacco are well recognised in the UK as risk factors for developing oral cancers,’ he said.

This paper raises interesting issues, but the evidence showing any link between the prolonged use of mouthwash containing alcohol and oral cancer is not conclusive, and requires further trials to establish if there is a genuine connection.

‘If patients are in any doubt about using mouthwash, they should consult their dentists.’

Dr Nigel Carter, the chief executive of the British Dental Health Foundation, rejected the findings and said: ‘A recent, and more thorough review of all available evidence carried out by leading experts on behalf of the foundation concluded there were no proven links between alcohol-containing mouthwashes and increased incidence of mouth cancer. The public should not worry.’

Last night, a spokeswoman for Johnson & Johnson Ltd UK, the manufacturer of Listerine, said: ‘There is no scientific evidence to support an association between the use of alcohol-containing mouthwashes, such as Listerine, and an increased risk of oral cancer.’
Editorial comment

The price of success

If at first you don’t suc-
ceed, try, try and try
again. These fitting
words were as good as
written for Dr Eddie
Crouch, who never once
thought about throwing in the
towel. Some of us are born to
fight, while others — well they
just don’t have it in them. But
what a way to end 2008 — not just
for Dr Eddie Crouch, but also for
the profession. Furious right
from the start on the way the ‘un-
tried and untested’ contract was
thrown at the profession, Dr
Crouch was having none of it.

Challenge — designed to ‘cham-
pion the cause of individual
General Dental Practitioners
(GDPs) who feel unable to fight
the might of the Primary Care
Trust (PCT) or the Department
of Health’ was quickly set up. It
attracted many followers but
clearly this was not enough. The
new clause allowing Primary
Care Trusts to terminate the
contract with GDPs without
cause or notice was, according
to Dr Crouch and most of you out
there, not just an insult but an
absolute joke. Only a man with
steely determination could fight
this one out in court and it had to
be Dr Crouch. But not only did he
have to fight this largely unsup-
ported (think David and Goliath
First Samuel 17), it drained him
economically and financially, the
latter costing him thousands
and thousands of pounds. And
he won. But then the news that
the DH was going to appeal the
hearing was the next blow. The
British Dental Association
(BDA) showed some support at
this stage but did not pay any
costs at all. Said Peter Ward,
’Separa
tely, the BDA had at-
tempted to reach an agreement
with Dr Crouch that would have
protected him financially, but
for his own reasons, Dr Crouch
preferred to instruct and pay for
his own legal team.’ Thank you
BDA, at least we now know how
far the profession’s association is
truly prepared to go when it come
to achieving a historical victory
for dentists.

Nevertheless, at least the
BDA turned up in the end. Dr
Crouch says it shows ‘the huge
learning curve the profession is
on with dealing with these is-
sues’, and that the BDA for ‘vari-
us reasons’ chose never to pay
any of the legal bills. Dental Tri-
bune thinks he is being kind. In
short the BDA paid him a big fat
zero — what a generous, support-
ive Association we have. So as
usual in situations like this, it is
our true friends who have come
up trumps.

All in all Dr Crouch’s act of
bravery shows not just courage
but also a side of utter selfless-
ness. For he did this not
just for himself but for
the whole profession,
and it will never be for-
 gotten.

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get on with their normal daily life without worrying about how they look or what they eat. That’s why leading Invisalign® practitio-
ers state that the majority of their patients come from patient to patient referrals.

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UK Invisalign® Patient

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ers state that the majority of their patients come from patient to patient referrals.

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Government launches ‘independent review’

Dental bodies have welcomed an independent review of NHS dentistry launched by the government.

The review was set up following a damning report by the Health Select Committee which criticised the new dental contract.

One of the key aims of the review is to identify ways the government and local NHS can work together to increase access to NHS dentists and improve quality of services. The review team will examine why there are improvements in some parts of the country, while problems continue elsewhere.

It will also investigate whether the decline in complex treatments reflects the clinical needs of patients.

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It will also investigate whether the decline in complex treatments reflects the clinical needs of patients.

The results of the study, A Review of NHS Dentistry in England will be published in the spring.

The British Dental Association (BDA) called the independent review ‘a step forward in addressing the significant problems facing NHS dentists and patients’.

BDA executive board chair Susie Sanderson said: ‘The BDA is pleased to see the long overdue announcement of a review of NHS dentistry in England.

The independent review team will be chaired by Professor Jimmy Steele, chair in Oral Health Services Research at the School of Dental Sciences in Newcastle. The other members of the team are Eric Rooney, consultant in Dental Public Health, Cumbria Primary Care Trust (PCT), Janet Clarke, clinical director of Salaried Dental Services, Heart of Birmingham Teaching PCT and Tom Wilson, director of contracts, Milton Keynes PCT.

The announcement recognises the significant problems patients and dentists face, and places the Department of Health on a path to addressing those problems.

Iain Hathorn, chairman of the British Orthodontic Society (BOS) voiced his concern about what he calls a poor report from the Health Select Committee. There is a high turnover of managers in dental commissioning, who need help to understand the complexities of dental and orthodontic contracts, to ensure the highest numbers of patients get the treatments they deserve.

Chief executive of the British Dental Health Foundation, Dr Nigel Carter said: ‘The government must address the issues, and the independent review is a start.

Official figures released by the NHS information centre in June showed that the number of people seeing an NHS dentist had fallen by a million after April 2006, when the reform package came in.

BDA supports fluoridation plans

The British Dental Association is backing a proposal by the South Central Strategic Health Authority to fluoridate the water in Southampton and parts of South West Hampshire.

The British Dental Association (BDA) claims it has drawn widely from available scientific evidence and believes that fluoridation of the water supply is an effective method of reducing dental decay in people of all ages and from all social backgrounds.

It also agrees with the World Health Organisation’s position that the level of dental caries falls from seven at a fluoride concentration of 0.1mg to around 3.5 at a fluoride concentration of 1.0mg (i.e. one part per million).

The BDA’s scientific adviser, Professor Damien Walmesley said: ‘The BDA backs its support for the proposed scheme on solid research. This has been carried out nationally and internationally.

On a local level we have looked at the impact of fluoridation on the dental health of people living in Birmingham. Five-year-olds in Britain’s second largest city have half the rate of tooth decay as their peers in Southampton where it isn’t fluoridated.

I believe that if fluoridation was introduced in Southampton it could play a major role in helping to reduce the high rates of tooth decay there as it makes teeth more resistant to disease.’

This is the first consultation of its kind in England since a change in the law over the way fluoridation can be introduced. The three-month long consultation ended on 19 December. The responses will now be assessed and the 12 board members of South Central Strategic Health Authority will vote on the consultation on 19 December. The responses will now be assessed and the 12 board members of South Central Strategic Health Authority will vote on the consultation on 19 December.
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Gel-phase for easy clean-up of excess material
GDC appoints new committee members

The General Dental Council has appointed new members to its independent Appointments Committee - which monitors its Fitness to Practise Panel.

The role of the Appointments Committee is to oversee the training and performance of the General Dental Council’s independent Fitness to Practise Panel, made up of 76 members, and recruit new members as required.

In the future it will also be responsible for recommending members for the Council’s Investigating Committee, which considers allegations of impaired fitness to practise and decides whether a case should be referred to one of the Practice Committees.

Sally Irvine, the new chair of the Appointments Committee is currently a member of the GDC and will be resigning before she takes up her appointment.

She said: ‘All those joining the new Committee bring a wealth of invaluable experience from a variety of sectors, and I look forward to working with them to ensure that the GDC’s high standards continue to be met.’

The other new members are Nicola Billot, currently working as a dental nurse manager for Gwent Healthcare NHS Trust; Jeanne Goulding, a lay member of the General Medical Council’s Fitness to Practise Panels and a management consultant; John Hunt, chief executive of the British Dental Association from 1992 to 2000; Ray McAndrew, clinical director for Community Dental Services in Glastonbury; Marcia Roberts, chief executive of the Recruitment and Employment Confederation; James Walker, independent assessor for the Office of the Commissioner for Public Appointments.

Monitoring tool for PCTs

Smile-on has launched a tool for primary care trusts to check that dental practices are implementing satisfactory clinical governance.

The Clinical Governance Performance Management (CGPM) system has already been selected by the Dental Governance Committee (representing three primary care trusts (PCTs)) and the KSS Dental Postgraduate Deanery.

A spokeswoman for Smile-on said: ‘Because the responsibility for ensuring that practices implement satisfactory Clinical Governance lies with the PCTs, Smile-on has provided CGPM, which allows practices to upload progress details to www.cgpmuk.com for easy monitoring by PCTs.’

Key features of CGPM include a free-of-charge messaging system and resources from the KSS Deanery and PCTs that are constantly updated.

The programme enables practices to meet clinical governance core requirements.

Clinical governance is part of the NHS drive to improve the quality of health care and to make providers accountable for delivering a consistent standard on which patients can rely.

Barry Cockcroft, chief dental officer, who was present at the launch of the programme, said he believes clinical governance is vital because ‘it’s a key part of delivering a quality service to patients’ and because ‘an initiative like this makes the dentists feel really involved’.

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Landmark victory

In an exclusive interview with the Dental Tribune, the profession’s stalwart Eddie Crouch reveals the highs and lows of his court case and explains why it was vital that the Department of Health did not win the appeal.

Dr Eddie Crouch finished 2008 on a high when he prevented the Department of Health overturning its appeal.

If the department had won, it would have given health bosses the right to terminate dentists’ contracts without cause or notice.

The appeal was lodged by the DH, following an earlier ruling, which said primary care trusts (PCTs) were wrong to insert this clause in the NHS dental contracts.

The Court of Appeal upheld the earlier ruling to the delight of Dr Crouch and the dental profession up and down the country.

Dr Crouch has been a vociferous critic of the new dental contract since it was introduced in 2006.

He believes this case ‘highlights so many of the problems arising from the NHS Dental Contracts of 2006. He said: ‘It shows that the rush to implement the contracts in April that year, led to some rapidly and as it turns out, poorly drafted regulations, and the lack of negotiation between the profession and the DH in these issues compounded these problems.’

Dr Crouch believes that the DH decided to appeal against the Judicial Review made in February not because it wanted to clarify the regulations, but because ‘the Department was seeking to regain the power to terminate contracts even when the dentist was fulfilling their side of the agreement’.

He calls this ‘determination for such power’ worrying for ‘every single dentist within the NHS’.

The case decided by the High Court last year has left Dr Crouch in ‘front of the leading judges in the land, fairness was seen to be upheld’.

He hopes it will ‘encourage others to challenge inappropriate powers that PCTs and the Department try to influence’.

However, it has not all been plain sailing and Dr Crouch’s courage in taking on the government, has left him paying thousands of pounds in court costs.

The total cost for the two cases exceeded £80,000 with just over half coming from donations from fellow dentists and orthodontists.

Dr Crouch had hoped to get financial support from the British Dental Association (BDA) however after negotiations, they failed to come to an agreement.

This has confirmed to Dr Crouch how important it was for him to enter into the dispute in the first place.

He calls it ‘reassuring’ that when things began to be placed in ‘front of the leading judges in the land, fairness was seen to be upheld’.

He hopes it will ‘encourage others to challenge inappropriate powers that PCTs and the Department try to influence’.

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Dr Crouch had hoped to get financial support from the British Dental Association (BDA) however after negotiations, they failed to come to an agreement.

He said: ‘Mistakes were made, both by myself and the BDA, that meant a collective approach with financing the case never happened, and this left me vulnerable to the costs.’

He claims the ‘case would never have been successful without the generosity of many colleagues to assist my legal fees. The BDA for various reasons chose never to pay any of my legal bills, as a result this case has severely drained my savings.’

He added: ‘If such cases are to be better handled in the future, the BDA must make clear to members in what circumstances they will support and indeed fund such action, as individual dentists the risks are heavy with costs.’

He is now calling on the BDA ‘to work with a group of members including myself, to see how such future cases can be better managed’.

Ideally he would like the BDA to set up a separate funding stream from membership subscriptions for cases such as his.

This could be used ‘to deal with the power of the government, who simply use tax payer’s money to stretch the their large muscles of power’, concluded Dr Crouch.

The BDA chose never to pay any of my legal bills, and as a result this case has severely drained my savings.’

‘The BDA chose never to pay any of my legal bills, and as a result this case has severely drained my savings.’

Dr Crouch said: ‘The BDA chose not to pay any costs because they had no control of the case and asked me to sign a confidentiality agreement before making any offer for the appeal.

‘I chose not to sign the agreement as I wanted to know what the offer amounted to before signing, they said that was not possible, in the end no agreement could be reached.’

The BDA’s claims that throughout the whole process, it has followed ‘a fair and equitable approach’.

After requests for financial help, the BDA held a meeting with Dr Crouch.

Peter Ward, chief executive of the BDA said: ‘Dr Crouch was not prepared to enter a confidentiality agreement regarding the terms of any assistance.

The BDA felt that having the safeguard of a signed confidentiality agreement was essential, as any arrangement would have involved the BDA sharing its tactical considerations and legal opinions of the case.

However, Dr Crouch rejected this despite the BDA’s offer of further discussions.

Dr Crouch has announced that his lawyers agreed with the DH a neutral cost agreement, as he was concerned that costs might be awarded against him. This was done without the BDA’s knowledge and has prevented any application he may have been able to make for a costs award against the Department of Health.

According to Dr Crouch, the whole case highlights the huge learning curve the profession is on, with dealing with these issues.

He said: ‘Mistakes were made, both by myself and the BDA, that meant a collective approach with financing the case never happened, and this left me vulnerable to the costs.’

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News & Opinions

BDHF slams politicians

The British Dental Health Foundation has called on politicians to stop playing politics with people’s oral health, after the Tories made claims that dentists were overcharging patients, so they could make more money from their NHS contracts.

The Conservatives asked every PCT in England how many patients were having to go back to their dentist within a three-month period for treatment and were paying more than once. They claimed the analysis revealed that dentists are pushing patients just over the two-month limit of what can be counted as one course of treatment, charging patients twice and therefore earning more money.

The shadow health secretary, Andrew Lansley, said: ‘The blame here lies with Labour’s botched dental contract, which incentivises dentists to increase the number of charges to patients and has led to such drastic cuts in the number of people being able to find an NHS dentist.’

However Health Secretary, Alan Johnson, said: ‘The question of whether dentists are fiddling the system to the tune of £109m is what Andrew Lansley is claiming, I think, is wrong.’

The government recently appointed an independent committee to review NHS dentistry. One of its roles will be to look at the system and find out whether there is too much ‘gaining’ in the system – of dentists calling people back just to make money.

In the wake of this furore, the British Dental Health Foundation (BDHF) is concerned that patients will be put off from having dental check-ups.

The BDHF’s chief executive Dr Nigel Carter said: ‘A million fewer people are visiting the dentist since the new contracts came into effect four years ago. Clearly dentists are not targeting contracts for easy money.

The government must address the issues, and the independent review is a start. The Opposition and the political elite should get behind this review and support a positive change.’

He added: ‘Negative messages run the risk undermining Britain’s oral health. For nearly 40 years we have campaigned with the key message advising people to visit their dentist regularly – as often as they recommend.

It is vital to get regular check-ups from an expert. This is so important to dental health, its systemic links to overall health issues such as diabetes, and in checking for mouth cancer, which kills one person every five hours in the UK.’

DDU launches more courses

The Dental Defence Union has again joined forces with experts from King’s College London to offer two further courses worth 12 hours of verified continuing Professional Development (CPD).

The courses will be held in Stratford-upon-Avon on 25 and 26 February 2009 and will cover topics such as complaints, radiography, medical emergencies and infection control, all part of the General Dental Council’s recommended core CPD subjects.

Rupert Hoppenbrouwers, head of the DDU, said: ‘We had a great response from delegates who attended this year’s London CPD courses, which were fully subscribed, and we are looking forward to hosting them again in the West Midlands.

The courses are a great opportunity for all members of the dental team to hear leading experts discuss a broad range of important dento-legal issues. All delegates will receive a signed certificate confirming their completed CPD hours.’

He added: ‘Now that CPD is compulsory for Dental Care Professionals (DCPs), we are also delighted to be able to offer DCP members of the DDU a complimentary place on the course if they are accompanied by a full paying delegate.’

Day one will include a combined session for dentists and DCPs on responding to complaints, presented by Bryan Harvey, deputy head of the DDU. There will also be a course in dental radiography and radiation protection for dentists and an interactive session for DCPs to help them understand the dento-legal environment.

On day two, Dr David Craig and Dr Chris Dickinson of King’s College London Dental Institute will present sessions covering medical emergencies and infection control. The day will conclude with an overview of legal and ethical issues, presented by Rupert Hoppenbrouwers, head of the DDU.

The courses cost £235 (one course) or £465 (both courses) for DDU members and £290 (one course) or £515 (both courses) for non-members.

DCPs who hold DDU membership can attend free when accompanied by a full paying delegate.

Dentists turn commando

The commandos completed the course in one hour and 15 minutes raising a total of £368.75 for the Devon Air Ambulance and Heroes charity.

Lisa McKinnon, area manager, said: ‘It was a fantastic day with all members leaving covered in mud, but having had a great time!’
Some years ago, many people working in the pensions world advised investors not to touch their pension until it was absolutely necessary. The main reason for this was that pensions grew tax-free, so the older you were, the bigger the pension you could buy.

A case in point

One particular client’s personal pension policies had not shown any growth in recent years; one reason being that they no longer grow tax-free following the introduction of Gordon Brown’s stealth tax in 1997, when he removed dividend tax credits from pension funds (raising £5 billion a year in the process).

The most frightening aspect, however, is that annuity rates do not always increase with older age. So we looked more closely at each of the client’s policies.

Many policies, particularly older individual ones, contain guaranteed annuity rates. This means there is a contractual obligation on the company to pay you a significantly greater pension than you could buy on the open market. One of the reasons Equitable Life got into trouble was that it offered guaranteed annuity rates at all ages in all situations.

Not all policies work this way and our client’s old Sun Life policy has a guaranteed annuity rate but, unusually, it applies only on your 60th birthday. It is available only on that date and so we advised them to look to take benefits from this arrangement.

The client had another older with-profits policy, which we wanted to move for several years, but didn’t because of high penalties. Due to the client’s employment circumstances when this policy was taken out, we have been able to provide protection for the tax-free Cash, which means the whole policy is now available as a one-off cash payment. Continuing with this policy in its present form with tax-free cash protection would mean that the lump sum available would be unlikely to increase because of the investment fund used.

Transferring a policy

On your 60th birthday, we have the ability to transfer the...
policy to another arrangement, retaining the tax-free cash protection and achieving a better return.

However, if the client feels, like many commentators, that it’s going to be several years before there is any return on investment funds and they could use a cash payment now, we suggested they consider taking the cash.

Interestingly, while their Sun Life policy offers them the chance to take some of the money as a tax-free cash payment, we suggested that they consider taking all the cash from the second policy and no cash from the Sun Life policy, to take advantage of the guaranteed annuity rates.

Another interesting twist with one of their contracts is that should they die, unlike all new pension policies where the full fund value would be paid out on death, their policy provides only for a return of contributions paid. Being an old with-profits contract, our client can access the full fund on their birthday. I am happy that it should stay within the pension environment, but they should transfer it to another arrangement where they have greater control over the investments, but should you die, the full fund value would be payable to your nominated beneficiaries.

To cash in or not to cash in?

Keep on track
As you can see, there are many circumstances why you should always review pension policies as they approach their stated normal retirement date. In fact, we would go one step further and suggest that all investors should review their pension contracts as soon as possible as it’s crucial to ensure the money is invested in line with your risk profile and risk tolerance levels (for example, what percentage fall in value you will accept during tough stock-market conditions).

The key point
No one knows what will happen to annuity rates. Over the last 15 years, we have seen the amount of pension that can be purchased fall from around 15 per cent to six per cent. The economic climate is very worrying. There is a belief that interest rates will have to fall and if they do, you can expect annuity rates to worsen.

Changes from RH to LH in seconds without the need for any tools

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New Tridec 6 Gala way unit with touch panel controls and dual water taps.

Splintion with one piece ceramic top and dual controls.

Suction OBE on articulating arm.

Optional chair mounted operating light and camera monitor bracket.
Cracking the pain dilemma

Pain is a protective mechanism and a warning sign that damage has occurred so it’s important that a general practitioner has the ability to recognise a patient’s threshold. Dr Daniel Flynn explains.
neural fibres in the pulp and do not assess the actual blood supply, which determines vitality. You should not rely solely on a sensitivity test when making a diagnosis. The main purpose of these tests is to:

1) Reproduce the symptoms the patient complained of
2) Localise the symptoms
3) Assess the severity of the symptoms

I use a refrigerant spray (−50°C) for thermal tests, along with the electric pulp test as standard. A tooth in the contralateral quadrant and adjacent teeth should be used to provide baseline information as there can be a large variety in the responses of patients to stimuli. The teeth should be dry and the stimulus placed at the cusp tip of molar teeth and near the incisal edge of incisor teeth corresponding to the area of greatest innervation in the underlying pulpal tissue. If one suspects that the stimulus is being conducted to an adjacent tooth via metal restorations a piece of rubber dam may be placed in the contact area to act as an insulator.

Always remember that neither the history nor the clinical findings alone are sufficient when reaching a diagnosis. I will try and highlight some of the difficulties one may encounter in the case report below and demonstrate the systematic approach that I take.

Avoiding the pitfalls
A 47-year-old female presented for consultation and reported a history of short sharp pain from the LL7 on hot stimulation or occasionally on eating. The patient was asymptomatic on the day of the appointment. The patient reported root canal treatment of LL7 was initiated around six months previously, and the following treatment options were discussed with the patient:

1) To monitor
2) Root canal treatment
3) Extraction +/- prosthetic replacement

It must be emphasised that antibiotic therapy does not relieve the symptoms of pulpsitis and should never be prescribed in these instances. In fact the vast majority of symptomatic endodontic cases may be treated with canal instrumentation and analgesic drugs. We rarely prescribe antibiotics in our practice.

Carrying out treatment
Consent was obtained and root canal treatment was initiated on LL7. The extent of the crack was investigated. As a general rule of thumb, if the crack extends on the floor of the pulp chamber the long-term prognosis of the tooth is considered guarded/poor and this information is relayed to the patient so they can make an informed decision.

In this case, a large pulp stone was encroached in the pulp chamber and a pulpotomy was performed. A pulpotomy alone will relieve over 90 per cent of the symptoms of irreversible pulpsitis. This is because the vast majority of inflammatory mediators and pulp tissue is located in the coronal portion of the tooth. If one is not confident that all the pulp tissue can be removed and the canals completely chemo-mechanically prepared, it is better not to place a file into the canals but just to remove coronal pulp tissue and place a dressing. In this case all symptoms resolved following the pulpotomy and the root canal treatment was subsequently completed on LL7 at the next visit, as all four canals were identified, chemo-mechanically debrided and obturated with a thermoplastic technique. It may be prudent to use a higher concentration of NaOCl in vital cases as this increases its ability to dissolve pulp tissue. Increasing the concentration doesn't increase the antimicrobial potential.

An IRM plug is placed over each of the canal orifices prior to an amalgam core to ensure a good coronal seal is in place. In our practice the patient is then referred back to the GDP for immediate placement of a cuspal coverage restoration.

Discussion
Diagnosis of a cracked tooth can be very difficult. In this case root canal treatment had been completed on LL7 without the alleviation of pain, yet the patient was convinced that the symptoms were originating from this tooth. It is vital to reproduce the symptoms prior to undertaking treatment to ensure that the correct tooth is being treated. On occasions patients have taken a significant amount of centimetre inflammatory medication and this can complicate the picture as there are no symptoms on the day and none of the teeth produce an exaggerated response when pulp testing. Often I tell the patient to return in two to three days and redo all the tests, rather than hastily beginning treatment if there is doubt as to the offending tooth.

The reason for an exaggerated response to pulp testing when there is pulpal inflammation is that the threshold for firing of the nociceptors has been reduced by inflammatory media tors and there is nerve sprouting which increases the number and distribution of fibres that may be activated.

In the above case a conservative treatment approach was initially taken. Some clinicians elect to place composite restorations, others place temporary/permanent cuspal coverage restorations and some electively dise talise the pulp. Thus it can be seen that not only is it difficult to detect and correctly diagnose cracks but the treatment can also pose difficulties.
Answers to common endodontic questions: Comparing different perspectives

By Richard Mounce

From my lectures globally, the two clinically relevant questions below predominate, especially from general practitioners. Among specialists, these same questions are often answered passionately with divergent answers. My answers to these questions are discussed with other clinical perspectives reviewed for comparison.

1. How large do you instrument canals and to what tip size and taper?

As a guiding principle, instrumentation should leave the minor constriction (MC) of the apical foramen at its original position and size. It is my empirical opinion that all instrumentation, irrigation, and obturation ideally terminate at the MC (if a MC is present) in both necrotic and vital cases. Arbitrarily instrumenting short of the MC in certain cases (1mm short for example in vital canals or 0.5mm short by intention in non vital cases as I have heard advocated by some) is by definition intending to leave untreated space within the canal system. Such recommendations are puzzling. The position of the MC can primarily be determined very accurately with electronic apex locators such as the Elements Diagnostic Unit (SybronEndo, Orange, CA) and bleeding point measurement. The above measurements can be confirmed subjectively with the clinician’s tactile feel and a comparison to the estimated working length taken via digital radiographs ideally before treatment (DEXIS, DEXIS digital radiography, Alpharetta, GA). In other words, why would it be desirable to back away from a reproducible landmark in treatment for what are most often wholly arbitrary reasons (safety, less extrusion, a desire to leave a stump of vital tissue, etc.) that have little if anything to do with the anatomy of the canal at hand (Fig. 1)?

The final prepared master apical diameter is primarily a function of several parameters: the diameter of the MC, root length, initial canal taper and diameter along its entire length, the width of the root (the thickness of the remaining root walls), the degree of fluting present and the presence of resorption when applicable.

In addition, the following factors are secondarily relevant to the optimal size of apical instrumentation:

- Whether the tooth has had previous root canal therapy and whether the MC has been enlarged or moved. A transposed MC could also modify the ideal final prepared diameter. A tooth that has had a post placed into it and needs to be re-treated might require that the
Fig. 1: Obstruction to the minor constriction in all three roots. Note the diffuse stippling of the obstruction material with the sealer path beyond.

Fig. 2 and 3: Severely complex root canal systems that will require significant hand instrumentation before possibly using RNT files.

Fig. 4: The K3 rotary nickel titanium file system (SybronEndo, Orange, CA).
simplest and most direct explanation of how to negotiate curved canals arises from an appreciation of the appropriate use of hand files in the canal at all times in the process. In practical terms, this means that the clinician must always assure that the canal path is kept open, negotiable, freely accessible, and patent to the apex, irrespective of the stage of the process in which the clinician is engaged.

For example, in the most extreme curvatures, the clinician must begin with the smallest possible hand files and in the presence of a viscous EDTA gel like File-EZE, (Ultradent, South Jordan, UT), the clinician can take a precurved hand file (optically curved with an Endo-Bender pilers, SybronEndo, Orange, CA) and slowly advance the hand file taking note of how much resistance is obtained by slowing moving the file apically. Using hand files first and RNT files second the clinician can assure that the canal space is patent from the beginning of the process and recapitulate the canal as often as needed so as to never allow a blockage of ‘dentin mud’ to lodge in the apical third of the root or at any acute and narrow curvature and risk losing patency.

Management of curved canals requires: coronal straight line access, an orifice that is opened to the correct and most ideal given diameter for the particular cervical tooth anatomy, either 0.12, 0.10 or 0.08 taper, removal of the cervical dentin triangle, and then coronal third enlargement to the level of the first significant curvature in the root. In other words, the clinician should remove all restrictive dentin above the given curvature to allow a clear and unobstructed access to the level of curvature. If a canal has multiple curvatures, each curvature should be negotiated and enlarged first before more apical curvatures are addressed. This approach to managing curvature is strictly crown down. In specific terms, if a root should possess an S shaped curvature the more coronal curvature should be addressed and enlarged entirely before trying to negotiate the more apical curvature. Attempting to work beyond curvatures without working in a sequential manner is fraught with problems and highly likely to create a ledge or blockage of debris or separated file among other possible iatrogenic problems at the point of negotiation.

For example, in the most extreme curvatures, the clinician must always assure that the canal path is kept open, negotiable, freely accessible, and patent to the apex, irrespective of the stage of the process in which the clinician is engaged. This means that the clinician must always assure that the canal path is kept open, negotiable, freely accessible, and patent to the apex, irrespective of the stage of the process in which the clinician is engaged. This means that the clinician must always assure that the canal path is kept open, negotiable, freely accessible, and patent to the apex, irrespective of the stage of the process in which the clinician is engaged.
Endodontic success and working length: thinking 5-dimensionally

By E. Steve Senia, DDS, MS, BS

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n the article "Endodontic success: it's all about the apical third (Endo Tribune, March 2008, pages 8-11), we introduced the term working length (WL). Don't be surprised if you have never heard this term—it's quite new to dentistry. Working length is defined as the distance from the apex to the gutta-percha. WL is the canal's greatest dimension. Instrumentation should address a working length and a working width. My last article focused on working width; this article focuses on working length.

Definition of working length

There is considerable disagreement regarding exactly where working length (WL) should terminate. Let's explore the reasoning behind the choice of sense of all of it. The American Association of Endodontists' Glossary of Endodontic Terms states: "Working length is the distance from a coronal reference point to the point at which canal preparation and obturation should be terminate." Where is the disagreement? The definition doesn't tell us where WL should terminate. Exactly where should it be? Our forefathers hotly debated the question for many years, and the forefathers hotly debated the question for many years, and the apical foramen, but positions the apical constriction 'usually 0.5 to 1.0 mm from the apex of the foramen.'

Exactly where should it be? Our forefathers hotly debated the question for many years, and the forefathers hotly debated the question for many years, and the apical foramen, but positions the apical constriction 'usually 0.5 to 1.0 mm from the apex of the foramen.'

Our forefathers concluded that instrumentation should end at the cementoenamel junction (CDJ) (Fig. 1), which is approximately colocated with the apical constriction. Most agree with that location, because the pulp makes dentin and the periodontium makes cementum. Instrumentation should remove pulp tissue and not invade the periodontium. That's not to say I'm against passing a patency file past the CDJ or even slightly beyond the foramen. However, remember the area is four times the radius squared. This means that a #15 (.03 mm) patency file's tip occupies approximately 5 per cent of the average foramen's cross-sectional area (0.60 mm) and only 25 per cent of the average constriction's area (0.30 mm)!

I suspect patency files are used more for warning of an impending ledge than for maintaining patency. The downsize is the likelihood of a patency file lacerating vital tissue beyond the constriction and possibly causing postoperative pain in an asymptomatic vital case. A clean cut of the pulp at its narrowest point (apical constriction) is an evolutionarily acceptable approach. In necrotic cases it would likely push infected material into the periapical tissue and possibly cause a flare-up.

Termination Point

Where to terminate WL (our clinical target) requires two reference points. The first one is the coronal reference point on the crown, and the second is in the apical part of the canal. The AAE Glossary notes that a root canal is: 'a passage or channel in the root of a tooth extending from the pulp chamber to the apical foramen.' Note that the foramen defines the end of the canal. This narrows the choices for WL to somewhere between the foramen and the CDJ/constriction.

The Glossary positions the apical constriction 'usually 0.5 to 1.0 mm short of the center of the apical foramen,' but positions the CDJ "ranging from 0.5 to 5.0 mm from the anatomical apex.' The last word, apex, is very important. If the CDJ can be as much as 5 mm from the apex, it means that the apex is not a precise reference point for WL determination and should not be used. Clearly, apices and foramina can't be used interchangeably, and evaluating the quality of an obturation by its distance from the apex is wrong.

A meaningful discussion of WL can only take place when it is understood to be measured in millimeters from the foramen and not the apex. So, let's not talk about the apex because it's irrelevant, and let's not pretend that the apex is the same as the foramen. It's all about the foramen, which is usually not at the apex.2,3

Gutierrez and Aguayo examined 140 teeth with a Scanning Electron Microscope. They found no foramina located exactly at the apex, and the average distance of the foramen from the apex ranged from 0.2 mm to 3.8 mm. The foramen gives a precise reference point for WL determination—the apex does not.

If we use the foramen, rather than CDJ/constriction or apex, as a reference point, we can readily narrow down the best locations for WL. We purposely use the following to emphasize the two acceptable locations—0.5 mm from the foramen or 1.0 mm from the foramen. Why not agree on a WL that ranges from 0.5 mm to 1.0 mm? I think that's reasonable, and here's why. Let's say that I believe WL should be from 0.5 mm to 1.0 mm short of it. Could I say that my choice is correct, whereas yours isn't and your treatment will fail? Of course not!

Body's defenses

Let's say you put WL further using a photograph of a root end (Fig. 2a) and add an instrumented and obturated canal (Fig. 2b), closing the door and preventing further bacterial contamination of the choices for WL. What happens to the bacteria at the gutta-percha seal when the WL is perfect or 1 mm short of the 'bells, lights or whistles' tells us what to do. The bacteria are destroyed by polymorphonuclear leukocytes (PMN), and any remaining debris is cleaned up by the macrophages.

Hypothetically, let's now miss our WL by 1 mm (short) (Fig. 2c). Just as in Fig. 2b, the door has been shut and the bacteria are trapped. What happens to the bacteria between the foramen and the gutta-percha seal when the WL is perfect or 1 mm short of the 'bells, lights or whistles'? Same answer, the bacteria are attacked and destroyed by the PMN — the major circulating cells in the immune system, whose function is to kill bacteria. (In fact, when the body encounters something foreign, the production of PMN increases tenfold.) Another body defense cell is the macrophage, whose function is to clean up the debris—a task it does very well— as evidenced by the rapid disappearance of extruded root canal sealer.

How to locate WL clinically

Let's say you use the foramen to determine WL. WL should range from 0.5 mm to 1.0 mm from the foramen, how do we find it? I believe electronic apex locators (EALs) have contributed greatly in making WL determination more scientifically based. No longer do we have to engage in the foolishness of evaluating a treatment by the aesthetic proximity of obturating materials to the radiographic apex. It's worth repeating: the apex has nothing to do with WL—it's all about the foramen. This, then, begs the question— why are the electronic devices called apex locators? An apex locator is a poor name, and the manufacturers should call them whatever they are — foramen (or apex) obturators. I recommend we use electronic foramen locator (EFL) and get rid of the term apex locator from here on.

Using electronic foramen locators (EFLs), we can locate WL directly. How? By using imaging systems, whose function is to kill bacteria. (In fact, when the body encounters something foreign, the production of PMN increases tenfold.) Another body defense cell is the macrophage, whose function is to clean up the debris—a task it does very well— as evidenced by the rapid disappearance of extruded root canal sealer.

Now, let's change the situation to where WL is perfect, but the case failed. (Fig. 2d). There is a dramatic difference between what happens to the bacteria in a correctly cleaned and filled canal (Fig. 2e) versus one where necrotic tissue remains. When this happens, the door is not shut since the root canal sealer cannot replace the infected tissue. bacteria feast on the tissue and reproduce rapidly. Because the infected pulp is 1 mm from the apex (Fig. 2d), the continuous production of bacteria and their toxins exiting the foramen was too much for the body defenses and the case failed.

There seems to be a widespread belief that the immune system behaves differently at the apex compared to other places in the body. The apex is not a mystery zone—the defense mechanisms there are 'alive and well' and fully functional. The misunderstanding, I think, arises from the errant belief that canals in necrotic cases lack a blood supply. This is true—high up in the canal—but not within the region of the gutta-percha seal. When the canal is in close proximity to a generous blood supply.

During my teaching years, we evaluated radiographs—dead-on 'apex' obturators. When the teeth were extracted or viewed during surgical retreatment, the dead-on’s were overfills of most of the time. I had to constantly remind my students of this fact (and proved it during their training). Each error, whether through the construction to or slightly beyond the foramen and obturating to that point in an aesthetically pleasing X-ray is not scientifically justified.

Knowing the limitations of radiographs for WL determination, let's see how electronic foramen locators provide greater accuracy. As with all electronic devices, carefully read the instructions. But, if they say that the activation of the ‘bells, lights or whistles’ tells you the amalgam tip is at the apex, isn’t this misleading? Since the apex is not the end of the canal, exactly where is the tip? How do we solve this dilemma and make EFLs clinically useful? Unfortunately,
we have to do what the manufacturers should have done. If the alarms indicate the tip is at the apex, but we think it’s at the foramen we should subtract 0.5 mm to 1.0 mm from the file insertion length to get WL. If the alarm is indicating apex but we believe the tip is actually at the constriction, then we should use that for WL. And finally, if the manual says that the bells, lights or whistles go off at the constriction, you will have to confirm the accuracy of that statement. You may have to do some finetuning as you gain practical clinical experience with the manufacturers’ devices. A little practice and careful observations while using your EFL will be required.

The good news is that in spite of their shortcomings, EFLs provide consistently better accuracy than X-rays. They also should help resist the temptation of indulging in ‘aesthetodontic’ contests. In our lectures and writings we could show X-rays of cases that appear ‘short’ but are not without worrying about our work being judged inferior. All we would have to do is advise the audience beforehand that all WL were 0.5 mm to 1.00 mm from the end of the canal using the accuracy of an electronic foramen locator rather than the inaccuracy of an X-ray.

**Alternative technique for WL determination**

I give credit for this technique to Bill Wildey, the co-inventor of Light-Speed™. Bill uses Light-Speed™ instruments (Discus Dental Inc., Culver City, Calif.) to fine-tune WL. He starts with the estimated length given by the EFL; he then goes 1-2 mm beyond that length with the LSX, rotating in the handpiece. The short blade of the LSX #20 (Fig. 3a) usually passes easily through the constriction, because the diameter of the constriction is roughly #50. Depending on the actual diameter of the constriction (if one exists), the LSX #25 or #50 usually engages the walls of the constriction and a ‘popping’ sensation is felt when the blade goes through the constriction. This tactile feedback gives the exact location of the constriction and the desired location of WL. The key is to advance the instruments very slowly to feel what’s happening in the canal. If a constriction is not present, the popping sensation will be felt passing through the foramen.

Larger LSX sizes, if advanced slowly (recommended technique) to the same WL, will allow for the development of an apical stop (matrix). Once developed, the LSX would have to be pushed hard to force it past the stop. Of course, demolishing the constriction where the stop is located (the WL) is not recommended. The apical stop confines our fills to the WL and helps minimise the incidence of over-fills.

Notice the length marking rings on the shank of the LSX (Figs. 3b, 5c). I can assure you that significant time savings (and greater accuracy) is possible if you use the rings in lieu of rubber endo stops. In fact, Bill Wildey recommends you have your assistant remove the stops before bringing them chairside to force yourself to make the transition.

**Conclusion**

In our subconscious minds, we are aware there is a biologic tolerance to WL. Cases obturated a little short (or a little long), are usually successful when everything else is done correctly. WL need not be perfect for a successful outcome (biologic tolerance), but the tolerance for an inaccurate WW is not so generous. Avoid the temptation of indulging in ‘aesthetodontic’ contests. The endodontic community should agree to a WL that ranges 0.5 mm to 1.0 mm from the foramen (not apex) and move on to more important issues.

I recommend all manufacturers use the term electronic foramen locator (EFL) rather than apex locator to describe these devices. EFL manufacturers should eliminate ambiguous markings on their devices and simply pin-point only the foramen. Dentists would then ‘do the math’, thereby choosing a termination point that is either 0.5 mm or 1.0 mm short of that location. And finally, emphasis should be placed on cleaning the main canal as well as possible (correct WW) close to the construction/CDJ. Doing so closes the door, prevents bacterial/toxins from contaminating apical tissues and increases the chances of endodontic success.

Smart Endodontics™ offers many helpful tips. To learn more, please call Discus Dental at (800) 817-3636. Request the free CD showing what Smart Endodontics is all about.

I wish to thank Steven S. Senia, BSIE, MBA, for his valuable contribution to this article.

**References**


**About the author**

Dr. E. Steve Senia

earned a DDS degree from Marquette University in 1963. He entered the Air Force (previously served as a pilot) and completed a GPR Residency. In 1969, he received a MS and Certificate in Endodontics from The Ohio State University. He served in the Air Force and retired in 1981 as a Colonel Chairman of Endodontics at Lackland AFB, Texas. He then became Professor and Director of the Endodontic Post-graduate Program at the University of Texas Dental School at San Antonio. He retired in 1992. Dr. Senia is a Diplomat of the American Board of Endodontics. He is a former member of the Editorial Board and the Scientific Advisory Panel of the Journal of Endodontics, an editorial advisor for the Journal of Endodontic Practice and a consultant for the NASA Space Program. He has lectured and published extensively and is the co-inventor of the Light-SpeedLSX™ root canal instrumentation and SimpliFill® obturation systems. You may contact Dr. Senia at DrSteveSenia@aol.com.

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**Fig. 3a:** LightSpeedLSX™ NiTi Rotary instruments with a very short blade and noncutting shaft.

**Fig. 3b:** Length-marking rings on the shank can be used as an alternative to rubber endo stops (15 mm LSX).

**Fig. 3c:** Length-marking rings on 21 mm LSX.
Yes, you can recover lost referral sources!

By Roger P. Levin, DDS

A s an endodontist, you’re very aware of how important your referring doctors are to the success of your practice. Every year, hundreds of thousands of dollars in production are referred to your practice by these doctors. Therefore, when a referral source starts slowing down, or stops referring altogether, it’s a major cause for concern. What to do about lost referral sources is one of the most difficult questions I am ever asked about managing and marketing a practice.

Why referral sources are lost

Most specialists have friendships, or social relationships with their top one, two or maybe three referral sources who are general dentists. They’ll regularly talk to these individuals on an almost weekly basis. Beyond the top two or three referral sources, there is a huge drop-off in the amount of time and attention paid to the remaining referring doctors. When questioned about these other referral sources, endodontists admit their contact with them has fallen off. It’s no coincidence that these referring doctors eventually feel inclined to respond to invitations from other practices.

The importance of tracking referral sources

I repeatedly hear that it took approximately six months before the doctors even realised that the referral source had been lost. It is essential to know as soon as possible that the referral source has stopped referring. The earlier you know, the better your chance of recovery. Although most software programs will indicate referral patterns, these reports are often underutilised. Levin Group recommends that you scrutinise your monthly referral marketing reports and analyse this year’s performance versus last year’s. It would also be helpful to evaluate monthly performance compared to the same month last year. In addition, recommend creating reports that reveal the drop-off rate of your set of lost referral sources.

Relationship-building with referring doctors

Further steps should be taken with referring doctors whose referrals have dropped or ceased altogether. These steps are recommended:

1. Increase contacts to enhance the relationship. Normally, referral sources leave endodontists because someone else has paid more attention to these dentists, or a competitor began marketing more aggressively. During this time of relationship-building it will be critical to use more than one referral marketing strategy.

2. Emphasise education and a commitment to the general dentist’s practice. Discuss specific patients that have been referred over the years and the patients that have been referred by the individual begin to reframe his or her view of your practice.

3. Bring illustrative clinical cases to meetings when appropriate. Demonstrate quality, but talk about service. Most general dentists are equally concerned about both. They want excellent care for their patients, but they also want their patients to be treated extremely well.

4. Emphasise that your practice schedules patients in a timely manner. Levin Group recommends follow-up within seven to 10 days with consultations for patients referred to your practice. This helps to keep the level of patient motivation high. We also recommend that endodontists design a schedule with time built-in for consultations with new patients (one to three slots per day).

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About the author

Dr. Roger P. Levin, DDS, is founder and chief executive officer of Levin Group Inc., a dental practice management consulting firm that provides a comprehensive suite of lifetime services to its clients and partners. Since 1985, Levin Group has embraced one single mission—to improve the lives of dentists.
Chalk and cheese?

When it comes to carrying out endodontics under the UDA system, Jerry Adams suggests a little give and take is necessary to make it work.

“The preliminary results of the dental treatment band analysis in England from April to July 2007 demonstrate that there has been a reduction in approximately 45 per cent of adult courses of treatment that contain a root-filling episode from 2005/04 to 2007 and an increase in extraction figures to 2007/08. This is a direct quote from a British Endodontic Society memorandum, (DS05) to the House of Commons health committee a year ago, while the Department of Health (DHS) reports that figures are even worse. In 2008, this situation has become out of control and the reasons for the severe change are two fold.

Root problem

The UDA situation regarding root canal therapy is the core of the problem. The Government’s position is that the UDA banding and contract-value allocation to an individual practice was based on historic treatment patterns of that practice.

The Government will argue that under the new system, a practice should continue to provide 50 RCT treatments, seeing as they were part of the historic value, and as a result, there is reluctance from the Government to provide extra funding for what they perceive they have already paid for. On whichever side of the fence you sit, it is an argument that is difficult to argue against.

From the practitioner’s point of view, there is a different dilemma that has arisen from the GDP looking at an individual treatment within what is no longer an item of service contract. The practitioner either provides the root treatment, which will be part of the treatment that attracts three UDAs anyway, thus creating the view that the root treatment is being provided for free, seeing as it does not increase the UDA value. Alternatively, the practitioner extracts the tooth and provides a denture that attracts 12 UDAs. It can be argued that there is little wonder the number of these treatments has decreased to such an extent.

What’s the solution?

The Government needs to decide whether it is serious about funding care such as root treatment and introducing a band of say five or six UDAs for complex non-laboratory treatment – that would be a good compromise. The flip side to this would have to be a reduction from the simple treatment UDA value.

The biggest loser

One thing is for certain, the status quo cannot be allowed to exist; it is the ultimate lose, lose, lose situation. Politically, the Government will be shown to have moved dentistry back 20 years and have orchestrated a definite two-tier system, something they have been desperate to avoid. Practitioners will lose as the Government will blame this failure on them, and they can expect little sympathy from the public following the latest report, which shows that practitioner NHS earnings have averaged over £100,000 under the new contract. Ultimately it is the patients who are the biggest loser and at the end of the day surely that it what is most important?

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05 March 2009 Preston Marriott Hotel
12 March 2009 Newcastle upon Tyne Holiday Inn
19 March 2009 Edinburgh Marriott Hotel

Delegate rates: £55 - dentists, accompanying nurse free of charge*. Delegates attending the seminar will receive a 50% discount against the purchase of an introductory pack of smartseal, “one nurse per dentist

About the speaker: Jerry Watson is a general dental practitioner based near Stamford. Jerry is a well respected trainer and has worked with many companies and organisations to deliver training for dental teams. He has been involved with Smartseal since the late 1990s.
Avoiding problems with veneers

Veneers can give beautiful results, but creating and fitting them is a complex procedure that has to be done with great care, says Dr Sultan

More and more patients are undergoing elective procedures to improve their smiles. Porcelain veneers and bleaching treatments are now being sold by many dentists who have updated their skills and are helping out their patients unhappy with the position or colour of their teeth. There seems to have been a rise in the number of patients presenting with acute sensitivity and pain following these procedures.

Patients are often angered and dismayed by the fact that their once intact teeth are hurting, which is why measures must be taken to inform a patient before treatment of any possible problems, as well as taking steps to avoid problems during preparation.

The first step
First as always comes diagnosis and consent. A patient should always be warned that they are undergoing an elective procedure, and that any procedure involving the preparation of a tooth can cause inflammation. If all goes well, this will be transient and should settle by itself.

Radiographs and models should be taken to assess tooth position and preparation with regards to proximity to the pulp. Ideally, if teeth are poorly aligned, the both orthodontic and endodontic options should be discussed.

Many of the leading cosmetic practices now have close relationships with orthodontists. Aligning teeth makes the veneers easier to place and gives a superior cosmetic result. If the patient does not want to undergo orthodontics, they can consider elective endodontics so that the tooth can be further reduced and realigned.

The other options
Once a patient has agreed to veneers, it’s worth keeping in mind what are the worse things we can do to teeth:

Take a perfect tooth, and then remove all the enamel with a high-speed bur. If the bur is blunt or there is not enough water, the tooth will heat up dramatically causing severe pulpal inflammation and possible pulp death. Using brand new burs and plenty of water will keep all the teeth moist and cool.

If there are multiple preps being done at the same time, the first teeth can desiccate. Moist gauze can be placed over the preparations.

Try not to over prepare teeth. The best preps are in enamel and this ensures a better bond. Trial preps on a model, following the methods used by Dr Gurel, will ensure minimal but adequate preparation.

Temporaries tend to be spot welded to ensure easy removal, but may also lead to bacterial leakage. If the tooth has already been traumatised by the preparation then bacterial leakage at this stage can cause real sensitivity and pain. The bacteria can penetrate the freshly opened dentinal tubules in the heavily prepared areas, especially if there is a good shoulder preparation at the neck of a tooth.
Good, well-fitting, temporary veneers therefore are essential, as is protecting the teeth before the impressions are taken. A fourth generation dentin bond like Optibond SL by Kerr, will help seal the tubules, cutting down on the potential for leakage.

Fitting the veneers
The next problem is actually fitting the veneers. Taking off temporaries and etching a tooth can exacerbate an already sensitive tooth and can be excruciating. If the tooth has been well protected beforehand this should not be a problem.

It is inevitable that teeth will be sensitive to cold stimuli following a procedure and this should be closely monitored. Often the patient guides us and when teeth just aren’t settling, a decision has to be made to denervate a tooth.

Veneers can give a beautiful result but are really a very complex restoration that has to be done with great care so that healthy teeth do not need to be root treated later.

**About the author**

Dr Michael Sultan
BDS MSc DFO

is a specialist in endodontics and the clinical director of Endocarp. Michael qualified at Bristol University in 1986 and worked as a general dental practitioner for five years before commencing specialist studies at Guy’s Hospital in London. He completed his MSc in endodontics in 1993 and worked as an in-house endodontist in various practices before setting up on his own at London’s Harley Street in 2000. He was admitted onto the specialist register in endodontics in 1999 and has lectured extensively to postgraduate dental groups as well as lecturing on endodontic courses at the Eastman Dental Institute at University of London. He has been involved with numerous dental groups and has been chairman of the Alpha Omega dental fraternity. In 2008, he became clinical director of Endocarp, a group of specialist practices. Dr Michael Sultan can be contacted for advice regarding patients or any issues raised in his articles, on michael@endopro.co.uk.
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What makes a good complete denture?
Justin Stewart discusses four areas to focus on when creating a complete set of dentures and offers tips for making the best set possible

Creating excellent dentures requires attention to detail.

With dental universities cutting back on the removable prosthetic curriculum, it seems there are fewer dentists who take a dedicated interest in denture-related work, which can result in poorly constructed and ill-fitting dentures. Implementing a routine system with distinct areas to focus on will generate better functional and cosmetic solutions. By ensuring there is a high standard in each area of focus, dentists can guarantee a secure, cosmetic denture.

Four areas of focus are: the fit surface of the denture, the bite, restoring the facial height and the position of the teeth. The following is particularly true for complete dentures and extensive partial dentures:

1. The fit surface of the denture will be more accurate by taking a functional impression. The key part is border moulding and getting the patient to make mouth movements, which removes the guesswork relating to how deep the flanges need to be. TIP: Look down on a full lower impression and look for an ‘S’ shape. If it is not there, double-check the impression, as it is usually present.

2. When a patient closes, the bite may appear to be correct, but often it is not, as their lower jaw is posturing forward to get to maximal intercuspation, but this is not the retruded jaw position. There are a number of ways of procuring the correct bite; arguably, an intraoral gothic arch tracing is the most accurate technique. TIP: At the try-in stage, have the patient bite on cotton wool for 30 seconds, and observe the patient closing gently, looking for premature contacts.

3. With dentures where the vertical height is less than it should be, it is difficult to get the correct cosmetic result. The vertical height is fundamental to achieving the best cosmetic result. Also, if the teeth are not as forward as they should be, the lips and cheeks will look collapsed. TIP: Slightly overbuild the facial support, as over the first two to three weeks, the facial musculature falls further around the dentures, and patients may feel not enough of their teeth are showing.

4. Getting the patient to supply old photos of themselves with natural teeth is helpful. Generally, the denture should follow the natural skeletal class of the patient. TIP: It is almost impossible for the technician to get the cosmetics of the denture correct at the lab bench. Dentists should be encouraged to move the teeth themselves at the wax try-in which is usually fun to do.

Creating excellent dentures require attention to detail. Any dentist taking on a full-mouth reconstruction would spend a lot of time making sure that every stage of treatment was carried out correctly. That same attention to detail should be applied to complete denture reconstruction.

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About the author

Justin Stewart was the first qualified Biofunctional Prosthetic System (BPS®) dentist in the UK. He is a member of the American Prosthodontic Society and the British Society for the Study of Prosthetic Dentistry. He has recently been appointed to Dr Joe Massad’s International Advisory Board and is an experienced lecturer. For further information, email Justin Stewart at enquiries@thedentureclinic.co.uk.

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Discovering state of the art patient education solutions

Ideally, dentists would love to be able to sit down with each and every patient and discuss their oral and dental care routine at length, as well as go through the comprehensive list of treatment options open to them. However, with many dentists barely having enough time to grab a sandwich at lunchtime, this seems impossible.

Of course, technology is always being developed to make the lives of dentists, and their patients, that much easier. There are now systems available to promote patient education in the practice. Until now, the dentist who wanted to reach out to patients and keep them as informed as possible would invest in a stylish new website, rich in informative content, regularly updated and augmented with treatment animations and before & after images.

One step further
Systems like the award-winning e-touch (winner of the first ever Product Innovation category at the 2008 Probe Awards) bring High Definition treatment animations and professionally recorded audio into the waiting room, all easy accessible using the latest touch screen technology.

By placing such a touch-screen system in your waiting room, patients will be encouraged to use it while they wait.

Also, the dentist or front desk staff can steer the patient to the touch screen system, should the patient require further information. The most obvious benefit is that this saves time for the dental team, but these systems do more than that.

The educational style of a touch screen system is both visual and kinetic, with its blend of images and animations. This means that the information captures the patient’s imagination more than the auditory style of the dentist or dental nurse.

Also – and this is a key benefit – the patient is able to progress at his or her own pace, replaying sections of the animation and controlling both the speed of the animation and text, and the depth of technical detail. This means that the patient can develop a complete understanding without being baffled by complex dental terms – but if the patient wants to know the more technical aspects of a procedure, then that option is available too.

Sit back, relax
Educated patients are more likely to be relaxed when they enter the surgery, as they know exactly what the procedure involves. Also, they will be able to make informed choices as to what treatment options they wish to take. Once your patients have achieved a nice, healthy smile, you can direct them to the touch screen system so they can find out how best to maintain their smile.

With a bespoke information resource of this calibre, you will feel the weight slip from your shoulders as patients requiring more information seek out the sleek new kiosks, desktop or wall-mounted systems. In fact, you might feel a little bit like a hipster.

Amy Rose
Amy has over six years experience in the dental profession, working predominantly in a marketing capacity. Amy currently heads up the design and marketing team at Den-tal Design Ltd. Visit www.touch-ed.co.uk to find out what the leading system offers, call 01282 677277 or email contact@touch-ed.co.uk
The average age of a DCP is on the rise, in common with that of other dental team members. While some would say this emphasises the value of experience within the profession, the downside is that not enough young people are being attracted into laboratory work. As a result, we face a looming skills shortage.

Tackling training

Part of the problem is a lack of training opportunities. There is still a school of thought which regards the dental technician as an optional extra, although the recent advances in restorative procedures and prosthetics have in fact expanded the technician’s role in the treatment process.

Graduate wastage is another factor reducing the availability of skilled laboratory labour. Graduating technicians are frequently tempted by the attractive salaries and bonuses offered to sales representatives, and others return to training seeking to become dentists themselves.

The damaging effects of reduced recruitment are not confined to the dental laboratories. As public awareness of oral health issues in the UK continues to rise, the dental industry as a whole may find itself unable to meet patients’ expectations. We also need to remember that skilled dental technicians cannot be trained overnight, and that without an adequate young entry the experience of more senior technicians will not be passed on.

There are currently only 11 venues across the UK offering training in dental technology, none of them in Northern Ireland. Many students are prevented by personal circumstances from travelling the length and breadth of the country to find a suitable course. From every point of view, the present situation is untenable and unacceptable, and a future crisis can only be averted by action now.

Making changes?

There are a few beacons of light alleviating the gloom and pointing the way forward, and which should be attracting the attention of the Department of Health and the Tertiary Education Funding Councils. One example is presented by the University of Kent’s Division of Dentistry, which has applied for a new study route to be approved for dental technicians seeking permission to register after three or more years of working experience. The proposal is presently being reviewed by the GDC, and while the DLA is hopeful a positive outcome is by no means certain.

Assuming approval is granted, the new course would allow dental technicians with fewer than the required seven years of experience to be entitled ‘trainees’ while they work towards full GDC registration. The measure would encourage unqualified staff to remain in the industry and progress towards the full professional recognition achieved through registration, and at the same time prevent the penalising of those who currently work alongside them.

All UK dentists, whether specialists or in general practice, should be pressing for action to close the widening generation gap and attract more high-calibre recruits to service the technical and creative needs of the industry.

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The HotShot™ is cordless, compact and easy to handle. It features variable temperature set settings which allow Practitioners to control the flow characteristics of the material, a rechargeable lithium ion battery which will support hours of use from a single charge; and a choice of needle size 25g and 25g with a 3600 swivel for improved access.

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accuracy and control. By using NSK’s iPex digital apex locator you get all the information at glance to be able to do exactly that.

The New SimpliFill™ Obturation Delivery Device is the only carrier-based obturation system that features a removable carrier allowing you to easily move the carrier behind the canal except for the obturation material. Other systems which leave the carrier behind may result in difficulty placing posts or retreatment. With a simple twist the SimpliFill® carrier is removed leaving an Apical Plug securely in place.

SimpliFill® plugs and LSX™ preparations are a natural fit. No other system can prepare the canal so accurately and provide so perfect a matching plug obturator.

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They have an innovative cross section which is an “approximate equilateral spherical triangle”. This convex triangular cross section allows a more free space for debris removal. Whilst retaining its core strength, it also allows excellent flexibility and maintains a perfect cutting edge.

Pre-sterilised K and H Type SteriFiles® are sterilised by gamma irradiation and individually blister packed. They are manufactured from high-grade stainless steel, which maximises both flexibility and strength. The K Type files feature an enhanced non-cutting tip, they are the first choice for preparing curved and narrow canals.

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Industry News

Congratulations More Accredited Members Within The BACD

The British Academy of Cosmetic Dentistry (BACD) is dedicated to the practice of quality cosmetic dentistry, and in 2005, introduced credentials allow -
Oraldent offers effective help in the treatment of Periodontitis

Periodontal disease is not exactly rare in the UK, and dentists need as much help as they can get in treating this disease.

The great news for patients, and for dentists who pride themselves on providing quality care, is that Oraldent, the leading specialist in preventative oral care products, is proud to be distributing Periostat® 20 mg film-coated tablets (doxycycline) in the UK to meet the need for an adjunctive therapy.

David Bloom, Julian Caplan, Neil Gerrard & James Russell

They have completed the Accreditation process and received a plaque allowing them to state themselves as an ‘Accredited Member of the BACD’. UK practitioners have designed the process for UK dentists and technicians. Accreditation involves anonymous submision of clinical cases demonstrating a range of different clinical skills in cosmetic dentistry with before and after pictures supporting their independent work.

For dentists, completion of Accreditation allows recognition of their skills by patients and colleagues alike. For technicians it allows them to demonstrate their skills in planning and producing restorations as an active member of the dental team.

FREE Book and Beautiful II from Shofu

Shofu are offering the first 10 readers to call the opportunity to win a fabulous full colour guide to ‘The Art of Clinical Crown and Bridge’ by Professor James Roelofse, Professor of Anaesthesiology, is Programme Director and is supported by Dr Yusof (Joe) Omar and Dr Andre du Plessis and a faculty of experienced teachers. Some of the topics to be covered include:

• Treatment planning and pain management
• Behavioural management techniques
• Patient assessment and clinical examination
• Introduction to paediatric sedation
• Practical aspects of setting up a sedation service

The UCL Eastman Dental Institute will next deliver their Dental Sedation and Pain Management Course on 6th, 7th, 9th and 10th May 2009 with practical training and further didactic teaching being delivered over the following six months.

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• Practical aspects of setting up a sedation service

Course participants will administer conscious sedation to patients under the close supervision of experts. They will be encouraged to demonstrate this in their own practices, seeking advice from their course mentors when necessary.

The course is suitable for both dental and medical practitioners as well as hospital based clinicians from all specialties.

For more information contact Suzy Rowlands on 0207 612 4166, email: info@bacd.com or visit www.bacd.com.

An orally administered, film-coated tablet available on prescription only, Periostat® contains a sub-antimicrobial dose of 20mg doxycycline. Specifically designed to be taken twice a day for three months, Periostat®is an adjunct to professionally delivered scaling and root planing procedures.

Periostat® suppresses tissue-destroying enzymes including collagenase and can actually reverse the disease process1, making it a valuable addition to your array of treatments for periodontitis.

For more information please call 01480 862080, email enquiries@oraldent.co.uk or visit www.oraldent.co.uk.

UCL Postgraduate Certificate in Dental Sedation and Pain Management

Molar Ltd and the BSDHT have worked together to provide a new Hygienist and Therapist forum, YTU (You Tell Us).

The new YTU Forum allows members to evaluate and comment upon various aspects of the society including CPD provision, through the Dental Health Journal and the website, together with a whole range of professionally related services and materials.

Your opinions are important and, with a total of 15 questions, the BSDHT and Molar Ltd have made it quick and simple to share your views. Upon completing the questionnaire you will be entered into a prize draw to win either a TePe TV or a place on the ever popular Learning Spa course in 2009!

Just click onto www.bsodont.co.uk and tell us what you think!

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Vizilite® Screening Test for Oral cancer

Vizilite® is a simple technology to assist in the early detection of oral abnormalities including premalignant lesions and oral cancer.

Vizilite® comprises of a chemiluminescent light source designed to detect cation of lesions and a blue phe-nothazine dye (TBI) to mark those lesions identified by Vizilite. Carried out as part of a general check up, Vizilite® is a simple, low cost, pain free and 100 % sensitive test that can help save lives or give Patients peace of mind.

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With a reputation for innovation, design, construction and expert care, Genus Interiors are the trusted name for transforming dental practices.

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In dealing directly with manufacturers and suppliers and employing their own installation teams, Genus offer extremely cost efficient transformations.

With an invaluable knowledge of the building industry, coupled with their step by step approach and reliability, Genus delivers a high quality approach to interior refurbishment within the dental profession, all carefully managed to match agreed budgets and timescales.

Transform your practice with the innovative team from Genus Interiors. Visit www.genusinteriors.co.uk or call 01582 840 484.

Periodontitis – A “Talking Point in Dentistry”

GlaxoSmithKline Consumer Healthcare (GSK), manufacturer of Aquafresh, Corsodyl, Poligrip and Sensodyne, has announced details of the speakers for the 2009 Talking Points in Dentistry lecture series.

The topical evening lectures are free for the whole practice to attend and offer verifiable CPD accreditation.

Phil Over and Graham Smart have titled their lecture “Periodontitis – Disease or Defence” and will show how effective periodontal care can be delivered in a general practice setting, involving all members of the team.

Ashley Latter will propose to the audience that “Communication is a Team Effort”. This topical presentation will address the common behaviour within dental practice of offering treatment solutions before finding out what patients require and will help team members to connect with patients and build better relationships.

Dates for the 9 venues in the 2009 programme are:

5th May IBIS Hotel Earls Court – London
6th May The Marriott Hotel, City Centre – Bristol
11th May De Vere Whites Hotel, Reebok Stadium – Bolton
12th May The Hilton Hotel – Watford
13th May The Novotel – Southampton
14th May Motorcycle Museum – Solihull
19th May Arth Castle – Falkirk
20th May The Marriott Metro – Newcastle
21st May Elland Road Football Club – Leeds

Thirdly, the option of integrating endodontic and implantology motors. Let us also not forget the new dentist’s stool IICHO, which promotes ergonomic sitting posture.

TENEO – simplicity redefined. Innovative technology combined with maximum comfort and convenience for the dentist and the patient.

It will be a great day. With Sirona.

For further information please contact: Sident Dental Systems Telephone: 01532 582988
Henry Schein Minerva Dental Ltd Telephone: 08700 102041

Deep Clean With The Pik Pocket® Tip

Dental professionals worldwide have recommended the Waterpik® Dental Water Jet. The vast research has demonstrated a significant reduction in bleeding and gingivitis associated with periodontal infections.

A recent study demonstrated that using a manual or power toothbrush with the Waterpik® dental water jet was up to 95% better at reducing gingival bleeding and up to 52% better in reducing gingivitis compared to regular brushing and flossing.

For more information about the BOS visit www.bos.org.uk

British Orthodontic Society welcomes an Independent Review of NHS Dentistry

The British Orthodontic Society (BOS) has welcomed an Independent Review of NHS dentistry following the adverse comments from the Health Select Committee (HSC) enquiry into the new dental contract arrangements.

Iain Hathorn, Chairman of the British Orthodontic Society who made the statement on 16 December 2008 added “The BOS is also committed to help inform commissioners for primary and secondary care who were given such a poor report from the HSC. There is a high turnover of managers in dental commissioning, who need help to understand the complexities of dental and orthodontic contracts, to ensure the highest numbers of patients get the treatments they deserve”.

Background information

The British Orthodontic Society represents the interests of specialist orthodontists in primary care, secondary care, the university sector, community orthodontists and dentists with a special interest (DwSIs) in orthodontics and the provision of best possible orthodontic care.

The Society is a charity and alongside its traditional focus on research and on promotion of the highest clinical and ethical standards, the BOS and its members aim to increase understanding of orthodontics and the benefits offered by treatment.
The Waterpik® dental water jet has been clinically proven to have the ideal combination of pulsation and pressure to clean where brushing and floss cannot reach. The studies have shown the product is safe and effective.

The biggest problem with periodontal pockets is daily cleaning, but using the Waterpik® dental water jet with a Pik Pocket™ subgingival delivery tip will allow easy and gentle deep cleaning, even in 6mm pockets.

For your professional courtesy discount on the Waterpik® Dental Water J e t s speak to your dental wholesaler or for more information visit www.waterpik.co.uk. The product is also widely available in Boots stores.

Easyshade™ Compact

From Vita, the world leading expert in shade determination, the new Easyshade™ Compact is a fast and reliable way to take shade at the push of a button. High measuring accuracy due to spectrophotometric measuring, this cordless, mobile and lightweight unit reads up to a potential 97 shades combination, both in Classical and in the 3D system. User friendly and easy to learn, with Easyshade™ Compact, you can read one single shade or 5 different areas in the tooth and check restorations. Up to 25 shade taking results can be stored in memory. No more worries about lighting conditions or costly remakes!

Pandanet 01689 88 17 88 or visit www.pandanet.net

Selling Easy With DPCS

Dental Practice Consultancy Service (DPCS) has been successfully selling dental practices since 1980. Utilising its approach, DPCS recognises the individual character of each practice and has earned a reputation for securing the best price with the minimum of stress for the vendor.

The market today is particularly active, with an unusually large number of buyers, including dentists seeking to acquire their own practice. In this situation the complexity of matching buyers to sellers is instantly apparent, and the process must be effectively managed to afford satisfaction to both parties.

Conditions in the property market are constantly changing, and in sectors with a commercial element such as dentistry are influenced by the current trading climate. DPCS has the experience and expertise to take these conditions into account.

DPCS provides advice to both sellers and purchasers of dental practices. Whatever your situation, with DPCS you can be sure you’re in safe hands.

For more information visit the Dental Practice Consultancy Service website, www.dental consultancy.co.uk

TePe G2™ – The best just got even better!

Molar Ltd are pleased to announce the introduction of the NEW TePe G2, the latest generation of interdental brushes to the UK. When dental professionals around the world asked for the smaller-sized interdental brushes to be even stronger, longer wires, TePe rose to the challenge and the TePe G2 was developed.

The TePe G2’s new soft, low, flexible tip is designed to prevent trauma. This exciting and innovative design allows the brushes to be inserted further between the teeth and the flexible neck also increases the brushes durability. Testing by dental professionals and their patients reported 94% saying they would choose the TePe G2 over the original brushes. Patients preferred the more comfortable feeling of TePe G2 over brushes in contact with the teeth and gums.

If you would like more information on the new G2 Interdental Brush, or a sample, please contact Molar Ltd on 01954 710022 or email info@molarltd.co.uk.

Practice Plan Help Tanzania

practice plan has been raising funds to invest in 2008 to support the work of the UK registered charity Bridge2Aid (R2A) who help those in desperate need of dental treatment in North West Tanzania. Funds were also raised to enable a team of practiceplan employees to fly to Tanzania and refurbish a dormitory block in Bukumbi.

In order to raise money for his Tanzania trip, practiceplan employee, Jamie raised £550 and is set to do it all again.

With no access to a dentist, Tanzanians suffer the daily agony of severe toothache. R2A is safely removing the pain of hundreds of thousands of people each year through treatment and training programmes, which sees UK qualified dentists teaching Tanzania’s basic dentists.

To find out more about practiceplan’s fundraising activities please visit www.practiceplan.co.uk/bridge2aid/about.aspx. For more information on all the hard work Bridge2Aid have been doing please visit www.bridge2aid.org.

Raisin selection has removed the stigma from tax investigations

With the tax authorities selecting the names of dentists almost entirely at random, it is no longer a cause for embarrassment or shame to seek support.

Fortunately, Professional Fee Protection offers a range of flexible, reliable and practical Tax Investigation Cost Protection policies to provide support and peace of mind. Clients benefit from an insurance of up to £75,000 towards accountant’s fees in the event of a tax investigation.

Professional Fee Protection can help with:
• Full Enquiries into all aspects of the Self-Assessment tax return.
• VAT Returns. Whether VAT has been operated correctly and over the amount of VAT due.
• PAYE & NIC Dispute over the accuracy or completeness of submitted returns.
• Aspect Enquiries into one or more aspects of the Self-Assessment tax return.

With PAYeMaster and TaxMaster policies from Professional Fee Protection, clients can find the right policy to suit their needs, and also enjoy comprehensive help including expert advice and administrative support to reduce the stress of the investigative process.

For more information call Professional Fee Protection on 0845 507 1177 or email info@ppfuk.com, www.ppfonline.com

Promoting Superior Treatment With The OPMI Pico

The Carl Zeiss OPMI Pico microscope was designed exclusively for use in dentistry. With 5 different magnification settings, the user enjoys stereoscopic vision, excellent contrast and depth orientation, in the best ergonomic posture.

3 months ago, Mr James Whitehead of House Dental Practice, Sussex, purchased an OPMI Pico. “It has made some dentistry much easier,” he says, “and some, much better.”

“Finding difficult canals is now much easier.” Mr Whitehead continues, “but the biggest change has been in irrigating canals. What I would previously have accepted as clean with my loupes had inevitably still got debris somewhere on the surface. With the OPMI Pico is it possible to see along and down each canal. I have therefore changed my irrigation technique for the better.”

He is full of praise for Nuview’s service. “The team could not have been more helpful integrating the OPMI Pico into my surgery, where it is now one of my proudest possessions.”

For more information on Nuview’s products, please call +44(0)1455 750650, email info@nuview-ltd.com or visit www.nuview-ltd.com

Free CPD with Oral-B

P&G Professional Oral Health (Oral-B) are inviting dental professionals to attend a complimentary CPD accredited evening seminar at various locations across the country. Brighton (The Grand, 19 Feb), Thame (The Oxford Belfry 25 Mar), Slingin (Arth Castle, 22 Apr) and Durham (the Radisson SAS, 7 May).

The guest speakers are Prof Iain Chapple and Dr Craig Barclay and the evening will be hosted by Dr Robert Thomas. Prof Iain Chapple, from Birmingham Dental School, will discuss the most important risk factors for periodontal disease and periodontal prognosis. He will provide evidence that a risk-based approach to care can improve tooth retention and manage the disease.

Follow on from Prof Chapple and exploring specific periodontal issues, Dr Barclay, from Manchester Dental School, will outline the increasing problems of implant maintenance. He will discuss some of the myths surrounding dental implant success and how to manage failure when it occurs.

Spaces at these events are limited and are allocated on a first come, first served basis, so if you would like to attend please contact Michelle Hurd on 07920 178179 or e-mail michelle@ab-communications.com.

Learn More from Sirona!

With the huge success of CEREC CAD/CAM, Sirona Dental Systems place a greater emphasis on training. With over 22,000 systems worldwide, Sirona have been able to place an even higher level of training with a blueprint of over 20 years in training CEREC users of all levels whether you are an experienced CEREC user or someone who has just taken delivery of their CEREC for the first time. Our training is designed to ensure new users gain confidence quickly whilst those more experienced users look to carry out more complicated cases.

The CEREC new user dates for 2009 are as follows: February 20th and 21st, March 20th and 21st, April 17th and 18th, June 19th and 20th, July 17th and 18th, August 14th and 15th, September 18th and 19th.

Numbers on these CDP Accredited courses are restricted so please book early to avoid disappointment. To reserve your place or further information please contact Sirona UK Ltd directly on 0845 071 5040 or e-mail mark.buckland@sironadental.co.uk or visit www.sironaeducationsolutions.co.uk

OPMI Pico

With PAYeMaster and TaxMaster policies from Professional Fee Protection, clients can find the right policy to suit their needs, and also enjoy comprehensive help including expert advice and administrative support to reduce the stress of the investigative process.

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The course starts from the basic principles of implants.

### BioHorizons’ year-long course

For those who have an interest in implants and new techniques, the BioHorizons course at the Tatum Clinic in Birmingham is definitely worth attending, says Neil Nathwani.

This one-year course is held once a month on a Saturday from January through to October and it is run by Dr Ben Aghabeigi and Dr Stephen Salt. Dr Ben Aghabeigi is an experienced consultant oral surgeon whose time is spent at Birmingham Hospital and in private practice (Tatum Clinic, Birmingham). He also has 20 years of dental implantology experience.

Dr Stephen Salt is a specialist prosthodontist who has 16 years’ of experience in dental implantology. His time is divided between Guy’s and St Thomas Hospital teaching duties and a private practice in London (Century Dental Clinic, Putney).

#### Fun while learning

Both tutors make the course fun, interactive and since the group is limited, one-to-one teaching is possible. The pair have a constant joking banter and debate of the different controversies in implants and they actively encourage discussion among the group.

The course tutors cover a core curriculum, but are receptive to the educational needs of participants and are flexible in their teaching methods. They provide a comprehensive, multidisciplinary introduction to oral implantology.

The course starts from basic principles of implants, which is ideal for those clinicians out there who want to start from the beginning and have only just recently qualified. Basic implant principles, treatment planning including CT scans, surgical techniques, restorative techniques and complications are all examples of the topics that are covered.

#### Hands-on learning

There are a number of interactive lectures, hands-on techniques, practicing on models: surgical skills of lifting flaps, suturing and placing implants in models to understand how the system works. Every month, live surgeries are demonstrated and course attendees are encouraged to take turns with assisting with surgical implant procedures.

The course aims to allow everyone to have an opportunity to treat their own patients, placing implants under the direct supervision of Dr Aghabeigi and Dr Salt (who are very calm and encouraging) which is an excellent place to start. The BioHorizons’ representatives, Chris, Janet and Sue are also very knowledgeable in discussing the system and explaining queries. The BioHorizons Implant system in particular is a very simple and safe system for beginners to use.

The entire course is well constructed, educational and worth the 70 hours of CPD and certificate received at the end. Knowledge from the course can definitely be applied in practice. The course has been a good experience; I feel I have been able to gain clinical knowledge and clinical skills in a vastly expanding field of dentistry. I would highly recommend the course and look forward to building on the solid foundation that the one year BioHorizons course has given me.

### Surgical & Restorative Implant Training

**The BioHorizons Year Course 2009**

**Tatum Clinic**

**Birmingham, England**

**10 Days, March-December**

Extensive training in the surgical and restorative aspects of dental implantology demonstrating the latest range of implant solutions by BioHorizons. The expertise of our tutors provides a multidisciplinary approach to oral implantology and a comprehensive introduction to dental implantology.

**Dr. Stephen Salt**

BDS, MDent (Rand)

A graduate of the Misch Institute with more than 10 years of experience in Oral Implantology, teaches restorative dentistry at Guy’s & St Thomas’s School of Dentistry and is the lead trainer in prosthetic aspects of Oral Implantology at the Tatum Institute.

**Dr. Ben Aghabeigi**

PhD, MSc, FDSRCS, FFDRCSI

More than 20 years of experience in teaching and clinical practice of dental implantology, a consultant / senior lecturer in Oral Surgery at the Birmingham Dental Hospital, the academic director of the Tatum Institute in Edgbaston, Birmingham, a graduate of the Misch Institute and fellow of the International College of Oral Implantologists.

**Course Format**

The participants will actively take part in treatment planning, surgical placement and restoration of implants for their patients under supervision of the specialist tutors. Case-based discussions, practical exercises and live demonstrations are included. Mentorship & coaching is available after the course to complete the learning experience.

**Venue**

This course will be conducted at the Tatum Clinic, a state of the art facility with its own lecture theatre and dedicated surgical suite with video link.

**Testimonial**

“Fantastic teaching in a fun yet informative way. Both of the lecturers strive for perfection in their treatment of patients, inspiring the class. The lecturers are always approachable. A great course!”

Dr. Matthew Nolan, Merivale Dental Practice

**For additional information:**

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The fee per delegate is £345 and qualifies for 6.5 hours CPD.

St Pierre, Chepstow, Monmouthshire ............................ 6 March 2009
Tudor Park, Maidstone, Kent ............................... 13 March 2009
Waltham Abbey, Essex ............................... 8 May 2009
Five Ways, Birmingham ............................... 15 May 2009

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Introducing the new 8cm scan height

Prices from **£72k+VAT**

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- **SAME** reliable flat panel technology and all the things that made the i-CAT the best CBCT scanner on the market.