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 insert 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 a toxic breakdown product of alcohol called acetaldehyde that may accumulate in the oral cavity.

Free service

Dentists are to get a free, confidential service giving them support and advice on physical and mental health issues.

The Practitioner Health Programme (PHP) which is also aimed at doctors, is initially being piloted in the London area. Dentists and doctors have high rates of mental health problems, especially addiction problems and depression. Doctors and dentists also find it difficult to ask for help and often their problem reaches crises levels before they feel able to seek help.

This new service and the first of its kind, will help dentists and doctors, particularly where their condition may be affecting their ability to work.

Judith Husband, vice chair of the British Dental Association (BDA), said: ‘It takes courage for health care workers suffering from an illness or an addiction to acknowledge that they have a problem in the first place, so taking the next step in accessing appropriate treatment can present real difficulties. We believe this dedicated, one-stop confidential service that has been designed specifically for health professionals, will make it much easier for dentists to get the support they need.

If it is successful, the service may be extended to other areas across the country.

For more information, see www.php.nhs.uk

New member

The Chief Dental Officer, Barry Cockroft has been invited to join the new strategic group that will oversee all medical education and training in England – Medical Education England (MEE).

The group was formed following recommendations by Sir John Tooke’s Inquiry into Modemising Medical Careers and was endorsed by Lord Darzi in his NHS Next Stage Review. MEE will coordinate a major restructuring of postgraduate training for dentists, doctors and other healthcare professions, and will also carry out national-level scrutiny of workforce planning and the commissioning of education and training by strategic health authorities.

More complaints

The Dental Complaints Service (DCS) logged 1,527 complaints in October and 158 complaints in November last year. For January and November 2008, the DCS logged 1,501 complaints, an increase of nine per cent over the same period in 2007. The average number of complaints logged since the DCS was launched in May 2006 is around 32 per week.

In the end, the total cost for the two cases was more than £80,000, with just over half coming from donations.

The BDA supported Dr Crouch’s case by sending a barrister to represent the dentistry profession in both of the hearings, but did not offer any financial support.

The orthodontist said: ‘Without the support of my colleagues, many of whom I have never met, and their encouragement this would never have been possible.

‘I can never repay that, and I hope they share this victory with me, which is the victory over draconian actions of a government against health care providers.’

Peter Ward, chief executive of the BDA, called it a case with ‘potentially far-reaching and devastating consequences for the profession’. He added that the DH needed to ‘send a clear signal of support to dentists by acknowledging and accepting the ruling’.

* See page seven for the exclusive interview.

For more information: Crouch’s case was go to www.molarltd.co.uk

www.dental-tribune.co.uk
Political gripes, dental dilemmas, guest comments, general feedback...
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In my opinion, the public are more likely to be misled by a PhD in Chemistry calling themselves ‘Dr’ than by a Dentist with a DDS or BDD qualification who is indeed a health professional of equal status to our medical colleagues.

This is nothing more than an age-old argument driven by ego-centric motives rather than the often purported ‘need to protect the public’. In my experience, the public are not as foolish as they are portrayed, and will not walk into my practice seeking a medical nomenclature treatment just because I use the title ‘Dr’. It is also NOT in my best interest to mislead potential clients in adverts or on my door sign because I just would not attract the business that I would be looking for, i.e. dental patients!

In summary, there really is no competition between the professions because we offer different parenteral services from each other therefore there is no need for petty rivalry.

Dr Mairosi

Mouthwash link with cancer

Dr Gregory, a former dental public health consultant for NHS Bedfordshire, 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 that you do, and this is a really fitting ending to a wonderful few months.’

M Matlabi

New president for the BSDHT

Marina Harris is to be the new president of the British Society of Dental Hygiene and Therapy.

Ms Harris trained in the RAF and qualified as a dental hygienist in 1984.

She works in the RAF Dental Department and qualified as a dental hygienist in 1984.

She has been working closely with Mike Wheeler, the former

Dr吉利 savage is awarded an OBE

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More Honours for the profession

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Editorial comment

The price of success

“... If at first you don’t succeed, 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 ‘champion 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 unsupported (think David and Goliath - First Samuel 17), it drained him emotionally 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, ‘Separately, the BDA had attempted 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 comes to achieving 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 issues’, and that the BDA for ‘various reasons’ chose never to pay any of the legal bills. Dental Tribune thinks he is being kind. In short the BDA paid him a big fat zero – what a generous, supportive Association we have. So as usual in situations like this, it is our true friends who have come up trumps. Dentists and orthodontists have dug pretty deep – and paid for almost half the costs.

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

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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.

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 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 at the proposed one part per million is a safe and 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 carries 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 Walmsey said: ‘The BDA bases 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 in a special meeting on February 26.
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The General Dental Council has appointed new members to its independent Appointments Committee - which monitors its Fitness to Practice Panel.

The role of the Appointments Committee is to oversee the training and performance of the General Dental Council (GDC)’s independent Fitness to Practice 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 Galsgow; Marcia Roberts, chief executive of the Recruitment and Employment Confederation; James Walker, independent assessor for the Office of the Commissioner for Public Appointments.

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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.

The case: Dr Eddie Crouch won the battle

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 confusion 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’.

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 were 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’.

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.

‘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 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.’

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 their large muscles of power’, concluded Dr Crouch.
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 as which 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.

On responding to complaints, presented by Bryan Harvey, deputy head of the DDU, there will 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 Kings College London will present sessions covering legal and ethical issues, presented by Rupert Hoppenbrouwers, head of the DDU.

On the courses cost £255 (one course) or £405 (both courses) for DDU members and £290 (one course) or £455 (both courses) for non-members. DCPS who hold DDU membership can attend free when accompanied by a full paying delegate.

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 verifiable 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 who turn commando

Dental professionals from the South West team at The Integrated Dental Holdings (IDH) turned commandos for the day and raised over £550 for charity.

The commandos completed the course in one hour and 15 minutes raising a total of £306.75 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!’

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KaVo. Dental Excellence.
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.

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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.

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.

To cash in or not to cash in?

Take action now
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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

The busy general practitioner is often faced with a difficult diagnostic dilemma when a patient presents with pain of pulpal origin that is not localised to a specific tooth. The pain can be generalised or sometimes even radiate to another quadrant. A systematic approach is essential in these cases so that the correct diagnosis is attained, thereby allowing the appropriate treatment to be executed. This avoids the embarrassment of providing treatment, but without alleviation of the symptoms.

The art and science of diagnosing a patient’s pain is an essential tool in the armamentarium of the general practitioner. A good understanding of the underlying biological processes is essential. Following a thorough history, the diagnosis can be made in a majority of cases. The clinical examination and special tests are then used to ascertain which tooth fits the diagnosis.

What is pain?
Pain is a protective mechanism to warn us when damage occurs in the tissues. A-delta fibre activation results in short sharp pain and may be activated in healthy and inflamed pulps. These fibres are peripherally placed and are the first activated. The deeper c-fibres are generally dormant and are only activated during health when a prolonged and intense stimulus is applied to a tooth. Stimulation of these fibres are associated with dull throbbing pain, but once inflammation has spread deep into the pulpal tissue, these fibres become sensitised to the point where pulse pressure or even body temperature can activate them. This is why occasionally a patient will present with severe pulpitis pain, which is relieved by holding ice against the tooth. The ice decreases the temperature below the required threshold and prevents the apparent spontaneous firing of the fibres.

It may come as a surprise, however, to learn that a large proportion of pulpitis cases are asymptomatic. However, when one considers the number of cases of apical periodontitis found on routine radiography where the patient has never been aware of symptoms this phenomenon becomes more apparent. The pulpal tissue has regressed from vitality through the inflammatory stages and has become necrosed and infected without the warning signs of pain. The exact reason for this is not fully understood, but recent research suggests there are local opioid systems present in the pulp, which could modulate the pain. There are also likely to be central mechanisms that prevent the pain registering in the cerebral cortex.

Making sense of tests
The limitations of the clinical tests need to be understood. Thermal and electrical tests stimulate the

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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 stimuli on an occasional basis. The patient was asymptomatic on the day of the appointment. The patient reported root canal treatment of LL7 was initiated around six months previously, which did not alleviate the symptoms. The sharp pain, which did not linger, was exacerbated when tea or other hot liquids were consumed in the area around LL7.

The radiographic examination confirmed the LL7 and UL5 to be root treated. A periapical radiograph suggested that there was no obvious pathosis associated with LL7 despite the overextended root filling. A bitewing radiograph revealed an overhanging distal amalgam restoration in UL5.

When the patient was given hot water to drink the symptoms were reproduced. The upper and lower teeth were individually isolated with rubber dam, and hot water was syringed onto each tooth in order to identify the source of the symptoms. In this instance there was no pain from the LL7 however the LL7 exhibited painful symptoms on contact with the hot water. This was confirmed by giving a buccal infiltration of 2.2ml two per cent lignospan and adrenaline 1:80,000 around the UL7 and re-challenging the left hand side with hot water. Following a negative response to this test the amalgam was removed on LL7 and a crack was identified on the distal aspect of the tooth extending towards the centre (figure 5). The crack was stained with methylene blue to aid identification and examined under microscopical visualisation. Azine oxide eugenol filling and an orthodontic band were placed which alleviated the symptoms.

However, two months later the patient reported spontaneous short sharp pain on the LHS. Pain on heat stimulation had also returned now localised to UL7. The UL7 was tender to percussion and had lingering pain following sensitivity testing with cold and the electric pulp tester.

A diagnosis of Cracked-tooth syndrome with development of irreversible pulpitis and acute apical periodontitis associated with the UL7 was made.

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 pulpitis 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 pre-prescribe antibiotics in our practice.

Carrying out treatment

Consent was obtained and root canal treatment was initiated on UL7. 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 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 encountered in the pulp chamber and a pulpotomy was performed. A pulpotomy alone will relieve over 90 per cent of the symptoms of irreversible pulpitis. 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 UL7 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 does not 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 the 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 anti-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 begin 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 mediators 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 derive pulp tissue. Thus it can be seen that not only is it difficult to detect and correctly diagnose cracks but the treatment can also pose difficulties.

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Some clinicians elect to place composite restorations.
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 transported 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...
final preparation not have entirely narrowing cross-sectional diameters or might not allow a tapering funnel across its entire length.

In addition, it is important to know if an obstruction is present and if so, where and whether or not it can be bypassed or irritated away. For example, if a plug of dentin debris is present near the MC, it can be bypassed or irritated away. Will its presence create the potential for its being extruded from the MC into the periapical tissues with coincident extrusion of irrigants apically? In essence, will this debris have an effect on the clinician’s ability to create a final prepared diameter of choice without restriction?

If the tooth has suffered trauma and is the apex open to any appreciable degree? Open apices represent challenging clinical entities that are best managed under a SOM and in the hands of a specialist.

The above notwithstanding, in my empirical opinion, the primary and single most important determinant of the ideal final prepared diameter is the initial untouched diameter of the MC at the apical foramen. A knowledge of this initial diameter of the MC can alert the clinician to the biologically relevant (i.e. relevant to the particular canal) final diameter of the preparation. The other factors of course are important, but if the initial diameter of the MC is not determined, it is challenging to know what diameters must be shaped into the canal system to create a tapering funnel along the entire length of the canal system.

Ideally, before starting, the canal system can be mapped with multiple digital pictures. These digital radiographs taken ideally from three angles – mesial, distal and straight on—can tip the clinician off to both what the final prepared diameter and taper might be in advance of starting the case. This said, caution is advised, the tactile sensation in a moderate to severe three-dimensional curvature can alert the clinician to the dangers of root perforation, potential file separation, and other iatrogenic potentials if one arbitrarily makes a decision as to the final prepared diameter without taking into account the tactile information that the canal gives the clinician as well as the visual information which might be gained from working under a surgical operating microscope (SOM) such as the Global SOM (Global Surgical, St. Louis, MO), and the digital images.

Shaped acute curvatures in the apical third can easily fracture a RNT file due to torque related or cyclic fatigue failure. In clinical cases, the initial estimated diameter of the final prepared diameter might and often does change. In the most general terms, the greater the width of root thickness present circumferentially, the larger the taper and tip size of the final prepared canal. The more complex the canal system with regard to calcification and curvature, the smaller the taper that will needed to be employed with the caveat that the final prepared apical diameter of the canal, determined by gauging irrespective of the calcification and curvature (Figs. 2, 5).

From the digital pictures, before starting the clinician can determine an estimated working length (EWL). Ultimately, when the clinician first reaches the EWL with a hand or rotary nickel titanium file, the exact position of the MC can be determined with an apex locator. After thorough preparation of the canal, if the TWL is taken, the MC gauged and final preparation can be carried out.

Gauging is simple, effective and provides a clinically relevant diameter upon which to base the final prepared diameter. Gauging is best described by example. In a given tooth, if the MC gauges to a 25 (a hand 0.02 tapered file resists displacement at the MC) the clinician can instrument the canal to a 40–50 or larger as needed at the apex. Enlarging the canal to the MC at this diameter assures the clinician that the entire canal space is circumferentially enlarged to the level of the MC.

Enlarging canals safely and efficiently in complex cases with such calcification and curvature is beyond the scope of this article. However, I say that in my empirical opinion, it is possible to enlarge canals safely and efficiently with K3 files alone (SybronEndo, Orange, CA) for the totality of the canal space from the orifice to the MC and in doing so create larger apical diameters. K3 represents a complete system in that it is available in three tapers 0.12, 0.10 and 0.08 for the orifice shapers, and 0.02, 0.04 and 0.06 for the canal shaping files in tip sizes that range among these tapers from 15–60. K3 is durable, very flexible, resists fracture, cuts extremely well, and has a delicate tactile control. It is also possible, clinician dependent, to use Lightspeed files (Discus Dental, Culver City, CA) for the apical third shaping in combination with K3 in what might be considered a hybrid technique. Lightspeed can, in essence, be used as an apical finishing file. While K5 alone is certainly capable of instrumenting canals to larger apical diameters, Lightspeed, if desired by personal preference, as an adjunct to K5, can act as an apical enlarging instrument after the K5 has been taken to the TWL (Fig. 4).

Alternatively, some clinicians arbitrarily finish all canals to a particular apical diameter without taking into account the pre-existing diameter of the apical foramen or other anatomical considerations. Such clinicians essentially ignore the relevant literature that shows what canals enlarged to a larger apical diameter provide a cleaner canal. Most often, these clinicians regard the entire concept of enhanced apical preparation as irrelevant. Clinically, this is manifested as a case where the tooth is taken to a 0.08 25 or 50 arbitrarily or such tip sizes in a 0.04 taper. These clinicians do not gauge the apex and the clinician imposes an arbitrary master apical diameter onto the canal that has nothing to do with the given anatomy of the tooth in the apical third. While this approach can work in some cases, over the broadest spectrum of anatomy, this creates the possibility and virtual certainty of leaving uncleaned and unfilled space within the canal and iatrogenic events. It would be hit or miss if the chosen prepared diameter had any relevance for the apical third of the root. For me, I say that if a canal is prepared to a 0.06 taper and 20 tip size and in fact, the MC is a 25 or larger the apical third of the root will not be instrumented circumferentially and the clinician will be relying heavily on irrigation for apical third cleansing. Traditionally, the literature shows conclusively that the apical third has been the most challenging to irrigate predictably. Alternately, if the canal gauges to a 20 apically and the clinician arbitrarily takes the canal to a 35 or other arbitrary master width, the clinician could easily risk iatrogenic potential if the exact location of the MC is not determined and subsequently respected especially if the RNT file were to be extended beyond the MC.

2. How do you get around curved canals?

Negotiating curved canal spaces is a function of blending many strategies and concepts that cumulatively respect the anatomy of the original canal space while only enlarging it in three dimensions. Clinically, these various components require that they be juggled simultaneously. For example, as the clinician moves down a curved and restricted canal space they must simultaneously assure that they have lubricated, irrigated and negotiated the canal space correctly before trying to enlarge it to any significant degree while applying the correct amount of apical lateral pressure to avoid the creation of a ledge or plug of debris ahead of the RNT file among other possible iatrogenic events. The
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 viscus EDTA gel like File-EZE (Ultradent, South Jordan, UT), the clinician can take a precurved hand file (optimally curved with an Endo-Bender pliers, 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 canal instrumentation, if possible hand files and in the presence of a viscus EDTA gel like File-EZE, (Ultradent, South Jordan, UT), the clinician can take a precurved hand file (optimally curved with an Endo-Bender pliers, 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.

I do not use 25mm files for negotiation unless the tooth is more than 21mm long, I use 21mm hand K files for negotiation almost exclusively except as noted above. In some fine and narrow curved roots, hand files are required that might be slightly shorter and stiffer than the 21mm variety. In this case, I will take a 21mm #6, 8 or 10 file, and case dependent, clip the end of the hand file to create a slightly shorter instrument that is stiffer than its original length. The shorter file is usually sharp and stiff enough to get through blockages of debris that might accumulate regardless of how careful the clinician is in negotiation. Alternatively, the clinician can use a Pathfinder CS (carbon steel) file that gives the same type of stiffness to reach though blockages and negotiation fine canal spaces. The pathfinder or any small hand K file for that matter (#6–10) can be placed into a M4 safety hand-piece used to gain an initial diameter in a narrow and restricted canal easily and efficiently if used correctly. The hand file, whether a #6, 8 or 10 is placed in the M4 to the level of the estimated working length and at 900 RPM and with the TCM HP or ELECTROtorque TLE (Kavo, Lake Zurich, IL), the clockwise, counterclockwise enlargement of the M4 can provide a rapid and safe minimal initial enlargement which reduces hand fatigue and saves time before the placement of RNT (Figs. 5, 6). (All SybronEndo, Orange, CA)

Finally, negotiation of curvatures in roots is a function of using the correct sequence of instruments, which for me is done with K5 RNT files in a crown down manner, from larger tapered and tip sizes to smaller beyond the particular clinical indication.

Literature

Dr Mounce does not have a commercial interest in any of the products mentioned in this paper.

About the author
Dr Richard Mounce lectures globally and is widely published. He is in private practice in endodontics in Vancouver, WA. Among other appointments, he is the endodontic consultant for the Beloas National Hospital Dental Clinic in the Republic of Palau, Koror, Palau (Micronesia). He can be reached at: RichardMounce@MounceEndo.com
Endodontic success and working length: thinking 5-dimensionally

By E. Steve Senia, DDS, MS, BS

In 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 reasonable. The description: WL is the canal's preinstrumented diameter, adjacent and coronal to the apical constriction. Fig. 1, I like this term very much, because it is a valuable reminder that canals are three-dimensional. 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 these reasons and gain a 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 terminate.1 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 issue appeared to be resolved. Unfortunately, WL is once again embroiled in controversy.

Our forefathers concluded that instrumentation should end at the cementoenamel junction (CEJ) (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 that I'm against passing a patency file past the CEJ or even slightly beyond the foramen. However, remember that this area is very narrow—2 to 4 times the radius squared. This means that a #15 (.05 mm) patency file's tip occupies roughly 5 percent of the average foramen's cross-sectional area (0.00 mm2) and only 21 percent of the average constriction's area (0.00 mm2).

I suspect patency files are used more for warning of an impending ledge than for maintaining patency. The ledges are the likelyhood of a patency file lacering 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 anatomically acceptable approach. In necrotic cases it would likely push infected material into the foramen 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 states that a root canal's length is: 'a passage or channel in the root of a tooth extending from the pulp chamber to the apical foramen.'1 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 apicocentric point.'2 The last word, apex, is very important. If the CDJ can be as much as 3 mm from the apex, it means that the apex is not a precise reference point for WL determination and should not be used. Clearly, apex and foramen 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 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 usually is not at the apex.3

Gutierrez and Aguayo1 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 firm reference point, we can really narrow down the best locations for WL. I purposely use the plural 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 1.0 mm short of the foramen whereas you think it should be 1.0 mm short of it. Could that say my choice is correct, whereas yours isn’t and your treatment will fail? Of course not!

Body’s defenses

Let’s say that 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—what is the WL? Is it apical to the gutta-percha cornered with no place to run. They 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 ‘length? Same answer, the bacteria are attacked and destroyed by the PMN—the major circulating cell in the immune system, whose function is to kill bacteria. (In fact, when the body encounters infection, the production of PMN increases ten-fold.) 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 WW is not (Fig. 2d). There is a dramatic difference between what happens to the bacteria in a patent file-lacerating case and any remaining debris is cleaned up by the macrophages. (In fact, when the body encounters infection, the production of PMN increases ten-fold.) 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 that 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?

Apex locator is a poor name, and the manufacturers should call them what they are—foramen (or apical) locators. I recommend we use electronic foramen locator (EFL) and get rid of the term apex locator from here on.

During my teaching years, we evaluated radiography: ‘dead-on’ the apex, obliteration. 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 students of this fact (and proved it during their training in retreatment, each tool reaching through the constriction to or slightly beyond the foramen and obliterating to that point for 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 ‘hells, lights or whistles’ tells you the tip is at the apex, isn’t this incorrect? Because 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 burs, lights or whis- tles 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 specific systems. A little practice and careful observa- tions 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 ‘aestheticodontic’ contests. In our lectures and writings we could show X-rays of cases that appear ‘short’ but are not with- out 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 LightSpeed™ instruments (Dis- cus 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 diam- eter of WL. The key is to ad- vance 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 tech- nique) 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, destroying the con- striction where the stop is located (the WL) is not recommended. The apical stop confines our feels to the WL and helps minimise the incidence of over-fills.

Notice the length marking rings on the shank of the LSX (Figs. 3b, 3c). 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 as- sistant 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 successfully when everything else is done correctly. WL need not be perfect for a success- ful outcome (biologic tolerance). However, the tolerance for an inaccu- rate WW is not so generous. Avoid the temptation of indulging in ‘aestheticodontic’ contests. The endodontic community should agree to a WL that ranges 0.5 mm to 1.00 mm from the foramen (not apex) and move on to more im- portant issues.

I recommend all manufactur- ers use the term electronic fora- men locator (EFL) rather than apex locators to describe these de- vices. EFL manufacturers should eliminate ambiguous markings on their devices and simply pin- point only the foramen. Dentists would then ‘do their math’ before choosing a termination point that is either 0.5 mm or 1.0 mm short of that location. And finally, em- phasis should be placed on clean- ing the main canal as well as poss- ible (correct WW) close to the constriction/CDJ. Doing so closes the door, prevents bacte- ria/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. Se- nia, BSIE, MBA, for his valuable contribution to this article.

References


About the author

Dr. E. Steve Senia
earned a DDS degree from Mar- quette University in 1965. He re- entered the Air Force (previously served as a pilot) and completed a GPR Residency. In 1969, he re- ceived a MS and Certificate in En- dodontics from The Ohio State Uni- versity. He served in the Air Force and retired in 1984 as a Colonel Chairman of Endodontics at Lack- land AFB, Texas. He then became Professor and Director of the En- dodontic Postdoctoral Program at the University of Texas Dental School at San Antonio. He retired in 1992. Dr. Senia is a Diplomate of the American Board of Endodontics. He is a former member of the Editorial Board and the Scientific Advis- ory Panel of the Journal of En- dodontics, 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 instrumen- tation and SimpliFIl® obturation systems. You may contact Dr. Senia at DrSteveSenia@aol.com.
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 often 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 drop-off 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 service you offer. Asking how to improve the level of service to this doctor’s patients will create a discussion that helps 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).

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 by RAND from April to July 2007 demonstrate that there has been a reduction in approximately 45% of adult courses of treatment that contain a root-filling episode from 2003/04 to 2007 and an increase in the number of courses in the simple treatment band. This is a direct quote from a British Endodontic Society memorandum, (OS 05) to the House of Commons health committee a year ago, while the Department of Health (DH) reported 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 six 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 treatments 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 a reduction in the simple treatment band analysis. 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?

Predictable Endo for the General Dental Practitioner

smartseal are delighted to announce dates for their popular evening seminars. The events will be hosted by Jerry Watson BDS, a practising GDP from Lincolnshire.

Aim of the course

To provide course participants with the necessary knowledge and skills to be able to implement the smartseal endodontic system in their practice.

Course objectives

By the end of the course participants should:

- have an understanding of the science behind the smartseal system
- have knowledge of the polymer plastics used in the system
- have the necessary skills to be able to use the smartseal system
- understand the nature of the material and its uses
- be able to interpret x-rays where a smartseal endodontic treatment has been used.

Format of the evening

6.30pm light buffet/networking with colleagues
7.00pm overview of the system, science behind the material and how it works
hands on session using endo blocks, allowing delegates to see exactly how the smartseal system works and get a feel for using it
9.00pm close

Dates and venues

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<td>19 Mar 2009</td>
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<td>Marriott Hotel</td>
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Delegate rates: £65 - dentists, accompanying nurse free of charge*

* Be able to interpret x-rays where a smartseal endodontic treatment has been used.

About the speaker:

Jerry Watson is a general dental practitioner based in Stamford. He 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.
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.

Temporary tends 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.

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**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.

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.

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 rendered patient animations 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 much 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 require more information seek out the sleek new kiosks, desktop or wall-mounted systems. In fact, you might feel a little bit like a Stones (if you’re in the mood for music).
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 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.

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
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- Patient assessment and clinical examination
- Introduction to paediatric sedation
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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 Victoria Banks, Course Administrator, on 020 7985 1251, email v.banks@eastman.ucl.ac.uk or visit www.eastman.ucl.ac.uk/cpd

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UCL Eastman Dental Institute

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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 Peristat® 20 mg film-coated tablets (doxycycline) in the UK to meet the need for a proven adjunctive therapy.
tions of water or antiseptic mouth rinse flush out the bacte-
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The University of Buffalo carried out a study using the Waterpik®Dental Water Jet plus the Pik Pocket™ Subgingival Irrigation Tip with 0.06% chloro-
hexidine. It proved to be 87% more effective in reducing bleeding around the implants than the traditional rinsing method (0.12%).

Waterpik® Dental Water Jets are now widely available in Boots stores or speak to your dental wholesaler for your pro-
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British Orthodontic Society welcomes an Independent Review of NHS Dentistry

The British Orthodontic So-
ciety (BOS) has welcomed an Independent Review of NHS dentistry following the adverse comments from the Health Se-
lct 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 pri-
mary and secondary care who were given such a poor report from the HSC. There is a high turnover of managers in dental commi-
isioning, who need help to understand the complexities of dental and orthodontic con-
tacts, to ensure the highest numbers of patients get the treatments they deserve”

Background information

The British Orthodontic So-
ciety represents the interests of specialist orthodontists in pri-
mary care, secondary care, the university teachers, community orthodontists and dentists with a special interest (DWSs) in ortho-
dontics 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 ethi-
cal standards, the BOS and its members aim to increase under-
standing of orthodontics and the benefits offered by treat-
ment.
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 Jet speak to your dental wholesaler or 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!

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Dental Practice Consultancy Service (DPCS) has been successfully selling dental practices since 1990. Utilising their tried and tested 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.

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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 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 and found it even in contact with the teeth and gums.

The TePe G2’s new soft, flexible tip is design-protected. 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 and found it even 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 716922 or email info@molarltd.co.uk.

Practice Plan Help Tanzania
practiceplan has been raising funds since 2008 to support the work of the UK registered charity Bridge2Aid (B2A) who help those in desperate need of dental treatment in North West Tanzania. Funds were also raised to enable a team of practiceplan members to travel to Tanzania and refurbish a dormitory block in Bukumini.

In order to raise money for his Tanzania trip, practiceplan em- ployees agreed to spend over 20 hours in the saddle. He set himself the challenge of mountain biking from Offa’s Peak, South Wales to the end of Olfa’s Peak, North Wales in just three days! After this tough, but rewarding challenge, Jamie raised £500 and is set to do it all again.

With no access to a dentist, Tanzanians suffer the daily agony of severe toothache. B2A is solely reliant on the generosity of hundreds of thousands of people each year through treatment and training programmes, which sees UK qualified dentists teaching Tanzanians basic dentistry.

To find out more about practiceplan’s fundraising activi- ties 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

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 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.”

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The CEREC new user dates for 2009 are as follows: February 20th and 21st, Manchester (Holiday Inn Manchester), 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 disappoint- ment. To reserve your place on further information please con- tact Sirona UK Ltd directly on 0845 071 5040 or e-mail mark.buckland@sirona-uk.com or visit www.sironaacademysolutions.co.uk.

The guest speakers are Prof- lain Chapple and Dr Craig Barclay and the evening will be hosted by Dental Journal of Chap- ple, from Birmingham Dental School, will discuss the most im- portant risk factors for periodont- itis and how such risk indicators may affect periodontal disease and periodontal prognosis. He will pro- vide evidence that a risk-based ap- proach to care can improve tooth retention long-term and will demonstrate the use of the first val- idated online periodontal risk and disease calculator to become avail- able.

Following on from Prof Chap- ple and exploring specific peri- odontal issues, Dr Barclay, from Manchester Dental School, will outline the increasing problems of implant maintenance. He will dis- cuss some of the myths surrounding dental implant success and how to manage failure when it occurs.

Spaces at these events are lim- ited and are allocated on a first come, first served basis, so if you would like to book a place contact Michelle Hurden on 07920- 178179 or e-mail michelle@ ab-communications.com.

Learn More from Sirona!
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.
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