Chief dental officer awarded CBE

New Year’s Honours List sees both CDO and former GDC president named

The chief dental officer for England and the GDC’s former president were both awarded CBEs in the New Year Honours List. CDO Barry Cockcroft received a CBE for his contribution to dentistry and public health in Britain.

Prior to joining the Department of Health, Dr Cockcroft, chief dental officer since June 2006, worked as a NHS general practitioner for 27 years.

He commissioned Prof Steele to carry out the Steele Report, an independent review of NHS dentistry, following the House of Commons Select Committee review of the new contract.

Dr Cockcroft is currently working on behalf of the government to carry out the recommendations of the report.

Former President of the General Dental Council’s (GDC) New Mathewsson was awarded a CBE in the New Year’s Honours list for his services to healthcare.

Mr Mathewsson has been a member of the GDC since 1996 and was president from 2003 until September 2009 when he became the Council’s first ever chair. He handed over to Alison Lockyer in January 2010.

Ms Lockyer said: “No one could have done more for the GDC than Hew over the six years he was in the chair. We’re indebted to him for his assiduous efforts. This award is really well deserved.”

Interim chief executive, Alison White, called his commitment to improving protection for patients ‘unwavering’ and said: “I’d like to take this opportunity to congratulate Hew most warmly. This CBE recognises all of his hard work and achievements at the General Dental Council.”

She added: “We are absolutely delighted to see his dedication to healthcare is being recognised by this honour.”

Janet Clarke, former chair of the Central Committee for Community and Public Health Dentistry, of the BDA and member of the Steele Review, was also honoured with an MBE.

MBEs were also given to Donna Hough, dental workforce development lead for DCNs, North Western and Mersey Postgraduate Deanseries and Laura Mitchell, consultant orthodontist and clinical lead at St Luke’s Hospital Bradford Teaching Hospitals NHS Foundation Trust.

Mrs Mitchell has worked at the hospital since 1995 and last year co-wrote the Oxford Handbook of Clinical Dentistry with her husband. The book has been translated into nine different languages, selling more than 100,000 copies.

Angus Robertson, principal fellow in clinical illustration, Leeds Dental Institute, was also awarded an MBE. Mr Robertson has been a practising clinical photographer for more than 56 years. He has specialised in dental photography since he took up a position as head of medical and dental illustration at the Leeds Dental Institute in 1985.

A spokesman for the Institute of Medical Illustrators said: ‘His dedicated contribution to the medical illustration profession has been great and this was recognised when in 1995, 1MI awarded him his most prestigious award, the Norman K. Harrison Gold Medal. Our sincerest congratulations go to both Angus and his family for this well deserved award.”

The British Dental Association in Northern Ireland has received a public apology after a government body released inaccurate figures inflating the incomes of NHS dental practices.

The figures were given to the Belfast Telegraph by the Business Services Organisation following a freedom of information request. The British Dental Association (BDA) claimed that the figures reported by the Belfast Telegraph in December were wrong in six out of 20 cases, and overstated dental practice turnovers on the health service by up to 73 per cent.

The Belfast Telegraph reported that three practices in Northern Ireland received more than £1m last year from the Department of Health. The BDA said that releasing this incorrect information damaged the reputation of these dentists and their practices.

Claudette Christie, BDA director for Northern Ireland, said: “This has caused personal distress directly to a number of hardworking dentists and to the wider profession. You will notice in the issues to come that I will be talking a great deal about Bridge2Aid and its work in the village of Bukumbi in Tanzania. This is because Dental Tribune, and particularly myself now have a vested interest in the work as I will be travelling out there in April with colleagues from Schülke and Henry Schein to help build a community centre at the Bukumbi Care Centre. This vital project is the perfect opportunity for us non-clinical folk to help Bridge2Aid’s work.

Anyone who wishes to donate funds to this worthy cause is welcome to do so at www.justgiving.com/bukumbibound my dedicated fundraising page for this trip. A special thanks already goes to Smile-on and Practice Plan who have supported me; and I hope DT readers will get behind me as well. Just think what £1 from every reader could do to the lives of ordinary Tanzanians!

**BDA NI gets public apology**

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Claudette Christie, BDA director for Northern Ireland, said: “This has caused personal distress directly to a number of hardworking dentists and to the wider profession.”

She added: “Dentists across Northern Ireland are at the heart of their communities, working hard to care for their patients. They devote their professional lives to building relationships with their patients that enable them to provide the best possible standards of care for each individual. To have those relationships swept away by the failure of a government agency to quality assure its figures is devastating.”
Smile-on reaches the big 1-0

Education and training provider, Smile-on, has been creating, as January 2010 saw the company enter its 10th year. Smile-on provides education and training solutions that are flexible and inspirational for everyone in the dental profession.

A spokeswoman for Smile-on said: ‘The company’s key values of partnership, imagination, innovation, creativity and potential have helped evolve the products from simple training courses into the multi-media learning platforms of today. Smile-on has become the source for cutting edge software and training resources.”

After the success of last year’s Clinical Innovation Conference, Smile-on will be offering dental professionals yet another outstanding conference for 2010 - May 7-8 at the Royal College of Physicians in Regent’s Park, London.

Delegates will be able to gain an insight into new technologies, materials and ground-breaking techniques in dentistry.

International speakers will be delivering inspirational speeches alongside exhibitors offering the latest dental technologies from all over the globe.

Smile-on has announced that this year they will be working in conjunction with the Anglo-Asian Odontological Group (AOG) and will be sponsored by the Dental Directory.

For more information call 020 7400 8989 or email info@smile-on.com or to become a CIC sponsor visit www.clinicalinnovations.co.uk.

Help at last for dental entrepreneurs

Dental entrepreneurs can now turn their dental inventions into a business opportunity with the support of the first dental business incubator company.

Dental companies spend millions on the research and development of new products, with Nóbels Inc., one of the biggest spenders in the dental industry spending about 4-5 per cent of its annual turnover on research and development.

However there are thousands of ideas developed by individual dentists that will never be implemented because their inventors lack the funds or expertise to market their ideas or are downsized by shrinking research and development budgets in difficult economic times.

These individuals can now turn to Dentucubator, the first dentistry incubating network.

The programme helps entrepreneurial companies through support resources and services, such as legal help, funding prototypes and finding distribution channels.

Dentucubator was founded last year in America from a loose network of renowned dental specialists around the globe and so far the programme has evaluated 48 submissions and it aims to support as many as 80 over the course of the next five years.

Dentucubator is a virtual entity, which means that its members meet by phone, e-mail or through webinars.

Once an idea is submitted through one of the committees, it undergoes a four-week screening process to evaluate its marketing potential.

Special emphasis is placed on the ability to re-design a product for emerging markets such as Asia or Latin America.

“By testing each submission for its applicability to emerging markets country, we have the opportunity to offer the products and techniques associated with outstanding oral health care to a broader audience than the typical markets of Western Europe, Japan or the United States,” said a Dentucubator representative.

The network provides its services with compensation taken in equity in the ownership of the idea, once the idea has been approved for funding.

The process typically takes up to three months to be completed.

Once Dentucubator becomes an equity partner and develops and protects the idea, discussions are initiated with the directtors of acquisition or research and development departments of global dental companies.

A recent study found that incubating programmes which support start-up companies to develop new products enable nearly 90 per cent to stay in business for the long-term.

Dentucubator sees itself as a complement to traditional research and development and as an alternative source for funding, development and access to market resources.

“We are under no circumstances in the business of replacing research and development budgets. We are the nursery which nurtures the small seed of an idea, grows it and then brings it to market,” the representative said.

British Dental Conference

The respected clinical expert, Dr Avijit Banerjee, is to join the panel of speakers at the 2010 British Dental Conference and Exhibition.

The conference and exhibition will be held 20-22 May 2010 at the Liverpool Arena and Convention Centre (ACC).

Dr Banerjee, senior lecturer and honorary consultant in restorative dentistry at King’s College London (KCL) Dental Institute at Guy’s Hospital will be delivering a presentation entitled ‘Revolutions in caries management - minimal invasive dentistry in practice.’

The presentation includes: ‘The methods for monitoring patients with a high risk of developing caries’ ‘Understanding the pathology of caries’ ‘How to bond to caries - affected dentine and the therapeutic effects’

Dr Banerjee has carried out extensive clinical research into cariology, caries removal techniques, microbiology and microscopic imaging of dental caries. He also won 2009 Kings College London Teacher of the Year Award.

A spokeswoman for the conference said: ‘His passion for translating scientific research into clinical practice will ensure that his guidance will feature the latest clinical findings, delivered in a manner relevant to today’s GDPs.’

For more information on the conference and exhibition, register on www.bda.org/conference or call 0870 168 6625.
The British Dental Association has been shortlisted as one of this year’s Business Superbrands.

An independent panel of experts from The Centre for Brand Analysis, along with 1,500 individual business professionals, examined thousands of applications, before selecting only 500 ‘Superbrands’.

In order to qualify as a Business Superbrand, an organisation has to have established the finest reputation in its field, and offer customers significant emotional and/or tangible advantages over its competitors.

The brand has to display that it represents quality products and services, can deliver a consistent and reliable customer service and be distinctly unique within its market.

A spokeswoman for the BDA said: “Being nominated as a Business Superbrand is testament to the determined efforts made by the BDA team to ensure that it continues to offer members advice, support and improve the nation’s oral health.”

Transitions: Dental Protection launches event for Scottish dentists

Dental Protection is pleased to announce a brand new event called Transitions which will be staged in Scotland this April.

The full-day event is scheduled for Saturday April 17 in Cumbernauld near Glasgow. The programme is suitable for dentists at all stages of their career and will provide keynote lectures on the recommended CPD topics, complaint handling and ethics.

The programme will feature three renowned speakers, Hugh Harvie, Kevin Lewis and James Foster who will explore complaints and ethical dilemmas based on actual cases drawn from Dental Protection’s extensive archive.

The day will also include an interactive workshop session, which will demonstrate problems which any dentist might encounter at some time in their career, and will examine the issues which could effect the way in which dentist handles the situation. Sessions on law and ethics and complaint handling will explore the role of communication skills in effective complaint handling.

Describing the event, Hugh Harvie, Head of Dental Services Scotland said: “DPL is pleased to launch an exciting new event for the benefit of our members in Scotland. The programme will address the recommended CPD needs of all dentists, and will serve as a useful introduction, or a reminder, to dentists regardless of what stage they may have reached in their career.”

Tickets for the event cost £75 (£50 for VDPs and DPL Xtra members) and will provide 5.5 hours verifiable CPD.

Delegates are advised to register their interest in the DPL programme early to avoid disappointment.

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Original Ideas

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Friday 7th and Saturday 8th May

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Credit Crunch Clinic
Dentists drop price of dental implants & increase sales

One dentist who has been able to drop his prices by 30% after switching to DIO implants is Dr. David Fairclough, who's prime interests are dental implants and cosmetic dentistry. He believes that using implants of this kind could lead to them becoming cheaper for patients across Britain, currently one of the most expensive places in Europe for dental implants.

In a recent interview Dr. Fairclough said, “There is no reason why it can’t be as cheap here as it is abroad, when you factor in travel and accommodation expenses. The savings I am making have meant that I’ve been able to reduce my prices by 30%, so it has made a huge difference. It means that those people who are thinking about going abroad for implants may consider staying in Britain and those who thought they couldn’t afford implants can now consider it an option.”

Dr. Fairclough was initially drawn to DIO by their lower prices, however he changed suppliers when he found that their implants were easier to place as well as achieving more aesthetically pleasing results than implants he had used previously.

Dr Fairclough said, “I’ve been doing dental implants for over 20 years now and I’ve tried most systems. When I came across DIO’s system it seemed to be the easiest to use at an affordable price. The implants are very easy to place and they have very good primary stability which is important.”

This increased primary stability comes from the multi-platform design and double-threaded head which offers high stability in low bone density. Alongside this, the stability offered by the root form design reduces the possibility of interference with other teeth.

“One of my big criticisms of implant companies is that they sell you the implants and then you get very little from them again. There’s poor back-up. This hasn’t been the case with DIO.”

DIO UK aims to assist all of its dentists during the integration stages in understanding the implant system. Rather than hosting clinical days attended by large numbers of dentists, DIO involves new clients in live implant placements alongside an existing user, often without a DIO representative being present. This allows the session to be very open between the two dentists meaning they are free to discuss the implants candidly. It also means that the dentist new to the system benefits from one-on-one tutoring.

“The back-up service I have been given has been invaluable.” said Dr Faiclough, “One of my big criticisms of implant companies is that they sell you the implants and then you get very little from them again. There’s poor back-up. This hasn’t been the case with DIO.”

Dr David Fairclough BDS(Lond.) LDS RCS (Eng.), Circus House, Bennett Street, Bath

DIO Implant of South Korea is now operating in the UK after recently identifying a gap in the UK market. DIO UK is offering dental implants at prices less than half that of the most established of UK brands (e.g. DIO grade-4 titanium RBM fixtures for under £98.00). DIO Implant has been around for over 25 years and is one of the largest implant manufacturers in Asia.
Nationwide mobile dental practice launched

The first nationwide mobile dental practice has been launched in the UK. DentalXpress hopes to improve access to dental care with its fleet of multi-clinic room portable dental units.

The idea is that in areas where a dental practice is needed, DentalXpress will be able to plug the gap with one of its mobile units.

DentalXpress spokesman Amarjit Gill said: “The population of the UK is projected to rise to 67m by 2051 and as NHS dentistry budgets decline, there is going to be even greater pressure on already limited resources, as funding is further stretched. Primary Care Trusts are constantly looking for innovative solutions and don’t want to invest in fixed practices at a cost of £500,000 to £750,000 if the demand for dentistry does not materialise.”

Data from the NHS Information Centre released recently shows that only 58.3 per cent of the population saw an NHS dentist in the two years ending March 2009.

The government said in May this year we aim to ensure that everyone who wants to see an NHS dentist can by March 2011. However the same data source showed that last year nearly 50 per cent of NHS dentists did not take on any new patients.

NHS Leicestershire County and Rutland is the first Primary Care Trust in the country to introduce the service and DentalXpress is currently in discussions with six further PCTs to launch similar services in their areas.

Leicestershire is opening the first DentalXpress practice in the Syston area of the county and aims to provide NHS dental care for 400 people a month.

DentalXpress is a social enterprise with an ethical principle to deliver lasting social change.

It has pledged to reinvest 75 per cent of any profits it makes delivering NHS dentistry back into expanding its service and is currently exploring ways it can expand its provision to serve schools, the armed forces, domiciliary care homes for the elderly, universities and the homeless.

The mobile units offer all the amenities expected in a normal bricks and mortar practice; they have a reception area, four interconnecting treatment rooms, a disabled toilet and a staff room.

Wherever possible all the dental instruments used will be disposable.

The organisation’s logistical expert will carry out an assessment of each location; the size of the space required to accommodate the mobile unit as well as access roads, power, drainage and so on.

Each unit will be staffed by two to three dentists and three dental nurses and served by one receptionist who will work continuously throughout the day.

There will be a computer and telephone booking system (with a freephone number) and confirmations will be offered via email and text.

The aim is to set up a DentalXpress service in each PCT area it serves for four-six weeks and return to each of these areas on a four-six weekly basis.

The organisation is currently recruiting dentists locally to serve a particular community, which will help them build relationships with the patients they treat and local practices to which they will need to refer.

The objective is that these dentists will work as self-employed practitioners on a sessional basis and will be paid according to the number of patients they see, which should encourage them to build up a local following.

The dentists undertaking sessions for DentalXpress will be encouraged to join local Managed Clinical Networks, to liaise with other dental providers in the area to whom they may want to refer and establishing good local relationships.

Dental nurses will be employed by the company and will work with the same dentist in pairings to encourage team building and each unit team will have a receptionist.

Toby Cobb, managing director of DentalXpress said: “We applaud NHS Leicestershire County and Rutland’s forward looking approach to providing additional dental services for those currently without access to an NHS dentist. We anticipate that it won’t be long before many other Primary Care Trusts will be announcing similar arrangements for every resident within their boundaries who needs an NHS dentist.”

Success for student orthodontic therapists

All fifteen students on the University of Central Lancashire’s first Orthodontic Therapy programme have passed its examination and are now eligible to practise as qualified orthodontic therapists.

The new one-year taught programme began last January with students attending a one month full-time training programme delivered by the course leader Dr Hemant Patel and other specialist orthodontists in the Institute for Postgraduate Dental Education at University of Central Lancashire (UCLan).

After this period the students returned to their clinical practices and worked with their clinical mentors (again specialist orthodontists) to treat patients under close supervision.

Over the past year, students have returned to Preston each month to pick up further clinical skills, working in the phantom head room in the university’s Greenbank Building, and having ongoing clinical and academic assessments.

One of the first successful students to pass the course was 39 year-old Linda Rice from Barking in Essex.

She said: “I have gained more confidence in myself and my abilities through doing the course, which I’ve really enjoyed. I liked the practical side of the course and as I gained more experience and got further into the course it was good to put the information I had received in lectures into practice and see my new skills at work.”

Course leader Hemant Patel said: “I am delighted to see our first cohort of UCLan therapists do so well. They have all worked so hard and their success is well-deserved. The course has been such a fantastic success and I think it’s wonderful that orthodontic staff now have the opportunity to move their careers in such an exciting direction.”

For more information on UCLan’s Orthodontic Therapy programme call 01772 895865 or visit www.uclan.ac.uk/dentistry

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Programme Progress

Department of Health (DH) national director for NHS dental access, Dr Mike Warburton, has iterated that the template agreement, launched in November to procure additional dental access for patients through the Dental Access Programme (DAP), is having a positive impact.

Wolverhampton City, Brighton & Hove, Newham and County Durham PCTs have been chosen to participate in dental access communication pilots. These are intended to develop and assess methods of improving public perception about NHS dental access, through public engagement campaigns.

Speaking at a DH press conference in December Dr Warburton said: “The access programme is responding to patients’ demands with regards to improved access. This is to be achieved through giving support to PCTs in the procurement of new services, contracts and improved communications.”

He emphasised that the DoH is working closely with PCTs and providers to make them aware of the details about how to procure services. He said ongoing meetings with Strategic Health Authorities to talk through relevant dental issues and ensure clarity about the national guidance on the frequency of patient attendance, had been well attended. He explained: “These meetings are organised to take providers and identifiers through the rationale of the content. There seems to be interest in procurements and there has been a good response to adverts to date, which hopefully will continue.

“We are working with PCTs to improve contract commissioning and are launching a dental contract management handbook contract care handbook, as well as ongoing workshops to facilitate.”

Fuller dental contract change proposals will emerge out of the contract pilots, which are scheduled to start in March. These are in line with the implementation of Professor Jimmy Steele’s NHS Dentistry Review, NHS dental services in England, published in June last year.

The DAP is undertaking local patient experience surveys before the four campaigns begin and also allowing providers to evaluate their success. Dr Warburton said the new patient experience indicator survey was an essential component of the programme. He said: “The patient experience indicator is validated as high when there is good NHS dental access and low when there is bad access.”

He added: “The survey will go to large numbers of people from each PCT and so we will know accurately if we are meeting the demand.

Patients need to know that there is good access and it is important to increase perception of this.”

The first PCTs will get their survey results in June 2010.

Chief Dental Officer for England, Dr Barry Cockcroft added: “The Which report last year stated that 88 per cent of patients who tried to access NHS dentistry, could do so.”

Dr Cockcroft said the latest NHS dental access data showed that 959,000 people have been able to access an NHS dentist in the last five quarters. But he did admit that although there was good access in some areas of the country, in other areas it was much lower.

More than £2.25bn of the £90bn NHS budget is allocated to NHS dental services each year, with patient charges adding a further £550- £600m. In 2008-09, the national budget for NHS dentistry was increased by 11 per cent, with a further 8.5 per cent in 2009-2010 to enable improvements.

PCT commissioners are being encouraged to make use of the new template agreement to procure additional access for patients which the DH claims, contains quality and access measures for the first time. This allows contract holders to be rewarded for high quality provision through specification of service quality standards by PCTs. The DH believes the measures will also enable providers to better understand what is required and price their services accordingly.

The DAP was set up by the DH in March last year to support the NHS to deliver its commitment of NHS dental access for all who actively need it. The DH claims, contains quality and access measures, contracts and improvements.

The programme aims to:
• Increase access through opening new dental surgeries,
• Improve management of existing contracts to ensure patients receive the best service,
• Ensure better information to patients about available NHS appointments,
• Develop access measures based on patients’ actual experience.

A template letter for PCTs to send to their dentists, letting them know what is going on to improve dental access at both national and local level is available for PCTs to download and send out. Dr Warburton said PCTs were already carrying out innovations to let patients know about the programme, such as placing advertisements on buses.

“We are looking at what works best, whether leaflets, ads or radio campaigns.”

What is gleaned from the use of the new agreement, along with the inclusion of Key Performance Indicators (KPIs), will be fed into the overall contract review process. Sue Gregory, deputy chief dental officer for England, said KPIs would be set according to the local situation of a given area.

Other key factors of the agreement are that it is more specific and thereby could facilitate more effective contract management by the PCT. It is also underpinned by new national data collection arrangements.

The Government’s commitment is that by March 2011, access to an NHS dentist will be available to all who seek it. But the British Dental Association’s General Dental Practice Committee (GDPC) is of the view that providers should seek advice first before entering into any agreement. The GDPC thinks that dental access funding contracts are unnecessarily complex. The body believes that fundamental new provisions, such as the payment mechanism, the need to comply with new KPIs and the dental care assessment of patients should have been developed and piloted in conjunction with the wider profession through the implementation of the Steele review.

GDPC chairman, John Milne, said: “Although it must be an individual business decision, we advise dentists to think very carefully and seek advice before taking on one of these contracts as the dangers of breach are rife, and the consequences of breach may be very damaging to practices.”

However, initial feedback from providers with whom the template has been discussed, suggests that there will be sufficient providers willing and able to tender for these services.

The, publication of the DH’s Delivering Better Oral Health toolkit last year, has also made an impact on the accessibility of dental health, with significant increases by patients in the use of high-concentration fluoride products.

The draft access agreement, can be viewed on the BDA website, at: www.bda.org.uk
Out with the old?

Chris Hindle asks ‘what impact a Conservative government would have on NHS dentists?’

With a possible change of government looming on the horizon, it is interesting to contemplate potential changes that a Tory government may make to the running of NHS dentistry should Mr Cameron et al achieve power.

Transforming NHS Dentistry, published last year by the Conservatives, received a cautious welcome from BDA General Practice chair John Milne, Mr Milne stated: ‘The dental contract introduced in 2006 has created significant problems for dentists and patients. These problems have been well documented by the BDA, patient groups and the Health Select Committee. In seeking to address those problems, it will be important to afford access to dentists to all and ensure that dentists can provide modern, preventive care’.

Traditional thinking

Much of the proposed policy expressed in the document fits in with traditional Tory philosophy and thinking – such as reducing bureaucracy, less state interference, greater access to information, more patient choice, further opening up of the dental services market and financial incentives for dentists to increase capacity.

One of the lynchpins of the proposals centres around dentists being able and encouraged to offer preventative treatment – can this be paid for through the anticipated cost saving it is hoped will be brought about by an assumed, consequent decrease in curative and restorative activities?

The idea of providing increased statistical data to the public demands less bureaucracy rather than less. Dentists will be concerned to see which of their activities will be measured and how the data is presented.

Patient charges

Dentists may find themselves involved as enforcers to some new, hard-line, money-saving measures – being able to fine patients who miss appointments for example and also, although only a point for consultation at this stage, as to how they can help in preventing patient fraud. There is a belief that dental care funding is losing out as a result of patients wrongly claiming exemptions. A figure of £120m has been quoted as the figure the PCTs lost in income, since the introduction of the new dental contracts, due to patient charges being lower than anticipated.

A welcome change

There is though plenty in the proposals that dentists may welcome – such as dentists having the opportunity to achieve more control over their own destinies. The current target-based contracts system would be phased out when the time-limited contracts expire.

This also raises the worrying prospect of already overburdened PCTs having to take on and run a dual system. The proposals would allow dentists to return to having their own lists of registered patients – and for those practices it would certainly make it easier to define what is meant by practice goodwill; thus meeting a much welcome requirement of dentists to make it easier to buy, sell and fund NHS practices.

Some dentists will welcome proposals to allow a child-only NHS facility at their practices, no doubt helping the envisaged Tory crusade on encouraging prevention rather than cure.

Whether or not the Tory proposals have the substance the profession wants for reform remains to be seen; the Tories certainly seem to have taken note of dentists’ cries for reform. Any changes though will take a lot of time, energy and of course money.
Access over quality = prescribed neglect?

Although high-need patients can be seen for dental treatment, Neel Kothari thinks the jury is out as to whether they are getting the treatment that best meets their needs.

Over the last few days, I witnessed a miraculous cure to my writer’s block when a patient I recently treated brought to my attention some of the issues that can still be seen within NHS dentistry.

This patient is a young lady of around 25 who presented in a great deal of pain from a lower abscessed molar tooth, as well as rampant caries elsewhere. I asked her when she had last seen a dentist and she replied: ‘Only last week, I booked in to see a dentist under the NHS, but at the end of my session I was told that this was only an emergency visit and they did not have the time to see me for treatment!’ She was told to find another dentist and was given a prescription for antibiotics, but still could not sleep or eat.

Funny enough, this is not the first time this has happened and I am sure that many of you may have encountered something similar. The problem here in my opinion cannot purely be put down to the new contract, but when any system is based solely on ‘improving access’, surely the architects of the NHS patient numbers is based on ‘improving access’ tends to be the key driver. But how sensible is this aim? Of course everyone who needs a dentist should be able to get one, especially as it’s called a National Health Service, but exactly what are they getting?

In Hampshire and the Isle of Wight, access figures are clearly well below average. Regardless of how much investment into dentistry has been made here in recent years, according to prospective Parliamentary candidate Terry Siviven, thousands of people across the New Forest still have no access to an NHS dentist.

One of the problems here is that any new practice commissioned by the PCT would be subjected to a massive number of patients, many of whom may require treatment for years of dental neglect. That’s great, you may say! Surely that’s exactly what a new dental practice needs, isn’t it? Well, yes and no; we hear a lot about NHS efficiency savings and getting more for less, but there comes a point where less is definitely less and if PCTs choose to fund new services based around improving access rather than quality, just exactly who are they accountable to? And at what point does this transgress from governing to influencing clinical decisions?

The promises made at the recent Labour Party Conference should really be measured up against Labour’s own record. After the introduction of the New Forest still have no access to an NHS dentist.

Meeting bottom line

While I have some sympathy for dentists having to provide an unlimited mass of dental treatment for a fixed level of remuneration, surely there can be no excuse for kicking out patients in pain and agony while cherry picking those patients who help to better meet the bottom line? Cases like these do raise important questions as to how the profession deals with those patients needing much restorative intervention. When trying to find out what the ‘powers that be’ (various PCTs and dental unions) seem to think, I was not surprisingly bombarded with a myriad of different options ranging from treating all dental disease within one course of treatment, to treating some of the major problems, stabilising the patient and spreading the treatment over multiple courses.

While they all agreed that it was unacceptable to leave a patient in pain, I’m afraid across the nation, many dentists are apparently still working in different ways and it is clear that we still all have different interpretations of exactly how the new dental contract should be implemented. One problem still remains: when one dentist chooses to cherry pick patients, this leaves others to unfairly pick up the pieces.

Disastrous consequences

Ten years ago, in September 1999, Tony Blair told the Labour Party Conference: ‘Everyone will have access to an NHS dentist within two years!’ Ten years later the drive to (still) try and achieve this has clearly had disastrous consequences. Rather than improve quality, access and patient satisfaction with the service, the reality of the situation is that in real terms we have gone backwards.

The promises made at the recent Labour Party Conference should really be measured up against Labour’s own record. This in fact shows loss of access. After the introduction of the New Forest still have no access to an NHS dentist.

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One of the problems here is that any new practice commissioned by the PCT would be subjected to a massive number of patients, many of whom may require treatment for years of dental neglect. That’s great, you may say! Surely that’s exactly what a new dental practice needs, isn’t it? Well, yes and no; we hear a lot about NHS efficiency savings and getting more for less, but there comes a point where less is definitely less and if PCTs choose to fund new services based around improving access rather than quality, just exactly who are they accountable to? And at what point does this transgress from governing to influencing clinical decisions?

Of course since the inception of the NHS, dentistry has always been used as a political football where successive governments have incentivised clinical choices they deem favourable. However in incentivising access over quality, while high need patients are able to be seen for dental treatment (according the DH), for me the key driver? According to Neel Kothari, a key driver?...
The auditorium filled with the sound of Scottish bagpipes, but not playing the familiar tunes of folk classics such as Amazing Grace or Auld Lang Syne; it was the famous guitar intro from AC/DC’s 1990 track Thunderstruck as re-interpreted by the Red Hot Chilli Pipers. The performance by the Scottish ensemble, who won the BBC’s When Will I Be Famous television show in 2007 and conquering stages in Scotland and worldwide with energetic bagpipe rock, was one of the highlights of this year’s European Society of Endodontology (ESE) congress in Edinburgh.

The 14th biennial ESE meeting, which was the second held in the UK (the first was the London congress in 1995), saw a record attendance of more than 1,400 endodontic specialists from 50 countries. They had been invited to join a comprehensive lecture programme discussing key issues such as the rights and wrongs of different instrumentation as well as the realities of microbial biofilms and the challenges of 3-D imaging. New this year was a significant offering of 20-minute presentations that illustrated the latest clinical findings from research groups throughout Europe and further afield.

At the accompanying trade show, the company W&H presented its new anaesthetic system Anesto that allows targeted local anaesthetisation of individual teeth. SybronEndo, a gold sponsor of the meeting, said that its successful TF rotary NiTi files are now available in apical sizes 30, 35 and 40. French Acteon had its EndoSuccess range of tips for apical surgery on display.

“This was a record-breaking blockbuster for the ESE and we were delighted to have been able to host an event of such quality and size in Edinburgh. Each of our invited speakers brought their own style and insights, producing a varied and balanced programme for a large and diverse audience. ESE has become a beacon meeting, an exceptional gathering for scholarship, fellowship and discovery,” said Prof John Whitworth from Newcastle University and President of the British Endodontic Society.

Delegates at the General Assembly elected former ESE secretary Prof Claus Löst as new president. Prof Löst is currently Clinical Director of the Center of Dentistry, Oral Medicine and Maxillofacial Surgery at the Tübingen University Hospital in Germany. He will succeed incumbent president Prof Gunnar Bergenholtz from Sweden at the beginning of 2010. More staff changes are expected to be announced soon. Amongst others, treasurer Prof Dag Ørstavik from Norway will step down.

The Executive Board proposed the co-funding of a symposium in July 2010 with the Pulp Biology and Regeneration Group of the International Association for Dental Research, which will address the topics of inflammation and regeneration.

ESE, founded in April 1982, is a federal organisation representing national endodontic and dental societies in 27 European countries. The next congresses will take place in Rome (Italy) in 2011 and in Lisbon (Portugal) in 2013.

Daniel Zimmermann, recalls a successful meeting in Edinburgh for the European Society of Endodontology
Of visual importance

Dr Craig Barrington discusses crown preparation techniques utilising the dental operating microscope

Successful crown preparations start at the diagnosis. Early detection of the need for full coverage restoration can minimise many difficulties associated with the preparation of a tooth for a crown, obtaining an accurate impression, and the achievement of a precise fitting, long-lasting, esthetic restoration. Proper diagnosis is the all important first step.

The importance of vision

The second most important ingredient is vision. The dental operating microscope (DOM) has shown itself to be valuable in endodontics, but it is just as valuable or more valuable with restorative efforts. High magnification above 4X is necessary to impose/create good finish lines that are easy to impress and temporise. Magnification of 2X-24X is available with the DOM. Management of gingival health and biologic width is important to the overall final look of the crown and the cleanability by the patient. A poor finish line and a poorly positioned finish line results not only in poor impressions and final restoration fit but also makes for poor fitting provisionals.

If one cannot find their own finish line, one cannot properly trim and fit the provisional restoration and remove any temporary cement properly. When patients return, gingival tissues can be irritated making the placement of the final restoration challenging. If by chance one does achieve a good fit, then when the soft tissue heals, the junction of the final restoration and the tooth may be visible and the overall esthetics ruined.

Good patient management

Working at high magnification with the DOM requires good patient and procedural management. If the patient is moving or uncomfortable, then the operator cannot focus and concentrate on proper reduction or the task of placing a solid, conservative finish line on the tooth. Therefore, the third most important ingredient in crown prep success is the dental rubber dam.

For most, using a dental dam for a crown prep is a widely misunderstood concept. Simply put, the rubber dam is the most under-utilised, inexpensive and simple piece of equipment an operator can incorporate into their crown preparation protocol. With a little training, dentists and assistants can learn techniques that will benefit all individuals involved in the restoration of a tooth or teeth. Note in all of the photographs that a dental dam is in place before and after.

Tissue management is the fourth concern and this points back to the number one concern of early diagnosis versus waiting until a tooth is severely decayed or broken down. Working deep subgingival and in irritated tissues exponentially complicates the task of crown preparation. Hemorrhagic areas, or those that are deep subgingival, can be difficult to visualise and control. Early diagnosis can minimise these tissue complicat-
Radiosurgery instruments
Lasers have been in dentistry for quite some time but their cost and other fundamental limitations make them difficult to acquire and use. However, radiosurgery has been around for years and is an affordable and useful instrument that can solve many problems regarding finishing line visualisation, finishing line exposure, and hemorrhage control. In addition, this simple, conservative machine can make cord placement quick and simple by preserving the gingival architecture.

The Parkell unit with a #118 tip allows the creation of a very conservative “trough” or “trench” around a tooth. In combination with good visualisation from the dental operating microscope (DOM), and good patient and procedural management with the rubber dam, we can reliably create a finish line, expose it, place a cord if necessary and impress it.

With a radiosurgical unit, inflamed tissue can be removed such that the healthier tissue is exposed to our hemostatic agents. Healthy hemorrhagic tissue responds better to hemostatic agents than inflamed hemorrhagic tissue. When inflamed tissue are encountered, use of high magnification and the radiosurgical tip to conservatively contour or remove this nuisance tissue can provide predictable result. Removing tissue “thickness” and not modifying tissue “height” can leave the gingival tissue in proper position such that we achieve nice esthetics in our final result.

Handpiece and bur choices
The final item and of least concern in this protocol is handpiece choice and bur choices. There is existing debate between electric versus air driven hand pieces and over which bur is best for which task. The specification of a particular handpiece or bur, would be similar to directing an artist over which paintbrush to use. “What works in one's hands” is the most important factor and that changes from individual to individual and situation to clinical situation. If a practitioner will meet the diagnosis, magnification, isolation and tissue management protocol, then burs and handpiece choices will fall into place with time and experience. I typically use an air driven handpiece and an assortment of Axis turbo diamonds.

In a stepwise fashion for an individual crown prep, the primary concern is achievement of proper anesthesia such that the patient is comfortable in all capacities. Once this is done, the rubber dam is placed. I use a split or “slit” dam technique. The key to success with this rubber dam technique and crown preparations is the distance at which the holes or place apart from each other. Generally speaking, holes are punched too close together for this technique. It is best to punch the holes at a distance from each other on the dam that essentially matches the true anatomical distance between the teeth to be isolated.

Next step: occlusal reduction
Once the tooth is isolated and the patient is confirmed to be comfortable, the next step is the occlusal reduction. This makes the tooth shorter and allows better access and visualisation for the axial reduction. If there is an existing restoration in the form of an alloy or composite filling, it is removed, and the tooth is reduced to the level of this restoration. Existing restorations usually provide a fine guide to getting nice occlusal clearance without having to verify prior to the next step. Hopefully, I have not diminished the importance of this step as I know this can make or literally break a final restoration.

Doing the occlusal reduction first allows me to get “warmed up” and work out any kinks in terms of patient issues, patient positioning, handpiece water flow or bur choice etc, before moving to the more complicated axial reduction. On the upper arch the full crown preparation is done with a mirror and indirect vision.

The microscope puts us in an ergonomic position for doing this and the rubber dam creates a nice situation for a high volume suction to create an air flow that will keep our mirrors clean(er) of the water spray from the handpiece. On the lower arch, I will do ¾ of the procedure choice and bur choices. There is
with direct vision and then fin-
cish certain corners through in-
direct vision. Indirect vision on the
lower arch is not a common tech-
technique but with understand-
ing and desire, it is an easy task/
techique to master.

The axial surface reduced
first depends on which tooth is
being treated. For example, I am
right-handed, so on an upper
right first molar I reduce the pal-
atial side first and then move to
the interproximals. On an upper
right first molar I break contact
on the mesial first, moving from
the palatal side breaking the
contact towards the buccal side.

This is the easier of the two
surfaces to break. First, it is fur-
ther forward in the mouth and
therefore easier to reach and sec-
ond, it is a shorter contact as it
is against a premolar. Following
the mesial contact break, I con-
tinue around the tooth through
the mesio-buccal line angle onto
the buccal surface. I then break the
distal contact, also moving from
the palatal side to buccal direction.
The most challenging
area to prep on an upper right
first molar is the disto-buccal
line angle. So I prepare the tooth
as far as I can through the dis-
tal contact and around the dis-
to-buccal line angle. I then com-
plete the buccal reduction and
connect the buccal finish line at
the disto-buccal line angle.

Mirror position is critical to
achieve a solid finish line on
the entire tooth including the
DB line angle. These steps, for
me, remain true for most upper
right teeth with difficulties being
increased as we move more pos-
teriorly and considering patient
limitations in anatomy, patient
attitude, tooth anatomy and ex-
sting restorations or decay.

Axial reduction

The steps for axial reduction
on the upper right arch mirror
themselves on the upper left
arch. On the upper left arch I first
reduce the buccal and break con-
tact from the buccal to palatal di-
rection. The difficult area to pre-
pare in an upper left tooth is the
disto-palatal lingual line angle.
The difficulty varies depending
on the tooth being treated and/or
patient, tooth limitations.

The lower arch is different
from the upper arch in that direct
vision can be utilised for most
of the preparation. The buccal
reduction is done first on both
lower arches and interproximal
contact is broken in a buccal to
lingual direction starting with the
mesial contact first. Once
both mesial and distal contacts
have been broken, the lingual
reduction is accomplished. For
a lower tooth, the disto-lingual
line angle tends to be the most
difficult area to visualise so this
is the part that is refined using
indirect vision.

Tissue management and
cord placement

Once all occlusal and axial re-
duction has been accomplished,
the next step is tissue manage-
ment and cord placement. I start
with the radiosurgical unit with
a #118 tip to create a conserva-
tive trough around the tooth;
mostly removing tissue thick-
ness and/or reducing any vol-
ume of inflamed tissue. This is
a very conservative step under
the microscope. The DOM allows
precise and accurate tissue re-
moval. The DOM also increases
tactile sense and the steadiness
of our hands.

Size 00 cord is soaked in a
hemostatic agent from the start
of the procedure. Literature sup-
ports that a cord soaked for 15
- 20 minutes in a hemostatic agent
works better than any other al-
ternative cord/hemostatic agent
combination or method. Personal
clinical experience and observa-
tions find this to be true. Having
the radiosurgical gingival trough
in place, the cord placement is a
simple, pressureless and quick
step followed by copious air/
water syringe rinse. In the time
that it takes to place the cord and
rinse, most, if any hemorrhage
will be controlled.

Now the sharpness and po-
osition of the finish line can be
re-evaluated and refined. An
ultrasonic unit is used, with the
irrigation on, to clean the
crown preparation of calciu-
and/or other debris. Occa-
sionally, a Buc 1 endodontic
tip (which is about the same
size and shape as a #140
diamond bur) can be used in
the ultrasonic unit to refine
the crown preparation fin-
ishing. This is done with
the irrigation feature turned
off on the ultrasonic unit. To
sharpen, slightly refine, or
minimally move a finish line,
I may occasionally run the
handpiece at a very low speed
without water.

Rinsing and drying

Once all refinements are ac-
complished, the preparation is
rinsed and dried and for the
first time, the entire prepara-
tion is evaluated in one view.
The uniformity of the axial
reduction and the position of
the gums with relation to
the cord, and the cord with rela-
tion to the finish line are all
evaluated. The axial reduc-
tion should have uniform
thickness throughout the dif-
ferent positions as different
areas need more reduction
and some need less based
on material and esthetic de-
mands. There should be no
areas where the gingiva is
over the cord. If this does
occur, that area is refined with
the radiosurgical unit, to in-
sure a full view of the cord 360
degrees around the tooth of
“tooth-tissue-cord”.

One of the main reasons we
use polyvinyl siloxane
impression materials is be-
cause they are repourable. If
adequate strength and thick-
ness of this material is not
obtained, through proper ra-
diosurgical troughing tech-
nique, then it may tear upon
separation of the model. Hav-
ing an impression tear after
the first pour, limits the abil-
ity to fabricate a well fitting
restoration.

When a clear “tooth-
tissue-cord”, visible, sharp
finish line is present, the
rubber dam is removed and
the preparation is evalu-
ated in all dimensions with
the naked eye. At times the
DOM can create a “can’t see
the forest for the trees” type
of situation, so it is always
valuable to take another look
from a different perspective
without the DOM. This can
allow one to catch sharp an-
gles or irregularities in the prep.

Full-arch impressions

A full-arch impression is taken
with a single tray for the arch
that contains the prepared
tooth. For the opposing arch, a
full arch alginate impression is
taken. With full-arch impres-
sions, a bite registration is usu-
ally not required. Most often one
chair side assistant is utilised
for the entire procedure, but
for the difficult and challenging
impressions, a second assist-
ant may be utilised for saliva or
tongue control.

Once all the impressions are
taken, a provisional is fab-
ricated, refined, polished and
cemented. Shades are taken and
the patient is released with post-
operative instructions.

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Treating a calcified mandibular molar: A Modern Day Protocol

Rafael Michiels, DDS, MSc presents a case study showing old dogs can use new tricks for success

Endodontics has evolved enormously in the last few decades. However, the basic principles from the past are still up to date. This case report gives an example of how the old principles are carried out with newer techniques, devices and materials.

History & Diagnosis
A 37-year-old female patient, was referred to our practice for a problem with the lower right second mandibular molar (#4.7). She had no health issues, and was given an ASA score of 1.

The referring dentist opened the tooth, because of an acute pulpitis due to an extensive caries lesion disto-lingually. She had difficulties in locating the mesial canals because the pulp chamber was heavily calcified. She placed calciumhydroxide in the pulp chamber and sealed the tooth with a cotton pellet and a temporary restoration after the cavity was created. From here on, I could start with the actual root canal treatment. Two mesial canals were located and coronally pre-flared with Protaper adapter (Carl Zeiss Belgium, Zaventem, Belgium).

Visualisation and magnification can greatly help clinicians in cases like this one. Without the use of a surgical operating microscope it is very difficult to locate canals when there is much calcification. “You cannot treat, what you cannot see” is a quote that is regularly heard, but it hits the nail on the head. Visualisation and magnification were obtained through the surgical operating microscope (Opmi Pico, Carl Zeiss Belgium, Zaventem, Belgium). Photos were taken with a Canon powershot A550 IS (Canon Belgium, Diegem, Belgium) mounted on the Flexostill system (Canon Belgium, Diegem, Belgium). There was a lot of calcification. “You cannot treat, what you cannot see” is a quote that is regularly heard, but it hits the nail on the head. Visualisation and magnification were obtained through the surgical operating microscope (Opmi Pico, Carl Zeiss Belgium, Zaventem, Belgium). Photos were taken with a Canon powershot A550 IS (Canon Belgium, Diegem, Belgium) mounted on the Flexostill system (Canon Belgium, Diegem, Belgium).

Treatment & Discussion
A diagnostic radiograph (Fig.1) was taken to see the extent of the lesion and to have a look at the anatomy of the roots. It is essential to determine your strategy. The patient was then anaesthetised by giving a lower alveolar nerve block with articaine 4 per cent - 1:100000 epinephrine (Septanest Special, Septodont, Brussels, Belgium). The temporary filling and cotton pellet were removed exposing a large carious lesion. In order to facilitate the temporary restoration after treatment, an automatix (Dentsply Caulk, Milford, USA) was placed. This also enables better isolation. The tooth was then isolated with a rubberdam (Coltène/Whaledent, Langenau, Germany) mounted on the Flexostill system (Canon Belgium, Diegem, Belgium). There was a lot of calcification. “You cannot treat, what you cannot see” is a quote that is regularly heard, but it hits the nail on the head. Visualisation and magnification were obtained through the surgical operating microscope (Opmi Pico, Carl Zeiss Belgium, Zaventem, Belgium). Photos were taken with a Canon powershot A550 IS (Canon Belgium, Diegem, Belgium) mounted on the Flexostill system (Canon Belgium, Diegem, Belgium).

Isolation is one of the fundamental principles in endodontics and is more than 100 years old. Already in 1864 Sanford C. Barium developed the rubber dam and it was generally accepted that its use was necessary to achieve a good isolation and a better prognosis.10

“The first step in the treatment of a tooth… is the adjustment of rubber dam over the diseased tooth to preclude the possibility of the entrance of germs in the oral secretions into the pulp chamber. This should be the invariable rule.”10

However in a recent survey only 5.4 per cent of general dental practitioners used the rubber dam in their endodontic routine.19

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In this manner the NaOCl can come into direct contact with the apical dentine.19 This results in a significant better removal of debris out of the apical part of the root.10 In order to get a bigger apical diameter, a Profile

References
50.06 (Dentsply Maillefer, Ballaigues, Switzerland) was taken to working length in the mesial canal and a Profile 35.06 in the distal canal. Patency was kept in all three canals throughout the entire treatment, with a ISO size 10 K-file. After the canals were shaped, they were rinsed with citric acid 10 per cent, which was ultrasonically activated, three times for 20 seconds, with an Irrisafe tip. During the third activation, the tip fractured and got stuck in the isthmus between the mesial canals. Cotton pellets were placed in the mesio-lingual and distal canal to avoid that the instrument would fall into these canals during its retrieval (Fig. 5). Retrieval was done with another Irrisafe tip (Fig. 6). A final rinse was performed with NaOCl 5 per cent, which was warmed by giving a few bursts with the System B (Elements Obturation Unit, Sybronendo, Orange, USA). Finally, cone pumping was performed with a tapered 06 gutta-percha. Cone pumping is known in the literature as manual dynamic irrigation and it has been showed that manual dynamic irrigation is more effective than regular irrigation.\(^7\)

A confirmation radiograph was then taken with gutta-percha master cones (Dentsply Maillefer, Ballaigues, Switzerland) in place (Fig. 7). The canals were dried with paper points (Roeko, Langenau, Germany).

Obturation was performed with a hybrid technique in which cold lateral condensation is used to fill the apical 4mm. After that the System B needle is taken into the canal, four mm short of working length. Backfill was performed with the Elements Extruder in small increments of two mm each time, to reduce shrinkage. Topseal (Dentsply Maillefer, Ballaigues, Switzerland) was used as a sealer. During the backfill, I could see the isthmus being obturated with gutta-percha (Fig. 8), which is a desirable result. If tissue would have been left in the isthmus, it could have led to failure. After obturation, the excess of sealer in the pulp chamber was removed with alcohol 96 per cent (Fig. 9). A temporary restoration was then placed with Fuji IX Fast A2 (GC Europe, Leuven, Belgium).

Final radiographs (Figs. 10 & 11) were taken and the patient was sent home with instructions about post-op discomfort and a prescription for ibuprofen 400mg.

**Conclusion**

In the past there have been several revolutions in the field of endodontics. These comprise the isolation procedure with the rubber dam, cleaning with NaOCl, shaping with rotary instruments and others which we cannot think away anymore. In the present we are still holding on to these revolutions, but we are using evolutions of the originals to make treatment easier, better controlled and to gain a favourable outcome. I presented this case to give an overview of the current evolutions which are used in modern-day endodontics.\(^7\)
Illustrating principles of diagnosis and treatment

A case report by Dr Kendel Garretson

Endodontic anatomy varies greatly and single canal filled teeth provide an opportunity to illustrate principles of diagnosis and treatment. In this case (Figure 1), a patient presented with a “toothache”. Medical history was non-contributory. Diagnostic testing revealed a necrotic maxillary central incisor with symptomatic periapical periodontitis. Even in cases with obvious pathology, thorough endodontic diagnosis is completed to determine the proper pulpal and periodontal status of teeth in the affected area, including examination of the affected sextant and the opposing arch.

Based on these findings, a decision was made to treat the tooth in two visits. Emphasising debridement in a crown down fashion, the canal system was entered and flared coronally. A variety of instruments can be used for this purpose, including Gates–Glidden drills as used in this case, followed by tapered rotary nickel titanium instruments. No attempt is yet made to instrument to full length until coronal flaring and preliminary disinfection can be completed. The goal is to minimise the risk of pushing debris through the apical foramen. A preliminary canal length is established, followed by a definitive working length as treatment progresses.

Apical preparation

The apical preparation was sized and finalised with non-tapered rotary instruments (LSX, Discus Dental). Again, a variety of instruments can be used for this purpose. The goal is to thoroughly debride the apical extent of canal system, and prepare the tooth for obturation. Irrigation was accomplished with sodium hypochlorite, as well as aqueous EDTA, with sonic agitation and copious irrigant exchange was encouraged with small k-files used in an exploratory fashion.

After drying, a non-setting calcium hydroxide paste was delivered to length in the canal and a secure interim restoration was placed. Calcium hydroxide aids in tissue digestion, disinfection, and neutralisation of LPS. Other agents may also be used, both as irritants or dressings, to help optimise microbial control.

The patient returned in two weeks to complete treatment. Symptoms resolved within a day or two of the initial visit. Use of aqueous EDTA, with sonic activation and instrumentation, assisted removal of the dressing. The apical preparation was confirmed prior to obturation. Since the tooth was prepared with LSX, a corresponding Simplifilet (Discus Dental) gutta percha obturator was used. This allows for excellent apical control and compaction of gutta percha, and this was followed by a backfill from a heated gutta percha delivery injection device. Composite resin was then used to complete access closure. Several lateral canals are noted after obturation, demonstrating hydraulic pressure and thorough obturation of the canal system. (Figure 2).

Predictable healing

A second case is included, previously treated, with similar presentation and preparation philosophy, along with a 16-month control image (Figures 3,4). By adhering to biologically based treatment philosophies which flow from a thorough diagnosis, our patients can expect predictable healing and disease prevention.

About the author

Dr D Kendel Garretson is a 1989 graduate of the University of Texas Health Science Center at San Antonio, Dental School. Since 2004 Dr Garretson has limited his practice to endodontics and lectured on a regular basis in AEGD residencies on a variety of endodontic topics. He is a member of the ADA and an associate member of the AAE. Questions and comments welcomed at onlyendo@gmail.com.

References


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Periapical microsurgery for removal of a fractured endodontic instrument

Leandro AP Pereira details a case presentation using a piezoelectric device for removal of a fractured endodontic instrument

During endodontic treatment, procedural errors may occur, such as the breakage of endodontic files. These accidents may compromise the treatment and prognosis of the clinical case. Frequently, it is necessary to perform additional procedures to resolve the problem.

With the development of cleaning and shaping endodontic systems, there is decreasing frequency of procedural problems in dental practice. However, concern persists that rotary NiTi instruments are more susceptible to breakage. This has been the second most common reason for dentists not using rotary instruments.

A recent study has shown that the incidence of broken instruments accounts for 11.7 per cent of all endodontic malpractice cases. The incidence of NiTi file fractures has been shown to range from 0.4 to five per cent and their use is considered safer. Fractures can occur through torsional failure or as a result of flexural fatigue.

Minimising breakages

To minimise these incidents, care must be taken as follows: evaluate the tooth anatomy carefully before treatment; ensure a straight-line access; create a "glide path" with small hand files; use the crown-down technique; use a torque-controlled motor; keep files moving in and out of the canal and control the number of times files are used discarding files after a specified number and types of canals.

Fractures of endodontic instruments inside canals may be classified according to their intraradicular position as occurring in the cervical, middle or apical thirds. The success rate for removing fractured instruments in the cervical and middle thirds is higher than it is in the apical third, and the incidence of iatrogenies during the attempt to remove them is lower.

The prognosis of treatment can be altered as a result of the presence or absence of endodontic infection. Cases of pulp necrosis have a worse prognosis than cases with live pulp, as the presence of a large quantity of bacteria and the limitation of correctly eliminating them may lead to treatment failure.

Failure to remove the fractured endodontic instrument results in deficient cleaning, shaping and filling of the root canal system. Under these conditions, in addition to the endodontic diagnosis, the time during treatment when the instrument fracture occurs is of great importance in the prognosis of the case.
When instrument fracture in a contaminated canal occurs at the beginning of treatment, the prognosis is worse, because there is still a large quantity of bacteria, and the presence of the instrument may prevent adequate microbiological control. The presence of the instrument may also contribute to inadequate endodontic filling. The prognosis is better when the fracture occurs near the end of the canal-cleaning and shaping process, as it is a more advanced stage of endodontic microbiological control.

In situations of instrument fractures associated with pulp vitality, the prognosis does not change significantly.

Removing broken instruments

When taking the decision to remove the instrument, factors such as pulp diagnosis, location, root curvature and length, size and type of fractured instrument, remaining dentinal thickness, and risks of iatrogenies during the attempted removal must be taken into consideration.

A technique commonly used for removing fractured instruments is to achieve a bypass with a manual file, so that the fragment can be drawn to the pulp chamber and be removed. Another removal technique is by means of ultrasonic vibration of the fractured fragment, associated with the use of an operating microscope. The application of ultrasonic energy causes the fractured instrument to vibrate, causing it to detach from the canal wall, and it can then be drawn to the pulp chamber and finally removed.

The application of these methods in atresic canals may result in excessive wear of the root walls; therefore their use associated with the operating microscope is safer, due to the possibility of improving visualisation through the magnification and illumination provided by the microscope.

In cases of unsuccessful removal of the instrument and control of infection, with persistence of signs and symptoms of endodontic disease, surgical removal of the fragment may be indicated.

A clinical example

This article demonstrates the resolution of a clinical case in which there was fracture of a K3 rotary instrument in the apical third, extending out of the root apex.

The patient, a healthy 44-year-old woman, pulse 68bpm, BP 115x65 mmHg, SpO2 98 per cent, temperature 36.5°C, came to the dental office complaining of constant, low intensity, spontaneous pain, in the vestibular apical region of tooth 24, and presented intra-oral edema, pain on chewing and vertical percussion. She reported having undergone endodontic treatment in tooth 24 more than six years previously. In the periapical radiographic exam it was possible to visualise deficient endodontic treatment and the presence of apical bone rarefaction (Figures 1, 2). The diagnosis of acute periapical abscess was made.

The proposed treatment was endodontic re-treatment, because in the previously performed treatment there was inadequate canal cleaning and shaping, leading to filling with empty spaces and maintaining the intracanal endodontic infection. Periapical surgery was contra-indicated due to the presence of deficient endodontic treatment.

Endodontic re-treatment began with access to the pulp chamber, with removal of the occlusal resin restoration, using ultrasonic diamond inserts.
CVDentus CR1 (Figure 3). Filling was removed from the root canals with the use of ultrasound and type K hand files, without the use of solvents (Figure 4). As auxiliary chemical substances, 2.5 per cent Sodium Hypochlorite, ENDO-PTC and 17 per cent EDTA-T were used.

After removing the fillings from the canals and establishing the working length by means of the apical locator, Elements Diagnostics (SybronEndo), root canal preparation began with oscillating hand endodontic files in M4 handpiece up to type K #20 file. After this, preparation of the canals continued with K3 Sybron Endo VTVT Pack files, driven by an NSK electric motor with torque control adjusted to 1.2N and speed of 350rpm.

At the time of using instrument K5 50.04 in the apical region, there was no adequate control of the pre-established working length and the instrument overtook the root apex and fractured. The fractured fragment measured 5mm, and approximately 1mm of it was outside of the apex.

The bypass technique
Several attempts were made to remove it using the bypass technique associated with the use of ultrasound and operating microscopy. In spite of making the bypass with a type K #08 file, and successively with type K #10, #15, #20 and #25 files, the fragment did not come out. The position of the instrument in the apical third, associated with the root curvature in the region was responsible for the failed attempt to remove it.

At this stage of the treatment, disinfection of the root canal system had not yet been concluded. The present of the instrument, made it impossible to sanitise the canals correctly and the signs and symptoms of endodontic infection persisted.

In an endeavor to perform additional decontamination, Calcium Hydroxide was used as intracanal medication for three weeks, but the signs and symptoms of endodontic infection did not yield. As a result of failure to control the infection, in this case, supplementary surgery was proposed to remove the apical root third, since it was not possible to shape and disinfect it due to the presence of the instrument.

For the complete resolution of infection, the root canals were filled and after this, piezoelectric periapical microsurgery was performed to resect the apical third of the root.

A full thickness flap was raised and a fenestration was performed to expose the root apex. The fractured instrument was removed using a type K #25 file and operating microscopy. The root apex was then resected using a piezoelectric microsurgery system. The root canal system was then disinfected using a mixture of calcium hydroxide and 2.5 per cent Sodium Hypochlorite, and the root canals were filled with gutta percha and sealer. The root apex was sealed with a calcium hydroxide paste and a resorbable membrane was placed over the fenestration.

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A full thickness flap was raised and a fenestration was performed to expose the root apex. The fractured instrument was removed using a type K #25 file and operating microscopy. The root apex was then resected using a piezoelectric microsurgery system. The root canal system was then disinfected using a mixture of calcium hydroxide and 2.5 per cent Sodium Hypochlorite, and the root canals were filled with gutta percha and sealer. The root apex was sealed with a calcium hydroxide paste and a resorbable membrane was placed over the fenestration.

For the complete resolution of infection, the root canals were filled and after this, piezoelectric periapical microsurgery was performed to resect the apical third of the root.
made with a seminar incision. The option for this type of incision was determined by the absence of a large, radiographically visible bone defect (Figure 2) and for aesthetic reasons. This type of incision does not carry the risk of post-operative gingival recession.

After raising the surgical flap, it was possible to note the integrity of the cortical bone. The osteotomy was performed with surgical piezoelectric ultrasound and CVDentus® W1-0 insert for more precise control of the cut, followed by apicectomy, also performed with ultrasound.

The benefits of ultrasound

There are technical and biological advantages to osteotomy performed with ultrasound when compared with the use of high or low speed burs. Ultrasound has highly selective tissue cutting ability. Its action occurs only on mineralized tissues such as bone and teeth, preserving soft tissues such as nerves, vessels and mucosa. During osteotomy, the amplitude of the micro-movements generated by the ultrasonic insert ranged between 60 and 210 micrometers making the hard tissue cut extremely precise. This is associated with the formation of acoustic microstreams and cavitation in the operative field which promote a clean field, as observed in Figures 8a, 8b and 8c, 13, 14, 15, 16, 17, 18, 19.

The biological benefits of piezoelectric surgery particularly involve the maintenance of cellular viability in the operated region, so that the first post-operative stages of the bone repair process are better. It induces a faster increase in morphogenetic bone proteins and modulates the inflammatory reaction, in addition to stimulating healing.

The fractured instrument was removed together with the apical root third in the apicectomy (Figure 8d). The apical root cut was performed at an angle of 90° to the long axis of the root, to expose the smallest quantity of dentinal tubules and preserve the most root extension, favoring microbiological control and function of the dental remainer.

The quality of the root remaner filling was evaluated by introducing a micromirror into the apical bone recess and reviewing the root remaner filling, considered satisfactory if it uniformly filled the root canal (Figure 8c). This was the criterion used for not performing retro-preparation and retro-filling of the root canals, since this region of the canal had been adequately cleaned, shaped and filled.

The sutures were made with the aid of the operating microscope. Two simple stitches with Vycril® 6-0 thread were made to stabilise the flap, and another continuous stitch with Vycril® 9-0 thread to coat the edges (Figure 9).

Clinical control was performed after seven, 30 and 90 days. There was remission of all the clinical signs and symptoms of endodontic infection.

References


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Managing maxillary molars - case study

How meticulous root-canal therapy lays the foundation for successful long-term retention and restorative care - Dr Mark Dreyer

Maxillary first molars are complex root canal system morphology. The mesio-buccal roots are characterised by an irregular ovoid morphology, resulting in an isthmus or fin of pulpal tissue extending in the palatal direction off of the princi-ple mesio-buccal canal. This case report presents steps taken to address this anatomy to maximise the disinfection and debridement of the root canal system. Failure to address this anatomic complexity may lead to persistence or recurrence of endodontic disease.

Endodontic evaluation
A 58-year-old female patient presented for endodontic evaluation and therapy in the upper left quadrant. Mild pain was reported by the patient for several days prior to the appointment. Medical history was non-con-tributory and dental history was remarkable for multiple existing large amalgam restorations (Figures 1, 2, 3). Clinical examination and diagnostic evaluation were performed for all posterior teeth on the right side, including cold testing, percussion, palpa-tion, periodontal probing and bite challenge. Findings led to a pre-operative diagnosis of irreversible pulpitis/maxillary right first molar with normal peri-radicular.

After anesthesia, and isolation with the rubber dam, entry was made into a calcified pulp chamber. Use of the dental operating microscope greatly enhances lighting and visibility allowing for careful and deliberate clearing of reparative dentin, pulp stones, and other potential impediments to canal orifices. It is important to stress resisting the urge to take files into the canals prior to developing proper access form. In such cases, ledging and blockages can easily occur, needlessly compromising and complicating treatment. The palatal pulp tissue was calcified and extirpated in toto, as seen in Figure 1.

Ultrasonic tips
In this case, ultrasonic tips were used to plane the pulpal floor and increase visibility. These instruments are available from many manufacturers in a var-iety of sizes and shapes designed to address specific case needs. In this case, the orifice of the MB2 canal was located toward the palatal orifice in an unusual presentation (Figures 5, 6). This stresses the impor-tance of continuing to examine the pulpal floor with the micro-scope throughout the procedure, as irrigants and instrumen-tation constantly alter the present-ation of subtle cues and clues to orifice location.

Once orifice location is completed, canal negotiation and instrumentation is carried to completion. Warm vertical compaction of gutta percha and ZOE sealer is used in this case, demonstrating the treated canal morphology (Figures 7, 8, 9). The MB2 canal was addressed as a completely separate canal. One study examined more than 1,700 teeth, which included more than 1,000 first molars. The presence of the MB2 canal was demon-strated in 93 per cent of these teeth (Stropko, JOE June 1999).

These findings are not sur-prising given the morphology of the mesio-buccal root in maxil-lary molars. Use of ZOE sealer is used in this case, compaction of gutta percha and instrumentation is carried to completion. Warm vertical and instrumentation is carried to completion. Warm vertical and instrumentation is carried to completion. Warm vertical and instrumentation is carried to completion. Warm vertical and instrumentation is carried to completion. Warm vertical and instrumentation is carried to completion. Warm vertical and instrumentation is carried to completion. Warm vertical and instrumentation is carried to completion. Warm vertical

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The 10th dimension... the power of 10

Ed Bonner and Adrienne Morris discuss the underrated art of listening

A n oft-quoted expression is that we are given two ears and one mouth and that we should use these in the same proportion. Put more simply, we should talk less and listen more. But even if we did ‘listen’ more, would we actually hear more or learn more?

An analysis of modes of listening would suggest very much the contrary. Consider the following ten types of listening, and how many of them apply to you:

1. **On-off listening**
   It has been estimated that most people think four times faster than most people speak. This means that for every minute someone listens, they have 45 seconds available to think: 15 seconds on, 45 seconds off. This spare ‘thinking’ time is used to think of personal affairs, trouble and concerns, sex or any other interests instead of attentive listening.

2. **Red-flag listening**
   To almost all of us, certain words are red-flags, like waving a red flag at a bull. When we hear words, such as ‘should’, ‘must’, ‘have to’, or ‘new contract’, ‘government’, ‘GDC’, and a myriad others, we get irritated, annoyed, angry or upset. There is an automatic response: we stop listening and tune out on the speaker.

3. **Open-eyed/closed mind listening**
   Oft-times we decide that either the subject or the speaker is boring or does not make sense. In such circumstances, we may jump to conclusions about what the speaker knows and/or attempt to predict what the speaker will say. Either way, we have decided that there is no need to listen, because we will not learn anything new.

4. **Glasses-eyed listening**
   Has it ever happened that you look intently at a person and seem to be listening intently whereas in fact your mind may be on something else completely? When you do this, you drop back into the comfort of your own thoughts and feelings. This may be a counter-attack – and of course this means we are no longer listening.

5. **Subject-centred listening**
   Sometimes we concentrate on the problem and not on the person with the problem. Detail and fact about an incident become more important than what people are saying about themselves.

6. **Matter-over-mind listening**
   When our opinions, pet ideas, prejudices and points of view are overtaken or our judgments challenged, we generally do not like this, and so what we do is when the listener starts talking in response, we become defensive and start placing up our barriers and counter-attack – and of course this means we are no longer listening.

7. **Pencil listening**
   Trying to put down on paper everything said by a speaker. Most doctors mean that we leave out some of it, because the person speaks quicker than we are able to write. We also lose eye contact.

8. **Hubbub’ listening**
   When there are any distractions clamouring for our attention (TV, radio, music, someone else’s conversation), noise, movement etc., the hubbub distracts from what we should be giving total attention to.

So now you are able to identify exactly what kind of listener (or perhaps more to the point, non-listener) you are, you can go away and practice listening better and maybe even talking less.

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**My day on ‘the other side’**

Dentist Simon Thackeray details a BDTA Dental Showcase visit with a twist...

I t has been estimated that nearly 100% of the UK’s dentists have found some aspect of the latest BDIA Dental Showcase valuable enough to return year after year. As one of those dentists, I was particularly interested in how the British Dental Plan Providers Federation (BDPP) was represented.

Simon Thackeray of Thackeray Dental Care tells us about his unique experience at the Birmingham NEC Arena back in November...

Firstly, I have to say it was a privilege to be asked to represent Practice Plan at the recent BDIA Showcase. At first I wasn’t sure about what to expect, and never having experienced the ‘other side’ of the BDIA before, it certainly was an eye-opener for me!

It was great to support a company that has helped me so much in the past, and I hope that I did the honourable justice, by telling prospective customers the truth about my experiences with Practice Plan over the last five years.

Having met the majority of the team at one time or another, I can say I don’t think there can be a more friendly, genuine, professional and thorough team in the UK today (except my team!) They know the industry, they care about their clients, but they have an approach that makes you complete lack of ego that is so refreshing to see. They share the same values as I do, with regard to the care of patients and customers, and they never fail to make me feel like I am their most important client.

Being on the stand was so different to visiting the show; I couldn’t believe how busy I was in the first couple of hours, and even forgot about taking some time for lunch until I was reminded! Throughout the day there were people who chatted to me about problems that they thought were unique to them, but who suddenly realised when talking to me that I had been through the same kind of situation, and that there was a way that Practice Plan could help.

People were interested to know what was behind my decision to convert to private practice and I explained that I had watched the developments of the new contract unfold and observed how it would potentially result in me losing control of my practice and prevent me from caring for my patients to the highest standards, so the verdict on converting was pretty straightforward.

I was thorough in my research when looking at the range of dental plan providers; I realised I needed some form of mechanism to allow my patients to budget for their treatment, but felt that those patients that had more complex treatments would have to pay more than others for their maintenance. Practice Plan stepped in and provided me with a plan that could cater for the range of patients and products they offered was both competitive, comprehensive and good value for money.

The continuous support I received from Practice Plan is fantastic, and I regularly use all of the support tools that they have to offer. The Marketing Team has helped us with the design and print of our welcome packs, referral packs, newsletters, customised stationery, and all our business and referral cards. A one-stop shop with someone who ‘gets’ what our practice is all about is invaluable.

And, it was these experiences I tried to share with the attendees of the BDIA, because I’ve been there and done it and know from experience what benefits working with Practice Plan can provide.

There was a huge amount of fun on our stand too, especially with the Cocktail bar, which is one of the great things about the ethos of Practice Plan - you can be totally committed to the customer and totally professional, but still have a good time.

I would certainly be more than happy to offer my time again if I were asked!

Thackeray Dental Care

Once nearly a 100 per cent NHS practice, Thackeray Dental Care in Nottinghamshire now runs an successful private practice with, a reputation for delivering innovative and high-quality dentistry, especially the more complex type of work. The team is made up of five dentists, six nurses and a therapist who pride themselves in providing the very best dental care, whilst in a warm and welcoming atmosphere.
Hitting a high note

Here, Dr Solanki outlines how to make sure that your potential customers know you’re out there.

The practice is looking fresh, advice the most up-to-date, modern equipment has been installed and the crack team that you have recruited to help you in your quest to provide a service that will require them now or in the future. Capturing an audience or a demographic of people that find your services engaging and potentially a beneficial option that they would like to explore is how to turn marketing into money.

As discussed in parts one and two of this series, there are many factors that contribute to a successful marketing plan. If patients are going to invest considerable sums of money in your services, make sure that your practice image conveys excellence. This is both the aesthetic appearance of your practice and also the image of your literature.

Maintain professionalism

A few pounds spent on good-quality business cards, appointment cards and letterheads can make all the difference when you are dealing with potential clients. If you are wishing to attract patients who desire life-changing work, then your practice literature, treatments plans and welcome pack will need to reflect this.

What logo or image represents your work? The point of having a recognisable logo/brand is so that when patients view your practice image they will associate it with you and the care that you provide. You may already have a logo that you are happy with. If not, investing in a recognisable image or brand will more than pay you back in the medium and long term. Ask around and find out from your patients what images they would associate with your practice and also take advice from a creative agency. Designing your literature (in line with a corporate image or logo) will require you to employ a professional designer. This may not be an expensive as you think.

Creating your literature

There are a few things to remember when you’re deciding on your brand literature. Here are a few tips:

- Keep it simple. This is the golden rule with your ALL, your literature either digitally or on paper. Remember a good design should be easy catching not cluttered with lots of information. If you are advertising will it stand out on the page if placed next to your competitor?
- Does your digital literature and online information pages (including your website) clearly display your telephone number?

Get the TOTAL cost from the creative agency. You don’t want to pay for amendments if you’re not happy with the ideas the agency has designed or the time they spent designing an image you are not happy with. Arrange a time to meet with the agency and invite them to come to your practice. The more they understand you and your services, the easier it will be for them to translate your unique selling points (USPs).

Shop around. A great logo doesn’t mean a great expense. Many up-and-coming designers will have an excellent eye for design and will be keen to get work. Tell the designers as clearly as you can your ideas and if you don’t have any, write down your USPs so they can create images for you. Have you seen an image recently that you quite like? The more information you give to the agency, the better chance you have of successful representation.

Making an effort

Consider how would you spend thousands of pounds with someone who has guaranteed a beautiful aesthetic finish when their brochure is a printed Microsoft Word document?

In terms of content, your brochure should cover the practice philosophy and details of services available, opening times, maps and contact details etc. Providing patient testimonials and pictures of work that has been previously carried out is also a nice touch that instils confidence in potential patients.

As important as the appearance of your paper literature, your website should be smart, crisp and easy to navigate. More and more people use the web to buy and search for services online and it is now more important than ever to have an online presence. In creating a practice website you should clearly display:

- Your services
- Contact details
- A strong image of your practice
- Email contact form

If you are looking for new patients then enrolling on a reputable directory service is a great way to encourage online traffic to your site, and customers to your practice.

Nothing is free

Remember just as you are unique, marketing also comes in all forms, shapes and sizes. You could call in help from a professional PR marketing company to help you spread the word. Remember a few key things when spending money on any marketing ploy or with a company.

1. What is the heritage? Is the company established?
2. Who do they work for or who uses their services? Have the big guns employed them or advertised with them and if so have they given any testimonials as to their services?
3. What do your colleagues say? (Although word of mouth is somewhat slow, it is an excellent marketing tool!)
4. If it sounds too good to be true, it probably is! If it’s free ask why?

- What do they need from you?
- What information do they require?
- If the service is performance based, what are the clear success indicators?

As the old adage goes nothing is for free. Investigate the small print and look into what you are being offered. You end up paying excessive amounts in the long run.

Remember marketing takes time and setting yourself realistic goals from your campaign is a great way to measure your marketing activity. Have you received any exposure? Are the companies you have employed helping to extend this exposure by investigating opportunities for you or just spending money on advertising for you?

Is there more online activity on your website?

A marketing plan will take some time to build up steam, but with the right plan in place, you will benefit from a raised profile and an increased profit margin.

To find out more about anything within this article visit www.cosmeticdentistryguide.co.uk.

About the author

Dr Solanki studied medicine at the University of Oxford followed by a PhD. Having come from a business-oriented family he followed his passion of starting up a dental marketing company with its strengths in online search marketing in early 2007. Since then, he has undertaken extensive search engine optimisation (SEO) training from some of the world’s leading experts in this field and continues to do so. He offers advice on SEO, business consultancy and strategic marketing campaigns for his clients. He is also the founder of www.cosmeticdentistryguide.co.uk. Dr Solanki now offers dedicated marketing strategies for practices on a referral only basis.

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Breaking through the barriers

During a check-up, is it acceptable to comment on how to make their teeth look better cosmetically, or wait to be asked? Jacob Krikor explores

Whether as a dentist, it's your job to recommend cosmetic enhancements while carrying out an annual check up, is a difficult question, and one I ask myself a few times each week. As patients sit in the chair and open wide waiting for me to investigate caries and perio problems, I find it difficult to forget about the discoloured crack incisors or the retroclined central incisors that are making the laterals stick out more than they deserve. Or in the case of the young lady who spends hours on her make-up ignoring the fact that her teeth and her smile, in fact all her face, could look much more attractive with brighter teeth. Of course I still have my preconceptions: this patient would most likely not bother about the front teeth, are not interested in having brighter teeth and most likely don't mind the discoloured filling on their incisor. But how many times have I found myself mistaken? Patients have asked often me what I could do to improve their smiles, at which point I feel triumphant when I start talking through the options.

Asking the question
I have recently started asking patients that I have been seeing for many years that very question which I did not have the courage to ask before. Many patients follow make-over programmes on TV and think that the dentistry offered there is probably too expensive or too Harley Street or only done by celebrity dentists.

So, unless you show your patients what you can offer and what your team is capable of achieving, they will always have that misconception.

I am not advocating going crazy and looking at every patient as a make-over case. I am simply explaining how I found myself developing into a more confident dentist trying not only to correct the function, but also the aesthetics.

The worst thing that can happen now is when the patient says: 'Ah, I've had it for so long that I'm not bothered anymore'. That's it. You can then go on digging in the molars and inspect the palate and shuffle the tongue from right to left.

A happy patient
I have a lady who is an existing patient of mine that I have been seeing for few years now. I've made her a bridge from the UL1 to UL5 some years ago to match the right side to replace an old bridge that she wasn't happy with, without me seeing the bigger picture. Until a couple of months ago, and for some reason, I asked whether she wanted to have something done to improve her smile. It didn't take long before she explained how much she was aware of her teeth and how often she hid them. She said: 'Well, you know, I moved to the UK and now have his own practice in Sweden for two years, but moved to the UK and now has his own practice in South East. I've also the founder of two websites: www.askyourdentist.com for patient information and www.odonti.com, created to make life easier for dental professionals. To contact him, email drjacob.krikor@odonti.com.

Before this case, I always thought of the plastic surgeons Sean McNamara and Christian Troy in the glamorous American series Nip/Tuck and the way they start their conversation with their patients: “So, what don't you like about yourself?” And I'll be honest with you, I did not like the sound of it simply because I wasn't one of them. Today, I ask my patients the same question and I like the sound of it because I am a dentist with the power to improve smiles every day.

About the author
Jacob Krikor graduated from Dental School (Odontologen) in Göteborg, Sweden in 1998. After working in general practice in Sweden for two years, he moved to the UK and now has his own practice in South East. Jacob is also the founder of two websites: www.askyourdentist.com for patient information and www.odonti.com, created to make life easier for dental professionals. To contact him, email drjacobkrikor@odonti.com.

Fig 1. Before 1 Fig 2. Before 2

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Dentists should reduce their reliance on the NHS pension to fund their retirement. Massive government debt includes a public sector pension liability of £650 bn. Both Gordon Brown and David Cameron have vowed to reduce the MPs’ pension scheme so they can ‘look other public employees in the eye’ when introducing pension reform.

We predict that dentists under the age of 35 may well be most heavily affected. Dentists under 35 may have adequate time to build a back-up strategy but need to start now to achieve this. Few commentators expect the NHS pension scheme to exist in the current format by 2035. Sweeping changes to the scheme in 2008, including increased contributions and an extended retirement age of 65 for new joiners just won’t be enough to withstand the political and economic pressure the NHS pension scheme faces.

We advise all dentists to continue with NHS pension contributions where possible. However a personal pension could offer an additional and valuable source of income especially for practitioners with some private fee income. Personal pensions offer the prospect of significant tax breaks and the advantage of a long-term investment horizon. Tax relief is still available for most dentists this is how it works for higher rate taxpayers:

**TAX relief example**
- **• You pay £500 per month**
- **• The government adds £125 per month**
- **• Your total contribution becomes £625 per month**
- **• You reclaim £125 per month through self assessment**
- **• A £625 contribution costs you £375 net of tax**

The elephant in the room – Private fee income

Individual dentists may have little power to prevent changes to the NHS scheme benefits or the political agenda. Our experience of helping practitioners with their retirement planning reveals that the greatest threat to retirement income is often a failure to take account of increasing private fee income and the resulting loss of valuable NHS Pension benefits. Here we look at two practitioners and how their career choice of fee income affects their financial future.

**Case studies**

The NHS dental practitioner: Mr Brown retires at 60 with 37 years of NHS service. He has enjoyed a long career treating NHS patients. He can expect to receive an index-linked pension of £50,000 pa and a lump sum of £150,000.

The Private dental practitioner: Mr Cameron retires at 60 with 15 years NHS Service. At age 38 he stopped treating patients on the NHS and then enjoyed 22 years of private fee income. His total net profits remained the same as Mr Brown yet he can expect to receive an index-linked pension of only £20,200 pa and a lump sum of £60,800.

Our private practitioner receives a pension and lump sum which is nearly 60% less than the NHS practitioner.

How to take account of private fee income

A good independent financial adviser (and one who understands the NHS Pension) should recommend suitable strategies to mitigate a reduced NHS pension. This may well involve personal pension contributions which still attract tax relief at your highest rate.

About the author

Jon Drysdale BA (Hon) CFPF is a qualified independent financial adviser and director of Practice Financial Management Ltd (PFM). PFM offers specialist and independent financial advice for dentists in England Scotland and Wales. For a review of your NHS pension and retirement planning contact Jon Drysdale at PFM on 01904 670820 or contact Jon on jon.drysdale@pfmdental.co.uk

Money Matters 25

**Retirement – can you rely on the NHS?**

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Lisa Bainham, Practice Manager, The Old Surgery Dental Practice, Cheshire

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Behind the spin

ASPD member Greg Penfold looks at what’s in store this year in terms of the Government’s Budget plans and how it could affect dentists and their practices

This year’s Budget supposedly sees belt-tightening measures across the board, including a public sector pay cap and a rise in National Insurance contributions, that is. This seems at odds with Gordon Brown’s existing pledge to boost spending, and it has been speculated that Treasury officials had wanted to announce even more spending cuts in order to lend credibility to their plan to halve the £178 billion deficit within four years.

Whatever happens, the Pre-Budget Report (PBR) contains a number of detailed proposals behind the spin. The following article gives a brief overview of what next year may have in store, and how dentists can use this information to plan for their economic future.

Public sector pay and pensions
One of the biggest measures announced in the PBR is a cap of one per cent on public sector pay settlements in 2011/12 and 2012/15, and reforms to public sector pensions from 2012/15. This news will no doubt come as a blow to dental professionals in the NHS, many of whom will already feel disgruntled by recent changes in the industry, where morale is already at a low.

Personal tax
Practitioners should pay close attention to any increase in their earnings over the next few years. If they do rise, more and more people will find themselves hav- ing to pay substantially higher taxes as they fall into new, higher tax brackets.

Normally, tax-free allowances and the threshold for higher rate tax are increased by inflation, but due to the dire economic situation these figures have all been frozen at their 2009/10 levels. The PBR included the long-term announcement that the threshold for higher rate tax will be frozen in 2012/13 at the same levels as in 2011/12. This means that if your annual earnings reach £57,400 to £150,000 category that year, you will be liable to pay 40 per cent tax. If your earnings creep above the £150,000 mark you will pay 50 per cent tax.

Pension contributions
With regards to pensions contributions the rules are complex, and anyone who has had a total income approaching £150,000 in any of the last three years should seek professional advice before paying a pension contribution totaling more than £20,000 in a year.

As it stands, people who earn in excess of £150,000 and make a “special pension contribution” of more than £20,000 may suffer a charge of the difference between the higher rate relief they would expect and the basic rate relief that they would be entitled to in 2011.

Inheritance tax
Inheritance tax limit was set to rise to £550,000 in 2010 but the Chancellor made a U-turn in the PBR, meaning that levels will stay at £325,000 (effectively £650,000 for a married couple or civil partnership) in 2010/11. As property prices are now back on the rise, increasing numbers of properties will fall in line with the current allowance.

Value Added Tax
Rumours that the Chancellor would increase the rate or the scope of VAT went unfounded after the release of the PBR, unless of course he plans to break the news to us after the general election. The standard rate goes back up from 15 per cent to 17.5 per cent on 1st January 2010, but there is no indication that it will go up again after that, or be applied to any of the categories that are currently VAT-free such as food, children’s clothes, newspapers and new houses.

Other measures
Yet again, practitioners are reminded that they should stay on the right side of HM Revenue and Customs. If a taxpayer fails to file a tax return on time, they may be issued with an estimation by HMRC. In the past, HMRC have offered a relief called “equitable liability” where if it was clear their estimation was excessive, they would not collect the tax.

The bad news is that recently a number of concessions have been withdrawn, including equity-related liability. The good news is however, the liability will now be included in the law itself. To qualify for this relief, a taxpayer must be able to show that the amount of tax demanded of them is too large, and must bring his or her tax affairs up to date by filing appropriate tax returns and paying outstanding tax, interest and penalties. However, prevention is better than cure, and it still pays to fill out your tax return in a timely manner rather than relying on this new rule as a get-out clause.

In short, the Chancellor’s Pre-Budget Report will not make good reading for everyone, and it is still unclear as to whether the Prime Minister’s plans to increase spending are just a ploy to hide the bitter taste of cut-backs and debt for which we will all have to foot the bill.

About the author
Greg Penfold is an accountant with Humphries & Co, chartered accountants, business and tax advisers. He specialises in acting for dentists and is a member of the Association of Specialist Providers to Dentists (ASPD). To contact him, call 01323 730631 or email gpenfold@humph.co.uk or visit www.humph.co.uk. For more information on the ASPD call 0800 436 8773 or visit www.aspd.co.uk.

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Time for change?

Now’s a good time to make sure your practice and its team are prepared should difficult times continue into 2010. Mhari Coxon offers some ideas

I went to visit Tate Modern recently and walked into Miroslaw Balka’s dark hole piece. It is a large metal structure lined with black velvet, making it almost impossible to see once you get inside. On walking towards it, I felt slight anxiety, a need to slow down and watch my footing. Although I couldn’t see in front of me I was determined to reach the end. When I did finally touch the wall at the end, I turned and saw that it was not so dark looking out. It was interesting to watch the caution of those walking in my vantage position.

I am trying to use this impression of this piece of art has left on me, to see a way out of this dark year. If the media and those in the know (who are they by the way?) are to be believed then we all desire. Many who have been subsidised by a flow, but not a flood, of new patients. I am grateful that, five years related advisors has increased. Although all the things I have pression taker and tray maker. The latter makes bleaching an affordable boost to our patient’s smiles. We have resourced a lot of our consumables and have checked costs more regularly instead of settling with one sup- plier. Labs are interested in ne- gotiating as work slows.

Developing the team

The positive is that this is the perfect time to build a plan for each staff member, listing some targets they would like to achieve – team targets can be a good way to get us all working together.

The worst of the downturn in the market is over and the recession has bottomed out. Although his- tory tells us it might take a good few years more for this country to get back on track.

2009 in dentistry

Over 15 per cent of the UK public have cancelled a dental appointment due to cost, says a new study by Saga Health Cash Plan. Routine healthcare is becoming a victim of the current economic climate, with over a quarter (27 per cent) of Brits cancelling fee- payments due to cost, says a new study by Saga Health Cash Plan. Routine healthcare is becoming a victim of the current economic climate, with over a quarter (27 per cent) of Brits cancelling fee-

The positive is that this is the perfect time to build a plan for each staff member, listing some targets they would like to achieve – team targets can be a good way to get us all working together.

Speculate to accumulate

Although all the things I have mentioned are ways of improv- ing the practice without cost, the reality is you get what you pay for. Sometimes an injection of new ideas and being open to someone else’s experience is all you need to get the growth of the practice back on track. In recent years, the number of dental-related advisors has increased.

Their proven track records with successful practices encourage others to take the step to change. They do come with a price tag which some may balk at. But they would not still be here if their programmes, books and advice did not succeed. A cost-effective way of dipping a toe in the water is to attend a one-day seminar as a group.

Infection control compliance

Now could be the time to build the business plan and make a time-line for the practice to com- ply. Many companies have high- ly educated colleagues work- ing with them to support the change in practice. Carmel Ma- her, working with Opident is a perfect example, having worked closely with Mike Martin and Martin Fulford.

Cementing your team

Team building can help to unite everyone in difficult times and can become a practice builder in its own right as most patients en- joy a friendly, supportive atmos- phere that is based on respect.

The more we can work as a close team, the more flawless and smooth the patient experi- ence becomes. Team building doesn’t have to be expensive; taking time each day to meet and listen to each other is not a waste of time or money and is a simple way of building the respect.

For those who fancy chal- lenging themselves and their team, try somewhere like team- buildingsevents.co.uk which has lots of options you can choose from to help reduce your weaknesses as a team.

Make the change

Whatever changes you decide to implement in practice, remem- ber that the team is working hard to keep things going in this diff- icult time and should be recog- nised for this. It is too easy to find fault when things are not how we would like them to be. Lead by example.

About the author

Mhari Coxon is a dental hygienist practising in Central London. She is chairman of the London British Society of Den- tal Hygiene and Therapy (BSDHT) regional group and is on the publications committee of its journal, Dental Health. She is also the clinical director of CPDforGP, which provides CPD courses for all DCPs. To con- tact her, email mhari.coxon@cpd- events.co.uk.

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Class II Challenge

Robert Lowe discusses various clinical solutions to common problems dental professionals face when placing class II direct composites

Direct composite restorations that involve posterior proximal surfaces are still considered a common finding in many dental patients. Unlike dental amalgam, which can be a very forgiving material technically, the inlay/onlay is carved against a matrix band to create a proximal contact, proper placement of composite restorative materials present a unique set of challenges for the operative dentist. The adhesion process itself is well understood by most clinicians for its isolation and execution, however, there are some steps in the placement process that cause difficulty and ultimately lead to a less than desirable end result. In this article we will look at three specific areas, 1) Management of the soft tissue in the interproximal region, 2) Creation of proximal contour and contact and 5) Finishing and polishing of the restoration.

Management of the Interproximal Gingival Tissue

The most common area for the adhesion process to fail is the proximal gingival margin. Compounding this problem is the inability to gain access to the area to affect a repair without removal of the entire restoration. As stated by Dr. Ron Jackson, bonded restorations are unique in that minor defects (decay or microleakage) at the marginal interface can often be "renewed", or repaired by removal of the affected tooth structure and repair with additional composite restorative material. Because of the bond of the restorative material to enamel and dentin, the recurrence is usually self limiting. This is not true with metallic restorations that are not bonded to tooth structure. However, if the defective area is at the proximal gingival margin or line angle, access is not possible. Therefore precise marginal adaptation of the direct composite restorative material and the seal of this margin in the absence of moisture or pulpal fluid contamination is of paramount importance! However, whether due to the subgingival level of decay and/or gingival inflammation, it can be hard to seal the gingival margin with a matrix in the presence of blood.

Proximal Contact and Contour

Another challenge for the dentist has always been to recreate the adjacent tooth contour at the same time, restore proper interproximal anatomical form given the limitations of conventional matrix systems. The thickness of the matrix band and the ability to compress the periodontal ligaments of the tooth being restored and the one adjacent to it can sometimes make the restoration of proximal tooth contact arduous at best. Anatomically, the posterior proximal surface is convex occlusally and concave gingivally. The proximal contact is elliptical in the buccolingual direction and located approximately one millimeter apical to the height of the marginal ridge. As the surface of the tooth progresses gingivally from the contact point toward the cemen-tonemal junction, a concavity exists that houses the interdental papilla. Conventional matrix systems are made of thin, flat metallic strips that are placed circumferentially around the tooth to be restored and affixed with some sort of retaining device. While contact with the adjacent tooth can be made with a circumferential matrix band, it is practically impossible to recreate the natural convex/concave anatomy of the posterior proximal surface because of the inherent limitations of these systems. Attempts to "shape" or "burnish" matrix bands with elliptical instrumentation may help create a nonanatomic contact, but only "distorts", or "indent" the band and does not recreate complete natural interproximal contours. Without the support of tooth contour, interproximal papilla may not completely fill the gingival embrasure leading to potential food traps and areas for excess plaque accumulation. Direct Class II composite restorations can present even more of a challenge to place for the dentist because of the inability of resin materials to be compressed against a matrix to the same degree as amalgam making it difficult to create a proximal contact.

Finishing and Polishing Composite Restorations

Direct composite material does not carve like amalgam, although many clinicians wish that it did! Unfortunately this means that most posterior composites are carved with a bur. This is not part of the finishing and polishing of the restoration. It must be remembered that cuspal forms are convex and cannot be carved with a convex rotary instrument that imparts a concave surface to the restorative material. Composite should be incrementally placed and sculpted to proper occlusal form prior to light curing. The finishing and polishing process is done to accomplish precise marginal adaptation and make minor occlusal adjustments. Rubber abrasives further refine the surface of the composite, and surface seals are used to gain additional marginal seal beyond the limitations of our instrumentation.

Case Report:

The patient shown in Figure 1 presented with radiographic decay on the mesial proximal surface of tooth number 5. The operative area is isolated using an OptiDam (kerr Hare). The decay is minimal, so the operative plan is to keep the preparation very conservative.

After removal of the decay, and completion of the proximal and occlusal cavity form, the operative area is isolated with a rubber dam in preparation for the restorative process. Figure 2 clearly shows that the proximal gingival tissue was deflected away and bleeding is absent allowing easy placement of the sectional matrix band. Even if this is successful, it is likely that blood will infiltrate into the preparation in the gingival area and make etching and placement of the dentin bonding adhesive without contamination impossible. An excellent way to manage the proximal tissue hemorrhage quickly and completely to apply Expa-syl (Kerr Corporation) to the area, tap it to place with a dry cotton pellet, and wait one-two minutes (Figure 5). Using air-water mixture, rinse away the Expa-syl leaving a little bit of the material on top of the tissue, but below the gingival margin of the preparation (Figure 4). The Expa-syl will deflect the tissue away from the preparation margin, maintain control of any hemorrhage, and facilitate placement of the proximal matrix without the risk of contamination of the operative field. Class II preparations that need a matrix band for restorative repair will require rebuilding of the marginal ridge, proximal contact, and often a large portion of the interproximal surface. The goal of composite placement is to do so in such a way that the amount of rotary instrumentation for contouring and finishing is limited. This is especially important since formation of Class II restorations is limited. This is especially for easy placement of the sectional matrix band.

Figure 1: This occlusal preoperative view shows a maxillary molar that has radiographic decay on the mesio-proximal surface.

Figure 2: The hemorrhage away with washing the cavity preparation and there exists that houses the interdental papilla. Conventional matrix systems are made of thin, flat metallic strips that are placed circumferentially around the tooth to be restored and affixed with some sort of retaining device. While contact with the adjacent tooth can be made with a circumferential matrix band, it is practically impossible to recreate the natural convex/concave anatomy of the posterior proximal surface because of the inherent limitations of these systems. Attempts to "shape" or "burnish" matrix bands with elliptical instrumentation may help create a nonanatomic contact, but only "distorts", or "indent" the band and does not recreate complete natural interproximal contours. Without the support of tooth contour, interproximal papilla may not completely fill the gingival embrasure leading to potential food traps and areas for excess plaque accumulation. Direct Class II composite restorations can present even more of a challenge to place for the dentist because of the inability of resin materials to be compressed against a matrix to the same degree as amalgam making it difficult to create a proximal contact.

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true for the interproximal surface. Because of the constraints of clinical access to the proximal area, it is extremely difficult to sculpt and correctly contour this surface of the restoration. Proper reconstitution of this surface is largely due to the shape of the matrix band and the accuracy of its placement. After removal of curies and old restorative material, the outline form of the cavity preparation is assessed. If any portion of the proximal contact remains, it does not necessarily need to be removed. Conserves as much healthy, unaffected tooth structure as possible. If the matrix band cannot be easily positioned through the remaining contact, the contact can be lightened using a Fine Diamond Strip (DS25F - Komet USA).

Figure 5–7: 1) A sectional matrix band gripped by Composi-Tight® Matrix Forceps, an instrument that enables precise placement of sectional matrix bands without deformation. 6) The WedgeWand® during clinical application with the wedge bent at a 90° angle to the handle. 6a) WedgeWand provides an excellent seal. 7) The Soft Face® 3D-Ring in place. Note the precision of the cavosurface and marginal seal by the sectional matrix.

The Composi-Tight 3D™ Matrix System has been chosen to aid in the anatomic restoration of the mesial proximal tooth morphology of this maxillary first molar. The appropriate matrix band is chosen which will best correspond anatomically to the tooth being restored and also, to the width and height of the proximal surface.

The height of the sectional matrix should be no higher than the adjacent marginal ridge when properly placed. Because of the concave anatomic shape, the proximal contact will be located approximately one milimeter apical to the height of the marginal ridge. The Composi-Tight® Matrix Forceps is used to place the selected sectional matrix band in the correct orientation in the proximal area. The positive grip of this instrument will allow for more exact placement than a cotton plier, which could damage, or crimp the matrix band. The sectional matrix band (Garrison Dental Solutions) is positioned and placed using the Composi-Tight Matrix Forceps to the mesial proximal area of tooth number 14 (Figure 5). The orientation of the band and the positive fit in the makes precise placement possible, even in posterior areas with light access. Next, the gingival portion of the band is stabilized and sealed against the cavosurface margin of the preparation using the appropriate size. WedgeWand® flexible wedge (Figure 6). The size of the WedgeWand flexible wedge should be wide enough to hold the gingival portion of the matrix band sealed against the cavosurface of the preparation, while the opposite side of the wedge sits firmly against the adjacent tooth surface. To place the wedge, the Wedge Wand is bent to 90 degrees where the wedge meets the handle. The flexible wedge can now be placed with pressure conveniently, without the use of cotton forceps, that often times can be very clumsy. Once the wedge is in the correct orientation, a twist of the wand releases the wedge. The G-Ring® forceps is then used to place the Soft Face® 3D-Ring into position. The foot of the Soft Face 3D-Ring are placed on either side of the flexible wedge and the ring is released from the forceps. The force of the 3DRing causes a slight separation of the teeth due to periodontal ligament compression and the unique pads of the Soft Face 3D ring hug the proximal morphology of the buccal and lingual surfaces of the adjacent teeth while at the same time creating an unbelievably precise adaptation of the sectional matrix to the tooth cavosurface margins (Figure 7).

Once the sectional matrix is properly wedged and the Soft Face 3D-Ring is in place, the restorative process can be started. A 15-second total etch technique, 10 seconds on enamel margins and five seconds on dentin surfaces is performed using a 37 per cent phosphoric etch. The etchant is then rinsed off for a minimum of 15 to 20 seconds to ensure complete removal. The preparation is then air-dried and retwd with AcquaSeal desensitiser (AcquaMed Technologies) to disinfect the cavity surface, create a moist surface for bonding, and begin initial penetration of HEMA into the dentinal tubules. A fifth generation bonding agent (Optibond Solo Plus: Kerr Corporation) is then placed on all cavity surfaces. The solvent is evaporated by spraying a gentle stream of air across the surface of the preparation. The adhesive is then light cured for 20 seconds. The first layer of composite is placed using a flowable composite (Revolution 2; Kerr Corpora-) to a thickness of about .5 millimetres. The flowable composite will “flow” into all the irregular areas of the preparation and create an oxygeninhibited layer to bond subsequent layers of microhybrid material. After light curing for 20 seconds, the next step is to layer in the microhybrid material. First, using a unidose delivery, the first increment of microhybrid composite (Premise: Kerr Corporation) is placed into the proximal box of the preparation. A smooth ended condensing instrument is used to adapt the restorative material to the inside of the sectional matrix and preparation. This first increment should be no more than two millimetres thick. After light curing the first increment, the next increment should extend to the apical portion of the interproximal contact and extend across the pulpal floor. Facial and lingual increments are placed and sculpted using a Goldstein Flexithin Mini 4 (Hu Friedy). A #2 Keystone brush (Patterson Dental) is lightly dipped in resin and used to feather the material toward the margins and smooth the surface of the composite. Figure 8 shows the restoration after completion of the enamel layer prior to matrix band removal. The Composi-Tight Matrix Forceps is used to remove the sectional matrix after removal of the flexible wedge and Soft Face 3D-Ring. The Composi-Tight® 3D-Ring reduces flash to a minimum. Finishing and polishing will be accomplished using Q-Finisher Carbide Finishing Burs (Komet USA). Typically, three grits and correspondingly, three different burs are used to finish composite materials. With the Q-Finisher system, the blueyellow-striped bur with its unique blade configuration does the work of two burs with one. An excellent surface quality on composite and natural tooth is achieved due to the cross cut design of the cutting instrument.

The small, pointed (H154Q-014) Q Finisher is used to make minor occlusal adjustments on the restorative surface as needed and to smooth and refine the marginal areas of the restorative material where accessible (Figure 9). The fine, white stripe (H154UF-014) ultra fine finishing bur is used in the adjusted area of the precise finished (Figure 10). Komet Diamond Composite polishing points (Green – Polishing and Gray – High Shine) are then used to polish and refine the restorative surface (Figure 11). Once polishing is complete, the final step is to place a surface sealant (Expa-syl: Kerr Corporation) to seal and protect any microscopic imperfections on the restorative marginal interfaces that may be left as a result of our inability to access these areas on the micron level. Remember, an explorer can “feel” a 50-micron marginal gap at best. Bacteria are 1 micron in diameter. The purpose of the Seal and Shine is to fill these areas. Figure 12 shows an occlusal view of the completed Class II composite restoration. Conclusi-
Open to options

Sandy Brown discusses the steps private practices can take to ensure their bank balance benefits in these troubling financial times.

Although there does seem to be light at the end of the tunnel in the current economic climate, it is still certainly proving to be an unstable entity. As a result, many businesses, including dental practices are anxious about changing their providers, services or moving away from their established working methods.

It would be unrealistic to assume that dental practices are immune to the effects of the recession and, in fact, many are still noticing changes in how their patients spend their money. However, it is possible for all dental practices not only to survive in the recession - but thrive. The following tips look at the support and guidance available for private practices to ensure financial security in these difficult times.

Support for patients
Providing your patients with a range of options to pay for their treatment will not only ensure their loyalty but will also provide you with a guaranteed regular income. It can also help you differentiate your practice from the competition, attract new patients and increase your chances of success. In fact, a recent report in the New York Times stated that consumers are more inclined to take a preventive approach to their health during a recession - but thrive. The following tips look at the support and guidance available for private practices to ensure financial security in these difficult times.

A recent national consumer survey by Denplan monitored delaying behaviours among dental patients, both private and NHS, to understand those most likely to delay or cancel appointments. It found that the proportion of people who say they attend the dentist every six months has declined from 59 per cent to 45 per cent over the past year. Overall, 69 per cent of people regularly attend, compared with 77 per cent in 2008 - the lowest figures since 2001. Private payment-plan patients are still least likely to delay a check-up and are also least likely to cancel a scale and polish.

Patient loans
Clearly people are still spend-
Have you had enough of...

- The limited treatment options you can offer your patients?
- Extracting teeth rather than choosing other treatments?
- Chasing targets and delivering UDA’s?
- The PCT’s involvement in your practice?

Yes?

Are you a dentist with an NHS contract? Then take the opportunity to talk to colleagues who understand what you’re going through by coming to an evening with Denplan and guests.

Get Answers
In one evening, you can get answers to any questions about moving to private practice.

Get Options
Guest speaker, Raj Rattan, will help you think strategically to make your practice prosper.

Get Reassurance
One and a half hours of your time could make a world of difference to your future.

Join us for a free evening with Denplan and guests on

Tues 2 March Warrington, Park Royal
Weds 10 March Northampton, Marriott
Tues 16 March Bromley, Sundridge Park Manor
Tues 30 March Newcastle, Marriott Metrocentre
Weds 31 March Darlington, Barcelo Redworth Hall

Tues 27 April Guildford, Holiday Inn
Thurs 29 April Birmingham, St John’s Hotel
Weds 5 May Swansea, Marriott
Weds 12 May Leeds, Thorpe Park Hotel
Weds 26 May Falmouth, Royal Duchy Hotel

To join us call 0800 169 9934, or visit www.denplan.co.uk/dentists and click on Denplan Events.

‘Retaining existing patients is much more cost effective than recruiting new ones, so it’s vital to keep existing patients satisfied.’

— Sandy Brown

about moving to private practice.
We’re focusing on your vision...

Evident

Evident’s next range of lipids and lights are expertly custom-made by leading tissue engineer "Tavom" to manufacturer committed to delivering superior design and craftsmanship, qualities which perfectly complement our 16 years of unrivalled lipsex and outstanding customer service.

Available in two styles, three frame colours, three frame sizes and four magnifications, each ExamVision™ loupe is individually crafted to your personal measurements and requirements. Whether you normally wear glasses or not, ExamVision™ high-definition lipex will vastly improve your detailed vision of the whole treatment area, whilst also improving your comfort, making it easier to work and reducing stress.

Evident are the UK’s No.1 supplier of lipsex and lights and our vision is to supply the very best precision products, combining exceptional quality and service with outstanding design.

Interested in lipsex? FreeCall 0500 321111 or visit our website www.evident.co.uk

Tavom has been supplying dental practices with high quality instruments, cabinetry and equipment since 1975, and today is recognised as a committed market leader with unparalleled expertise in this specialised field.

With a vast product range benefiting from the latest materials and technology, Tavom offers ergonomic, cost effective and durable solutions to every furnishing dilemma.

To meet patients' rising expectations of the dental experience, as well as to attract and retain quality staff, the surgery environment must be welcoming as well as functional. Consultants alike will refer to this as the emotional impact of colour compatibility and product suitability for specific applications.

As well as incorporating the benefits of ongoing research into materials and design, all Tavom products are backed by standards of customer service celebrated throughout the industry.

Whatever your refurbishment or replacement needs, call Tavom UK on 0800 752 1121 for specialist advice and a professional solution.

Quality and unbeatable value!

Kalto offers a full range of Kalto products and services including units, imaging products, surgery planning and cabinetry and flexible finance options please contact us on Freephone 0800 1210250.

Dental Plans are a tried and tested solution to affordable dental care, offering discounts to patients while maintaining profitability for the practitioner. Patients pay a nominal monthly fee to join the Plan and then receive 20% off most treatments from a participating dentist, and are able to pay at time of service.

Joining the scheme for dentists is FREE and practitioners additionally enjoy free marketing and promotion of their practices alongside a substantial professional patient list, as well as discounts on certain lab fees.

Patient Referral Plans provide excellent benefits for both practitioner and patient in difficult times, increasing treatment plan acceptance rates for the patient and ensuring that patients continue to use their preferred practitioner, avoiding any long term health impacts from a lack of regular dental care.

For more information please call The Dental Business on 01908 928937 or visit www.thedentistrybusiness.com

For further information please contact GC UK Ltd on 01908 218999, e-mail gcuk@hansdell.com or visit www.gceurope.com

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Dental Phobia

Dental phobia is a surprisingly common, yet usually completely misunderstood condition. Some suffers cope by avoiding the dentist altogether and risking their oral health, and many do not realise that their condition is not only recognised, but also very treatable.

Currently the highest rated site on google for the key phrase "Dental Phobia" the website offers features including patient case studies, Q and A boards for discussion and detailed explanations of the most common dental procedures. Dentalsafety.co.uk also offers an extensive directory of Dental Phobia Qualified practitioners across the country. This extensive database helps patients find a dentist who understands their fears and can offer the level of care and sympathy that they need.

Promoting the fact that a practice is understanding, and offers a tailored service for nervous patients, will not only improve the patient relationships, but also encourage nervous patients to face up to their oral health, and help them conquer their fears.

For more information about Dental Phobia Certification or to find out how to qualify for placement on the dental phobia directory, visit www.dentalsafety.co.uk

DENTSPLY listens to Professor Steele

Practitioners have always shared the belief that prevention is better than cure, and with Professor Steele recently stating his belief in nerve regeneration.

The Castra™ ultrasonic scaler system is number one in the market for a reason; it effectively removes subgingival biofilm to help towards improving periodontal health. The Castra™ can be used with a variety of insert, including the new Castra™ TherBiT for subgingival root surface debridement, to the Castra™ Softtip™ insert, which allows comprehensive scaling around titanium implants.

Oseph® (25mg per g periodontal gel, lucrative, procaines) is a non-irritant, local anaesthetic which has been designed for use in scaling and root planing procedures. Designed with a mean burst of just 10 seconds and a relatively short duration (20 minutes), it is both a quick-practitioner and short lasting for improved patient comfort.

For more information, or to book an appointment with your local DENTSPLY Product Specialist, call +44 (0)800 072 3313 or visit www.dentsply.co.uk

The UCL Eastman Dental Institute is pleased to announce that the third edition of an important reference text is now available.

Medical Statistics at a Glance has been written by Avna Petrie, Head of Biostatistics and Senior Lecturer at the UCL Eastman Dental Institute. The book is a concise and accessible introduction and revision aid for this complex subject. The self-teaching guide is no different.

Published by Wiley-Blackwell, this popular reference text offers up-to-date, practical guidance on the whole range of common dental procedures.

The emphasis of the course is to equip clinicians with the knowledge, skills, and confidence to provide effective and safe sedation for their patients. The speakers are all leaders in their field with a practical wealth of knowledge to share. Topics to be covered include:

• Patient assessment and clinical examination.
• Treatment planning and pain management.
• Prevention and management of sedation complications.
• Basic life support – resuscitation and medical emergencies.
• Pharmacology of sedation.

For more information, please contact the Course Administration Team on 020 7903 1234 or email cpd@eastman.ucl.ac.uk

More and more dental specialists are using their products every week!

Inventory Circle is the place for you to find dental supplies and equipment at greatly reduced prices, and connect with a community of colleagues who have signed up (for FREE) to benefit from:

• Time-saving access to suppliers
• Returned equipment and supplies
• Used equipment and supplies
• Equipment repair
• End of line supplies

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For more information please call without obligation on 0800-458 9903.

Experience Matters

We seek experience and expertise, in all aspects of day to day life. It seems obvious but you wouldn’t ask your doctor to help with a tax return, nor would you make an appointment with an accountant if you were feeling fit. Each profession brings expert knowledge to different areas, and the dental industry is no different.

Ian has gained a wealth of experience in almost thirty years in the dental industry. He began in the engineering side, overseeing installations and service staff before moving into sales, building a comprehensive knowledge and skill set of excellence and customer service. As a supplier of both equipment and after sales maintenance services, a 96% success rate in providing an engineer on site within 24hours is impressive indeed. For more information please call without obligation on 0800-458 9903.

The UCL Eastman Dental Institute is delighted to report that Professor Crispian Scully receives BMA Medical Book Award

The UCL Eastman Dental Institute is delighted to report that the British Medical Association (BMA) has awarded a highly commended certificate to Professor Crispian Scully CBE.

The Professor received the certificate for his textbook Oral & Maxillofacial Medicine: The Basis of Diagnosis and Treatment (second edition Elsevier) in the 2009 round of their Medical Book Awards.

The BMA annual competition awards prizes in 24 categories and aims to encourage and reward excellence in medical publishing. Oral and Maxillofacial Medicine was commended in the Medical Book category. The book offers up-to-date guidance on the whole range of conditions and potentially serious disorders affecting the oral and maxillofacial region.

The first edition of the textbook won the New Author Book Award from the Society of Authors and Royal Society of Medicine Prize in 2004.

Professor Crispian Scully is one of the most prolific authors in Dentistry worldwide, and his books have received extensive acknowledgement, including the Doody Prize in 1999.

For more details about the UCL Eastman Dental Institute, please visit www.eastman.ucl.ac.uk or telephone 020 7915 1038

RON JACKSON SEMINAR & COMPLETE SUCCESS

The recent ICONic VHF seminar held at the new state-of-the-art London Dental Education Centre (LondDEC) in conjunction with renowned international aesthetic dentist speaker Ron Jackson.

The new centre high specification facilities include a comprehensive training suite and dental skills training room, equipped with 26 state of the art simulation units. Practitioners’ clinical skills will greatly benefit from the availability of LondDEC.

Dr Jackson stressed the importance of maintaining high standards and discussed the meeting challenges faced by modern dentists today. Focal points included gaining an approachable manner, the ability of composite resin and methods used to achieve like-for-like restorations.

Participants had the opportunity to use some of the products in the ICONic VHF range including the new, IPS Empress Direct composite system.

Further specialist seminars will be held nationally throughout 2010, the next one being with ‘The Team Approach’, with Oliver Bros at the Guildhall, Bath 11th February. As places get reserved quickly it is advised to contact London direct on 0114 284 7888 to confirm your attendance.

BDJ Online CDP Statistics Showcase Steady Rise

Recent figures have shown that the BDJ Online CDP courses are becoming more popular for this year there have been 78,193 visits to the site, up from 71,000 in 2008.

Current, there are over 1,400 registered users, with approximately 0,000 log-ins per month from 3,000 individuals. The most popular location of the UK, followed by Australia and then the US units, respectively, but the site has been accessed from 135 countries around the world.

In total, 55,000 pages have been viewed.

These statistics provide an interesting view on how dental practitioners from around the world are using the BDJ Online CDP website to fulfill their requirements for verifiable CPD.

UCL Eastman CDP offers a wide range of on-site opportunities to support all areas of clinical practice from traditional short hands on courses to innovative CDP challenges. The UCL Eastman Dental Institute is also committed to providing access to lifelong learning through a range of flexible-learning Certificates, Diplomas and Masters courses.

For more details about the UCL Eastman Dental Institute, please visit www.eastman.ucl.ac.uk or telephone 020 7915 1038

Working with proven specialists will help to achieve the best results for your budget.

Genus has been applying workplace partnering concepts to its innovative practice design, refurbishment and new build projects since 1992, and has refined this unique approach to meet the high expectations of today’s dentists, who need a stylish, well-planned environment in which to treat patients in a competitive edge to be retained.

Understanding the requirements of the dental industry, Genus has been working with proven specialists in the trade to produce excellent bespoke practices, Genus really does deliver.

For more information, contact Genius on 01582 840484 or email chris.davies@genusgroup.co.uk

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UCL Postgraduate Certificate in Dental Sedation Medicine (Conscious Sedation)

Now Available

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For more information, please contact the Course Administration Team on 020 7903 1234 or email cpd@eastman.ucl.ac.uk

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The best results and improved designs • Projects completed to budget in time and on time • Obtained award for excellence • Cost-effectiveness • Quality assurance • A non-adversarial approach making the most of resources and skills

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Denticymic: The Best Adjunctive Treatment for Periodontal Disease

Available from Blackwell Supplies, Denticymic is a periodontal gel that effectively reduces pocket depth and reduces bleeding while actively promoting periodontal healing. The gel contains 2% Miramyl, an anionic wetting agent with its ability to eliminate key periodontal pathogens.

It has a positive anti-inflammatory action, which promotes connective tissue regeneration, and contains 2% Miramyl, which reduces the depth of treated pockets. These changes indicate an improvement in gum health. Denticymic is supplied in easy to use, pre-filled applicators that allow the delivery of the gel directly into the periodontal pocket for immediate effect.

For more information please call John Jesshop of Blackwell Supplies on 020 7224 1667, fax 020 7224 1664 or email john.jeshop@blackwellsupplies.co.uk

A brighter future: Whitening bucks the recession

Despite the recession there appears to be a burgeoning rise in patient demand for tooth whitening. A recent survey conducted by market research group Mintel identified that patients consider the look of their teeth as of the upmost importance.

Guaranteed to whiten, Philips can provide a cost-effective way for patients to achieve whiter looking teeth as its Sonicare HealthyWhite brush is clinically proven to whiten teeth by 190x230mm, the wipes are in a inner poly pouch in order to prevent premature drying. A brighter future: Whitening bucks the recession - Visiting patients can order 5 and get 1 free (copy invoice to DENTSPLY, please see website for address).

For more information or a FREE compliance survey, please call Jo Hay on 0845 241 5776 or email info@yoyodental.com

www.yoyodental.com

Industries

Press release for January 2010 issue

Monthly Prize Draw winner

Kerr won the Colour Choice Prize Draw for February 2010 in which she won a kit of Kerr’s Tronac GC composite, all the necessary Kerr products for a complete posterior crown and an email certificate for Kerr.

Stec Grafting and Bone Augmentation With Hands-on Cadaver Surgery

Advanced Certificate Course

The 2009 Stec Grafting and Bone Augmentation With Hands-on Cadaver Surgery received an incredible response from delegates and offered outstanding training including:

 Hands-on dissection and live surgery
 Aetiology of bone loss + Surgical anatomy of the maxillary sinus + Indications for sinus augmentation and grafting + Evidence base for maxillary sinus grafting procedures + Closed and open sinus lift procedures + Regenerative materials, science, handling, equipment and instrumentation + Extra-oral bone harvesting techniques including block grafting for lateralisation + Patient communications and fixation setting

Dr Korry Feran, Professor Cemal Ucer and Professor Vishy Mahadevan are pleased to be accredited as new workform for this outstanding course on Thursday 8th – Saturday 10th July 2010.

For more information please visit www.murrensootsson.co.uk

Solve Staffing Shortages!

The Key for Dental Professionals

Dr. Koray Feran, Professor Cemal Ucer and Professor Vishy Mahadevan are

Dentists to help them research their products.

Dental School. Kemdent have always valued the contribution of experienced dentists to help them research their products.

For more information please call John Jesshop of Blackwell Supplies on 020 7224 1667, fax 020 7224 1664 or email john.jeshop@blackwellsupplies.co.uk

Don’t Clean Mirrors, Use Everclear

The first design to self-clean, Everclear from Novex is a groundbreaking Sees design that uses the latest precision micro-technology to create a tool dentists can trust to clean any surface.

Everclear uses a high optical-polish mirror that spins away spray and debris to provide continuous visibility. Powered by a quiet motor, Everclear’s powerful suction is powerful enough to change the direction of the blade-sided mirrors, which are floating on aerospace ceramic ball bearings.

The advantages of Everclear are obvious:

 Visual acuity is increased and time saved with no repetitive cleaning
 Ergonomically balanced with a4 handles, non-slip medical stainless steel handle
 Long lasting, rechargeable batteries, with an extra battery on charge
 Ensures continuous performance

Providing uninterrupted crystal-clear image reflection, the Everclear dental mirror is a revolution in dental technology and an essential daily tool for every dentist.

For more information please call Novex on 01453 79693, email info@novexid.co.uk or visit www.novexid.co.uk

The new Super Max-Wipes hard surface disinfection wet wipes

Topdental manufacture the new Super Max-Wipes hard surface disinfection wet wipes. Topdental manufacture a range of infection control products and wipes, the ‘Super Max-Wipes’ is the latest innovation to this family. The wipes are effective against the following: MRSA, H1N1 Human Influenza Virus, E-Coli, Pseudomonas aeruginosa, Enterococcus faecalis, Mycobacterium tuberculosis (TB), Clostridium difficile vegetative cell formation (growing cells) of Gram positive organisms, HIV 1, Human Influenza Virus (H5N1), Staphylococcus aureus, Hepatitis C virus (HCV), Aspergillus niger, Candida albicans and many others.

And is tested to BS EN14476, BS EN12173, BS EN14240, BS EN17104 and BS EN14126.

The product is also currently under testing for the highest European DGHM standards.

Each economy dispenser bucket contains 500 wipes, each wipe being 190x230mm, the wipes are on a inner poly pouch in order to prevent premature drying. The product the workouts is of Ethanol, Propanol and Chlorhexidine solution with a pleasing lemon aroma.

In order to be able to re-use the plastic bucket container Super Max-Wipes is also available in a refill pack.

To order or for further information telephone 0844 414 0471
Or visit our website www.topdental.co.uk

Superior Sterilisation – SpectraWipe

A leading infection control solutions provider, Ytoys delivers dental professionals with advanced autoclaves and washer disinfectors, fully compliant to HTM 01-05 guidelines.

Ytoys’ groundbreaking SpectraWipe autoclave features:

 True Air Detection System – User executed test cycle, a predeteremined volume of air can be detected and killed during sterilising phase.
 Redundancy Engineered Independent Cycle Validation System – Dual independent temperature and pressure sensors give optimum cycle reliability and performance.
 Safety and Sensing System – System sensor, automatic temperature resetting and pressure cut out systems operate to rapidly and safely cool areas that require user attention.
 Fully Steamed – Easy to remove large onboard waste tank, cooling system ensures waste is cooled to a safe temperature.
 A canister-designed system with问责metric water diversion goes fast and economic chamber filling, and SpectraWipe stackable design enables multiple machines to be safely mounted and operated one after the other without additional systems.

For more information, or for a FREE compliance survey, please call Ytoys on 0845 241 5776 or email info@yoyodental.com

www.yoyodental.com

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 Hands-on dissection and live surgery
 Aetiology of bone loss + Surgical anatomy of the maxillary sinus + Indications for sinus augmentation and grafting + Evidence base for maxillary sinus grafting procedures + Closed and open sinus lift procedures + Regenerative materials, science, handling, equipment and instrumentation + Extra-oral bone harvesting techniques including block grafting for lateralisation + Patient communications and fixation setting

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