EARTHQUAKE APPEAL

We have all been shocked by the emergency situation in the Republic of Haiti after the earthquake which has claimed thousands of lives and left the survivors in turmoil. Dental Tribune is appealing to all readers who wish to help by donating much needed funds to help the relief effort to Médecins Sans Frontières (MSF), an international, independent, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, healthcare exclusion and other natural or man-made disasters. What makes this the more poignant is that the team at MSF responding to this disaster is still trying to account for colleagues who were already working in Haiti, and who may have not survived.

To help, go to www.msf.org.uk/supportus.aspx and click on the link to donate to the Haiti relief fund. Thanks in advance for your support.

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 Honour 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 recommen-
dations of the report.

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

Mr Mathewson 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 at the helm. We’ve 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 DCPs, North Western and Mersey Postgraduate Deaneries 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, IMI 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.”

NEWS IN BRIEF

Tories fine patients

Dentists will be able to fine patients who consistently miss appointments, under Tories’ NHS plans. The smallprint of the Conservatives’ Reform Plan For The NHS, said: “We will introduce a new dentistry contract that will allow dentists to fine people who consistently miss appointments. The fine is expected to be around £20. Andy Burnham criticised the proposal and said: “People who are most in need of care will be hit hardest by fines from their own dentists.”

Scottish waiting lists

Patients are calling on the Scottish government to look again at its oral health care provision after it was revealed that the total number of patients on the waiting list in Scotland has reached a standstill and is not decreasing. Despite waiting figures dropping from 82,166 last year to 79,375 this year in many rural areas waiting list numbers have grown. NHS Grampian revealed that the number of patients on its waiting list has risen from 30,936 to 35,798.

Despite waiting figures dropping from 79,375 this year in many rural communities waiting list numbers still and is not decreasing. Scotland has reached a standstill and is not decreasing.

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Dentistry goes mobile

New service launched to help ease access problems in rural communities

DAP review

Dental Tribune looks at the progress made since the launch of the Dental Access Programme

Case report

Dr Kendel Garretson illustrates principles of diagnosis and treatment

ENDO TRIBUNE

The ‘other side’

Simon Thackeray on working a company stand at BDITA

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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.

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

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.”

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.”
Dental entrepreneurs can now turn their dental innovations 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 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 Dentcubator, the first dental incubating network.

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

The network provides more 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 Dentcubator becomes an equity partner and develops and protects the idea, discussions are initiated with the directors 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. Dentcubator sees itself as a complement to traditional research and development and as an alternative source of 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 offers a seed of an idea, grows it and then brings it to market,” the representative said.

A spokeswoman for Smile-on, one of the biggest spenders in the dental industry, said: “The company, key inventors lack the funds or expertise to evolve the products from simple prototypes and finding distribution channels to market. It aims to support as many as 80 over the course of the next five years.

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A spokeswoman for the conference said: “His passion for translating scientific research into clinical practice will ensure that his guidance will feature into clinical practice will ensure that his guidance will feature in the latest dental technologies from 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. Dentcubator is a virtual entity, which means that its members meet by phone, e-mail or through webinars.

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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 caries biology, caries removal techniques, microbiology and microscopic imaging of dental caries. He also won 2009 Kings College London Teacher of the Year Award.

A spokesman for the conference said: “His passion for translating scientific research into clinical practice will ensure that his guidance will feature into clinical practice will ensure that his guidance will feature in the latest dental technologies from 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. Dentcubator is a virtual entity, which means that its members meet by phone, e-mail or through webinars.

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For more information on the conference and exhibition, register on www.bda.org/conference or call 0870 186 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.”

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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DT dental Protection nominated as Business Superbrand

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

A company selling dental implants for almost half the price of other suppliers are giving dentists the opportunity to pass this saving on to their patients, potentially dropping the price of dental implants in Britain without compromising on patient care.

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.

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 Fairclough, “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

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Success for student orthodontic therapists

ill 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’m 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 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.
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 are amongst four PCTs to put in place 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 details 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 bid- ders 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 after they last. Dr Warburton 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 939,000 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 £0.9bn 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 seek it, at the latest, by March 2011.

The programme aims to:
• Improve 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-concentra- tion 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.

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 over quality’, surely the architects of the new contract must accept some culpability for introducing a system that, through a lack of proper piloting, has effectively prescribed neglect across the nation.

The good news for the Department of Health (DH) is that this patient will now probably count twice in the access figures! Leading me to question, just how exactly does the Government collate access figures?

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 contract, the number of people accessing NHS dentistry fell by one million. Some 2.5 million people are not going to an NHS dentist, because it is hard to find one. Fewer children are accessing NHS dentistry – more than 100,000 fewer than before the new dental contract and dental caries is now the third most common reason for children’s admission to hospital.

A key driver?

Regardless of how the Government dresses up various new schemes and initiatives to improve NHS dentistry, it does not take long to realise that ‘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 Serven, thousands of people across the New Forest still do not have 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?

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 jury is out as to whether they are getting the treatment that best meets their needs.}

About the author

Neel Kothari qualified as a dentist from Barts and The Royal London in 1991 and completed a year-long postgraduate certificate in implantology at UCL’s Eastman Dental Institute, and regularly attends postgraduate courses to keep up-to-date with current best practice. Immediately post graduation, he was involved in the older NHS system and saw the changes brought about through the introduction of the new NHS system. Like many other dentists, he has concerns for what the future holds within the NHS and as an NHS dental associate GP, he has seen some difficulties in providing dental healthcare within this widely criticised system.

Since the inception of the NHS, dentistry has always been used as a political football.
ESE holds record meeting in Scotland

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

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.

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.
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 cleansability 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 his/her 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 complica-
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 finish line visualisation, finish 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 “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.
with direct vision and then fin-
cish certain corners through in-
direct vision. Indirect vision on the
lower arch is not a common

technique but with understand-
ing and desire, it is an easy task/
technique 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-
atal 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-
thorward in the mouth and there-
fore 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 post-
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 direc-
tion 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 non-
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-

tion 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 calcuru-
lus and/or other debris. Occa-
sionally, a Bucc 1 endodontic
tip (which is about the same
size and shape as a #172 dia-
mond bur) can be used in the
ultrasonic unit to refine the
crown preparation finish
line. This is done with the
irrigation feature turned off
on the ultrasonic unit. To
shape, 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 insur-
e a full view of the cord 360
degrees around the tooth of
“tooth-tissue-cord”.

One of the main reasons we
use polyvinyl siloxane impres-
sion 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.
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 (#47). 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 carious lesion disto-lingually. She placed calciumhydroxide cement in the pulp chamber. This should be the invariable rule.1

However in a recent survey only 5.4 per cent of general dental practitioners used the rubber dam in their endodontic routine.2

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 A650 IS (Canon Belgium, Diegem, Belgium) mounted on the Flexistill adapter (Carl Zeiss Belgium, Zaventem, Belgium).

Next, I removed the carious dentine with LN burs (Dentsply Maillefer, Ballaigues, Switzerland). There was a lot of calcified tissue in the pulp chamber (Fig 5), this was also removed with LN burs. The calciumhydroxide was easily removed with citric acid 10 per cent.

By now, a clean opening 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 S1, S2 and F1 in the mesial canal sufficient taper, but a small apical diameter. Many controversies are present about shaping the apical diameter. I prefer an apical diameter of at least a size 50, because I rinse with a 50-gauge irrigation needle. In this manner the NaOCl can come into direct contact with the apical dentine.3 This results in a significant better removal of debris out of the apical part of the root.4 In order to get a bigger apical diameter, a Profile SX (Dentsply Maillefer, Ballaigues, Switzerland)(Fig 4). Working length was determined with a ISO size 10 K-file (Dentsply Maillefer, Ballaigues, Switzerland) (Table 1) and the Root ZX mini apex locator (J. Morita Europe, Dietzenbach, Germany). A glide path was then established with K-flexibles sizes 15 and 20.

Cleaning was performed with NaOCl 5 per cent, which was ultrasonically activated with an Iri-sate tip (Satelec, Mérignac Cedex, France) several times throughout the procedure. The ultrasonic activation of the irrigating solution results in more removal of organic tissue, debris and planktonic bacteria.5 It is a very easy and cheap procedure and should be incorporated in every endodontic routine.

Shaping was done with Protapers S1, S2 and F1 in the mesial canals and up to Protaper F2 in the distal canals. This gives the canal sufficient taper, but a small apical diameter. Many controversies are present about shaping the apical diameter. I prefer an apical diameter of at least a size 50, because I rinse with a 50-gauge irrigation needle. In this manner the NaOCl can come into direct contact with the apical dentine.3 This results in a significant better removal of debris out of the apical part of the root.4 In order to get a bigger apical diameter, a Profile

References
1. Dr. CAMPBELL. The preparation of roots for crowning, and gold crowns. Dominion Dent J 1895 7(2):41-45
2. Dr. EIDT. Treatment of blind abscess. Dominion Dent J 1900 12(7):231-233
50.06 (Dentsply Maillefer, Bellaiques, Switzerland) was taken to working length in the mesial canal and a Profile 55.06 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 3 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 96 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.67

A confirmation radiograph was then taken with gutta-percha master cones (Dentsply Maillefer, Bellaiques, 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, Bellaiques, 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.  

<table>
<thead>
<tr>
<th>Canal</th>
<th>Working length</th>
<th>MAF</th>
<th>Reference Point</th>
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<td>21,5mm</td>
<td>35</td>
<td>DB cusp</td>
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<tr>
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<td>50</td>
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<tr>
<td>ML</td>
<td>22,5mm</td>
<td>30</td>
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Illustrating principles of diagnosis and treatment

A case report by Dr Kendel Garretson

Endodontic anatomy varies greatly and single canal 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 periradicular 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 (LxS, 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. Irrigants were activated with sonic agitation and copious irrigation exchange was encouraged with small k-files used in an exploratory fashion.

After drying, a non-setting zinc oxide Eugenol sealer was placed. Calcium hydroxide aids in tissue digestion, disinfection, and neutralisation of LPS. Other agents may also be used, both as irrigants 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 again verified prior to obturation. Since the tooth was prepared with LxS, a corresponding Simplifil (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, again verified, 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.

References

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.
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 115X 65 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.
CV Dentus CR1 (Figure 5). 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 30.04 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 3mm, 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 sign 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, complementary 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
made with a semilunar incision. The option for this type of incision was determined by the absence of a large, radiographically visible bone defect (Figure 2) and also for esthetic 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 CVDenus® W-1 insert for more precise 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 microovement generated by the ultrasound 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. It reduces the inflammatory reaction, in addition to stimulating healing14.

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 remainder15.

The quality of the root remainder filling was evaluated by introucing a micromirror into the apical bone recess and reviewing the root remainder filling, considered satisfactory as it uniformly filled the root canals (Figure 8e). This was the criterion used for not performing retropreparation and retrofilling 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 Vicryl 9-0 thread were made to stabilise the flap, and another continuous stitch with Vicryl 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
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 known for their complex root canal system morphology. The mesio-buccal roots are characterised by an irregular ovoid morphology, resulting in an isthmus or fin of pulp tissue extending in the palatal direction off of the principal 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-contributory 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, palpation, periodontal probing and bite challenge. Findings led to a pre-operative diagnosis of irreversible pulpotis/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 canal 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 4.

Ultrasonic tips
In this case, ultrasonic tips were used to plane the pulp floor and increase visibility. These instruments are available from many manufacturers in a variety 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 importance of continuing to examine the pulpal floor with the microscope throughout the procedure, as irrigants and instrumentation constantly alter the presentation 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 demonstrated in 93 per cent of these teeth (Stropko, JOE June 1999).

These findings are not surprising given the morphology of the mesio-buccal root in maxillary molars. To better acquaint oneself with this anatomy, examine extracted teeth or see Brown and Herbranson’s Tooth Atlas, a rich source of 3D imagery. The final radiographs demonstrate placement of an orifice barrier, subsequent to temporisation and referral back to the restorative dentist. Image (not included) shows the easily identifiable bonded high contrast composite used for this purpose.

A complex system
This case presented an opportunity to demonstrate the complex canal system anatomy present in maxillary molars. Use of the dental-operating microscope throughout a carefully executed coronal and radicular access procedure maximises the ability to disinfect and debride these teeth.

Ultrasonic instrumentation allows for the judicious removal of dentin required to prevent iatrogenic mishaps and unnecessary weakening of the tooth. When patients present with endodontic disease, meticulous root-canal therapy lays the foundation for successful long-term retention and restorative care.

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Introducing a dental technology so advanced, it revolutionises preventive care.
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 give 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 speaker or the subject 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. **Glassy-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 some other thing entirely? When you do this, you drop back into the comfort of your own thoughts and become glassy-eyed but is brought on by having little understanding of what is being said and not having the wit to ask. There is the big risk here that one will shut off completely and not listen at all.

5. **Too deep for me! Listening**

   This is a variation of being glassy-eyed, but is brought on by having little understanding of what is being said and not having the wit to ask. There is the big risk here that one will shut off completely and not listen at all.

6. **Matter-over-mind listening**

   When our opinions, pet ideas, prejudices and points of view are overturned 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 planning our counter-attack – and of course this means we are no longer listening.

7. **subject-centred listening**

   Sometimes we concentrate on the problem and not on the person with the problem. Detail and fact over an incident become more important than what people are saying about themselves.

8. **Fact listening**

   Often when we listen to another person speaking, we try to remember the facts and repeat them to ourselves over and over again to drive them home. As we do this, the speaker has gone on to new facts, which we lose.

9. **Pen and paper listening**

   Trying to put down on paper everything said by a speaker is a common version of listening, and that we leave out some of it, because the person speaks quicker than we are able to write. We also lose eye contact.

10. **Hubbub listening**

   When there are any distractions clamoring 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.

My day on ‘the other side’

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

T

his year’s BDTA Showcase was just a little different for dental plan provider Practice Plan, as it wasn’t just them mansing their stand; some of their customers helped too! 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 BDTA Showcase. At first I wasn’t sure about what to expect, and never having experienced ‘the other side’ of the BDTA 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 UK dentistry today (except my team) They know the industry, they care about their clients, but they have an approachable, fast and professional manner.

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 thoroughly impressed 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 to the needs of my patients and the product they offered me was competitive, comprehensible and good value for money.

The continuous support I receive 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 BDTA, 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 experienced and dedicated 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, a must-up-to-date, modern equipment has been installed and the crack team that you have recruited to help you in your quest are all ready to grow. Are you ready? It's now time to announce your arrival and get a steady stream of patients through the door.

If you are looking to spread the word about your services and your work, how can you ensure you're not throwing money down the drain? Is there such a thing as a reliable marketing plan?

Define your services
The most efficient way of spreading the word about what you do is to firstly define what services you are going to offer. This will allow you to target 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 design agency. This may not be as 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 eye 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, professional 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 instills 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 or 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? What do your colleagues say? (Although word of mouth is somewhat slow, it is an excellent marketing tool!)
3. 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...
Retirement – can you rely on the NHS?

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 (Hons) Cert PFS 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.

More than just a dental plan provider...

“Always supportive and never intrusive, Practice Plan helps us in so many ways; including developing our brand in a way which truly reflects our individual style.”

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

Marketing your practice has never been more important. This is exactly why we have a team of dedicated marketing advisors and designers who can help you build a strong brand and develop the marketing activity that is right for your practice.

From constructing a website to creating a brand which encompasses your practice ethos, image and goals, we’ll provide the level of support that’s right for you. When it’s right for you.
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.

T
his year’s Budget suppos-
edly 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 specula-
ted 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 an-
nounced 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 denial profession-
als in the NHS, many of whom will already feel disgruntled by the long-term announcement that the threshold for higher rate tax will be frozen in 2012/15 at the same levels as in 2011/12. This means that if your annual earnings reach the £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 contri-
butions 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 ad-
vice 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 £500,000 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 ap-
piled to any of the categories that are currently VAT-free such as food, children’s clothes, newspa-
ners and new houses.

Other measures
Yet again, practitioners are re-
minded 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 eq-
uitable 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 fil-
ing appropriate tax returns and paying outstanding tax, interest and penalties. However, preven-
tion is better than cure, and it still pays to fill out your tax re-
turn 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 in-
crease 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.
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 apprehension, 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 from my vantage position.

I am trying to use the impression 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 the worst of the downturn in the market is over and the recession has bottomed out. Although history 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-based appointments.

If you and your practices have been fortunate, this year may have seen a slowdown on cosmetic cases, but otherwise things have remained stable.

I am grateful that, five years in, my practice has a large list of patients who appreciate the need for maintenance as part of their oral hygiene routine. This has been subsidised by a flow, but not a flood, of new patients.

Time to plan
Now that we are turning back to look at the light, I can’t help feeling we still have a tough year or two ahead. I think we can see the change, but it does not mean that 2010 will see the rapid recovery we all desire. Many who have been scraping by this year may fall when the recovery is not as quick as they had hoped.

And so, we as a practice are looking at ways to keep our turnover increasing in the coming months. As part of our plan we have already utilised Kimberley as our oral health adviser, im-

‘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.’

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 comply. Many companies have highly educated colleagues working with them to support the change in practice. Carmel Maher, working with Opident is a perfect example, having worked closely with Mike Martin and Martin Fullord.

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 enjoy a friendly, supportive atmosphere that is based on respect.

The more we can work as a close team, the more flawless and smooth the patient experience 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 challenging themselves and their team, try somewhere like teambuildevents.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, remember that the team is working hard to keep things going in this difficult time and should be recognised for this. It is too easy to find fault when things are not how we would like them to be. Lead by example.

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.

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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 a common finding in many dental patients. Unlike dental amalgam, which can be a very forgiving material technically and clinically, the placement of direct composite involves first the construction of a matrix band to create a proximal contact, proper placement of composite restorative materials present a unique set of challenges for the operative dentist.

Proximal Contact and Contour

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 cementoenamel 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 normal 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 nonanatomic contact, but only “distorts,” or “indents” the band and does not recreate complete natural interproximal contours.

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

Proximal Contact and Contour

Another challenge for the dentist has always been to recreate contact on the adjacent tooth. At the same time, restore proper interproximal anatomic 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 cementoenamel 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 normal 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 nonanatomic contact, but only “distorts,” or “indents” the band and does not recreate complete natural interproximal contours.

Without the support of tooth contour, the interdental 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.

Conclusion

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 abraded during cavity preparation and there is evidence of hemorrhage. It is not advisable to try and “wash” the hemorrhage away with water and quickly apply the 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 is 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 restoration 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
true for the proximal 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 mate-
rial, 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 posi-
tioned through the remaining contact, the contact can be light-
ened using a Fine Diamond Strip (DS25F - Kerr USA).

The Composi-Tight 3D™ Ma-
trix System has been chosen to aid in the anatomic restoration of the mesial proximal tooth mor-
phology of this maxillary first molar. The appropriate matrix 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 tight ac-

The gingival portion of the band is stabilized and sealed against the cavosurface margin of the preparation using the appro-priate size.

WedgeWand®: A 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 cavosur-
face of the preparation, while the opposite side of the wide sits firmly against the adjacent tooth surface. To place the wedge, the WedgeWand is bent to 90 degrees where the wedge meets the han-
dle. The flexible wedge can now be placed with pressure conven-ti-
ently, without the use of cotton forces, 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 feet of the Soft Face 3D-Ring are placed on either side of the flexible wedge and the ring is released from the forces. 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 tug the proximal morphology of the buccal and lingual surfaces of the adjacent teeth while at the same time creating a unbelievably precise adaptation of the sectional matrix to the tooth ca-
vosurface margins! (Figure 7).

Once the sectional matrix is properly wedged and the Soft Face 3D-Ring is in place, the re-

1.05 second total etch technique, 10 seconds on enamel margins and five seconds on dentin sur-
faces is performed using a 57 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 rewet with AcquaSeal desensi-
tiser (AcquaMed Technologies) to disinfect the cavity surface, create a moist surface for bond-
ing, and begin initial penetration of HEMA into the dentinal tu-

cles. 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 sec-

2. The first layer of composite is placed using a flowable com-
posite

(Revolution 2; Kerr Corpora-
tion) to a thickness of about .5 millimetres. The flowable com-
posite will “flow” into all the ir-

regular areas of the preparation and create an oxygeninhibited unique blade configuration does the work of three with one. An excellent surface quality on composite and natural tooth is achieved due to the cross cut de-

sign 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 restora-
tive material where accessible (Figure 9). The fine, white stripe (H154UF - 014) ultra fine finishing bur is used in the adjusted area for the precise finishing (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 polish a surface sealant (Revolution 2: Kerr Corpora-
tion) to seal and protect any microscopic imperfections on the restorative marginal interface that may be left as a result of our inability to access these areas on the micron level. Remember, an explorer can’t “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 ar-
eas. Figure 12 shows an occlusal view of the completed Class II composite restoration. Conclu-
sion A technique has been de-
scribed

1) to control proximal tissue bleeding prior to matrix place-
ment with Expan-si (Kerr Corpora-
tion), 2) utilise a sectional ma-
trix system (Composi-Tight 3D™), WedgeWand®: Garrison Dental Solutions and a nanofilled mi-
crohybrid composite (Premise: Kerr Corporation) to create an anatomic proximal surface (Figure 5), and 3) Use the Q Fin-
isher, two bur composite finish-
ing system (Komet USA) to finish the polish with a larger and more ef-
ficient composite abrasive (Komet USA) refining marginal integrity with-
out destroying occlusal anatomic form. The interproximal surface has been recreated with natural anatomic contour and has a pre-
dictable, efficient contact with the adjacent tooth. With proper occlusal and proximal form, this “invisible” direct composite res-
toration will service the patient for many years to come.
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 to not only 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, believing that taking better care of themselves will avoid paying out for costly treatments.

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 spending money on high value dental treatments such as cosmetic whitening and orthodontic treatments, despite the financial climate, but instead of raiding their savings, they are using interest-free loans. In fact, interest-free loans can also benefit the dentists, as it provides them with the confidence to recommend modern, higher value treatments and some dentists have even attributed patient growth to their ability to offer interest-free loans.

**Development for you and your team**

Support isn’t just for your patients. Providing your team with support and opportunity to develop is not only encouraging and motivating for staff, making them feel valued, but it can also benefit your business. Some payment plan providers offer a range of training events for the whole practice team. This type of development is not only encouraging and motivating for staff, but it can also benefit your business.

Open to options

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

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Sub- and supraingival air polishing as with the Air-Flow Master. Plus scaling as with the Piezon Master 700. It all adds up to three applications in one with the new Air-Flow Master Piezon, the latest development from the inventor of the Original Methods.

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> Original Air-Flow and Perio-Flow Handpieces

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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?

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As well as incorporating the benefits of ongoing research into materials and design, all Tavom products are backed by standards of customer service and support, unrivalled loupes experience and outstanding customer service.

Interested in Tavom? FreeCall 0800 321111 or visit our website www.tavom.co.uk.

Tavom

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

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Professional from the ASPD

More information on this at www.aspdc.co.uk

The Association of Specialist Providers to Dentists (ASPD) comprises highly reputable businesses across wide ranging specialties, providing a range of professional services committed to meet the specific needs of individual dentists and Dental Practices.

Membership with the ASPD means more than a signature and a recommendation only. Prospective members must undergo a rigorous application process and each member has the unique quality that they are all well recommended to confess each fellow member you meet.

ASPD companies have access to the resources and expertise of their fellow members, so complicated situations can be resolved by combining the strengths and experience of more than one adviser, a distinct advantage of engaging a professional who specialises in working with dentists.

For further information on the ASPD, its members and services, call 0800 458 6775 or visit www.aspdc.co.uk

Quality for your patients

Dr. Matthew Jones holds a Master's degree from the University of Birmingham and is experienced in general dental practice and oral surgery. He is the principal of Ivory Bespoke Dentistry in Henley-in-Arden, a practice which he established to further his interest in patient led treatment planning excellence in dentistry.

Dr. Jones recently upgraded to the A-Dec 500, supplied by Clark Dental, as the best choice for him and his patients. “I like the continous delivery system, thin front and backrest support and general style. The streamlined design of the A-Dec chairs allows easy access for treatment and I highly recommend the A-Dec 500” he adds. The “All general styling also helps create the right clinical environment.”

In addition to its design and surgery build, Clark Dental provides practices with a range of superior products, from dental chair and cabinetry to top specification equipment including the Schick Technologies range Senita Galileos 3D. These latest developments in digital imaging, spacious cabietry, portable X-ray, Florida Pride and Carecan Pro™.

For more information contact Clark Dental Wickford Essex Office on 01268 735146 or email enquiries@tedental.co.uk

A Dec 500: the Best Choice for Practitioner and Patient

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Gentle and Effective Cleaning with Curaprox

Curaprox are providers of high quality oral healthcare products and know that clean teeth and healthy gums means happy patients. Using the right toothbrush is the first step in effective preventative care, and hard bristles can cause gum damage. In response, Curaprox have developed a range of soft bristle brushes for gentle, yet effective cleaning.

C3590 - With 3900 filaments, this intermediate brush will clean effectively while the patient learns to exert less pressure, helping to keep the gum-line healthy.

C35405 - The softest and most durable number of bristles in the series. No risk of gum trauma as only smallest amount of pressure is needed. By using the recommended soft bristle Curaprox brush, patients will immediately see an improvement in their oral health, whilst protecting their teeth and gums.

For free samples please email claims@curapox.co.uk

For more information please call 01480 862084, email info@curapox.co.uk or visit www.curapox.co.uk

Learn how to separate yourself from the competition

The British Academy of Cosmetic Dentistry is pleased to announce a new next meeting, to be held on the 23rd of April 2010.

James Goolnik will provide the guidance necessary for practitioners to create their own Dental-Braned Experience™ as a way of standing out from the competition.

Explaining the importance of branding, how and when to brand and how to convert potential into revenue, delegates will benefit from the knowledge and experience of two leading figures in corporate dentistry.

For over 12 years Chris Barrow has been a consultant, trainer and coach to the UK dental market, and can offer a wealth of experience having delivered a business-coaching programme to over 400 UK dental practices.

President of the BACD, James Goolnik is also the owner and founder of Box Lane Dental Group. Voted London Practice of the Year in 2006, James has gone on to establish his own training company, Smiles by James Ltd, as well as the dentistry retreat, Smiletops.

For more information or a booking from please contact Suzy Rowland on 0208 241 8356 or email suzy@bad.org.uk

Over 50% more patients prefer clean compressed air systems to clean compressed air systems for inspiration for their practices.

For more information on the ASPD, its members and services, call 0800 458 6775 or visit www.aspdc.co.uk

Keeping a Clear View

Higgs eyewear is well known for its provision of uncompromised safety combined with stylish design. Now the Higgs Plus Eyewear range features innovative air vents that will provide the best protection for your eyes.

The high quality polycarbonate lenses have enhanced scratch, fog and solvent resistance on both sides, as well as a resilient water-repellent coating. These make the Higgs Eyewear easy to keep crystal clear, even when using infection control products.

Made from medical grade silicone and stainless steel, the nosepiece is fully adjustable for optimum positioning and incredibly comfortable to wear.

As well as being stylishly designed and available in a range of colours, the Higgs Eyewear range comes complete with a bag and an air flow, helping to prevent the lens fogging and the view clear.

The lightweight Eyeguards from Higgs clearly offers the best protection for your eyes.

For more information please call John Jessop of Blackwell Supplies on 0207 224 1457 or fax 0207 224 1694

The conference programme includes sessions on:

- Predictable isolation and occlusion in everyday practice
- Dental documentation in English complying with HTM01-05
- The future of dentistry: one unified profession?
- Managing your business options in the current financial climate

The exhibition will see all the industry’s most prominent suppliers and a number of new entries to the market so it will also be a chance for delegates to explore hundreds of new products and technologies.

For more information on the conference and exhibition, register on www.bda.org/conference or call 0845 662 6652.

Is your skin treatment competitive?

Association for Facial Aesthetics benchmarking reveals growing competition

COADE – The Association for Facial Aesthetics has just published the results of its annual survey of facial aesthetics treatment and prices. The survey, which was conducted via online questionnaire charged for different procedures, includes for the first time new treatments such as Dermalander and RBF treatments, which have become more popular during 2009.

Interestingly, though, this year’s results reveal a much wider discrepancy between the highest and lowest fees being charged for botulinum toxin treatment compared with last year, with the fees for three areas of treatment ranging from £167 to £317 and one area of treatment being offered for as little as £47.

The full report is issued free to CODE ARA members. For more information about the report or more about the Alliance please visit the face-a.co.uk, email info@code-a.co.uk or phone 01404 254 354. To watch videos on facial aesthetic treatments visit the YouTube channel paadcork-
Dental Phobia

Dental phobia is a surprisingly common, yet usually completely unacknowledged condition. Some sufferers cope by avoiding the clinic, while others try to fight through their fear and, many do not realise that their condition is not only recognised, but also very treatable. Currently the highest rated site on google is www.dentalphobia.co.uk, which offers features including patient case studies, Q and A boards for discussion and detailed explanations of the common dental procedures. Dentsplyhobia.co.uk also offers an extensive directory of Dental Phobia-Certified practitioners across the country. This extensive database allows patients to find a dentist who understands their fear 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 just improve 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.dentalphobia.co.uk

DENTSPLY listens to Professor Steele

Practitioners have always shared the belief that prevention is better than cure, and with Professor Steele recently providing further reinforcement for this belief, more than ever DENTSPLY is backing this notion.

The Cavitron™ ultrasonic scaler is number one in the market for a reason; it effectively removes subgingival biofilm to help towards improving periodontal health. The Cavitron can be used with a variety of inserts, including the new Cavitron™ THINsert, which has received much support already. Testimonials received include:

- 'I couldn’t believe how well I could access areas that were almost impossible to reach before.'
- 'Excellent adaptation to furcations and in furcations.'
- 'I love it! I want one now!'
- ‘The new THINsert is available to purchase from your dental supplier. For more information, please call freephone +44 (0)800 072 3313 or visit www.dentsply.co.uk’

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

Professor Crispian Scully receives BMMA Medical Book Award commendation

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 Eleventh) in the 2009 round of its Medical Book Awards.

The BMA annual competition awards prizes in 26 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 common 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-Pinz in 2004.

Professor Crispian Scully is one of the most prolific authors in Dentistry worldwide, and this book has received extensive acknowledgment, 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 1039

Student Practice Centres

The new centres high specification facilities include a comprehensive training and simulation units. Practitioners’ clinical skills will greatly benefit from the development of a range of simulation software, enabling the practitioners to develop strong communication with the involved parties, with this approach, Genus ensures:

- The best results and improved designs
- Projects completed to budget
- Reduced set-up and downtime
- Obtaining the most competitive quote
- Cost-effectiveness
- Quality assurance
- A non-adversarial approach making the most of resources and skills

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

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

Dr Jackson stressed the importance of maintaining high standards and discussed the meeting challenges faced by modern dentists today. Focal points included gaining an appointment, the tendency of composite resin and methods used to achieve this, and the availability of alternative therapies.

Patients have the opportunity to use some of the facilities in the local Wadhurst range including the new, IPS Empress Direct composite system.

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

Inventory Circle is the place to look for dental supplies and equipment at greatly reduced prices. Inventory Circle has signed up (for FREE) to benefit from:

- Time saving to source supplies
- Returned equipment and supplies
- Used equipment
- An array of supplies
- End of line supplies

Inventory Circle today and see how much you could save!
**Industry News**

**Solve Staffing Shortages!**

The New Year is a time when staff can often look for a new career and new opportunities. For this reason Kemdent is offering a new reward that can then be used as a staff heading for you! But, all the staff that you need could just be a click away. Visit PracticeCity.com and you place your vacancy and you can reach thousands! Simply place your ad whether it be for an associate, hygienist or dental nurse and you’re sure to find the right person for you. Visit www.PracticeCity.com today and solve your staffing issues.

**New Year Saving with Snappy**

The key for Dental Professionals treating children this year is to find that happy medium where the patient can be given valuable time by reducing unnecessary procedures. Snappy restorative GIC from Kemdent can save significantly on treatment times, meaning the patient can enjoy shorter dental visits whilst retaining quality dentistry.

Diamond Snappy GIC is a way to pack and place, genuinely flowable, leaves no bitter after taste and sets in less than 2 minutes from a mixing ratio of 3:1. Diamond Snappy GIC is ideal for restoration in children, preventing long cavities in deciduous teeth. It comes in a natural white shade with translucency retaining quality dentistry.

For more information please call 0800 234 3558 or visit our website www.topdental.org

**Dentosynct: The Best Adjunctive Treatment for Periodontal Disease**

Available from Blackwell Supplies, Dentosynct is a periodontal gel that effectively reduces pocket depth and bacteria levels while actively promoting periodontal healing. The gel contains 2% Mercaptoethanol, an anti-bacterial well-known for its ability to eliminate key periodontal pathogens.

Used in conjunction with scaling and root planing (SRP), Dentosynct achieves a marked reduction in bacteria in patients with periodontal disease. It has a positive anti-inflammatory action, which promotes connective tissue attachment.

Dentosynct binds to the tooth surface and is released slowly, attacking the bacteria, clinical studies have shown that Dentosynct treatment reduces the bacteria that cause periodontitis and reduces the depth of treated pockets. These changes indicate an improvement in gum health.

Dentosynct 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 Jeseph of Blackwell Supplies on 020 7224 1667, fax 020 7224 1664 or email john.jeseph@blackwellsupplies.co.uk

**Flexible hand instruments fit perfectly in your hand. With a wide grip at the working end and a narrow centre, the designed help stop hand fatigue and prevent ‘pinching’ of the hands, thus improving grip and rotational control.**

Flexible tips are replaceable, so should one break or be over sharpened, they can be easily replaced.

The complete range of DENTSPLY Flexible® products are guaranteed to simplify treatment procedures and help provide a more efficient service for both practitioners and patients.

For a limited time DENTSPLY is offering a promotion on Flexible® hand instruments; buy 5 get 1 free (copy voucher to DENTSPLY please see web site for address).

The whole range is available to view online at www.dentsplyuk.co.uk, or for more information, book an appointment with your local DENTSPLY Product Specialist by calling 0800 072 5315.

**Superior Sterilisation – SpectraM6**

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

Yttof’s groundbreaking SpectraM6 autoclave features:

- **True Air Detection System – User executed test cycle, a predetermined volume of air can be detected and dried inside chamber during sterilising phase**
- **Redundancy Engineered Independent Cycle Validation System – Dual independent temperature and pressure sensors give optimum cycle reliability and performance**
- **Safety and Sensing Systems – System sensor, automatic temperature resetting and pressure cut out systems operate to rapidly and shut off sterilisation areas that require user attention.**
- **Fully-manual operation**

Easy to use large on-board waste tank, cooling system ensures waste is cooled to a safe temperature

A unique chamber filling system with volumetric water dosing, glass mast and economic chamber filling, and SpectraM6 stackable design enables two handpieces to be safely mounted and operated one above the other without interference.

For more information, or for a FREE compliance survey, please call Yttoes on 0845 241 5776 or email info@ytofidental.co.uk www.ytofidental.com

**Kemdent: the perfect choice for 2010.**

Kemdent were very pleased to announce, Michael, a member of the Family Dental Practice in Llanelli, £1000.00 for Marks & Spencer vouchers. My congratulations to Mr. Foulsham who was the Kemdent prize draw winner for October. He completed a CCTV Evaluation form for Diamond Capsules and it was entered into the Kemdent monthly prize draw.

Kemdent are currently funding a project to carry out extensive research into Diamond GIC Dental materials, with the support of Exeter University and Bristol Dental School. Kemdent have always valued the contribution of experienced dentists to help them research their products.

The completed evaluation forms will provide a valuable contribution to the project. For this reason Kemdent is offering an added incentive. Completed evaluation forms will be entered into a monthly prize draw with a chance to win £100.00 OR £5 vouchers.

For information on all Kemdent products call Jackie or Helen at Kemdent on 01793 970 996 or visit our website www.kemdent.co.uk

**Access to More Patients with Munroe Sutton**

Delegates of the sixth annual BACD at the DEC in Edinburgh were introduced by Munroe Sutton to a truly world class Patient Referral Plan to successfully grow their patient base and increase referrals.

The Patient Referral Plan has been developed by dentists, for dentists, and proven successful in the US for three decades. Now tailored to the UK market, Munroe Suttons outstanding solutions hit practices:

- Increase cashflow with payment at time of service
- Reach out to more patients with FREE marketing solutions

Offer a seamless service with an automated patient verification system and treat MORE patients!

Munroe Sutton was proud to sponsor the 2009 BACD and delighted with the success of the conference. Delegates to the Munroe Sutton stand were introduced to the first step towards growing their practice with full appointment books, cost-effective treatment plans, happy patients and the support of a world leader in highly effective patient referral plans.

For more information please call 0800 234 3508 or visit www.munroesutton.co.uk

**Dentomycin:**

Dentomycin is supplied in easy to use, pre-filled applicators that allow the treatment of key periodontal pathogens.

Minocycline, an antibiotic well known for its ability to eliminate key periodontal pathogens.

Dentomycin binds to the tooth surface and is released slowly, attacking the bacteria, clinical studies have shown that Dentosynct treatment reduces the bacteria that cause periodontitis and reduces the depth of treated pockets. These changes indicate an improvement in gum health.

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**Don’t Clean Mirrors, Use Everclear:**

The first direct terror that self-drivers, Everclean from Nanox is a groundbreaking Seas design that uses the latest precision micro-technology to create a tool dentists can trust to clean dental mirrors.

Everclear uses a high optical-polish mirror that spins away spray and debris to provide continuous visibility. Powered by a quiet electric motor, Everclean offers an innovative change for the double sided mirrors, which are floating on porcelain ceramics ball bearings.

The advantages of Everclean are obvious:

- Visual acuity is increased and time is saved with no repetitive cleaning.
- Ergonomically balanced with a collider, non-slip medical stainless steel handle.
- Long lasting, rechargeable batteries, with an extra battery on charge ensuring 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 Nanox on 01453 796395, email info@nanox-ltd.com or visit our website www.nanoxs.co.uk

**Super** **MA** **-** **W** **IPE**

Toothpaste introduces the new **Super** **Max** **-** **Wipe** hand surface disinfection wet wipes. Topolindental manufacture a range of infection control products and wipes, the **Super** **Max** **-** **Wipe** is the latest innovation to this family.

The **Super** **Max** **-** **Wipe** is effective against the following:

- **MRSA**, **HIV**
- Human Influenza Virus, **E-Coli**
- Pseudomonas aeruginosa, Enterococcus hirae, Mycobacterium tuberculosis (TB), Clostridium difficile
- Vegetative cell formation (growing cells) of Gram positive organisms, HIV 1, Human Influenza Virus (HIV), Staphylococcus Aureus, Hepatitis C Virus (HCV), Aspergillus Niger, Candida albicans.

And is tested to BS EN14476, BS EN13727, BS EN14204, BS EN13704 and BS EN13705.

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

Each economy dispenser bucket contains 500 wipes, each wipe being 150x20mm, the wipes are a in a inner poly pouch in order to prevent premature evaporation of the wipe. The wipe concentrate is Ethanol, Propanol and Chlorhexidine Dechloride with a pleasing lemon aroma.

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

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

For more information please visit www.yoyodental.com or call Law and Ro...
The British Academy of Cosmetic Dentistry's "Cosmetic Dentistry 2009" conference was a huge success, according to delegates' comments. The conference represented an important praise and approval for its location, catering, facilities and suitability for future meetings.

Enthusiastic delegates' comments included:
"The best conference I've EVER been to!" - The British Academy of Cosmetic Dentistry's Sixth Annual Conference 2009 "The future of Endodontics was a huge success, according to delegates' comments. The conference represented an important praise and approval for its location, catering, facilities and suitability for future meetings.

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All you need to know is we’re the dental legal experts.

And here is how to get in contact with us.
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dentalexpert@dentax.biz  Call 01438 7222242
Geoff Long FCA 2010 Tax Planning Slate Now Available!

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For more information please contact
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E-mail: info@awbtextiles.co.uk Web: www.awbtextiles.co.uk
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P M  “How will private fee income affect my NHS pension?”

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