Low fluoride children’s toothpaste fails to combat tooth decay

Children’s toothpaste that contain low concentrations of fluoride fail to effectively combat tooth decay, according to a recent study.

Researchers found that toothpaste containing fluoride concentrations of less than 1,000 parts per million are as ineffective as toothpaste with no fluoride at all.

For optimal prevention of cavities in children over age six, toothpastes should contain at least 1,000 parts per million of fluoride, according to the study carried out by the University of Manchester School of Dentistry.

The review, published in the latest issue of The Cochrane Library, a publication of The Cochrane Collaboration, examined results from 70 controlled clinical studies on 75,000 children, found the benefits of fluoride are reduced for toothpastes that contain less than 1,000 parts per million of fluoride.

“ Toothpastes with lower fluoride levels, in the 440 to 550 range, give results that are no better than the results seen with toothpaste that does not contain fluoride,” said co-authors Professor Helen Worthington and Dr Anne-Marie Glenny.

The study also found that brushing a child’s teeth with a fluoride toothpaste before the age of 12 months could lead to an increased risk of developing mild fluorosis.

Children’s toothpastes currently range from 100 parts per million to 1,400 parts per million.

Dr Glenny said: “From a public health point of view, the risk of tooth decay and its consequences such as pain and extractions is greater than the small risk of fluorosis. Children would have to swallow a lot of toothpaste over a long period of time to get the severe brown mottling on the teeth, as opposed to the more typical mild white patches.”

She added: “For children that are considered to be at a high risk of tooth decay by their dentist, the benefit to health of preventing decay is likely to outweigh the risk of fluorosis.

“In such cases, careful brushing of their children’s teeth by parents with a small amount of toothpaste containing higher levels of fluoride would be beneficial.

“If in any doubt, we would advise parents to speak to their family dentist.”

EARTHIQUAKE 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 humanitarian aid to people affected by armed conflict, epidemics, healthcare exclusion and natural or man-made disasters. What makes this all 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.msfor.org.uk/supportus.aspx and click on the link to donate to the Haiti relief fund. Thanks in advance for your support.

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The Peninsula Dental School has opened two IOW practices

The Clinical Innovations Conference is now in its seventh successful year, and will be a lecture on the Management of Endodontic Failure.

The lecture will focus on common reasons for endodontic failure, and come up with suggestions for addressing these issues - helping practitioners ensure successful outcomes with tooth retention as the primary goal.

Dr Webber is internationally renowned for his knowledge and understanding of endodontic procedures, and has lectured around the world.

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The Clinical Innovations Conference hosted by education and training provider, Smile-on, will be held May 7-8 at the Royal College of Physicians, Regent's Park, London.

Dr Webber’s contribution to the conference, which is now in its seventh successful year, will be a lecture on the Management of Endodontic Failure.

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CDO opens two IOW practices

The Chief Dental Officer has officially opened two NHS dental practices on the Island of Wight, giving 12,000 more people access to treatment.

The practices, Cross Street Dental Centre in Ryde; and Whitecross Dental Care in Freshwater, are the result of a joint venture between NHS Isle of Wight and Integrated Dental Holdings.

Barry Cockcroft, Chief Dental Officer at the Department of Health officially opened both practices.

Caroline Morris, senior commissioner for primary care at Island NHS, said: “Over the past four years we have invested more than £4m in dental services for people on the Isle of Wight, which has almost doubled the level of NHS dental provision on the Island.”

“In 2006 we were reaching only 26 per cent of the Island population. We are now reaching 50 per cent and are aiming for a further ten per cent in the next year.”

She added: “It is really important for the public to know how to access NHS dentistry, and who to contact should they require advice or emergency treatment.

“The Hampshire and Isle of Wight Dental Helpline can provide information and advice on all aspects of NHS dental care.”
Editorial comment
Always look on the bright side of life

It seems that the doom and gloom that has beset the country is slowly beginning to lift. No, I’m not talking about that bastion of British whinging – the weather, we’ll need at least until May for that – rather the economic climate. Figures released by the Office of National Statistics has shown that the economy grew by 0.1 per cent in the last quarter of 2009. While it’s not quite time to run about the streets cheering, this does mean that it may be time to quietly plan for more optimistic times ahead.

There has been more positive news in the profession as well – half a million pounds of funding into the use of virtual reality and nanotechnology in dentistry given to the Peninsula Dental School; a new dental school in Scotland; new dental practices opening in the Isle of Wight – it looks like a new year and a new decade has seen the turnaround into a more positive outlook, and long may it continue.

Also looking into the future, careers in dentistry are taking centre stage with the holding of a live Q&A session discussing careers in dentistry and the upcoming Career Opportunities in UK Dentistry conference next week.

Don’t forget to visit my fundraising site – www.justgiving.com/bukumbibound to find out more about how I will be supporting the work of Bridge2Aid in the Tanzanian village of Bukumbi and to help by donating.

Guardian holds live Q&A on dentistry career

The Guardian Newspaper website held a live Q&A on careers in dentistry.

The session was hosted by the Careers section of the website as part of its National Occupation Shortage List Series.

Experts on the careers panel taking questions and giving advice included practising dentists and an orthodontic consultant from the British Orthodontic Society.

Scott Deacon, lead consultant orthodontist for cleft patients in the South West of England appeared on behalf of the British Orthodontic Society.

Mr Deacon is training programme director for Specialist Orthodontic Training in the South West and course director of the postgraduate orthodontic programme at the University of Bristol.

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Civil litigation report welcomed

Unsuccessful defendants should no longer have to pay ‘After the Event Insurance’ and success fees, according to proposals in a final report into civil litigation costs.

The Medical Defence Union (MDU), has welcomed the Right Honourable Lord Justice Jackson’s final report into civil litigation costs and claims it will improve the civil litigation process for claimants and defendants.

MDU head of claims, Jill Harding, said: “In our response to Lord Justice Jackson’s 2009 review of claims costs, we suggested a number of reforms which we believe are necessary to restore fairness and balance to the civil litigation procedures.

“We are delighted that many of these seem to have been proposed.

“We are particularly pleased that he has recommended unsuccessful defendants no longer have to pay for ‘After the Event Insurance’ and success fees which have contributed to the disproportionate costs faced by defendants, including MDU doctors and dentists.

Lord Justice Jackson in his report accepted the need for wholesale reform of costs management including the time spent on a case and solicitors’ hourly rates.

The report also recommends that specialist judges manage and try clinical negligence cases to ensure better cost and case management.

“Forg example, in the MDU’s experience, success fees can double claimants’ costs.”

Dental Protection communications manager David Groser commented: “Dental Protection welcomes the final report of Lord Justice Jackson on civil litigation costs.

Lord Justice Jackson consulted widely during the consultation process and DPL together with its medical colleagues within MPS made two submissions and also provided data to the review team; we believe that the report represents a fair and balanced review of costs. The report includes specific recommendations for clinical negligence litigation including removing the obligation that the losing defendant must pay the claimant’s after-the-event insurance cover and success fees.

Although DPL takes a firm stance when negotiating costs after settlement of a claim, these additional costs can sometimes double the costs which must be paid and this is necessarily reflected in the subscriptions charged to dental members.

“We would like to see the government bring forward legislation to implement these important changes. It would be a real shame if the momentum for reform of civil litigation costs was lost in the run up to a general election.”

‘Money-making’ dentist struck off

A dentist who conned patients out of thousands of pounds for fillings they didn’t need has been struck off by the General Dental Council.

Dr Constantine Saridakis, who worked at the Birchwood Dental Practice in Lincoln, was found guilty of 10 incidents of giving unnecessary treatment between May 2007 and March 2008.

In a number of cases, he recommended multiple fillings on patients who actually had no tooth decay. His partner gave a second opinion on some the cases, often finding no decay.

When confronted, Dr Saridakis allegedly said: “Sometimes I’m preventative, and sometimes I’m in a money-making mood.”

Dr Saridakis was suspended from NHS Lincolnshire’s dental performers list last April. However, he still treated two children then backdated the paperwork.

Two dental nurses voiced their suspicions when patients with healthy teeth were informed they needed fillings.

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New dental school for Scotland

Scotland’s First Minister has opened a dental school in an area where more than 51,000 people do not have a dentist.

First Minister Alex Salmond formally opened the £17m Aberdeen Dental School.

The Scottish government hopes the dental school will lead to a rise in the number of people entering the dental profession in Scotland - and in doing so reduce waiting lists.

Recent figures showed that nearly 80,000 people in Scotland are still without an NHS dentist, with NHS Grampian having more than 31,000 on its waiting list.

North-east Tory MSP Nanette Milne said: “There have been a number of difficulties in recent years with regards to patient access to NHS dentists in the Grampian area and I hope that the opening of the Aberdeen Dental School will help increase the number of dental students in training and the number of dentists who remain in the Grampian area after training.”

SNP MSP for Aberdeen North Brian Adam also expressed hope that the dental school will make a difference and said: “The Scottish Government and NHS Grampian are investing in North East dentistry to tackle the long waiting lists and poor oral hygiene in Aberdeen and Grampian which this government inherited.

“Since the SNP came to power we have seen the number of dentists in Grampian rise to 504, with an increase of 21 last year and nearly 8,000 people have been taken off the waiting list.

“State of the art dental school will see 20 new dentists graduate every year from Aberdeen. Hopefully we can retain these dentists in Grampian and with their help make those long queues of people signing up to a dentist, a thing of the past.”

Rise in tooth whitening

Despite the economic downturn, there has been a rise in the demand for tooth whitening products and treatments, according to a recent survey.

A recent survey conducted by market research group Mintel found that around a third are concerned by the look of their teeth and 18 per cent do not like to show their teeth in photographs.

Tooth whitening has become a key reason for people to visit their dentists and sales of tooth whitening products rose to £37m last year and are predicted to increase by 96 per cent to £269m by the end of 2010.

The trend towards using tooth whitening treatments is being actively promoted by celebrities such as Simon Cowell who advocates Sonicare with all X Factor finalists being sent a Philips Sonicare as part of their make-over.

A healthy looking smile has been shown to influence well-being, enhance self-confidence and make people appear more youthful.

Philips has created ‘Patient Profiles’ information cards and fact sheets to help dental professionals communicate better with their patients and show the benefits of its Sonicare HealthyWhite toothbrush.

The fact sheets can be personalised with a patient’s details and downloaded for free from the Sonicare website www.sonicare.co.uk/dp.
Dental nurses petition government

Nearly 600 dental nurses have signed a petition on the Number 10 website calling for the government to put pressure on the General Dental Council to reduce the Annual Retention Fee.

The General Dental Council (GDC) decided to freeze the Annual Retention Fee (ARF) of £56 for dental care professionals for the third year running.

However, dental nurses claim it is unfair that dental professionals on higher salaries pay the same ARF.

An online No 10 petition needs to get at least 500 signatures before it will reach the Prime Minister’s office.

The petition lodged by Xy-anthe Lambert says: “We the undersigned petition the Prime Minister to reduce the annual Retention Fee for Dental Nurses to ensure a fair comparison ag-ainst the higher salaries of hygienists/therapists and lab technicians, compared to Dental Nurses lower pay.”

She adds: “I would like to highlight that dental nurses are on a lesser wage than hygienists/therapists and laboratory technicians, but are expected to pay the same annual retention fee as them.”

However, Pam Swain, chief executive of the British Dental Nurses Association (BADN) believes that the most effective way of getting things changed is to join the BADN.

The BADN is currently gathering information about the salaries of dental nurses so it can highlight the low pay they get and present its case to the GDC.

GDC president, Angie Mc-Ilain claims that the GDC fails to take into account the fact that many dental nurses only work part-time and yet are expected to pay the same as hygienists and therapists (who are paid a minimum of £25,000 when newly qualified).

BADN want a complete revi- sion of the registration fee to in- clude lower fees for dental nurs- es, reduced fees for all part time registrants and payments to be spread across at least two instal- ments over the year, as well as for BADN to be consulted fully on all matters concerning dental nurse registration in the future.

Career opportunities event

The one-day event ‘Career Opportunities in UK Den- tistry’ celebrates its tenth year this February.

The event organised by the British Dental Association and UCL Eastman Dental Institute is being held on 12 February at a new and bigger venue – the Cen- tral Hall Westminster, located opposite Westminster Abbey and the Houses of Parliament.

The conference is aimed at vocational dental practition- ers, young dentists, anyone con- sidering a change of career or returning to dentistry after a ca- reer break, as well as dentists from overseas.

The day will consist of a pro- gramme of lectures by knowl- edgeable speakers. There will also be an exhibition with em- ployers of dentists and organi- sations who support dentists throughout their careers.

Professor Jimmy Steele will be making the keynote address discussing challenges and op- portunities that have arisen from the Steele Report.

There will also be a panel debate attended by Stephen Pur-

ret, professor of Oral Medicine and director at the UCL East- man Dental Institute Susie Sanderton, chair, British Dental Association Executive Board; and Jimmy Steele, professor of Oral Health Services Research, School of Dental Sciences, New- castle University.

For more information about the event, please visit: http://www. eastman.ucl.ac.uk.
GDPUK round-up

With the GDPUK online community remaining a continual bubble of activity over the holiday period, forum founder Tony Jacobs says there’s much to look forward to in 2010

GDPUK readers were busy through the December holiday period with the site even busier in early January when the snow meant more colleagues were at home with time to spare. The activity on the site suggested that catching up with the practice book-keeping was the last thing on their mind. In the early part of the New Year, a topic was raised asking what dentists were talking about 10 years ago. I had a look back in the archives of messages posted in January 2000, and although I cannot promise it was a perfect and thorough review of all the postings at that time, some of the topics might jog your memory.

Debates from that time concerned the bleaching of teeth, the different methods, and the pros and cons of each style of treatment. Then there were discussions on the erosion of teeth, pregnancy, and NHS services in specific towns and holistic dentistry. There were also arguments as there are now, about the effectiveness of the British Dental Association (BDA) in representing the profession. Obviously this is a perpetual discussion point, and may always be.

Today’s hot topics
Back to the present, I will tell you about the hot topics now. The concept of the use of homeopathy in dentistry was raised with one or two proponents. This argument was attacked by a group of members, citing many reasons why this was unscientific. To give non-members a flavour of how severely debated these topics can be on GDPUK as a vibrant forum, this topic attracted 107 replies within a few days.

On a lighter note, there was an informal competition to post pictures showing the lowest temperature on a car’s external thermometer during the period of snow [I managed -11°C in Manchester]. Travel in the snow, and some beautiful views from practice windows were posted, allowing for expressions of wonder and awe.

Other topics included advice on instrument washers, a discussion on lesser-known implant brands, section 63 courses and their organisation, as well as a small dental Christmas carol competition.

UDA claim campaign
Meanwhile, Ian Gordon started a campaign supporting NHS practices being able to claim some reduction in UDAs targeted for this year due to the disruption caused by the snow in early January. When the subject of the weather was broached, the whole country was unanimous in how much dental practices had been affected, with the public being given local or national advice not to venture out, with warnings of particular danger to the elderly and very young.

Has the campaign been successful? You will have to watch this space.

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Clinical Governance

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Dental Tribune

United Kingdom Edition

February 1-7, 2010

And all from the back of an envelope!

Dental Tribune speaks to Raj Rattan about his involvement in the development of Clinical Governance Progress Management and how it can save practices valuable time

Clinical Governance has been gaining momentum in practice thinking over the last 18 months or so. With it being a requirement of the NHS contract, and the upcoming strategies that the Care Quality Commission will be putting in place, the time really is now for practices and PCTs to ensure their CG procedures are in order.

One of the PCTs who have been more forward thinking about how they ensure compliance with CG is Bromley. Starting in 2005, the PCT had been running an IT seminar; something that Bromley dental practices two years ago the PCT decided that what they then needed was a programme whereby they could measure consistently practices’ performance in the different areas of CG and identify the gaps.

Ambitious project

This is where Raj came in. Raj Rattan is a practitioner based in West Bromley, and a Dental & Ophthalmic Commissioning & Performance Manager and Carol Adeloye – Dental & Ophthalmic Commissioning & Performance, Emma Wallis – Dental & Ophthalmic Commissioning & Performance Manager and Carol Adeloye – Dental Practice Advisor) and the team at Bromley PCT.

Raj recalled: “Once the PCT had asked me to come up with a local Clinical Governance programme, I devised a concept that was essentially based on the seven domains which the Health care Commission of the time had identified in the Standards for Better Health document. Following on from that came a list of criteria and a scoring system, which allowed people to self-assess as well as allowing the PCT to analyse what was going on. It was all built in Excel; the outcome was that it would generate a series of graphs which would show practices where they were in each of the domains and how much each practice still needed to do.”

It was the chance to work on something other than the TLC as Bromley’s lead on CG, Harry Goldingay, had spoken to Smile-on, a provider of online Clinical Governance programmes, about a new online CG programme. Raj said: “I gave my presentation on the Excel-based programme I had been working on and Harry commented to me that this is really interesting as what you’ve shown us I think would fit nicely with a call I had this afternoon from both practices and the PCT on their programme! This then lead to a meeting between the PCT and the company and I was asked to present my Excel ‘product’.”

With CGPM, Primary Care Trusts can:  
• Use CGPM to undertake Clinical Governance assessment procedures; PCTs can call in and monitor progress, dentists can upload their evidence which the PCT can read, which is fantastic.

The workshops ran over a period of six months at the end of last year. A small number of groups did a pilot programme that was designed to allow dentists to access a computer workstation so they could log on to the system and try it out. Raj said: “We had originally run a series of workshops before we introduced CGPM we went to a lot of trouble to engage with dentists throughout the programme; we also consulted with the LDC. The PCT told the practices ‘this is what we want to do’. There was resistance, there’s bound to be, but the majority said ‘ok if this is what we need to do, let’s face the nice way in which to get it done and have a supportive way to do it’.

The workshops ran over a period of six months at the end of last year. Because they were run in small groups, what we did was get the first cohort up to speed then they were the first group to be visited, then the second were to be visited and so on. So the whole programme was done in a very structured and supportive way because there was resistance to CGPM, but that it was a common occurrence when change of this scale happened. “What was very interesting for me personally – I love working on new projects and I always felt that the hard bit of governance was actually doing the gap analysis; also measuring the improvement of practices. How I feel about it as an individua-
Considering risk assessment when planning treatment

Dental Protection looks at assessing facets of case preparation

Every treatment plan, from the simplest to the most complicated, employs a dual process of data collection. The initial input from the patient is enriched with information from the clinical examination and any relevant investigations, so that a suitably informed diagnosis can then be made before a treatment plan is formulated for discussion with the patient as part of the prudent foundation for the consent process. All these stages raise questions that have to be correctly answered to ensure a correct assessment. Sometimes the ‘stations’ on this journey are passed through at a brisk pace. When the diagnosis is self-evident, or a sample for bacteriological examination is enriched with information that have to be correctly answered, the quality of the decision tends to improve in direct proportion to the quality and accuracy of the available information.

Investigations
Investigations and tests can take many forms, and the questions of Which?, When? and For Whom? are highly relevant.

Diagnostic phase
What? (eg what is causing the patient’s pain?) Why? (eg why does this filling keep fracturing?)

Treatment planning phase
How? Is a question that is added at this stage along with considerations of What? and When? The prudent clinician will also be asking: Why not? When not? How not? Who? Etc.

In most clinical situations – including diagnosis and treatment planning – the clinician is faced with choices. As in any decision-making process, the logic or appropriateness of any further problems for the patient, the dento-legal problems may be compromised and the risk to both or jaw fracture may be high. Third molars are another obvious area where knowledge of the root configuration, the overlying bone, and the relationship of the tooth to adjacent teeth, the inferior dental nerve bundle, and the lower border of the mandible, is essential. If radiographs are not taken, and a serious problem occurs, the dentist will be under pressure to demonstrate that the absence of the radiograph(s) could not have contributed to the problem in any way.

Radiographs are similarly an important investigation in cases where orthodontic extractions are contemplated (to confirm any congenitally absent teeth or other pathology), as well as serving as an aid to orthodontic treatment planning and case management. Similarly, in association with the diagnosis and treatment of periodontal disease, and endodontic problems, the absence of radiographs leaves a dentist highly vulnerable to the allegation that the dentist or his assistant failed to carry out a relevant and material investigation. If a delayed diagnosis and treatment results from this lack of radiographs and has led to any further problems for the patient, the dento-legal problems for the dentist are compounded.

In endodontic cases, relatively common problems such as fractured instruments and under and over-root fillings, have all been attributed on occasions to the absence of relevant X-rays – perhaps no pre-operative X-ray was available to forewarn of a root curvature or sclerosis, or an exceptionally fine canal, or perhaps no working length X-ray was taken to assist in controlling the length of the filling (although in the latter situation, electronic apex locators are an alternative investigation which can be depended successfully).

Cases where it is alleged that the ‘wrong tooth’ has been extracted or filled, or its pulp tissue has been unnecessarily extirpated, often hinge upon the evidence of proper investigations. In situations where the diagnosis is initially equivocal or inconclusive, cases may hinge...
Occlusal investigations can take many forms, ranging from the use of articulating paper, wax, indicator spray or other occlusal ‘marking’ devices, through articulated study models, to a more detailed facebow registration, pantograph tracing or devices which measure and record muscle activity. The use of a stethoscope also has its place in TMJ auscultation. The skill lies in knowing which investigations are appropriate, for which patients, and under what circumstances. The danger lies in erring on the side of too few, or too superficial, investigations.

**Recording investigations**
The key to the investigation process is to record what investigations are being carried out, and the findings so that, if necessary, one can demonstrate at a later date, a logical and carefully-followed process leading to a diagnosis and treatment plan. It is much easier to defend a practitioner’s actions if supported by and consistent with a meticulously-recorded series of relevant investigations, (even if subsequently proved to be misleading or incorrect), than the commonly-encountered responses such as:

“I would probably have checked the tooth vitality and looked for any tenderness to percussion; I wouldn’t always write it down”.

or perhaps:

“I presume the periodontal condition must have looked better that day, or I would have done some further treatment and made a note in the patient’s records.”

The clinical records should make it possible to follow the clinician’s logical thought process through the stages leading to any particular course of treatment. All the relevant components of the case assessment process on whether the investigations carried out were sufficient to support a given diagnosis and treatment. On the other hand, there is little point in carrying out full and proper investigations, and then failing to act upon the results.

In the case of some infections, taking the patient’s temperature can indicate the presence or absence of systemic involvement, and other specific measurements of the site, size and appearance of oral lesions (ulcers, swellings, white patches, and other dysplasia) - perhaps with the help of an intra-oral photograph - can make it much easier to monitor the development of resolution or oral pathology. The increasing frequency of cases involving missed diagnosis or oral carcinoma, stresses how important this can be.

Similarly, periodontal probing depth measurements are a valuable investigation whether in the form of a BPE screening, or a more extensive chart either around specific teeth, or all standing teeth.
Case module 13.4

Case module 13.3

Case module 13.2

Simple audit

It is a useful exercise to take any ten record cards for patients who have had a significant amount of treatment, or an unusual treatment episode, and to 'audit' these cards just as a third party might do, were a problem to arise today.

- Are there any questions left unanswered by your records?
- Can you demonstrate the investigations you carried out?
- Do they now appear to have been sufficient or might it have been helpful to carry out and record additional investigations?
- Are you omitting to record investigations you do carry out (percussion/mobility testing is a familiar example of this), perhaps because you see them as a routine part of a clinical investigation? Many dentists tend to record only 'positive' or 'abnormal' findings, whereas 'negative' and 'normal' findings can be equally (or sometimes more) valuable - such as 'no tenderness in sulcus', or 'normal response to ethyl chloride'.
- Is it clear from the records how and why the diagnosis and treatment plan reflected the patient's condition? The consent process is only valid if one or more important and relevant treatment options have not been discussed with or offered to the patient (by referral, if necessary). Similarly, it is unwise to steer a patient too forcibly towards one particular treatment option without explaining its risks and limitations.

The more experienced a clinician becomes, the greater the danger that their histories, discussions and investigations will be viewed by them in this light, with diagnoses made and treatment plans decided upon apparently 'instinct'. There is even greater room for criticism when the records create the impression that the clinician was determined to carry out the chosen treatment (whether or not it was justified in the light of the specific clinical circumstances of the individual patient concerned) and that no other treatment option was really considered at all. It is helpful, therefore, to carry out a periodic audit of one's clinical records as described above, not only as a valuable self-assessment process, but also as a useful platform for constructive peer review discussions.

Dental care is not static, it affects and is affected by the changing continuum in the patient's general health and therefore consideration must always be given to the possibility of having to change the diagnosis and treatment plan as the patient's condition alters.

Consent

When one or more treatment options have been identified, or a provisional treatment plan has been reached, it is necessary to involve the patient fully in a consent process which explains the nature, and likely outcome of each of the possible alternatives, compares their relative advantages and disadvantages, benefits, risks and limitations (and costs, where applicable). The consent process is only as good, however, as the quality of the information and treatment choices that the clinician invites the patient to consider. Consent may not be valid at all if one or more important and relevant treatment options have not been discussed with or offered to the patient (by referral, if necessary). Similarly, it is unwise to steer a patient too forcibly towards one particular treatment option without explaining its risks and limitations.

Summary

A typical scenario is the situation where a tooth becomes pulpitic very soon after a crown, bridge or veneer is placed and then needs to be root filled. In such a situation it is invariably difficult to persuade the patient that he/she should pay for a root filling, or for a new replacement restoration (if necessary). The clinician may well be asked whether:

- Was more than one treatment option recorded?
- Is it clear from the records how and why the diagnosis and treatment plan reflected the patient's condition?
- Can you demonstrate the investigations you carried out?
- Do they now appear to have been sufficient or might it have been helpful to carry out and record additional investigations?
- Are you omitting to record investigations you do carry out (percussion/mobility testing is a familiar example of this), perhaps because you see them as a routine part of a clinical investigation? Many dentists tend to record only ‘positive’ or ‘abnormal’ findings, whereas ‘negative’ and ‘normal’ findings can be equally (or sometimes more) valuable - such as ‘no tenderness in sulcus’, or ‘normal response to ethyl chloride’.

A preoperative radiograph to view the apex, vitalitv test(s) to confirm pulpal health had been performed and any other clinical and pathological examination relevant to the patient's condition. There are occasions when treatment itself forms part of the investigation. The outcome of such treatment is then fed into the diagnostic process.

Consent

Correct diagnosis is the outcome of successful and appropriate investigation including history taking, visual and radiographic examination and any other clinical and pathological examination relevant to the patient's condition. Sometimes only a provisional diagnosis can be reached which leads to further investigation. Each subsequent step/investigation/diagnosis leads to a definitive diagnosis which in turn will lead to a definite treatment plan. There are occasions when treatment actually forms part of the investigation. The outcome of such treatment is then fed into the diagnostic process.
Tailor-made agreements

A properly drawn-up associates contract, although not entirely conclusive, may go a long way to avoid future challenges that a self-employed associate is actually an employee. Tim Lee explains

Cases involving the employment status of ostensibly self-employed associates continue to come before Employment Tribunals (ET). ETs are “first instance” tribunals, so the decision of one ET is not binding on others. However, in practice, tribunals often look to earlier ET decisions for guidance (and perhaps sometimes inspiration!).

The higher courts (whose decisions may be binding) have said, time and time again, that decisions involving employment status depend entirely on the facts of each case. The courts stress that a simple “checklist” approach to the problem is not sufficient. Each court or tribunal has to look at all the circumstances of each case.

Grotepass v Singh

In the recent case of Grotepass v Singh (which came before the Southampton ET in July 2009), the Claimant who had been an associate of the Respondent principal, claimed he had actually been employed. There had been no written associate’s agreement.

The ET found that the Claimant had been treated as self-employed for tax purposes. Fees were made up of private patient fees per item charge, and a licence fee of 58 per cent. The ET also felt that the Claimant’s freedom, dealt with his own complaints, and chose his own dental lab.

In Grotepass, the preliminary point relating to the employment status of the Claimant fell for preliminary discussion. However, in Kalsoom, the ET also went on to consider whether the Claimant also met an extended definition of “employee” under the Sex Discrimination Act, and the definition of “worker” under the Employment Rights Act. A finding that the Claimant fell within the extended definition of “employee”/“worker” for those purposes, might enable the Claimant to pursue claims of discrimination, unlawful deduction of wages etc (regardless of the Claimant’s status as an employee to seek compensation for alleged unfair dismissal). The ET took the view, on the facts of this case, that the Claimant had not been an employee. The tribunal felt that there had been no “mutuality of obligation” between the principal Respondent and the associate Claimant, for example, that there had been no binding obligation on the principal to provide the associate with any particular amount of work or work of a particular kind.

The ET pointed out that the Claimant had absolute clinical freedom.

The ET also felt that the fact that the Claimant had not been paid a regular annual salary, and had no fixed hours, together with the “self-employed” arrangements for his pay, were all inconsistent with his being an employee.

Kalsoom v Clements & Pema

Interestingly, the finding of the Southampton ET in connection with the “mutuality of obligation” point, was not consistent with the finding of the Birmingham ET in the case of Kalsoom v Clements and Pema, which was heard January 2009.

As in Grotepass, the preliminary point relating to the employment status of the Claimant fell for preliminary discussion. However, in Kalsoom, the ET also went on to consider whether the Claimant also met an extended definition of “employee” under the Sex Discrimination Act, and the definition of “worker” under the Employment Rights Act.

In Kalsoom, the Employment Judge did find that there was sufficient “mutuality of obligation” to create a contract between the parties sufficient to enable the ET to decide that the extended definition of “employee” applied, to enable the Claimant to pursue her claim for discrimination. The ET also found the Claimant was a “worker”.

On the facts of this case, the ET did not consider however, that Ms Kalsoom was an employee for the purposes of bringing a claim for unfair dismissal (a similar finding to Grotepass).

What this means

Although the Kalsoom and Grotepass cases provide some guidance, nevertheless the legal position on the status of associates for employment law purposes remains murky. The ETs latched onto the fact that, in each case, the Claimant had sole clinical judgement, and thought this to be indicative of self-employment rather than employment. On this point I remain unconvinced.

Lessons to be drawn

In dealing with practice acquisitions and sales, I am often surprised at the number of practices that I encounter where there are no written associates contracts in place.

One important lesson to be drawn from these two recently reported cases, is that a properly drawn-up associates agreement, although not entirely conclusive, may go a long way to avoid future challenges that a self-employed associate is actually an employee.

It is important to remember that associates’ agreements are not “one size fits all”. Each situation should be properly and individually considered, taking legal advice where necessary, and ensuring that agreements are tailored to particular circumstances.

The author

Tim Lee is commercial law director and solicitor at Young and Lee Solicitors Limited in Birmingham. For more information, visit www.younglee.co.uk or call 0121 655 3257.

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Dr Julian Webber
After qualifying from Birmingham Dental School, UK in 1974, Dr Webber worked as an Associate in a National Health Service Practice for two years before continuing his education at Northwestern University Dental School, Chicago, Illinois, USA. As the recipient of the prestigious Charles Freeman Scholarship of the American Dental Society of Europe he was the first UK dentist to receive a Master of Science Degree and Certificate in Endodontics and returned to the UK in 1978. Dr Webber has held teaching positions both at Guy’s Hospital and Eastern Dental Schools in London whilst maintaining a practice limited to Endodontics in central London since 1978. In October 2002, he opened the Harley Street Centre for Endodontics, a purpose built state of the art clinical teaching facility. Dr Webber devotes much time to teaching and writing having contributed to numerous journals and textbooks on Endodontics and extensively lectured around the world. Dr Webber is a former President of the British Endodontic Society, a member of the American Association of Endodontists, European Society of Endodontology, a member of both the American Dental Societies of London (past president) and Europe (current vice president), a member of the Pierre Fauchard Academy and a Fellow of the International College of Dentists. He is a faculty member of the Pacific Endodontic Research Foundation in San Diego, California, where he has perfected and taught techniques on Microscope, Conventional and Surgical Endodontics. He is a visiting Professor at the University of Belgrade, Serbia and Montenegro.

Julian will be speaking on Management of Endodontic Failure

Dr Trevor Bigg
Dr Bigg has been working in private practice in West Oxfordshire for nearly 40 years and has treated up to four generations of some families. He operates a general practice and take referrals for cosmetic dentistry, the non-invasive restoration of the worn dentition and treatment of Temporomandibular Dysfunction (TMD). He was a tutor to the Central London Study Group for five years with MGIDS students and mentor practitioners who are taking the FFGDP(UK). Dr Bigg lectures at home and abroad on crown and bridge updates, posterior and anterior composites, bleaching and Minimal Intervention Dentistry. He also runs day ‘hands-on’ courses for Denplan and Dentistry on Contemporary Aesthetic Dentistry and presented a Smile-On webinar on Bleaching. Dr Bigg holds a membership in General Dental Surgery at the Royal College of Surgeons, London and Fellowships from the College of Surgeons in Edinburgh and London and is a Past-President of the British Society for General Dental Surgery.

Trevor will be speaking on Progressive Tooth Whitening

Dr Wyman Chan
Dr Wyman Chan has qualified at Guy’s Hospital Dental School, London. He set up the first dedicated teeth whitening spa smiles studio in UK in 2002, and then a licensing network of smiles studio outlets a year later. He is the founder of smiles studio Teeth Whitening Academy, which began training the dental team on teeth whitening processes in 2005 with his hands-on format. He has trained more than 1,500 dentists, dental hygienists, dental therapists, dental nurses and other dental team members.

Wyman has worked with all major home and power whitening systems and has performed more than 5,000 whitening procedures. His innovative research in the field of teeth whitening led to five UK granted patents and several more pending. Wyman won the prestigious Procter and Gamble Investigator Award at the 2008 International Association for Dental Research meeting in Toronto, Canada. He is a part-time PhD research student at the Centre for Materials Research in Education at the University of Bolton, United Kingdom. Through his research and experience of treating thousands of patients, Wyman has discovered some important phenomena in the texture of teeth, and utilised them to establish some important protocols and metrics that have contributed to the understanding and improvement of safety and efficacy of teeth whitening processes. He has many articles published in dental journals and is well regarded as an expert in this field.

Wyman is a wet-handed teeth whitening dentist and treating around 1,000 patients every year in his dedicated teeth whitening Centre, and spend the rest of his time on research. He lectures internationally and runs regular hands-on power whitening seminars in London.

Dr Edward Lynch
Edward is Head of Restorative Dentistry and Gerodontology at Queen’s University Belfast and is also Consultant in Restorative Dentistry in the Royal Hospitals. A specialist in endodontics, prosthodontics and restorative dentistry, he is also on the editorial board of numerous international journals and has published more than 450 publications. Professor Lynch is very much a ‘wet gloved’ academic, treating many specialist referrals every week.

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If you keep one New Year’s resolution this year, says Peter Dunn, make sure it is the one to be more financially efficient.

Even if you begin with a comprehensive analysis of your current situation, which is always the first approach of any good financial adviser, just take that initial step. Think about all the policies you probably have: critical illness cover, life assurance, pensions, savings and investments, loans and mortgages; the list goes on. Get them working for you! Make sure that your financial decisions are informed and focused on an end goal that realises the life goals you most desire. Everything is possible when you combine action with purpose.

Half-hearted plans to do more exercise, drink less alcohol or eat more healthily – they are all well and good, but none of them will help you achieve your long-term aims – goals and aspirations that really matter. Make sure your New Year’s resolution for 2010 really counts – make an appointment with a financial adviser, ask around and see who comes highly recommended. Enjoy the peace of mind that comes with knowing your future is planned, your affairs are in order and your financial success is secure.

**About the author**

Peter Dunn is director and senior consultant for Heritage Financial Advisers, a team of independent, fee-based financial planning specialists dedicated to the dental sector. Peter has over 20 years experience of working within the dental industry in financial services companies allied to Dental Business Solutions and Practice Plan. In 2001, he relocated to Newbury with what is now Heritage Financial Advisers and assumed joint control of the company in 2006. To contact him, call 01635 48727 or email info@hfadvisers.co.uk.
Closing the gap
Dr Edward Young shows how the Clearstep method has helped a young lady gain her confidence and a beautiful new smile

Our patient, a 25-year-old female, had no history of orthodontic treatment and she came to us with concerns with the appearance of her upper anterior teeth. In particular, she felt that both her UL2 and UR2 were moving backwards and UL1 and UR1 were moving forwards.

At that particular point, she was beginning to be very self-conscious with the appearance of her teeth. Her interest was principally in Clearstep as they are invisible and unobtrusive; she works as a primary school teacher and felt this would be a perfect choice. Although her lower teeth are also crowded, she sought only to have upper arch teeth treatment.

Closer examination of her teeth revealed that both her UR2 and UL2 were instanding and that she was tending to favour a Class III edge-to-edge incisal relationship. Her upper arch was also somewhat narrow and her overbite decreased.

Taking impressions
Relevant intra-oral and extra-oral photos, x-rays and accurate impressions were sent to OPT for analysis. On receipt of the detailed report, it was explained to the patient that in order for the perfect result she would need to consider having lower arch treatment too.

However, in order to address her problems, we would first have to expand out her upper arch using the Clearstep Orthodontic Dentofacial Aligner (CODA system), thus making her upper arch wider and then finally use Clearstep positioners to align. The CODA is a removable lateral expansion device made with very light elgiloy wire and soft esther acrylic. It is highly discreet and has a minimal affect on speech. I find the appliance encourages more effective lateral movement of teeth than a box of positioners.

Treatment recommended
We advised the patient to wear two CODAs for 14 weeks in order to expand out her upper anterior teeth, particularly UR2 and UL2. Prior to fitting the CODA, Clearstep enclosed composite templates to allow placement of material on the palatal surfaces of her UR2 and UL2. This allows the acrylic portion of the CODA to be inserted snugly underneath them to encourage gentle, consistent, favourable forces. It was also noted earlier that the patient had a decreased overbite and this could be made worse by a potential appliance propping open her bite. In order to address this issue, posterior bite raisers were fitted in her UR7 and UL7. The CODA can be worn at all times and typically patients adjust to the appliance very well. The patient was advised to return after 14 weeks to monitor her progress and to take fresh impressions for the move onto Clearstep positioners.

Long-term retention
After nine months of clear positioners, the case came to an end, and again, three retainers were given to the patient to encourage long-term retention.

The above case uses a number of techniques and appliances, systematically implemented in order to encourage favourable tooth movement to full effect. Clearstep positioners alone would have taken a little longer.

Throughout treatment, the patient had been able to continue her busy working life looking after a classroom of children as well as live her active social life while her smile continued to improve with no obscurities or problems.

The patient is delighted with the results and the tooth movement is apparent from the occlusal views in the images.

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About the author
Qualifying from Sheffield University in 2004, Dr Edward Young practices at Ambleside Dental Care where he has a special interest in cosmetic restorative dentistry and orthodontics.
Cutaneous sinus tracts: An endodontic approach

Diagnosis and treatment for a successful outcome

Misdiagnosis of an extra-oral sinus tract usually leads to a destructive invasive treatment of the local skin lesion that is not curative and often mutilating (Fig. 1). Attempting to treat such lesions with a circular incision of the orifice of the cutaneous fistula and excision of its entire tract with all the ramifications is not consistent with the present standard of care. Unfortunately, cutaneous fistulae are sometimes treated as though they are independent dermatologic lesions with the pathogenic characteristics and treatment prognoses typical for mucosal fistulae. However, even skin biopsy may produce unnecessary scarring.

Correct diagnosis is the key to treating this kind of lesion. A gentle digital finger pad pressure on the apical region of the area suspected can create a discharge of pus. A Dentastar can provide reliable information that will help with the final diagnosis and the subsequent treatment plan. A correct diagnosis will lead to a simple, yet effective treatment—the removal of the infected canal tissue from the root canal space—resulting in minimal cutaneous scarring.

Cutaneous sinus tracts of dental origin have been well documented in the medical literature, dental literature, and dermatological literature. However, these lesions continue to be a diagnostic dilemma. Patients suffering from cutaneous fistulae usually seek treatment from a physician or a plastic surgeon instead of a dentist and often undergo multiple surgical excisions, multiple biopsies and antibiotic regimens with eventual recurrence of the cutaneous sinus tract because the primary dental cause is frequently misdiagnosed.

The evaluation of a cutaneous sinus tract must begin with a thorough patient history and awareness that any cutaneous lesion of the face and neck could be of dental origin. The patient’s history may include complaints of dental problems. However, patients may not have any history of an acute or painful onset. There may also be complaints of episodic swelling or drainage from the cutaneous site with persistence of the cutaneous lesion. Occasionally, there is a history of injury to the tooth.

Correct diagnosis of the cutaneous sinus of dental origin should be suspected by the gross appearance of the lesion. These cases typically present as erythematous, symmetrical, smooth, non-tender nodules of one to 20 mm in diameter with crusting and periodic drainage in some cases. The most characteristic feature of the nodule is its depression or retraction below the normal surface. This cutaneous retraction or dimpling is caused by the fixation of the tract to the underlying tissues and may be secondary to the healing process or a late finding in active disease. Lesions that previously underwent biopsy and treatment are usually characterised by the absence of at least part of the nodule and frequently by an orifice of draining sinus at the base of the fixed depression.

Endodontic infection, the product of cellular degeneration—bacterial toxins—and, occasionally, the bacteria themselves within the canal spread through the apical foramen into the surrounding tissue. Thus, a slow inflammatory process begins in the tissue contained within the periodontal ligament. Left to itself, it may manifest in a variety of ways, ranging from simple widening or thickening of the ligament to granuloma or cyst. It may even traverse the periodontal ligament to granuloma or cyst. Sometimes a fistula may develop, with the patient reporting intermittent discharge of pus.

The fistula provides a means of continuous drainage of the lesion. The opening of the fistula may be found on the mucosa overlying the tooth that sustains it, but often it may also be found at a considerable distance from the diseased tooth. In some cases, the fistula may run in the space of the periodontal ligament of the same tooth. It may even traverse the periodontal ligament of the adjacent healthy tooth, thus stimulating a lesion of periodontal origin. In such cases, negative pulp tests performed on the crown of the tooth, indicated by a gutta-percha cone inserted into the fistula, assist in making the correct diagnosis.

If the drainage of the fistula is not continuous but intermittent, it is preceded by a slight swelling of the area as a result of the increased pressure of pus behind the closed orifice. When the pressure becomes strong enough to rupture the thin wall of soft tissue, the suppurrative discharge issues externally through the small opening of the fistulous orifice. This orifice may heal and then re-close, only to re-open later. The discharge of pus is never accompanied by intense pain. At most, the patient will complain of slight soreness in the area prior to reopening of the external orifice. The pus creates a tract in the surrounding tissues, following the locus minoris resistentiae. It may exit, at any point, in the oral mucosa or even in the skin. It is not uncommon, particularly in young patients, to find a cutaneous fistula at the level of the mental symphysis, if lower incisors are involved, or in the sub-mandibular region, if a lower first molar is involved. Also, it may be found in the floor of the nasal fossa, if a central incisor is involved.

Attempts to treat cutaneous fistulae with a circular incision of the orifice of the cutaneous fistula and excision of its entire tract with all the ramifications cannot be considered to comply with the present standard of care and should be regarded as highly undesirable. Most of the time, root canal therapy is the ideal treatment for such lesions. However, Grossman states that such tracts are lined by granulation tissue. In his study, Grossman was unable to identify any epithelium at all. Bender and Seltzer also conducted histological studies of numerous fistulous tracts without finding an epithelium lining. Given the current state of knowledge and scientific data, there is no reason to recommend surgical removal of such tracts, just as there is no reason to believe that even epithelum-lined fistula tracts should not heal after appropriate endodontic therapy.

Obviously, these fistulae must be distinguished from congenital fistulae of the neck, both lateral-arising from the second brachial cleft—and medial—arising from the retroglottal duct—which are lined by an epithelium. Such fistulae are of a different pathogenesis and definitely do not resolve spontaneously but only after careful surgical excisions of the tract.
The differential diagnosis of the case in question included the following:

- localised infection of the skin, such as pyoderma, pimples, ingrown hairs and obstructed sweat glands;
- traumatic or iatrogenic lesions;
- osteomyelitis;
- tuberculosis; and
- actinomycosis.

**Case presentation**

The patient was referred to me from overseas with a large mandibular fistula, which had previously been misdiagnosed as an infection of the submandibular gland. Surgery had been performed and his submandibular gland had been extracted. The wound had not healed and the clinical situation was fast worsening. Thus, the wound had opened and subinfectd with a heavy discharge of pus.

A dentist invited to see the patient immediately telephoned me and sent a photo of the wound to me via his mobile phone. Following my recommendation, the patient was immediately put under double antibiotic therapy (Amoxicillin 1000mg twice daily, Metronidazole 500mg twice daily). The patient presented to my clinic the following day, where we started with a detailed questionnaire to collect all the information about the history of the wound. The patient reported that he had been suffering from this fistula for quite some time already with intermittent phases of discharge of an exudates and numbness of the lower lip. No dental pain was reported.

A panoramic X-ray showed some bone rarefaction under teeth 47 and 46, but no invasion of the mandibular nerve tract was evident (Fig. 2a). A dental scan with 0.5 mm increment was performed in order to gain a better idea of the clinical situation. One of the sagittal slides (015) clearly shows the lesion around the distal root of tooth 47, surrounding the apical part and destroying the cortical bone invading the soft tissue (Fig. 2b). Furthermore, the mesial root of tooth 46 showed apical radiolucency, invading the tract of the lower mandibular nerve (O14; Fig. 3). This pathology explains the numbness of the lower lip, while the pathology around the distal root of tooth 47 explains the extra-oral fistula.

Careful review of the axial slides in the area of tooth 47 (006) offers an idea about the amount of bone destruction in the lower lingual area. The axial slide under tooth 46 reveals the communication between the lesion under the mesial root and the mandibular nerve tract (Fig. 4).

Next, we established a clear diagnosis that the lesion was an extra-oral cutaneous fistula of dental origin. The patient was suffering from a large, infected open wound and a suitable treatment plan had to be established quickly. The following solutions were presented:

1. Extraction of the teeth and curettage of the area, with extra attention paid to the mandibular nerve: This plan could provide the patient with a solution for eliminating the infection and allowing the wound to heal. Yet, two strategic molars would be lost with this solution and a replacement would not be an easy job with this amount of bone destruction in the infected area.

2. More conservatively, a root canal treatment in order to clean and disinfect the root canal systems of the two molars, followed by an internal medication and a 5-D obturation capable of blocking the bacteria from reaching the apical part and trapping the remaining bacteria inside the root canal system. This approach would allow the patient to keep his molars and would provide an environment in which the healing process could begin. The risk would be the establishment of an external biofilm that cannot heal by itself and may require microsurgical removal.

The patient and I decided to preserve the two molars. Immediately, root canal treatment, cleaning and shaping of the canal space using TF files (SybronEndo) with copious saline, and alternate irrigation of Chlороhexidine, SmearClear (SybronEndo), distilled water, and sodium hypochlorite with ultrasonic activation in a well-established sequence, was performed. An apical enlargement to size 40 in .04 taper was performed after crown down with K3 files (SybronEndo), to disturb the biofilm mechanically and to help reduce the colony formation unit (CFU).

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An intermittent paste was injected inside the shaped root canal system. The paste of two different antibiotics (Augmentin and Metronidazole) was manually mixed and injected with a paste filler. A hermetic temporary filling was placed for a week. The wound was covered with a dressing of steroids and antibiotic paste to prevent further external infection. A week later, the patient was already showing good progress. The wound had started to close and less inflammation and swelling were observed (Fig. 5). The root canal was reopened and cleaned, and no internal fluids were coming from the periapical region. RealSeal material was used as obturation material in a vertical condensation using RCPSL (Hu-Friedy) and an immediate build-up was performed. Thereafter, the patient was invited for regular control check-ups. A few weeks later, a post-op X-ray (Fig. 6) and photos were taken. The wound seemed to be in good condition and some skin and fibrous tissues were forming.

While I was writing this article, the patient visited Beirut and decided to come in for a check-up. He complained of a muscle disturbance of his lower lip, but all the previous numbness had disappeared. He agreed to perform an i-Cat scan in order to find out what was going on and to detect any pathology. I was amazed by the bone formation and complete healing (Figs. 7–9). The wound had also healed very well (Figs. 10a & b). I contacted a plastic surgeon and asked his opinion regarding the muscle disturbance. He posited that such symptoms may be caused by the tremendous loss of structure.

Discussion

An important diagnostic modality is the determination of the nature of fluid draining (if any) from the cutaneous sinus. During palpation, an attempt should be made to milk the sinus tract. Any discharge obtained should be scrutinised to determine its nature (saliva, pus or cystic fluid). Culture and sensitivity testing of the fluid should also be performed to rule out fungal and syphilitic infection.

Laskin elaborates on the physiological and anatomical factors that influence the spread and ultimate localization of dental infections. Stoll and Solomon also emphasise that the ultimate path of the sinus (irrespective of the source) depends on several factors: most importantly, the anatomy of the tooth involved, muscular attachments to the jaw, fascial planes of the neck, and involvement of permanent or deciduous teeth. Cutaneous rather than intra-oral lesions are likely to occur if the apices of the teeth are superior to the maxillary muscle attachments or inferior to the mandibular muscle attachments.

A pustule is the most common of all purulent draining lesions and is readily recognised by its superficial location and short course. Actinomycosis exhibits multiple draining lesions and characteristic fine yellow granules in the purulent discharge. The tooth is often not involved radiographically. If a sinus tract does not close after appropriate removal of the primary cause, the most common alternative cause is actinomycosis. (Fig. 5)

The challenge in these kinds of cases is to assemble all the pieces of the puzzle and build up a full idea of the clinical situation. Assembling the pieces means that all the diagnostic materials, such as a history questionnaire, X-rays, CT scans, and sometimes biopsy and bacteria culturing, must be provided in order to establish a correct diagnosis. Most of the time, the solution will only be a simple routine that must be performed in certain conditions. Turning to solutions that are more complicated—and that certainly can be more profitable—is not always the right choice, nor the most ethical one.

The author would like to thank Yulia Vorobyeva, PhD, interpreter and translator, for her help with this article.
Aesthetically speaking
Dr Bob Khanna discusses the benefits of offering non-surgical facial aesthetic treatments dental

Every dentist has the ability to offer non-surgical aesthetics. A dentist’s underlying knowledge of the head and neck region, as well as the skills and dexterity required to be able to perform everyday dental tasks offers a solid grounding from which to build a career in this fast-paced industry.

As well as technical skills, I believe that dentists by nature have to be personable, and possess excellent communication skills to help alleviate any stress and anxiety within patients. This calming influence is hugely beneficial when working with patients who may not have had facial aesthetic treatments before, and may not be sure of exactly what to expect. After all, a calm patient is much easier to work with.

Desired v required
There are many benefits to performing facial aesthetics within a practice. For example, being able to combat pre-conceived ideas about what happens in a dentist’s chair. In the course of a normal day in surgery, dental phobia is a hurdle many practitioners have to overcome. However, I have found that patients are not as nervous when they are having a cosmetic procedure – despite being in a dental environment. I believe this is due to the ‘desired v required’ phenomenon.

When a patient is informed that they require a procedure, the concept is not a desirable one. If a patient desires aesthetic treatment, regardless of how long it will take, or how painful it is, people find strength to temper their anxiety in order to benefit from having the treatment.

Having an appealing facial aesthetic treatment in a dental environment also helps alleviate the general fear of visiting the dentist. They realise that the environment is not as scary as they may have imagined, and understand that they are safe in the hands of someone they trust. The environment is then associated with a pleasurable experience; their practitioner after all has provided them with something that they desired, so the fear of returning lessens considerably.

Boosting your client base
As well as helping patients face their phobias, I have found that I have also inherited a lot of dental clients from the facial aesthetics side of my business – one of the major benefits to offering the service. If your practice is set up well, patients should be able to get their hands on information about the cosmetic dentistry market, as a stand-alone modality, is highly profitable. Products such as Botox are defying the recession as consumers are choosing to opt for longer-lasting cosmetic treatment instead of short-lived expensive non-medical-based high street skincare routines. Also, a growing acceptance of such cosmetic procedures means that the demand for non-invasive procedures is increasing, and being able to offer patients such a service has the potential to increase revenue.

Boosting your client base
Taking an Award-Winning Panoramic X-ray System to the Next Level

Dr Bob Khanna has widely regarded as one of the world’s leading exemplars of dentistry and facial aesthetics. President and founder of non-profit organisation The International Academy for Advanced Facial Aesthetics (IAAFA), Dr Khanna heads the only UK organisation to combine medical and dental professionals. He is the appointed clinical tutor in facial aesthetics at the Royal College of Surgeons and has trained thousands of dentists and doctors through the Dr Bob Khanna Training Institute.
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Doing the right thing
Caroline Holland reports from the tenth anniversary Dental Law and Ethics Forum

Changes in the processes, culture and tone of the profession’s regulator, the General Dental Council, were laid bare by the outgoing Chief Executive and Registrar, Duncan Rudkin, in a frank and illuminating talk to the Dental Law and Ethics Forum, currently marking its tenth anniversary.

Just two weeks before his departure from the General Dental Council (GDC) and taking up his new role with the General Pharmaceutical Council, Mr Rudkin looked back on his 11 years with the council. He analysed critically the approach the GDC had taken in the past. ‘Sometimes we might have appeared to give the impression that we must protect the public from the profession, and that would be a big mistake.’

This valuable insight was partly attributable, he said, to former GDC member, Joe Rich, partly attributable, he said, to anything about facilitating or undermining professionals themselves in providing protection.

Mind over matter
Fitness to Practise, or disciplinary issues, came into the category of things that keep him awake at night, he said, “How can a regulator work effectively and fairly to deal with the small number of rogues and villains without sucking into the system those who are not rogues and villains but maybe having a bad day or an unfortunate set of circumstances?”

He said the GDC need to make Fitness to Practise a more efficient and cost-effective process and the Council was committed to undertaking a systematic review to achieve these ends. In answer to a question on the Dental Complaints Service, Duncan replied: “We don’t pretend it’s an independent body because it isn’t, we are accountable for it.” He went on to say that he had naively thought the complaints service would reduce the number of conduct cases, but rather than taking a slice of the cake, it looked as if it made the cake bigger.

His review of the changing nature of dental regulation began with a moment in 1998, soon after he joined the Council when it banned, with immediate effect, the provision of General Anaesthesia in dental practices.

It would be inconceivable today, he said, that such a change could take place without consultation, but that was the culture of the time. ‘In 1998, when the GDC did things in a high handed fashion for the best and knew what the best was, we did not have “stakeholders”!’

He added: ‘When I arrived in Wimpole Street, I felt as if the outside world was dentists waiting to be told what to do and that was it! Now, he said, there was a danger that the pace of consultation to which it was committed could paralyse the GDC and that there needed to be a balance.

A little disappointment?
He reflected on the changes brought by the addition of a register for Dental Care Professional (DCPs), expressing the opinion that the registration of DCPs might have led to some disapponted expectations for some, if they had thought of registration as principally there for the benefit of professionals, which it was not.

He admitted that the GDC changed its tone when publicising the new register for DCPs. Initially the benefits of registering DCPs were promoted, but this gave the impression that it was optional whereas it is irrevocable.

He pointed out that this was a generational change – given the small number of rogues and villains, which it was not.

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Another significant change was devolution. Its impact had not been fully felt yet, he warned, but would be more significant than appreciated in changing the relationship between the regulator and the state. Today, he said, the GDC interacted with four health services and four different funding systems, which meant the pace of legislative change was far slower than some would like. There were also a number of different regulators who needed to work together. ‘Regulators need to concentrate their efforts on their job and maybe not so much on managing their reputations.’

In the questions after the session, Chris Morris, President of the BLEF, observed that he had enjoyed a “seminal moment” when some years ago, Duncan told him that his favourite definition of professionalism was: “Doing the right thing when no-one is looking.”

Chris told the meeting that no other BLEF speaker had ever been invited back, but Duncan had been invited back twice, a reflection of the important role he had enjoyed in the dental world.
A cause for celebration
BACD enjoys a triumphant sixth annual conference in Edinburgh

The British Academy of Cosmetic Dentistry is celebrating one of its most successful annual conferences. Entitled ‘The Future of Dentistry’, Edinburgh played host to a wealth of prominent dental professionals from around the globe.

The opening ceremony saw a spectacular performance from The Red Hot Chilli Pipers, an incredible show of rock bagpipes and blistering drumming that had the audience up on their feet; an unforgettable introduction to the conference.

Over the course of the three days, world-renowned speakers shared their knowledge and expertise on a range of subjects. Mr Khaled Shahbo, who talked about his successful business in a lively presentation, gave the opening address.

Dr Lynn Jones gave her advice on how to best manage the treatment of patients with occlusal and TMJ problems, while Dr Lorne Lavine revealed some interesting thoughts on digital progress made towards a paperless office.

In his presentation on adhesive systems, Professor Paul Lambrechts gave an overview of some of the current options dental professionals have at their disposal for minimally invasive tooth preparations.

Dr David Bloom gave an in-depth look into the theory and practice of photography necessary to achieve BACD accreditation.

Achieving Ultimate Aesthetics was the theme of Dr Tidu Mankoo’s address; a full-day lecture that provided attendees with a wealth of information and understanding on the interdisciplinary management of the aesthetic zone.

In another full-day course, Dr Ryan Swain and Dr Barry Buckley outlined the treatment philosophy behind short-term orthodontics, so that attendees could be confident to offer this orthodontic alternative in their own practices.

Dr Bhavna Doshi provided an enlightening address on the fundamental strategies for a successful practice, with step-by-step guidelines for creating a profitable business.

Although considered entry-level treatment for many patients, tooth whitening requires dental professionals to demonstrate they have undergone appropriate training in the techniques. Dr Dominique Kanaan and Dr Zaki Kanaan gave a full-day certification course in the techniques required for successful treatment.

Dr Julian Caplan’s presentation, entitled ‘Beautiful anterior porcelain restorations are now possible in a day’ provided the
Dates to remember
There’s no better time than the new year to implement change, says Sharon Holmes

Seeing as the financial market is still depressed financially and patients aren’t keen to part with their hard-earned cash, the Dental Arts Studio has been developing a marketing campaign. Each month there has been a deadline to meet and a panic to get our marketing material ready to meet print deadlines.

A lesson learned
Out of this panic, and as a New Year’s resolution, I have decided to be proactive. To avoid this mad panic, I’ve devised a special events calendar, as a way of staying on top of these deadlines throughout the year. It reminds my practice managers to prepare the marketing material two months in advance, to allow time for adjustments and for the ordering and printing of the adverts or leaflets. In doing this, it avoids disappointment for the patients and also stops them from thinking that we are inexperienced and unprepared.

The second calendar is in relation to clinical governance. Seeing as I manage a mini-corporate group, it is very difficult to monitor whether all essential documentation is on record for each member of staff, so it helps me to keep tabs on what we have and are missing. I have now made the decision to carry out an audit across the group twice a year due to the staff changes that take place from time to time and due to this paperwork is often overlooked which can lead to legal implications due to negligence.

Meeting patients’ needs
The third task that I have set is aiming to meet the needs and desires of our patients. I have completed a patient survey throughout the group in relation to patient care and services. I will use the data to devise a better service. The forms show that patients are uneducated when it comes to oral health, many stating that visiting the oral hygienist was not important or the health of their gums.

Yes, I know this is going to entail major in-house training for staff and close monitoring to ensure that they implement what is being taught, but I’m willing to give it a shot. Knowing this has made me more determined to train my staff to better educate our patients, because what the surveys are telling me is that the patients have not been previously educated in relation to the most important aspects of oral care. Where are we failing our patients?

Another breakthrough from PracticeWorks
PEARL is the new iPhone or Blackberry application for R4.

Better education
It is vital that time is taken to discuss dental care with patients. The more we educate them, the better they will respond to treatments, without thinking we are trying to extort money by trying to sell cosmetic dentistry privately. This was another point apparent from the patient survey, that patients did not see it important to have a cosmetically enhanced smile.

However, whatever was very high on the list of importance was, the dentists’ skill, pain control, trust and clarity with knowing the costs prior to the start of treatment which brings me back to the importance of writing up treatment plans that have been discussed openly with the patient prior to starting treatment.

As John D Rockefeller said: ‘I believe in the dignity of labour, whether with head or hand; that the world owes no man a living, but that it owes every man an opportunity to make a living.’

About the author
Sharon Holmes has worked in dental practice management since 1992. Arriving in the UK in 2002, she took a post in a mixed NHS and private practice in Wembley, eventually taking over its management, converting it to a fully private practice. In 2003, she moved to London City Dental Practice where after 18 months, was responsible for managing four practices in the group. The London City Dental Practice is part of a highly successful group called the Dental Arts Studio, to which she has been instrumental in its creation. She holds the position of operations director and manages every aspect of the group alongside her principal dentists.
Positive impact, positive results!

It's important to make a positive impact from the start, to entice dental patients back. Success coach Adrienne Morris offers some advice to help get on the right track.

1 Promise less, deliver more. The old adage is true – it really pays to undersell what you are giving and then over-deliver: the end result, a client who is thrilled to have gained a truly valuable product/result which exceeded their expectations. At the same time you will have made an initial brief and hopefully have an extremely satisfied client who will be happy to recommend you and use your services again and again. Whatever you have gained profit-wise, you will have vastly exceeded as far as your reputation for performance, delivery and reliability is concerned.

2 Play full out. You know this isn't a dress rehearsal. Treat each and every opportunity as if it's the most important in your life and give it everything you've got. You never know who is watching to see how you're performing. Even if they don't sign up this time, it may take just one more occasion for them to see you or the results of your work in action to convince them you are the one they are going to want. Don't be disappointed if they don't give you an order or booking at the first meeting or the next – you have to build up trust and confidence. And if you're always giving of your best, this will be enhanced each time they meet you or hear about you.

3 Pay attention to detail. Don't be sloppy – attend to even the smallest detail because all those minute details add up to a great professional finish and that's always going to make a good impression. Check spellings of names; check titles and how people like to be addressed.

4 Know your subjects. If you're trying to reach someone, get names of the ‘gatekeepers’ ie, secretaries, personal assistants, receptionists – establish a rapport with them – they're the ones who might just get you through the door when they're rejecting everyone else (Peter Thomson, the renowned business consultant, refers to receptionists as ‘rejectionists’ with good reason).

5 Follow up good contacts. Always follow-up when you meet someone new with whom you feel you have really connected – drop them an email and remind them of what it was you had in common or had chatted about, remind them what it is you do, and for whom you have done it. If you have to write a thank-you, a hand-written note will always leave a good lasting impression, as long as it's legible. Mention that if you meet someone who could be a potential client for them in whatever they do, you will definitely put them in touch – and do so. Hopefully in time they will reciprocate.

6 Be positive and put on a happy face. Sure it's hard to remain positive when you're feeling overwhelmed, but when it isn't an attractive quality. The Tony Robbins mantra ‘attitude of gratitude’ really does have power. Whenever you're facing a setback, do a mental checklist of what IS working in your life right now, what you DO have going for you, what you can still cheer you on, and give thanks for your good health, for a roof over your head, for your friends and family. This encourages you to be striving to do better. Lift up your head, put your shoulders back and smile – you should feel better straight away.

7 Focus on solutions, not problems. You have to switch your focus to solving the issues preventing you from getting to where you want to be. During the process every step will be a learning exercise and it is this learning that is going to help you grow and in itself be life-changing. This, as well as the end result, is going to make a significant difference to you in the long run. Facing a seemingly daunting task but breaking it down into manageable chunks and dealing with each of these, one step at a time, will make it seem much more approachable. The learning you get will get you on track and you will be happy to recommend others.

8 Walk the walk. Spend time with the peer group you want to be in – in other words, hang out with people already living the kind of life you want, doing what you want, who have what you want. Don't be nervous about asking for advice. You must have noticed how people love to give it, even when you haven't asked for any. Copy their behaviour, their style, dress the part, talk the talk – but only if it feels right for you because if you don't feel relaxed, it will show in your body language. Be a ‘player’ and remember the coaches' adage – 'fake it ’til you make it!'

About the author

Adrienne Morris is a success coach helping professionals and small businesses reach new heights of success. For more information please contact 07565 514714, email coach@alplifecoach.co.uk or visit http://alplifecoach.co.uk.

Company Feature

Is The Joke on You?

Is it possible for dental practices to attract more patients without spending more money on marketing?

A young dentist was starting his career. He rented a beautiful practice, engaged an interior designer and invested in the latest, most technologically advanced equipment. He was sitting behind the reception desk when a man came in. Wishing to appear busy, the dentist picked up the phone and pretended he was booking an appointment. Finally he hung up and asked the visitor, “Can I help you?” The man said, “Yeah, I’ve come to activate your phone!”

As they say in the stand-up comedy profession, the old jokes are the best. Unfortunately, trying to find new patients in the current economic climate is certainly no joke. The recession, combined with greater competition between practices than ever before, has left many dentists with gaps in their appointment books as they struggle to maintain, never mind increase, their patient lists.

With their discretionary spending under pressure, potential patients are more demanding and discriminating than they ever have done before. Nevertheless, they are still prepared to pay for a quality service which they feel is worth the extra. In today's world, dental practices must offer the highest standards of treatment within a competitive fee structure, and also deliver outstanding customer care, comfort and convenience - concepts not traditionally associated with the healthcare industry but which are now vital considerations in the pursuit of success.

So how can you reduce your rates and still make money?

A woman phoned her den- tist when she received a huge bill. “I’m shocked,” she complained. “This is three times more than usual.”

“I know,” said the dentist, “but you yelled so loudly during surgery you frightened away my next tenant.”

There are many, relatively inexpensive, ways of improving customer service, but how can a dentist offer patients genuinely better value without damaging practice profitability? Solving this conundrum in isolation can be difficult, but with a little in- formed guidance and an innova- tive but proven patient plan now becoming available in the UK, dentists can again enjoy the lux- ury of being rushed off their feet!

In the US, creative and uni- versally accessible dental plans are helping practices to enjoy the best of both worlds: improved ca- sh flow and new patients.

With more than seven mil- lion Americans participating, US dental practices are invited to join the Dental Network and benefit from this vast pool of potential new patients. Patients can choose a plan to suit their na- tional member dentists and their specialisations in a number of ways, including:

• Daily database updates with agents and groups
• Via the distribution of printed directories
• An online provider search

(more than 250,000 hits in the US every month)
• Multi-lingual assistance to help patients find their ideal treat- ment provider.

Devised and designed by a dentist, Munroe Sutton’s Patient Referral Plan is the culmination of 50 years’ experience in the field of dental marketing and is now available to dentists through- out the UK, bringing the same proven benefits to both patients and practices as those enjoyed in the US. Treatment plans are made more affordable for the patients, and practices experience the ad- vantages of direct marketing at no cost to themselves. Acceptance rates rise steeply as the financial pressures ease for the patients, and with the option of receiv- ing immediate payment prac- tices’ cashflow is also enhanced. The scheme allows for bespoke reimbursement arrangements to ensure that participating prac- tices are never out of pocket and payment is guaranteed.

The independence of the prac- tice and any existing patient pay- ment plans are unaffected, and a 24-hour automated support line deliv- ers professional, efficient patient confirmation. The referral system places dentists in touch with an ever increasing, the strength and courage patients at no cost to themselves.

By joining a scheme widely accepted in America, UK practices nationwide now have an opportu- nity to expand their activities, pa- tient lists and profitability without compromising their individual goals, existing patients or estab- lished payment plans or fee struct- ures. Attracting even a few ad- ditional patients, at no cost must be a worthwhile result, so sign up and fill those blank spaces in your appointment book!

“Open wider,” requested the dentist, as he began his examina- tion. “Oh my word,” he said sud- denly. “That’s the biggest cavity I’ve ever seen - the biggest cavity I’ve ever seen!” “Dentists!” the pa- tient retorted. “I’m scared enough - but only if it feels right for you because if you don’t feel relaxed, it will show in your body lan- guage. Be a ‘player’ and remem- ber the coaches’ adage – ‘fake it ’til you make it!’

With the challenges fac- ing dental practices today, any scheme which offers free market- ing, encourages treatment accept- ance and guarantees prompt pay- ment is sure to attract attention. If your practice is not realising its full potential, perhaps it’s time you spoke to a DHA. A successful pro- vider like Munroe Sutton and dis- cussed the options. You could be laughing all the way to the bank!

For more information please call 0808 254 5555 or visit www. munroesutton.co.uk

Dr Martin Rinker The Chairman of the Board Munroe Sutton

February 1-7, 2010
Incorporation... isn’t that just a ‘trendy business’?

There are many myths surrounding the issue of incorporation. Michael Lansdell looks at some of the biggest ones and gives the business facts

Ever since the General Dental Council amended the regulations to allow dentists to trade through limited companies from July 2006, (incorporation) the profession has been awash with conflicting advice and opposing opinions. In this article, I will try to dispel some of the specific misconceptions which have grown up around the issue.

It’s often stated that any potential tax savings after incorporation will be cancelled out by increased accountancy fees. True or false?

False. Accountancy costs will rise, as there is more work accounting for a limited company, but this is only a minor element in the overall equation. Before incorporating, the annual net benefits should be weighed against the additional costs. Reputable accountants will usually agree to fix their fees in advance to facilitate an informed decision.

Incorporation allows you to withdraw from the company an amount equal to the value of your practice’s goodwill with an effective tax rate of only 10 per cent (on the first £1 million); if other family members are also shareholders, or work in the practice, further tax benefits accrue, and tax-efficient borrowing becomes possible which many dentists have used to reduce or eliminate their domestic mortgages.

It will be a nightmare when I come to sell

False. The practice can either be sold by the limited company, which you can then wind up or not as you please, or you can sell your shares and the purchaser takes over the limited company.

The first option is less tax-efficient, but the second is normally chosen as it’s usually beneficial for both parties. The new owner is able to immediately take over existing bank accounts and any other business arrangements, as the company is a separate legal entity and continues to exist, and to trade, whoever owns the shares. In fact, many incorporat-ed practices with PCT contracts are attracting a premium for this reason. When a sole trader practice is sold, all existing business arrangements cease and must be re-established in the name of the new owner.

It’s a tax dodge and the Inland Revenue might overturn it

False. Incorporation is entirely legitimate and is common commercial practice in every other sector. It’s only new to dental professionals because the General Dental Council did not previously allow it.

I’ll have to pay Capital Gains Tax on my goodwill value

True. When you sell the goodwill to the limited company you will pay CGT, usually 10 per cent, on the increase in its value since you bought or began the practice. However, you may now withdraw cash from the business up to the value of the goodwill without paying personal Income Tax, a huge advantage.

If I create a tax mitigation scheme instead, I may have not have to pay any tax at all

99.99 per cent False. Incorporation is a permanent, legal business structure that reduces your tax liability for the rest of your career, and is entirely different from a tax mitigation scheme. Tax mitigation schemes, which must be declared on your tax return, can expose every aspect of your own and your practice’s finances to the scrutiny of the Inland Revenue, may only offer benefits for one or two years, and can fail, meaning any “saved” tax must then be paid, with interest.

The Inland Revenue is increasingly determined to stamp out such schemes, and is introducing more and more restrictions. As a final warning, some schemes rely on borrowing, and failure can involve the dentist in losses that can exceed the amount of the original investment.

My accounts will be available to the public

True. An abbreviated balance sheet of every limited company in the United Kingdom must be filed annually at Companies House. However, it does not include confidential or commercially sensitive information, for example company turnover, expenses, profitability, etc.

My record keeping will have to improve

False. Any additional statutory formalities will be handled by your accountants; practice record keeping is broadly unaffected.

My NHS pension will suffer

Not necessarily. Incorporation does not restrict the NHS superannuable pay, but this is a complex area and increasingly determined to stamp out such schemes, and is introducing more and more restrictions. As a final warning, some schemes rely on borrowing, and failure can involve the dentist in losses that can exceed the amount of the original investment.

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Many PCTs have no objection to transferring a contract from a sole trader to a limited company, and those which do express doubts can often be persuaded.

In the case of an outright refusal, you can still go ahead with incorporation while continuing to hold the contract in your own name on behalf of the limited company, immediately transferring it to the contract receipts.

Incorporation offers undoubtedly benefits for many dentists, but it is not an off the peg solution to suit every practice. If you’re thinking it might help you, seek out informed advice from an industry aware, professional firm which will take the time to appreciate your own aspirations and individual circumstances.

‘Incorporation is entirely legitimate and is common commercial practice in every other sector: It’s only new to dentists because the GDC did not previously allow it.’

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About the author

Michael was brought up in South Africa, receiving his honours degree there in 1984. He completed his training with international accounting firm Grant Thornton and became a founder partner at Lansdell & Rose Chartered Accountants (SA) a year later.

Based in Kensington, London, Lansdell & Rose deal only on a long-term retained basis, exclusively with owner managed clients, generally dentists and doctors, and specialising in the incorporation of dental practices. As a chartered accountant, they look for sustainable long-term solutions for their clients that maximise profits, minimise tax and build wealth.

If you would like to read more articles and need to know more, please e-mail your name and address to racl@lanlondelow.co.uk and we will post you additional articles.

For more information about incorporation and the services available from Lansdell & Rose please call on 020 7797 8555.
impression materials

When it comes to surgery design and equipment solutions Clark Dental offers both style and affordability. And now the style of their surgery design can be perfectly complemented by NSK’s excellent range of high-quality turbines, handpieces and seat units. This newfound relationship stems from the decision that both market leaders feel it is important not only to be working together, but to be providing today’s practices with the most high-tech and innovative equipment that can be found.

NSK work closely with dental professionals to understand their individual needs and requirements, delivering high performance products for the whole dental team at affordable prices, so it’s only natural that their products are available from a family of dental specialists that boast over 50 years experience in the dental industry.

Together, Clark Dental & NSK can help you meet your daily demands. For more information, contact Clark Dental Ltd at one of the following locations, Tel: 01258 731146 or Email: enquiries@clarkdental.co.uk, alternatively contact NSK on 0800 634 1909.

Clark Dental, 3 Alvaston Business Park, Middlewich Road, Nantwich, Cheshire CW5 0PF

Tavom Sets New Standards in Ergonomics, Style and Comfort

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

With a vast product range benefiting from the latest materials and technology, Tavom offers ergonomic, cost effective and durable solutions to every furnishing alchemy. Stylish contemporary designs, customised or off the shelf, feature throughout the range to complement any existing floor plans and décor and deliver an environment which is both comfortable and practical.

To meet patients’ rising expectations of the dental experience, as well as to attract and retain quality staff, the surgery environment must be as pleasing as functional. Tavom has trained consultants available to offer advice on the emotional impact of colour compatibility and product suitability for specific purposes.

Whatever your refurbishment or replacement needs, call Tavom UK on 01932 752 1121 for specialist advice and a professional solution.

When to use Freealgin

Freealgin is the alginate alternative. This material offers an incredibly quick, 90 seconds intra-oral setting time and a pleasant lilac coloured medium body which comes in standard and exotic flavour. The heavy body is available to be used instead of the putty & comes in the new VivaPen delivery form. The amount of adhesive releasing total etch adhesives from Ivoclar Vivadent. The choice of the light-curing adhesives will be able to cure ExciTE F and ExciTE F DSC are fluoride-containing light-curing adhesives. Kerr's renowned OptiBond adhesive is renowned as a committed market leader with unparalleled expertise in this specialised field.

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Clark Dental, 3 Alvaston Business Park, Middlewich Road, Nantwich, Cheshire CW5 0PF

Tavom Sets New Standards in Ergonomics, Style and Comfort

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

With a vast product range benefiting from the latest materials and technology, Tavom offers ergonomic, cost effective and durable solutions to every furnishing alchemy. Stylish contemporary designs, customised or off the shelf, feature throughout the range to complement any existing floor plans and décor and deliver an environment which is both comfortable and practical.

To meet patients’ rising expectations of the dental experience, as well as to attract and retain quality staff, the surgery environment must be as pleasing as functional. Tavom has trained consultants available to offer advice on the emotional impact of colour compatibility and product suitability for specific purposes.

Whatever your refurbishment or replacement needs, call Tavom UK on 01932 752 1121 for specialist advice and a professional solution.

impression materials

When it comes to surgery design and equipment solutions Clark Dental offers both style and affordability. And now the style of their surgery design can be perfectly complemented by NSK’s excellent range of high-quality turbines, handpieces and seat units. This newfound relationship stems from the decision that both market leaders feel it is important not only to be working together, but to be providing today’s practices with the most high-tech and innovative equipment that can be found.

NSK work closely with dental professionals to understand their individual needs and requirements, delivering high performance products for the whole dental team at affordable prices, so it’s only natural that their products are available from a family of dental specialists that boast over 50 years experience in the dental industry.

Together, Clark Dental & NSK can help you meet your daily demands. For more information, contact Clark Dental Ltd at one of the following locations, Tel: 01258 731146 or Email: enquiries@clarkdental.co.uk, alternatively contact NSK on 0800 634 1909.

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Extra large Microfine & Economic wipes provide Effective protection against HIV/HTLV
CharSafe and ProtectSafe Extra Large Microfine and Economy wipes used correctly guarantee a safe inactivation of HIV/HTLV-I/II viruses (pathogens of same enve). These products can be used for daily disinfection of surfaces close to the patient/frequently touched surfaces (e.g. dental supplies, couch covers, bedsheets, instruments). The disinfection of hands and surfaces and also contaminated instruments play a major role in preventing the human-to-human transmission of the current circulating warms HIV-1a virus which belongs to the group of influenza A viruses, type H1N1.

All equipment/materials in direct contact to the patient have to be disinfected and sterilized after use and before use on another patient. Kemdent InstrumentSafe is suitable for the safe-inactivation of influenza A viruses at the respective concentration rates and exposure times of the product.

This is an excellent time to try the Extra Large Microfine or Economy wipes. Any orders placed before March 31st will have a 25% discount.

For further information on special offers or to place orders call Helen on 01793 779220 or visit our website www.kemdental.co.uk

Dentalghar

The new Dentalghar on Facebook
Dentalghar
Dentalghar on Facebook - Dedicated to pioneering advancements in education and inspiring better care.

Dentalghar aims to unite dentists of Indian origin from all over the world, offering a destination and online dental community. Thousands of dentists of all heritages can contribute to polls, surveys and articles and have 24-hour access to interactive discussions, fascinating insights and the chance to discuss their experiences and receive advice.

Dentalghar offers an invaluable opportunity for professionals to share the same concerns and to learn from the expertise of those who have found the latest news, case studies, intensive, special offers and charitable events. Professionals looking to stay up-to-date on the latest outstanding and relevant information and those with an interest in0 orating skills and to win bursaries to contribute to their education and volunteering opportunities in the UK and abroad.

For more information on Dentalghar visit www.dentalghar.com

Septodont is the specialist in safely delivering dental anesthetics. The Ultra Safety Plus is a remarkable single use patient safety syringe with a sliding sheath. With recent studies showing 48% of all nurses having been injured by an injury using a needle, it had previously been used on a patient and 41% of respondents felt at risk of contracting diseases such as HIV and Hepatitis, Ultra Safety Plus can limit the consequent cost and distress that can be suffered following a needle stick injury.

With the option of a new single use handle (non sterile) which has been designed to minimise the risk of cross contamination and designed exclusively TO WORK WITH Ultra Safety Plus syringe, Ultra Safety Plus is now 100% disposable.

To find out more about Septodont and its specialist range of dental care essentials: call 01622 695520 or log onto www.septodont.co.uk

Septodont

25 years talking points
Talking Points in Dentistry Celebrates 25 Years with 3 Very Special Speakers
GlassSmile/Hawe Consumer Healthcare (SM) Ltd., manufacturers of Aquafresh, Benetin, Collonil, Policegum, Sensodyne and Sensodyne Proraseal have announced the speakers for a special anniversary addition of Talking Points in Dentistry.

First introduced in 1983, Talking Points was designed to provide topical and thought provoking lectures for the whole dental team. Over the last 25 years more than 50 industry experts and professionals have delivered these lectures with audiences exceeding 400 dental healthcare professionals each year.

To celebrate the anniversary Talking Points will he this year showcase 3 respected experts, Roy Higson, Mike Wanless and John Tiernan.

The events will take place in 9 venues across the UK during May and for full details on all the shows visit www.the-ddu.com/ucleastman or call Rachael Irsoz on 0780 750 5358.

Talking Points in Dentistry is free to attend and offers verbal CPD for the whole practice team.

NobelProcera® - CAD/CAM technology for General Dental Practitioners

Setting a new standard for the development, design and manufacturing of implant prosthetics, NobelProcera® offers professionals the most comprehensive technological expertise in special products within CAD/CAM dentistry.

NobelProcera™ incorporates cutting edge 3D design software and superior patented computer holographic optical technology – on Nobel Biocare and continuously updated competitor implant platforms.

– Precise impression scanning capabilities, supported by delivery of the restorative on an accurately milled model.
– Precise angled, tooth-shaped and angled products (from cement to screw retained restorations)

Launch of new materials for cost effective solutions – such as cobalt chrome and acrylics for different indications.

– Differentiation of a wide range of investment and screw retained bar solutions – on Nobel Biocare and continuously updated competitor implant platforms.

Easy preparation, fully supported by readily available guidelines, NobelProcera™ offers dentists the capability to deliver the highest quality restorations simply, affordably and quickly ensuring an excellent fit and consistently reliable products.

For further information on any of the new Nobel Biocare products please call +44 (0)1895 452 912, or visit www.nobelbiocare.com

Dental Tribune

New Name, Brush Remains the Same
Oral-B CrossAction toothbrush has been re-named Oral-B Pro-Expert CrossAction. The name change is a part of a wider rebranding exercise to help consumers differentiate the brush from the plethora of manual toothbrushes on offer at most retail outlets. Oral-B can speak with some authority on matters of toothbrush design. In terms of plaque removal the Pro-Expert range has been compared with controls favourably on numerous occasions. The study was conducted by a UK based independent laboratory on 35 clinical studies.

Pro-Expert CrossAction incorporates multi-filament, soft tipped, rounded filaments which have been carefully angled at 16º in both directions to provide an improved brushing action that penetrates, lifts and sweeps away plaque on both forwards and backwards strokes.

This enhanced capability removes plaque specifically from the areas normally least well served by brushing: the gingival margins, approximal surfaces and distal areas.

Pro-Expert CrossAction is a contemporary brush with design features that provide discernible patient benefits. It comes with the Oral-B pedigree of technological superiority and clinical satisfaction.

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opportunity for attendees to gain hands-on experience in re-contouring Empress crowns to give the correct aesthetic from of a central incisor.

Among the panel presentations held during the conference, the Complex Case Management discussion provided a great opportunity to consider how to provide optimum care for a patient, giving practical advice on sequencing treatment, clinical techniques and communication with both the dental team and the patient.

‘Simple Orthodontics For You and Your Patient’ brought together four of the orthodontic treatments that are easily accessible to the GDP for treating patients.

‘Simple Orthodontics For You and Your Patient’ brought together four of the orthodontic treatments that are easily accessible to the GDP for treating patients. Each speaker, representing Invisalign, Clearstep, Six Month Smiles, and Inman Aligner, had the opportunity to present the advantages as well as some of the limitations of their systems.

A chance to network
As well as the wealth of learning opportunities at the conference, delegates were also able to network with suppliers and to explore the latest in equipment and materials to enhance their dentistry.

The conference also provided the current BACD President, Dr Elaine Halley, to wish her successor, Dr , the best of luck for the future.

For information on the 2010 BACD conference, please contact Suzy Rowlands on 020 8241 8526 or email suzy@bacd.com.
Approximately 1 in 3 adult patients suffer or have suffered from dentine hypersensitivity, and over 50% of sufferers don’t mention it to their dental professional. This may be because they fear it requires major dental work, the pain may be variable so they don’t report it or because they may be using techniques to try and avoid the pain.

These findings highlight the important role that dental professionals play in actively diagnosing dentine hypersensitivity.

Recommending daily brushing with Sensodyne Total Care F is a simple, effective solution which is clinically proven to reduce the pain of dentine hypersensitivity.

“There are no issues anymore, no barriers. I can do what I want and eat what I want.”

Asher Burrell, dental patient, Battersea, UK.

Potassium nitrate, Sodium fluoride

Advice that’s appreciated

Sensodyne Total Care F Toothpaste. Presentation: Potassium nitrate 5.0% w/w, Sodium fluoride 0.306% w/w. Uses: Relief from the pain of dental sensitivity, an aid for the prevention of dental caries. Dosage and administration: To be used 2-4 times a day, in place of ordinary toothpaste. Contraindications: Sensitivity to any of the active ingredients or excipients. Precautions: For children under 6, use a pea-sized amount and supervise brushing to minimise swallowing. Side effects: Very rarely, isolated cases of hypersensitivity type reactions such as angioedema, oral and facial swelling have been reported in patients using potassium nitrate containing toothpastes, particularly in patients who are predisposed to hypersensitivity type reactions. Legal category: G.S.L. Product licence number: PL 00008/0103. Product licence holder: GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. Package quantity and RSP (excl. VAT): 45 ml tubes £2.09, 75 ml tubes £3.11, 100 ml tubes £3.65 and 100 ml pumps £3.65. Date of preparation: August 2009. Sensodyne is a registered trade mark of the GlaxoSmithKline group of companies.