Positive review of HIV health staff ban

The Department of Health confirms review of ‘outdated’ HIV policy

The Department of Health has confirmed that the policy which currently prevents HIV-positive surgeons and dentists from working in the UK is being reviewed.

Under Department of Health rules, HIV-positive health workers working in surgery, dentistry and specialist nursing, plus obstetrics and gynaecology are not allowed to carry out invasive surgery or ‘exposure prone procedures’ that could risk blood contamination.

The announcement has been welcomed by campaigners and Aids charities, who say advancements in HIV therapy drugs makes it easier for people to undertake such clinical roles.

British policy is stricter than in many European countries plus the US and Australia, where dentists with HIV can work.

According to reports, there have been no reported healthcare worker to patient HIV transmissions in the UK, and only four such cases recorded worldwide and furthermore, dentists with HIV are permitted to work in the US and Australia.

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The Department of Health guidance recommends that healthcare workers infected with HIV do not undertake these procedures.

One dental professional said: “I think that this review hopefully leading to a change in stance by the DH, has been a long time coming.

“However the chance of an accidental injury with a contaminated instrument to a healthcare professional is very real. Dentists and healthcare professionals never differentiate between patients.”

“I feel it is about time that the discrimination stops against us as well.”

Another dentist replied to this response saying: “Following the legislation associated with the CQC I cannot see why a HIV dental professional cannot work normally assuming they are under the care of a medical practitioner, suitable medication regime and an undetectable viral load.”

One angry dentist said: “It would appear that it is wrong and unprofessional to regard HIV/ HBV +ve patients as being any sort of risk but, if dedicated professional should become so afflicted they become pariahs, unable to work and subject to draconian restrictions.

“Typical DOH, constantly bleating about evidence based practice, yet ten years behind the times.”

AIDS charities, who say advancement in drug treatments raise awareness about the importance of maintaining good oral health. Developing good habits at an early age helps children gain a good start on a lifetime of healthy teeth and gums so dentists and their staff will provide dental education for children and parents.

Dental Divas launches Dental Divas, an American organisation designed to support the needs of women dentists, has announced the official launch of Dental Divas Online. The interactive website allows members to connect with other dentists, providing women dentists a place to share their ideas and network themselves.

According to an ADA study, the dental industry is comprised of 40 per cent women dentists, and yet until recently, there were very few options in the form of resources, networking, and support for the challenges that women dentists face. The interactive website provides informative articles and a variety of discussions on hot topics of interest, such as running a practice, peer advice, job opportunities and even help finding maternity leave fill-in.

Dental Divas Online can be found at: www.dental-tribune.co.uk

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Workers Infected with Blood-borne Viruses (UKAP), the Advisory Group on Hepatitis and the Expert Advisory Group on Aids.

The DH has reportedly said that the review is expected to be completed within the next few months, and that it would consider any recommendations received from the three advisory panels.

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Dental Protection voices concern regarding Fitness to Practise procedures

O n the front cover of the latest issue of Riskwise you will find an article that takes a close look at the GDC’s Fitness to Practise procedures which are currently operating at a level never before seen in the UK.

On a purely statistical basis, UK registrants are at least twice as likely as their colleagues in the USA and Australia (for example) to find themselves under some kind of challenge from their professional regulators, and they are several times more likely to do so than their colleagues in many other parts of the developed world, including Europe.

The article details aspects of the current GDC procedure which give rise to concern as well as offering support for the Council’s intention to review some of their procedures.

Speaking from their Ed- ingburgh office, Kevin Lusby, Director of Dental Protection said: “DPL has always taken an active role by working at the heart of the profession on behalf of the 70 per cent of dental registrants who are also DPL members. In addition to high- pressive regulation of the dental profession, we look forward to contributing to the GDC’s recently announced review of its existing guidance documents, with a view to producing new guidance in early 2012, in the hope that the concerns we raised in Riskwise will be addressed.”

“It would be very easy for Dental Protection to criticise from the sidelines, but we feel that it is more constructive and in the interests of our members to maintain a dialogue with the GDC and this is precisely what we are doing. However our mem- bers have a right to know what our position is on these impor- tant matters and the reasons for it.”

Members of Dental Protection can read the full article on riskwise.dentalprotection.org.uk.

Fluoride debate

Resident Geraldine Milner is taking legal action to challenge the decision made in 2009 by the South Central Strate- gic Health Authority (SCSHA) to illegally force the fluoridation of Southampton’s water.

The SCSHA has illegally forced the fluoridation of Southampton’s water, the High Court has heard.

The SCSHA, which believes the move will improve dental health, gave the go-ahead ahead of a public consultation showing 72 per cent opposed the idea.

According to reports, Ms Mil- ner’s counsel David Wolfe told a judge that, if the scheme goes ahead, the mother of three teenagers would be left “with no choice but to drink water to which flouri- ride has been added”. As oppo- nents of fluoridation demonstrated outside the Royal Courts of Justice in London, Mr Wolfe said approxi- mately 195,000 people in South- ampton and parts of south-west Hampshire “would have fluoride added to their water whether they liked it or not.”

He told Mr Justice Holman this was contrary to government policy that no new fluoridation schemes should be introduced unless it could be shown that the local population was in favour.

The SCSHA reportedly stated statutory powers to in- struct the local water supplier Southern Water to go ahead with fluoridation in February 2009 to improve dental health, even though 72 per cent of the public who responded to the pub- lic consultation opposed the idea.

However, the High Court also heard that an opinion poll commissioned by the SC- SHA showed that 58 per cent were against the scheme, 52 per cent were in favour and the remaining 29 per cent were “don’t knows”, the court heard.

Reports said that Mr Wolfe accused the SCSHA of failing in its legal obligation to properly assess the cogency of the arguments for and against mass fluoridation. He added that the application for judi- cial review was not about the actual merits and health arguments over fluoridation. It was about the legality of the compulsory scheme, the first of its kind in the UK for 20 years.

Mr Wolfe said: “Four out of five local authorities and three out of four local MPs expressed their opposition within the consultation process”.

The hearing continues.

Maximising quality through competition

Heath Secretary Andrew Lansley has outlined how the NHS must embrace value-based competition if it is to meet the needs of the public it serves.

Speaking at the Maximising Quality, Minimising Cost con- ference, hosted by Monitor, the future economic regulator, and UCL Partners, the Health Secre- tary outlined how competition must be based on the quality of results for patients and not cost alone. Under the plans to modernise the Health Service, providers that deliver excel- lence will benefit from more patients choosing their serv- ice. Those that do not will have a strong incentive to change and improve.

A recent report from the Eu- ropean Association for Cardio- thoracic Surgery showed that survival rates of heart surgery in England had improved as a result of the publication of out- come data by cardiac surgeons themselves. This drove competi- tion and forced up standards dramatically, de- livering benefits for patients.

This is an example of value- based competition.

Responding to concerns that competition leads to varia- tion and divergence across the country, the Health Secretary said: “Despite the best efforts of the centre, variation already exists. The difference will be that future variation will be be- cause local communities have chosen that variation. It will be the very opposite of the post- code lottery.”

Dental Group acquires dental service

G lobal alternative asset manager The Carlyle Group (Carlyle) has an- nounced that it has signed a bind- ing agreement to acquire Integrat- ed Dental Holdings (IDH), from Bank of America Merrill Lynch Capital Partners (BAMLCP), and simultaneous sale of associated Dental Practices (ADP) in partnership with private equity firm Palamon Capital Partners (Palamon). Carlyle will hold a majority of the newly combined entity and Palamon will share joint governance. BAMLCP is fully exiting its stake in IDH. The pro- posed merger of IDH and ADP is subject to relevant regulatory ap- proval. Financial details were not disclosed.

IDH and ADP are two leading providers of dental care in the UK, primarily focused on NHS den- tistry, with close to 450 practices treating more than 3.5 million pa- tients per year. Carlyle and Palam- on will invest to enhance the qual- ity of patient care and grow dental services.

Furthermore, this investment will facilitate the company’s di- versification into other prima- ry care services and cosmetic treatments. New equity for this transaction comes from Carlyle Europe Partners III (CEP III), a 5.4 billion euro buyout fund focused on investment opportunities in Europe.

Palamon Capital Partners had invested in ADP through its second fund, Palamon European Equity II, a mid-market pan-European fund focused on growth serv- ices businesses. In 2010 Palamon’s portfolio company profits grew by an average of 58 per cent; at the same time the Firm concluded six realisations generating almost 450 million euros of proceeds.
Editorial comment

Online training – the future

An interesting piece of research has been published by the British Dental Trade Association (BDTA), looking at how dental practices are adopting new technologies within their surgeries.

The topics looked at included the adoption of computers and their use within the practice, imaging software and the move to digital and the influencing factors for product choices (good to see that editorial review is holding steady or I could be out of a job!).

The main topic of interest for me however, is the increasing acceptance of online education for dental professionals looking for options for CPD. Sixty per cent of respondents to the survey said that they were planning to participate in online training in 2011. Forty-three per cent state that they are looking to increase their online training provision; a further 45 per cent will maintain their online training at its current level.

These are by no means figures to be sneezed at. With the emphasis on quality and value for money these days, the convenience of webinars, online courses varying from short courses to full MSc degree programs, the ability to complete and store your core CPD remotely and securely and the ability to train not just yourself but the whole of your team using the power of the practice computer is a big advantage for hard-pressed principals and practice managers.

This is also good news for providers of online educations such as Smile-on Ltd.

Subjects for this type of training also provided some interesting reading. Restorative topped the charts by a long way, with aesthetics/cosmetics second and endo third.

I am a big believer in online training; having watched webinars from both sides of the fence and seen the interactivity and knowledge used and gained by both lecturers and delegates. Distance learning is not new, but the level of interactivity and connectivity that online education can now give to students of all levels cannot be underestimated.

Online learning – it’s the future, and it’s here.

A

I am a big believer in online training

‘I am a big believer in online training’

Online training is the future

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• Great flavour
• Low abrasion
BDTA Donates to Bridge2Aid

The BDTA is pleased to announce the donation of nearly £1,000 to Bridge2Aid following the submission of completed memberquestionnaires and technology surveys sent out last year. In order to assess how well the Association is meeting the needs of its members, questionnaires were sent out to each member company, and the BDTA offered to donate £5 to the Bridge2Aid charity for every questionnaire completed and returned. Executive Director of the BDTA, Tony Reed, stated: “It is important for us to understand the needs of our members in order to continue to serve them effectively and introduce new benefits. It is vital for our members to understand how the dental team respond to new technologies and the mix of training preferred. We were extremely pleased with the response achieved from the questionnaires and to be able to donate funds to Bridge2Aid made the research worthwhile on a number of levels. Thank you to all those who participated.”

Mark Topley, Chief Executive at Bridge2Aid, commented: “The BDTA has been a great support to us over the past 6 years and helped us to achieve so much – raising tens of thousands of smiles and changing many lives in Tanzania. This donation will go a long way towards helping us relieve the pain of thousands more people in the coming year and extend our work to new areas desperately basic dental services and care.”

For further information on the BDTA visit www.bdta.org.uk

The LED smile

Forget Kanye West and his diamond teeth, Japanese schoolgirls could be the driving force behind a new era of fashionable tooth accessories. Instead of diamonds taking the "fronts" contain bright multi-coloured glowing LED lights that simply fit in your mouth – minus the tooth loss.

Japanese schoolgirls have pounced on the product – which is being advertised as a ‘party in your mouth’ - and demand has gone through the roof.

The LED smile is taking Japan by storm

Dental property firm acquires first assets

Dental property Holdings (DPH), a new niche commercial property investment firm, has completed £1.2m in property acquisitions from one of the UK’s leading dental operators. The five sites, purchased on a sale and leaseback basis, are located in Chelmsford, Wigan, Leicester, Milnathorpe (Cumbria) and Llandeli, and represent the initial assets purchased by DPH in an ambitious programme of investment which aims to acquire £10m of new properties in this year. This follows recent changes in UK legislation allowing dental practices to be bought and sold, leading to corporate dental groups undertaking aggressive acquisition strategies resulting in rapid consolidation, increased revenues and higher margins.

Co-founder of DPH, Patrick Ryan, explains: “Dental practices now provide attractive investment opportunities for large, private equity-backed dental groups. However, their aim is to operate and profit from dental businesses, not from property and property management and so our offering allows for simultaneous acquisition of the operating business by the dental group and the purchase of the property asset by DPH. This saves dental groups between five per cent and 10 per cent of acquisition and onward disposal costs as well as significant management time. DPH source, appraise and manage the properties which, due to our portfolio approach, benefit from cost and management efficiencies.”
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Missed dental appointments costs patient care

Patients failing to attend NHS dental appointments in England could be denying significant numbers of other people the chance to access care, according to a survey by the British Dental Association (BDA). The survey suggests that committed NHS dentists in England each lose the equivalent of almost two weeks a year because patients fail to turn up for appointments. The BDA believes that the research highlights a problem of a significant scale and that the option to charge a fee for missed appointments, abolished as part of the widely-criticised 2006 reforms to dentistry, should be reinstated.

If the experiences of the dentists surveyed by the BDA reflect those of predominantly NHS dental practices across England, the research would indicate more than three-and-a-half million dental appointments were missed last year. Responses to the BDA research suggest that the problem is more prevalent among new patients than those who have been visiting a practice for many years. They also suggest that the problem has become more acute since dental practices’ ability to charge patients for missed appointments was abolished in 2006.

John Milne, Chair of the BDA’s General Dental Practice Committee, said: “Sometimes there are genuine reasons why it’s just not possible for a patient to keep an appointment with their dentist and everybody understands that, but the results of this research suggest that the scale of this problem is significant.

“Dental surgeries use letters, telephone calls and even text messages to remind patients of forthcoming appointments, so it’s really disappointing to see that so many people appear prepared to deny others access to care by failing to show up. This not only wastes dentists’ time, but also taxpayers’ money. With many people still failing to secure the dental appointments they want, and the public purse under pressure, that’s simply unacceptable. This problem needs to be tackled and the BDA believes that the Government should consider re-introducing a fee for patients who miss appointments to deter them from doing so.”

GDC event in Birmingham proves popular

Registrants are being urged to book early for the General Dental Council’s events in Edinburgh and Cardiff after all the available spaces were quickly snapped up in Birmingham.

As the UK’s dental regulator, the GDC wants to meet its registrants face to face in a bid to help dental professionals learn more about how its work affects them, help shape its review of its Standards guidance, take the role of a GDC Investigating Committee and get the answers to questions they want to ask.

The GDC has arranged four free events across the UK that can count as two hours of verifiable CPD. The Birmingham event on 17 February 2011 has been fully booked well in advance of the event.

Booking is now open for two further events in Edinburgh on 23 March and in Cardiff on 25 May at www.gdc-uk.org.
How do we pay for NHS dentistry?

Neel Kothari discusses piloting and the new contract

The seemingly endless cycle of reorganisation, upheaval and change has now culminated in a new set of dental pilots due to be unravelled by the coalition government in April. These pilots are aimed at testing a range of different models to gradually move away from the UDA-based system towards a system based on capitation and a quality and outcomes framework.

Much of the rhetoric surrounding this change sounds similar to that proposed when the 2006 dental contract was first suggested with once again an emphasis of movement away from a treatment based system to a more preventative based one. Essentially these pilots will be based on a capitation system where dentists will be paid on how many patients they look after and the healthcare outcomes they achieve, rather than just the amount of treatment they provide. However with the country in economic straits and goodwill with the profession virtually extinct, one must question whether this new set of pilots will work with the profession to bring change or once again impose reform without the informed consent or will of its members.

Of course, until the pilots reach their more conclusive stage, one cannot say that I am against the prospect of piloting and, just like the 2006 contract, many of the aims proposed by the government resonate strongly with the profession, none more so than one of the Department of Health’s (DH) overall priorities for the NHS, which is to cut bureaucracy and improve efficiency. With many practitioners, including myself, currently dealing with the rigmarole of the CQC and compliance with HTM01-05 I certainly welcome any plans to learn from this process, but more importantly if we are to learn from the mistakes of 2006 surely the profession needs a greater say in how best to move forwards.

An example of how the coalition government in my opinion can do better is by looking at the issues surrounding HTM 01-05. On behalf of the profession, the British Dental Association (BDA) has repeatedly requested an evidence based evaluation of the HTM 01-05 proposals via NICE prior to their bureaucratic implementation and as yet it does not seem that this is likely to happen. If the DH wishes to restore goodwill with the profession and is serious about reducing bureaucracy, why not start by asking whether all aspects of the HTM01-05 are really necessary and based on sound evidence?

The initial set of pilots look at testing three simultaneous models, where, unlike the current system, dentists do not have to carry out a specified number of UDAs but are instead paid based on the number of patients they see. The type 1 pilots aim to establish a fair baseline capitation value by looking at the way dentists carry out treatment without the financial incentives of providing UDAs. The type 2 pilots aim to test the implications of a national weighted capitation model based on age, gender and social deprivation, where dentists will also be eligible for payment against the QOF. In the final type 3 pilots the dental budget will be split, the capitation payment covering only basic care and a separate budget catering for complex care that involves dental laboratory work.

Currently the Department of Health intends to run between 50 and 60 pilot sites which will be assessed after an initial period of one year, with scope to extend them until the new contract is ready in its final form where they are successful. The Department says that changes to the patient charge system required by the new contract will require changes to legislation, a process which will take time and is subject to Parliamentary approval. It is anticipated by the DH that a new contract will be ready by April 2014. Clearly dentistry differs from other aspects of the NHS by having a patient charge. Whilst many patients are used to paying a fee for NHS dentistry, the government still adds more than £2bn a year in England to support NHS dentistry, so even though the service continues on under the umbrella of the ‘NHS’, for most people it cannot be said that it is free at the point of delivery.

Whether we like to admit it or not, operating under a fixed budget clearly involves a level of rationing and, with due respect to the taxpayer, this is not an unreasonable expectation. Under the current system, whilst the payments to dentists are roughly based on pre-2000 values, the burden of responsibility for high risk patients requiring advanced dentistry seems to be unfairly distributed, introducing what the coalition government calls ‘incentives’. Whilst we can have various discussions on essentially how dentists should get paid, the elephant in the room is an open discussion on what NHS dentistry should really provide, how much they should provide and to whom? After all, advanced treatment in dentistry is not just a highly complex, skilled activity, but an expensive one too.

In an article for the BBC, Professor Jimmy Steele makes the point that if taxpayers are contributing to the NHS to provide costly and difficult treatment, asking the patient to provide a healthy mouth first seems a reasonable deal, doesn’t it? Professor Steele accepts that this does sound like a form of rationing, however unlike restricting liver transplants to those on the waiting list or by-passes to nicotine quitters which involve chemically addictive processes, he draws a clear contrast that cleaning teeth properly usually requires much more than a few short and sensible conversations with a professional, a toothbrush and some toothpaste.

It appears that any changes to the current system are still far away, at the earliest April 2014. The widespread criticism of the lack of piloting prior to the introduction of the 2006 contract seems to be being addressed by the coalition government, but after the farce of 2006 it is difficult to know whether the profession will welcome these changes with open arms or merely see this as another upheaval too far. It is unlikely that many of the 2000 or so dentists who left the NHS in 2006 will come back and it is even harder to envisage how the profession would cope if the new new dental contract resulted in a further cull of dentists away from the NHS.

ABOUT THE AUTHOR

Neel Kothari qualified as a dentist from Bristol University Dental School in 2003, and currently works in Cambridge as an associate within the NHS. He has completed a year-long postgraduate certificate in implantology at the Eastman Dental Institute, and regularly attends postgraduate courses to keep up-to-date with current best practice. T

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About the author

Neel Kothari

Kothari qualified as a dentist from Bristol University Dental School in 2003, and currently works in Cambridge as an associate within the NHS. He has completed a year-long postgraduate certificate in implantology at the Eastman Dental Institute, and regularly attends postgraduate courses to keep up-to-date with current best practice.

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Averting a tax disaster
Nick Ledingham has advice for dentists running late on their tax bill

If someone doesn’t have enough money to pay their tax bill, then it’s not the end of the world. We sometimes get calls in February from clients who, for one reason or another, have not been able to meet the January 31st deadline. We thought it might be useful to let readers of Dental Tribune have an update on what happens when tax isn’t paid.

First of all, the rate of interest charged by HM Revenue & Customs when tax is not paid by the due date (in this instance 31 January) is currently three per cent per annum, (which is less than most people’s overdraft rate).

If however the tax remains unpaid by the end of February, then a surcharge will be made which amounts to five per cent of the actual tax owed at that date (not just five per cent per annum!). There will be a further five per cent surcharge if any of the tax that was due on 31 January still remains unpaid after 31 July.

Borrowing Time
It may effectively be cheaper to “borrow” from HM Revenue & Customs up until the end of February than to go into overdraft. However every effort should be made to pay the tax by the end of February to avoid the five per cent surcharge. Indeed, if somebody can only pay part of the tax bill by the end of February then they should do this, because it will save the five per cent surcharge on the amount that is paid.

If profits have fallen since the previous year end, then it may be possible to apply to reduce the payments on account and this can help reduce the amount due at the end of January, even if an application to reduce the payments on account is made after the end of January. Some tax payers however are tempted to apply for reductions in payments on account even when they know that their profits have not fallen. When this happens, interest still runs on the underpaid/postponed amounts at a rate of three per cent from the due date of payment (31 January) to the day before the actual payment is made (which would then usually be the following 31 January).

Options
If somebody is completely unable to scrape together enough money to pay their tax bill, then there are a couple of options open to them. The first is...
to ask HM Revenue & Customs for time to pay.

HM Revenue & Customs’ Business Payments Support Service was set up to meet the needs of businesses and individuals who are experiencing difficulties in paying their tax, originally in response to the “credit crunch”. Depending on the tax payer’s circumstances, HM Revenue & Customs may agree time to pay where it believes that somebody is genuinely unable to pay in full and on time. HM Revenue & Customs will still charge interest on any unpaid tax.

The five per cent surcharge on tax unpaid for more than 28 days will usually be waived, but only if the Business Payments Support Service is contacted prior to the date that the tax was originally due (usually 31 January). HM Revenue & Customs’ Business Payments Support Service can be contacted on 0845 302 1435.

Another option is to borrow the tax due.

There are a number of finance companies such as Braemar and LDF Professionals who specialise in making loans to dentists over six or 12 months to allow them to spread their tax bills.

The interest charged usually approximates to bank overdraft rates although it is usually much easier to borrow from one of these specialist companies.

A Rainy day

Although it is easy to say, the best answer is always to put some money aside each month in order to have sufficient money to pay tax bills. We are always happy to give clients an estimate of how much they should be saving each month, tailored to their own personal circumstances.

It can also help to have a “flexible” or “offset” mortgage whereby you effectively receive the same rate of interest on your tax savings as you are paying on your mortgage, and you are allowed to draw down on the savings/mortgage each January and July.

If any readers who have not yet paid their January tax bills are having difficulties then they should contact their specialist dental accountant straightaway.

Have you hit a brick wall with your tax bill?

About the author

Nick Ledingham is a partner in specialist dental accountants Morris and Co and Chairman of the National Association of Specialist Dental Accountants.
Taking a holiday?
Richard Lishman of money4dentists discusses the current issues concerning furnished holiday lettings for businesses

Though the letting of property in itself does not constitute a trade, the Furnished Holiday Letting (FHL) rules mean that landlords of furnished holiday properties are entitled to some of the tax treatments available to traders.

In the past, to qualify as a furnished holiday letting, a property must be let on a commercial basis, with the tenant making use of the furniture, and must be publicly available to let for at least 140 days and actually let for at least 70 days, in a twelve month period.

However, in the April 2009 Budget, changes were made to the rules for Furnished Holiday Lettings. In order to qualify as an FHL, a business would have to meet both the commercial condition and the letting condition. This means the property must be let on a commercial basis in order to acquire profits and obtain tax reliefs. This is an important consideration when taking loss relief into account because, for example, if losses arise over three years, it may prove challenging to validate that the property is being let commercially.

In addition to this, the Budget 2009 announced that the previous tax reliefs would be discontinued from 6 April 2010 (1 April 2010 for companies) and in order to benefit from the previous tax reliefs, businesses operating as FHLs will need to prove that they are functioning trades. Ironically, this was the situation that existed before Finance Act 1984.

Conversely, the new coalition government has announced that the Budget 2009 will not now take place. Instead, the previous FHL rules will apply during 2010/11. The government plans to consult over the summer on the change of the tax treatment of furnished holiday lettings from 6 April 2011.

The government has declared that the FHL rules need to be changed to comply with EU law. They are seeking to change the rules in a way that is consistent with deficit reduction and without compromising UK businesses.

The FHL rules granted the following tax conditions to lettings that qualify as a trade:

- Loss relief
- Capital allowances
- Landlords Energy Saving Allowance (LESA)

These include:

- Business asset roll-over relief
- Entrepreneurs’ relief
- Relief for gifts of business assets
- Relief for loans to traders and exemptions
- Disposals of shares by companies with a substantial shareholding
- Relevant UK earnings when calculating the maximum relief due for an individual’s pension contributions.

It is worth noting that, as a trade, any income received from the property will be taxed as earned income. But what defines a trade? There appears to be little in the way of a legal definition, aside from section 989 ITA 2007 which defines trade as including any venture in the nature of trade. This is rather limited as definition and although judgements in various court cases can provide some guidance, the crux of the matter will be whether a person’s income is being obtained through trading or if they are a mere landowner who is exploiting the property for income.

For example, a hotel would amount to a trade due to the services that are provided, whereas a person letting a self-catering apartment without providing any services, would most likely be regarded as undertaking an investment business.

With regards to National Insurance, FHL has been regarded as land and property income for NIC purposes. There has been no need to justify that an FHL is a trade due to the statutory provisions that are in place. In addition, in the context of FHL, inheritance tax business property relief does not rely on a business satisfying the statutory definition within section 525(2) ITTOIA 2005. However, the FHL must be a business that is not an investment business, ie: it should not deal in or hold investments, in this case land.

As they did previously, these FHL rules will continue to apply to holiday lettings situated in the UK during the tax year 2010-11. Furthermore, HMRC will continue to apply the FHL rules to properties situated elsewhere in the European Economic Area (EEA) during the tax year 2010-11. However, holiday lettings located outside the EEA do not qualify under the FHL rules and are instead taxed under the normal property income laws.

The Government is looking to reintroduce the FHL rules from 6 April 2011 (1 April 2011 for companies) for effect from tax year 2011/12. These will not only ensure the FHL rules apply equally to properties in the EEA but will also change the way in which FHL loss relief is given. Furthermore, it will increase the number of days FHL businesses have to be available to let as commercial holiday letting.

Full details about the proposed changes will be discussed over the summer, and the legislation will be drafted in the autumn. With the finer details unclear at this point, property owners should seek out professional tax advice in advance of 6 April 2011 to make sure that their business profile gives them maximum scope for tax reliefs.

Richard Lishman of money4dentists, which are a specialist firm of Independent Financial Advisors who help dentists across the UK manage their lifestyle and achieve their financial and lifestyle goals, can provide further information. Richard is the author of the article. For more information call 020 354 50500 or email info@money4dentists.com.
Property update

Ray Goodman discusses the current legal issues regarding the sale of a leasehold practice

As many clinicians will have realised, banks are becoming increasingly discerning when it comes to lending for the purchase of dental practices, tightening their requirements as well as their belts.

Whereas before the credit crunch banks were falling over each other to lend for the purchase of practices (often at low margins over the base rate and with little security other than a charge over freehold property and in most cases they would take a view if there was no freehold), nowadays the terms on which they will lend are increasingly strict. Fortunately though, the window of opportunity has not entirely closed, and dental practices seem to be one of the few remaining sectors to which the banks are still lending, albeit somewhat more frugally.

What we are seeing now, however, is that the banks are still prepared to lend but are seeking greater security; for example where the practice premises are leasehold, they are insisting on taking a mortgage over the lease and are looking for a minimum term of 10, 15 or 20 years left to run on that lease.

In cases with a shorter period before the lease expires, before the deal can go ahead it is necessary to negotiate a new, longer lease with the landlord. There is no obligation for a landlord to negotiate the terms of an existing lease, so it is a matter of negotiation as to which terms he or she may wish to impose. Fortunately, it often benefits the landlord to have a tenant tied in for a longer period of time, so they will usually cooperate as long as you agree to pay the legal costs involved. The process can take some time as the landlord is not under any obligation to deal with your request with haste and their solicitors’ fees may be substantial.

If you are thinking of selling your practice in the next year or so it is possibly worth starting the procedure to extend your lease as soon as possible so that the practice is saleable when you need it to be. Dentists choosing to go down this road are reminded of the importance of having the work carried out by specialist solicitors. They will be familiar with the individual requirements the various banks lay out regarding the lease of dental practices. This is because in addition to the minimum unexpired term of the lease, different lenders have different requirements when it comes to the other provisions they may wish to include in the lease. Experienced solicitors working within the dental sector will be able to navigate the legal minefield on your behalf to ensure you get the most value out of your dental practice.

The views expressed in this article are general and not intended as advice in any particular scenario. You should seek specific advice before taking any steps in relation to your property or practice.
What worries patients about dentistry

Ernestine Wright, managing director of Breathe Business, draws on her years of experience to provide the questions behind the eyes of the patient.

As dentists and members of the practice support team, we tend to naturally believe that cost is the primary reason that patients don’t choose to see us or to take up our treatment plans. This assumption is wrong. The three top factors consistently cited in not visiting the dentist are, in order of popularity:

1. Fear
2. Time
3. Money

We frequently discuss this situation with Breathe clients and look at strategies for overcoming the objections from patients.

The purpose of being aware of what worries patients about dentistry is to develop a client experience that overcomes their fears and provides them with the reassurance and information they require, ideally before they even need to ask.

If the dentists and the reception team are consistently warm, caring, confident and knowledgeable, and the client has developed a rapport and trust with them, then the client is much more likely to accept the treatment they are recommending because they see the dental staff as trusted advisers. Furthermore, this confidence will mean the client will return to that practice and recommend it to others.

An important distinction to make is between the issue of cost and the issue of money. Many patients are less concerned about the overall cost of the treatment, than how they can pay for the treatment and when. Everyone on the team should be confident about what the practice offers (including the fees) as this makes a considerable difference to how your patients perceive you and trust you.

Over time, our clients have built a comprehensive, detailed list of what worries patients about dentistry and here is a summary of that list, in order of popularity:

• Will it hurt at the time?
• Will it hurt afterwards?
• Finding the practice for the first time
• Parking
• Being reprimanded
• Meeting the dentist
• The equipment
• The instructions
• The drill
• Having injections
• What will be done?
• Why is the treatment needed?
• Appointment times
• Will I have to wait?
• How the practice is organised
• Will I be at work afterwards?
• Lying down in front of unfamiliar people
• Fingers and instruments in the mouth
• Being unable to speak clearly
• Having to spit in front of someone else
• Will I be embarrassed?
• How long will it take?
• When do I pay?
• How do I pay?
• How much will it be in total?
• Will I look odd afterwards?
• Will I take odd afterwards?
• Will I be able to chew?

There are a variety of reasons why patients worry about dentistry.

About the author

Ernestine Wright is a founding partner and managing director of Breathe Business. She draws on her years of experience in the corporate world as a senior director for Reuters. She helped Reuters set up a joint venture with Dow Jones, running their UK business. With a background in marketing and sales, she has set up and led successful business teams across three continents. Ernestine specialises in coaching dentists and their teams on leadership, sales and marketing as well as building high performing teams. If you would like to know more about how Breathe can help you, please contact us at: Breathe Business; 0843 209 7289; email: info@now-breathe.co.uk

Have you ordered your free Patient Referral Leaflets?
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Are you up to speed on equality?

Glenys Bridges provides some advice on the code of equality

Alongside the professional requirements set out by the General Dental Council, dental professionals must make sure their day-to-day activities meet generic legal requirements. There has always been a considerable overlap between the professional legal requirements, now Care Quality Commission’s mandate is to blend these factors into a joined-up code of practice for providers of health and social care. To fulfill this role they must ensure timely integration of new legal requirements into practices working procedures. Therefore, practices cannot afford to overlook new legislation or fail to make any required changes.

Some new legal codes will have a minimal impact of dental team’s. Others will be more significant. One significant change was introduced by the new Equality Act which was introduced on October 1, 2010. Under this Act all employers and providers of goods or services to the public need to be aware of some significant changes.

The Act was introduced to streamline and combine previous legislation and make things easier for businesses. Its objective is to help protect minority groups and those who are discriminated against, which is unarguably good society as a whole, but reality places increased pressures on care service providers.

Key changes

The Act specifies ‘Protected Characteristic’ and types of discrimination:

Protected Characteristics
Age; disability; race; religion or belief’s; sexual orientation; gender reassignment; marriage and civil partnership; pregnancy and maternity.

Different types of discrimination:
Direct discrimination; Associative discrimination; indirect discrimination; Harassment; Harassment by a third party; Victimisation; Discrimination by perception.

The response to these changes must continue to actively promote equality, diversity and human rights. On this basis you can plan actions to cater for patients with specific needs, including those with disabilities.

You will need to Introduce practice processes to receive patient feedback and act on it. So that patient wants and needs are accounted for when shaping your services.

Practice managers need to determine practical ways to introduce and monitor both existing and updated measures into their practices. The most effective way to roll out the practices best intentions is to involve all staff in setting and measuring the observation of standards. In most cases this requires some training and development for the team.

In house training options are an ideal way to set-up what will become a self-perpetuating training and development culture. At present in certain circumstances a £1,000 training grant can be accessed for this purpose.
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dental services are commissioned and run. Whilst primary and secondary dental services are to be commissioned by the NHS Commissioning Board through the establishment of health and wellbeing boards at every upper tier authority from 2015 (although they could be operating in shadow form as early as from 2012).

Until now, local councils have only been involved in the provision of social care. A separate new body, called Public Health England, will be created to improve public health and reduce health inequalities between the richest and poorest. At the same time, the number of health Arm's Length Bodies (ALBs) is to be reduced from 18 to between eight and 10. Organisations which are no longer needed will be removed from the sector, with essential work moved to other bodies. ALBs facing the chop include the Health Protection Agency, and the National Patient Safety Agency.

The proposed reform of the NHS and the abolition of Primary Care Trusts has been met with skepticism and mixed reactions in a wide range of stakeholder groups. There is widespread concern that there will not be enough dental expertise amongst board members involved in the commissioning of dental services, and a lack of thorough knowledge of how dental practices are run. In the proposed structure, the channels of responsibility are opaque and confusing, and there are question marks of where accountability will lie.

Dr Susie Sanderson, the British Dental Association's Executive Board Chair, has said that: “There will clearly need to be an involvement of experts such as consultants in dental public health, dental practice advisers and local dental committees to ensure that patients' needs are addressed as services are commissioned.”

According to Paul Burstow, Minister of State for Care Services, local authorities will have the power to require information and attendance at scrutiny meetings of any provider that is funded by the NHS. This includes the scrutiny of GP practices, dentists, pharmacies, and independent and voluntary sector providers.

An NHS dentist from South East London, who does not wish to be named, has said that councils “will not be perceived as having enough knowledge or expertise in the dentistry arena to be able to pass judgment on healthcare professionals. High street general dentistry is still mainly delivered by independent practices, run by principal dentists as small businesses, and it is likely that they will not be happy having pen pushers from the Council calling the shots.”

The BDA has also pointed out that until now the coalition government has failed to address a number of important issues for dentists and their patients, leaving many questions unanswered. Importantly, these include the Government’s intentions for how dental public health fits into the envisaged arrangements and arrangements for care for vulnerable patient groups.

Dr Sanderson has said that: “This Bill must answer those questions.”

While the exact details of the relationships between the NHS Commissioning Board, GP consortia and local council authorities are still to be clarified, a spokesperson for the Department of Health has said that: “The NHS Commissioning Board will commission both hospital and primary dental care services to ensure integrated dental services.”

However, the Department of Health has not revealed what extra funding, if any, Councils will need in order to be able to meet their new obligations under the new bill. It is also unclear how much budget has been identified for the commissioning of dental services.

The NHS reforms come at the same time that a new general dental practitioner contract is being drafted. Last December the Department of Health announced that pilots will begin in April and will test any contract models that focus on providing continuing care for registered patients and improving access. They will also explore ways of moving away from the target-driven basis of the current dental contract and instead focus on prevention and quality of care. The new contract is due to be published in 2014; however, dental groups have expressed concern over the timing of the NHS reform and are worried that energies will be diverted into implementing the new contract rather than on securing a good deal for dentists and patients.

Lord Colwyn, Vice-Chair of the All-Party Group for Dentistry, has highlighted that in 2005 a new dental contract was introduced at the same time as PCTs were reorganised and that during the restructuring many dental leads and commissioners were not in post to oversee the implementation of the new contract.

The NHS reforms pose questions such as what criteria will the local authority council be measuring, and to what level will they be able to scrutinise? What happens if a council deems a practice not performing adequately? Who will monitor practices, and will they be qualified? Such issues will remain unanswered for some time while the next step of Health and Wellbeing is due to be published in 2014. It is unclear how much budget has been identified for commissioning dental services.
Traditionally, cosmetic dentistry has always faced the challenge of treating poorly aligned teeth. Treatment options available for mildly and moderately crowded teeth include orthodontics and restorative dentistry. Many patients have chosen the restorative approach, for example porcelain veneers, over orthodontic techniques because of longer treatment times combined with either unsightly labial wires and brackets or the expense of ‘invisible’ braces.

In cases in which patients choose to have crowded upper and lower anterior teeth treated with veneers, it is extremely challenging to prepare teeth conservatively, owing to their anatomy and the minimum thickness of porcelain required.

A difficult balance has to be found between over preparing the teeth and placing over-contoured restorations. However, owing to the excitement and emotion created by the effect of popular large smile makeovers, aggressive tooth preparations, in which teeth are prepared to stumps, seem to have been accepted as normal practice, simply because there has been no alternative that could achieve the patient’s objectives in a sufficiently short period.

Inman Aligners are now offering a minimally invasive alternative to patients in the U.K. With only one appliance, most Aligner cases can be completed in six to 16 weeks. In anterior crowding cases, Inman Aligners have proven to be much more time and cost effective than invisible braces or conventional fixed and short-term orthodontics. To date, I have treated about 1,000 cases and have found that case acceptance has been close to 100 per cent, simply because many patients much prefer a removable solution that fits their lifestyle more easily. Treatment can also easily be combined with simultaneous bleaching and final edge-bonding for quick and non-invasive, dramatic results. From this, a new procedure has arisen in cosmetic dentistry—alignment, bleaching, bonding—which will be covered in the second part of this series. The cases presented in this article will outline some case types that can be treated.

The Inman Aligner
For over 30 years, spring aligners were used to correct minor tooth movements. Previous spring aligners were useful, but several problems always limited the amount of tooth movement achievable. Their active components were made from stainless-steel wire, which is relatively inflexible and lacks any innate springiness.

As a result, traditional removable appliances required periodic reactivation, leading to short-lived force application that limited the speed of tooth movement, owing to the need to allow the bone around the roots of the teeth being moved to ‘rest’ between successive activations. In addition, the direction of force application with traditional springs was less easy to control, leading to a mouse-trap-like force that tended to unseat the appliance. These factors limited the degree of correction that could be accomplished. For larger movements, single appliances were insufficient to complete the movement.

The Inman Aligner - Part 1
An effective tool for minimally invasive cosmetic surgery by Dr Tif Qureshi
For all your orthodontic needs

Inman Aligner
for moderate anterior crowding

Clear Aligners
for mild anterior crowding

Bracket Indirect Bonding service
for full arch alignment

Inman Aligner hands on courses

24th Feb Manchester SOLD OUT
19th March London
15th April London
22nd July London
21st October London
25th November Newcastle

Lectures -
May 6th London Clinical Innovations Smile-On
May 21st BDA National Conference
July 2nd Accessible Aesthetics Day Seminar

For course details contact Caroline Cross
www.straight-talks.com
Please phone 02072552559

Visit www.straight-talks.com for online learning,
support and Spacewize™ digital crowding calculator.
In developing the Inman Aligner, Donal Inman CDT created a patented design that takes advantage of the gentle, steady and consistent forces generated by NiTi. The design relies on piston-like components driven by NiTi coil springs. Inman designed lingual and labial components to function or move in parallel to the occlusal plane, eliminating the mouse-trap-like unseating forces and allowing actual physiological movement of teeth. Inman Aligners are ideally worn for 16 to 20 hours a day. Studies have demonstrated that the removal of orthodontic forces for four hours a day massively reduces the risk of root resorption1 and that risk of root resorption is lower in removable versus fixed appliances.2

A standard Inman Aligner as described in the following cases consists of both lingual and labial components.

The forces have the effect of squeezing the teeth into alignment. The components can be used in isolation to retract teeth with a more steady force, requiring less adjustment than a standard labial bow retractor. Strategic placement is required to understand the correct amount of space required. Cases with over three mm of crowding require additional space creation techniques, as pioneered in the UK, which should only be attempted with training. It is quite possible to treat cases with 5.5mm crowding easily and predictably in less than 16 weeks.

4. Cases should have fully erupted posterior teeth to facilitate re-entrant clasps, with a reasonably well-aligned arch form to facilitate the path of insertion of the appliance.

5. Cases should be stable and preferably free from periodontal disease.

6. Patients must agree to wear the Aligner for about 20 hours a day and be responsible for good appliance and oral hygiene. Should the patient wear the Aligner for 14 hours a day only, treatment will still be successful.

Model evaluation/arch analysis with Spacewize Arch analysis should be performed before any Aligner case is attempted in order to ensure that the case is suitable and, if not, what additional space creation techniques will be needed to allow the Inman Aligner to work. The extent of crowding must be measured from the distal surface of one canine to the distal surface of the other canine.

Using an orthodontic retain-er or jeweller's chain or a polishing strip, the ideal arch form is then measured from the distal of each canine in alignment with the ideal arch form following orthodontic correction.

Critically, the arch needs to pass through the suggested position of the contact points and not the incisal edges. This is described as the available space or the curve.

It is possible to perform this task more quickly and just as accurately with software such as Spacewize. Just one simple occlusal photograph is required, which can be taken chairside. One tooth needs to be measured for calibration. A curve can be digitally established and this is normally easier when observing the patient's aesthetic requirements and occlusion directly. The extent of crowding is immediately calculated using such software.

Laboratory requirements

Accurate upper and lower impressions are taken, preferably two of the arch being treated. Simple alginate can be used if cast quickly. A bite registration and prescription should be completed and sent to a certified Inman Aligner Laboratory. The technician should be informed of the amount of crowding calculated. The teeth to be repositioned should be noted clearly. The prescription should provide full details to the technician regarding the teeth to be moved, the area they are to be moved to and the distance they are to be moved. A Spacewize trace of the ideal curve can also be submitted.

Interproximal reduction

Interproximal reduction (IPR) is begun at the fitting appointment using abrasive strips or discs. The model analysis will have already calculated the extent of IPR required.

Many authors acknowledge that the reduction of half of the interproximal enamel on the mesial and distal of each incisor tooth is a safe technique.3–7 This equates to 0.5mm per contact point, creating 2.5mm of space between the canines. In some cases, the distal of the canine and mesial of the upper lateral can be approximat-ed allowing for a total of 3.5 to 4.5mm. These cases will require more experience in using the system but offer a number of possibilities for clinicians once trained to use the system correctly.

Meticulosus records of the amount of stripping performed should be kept. An in-surgery fluoride rinse or application of topical fluoride is recommended after any enamel reduction procedure.

Similarly, the lower canines should be reduced using similar techniques. The following criteria should be met before treatment proceeds:

1. Cases should require move-ment of incisor and/or canine teeth only.
2. Root formation of the teeth to be moved must be complete.
3. Crowding or spacing should be less than or equal to three mm. Arch evaluation must be performed to determine the amount of space required. Cases with over three mm of crowding require additional space creation techniques, as pioneered in the UK, which should only be attempted with training. It is quite possible to treat cases with 5.5mm crowding easily and predictably in less than 16 weeks.

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Critically, Inman Aligner treatment uses progressive, anatomically respectful IPR. While the extent of IPR required is already known, it is never carried out in one treatment. In order to ensure minimal risk, IPR (0.15mm per visit per contact point) is carried out only in small increments. The patient is sent away with the Aligner. Owing to the Aligner forces, the gaps will be closed after two weeks. Interproximal reduction is performed at each appointment only as needed, using strips or discs, which ensures the stripping is far more anatomically conservative than would be the case using bars. This significantly reduces the risk of excess space formation, gouging or poor contact anatomy.

Lingual/labial anchors

Composite resin just incisal placed either incisal or gingival to where the bows contact will help them to function more efficiently. This can also be used for the labial surface, especially in cases in which teeth are being retracted. Strategic placement is vital for success and can be very helpful in the treatment of rotated teeth and the extrusion of teeth.

Appliance adjustment

The forces can be varied by adjusting the spring components or replacing springs for larger, longer springs. Generally, adjustments are not necessary, except in more complex cases, for which training is required to understand the correct spring types and compression rates to use.
Case I
The 25-year-old female patient complained about the appearance of her lower anterior teeth. She gave a history of orthodontic treatment in her teenage years, having a fixed appliance fitted for a period of two years. She had been given a retainer at the time but was told to wear it at night for three months only. She had noticed her lower four incisors starting to become crowded again. Treatment options discussed were invisible braces, conventional fixed brackets or an Inman Aligner.

The amount of space required for reduction was calculated as 3.5mm. Interproximal reduction was performed using diamond strips (Brasseler). A reduction of 0.13mm at each contact point was achieved at the fitting appointment. This was verified with a thickness gauge. The patient was seen three weeks later and a further 0.13mm was reduced at each contact point. The teeth were aligned in just over nine weeks. The Aligner was left in for one month to stabilise the tooth positions. Tooth whitening was undertaken for two weeks during the last two weeks of treatment. Simultaneous bleaching is a significant advantage in removable systems and helps patient motivation. Finally, an orthodontic retention wire was bonded in place on the lingual surfaces, ensuring the patient could still use super floss for hygiene.

Case II
A female patient presented complaining mainly about her rotated upper right central tooth. She was considering veneers to redistribute the space over the four front teeth. This would have meant that she would undergo three aggressive preparations and one invasive preparation with endodontic treatment of the upper right central tooth. Space calculation with model analysis indicated that treatment would be possible with an Inman Aligner. Because of the relatively low cost, the patient selected this option, understanding that we would not be able to achieve Golden Proportion, owing to the width and length of her lateral teeth.

A midline screw was incorporated to allow for a small amount of operator-controlled expansion to provide a little more space. (Incorporated expanders can be used to release extra space in cases with very constrained space.) Up to 2 mm of space can be created by expansion, which has the effect of pushing the cuspids away from the lateral. After alignment, this expansion will just relapse. It is a temporary technique to create sufficient space to align the anterior teeth. After alignment, the expander can even be unwound if required.

Treatment took 15 weeks with three sessions of IPR. A total of three mm was stripped and one mm was gained with the expander. The teeth were retained using orthodontic gold wire bonded from canine to canine. An upper Essix Retainer was also worn nightly as back-up for retention.

Case III
The patient in this case originally presented for porcelain veneers on her upper anterior teeth. The preparations would have required root-canal treatment of two of her incisors in order to provide sufficient space for alignment. Simultaneous bleaching is a significant advantage in removable systems and helps patient motivation.

The preparations would have required root-canal treatment of two of her incisors in order to provide sufficient space for alignment.
to achieve adequate emergence profiles.

After case options had been discussed in detail, the patient decided upon an Inman Aligner to align the teeth with veneers following this treatment. The patient was aware that after alignment, retention would be mandatory. Spacewize arch analysis calculated only 0.8 mm crowding in deviation from the ideal curve.

An upper Inman Aligner with combined expander was fabricated and fitted. Minimal IPR was carried out with a 0.1 mm reproximation strip to separate the teeth. The patient turned the screw every five days for six weeks, which created nearly 2mm of space. This allowed the teeth to move passively, and de-rotate. At this point, the expander was unwound to ensure that any mild residual spacing had closed. The teeth were aligned within nine weeks.

An Essix Retainer was used to retain the teeth passively for a further four weeks, after which a bonded wire retainer was placed. The patient was very pleased with the alignment and decided that she would not need veneers. Veneers could always be used at a later stage if necessary, after more enamel has eroded with age and when veneers can be placed adaptively, for example.

The result was not a perfect smile with regard to the criteria defined by Smile Design theory. Yet, she no longer wanted veneers and decided that she would not have the upper Inman Aligner treatment.

Retention

Retention for anterior alignment is essential.10–12 Recommended retainer types are bonded canine-canine fixed retainers commonly fabricated from .0195” or .0175” multi-strand stainless-steel wire. An indirect method can be used to adapt the wire to a working model. This can then be transferred to the teeth, using a specially made jig and bonded with flowable composite resin to the backs of the aligned teeth. The occlusion must be clear when placing a retainer on the maxillary arch.

Advantages of this method are that the flexibility of the arch wire allows for physiological tooth movement and prevents bond fracture through occlusal forces. Periodontal ligament stability is also achieved with this technique.13

Essix Retainer

This retainer is a thermoformed, clear, thin appliance that is easily made and very comfortable for patients. The recommended post-operative regimen for Inman Aligner treatment is to wear the retainer at night for 18 months and after that for two nights a week indefinitely.

Conclusion

With the Inman Aligner, patients previously put off by the treatment time and fixed brackets of traditional orthodontic techniques or the expense of more recent invisible braces, could, if their case is suitable, achieve anterior tooth alignment far more quickly with a simpler, single appliance. Inman Aligners are suitable for alignment of incisors and canines with up to 3mm of crowding.14 It is also possible to achieve posterior tooth alignment with the Inman Aligner, and a maximum of 3–4mm of space can be created for posterior tooth alignment.

The Inman Aligner allows for a rapid and aesthetic alignment of incisors and canines at a very low cost and low risk to the patient. The patient is able to preview the staged changes of alignment, perhaps followed by bleaching and bonding.

As a result, the Inman Aligner is profoundly changing the approach to cosmetic dentistry in the UK and Europe.

This new approach to cosmetic dentistry in the UK has been confirmed by figures from the British Academy of Cosmetic Dentistry (BACD). The 2008 study of data from 200 BACD members demonstrated a massive 545 per cent increase in the use of invisible braces and retention far more quickly with a simpler, single appliance. Inman Aligners are suitable for alignment of incisors and canines with up to 3mm of crowding. It is also possible to achieve posterior tooth alignment with the Inman Aligner, and a maximum of 3–4mm of space can be created for posterior tooth alignment.16

The Inman Aligner in cases in which patients would not otherwise have had their teeth treated, owing to the time cost of fixed braces and no desire to have appliances adhered to their teeth.

Many of these patients were those who would have opted for aggressive preparation of their teeth for veneers, before the Inman Aligner.

Acknowledgements

I would like to thank Donal Inman CDT (Inman Orthodontic Laboratory), NimrodDENTAL Orthodontic Laboratory—the only Straight Talks Seminars—Orthodontic Laboratory—the only Straight Talks Seminars—and Dr James Russell for Case III.

A complete list of references is available from the publisher.
The Importance of Documentation in Micro Dentistry
Nicholas Gibb discusses the benefits of the dental operating microscope in recording treatment plans

With the wide acceptance of the dental operating microscope in endodontics and other dental specialties the use of routine documentation is now possible and desirable.

What is Documentation?

Documentation is the recording of images and data in different formats.

Why incorporate Documentation?

This is important for many reasons:-

• Accurate recording of patient data, anatomy, conditions and results
• Documentation provides material for analysis, review of cases and resultant improvement of techniques
• Documentation provides images for education and presentation
• Medical/legal requirements
• To provide information for nursing staff and patient education

Types of Documentation

Documentation can be provided through the microscope or externally. With the Dental Operating Microscope the choice of documentation types is even wider; multiple types of digital photography, digital SLR photography, video documentation, combined video and digital stills photography and assistant microscopes.

Which types of combinations to use

Determine your criteria (patient records, presentations, education, staff participation, referral information, legal).

How to achieve quality images

Through the dental microscope a beamsplitter is required. With Global, different beamsplitter configurations are available depending on imaging required.

A camera mount is required to suit camera of choice (dig-
A camera is required, multiple types, makes and specifications are available with widely varying prices. One should choose a system that meets all criteria, resolution, ease of use features, compatibility and cost. Once chosen Global can provide adapters for most cameras.

What do you want to achieve?
1. Routine continuous video/images for nursing staff and patients: Use a 95/5 beamsplitter, this provides increased camera depth of focus.

A conventional C-Mount video adapter tube and C-Mount camera will provide the required results.

Continuous video images enable the dental nurse to participate in and anticipate the operators requirements, the monitor must be positioned in the nurses line of sight.

2. A binocular assistant scope also enables full participation by the nurse. If this option is chosen a 50/50 beamsplitter should be used.

3. Capture of specific still images. For convenience use a digital stills camera of choice.

A 50/50 beamsplitter is required plus a digital camera mount, (X-Mount) with adapter to suit camera model. These cameras can be adjusted (eg. zoom) independently of microscope: high quality low cost cameras are available.

4. Combination (Video & Digital stills) provides very flexible documentation. Use a 50/50 beamsplitter, X-Mount adapter and the appropriate camera mount.

5. Digital SLR with a 50/50 beamsplitter and camera mount.

All these options can be added to the Global Dental Microscope with ease, this upgrade facility is important as operators requirements may vary with time. These instant microscope upgrades are an important Global facility not found on all microscopes. Camera specifications are continuously improving hence the need for upgrade compatibility.

Many operators use the same camera as they are comfortable with unit and results and do not see the need to upgrade. This demonstrates that documentation should follow the operator’s requirements and skills.

The global perspective on documentation

Digital Documentation

SLR X-Mount & Digital X-Mount Adapters

Automatic Framing – Capture the exact replica of what you see.

“Framing” is automatic. Images are recorded with virtually no interruption to the treatment.

Easy Upgrade – Modular design allows for upgrading your camera at little or no cost to change the adapter.

Efficient Archiving – Entire procedures can be electronically documented; allowing for efficient archiving in patient records.

No Blurring – The wide optical path of the X-Mount and SLR Mount allow for faster shutter speeds, thus reducing blurring.

Video Documentation

Communication/Archive – Record the procedure, let the patient watch the procedure, communicate clearly what treatment is needed and why.

Capture the entire procedure for communicating to colleagues, referring dentists, the patient’s parent, your study club, and insurance companies.

Educate and persuade your patient

The greatest benefit: gain patient acceptance of treatment. Those cracks that cannot be seen with the naked eye can easily be seen through the microscope and then shown to the patient via the camera image.

Superior to Intraoral Cameras – Images are magnified optically, not electronically; making the resolution of the microscope’s video image far superior to traditional Intraoral cameras. Also, unlike Intraoral cameras, the microscope/video camera allows you to document the actual procedure.

More Light – The patented Virtual Beamsplitter provides a clear image to the video camera while removing less than five per cent of the light from the user. Other beamsplitters rob the user of 20 per cent or more of the light.

Greater Depth of Field – The Virtual Beamsplitter also provides incredible depth of field for the video image.

Flexibility - Camera can be placed on either side of the microscope for user convenience.

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The Dental Directory: Experts on Digital Imaging Equipment

Digital Imaging is an extremely fast growing area within today’s dentistry field, and one that may require a dentist to make a substantial investment in terms of equipment. Due to the complex nature of Digital Imaging, the necessary equipment currently available is often highly advanced and relatively new to the market. With this in mind, it is vital that suppliers keep up to speed with industry developments; keep up to speed with it is vital that suppliers

market. With this in mind, it is vital that suppliers keep up to speed with industry developments; and one that has is The Dental Directory.

Dr Boota S Ubhi is the Specialist Periodontist and Implant Surgeon at the Birmingham Periodontal and Implant Centre. He works alongside Dr Tuss Tambra who is an American trained Specialist Prosthodontist. The practice is a large specialist centre based in Harborne, Birmingham and has a wide referral base covering most of the Midlands. He has been a client of The Dental Directory for the last thirteen years.

'I have been using the services of The Dental Directory since 1997 and have had only positive experiences in all of my dealings with them. Initially The Dental Directory offered me a very good deal on a particular product, the

has been accepting referrals for advanced dental care since 1996. Dr Tambra is a registered specialist Prosthodontist in Canada, UK and USA.

In addition to this, the practice facilities which include a large lecture room and dedicated surgical suite allow them to provide training to

and after treatment. Five years ago, Dr Ubhi changed to using both the intra-oral and extra-oral digital imaging supplied by The Dental Directory. He was extremely pleased with how this worked out and investigated the CT scanner options.

Having read research produced by the University

'The equipment arrived promptly and was exactly to spec; I was delighted. The whole experience was thoroughly well-planned, low stress and professional; qualities that I’ve come to expect from The Dental Directory.'

The Gendex GXCB-500 provides powerful, instantaneous diagnostic and treatment planning tools; giving distortion-free images to reveal critical anatomical details. This scanner is one of many pieces of Digital Imaging equipment available from The Dental Directory, and Dr Ubhi is extremely happy with his purchase. He feels that the addition of 3D imaging to his practice means that he is providing a much higher standard of care for his Implant cases. The planning and execution of his treatment is much quicker and safer due to the on site CT scanner.

Dr Ubhi’s multidisciplinary practice specialises in treating patients with advanced periodontal problems, fixed and removable prosthetics and Implant therapy. Dr Ubhi was entered onto the General Dental Council’s Specialist Register in Periodontics in 2000 and referring dentists and their staff to enable them to gain the understanding and confidence to deal with advanced dental care. The Surgical and Prosthodontic 10 day modular implant course is now in its 5th year. This course covers surgical implant therapy, sinus and bone grafting, bone augmentation and the Prosthodontic aspect of Implant therapy. Nurse’s courses are also run and cover a range of topics including basic implant techniques, care of instruments, sterile techniques, implant kits and care of patients before of Manchester, Dr Ubhi learned that the i-CAT scanner provided the best quality images, and most importantly, the lowest dose of radiation available on the current market.

After intensive consultation, The Dental Directory supplied Dr Ubhi with a Gendex GXCB-500 CBCT System.

‘After considering the necessary specifications, I approached several different suppliers, one of which was The Dental Directory. I discussed my requirements with them

and they were extremely knowledgeable. They have a dedicated Digital Imaging Manager, Mohammed Latif who is on hand to offer advice and explanation. Their expertise was invaluable and made me feel confident that my choice of equipment and supplier was the right one.'
The support provided by The Dental Directory is second to none…’

Mohammed Latif, Digital Imaging Manager for The Dental Directory, worked closely with Dr Ubhi throughout the project.

well-planned, low stress and professional; qualities that I’ve come to expect from The Dental Directory.’

After-sales and backup support is a key area for consideration after having purchased a new piece of equipment. Should something go wrong, it is always vital that the appropriate expert be on hand to support the customer and resolve the issue quickly and effectively. The Dental Directory boasts highly skilled and knowledgeable staff members, who are able to offer the right levels of support should it be needed. As Dr Ubhi says, ‘The support provided by The Dental Directory is second to none. They offer a consistent level of customer care, and will always do over and above what is necessary in order to resolve an issue. This is very reassuring and certainly encourages customer loyalty. After the i-CAT scanner was set up, a member of The Dental Directory team came down to provide us with two days of training. All of his instructions were extremely clear and any questions or queries that were raised were answered precisely and confidently. We were also offered further software training after the initial training session, which we took up. This we found invaluable as it cleared any queries we had after the installation.’

If you are a dental professional needing astute, unbiased and impartial advice on which Digital Imaging solution is best for your practice, The Dental Directory should be your first port of call.

For more information on how digital imaging systems can improve your practice, call Mohammed Latif on 07808 943647 or The Dental Directory Equipment Department on 0800 585 585.

Priding itself on not being tied to any particular manufacturer, The Dental Directory has Technical Sales staff that can give you comprehensive advice on the best Digital Imaging equipment to meet your unique requirements.
The beauty of modern materials
Dr Ian Cline discusses how to achieve clinical success with posterior composites

Composite and ceramic tooth-like restorations are without doubt favoured by most patients. These restorations are also, increasingly, the choice of the clinician and a significant number of practices have now become amalgam-free. Posterior composite restorations offer a number of advantages over amalgam, such as excellent aesthetics, minimal preparation of tooth tissue, and the potential reinforcement of tooth tissue.

Amalgam has served the dental profession well for more than a century and is a fairly forgiving material in terms of placement and shaping. Composite on the other hand presents a number of difficulties in isolation, dentine bonding and material placement. In particular, when restoring interproximal lesions, technique and operator ability become of the utmost importance. Otherwise, numerous complications may result. These include post-operative sensitivity, premature failure of the restoration due to microleakage and recurrent caries. Of particular difficulty are the production of good contact areas/points and the reproduction of good interproximal form.

Clinical case to illustrate key aspects required for success (Figures 1-6).

When providing a posterior composite, there are several phases. At each phase, things can and do go wrong and each phase requires attention to detail. Of particular importance are:

1. Isolation
2. Tooth preparation
3. Bonding protocol
4. Matrix application

1. Isolation
Whilst rubber dam use is taught and practiced routinely at dental school, many dentists quickly fall into a habit of only using such isolation for endodontic treatment. Lack of familiarity with rubber dam can lead to reluctance to use it for posterior composites. However, the reluctant clinician should practice the use of a “one-shot” technique where the barrier is stretched over the frame and a winged clamp is used. This technique can be very fast and simple, often taking less than a minute to isolate one or two teeth and a couple of minutes for a quadrant. The advantages of rubber dam use outweigh the negatives of blood and saliva contamination which ruin bonding. The use of rubber dam should be practiced for the vast majority of cases.

2. Tooth preparation
Tooth preparation should be limited to access and removal of any failed restoration and caries. The cavity preparation should be rounded in form with no sharp internal angles so as to prevent potential stress concentration and to make it easier to adapt the composite material to the cavity. Placement of bevels on the vertical walls of a Class II restoration has been shown to improve adaptation and reduce microleakage. Bevels on the occlusal surface only seek to disguise margins and may have a detrimental effect in terms of thin sections of composite on the biting surface, which may fracture with time.

3. Matrix application
The use of conventional “passive” type matrix bands, such as Toffenine and Silvland types (which are suited to amalgam restorations), are often found to be inadequate for posterior com-
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a great deal of Bornishing and wedging apart of the teeth to produce adequate contact points, and the anatomical interproximal contour is often not accurately reproduced. The best way around this problem is with the use of a sectional “active” matrix system such as the V3 Ring System or the Palodent system. This comprises a very thin sectional metal band which is wedged and then held in place with a ring, not dissimilar to a rubber dam clamp. This ring, as well as holding the band in place, will push apart the teeth sufficiently so that when ring and matrix are removed, there will be a good tight contact point/area.

4. Bonding protocol

Understanding proper dentine bonding technique is essential. Enamel bonding is well understood and relatively simple and reliable. Dentine bonding, however, has undergone numerous changes over the past 15 years with several generations now available. The range of systems can be a little bewildering; however, the use of high quality dentine bonding systems, such as Optibond Solo or Prime & Bond NT, if used correctly, will lead to good results.

Poor bonding technique can lead to post-operative sensitivity and premature failure of the bond leading to micro-leakage and secondary caries. The most important thing is to read the instructions; it is amazing the number of people who don’t! Each generation of bonding system has particular peculiarities to it, such as having to shake the bottle before use, or to having to keep the product refrigerated, it is therefore essential to read the instructions and to follow the protocol correctly for optimal results.

To perform with confidence call NSK on 0800 6341909 or visit www.nsk-uk.com
Innovative Scandinavian design is best for dental ergonomics

Long working hours and bad ergonomics often lead to a number of sitting–originated ailments in dentistry work. Bad working posture results in huge financial costs: reduced working hours, necessitating early retirement and an overall, poorer quality of life. Alarming numbers of European dentists – over 60% – have to retire earlier because of so-called sitting disorders. Most people working in dentistry are affected by these disorders, whether they are aware of them or not.

As new thinking has been needed to make working postures healthier and more comfortable in dental work, a new ergonomic design has emerged from Scandinavia: a saddle chair with a two-part width adjustable seat. The riding-like position with adjustable width saddle seat offers the user the possibility to tailor adjust the width to create the best possible sitting comfort for themselves.

Most dentists and assistants are exposed to a large physical workload every day. In particular, the back, neck and shoulders are strained as a result of static working posture and bad sitting.

When sitting on a traditional chair with a back rest or on a dental stool, it is not possible or at least it is very difficult to maintain straight posture for longer than a few minutes. The reason behind this simple: when the angle between the upper body and thighs is only approximately 90°, it is quite impossible to maintain upright posture as it requires keeping the pelvis tilted slightly forward. On the contrary, many dentists and assistants tend to sit with the pelvis tilted backwards, “relaxed” and round-backed position, which in the long run causes back pain and tension.

What is healthy sitting?
The ideal sitting position is achieved when the spine is in an upright position and at the same time the natural lower back curve (lordose) is maintained. For the spine this is the natural and unloaded position where the disc, and at the same time shoulders and arms are relaxed.

Nonetheless, sitting straight is only possible if the design of the seat allows the pelvis to tilt forward. A saddle chair is a good solution since the riding position creates upright posture, however, on a traditional one-part saddle chair pressure is focused on the discs, and at the same time shoulders and arms are relaxed.

Benefits of Adjustable two-part saddle seat in practical dental work

The two-part saddle seat has many favorable effects on the daily work of dental professionals. In addition to diminishing shoulder and neck tension, the blood and fluid circulation in the lower limbs is activated, which, in turn, prevents swelling and numbness. As the angle of the knee joint is wider, the knees are also less stressed. Breathing deepens and one can feel energetic even after a long working day.

When sitting on a saddle chair, one can place the feet partly underneath the patient’s chair, thus allowing the distance to the working area to be shorter. When one sits upright with the arms free and relaxed near the sides, many of the work positions that earlier felt difficult become easier, because the muscles in the neck and shoulders no longer get strained. This work position is also very good when performing operations that require precision and care, because the visibility of the patient’s mouth is better. Moving during the operation is effortless, because the chair rolls with you and your feet are never in the way.

The Finnish company Salli Systems pays special attention to sitting health and comfort in its research and development. Divided Salli saddle chairs were showcased at NEC, Birmingham from the 4th to 5th of March.

www.salli.com

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Invisible, ingenious and speedy
Angela Auluck reports on the BLOS annual meeting

Lingual Ingenuity was the title of the annual meeting of the British Lingual Orthodontic Society. The aim was to give members a varied day of clinical and non-clinical information, provided by a highly impressive team, each with vast experience in their field.

The morning session was opened by Robbie Lawson, a Specialist Practitioner in Edinburgh and a member of the Incognito Key Opinion Leader Programme. Robbie’s enthusiasm for lingual appliances was demonstrated by his vast experience.

Asif Chattoo, the founder of the London Lingual Orthodontic Clinic, is one of a number of leading Orthodontists who is trialling the AcceleDent oscillating device. Asif introduced the theory behind this cutting edge appliance which produces cyclical forces and thus accelerates bone remodelling at a histological level before demonstrating to us the success of the appliance in his clinical cases.

Consultant Maxillofacial Surgeon, Keith Altman shared his experience of developing a unique fixation system for patients with lingual appliances undergoing orthognathic surgery. Keith described the pitfalls of previous techniques such as switching to labial appliances prior to surgery and presented his method of the use of Vector TAS miniscrews.

The President of BLOS, Didier Filion, shared his ingenuity of Class II mechanics. He took the audience back in time and showed how he treated Class II div 2 cases using the Sb 17th generation system. Didier then described and contrasted his management of a similar case using the Orapix system of customised bracket positioning and a straight wire technique.

Among those who shared the tricks of the trade with their clinical pearls were Rob Slater, Megan Hatfield, Paul Ward, Ian Hutchinson and Virginia Rootkin-Gray.

But the day was also important for the contribution from non-orthodontists – dental nurse Emma Boca who presented the results of an audit in her practice and Dan Fielder, from the e-consultancy Sticky Content and an authority on website content.

Emma described the audit of patients who were given three different types of wax to try out in the week following placement of their braces. While the response rate was disappointing, the results were clear – the most popular type of wax was Gishy Goo.

Dan Fielder provided all the essential considerations for any orthodontist embarking on a new website. Content creators should ask themselves the following questions:

1. Is my title/headline search-able?
2. Are my links effective?
3. Is my copy original and engaging?
4. Have I used the right keywords – search words?
5. Does my description text tell people what to expect?
6. Have I written for people first?

The audience was also given an overview of the findings of the Ipsos MORI survey commissioned by BLOS, the brainchild of our media advisor, Caroline Holland. For further information please visit the BLOS website.
The International Foundation for Oral Design will be hosting the “2011 Symposium” in London, over three days from Friday 6th to Sunday 8th of May 2011. The symposium will comprise of lectures on the Friday and Saturday and will be aimed jointly at both technicians and dentists, with the majority of presentations being co-presented by dentist-technician teams. The meeting will be held at Central Hall Westminster, by the Houses of Parliament, and there will be a hands-on program for Dental technicians and Dentists at Guy’s Dental Hospital on the Saturday and Sunday. There will be an extensive trade show during the conference and, during breaks, Oral Design members will be sited between some of the stands doing mini master classes to attract the delegates to the trade show.

6 CPD POINTS FOR EACH DAY ATTENDED

The symposium will feature presentations by the following speakers:

- Dr Stephen Chu (USA)
- Dr Daniel Abbondanza (AUS)
- Dr Douglas Terry (USA)
- Dr Giuseppe Allais (ITA)
- Dr Luca Dalloca (ITA)
- Dr Martijn Moolenaar (NL)
- Eric Van der Winden (NL)
- Jason Kim (USA)
- Joachim Maier (DE)
- Juergen Mehrhof (DE)
- Michel Magne (USA)
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