**New statistics claim an eight-year attendance low**

Survey reports a decline in dental patient numbers

Dental attendance figures are in the spotlight again after a new survey claims that the number of patients visiting the dentist has hit an eight-year low.

The survey, conducted by YouGov on behalf of Denplan, asserts that the number of people who say they attend their dental practice every six months has dropped from three in five, to barely two in five people in just one year (from 59 per cent to 45 per cent), statistic show. Meanwhile the numbers of people who visit the dentist regularly are down to their lowest figure since 2001 (to 69 per cent).

The research, which was carried out as an online survey, looked into some of the reasons given for not attending the dentist, with finances being the biggest reason. More than 40 per cent of respondents said they couldn’t afford to go, with dental phobia (28 per cent) and lack of access (25 per cent) the next most given reasons.

Interestingly, it is reported that women are finding it hardest to prioritise their check-ups, with almost half saying they don’t have the funds to go (48 per cent) compared with just over a third of men (36 per cent).

Denplan’s CDO Roger Mattheus, said: “It is clear that patients are finding cost an issue in the current economic climate. While this may not be a surprise, it is important that the dental team focuses on retaining their patients by offering a range of payment options. Our own internal research indicates that those patients using a payment plan are least likely to cancel or delay routine dental check-ups, while they provide the practice the peace of mind from a regular form of income.”

However, these figures go against the published Information Centre governmental figures, which report a regular increase in attendances over the last 15 months. Chief Dental Officer for England, Barry Cockcroft said: “We have invested more than £2bn in NHS dentistry resulting in more NHS dental practices expanding and opening all the time.”

A spokesperson for the British Dental Association commented: “Regular visits to the dentist are important to maintaining good oral health. As well as looking out for conditions such as dental decay and gum disease, dentists can also spot oral cancers, potentially saving a patient’s life. It’s really not a good idea for patients to avoid check-ups.

“Patients with concerns about locating an NHS dentist or charges should seek advice from NHS Direct. And there’s really no need for patients to be anxious. Dentists work hard to put patients at their ease, explaining the care they provide to provide the best possible experience.”

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**News in Brief**

**Clinical Innovations**

- Education and training provider, Smile-on, is expecting more than 500 dentists to attend this year’s Clinical Innovations Conference. The conference is being held 7-8 May at the Royal College of Physicians in Regent’s Park, London. Promising to be the biggest conference yet, the CIC 2010 programme has been put together in consultation with a panel of international experts with the aim being to update participants on new technologies, materials and techniques in dentistry. The 2010 conference will host a line-up of highly prestigious international speakers alongside exhibitors offering the latest in dental technologies from around the world. A spokesperson for Smile-on said: “After the success of last year’s CIC, the Clinical Innovations Conference is growing and the 2010 conference is expecting delegate numbers in excess of 500 highly motivated dentists who are passionate about learning. Dedicated to helping professionals remain at the peak of their profession, Smile-on is committed to boosting standards in the UK dental industry by promoting excellent patient care and career satisfaction. For more information call 020 7400 8989 or email info@smile-on.com.

**Dental nurse award**

A dental nurse tutor has been named Dental Care Profession al Teacher of the Year for 2009 after her students nominated her in a secret ballot, Nicky Bartholomew, who teaches at the School of Professionals Complementary to Dentistry (SPCD), won £250 for herself, £1,000 for educational materials and £150-worth of Marks and Spencer vouchers. Ms Bartholomew said that she felt “surprised and delighted” and added: “It’s great to receive this type of recognition because it shows that my personal approach to education is supported by my peers and students alike.” She didn’t even know her students had nominated her until the shortlist of finalists were announced last October. Dental Defence Union (DDU), which organised the ceremony, awarded the title to Ms Bartholomew after she gave them a 15-minute presentation and did a Q&A with the judges. She has been teaching at SPCD for six years and is the first dental nurse tutor to be awarded the title. SPCD head Sara Holmes said that Ms Bartholomew puts everything into her teaching and deserved to win. Rupert Hoppenbrouwers, DDU head, called her an “asset to the profession.”

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**Vital pipeline**

The specialist dental receptionist is vital to relationships with referrers, says Beverly Street
Statistics are wonderful things. Depending on how pretty you make them, they can say anything you want them to. For example, last week I was named player of the match for my rugby side with 75 per cent of the votes. Now that is not bad going, but when you look deeper you will find that actually only four of the team voted, and I didn’t vote for myself! (not that I’m telling anyone else that, I was player of the match don’t you know?)

Now, I am not for one minute suggesting that the statistics reported by Denplan don’t stand up to further scrutiny, or that the Information Centre statistics regarding dental access are incorrect; just that sometimes you need to step back and look objectively at how the data is put together. A perfect time to practice those EBD skills!

Editorial comment
Lies, damn lies and statistics

Free work

The British Academy of Cosmetic Dentistry has joined forces with the American Academy of Cosmetic Dentistry to host an international conference in London.

A spokeswoman for the BACD said: “Dental professionals, exhibiting partners and educators will be brought together by their passion for cosmetic dentistry.”

The event on 23-25 September is being hosted by the AACD, BACD, Dental University of Paris Study Group, the European Society of Cosmetic Dentistry, the German Society of Cosmetic Dentistry, and the Swedish Academy of Cosmetic Dentistry.

For more information call Susy Bowlands 0207 612 4160
Website to support oral mucositis sufferers

A new website has been launched, giving advice and information to people suffering from oral mucositis.

The painful condition, normally associated with both chemo- and radiotherapy, can prevent sufferers from talking and even eating - and in severe cases a feeding tube is sometimes necessary so the patient can get the nutrients required to continue with the cancer therapy.

In a survey of nurses, it was identified as the most debilitating and significant problem associated with cancer therapy.

Iain McGill, president, Europe and International, at EUSA Pharma (sponsors of the mouthsmadegood website), said: "Oral Mucositis is a particularly common and often devastating side effect of cancer therapy. We hope that we've provided a useful and informative forum, where people can share their own insights and help others overcome this lesser known side effect of cancer treatment."

The new site provides information about the condition itself and its symptoms, the type of people at risk, the consequences of Oral mucositis and how to manage the condition.

The site also enables sufferers and carers to share their experiences, comment and ask questions as well as upload their own video blog to help others in the same situation.

For more information please visit the new website www.mouthsmadegood.com.

BDA exhibition celebrates dental pioneer’s life

T he British Dental Association is holding an exhibition celebrating the life and achievements of Victorian dental pioneer, Sir John Tomes.

The exhibition features a number of Tomes’s inventions including his patients’ chair and hand instruments. The design of his forceps, which are also in the exhibition, has been acknowledged as the forerunner of those used today.

Peter Ward, chief executive of the BDA, said: "It is the BDA’s 150th birthday this year, so it is particularly fitting that we are celebrating the life of Sir John Tomes, our first president, with this exhibition.

"His achievements and innovations have had a profound influence on the way dentistry is organised, regulated and practiced today, and every dentist owes him a huge debt of thanks. This exhibition highlights his achievements with some remarkable exhibits and we are proud to be hosting it."

Other items in the exhibition include his work room book containing drawings of sections of teeth and bone, the letter from the Royal Society awarding him his Fellowship and his cuttings book, which includes the telegraph informing him that the 1878 Dentist’s Act – the legislation that confined the use of the term ‘dentist’ to qualified practitioners – had been passed.

Tomes was a clinical, technical and political pioneer in dentistry. As well as being the first registered dentist and the first president of the BDA, he was the first dentist to be elected a Fellow of the Royal Society due to his dental research.

Martin Rees, president of the Royal Society said: “In its anniversary year, the Royal Society is delighted to be working with the BDA Museum to celebrate Royal Society Fellow Sir John Tomes.

“Our past Fellows share a remarkable role in history, advancing our understanding of the world around us in extraordinary ways. They truly are the giants on whose shoulders we have stood and we hope that this exhibition will inspire the next generation of British scientists to do the same."

It is open during normal museum opening hours (Tuesdays & Thursdays 1-4pm), but visitors are welcome at other times by appointment. Admission is free.

Mouths’ fifteen minutes of fame in dental surgery

P atients at a dentist surgery in Scotland will be able to watch what is going on inside their mouths on a flat screen TV, as they undergo treatment.

Mark Skimming has set up the £1m Dentistry practice in Queens Park, Glasgow which looks set to be the largest NHS dental practice in Scotland.

He also wants to install a television screen in the ceiling so people can watch DVDs during long procedures.

By 2012, the surgery, is expected to have 10,000 patients and six dentists.

People who are unable to take time off work for dental appointments will be able to visit the dentist up till 9pm on a Monday night or alternatively on a Saturday morning.

Dr Skimming, who studied at the Royal College of Surgeons, is set to become the youngest Masters qualified restorative dentist in the UK later this year.

His wife Claire, 26, is helping to run the practice.

The practice was opened by First Minister Nicola Surgeon.
Free literacy & numeracy tool for workers

Dental care providers are now able to assess the numeracy and literacy skills of their practice teams with the help of a free online tool.

The Skills for Health sector skills council has launched the first sector-specific initial assessment tool.

Skills for Health divisional manager Rosemarie Simpson commented: “The importance of literacy and numeracy skills in healthcare can’t be understated.

“They’re key to delivering high quality patient care, as well as improving the career prospects of staff.

“What healthcare staff generally have higher literacy and numeracy levels than some other workforce sectors, but many people will not have checked their skills for some time.

“The online tools provide an effective way to identify skill levels, show what people are good at and identify what they might need to brush up on.”

An NHS Skills for Life survey carried out in 2005 found that within NHS England, 26 per cent of staff have literacy skills below Level 2 (equivalent to a GCSE at A*-C), while a greater proportion would benefit from refreshing their numeracy skills.

The free-to-use online tools are designed specifically for staff working in healthcare in the UK and draw on ‘real-life’ scenarios.

Examples include listening to messages from patients, interpreting instructions, tables and charts and calibrating equipment.

Another key feature is ‘intelligent’ software that analyses users’ responses and modifies questions according to the level they are working at – meaning that the tools can be used across a range of healthcare grades and roles.

Staff who use the tools receive an assessment indicating their literacy and numeracy levels, which can be used to support skills development activities and a route into career progression.

Skills for Health claim that using the tool will lead to improved patient care, better clinical governance and higher staff retention levels.

It recommends that the tools be used as part of a ‘whole organisation’ approach in which literacy and numeracy assessment is embedded in staff development processes.

The tools can be used as part of induction, a personal development review or prior to or as part of training.

The Initial Assessment Tools are designed to indicate the approximate skills levels of an individual between Entry Level 1 and Level 2 in the English qualification framework, and SCQF levels 2 to 5 in the Scottish framework.

Each online tool takes approximately 25 minutes to complete, and individuals may be supported by a manager, trainer, or Union Learning Representative.

Alternatively, they may access the tools themselves. The initial assessment can be used as part of a learning programme, following on from a skills check and leading on to diagnostic assessments.

They can also be used alongside an NVQ/SVQ or Adult Apprenticeship, and can be carried out on an individual basis or in a group setting.

They were commissioned by the Extending Participation team within Skills for Health, and can be accessed via www.skillsforhealth.org.uk/IATool.
Fresh Air & Electric Versions

The unique Cleo II ‘Surgery System’ with folding and extending legrest permits multiple dental procedures in the most comfortable working conditions. Operator control over instruments, chair movements, spittoon and light is increased with the introduction of an advanced ‘electric’ version.
Understanding orthodontics

The British Orthodontic Society (BOS) has produced two new guides for dentists and patients on orthodontic treatment.

The guide specifically for dentists is titled ‘Managing the Dental Occlusion: A guide for dental practitioners,’ and advises practitioners about orthodontic treatment for children.

‘Managing the Dental Occlusion’ is a 16-page, in-depth guide which helps dentists to examine children’s teeth from an orthodontic point of view and highlights the possible interceptive treatments and procedures available.

It provides written and visual guidance to dentists for recognising any deviations from the norm in a young person’s dental development; from a lack of spacing in the deciduous dentition to a change in the sequence of eruption, and when it is best to refer a patient to an orthodontic specialist.

The guide also provides further recommended reading on the subject.

The patient guide is a readable new Patient Information Leaflet (PIL), providing easy-to-understand facts about Interproximal Reduction.

The Patient Information Leaflet uses simple and informal language and includes a question and answer section, to help patients to properly understand their potential treatment and its on-going care.

The leaflets help reinforce and act as a memory aid for the verbal advice given to orthodontic patients (and their parents) during a consultation, as well as providing a further point of reference for information covered by the orthodontist during the consultation.

A spokeswoman for the British Orthodontic Society (BOS) said: “They are deliberately kept short, to a double page, and to the point so that patients can easily assimilate the information without being overwhelmed. It helps to leave a lasting impression.”

The leaflets have been produced with guidance from the British Dyslexia Association, Plain English Campaign and the Scottish Dyslexia Association. Copies of ‘Managing the Dental Occlusion: A guide for dental practitioners and the Interproximal Reduction’ patient information leaflets are both available from the BOS.

Managing the Dental Occlusion aims to make orthodontic treatment more accessible to people with dyslexia.

Scotland sees rise in dental registrations

There has been a rise in both child and adult dental registrations over the last three months, according to the Scottish government.

However, Public Health Minister Shona Robison admitted that despite the increase, people in Scotland are still having problems accessing an NHS dentist in certain parts of Scotland and said: ‘We are continuing to tackle this.’

She added: ‘Last year we announced, capital funding of £82m through the primary and community care modernisation programme, most of which will be used for the development of NHS dental services – one of our top priorities.’

“I think that by opening this surgery, there will be enough cover for everyone on the NHS Dental Access Database, but there may be more people out there who want an NHS dentist.”

Ringway House will house four surgeries - one designed to meet the needs of patients with a disability - a large reception area, an X-ray unit, a training room andstaff and storage facilities.

“This includes 15 new stand alone dental centres across Scotland and two more as part of multi-function health centres.

“We now have outreach training centres in place throughout Scotland including Aberdeen, Inverness and Dumfries and Galloway and NHS Boards now have the authority to appoint directly salaried dentists.”

The Scottish government has also increased the number of dental students in training and recently officially opened Scotland’s newest dental school in Aberdeen. The facility will produce 20 trained dentists every year.

Ms Robison added: “In addition, more than 500 students now receive a dental undergraduate bursary scheme of £4,000 per year in return for commitment to work in NHS dentistry in Scotland.”
Bukumbi bound with Bridge2Aid

_Dental Tribune_, in our ongoing series looking at the Bukumbi Care Centre in Tanzania and the work of Bridge2Aid, describes how one conversation can inspire people to make a difference...

It's funny how a chance conversation can lead you to the greatest adventures. Previously, chance meetings have lead to fantastic weekends in France, journalistic opportunities and invitations to meet people it wouldn't normally be possible to.

This time, it was in the sparkling surroundings of the 2009 BDA Honours and Awards Dinner that serendipity lent a hand. I was sat at a table with colleagues from one of the dental dealers and we were discussing projects we would like to get involved in doing when one of them mentioned that he was participating on a trip with Bridge2Aid (B2A) to help build a community centre at a small Tanzanian village who supported some of the most disadvantaged people in that region.

This piqued my interest because for a while I have felt that as a supporter of dental professionals I would like to make a real contribution to the work that charities such as B2A do, but as a non-clinician I thought there was nothing I was able to do. The rest, as they say, is history.

I was put in touch with Andrew Thurston, divisional manager of cross infection control product manufacturers Schülke UK and lead organiser of the trip. A few days later and I was on the list of intrepid volunteers going to the village of Bukumbi.

Bridge2Aid is a charity working in the Mwanza region of North West Tanzania. It works closely with the Tanzanian Government to deliver aspects of their dental strategy. Its main scheme is the operation of a not-for-profit dental clinic in the city of Mwanza and the training of Rural Clinical Officers (to provide basic emergency dental care in their communities), and have a community development programme for the poor.

This is where the Bukumbi Care Centre comes in. B2A are working in this community to help a group called the Maskini, who are isolated and marginalised by society because they suffer from diseases such as leprosy and other disabilities. This means they have difficulty meeting some of the most basic of human needs such as:

- Clean drinking water
- A nutritionally balanced diet
- Washing facilities for personal hygiene
- Funds to secure medical-dental treatment
- Any means of income generation

B2A is committed to a long-term plan of improvements at Bukumbi, involving input from the community itself and utilising volunteers to carry out refurbishments. As well as providing on-going access to both medical and dental treatment, B2A has, amongst other things:

- Refurbished the toilet blocks and four of the six dormitories
- Provided new beds, bedding, mosquito nets and secure storage for belongings
- Raised £14,500 to fund a new water system for the Centre
- Employed community development worker Kibibi Kengia, who has set up an income generation scheme for residents to make and sell their crafts for a small profit.

The main building project for 2010 is the establishment of a community centre, which is what myself and the team from Schülke, Henry Schein and other areas will be working on. Although the main building work has already been completed, there will be plenty to keep us busy as we help fit it out and make it ready for use. The funds we have raised will also go towards not only this project but many of the other projects that B2A are involved in. In addition, my journalistic experience will come in handy as _Dental Tribune_ tries to document the lives of both the people in Bukumbi and the team at B2A trying to make a difference at both a national and local level.

I am still raising funds for this worthwhile cause. My thanks so far go to my colleagues at Smile-on and Practice Plan for their generous support; also individual sponsors including Aideen, Mia, Sarah, Sam, Louise and David – Thanks for your help!

To donate, go to my fundraising page: www.justgiving.com/bukumbibound. This page is directly linked with the charity, so you know your money is going where it is intended.😊

To donate, go to my fundraising page: www.justgiving.com/bukumbibound. This page is directly linked with the charity, so you know your money is going where it is intended.😊
The Access and Quality Agenda – in the slums of India

When I heard that 6,000 children die every day in India, my first question was: WHAT? WHY? And isn’t India an emerging economy? ...in that order.

Growing up in sub Saharan Africa (Zambia) I had seen poverty, but I had never appreciated that India had 20 times the population of the UK and 100 times the population of Zambia. One billion in Africa - 47 governments, 1.2 billion in India - one government. Not easy.

Awareness
No surprise then, when I was approached in the Autumn of 2009 to participate in the Channel 4 series, Secret Millionaire, that I felt compelled to say yes. I meet dentists and doctors from the Asian subcontinent every day, and we often wonder how many of us owe our success to our brave ancestors who migrated in search of a better life and to the opportunities that Britain gave us. I also meet many dentists and doctors who are not from the Asian subcontinent, who want to give time and love to those less fortunate in Africa and Asia - eg through Bridge2aid.

Safeguarding and Safety
Some really bizarre thoughts went through my mind when I first arrived in Dharavi, the largest slum in Southeast Asia. It houses 1.2 million people in 1 square mile; in fact 60 per cent of Mumbai’s residents live on six per cent Mumbai’s land. I wanted to pick some of those helpless children up and cuddle them...but what were their local child protection policies? I wanted to pull them away from the flying glass in the recycling areas – where was their health and safety policy, let alone risk assessments and safety glasses?

It got worse. The dumping ground was a cesspit, swarming with flies, sewage, animals and people. Not much infection control going on here; HTM 01-05 wouldn’t get a look in. Slips and trips policy? Well in a nutshell, ‘try not to slip or trip when the bulldozers come to the dump to make space for more garbage, or you will get hurt.’

We are just waking up to the fact that one year is a challenging timetable for us to meet the standards of the Care Quality Commission. What would happen if CQC came to the slums?

Re-defining my raison d’etre
The experience changed my life. I sat in a comfortable space back home in London - I understood Delivering Better Oral Health and care pathways in dentistry, we risk assessed our patients in East London and targeted high needs patients with preventive advice, fluoride and fissure sealants.

Dental disease was preventable and I was used to droning on about sugar intake and cleaning habits, and spending hours on questionnaires, I learnt not to judge what I see in India, but to accept it as it is, with its multiple social and commercial facets, and many cannons firing simultaneously. India is cited as one of the BRICS economies by Goldmann Sachs, and Indians are deservedly proud and work hard for what they have.

However, it requires foreign investment, an influx of wealth, and a speedier pace of development to help its people. Go India, you are home to 17 per cent of the world’s population; you need a measurable share of the world’s wealth to care for them.

Otherwise 6,000 children will die every day for some time to come.

If you would like to get involved with my charity work, contact me through www.seemasharma.co.uk.
A critical decision
You’re covered in the event of redundancy, but what about if you get sick? Thomas Dickson considers the benefits of critical illness cover

In today’s society, most people live with a certain amount of debt. So, making sure you are adequately covered to meet the demands of a credit-laden life should you fall ill and be unable to work is essential. It’s common for dental practitioners to take out multiple policies to meet their requirements in times of adversity, with life assurance and income protection being two universal options. However, an alternative that should be considered is critical insurance cover (CI).

The essential element of any policy is to provide a basic level of income when the policyholder is unable to work and Income Protection will do this. However, CI will provide a tax-free lump sum of cash on the diagnosis of serious illness or permanent disability, which could be useful for those without an accumulation of assets as a safety net.

We are twice as likely to suffer a serious illness than die before the age of sixty. For a multitude of reasons, including the advances in medical sciences and technology, the survival rates for once fatal illnesses are much higher. A consequence of this is families contending with the unwelcome cost of treatment while having to meet daily financial commitments, often on a reduced income. For dentists this could also include the running costs of the practice.

Two main policies
There are two main types of policy available: ‘term’ (level) or ‘mortgage’ (decreasing). When considering CI, there are several factors involved. Firstly, there are your current mortgage commitments, for both the home and the practice. It is necessary to balance the current costs of living with the cost of providing financial cover when you are unable to work.

Secondly, although generally cheaper, a mortgage critical illness plan means the amount that can be paid out decreases over the course of the cover. In contrast, a level term critical illness cover payout remains constant throughout the life of the policy. The advantages for both types will require careful consideration.

Check the small print
At the outset, choosing the right provider of your cover is vital as there will be no option to change if your health deteriorates. One of the main areas for dentists to consider with critical illness policies is to make sure the wording on the small print covers you as a dentist. Very few insurance companies have the necessary ‘own occupation’ that could be crucial in the event of a claim.

One in four women and one in five men will suffer a serious illness before retirement age. Taking adequate measures to ensure that the recovery process is not hindered by financial worries seems a prudent step.

NEW EVIDENCE FOR THE BENEFITS OF INCREASING BRUSHING TIME

To motivate behavioural change, it helps if patients understand the benefits of brushing for at least 2 minutes twice a day with fluoride toothpaste, compared to an average brushing time of around 45 seconds.

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- Significantly increases plaque removal
- Improves enamel strength

In situ enamel remineralisation clinical study (n=58)*

* US formulation of Aquafresh Enamelock Formula (1150 ppm F [fluoride]).

References
2. GlassSmilth data on file (Dental Hyg) 2009

About the author
Thomas Dickson considers critical illness cover for dentists.
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The Implant Centre helps more GDPs restore cases for their own patients

One-day events in Crawley help general dental practitioners gain the confidence to undertake the restoration phase of their patients’ implant treatment

More than 150 general dental practitioners attended two one-day events in Crawley at the end of November 2009 to learn more about restoring dental implants for their own patients. Presented by Mr Bill Schaeffer, Mr Guy Barwell, Dr Tony Rose and the team from The Implant Centre Haywards Heath, the events featured the ANKYLOS implant system and were supported by DENTSPLY Friadent.

Currently placing 1,000 implants per year, The Centre has grown rapidly, with increasing referrals from dentists who restore cases for their own patients. It holds regular free courses to introduce colleagues to dental implant treatment and help them learn how to undertake the restoration phase. The courses include ‘RiLA-X’ evenings and whole day restoration conferences, with three-six hours of verifiable CPD. Because of the growing numbers of dentists referring and restoring cases, The Implant Centre has already outgrown the premises in which the practice was established only three years ago.

According to Bill Schaeffer, “We’re seeing more and more implant cases referred every week, with around 40 per cent currently being restored by the patient’s own dentist. Many more local dentists are enjoying the excitement and satisfaction of restoring dental implants, and are finding them to be an easy, fun and profitable part of their practices. Most dentists who attend the training feel completely happy to begin restoring dental implants straightforward ways provided with detailed letters, photographs and the correct impression components for each case. We even partially complete the lab sheet needed for the specialist dental implant laboratory that we recommend”.

The Implant Centre offers a dedicated dental implant service to provide a permanent solution to missing teeth. Located in Haywards Heath, Mid Sussex, the state-of-the-art facility was designed specifically to provide dental implant surgery for dentists and their patients across southeast England. According to Bill Schaeffer: “Our team of doctors, dentists, nurses and support staff are committed to making the experience of dental implant treatment simple, efficient and pain free in a relaxed and contemporary environment!”

More than 300 local dentists refer cases to The Implant Centre, an increasing proportion of which are restored by the patient’s own general practitioner. Following initial assessment and implant surgery, as soon as each implant has osseointegrated the patients are returned to their own dentist with the appropriate impression components. Guy Barwell adds: “Simple dental implant cases can be even easier to restore than natural teeth. Let’s face it, dental implants don’t have a pulpal you need to avoid and you don’t even need to use fiddly retraction cord! For dentists involved with implants, bridges are fast becoming a thing of the past”. Implant Restoration in General Practice is a course designed for dentists who are considering advancing from simply referring patients for treatment to becoming involved in the restoration. The day includes hands-on training using models and provides attendees with a sound knowledge of cases that are suitable for implant treatment. The programme shows numerous cases that have been restored by GDPs. It covers treatment planning, impression taking, restoring straightforward cases and avoiding complications.

The Advanced Implant Restoration course examines the next level of implant restoration for more experienced practitioners. It is aimed at dentists who have already attended the Implant Restoration in General Practice course and have restored at least one case. Attendees examine more advanced treatment planning and more complex restorations, including screw retained restorations, bridgework and full arches.

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The Endo-Implant Algorithm

Dr Jose Hoyo explores the concept of endo-implant Algorithms and the surprising importance of endodontists in dental implant treatment planning

There’s a new vision in dentistry which is slowly being recognised and referred to as the “Endo-Implant Algorithm”. This new approach sees the role of the endodontist as a critical one when considering whether a tooth can be saved or whether extraction and replacement with a dental implant is the correct treatment protocol. An endodontist is in a unique position to evaluate critical factors leading to endodontic failures to determine whether another endodontic procedure will lead to a predictable and successful outcome. If the outcome is not favourable, then extraction and replacement with a dental implant will be the protocol to follow.

When considering what the ideal treatment plan should be, it is imperative to provide the patient with all treatment options as well as the financial cost and procedures associated with each treatment option. In doing this, the patient is then being given the opportunity to make an educated decision as to what is the best treatment protocol for him or her. The information presented to the patient should include what, in the endodontist’s opinion, is more practical and predictable.

Figure 1: Pre-operative radiograph prior to extraction.
Figure 2: Bitewing radiograph after decay was removed.
Figure 3: Grafted socket following extraction.
Case study
A patient with a non-contributory medical history was referred to our office for evaluation of the maxillary left first molar. The pa- tient was asymptomatic and the tooth had been endodontically treated by a general dentist approxi- mately seven months prior to the consultation and had nev- er been restored.

Clinically it presented no temporary restoration, extensive decay, probing depths of three mm all around, and exposure of the obturation material to the oral cavity. Radiographically, no periapical lesions were detected, and the bone levels around the tooth were adequate. (Figure 1)

Under the isolation of a den- tal rubber dam, the use of 4.5x magnification and supplemen- tary illumination provided by the use of a fiberoptic head- light, some excavation was per- formed to determine the integ- rity of the tooth structure. After removing the same decay, a bitewing X-ray was taken (Fig- ure 2) and the following was determined: a) the floor of the pulp chamber was too shallow and b) it was too close to the perforation and c) the periradicular dentin was not strong enough to sup- port a permanent restoration. These were critical factors, in my opinion, rendered the tooth non-reconstructible.

A cotton pellet and Cavit were placed in the access cavity and a rubber dam isolation was used. With the referring dentist was conducted to update him on the condition of his pa- tient and to determine what rec- ommendations should be given in regards to the tooth. It was recommended to the patient that the tooth be extracted and the socket preserved through a minor grafting procedure. This would allow for an ideal amount of bone to receive a dental implant approximately four to six months down the line.

It was also recommended that he receive some orthodon- tic treatment prior to the implant being placed so that all the di- stances were close and the den- tition properly aligned for this procedure. The patient clearly understood the concept and the logistics of the orthodontic treat- ment that was being recom- mended but expressed no interest in this approach.

The bigger picture
It is very important when getting involved with implant dentistry to look at the whole dentition and not just the space or tooth in question. We should keep in mind that implants unlike teeth do not move, so if there are any misalignments in the dentition the recommendation of ortho-

Implant innovation at The Dentistry Show
UK first at March exhibition with DIO Implants

Mary UK dentists choose not to provide dental implant surger- ry either because they are not familiar with the technique or because they perceive the costs to be too high for their patients. However DIO is quickly demonstrating that the cost is rapidly becoming less of a problem and, by using the company’s range of dental implants, even dentists that are relatively inexperienced in implant surgery can quickly learn to perform the procedure successfully. What’s more, DIO will assist dentists in mastering their surgical skills and help their practice to publicise and market their services to patients.

To prove how easy the new DIO implants are to use, Dr. Arif Lalani, principal of Smile Dental Implants and the dental advis- or for the Kingston vocational training scheme at Kingston Hospital, will be performing live implant surgery at The Den- tistry Show 19-20 March at the NEC. This will be the first time live implant surgery will have been shown in public in the UK. Although Dr. Lalani is comparatively new to implant surgery he says that working with the DIO implants makes the process relatively easy. “Working with DIO’s implants is so simple and straight forward. They have no quirks,” he says. “They are the perfect way to start for those dentists consider- ing offering implants as an extra service to their patients.”

Dr Lalani learned the techniques necessary from one-on- one training with Dr David Fairclough, an experienced DIO trainer and a founder member of the Association of Dental Implan- tology. “I’ve been using dental implants for over 20 years now and I've tried most systems. When I came across DIO’s system it seemed to be the easiest to use at an affordable price. The implants are very easy to place and they have very good primary stability which is important,” he said. He added that the back-up service he received from DIO was very valuable to him. “One of my big criticisms of implant companies is that they sell you the implants and then you get very little back-up from them afterwards. This hasn’t been the case with DIO.”

DIO’s UK Managing Director, Iain Forster, said that DIO and Dr Lalani were a perfect fit. He said, “Arif is one of the refreshing breed of implant surgeon who is not blinkered by convention and happy to do whatever is best for his patients and his business. It is freethinking pioneers like Dr Lalani who will lead the new generation of implant care.”

The best implant on the market?
The simplicity of the process is largely attributed to the innovative design of the implants fixtures them- selves. The advanced tapered design features a dou- ble thread to increase primary stability, achieve high stability even with low bone density, prevent cortical bone loss, significantly reduce stress and increase the opportuniy for immediate loading. The self tapping cutting edge allows easy insertion and automatically removes cut bone. The design also promotes fast heal- ing and gingival recovery.

Tackling the cost
DIO has made significant strides to reduce the cost of the implants themselves thereby reducing the overall cost of treatment making implant surgery a real option for many patients who would have considered it too expensive in the past. According to Dr. Ikv Dandapat, the principal dentist at The Dental Implant Centre, Reading, British dental patients have been paying over the odds for dental implants for years with patients often travelling abroad to find treatment they can afford. In a recent interview Dr. Dandapat said that it’s now time for a change. “Either the implant companies are going to support us through this recession or we’ll learn from our experiences and move on,” he said, adding that the UK price to a patient for a dental implant, abutment and crown varies from around £1,800 to £5,000 per tooth. In Europe the same treatment is available for approximately €1,100. “We can’t compete with that unless the implant manufacturers help us.”

DIO has taken up the challenge and is marketing its popular DIO SM implant in the UK at prices that are less than half of most of the competition. Dr. Dandapat states, “The significant savings achievable are probably sufficient to stop patients buy- ing a ticket to Delhi, New York or Paris to have the work done – thereby keeping the business at home for British dentists.”

Marketing help
DIO is very much aware that it’s all very well for dentists to learn new skills and develop new services, but the effort is often wasted if their patients are not made aware of what’s on offer. A few posters in the surgery don’t constitute a market- ing plan.

So, to help dentists promote their implant services the com- pany is providing advice and guidance on marketing tech- niques that dentists can employ to spread the word. These can include help with local PR, website design, search engine optimisation, brochure and leaflet design and production, the use of social networking, etc.

Iain Forster explained that this is not simply altruism from DIO. “For us, it’s not enough to simply provide our high quality implant systems for the UK market. We need to help our dentists to promote their services. By helping to in- crease sales and marketing efficiency, whilst enabling them to simultaneously increase their margins, we’re helping the dentists to help their patients and increase turnover, which is helping us too. Everyone wins!”

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For more information on DIO implants and to see first hand how the surgery is performed, visit The Dentistry Show, 19-20 March at the NEC.
The sutures are removed two weeks later, and two weeks after the suture removal, the patient was seen again for the removal of the membrane. This step is done by gently picking at the membrane with cotton pliers and just pulling on it – there is often no need for anesthesia.

The benefit of using this mixture of allograft is that the waiting period for re-entry is approximately four to six months versus six to nine if we had used a xenograft material. The quantity and the quality of the bone seem to be much better with the use of this (or a similar) allograft cocktail.

At the time of re-entry the patient's blood pressure was 115/69, HR 64. (Figures 4&5)

Under local anesthetic (Lidocaine two per cent Hcl with epinephrine 1/50,000 x 2 cpl) a tissue punch access was done using a 3.8 tissue punch (Xive osteotome). The pilot drill from the Ankylos implant system (DENTSPLY Friadent) was then used for the de-mineralised part, and it was prepared up to a depth of 11mm. (DENTSPLY Friadent) starting from size 2.0 and going up to 3.4 were used to perform a sinus lift applying the Sumter's technique. The osteotomy was prepared up to a depth of 11mm. (Figure 7)

A series of Xive osteotomes (DENTSPLY Friadent) starting from size 2.0 and going up to 3.4 were used to perform a sinus lift applying the Sumter's technique. The osteotomy was prepared up to a depth of 11mm. (Figure 7)

A Valsalva test was performed to ensure that the sinus had not been perforated. An Ankylos implant A11 (3.5mm x 11mm) was placed and primary stability was obtained. The density of the bone perceived as D-5 during the drilling stage, more than likely changed to D-2 with the use of the osteotomes. The implant-transfer mount was removed as was the cover screw which came pre-mounted inside the implant and a 1.5mm sulcus former (healing abutment) was placed into the implant. (Figures 8&9)

This case clearly shows one of the reasons why endodontists are getting more and more involved in implant dentistry. They are able to provide a comprehensive evaluation of the tooth in question and they are able to present the patient with the best options based on clinical assessment.

About the author
Dr Jose M Hoyo graduated from the University of Puerto Rico School of Dentistry in 1984. He practiced General Dentistry in Puerto Rico for eight years and in Spain for two years. He received his Certificate of Advanced Graduate Studies in Endodontics from Boston University’s Henry M Goldman School of Graduate Dentistry in 1984. He practices as a specialist in Endodontics and Implant dentistry in south-eastern Massachusetts, with locations in Stoneham and Taston. He is a member of the American Endodontic Association, The Massachusetts Dental Society, and has a Fellowship with The International Congress of Oral Implantologists. Dr Hoyos is also the founder of Northeastern Implant Seminars. His lectures typically include in-office surgical demonstrations of bone graft placement, sinus lift procedures and implant placement.
As we are continuously bombarded in our professional media with the benefits of one dental implant system over another, it can be difficult for those of us who have not yet chosen a system to make an objective choice based on true clinical and research-based findings.

For those of us who already have chosen to go with one system or another, we sometimes find ourselves questioning whether or not we should be looking at switching, or if the system we use still serves its purpose adequately. Should we all be using different systems for different applications? Is there any one system that serves all purposes?

Starting our search
In terms of what parameters to look at when selecting or evaluating a system, this can be broadly outlined into the following aspects:

1. Implant material
   a) Commercially pure titanium vs. titanium alloy
   b) Surface treatment and additions to the surface
2. Implant design
   a) Body shape
   b) Abutment connection
   c) Shoulder design
   d) Threads and microthreads
   e) Connective tissue connection
   f) Widths and lengths
   g) Conical seal
3. Prosthetic choice
   a) Choice of abutment systems
   b) Technician’s advice
4. Ease of use
5. Long term studies specific to the system
6. Cost
7. Support

**Implant materials**
The majority of implant systems in the dental world are either made of commercially pure titanium or an alloy of titanium, aluminium and vanadium. Titanium alloy is less costly and has four times the fracture resistance of commercially pure titanium. On the other hand, long-term studies suggest that the bone to implant contact and long-term stability of titanium alloy is inferior to that of commercially pure titanium.

Osseointegration is not only a property of pure titanium, but also of the titanium oxide ceramic coating that forms on the surface of titanium. Titanium alloys containing aluminium and vanadium have been found to cause ionic activity from the aluminium, which can affect the long-term stability of the osseointegration.

Surfaces of implants started off as simply machined and then surface roughening later followed as one of the major advances, increasing bone-to-implant contact by increasing the available surface area, but more importantly, by somehow simulating the roughness of bone.

Roughening actually increases the speed and degree of osseointegration by stimulating various local factors (ie PGE, TGF). It has been found that a specific range of roughness (Ra 3-7 microns, also referred to as ‘medium rough’) increases the rate of production of these factors and thus the degree and rate of osseointegration as well as the response of osteoblasts to systemic hormones.

On the other hand, surface roughness is not without its drawbacks. If the rough surface becomes exposed, biofilm formation can be more problematic which can lead to various degrees of peri-implant problems. Different studies have proposed different ways of dealing with this including treatment of the surface with various antimicro-
Various products have been applied to implant surfaces to increase the rate and stability of osseointegration including calcium phosphate in various forms (hydroxyapatite, tricalcium phosphate) and fluoride, and various biological agents such as PRP and BMPs. Hydroxyapatite has been found to initially stimulate formation but to later separate in part from the implant surface and thus reduce the overall long-term stability, as it forms a low-strength interface between the bone and the implant surface. Fluoride treatment is claimed to increase the speed of osseointegration, which increases the ability to immediately load the implant, but does not affect the long-term degree of BIC (bone-to-implant contact) or resistance to bone loss. Other systems that use other methods make similar claims.

Sterilisation and packaging
The way in which the implant is sterilised and stored also has some effect on the rate and degree of osseointegration. Watertightness of an implant surface, a characteristic related to its surface energy, affects the rate of adsorption of tissue proteins that comprise the initial phase of cellular adhesion (and hence the quality of osseointegration). Discussion of this is beyond the scope of this article, but it is wise to enquire into the treatment and packaging of the implant system being investigated.

The implant design
Root form implants available in the market all tend nowadays to follow a similar shape and form. It is now commonplace to find implants with either a straight or tapered body, threads at various distances along the body and ‘micro-threading’ at the coronal aspect of the implant. Microthreaded implants were found to maintain bone levels more securely at the coronal aspect, it is claimed, by wider distribution of stresses.

Body shape appears to be a matter of choice. Generally they are either parallel-sided or tapered (whether or not there is an additional coronal flare). Tapered implants would seem ‘safier’ implants in tight gaps or where roots of neighbouring teeth converge. There do not seem to be any other advantages with regard to stress distribution or general strength of the implant. (Figure 1)

Implants with rounded apical aspects would seem to be safer when being placed near vital structures and sinus membranes and the inferior dental bundle, but again, this is probably a matter of choice to the surgeon as there are no comparative studies of these variations.

Thread width and distribution again tend to be a matter of choice. Wider threads (thread pitch) are claimed to increase primary stability, but this has to be balanced against the increased overall width or the strength of the implant body. More widely distributed threads tend to drive the implant in more quickly. Again, no comparative studies will show whether or not this is an improvement. Some implants have threads that form an acute angle with the implant body, designed to help drive in the implant and secure it.

Platform-switching
Many implant systems now have a ‘platform-switching’ feature, either by means of a narrower abutment connecting to the implant, or a bevelled shoulder, or both. This design feature is thought to accommodate the soft tissue phase around an implant/abutment complex referred to as the biologic width and studies found that as long as the amount of tissue exists and amounts to two-three mm it made no difference whether it climbs vertically up the implant collar or ‘around’ a bevelled margin or stepped implant-abutment connection. This then allows for predictable maintenance of the bone level at the top of the roughened part. (Figure 2)

Treatment of the polished part of the collar or shoulder in one system by laser etching has found the potential attachment of...
connective tissue fibres, not only parallel to and circumferentially around the implant/abutment but also perpendicularly with the laser etched surface, interlocking with the uniquely etched laser-locks. This is claimed to increase the integrity of the soft tissue junction with the implant and thus to protect the bone levels achieved. It will need to be substantiated whether or not this connective tissue locking does in fact protect the bone levels compared to an implant with a polished bevel or collar (or neither) and by how much.

Self-tapping implants (when the implant cuts its own channel into the bone as it is driven in) are claimed to increase primary stability by engaging with the bone chips produced as they cut through. When compared with pre-tapped implant systems (where a ‘bone-tag’ is first used to create the channel), the difference is not significant.

A range of sizes
Most implant systems have a range of widths and lengths. General wisdom and most studies will show that anything equal to or above four mm width is very fracture resistant. Implants less than four mm in width (often required in tighter spaces or thinner ridges), were at first approached with caution, partly because of the reduced sturdiness of their connecting components. However, 3.5mm and 3.75mm implants are now in common usage and have shown good clinical results.

Wider implants are useful by giving better emergence profiles for posterior units and by increasing surface area especially in low height situations, but should be placed with thought for crestal bone preservation. Less than one mm of surrounding bone at the implant shoulder can lead to its resorption.

Short implants are still the subject of some debate which will be covered in a future article.

External hex vs internal connections
Interestingly, a number of prominent implantologists continue to use implants that feature an external hex abutment connection. This type of connection tends to concentrate occlusal forces at the neck of the implant and can potentially cause bone loss at this coronal aspect. The various internal connections, particularly the internal cone connection has been found to help distribute forces along the coronal aspect of the implant (Figure 3). Internal cones (whether with or without screws) also tend to be more stable against lateral forces and to significantly decrease the width of the ‘microgap’ that has been the subject of many studies.

This microgap, often found in ‘flat-top’ external hex connections, its dimension being on average about 50 microns, tends to harbour a biofilm, the inflammatory reaction of which has been suspected to cause bone to resorb away from it. Once a certain amount of resorption occurs, the bone can then remain stable. The elimination of the microgap seems to be the logical approach though.

To eliminate the microgap, implant manufacturers developed the ‘conical seal’. This internal cone connection (which can be screw retained or tapped in, indexed or non-indexed), gives rise to a longer implant-abutment connection which virtually cold-welds. The microgap is almost totally eliminated. Both research and clinical evidence show much lower rates of biofilm formation. Clinically, this is most often noticed by the lack of an offensive odour, when the abutment is detached.

Bone-level vs tissue level
Generally, the ability to place implants at bone level (Figure 4) and to leave them submerged while maintaining the bone at the level of the implant shoulder would seem to be an advantage. It was postulated by manufacturers who produced exclusively tissue level implants (for example, implants that have polished collars and are placed in a non-submerged technique), that bone level implants would potentially lose bone due to the repeated connection and disconnection of the abutments.

Certainly, this was found to have some effect on bone stability, and it is advised that once an abutment is finally connected, that this is no longer removed. On the other hand, even the stalwarts of the tissue level implant have now produced bone level implants, to increase ‘flexibility’. Undoubtedly, a bone level...
implant gives one the chance to increase or decrease the emergence profile as required and to adjust the angulation of the abutment as required without risking show of metal.

Abutment choice
Any implant system of worth should be able to provide the operator with a range of abutment options. It is, in my opinion, vital that screw-retained prostheses be possible with the system and that cement retention is not the only option.

Screw retention (Figure 5) is when the abutment and crown (or bridge unit) are one unit, screwed directly down onto the implant. The primary advantage of this is serviceability. For those of us who have been providing implants for long enough (and most studies will also show), it is more likely to be a defect of the prosthesis (or superstructure) that requires correction after seven to eight years of service and not the implant fixture.

This requires, in the case of cement-retained prostheses, a fairly tricky removal of the crown or bridge without damaging the abutment or the implants. With screw retention, all that is required is a quick removal with a screwdriver. Certainly this is not possible in all cases, especially angulated implants in the aesthetic zone, but restoring most posterior units this way has its merit. This entails the implant manufacturer providing some form of castable abutment (often referred to as ‘UCLA-type) for single unit and multiple unit cases. It is very difficult in my opinion to get away with having only ready-made angulated abutments. (Figure 6)

Another important feature is indexing. This is when the abutment has an anti-rotational feature, which is very useful in single tooth cases. This can be by any number of sides internally as long as it ensures the abutment will not rotate. The greater the number of sides, the greater the positional flexibility in terms of implant placement as you won’t have to rotate the implant in to a specific rotational position.

Some systems also give the option of CAD-CAM abutments, which are useful as these can be made to exact requirements in the material of choice.

Zirconia abutments are a good option to have available as these can get one out of a bad situation in the aesthetic zone. Abutment fracture of ceramic abutments has been documented, so they are best used with caution. More research and numbers are needed. (Figure 7)

A technician’s opinion
It’s always a good idea, when choosing an implant system, to check with your technician what he/she finds easy to use and what they think provides the best results. Technical flexibility is absolutely vital as we can’t always provide our implants at the exact required angle and position. Sometimes, for clinical reasons, it’s actually a good idea to angle an implant and sometimes it is inevitable. Occasionally we make the mistake of not judging soft tissue thickness or bone response or even the outcome of carefully planned GBR.

In all these cases, having flexible and precise prosthetic systems can often save the day. This is of course, no excuse for bad implant placement and all care should be taken prior to embarking on a case to ensure that all the necessary information has been gathered and prosthetic-driven planning performed. Working with an experienced technician who has used more than one system is vital to the success of your implant practice.

Ease of use
From a surgical viewpoint, it’s always nice to have a system that’s straightforward. Fewer steps to place an implant, making placement faster and simpler would be good for both operator and patient. On the other hand, it makes sense to have a system that covers all possibilities.

Certain situations require a degree of flexibility and a greater variety of implant drills. For example you may wish to under-prepare an osteotomy because the cancellous bone is soft. In the same osteotomy, you might need to prepare the cortical bone to the standard drilling.
A system that has a one-size-fits-all protocol may leave you unable to handle a tricky situation thus compromising your treatment outcome. Having osteotomes to hand (that match the system) is also a useful tool in your armamentarium.

As previously mentioned, a good range of prosthetic choice is useful. The fewer the number of prosthetic instruments though would be highly commendable!

Long-term studies
It is an unfortunate result of market forces that more and more implant manufacturers, even the highly reputed ones, tend to launch new products or designs onto the market with fairly short studies showing their efficacy. As they are all in a race to gain market share, one-year studies seem to be the norm nowadays, whereas in the past, three to five-year, even 20-year studies were available for comparison.

It is unlikely that we shall return to the balmy days of 20-year studies, but it would seem essential that a new system we haven’t used before should have at least a three year study showing it’s stability over this period of time. Even better would be a well-designed study with a large number of cases. Even better than that would be two or three independent studies.

So many factors come into play with dental implants. Just because a new system seems to be the same as another well-known one, it doesn’t mean that it is. The manufacturing process may be poor. The packaging of the implant may be inadequate. The abutment screw might not fit correctly etc. Even new items produced by well-known manufacturers ought to be approached with caution and a degree of lateral thinking, but again without compromising the principal of the null hypothesis: that it may not work. One or two manufacturers have had to sheepishly retract new products from the market once their poor performance was discovered.

A matter of cost
Without doubt one of the major factors in your choice of implant system will be cost. There is a wide variation, with the most well-known manufacturers being fairly costly. It would be easy to get on a high horse and say that only the more expensive implants deserve to be used. This would be unfair and incorrect. Some systems are less expensive while maintaining the use of good-quality materials, design and manufacturing.

Hopefully, their increased usage will bring down the costs incurred by the ‘high-end’ manufacturers. This is not without good reason as many of us are faced daily with patients who would genuinely benefit from dental implants but are limited by finance. It is our duty as healthcare providers to try our best to solve this problem. Often it is the dentist who bears the cost of this, but ultimately, it will be a win-win situation in the long run.

There is some merit in choosing a manufacturer that is likely to still be in business a few years down the line. As implants age with the patients, components will need to be replaced and renewed. Problems would arise if the company that made your implant has gone out of existence and you can no longer get the necessary abutment screw. Then again, you’ll probably be able to get it made in China!

Finally, many companies claim that they will provide you with support in the forms of technical and marketing support. Technical support is vital, as even the best of us will come upon new systems and new techniques that we need to be adequately informed about. A rep who knows the system well is invaluable. Marketing support is probably best taken with a pinch of salt, in my opinion. Inasmuch as a company can print a nice brochure and let people know about you, it is ultimately our own work and how well we provide it that will promote us in the eyes of our patients.

Aesthetics enhanced by technology
BioHorizons is known for using science and innovation to create unique implants with proven surgical and aesthetic results. Laser-Lok microchannels exemplify our dedication to evidence-based research and development.

The effectiveness of Laser-Lok has been proven with over 15 years of in vitro, animal, and human studies at leading universities. This patented precision laser surface treatment is unique within the industry as the only surface treatment shown to inhibit epithelial downgrowth, attract a true, physical connective tissue attachment to a predetermined zone on the implant and preserve the coronal level of bone: long term.

Laser-Lok is currently available on Tapered Internal, Single-stage, and Internal Implants.

About the author
Ali Abdellatif completed a Master’s Degree in Implant Dentistry at King’s College (Guy’s Campus) in 2007. He has since set up a general and implants referral practice in Devonshire Place. He enjoys treating difficult cases and helping colleagues to offer dental implants to their patients. His practice is based at 2 Devonshire Place, London W1G 6HL. You can contact him on 020 7496 2225, 07965 499 875 or by email: ali@dentalimplantslondon.com. Ali is happy to receive correspondence or referrals from colleagues.
Combined Endo/implant treatment

Terry Pannkuk shows how a combination of digital communication, microscopy, precision measurement, and team co-ordinated implant placement led to success.

This case represents a combined endodontic-implant treatment plan. Generally, I do not extend my implant services beyond that which is a natural extension of my endodontic treatment plan, but this case was a little different. Sometimes I feel a need to break the political and philosophical rules for “special circumstances”. This was one of those cases.

The patient lived outside my referral area and did not have a relationship with a local periodontist/oral surgeon (Figure 1). I treated tooth #5, which was severely compromised, necessitating removal of the pontics to lighten the occlusal load (Figure 2) and shelling out the gold abutment to use it as a matrix for the extensive dual fiber post build-up. Once the implants have integrated, and if #5 holds up, it can be restored after implant restoration assuming the implants will share more of the load and the occlusion on #5 will be protected if it goes to final restoration.

Precise placement
This is a technique I developed to “home” in precise placement. It’s very easy for single-implant placements and a bit more complicated with more math measurements for multiple implant placements such as this one. Restorative dentists may have one perspective about where the implants should be placed which does not always coincide with the implant surgeon’s perspective. One of the biggest problems an implant surgeon has is ‘communication’. Digital imaging and email communication eliminates these conflicts.

I make my own diagnostic casts and surgical guides using a suck down machine and light plastic, not really using any rigid metal for the guide hole because in a case like this where the patient had limited jaw opening, I only used the surgical stent to get the initial penetration drill holes in the right position on the tissue surface.

Work before treatment
Here’s what I made sure I did before I carried out the necessary work.

1. Email correspondence between the restorative dentist and surgeon creates an exchange to determine the best placement. This was done by taking digital photographs of the casts and marking where preliminary entry locations should be positioned through the pontics. Actual “in-mouth” photographs were taken to compare actual soft tissue measurements to the study models (Figure 5).

I suggested drilling through the lingual cusps of the pontics knowing that the buccal bone would be resorbed a bit. Centered force vectors are also on the lingual cusps of maxillary teeth having normal occlusion. If the buccal plate is significantly resorbed, grossly altering ideal placement of implants, onlay grafting could be performed. Grafting should not be performed cavalierly, creating an unnecessary layer of complexity and increased risk of failure. In the final analysis it was decided to move the entry points a bit more buccal with the #3 replacement being the most buccal due to thicker buccal bone. If the implant is placed slightly...
lingual, placing it deeper allows for a better emergence profile.

Mesiodistal angulations were also considered and a compromise was required for the fact that #5 had a distally curved root and was slightly tilted toward the distal. If #5 had been extracted, or planned for extraction, its alignment would not have factored into the plan. The tentative plan to keep #5 dictated the angulation of the #4 guide pin as it was angled a little less parallel to the #3 guide pin, idealising it with the occlusion generated by #5 and #2. This tended to align the implants parallel to the roots of the adjacent natural teeth while not as parallel to each other.

There was more than enough bone between implants and natural teeth and they may not require splinting, allowing for easier oral hygiene. Many times adjacent implants in the posterior arches are splinted for better biomechanics, especially if space is tight. These two implants can still be splinted but it might require angled or custom abutments.

2. After the final email discussions, I drilled the guide pinholes through the desired areas on the pontics of the model, compromising my suggestion a bit toward the middle of the tooth in consideration of the restorative perspective (Figure 4). The plan was to place the implants as buccal as prudent, still hoping to avoid grafting. At this point models with drilled holes for guide pins (pontics drilled away) were photographed and emailed. It was decided to slide the four-guide pin a bit more buccal than I had initially planned.

The hole was drilled more to the buccal and the guide pin was secured in a more buccal position with sticky wax. I then decided I was going to flap the case to make sure the implants were in bone. If the osteotomy had created a dehiscence I would be prepared to tack down a re-sorbable membrane, folding up buccal graft particles to insure thread coverage (it ended up not being necessary but laying a flap allowed for the option if it had been necessary).

3. The implants and parts were ordered.

4. The surgical flap was performed with releases.

5. The final email discussions:

- The implants and parts were ordered.
- The surgical flap was performed with releases.

How do you get optimal long-term treatment outcomes for your patients? The standard norm regarding dental implant treatment success from 1986 does not reflect what is possible to achieve today. There are no reasons why the clinician or the patient should accept a marginal bone loss of up to 1.5 millimeters based on a standard set 20 years ago. It has been proven in study after study that with the Astrotech Implant System™ the mean marginal bone level reduction is only 0.3 millimeters over five years.

It is time to close the gap.
5. I placed the surgical guide, made initial penetration holes with a pointed precision bur, and matched the penetration holes to the prepared cast making small adjustments.

6. I took a series of drill-sequence radiographs to insure that I was following planned angles, making minor corrections with the small drills, making sure it was ideal before proceeding to larger drills. The site implant was placed first because it was the most difficult one to access and I wanted its placement to dictate any small required adjustments of the subsequent implant (5), which was going to be simpler to place due to handpiece positioning. There were no problems with positioning so that concern was not an issue.

The recurring theme in the planning and placement of implants is to anticipate and account for all potential complexities. Implants were placed in the #4 and #3 positions to my satisfaction and I measured the critical distances along the way, making sure the paths and angles were correct. In the process of performing the #4 osteotomy I removed a retained root tip. I placed a longer implant in this site for better primary stability (there were no sinus proximity concerns). I tapped the sinus in the #5 site with osteotomes lifting the Schneiderian membrane two mm for the 10mm long implant (15mm long in the #4 site) (Figure 5).

7. Cover screws were placed and the flap was sutured, burying the implants completely. I swabbed the implant cover screws and internal space of the implant thoroughly with Metronidizole gel, keeping the blood out with microsuction.

There is a distinct advantage to using a microscope, employing digital imaging, and communicating via email. One of the biggest complaints a restorative dentist tends to have with an implant surgeon is the lack of communication and failure to coordinate plans. Preplanning and precise measure of each drill sequence allows the surgeon to stay on the planned path. CT-planned surgical guides cannot always be used effectively if the patient has limited jaw opening. I have personally found that the guides are often too bulky and prevent proper positioning of the handpiece.

You can be just as accurate by ‘measuring twice, and cutting once’ (old carpentry proverb). Sometimes it’s very frustrating to order a CT-planned precision guide only to find out you want to change the angle slightly or that the patient cannot open wide enough to use it. There is a great sense of satisfaction and confidence showing implant positions within two-tenths of millimeter accuracy on the final radiographs when comparing them to the preoperative planned positions (Figure 6). In summary, successful implant placement requires communication and precise adherence to the plan.

I would like to thank Dr Robert Caraco of Santa Barbara, California for his input and contributions to this case.

\*Dr Terry Pannkuk, a native of California, graduated from the University of California at Los Angeles with a degree in biology; Georgetown University Dental School with a DDS; and Boston University with an MScD in endodontics. He is a Diplomate of the American Board of Endodontics, former editor and publisher of The Endodontic Report, former president of the Boston University Endodontic Alumni Association, current reviewer for the Journal of Endodontics (official journal of the American Association of Endodontists), and international lecturer-author of topics relating to clinical endodontics. He lives with his wife and two sons, and practices in Santa Barbara, California.
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The 10th dimension... the power of ten

Ed Bonner and Adrianne Morris discuss how being consistent in your work can be both a benefit and a hindrance to your success as a practitioner.

At first glance, consistency may seem to be an admirable quality. Consider the alternative: if you say you want things done in a certain way today, and then decide the following day you want to do them differently, you are likely to cause frustration and anger in those working with you. However, those who make decisions and remain wedded to them through changing circumstances display an unenviable level of obduracy and inflexibility. Only jobsworths do this.

Think of the two children who were not allowed to participate in their school nativity play because they had been absent for four days. When it was explained that their absence was due to the death and burial of their father, their absence was due to the same thing the same way all the time.

The children were not allowed to participate in the school nativity play because they had been absent for four days. When it was explained that their absence was due to the death and burial of their father, their absence was due to the same thing the same way all the time.

A stable relationship?

Working with an associate can be problematic, but the relationship can also work if you manage it well from the start. Geoff Long offers some pointers.

Very often, being awarded additional UDA’s under the new NHS dental contract leads the principal to conclude that he will have to hire an associate to cope with the influx of new patients. He sees the acquisition of an associate as a solution to the problem of stress associated with a single-chair practice. An associate may be a means of relieving one set of problems but over time is almost guaranteed to replace them with another set.

Stress is usually the former, and invariably money is involved in the latter.

In taking on an associate, you will invariably discover the unpleasant side of the ethical pursuit of dentistry. There is no code of ethics when it comes to the associate/principal relationship and difficulties situations can develop; promises are broken, principals are blackmailed, goodwill is high-jacked and associates gone free in competition next door.

It gets worse

Associates are generally deterrents to practice profitability. There are two reasons for this:

1. Low grossing
2. Instability

The monthly break-even point for an associate is usually £8,000 to £9,500 per month depending on practice overheads. Many associates work part time or do not make the break-even gross.

I took a sample of associates’ pay and the results were staggering. Depending upon ability, an associate can earn the principal anything in the range of £20,000 to £30,000 a year profit. On top of that, taking on an associate will probably add £10,000 to your practice overheads. While you fund the increased overheads, the associate is probably more up-to-date than you.

Rewriting the rules

To overcome this inbuilt problem with associate’s profitability, I have rewritten the associate contract to include a more representative proportion of the practice’s fixed overheads. This not only helps the associate appreciate how expensive it is to run a business, but also transfers some of the financial risk from the principal to the associate. It also strengthens the associate’s self-employed status under the new NHS contract.

On top of that there is the problem of instability. The minute they get their gross to £10,000 a month, they invariably leave to start their own practice or get another job. To overcome this problem, the principal needs a much more sophisticated recruitment strategy than sticking an advert in the back of the BDJ or along with all the others.

For those dentists who still insist on taking on an associate, here are some points to look out for:

• DO treat the associate as an equal clinical partner in the practice
• DON’T pay the associate more than 45 per cent. This is the quickest route to the bankruptcy court.
• DO give the associate his fair share of the new patients. Don’t hog them all yourself.
• DON’T interfere with his clinical judgment. Remember he is a professional in his own right. Ask his opinion occasionally, after all he is probably more up-to-date than you.
• DO make sure you have clear systems in place when you take on an associate and make sure you are properly prepared before he starts.
• DON’T assume your associate will be like you. He is a professional in his own right and will have his own idiosyncrasies (he will have his own way of doing things). Be flexible in your response.
• DO have up-to-date equipment and service contracts to ensure breakdowns are quickly dealt with and kept to a minimum.
• DON’T sound out about your abilities as a dentist. It is very demoralising for the associate.
• DO be aware of the older “professional” associate. Why hasn’t he his surgery of his own?
• DON’T forget to have a written agreement that is both comprehensive and fair with the associate covering such things as pay and “binding out”.
• DO ensure there is sufficient work to keep the associate busy.
• DON’T forget to keep the channels of communication open with the associate and hold regular meetings.
• DO have a gentleman’s agreement that the associate will stay for a minimum two-year period.
• DON’T forget to give the associate clear goals to work towards.
• DO ensure the associate has a good dental nurse.
• DON’T be unreasonable about hours and holidays.
A good intention or genuine resolve?

Nigel Jones discusses the work life balance and whether dental professionals can attain it

Apparently, the sale of sal-ads were unreasonably low he theory is that the cold and snowy weather gave everyone a “get out of jail free” card when it came to resolutions about leading a healthier lifestyle. I suspect the fitness clubs also saw less of a fight for equipment than is usual at this time of year. Not only was the difficulty in getting to a gym a convenient excuse not to go, but compared to gritting your teeth on a cross-trainer, gritting the drive seemed preferable!

The interesting thing will be whether or not the good intentions announced on New Year’s Eve can get back on track in February or, if people will apply Olympic rules to this year’s false start and disqualify themselves from all resolutions until 2011. For many, giving up was inevitable and it probably doesn’t matter. For others, it will be a missed opportunity and they will be the poorer for it.

Take, for example, that plan to restore a better balance to your life, to get a better work life “blend” as the HR professionals would nowa-days describe it. For some, even the pressure to deliver UDA targets didn’t stop them feeling quietly re-lieved that the snow legitimised a postponement of that re-engage-ment with the NHS treadmill, as well as the one at the gym. That’s potentially quite revealing.

I have always been intrigued by those dentists whose response to questions about how things are going is to talk almost exclusive-ly about the size of their practice turnover. The twist these days is to talk about the size of their NHS contracts and the volume of UDAs to which they have committed. But, is that really what success is all about?

Last year, my young children were having tennis lessons along-side a five year old son of an NHS dentist who had the highest UDA target I’ve ever encountered. Both sets of parents spent Sunday morn-ings dutifully camped at the side of the court, willing their children to hit more than air, as the ever patient coach fed an endless stream of ten-nis balls in their direction.

Actually that’s not quite true. The NHS dentist was dealing with an endless stream of calls fed to him from his practice team, so was un-able to camp anywhere let alone watch how his son was faring. As he paced to and fro staring at the ground, he avoided the disap-proving glances from other parents and also a look of such re-signed sadness on his wife’s face. This was clearly the norm.

This brought to mind a dentist I knew who decided to turn private at the time of the 1990 “new” contract. Despite be-ing fearful of the recession, the wide availability of NHS dentists, and probable resistance to private charges and the potential lack of pa-tient loyalty (sound familiar?), this dentist felt he could only avoid compromising patient care if he moved away from the NHS.

Ten months later, I returned to the practice knowing his bravery had been rewarded with a demon-stration of faith from his patients, which had created a thriving private practice with a turnover of which he could only previously have dreamt. Upon my arrival, I asked his wife, the practice manager, how things were going, “Fantastically” she said. “He’s coming home and actually talking to our kids now.” Now that’s a measure of success.

If you haven’t already, you may find it interesting to have a flick through Jack Black’s Mindstore book and, in particular, the section about The Wheel of Life. This idea helps you think about eight dimen-sions of your life of which work is only one. Family is inevitably an-other and so are health, financial, social, personal development, atti-tude and spiritual.

For each element, give yourself a score out of ten for how comfort-able you feel about that aspect of your life where ten is perfect and zero is where you need help. Then, draw a circle and divide it into eight equal sections, like a pie chart or the spokes of a wheel. Each spoke represents one of the dimensions so with zero being the centre and ten the outer edge, mark the scores you gave yourself earlier.

Connecting these marks will create a shape that can say a lot about the balance in your life. Most NHS dentists I speak to would have a wheel that is unlikely to roll smoothly, others have allowed their work to take over so much of their lives that their wheel would look as if it is about to stop rolling alto-gether. This simple exercise can be so revealing and give you the spur you need to focus on areas of your life that may have been neglected in recent years.

Of course, it is possible that your NHS practice is giving you that balance already, in which case, congratulations. Alternatively, you may already feel out of control of your practice workload and it may be hard to quell the rising sense of desperation, let alone start reducing your time commitment to your practice.

But look around you. You will almost certainly be surrounded by fellow practitioners who once felt much the same way yet are now running successful private practic-es and, like the dentist with whom I was talking with just last night, are walking their kids home from school every Friday.

Of course some will decide to wait in hope that whichever Gov-ernment is in place in the summer will take the decision for them. If so, at the very least, I hope they get a plan of action in place so they re-tain some semblance of control if a major move of the goalposts were to happen. However, others will decide to take the initiative themselves and not rely on external forces to con-trol their destiny.

As the wintry weather has proved, it can be easy to have your good intentions derailed but, with a pivotal year for UK den-tistry ahead, so now is the time for genuine resolve.

About the author

Nigel Jones has worked in primary care for over 16 years. Recently returning to the dental industry from Virgin Healthcare, Nigel has helped over 400 dental practices successfully convert to private practice.
A rewarding outcome
Choosing your learning style and needs is important, says Glenys Bridges, to ensure you get a good return on your investment.

Over the recent months, professional development for all members of the dental team has become a burning issue. In response to Continuous Professional Development (CPD) requirements for registered Dental Care Professionals (DCPs), a wide range of learning pathways have been introduced, leading to both core and general CPD. To make sure your time and money are well spent, you must choose the learning resources best suited to your learning style and needs.

Over recent years, the internet has become a popular education medium, mostly because it offers the flexibility essential for students running a full-time job alongside academic studies. Internet learning works very well for students who are confident in their IT skills, although this type of learning provides an opportunity to develop computer skills for those who have not previously needed them.

What is your style? Once the necessary IT skills are in place, it is a good idea to build learning styles analysis into your Personal Development Plan (PDP). When you know how you learn best, you will be able to make informed choices when selecting learning opportunities. Some good training companies offer a learning styles analysis test so they can advise students on how to organise their studies to maximise their learning.

Since September 2009, each student enrolling for our courses are asked to complete a learning styles questionnaire. On receipt of their answers DRC provides students with details of their individual learning style and a tuition package formulated to meet their needs. The basis of analysis we have chosen for our students identifies their VAK preferences. That is the extent to which the retain information provided through Visual, Auditory and Kinaesthetic media. Some people find that their preferred learning style may be a blend of two or more styles, whereas some people have a one very strong preference.

Visual learners have a preference for seen or observed things, when learning they like to see pictures, diagrams, demonstrations, displays, handouts, films, flip-chart, etc. These people will use phrases such as ‘show me’, ‘let’s have a look at that’ and will be best able to perform a new task after reading the instructions or watching someone else do it first. These people like the back-up of working from workbooks, lists and written directions and instructions.

Auditory learners have a preference for learning through listening, to the spoken word, of self or others, of sounds and noises. These people will use phrases such as ‘tell me’, ‘let’s talk it over’ and will be best able to perform a new task after listening to instructions from an expert. These are the people who have been given verbal instructions over the telephone, and can remember all the words to songs that they hear!

Kinaesthetic learners learn best from experiences such as touching, feeling, holding, doing, and practical hands-on experiences. These people will use phrases such as ‘let me try’, ‘how do you feel?’ and will be best able to perform a new task by going ahead and trying it out, learning as they go. These are the people who like to experiment; they often lack the patience to carefully read instructions before things out.

The Dental Resource Company offers reader of Dental Tribune the chance to complete a learning-styles diagnostic free of charge to find out details of the learning opportunities best suited to you. For your free questionnaire, please email Claire@dental-resource.com; quoting ‘Dental Tribune learning styles diagnostic’ and we will send you one.

Building bridges between specialist & referrers
The receptionist at a specialist dental practice, says Beverly Street, plays a vital role in boosting and maintaining relationships between specialists and referring practices

As more practices refer their patients to specialists, the regular duties of the receptionist must be responsible for other things.

Making the call
Greater emphasis is now placed on the specialist receptionist to make accurate judgement calls in regard to the type of appointment that the patient will require. Determining an urgent case that will need active treatment as opposed to a patient who requires a consultation must be distinguished in order to correctly schedule appointments, ensuring maximum workflow and of course, patient comfort and care.

Other duties that are often required by today’s specialist dental receptionist can involve marketing the practice to other dentists and consumers, gathering and successfully relaying treatment information to patients and operating modern software systems such as electronic appointment scheduling, electronic ordering and updating websites and online activities including blogging.

A sympathetic ear
As specialist procedures such as Root Canal Treatment (RCT) is often associated with a painful trip to the dentist by many people, the stories that surround RCT are normally of an incredibly horrific nature but also, quite dated and out of step with modern practice. Patients don’t know what to expect and will often need a sympathetic ear to help answer questions such as:

• Will it hurt?
• How long will it take?
• How many appointments will I need?
• What is the endodontist like?
• Is he/she gentle?
• How much will it cost?

It is up to the specialist dental receptionist to answer these questions and provide comfort to the patient without judgement.

After the treatment
Aftercare is also an important role for the specialist receptionist. Quickly dealing with any questions and provide comfort to the patient and it gives us the chance to check on the treatment and chat with the patient about their recovery.

As an endodontic practice, the most important thing we can do for our patients is deliver outstanding successful treatment that combines a level of customercare that is exceptional. This begins and ends with the endodontic receptionist.

‘The regular duties of the receptionist have become more complex and demanding.’

Many specialist dental practices work closely with referring dentists and very much become part of their team. The relationships that are built between specialist and referring dentists are crucial to not only patient care, but also the future growth of the specialist practice.
As a professional dentist, it’s likely you’ll have developed a good reputation and positive relationship with your patients throughout your time in a practice. So after investing what is often an entire life’s hard work building these things up, the last thing you want to do when selling your practice is making a hasty decision, and risk leaving your patients in the hands of a less reputable practitioner. This might not happen, but it could if you don’t follow certain steps.

Avoid conflicting interests

If you plan to sell up, you should find a sales agent you can rely on with an in-depth knowledge of the dental industry, who understands that the highest price offered may not necessarily be the best option. It’s also important to make sure the agent is operating honestly and not working with a conflict of interest as they could undervalue the practice to make a quick sale. By accurately and transparently appraising the surgery, and by guaranteeing they will never work for both the buyer and seller in the same transaction, professional agents will be putting the seller’s needs first.

Check the services they offer. By reviewing sources of income, assessing goodwill, equipment, fixtures and fittings, together with a review of the owner’s financial accounts, an independent valuation will provide an accurate market value of the practice. This will enable comparisons to be made with the expenses of other similar types of practice.

Marketing your practice

The next stage of the process is marketing. To successfully do this, the agent will need to collect all of the relevant business details to pass on to prospective buyers. After the agreement of these particulars, the most appropriate marketing strategy will be determined. This will involve arranging viewings so prospective buyers can visit the practice for themselves.

It’s important that these viewing times fit into your schedule, so you get to meet prospective buyers personally. It may be a good idea to arrange an open day when you can focus solely on selling the practice, rather than shoe-horning in viewings around patient treatment times.

Commitment and stability

When buying or selling any property in today’s climate, the market is tough. It can sometimes seem people are out for themselves, pulling out of agreements and making last-minute decisions, which ultimately have a negative knock-on effect on all of the parties involved. It’s important to find commitment and stability. Once a suitable buyer has been identified and an offer accepted, the sales agent should request a non-returnable commitment payment from the purchaser to demonstrate their serious intention to buy. This payment will be held by the agent until the transaction is complete and will be put towards the purchase price if everything goes smoothly. At this time, the practice will be taken off the market and solicitors’ details will be exchanged.

A tailor-made solution

The most professional sales agents will offer tailored solutions to each individual practice. They will strive to gain an in-depth understanding of the client’s needs, acting confidentially and ethically, with the seller’s best interests at heart.

Protecting your interests

Don’t make a hasty decision when selling your practice, says Andy Acton

About the author

Andy Acton is director of Frank Taylor & Associates, independent valuers and consultants to the dental profession. Andy has helped a number of dental specialist banks develop their services to the dental profession, including NatWest and Bank of Ireland. For more information, call 08458 125454, email team@ft-associates.com or visit www.ft-associates.com.

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To help dentists promote their practice DIO is providing practical advice and useful tips on marketing techniques. These can include help with your website, market and place design, search engine optimisation, brochure and leaflet design, networking, etc.
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**Up to date, the Sonette Fluoracare was reviewed at the BD&A Showcase in London in November 2009 and attracted a large number of early enthusiasts. As a result the Company has just announced that from March 2010 the brush will be available for practice trials by BACD members.**

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To reserve your place or for further details and venues, please call Sue D’Oraire on 020 29 24 48 18 or email education@henryschneider.co.uk.

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For more information please visit www.immolandrose.co.uk or call Lansell & Rose on 020 7735 9333

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**BACD Awards**

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To date, the Sonette Fluoracare has been awarded at the BD&A Showcase in November 2009 and attracted a large number of early enthusiasts. As a result the Company has just announced that from March 2010 the brush will be available for practice trials by BACD members.

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**Mobile: 07734 044077, E-mail: mark@velopex.com**
Ready and willing to learn
The British Association of Dental Nurses is offering ways to build up your CPD this year with various events around the country.

Following the success of the 2009 conference and excellent feedback from delegates on the Blackpool Hilton, BADN is returning for more, having decided to use it as the venue for this year’s National Dental Nursing Conference, which will take place on November 26-27, 2010.

The final programme isn’t ready yet, but it’s very like it will include a full-morning option, which will provide the core CPD radiography element for dental nurses who don’t have the radiography qualification. Even dental nurses who don’t take X-rays are required to complete five hours’ verifiable CPD in radiography, and taking part in this morning event will provide three of those five hours.

You can also expect a talk from a local dental entrepreneur during the programme and a presentation on dental hypnosis, with many more speakers to be finalised.

Information on its way
Details of the conference will be in the Spring (April) 2010 edition of the British Dental Nurses’ Journal, and registration will be available online through the link on the conference page of the BADN website at www.badn.org.uk, or by email invitation from early May.

If you are not already receiving event invitations through the BADN CVENT system, but would like to be included on the list, please send your details to katie@badn.org.uk with “2010 Conference” in the subject line and state in the body of the email whether you are a current BADN member, and whether you are a RDN, student dental nurse or other member of the dental team.

Back to school
As well as the conference, there’s another chance to gain more CPD hours, this time earlier in the year at the BADN East Midlands study day. It’s to be held at the East Midlands Hilton near Loughborough on March 13 2010. All dental team members are welcome, with the programme covering a variety of subjects, including cross infection control, and offers three hours verifiable CPD.

Details will be available shortly on the East Midlands page of the BADN website which contains a link to the online registration, or via invitation email. Again, if you are not on the list, but would like an invitation, send your details to katie@badn.org.uk with “East Midlands” in the subject line and state in the body of the email whether you are a current BADN member, and whether you are a RDN, student dental nurse or other member of the dental team.

For more details on BADN events, please visit our website www.badn.org.uk or contact Katie on 01253 338364.
It wasn't the champagne that gave him the confidence to make his speech, it was his dentist.

The biggest problem for some new denture wearers isn't their dentures, it's the emotional impact of losing their teeth. This can affect people's confidence in social situations, so even dentures that fit perfectly can't always overcome that feeling of self-consciousness. This is where recommending a denture fixative like Poligrip can help.

Because it gives people the extra confidence to feel comfortable about themselves and so at ease with others. Even if they are telling bad jokes in front of a hundred people.

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