The 21st century practice-builder is Botox

The impressive Bishopsgate dental centre in London’s Spitalfields was the venue for the most recent of CODE’s hands-on Botulinum Toxin Type A courses. By the end of the day, its principal, Dr Russell McDonald, and four other dentist delegates had acquired the knowledge and experience necessary to start offering facial aesthetics to patients.

The tutor was Dr Tim Eldridge, a board member of CODE Association of Facial Aesthetics (AFA) and a dentist in Hereford. With five years worth of experience in the field, he has found BOTOX® provision to be a successful practice builder and he enjoys building confidence in colleagues who, like himself, have patients wanting the treatments.

Dr McDonald said: ‘I thought the course was very well run and Tim in particular is a very good presenter and demonstrator. By the end of the day I felt very at home with the whole procedure.’

The day started with Tim covering all aspects of Botulinum Toxin Type A: the history, the brands and pharmacology, contraindications, patient selection and then he moved on to discuss injection techniques, dosage and injection sites, post-treatment advice, advertising, insurance and pricing. (see box for top tips)

In brief, the bacterium Clostridium Botulinum was first isolated 201 years ago. It wasn’t until more than a century later that its benefit for patients with uncontrolled muscular movements such as dystonia, was identified. Botulinum Toxin Type A was first approved for medical use by the FDA in 1989 – mostly for patients with conditions like strabismus, blepharospasm and then for cosmetic use in 1997. In the UK it is approved for medical use but only the Vistabel brand has a licence for cosmetic use and this is limited to the treatment of glabellar lines. For any other area of the face the UK practitioner is off licence.

However, the protein has a favourable safety record with no studies reporting any severe adverse events. Tim stressed the importance of talking honestly to patients about risks and side-effects as well as the limits to its efficacy. ‘Never,’ he said, ‘imply you can turn back time.’

Botulinum Toxins are biological products and not pharmacetical preparations and so there can be no generic products. Delegates worked with Dysport, a less condensed type of Botulinum Toxin Type A and Tim made sure his group gained experience in reconstituting the protein accurately by combining with preserved saline to achieve the correct dose and a syringe without bubbles.

However, BOTOX® provision to be a successful practice builder and he enjoys building confidence in colleagues who, like himself, have patients wanting the treatments.

Dr McDonald said: ‘I thought the course was very well run and Tim in particular is a very good presenter and demonstrator. By the end of the day I felt very at home with the whole procedure.’

The day started with Tim covering all aspects of Botulinum Toxin Type A: the history, the brands and pharmacology, contraindications, patient selection and then he moved on to discuss injection techniques, dosage and injection sites, post-treatment advice, advertising, insurance and pricing. (see box for top tips)

In brief, the bacterium Clostridium Botulinum was first isolated 201 years ago. It wasn’t until more than a century later that its benefit for patients with uncontrolled muscular movements such as dystonia, was identified. Botulinum Toxin Type A was first approved for medical use by the FDA in 1989 – mostly for patients with conditions like strabismus, blepharospasm and then for cosmetic use in 1997. In the UK it is approved for medical use but only the Vistabel brand has a licence for cosmetic use and this is limited to the treatment of glabellar lines. For any other area of the face the UK practitioner is off licence.

However, the protein has a favourable safety record with no studies reporting any severe adverse events. Tim stressed the importance of talking honestly to patients about risks and side-effects as well as the limits to its efficacy. ‘Never,’ he said, ‘imply you can turn back time.’

Botulinum Toxins are biological products and not pharmacetical preparations and so there can be no generic products. Delegates worked with Dysport, a less condensed type of Botulinum Toxin Type A and Tim made sure his group gained experience in reconstituting the protein accurately by combining with preserved saline to achieve the correct dose and a syringe without bubbles.

However, the protein has a favourable safety record with no studies reporting any severe adverse events. Tim stressed the importance of talking honestly to patients about risks and side-effects as well as the limits to its efficacy. ‘Never,’ he said, ‘imply you can turn back time.’

Botulinum Toxins are biological products and not pharmacetical preparations and so there can be no generic products. Delegates worked with Dysport, a less condensed type of Botulinum Toxin Type A and Tim made sure his group gained experience in reconstituting the protein accurately by combining with preserved saline to achieve the correct dose and a syringe without bubbles.

However, the protein has a favourable safety record with no studies reporting any severe adverse events. Tim stressed the importance of talking honestly to patients about risks and side-effects as well as the limits to its efficacy. ‘Never,’ he said, ‘imply you can turn back time.’

Botulinum Toxins are biological products and not pharmacetical preparations and so there can be no generic products. Delegates worked with Dysport, a less condensed type of Botulinum Toxin Type A and Tim made sure his group gained experience in reconstituting the protein accurately by combining with preserved saline to achieve the correct dose and a syringe without bubbles.

However, the protein has a favourable safety record with no studies reporting any severe adverse events. Tim stressed the importance of talking honestly to patients about risks and side-effects as well as the limits to its efficacy. ‘Never,’ he said, ‘imply you can turn back time.’

Botulinum Toxins are biological products and not pharmacetical preparations and so there can be no generic products. Delegates worked with Dysport, a less condensed type of Botulinum Toxin Type A and Tim made sure his group gained experience in reconstituting the protein accurately by combining with preserved saline to achieve the correct dose and a syringe without bubbles.
The idea of clinical photography scares many practitioners unnecessarily. With the correct equipment, practice and knowing which photographs to take, it will become one of your most useful tools. This will have the knock-on effect of improving the quality of your clinical dentistry, aid in patient communication and enable postgraduate credentialing including that for the British Academy of Cosmetic Dentistry (BACD), www.bacd.com

Which Camera do I get?
While there are still many film cameras still available, there is no doubt that digital cameras offer the greatest number of advantages. This includes seeing the image instantly, ease of image storage and easy incorporation onto websites, into practice literature and for presentations. When considering which camera to get, there are only two manufacturers that currently meet the needs with respect to clinical dental photography:

1 – Nikon D80 and D200 (older versions include the D70 and D100 which you may be able to pick up second hand but these do not take raw and jpeg images simultaneously) with a 105mm macro lens and SB R1-C1 macro flash (two flash heads and hot shoe collar – this is very good for technicians) or Nikon R1 macro flash.

2 – Canon D400 (Rebel Xti) or 30D (older versions include the D350, 10D and 20D which you may be able to pick up second hand) with a Canon 100mm macro lens and Canon MR14EX ring flash. If you wish to take more artistic photos then the Canon MT24EX twin light is an excellent second choice al-

Clinical photography – how, why and when

With the right equipment and knowledge, mastering the art of clinical photography can improve the quality of your dentistry, say Jay Padayachy and David R Bloom of Senova Dental Studios
though the ring flash is more convenient.

Higher specified camera bodies from these companies are available, for example the Canon 5D, but these are probably overkill unless photography also happens to be your hobby. It is possible to use the 105mm macro lens and EM-140 DG ring flash from Sigma if you want to reduce your costs. But if using a Sigma lens then use a Sigma ring flash rather than trying to mix and match a Sigma product with a Nikon or Canon product. Details and help concerning choices can be found from Photomed (www.photomed.net) or Calumet (www.calumetphoto.co.uk).

All the newer models mentioned have the ability to take pictures in both a RAW and JPEG format. The raw file is essentially a digital negative and cannot be tampered with. This is very important if the case is being submitted for any form of accreditation and is compulsory for BACD accreditation for pre-op and post-op pictures from January 2009.

The JPEG file offers high resolution and is fine for all other forms of clinical photography not related to post-graduate examinations. However it will lose quality each time it is saved as it is in, lossless format rather than non-lossless which is called a TIFF file and need not concern us in this article. The other advantage of JPEG files is they can be easily sent in e-mails, used in presentations and stored, as they do not use as much space on your hard disc as a raw file.

Photographic shots required
This part is divided into three parts, one for the shots for BACD accreditation and these we take for all our new patients together with two additional shots which are also useful for lab communication and any other views which may be required to show other aspects of the patients mouth.

For BACD accreditation:
1. 1:10 full face and natural smile (Fig. 1) - the head should be in full view with the patient exhibiting a full natural smile from their chin to nearly the top of their head without showing the shoulders (Fig. 2) or too little of their head (Fig. 3). The patient's nose should be in the centre of the photograph that is taken directly in front of the patient using a uniform background.

PracticeWorks
Exclusive makers of Kodak Dental Systems

Leading the way to a brighter future

In the current economic climate of money market uncertainty, the ongoing PCT funding and contract cuts, your practice management and business skills will need to be fit for the future.

Maximizing your income and minimizing your costs in every aspect of your practice will be key to success in the difficult times being forecast.

However, you can stay one step ahead of these additional challenges at the same time as improving your business and, safeguarding your future.

It's so easy to do with our market leading practice management and new business software.

NEW
KODAK Back Office Business Software &
KODAK R4 Practice Management Software

Packaged with more features than any other Dental Software, designed to make a significant contribution to the success of your practice and your business.

Offering security in an uncertain world

For further information or to place an order telephone 0800 169 9692 or visit www.practiceworks.co.uk

© Practiceworks Limited 2008. The Kodak trademark and back-office software information from Kodak.
1.2 Natural smile including lateral views (Fig. 4) - the patient needs to show a full natural smile to document the number of teeth and extent of the gingivae they normally display when smiling. The incisal plane of the upper teeth should be the horizontal midline of the photo. Focus on the incisors to allow an adequate depth of field so that all visible teeth are in focus. Do not tilt the camera to compensate for canted teeth. For the lateral views, focus on the lateral incisor. The vertical midline of the photo should also be the lateral incisor. This is not a profile view and the contra-lateral central incisor and possibly the contra-lateral lateral incisor should be visible.

1.2 Retracted teeth apart including lateral views (Fig. 5) - the retracted shots should be taken with the teeth slightly parted to show the incisal edges and as much of the gingivae as possible. For the lateral views the same criteria as the un-retracted views apply.

1.2 Retracted teeth (anterior) apart including lateral views (Fig. 6) - use the midline to centre the teeth in the frame. The opposing eth should not be visible but the gingiva adjacent to the teeth in the frame should be clearly visible. For the lateral views the lateral incisor should be centred in this view. For all these three views, the retractors and opposing teeth should not be visible, a contrasting device to mask out the background is optional.

1.2 Upper and lower occlusal (Fig. 7) - these are the hardest shots to take and do need much practice. Always use a high quality photographic mirror and ensure that the retractors are in place to avoid the soft tissues obscuring the teeth. The central incisors should be visible near the outer frame of the photo and should extend to the mesial of the second molars.

1.2 Posterior quadrant (Fig. 8) - as above but ensure the extent of molars and premolar teeth are visible.

Two additional views for lab communication:

1.2 Lips at rest, 'M' sound (Fig. 9) - enables you to see how much tooth is visible when the lips are relaxed and at rest.

1.2 Retracted teeth together (Fig. 10) - to give an understanding of how the teeth occlude.

Other views:

1.2 'E' sound (Fig. 11) - ask the patient to say a long lasting 'E' sound to show maximum gingival display to help ascertain if the patient is guarding their smile, which will often be the case if they do not like their smile as they do not know how to smile.

1.2 True lateral views (Fig. 12) - these maybe more appropriate for orthodontics or if you want to