New guidelines on antibiotics for ‘heart’ patients

Ever since most of us qualified, we have asked standard medical history questions to try to identify those who might be at risk of infective endocarditis as a result of invasive dental procedures. Most of such patients are now accustomed to receiving prophylactic doses of antibiotics such as amoxicillin before treatment.

Now it is time for change. The National Institute for Health and Clinical Excellence (NICE) has issued a new clinical guideline on this issue. This recommends that antibiotics to prevent infective endocarditis should not be given to adults and children with structural cardiac defects, who are undergoing dental and a number of non-dental interventional procedures.

The 2008 NICE guideline is based on the best available published evidence and a consensus of multidisciplinary, expert opinion within the Guidelines Development Group (GDG). The guideline concludes that there is no consistent association between having an interventional procedure, dental or non-dental, and the development of IE and that the clinical effectiveness of antibiotic prophylaxis is not proven.

The evidence also suggests that antibiotic prophylaxis against IE for dental procedures is not cost effective and may lead to a greater number of deaths through fatal anaphylactic reactions than not using preventive antibiotics. NICE has also issued the guidance in a patient-friendly form for the general public; this may be useful when explaining the new protocol to patients. The new guidelines are also summarised in the new edition (No 55, March 2008) of the British National Formulary.

In a revised position statement, Dental Protection advises its members that dentists working within an NHS contract are required under the terms of their contract to observe the guidance of NICE when writing prescriptions. Clinicians working privately may not have a contractual obligation to follow this guidance, but they would need a very strong justification for choosing not to do so. Dental Protection has also issued a most useful set of answers to frequently asked questions for its members.

The chief dental officer for England has stated, ‘I am delighted that NICE have produced definitive guidance on this complex issue. This will ensure that dentists can give consistent and evidence based advice to their patients. We will work with NICE and other professional bodies to ensure that this advice is disseminated to the profession so that dentists will be in a position to start applying this guidance immediately.’

The British Dental Association’s (BDA) scientific adviser, Professor Damien Walmsley, told Dental Tribune that the association welcomed the new guidance that clarified best practice and places the UK as a leader in this area. BDA members (including Professor David Wray and Martin Fulford) had been on the reference group and they were able to brief the Health and Science Committee and in turn the Executive Board on this issue.

Some disquiet had been expressed by dentists about how to deal with patients. The patient’s cardiologist recommends that antibiotics should continue to be prescribed despite what the guideline says. Professor Walmsley said that the new guidelines applied to everyone working in the NHS and they were now the definitive guidance. He also pointed out that there were several well respected and eminent cardiologists on the reference group.

NICE’s summary of the guidance is reproduced on page 2 of this issue, but readers may find it useful to look at the full report (CG64 Prophylaxis against infective endocarditis: NICE guidance) which can be found at: www.nice.org.uk
National Institute for Health and Clinical Excellence: prophylaxis against infective endocarditis

Summary and list of all recommendations on antimicrobial prophylaxis against infective endocarditis in adults and children undergoing interventional procedures – issued March 2008

Adults and children with structural cardiac defects causing hemodynamic abnormality or with prosthetic heart valves or a history of infective endocarditis

Healthcare professionals should regard people with the following cardiac conditions as being at risk of developing infective endocarditis:

- acquired valvular heart disease with stenosis or regurgitation
- previous valve replacement
- structural congenital heart disease, including surgically corrected or palliated structural conditions, but excluding isolated atrial septal defect, fully repaired ventricular septal defect or fully repaired secundum atrial septum, and closure devices that are judged to be endothelialised
- previous infective endocarditis
- hypertrophic cardiomyopathy

Patient advice

Healthcare professionals should offer people at risk of infective endocarditis clear and consistent information about prevention, including:

- the risks of undergoing invasive procedures, including non-medical procedures such as body piercing or tattooing
- prophylaxis against infective endocarditis

Antibiotic prophylaxis against infective endocarditis is NOT recommended:

- for people undergoing dental procedures
- for people undergoing non-dental procedures at the following sites:
  - upper and lower gastrointestinal tract
  - genitourinary tract; this includes ear, nose and throat procedures and childbirth
- Chlorhexidine mouthwash should not be offered as prophylaxis against infective endocarditis

Infection

Any episodes of infection in people at risk of infective endocarditis should be investigated and treated promptly to reduce the risk of endocarditis developing.

If a person at risk of infective endocarditis is receiving antimicrobial prophylaxis because they are undergoing a gastrointestinal or genitourinary invasive procedure at a site where there is a suspected infection, the person should receive an antibiotic that covers organisms that cause infective endocarditis.

Overview

Antimicrobial prophylaxis against infective endocarditis in adults and children undergoing interventional procedures

Interventive endocarditis (IE) is an inflammation of the endocardium, particularly affecting the heart valves, caused mainly by bacteria but occasionally by other infectious agents. It is a rare condition, with an annual incidence of fewer than 10 per 100,000 cases in the normal population. Despite advances in diagnosis and treatment, IE remains a life-threatening disease with significant mortality (approximately 20%) and morbidity.

The predisposing factors for the development of IE have changed in the past 50 years, mainly with the decreasing incidence of rheumatic heart disease and the increasing impact of prostatic heart valves, nosocomial infection and intravenous drug misuse. However, the potentially serious impact of IE on the individual has not changed (Prenzgerd 2006).

Published medical literature contains many case reports of IE being provoked by an interventional procedure, most frequently dentistry. IE can be caused by several different organisms, many of which could be transferred into the blood during an interventional procedure. Streptococci, Staphylococcus aureus and enterococci are important causative organisms.

It is accepted that many cases of IE are not caused by interventional procedures (Brunet et al, 2006), but such a serious condition is reasonable to consider that any cases of IE that can be prevented should be prevented. Consequently, since 1995, antibiotic prophylaxis that aims to prevent endocarditis has been used in at-risk patients. However, the evidence base for the use of antibiotic prophylaxis has relied on extrapolation from animal models of the disease (Pallash 2005) and the applicability of these models to people has been questioned. With a rare but serious condition such as IE, it is difficult to plan and execute research to generate clearly defined study designs. Consequently, the evidence available in this area is limited, being drawn largely from observational (case–control) studies.

The rationale for prophylaxis against IE in endocarditis usually follows bacteremia, certain interventional procedures cause bacteremia with organisms that can cause endocarditis, these bacteria are usually sensitive to antibiotics; therefore, antibiotics should be given to patients with predisposing heart disease before any procedures that may cause bacteremia (Durack 1995).

For prophylaxis to be effective, certain requirements must be fulfilled: identification of patients at risk, identification of the procedures that are liable to provoke bacteremia, and choice of a suitable antibiotic regimen. There should also be a favourable balance between the risks of side-effects from prophylaxis and development of the disease (Moreillon et al, 2004). Underlying these principles is the assumption that antibiotic prophylaxis is effective for the prevention of IE in dental and non-dental procedures. However, many researchers consider this assumption to be not proven (Prenzgerd 2006), which has led to calls for significantly reducing the use of antibiotic prophylaxis in this setting. This shift in opinion is reflected in national and international clinical guidelines for prophylaxis against IE. Guidelines used to recommend antibiotic prophylaxis for IE patients with a wide range of cardiac conditions differ on the need for prophylaxis during interventional procedures, both dental and non-dental. They now tend to recommend that only those with one of a small number of high-risk cardiac conditions should receive antibiotic prophylaxis when they undergo a limited number of specified dental procedures.

Throughout the history of prophylaxis being offered against IE, professional organisations have sought to clarify the groups of patients that are considered to be at risk of IE and the procedures (dental and non-dental) for which prophylaxis may be considered. The Guideline Development Group (GDG) have produced recommendations and conclusions of relevant national and international guidelines to help inform its own decision making. This decision-making process has been important because, for many of the key clinical questions covered in this guideline, there is no evidence base that would make an evidence-based quality criteria (BCS) possible. Four clinical guidelines on the prevention of IE are discussed in the corresponding sections: American Heart Association (AHA) 2007 (Wilson et al, 2007), British Society for Antimicrobial Chemotherapy (BSAC) 2006 (Gould et al, 2006), European Society of Cardiology (ESC) 2004 (Horstkotte et al, 2004) and British Cardiovascular Society (BCS)/Royal College of Physicians (RCP) 2004 (Advisory Group of the British Cardiovascular Society Clinical Practice Committee 2004).

The recommendations of these four guidelines, and where reported the rationale for their recommendations, have been considered by the GDG in the development of this guideline. However, it should be emphasised that the GDG has based its recommendations on an independent consideration of the available clinical and cost-effectiveness evidence and, where appropriate, expert opinion. The guideline developers have also sought to make the rationale for their recommendations as transparent as possible, set out in the relevant ‘Evidence to recommendations’ sections.

This clinical guideline aims to provide clear guidance to the NHS in England, Wales and Northern Ireland regarding which dental and non-dental interventional procedures require, or do not require, antimicrobial prophylaxis against IE. In contrast to other recently published national and international guidelines, it explicitly considers the likely cost effectiveness as well as the clinical effectiveness of antibiotic prophylaxis.

In summary, this guideline recommends that antibiotic prophylaxis solely to prevent IE should not be given to people at risk of IE undergoing dental and non-dental procedures. The basis to support this recommendation is:

- there is no consistent association between having an intervention and the development of IE
- regular toothbrushing almost certainly presents a greater risk of IE than a single dental procedure because of repetitive exposure to bacteremia with oral flora
- the clinical effectiveness of antibiotic prophylaxis against IE for dental procedures may lead to a greater number of deaths through fatal anaphylaxis than a strategy of no prophylactic antibiotic prophylaxis, and is not cost effective.

Given the difficulties in relating risk directly, in a simple classification of conditions into either groups at risk and not at risk, was undertaken.

The full report (CG64 Prophylaxis against infective endocarditis: NICE guidance) and guidance for patients can be seen at: www.nice.org.uk
Is the answer the £1 UDA?

Michael Watson looks at the controversy over units of dental activity (UDAs) and suggests a fundamental rethink on the issue.

When the concept of the £1 UDA was first put to me by an economics expert, my first reaction was to suggest that she take a little more water with it. After all much of the controversy over UDAs centre around their low value especially after a tendering process and concern about what might happen after 2009. But as she explained the concept I warmed to it.

But first let us look at the background. At this time of year the media runs stories about dentists running out of UDAs and spend more time with their golf clubs or on exotic foreign holidays, leaving patients in the lurch. As an aside we might question why this is a story, if dentists have worked hard to achieve their targets, surely they deserve some relaxation.

Nevertheless there are sections of the media that disapprove of dentists enjoying themselves and the department of health says that they should manage their workload evenly throughout the year. Some PCTs are in a position to offer some additional UDAs on a temporary basis to ensure continuity of services.

So where does the £1 UDA fit in? Under this suggestion all UDAs would be valued at £1. In an average contract this would mean about £7,000 of the contract value would be accounted for by UDAs. This would be the maximum that could be clawed back for failing to reach the target, although in reality such clawbacks would be far less.

The rest of the contract value is a payment to the dentist(s) for keeping the practice open and being available to patients; opening times already form part everyone’s contract as it is. The primary care trust (PCT) could agree with the practice a range of services that could be offered, such as a prevention programme, simply to see more patients or patients from specific postcodes.

In coming years the focus of PCTs will have to move away from UDA targets and towards better access to more patients. This is now a national NHS requirement and they will be judged on whether they achieve it. They will not do this by continuing with their current obsession over UDAs.

The £1 UDA does not require redrafting of the regulations and it removes from dentists the threat of clawback. It also allows dentists and PCTs to work together to provide services that are more effective and more relevant to their patients. Not the bad idea I first supposed.

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Polish dental tourism expands

British-Polish medical tourism provider StatMedica, has added a new dental clinic in the outskirts of Warsaw to its portfolio. The company now claims to be able to expand on its ability to offer high quality dental care at some of the most competitive prices in Europe, with dental implants starting at £480, crowns starting at £200 and veneers starting at £250. These prices, it says, ‘are approximately 70 per cent less than the typical price of treatment in the UK’.

Low-cost flights from cities across the United Kingdom to destinations across Poland and affordable hotel accommodation in Poland ensure that significant cost savings can apparently be made by travelling to Poland. Alison Hope, director of StatMedica’s London office said: ‘The cost savings that can be made by travelling to Poland for dental treatment are immense even once you factor in the cost of flights and accommodation’.

But BDHF advises against

However the British Dental Health Foundation (BDHF) has backed a ‘Which?’ report advising against going for medical treatments abroad. It has urged members of the public not to travel abroad for dental treatment after a report by consumer advice group found that almost one in five medical tourists suffer problems after treatment.

The BDHF was speaking after the report revealed that more than a quarter of patients travelling abroad for medical treatment did not feel they received the follow-up care they needed, while a further 18 per cent reported complications.

The survey follows a recent warning against dental tourism by the BDHF after a number of callers to its free Dental Helpline service (0845 063 1188) reported that they did not know how to resolve problems that followed dental treatment undertaken outside of the UK.

Dr Carter, chief executive of the Foundation, commented: ‘It is a big concern that UK patients are so willing to travel abroad for dental treatment without being fully aware of the risks. Not all dentists are as highly trained as those in the UK, where extensive training and strict examinations are undertaken to ensure they meet the high standards required and this also applies to foreign dentists practising in the UK.

So called ‘dental holidays’ are presented as a cheap and hassle free alternative to getting treatment in this country but we know from calls to our Dental Helpline that if things do go wrong then they are anything but, as patients can be left facing all sorts of questions; am I willing to fly back? What are my legal rights as a foreign patient? Am I prepared to go through the courts? Do I have the money required to correct the treatment in this country?’

 Dentists asking for retired list

The Dental Practitioners Association (DPA) has backed Baroness Gardner of Parkes, who is seeking to amend the forthcoming Health and Social Care Bill to enable retired dentists to stay on the General Dental Council (GDC) Register at a nominal cost and without CPD requirements. The baroness is herself a retired dentist.

During the second reading of the Bill in the House of Lords on March 25, 2008, she said: ‘This lack of distinction between the honourable and the dishonourable absence from the register is invidious and has upset many dentists... There is a public interest in non-practising dentists remaining on the list, as many non-practising dentists continue to work on boards, trusts, charities and other bodies, public and private. If they claim to have been dentists with an honourable record, it should be verifiable’.

Baroness Gardner is appealing to interested dentists to write to their MPs in April supporting her amendment, which will enable the GDC to set up a separate list for dentists not currently practising.

At present, dentists who retire and do not wish to keep up with the requirements for CPD and pay the £458 registration fee are struck off.

‘This is what I object to the most’, said Baroness Gardner speaking to the DPA, ‘you get a letter saying you have been struck off after a lifetime of honourable service. It is the same whether you are a retired dentist or have been struck off after a lifetime of malpractice’. The DPA believes that all dental professionals have a right to appear on the GDC register as a right by virtue of their qualifications—except those who have been moved on disciplinary grounds.

Record entries for the student technician award

Congratulations go to Rachel McMichan on winning the 2008 British Orthodontic Society (BOS) student technician award.

Rachel received her award at the Orthodontic Technicians Association (OTA) annual conference in Edinburgh which took place on March 14-16, 2008, from David Bearn, chairman of the BOS scholarship & grants committee.

This year’s competition attracted a record number of entries and the judges had a very difficult time selecting the winner.

The entrants were required to prepare a removable appliance to a given prescription, and Rachel’s imaginative use of colour in the baseplate certainly stood out. The entrants also had to design and produce an appliance to achieve certain tooth movements and present a written commentary on the rationale for the design chosen.

Rachel’s prize was a complimentary conference package to attend the OTA conference in Edinburgh, along with a cheque from the BOS.
For as long as most of us can remember access to NHS dentistry, or rather lack of it, has dominated the media. This was accentuated by the recent figures showing that since the new contract came in a quarter of a million fewer patients had been seen.

Primary Care Trusts (PCTs) have been pulling out all the stops to try and paint the opposite picture, putting out press-releases whenever new practices have been established. The department of health tells us that from this April the focus will be on making sure more people are seen, rather than the current pre-occupation with units of dental activity. In the meantime, here are some stories from around the country.

**PCT's dental access pledge**

PCT managers have pledged that soon no-one in Burnley and Padiham should be waiting to see an NHS dentist. Thousands of people in East Lancashire gave up trying to find a dentist two or three years ago, amid a number of practices deciding to see only private patients.

But now Burnley MP Kitty Ussher says more dentists are carrying out NHS work and she has received a letter from East Lancashire Primary Care Trust saying that substantial progress has been made in tackling the issue. Trust chief executive David Peat has told the MP it is hoped that everyone currently on their dental access allocation list will be offered an NHS dentist in the near future.

**Sheffield PCT invests in services**

People across Sheffield are set to benefit from a £400,000 investment from Sheffield PCT in NHS dental practices. The investment is expected to increase access for NHS patients in the city. 17 practices that offer an NHS service throughout the city will be receiving the funding, which will allow them to either continue to accept new NHS patients if they currently do so or give faster treatment to those patients who are waiting to receive NHS dental care.

John Green, director of dental public health said: 'This is a great opportunity to make sure people don't have to wait too long for dental care, by offering earlier treatment appointments.'

**Scarborough in news again**

In 2004 Scarborough hit the national media when hundreds of people were filmed as they queued to be put on the list of an NHS dentist in the town. Now, a spokesman for North Yorkshire and York PCT said the current situation was 'very positive' and so far this year 2,189 patients had been allocated an NHS dentist.
Westminster week
Prime Minister backs water fluoridation

At prime minister’s questions on March 26, conservative MP and dentist Sir Paul Beresford asked Gordon Brown to confirm that he agreed with the need for fluoridation, and would he meet a delegation to discuss the changes needed to implement it.

The prime minister replied that he was personally very sympathetic to what Sir Paul had said and had seen the benefits of fluoridation himself. One reason for the Government putting extra money from the health budget into fluoridation was to encourage that to happen around the country. He added that he would be very happy to meet the proposed delegation. ‘It is a good thing for the teeth of the people of this country’ said the prime minister.

A friendly labour backbencher and fellow Devon MP, Linda Gilroy asked the minister to congratulate Plymouth PCT, which a short time ago had 12,000 patients on its waiting list, but had turned things around and now had about 500 patients on it. The minister was happy to do this and also congratulated his own PCT (Exeter), which had halved the number of people on its waiting list in the past 12 months.

However the conservative shadow dentistry minister, Mike Penning, attacked the minister for denying that there was a crisis in NHS dentistry, despite the evidence in the recent Patients Association report. ‘Whom should we believe?’ he asked, ‘the Government or the Patients Association’. The minister said he would rather listen to the testimony of MPs, speaking from experience of their constituency, and to the facts.

‘Given the introduction of the new contract, and the new investment that is now coming on stream in dentistry, I am afraid I have to tell the hon. Gentleman that not for much longer will he be able to say in the House that NHS dentistry is in crisis’, he concluded.

Health questions
Philip Hollobone conservative MP for Kettering had an oral question down for health ministers last month. He wanted a statement on access to NHS dentistry in both his constituency and England. The reply was given by the minister of state, Ben Bradshaw, who said that there had been an increase of seven percent in the number of dentists in Northamptonshire last year; nationally there were 4,000 more dentists than in 1997, and investment in NHS dentistry has more than doubled.

Mr Hollobone pointed out, however, that according to the latest figures the number of patients in Northamptonshire seen by their dentist has fallen by 13,000 since the new dental contracts were introduced. He also pointed out that Northamptonshire primary care trust (PCT) had yet to undertake a needs assessment of children’s orthodontics. The minister urged the PCT to get on and do it. He also said there was now a requirement for all PCTs to increase, year on year, public access to NHS dentists. ‘There is no excuse for any PCT, including the hon. Gentleman’s, not to improve its results’, he said.

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USA news round-up

The old saying is that if Wall Street catches a cold, the City of London develops pneumonia. Not always true in dentistry with our two very different healthcare systems, but ideas, materials and techniques do cross the Atlantic. Many news stories from the USA also have echoes in the UK, so here are some that caught the editor’s eye.

Grey health
A study by Tefen USA, a management consulting company, warns that ‘the approaching onslaught’ of more than 70 million aging baby boomers could ‘overwhelm’ the USA health care system and engulf the economy. A recent report from the Centers for Medicare and Medicaid Services (CMS) predicts that US health care spending will double to just over $4.5 trillion by 2017, nearly 20 percent of the nation’s gross domestic product. Tefen warns that CMS’ projection could actually be too low because people over 65 face nearly three times as many hospital days per thousand as the general population, and 62 percent of 50-to-64-year-olds have at least one of six chronic health conditions: arthritis, high cholesterol, cancer, diabetes, heart disease and hypertension.

Oral Cancer
Approximately 35,000 Americans are diagnosed with oral cancer each year and nearly 8,000 people died of these cancers in 2007 alone. Early detection is an integral part in battling the disease and can even help identify precancerous cells before they become cancerous. The Pennsylvania Dental Association (PDA) stresses that regular dental checkups play an essential part in the early detection of oral cancer.

No laughing matter
A Long Island dentist has been arrested for inhaling laughing gas (nitrous oxide) for non-medical reasons. Police arrested Dr Norman Rubin and charged him with inhalation of hazardous inhalants, a misdemeanor. They were called to Rubin’s office by a patient who found the dentist in apparent distress. Police and emergency medical technicians learned that Rubin had been inhaling nitrous oxide. After being treated, he was arrested.

Independent hygienists
Dental hygienists in the USA may secure right to operate independently. The New Hampshire and Maine state legislatures are considering whether dental hygienists should be allowed to set up their own practices, or at least operate with more autonomy. However retired dentist Ray Jarvis of Rye, secretary of the New Hampshire Board of Dental Examiners, said the board is opposed to any legislation that would let hygienists establish private practices. Jarvis said hygienists must work under dental supervision so serious oral diseases are not missed.

Shop and bleach
Regulators in the States are looking into business that set up in shopping malls and offer tooth whitening. Many not only sell the products but offer customers the opportunity to use them right then and there. Shoppers like them because they are convenient and cheap – usually about $100 instead of the $500 or $600 charged at a dentist’s office. But regulators and dentists have raised concerns about the safety of such practices. Officials say the question that needs to be answered is whether the people at the kiosks are technically performing dental work, which would be illegal.
The 10th Dimension – The power of 10... 

...a series of articles by Dr Ed Bonner BDS MDent, Sloan Fellow London Business School, practice coach & development consultant

10 things you should know about delegation

1. Understanding delegation
   Delegation is a skill essential to any manager and practice owner. Used effectively, it enables expansion of that most powerful and elusive of resources available to a leader.

2. Selecting tasks
   An example of a delegatable task is stock control. The practice owner should be the one finding out what materials are required, where to get them at the best possible price, and ensuring that the practice neither runs short of nor has a surplus of necessary materials.

3. Under-use of delegation
   Insecure managers who do not delegate underuse employees, which acts as a denotative order to others who know they can do the job at least as well as you but significantly lower cost. The cost of delegation should not outweigh the costs of non-delegation.

4. What is involved in delegation?
   Delegation involves the loss of direct control but the retention of direct responsibility. The basic elements involved in delegation are autonomy and control.

5. Why delegate?
   If you often say 'I don't have enough time', you are badly organised and a poor delegator.

6. Accountability
   Accountability is at the very core of delegation, so it is essential that delegates know what their responsibilities are. If guidelines should be set in writing.

7. Choosing the right person
   A manager who does not delegate overuses employees, which acts as a demotivator for others who know they can do the job at least as well as you but significantly lower cost. The cost of delegation should not outweigh the costs of non-delegation.

8. Training
   Delegation is an important part of the training process. Consider which skills will need to be developed and taught to enable the delegate to be able to carry out the task successfully. Training will motivate the delegate and strengthen their self-confidence.

9. Feedback
   Meet regularly, but not over-frequently, for feedback sessions. As a delegation proceeds, you should gradually reduce the frequency of meetings.

10. Provide backup
    Ensure you provide enough support and back-up to each person delegated a task, especially when things go wrong. Don't use delegates as scapegoats when things go wrong. Establish a culture that recognises success and avoids blame for failure.

Listening to the market

This is the fifth in a new series of articles by Dr Ed Bonner

A modern adage: when you can see a bandwagon, you've missed it!

Market opportunities
   Every business (and dentistry is no exception) needs to be able to identify new market opportunities. None can rely nor depend on the existing market lasting forever. Many practice owners may think that there are few opportunities to develop and renew themselves regularly, but this simply shows a lack of a strategic overview and a lack of belief in their own abundant strengths. In preparing a marketing plan, we need to listen carefully to what the world out there is saying about it - self, about us, and to us. We don't want surprises. We dare not live in that protected cocoon called 'this does not apply to me, I'm a dentist not a businessman'. Our comfort zone of the past is under siege.

We require information
   To understand what our patients/customers want, we need a plentiful supply of timely, accurate information: information about the environment; about how we are perceived by the media and by the public; about government thinking. We need all of this because we need to be able to respond rapidly to current fashions, trends and, not least, prejudices. This information will come from market research, which tends to be an expensive luxury for us. For, but not for our suppliers, so why they will set the agenda for us, rather than the other way round.

Gathering market intelligence
   What dentists can do is involve themselves more actively in intelligence gathering. Market intelligence is everyday information about important environmental events, new laws, social trends, technological breakthroughs, demographic shifts and competitor manoeuvres. From a marketing perspective, the following questions need to be answered:

- What decisions are we regularly called on to make?
- What types of information do we need to make those decisions?
- How do we get the information we need?

We can get this information in a variety of ways; here's 10:

- Reading dental journals and magazines from a different perspective
- Attending lectures, courses, seminars and workshops
- Talking to patient representatives
- Government publications
- Through associations/organisations such as CDOE
- Reading adverts and advertorials by other practices in local magazines
- New staff employed from other practices - they are competitor ex-employees
- Listening to our patients
- Watching television and reading newspapers
- Searching the web

The good news is that all the above are within our existing capabilities. The better news is that not one of the above list will cost you a single penny. What will cost you is not to do anything.

Planning from strength
   Once we have the necessary information, we can plan either defensively, for example, re-
Measure for measure

If you want to increase production and revenue at your practice, you need to keep a close eye on your progress and spending, says Simon Hocken

I am still amazed how many clients continue to run their businesses on their bank statements, plus the annual meeting with their accountant. Each month, they roll the dice and take home whatever’s left in their business account (and sometimes more). In this article, I want to make the case for a coaching phenomenon; that if you measure your performance you will improve your performance.

The reason for this is that the day-book acts as a ‘real-time’ record of how the day is going (financially) and if half-way through, it’s not looking good, it may be possible during the second half of the day to make up some lost ground by changing the focus of an appointment(s).

Attention to detail
In many cases, this small task is all that’s necessary to improve the personal production of the dentists and other fee earners and get a poorly performing practice back on track. The very act of measuring focuses your team’s attention on what they are doing/not doing and their production improves. I recently worked with a dentist whose daily gross fees increased by a third just by doing this!

The next step in using this tool is to set targets and to measure your situation against a target that represents success, (be it; weight loss, debt reduction or dental productivity!) The trick here is to measure and measure often against a realistic, incremental target. And the next trick is to give yourself/them a reward when you/they reach these targets!

Key performance indicators
I find that I can often measure a dental practice’s financial success by using a relatively small number of key performance indicators. I think of them as like a health check. Just like the clipboard that used to hang on the end of a patient’s bed, which the Consultant would pick up and quickly see the vital signs and progress of the patient. I have observed that dental principals who have put in place their own version of this “health check” and look at it regularly, often have more successful practices than those that don’t.

Setting goals for the turnover of your practice, the net profit it creates and your personal income forms part of your vision for your professional future and should never be left to chance. Measuring your progress against targets is an effective way of making real progress and turning your plans into reality.

Ten things worth mentioning in your practice:
1. Daily production of every fee earner in pounds
2. Daily collection of every fee earner in pounds
3. Total practice sales
4. Total Practice expenses
5. Net profit
6. Cash flow
7. New patients
8. Patient retentive (as a percentage)
9. Client satisfaction (using feedback questionnaires)
10. Employee satisfaction (using personal interviews).

Ten things worth measuring in your personal life:
1. Weight
2. Fitness/health
3. Net worth
4. Bank balance
5. Wealth creation activities (as opposed to income)
6. Days off
7. Glasses of water daily
8. Cups of coffee/tea daily and alcohol units weekly
9. Time spent exercising weekly
10. Cholesterol/ blood pressure/ resting pulse rate.

The practice health check
Five key performance indicators for every dental practice.
1. Average daily productivity in £ of all fee earners (from day book, not from money over counter) graphed each month to show trends.
2. Net Profit of practice as a percentage graphed each month to show trends.
3. Bank account, worst figure, best figure each month, (tracked as a graph).
4. Active patient list size for each dentist, (tracked as a graph)
5. New patient numbers per month, sex, age, location, source.

And I suggest you measure people by what they do, not by what they say they will do.

About the author
Simon Hocken BDS
is an accredited coach who specialises in working with dentists and their teams to create top practices. He runs Jump Coaching and works in partnership with Chris Barrett at The Dental Business School. Recently voted one of the top 50 influencers in dentistry, he works with around 40 practices every month to help them become and stay a top practice. You can contact him at simon@jumpcoaching.com.
New faces on BADN Council
Meet the new additions to the BADN team

Susan Bruckel has taken over from retiring chairman Elena Graham on the BADN Council from March 2008. Sue qualified as a dental nurse in 1972 and since then has worked for the community services. In 2001, she qualified as a special care dental nurse and in 2005 passed the National Diploma in Occupational Health and Safety. Most recently, Sue gained a City and Guilds Licentiateship Award in Dental Nursing and also became a Justice of the Peace.

New regional coordinators
The BADN Council also includes three new regional coordinators, for the North East, East Midlands and South Central regions. Melanie Joyce began dental nursing in a mixed NHS and private practice in Leeds city centre and obtained the NVQ3 in 2006. She currently works in a mixed practice also in Leeds. Melanie has also completed the ILM Certificate in First Line Management Level 3 and the Certificate in Dental Radiography, as well as the 7503 teaching qualification. She is currently completing the 7504 qualification.

Vicky Norton began dental nursing in 1996 in an NHS general dental practice. She moved to Leicester in 1999 and worked again in general practice. She is currently working as clinical manager in a predominantly private practice in Leicester, which provides implants, sedation, orthodontics and cosmetic and general dentistry. Vicky obtained the NVQ3 in 2005 and the Sedation qualification in 2007, and plans to take the Radiography qualification next year.

Leanne Covey began dental nursing in general practice in 1986, qualifying in 1990 before moving to maxillo-facial in hospitals. Leanne is a qualified Operating Department Practitioner, Assessor and Internal Verifier. She also holds a Certificate in Education, the General Anaesthetic Dental Nursing award and is currently studying for a BA Hons in Education and Training.

A new chairman
Two BADN national groups: the Armed Forces National Group and the National Education Group, also have new chairmen. Amanda Watson is currently employed as a dental practice management tutor in the Defence Dental Services Training School in Aldershot. She began her dental nursing career in 1990 at a dental practice in Ormskirk, gaining the National Certificate in 1993 and joining the Royal Navy in 1994. Since joining, she has served in Portsmouth, Somerset, Scotland, Gibraltar and Aldershot. Amanda has been a member of the AFG since 2002 as the Royal Navy representative, Secretary and now Chairman.

Sam O’Neill is employed as a dental nurse tutor by Bury Primary Care Trust. She qualified as a dental nurse in 1996 by achieving the National Certificate in Dental Nursing. Since then, she has been awarded the NEDN Certificates in Conscious Sedation, Dental Radiography and Oral Health Education, as well as the Diploma in Management and the 7407 Adult Teaching Certificate. Sam is currently studying towards the Certificate in Education and the A1 NVQ Assessor award which she is due to complete in June 2007.

Further enquiries, contact Pam Swain on 01253 338365 or email pam@badn.org.uk
Taking technology forward – technicians and technical skills

Another article from the Dental Laboratories Association: this month on keeping technical skills up to date and CPD

Competition is a relatively new phenomenon in dentistry. Twenty or thirty years ago most patients who needed a dentist approached the local surgery with no thought of seeking a second opinion, took what was on offer and went contentedly on their way.

Not any more. Today’s patients, conscious of costs and treatments, are prepared to travel for the best deal, and thanks to the media’s new found interest in dentistry have a far greater knowledge of different procedures and awareness of what is possible in terms of improving their appearance. And the tentacles of competition reach beyond the high street to those who too have a responsibility to constantly hone their skills to ensure the practice they serve maintain a competitive edge and keep up to date with the latest developments in materials and methods.

All dentists seek to offer a wide spectrum of treatment options, each reflecting the highest standards of professional care. Technicians have the same ambition, to create protheses and appliances of the highest quality which satisfy patient expectations and complement the talents of their clinician partners. However, compatible ambitions need compatible knowledge. To ensure the milieu and the striker are playing the same tactical game, both must pay attention to the team talk. Continuing Professional Development (CPD) keeps the different elements of the dental team not only up to date but communicating in the same language.

Learning new skills is personally challenging and commercially productive. For practices which engage with and exploit the latest developments as they occur, unlimited progress becomes possible. Staff are highly motivated, the patients benefit, and profitability soars. In many respects, technicians man the engine room driving the practice forward; advanced clinical protocols within the surgery cannot succeed without the support and certified, proven expertise of the technician behind the scenes.

Undertaking CPD, with its emphasis on promoting understanding of key aspects such as new materials and handling fac¬ilities, broadens the technicians’ knowledge and practical abilities. Another area rapidly increasing in importance for all technicians is public relations. While technicians themselves rarely have a face to face contact with the patients, their specialist knowledge, which is not shared by the ‘front line’ members of the dental team, has led to a recommendation that they pursue the same CPD syllabus in legal and ethical issues and complaints handling as other members of the team. In the 21st Century, communication skills have a more prominent role than ever before in every professional activity, and certainly not least in the delivery of healthcare in all its forms.

The General Dental Council is asking all unregistered technicians to register immediately. The new requirement, due to come into effect shortly, for all dental care professionals to complete 150 hours of recorded CPD every 5 years, is indicative of the importance now being attached to ongoing training and education. Dentists need to ensure that every member of their team is prepared to meet these new professional standards.

The BDPMA means business

If you’re in need of an inspirational boost, the BDPMA has events and training courses to suit everyone involved in dental practice management, says Vikki Harper

Has your career in dental management just begun and you’re wondering how on earth you’ll learn all there is to know – as quickly as possible? Has your career hit a plateau and are you in need of an inspirational boost? Are you a competent and successful manager who feels undervalued and under-rewarded? Or would you just like to meet like-minded managers to bounce around ideas with?

It doesn’t matter what your circumstances, the British Dental Practice Managers’ Association (BDPMA) helps everyone involved in the management of a dental practice, no matter what their position or level of experience, to fulfil their career aspirations. If you’re interested in achieving a long term and successful career in dental management, then there has been no better time to join the BDPMA than now because the Association has invested heavily in providing its members with the tools they need to become better and to benefit from their advanced skills.

Build your confidence

The 2008 BDPMA Conference & Celebration Dinner on June 15 and 14 at Stratford upon Avon is set to be the highlight of the dental management calendar. It provides delegates with a two-pronged approach to success by firstly concentrating on personal accomplishment and then moving onto business achievement.

It’s aimed at everyone associated with management including practice managers, principals, senior nurses and receptionists and to encourage team development, BDPMA members can extend their privileged rate extended membership to other members of their teams.

Speakers include Stephen Hancock OBE, Coach Clare Mc Namara, representatives from BDA Good Practice, Investors in People, NHS BSA and NHS PCT, and colleagues Sharna and Phil Loughnane from the award-winning Chipping Manor Dental Practice.

Boost your career

What happens when we meet a challenge at work? We usually feel unconfident to tackle it. It could be a new payroll system, determining budgets or creating a marketing plan but whatever it is, it fills us with fear.

The remit of the practice manager is broad so developing a broad skill base is important. That’s why the BDPMA, in association with Henry Schein, offers all managers the opportunity to further their management capabilities with funding of up to £2500 towards a recognised management qualification.

To enter, just appraise your practice; what are its strengths and weaknesses? How do you deliver value to your patients and how can you increase this value? Look at your patient journey and what needs to be changed? How can you make those changes and what do you need to be able to facilitate that change?

You don’t need to write an essay – bullet points are fine. Download an entry form from www.bdpma.org.uk or ask your BDPMA contact to send you one. Follow the instructions; send it to the BDPMA by APRIL 25th. Don’t forget to keep a copy for yourself, after all, it’s an action plan for your practice and is a useful tool even if you don’t win. But – you’ve got to be in it to win it!

What is a manager worth?

As a manager of a dental practice, how do you know if you are up to scratch? Taking this course leads to self-assessment and can provide a benchmark for personal accomplishment and then moving onto business achievement.

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The rationale for infection control and safety
Dr. Raghunath Puttaiah

Many countries in the Western hemisphere followed acceptable standards in dental infection control and safety dictated by a higher level of practice standards. These standards are formulated by regulatory agencies in their respective countries or regions to improve the level of patient care and personnel safety.1, 2, 3

Many patients were infected with the Hepatitis-B virus by dentists and dental surgeons in the United States in the 1960s and ’70s. Despite this, infection control did not gain in importance, possibly due to the advent of vaccines to combat the Hepatitis-B virus. Although concepts in dental infections were developed in the 1960s (due to Hepatitis-B viral infections),4, 5 this field only gained priority after HIV infections reached epidemic proportions.

Infection control gained further momentum in the U.S. after patients treated by an HIV-positive dentist later tested positive for the virus,6 and also after health care workers became infected while involved in patient care activities.7

While this disease has been ravaging the African continent since the late 1980s, and today in Asia and South Asia in particular, it is now being controlled in the U.S. and Western Europe where dentists have improved their practice of infection control either voluntarily or involuntarily.

The number of individuals infected with HIV and developing severe disease (i.e., AIDS) continues to rise worldwide. There is an annual increase, each with high morbidity levels within the populations, but with dramatic regional variations.8 While the case loads in the Americas and Europe are increasing, it is not as much as in Asia,9 with India having about 5.7 million cases, and China about 650,000 cases of HIV infections.10

Apart from HIV and AIDS, there are a plethora of blood-borne and other common diseases encountered in the dental clinic that may pose a risk (see Table 1 for a list of conditions/pathogens, habitat and routes of transmission that has been described).

### Table 1: Infectious diseases commonly encountered in dentistry

<table>
<thead>
<tr>
<th>Condition</th>
<th>Habitat</th>
<th>Routes Of Transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexually transmitted diseases</td>
<td>Oral/pharynx, anogenital, skin, eyes, ear</td>
<td>Contact-lesion exudate, saliva, sexual contact, blood</td>
</tr>
<tr>
<td></td>
<td>Oral, gingiva, pharynx</td>
<td>Contact-lesion exudate, saliva, blood</td>
</tr>
<tr>
<td></td>
<td>Palpebral, hands</td>
<td>Contact-lesion exudate, saliva, blood</td>
</tr>
<tr>
<td></td>
<td>Oral, pharynx, gastrointestinal tract</td>
<td>Contact-lesion exudate, saliva, blood</td>
</tr>
<tr>
<td></td>
<td>Genitalia, eyes, urogenital</td>
<td>Contact-lesion exudate, genital secretions, secretions from eye</td>
</tr>
<tr>
<td></td>
<td>Genitalia, urethra, oral, gastrointestinal</td>
<td>Contact-lesion exudate, mucosa, saliva, blood, body fluids</td>
</tr>
<tr>
<td></td>
<td>Genitalia, skin, oral mucosa, oropharynx</td>
<td>Contact-lesion, mucosa, saliva, blood, body fluids</td>
</tr>
<tr>
<td></td>
<td>Skin, oral mucosa, genitals, parotid, saliva</td>
<td>Contact-lesion exudate, saliva, lesion exudate</td>
</tr>
<tr>
<td></td>
<td>Liver, blood, body fluids</td>
<td>Contact-blood, saliva, body fluids</td>
</tr>
<tr>
<td></td>
<td>Liver, blood, body fluids</td>
<td>Contact-blood, saliva, body fluids</td>
</tr>
<tr>
<td></td>
<td>Liver, blood</td>
<td>Contact-blood, saliva, body fluids</td>
</tr>
<tr>
<td></td>
<td>Blood, oral mucosa, skin</td>
<td>Contact-blood, semen, non-intact skin</td>
</tr>
<tr>
<td>Respiratory Diseases</td>
<td>Upper Respiratory Tract</td>
<td>Aerosol, droplet</td>
</tr>
<tr>
<td></td>
<td>Upper Respiratory Tract</td>
<td>Aerosol, droplet</td>
</tr>
<tr>
<td></td>
<td>Upper Respiratory Tract</td>
<td>Aerosol, droplet</td>
</tr>
<tr>
<td></td>
<td>Respiratory Tract</td>
<td>Aerosol, droplet</td>
</tr>
<tr>
<td></td>
<td>Respiratory Tract</td>
<td>Aerosol, droplet</td>
</tr>
<tr>
<td></td>
<td>Respiratory Tract, Gastrintestinal Tract</td>
<td>Aerosol, droplet, intimate contact</td>
</tr>
<tr>
<td>Childhood Diseases</td>
<td>Oral, skin</td>
<td>Droplet, contact</td>
</tr>
<tr>
<td></td>
<td>Oral, pharynx</td>
<td>Droplet, contact</td>
</tr>
<tr>
<td></td>
<td>Oral, hands, feet</td>
<td>Droplet, contact, ingestion</td>
</tr>
<tr>
<td></td>
<td>Respiratory Tract, Oral/Pharynx</td>
<td>Droplet, contact, saliva</td>
</tr>
<tr>
<td></td>
<td>Salivary glands</td>
<td>Droplet, contact, saliva</td>
</tr>
<tr>
<td>Other Common Conditions</td>
<td>Upper Respiratory Tract, Gastrintestinal Tract</td>
<td>Aerosol, droplet, intimate contact</td>
</tr>
<tr>
<td></td>
<td>Liver, gastrointestinal tract</td>
<td>Ingestion, rarely blood</td>
</tr>
<tr>
<td></td>
<td>Liver, gastrointestinal tract</td>
<td>Ingestion, rarely blood</td>
</tr>
</tbody>
</table>

Note: Conditions addressed in the table are frequently seen in dental patients and therefore need to be considered in protecting patients and the dental health care workers. The modes of transmission in dentistry are commonly direct contact with lesions, saliva, blood, oral mucosa, and droplets or aerosols containing infectious agents.

---

**Fig. 1:** Examples of the “Critical Category” of devices that must be sterilized between patients or be sterile single-use disposable items.

**Fig. 2a, b:** Examples of the “Semi-Critical Category” of devices that must be sterilized between patients or be sterile single-use disposable items including clean supplies.

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Percutaneous (high risk): Inoculation of microorganisms from patient to patient, dentist to dentist, or region, high standards of dental infection control and occupational safety must be followed by the dental team for the safety of the patients and dental health care workers. Dental health care providers must be knowledgeable about the diseases commonly encountered during dental care, and must responsibly provide care to patients without getting infected or infecting patients.

Rationale
The rationale is to control iatrogenic, nosocomial infections and potential occupational exposure of care providers to diseases causing microbes. The terms “disease control” or “infection control” do not mean total prevention of iatrogenic, nosocomial infections or occupational exposures to blood and other potentially infectious material. Although control goals are to avoid or reduce occupational disease transmission, reduction in potential risks of disease spread is only practical.

Routes of disease transmission
Routes of disease transmission can be specific to various fields of health care. In dentistry, diseases can be transmitted from patient to patient, dentist to patient, and patient to dentist when adequate precautions are not followed. Dental health care workers and patients can further transmit the diseases to their families and friends. The common modes of disease transmission in their order of severity are:

- Percutaneous (high risk): Inoculation of microbes from blood and saliva transmitted through needles and sharp instruments.
- Contact (high risk): Touching or exposing non-intact skin to infectious oral lesions, infected tissue surfaces or infected fluids, splash and spatter of infected fluids.
- Inhalation of aerosols or droplets containing pathogens (moderate risk): Breathing bioaerosols suspended in the clinician’s ambient air laden with infectious material while using hand pieces and scalers or droplet nuclei from coughing.
- Indirect contact through fomites (low risk): Touching contaminated inanimate surfaces in the dental treatment room or operatory.

The risks of disease transmission may vary depending upon host susceptibility, virulence and infectivity of the organism, dose or number of organisms, period of exposure (time span) and, finally, the mode of transmission. Controlling virulence of all pathogenic organisms or trying to reduce inerent patient susceptibility is next to impossible.

A practical approach would be to understand the disease processes, routes of transmission, and methods for controlling transmission, and to implement adequate infection control and safety measures during practice to break the chain of infection. Immunization against diseases, use of practical barrier techniques, use of personal protective equipment, engineering and work practice controls, disinfection of contaminated surfaces/ equipment, sterilization of critical and semi-critical instruments, and the use of aseptic protocols during treatment broadly encompass the realm of dental infection control.

Decontamination and Spaulding’s classification
The first level of decontamination is called sanitization, which is a process of thorough physical cleaning to reduce the quantity of microbes and bioburden (normally a solution containing a detergent is used). Sanitization or thorough cleaning is carried out prior to disinfection or sterilization. This can be achieved by thoroughly cleaning the surfaces with soap and water, or initially with disinfectants that have a detergent.

The second level of decontamination is disinfection, a process that kills all vegetative microorganisms, fungi and some viruses, but not necessarily bacterial endospores using chemical germicides, radiation, ultraviolet rays or heat.

The third level of decontamination is sterilization, a process that kills all bacteria, fungi, viruses and bacterial endospores. If chemical methods such as heat or heat, steam under pressure, or radiation are used.

Before one uses any infection control measure, it is necessary to understand the criticality of the surfaces. In 1968, Earle H. Spaulding categorized medical devices based on the risk of disease transmission and their reprocessing methods prior to their use in patient care. The same principles were modified by Faviero & Bond16 to include four categories (to include environmental surfaces as a category). Table 2 is an explanation of this modified classification as it applies to dentistry.

Instrument and operator surfaces can be classified as critical, semi-critical, non-critical or environmental surfaces based on their potential of disease transmission. All materials being used should be approved for patient care in the respective countries of use. Items that are considered single-use-disposable must be discarded after one use and not be reprocessed. Table 2 addresses the specifics of Spaulding’s Classification as it applies to dentistry.

Table 2: Adaptation of Spaulding’s Classification.

<table>
<thead>
<tr>
<th>Category/Level</th>
<th>Disease Risks</th>
<th>Control methods</th>
<th>Materials/Devices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical</td>
<td>High</td>
<td>Sterilization by:</td>
<td>Items that are used in surgery which pierce soft and hard tissue—Scalpel blades, instruments, forceps, elevators, needles, files, bone-removers, periodontal instruments used in prophylaxis, surgical drills for abcesses, and any other instrument used in surgery, dental explorers, periodontal probes, biopsy punch, surgical drains, endodontic files and chisels.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or</td>
<td>Sterilization by:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sterilization by:</td>
<td>Sterile single-use-disposables.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or</td>
<td>Semi-critical:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sterilization by:</td>
<td>Sterile single-use-disposables.</td>
</tr>
<tr>
<td>Semi-critical</td>
<td>High</td>
<td>Sterilization by:</td>
<td>Sterile single-use-disposables.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or</td>
<td>Non-critical:</td>
</tr>
<tr>
<td>Non-critical</td>
<td>Moderate to low</td>
<td>Sterilization by:</td>
<td>Disposable Barriers.</td>
</tr>
<tr>
<td>Environmental</td>
<td>Low</td>
<td>Sterilization by:</td>
<td>Items used in dentistry which do not cross the vermilion border or penetrate the soft tissues—chair light handles, instrument trays, high touch work surfaces, brackets, chair controls, air/water syringes, and dental chairs.</td>
</tr>
</tbody>
</table>

Table 2: Adaptation of Spaulding’s Classification.
In conclusion, one should allocate a budget specifically for infection control and safety. Educational institutions should be involved in developing a basic curriculum that includes both didactic and practical training of future dental healthcare workers. Practicing dentists must be trained in the state-of-the-art protocols for providing safe dental care.

**Literature**


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The 21st century practice-builder is Botox

The impressive Bishops-gate 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 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 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 pharmaceutical 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.

Tim encourages all delegates to offer BOTOX® injections to their patients to experience it for themselves. By late morning, delegates were starting to analyse and mark each other’s faces in preparation for the delivery of injections. In the afternoon, patients came to the practice so that delegates were able to give their first injections under supervision. Tim’s advice was to give just enough to make a difference so that at the review appointment two weeks later BOTOX® could be administered if the patient wants.

Tips for injecting Botulinum Toxin Type A

• Always inject away from the eye
• Keep patients sitting back, slightly, not lying down
• Recommended saline dilution is 2.5cc of saline in a 100 unit Botox® bottle or of a 500 unit bottle of Dysport®, 1.25ml saline in a 50 unit bottle of Vistabel® – the more it is diluted, the more it will spread, which is to be avoided
• Make sure you inject 1cm at least away from the orbital rim which is usually below the eyebrow but be aware that in some people the orbital rim is within or above the eyebrow line
• Always lightly touch the area you are about to inject so that the patient knows where to expect the injection
• Always use a new needle when injecting to make it more comfortable for the patient
• Always take photographs before and after treatment and make sure patients are aware of their facial asymmetries before embarking on treatment
• Patients should be informed that injections can activate reciprocal muscles and this may have pros and cons – for instance injections in the corrugator muscles might make eyebrows more arched which women may like but men would want to avoid
• Men can need higher doses than women but are also more likely to want to retain more lines, illustrating how important it is to ensure patient expectations are fully discussed
• Botulinum Toxin is a prescription drug and cannot be advertised although you can tell your patients you offer wrinkle-reduction treatments

The 21st century practice-builder is Botox

The 21st century practice-builder is Botox
The idea of clinical photography scares many practitioners unnecessarily. With the correct equipment, practice and knowing which photographs to take, it will become one 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 post-graduate 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 a TIFF file and needs concern not be so much 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:

1.10 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.

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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 contralateral central incisor and possibly the contralateral 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 should be on view 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 sextant of molars and pre-molar teeth are visible.

Two additional views for lab communication:

1.2 Lips at rest, ‘M’ sound (Fig. 9) – enables you 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
check a patient’s overjet or lip position.

Post-op views for marketing (Figs. 13-15) – If you are confident in your photographic skills and you set aside part of your practice which can be turned into a small studio, you can take portrait or staged shots. These can be placed on your web site, used in your practice literature or blown up and framed to use as artwork around your practice. If not then build a relationship with a local photographic studio to do these for you.

Uses of Clinical Photography
1. As a point of reference for how the teeth looked at that particular point in time i.e. a medico-legal record. This is especially important before embarking on any form of restorative treatment.

2. Diagnosis and treatment planning for any case involving the anterior teeth so that you can assess the patient’s smile on a large screen.

3. Case presentation of your findings to the patient, this can even be placed onto a disc in the form of a PowerPoint presentation for them to take home.

4. Digital imaging with the appropriate software or Photoshop.

5. Lab communication for any form of diagnostic work especially.

Fig. 11a
Fig. 11b
Fig. 12a
Fig. 12b
Fig. 13a
Fig. 13b
Fig. 14a
Fig. 14b

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Presented by:
Dr. David Bloom BDS Msc
Dr. Jay Padayachee BDS Msc
Melanie Prebbble BDT EDH

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Fig. 13a
Fig. 13b

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cially wax-ups and of the provisionals prior to construction of the definitive restorations.

6. Assessing your provisional restorations in a smile design case that can be looked at before the patient returns. As you will often spot potential issues to be corrected when the patient returns, one cannot emphasise how much easier it is to see these on a 17 or 19 inch monitor than in a four-inch smile.

7. Building a portfolio of your own work for use in marketing etc.

Conclusion

Clinical photography is now such a useful and important tool in a clinician’s armamentarium, and with the advent of high-quality digital cameras it has never been so easy. However, it does take time and practice initially, but like riding a bike once you know how to you never forget. This can also be carried out by your team to free up your time for something more productive, whilst also being rewarding for them as they now have another feather in their cap.

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David Bloom is a graduate of the Newcastle-upon-Tyne Dental School, and has been a principal at Senova Dental Studios since 1990 focusing on comprehensive restorative and cosmetic dentistry. A full member of the British Academy of Cosmetic Dentistry, David was appointed President in 2007. He is a member of The British Society of Occlusal Studies, The British Society of Restorative Dentistry, The Pankey Association, The British Society of Periodontology and the American Academy of Cosmetic Dentistry of which he is a sustained member. He is also a fellow of the International Academy of Dental Facial Aesthetics and a clinical director for Coopr8 seminars.

Jay Padayachy is a graduate of the Newcastle-upon-Tyne Dental school, and has been a principal at Senova Dental Studios since 1998 focusing on comprehensive restorative and cosmetic dentistry. He’s a full member of the British Academy of Cosmetic Dentistry and is on the board of directors. He is a member of The British Society for Occlusal Studies, The British Society of Restorative Dentistry, The Pankey Association, The British Society of Periodontology and the American Academy of Cosmetic Dentistry of which he is a sustained member. He is also a clinical director for Coopr8 seminars.
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Winner of 2008 DENTSPLY/ BDA Student Clinician Programme

The 51st anniversary of the DENTSPLY/BDA student clinician programme was held at the Sheraton Hotel Park Lane on Friday the 8th of February 2008.

15 teaching schools put forward an entrant for the adjudication which was held at the BDA headquarters during the day. Each student presented a piece of original research to the three adjudicators: Professor Nairn Wilson, Head of School and Dean of Kings College London Dental Institute; Dr John Drummond, Senior Lecturer and Honorary Consultant of Dundee Dental School; and Professor Robbie McConnell, Head of the College of Medicine, Cork University Dental School.

The first prize of an all expenses paid trip to the American Dental Association meeting in San Antonio later this year went to Ryan Olley from Kings College London Dental School.

Lecturer and Honorary Senior Lecturer and Honorary In-Team Manchester, Dr John Drummond,chai programme was held at the BDA Dental School. To match the preeminence of the venue, the BOS has organised a comprehensive series of talks on temporary anchorage devices in orthodontics throughout the day, culminating in clinical presentations relating to all and open bite cases. Dr Jason Sandler will present some difficult clinical scenarios in addition to considering the involvement of the National Institute of Clinical Excellence (NICE) in provision of temporary anchorage devices. The triumvirate is completed by Sheila Scott, a management expert, highly experienced and respected in the dental field, who will address the difficulties of introducing new techniques to the dental team.

To the Manor born

The British Orthodontic Society (BOS) spring meeting is to take place at the Celtic Manor in Wales on Saturday 10 May 2008. This world class golf resort is the venue for the 2010 Ryder Cup and is something of a golfing mecca. It is a great place to host the BOS event. The British Orthodontic Society is an organisation that represents and supports orthodontists in the UK, and it is dedicated to promoting the highest standards of orthodontic care and education. The BOS provides a platform for orthodontists to share ideas and best practices and to further the advancement of orthodontics as a specialty. The annual spring meeting is an opportunity for orthodontists to come together to discuss the latest developments in orthodontics, to learn from each other, and to network with colleagues. This is an event that is highly valued by orthodontists in the UK and is an important aspect of their professional development.

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Breathe Business was set up by leading coaches Simon Hocken and Chris Barrow to give dental professionals the support and skills to move their business forward. With 15 years' experience of running a business coaching with more than 750 practices in the UK, Chris and Simon know what it takes to be a successful practice owner and effective leader.

The Breathe team is currently running a training day to Focus on Time and Money. With expert coaching, you will discover how to realign your business vision and achieve your goals by making time work for you rather than against you.

Motivate and energise your team with stand-alone training days for you and your team. When you need a boost of inspiration to make that next step, or enhance your leadership skills and your team's understanding of the business, call Breathe and learn from the best. Focus on Time and Money will be running at various locations throughout April to June. Call the Breathe team to book on one of these popular dates.

For more information, call 01326 577078 or email bonnie@nowbreathe.co.uk

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To reserve your places, call 01326 577078 or email bonnie@nowbreathe.co.uk

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Collardam is something of a golfing mecca, it is a great place to host the BOS event. The British Orthodontic Society is an organisation that represents and supports orthodontists in the UK, and it is dedicated to promoting the highest standards of orthodontic care and education. The BOS provides a platform for orthodontists to share ideas and best practices and to further the advancement of orthodontics as a specialty. The annual spring meeting is an opportunity for orthodontists to come together to discuss the latest developments in orthodontics, to learn from each other, and to network with colleagues. This is an event that is highly valued by orthodontists in the UK and is an important aspect of their professional development.
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Beverly Hills Formula

Beverly Hills Formula is working with The British Dental Health Foundation to spread the National Smile Month message “Brush for Health”. Keeping plaque at bay is at the heart of the good oral health message being emphasised by Purity Laboratories (Beverly Hills Formula). The message links a healthy mouth with a healthy life and states the importance of a lifelong oral hygiene programme.

The Purity Laboratory’s Smile Doctor recommends a multifaceted approach in order to prevent oral diseases. Maintaining optimum
Astra Tech Business Day with Ashley Latter

Astra Tech is delighted to have held a special open day for its customers to help increase their referrals. Renowned dental sales coach, Ashley Latter delivered the programme that comprised two excellent presentations and a unique opportunity to speak to him about any aspect of Marketing and Ethical Sales & Communication.

Latter’s presentations are for people and companies who are looking for new information, to be inspired and increase opportunities and solutions to their everyday business challenges.

The first presentation at the Astra Tech open day was entitled ‘Strategic Management of Referrals/Accounts’ and covered a range of topics including:

• How to strengthen relationships with existing referral practices.
• How to maximise and increase the number of referrals from existing referral practices.
• How to add value and take relationships to the next stage.
• Grading the referrals to maximise opportunities and new treatment opportunities.
• Attract new referral practices.

‘Introduction to Ethical Sales & Communication Skills’ was the final presentation of the day. Ashley took attendees through a seven-step process in a three-hour long presentation that gave an overview of techniques and skills that will enable improved patient relations, increased patient acceptance rates, greater confidence with the sales process from start to finish and much more.

To register your interest or for further information about this interactive, motivational and fun business day, please contact Astra Tech via e-mail to info@astratech.com, telephone 0845 4500586 or visit www.astratechuk.com.

The British Orthodontic Society (BOS) spring meeting is to take place at the Celtic Manor in Wales on Saturday 10 May 2008. This world class golf resort is the venue for the 2010 Ryder Cup.

To match the pre-eminence of the venue, the BOS has attracted three internationally renowned speakers to address the conference. Keynote speaker Dr Jason Cope will be presenting a comprehensive series of talks on temporary anchorage devices in orthodontics throughout the day, culminating in clinical presentations relating to Class II and open bite cases.

Dr Jonathan Sandler will present some difficult clinical scenarios in addition to considering the involvement of the National Institute of Clinical Excellence (NICE) in provision of temporary anchorage devices. The triumvirate is completed by Sheila Scott, a management expert, highly experienced and respected in the dental field, who will address the difficulties of introducing new techniques to the dental team.

If you would be interested in attending the BOS conference as well as availing yourself of the sporting and leisure facilities during the weekend of 9 and 10 May, please call 020 7353 8680 or visit www.bos.org.uk. Early booking discounts are available.
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DENTAL TRIBUNE United Kingdom Edition · April 14–20, 2008