Eye-opening dental venture across Yorkshire

Dental chain to open surgeries in opticians across Yorkshire in innovative joint venture, which is first of its kind.

A dental chain is to open a string of surgeries in optician practices across Yorkshire, in what is thought to be one of the first partnerships of its kind.

Ideal Dental Care has signed an agreement with Premier Vision Opticians to open four new joint venture dental surgeries in opticians in Castleford, Huddersfield, Bradford and Wakefield.

The first is expected to open in Huddersfield in July, and the remaining three are scheduled to open by the end of the year.

The practices will be branded Ideal Dental Care and will operate on a joint venture partnership basis within the opticians.

Both Ideal Dental Care and Premier Vision Opticians see a synergy between dentistry and optometry and want to create a one-stop shop on the high street for patients.

It is a new venture for both parties, according to Ideal Dental Care’s managing partner, Peter Thompson, and one which is centred on delivering a value for money, patient-oriented experience.

“This can only be a good thing for consumers because they can access care for their eyes and teeth under one roof. Both companies have a remarkably similar outlook on business and the way we want to deliver service and treatment,” said Mr Thompson.

He added: “We are committed to delivering the very highest standards of care which represent excellent value for money and having this proposition on prominent high-street locations makes it extremely accessible for customers to choose to seek a range of treatment under one roof.”

Premier Vision managing director, Steve Keough, said he had been looking to develop his business model and saw dentistry as the perfect partner for his opticians.

“Ideal Dental Care were the first people I came across that were serious about joint venture partnerships and had a well-developed and robust franchise model,” said Mr Keough, a former operations director with Specsavers.

“I know that in the conception of Ideal Dental Care, Peter Thompson studied the Specsavers model in great detail and this goes a long way in explaining how he has created a business model which resonates with the way I run my business,” he added.

Both Mr Thompson and Mr Keough said they are delighted to have reached an agreement and are excited about rolling out the dental-optical proposition and developing a niche in the market.

Ideal Dental Care already has practices in Lancashire, London and South Yorkshire.
Oral health set to improve as more smokers quit

The oral health of the nation looks set to improve as more smokers kick the habit.

Almost 250,000 people in England stopped smoking between 1 April and 31 December 2009, a rise of 10 per cent compared to the same period in 2008 according to the results of a new national survey. Results from the NHS Stop Smoking Services survey also showed that more than another 375,000 of the country’s smokers have decided to kick the habit for good and set a quit date.

Chief executive of the British Dental Health Foundation, Dr Nigel Carter, has welcomed the results but insists that more needs to be done to educate people on the hazards of smoking.

Dr Carter said: “Most people are now aware that smoking is bad for our health. It can cause many different medical problems and in some cases fatal diseases. However, many people do not realise the damage that smoking does to their mouth, gums and teeth.

“Smoking can lead to tooth staining, gum disease and tooth loss.

“When people think of the dangers of smoking they instantaneously think of lung and throat cancer, but many are still unaware that it is one of the main causes of mouth cancer too.”

He added: “Mouth cancer can appear in different forms and can affect all parts of the mouth, tongue and lips. It can appear as a painless ulcer that does not heal normally. A white or red patch in the mouth can also develop into a cancer. It is important to visit your dentist if you have any concerns about your oral health.

The oral health of the population of Scotland is generally poor, with 55 per cent of adults and 17 per cent of children not registered with a dentist. However, members of the public who have an emergency dental problem can access out-of-hours emergency dental care. This service is provided by NHS 24 in partnership with NHS boards on 0845 2424244.

‘Unfairly dismissed’ after affair

A dentist receptionist was ‘unfairly dismissed’ from her job, after she began an affair with a married colleague, a tribunal in Reading found.

Tanya Henderson, 21, began having a secret affair with her married colleague, Alamain Salim, at Riverside Dental Practice in Caversham, Berkshire. Salim did not see his wife very often because she lived abroad.

However, when his wife moved to the UK, Ms Salim allegedly told Ms Henderson that he wanted to rebuild their marriage and wanted their affair to stop.

Ms Henderson claims that when her colleagues suspected the two were having an affair, she became the victim of practical jokes.

She claimed that a colleague uploaded pornography onto her computer and when it appeared, the practice owner Changiz Fahami told Ms Henderson she was too young to be looking at the images and gave her a slap on the head.

Mr Fahami claims the affair caused a lot of problems at the surgery and said he told Mr Salim that either he or Ms Henderson must leave the practice.

The tribunal decided that Ms Henderson had been unfairly dismissed. She has agreed a private settlement with Riverside Dental Practice.

While public health minister Shona Robison said: “It is excellent news that this service has made such good progress.”

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Scottish NHS boards make ‘good progress’

NHS boards in Scotland are meeting the national standards to provide out-of-hours emergency dental services, according to a new report.

NHS Quality Improvement Scotland (NHS QIS) reviewed individual NHS boards and found that all boards had the correct measures in place to treat patients with dental problems outside normal working hours.

NHS QIS also showed evidence of so-called ‘optimised’ services, meaning they showed exceptional performance.

The boards were assessed against three key standards: accessibility and availability at first point of contact; safe and effective care; audit, monitoring and reporting.

Jan Warner, director of patient safety and performance assessment for NHS QIS, said: “Good dental care is critical to our quality of life.”

She added: “It is clear that NHS boards have put a lot of work into establishing emergency services and these are now in place across Scotland.”

Shona Robison said: “It is excellent news that this service has made such good progress.”

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Editorial comment

Karibuni Tanzania

A big hello from Tanzania! (or as my new Swahili goes ‘Karibuni Tanzania’)

As I write this, it has been our first full day in Mwanza, the city where we are based for the next two weeks on our trip to the Bukumbi Care Centre to renovate a community centre in the village there.

Today has been a day of complete contrast, where we began the day at one of the nicer hotels in the area to have an orientation meeting, and then got a taste of the poorer side of life for resident Tanzanians. In the meeting, we discussed the history of the centre, which has been in existence since the seventies, but has seen a resurgence since Bridge2Aid began to build relationships there.

The orientation meeting really served to fire our already high enthusiasm, and you can feel in the group that we just want to get going in our project here. This was not lessened by the afternoon’s visit to Bukumbi, where we got to see just what we will be doing in the next two weeks (we will be extremely busy!), it also gave us a chance to see firsthand the life the people of Bukumbi lead, and practise our swiftly learnt Swahili with the locals! Our arrival sparked much excitement amongst the children, who were fighting over who got to hold hands with a particular team member!

The visit really hit home how little this community had, which in turn was much more than many other communities here. Walking around and meeting people who were genuinely pleased to see us and were grateful for what we had come out to do was very moving, and a little saddening too, but it’ll take more than this comment to explain that...!

BDA Conference

A general dental practitioner from Lichtenstein will be exploring the limits of material and techniques at this year’s British Dental Conference.

Gary Unterbrink, who has more than 15 years’ experience in research and product development, will be arguing that there are quite often striking conflicts between practitioners’ clinical experiences and the conclusions of evidence-based dentistry, and that there are many areas of dentistry where additional knowledge is still required.

Dr Unterbrink headlines two sessions on the first day of the 2010 British Dental Conference and Exhibition, which takes place at Liverpool’s Arena and Convention Centre between 20-22 May.

The first, Direct composites – exploring the limits of materials and techniques, will help attendees develop their knowledge of the ideal preparations for composite restorations, the selection of adhesives and composites and application techniques that combine efficiency, function and aesthetics.

His second session, Effective indirect adhesive restorations, will consider diagnosis and treatment planning, the critical role of preparation technique for success with indirect adhesive restorations and the co-ordination of practice and laboratory factors.

For more information on the 2010 British Dental Conference and Exhibition, or to register, visit www.bda.org/conference or call 0870 166 6625.

Do you have an opinion or something you want to say on any Dental Tribune UK article? Or would you like to write your own opinion for our next comment page?

If so don’t hesitate to write to:
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Britain to host International Symposium

Britain will be hosting the International Symposium on Dental Hygiene this year. The forthcoming international dental industry conference will take place in Glasgow in July.

The 18th International Symposium on Dental Hygiene is entitled ‘Oral Health - New Concepts for the New Millennium: New technology for preventing and treating oral diseases, including alternative treatments’.

A spokesperson for the International Federation of Dental Hygienists said: ‘This symposium is likely to witness the greatest ever gathering of oral health professionals from around the world. It’s not surprising, therefore, that the Scientific Programme is packed with eminent speakers and topics of equal gravitas.’

Professor Jeremy Baggs, head of School, University of Glasgow Dental Hospital and School will be making the keynote address ‘Challenge and change in infectious diseases: a global issue’.

Periodontitis will be explored by Prof Francis Hughes, a recognised expert in all aspects of periodontal disease and regeneration working at the Institute of Dentistry (School of Medicine and Dentistry), Queen Mary University London.

Tracey Lenneman will address the subject ‘The dental hygienist in the new millennium’.

Ms Lenneman has been a practising clinical periodontal dental hygienist since 1986, and has experienced many facets of dental hygiene in the USA and in Europe.

Warren Greshes, an internationally acclaimed speaker, author and broadcaster, will be discussing broader issues under the title ‘Adding value to the dental practice’.

His presentation, ‘Customised aesthetic treatment using minimal or non-invasive feldspathic porcelain veneers’, will explore the rationale behind the use of such veneers as an alternative to composite resins.

The session will provide a step-by-step guide using clinical case studies to demonstrate the processes involved in order to create an enhanced smile for patients.

There will be a number of abstracts and research sessions interspersed in the programme, providing delegates with opportunities to meet the authors of papers, on important topics and to discuss their research and conclusions.

In addition, there will be workshops at which delegates can gain hands-on experience of products, tools or materials relevant to oral healthcare.

The British Dental Trade Association (BDTA) is one of the main sponsors of the event being held 1-5 July.

BDTA executive director Tony Reed said: ‘The fact that the UK has been chosen to host the International Symposium is an accolade for the BSDHT and we are proud to be playing a part in making 2010 a conference to remember.’

Expert advice for non-invasive aesthetic treatment

A renowned expert in the area of aesthetic dental care will be chairing a presentation at this year’s British Dental Conference (BDC) and Exhibition.

Aimed at general dental practitioners and young dentists, the lecture has been designed to give clinicians a practical treatment approach that allows for the predictable enhancement of the smile.

Dr Irfan Ahmad will be introducing Dinos Kounturas, a general dental practitioner at The Dental Implant Clinic in Thessaloniki, Greece, as the speaker for the session.

His presentation, ‘Customised aesthetic treatment using minimal or non-invasive feldspathic porcelain veneers’, will explore the rationale behind the use of such veneers as an alternative to composite resins.

Check your registered address is up to date

The General Dental Council is calling on all dental professionals to check that their registered address is up to date.

This is a requirement of registration and helps ensure that registrants don’t miss out on important General Dental Council (GDC) information, according to the GDC.

Registration projects manager, Sarah Arnold said: ‘When registrants move from their registered address, whether home or work, the GDC should be on the check-list of organisations they need to contact.

“We regularly send things out by post – such as Annual Retention Fee information, Annual Practising Certificates and the Gazette. If these haven’t been arriving, it’s worth making sure we have the right contact details. The registered address can be of a home, a practice or even a Post Office Box number as long as it is somewhere we can get in touch, but remember, the address you give will be published on our website.”

Dental professionals can check their details are right by logging on to www.GDC-uk.org and searching the registers using their registration number.

By law, dental professionals’ registered details (full name, registered address, qualifications and date of first registration) are all public information.

Members of the public can check any registrant’s details by contacting the GDC or by checking the Dentalists Register or Dental Care Professional Register online at www.gDGC-uk.org.

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DIO Professional Implant Education

Following the success of the UK’s first public live theatre at the Dentistry Show, DIO Implant continues to boldly progress with its mission to change the face of the UK implant market for the better of everyone. DIO’s Managing Director explains, “For most patients, dental implants are a necessity. At DIO, we aim to bring the benefits DIO provides by any patient who needs it, without compromising on quality of treatment or jeopardising the livelihoods of our valued UK implantologists.”

The next stage of their roadmap is to introduce a dedicated educational programme, designed especially for dentists wishing to provide the highest standard of care to their patients.

The format of the course addresses both the requirements of practitioners looking to start providing dental implants as well as those who are already placing implants from other manufacturers.

For non-implant dentists, the introduction days lead on to a one-year, hands-on and distance learning certified course, equivalent to approximately 120 hours of verifiable CPD. The course, directed by Sam Mohamed of Smile Lincs, aims to impart everything a qualified dentist needs to know in order to confidently provide dental implants to their patients.

The introductory two-day course During an initial two-day course practitioners are given an overview of the evolution of dental implants and how they can be integrated into a normal dentistry practice in the most cost-effective way. The course looks at the basics of dental implantology, discussing osteointegration, treatment planning principles, radiographic techniques and restorative techniques. It also covers more practical aspects of dental implantology such as practice setup and marketing and introduces patients to implantology to ensure a good return on investment.

Day 1 is aimed at providing non-implant dentists with an introduction to implant procedures. Practitioners will leave knowing whether dental implants are both right for them as an individual and a feasible business proposition for their practice. DIO is also welcoming existing implant practitioners on the introduction day, which DIO claim exposes them to a new perspective and allows for non-biased discussions and a healthy propagation of expertise to all attending.

Day 2 focuses on the clinical and restorative aspects of DIO Implants in more depth and is therefore applicable to both new and existing implantologists alike.

Once the introductory course is complete, practitioners can confidently decide whether to sign up for the year-long modular course to expand their knowledge and become implantologists. Mr Forster states, “Dr Mohamed and I struck a chord – we both have the interests of UK dentists at heart. Sam has extensive expertise and relentless enthusiasm. Combine these qualities with a genuine desire to help individuals achieve at the highest level and you have the ingredients for success.”

Modular Course

The year-long modular course aims to provide dentists with everything they need to know to become knowledgeable and confident implantologists. The course includes ten in-depth modules, both theoretical and practical, covering:

- Osteointegration
- Biomaterial in relation to bone augmentation and membranes
- How to select suitable dental implant patients
- Treatment planning
- Radiographic techniques in implant dentistry
- Surgical techniques
- Surgical kit orientation
- Possible surgical complications
- Restorative techniques
- CT scanning and computer guided surgery
- Marketing and promoting your new service

Dentists are mentored throughout the course by Dr. Sam Mohamed and his team. Dr. Mohamed is a highly trained dental implant surgeon. Having trained with some of the world leaders in implant dentistry, including Dr. Hilt Tatum Jr., the former president of the American Academy of Implant Dentistry (AAID), and Prof. Manuel Chanaz, the Head of Oral and Maxillofacial Implantology Department at the University of Lille2, Dr Mohamed has been placing implants for over 15 years. He is a member of both the Association of Dental Implantologists (UK) and the AAID.

Dr. Mohamed said, “Practitioners will attend our course built once a month to perform implant surgery under close supervision. This will give them real, hands-on experience and will quickly build their confidence in their own skills.” To supplement the hands-on training, Dr Mohamed is providing distance-learning facilities via the Internet.

Once the course has been completed practitioners will be awarded a certificate and logbook showing the number of patients they have treated and the individual details of each case. Most importantly though, dentists completing the course will have all of the skills they need to effectively place implants and treat most patient cases. However, the professional support doesn’t stop there. Successful implantologists are supported by Dr Mohamed’s “Continuing in Excellence” mentor program.

Marketing Assistance

DIO is very much aware that it’s all very well for dentists to learn new skills and develop new products, but the effort is useless if their patients are not made aware of the services that are on offer. So, to help dentists promote their new techniques the company is providing advice and guidance on marketing techniques that dentists can employ to spread the word. These can include help with local PR, website design, brochure and leaflet design and production, Search Engine Optimisation, the use of social networking, etc.

For more information on DIO implants and their training programmes visit www.DIOUK.com or call 0845 123 5960.
University of Warwick welcomes ‘most influential’ academic

Edward Lynch has joined the University of Warwick as Head of Dental Education and Research for Warwick Dentistry.

Edward Lynch, voted by his peers as this year’s most influential person in UK Dentistry, has joined Warwick Medical School from Queen’s University, Belfast, where he was Professor of Restorative Dentistry and Gerontology for the past ten years.

During his career, Edward Lynch has been awarded 94 research grants totalling around £5 million and has more than 500 publications including chapters in books and refereed abstracts.

He is a specialist in three disciplines: Endodontics, Prosthodontics and Restorative Dentistry, as well as being a BUPA consultant in Oral Surgery. Edward is a Consultant to the American Dental Association, a spokesperson for the British Dental Association, and a scientific board member of the International Health Care Foundation.

Edward Lynch is also the Chairman of the European Experts group on Tooth Whitening and he is actively seeking to change EU legislation to legalise Home Bleaching. He has presented to the EU parliament two occasions on tooth whitening.

Edward Lynch said: “I am delighted to join the excellent team at Warwick Dentistry as the Head of Dental Education and Research. Warwick Dentistry aims to be a world-leading postgraduate unit, internationally renowned for the high quality and relevance of its education programmes and for the excellence and significance of its research. The University of Warwick is already one of the top 10 universities in the UK and I am very proud to be joining their team.”

Prof Jeremy Dale, Head of Warwick Dentistry at Warwick Medical School said he was delighted that Dr Lynch had accepted the position.

He said: “Warwick Dentistry is building a team of world-class academics to become a centre of excellence in dental education and research. Edward Lynch has an outstanding international reputation, and we are delighted and honoured that he has chosen to move to Warwick.”

In Safe Hands

A n essential part of Dental Protection’s mutual ethos is reflected in the work done with members, through education, to prevent avoidable harm to patients. This concept provides the rationale for Dental Protection’s Annual Review for 2010 which is called ‘In Safe Hands’.

Over the next few weeks, 60,000 copies of the publication will be distributed to members in 70 countries and territories worldwide. Dental Protection has used its wide international experience to create a volume of stimulating articles contributed by some of the most popular dental writers in the UK. Alongside the case studies drawn from real-life episodes there are practical tools that can be adopted by dentists and dental care professionals everywhere to improve all aspects of the care and treatment that they provide.

Dental Protection is very much in the ‘safety and security’ business and has been for almost 120 years. ‘In Safe Hands’ now joins the growing library of risk management content that is available to members in a variety of media formats. As an additional benefit, readers of ‘In Safe Hands’ can also obtain three hours verifiable CPD online at www.dentalprotection.org.

Kevin Lewis, Director of Dental Protection said, “No health professional gets out of bed in the morning with the intention of harming a patient under their care. But sometimes the unthinkable happens, whether through an act or omission on the part of the clinical team, and despite their best efforts. If and when that situation arises, Dental Protection is there to help and support the member(s) involved, keeping them safe and providing security, so that they can continue their professional career without financial loss or undue damage from the stress associated with a legal challenge.”

BACD Belfast Study Club

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BACD Belfast Study Club

The British Academy of Cosmetic Dentistry (BACD) is holding a Belfast Study Club in June.

Dr Ian Buckle will be present- ing a lecture on ‘3D Treatment Planning: 10 Steps to Predictable Aesthetics and Function’ giving attendees a structured method for effective diagnosis and treatment planning.

While photographs and radiographs provide information to visualise the position of the teeth in two dimensions, determining how the teeth fit in relation to each other and the patient’s face is a challenge for the practitioner.

With 20 years of experience, Dr Buckle will be showing mem- bers how to successfully realise optimal dentistry from an aesthetic, functional, biological and structural perspective.

Special emphasis will be pla-ced on the four options of treat- ment (reshaping, repositioning, restoring and surgical correction), so that the correct options are chosen for each patient.

The event will be held on Thursday 17 June.

The lecture will also demon- strate how to segment large treatment plans to help patients with financial problems. For more information or a bo- oking form, please contact Suzy Rowlands on 020 8241 8526 or email suzy@bacd.com.

GDC announces new Chief Executive and Registrar

E ylvonne Gilvarry has been named as the new Chief Executive and Registrar of the General Dental Council (GDC). She will take up the position later in the year.

Alison Lockyer, Chair of the Council of the GDC said: “I’m delighted that Eyvonne will be joining us. I know that she shares my vision of making the General Dental Council best in class as a healthcare regulator. We will be working closely together as we develop the strategy for the council and improve our performance in Fitness to Practise.”

Eyvonne Gilvarry will join the GDC from the General Osteopathic Council (GOsC), the statutory regulator of osteopathy in the UK, where she is currently Chief Executive and Registrar. She has held this post since November 2007. Previously she worked in various senior policy and management roles at the Law Socie- ty, the regulator and professional body for solicitors in England and Wales. She is qualified as a lawyer and mediator.

Eyvonne Gilvarry said: “I am very pleased to take up this ap-pointment and look forward to working with the staff and the Council of the GDC to deliver an excellent performance.”

Interim Chief Executive and Registrar Alison White will complete her contract at the end of June.

Alison Lockyer said: “Alison has led the organisation through a complex and difficult re-budgeting process, and built the framework which will underpin future planned improvements in our regulatory processes. I would like to thank her for her commitment and hard work.”
Cardiff student wins Grand Ideas Award

A young entrepreneur based in Cardiff has scooped a national award after setting up his own company selling loupes to fellow dentistry students in an aim to improve their physical wellbeing.

Around 70 per cent of dental students report chronic musculoskeletal pain by their third year of training, but are unable to buy magnification loupes—a magnification tool that helps dentists improve their posture and decrease their operating time—due to their extortionate price tag. UKloupes was set up to counteract this and enable students to buy high quality loupes at a fraction of their retail price.

Dave Stone aged 27, impressed the panel of judges in the Shell LiveWIRE Grand Ideas Awards with his business idea and has been awarded £1,000 to develop UKloupes.

As a final year dental student, Dave was determined for loupes to be made available to all oral healthcare students. Concerned about the high prices of loupes on the market, he looked into selling the device directly to his peers and found by cutting out the middle man, he could sell them at a more affordable price. UKloupes was originally set up and run by students, for students but now also sells loupes to postgraduate trainees, SHOs and surgical practitioners.

The Shell LiveWIRE Grand Idea Awards, launched in 2009 against the backdrop of the recession, are designed to give aspiring entrepreneurs a no-strings-attached financial boost of £1,000 to help them get their business ideas off the ground. The awards are held monthly and entrepreneurs from all over the UK can submit their entries through the LiveWIRE website.

Dave Stone, founder of UKloupes, comments: “In such a tough economic climate, it’s easy to be disheartened about setting up on your own, but for all the young entrepreneurs out there, I urge you to give it a go. Initiatives, like Shell LiveWIRE, are often key to turning your business ideas into a reality. The financial boost of winning a Grand Ideas Award has been a huge help and will allow me to attend many important trade fairs, but in the long run, it’s the credibility of winning an award like this that really makes a difference.”

Dave hopes to expand his business and help other dental students by training a representative at every dental school in the country to teach other students about the benefits of loupes and UKloupes products.

James Smith, Chairman of Shell UK, said: “There is a wealth of entrepreneurial talent in the UK and I hope other young entrepreneurs will be inspired by Dave to capitalise on their own ideas. We wish UKloupes every success and hope the Shell LiveWIRE Grand Ideas Award will help Dave to take the business all the way.”

To find out more enter the Shell LiveWIRE Grand Ideas Awards visit www.shell-livewire.com
The Shirley Glasstone Hughes (SGH) Trust Fund recently announced that a £200,000 research budget has been made available to fund research into primary dental care. The SGH Trust Fund invites applications from research teams that include practitioners currently working in a primary care setting to conduct research in answer to the following question: Do people living in deprived areas define oral health differently from people who live in less deprived areas, and what influences their oral health-related behaviours?

Commenting on the topic, Peter Ward, Trustee of the SGH Trust Fund said: “Much-needed evidence centres around the attitudes of people from different socio-economic groups towards oral health. No substantive evidence currently exists and the Trust is now looking to commission primary research in this important area.”

The closing date for applications is 31 July 2010. The topic for research was selected by dentists and dental care practitioners who were offered an opportunity to vote for their preferred area of research via the Trust’s website, the Primary Care Dentistry Research Forum. Meanwhile, voting on the website is ongoing to select questions for consideration for the next call for funding applications.

In 1990, Shirley Glasstone Hughes, a dentist, researcher and BDA member, left her legacy to a charitable trust. This trust was established as The British Dental Association Shirley Glasstone Hughes Memorial Prize for Dental Research.

For further information, please contact Beth Caines at b.caines@bda.org, by phone at 029-20 436 184, or log-on to www.dentistryresearch.org.

£200,000 offered for research into primary care concerns

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Free tax advice

Dentists, who are members of the Dental Defence Union, can now get free expert advice on tax and VAT.

The Dental Defence Union has joined forces with Taxwise, one of the UK’s leading providers of advice on tax and VAT, to give members the opportunity to consult a team of professionals. The Taxwise telephone helpline is available in office hours until 30 June 2010, when the deadline to declare undisclosed tax liabilities, under the HMRC’s tax Health Plan, expires.

Rupert Hoppenbrouwers, head of the DDU, said: “We know that HMRC is now carrying out targeted investigations aimed at medical and dental professionals who they believe have not made a full declaration. “We anticipate that this will be a concern for dentists, even if they have nothing to declare, and they may need to seek advice on how to respond to an approach from an HMRC inspector. At the same time, those who have already notified HMRC that they plan to make a declaration may need advice about how to do this.”

DDU members who wish to use the service should call Taxwise on 01445 852 789 and quote the reference TXDDU1, as well as their DDU membership number.
Developed by a Japanese chemist in 1919, and was used during World War II to help soldiers stay alert. After the war, a massive supply of meth formerly used by the Japanese military, became available, which skyrocketed addiction. Meth causes severe tooth decay in a very short time and it has been noted that users lose their teeth abnormally fast due to a combination of side effects.

Indeed the term ‘meth mouth’ has been used to describe the extensive damage typically caused by this drug. It is reported to attack the immune system, so users are often more prone to infections such as A.U.G. It is also highly acidic and causes erosion. Other side effects include dry mouth, bruxism and jaw clenching.

Ecstasy. Also called ‘E’, the love drug and drug bivers. Ravers and anti-drug activists have long debated whether ecstasy causes brain damage, but both ignored a more serious and immediate problem few can deny – damaged teeth. This is as a result of the jaw clenching and tooth grinding that usually accompanies partaking of this club drug. Ecstasy users often carry a dummy and if one isn’t handy a lollipop will suffice, although recently orthodontic retainers have replaced these as the ‘en-vogue’ look at clubs. Such mouthwear is not only fashionable, it also helps ease the discomfort caused by bruxism. Research has shown that friction involved in bruxism combined with an abrasive dry mouth leads to extreme tooth wear which is often worsened by the consumption of carbonated acidic beverages needed to cool off ecstasy users raised temperatures. It goes without saying that users who experience nausea and vomiting after taking E are also more prone to erosion.

Others to consider

This list is by no means exhaustive; indeed there are many new substances on the pharmacutical block including ketamine and GHD. Also, the scale of poly-drug use is escalating; 15 years ago users would have made do with one ecstasy tablet, these days they’re taking a whole cocktail of drugs without being aware of their impact.

Any drug dependence or drug use that causes the person to neglect their personal hygiene, diet and dental care can significantly increase the risk of dental (and many other problems). Forget the image of the dropout on the park bench though – most people who use drugs are ordinary people who lead perfectly normal lives. This was highlighted by a paper published in the British Dental Journal last month relating to drug use among dental undergraduates and vocational trainees. Not only that, but a recent study indicates that, thousands of apparently successful, healthy and affluent people in their 20s, 30s and 40s choose to be heavy recreational drug users at the weekend. Indeed, in many areas, the main clubbing night has moved from Saturday to Friday to allow people to recover in time for work or lectures on a Monday morning.

Looking for signs

As dental professionals we have a major role to play in helping patients with their addictive behaviour and we need to look out for any signs and symptoms present in their mouths. Questions regarding drug use must be handled in a sensitive, non-judgemental and confidential manner. If drugs are causing problems, it may be necessary to discuss adjusting the method of delivery.

Prevention is certainly better than cure especially as restorative dental treatment can be expensive and time consuming. If patients are open about drug use, we can help them to manage the situation. Professional treatment depends on the particular drug and its effect on the teeth and gums but may include:

• Referral to an appropriate cessation service
• Application of topical fluoride and use of fluoride mouthwashes to reduce sensitivity and prevent decay
• Recommending products aimed at limiting the damage caused by erosion, such as Pronamel toothpaste and mouthwash
• Diet advice, for example, sugar-free lollies and diet drinks (preferably non-carbonated) for ecstasy users
• Wearing a night guard to ease the symptoms of bruxism.

It seems that we need to become more competent at diagnosing and managing drug-related problems because it’s possible that for many of our patients, gone are the days of getting high naturally.

About the author

Alison Lowe is a dental hygienist based at Cardiff and The Orthodontic Centre, a private practice specialising in implants, orthodontics and cosmetic surgery. She has won several awards including Hygienist of the Year 2009 and is a columnist for the Dentists Mail- She thoroughly enjoys what she does and is delighted to be contributing to Dental Tribune.

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The Lava Chairside Oral Scanner (C.O.S) at work

Dr James Hooper from The Dental Practice in Hove sets out to highlight the advantages of using the Lava C.O.S through a new series of detailed clinical case studies

At the end of last year, I welcomed the new Lava Chairside Oral Scanner (C.O.S) from 3M ESPE into my practice. The scanner handles like an overgrown intra oral camera and offers brand new video capture technology that creates a 3D image simultaneously live on screen as you scan the patient's teeth.

I have a somewhat old fashioned arrangement, by having a dental laboratory within my practice. As a result, I decided to install the Lava Scan ST scanner and software in the laboratory to back up the clinical Lava C.O.S scanner. Together with my technician, Frank Warburton, we had a very intense week of training to come to grips with all the new features that CAD/CAM can bring to dentistry. I have made a considerable leap forward in the complete digital workflow envisaged by 3M ESPE.

I hope to share with you my journey into this brave new world of advanced technology, and highlight the considerable advantages that I see digital dentistry bringing to my workplace, and of course the benefits to my patients.

One of my first cases is a gentleman who was just coming to the end of a complete rehabilitation having presented in his early forties with a considerable amount of wear. Conventional impressions using 3M ESPE's Impregum polyether material had been used for his restorations but two final upper restorations were required on the first premolar and this seemed a suitable beginning for my intra oral scanning.

Following processing, the electronic image is transmitted back to my laboratory for margin marking and selection of the model holder using the Lava C.O.S laboratory software. On completion, the files are transmitted to a model-making facility where a SLA (Stereolithography) model is produced. This process in my opinion is very high tech and results in a high quality resin model, which is then shipped back to me in just three days.

The flexibility of this system now allows me to choose whichever type of restoration is appropriate. For the upper right premolar, a Lava zirconia core was ordered and a pressable core.

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www.e-teeth.co.uk
Dr James Hooper owns The Dental Practice in Hove. He graduated from Guy's Hospital in 1981 and worked in a large practice for four years, before opening his practice in 1985.

Dr Hooper achieved the Member of the Faculty of General Dental Practitioners in 1990. In 1994 he commenced training for using dental implants, which is now an important part of the practice. He has been working with the Lava C.O.S since the beginning of this year.

Looking at the upper left premolar this was lightly prepared for a porcelain veneer. The scanned image on the Lava C.O.S monitor shows high-quality resin model (this picture and below). Could this be made with conventional impressions? Of course, but the digital image is free of any distortion and the resin model is cleaner and more resilient than a conventional die stone.

In my next article I shall show how incredibly accurate the occlusal record can be. This just knocks spots off any other digital image taking system and puts 3M ESPE firmly at the forefront of this exciting new technology. For more information, visit www.3mespe.co.uk.

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Upper right premolar – Lava Zirconia Core
Implementing Invisalign

Many practitioners are not aware of the wide range of cases the Invisalign system can treat, insists Dr Benjamin Schwartz, who offers some examples of its flexibility.

The objective of this article is to show how Invisalign treatment can easily be implemented into any existing dental office. Being able to recognise which patients are potential candidates will be the first step in achieving a successful outcome. After reading this article, you should be familiar with the Invisalign criteria and be ready to implement this versatile treatment adjunctive into your practice.

Do you have any patients whose teeth look similar to those? These cases are typical of patients that frequently come into a dental office. Many patients do have some sort of misalignment, overlapping, or spacing present in their teeth. The objective of this article is to demonstrate how these types of cases (and many others), can be readily treated using the Invisalign system.

Align Technology manufactures Invisalign; a custom-made series of clear aligners used to orthodontically rotate, move, and align teeth. The Invisalign process is straightforward, and allows the practitioner to have full control over the course of treatment.

Invisalign is indicated for patients with up to five millimeters of crowding and/or spacing per dental arch. Rotations can be corrected within a range from five to forty degrees. Approximately between two to four millimeters of overjet or overbite can be relieved using Invisalign.

Once a suitable candidate has been selected, and no caries or periodontal issues are noted, detailed polyvinylsiloxane (PVS) impressions are to be taken for both arches. In addition, a bite registration is taken along with a series of extra-oral and intra-oral photographs. The photographic requirements are a full face photo, smile shot, profile, anterior teeth, right lateral, left lateral, maxillary and mandibular arches. These are then sent to Invisalign for the patient’s customized ClinCheck to be created.

ClinCheck (Fig. 2) is a 3D virtual movie of the teeth based upon the impressions sent to Invisalign. Treatment progression can be played out to mimic the natural movements of the teeth. This allows the practitioner to visualise the final phase of treatment, and make any adjustments as needed. Once the layout has been designed and approved, aligners are made in sequence based upon the projected ClinCheck models.

In certain cases, interproximal reduction (IPR) may be necessary. IPR allows the practitioner to create room in an otherwise constricted area, so that there is adequate space for the necessary tooth rotations or repositioning. IPR is achieved with the use of diamond strips and/or rotary disks, and is prepared before the actual tooth movements occur.

The patient wears each set of aligners for a two-week period. Aligners are worn full time, except when eating, drinking, and performing oral hygiene. During this phase, the patient is typically seen every month to monitor treatment progression and to make any additional adjustments as needed.
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- **TAKE A LOOK AT THE ITEMS SHOWN IN FIGS. A & B:**
  - Clinical appearances that can be treated using the Invisalign system.
  - FigA & B: ClinCheck representation showing spaces closed.
  - Case 1: This 35-year-old male patient presented to our office seeking to correct his minor crowding (Fig. 3).
  - His chief complaint was that his teeth were overlapping, causing food to become impacted. In addition, he was concerned with the aesthetic appearance of his smile.
  - This patient was familiar with the Invisalign brand name, and specifically asked if he would be a candidate for this treatment modality.
  - A complete dental and medical work up was performed. No carious lesions were noted, and his periodontal health was in order. Alternative treatment options were given, along with the risks and benefits of each choice. After a thorough discussion, the patient decided to proceed with Invisalign.

- **Detailed PVS impressions were taken (Genie Heavy and light Body, Sultan Healthcare) along with a bite registration (Genie Bite, Sultan Healthcare) and all necessary photographs using a digital camera (Canon Rebel XT).**

- **The ClinCheck was developed and can be seen in Fig. 5. The maxillary arch exhibits 4mm of overlapping, with the left lateral incisor being positioned slightly palatally. The left central incisor partially covers the lateral incisor, with the left canine protruding buccally. The mandibular arch has approximately 5mm of crowding present, the right lateral incisor is being pushed lingually and slight crowding is present in the rest of the anterior region.**

- **Treatment objectives were to rotate the canines and anterior teeth, creating more space for the lateral incisors to properly come into the arch. Once aligned, the anterior teeth would return back into position, allowing for a uniform, symmetrical arch form.**

- **The patient’s treatment lasted approximately nine months, and required minimal IPR on both the maxillary and mandibular arches.** At the end of treatment all teeth were aligned properly, with no overlapping present between them (Fig. 5). Notice how the ClinCheck matches exactly with the actual end of case photos (Fig. 6). Retainers were fabricated and instructions were given to the patient how to properly maintain his new smile.

- **This patient was glad to finally have this minor issue resolved after so many years. He never wanted to have his teeth treated, and actually wished to close the spaces present in both arches. (Fig. 5)**

- **Along with the Invisalign treatment option, the patient elected to continue with Invisalign treatment.**

- **PVS impressions, a bite registration, and photos were taken. The ClinCheck setup was constructed, and can be viewed in Figure 8. The maxillary arch exhibits 2mm of spacing present, most noticeably between the two central incisors. The mandibular arch has 3mm of spacing, and slight misalignment of the central incisors.**

- **The goal of treatment was to rotate the anterior teeth slightly, while rotating the canines to help close all diastemas. In addition, the teeth would be aligned properly with even contact points present between them.**

- **Since this case required only minor movements to achieve its desired goal, it qualified as an Invisalign Express case. An Express case is one where approximately 2mm of spacing or crowding is present, and less than twenty degrees of rotation is necessary (Fig. 9). Only ten aligners are fabricated for an Express case, and treatment time is six months or less.**

- **The advantage of this over a full Invisalign case is that the cost to the practitioner is significantly reduced.**

- **The treatment time for this patient was six months. At the end of the course of treatment, all diastemas were resolved, and the teeth were in proper alignment (Fig. 10). Again, take note how the ClinCheck and end of treatment photographs are identical (Fig. 11).**

- **Using just Invisalign, we were able to correct this patient’s concerns, allowing her to enjoy her new smile. Once treatment was finished, she was thrilled with her new smile and has become a spokesperson for our practice, and for Invisalign.**

- **Invisalign is a resourceful treatment tool that will help boost patient satisfaction and lead for a bright future for your practice.**

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**About the author**

Dr Schwartz graduated from Touro College with a Bachelor of Arts degree in Biology. He received his Doctor of Dental Surgery degree from New York University College of Dentistry. Dr Schwartz practices general and cosmetic dentistry in Midtown Manhattan. He is a member of the American Dental Association, the Academy of General Dentistry and the New York State Dental Society. He currently resides on Long Island with his wife and family. He is an avid magician and enjoys bike riding.

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**Fig5a: Fig5b:** Invisalign treatment photographs showing spaces present in the anterior region. Fig6a & b: ClinCheck model showing spaces present in the anterior. Fig7a & b: Patient with diastemas in anterior segments. Fig8a & b: ClinCheck representation showing spaces closed. Fig9a & b: Intraoral photographs show diastemas are resolved. Fig10a & b: ClinCheck showing all spaces closed. Fig11a & b: Patient with minor crowding present in both arches. Fig�a & b: ClinCheck representation showing spaces present in the anterior. Fig12a & b: Intraoral photographs show diastemas are resolved. Fig13a & b: ClinCheck showing all spaces closed.
Digital impression-taking technology is set to see double digit growth rates as laboratory technicians and dentists adopt this highly flexible, quick, and accurate solution to manufacturing and fitting dental restorations.

According to DentalProductsReport.com, the US market for digital impression-taking systems is estimated to reach $83.5 million by 2015, with the UK braced to follow suit.

In 2008, the US market for digital impression-taking systems increased by 73 per cent over 2007, following new technology as well as continued investment by laboratory technicians and dentists.

Commenting on the report, Julian Dorey, laboratory technician at the Kingsbridge dental laboratory, who uses the Lava chairside oral scanner (C.O.S) laboratory software from 3M ESPE said: ‘The Lava C.O.S is the only software that comes through to the laboratory and takes both the impression and makes a model - it’s definitely the way forward.’

He continued: ‘It has increased accuracy and the fit is considerably better now, and it certainly has the potential to improve the working relationship between dentists and laboratory technicians.’

The primary advantages of using a digital impression system over traditional processes is the elimination of many manual steps involved in creating a restoration.

The technology produces a more accurate restoration because the three-dimensional image is produced instantly, allowing the dentist to make any adjustments necessary to the prep site in real time.

Digital impression-taking technology offers many procedural enhancements for manufacturing and fitting dental restorations.

The Lava C.O.S is able to take an accurate digital impression of the teeth, instantly uploading the image and allowing the dentist to make any corrections or changes to the patient’s prepared dentition.

The benefits for the laboratory are impressive. For example, with the Lava C.O.S, there is an uninterrupted ‘digital workflow process’ meaning time-consuming steps such as plaster pouring, base and pin, die cutting, trimming, articulation and scanning are eliminated.

This process also eliminates the risk associated with a traditional physical impression changing size or shape during transportation, which can lead to an inaccurate final restoration.

According to a US market report for Dental Prosthetic Devices 2009, clinical studies have shown restoration remakes have been reduced from an average of five per cent using traditional methods, to less than 1 per cent with digital impression-taking systems. Following a typical life cycle of an emerging market, digital impression-taking systems are still in their embryonic stage, where the market is still developing.

According to the report, early clinical studies are encouraging as they have shown high levels of success, and are paving the way for more practitioners to adopt the technology.

More than 25,000 cases have now been produced with the Lava C.O.S, for further information on this device and the 3M ESPE digital workflow process, please visit www.3mespe.co.uk/lavacos or call 0845 602 5094.

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Embracing change

It’s all too easy to stick to what you know when it comes to the treatments you offer and technology you use, but to meet patient demand, you have to keep up with new trends. Neil Photay and David Hands of Costech explain

The field of dental technology is constantly evolving, and while the market for cosmetic dentistry continues to grow, science continues to respond – producing products designed to meet customer demands.

With this in mind, it is important that all practitioners ensure they keep up with the latest treatment options, and are able to offer patients the most-up-to-date products and procedures. Most professionals are open to trying new things, but it can be scary putting your faith, and finances, into an unknown. Nevertheless, there are laboratories that work hard to ensure the products they offer provide the best in aesthetics and durability. With this along with several education programmes designed to explain and demystify, there is very little for the dentist to fear.

Stuck in a rut?

It is very simple to get stuck in a routine. Many practitioners understand that whilst their favoured lab may provide the most up-to-date products possible, the older products have always done the job just fine, and argue that this is a perfect case of, ‘if it ain’t broke, don’t fix it’.

In 700 BC, it was common practice when repairing or replacing missing or broken teeth to simply remove the tooth, and replace it with a ‘substitute’ tooth, commonly taken from another human or even an animal. The substitutes were fastened to the existing teeth with gold bands and wires, and evidently filled the gap nicely. The procedure obviously worked, however it is hard to imagine that a modern patient would be very happy with this form of treatment now!

With this in mind, it is important to remember that just because something works, doesn’t mean it cannot be developed
in order to help it to work better. It may be consoling to know exactly what to expect, but staying too long in your comfort zone can have detrimental effects on both patient, and you in dental science mean that we have been able to move on from the stage of just pulling out teeth and fitting an animal denture in their place, but this is only possible due to the willingness of the practitioner and the patient to put their faith in the technicians and explore new treatment techniques.

**Suggesting new treatment**

It is understandable to be concerned about the reaction from patients when you suggest a radical new treatment option. It is likely that your patient may have carried out some prior research into various options, maybe even spoken to someone who has had similar treatment, and has an idea of what to expect. However, patients are primarily led by two aspects when considering treatment: the advice of their dentist, and the cost involved. Patients inherently trust their dentist’s advice, and if you are able to suggest a treatment plan that offers them aesthetic appeal, durability and simplicity, the reaction is likely to be a positive one.

**Securing best results**

It is undeniable that some of the newer technologies may be slightly more expensive than the more out-dated options. However, many patients are willing to spend that little bit extra to secure the very best end result. In terms of cost-effectiveness, a treatment plan that offers added durability and minimal after-care is usually a better option than the more traditional options, which can be prone to breakages, discoloration, and may not offer the very best biocompatibility.

To make the most of the advances in dental science, you cannot be shy when it comes to embracing change.
No clasps, please!

Ulrich Heker discusses techniques in precision dental prosthetics with highly engineered connections

Precision connecting elements including telescopic crowns and attachments are favoured solutions in many European countries, where patients are increasingly conscious of their aesthetic potential, practicality and cost effectiveness. The methods are within the reach of UK dental practitioners with recourse to quality dental technicians. This article gives an illustrated overview of the fundamental principles of these techniques.

No clasps please! “Please do not force me to have those ugly clasps with my new teeth!” you, as a practitioner, will all too often have heard patients exclaim. After all, who wants ancient teeth smiling from between young lips since it’s commonly suggested that ‘a smile is the mirror of the soul’?

Armed with Ayurveda, aromatherapy and Botox, today’s patient puts an increasing value on their health and a cultivated appearance in the pursuit of beauty. This of course includes dental treatment and consequently, interest in unobtrusive and invisible dental replacements without clasps is continuously rising.

In Germany, this need is met using precision connecting elements and a combination of permanent and removable replacements. These combination prosthetics provide a very comfortable and aesthetic solution, particularly where the remaining natural teeth still provide a stable foundation.

Combined dental replacement is generally applied when a completely fixed replacement is not feasible any more. This can also be in part for cost reasons, when a pure bridge construction becomes too expensive.

Precision connecting elements

In order to obtain a secure fit of the prosthesis, several or all of the remaining natural teeth are cored with a permanent crown. Precision connecting elements are then incorporated as part of, or attached to, the crown using an attachment that can be interlocking or press-fit anchors. Alternatively, the whole crowned tooth acts as a stable attachment - as with all double crown work. The prosthesis is firmly linked to the rest of the natural teeth via the attachment; however, it can be removed by the patient for the usual cleaning regime.

The methods mentioned here are not particularly ‘cool’, new applications; rather they have their origin in America in the 20th century. The anchoring of partial or hybrid prostheses with individually manufactured double crowns was first described by Peeso (1916) and Goslee (1925). Precision connecting elements come in a variety of forms, of which two will be considered here: a) treatments using double crowns and b) treatments using attachments.
opposing surfaces (often the distal and mesial dental surface) are made parallel to one another. This needs to be considered during preparation.

Using the resilience telescope is a frequently used solution, where there are only a few (one to three) existing teeth. Here, there is a 0.3mm to 0.5mm space between the primary and secondary crown on the occlusal face of the telescope. This means that the prosthesis rests on the mucosa – when it is not under pressure. The “resilience gap” is only removed with pressure of chewing and there is a particularly gentle load or strain on the remaining natural teeth. This form of telescope is the foundation for the so called “cover denture” prosthesis. Externally, it is indistinguishable from a full prosthesis.

The secondary crown is worked into the prosthesis (soldered, glued or embedded with retention within the synthetic matrix of the prosthesis). Only after the final fitting is the primary crown cemented firmly onto the prepared tooth stump. Telescopes are, next to attachments, seen as standard in Germany, Switzerland and Scandinavia for the treatment of larger dental gaps using a removable prosthesis. The construction of telescopic prosthetics requires a high standard of preparation and processing by the dentist and their dental laboratory.

Working with attachments
Like telescopes, attachments are invisible, firm anchoring, which can be released by the patient themselves. The male attachment elements (in this instance: Precivertix extracoronal) are attached to the crown blocks or bridges, while the relevant complementary element is attached to the removable dentures.

Attachments are prefabricated (off-the-shelf attachments) and are then joined to the bespoke denture in the lab (creating bespoke attachments). Attachments are also classified according to their fitting; either fitting into the anchor tooth (intracoronal attachments) or those with fittings external to the tooth (extracoronal attachments).

An attachment always comprises two parts; the receptive (or the female) part, and the insertion (or male) part. Which part sits on the crown and which on the removable denture depends on the manufacturer and the practitioner’s judgement on a given situation. Particularly popular versions are Precivertix and Rod Attachments and similar forms.

You can distinguish attachments according to the attachment mechanism: a) friction attachments (female and male components are joined by their precise fit – similar to telescopic attachments). b) Retentive attachments (the hold is achieved by using elastic elements which rest in grooves or indentations). c) The attachment can also be fitted with a bolt for optimal fastening.

‘The methods mentioned here are not particularly ‘cool’, new applications; rather they have their origin in America in the 20th century. The anchoring of partial or hybrid prostheses with individually manufactured double crowns was first described by Peeso (1916) and Goslee (1923)’
Getting started

Taking on combination methods into your own treatment palette is certainly possible without attending dozens of seminars and reading numerous textbooks that are in any case frequently unavailable in English.

Viewed objectively, an attachment project is nothing more than a larger bridge for the practitioner or a pair of integral crowns to which something is added in the lab. The parallel features are created, so to speak, by the technician.

With telescope work, this is perhaps a bit more challenging. Here you need to follow a particular workflow in order to prepare the relevant teeth, so that they can be considered as a “anchor group” and display the optimal parallelism. This leads to slender inner telescopes and thus to an unobtrusive total view with the completed work.

The most frequently prepared telescopic prosthesis is in the lower jaw with two telescopes on the still existing canines; this is effectively the “entry level” model. The collaboration between the dentist and the dental technician really comes into play here. Taking all things together and with good planning in place, this not a difficult process at all.

Conclusion

Combined dental replacement is the best method to meet the demands of the patient and practitioner without compromise. Combined dental replacement without clasps offers a high comfort for the wearer, more confidence and a very appealing aesthetic. Which combined dental replacement and which connecting elements form the best solution is determined by the professional with each individual patient.

The methods and techniques shown here do not represent a stand alone solution for partial dental replacement. Far from it! Combination methods can really come into their own when used together with implants. They give the practitioner the opportunity to find optimal solutions for the patient, who might otherwise only be treated with difficulty or not at all.

About the author

Ulrich Heker is the owner-manager of Ulrich Heker Dental Laboratory, founded in 1996 with the strapline "TEETH 'R' US". As a qualified master craftsman (German Master Dental Technician) since 1991, he has over 26 years’ experience both at the bench and in running a successful business. Ulrich lives in Mülheim on the river Ruhr and is an accomplished western-style rider in his spare time. Ulrich is fluent in English and can readily be contacted by calling +49 201 797 855, visiting www.german-smile.info, or emailing Ulrich@Teethrus.de.

References

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A tax bonanza

This month, Geoff Long looks at the tax breaks open to dentists starting their own practice

With ever increasing tax rates squeezing dentists all the time, one way to spectacularly slash your income tax bill is to start your own practice. There are many more tax breaks open to practice owners compared associates. The reason being that ever since the Magna Carta written in 1215, the rich in this country have made the tax laws. So what exactly are the tax breaks open to dentists?

Goodwill issues

Any young dentist buying a three or four-chair practice at the moment is going to pay a king’s ransom for the goodwill. Wouldn’t it be nice if the taxman could be persuaded to help out a little? Well actually, he can. Goodwill is tax-deductible if you are a limited company. This means the Government subsidy of as much as 28 per cent is made via the tax system. Given the colossal prices being commanded by goodwill at the moment, this is not to be sneezed at.

Goodwill and equipment

The purchase price will need to be apportioned between goodwill and equipment. Equipment can attract a 100 per cent tax deduction at the moment so a useful tax planning point arises here.

Annual investment allowance

Often a new practice needs some refurbishment or re-equipment. The first £50,000 of expenditure in any one tax year is 100 per cent allowable. Yes, it is all written-off your tax immediately. Any balance of expenditure is written-off at 20 per cent or 40 per cent, depending on the year. So it makes sense to phase your practice refurbishment over a number of years.

Incorporation

Incorporation is a big step for any dentist, and one that is often difficult to reverse. Depending on your earnings level and family circumstances incorporation can give you some, albeit modest, tax savings. Consideration will need to be given to your loss of flexibility when you incorporate, likely future tax hikes from the Government, and inherent difficulties in selling an incorporated practice.

Freehold purchase from a SIPP

If you are buying the freehold of your practice, a tax-efficient way of structuring the deal is via your SIPP pension fund. This means future growth in freehold value is free of capital gains tax and practice profits are slashed by SIPP rental changes. Ultimately, the SIPP can be used to fund your retirement, including a 25 per cent tax-free lump sum on retirement.

Tax refund – offset losses on a squat

By carefully timing refurbishment costs of a new squat practice, you can often engineer a start-up loss for your first accounting period. Generous tax rules allow you to set this loss against any other earnings for the current year, or indeed any of the previous three tax years. This can provide a valuable tax shelter for your associate earnings or generate a tax refund.

About the author

Geoffrey Long FCA is a specialist dental accountant based in Hertfordshire. Geoff advises on a wide range of dental tax issues and regularly writes for the dental press. Geoff has more than 15 years experience with dentists’ accounts and is recognized for his proactive approach to dental taxation and business problems. He can be contacted on 01438 722224 or by emailing office@gdmcax.f.sc.
Are you getting the right advice?

Jon Drysdale explains how dentists can benefit from fee-based financial planning

From 2012, new rules from the Financial Services Authority (FSA) mean financial advisers will be required to provide their clients with clearer guidelines on the cost of their advice and how charges affect pension and investment products. The FSA will implement a wide range of changes intended to remove ‘commission bias’ to ensure recommendations are not influenced by product providers and to raise the bar on adviser qualifications.

Independent financial advice is available from firms who offer fee-based advice comparing financial products from the entire financial market. Firms who offer products from a limited range of products without fee-based options, can’t call themselves independent.

A preferred route

The distinction between different types of financial adviser already exists. Good-quality firms already promote fee-based advice and their experience is that fee-based planning is fast becoming the preferred route for dentists. While fee-based advice will have you to reaching for your chequebook, investment charges are usually reduced making this potentially cost-effective over the medium to long-term.

Our example compares fee-based and commission-based advice for a dentist making a pension contribution of £500 per month. The figures speak for themselves.

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35-year-old male, £625 gross contribution, growth of seven per cent pa, retirement at age 60.

If your adviser is not independent, they may not offer you this saving. They may also impose limitations on fund and pension provider choice, so the case for non-independent advice is difficult to understand. This is especially true for dentists who often make larger than average personal pension contributions while requiring specialist advice.

If you have received advice from a bank or building society, it is possible that your adviser was not independent, or perhaps experienced in advising dentists. This may deny you access to fee-based advice and specialist knowledge on areas such as the NHS Pension. Even some national firms which offer dental-specific financial advice, do not offer independent financial advice. If you are currently taking advice from one of these firms, make sure you ask hard questions of the adviser relating to investment charges, commission and their very limited product range.

Dentists should settle for nothing less than independent financial advice from a firm specialising in financial planning.

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Dentists should settle for nothing less than independent financial advice from a firm specialising in financial planning.

Fee vs commission based advice*

* 35-year-old male, £625 gross contribution, growth of seven per cent pa, retirement at age 60.
For most patients, the best implant is a natural tooth, so maintaining a patient’s natural teeth is one of the main benefits of endodontic treatment over implant surgery.

Endodontic success is currently defined in the terms of the retention of a symptom-free tooth, which should require no further immediate treatment. The typical success rate of an endodontic procedure now ranges from 65 per cent to 95 per cent, depending on whether the procedure is carried out on a previously treated tooth or a vital, non-infected tooth.

Implant success, however, is determined in terms of survival, a potentially misleading phrase – the mere presence of a tooth or implant should not be perceived as a triumph. After all, if a patient requires time-consuming and potentially uncomfortable post-surgery treatment, the initial procedure can hardly be deemed a success.

It was commonly believed that for patients who have chosen an implant over and above endodontic treatment, the completion of the surgery was the end of the story. However, implant specialists are now seeing examples of late failures, as well as patients suffering from problems with the implant’s prosthetic component.

Priority: patient care

It is difficult to determine which procedure is the most successful. As healthcare professionals, our priority must be the patient, and working towards providing the best patient care possible should be the main objective. Bearing this in mind, I am aware that the most favourable option for the patient is usually to have the quickest treatment, minimising the hours spent in the dentist’s chair. The time involved in placement of an implant, as well as the potential subsequent appointments increases the treatment time for the patient. Implants are not just “popped in”, but are instead a very complicated, time-consuming and expensive treatment modality.

Recent indications from periodontists reveal that non-surgical periodontal treatment, even if further endodontic treatment is required, is preferable to implants as it helps save the original tooth, without the need for invasive procedures.

We all endeavour to offer top-talent patient care, and for most patients, maintaining their own teeth is of the highest priority. However, we do have to be aware that there is not always the option to save the tooth, and in this situation there is an undeniable argument for the provision of implants. However, a full-case assessment needs to be undertaken before any treatment is planned, and I would recommend a comprehensive discussion of the merits of a bridge versus an implant is a good idea. Also, the patient must of course be made aware and understand the full treatment process, and give full consent.

Effective communication

Maintaining a good professional dialogue with referral practices is key to providing patients with optimum patient care and honest advice. Building and maintaining relationships with periodontal, restorative, orthodontic and endodontic specialists enables referring dentists to become involved in both the planning and treatment stages of a patients’ procedure.
Managing small businesses with BIG requirements is not easy

Seema Sharma reflects on the skills sets required

A ll NHS and private dentists have to register with The Care Quality Commission (CQC) in 2011, and will be expected to comply with 50 regulations which can be grouped into six sections:

1. Involvement and information
2. Personalised care, treatment and support
3. Safeguarding and safety
4. Suitability of staffing
5. Quality and management
6. Suitability of management.

This article explores how Dentaby can assist your practice achieve the key outcomes and performance indicators expected by the CQC for section six: Suitability of Management.

Suitability of Management

A recent study associated with In-vestigo People showed that management has an important role to play in delivering company performance in terms of the improvements in quality, service and customer satisfaction. The good news is that it also showed that sound management structures lead to higher levels of profitability.

The more a dental practice embraces a management structure, the better its performance will be. This is because a good practice leader:

- Allows managers greater freedom and discretion to perform
- Supports the development of a learning culture for team members
- Enhances the effectiveness of the management processes being implemented
- Creates an environment where there is more focus on performance
- Ensures employees better understand their goals and their contribution to the practice.

Unfortunately, dental practices are often not big enough to accommodate a leader and a manager, so the practice owner/practice manager needs to have characteristics of both to have the ideal set of strengths for building a winning team.

So who's going to do it?

And so the challenge begins – getting the whole team on the same bus is a manager's biggest headache. You're right, it's not easy!

There are four basic styles of interaction:

The Director - driven and focused; can be impatient
The Socialiser – Friendly; thrives on compliments
The Thinker – Analytical, enjoys problem solving
Relater – Approachable, warm, loyal.

Inherent styles never really change, so my tip is to start by selecting the right personality style as well as the appropriately qualified person for the job during recruitment. Relaters make great nurses, socialisers are good on reception and thinkers and directors have management and leadership skills respectively.

With an existing team, get the whole team to try out a personality test when you are all in a staff meeting, to help team members understand that they will all see things differently. It's a lot of fun and it breaks the ice!

The 80/20 rule

If all this sounds daunting, remember that:
- • 80 per cent of your practice successes come from 20 per cent of your efforts.
- • 80 per cent of your practice headaches come from 20 per cent of your patients or staff!

By concentrating on leadership and delegating 80 per cent of the day-to-day routine management of your practice, you can lead your practice to uncharted success!

Leadership – can we do it?

A leader provides strategic vision, engages, motivates, inspires and aligns the practice team with the owner's core vision. By defining the practice's vision and setting out aims and objectives clearly, he or she empowers the team to work together towards end goals... and then he does not actually have to be there all the time!

The worst thing a practice owner can do is try to be all things to all people – it's time to learn how to delegate. More than ever before, leadership skills are required in the new world of dental practice management - there are a lot of goals to be achieved for CQC, and the vision needs to be developed now to get the whole team doing their bit!

Leadership styles can be:
- • Dictatorial
- • Authoritative
- • Consultative
- • Participative

A good leader applies the right style to the right situation – there is no right or wrong style. Not sure what your style is? The good news is that management traits can be acquired with the right mentoring and coaching.

Management – yes we can!

A manager on the other hand implements the strategy outlined by the leader by building teams, setting up systems, organising workflow and solving problems.

A great practice manager will get to know the individual strengths and weaknesses of each team member then know how to harness their strengths and reduce the impact of their weaknesses with support, training and sometimes firm action.

Delegation (not abdication) is a key tool in a manager's armamentarium too. The manager's role is to translate vision into action by empowering individuals to take on roles and generate results, but to stay at a close enough distance to provide assistance or guidance when required.

Relevant CQC Regulations

The following regulations are relevant to this section:

Regulation 5: Fitness of service provider
- Do all your team members have the necessary qualifications, skills and experience to fulfill their roles?

Regulation 5: Fitness of registered manager
- Do your leader or organisation have the skills to supervise management of your service?

Regulation 6: Registered person: general requirements and training
- Can you demonstrate that each team member carries out the service with appropriate training, competence and skill?

Regulation 26: Notice of absence
- Can patients and the CQC be confident that if the person in charge of the service is absent it will continue to be properly managed and be able to meet their needs?

Regulation 27: Notice of Changes
- Can patients and the CQC be confident that if there are changes to the service, it's quality and safety will not be affected?
Phelps supports Oral Healthcare for People Living with Cancer (PHLPC) to the tune of £150,000. The Cancer Conference aimed at preventing the European perspective on oral cancer in parallel sessions for two distinct audiences; Dentists, and Specialised oral surgery. Specialist care dentistry, dermatology, and Dentists and Dental Care Practitioners (DCPs) – and the cancer support team.

The Oral Health for People Living with Cancer (PHLPC) Conference which brings together some of the world's leading experts in the field of oral cancer, taken place on 11 June 2010. It is aimed to enhance awareness throughout the healthcare team of the importance of early detection of oral signs and symptoms, and of the prevention of cancer. In addition it is hoped that healthcare professionals who are better trained in early detection and early treatment and reduce complications from cancers and improve patients' outcomes.

Phelps is working with Professor Crispin Scully of the Eastman Dental Institute, UCL, who is one of the main speakers at the Oral Cancer Conference in the dockslands area of the city.

For more information about the conference is available on www.eventassociation.co.uk.
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Pedal power

A team of dental professionals combine cycling, rugby and adventure to raise much-needed funds for children’s charity Wooden Spoon

last year, Ian Mills, a partner at Torrington but also a National Clinical Fellow at the University of Birmingham Dental School, alongside Simon Hill, the owner of Wyndham House Dental Practice in Llanwit Major, Cardiff, organised a dental implant conference in Cardiff to coincide with the Wales vs. England game. The conference was a marvellous experience, I have a suspicion it may have been the latter.’

The group covered the distance in six days and arrived at the Millennium Stadium in time for kick off. ‘To arrive in Cardiff on match day and be greeted by family, friends and rugby fans was fantastic. To then cycle into the Millennium Stadium before the game was incredible, and really quite emotional,’ said Martin.

The group managed to raise over £10,000 for Wooden Spoon, which will be spent on local groups in Wales and Devon. ‘It was a marvellous experience, although I’d have to do all my dentistry standing up since I got back,’ quipped Ian who is based in Devon.

With hindsight, organising a conference might not seem such hard work after all, and Ian and Simon are already planning the 2011 Conference to coincide with the Wales vs. England game. We have it on good authority that Ian will not be arriving by bike.

About the charity

Wooden Spoon is a children’s charity that improves the quality and prospect of life for children and young people who are disadvantaged physically, mentally or socially. Strongly supported by the rugby community, it was formed in 1985, when the England rugby team received the ‘Wooden Spoon’.

Since then, Spoon has spent £1.5 million helping over 500,000 children and young people across the UK and Ireland. Spoon delivers rugby projects to help children and young people combat bullying, violence, crime, obesity and discrimination. It also makes grants to special projects that meet its aims, which have included hydrotherapy pools, young people’s life-skills centres and sensory rooms. Wooden Spoon now raises over £1.5 million a year through national events such as the Spoon Challenges and through regional volunteer fundraising.

The charity’s patrons are HRH The Princess Royal, the governing bodies of Rugby Union and Rugby League. It has the support of a host of rugby legends and other high profile celebrities from the worlds of music, sport and the media. To learn more about Wooden Spoon and its projects, visit www.woodenspoon.com.

Our focus is sustainability – empowering local people to improve their own lives over the long-term. We have Trustees and administration in the United Kingdom and we are a UK registered charity no. 1092481. Bridge2Aid is a registered Non-Governmental Organisation (NGO) in Tanzania with additional Tanzania-based Advisors.

The four key aspects of Bridge2Aid’s vision are:

• To provide primary dental care and oral health education to communities in Tanzania
• To equip and further train local health personnel to provide emergency dentistry to rural communities
• To care for and empower the poor and marginalised in Tanzania
• To provide opportunities for UK dental professionals and dental students to use their skills to serve Tanzania, as locums or participants on the Dental Volunteer Programme (DVP).

Further information, contact Lucy Jenkins by emailing lucy@bridge2aid.org or Mark Topley by emailing mark@bridge2aid.org.

Keep on running

Two willing dentists take part in London’s 30th Marathon to raise money for Tanzanian charity, Bridge2Aid

Two dentists managed to raise over their target sponsorship amount when they ran the Flora London Marathon in aid of dental charity, Bridge2Aid.

Dr Katherine Opie-Smith and Dr Chris Waith completed the 50th London Marathon on Sunday 25 April with over 55,000 other runners and together, raised over £4,500. Both have previously worked in Tanzania as part of Bridge2Aid’s Dental Volunteer Programme (DVP).

‘It was definitely a good day,’ said Katherine, who is also a Bridge2Aid Trustee and works at the Dulwich Village Dental Practice in London. ‘My time was 4:55:55. I was 64 seconds slower than when I did it in 2008 but I really only had time to recover from the hills.’

Pre-race nerves

‘At first I thought I was going into it a tad under-prepared,’ reported Chris who works at Cahill Dental Care Practice in Bolton, Greater Manchester. ‘I had shin splints and a sprained ankle in the lead up to the Marathon and was definitely not prepared to suffer too late to back out. He obviously wasn’t prepared to suffer alone, so quickly recruited Martin Docking a dental technician from Cornwall, Adrian Watts a consultant in Restorative Dentistry in Cardiff and a couple of other unsuspecting friends. So on the 14 March 2010, a group of nine cyclists, three support vehicles and an orthopaedic surgeon, set off from Murrayfield to pedal the 450 miles to Cardiff.

An idyllic adventure

The trip took them over snow-covered mountains in the Borders, up hills and dales in the Lake District and through the beautiful Brecon Beacons.

‘The first few days were fairly hard, but day four was certainly the most difficult. We cycled 94 miles from Warrington to Church Stretton in Shropshire which included an unplanned detour with some hideous hills,’ explained Adrian.

As if that wasn’t challenging enough, Adrian cycled the whole way on a single-speed bike, earning him the coveted yellow jersey, which was presented at the end of the tour. ‘I’m still not sure whether the award was for recognition of my courage or my stupidity,’ said Dr Watts, ‘but I have a suspicion it may have been the latter.’

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By the time Ian realised what he had let himself in for, it was too late to back out. He obviously wasn’t prepared to suffer alone, so quickly recruited Martin Docking a dental technician from Cornwall, Adrian Watts a consultant in Restorative Dentistry in Cardiff and a couple of other unsuspecting friends. So on the 14 March 2010, a group of nine cyclists, three support vehicles and an orthopaedic surgeon, set off from Murrayfield to pedal the 450 miles to Cardiff.

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Dentaid has produced a Full Instrument Kit available for purchase

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Ownership
The programme is designed to encourage the student to take responsibility for their own learning. The emphasis is on a self-directed learning approach.

Community
Students will be able to communicate with a diverse multi-ethnic global community of peers, with who they will also share residential get-togethers in fantastic settings around the world.

Opportunity
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New Cambodia project
About 1,200 families actually live in or around a toxic landfill site in Phnom Penh, driven by desperation to survive by selling scraps of plastic and metal scavenged from this, the largest dumpsite in Southeast Asia.

The Cambodian Children’s Fund (CCF) serves this needy community with four residential care centres and a school providing education for 450 children, and has just opened a medical centre with two full-time doctors offering free treatment. Now they have recruited a dentist who is ready to supervise a dental surgery with the help of volunteer surgeons and therapists – but only once equipment is found for it.

This is where Dentaid comes in! A fully refurbished surgery, (designed to meet the detailed local requirements outlined in Dentaid’s end-user questionnaire which every project applicant has to complete) can be crated and shipped to Cambodia for £3,750 – but first the funding has to be found. If you are interested in helping this project, please call 01794 324249 or email info@dentaid.org.

Contact information
If you would be interested in taking part in a Dentaid golf day in the north of England or attending a Christmas Ball, please email Diane on diane@dentaid.org to let her know where you are based.
For further details of Dentaid’s work and to get involved, please visit www.dentaid.org.
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Tel: 01444 204752

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- 26% more plaque removal was observed with brushing for 120 seconds compared with 45 seconds\(^2\)

**Significantly increases fluoride uptake and enamel strengthening**
- Surface microhardness (SMH) increased in a linear fashion over the period 30-180 seconds\(^3\)

References

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