Dental proposals thrash dentists

Dental principals are among the taxpayers likely to be hardest hit by the Chancellor’s Budget proposals, according to the National Association of Specialist Dental Accountants.

Mr Ledingham, said: ‘There will be little incentive for many principals, particularly those in NHS practices, to undertake additional work, despite the fact that the proposals are designed to kick-start the economy.’

He claimed that a dentist with taxable earnings of £120,000 in the current tax year, who earns an extra £10,000 in taxable profit in the 2010/11 tax year, will be asked to pay an additional £6,090, effectively a tax rate of 66.9 per cent.

Meanwhile, a dentist with taxable profit of £150,000 in 2009/10 will have to pay £7,690 if they earn an additional £10,000 profit in 2010/11.

Bob Cummings, NASDA’s tax specialist, said that when a person’s income exceeds £100,000 the personal tax allowance is gradually eroded and eventually reduces to zero as profits rise.

He added: ‘Dentists earning over £100,000 will therefore see their tax bills increase even if their profits remain the same. For those earning over £150,000, the highest income tax rate also increases from 40 per cent to 50 per cent.’

Mr Cummings predicted that dentists who had not incorporated might consider doing so because of the potential for reducing tax liabilities. But he stressed that all the pros and cons should be considered first and said: ‘I am sure all NASDA accountants will be working particularly hard to put in place tax strategies to ensure that their dental clients pay the minimum amount of tax legally possible.’

Mr Ledingham said: ‘It should be noted that in recent years not everything that the Chancellor has presented in his Budget speech has ultimately found its way into Statute. We will therefore have to wait until the Finance Act receives Royal Assent at the end of the summer before we know the final details. However, it is clear that the Chancellor is intent on increasing taxes and has his sights set on high earners.’

He added: ‘It is going to be particularly important over the next few years for dentists to ensure that they have access to high quality tax planning advice from people who are not only experts in the area of tax planning, but who also have an in depth knowledge of dentists and the business environment that they operate within.’

Teeth grinding

Teeth grinding is not recognised or treated by the majority of dentists in the UK, according to Dr Nigel Carter, chief executive of the British Dental Health Foundation. His comments are backed by a survey carried out by NoBrux, a UK company that specialises in the supply of US-made dental guards to dentists and sufferers.

Teeth grinding, or clenching, is more commonly referred to as ‘bruxism’, usually occurs at night. Although there are many possible causes, the main one seems to be stress. NoBrux claims bruxism is much more widely known, both by dental professional and the public, in America.
Northern Ireland ensuring people can get the health service dental treatment they need. Oasis has extensive expertise and experience in providing dental services to Health Trusts across the United Kingdom and the standards they have set are impressive.

My officials are working closely with the British Dental Association to achieve a new dental contract for all health service dentists in Northern Ireland and, I look forward to a successful conclusion to this process. However, there are access problems now that I have to address, and I am delighted that Oasis will work with us on this.

The British Dental Association (BDA) gave a broad welcome to the announcement of the award of a tender for 58 new dentists in Northern Ireland as part of the solution to the problems some patients face accessing care.

But the BDA also warned that the 800 dentists already working in Northern Ireland need more support and a new contract that allows them to provide the kind of modern, preventive care they are trained to do.

Dr Claudette Christie, director for the British Dental Association (BDA) in Northern Ireland, called the new contract ‘a welcome step’ but said: ‘However, while this is welcome news, it is not the sole solution to the problems dentists and their patients face.

Also important is that the dentists in Northern Ireland do have access to GP services now.’

This contract is another reounding endorsement of Oasis Dental Care and our ability to deliver excellent health service dentistry.

Plans are already well advanced for the new Oasis practices and we look forward to welcoming new patients from across the province later this year. We will ensure that we keep local communities informed of the progress of the building work and when they will be able to register for treatment.’

The former Western board area will get 16 new dentists - in Enniskillen, Omagh, Strabane and Londonderry. In the former Northern board area, eight dentists are to be located in Carrickfergus, Newtownabbey and Cookstown, Bangor/Donaghadee, Holywood, Dundonald/Castle reef, Lisburn/Dummurphy and Carryduff – in the former East ern board area - will get 10 dentists. The former Southern board areas of Banbridge, Dun gannon and Newry will each receive funding for two new dentists.

Oasis fills the gaps

Police renew murder appeal

Police investigating the alleged crimes of a Northern Ireland dentist accused of murder, have renewed their appeal asking for former patients to come forward.

Dr Colin Howell, is accused of murdering his wife and his ex-lover’s husband. The 56-year-old, from Castlerock, is also charged with drugging and indecently assaulting a number of women.

Two months ago, detectives wrote to former patients at practices in Ballymoney and Ballygally as part of their enquiries. They have now issued a renewed appeal.

Detectives are investigating alleged serious crimes which may have occurred at the Causeway Dental Implant Clinic in Ballymoney over a number of years and at Bangor West Dental and Im plant Clinic in Bangor between 2005 and 2008. The investigation does not involve any other member of staff at the clinics.

Officers are asking patients if they have any information that may assist the inquiry team or if they have concerns. Police have revealed that a number of patients have already come forward and this latest renewed appeal is to ensure that ‘every possible step has been taken to identify all victims in this part of the investigation’.

Police say any contact will be treated with the utmost confidentiality.

Howell, who has 10 children, is in custody charged with the murders of his wife Lesley, 50, and Trevor Buchanan. Their bodies were found in a car filled with carbon monoxide fumes in Castlerock in May 1991.
Editorial comment

Seeing the light

A friend said last week that her permanently and happily unemployed friend and her children regularly fly out to Florida for holidays at Disneyland. ‘How she does it when she doesn’t have a job I just don’t know,’ she said. But when she added up her friend’s tax credits, council tax benefits, plus the rest of the frills, it all became crystal clear. Now don’t get me wrong – there are plenty of people out there struggling to scrape by on benefits and deserve every penny and some, but there are also others who are positively living the life of O’Riley. So who’s paying for it all?

High earning go-getters have always been penalised by Mr Brown to some degree, but introducing these new taxes is like saying ‘bring on the brain-drain now’. For getting taxed to the hilt is hardly going to motivate the nation to work hard and build better businesses. Earning £100k in the UK is really not a lot these days – the average family household needs at least this to pay the mortgage, meet spiralling bills and put food on the table. So is having a holiday so much to ask after grafting the hours away day in, and day out in the practice? Apparently so, according to the Chancellor. Ok so he hasn’t said as much but actions speak far louder than words don’t they.

Thatcher’s children were all geared up to work hard and think about earning money and lots of it. She may have taken the milk away, but it didn’t half motivate us to work hard to make sure we earned enough to buy our own pint. But now why bother? For the harder we work, the less we earn. What a wonderful way to kick-start an ailing economy.

If so don’t hesitate to write to: The Editor, Dental Tribune UK Ltd, 4th Floor, Treasure House, 19-21 Hatton Garden, London, EC1N 8BA. Or email: penny@dentaltribuneuk.com

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

House raffle is extended

A dental technician, who put his £490,000 house up for sale in a £25 raffle, has extended the competition for a further three months, following poor ticket sales.

Stephen and Caroline Sicklemore are hoping to sell their £490,000 four-bedroom home in Devon, through a raffle. Tickets cost £25 each and if the couple sell all their tickets, they will get £675,000.

The winner will also get other benefits including their stamp duty paid, legal fees and a contribution towards moving expenses, plus an up-front payment of 12 months’ council tax of £1,700 for the Band E property. The detached Summer Breeze in Dawlish, comes with sea views, split-level design and three bathrooms.

The couple have promised to donate 5.6 per cent of the prize fund, up to £25,000, to Force cancer charity in Exeter. However, the couple have only sold 1,523 of the tickets since the raffle began in January. They have now decided to extend the competition for a further three months to the 24 July ‘to ensure we give the competition the chance of selling all of the tickets’.

People can buy tickets from the couple’s website where they have to answer three questions correctly as part of their entry to the draw.

To find out more, visit website www.summerbreezecompetition.co.uk

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The profession turned out in style last week to support the British Dental Health Foundation’s 34th National Smile Month campaign despite the Sri Lankan protest in Parliament Square.

Held at the House of Commons, Look After Yourself, Brush for Health was declared open by Deputy Chief Dental Officer Sue Gregory. After thanking sponsors, P&G, Oral B, Wrigley’s Orbit Complete and Tesco Dental Insurance, the Foundation’s chief executive Dr Nigel Carter said: ‘The foundation only acts as a facilitator to help make the campaign as it is, but it would never be as successful without the help from the rest of the profession.’

Following the welcoming speech from President Chris Potts, special guests took to the lectern to speak on the importance of the UK’s largest oral health awareness campaign.

Television star Dr Uchenna Okoye represented campaign supporters Oral B and was joined by Adrian Tosney, oral care brand manager for fellow campaign supporter Wrigley’s Orbit Complete. Tesco Dental Insurance was the third of a trio of Platinum Supporters for the campaign.

Said Dr Uchenna Okoye: ‘My idea was to talk about the F-word – floss – but my expectations were exceeded when I thought am I doing what I say?! Our job isn’t to beat our patients over the head with information but to counteract the effects of inadequate oral health. Everyone plays a part to get the message out there and I believe this will be the best campaign yet so well done.’

Following the celebrations Dr Nigel Carter said: ‘The National Smile Month launch proved a fantastic event as once more the great and the good of UK dentistry came to toast this year’s campaign. We are sure the campaign theme Look After Yourself, Brush for Health will get the nation talking about the importance of good oral health and we anticipate yet another successful campaign.

‘This event will hopefully prove to be the perfect platform for events across the country and we look forward to the activities organised by all our supporters.’

National Smile Month runs from May 17th until June 16th 2009, with a second National Smile Month USA running the length of June in conjunction with Oral Health America.

Scores of events across the UK will help drive the British campaign. Practices, schools, businesses, hospitals and Primary Care Trusts can find information, downloadable press release templates, sponsorship forms and a chance to register their activity at the website www.nationalsmile-month.org.

For a chance to win an oral health supply pack for the primary school of your choice upload your National Smile Month photos online to take part in the campaign photo competition.

For more information contact the Foundation on 0870 770 4014 or email pr@dental-health.org.
A potential development in mouth cancer treatment has been welcomed by the British Dental Health Foundation.

The British Dental Health Foundation has welcomed results of studies at the Albert Einstein College of Medicine of Yeshiva University in New York. The study ‘The histone deacetylase inhibitor LBH589 inhibits expression of mitotic genes causing G2/M arrest and cell death in head and neck squamous cell carcinoma cell lines’ showed that an anti-cancer compound killed off mouth cancer cells removed from head and neck cancer patients.

Nearly 5,000 people are diagnosed with mouth cancer in the UK each year and currently just half of those diagnosed survive beyond five years. The new studies — found when scientists tested a drug for its effects on blood cancer and reported in the online edition of the Journal of Pathology — will it is hoped, mark a significant breakthrough.

The experimental drug involved new chemotherapy agents known as histone deacetylase (HDAC) inhibitors — which limit cell growth.

Lead researcher, Einstein clinician Richard Smith, M.D. said: ‘This report shows that an HDAC inhibitor is effective on head and neck cancer cell lines, and that is the first step toward use in humans.’

The Foundation’s chief executive Dr Nigel Carter said: ‘Such news, though very early days, is to be welcomed as the low long-term survival rate from mouth cancer makes the disease one of the deadliest. Currently the best chance of beating the cancer comes from early detection, improving survival rates to more than 90 per cent, so it is important to follow the slogan of the Mouth Cancer Action Month campaign: ‘If in doubt, get checked out.’

He added: ‘Though this research could prove important, it is vital that dentists and health professionals continue to perform oral screenings and educate on how to look out for signs of oral cancer. Maintaining a healthy diet and lifestyle also helps to prevent problems developing.’

The most common causes of oral cancer are smoking and drinking alcohol to excess, linked to 80 per cent of cases. Research has recently suggested that the human papillomavirus (HPV) transmitted via oral sex, could soon become one of the most common causes of the disease.

Quitting smoking, cutting down on alcohol and eating a balanced diet with plenty of fruit and vegetables lowers the risk of mouth cancer.

Mouth Cancer Action Month 2009 takes place in November. For more information go online at www.mouthcancer.org or call the National Dental Helpline on 0845 065 1188.
A couple in the Midlands have set up the first dental practice in the UK that is solely for children. The children go into a brightly coloured room and they are then introduced to the hygienist and then the dentist.

‘By the time they eventually sit in the dentist’s chair they feel safe and realise that, actually, it’s no big deal,’ said Sara Reece who established Smilescool with partner Mike Reece.

Smilescool is aimed at pupils aged up to 11. The children learn how to brush and floss, and they can also carry out scientific experiments such as looking at their teeth under a microscope.

They get a two-minute egg timer for teeth brushing, a pen torch to see inside their mouth, and fun wall charts and stickers to record their progress on a daily basis.

Each week, they chew a disclosing tablet which shows dental plaque – then record the results.

‘The beauty of this approach is that parents can see in an instant if their child is brushing effectively and making progress,’ says Dr Reece. He points to the Government ‘Future Study’ 2005, which found that if children take care of their teeth and mouths in the early years, there is an 80 per cent chance that at 15 years old they will stay free from decay.

Dr Reece describes Smilescool as ‘the profile of the prevention programme’ and said: ‘It is not about fixing problems as they arise, it is about prevention’.

Chief executive of The British Dental Health Association, Dr Nigel Carter, called it a ‘highly innovative project that we are confident will help towards positive progress in children’s oral health’.

While Professor Chapple, professor of periodontology at the Periodontal Research Group at the Birmingham School of Dentistry described it as ‘the best innovation in dentistry that I have seen in many years’.

He added: ‘It is time we started implementing preventative care models properly, rather than paying lip service to prevention. This means we have to start with infants and influence their values and lifestyles to prevent common oral diseases. Given the strong associations established between periodontitis and cardiovascular disease, adverse diabetes outcomes and stroke, and the recognition that obesity, poor diets and sedentary lifestyles impact upon periodontal health and general health, we also have a key role to play in motivating youngsters to better lifestyles."

The successful implementation of M.I.K.E.S. System (a key component within the smilescool programme) will have a hugely beneficial effect in educating, motivating and empowering patients to achieve better oral health and therefore better general health.

Smilescool charges a monthly fee based on the age of the child, which ranges from £3.42 to £14.48.

The fees includes the ‘check-up’ provision by the dentist, any treatment the child might need, the services of the hygienist/therapist for preventative treatments such as fissure sealants and the educational, prevention focused oral health care ‘POD’ sessions with the dental health educator and smilescool team.

The child will also have access to one of Smilescool dentists for ‘out-of-hours’ advice and treatment in the event of a dental emergency. The child will also be eligible for UK & Worldwide insurance in the event of a dental injury or accident away from home.

The director for Scotland has been working hard to raise the ‘profile of the General Dental Council since he took on the new role this year.

The newly created role is the General Dental Council’s (GDC) next step in targeting its resources more carefully to meet the needs of the four nations of the United Kingdom.

Mr Jackson has a background in business development and consultancy and voluntary experience in education, and was previously partnership director at BT Scotland.

He said: ‘It’s a great opportunity for the GDC’s voice to be heard in Scotland – and for us to listen to others. I’m working closely with the Scottish Parliament, members of the public and the dental profession so they realise the GDC isn’t a London-centric regulator.

‘We are keen to find ways of making the GDC more relevant to people in Scotland. The GDC promises to protect patients and regulate the dental team – that’s the principal aim in all my work.’

Making connections with patient groups is a priority. He has also attended Scottish cross professional and regulatory groups, had informal discussions with the public health ministers and MSPs, and spoken at the Scottish Dental Liaison Committee’s Conference.

Speaking about his new role, Ian Jackson said: ‘Scotland is different in that it has its own system of government and professionals tend to interact differently. One of the challenges ahead is to work effectively within this framework.

‘My aim is for people in Scotland to better understand what the GDC does whether it’s giving dentists and dental care professionals guidance, checking educational standards or investigating complaints. And I’m here, ready to listen to find out more about how we can help develop the GDC’s role.’

The Dental Defence Union, has begun its annual search for Britain’s top dental teachers.

Students and vocational dental practitioners have until 31 August to nominate their teachers or trainers for the Dental Defence Union’s (DDU) Educational Awards, now in its seventh year.

Rupert Hoppenbrouwers, head of the DDU, said: ‘The DDU believes that dental educators make an enormous contribution to the future strength of the dental profession by demonstrating good practice, instilling professionalism and most of all, insuring the next generation of dental professionals.

‘We are always extremely impressed by the high standards of teaching we learn about during the Educational Awards and last year’s winners – Professor Dayananda Samarawickrama, Alison Grant and Stephen Brooks – were a great example of how great teaching has made a difference to many students and trainers.’

Dean Hallows, marketing director of Dentply, which is sponsoring the awards said: ‘Dentply is delighted to once again sponsor the DDU Educational Awards. Supporting our next generation is of paramount importance and dental teachers play a pivotal role in advancing the profession; these awards are just one way of promoting their success and highlighting excellence in this area.’

There are three award categories: Dental Teacher of the Year, Vocational Teacher of the Year and Dental Care Professional (DCP) Teacher of the Year.

The winners will be chosen on 18 November at an awards ceremony in central London.

Finalists will be awarded £250 each and the overall winners in each category will receive £1,000 towards the cost of educational materials for their schools or VT schemes.

Awards will be judged across a number of criteria, including knowledge of the subject and the ability to motivate others.

Students and vocational dental practitioners in the UK and Ireland can download or complete a nomination form online at the DDU website, www.theddu.com/dduawards, or obtain one from their DDU dental liaison manager.
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Nearly one in eight managers in the UK do not trust their staff when it comes to taking time off to visit the dentist. Thirteen per cent of bosses dictate when employees can visit the dentist and in some cases, actively discourage any visits to the dentist during working hours, according to Simplyhealth’s Annual Dental Survey.

Liverpool is home to some of the least trusting managers, with almost one in four admitting they strictly control when members of staff visit the dentist.

Managers in Cardiff are among the strictest, with more than a quarter requesting dental appointments are carried out during the employees’ own time.

A similar number of managers in Brighton (20 per cent) confess to operating a system where staff are ‘encouraged’ to get their teeth checked out during lunch breaks, after work or at weekends.

But while many managers admit to subjecting their staff to high levels of scrutiny, bad dentistry can have a negative effect on workers’ careers, according to health provider Simplyhealth.

Three-quarters of employees feel their chances of career progression could be affected because they have bad teeth, while four out of 10 managers say an employee with an unattractive smile or bad breath would not be taken to client meetings.

Nearly a third of bosses give bad teeth as a reason for not promoting an employee, the survey found.

The survey also suggests that while many employers are unhappy about staff taking time out of the working day to visit the dentist, more than half believe staff absenteeism would be significantly reduced if dental benefits were included in the employee benefits package. Meanwhile three-quarters indicate its provision would lead to an improvement in employee morale.

James Glover, corporate director at Simplyhealth, said: ‘All managers want to be able to trust their staff, as a positive relationship between manager and employee is far more likely to lead to a good and sustained working relationship.

But staff absenteeism is a frustrating and costly issue for many managers in the UK, and giving staff time off to get their teeth checked can have a significant impact on the day-to-day running of a business.

The economic conditions are certainly playing their part in how infrequently people visit the dentist, and indeed 45 per cent of people we questioned cited cost as the main reason for delaying treatment.

However, those who decide to put off dental treatment can only expect their teeth to get worse, which can ultimately result in more expensive treatment and the need to take more time off work.’
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Marketing your practice gives you the chance to make it utterly irresistible to patients. Simon Hocken explains

The benefit of being your own boss is that you can focus on the kind of dentistry that interests you. However, without a bespoke marketing plan designed specifically to suit your needs, you will not be able to attract the right patients and your expertise will go to waste.

Marketing enables you to:
- make your practice utterly irresistible to patients seeking your high-value treatments. It lets you tailor your patient base, picking and choosing who you want in your appointment book.
- encourage them to return to the practice by highlighting any completed treatment plans.
- draw up your marketing plan and assess the return on your investment. As you look at your dental team members’ lists, you are likely to need or take up.

After branding, the next stage is niche marketing, and implementing loyalty systems to reward patients who return for treatment, and encourage loyalty to your brand.

Marketing strategies
- Your business is unique. Your marketing approach needs to be unique too. The essential marketing strategies include reaching out to ‘dormant’ patients who perhaps have not returned to the practice in a while, and reactivating any incomplete treatment plans.

Send a letter out to patients who have not visited the practice for a certain period of time (24 months is a good yardstick). Make a point of pleasantly stating that you understand how the patient might be nervous about being reprimanded for not completing regular appointments. You could reinforce this with a special offer of a half-price check up, to be redeemed by a set date.

Patients with treatment plans that have not been completed should be contacted by the dentist and offered a ‘smile check’ to encourage them to return to the practice by highlighting any concerns they might have about their oral health.

Leading practices have also discovered the benefits of a referral card, which allows loyal patients (who are of course overjoyed with the service they receive) to pass on the practice’s contact details to their friends and family.

Also, if you have not implemented a website, you need to today. A website is the most cost-effective marketing tool, and can host news about your team, special offers, contact details and a wealth of information in several formats about your treatments. You can even include testimonials from happy patients.

Research, research, research
- Dentists need to understand the local demographic in order to have a complete picture of the patient base. Without this, any strategic business planning will be sorely limited.

As well as looking at prospective patients, you also need to look at your team. This requires an audit. Look at the skills each of your dental team members possess, and think about the opportunities these skills unlock. Also consider how to make the most of these skills.

When new patients come to the practice, find out how they respond to your brand, and what they think of the environment itself. This has the twofold effect of making patients feel like an intrinsic part of your business (which of course they are), and enables you to find out if your marketing strategy works.

One enormous question dentists need to answer when marketing their practices is, ‘Who is my audience?’ Divide your desired patients into segments such as the 50s in transition, orthodontics (adults/children), family dentistry and think about the opportunities that this affords.

The competition
- Of course, once you’ve analysed your audience, you then need to analyse the competition. Chances are, there are several quality practices in your area. Why not visit their websites, look at their treatment lists? You could even visit the practices themselves. Then compare the standard of service offered by the competition with your own standard of service.

You can do this by mystery shopping. Call your own practice at set hours through the day. Find out exactly what your prospective patients are experiencing when they make that first call. This may give you food for thought about how to improve things.

Ensuring a return
- When you are looking to break through to a new plateau of success with your business, ROI should be uppermost in your mind. Try and monitor how many new patients visit your practice, and how many return for treatment. Ask new patients where they heard about you, and why they chose you, so you can tweak your marketing to make it even more effective.

If you consider that your average marketing spend for each new patient is somewhere between £25 and £90, this will give you an idea of what you need to get a return on your investment. As you draw up your marketing plan and budget, consider how many prospective patients become actual patients, and what treatments they are likely to need or take up.

With marketing such a vital part of modern dentistry, many dentists have chosen to work with leading coaches to help them discover how to implement the best strategies in order to guide their business in the desired direction. With bespoke solutions, advice and support from Breathe Business, for example, dentists, principals and practice owners can learn from experts who not only possess a wealth of experience when it comes to working in dentistry and owning practices, but also have a firm grasp on developing market trends and proven business strategies.

About the author
Simon Hocken BDS has owned two private practices and is an accredited coach for the recently formed coaching company called Breathe Business. For more information call Breathe Business on 01548 853660, email simon@nowbreathe.co.uk
Through the keyhole

Chris Davies suggests looking to those who inspire you for motivation to create your ultimate practice

In all walks of life, you can only achieve excellence by looking to the best for inspiration. One of the many ways the current financial crisis has impacted on dentistry is that it has increased the need for competitiveness and it’s now a necessity to pull out all the stops just to survive. This means measuring your service against that provided by the UK’s best dental practices.

A great team of focused and dedicated dental professionals needs a suitably world-class environment in order to reach their potential. This does not necessarily mean fitting the surgeries with the latest, most high-tech equipment; but it does mean a practical layout that promotes efficient working processes and supports consistent compliance with industry requirements. In fact, as guidance such as HTM 01-05 are introduced, dentists whose practices are in converted domestic buildings are set to discover a wealth of logistical problems that a new lick of paint simply won’t address.

Design-and-build does not just let you develop a practice that ticks all the right boxes, it provides an astonishing opportunity to take a massive step up as a provider of high-quality dental care. Doubtless you’ve read about dentists who have followed their dreams and now offer treatment in environments that are space age by comparison with many high-street practices. Take the time to find out how they did it.

Raising the bar

Why not take a tour of some of the most remarkable practices? Many dentists who have invested in a new practice will be keen to market this via their websites, and may even provide the option of a virtual tour. This is a great way to gain a better understanding of where the bar is currently set, and how you can raise it even further with your own project.

Design-and-build is your chance to go that extra mile. Enlist a proven company that has comprehensive knowledge of the industry, and will work with you to create designs that enable straightforward compliance with new and existing guidance, and put you in a great position to roll with the punches when new guidelines are released.

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I am feeling lighter than ever – the feeling you get when you clean out your garage or closet. There is something magical that happens when you do this; ever notice your mind is a little clearer? The excitement of filling up bags or boxes of stuff is actually very cathartic for most of us.

You might be asking, “What the heck does this have to do with building my practice?” Good question.

For my five hour flight from Phoenix to Boston I packed a suitcase full of dental publications that had been growing in my office. You know that stack of guilt and obligation that confronts you every morning? You know it’s there and you beat yourself up for not getting to it. This stack of possible gems has been sitting dormant subconsciously screaming for my attention. Well, during my flight I read some amazing articles from the top dogs of dentistry. My brain is maxed. Reading was a great exercise in gaining more compassion for you, as I’m sure you do plenty of “advise reading” and end up feeling the same way I did – overwhelmed and not knowing where to start.

I share this with you to aid in addressing this week’s Chairside Challenge. If information were enough we would all be healthy, wealthy, in love, fulfilled and happy. We all know we have the information to get in shape, but do we do it? What stops us? More over, what keeps us from having our practice deliver on everything we want it to?

The root of it all is the belief you have on how much you allow in. If you think you can, you will and if you think you can’t, you won’t – either way you will be right. You will always validate your beliefs. Humans are not naturally wired to accept being wrong, especially if it is something we believe. It is a lot easier to make others wrong and make ourselves right. The most challenging thing on the planet to do is to invalidate a belief we have had either about ourselves or something we are personally attached to. Most of the time we make dramatic changes only when we have hit bottom and are sick and tired of how things are. I say, bring your bottom up. Do not stand for anything in your life that is not working. Life is not a dress rehearsal. If not now, when? We would rather guard the loss of what we already have than generate and create a bigger future. Focusing on not losing manifests more loss. Whatever you focus on you get more of. Start focusing on what is possible rather than what you might lose. You will experience many more wins and a renewed sense of joy and fulfillment.

I recently delivered a workshop in Las Vegas on Re-Thinking Your Practice and had noticed a dentist with eyes wide open, listening more intently than all of the graduating seniors in attendance. He approached me at the break and shared that his son (also a dentist) suggested he attend my workshop. He told me that he had been practicing dentistry for 44 years and had now decided to draw a line in the sand. “Drawing a line in the sand” is a term I use for acknowledging the past so you can start with a blank slate, reinventing a future not tied to your past.” – When he told me about his decision, I was floored.

He continued to share with me that his son had been practicing with him but recently decided to branch out on his own because of the way his senior practiced – old school, old equipment, caring environment. This father explained how he didn’t feel that he deserved to have an updated practice for 44 years and had now decided to draw a line in the sand. “Drawing a line in the sand” is a term I use for acknowledging the past so you can start with a blank slate, reinventing a future not tied to your past.” – When he told me about his decision, I was floored.

You see, once you truly make a commitment, everything conspires in your favor. The world around you figures out ways to help you get where you want to go. Most of our lives we spend going through the motions, wallowing in molasses.

Go ahead and dream again. The sixty something doctor I met in Las Vegas had the courage to. He inspired me and left me feeling eager to share his break-through with you. So enjoy the story, learn from it, and most importantly do something with it.

Once you decide what you want, find yourself an expert in customized implementation. Let’s come full circle. Remember back to the beginning of this article where I spoke about the “guilt stack”? Great data alone has little to no value. It might make you feel a bit smarter but we have all proven that being smart doesn’t improve cash flow, retirement savings, team harmony, patient compliance or your satisfaction and fulfillment.

Step to the edge of all you have known and take a leap. You’ll be glad you did.
Practical cabinetry

David Rhodes offers a tale of refurbishment, showing that it doesn’t need to be a stressful procedure

I finally decided the time had come for a much needed, no holds barred ‘makeover’ of my associate’s surgery, to bring its ergonomics and decor up to the standards of the rest of the practice.

This was going to involve a complete refurbishment of his surgery, and would mean stripping the walls back to the brick, rewiring, replumbing and then completely re-cluttering the whole room.

I am not fond of exposed pipes and cables, and a priority for me was to combine a new layout with astute cabinetry placement to enable the maximum concealment of the utility delivery systems.

Having refurbished the waiting room, reception area, sterilisation rooms and consulting room over the previous 18 months, I was fortunate to have an existing relationship with an excellent builder; I am also lucky to be married to an interior designer, who had her own ideas about the desired outcome. Domestic harmony was assured, however, as it became clear that we both held similar opinions on the appearance of the end product.

A vital element was the choice of cabinetry. It was important to choose cabinets of imaginative design, but whose visual impact was in keeping with the overall colour scheme and design aesthetic of the rest of the practice. (We have bold reds and blacks backed by light ceramic tiles throughout all the treatment rooms.)

I was already familiar with the elegant Tavom cabinetry range, supplied in the North West by RPA Dental Equipment Ltd, and a recent visit to international dental implant facilities in Dubai, created for the MSC programme run by Stewart Harding and Warwick University, gave me the opportunity to inspect Tavom cabinetry at first hand.

Fine design

I was impressed not only with the design, with its emphasis on clean lines and modernity, but also the build quality. It was no surprise to discover that Tavom cabinetry is designed and built in Italy, the natural home of fine design. The huge range of cabinet options is mixed, matched and assembled in the UK at RPA’s Wigan showroom and design studio.

With almost limitless choices and bespoke colours, all with stunning eye appeal, the ideal solution is achievable for any surgery.

RPA’s Ian Smith, with advice and examples in the showroom, helped us to create exactly the ambiance and aesthetics we were seeking. The whole process was enjoyable and straightforward.

The building team, lead by Simon Ferraris, liaised with an independent dental engineer and had only one working week to gut the surgery, dry line it, complete the rewiring, lay the ceramic floor and prepare the plumbing before the cabinets were delivered prior to redecoration.

Simon met his deadlines and the Tavom cabinetry and black glass worktops were fitted within a day. Only after fitting, to ensure absolute accuracy, were the measurements taken for a Corian top. One week later the Corian top was fitted and the dental equipment reinstalled. After only two weeks, our new surgery was complete, looked fabulous and was ready for action.

Ian’s attention to detail and pre-installation planning, complementing the excellent and efficient work of Simon and his team, had made the entire operation very much less stressful than it might have been. I have no hesitation in recommending RPA and Tavom, who were a pleasure to work with and whose quality of service and superior products made a huge contribution to the project’s success.

About the author

David Rhodes BDS
For more information on Tavom, call Tavom UK on 0890 752 121.
We have recently acted on several practice sales/purchases where the recent crash in property values has significantly affected the structures of the transactions.

This is not so much to do with lenders’ requirements tightening up (less of a problem with dentist practice purchases than in many other markets), instead it arises from the increasing reluctance of some dentists, who own the freeholds of their premises, to sell outright, in the current depressed property market.

Bridging the gap

Two possible approaches to ‘bridge’ this gap between seller and buyer are:

1. The seller grants the buyer a ‘right of pre-emption’; or
2. The buyer is granted a ‘call’ option.

A right of pre-emption is the right granted to the buyer, of first refusal, if and when the seller wishes to sell. The buyer’s rights are protected by registration at the Land Registry. From the seller’s point of view, the choice to sell is his/hers.

If the seller chooses a time to sell which is inconvenient to the buyer, (whether financially or otherwise), then the buyer may find that they are unable to exercise their pre-emption rights, and the seller may then go on to sell to a third party.

If the buyer has the benefit of a ‘call option’ (also registrable at the Land Registry), this means that the buyer, by exercising the option, can require the seller to sell, upon the terms of the option.

Rights of pre-emption and call options usually have conditions attached. Typically, there may be time limits on the exercise of a call option, providing a ‘window’ within which the option is exercisable.

Points to consider

Several important points need to be considered by prospective parties to rights of pre-emption/call options. The formula by which the property is to be valued at the relevant time is of major importance.

Often the valuation is to be at open market value at the relevant time, either to be agreed between the parties or, if not agreed, to be independently assessed. Independent assessment may be achieved by nominating a particular firm of valuers who then carry out an open market valuation, which ‘binds’ both parties. There are more sophisticated mechanisms for fixing valuations available.

A problem faced by a seller where there is a call option in place is that, with the current uncertainty in the market, the option may be exercised by the buyer at a time when the seller feels that property prices are still too low.

Fixing a value

One mechanism to avoid this problem might be to fix a minimum ‘threshold’ value, so that the buyer can only exercise the option on condition that not only has the option window been reached, but also that the property price has reached or exceeds the agreed threshold. Agreeing such threshold may be difficult, particularly when future property prices are so uncertain.

The ‘threshold’ issue is less of a problem with pre-emptions. If the seller considers that they would not achieve the right price, then they have the choice of not selling.

Some sellers are looking to retain the freeholds of their premises, (either personally, or in their pension funds) and grant 15 or more year leases to the buyers.

Some buyers – often associates with the practice – may be reluctant to proceed, if they might only be able to acquire the freehold at some time in the future and at the whim of the seller. Buyers may also be concerned at the possibility of the seller asking them for a premium price down the line.

About the author

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Keeping it simple

Despite all the financial doom and gloom, you still need to keep your practice stocked, which could be more economical if you stick to using just one supplier. Amy Casey explains.

Whether you’re a dentist or a plumber, you can’t fail to have heard about the economic slow-down that is affecting us all. The media, written, visual and aural, seems to take every opportunity to report the latest twist and turn in the continuing saga of international doom and gloom. We’re all becoming financial experts, and casual conversations are littered with reference to the collapse in house prices, global recession, interest rates and inter-bank lending, not to mention the high profile demise of Woolworths and several other long established and familiar High Street names.

Opinions also differ widely among professional commentators; some believe the pound’s rapid fall in value (to almost parity with the euro as we go to press) is purely temporary and will be reversed as the Eurozone economies stagnate, while others anticipate the arguments about the UK adopting the common currency to resurface.

Cutting costs

There is no escape for the individual from the effects of this turmoil in the world of high finance. While the weak pound makes overseas holidays and imported goods, including many foodstuffs, more expensive, businesses are also suffering.

For suppliers and distributors of imported goods, and it’s worth reiterating that dentistry is heavily dependent on imported European products, a pricing policy that reflects the near parity of the pound and the euro and yet still delivers value to the customer is vital. Many of the larger dental suppliers deal in euros, and Identaply, the largest dental wholesaler in the UK, is one of them.

Constant change

The volatility of exchange rates is fast rendering traditional printed catalogues and price lists obsolete almost before they have been published. A leading player in the dental wholesale market, focuses its advice to customers on measures of more immediate concern to their balance sheets, to avoid investing in products likely to become obsolete, and pending regulation, particularly in the area of cross-infection, to avoid investing in products likely to become obsolete as standards rise.

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One to one

The benefits of dealing with a single supplier are often overlooked by busy practitioners—not only is paperwork simplified, with an exclusive contract, it should be possible to negotiate an overall discount without compromising on product or service quality.

Dealing with a single supplier encourages a closer relationship with its representative, who is well placed to advise and inform on the latest products and the best deals available. It also pays to keep abreast of current and pending regulation, particularly in the area of cross-infection, to avoid investing in products likely to become obsolete as standards rise.

People will always have teeth needing attention, and with a captive market cost-responsive practices which deliver quality care can expect to survive the present economic climate, although we must all accept that it may be some time before the situation improves.

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The Clearstep System
Root resorption in orthodontics

Root resorption has been described as an idiopathic side effect in orthodontics. Although it may seem to be detrimental to the health of the dentition, it has been noted that root resorption could occur naturally and would not undermine the form and longevity of a normal functional occlusion.

Root resorption of the deciduous dentition is a normal, essential and physiologic process. Usually it is a necessary precursor to the eruption of the permanent teeth. Even with agenesis of its corresponding permanent teeth, some deciduous teeth still undergo root resorption. On the other hand, root resorption of the permanent teeth may play microscopic lesions of external root resorption (0.75 mm length and 0.10 mm depth).

The numbers of incisors with root resorption increases from 15 per cent before treatment to 75 per cent after treatment. The most frequent site is at the apex, followed by mesial, buccal, distal and lingual surfaces. The most commonly affected teeth (in decreasing frequency) are: maxillary laterals, maxillary canines, mandibular incisors, mandibular first molars, mandibular second premolars and maxillary second molars.

The differences between right and left sides or maxillary and mandibular teeth are negligible. When molars do exhibit resorption, they have greater resorption areas than the total root surface area.

Susceptibility to root resorption varies considerably. Teeth with radiographic signs of resorption prior to treatment have been reported to develop more extensive areas of root resorption than the intact teeth.

The type of appliances used in the management of the orthodontic malocclusion usually dictates the type of resorption. In palatal expansion, resorption develops mainly in the cervical part of the mesiobuccal surfaces and furcation area of multi-rooted teeth, and also buccal and apical egions of single-rooted teeth with only limited involvement of other areas. However, such cervical resorption generally remains undiagnosed unless it is extensive, whereas apical root resorption is often readily visible on radiographs.

Incidence and susceptibility

The incidence of root resorption varies in different studies. Most investigations, however, agree that idiopathic root resorption does occur in an untreated population. A high percentage (90.5 per cent) of untreated permanent teeth may show microscopic lesions of external root resorption.

The incidence and susceptibility of root resorption varies in different studies. Most investigations, however, agree that idiopathic root resorption does occur in an untreated population. A high percentage (90.5 per cent) of untreated permanent teeth may show microscopic lesions of external root resorption.

The numbers of incisors with root resorption increases from 15 per cent before treatment to 75 per cent after treatment, or from 4 per cent before treatment to 77 per cent after treatment. The most frequent site is at the apex, followed by mesial, buccal, distal and lingual surfaces. The most commonly affected teeth (in decreasing frequency) are: maxillary laterals, maxillary canines, mandibular incisors, mandibular first molars, mandibular second premolars and maxillary second molars.

The differences between right and left sides or maxillary and mandibular teeth are negligible. When molars do exhibit resorption, they have greater resorption areas than the total root surface area.

Susceptibility to root resorption varies considerably. Teeth with radiographic signs of resorption prior to treatment have been reported to develop more extensive areas of root resorption than the intact teeth. However, in most cases, it could still be very unpredictable.

The type of appliances used in the management of the orthodontic malocclusion usually dictates the type of resorption. In palatal expansion, resorption develops mainly in the cervical part of the mesiobuccal surfaces and furcation areas of multi-rooted teeth, and also buccal and apical egions of single-rooted teeth with only limited involvement of other areas. However, such cervical resorption generally remains undiagnosed unless it is extensive, whereas apical root resorption is often readily visible on radiographs.

Aetiology and type

The aetiology of root resorption is multifactorial. Whenever extensive areas of resorption occur, various predisposing factors have been proposed: vitality of the pulp, gender of the patient, type and mechanics of force delivery, bone density, magnitude and duration of the force and systemic factors (eg, endocrine disorders, asthma).

In general, clinical orthodontics often presents with three types of external root resorption: surface, inflammatory and replacement resorption.

Surface resorption is usually a self-limiting process involving small outline areas followed by spontaneous repair from adjacent intact parts of the periodontal ligament. Inflammatory resorption occurs when initial root resorption has reached dentinal tubules of an infected necrotic pulp tissue or an infected lesion cavity, whereas replacement resorption takes place when bone replaces the resorbed tooth material leading to ankylosis.

Root resorption encountered in orthodontic treatment is often surface resorption or transient inflammatory resorption. Occurrences of replacement resorption as a consequence of orthodontic tooth movement are rare.

Mechanism of root resorption

Orthodontic forces applied to the palatal surface (as in palatal expansion) cause bone resorption on bone and cementum. This bone-cementum interface is separated by the periodontal ligament (PDL). If there were no differences in the biologic behavior of these two organs, both would undergo resorption equally. However, for tooth movement to occur, bone has to resorb at a greater rate than cementum. Although it has been noted that under applied orthodontic forces, cementum does have a higher resistance to resorption than bone, resorption of the cementum and dentine also occurs.

Clinically, after the application of orthodontic force, it can take between 10 and 35 days for a resorbed crater to appear. This degree of resorption cannot be detected clinically with radiographs, especially when occurring on the buccal and lingual surfaces.

Resorption craters appear mainly on the pressure side and rarely on the tension side. When bone, cementum tends to decrease in thickness on the side of compression. If the pressure persists, root resorption progresses even if it was initially protected by uncalcified tissue. Human and animal research demonstrates that periodontal hyalinisation precedes the root resorption process during orthodontic treatment. Loss of root material occurs adjacent and subjacent to this area.

Three stages are described in the hyalinised zone: degeneration, elimination of destroyed products, and re-establishment. During the remodeling process of the hyalinised zone, the necrotic hyalinised tissue and alveolar bone wall are removed by phagocytic cells such as macrophages, foreign body giant cells and osteoclasts.

As a side effect of the cellular activity during the removal of the necrotic PDL tissue, the cementoid layer of the root and the bone are left with raw unprotected surfaces in certain areas that can readily be attacked by resorptive cells. Root resorption then occurs around this cell-free tissue, starting at the border of the hyalinised zone.

Further investigations by Brudvik and Rygh have noted that multi-nucleated giant cell-like cells with ruffled borders mainly accounted for the removal of this hyalinised tissue and subsequent resorption.

Force-related factors

The magnitude of force has been considered an important factor with regards to the rate of tooth movement in orthodontics. Bratthall has always advocated the use of light orthodontic forces in order to increase cellular activity in the surrounding tissues and reduce the risk of root resorptions. This was later confirmed by King and Fischklicher28. In an investigation with rats they found that light forces produced insignificant root resorptions whereas intermediate or heavy forces resulted in substantial crater formation. This result was in agreement with earlier findings, both in animals and in humans.

However, contradictory findings were reported by Stenvik and Mygstad in a study concerning premolar intrusion in humans. They observed that root resorptions increased after application of light forces, 55 g when compared to heavy forces, 250 g.

Storey and Smith reported the ‘optimal force’ theory and documented a range of pressure (150–200 g) on the toothborne interface that would produce the maximum rate of tooth movement for distalization of maxillary canines in humans. For pressures below this range, movement was limited due to the ability of the soft tissue to function as a shock absorber. If the force was increased beyond this optimum, the displacement would be reduced due to tissue necrosis of the PDL, ie, hyalinization.

This theory was critically reviewed by Bonstedt and Johnstone who found that the amount of space closure after premolar extraction was about the same if the applied force was 5, 8 or 11 ounces (140, 225 and 310 g), but significantly less if only 2 ounces (55 g) was used. A similar opinion has been presented by other researchers who suggested that tooth displacement was the same even if the applied force was increased.

However, other investigations demonstrated a more linear relationship between force magnitude and tooth movement: the heavier the applied force, the greater the rate of tooth movement. In the early 1970s two reports, one on humans and one on cats, presented a large variation in tooth movement in response to applied force magnitudes. This was further confirmed in an investigation in dogs by Malitha et al. They reported that bodily tooth movement
seemed to be related strongly to individual factors rather than to the magnitude of the force.

Recent investigations with beagle dogs revealed that the rate of tooth movement did not depend on the magnitude of forces used, but rather more on whether continuous or intermittent forces were applied. They found that there was a greater tooth movement in continuous light force application as compared to intermittent forces applied in premolars of beagle dogs. However, contrary to Pilou's study, they reported that if forces were sufficiently lighter, the increase in the magnitude of forces can influence the rate of tooth movement.

A more recent study further explored the extent of root resorption using this experimental setup. They reported that intermittent forces cause less root resorption than continuous forces, and that force duration plays an important role in the extent of resorption. However, they noted that root resorption may still not be sensitive to the magnitude of forces applied.

As a consequence of such diverse findings in previous studies, it becomes confusing as to whether there is a direct correlation of the magnitude of force used for hard tissue destruction in orthodontics. Closer examination of the methodologies of these studies explains intricate results and findings.

Quantitative evaluation of resorption using radiographs has proven to be highly inaccurate due to magnification errors and their inability to be readily reproducible. Studies using histology sections of samples have proven to be laborious and technically sensitive. Hereditary parallax errors and loss of material in data transfer have muddled the true understanding of this three-dimensional event. The case selection of subject matter is often unclear. Having a multifactorial aetiology, the study of root resorption becomes complicated if underlying systemic and local factors that may predispose to resorption have contributed to other confounding factors cited.

Recent findings in a more controlled clinical evaluation in humans have demonstrated that accurate volumetric quantitative results can be obtained. Heavy forces consistently generated more root resorption than lighter forces. There was more root resorption in the areas under high compression as compared to the areas under tension.

These events indicate that a higher level of forces does relate directly to root resorption, and the amount of using light forces in clinical orthodontics should be adhered to as much as possible.

Repair potential
Despite the negative reports on root resorption, most external root resorption could be self-limiting. It should be noted that self-limiting does not equate to a reversal of damage. Approximately 70 per cent of all defects seen in old teeth are anatomically repaired. However, the mechanism behind this self-limiting phenomenon has not been fully explored.

It has been suggested that once the level of force decreases, the healing process is initiated. Repair of resorbed crater is seen after 55 to 70 days after applied force declines. Some cemental resorbed crater are fully anatomically reconstructed. Deep dentin crater are repaired by a thin cementum layer that results in an irregularly shaped root. However, some authorities would have deemed this effect as irreversible damage. After both types of repair, the periodontal ligament width is usually normal. The root contour is frequently followed by bone contour, increasing tooth anchorage without compromising function.

Several studies have been carried out to elucidate the reparative process during retention after rapid maxillary expansion, and they all agreed that repair seemed to increase with retention time. It has been hypothesised that all resorptions will be repaired once the cause of root resorption has ceased. However, Vardimon and others claimed that all resorptions would heal provided that the resorbed surface area does not exceed the unsurved one.

Case report
The following report demonstrates a case with an underlying condition with a predisposition for root resorption and has shown marked progress of hard tissue destruction during the course of orthodontic treatment.

Case history and treatment plan
Patient RN was 17 years and 8 months old and attended the clinic when she first presented in the clinic for records (Fig. 1). Her chief complaint was her crooked front teeth. She had a history of trauma at region #21 when she fell and hit her front teeth on the side of a swimming pool a few years ago (Fig. 2). The tooth was asymptomatic, and her periapical radiographs did not show any signs of periapical lesion. She was diagnosed as a class II division into a skeletal 1 base with normal direction of growth.

The extraction of upper first and lower second premolars was indicated, followed by full fixed orthodontic appliance therapy. Her oral hygiene was fair, and special care was taken to take periodontal radiographs of her upper front teeth as treatment progressed.

Upper space closure should be done judiciously in round wires with light forces. Due to her marked upper midspace discrepancy, it was noted that her midspace might not be fully corrected at the end of treatment. The decision was made that her upper front teeth were to be restored after the completion of orthodontic treatment.

Treatment progress
RN’s treatment progressed well initially, but after a couple of months her oral hygiene deteriorated and she started to miss her appointments. She had repeated constant multiple breakages, but did not report them until the follow-up phone call to her mom revealed that they had some family problems to deal with at home. They were also on government welfare and pension. Most failed appointments were due to her inability to afford a train ticket to travel up for her appointments.

These issues, coupled with her complicated case history, got more complex when she called us up one morning reporting that she was expecting a child and was 16 months into pregnancy. As extractions, spaces were still present and the progress of her case slow due to her frequent failed appointments, the immediate plan was to complete space closure and get her into a functionally acceptable occlusion as soon as possible.

Her oral hygiene deteriorated further from this point, and after a couple more months, her mobile phone was disconnected and we were not able to contact her. RN did not return to the clinic until after she had her baby son, which was another 4 months later. She still maintained poor attendance at the clinic while we were trying to close up all the spaces and get her out of treatment as soon as possible.

We did not see her for another 6 months. This time she had another fall and hit her already compromised #21 and fractured it further. An emergency appointment was made for her to attend the general dentistry clinic to have that restored, but she failed to attend that clinic as well.

When she turned up again another 9 months later, there were generalised decalcifications, multiple caries detected and apicaling oral hygiene. At this stage, all the spaces were closed and immediate removal of the fixed orthodontic appliances was performed (Fig. 5).

Radiographs at this stage showed marked root shortening (Fig. 4); however, clinically, the teeth were not any more mobile than usual. Figures 5a–d documented her upper incisor root length through the progress of treatment. She was issued with immediate suck-down type retainers and appointments were made for her with the restorative dentistry department for the management of her caries and oral health conditions. However, she failed to attend any of these appointments.

Her total treatment time was spread over 47 months, and it can be noted from this experience that what could go wrong will go wrong in special cases such as this. In hindsight, we might not have started her case in the first place. With a compromised upper anterior dentition complicated by poor compliance and oral hygiene, root resorption or even crooked teeth may not be the issue of utmost importance. Her inability to juggle child birth and personal commitments with other social difficulties may have taken their toll on RN.

While we attempted to use light forces to achieve our objective of space closure, we wished we could activate these light forces more constantly by having shorter inter-appointment times. However, this was not possible with RN.

Despite our urgency to get her out of braces, multiple failed appointments and lengthy periods of neglect in supervision of ongoing treatment increased treatment time instead. Her combined endodontic periodontic restorative condition did not help the progress of her orthodontic treatment at all. Despite such an outcome, her arch forms and orthodontic treatment objectives were reasonably achieved. With proper management of the restorative condition of RN, the upper incisors may still be reasonaably maintained within the short to medium term.

Conclusion
Root resorption is and will remain a complicated subject matter for the orthodontist. The purpose of this article was to provide an overview of the subject and to introduce a more complex case with root resorption.

Acknowledgement
We would like to thank Dr Joe Greaney for contribution to the treatment and management of the case documented in the report, and Professor M Ali Daren-diller and Dr David Armstrong for proofreading this article.

A complete list of references for this article is available upon request from the publisher.

This article originally appeared in Dental Tribune Asia Pacific edition No. 6, Vol 2.

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Cost-effective denture treatment
Dr Salt offers a guide to fitting implants for denture wearers for the best results

Denture wearers, as a population group, are the people that can benefit the most from dental implants. As dentists we are only too aware that the wearing of dentures can be a crippling experience for many of our patients. Alveolar bone is unique in that it is generally only present to support teeth within the jawbone. The loss of teeth triggers the physiological resorption of the alveolar bone and wearing of a hard acrylic denture hastens the resorption process.

With the slow progressive loss of alveolar bone, ridge height reduces, attached gingiva gradually decreases and muscle attachments are moved closer to the crest of the ridge. This combination of loss of alveolar ridge height and movement of the soft tissues resulting from the under-lying muscle pull tends to increase the instability of the dentures.

Denture instability
This denture instability is most evident in the lower jaw. More often than not, most denture wearers have learned to tolerate an upper denture, but it is usually the lower denture that tends to cause the most grief. An upper denture has a propensity to be tolerated more readily because there is a larger surface area for the denture base to cover, which enables the “suction” effect, and the upper front teeth are key for smiling and talking when facing the general public. The lower denture on the other hand, has a much smaller surface area and the muscles of the tongue (on the inside), and lips and cheeks (on the outside) act to stabilise dentures. All the early implant studies were devoted to the placement of dental implants in the lower jaw, between the mental foramina, thereby providing an anchor to enable full lower denture wearers to overcome these problems.

Implants not only help to provide increased retention and stability for unstable dentures, but they also help to protect and retain the alveolar bone, and in some instances actually help to promote bone formation) from the continuous hammering that it receives from wearing dentures.

Improving denture wellbeing
In the lower jaw, the placement of two well-placed implants can dramatically improve the general wellbeing of a denture wearer. Although the overdenture on two implants is still predominantly mucosa-borne, it no longer floats around during function. In the more discerning patient, the placement of additional implants enables the denture to be less mucosa-borne and more implant-borne. Depending on the system that is used, as few as three to four implants can be used to support a fixed bridge. However, it is generally agreed that five strategically placed implants are required to support a fixed implant supported bridge. More than five implants in the lower jaw will enable a longer bridge to be constructed and provide back up should any of the implants fail. The number of implants placed should be determined by the type of restoration that will be placed; the quality and quantity of available bone height and the dentition in the opposing arch.

The number and placement of implants in the upper jaw is determined by the fact that the bone is of poorer quality than in the lower jaw. On average, a minimum of four implants are required for an implant supported overdenture and six to eight implants are required for a fixed implant supported prosthesis.

Cost-effective solution
A technically simple and cost-effective solution has been introduced by BioHorizons to improve the stability of the lower denture. The BioHorizons OS System can provide your patient with four implants to improve the stability of an unstable lower denture. For £99 (excluding VAT), the 5mm implant comes as a once-piece, transmucosal implant with the ball attachment already attached. The procedure is usually performed under local anaesthesia with a flapsless approach, thereby minimising postoperative discomfort. Unlike mini-implants, which are only licensed as a transitional implant, this system has FDA approval for “permanent” usage in the lower jaw.

At the time of placement, the patient’s existing denture can be adjusted to accommodate the implants, thereby immediately loading the implants. As this is a one-piece ball attachment implant, it cannot be “upgraded” to a fixed bridge in the future. However, it will provide the simplest and most cost-effective solution to a patient that will gain the greatest benefit.

About the author
Dr Stephen Salt, BDS MDent (Rand), specialises in prosthodontics and has 16 years of dental implantology experience. He is the principal of Century Dental Clinic, a state-of-the-art private dental practice situated in Putney. Dr Salt also teaches restorative dentistry at Guy’s Hospital and St Thomas’s School of Dentistry.
A team approach

To generate a loyal customer base, the entire practice team must make the patient’s experience worthwhile, not just the dentist. Dr Riz Syed explains.

In order to succeed in implant treatment, dentists must look beyond their own skills and expertise in terms of what they can offer patients. It is of paramount importance for the whole team to act as a single functioning unit for complete patient care.

I have heard many skilled surgeons complaining of the lack of patients being seen in their clinics despite heavy marketing, which costs valuable time and money. A motivated team is a reflection on the surgeon, indicating what they can offer and what care patients will receive when coming to the clinic.

The receptionist

The initial contact point for every patient is the receptionist and key areas of interest include how they deal with visitors and what level of knowledge they possess. It is important to train your receptionist in what each aspect of implant dentistry involves. This includes what an implant is, the procedure, post-operative care and the length of time involved.

Having the right implant system is crucial, but even with a solution from a leading implant company such as Nobel Biocare, patients won’t benefit if the receptionist cannot answer their questions.

Dental nurse

Having mentored many surgeons across London and the Home Counties, I see many nurses not adequately trained for the procedures carried out in their surgeries. It is important not to see implants as part of routine dentistry but as a specialist field. Nurses’ training courses (basic and advanced) are readily available and I would recommend that implant surgeons ensure that their nurses are sent on these courses. They should be aware of each component of an implant, the stages involved and the time frame.

Hygienist

The team approach extends beyond the receptionist and nurse to other specialities within dentistry. My initial therapy for a patient usually involves them seeing my hygienist first to maintain and achieve a healthy environment in which I can operate. Implantology is often seen by surgeons as an isolated field, dealing with a specific site. A full comprehensive treatment should be given to restore the mouth with implants complementing this treatment.

It is also important for the hygienist to secure the oral health of the patient and reinforce oral hygiene techniques following implant therapy.

Dr Riz Syed

qualified at the Royal London Hospital in 1999, runs a referral clinic in Islington and Walton-on-Thames, and was one of the first surgeons in the country to use NobelGuide. He is a mentor for Nobel Biocare, helping to train UK implant surgeons. Regularly consulted for complex treatment-planning cases, Dr Syed lectures on guided implant surgery. He is a member of the Association of Dental Implantology, the International Congress of Oral Implantologists and Fellow of the Royal Society of Medicine. His practice includes sinus grafting, surgical crown lengthening and hard and soft tissue grafting, and has been awarded the Clinic of Excellence in Implant Dentistry. To contact Dr Syed, email rizsyed@hotmail.co.uk or call 01923 223479 (Mulberry Dental Care) or 0207 2269797 (AG Dentistry). For further information on Nobel Biocare, call 01895 430650, email info.uk@nobelbiocare.com or visit www.nobelbiocare.com.
A good impression

Luke Barnett talks about making the most of the latest implant technology and the skills of your laboratory

There are numerous different implant systems with largely the same success levels. Your choice should be determined by the clinical parameters of the case and the patient’s precise requirements rather than a blanket preference.

Choosing a reputable brand – Nobel, 3I, Straumann, Ankylos, BioHorizons, Astra tech, to name a few – ensures that you are working with durable, quality materials designed with a high standard of craftsmanship and the right technical backup.

Zirconium is becoming increasingly popular as an implant material, but its integrity can be compromised by the way it is handled, for example, using the right diamond for adjustments and avoiding rapid or extreme changes in temperature during manufacture. It’s vital to follow the manufacturer’s instructions to ensure a durable outcome and that technicians use great care when designing abutments and substructures. I would however strongly recommend zirconium for use in the aesthetic zone.

Delivering results

Outside the aesthetic zone, and when space permits, titanium is perfectly satisfactory with the most recent brands being gold plated to enhance aesthetics. All ceramic systems, whether zirconium or pressed ceramics etc, will deliver excellent aesthetic results so long as the materials limitations are fully appreciated.

The key to success and good relations is communication. Encourage the use of a tissue model to replicate the gum to aid in the aesthetic zone. Equally detailed instructions for the handling of contacts and occlusal loading. These are critical to the success of the final outcome, take face bow records where possible to help to minimise functional adjustments. No dentist likes to grind porcelain and no technician likes to hear of his or her work being adjusted. Keeping the lines of communication open and offering accurate information saves misunderstandings on both sides and eliminates the need for unnecessary modifications or for work to be repeated.

Today’s patients have high expectations for their implants, and aesthetics must now be matched by the restoration of natural function. With the support of Cad/Cam technology and the extensive research, which underpins today’s implant systems, meeting these expectations has become the norm.
‘We are currently undertaking more revolutionary projects’
An interview with Mectron, the company who invented Piezosurgery

Mectron, based in Italy, has revolutionised dental surgery with their development of piezoelectric bone surgery. Recently, the company presented the 3rd generation of their Piezosurgery device at the IDS show in Cologne in Germany. We spoke with company founders Domenico Vercellotti and Fernando Bianchetti, as well as area managers Wolf Narjes and Alexandre Cadau, about the clinical advantages of their invention and how the company is reacting to the current market conditions.

Dental Tribune: Market prospects for 2009 are rather uncertain due to the financial crisis. Is your company prepared for a potential economic slowdown?

Fernando Bianchetti: The only way to withstand this crisis is to remain successfully in the market through investments in scientific and technical research, in Europe and other countries.

Domenico Vercellotti: What Fernando just said has always been our corporate philosophy; it will certainly help us in difficult times like this. Mectron offers high quality products at reasonable prices and puts a lot of effort into the development of new technologies and not merely into expensive marketing campaigns.

Wolf Narjes: Being a family-owned company, Mectron is currently undertaking more revolutionary projects.
probably more flexible and manageable than larger companies. Therefore, we can react relatively quickly to unexpected market changes.

Have you already experienced an economic climate change in Italy and other markets?

Fernando Bianchetti: Since our company was founded in 1979, we have already had to go through occasional tough economic times. However, nothing really compares with the latest financial crisis.

Alexandre Cadau: Fernando is right. At the moment, we are experiencing a huge loss of confidence in all consumer groups. On the other hand, we have always been challenged by the depreciation of various foreign currencies, like in 1992 when devaluation hit many countries.

Alexandre Cadau: Piezoelectric Bone Surgery is based on scientific techniques developed for Piezo-surgery which were first performed in 1979. Piezo-surgery is still evolving and has many advantages that are not available with comparable traditional surgical technologies. What are the main advantages compared to traditional surgical technologies?

Domenico Vercellotti: Metron invented piezoelectric bone surgery in collaboration with Prof. Tomasio Vercellotti almost ten years ago. Back then, it was not just another product: it was a significant innovation in the field of dentistry based on technical expertise and years of clinical research. Thanks to Piezosurgery, oral surgery evolved from traditional rotating instruments to a new system of cutting bone that spares soft tissue and accelerates the healing process.

Wolf Narjes: Our Piezodent has been studied, to ensure that applications for the device have been very open-minded to the latest innovation is tips for the implant site preparation that have demonstrated histological benefits and a better osseointegration of implants compared to the traditional twist drill (Giulio Preti et al., Cytokines and Growth Factors Involved in the Osseointegration of Oral Tita-nium Implants Positioned using Piezoelectric Bone Surgery Ver-

Wolf Narjes: I have found that several countries, including South Korea, Italy, and Germany, have been very open-minded to this new technology. Most Scandina-vian countries, however, have only begun to understand how to use this innovative technique.

Fernando Bianchetti: All the clinical protocols and tech-niques developed for Piezo-surgery are based on scientific publications endorsed by universities and credible specialists in the field of dental surgery. They confirm not only the benefits for the clinician, such as maximum surgical precision and wider intra-operative visibility, but also those for patients who suffer from less postopera-tive pain.

‘It is essential to be suitably trained in this technique.’

Alexandre Cadau: Piezo-surgery has certainly been one of the most important developments in the dental and medical field. This unique device allows the surgeon to work in less stressful and safer conditions. Postoperative healing times are also reduced threefold with this method.

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Training courses are regularly offered at the Piezosurgery Academy in Italy. Do you also offer courses in other parts of the world?

Domenico Vercellotti: Piezosurgery Academy was established by Prof. Tomaso Vercellotti to give scientific support to the Piezoelectric Bone Surgery. It is managing the whole clinical research and training activities in Piezoelectric Bone Surgery and works independently from Mectron.

Wolf Narjes: It is essential to be suitably trained in this technique. Therefore, we offer courses in Europe, Asia, as well as North and South America. Last year, we opened a new branch in Phuket in Thailand that serves as the Piezosurgery training centre for the whole Asia Pacific Region.

Alexandre Cadau: There is a reason that training is crucial for Piezosurgery. Users experience a steep learning curve before getting used to the micrometric movement of Piezosurgery, which is completely different to the traditional techniques. We organise workshops in many countries around the world that help dentists learn the differences between Piezosurgery and conventional burs and saws. In addition, we collaborate with universities, to offer attending clinicians cadaver dissection courses that help them appreciate the surgical benefits.

With four regional headquarters, do you consider yourself a global cooperation?

Fernando Bianchetti: Certainly, our branches in Germany, India, and the Asia Pacific region report to our headquarters in Italy. In other countries, we have worked successfully with local dealers for almost ten years, in some countries even 20 years.

Wolf Narjes: If you mean: are we represented in all the important countries around the world, then definitely yes. Our network is well established in more than 80 countries, and our sales team is working daily to extend it even more.

How closely do the regional headquarters work with the headquarters in Italy?

Domenico Vercellotti: In Mectron’s corporate organisation, the regional headquarters represent points of information exchange and contact between the headquarters in Italy and local clinicians.

Fernando Bianchetti: They work very closely with our main headquarters in Italy for different reasons. Mectron Italy helps the regional headquarters and, of course, our other distribution partners to provide their customers with technical support. The staff at regional headquarters, as well as our distribution partners, are regularly trained by our engineers in Italy.

Alexandre Cadau: All Mectron partners receive marketing support through the headquarters in Italy. In this way, we ensure that all our staff and partners, whether an Italian dealer or a South American distributor, keep up to date with the latest specifications and developments of our products.

Wolf Narjes: I have to add that although marketing is centralised, the structure of our company is still flexible enough to fulfil local demands.

Do you have offerings in other market segments as well?

Fernando Bianchetti: Let’s speak about the other products Mectron has been manufacturing for plenty of years like piezo-electric scalers, curing lamps and air polishers. Mectron was the first company to introduce on the market a scaler handpiece in titanium which has represented the new state of the art in life span and sterilization, as well as the first one to launch a LED curing lamp!

Wolf Narjes: Mectron has a lot of capacity for innovation. Therefore, our company is not only a leader in the field of the Piezosurgery technique, but also in the light curing segment.

Alexandre Cadau: We say we have succeeded to be a long-term market leader. As far as the production of LED curing lights is concerned, our company is still one of the biggest manufacturers worldwide.

Many companies are starting to extend their range of products. Are there any new products being developed that you would like to talk about?

Fernando Bianchetti: Apart from the further improvement of existing products, we are currently undertaking more revolutionary projects in our R & D department. A total of fifteen per cent of all staff working at Mectron are actually involved in this.

Domenico Vercellotti: Our mission is to implement new technologies for the dental market that are based on the latest evidence-based research. We will also stay on this track in the future to develop innovations that are economical and bring true clinical advantages.

Thank you all very much for the interview.
BDA conference and exhibition 2009

This year’s BDA conference programme will encourage and inspire all members of the dental team to realise their full potential.

The BDA is pleased to announce that the 2009 British Dental Conference and Exhibition will be held from June 4 to 6 2009 at the Scottish Exhibition and Conference Centre, Glasgow.

Based on the theme ‘Dentistry is transforming’, the conference programme will feature motivational, expert speakers who will inspire you to develop new ideas for your practice and enhance your career.

New clinical Speaker

Luca Dalloca, a Prosthodontist and Aesthetic specialist from Oral Design Milan, Italy, will talk about ‘Art and visual perception applied to aesthetic dentistry’. This speaker will give you insights into making your restorations fit your patient’s face while looking real and natural, a truly fascinating presentation not to be missed! Catch Luca Dalloca in the Lomond Auditorium from 2pm–5.30pm on Thursday June 4.

Charan Gill – Keynote speaker

Inspirational entrepreneur Charan Gill MBE, the man behind the Harlequin Leisure Group, will be the keynote speaker. He developed the largest Indian restaurant in the UK and built a reputation as Glasgow’s ‘Curry King’.

Cherylly Sheets - Main clinical speaker

Clinician, educator, author and lecturer Dr Cherylly Sheets will be presenting a day-long lecture on Friday June 5 2009 looking at ‘Meeting the demands of today’s aesthetic restorative practice’. Dr Sheets has a private practice in California and specialises in aesthetic rehabilitation, dentistry and implants. She is also Clinical Professor of Restorative Dentistry, USC School of Dentistry, Los Angeles and co-executive director of the Newport Coast Oral Facial Institute, an international non-profit teaching and research centre; considered to be one of the finest microsurgical training centres in the world.

Career and business development seminars

There will be a range of sessions focusing on career paths, setting up in practice, and business planning. If you are thinking of diversifying into areas such as whitening, smoking cessation and implants, the business development streams will help you explore opportunities in these areas.

Clinical seminars

You will also have the chance to attend a wide variety of clinical presentations covering topics such as management of failures, veneers, periodontics, caries detection and diagnosis, plus much, much more.

Exhibition-only tickets – FREE

You may be interested in attending the Exhibition only. If this is the case, you will be pleased to hear that this is FREE! Not only will you have access to 6,500 sq m of Exhibitors, but you will also be able to attend Exhibition hall seminars in the Exhibition hall throughout each day.

The exhibition

Running alongside the comprehensive conference programme will be the popular exhibition, which is set to be our largest yet. You can meet suppliers, pick up samples and learn about new products and services.

The 2009 exhibition will take place in the Scottish Exhibition and Conference Centre’s largest hall, Hall 4.

Book your ticket

Registration is now open. If you book online, you’ll receive a £20 discount on the price of a three-day ticket and £10 off the price of a one-day ticket. Visit www.bda.org/events/annual-conference/index.aspx for more details, call 0870 166 6625 or email bda@delegate.com.

Septodont will be at the BDA show in Glasgow to show why commitment to quality and innovative products have confirmed Septodont as the world leader of dental anaesthetics.

The BDA show will underline the success that Nu’Durance has experienced since it launched in October 2007. Nu’Durance® is a real landmark development for Septodont and comes after many years development in conjunction with a number of leading universities.

The revolutionary new dimer acid main matrix technology is unique and exclusive to Septodont and exhibits several outstanding advantages over existing material currently in the global market.

Today, Septodont are as committed as ever meeting the changing needs of the profession. So with numerous products in the final stages of development and the new CPD workshop being introduced, the future looks very bright.

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CEREC AC Bluecam – Seen in a new light.

Sirona UK is a specialist division of Sirona Dental Systems, the manufacturer of the CEREC System, and has now for the last 8 years supplied and supported CEREC 3 CAD/CAM all-ceramic restoration system here in the UK.

With product simplicity key to the success of any dental practice, Sirona are now proud to launch their new CEREC AC Bluecam imaging unit making the CEREC even easier to use for the dentist.

Sirona has helped to successfully integrate CEREC into dental practices for over 22 years, with more than 24,000 systems now in place worldwide. It offers convincing long-term aesthetic restorations in a single visit.

Sirona UK’s mission is to deliver satisfaction to the dentist using tried and tested in-surgery training methods supported by Sirona Specialist Practitioners who are dedicated to your success.

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Bambach Saddle Seat Confirmed Product of Choice

Bambach will be demonstrating the revolutionary Saddle Seat at the BDA Conference Exhibition. It is of interest to note that an elective study by 4th year dental students at Glasgow University confirmed Bambach’s Saddle Seat as product of choice when dentists wish to combat and prevent lower back pain whilst at work.

The paper entitled ‘A study of back pain in dentistry’ revealed that 86% of survey respondents reported back pain at some point in their career thus indicating the severity of the problem. All must all recognised that poor posture of work was a direct cause of this pain and nearly half (a staggering 43%) chose the popular Bambach Saddle Seat as a treatment and preventive measure (see link http://hdl.handle.net/1905/499).

The Bambach Saddle Seat is a scientifically designed and proven solution, endorsed by the Australian Physiotherapy Association, as it helps the pelvis attain its preferred neutral position.

To find out further information including details of Bambach’s 30-day trial, call 0800 581 108 or visit www.bambach.co.uk

Gemstar Services Ltd – Stand C27

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DENTSPLY – Bringing Excellence To The BDA

The dynamic DENTSPLY team will be showcasing their innovative and highly acclaimed products at the British Dental Association (BDA) British Dental Conference and Exhibition 2009. From the 4th-6th June, the Scottish Exhibition and Conference Centre, Glasgow will be host to some of the biggest names in dentistry.

The theme of the conference will focus on ‘securing your future and realising your potential’. DENTSPLY will be on hand to motivate delegates in using the latest pioneering equipment such as the Artic™ hand instruments.

The instruments are super lightweight with extra hard, strong steel tips that provide longer lasting sharpness. These affordable products are all colour-coded for their specific uses. Trip from the sale of all Artic instruments will be donated to the Mouth Cancer Foundation. Visit www.mouthcancerfoundation.org for more information.

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**For further information on kemdent products visit our website [www.kemdent.co.uk](http://www.kemdent.co.uk)**

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**BOS Debut – The British Orthodontic Society makes its first appearance at the BDA Conference**

**Experience the all new A-dec 300 at the Glasgow BDA Conference 4th-6th June 2009**

**The British Orthodontic Society (BOS) will make its BDA Conference debut in Glasgow in June. The Society, which represents 1, 800 UK orthodontists and is the largest of the dental specialty groups, is a registered charity and as part of its outreach policy is engaging more actively with general dentists.**

**In addition, the BOS has been working more closely with the BDA to help its members with issues relating to contracting, retirement and practice sales, to name but three. The two organisations stood shoulder to shoulder at the recent Parliamentary Health Select Committee and are in accord on many issues.**

**Stand visit: A visit to stand A48 in Hall 4 at the BDA Conference will give delegates a chance to meet the Chief Executive of the BOS, Las Jaffe and take the opportunity to find out more about the many ways in which orthodontics fits into an inter-disciplinary approach to dental care.**

**Those unable to make the trip to Glasgow for the BDA can find out more about the British Orthodontic Society by visiting [www.bos.org.uk](http://www.bos.org.uk)**

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**For more information or to visit our showroom contact 0844 871 1562 Email: sales@halchardmedical.co.uk BDA Conference Glasgow – A21**

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**GlaxoSmithKline Consumer Healthcare UK – Oral Care (stand B27)**

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**Kemdent has demonstrated its ability to innovate with the introduction of Diamond, a unique GIC that sets rapidly and is resistant to saliva.**

**Since it was first launched in 1997 it has gained a significant share of the UK restorative market and is successfully marketed in many European countries and the Middle East.**

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**For further information on kemdent products visit our website [www.kemdent.co.uk](http://www.kemdent.co.uk)**

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**For more information visit Stand A13 or if you are unable to attend the BDA call Jane White on 0800 6341909.**

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**GlaxoSmithKline Consumer Healthcare UK**

**Discover The Leading Patient Referral Plan**

**Tears and Transplants" on Friday 5th June at 14:15 in Boisdale Room 1.**

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**Denplan**

**Discover The Leading Patient Referral Plan At The 2009 British Dental Conference**

**Denplan sponsor BDA**

**Denplan, the UK’s leading dental payment plan specialist, is delighted to be a platinum sponsor of the BDA Conference and Exhibition 2009 and to be invited to the beautiful city of Glasgow once again.**

**This year, Denplan’s conference seminar: ‘Dental Care or beauty treatment? – a choice for today’s oral health care professionals’, features highly respected guest speaker, Richard Ibbetson, Director of the Edinburgh Post-graduate Dental Institute and Honorary Consultant in Restorative Dentistry, Lothian Primary Care Trust. This seminar will take place on Friday 5th June in the Boisdale Room 1 from 9.30 – 10.45.**

**Denplan’s knowledgeable and expert team will also be on hand throughout the exhibition at stand number A20 to talk to you about its range of flexible payment plans as well as some exciting company news for the future.**

**For more information about Denplan, please go to [www.denplan.co.uk](http://www.denplan.co.uk) or call us on 0800 401 402.**
Braemar Finance

Braemar Finance is a well-established direct lender to the dental profession, and as part of Close Brothers plc, are well capitalised and have funds available to help you develop your dental practice. Braemar are delighted to offer pre-approved finance, allowing you more time to locate and order the equipment which best suits your practice.

Braemar specialists in tax efficient funding for:
- Equipment Finance
- Vehicle Finance
- Computer Finance
- Practice Loans
- Personal Loans
- Commercial Mortgages
- 0% Patient Finance Facility

Visit us on Stand 817 at the BDA Conference & Exhibition at the SECC 4th- 6th June 2009, alternatively contact us on 01563 852100 where we are available to discuss your finance options.

Visit our web site www.braemarfinance.co.uk and register for any Braemar update that may affect your profession, we will only send relevant information when necessary.

P&G Professional Oral Health

Products sold in practices are often demonstrated to patients in order to ensure they’re being used correctly. In recognition of the time and effort this entails, P&G will include a free educational ODU and the entire Oral-B range of seven replacement heads with every Professional Care and Triumph power product sold. This is the first time the Profession have been given their own extra value pack sold only to dental professionals and by dental practices to help ensure patients use the right type of brush, the right way.

The launch of these packs coincides with some upgrades which are being launched into the Professional prior to June, or at the BDA Dental Showcase at the NEC between the 12th and 14th November.

For more information, please contact Mark Chapman on 07734 044877 or via mark@velopex.com.

For more information on our range of products, please see: www.velopex.com

GC Professional Oral Health

GC will be further promoting Minimal Intervention programme with two new products recently added to the range. GC saliva-Chek Xpert adds another dimension by showing whether a patient carries a high level of Streptococcus mutans in the saliva. This chain-side diagnostic tool demonstrates whether a patient is at further risk of caries development, without the need for bacterial cultures.

To make your denture patients more comfortable, allowing flow for the soft tissue to adjust particularly after implant surgery, GC has introduced Tissue Conditioner. This all-in-one soft-relin and conditioning material is classed as the next generation of acrylic soft relins materials, patented by GC.

Another new product within GC’s portfolio is GC Initial IQ; the new One Body, Press-over-Metal and Press-over-Zircon aesthetics and the intersection with customers. There is always a number of people wanting to try out the Xpocket and to chat about the applications.

For those of you going to Glasgow for the BDA, you can find us at the INAC in Westminster on the 12th and 13th of June, or at the BDA Dental Showcase at the NEC between the 12th and 14th November.

For more information, please contact Mark Chapman on 07734 044877 or via mark@velopex.com.

www.velopex.com

Dentists’ Provident

Dentists’ Provident offers 3 months’ free premiums

Dentists’ Provident is the leading provider of income protection insurance to dentists in the UK and Ireland. At the BDA Conference & Exhibition 2009 in Glasgow, any dentist applying for income protection at Dentists’ Provident stand A58 for three months free premiums. (Available for direct applicants only and cannot be used in conjunction with any other offer.)

As a specialist insurer, we understand the complex income protection needs of dentists. Our flexible contract gives you peace of mind that you are financially protected if incapacity prevents you from working, with the option of cover from the first day of your illness or injury.

Dentists’ Provident is a mutual organisation, which means it is owned by and managed solely for the benefit of its members. Visit stand A58 to find out why over 13,000 dentists have chosen to be a member.

For more information call 030 7222 3511, write to 9 Gay Street, London SW1P 3HN or visit www.dentistsprovident.co.uk.

Maximise Your Potential

Visit PracticeWorks and take your practice to the next level!

PracticeWorks will be inspiring delegates to be the best at the British Dental Association (BDA) British Dental Conference and Exhibition 2009. From the 4th-6th of June 2009, dental professionals will be attending the Scottish Exhibition and Conference Centre, Glasgow to discover the impressive products and services of leading providers PracticeWorks.

The expert team will be showcasing the R4 Practice Management Software Version 3 that is currently transforming dental practices all over Britain. There is no need to install any software or back up the system with the new Managed Service.

Learn more about the extensive digital imaging products also from PracticeWorks such as the new 9500 Core Beem CT Scanner. Professionals can now take high quality CT scans in the comfort of their own office. The incredibly high resolution ensures the anatomical information is undistorted, helping dentists give an accurate diagnosis.

For more information contact PracticeWorks on 0800 169 9692 or visit www.practiceworks.co.uk

Dental Defence Union

Visit the Dental Defence Union.

Half 4, Stand 822

Scan your badge and enter our prize draw for Marks & Spencer vouchers

Rest assured
You’re with the DDU

Membership hotline
0800 085 0614

www.theddu.com
The new NDT® syringe from VOCO

Hygienic and efficient use through non-dripping technology

Starting now, syringes that run, drip and leave strings and the accompanying waste of expensive material belong to the past. VOCO has successfully developed a non-running, non-dripping syringe based on the innovative non-dripping technology (NDT®) especially for highly flowable materials.

Test dentists are impressed with the new technology

The new NDT® syringe was extensively tested by numerous dentists over the past few months. All of the practitioners described the dosability and overall handling as exact and excellent. The runoff behaviour was likewise given a rating of excellent. Most dentists rate exactly this property as problematic for working with flow products. Almost all test dentists could establish that there was not any runoff of the employed material (Grandio Flow) with the use of the NDT® syringe. More still: The test dentists even stated that handling was improved by using the NDT® syringe.

Manufacturer: VOCO GmbH, PO Box 767, 27457 Cuxhaven, Germany, www.voco.com

For more information please contact Tim McCarthy UK Sales Manager, Mobile: 07500-769-615, t.mccarthy@voco.com

Panadent

Upgrade to the healthier side of whitening and stop Gingivitis before it starts

The product is the same as we had before with the three year expiration date, the reason we have two years on it because all new products have to go on stability before they can justify their expiration date whenever any changes are made, in this case with the container. The product passed an accelerated three month which justifies a two year expiration and it’s currently in the midst of an accelerated six months to justify the three year expiration. The next batch will have three years on it, this batch has over ten years of manufacturing till August.

The Velopex Team will be delighted to welcome you to Stand at the World Aesthetic Congress at the QEII Centre, Westminster between the 12th and 15th of June this year.

Exhibitions are always an exciting time for Velopex – both existing and new customers come and chat about existing products and new products.

On display will be the award winning Aquacut and the Velopex colour Diode laser along with the Aespio range of portable equipment, processors and the Velopex Digital system. We will also be talking through the exciting relationship that we have established with the California Centre for Advanced Dental Studies (CCADS) and how you could be put forward to receive an educational grant worth £18,500.00!

For those of you not going to the WAC in Westminster, you can find us at the BDTA Dental Showcase at the NEC between the 12th and 14th November.

For more information, please contact Mark Chapman on 07754 048877 or via mark@velopex.com.

For more information on our range of products, please see: www.velopex.com

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Buy 2 Practice-safe sprays and receive a 20% discount.

Surgery professionals appreciate the versatility of PracticeSafe spray. Not only can it disinfect the alcohol resistant surfaces of all types of medical products such as hand and angle pieces can be cleansed and disinfected to a very high standard.

For more information please visit: www.beverlyhillsformula.com

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For more information on our range of products, please see: www.velopex.com

Continued success drives Prestige Medical to new premises!

Prestige Medical has announced that it is relocating its offices and production from its current factory in Clarendon Road to a larger modern industrial unit currently being prepared on the popular Shardoworth Business Park in Blackburn.

Managing Director Ian Starkey commented: “We have a programme of continuous improvement and strive to ensure that Prestige Medical products consistently provide the best solutions for infection control. Our products are sold all around the world and we are delighted that, even in the current difficult economic climate, we are continuing to increase business and have now outgrown our old factory. The new premises are currently located just off the M65 motorway and we look forward to welcoming customers old and new to East House.”

Prestige Medical provides the healthcare industry with a full range of integrated decontamination solutions including portable and bench-top autoclaves; washer-disinfectors; associated decontamination rooms and advice on legislation compliance.

The new address will be: Prestige Medical Ltd, East House, Duttons Way, Shadsworth Business Park, Blackburn BB1 2QR Telephone: 01254 682 622 Fax: 01254 682 606

Grandio Flow – Now in new NDT® syringes

Hygienic and efficient use through non-dripping technology

Starting now, syringes that run, drip and leave strings and the accompanying waste of expensive material belong to the past. Grandio Flow is now available in the specially designed NDT® syringe. VOCO has successfully developed a non-running, non-dripping syringe based on the innovative non-dripping technology (NDT®) especially for highly flowable materials. The syringe permits especially for highly flowable materials. The syringe permits exact shade matching with 16 ten shades (A1, A2, A3, A3.5, A4, B1, B2, C2, D2, OA2). In addition to exact shade matching with Grandio, the universal restorative, nonstandard indications can also be fulfilled with Grandio Flow using the special shades Bleach Light (BL) and White Opaque (WO). Bleach Light is not only suitable for bleached teeth, but also for paediatric dentistry. White opaque

forms an excellent restoration foundation. Grandio Flow in the new NDT® syringe – hygienic, quick, precise and no waste.

Manufacturer: VOCO GmbH, PO Box 767, 27457 Cuxhaven, Germany, www.voco.com

For more information please contact Tim McCarthy UK Sales Manager, Mobile: 07500-769-615, t.mccarthy@voco.com

Communication in Dentistry: Smile-on and DPL Announce New Modules

After the success of its programme Communication in Dentistry: Stories from the Practice, Smile-on in association with Dental Protection Ltd (DPL) is delighted to announce the development of the next 5 modules.

Due to be launched later in 2009, Modules 4 to 6 of Communication in Dentistry are:

Module 4: Complaint handling and dealing with difficult patients

Module 5: Consent and communicating choices

Module 6: Recording communications

Supporting a flexible approach to learning, these modules can be taken separately or together, to suit individual requirements. Focusing on the key areas in which effective and reliable lines of communication are absolutely vital, these 5 modules will help the practice continue to develop working systems that will ensure patients receive the best possible standard of service, and that all relevant information is recorded to protect the practice medically-legally.

Communications in Dentistry is an example of how cutting edge technology and informative content come together to meet the educational needs of dental professionals.

For more information please call 020 7480 8899 or email info@smile-on.com

Dental Tribune


28 Industry News
Get ready to jump

Try a 10,000 ft freefall parachute jump and raise money for charity at the same time

Imagine standing at the edge of an open doorway in an aircraft flying at 10,000 feet – the noise of the engines and the wind ringing in your ears with only the outline of distant fields below. Now imagine leaning forward out of that doorway and letting go – falling forward into the clouds, diving down through the air (without the parachute deployed) for several thousand feet; while you’re harnessed to a professional parachute instructor at all times throughout the descent. This is the only way you can jump from such an altitude without spending thousands of pounds becoming a freefall parachutist. This is literally the chance of a lifetime! This jump is also much less demanding than the traditional ‘static line’ jump as it and the training are completed in one day and your instructor will control your landing.

What does it involve?

Technically the jump is called a ‘Tandem Skydive’ – you’ll be freefalling through the air (without the parachute deployed) for several thousand feet; while you’re harnessed to a professional parachute instructor at all times throughout the descent. This is the only way you can jump from such an altitude without spending thousands of pounds becoming a freefall parachutist. This is literally the chance of a lifetime! This jump is also much less demanding than the traditional ‘static line’ jump as it and the training are completed in one day and your instructor will control your landing.

Stop press

Dr Ian Wilson, Bridge2Aid’s co-founder and CEO, is not one to turn down a crazy opportunity – so he has taken up the challenge of doing a tandem skydive, alongside a brave group of B2A fundraisers. Ian’s dive will take place on June 15, 2009 at the Brackley jump site, near Oxford. He would love for more people to join him on this amazing day. All participants need a sense of adventure (very important) and will need to raise £395 (or more) to jump for free.

If you want to join Ian next June, or would like to jump at one of the 20 sites either singly or as part of a group, please visit www.bridge2aid.org or contact Kerry Dutton, our fundraising co-ordinator by email kerry@bridge2aid.org or by telephone 07881 912060.
Microscope use for the dental team

Join this one-day, hands-on course for an introduction to using individual Zeiss microscopes within a demo surgery set-up

Since its introduction into dentistry over 20 years ago, the microscope has become commonplace in endodontics and periodontics, but it can be used for so much more than just these procedures. Accuracy of both crown and cavity preparation is unequaled and the type of preparations and instruments used are often specific to the microscope. You can prep those margins you never could really see and be confident of a better fitting crown.

Caries removal is accomplished with the adjunct of caries stains, and is extremely accurate. The combination of excellent magnification and coaxial illumination give the best possible visual feedback. The microscope is an excellent teaching tool and can be used to record both video and photograph at the highest quality. These images are excellent for both patient communication and education, as well as being able to be used for teaching and contemporaneous record keeping. During the course we will talk about different imaging and archiving systems available.

Outputs to monitors enable nurses, patients, accompanying persons, or other to see what the operator is seeing. It adds tremendous value to the treatment and will help differentiate your practice.

An essential tool

If you want to offer the highest standard of endodontics possible to your patients then a scope is essential.

It is superb as a diagnostic tool, enabling early identification of fractures, caries, leaking restorations, resorptive defects and many more. Local anaesthetic can be delivered in a truly gentle manner by seeing the exact position of the needles bevel.

It is invaluable in retreatment, meaning that now many procedures are able to be treated non-surgically with techniques such as instrument removal, perforation repairs, open apex management and management of calcified canals becoming routine.

We will show examples of implant placement under the microscope, and how teeth are extracted utilising the scope and rubber dam. We will show surgery with microsurgical instruments, ultrasonic aids to cavity preparation, using the scope to find caries and fractures.

Reducing stress

During the day, delegates will be shown how to work effectively and ergonomically, speeding up procedures and reducing stress. We will show how to plan your surgery design to make scope usage easier, we will show correct positioning of dentist, assistant and patient to enable unsurpassed vision in all areas of the mouth. We will complete a full mouth exam under low and high power showing the versatility of the scope.

How to book

The course will be held at Highfield Dental Clinic, Birmingham on July 11 2009. Places cost £295 plus VAT per dentist and £100 plus VAT for one nurse. The course provides six hours of verifiable CPD. To book your place, contact Martin Hellawell on 01453 759659 or email martin@nuview-ltd.com.
An implant course to provide you with the necessary knowledge and skills to start a successful career in implants. The course is aimed at general dental practitioners looking to integrate implant dentistry into their patient care.

The course provides:
1. All necessary education to comply with the GDC guidelines as set out by the Faculty of General Dental Practitioners, UK and the Royal College of Surgeons, England, in the document entitled: Training Standards in Implant Dentistry for GDP’s 2008 (download at GDC.gov.uk)
2. Compliant with GDC guidelines for 185 verifiable CPD points.
3. Benefit from over 20 years of clinical knowledge & experience.

The course:
1. 18 full days spread over a 14 month period, located in Harley Street, London.
2. Maximum of eight candidates per course.
3. Each candidate will place and restore at least two implant cases under the direct supervision of Dr Mark Hamburger. In addition: treatment planning, surgical and restorative observation of all course patients.
4. Guest speakers:
   - Dr Henri Thuau, Consultant Maxillo Facial & Oral Surgeon
   - Dr Jo Omar, Medical Emergencies and CPR

For further information and to request a brochure/registration form, please contact:

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40% of adults across the world suffer from gum disease
(Source: BBC News - Health)

STOPS GINGIVITIS BEFORE IT STARTS

www.beverlyhillsformula.com