Vetting and barring scheme under review

Home Secretary withdraws scheme pending a ‘fundamental remodelling’; dental groups ‘wait with interest’

A vetting scheme for all dental professionals changing jobs or starting work for the first time has been put under review by the new government.

The Vetting and Barring scheme, aimed at protecting children and vulnerable adults, has been criticised by many as disproportionate, overly burdensome and unduly infringing on civil liberties.

It was announced last year that from July 2010, any dental professionals who were changing jobs or starting work for the first time would need to register with the Independent Safeguarding Authority (ISA) and that by 2015 all dental professionals would need to be registered with the Vetting and Barring scheme. However, registration with the scheme has been postponed.

Home Secretary, Theresa May said: “The safety of children and vulnerable adults is of paramount importance to the new government. ‘However it is also vital that we take a measured approach in these matters. We’ve listened to the criticisms and will respond with a scheme that has been fundamentally remodelled. Vulnerable groups must be properly protected in a way that is proportionate and sensible. This redrawning of the vetting and barring scheme will ensure this happens.”

Children’s Minister, Tim Loughton said: “Protecting vulnerable children is a top priority. Any vetting system should not be a substitute for proper vigilance by individuals and society. At the moment we think the pendulum has swung too far”.

The scheme was devised in response to an enquiry into the 2002 Soham murders which called for better information sharing. It was designed to protect children and vulnerable adults by preventing those who pose a known risk from gaining access to them through their work.

Within the meaning of the Safeguarding Vulnerable Groups Act 2006, the delivery of dental care is a ‘regulated activity’; therefore it was proposed that all those delivering that care must be registered with the ISA in the long term.

Head of standards at the General Dental Council (GDC), Janet Collins said: “We will watch with interest the review into this scheme by the government. We will make sure registrants are up to date with any changes which affect their obligations under the scheme, as well as what information the GDC is obliged to share with the ISA.”

British Association of Dental Nurses’ President Sue Bruckel said: “Whilst we at BADN acknowledge the need to safeguard children and vulnerable adults, we welcome the Government’s decision to review the proposed scheme; and await with interest further developments.”

Susi Sanderson, chair of the British Dental Association’s Executive Board, said: “We hope that the announcement of the halting of the proposed vetting and barring regulations signal a fresh approach to regulation that puts patient care before bureaucracy.”
Government to review its dental ‘inheritance’

The new dentistry minister has confirmed that the government will review the details of the NHS dental ‘system that we have inherited’.

Earl Howe, the Parliamentary Under-Secretary of State for Health with responsibility for dentistry, also confirmed that the government’s proposed reforms will be announced once they have talked to the profession and patient groups.

Earl Howe’s comments were said during the Queen’s Speech Debate in the House of Lords, in response to a speech by Lord Colwyn, a dental surgeon and Conservative Peer.

Lord Colwyn spoke of dentistry as being at ‘another crossroads’.

He said that the decisions made in this Parliament to transform the delivery of NHS dentistry will be “extremely important. We have been left with an unfinished reform following the 2009 Steele review. We must grasp this opportunity if we are to improve the oral health of the nation”.

Earl Howe, who is also an officer of the All-Party Parliamentary Group for Dentistry (to which the BDA is elected secretary), said that the challenge of reforming dentistry— to deliver a better system both for patients and dentists— comes at a time when tough financial decisions are to be made across all Whitehall departments.

He also welcomed the coalition government’s commitment in their programme for government.

“The acknowledgement of dentistry in this document is very positive and much needed,” he said.

He also alluded to the extra regulation that dentists will have to adhere to as both NHS and private practitioners will have to be registered with the Care Quality Commission by the end of March next year.

Lord Colwyn called the challenge threefold: “First, the government must complete the unfinished reforms, learning from the mistakes of the much criticised 2006 contract—in particular, avoiding the failure properly and dentists—to deliver a system that we have inherited’.

Under-Secretary of State for Health Dr Dan Poulter said: “We must make dentistry a priority. The task now is to work out the detail with the profession, to deliver real change for patients and dentists.”

The application features details of every NHS dental service in Bristol, their contact information and their GPS location.

It also contains information about GPs and Walk-in Centres. Other features include an ‘In Case of Emergency’ (ICE) option, an alert appointment reminder service and recorded messages with instructions on how to deal with specific health emergencies.

Deborah Evans, NHS Bristol chief executive, said: “This application is a way for us to open services up to the public and provide genuine information and choice for patients. I’m excited at the way we can use new technologies to improve patients’ choice and I’m sure that the people of Bristol will feel the same way.”

The application has been developed in partnership with Bristol-based company MyOxygen Mobile, and is the first application of its kind in the UK. It is in the process of being developed for the new ‘Android’ platform of mobile phones.

Andrew Farmer, MyOxygen Mobile manager, said: “We focused on making the application clear and accessible using familiar icons and images to help the user. We feel the application is great for the people of Bristol, a perfect way of using new technology and we are keen to see how successful it will be.”

The application can be downloaded for free through iTunes.

NHS? There’s an App for that

NHS Bristol has launched its new iPhone application giving people information about local NHS dental services.

The application can be downloaded for free through iTunes.

Andrew Farmer, MyOxygen Mobile manager, said: “We focused on making the application clear and accessible using familiar icons and images to help the user. We feel the application is great for the people of Bristol, a perfect way of using new technology and we are keen to see how successful it will be.”

The application can be downloaded for free through iTunes.
Editorial comment

Cut to the quick

The last few weeks have seen a wave of cutbacks by the coalition Government akin to an over-enthusiastic gardener and a new set of hedge trimmers.

First to go was the controversial Vetting and Barring scheme, which admittedly was much more political than fiscal. Then there was a cull of project funding which had been agreed by the previous government since January. Projects such as the Stonehenge Visitor Centre, the roll out of the Future Jobs Fund and the building of a new North Tees and Hartlepool hospital have all been cut, while the Health Research Support Initiative and Search and Rescue Helicopters are some of the projects which have been suspended.

Then there was the budget. Deputy PM Nick Clegg paved the way for doom and gloom in an email newsletter sent out the day before entitled Why we have to do this. Flashbacks of Dad with a paddle saying ‘it’s for your own good’ aside, the country braced itself for cuts in public spending, rises in tax and duty on all the good things in life and a rough ride as the country tries to stop the slide into a Greece-style financial crisis.

We will be looking into the budget in much more depth with regards to healthcare in the next issue of Dental Tribune, so watch this space.

LA law change

Dental hygienists and therapists can now prescribe and administer local anaesthetic and fluoride varnish, after a change in the law.

The legislation came into force on 1 June and dental hygienists and therapists can now prescribe and administer local anaesthetics and sell, supply or orally administer fluoride supplements and toothpastes with high fluoride content.

Under the Medicines Act 1968, local anaesthetic can only be prescribed by a suitably qualified prescriber - traditionally a doctor or a dentist.

Legislation was introduced throughout the UK in 2000 to allow certain other healthcare professionals to administer prescription-only medicine in specific circumstances.

However, dental hygienists and therapists were missed off the list of healthcare professionals able to administer medicines.

The General Dental Council (GDC) immediately publicised the problem and issued a statement to registrants informing them that, until the law could be amended, hygienists and therapists should only give local anaesthesia to patients if it had been specifically prescribed by a dentist.

The Medicines and Healthcare products Regulatory Agency (MHRA) has now added dental hygienists and therapists to the group of healthcare professionals who are able to prescribe local anaesthetic under a patient group direction.

Alison Lockyer, chair of the GDC said: “We are pleased that this change has been made; it addresses an anomaly in the legislation which we had identified. The change will enable more effective working by the dental team.”

New GDC panel website launched

A new website has been set up to recruit 50 new Fitness to Practise panel members to the General Dental Council (GDC).

The GDC wants dental professionals to get involved and play a key role in their work in protecting patients. The panel members will sit in public hearings and consider cases where a registrant’s fitness to practise may be impaired due to their health, conduct or performance, as well as applications for restoration to the registers and appeals against registration decisions.

Chair of the GDC, Alison Lockyer called it an ‘opportunity to make a real difference’. She said: “We welcome applicants from all walks of life. We’ll provide induction and regular training for successful candidates.

“So please take a moment to consider whether you or someone you know – could be the sort of person we’re looking for.

“We know that dental care professionals traditionally haven’t put themselves forward for these roles and we’re trying to reverse that trend in particular. The competencies required may look daunting, but including simple examples from your daily life at home, at work or any voluntary or community groups in your application is often enough to demonstrate that you meet them.

“I also hope that people will be encouraged by reading about the experiences of our current FIP panel members.”

Applicants must be able to demonstrate the following competencies: working within a legislative framework, analytical and decision-making skills, collaborative and professional communication skills, integrity and valuing diversity and team work.

The Fitness to Practise Committee is currently made up of 75 panel members. There are 56 dentists, 22 lay people and 15 dental care professionals on the Committee.

They are paid £555 a day and are reimbursed their expenses.

It is a part-time role, with members sitting for around 20 days a year and members are allocated to a particular hearing well in advance.

Computer imaging shows patient new smile

Patients can now see how cosmetic dentistry can transform their teeth, before they undergo the procedure.

Many people are self-conscious about their teeth and their smile, but are hesitant to agree to cosmetic dentistry because they’re unsure of the results. A new computer system called Smilevision allows the dentist to use a digital video camera to capture an image of the patient’s teeth. That image is then sent electronically to the Smilevision Laboratories.

The inventor, Dr Lawrence Brooks, and his team of experts alter the image and reconstruct the teeth via computer, taking into account the patient’s concerns, yellowing, uneven teeth, for example, or teeth that are too far apart or too small.

In about a week, the patient receives before and after photographs at home showing what his or her teeth could look like after cosmetic procedures.

Smilevision is different from other kinds of computer imaging in that it uses the patient’s own teeth in the after images.

Surrey dentist, Dr Eben van der Walt, from Portmore Dental Office in Weybridge, is among the first to have the new system.

He said: “For years we spent hours explaining what the options were and how a patient’s teeth could look, but it was hard for them to visualise. Now, we can show them definitively what the results will be.

“The patients are able to really know how they’ll look, and they get excited.”

Practice to take 8,000 patients

A new NHS dental practice opening in Hampshire is to take on more than 8,000 new patients.

The new practice is opening in the Fareham area at the end of July.

Julia Bagshaw, associate director for primary care commissioning for NHS Hampshire, said: “We are committed to increasing the number of NHS dental places for Hampshire residents and are really pleased that this practice is opening in Fareham. The new practice means we now have 189 contracts for NHS dental services in place across Hampshire and currently 44 of these are taking on new NHS patients.”

Appointments will be available in batches over the next few months. People are being told not to turn up at the dental practice without an appointment.

“The practice will not be able to accept patients who go directly to them, either in person or on the phone,” added Ms Bagshaw.

Short-term Ortho lecture

One of the first general dental practitioners to become a six-month smile provider will be giving a presentation on Short Term Orthodontics in Birmingham.

Dr Anoop Maini will be giving the lecture in September to British Academy of Cosmetic Dentistry Study Club members in Birmingham.

In line with the current trend for conservative cosmetic dentistry, Dr Maini will be explaining how GDPs can realistically utilise STO within their practice, outlining its strengths and limitations, as well as how it differs from the objectives of Comprehensive Orthodontics.

Dr Maini will also advise GDPs on how to identify patients within their practice who might benefit from STO treatment, as well as how to inform candidate patients about the different components of the six-month smile system.

The presentation, entitled Realign, Fast, Fixed Cosmetic Orthodontics for GDPs, will take place on 16 September at James Hull & Associates in Birmingham at 7pm and will be followed by a question and answer session. Tickets for members cost £25. Non-members are also welcome.

DENTISTS SORT OUT YOUR TEETH!
IMMEDIATE CASH FOR UNWANTED GOLD DENTAL CROWNS & BRIDGWORK - ANY CONDITION!
Contact our gold buying experts for a FREE, insured gold pack now on 0121 429 8103 or visit www.rexjohnsononline.com
8 Corporation St, Birmingham | 14 Birdcage Walk, Dudley | 71 Hertford St, Coventry City Centre Sheldon Shopping Centre | 526 Bearwood Rd, Bearwood | 116 High St, Bromsgrove | 3 Church St, Nuneaton 22 - 24 Friar Lane, Nottingham | 6 Mercers Row, Northampton | 2 Station Street, Burton on Trent
Get custom-fitted whitening trays for only £25.

Purchase any size NiteWhite ACP or DayWhite ACP kit and receive whitening trays delivered to your office free of postage.

We take your patients’ impressions and return lab-processed custom whitening trays in seven days.

• Includes both upper and lower trays
• No refrigeration required for whitening gel

Nitewhite and DayWhite are the only take-home whitening products with fluoride, potassium nitrate amorphous Calcium Phosphate (ACP).

Call today: 0800 032 3005
discusdental.com
Awareness of oral cancer ‘too low’ in the UK

Awareness of the risk factors and symptoms of oral cancer is ‘too low’ in the UK, according to the British Dental Health Foundation.

A new study published in the British Dental Journal revealed that the majority of mouth cancer sufferers ignore the first symptoms of the disease and do not seek the advice of a healthcare professional during the early stages.

The Scottish research, entitled The experiences of young oral cancer patients in Scotland: symptom recognition and delays in seeking professional help, was conducted by lead author Liz Grant, a public health pharmacist from NHS Greater Glasgow & Clyde.

The research team interviewed relatively young mouth cancer patients in Scotland and found that most had heard of oral cancer but didn’t think their symptoms were indicative of the life-threatening illness.

Furthermore, 40 per cent of the participants decided to self manage their symptoms and sought over-the-counter treatments which were suggested by a pharmacist.

Chief executive of the British Dental Health Foundation, Dr Nigel Carter said the study further confirms gaps in understanding and awareness of oral cancer.

He said: “Public awareness of oral cancer and the associated risk factors appears to be too low here in the UK. An awareness of the risk factors and symptom recognition by the public is a critical issue in determining survival rates, as early detection greatly improves the chances of survival.

“Almost 90 per cent of patients who were interviewed had a prior knowledge of oral cancer and the causes such as tobacco and alcohol. However, this prior knowledge was neither instrumental for them to suspect they may have mouth cancer nor did it prompt them to visit a healthcare professional in the first place.”

None of the interviewees thought it would happen to them.

A third of interviewees mentioned their first sign as some kind of ‘lump’, a few described a ‘white spot’ ‘mark’ or ‘patch’ and two described an abscess.

It was also found that wasting time of a healthcare professional or appearing to be a hypochondriac was a delaying factor in patients seeking help.

For those attempting self treatment there was an inevitably some delay in visiting their GP or dentist.

This period of delay in these cases ranged from a few days to two months. The period of time which elapsed between the interviewees noticing their symptoms and them making contact with a healthcare professional varied from a few days to a year, although two thirds saw someone within eight weeks.

Participants who had taken part were all in their thirties and forties and from Scotland.

Mouth cancer has previously been found to be more common in men than women and people over the age of 40, though an increasing number of women and young people are developing the condition.

Tobacco and alcohol are thought to contribute to at least three-quarters of mouth cancer cases.

Poor diet is linked to a third of all cancer cases. Evidence shows an increase in fruit and vegetables lowers the risk, as can fish and eggs.

Around 5,000 people in the United Kingdom are diagnosed with mouth cancer each year, claiming the lives of almost 2,000, making it the UK’s fastest growing cancer.
Healthy teeth rise in Scots kids

A record number of children in Scotland have healthy teeth, according to a new report.

The report, by the National Dental Inspection Programme, found that 64 per cent of pupils in primary year seven (last year of primary school) had no sign of tooth decay in 2009. In 2007, the figure was 59.1 per cent.

The figure exceeds the Scottish Government’s target for 60 per cent of 11-year-olds to have no obvious signs of tooth decay. However, the target was not reached in some parts of Scotland, such as Glasgow and Lanarkshire.

Children in Shetland recorded the best average last year while children in Greater Glasgow and Clyde, Dumfries and Galloway, Lanarkshire and Western Isles health board areas are still below the 2010 target.

The report found that dental disease is still being found much more in children from deprived backgrounds than those from affluent homes.

Minister for Public Health Shona Robison announced the report’s findings at an NHS Scotland event for National Health Service staff. She said: “There are now more kids in Scotland with healthy teeth than ever before. “We wanted 60 per cent of primary seven kids to have no sign of tooth decay by 2010 and I am pleased to say that this target has been met. “Dental health in Scotland is improving, particularly in deprived communities, and this is a trend that we want to continue. “Thanks to work to ensure that children know the importance of dental care at an early age, Scotland’s primary seven are now better placed to have a lifetime of good oral health.”

Ms Robison added: “Across all areas of the NHS, not just in oral health, we are committed to improving the wellbeing of our nation. That means supporting measures that prevent ill health. We don’t just want to treat people who are ill; we want to make sure people stay healthy. “In today’s tough economic times we need to be as efficient as possible and that means maximising our investment in the health of the Scottish people.”

The 2009 National Dental Inspection Programme (NDIP) is a development of the Scottish Health Boards’ Epidemiological Programme. It is a joint venture between all NHS Boards in Scotland, the Scottish Health Department, Glasgow Dental School (University of Glasgow) and the Dental Health Services Research Unit, Dundee.

Dentistry is child’s play in expanded scheme

A scheme where children dress up as dentists and dental nurses so they can learn about oral healthcare and visiting the dentist has now been launched in the north-west of England.

The programme Dental Play Box is run by Action for Sick Children and has been operating for a number of years in Scotland. It is now expanding into the north-west of England.

The play facilitator travels around nurseries and pre-schools running play sessions with a box of resources, which includes role play uniforms such as a dentist and dental nurse, hand puppets, toothbrushes, games, stories and a teacher’s pack. The settings are able to borrow the resources so children can explore the contents in their own time.

A spokeswoman for Action for Sick Children said: “These boxes help children to learn through play how to understand dental treatment and encourage them to co-operate with the dentist, which in turn makes a visit to the dentist a much less scary experience. Some of the items in-side the Play Box are dressing up outfits, a wide selection of toys and jigsaws, videos, books, dental tools and leaflets.”

The Dental Play Box, sponsored by Boots, is focusing on the north-west as it has bad statistics regarding oral healthcare. The charity’s long-term plan is to expand into different areas of the country.

Treatment pilot in care homes

Dentists are going to be offering NHS treatment to care home residents in Northamptonshire after a study found some older people are missing out on regular dental care.

Nine dental practices will offer oral health assessments to residents at 47 of the country’s care homes.

Any follow up care can then be done at the dental surgery or at the care home itself.

The scheme will run as a six month pilot and if it is successful, it will be rolled out across all the care homes in Northamptonshire.

An improvement in oral health has led to people retaining their teeth into old age, and so maintaining good oral health is important for daily comfort and living.

Di Fenton, head of dentistry for NHS Northamptonshire, said: “A sample of care home residents showed that all had some degree of tooth decay which can affect people’s general quality of life, and more seriously can lead to problems with eating. “We’ve a commitment that everyone resident in Northamptonshire should have the opportunity to access an NHS dentist, including those who would struggle to visit the dentist at their surgery.

“We’ll be carefully monitoring the outcomes of this pilot, and should it prove successful we hope to make it available to every care home resident in Northamptonshire in the autumn.”

Dentist shows children the joy of healthy teeth
A website is a dynamic low cost marketing tool for your practice
Says Seema Sharma of Smile Impressions and Dentabyte

D o you tend to treat everyone who wanders through your door, or do you have a dynamic growth strategy which moves your practice in the direction that you want to take it? When I decided to take time out to work ON my business instead of IN my business I found it had profound effects on my practice and my work/life balance.

There have always been two ways to achieve a pleasing bottom line - increase revenues or reduce costs. With the rising costs of rents in Docklands, my insistence on highly trained staff to implement my vision, and the costs of compliance brought about by the growing raft of regulations in dentistry, I have always found cost control quite a challenge, and have tended therefore to concentrate on revenue growth.

I have three mantras which have worked wonders for my practices over the years - market something different; market differently; market to different people.

Marketing something different
Routine dentistry has a routine hourly rate, so for ‘in-hours’ growth, the challenge became to balance this with higher value services to make a difference to the average hourly rate. Over the years we have introduced orthodontics, Invisalign, Clearstep, specialist oral surgery, implants, endodontics and of course aesthetic dentistry, and pushed our average hourly rate up by 50 per cent.

Marketing differently
Having spent years producing paper leaflets, I am now completely indebted to my web designer for the fantastic marketing tools my websites have become, and the direct and indirect costs we have saved. We built a layered website - simple visual information for those who just glance, depth for those who wanted more and comprehensive patient information leaflets which encourage treatment plan acceptance. All the text we used followed the FAB (Feature, Advantage, Benefit) approach - less about the features (treatments), more about the advantages and benefits of our services. We then trained our team to use the website as a treatment planning tool in the surgeries and show patients the benefits of our services and how to download information leaflets. As a result, my treatment coordinator’s job has become easier and our treatment plan acceptance. All the benefits of our services and how to download information leaflets which encourage treatment plan acceptance. All the text we used followed the FAB (Feature, Advantage, Benefit) approach - less about the features (treatments), more about the advantages and benefits of our services. We then trained our team to use the website as a treatment planning tool in the surgeries and show patients the benefits of our services and how to download information leaflets. As a result, my treatment coordinator’s job has become easier and our treatment plan acceptance.

The best growth strategy is one of referrals and recommendations - delivering the patient care and service that drives someone to talk about us at a dinner table is one of our key drivers. These days social networking is incredibly powerful – so getting patients to shout online for us is another growth strategy.

Conversion rates!
You could be found a thousand times a day but if you don’t give the patient compelling reasons to come to you, optimisation work is all lost. Building our low cost marketing proposition was key and should be the cornerstone of marketing activity for all practices, whether it is online or offline.

Conversion rates! You could be found a thousand times a day but if you don’t give the patient compelling reasons to come to you, optimisation work is all lost. Building our low cost marketing proposition was key and should be the cornerstone of marketing activity for all practices, whether it is online or offline.

Goodbye search engine optimisation, hello conversion rate optimisation! Say it, ensure your patients want it and then make it easy for them to act on it. To browse Seema’s practice website, visit www.smileimpressions.com. For more information email marketing@dentabyte.co.uk.
Our specialist Dental Innovations team of sales consultants, engineers and trainers have in-depth knowledge of every aspect of our innovative range of high tech products, giving you advice and guidance when you need it most.

The Kodak 9000 3D panoral imaging system gives you the best of both worlds by providing a two-in-one solution, with the capability to switch between panoramic and 3D imagery. This powerful system has an extended field of view giving you the ability to capture the entire arch and enhancing your diagnostic capabilities. The Kodak 9000 3D offers one of the highest resolution images available enabling you to accurately predict treatment options and is an innovative, cost effective tool that will help your practice grow.

Call: 08700 10 20 41
innovation@henryschein.co.uk
www.henryschein.co.uk
Bespoke solutions

One size does not fit all when it comes to working out which business structure is best for a particular practice, as Clive Lawrence explains.

There are now several business structures under which dentists can practice. The first point to make, very clearly, is that no one solution is best for every practice. All an advisor can or should do is work with their clients and their other relevant advisors to find the solution that best delivers the requirements of that practice.

The considerations are frequently complicated and involve weighing the pros and cons. The purpose of this article is to give an outline of some of the principal considerations that arise in coming to the right decision. These are guidelines only and specific advice on the individual circumstances is necessary in each case. But what are the options?

Sole tradership - Here a dentist will simply trade on his or her own account in a familiar manner. He or she is liable for all the debts and liabilities of the practice, including any uninsured loss, without limit. There is therefore no protection for the individual dentist from commercial or liability risks. The dentist is taxed as an individual and has few filing and regulatory responsibilities.

Limited company - A dentist has the option to transfer their practice to a limited company or simply to incorporate a new practice as a limited company. This is the tried-and-tested commercial structure for doing business and has the principal benefit of limited liability. In other words, the company is a separate legal entity from the dentist, and the liabilities of the company are not those of the dentist themselves, therefore giving some protection against commercial risk and uninsured claims.

This does not mean that it will eliminate every liability arising against the individual. Exceptions to the shield it provides may arise if, for instance, a dentist does not fulfil their statutory duties as a director. In addition, where banks or other creditors take security from the dentist for the liabilities of the company, it avoids limited liability working in relation to the debt.

The disadvantages of this can arise from the extent of disclosure, which is required by the regulations governing the filing of accounts and other information relating to the business, including earnings levels, with which some professionals are uncomfortable.

A limited company is taxed at Corporation Tax rates on its profits and the dentist’s earnings from it are taxed again, either under PAYE for salary or as dividends where applicable. Depending on both the dentist’s individual circumstances and their levels of earnings, this can be used to create tax advantages or can cause tax disadvantages. Tax advice therefore is a necessary component of any decision to incorporate as a limited company.

Dentists working together

Expense sharing - This is the ‘standard’ business structure that is put in place to organise the practice of dentists who work together in the physical sense of sharing a surgery, but keep their businesses and earnings essentially separate.

The dentists agree to share (and frequently to own in common) accommodation and equipment or facilities. They jointly employ staff and share management functions, agreeing to pay their agreed proportion towards the common expense of outgoings. Most dentists will pay laboratory and other fees directly connected with their dental practice themselves and retain all earnings from their own dental practice after those costs are paid and the share of common outgoings has been deducted. Each participant will deal with taxation in his or her own right as the basis of his or her own earnings.

This business structure has to be seen as a hybrid form, but essentially is a form of partnership. The extent of that partnership and the exact consequences will depend on precise circumstances in each case, and a broad range of conclusions is possible. In any event, the dentist practising in this way has unlimited liability for all commercial risks and uninsured losses.

Advantages of an expense-sharing agreement include the flexibility that is available to a group of dentists with different practices to differentiate between their respective contributions and earnings. Essentially, each dentist remains independent and in control of his or her own practice.

Exit routes for practitioners, however, are difficult, in that most expense-sharing arrangements will restrict its participants from freely leaving and taking their practice with them, and so will give an option to the other participants to purchase the practice from the departing partner. That can lead to a difficult exercise in balancing the rights and expectations of both the leaving and the remaining parties.

Partnership - An orthodox ‘unlimited’ partnership operates largely like an expense-sharing arrangement in practice, but proceeds on the clear understanding that all participants are involved in the same business. In that way, it differs conceptually from an expense-sharing arrangement. There is more sharing of information, responsibility and accountability between partners.

In a partnership which is not a Limited Liability Partnership, the partners have unlimited liability of the same nature as that which exists in an expense-sharing arrangement.

A formal partnership format allows less flexibility and outright self-determination to the practitioners in it than an expense-sharing arrangement; however, procedures on exit can be greatly simplified as a
departing or deceased partner is selling that partner’s ‘share’ in the overall business to the remaining partners, rather than looking to sell an individual business belonging to that partner. Provisions such as the use of life insurance to create funds for use in paying for partnership ‘shares’ released on involuntary departures (such as on death) can be more easily accommodated into a partnership structure. The differential between the earnings of individual partners from their ‘own’ practices can be more difficult to accommodate. However, careful drafting can be used to place the partners largely in the same position (and the same relative positions amongst themselves) as would be arrived at in an expense sharing arrangement.

A partnership will complete a Partnership Tax Return, but each partner is individually liable for his or her own tax on the basis of his or her earnings as an individual from the partnership.

**Limited Liability Partnership (LLP)** - An LLP operates day to day largely in the same way as an ‘ordinary’ or ‘unlimited’ partnership, but with some differences. The main difference is limited liability. The LLP is a separate legal person from the partners participating in it and the liabilities of the LLP are not therefore the liabilities of the constituent partners. Exceptions to this position can arise in the same way as with limited companies.

The members of the LLP (who are equivalent to partners in a partnership or directors of a company) have statutory duties similar to those of company directors, and also the LLP must file statutory information and accounts. This therefore can lead to a limited extent of publication of the earnings and profits of the LLP and of its constituent members. There are different levels of limitation on the reporting required depending on the turnover of the LLP and until the turnover of the LLP is in several million pounds, the disclosure required is not extensive.

An LLP has the same benefits in relation to ongoing management and entry and exit as those benefits afforded by a partnership. In the LLP context, those benefits are also increased by the fact that the party which pays the departing partner is no longer the other partners but the LLP itself. The partners are therefore in less of a situation of risk amongst themselves as well as to the outside world. The downside may be for the departing partner if the LLP does not have the funds required to pay him or her out.

**Limited company** - Dentists can choose to practice together in a limited company. The benefits, and downsides, are similar to those discussed above in the context of the sole practitioner. When more than one dentist is involved in a company, they would usually enter into a Shareholders Agreement taking effect between all the dentists involved, each of whom would usually be both a shareholder and a director of the company. This would deal with largely the same issues and concerns as those which would be covered in a Partnership or LLP Agreement and avoid the simple majority rule which otherwise obtains within a company from compromising the interests of individuals. That also permits the limited company to provide comparatively straightforward routes to entrance and exit for participants through the sale and purchase of shares.

A limited company can also be the best business structure where there is any mixture in ownership or business participation terms between dental professionals and people who are not dental professionals. A body corporate can conduct a dental practice so long as the majority of its directors are dental professionals, and a limited company therefore can provide a medium for diverse forms of dental business.

---

**Clinical Governance**

**Is your contract secure?**

Since the inception of the New Care Quality Commission it has never been more important to demonstrate that you are compliant with the Clinical Governance requirements.

**The Benefits:**

- Completing the programme will:
  - Improve patient experience and patient satisfaction
  - Limit the scope of error in practice
  - Encourage an evidence-based approach to clinical decision making
  - Create a culture of engagement and involvement of all team members
  - Provide a framework to help dentists comply with NHS contractual requirements

Clinical Governance is an educational base from which practices can continue pursuing quality insurance initiatives to benefit the practice and its patients. The product also aims to help dental practices become compliant with the NHS clinical government agenda by breaking down each of the seven domains as identified by the Healthcare Commission.

Ensure your compliance, call Smile-on now on 020 7400 8989 or email info@smile-on.com or visit www.smile-on.com
Reducing tax bill, part II

Dentists can ensure their tax burden is efficiently managed, says Thomas Dickson in the second of this two-part feature

As a number of dentists earn more than £150,000 a year, or aspire to, they need as much information as possible to reduce their tax bills.

Offshore investing
An offshore portfolio bond is an investment wrapper used to help with tax planning. Investing overseas can bring advantages to UK residents and offshore portfolio bonds are usually based in a number of different jurisdictions.

When bonds are held in the UK, income is paid net of tax. The benefit of an offshore portfolio bond is that it defers investment tax until you cash it in; the income can be rolled up gross over a number of years. The fund only becomes tax liable when the holder brings money back to the UK.

Offshore savings
Most of the big high street banks, as well as private banks, have subsidiaries that offer offshore accounts. Usually the minimum deposit is between £5,000 and £10,000, with anyone being eligible to open such an account.

It is important to remember that the UK Financial Services Compensation Scheme does not cover offshore institutions. Some banks and building societies have pledged to cover any liabilities that their offshore subsidiaries cannot meet, but not all of them have made such a commitment.

Offshore trusts offer a good way of reducing inheritance tax liability. Money put in trust will enjoy the benefit of compound interest to help the fund grow. When tax is payable, it will be at the basic rate, so long as the beneficiary is not a higher-rate taxpayer. As long as the donor has lived for seven years after setting up the trust, the money is free from inheritance tax.

ISAs
From April 2010, the rules governing ISAs has changed. For cash ISAs, the maximum that can be saved will be £5,100 per year. With an investment ISA account, the ceiling will be raised to £10,200 per annum can be saved, of which 50 per cent can be in cash. Since the personal allowance for capital gains tax is £10,200, an individual can make a healthy profit up to this amount without paying any tax.

The trick is to pick funds and/or individual shares and bonds that will deliver high returns for the lowest risk, with low charges. Seek the advice of an Independent Financial Adviser to ensure you make the right choice.

Employing a spouse
Transferring part of your income to your spouse is worth considering as a way of reducing the tax burden. There are important steps to take.

A commercially justifiable wage needs to be paid, and minimum wage regulations are likely to apply. Keep clear records of not only the work the spouse does for the practice, but also the payments, ideally into a separate bank account in the spouse’s name. An employment contract is also a legal requirement. A salary between £110 and £884 per week is subject to employees’ national insurance at 11 per cent and employers’ national insurance at 12.8 per cent.

About the author
Thomas Dickson, director of Essential Money Limited, formerly a partner of Money4Dentists. For more information, and to receive a free copy of The Little Book of Money, packed full of practical hints and tips, contact Essential Money on 0221 885 9090 or email thomas@essentialmoney.co.uk.
How to achieve better interdental healthcare routines

Clare Southards looks at the use of the interdental brushes in patients’ oral healthcare regimes

We all know what's good for us; eat well, exercise more, but there always seems to be a reason why we're unable to make the changes we'd like to see in our lives.

This is no different for our patients when it comes to maintaining a good oral healthcare habit. When it comes to interdental care, although many know the importance of removing the plaque that builds up unseen between teeth and below the gum line, there is still a lack of motivation to adopt a regular interdental routine.

According to a survey conducted in 1998, over half the adult population is suffering from periodontitis. As most dental practitioners know, the emphasis of the recent Steele Report was the need to improve oral health as a preventative method for the more serious complaints seen everyday in practices across the country.

The challenge for dental professionals is how to achieve and maintain better rates of compliance with oral healthcare routines by patients. Although 22 per cent of adults claim to floss regularly, is there good reason to be suspicious of this claim, and what might be the reasons for the low take-up?

Flossing is by no means a recent invention. Since the 1800s the notion of passing a silk thread between the teeth to loosen collected matter has been advocated as being an effective way of preventing tooth decay, but there’s evidence dating back to prehistoric times of such methods being employed. Since the 1970s flossing has become an integral part of oral healthcare, and yet it’s still undertaken by a relatively small fraction of the population.

Interdental brushing vs flossing

One reason may be that many dental practitioners find effective flossing difficult to teach, and patients often find it a tricky technique to master. For those with poor manual dexterity, limited mouth opening or a strong gag reflex, alternatives to flossing (such as interdental brushing) should be sought. Only requiring one hand to perform the task of plaque removal is certainly an advantage for many patients, regardless of their manual dexterity, especially when the handles are ergonomically designed for greater manoeuvrability.

There is evidence supporting the view that interdental brushing is a better option for patients. A three-month trial found that not only did the people become proficient in using the brushes more quickly than floss, but also plaque and gingival inflammation was reduced more.

It's been recognised that flossing may not always be the most effective tool for removing interproximal biofilm, and that flossing becomes progressively less effective in interdental areas that have slight to moderate recession or complete loss of the interdental papillae.

In contrast, interdental brushes offer the flexibility of a range of filament thicknesses and lengths, meaning that regardless of the gap, there is a brush suited to best reach the recesses, making the process more effective:

As evidenced, because the filaments are soft there is less risk of damaging the delicate gum membrane, causing the pain and bleeding which will often demotivate the patient from persevering with the oral healthcare routine.

Maintaining motivation

Dental professionals, particularly dental hygienists, are at the forefront of oral healthcare education. With the shift in focus in NHS dentistry set to change, and a recommended restructuring of the payment structure to reflect the practice’s efforts to improve oral health, motivating the patient to adopt and then maintain an oral healthcare routine should be in the minds of practice managers. The question is how.

Explain the risks: the connection between gum disease and heart disease has long been anecdotally suspected, but recent research has confirmed the link. It’s now understood that people with periodontal disease are almost twice as likely to suffer from coronary artery disease as those without periodontal disease.

Patients who are pregnant ought to be made aware that there is a relationship between periodontal infections and low birth rate.

Setting goals is a useful tool. Often a patient will claim a lack of time as being the reason for not maintaining a healthcare routine that involves flossing. One suggestion is to negotiate with the patient to produce a written healthcare plan.

One advantage of interdental brushes is their ease of use. The ergonomic grip makes reaching the trickiest of interdental spaces easy to reach with one hand, making it feasible to clean the gaps between teeth at times convenient to the patient, whilst watching television at home or on the move. The handy-sized brushes can be kept in a bag or purse to be used anytime or anywhere.

By creating a written plan the patient is far more likely to maintain an oral health routine, especially when another person (such as a dental hygienist) monitors their progress.

With more than 50 years of experience in designing interdental brushes, Curaprox have created the most durable and effective brushes now on the market. With ergonomic grips providing excellent manoeuvrability and control, patients will soon see an improvement in their oral health.
Periodontology is innovative

Prof. Dr. Liviu Steier looks at some of the new ideas in Periodontology as discussed by Robert J Genco

Genco summarised in his paper published the Journal of Periodontology the, clinical implications of the workshop on inflammation and periodontal diseases. In this paper, he managed to compile a list of innovations currently still in the pipeline. These can be categorised as follows:

**Short-term:** ready for clinical application over the next one to two years;

**Mid-term:** ready for clinical application over the next five to 10 years;

**Long-term:** ready for clinical application more than 10 years from today.

New risk profiles under development for periodontal disease and diabetes to be self-reported used in practice.

Risk assessment of risk for potential atherothrombotic vascular events in dental patients, with special consideration for those having periodontal disease using traditional markers of risk or C-reactive protein (CRP) in the Reynolds Risk Score.


Indication for use of nutraceutical and drug combinations (omega-5 fatty acid and aspirin) to control inflammation associated with periodontal infections.

Indication and application for use of inhibitors of matrix metalloproteinase for adjunctive management of periodontal disease as an adjuvant in surgical and non-surgical therapy.

**Mid-term innovations**
1) New diagnosis technology for measuring active bone loss
2) Application of diet rich in omega-5 fatty acids to reduce genetic predisposition to metabolic syndrome and the application of nutragenomics
3) Therapeutic approach to use of anti-inflammatory agents, the endogenous resolvins and protectins
4) New tests to control MMP-8 in saliva, and fragments of bone collagen in tissue fluids for monitoring periodontal disease
5) The application of bone sparing agents to inhibit osteoclast recruitment and limit bone loss
6) Application of statins and targeted anti-inflammatory therapies in periodontal disease for modulation of inflammation

**Long-term innovations**
1) New approaches to regulate and prevent bone loss
2) Apoptosis regulation to reduce bone loss
3) Dietary modulation with genetic influence on phenotype in pathogenic pathways, for example, cholesterol levels and obesity – leading to prevention and treatment of cardiovascular diseases and other complex inflammatory disease such as periodontal disease
4) Identification of genetic risk profiles for periodontal disease
5) Genetic test to identify correlation between CRP, inflammatory mediators, periodontal disease, diabetes, and premature atherothrombosis
6) New data and information regarding pathogenesis of periodontal disease which may be modeled by incorporating gene, protein, and metabolite into dynamic biologic networks
7) Vaccines using periodontal pathogens to protect against periodontal infection
8) New prevention approaches to avoid uncoupling of bone deposition and bone resorption.

For more information about LADDEC, please call us on +44(0)1344 752560 or email infouk@biohorizons.com or visit www.biohorizons.com

Where did all the periodontists go?

Dr Louis Malcmacher finds out what’s changed the face of periodontology

Through my weekly travels to different cities across America, I speak to many dental specialists and their groups on the hottest topics in dentistry, practice management and total facial esthetics.

There are definite trends that are changing in all specialties across the board, whether it is short-term orthodontics versus long-term orthodontics, adhesive resin endodontics versus traditional gutta-percha endodontics or the conversation as to whether or not general dentists should be providing some of these specialty services.

I would have to say that the biggest change of any single dental specialty that I have seen has been in the periodontal field. There has been a real mind-set change that deeply affects the profession. I am not commenting here on whether this change is good or bad – I will leave that up to the reader to decide.

It is certainly something to consider as general dentists who refer patients to periodontists on what your treatment will be for the long run.

I have always believed that general dentists are the quarter-backs of any patient treatment case and we certainly rely on the skills and input of dental specialists, but the ultimate responsibility should be on the general dentist.

Removing teeth

Here is what I am being told by many periodontists whom I have spoken to over the last couple of years: they would rather remove teeth and place implants than actually treat patients through traditional periodontal surgery and try having them maintain their dentition.

The reason for this is really quite simple and every dentist knows this inherently. Patients refuse to take good care of their teeth even after they have gone through the time, cost, commitment and pain of traditional periodontal surgery. This is certainly not earth-shattering news to any of you.

For years in our own practice, we have had patients who did not want periodontal surgery and would rather maintain the state of their oral health with three to four-month recall prophylaxis visits. We would often predict that their teeth would fall out within two to three years.

Surprisingly, many of these patients have done reasonably well 20 years later, with the occasional loss of a tooth here or there.

This thought was blasphemy to periodontists for years and years, but certainly it seems that conservative non-surgical periodontal recall visits and treatment has helped many patients maintain their dentition in a reasonable state so that they can function and smile with their original teeth for years.

Old habits

As general dentists we have known that even with the best periodontal surgery treatment, patients would often fall into their old habits and eventually their dentition would fail anyway. Not all patients, but many of them.

We have learned that we have to treat people as people and sometimes you just cannot change them no matter what you do.

It seems to me that periodontists have now caught up with this concept and that is where...
this mind-set has really changed periodontics today. Patients like the concept of implants, which are still vastly underused in periodontics today. Many patients would rather not have to take care of their teeth and have these unsightly, mobile teeth extracted and replaced with implants, which would restore their function and their esthetics.

With a 94 percent implant success rate, it is hard to argue when that success rate is so high compared to the poor long-term success rate of traditional periodontal surgery.

This is primarily because we have to depend upon the patients to keep up their regimen for the long-term success of their natural dentition,

New procedures – such as the wavelength optimised periodontal therapy (WPT) procedure with the Powerlase AT Laser by Larees Research, and LANAP procedures done with the Periolase laser by Millenium Dental – have brought periodontal services into the minimally invasive realm as a solution for patients who do want to keep their teeth without heavily invasive periodontal surgery.

Technology advances
New procedures – such as the wavelength optimised periodontal therapy (WPT) procedure with the Powerlase AT Laser by Larees Research, and LANAP procedures done with the Periolase laser by Millenium Dental – have brought periodontics today, Laser periodontal treatment will continue to develop and become even more effective in the future.

Laser periodontal treatment will continue to develop and be more effective in the future.

Procedures such as implants and minimally invasive laser periodontal therapy will continue to improve and change the way we practice in this new decade.

Is this good or bad? You are the dentist. So this is for you, the periodontist and the patient to decide.

This article was first published in Dental Tribune US edition Vol. 5, No. 12.

We are writing this letter in response to Dr. Louis Malcmacher’s article, which appeared in the May issue of Dental Tribune, entitled “Where did all the periodontists go?”

First of all, let us assure you that, as a specialty, periodontology is alive and well, and the increasing number of research studies supporting the peri-systemic link demonstrates that the role of the periodontist is more relevant than ever. While we agree with Dr. Malcmacher that general dentists are the “quarterbacks” of the dental team, we see the periodontist as the specialty team member who is uniquely qualified in providing an accurate prognosis of all viable treatment options, whether it is non-invasive periodontal therapy, periodontal surgery or extraction followed by replacement with dental implants.

Dr. Malcmacher mentions that he has spoken to many periodontists, but this is our view as an endodontist, and does not accurately represent the entire periodontal profession. We believe that the majority of periodontists make ethical decisions every day regarding retention of the dentition versus extraction and placement of implants.

Periodontists typically strive to base treatment planning on scientific and clinical evidence, not on what is easier for the patient or profitable for the dentist. General dentists and periodontists live and practice in a society that craves immediate gratification, where patients often demand quick fixes with minimal effort or change in behaviour. Both general dentists and specialists are underlining their clinical expertise and professional authority when they recommend patient-directed treatment options.

That is why the entire dental team of GP, hygienist, and specialist must provide a united front in explaining to patients why oral hygiene is important, why they should make every effort to save their natural teeth if appropriate, and why they should accept the recommended course of treatment, maintenance, and the at-home regimen.

Regards,
Samuel B. Low, DDS, MS, MEIA
President, American Academy of Periodontology
Donald S. Clem, III, DDS
President Elect, American Academy of Periodontology

About the author

Dr. Louis Malcmacher is a practicing general dentist in Bay Village, Ohio, and an internationally recognised lecturer and author known for his comprehensive and entertaining style. He is a columnist for Dental Tribune Reports, Malcmacher has served as a spokesman for the AGD and is president of the American Academy of Facial Esthetics. You may contact him at +1 440 892 1810 or email drlowza@ mail.com.
A challenging task
Prof Dr Liviu Steier discusses how to restore the aesthetic zone with implant-supported restorations

Restoring the anterior aesthetic zone using implant-supported restorations is one of the most challenging tasks. Knowledge of related literature, impeccable skills, a lot of experience and a well-trained team compliment a successful treatment. Different implant systems claim to offer the only technology leading to success. The author describes a case where an “outdated” system, external hex implant system offers a similar success rate, by only following a correct protocol.

Aesthetic 3-dimensional requirements
For optimal aesthetics, some literature suggests some key factors to be respected as they play an important role for long-term success:
• Availability of two mm buccal bone plate
• Implant tooth distance should be 1.5 mm
• Implant to implant distance three mm
• Biologic width is indicated with two-three mm

Clinical case
A 45-year-old male has been referred to the practice for rehabilitation of the anterior aesthetic zone. His medical and dental history, as well as his treatment desires, were recorded.

Dental history
The patient lost tooth 11 due to trauma about 17 years ago. He was advised to restore the gap with a PFM bridge. He also reported multiple recementation sessions. Later, insufficient root canal treatments (X-rays) seemed to have weakened the remaining tooth structure. The clinical picture below demonstrates also fractured adhesive posts.

X-ray diagnosis proved vertical root fracture of both teeth. Poor prognosis led to immediate extraction recommendation, to avoid further infection (leakage) and optional bone loss.

Treatment plan
The following treatment options were identified and discussed with the patient:
• Extraction and no treatment
• Extraction and restoration with a removable device
• Extraction and immediate implant placement.

Benefits and disadvantages of different treatment options

Extraction and no treatment
Benefits
• Fast
• No cost implication
Disadvantages
• Aesthetic breakdown of the anterior area
• Function and speech alteration

Extraction and with a removable device
Benefits
• Fast
• Minor cost implication
Disadvantages
• Aesthetic breakdown of the anterior area
• Function and speech alteration
• Removable device acts as an impediment

Extraction and immediate implant placement
Benefits
• Preservation of bone
• Optimal functional and aesthetic rehabilitation
Disadvantages
• Cost implication
• Extended treatment need

Patient decided to go for the extraction and have im-

o
mediate implants placed. Impressions were taken so the patient could be offered a removable temporary device once extraction and implants performed for the healing time.

**Treatment procedure**

Retained roots were extracted in local anesthesia (four per cent Articain) using minimal invasive procedure.

The alveolae were thoroughly scooped and cleaned. Available bone was sounded and found adequate for immediate implant placement. Two Biohorizons Ø 4.0mm x 12mm external implants were inserted in the alveolae. The remaining buccal gap to the buccal bone wall was less than 1.5 mm so that no further attention (fill) was requested.

Implant in position 11 was performed ad modum flapless surgery. Once drill protocol as recommended by the manufacturer has been performed a Biohorizons Ø 4.0mm x 12mm external implant could be seated.

Successful three-dimensional implant placement was performed following the criteria mentioned in the introduction. Bony and soft tissue healing went extremely well also due to available thick gingiva phenotype.

**After treatment**

Allocated healing time was five months. Second stage surgery was performed under local anesthesia. Temporary abutments were screwed in place and temporary crowns performed. The emergence profile could be nicely shaped during the next visits.

Impression was taken once optimal conditions were achieved. The technician manufactured three zirconia abutments. The final impression was taken and the final restoration were delivered after a try-in session with bisque bake.

The final crowns were cemented while a retraction cord in place to enhance cement excess removal. Occlusion was checked and patient received hygiene instructions. Recall sessions were scheduled.

**Conclusion**

It is of course only of anecdotal value to use a case presentation to exemplify the achievement of predictable aesthetics with conventional implant systems, but doubts might raised today about statements and claims made by modern implantology.

The author recommends the following criteria as mandatory:

- Good treatment planning
- Adequate protocols
- An excellent team (surgeon restorative and laboratory technician) for predictable long-term success

**About the author**

Dr Liviu Steier (PhD) is Specialist for Prosthodontics (www.dzgmk.de) and specialist in Endodontics (GDC UK). He is an honorary clinical associate professor at Warwick Medical School and course director of the MSc in Endodontics (www.warwick.ac.uk/go/dentistry). He is a member of the Scientific Advisory Board for the Journal of Endodontics (AAE) and maintains a private referral practice for endodontics, implantology, etc at 20 Wimpole Street, W1G 8GF London (www.msdentistry.co.uk).
Using resorbable barriers to make root recession coverage predictable

By Drs David L Hoexter, Nikisha Jodhan and Jon B Suzuki

Gingival recession is defined as the location or displacement of the marginal gingiva apical to the cementoenamel junction (CEJ). Recession is the exposure of root surface, resulting in a tooth that appears to be of longer length.

From a patient’s perspective, recession means an unsightly appearance and is associated with aging. The gingiva consists of free and attached gingival tissue, as seen macroscopically.

The free marginal gingiva, located coronal to the attached gingiva (AG), surrounds the tooth and is not attached to the tooth surface. The AG is the keratinised portion of gingival tissue (KGT) that is dense, stippled and firmly bound to the underlying periodontium, tooth and bone.

In ideal health, the most coronal portion of the AG is located at the CEJ, where the most apical portion is adjacent to the mucogingival junction (MGI). The MGI represents the junction between the AG (keratinised) and alveolar mucosa (non-keratinised).

Reasons for recession
There are numerous etiological factors that may result in recession. Generally, the etiology can be categorised as either mechanical or as a function of periodontal disease progression. Recession usually occurs due to tooth malposition\(^1\),\(^2\), alveolar bone recession\(^2\),\(^3\), high muscle attachments and frenal pull\(^4\), and iatrogenic factors related to restorative and periodontal treatment procedures.\(^5\)

The detrimental effects of recession include compromised esthetics, an increase in root sensitivity to temperature and tactile stimuli, and an increase in root caries susceptibility due to cementum exposure. Thus, the main therapeutic goal of recession elimination is gingival root coverage in order to fulfill esthetic demands and prevent root sensitivity.

Miller classifies recession defects into four categories:

- **Class I**: marginal tissue recession does not extend to the MGI
- **Class II**: marginal tissue recession extends to the MGI, with no loss of interdental bone
- **Class III**: marginal tissue recession extends to or beyond the MGI; loss of interdental bone is apical to the CEJ but coronal to the apical extent of the marginal tissue recession
- **Class IV**: marginal tissue recession extends beyond the MGI; interdental bone extends apical to the marginal tissue recession.

A possible treatment modality for recession includes restorative/mechanical coverage, such as cervical composite restorations. This kind of treatment may effectively manage root sensitivity and root caries. However, such treatment entails a long-term compromise from an esthetic perspective. Composite restorations stain over time, and any marginal leakage may lead to secondary caries, recurrence of sensitivity and/or local inflammatory changes.

Additionally, colour matching can be difficult and such restorations may involve the undesirable removal of vital tooth structure in order to create adequate retention form. Thus, clinicians must determine whether the restorative benefits outweigh the esthetic shortcomings and whether it is possible to employ a treatment modality with few, if any, functional and esthetic disadvantages.

**Muco-gingival surgery**
Another treatment modality for recession is muco-gingival surgery. Muco-gingival surgery refers to periodontal surgical procedures designed to correct defects in the morphology, position and/or amount and type of gingiva surrounding the teeth.\(^6\)

In the early development of muco-gingival surgery, clinicians believed that there was a specific minimum apical-coronal dimension of AG that was necessary to maintain periodontal health.

However, subsequent clinical\(^6\)\(^7\)\(^8\) and experimental studies\(^9\)\(^10\) have demonstrated that there is no minimum numerical value necessary.

However, for esthetics, a uniform colour and value of AG is desirable among adjacent teeth.\(^9\) Some of the earliest techniques for correcting recession involved extension of the vestibule.\(^9\) The subsequent healing usually resulted in an increase of AG. However, within six months, as much as a 50 per cent relapse has been reported in the AG. However, within six months, as much as a 50 per cent relapse in the AG has been reported. In the AG, the healing process is usually uncomplicated and can be expected to lead to a stable, esthetically pleasing result.

**Fig. 1**: Preop labial view of anterior teeth. Recession on tooth #6; tooth #7 surrounded by a small adequate zone of keratinized apical tissue.

**Fig. 2**: Flaps reflected preserve the interproximal tissue, which preserves the blood supply and prevents black triangles (unesthetic interproximal spaces).

**Fig. 3**: The GTR membrane was shaped and placed over the root surfaces of teeth #6 and #7.

**Fig. 4**: Gingival tissue was normally repositioned, covering the membranes and the roots of teeth #6 and #7, and sutured in place.

**Fig. 5**: Post-op view: the previously recessed roots of teeth #6 and #7 are covered with attached pink, keratinized gingival tissue, with no pocket depth upon probing.

**Fig. 6**: Pre-op labial view of anterior teeth.
of the soft tissue position was reported. Thus, these techniques did not adequately address recession.

In order to improve esthetics and increase KG for root coverage procedures, current periodontal surgery largely involves the use of gingival grafts. There are a multitude of surgical techniques, which can be distinguished based on the relationship between the donor and recipient sites.

Gingival graft procedures involve either (a) pedicle soft-tissue grafts, which maintain the pedicle blood supply or (b) free autogenous soft-tissue grafts. Techniques involving the latter type require the clinician to prepare two surgical sites: one to harvest the tissue and another to prepare the recipient site.

In this case, the autogenous soft tissue graft has a separate blood supply to the recipient site. Combinations of (a) and (b) have also been reported.

Soft-tissue grafts
The pedicle soft-tissue graft was first described by Grupe and Warren in 1956. This involved raising a full thickness flap and laterally positioning and then suturing donor tissue into place from an adjacent area while maintaining a pedicle blood supply. This technique and others that followed were designed to increase the zone of AG.

Procedures combining both free grafts and pedicle techniques have also been detailed. For instance, when a connective tissue graft is employed, the graft is placed sub-epithelially with a coronal advancement of the overlying keratinised tissue. GTR techniques have also been developed more recently. In 1992, Pino et al. described a combination technique of sub-epithelial placement of a membrane with coronal advancement of the flap, such as e-PTFE.

Later modifications of the technique included the double papilla flap – introduced by Cohen and Ross in 1968 – the oblique rotational flap and the rotational flap. Another type of gingival movement flap was described later as the coronally repositioned flap. This technique involves mobilising a full-thickness flap and repositioning the tissue to the CEJ, thereby covering the exposed recession.

The use of free gingival grafts was described in the 1960s by Sullivan and Atkins. The free autogenous graft can be made up of either epithelialised gingiva or connective tissue. Initially, the therapeutic goal was to increase the zone of KG. The clinical objective was to evolve to covering the recessed root with a zone of attached KG.

This can be achieved in one or two stages. Initially, Sullivan and Atkins described a one-stage procedure in 1968. Its purpose was to increase the zone of KG without concentrating on coverage of a recessed root. In the 1980s, a two-stage modification was suggested for an increase in root coverage, which proved to be more successful with increased predictability.

This involves first placing the free gingival graft or the free connective tissue graft apical to the zone of recession and using the coronally repositioned technique after healing.

Autogenous grafts
Free autogenous grafts are predominantly harvested from the palate. Recently, materials other than gingival grafts have been explored. Using a guided tissue regeneration technique (GTR) technique, an acellular dermal matrix has been reported to yield favorable outcomes in root coverage. This material may provide the patient with a less invasive alternative than a palatal donor site in order to achieve root coverage.

The function of the membrane is to maintain space during the healing period for tissue regeneration to occur. From a patient’s perspective, biodegradable membranes with GTR may be preferable in order to avoid a second-stage surgery for membrane removal.

Case report
A young, adult male patient presented with recession bilaterally in his maxilla. The upper right maxilla had extensive recession on teeth #6 and #7 (Fig 1). The deep soft tissue defect indicated that a GTR technique to a non-GTR technique in a split-mouth procedure involving the same patient.

The goal is to restore gingival health, colour and esthetics by covering the exposed root predictably with healthy gingival tissue and, in doing so, decrease sensitivity.

According to Sullivan and Atkins, the desired flap design was completed. There was an adequate zone of KG present before treatment, which was preserved and repositioned coronally. Upon reflection of the tissue, the full extent of the underlying recession was evident (Fig 2). The area and recession were uncovered following removal of debridement and granulomatous tissue.

The coronally repositioned flap was sutured in place with the flap covering the now submerged membranes and previous recession (Figs 3,4). Periodontal dressing was employed, had re-attached healthy gingiva that was not predictable.

The resorbable membrane was used (x-PTFE). The resorbable membrane is more predictable for the resorption of the membrane.

The following case report considers predictable esthetic root coverage by comparing a GTR technique to a non-GTR technique in a split-mouth procedure involving the same patient.

The goal is to restore gingival health, colour and esthetics by covering the exposed root predictably with healthy gingival tissue and, in doing so, decrease sensitivity. Using GTR and coronally repositioning techniques, we achieve predictably covered roots.

Other procedures
Variations in mucro-gingival procedures have been developed to include root surface bio-modifications by treating the root surfaces with a variety of regenerative products.

Recession was also present at the maxillary left side (teeth #11 and #12; Fig 6). After local anesthesia of the areas involved, a full-thickness mucoperiosteal flap was completed. This exposed the extent of the recession defect (Fig 7). Tooth #11 was treated, as was the other side of the mouth, by utilising the GTR technique using an acellular connective tissue membrane to preserve the space for regeneration.

Tooth #12 was treated the same way, except that no membrane barrier, resorbable or non-resorbable, was used (Figs 8). Thus, there was no use of a GTR technique on tooth #12. Both teeth had the flap manipulated with the coronally repositioned graft, covering the recessed root and suturing to the CEJ level.

Both sides were covered with periodontal dressing. Antibiotics (tetracycline) and an analgesic, (Tylenol-Codeine) were prescribed for the first week after the operation.

One week after the surgical phase, the dressing and sutures were removed and the mouth lavaged. Oral Hygiene was restored to good, maintainable habits following the healing phase of over two months. Upon observation, tooth #11, for which the GTR membrane had been employed, had re-attached healthy gingiva that was not predictable.
Comprehensive invisible orthodontics made easy

The Clearstep System is a fully comprehensive, invisible orthodontic system, able to treat patients as young as 7.

It is based around 5 key elements, including expansion, space closure/creation, alignment, final detailing and extra treatment options such as functional jaw correction.

GDP friendly, with our with our Diagnostic Faculty providing full specialist diagnostic input and treatment planning, no orthodontic experience is necessary. As your complete orthodontic toolbox, Clearstep empowers the General Practitioner to step into the world of orthodontics and benefit not only their patients, but their practice too.

Accreditation Seminar
This accreditation seminar is aimed at General Practitioners, providing you with all the knowledge and skills required to begin using The Clearstep System right away.

Personal Accreditation
Receive a visit from a Clearstep Account Manager, providing a personal accreditation in your practice at a time convenient to you.

Accreditation Seminars for 2010
30th March  London
27th May  Ireland
13th July  London
9th September  Birmingham
30th November  London

Further Courses
Once accredited, further your orthodontic expertise with our Hands On Course, where you will learn sectional fixed skills and other methods to reduce your costs and treatment times.

Clearstep Advanced Hands On Course
dates for 2010
7th - 9th April  London
25th - 27th October  London

To find out what Clearstep can do for you contact us today.

01342 337910
info@clearstep.co.uk
www.clearstep.co.uk
Know your patients

It’s important that you get all of the information you need when you meet a patient for the very first time, says Dr Michael Sultan

In dentistry, as in any medical field, it is advantageous to be as well informed about the patient as possible before proceeding with treatment.

The initial communication a practitioner has with their patient is often the most important, as this is the stage that the patient will form their first thoughts about the professional, and decide whether or not they feel comfortable with them. With this in mind, communication should be non-intimidating, open and sensitive, and accommodate active listening and acknowledgement of the patient’s concerns.

Dig deep

It is important to gain as much information about the patient as possible before they even get into the chair. This ensures the professional is armed with information on the patient’s medical and dental history, any fears or phobias, and the patient’s needs and desires for treatment from the very start. This allows the practitioner to offer a more tailored treatment plan, and any additional support, such as sedation or distraction techniques, should be required.

The whole dental team should be involved in the initial communication with a patient. After all, it’s not just the practising dentist who is seen! Many patients will be very nervous of a visit to the surgery, so a casual chat with a friendly receptionist, or a conversation with the dental nurse about the upcoming procedure before arriving at the surgery can often help put their minds at ease.

All patients want to deal with people who are empathetic to their situation, so an initial meeting with a team that is warm and friendly is one of the best ways to help relax a nervous patient. One of the key members of staff in this situation is the dental nurse. Ensuring that you have a strong nursing team is very important, as the nurse is the person who will be there to hold the patient’s hand and offer reassurance. Nobody can be taught how to offer this kind of support, so ensuring you have a compassionate and personable nursing team definitely makes the dentist’s job much simpler!

Address patients’ concerns

Good communication before an initial consultation is useful for patients to air any concerns or fears they have about a procedure. Concerns should never be ignored – acknowledging a patient’s anxieties and reassuring them that they are understood, and that you are prepared to tailor a treatment plan to ensure that they feel as comfortable as possible shows compassion.

While the personal approach is vital when a patient is in the surgery, the advent of modern technology has simplified the process of gathering initial information from patients. I have included a section on my website where referring practitioners can provide detailed information about referrals, so by the time a patient enters my surgery, I already have a comprehensive document detailing the patient’s previous dental care. This is incredibly useful when putting together treatment plans, however must be followed by a face-to-face conversation during the initial consultation!

A good relationship

If receiving a referral patient, working closely with the referring practitioner is vital – after all, the patient’s own dentist knows the most about the patient. Maintaining a good relationship also helps relax the patient, and they feel that the team they are visiting is an extension of their own practice. I often tell patients to imagine that my team and I are just another room in their own surgery – everything they know and trust is the same, and I we are simply an extension of their own practitioner’s team.

Occasionally you will experience a patient who is reluctant to offer any personal information. I would advise to proceed very carefully in this situation. Personally, I refuse to treat any patient who refuses to provide medical details, as a lack of information in this area can put everyone involved at risk. It is more difficult when discussing less clinical details, as many patients feel that their personal information is not needed to carry out dental treatment.

In many ways, this is the case, however I believe that the more I know about a patient the better the procedure. The relationship between practitioner and patient needs to be one of trust and respect, and I believe that it is very difficult to feel this way about a patient when all you have in your chair is the equivalent of a sheet of medical facts. Of course, knowing your patient’s favourite colour is slightly too much detail, but a certain amount of personal information is useful!

For example, if a patient doesn’t like the taste of mint, you can accommodate by using an orange-flavoured jellylax is paste instead – thus making the experience a more pleasurable one! Details like this helps ensure that a patient leaves the surgery feeling that they have experienced a good service, and are not likely to be as apprehensive should they have to return.

Communicate clearly

I firmly believe that the relationship between patient and practitioner is one that should be nurtured, and good communication from both sides is vitally important.

*Fact:* Handpiece repair and maintenance support for all KaVo handpieces.

The higher the quality of handpiece and its maintenance, the better its life-long performance.

KaVo, known and respected for quality, reliability and longevity.

A dental professional can be taught how to offer this kind of support, so ensuring you have a compassionate and personable nursing team definitely makes the dentist’s job much simpler!

To talk to a member of the Endocare team call 020 7224 0999 or email reception@endocare.co.uk for more information please visit www.endocare.co.uk.

Dr Michael Sultan BDS MSc FDS' in a specialist in Endodontics and the clinical director of EndoCare. Michael qualified at Barts University in 1986. He worked as a general dental practitioner for five years before commencing specialist studies at Guy’s hospital, London. He completed his MSc in and Endodontics in 1993 and worked as an associate endodontist in various practices before setting up in Harley Street, London in 2000. He was admitted onto the specialist register in endodontics in 1999 and has lectured extensively in postgraduate dental groups as well as lecturing on Endodontic courses at Eastman UCL, University of London. He has been involved with numerous dental groups and has been chairman of the Alpha Group of Endodontists. In 2003, he became clinical director of Endooce a group of specialist practitioners. To talk to a member of the Endooce team call 020 7224 0999 or email reception@endooce.co.uk or for more information please visit www.endooce.co.uk.

About the author

---

EndoCare. Michael qualified at Barts University in 1986. He worked as a general dental practitioner for five years before commencing specialist studies at Guy’s hospital, London. He completed his MSc in and Endodontics in 1993 and worked as an associate endodontist in various practices before setting up in Harley Street, London in 2000. He was admitted onto the specialist register in endodontics in 1999 and has lectured extensively in postgraduate dental groups as well as lecturing on Endodontic courses at Eastman UCL, University of London. He has been involved with numerous dental groups and has been chairman of the Alpha Group of Endodontists. In 2003, he became clinical director of Endooce a group of specialist practitioners. To talk to a member of the Endooce team call 020 7224 0999 or email reception@endooce.co.uk or for more information please visit www.endooce.co.uk.
A helping hand

A difficult situation, a chance meeting and a world of difference made possible by KaVo

It's not an easy thing to admit that a helping hand would be nice, but sometimes it's just what you need.

And that's exactly what happened for Peter Soin, dental surgeon, practice principal and student on the MSc in Restorative and Aesthetic Dentistry.

Peter, who qualified from the University of Liverpool in 1995, owns two practices - one NHS and one soon to be developed private cosmetic practice. He says: “I've been committed to the NHS for the last 15 years but as time has gone and so many things have changed I've been beginning to feel a little bit lost and I have been searching for a way to bring myself closer to dentistry.”

To achieve this, Peter chose the new offering from Smile-on and The University of Manchester, a two-year MSc in Restorative and Aesthetic Dentistry that is provided through online webinars, to allow students the flexibility to study wherever they are. “The MSc was something I would be able to manage because of my experience and my familiarity of many of the key components of the course and I felt that a degree course of this kind would give my career the focus it needed. ”

“The MSc has allowed me to not only to develop the cosmetic side of my career and be a fantastic refresher on other subjects to bring me up to current standards of dentistry, but also has enabled me to pick a new part of dentistry and focus on it.”

Though, like many students, Peter’s plan hasn’t quite followed the script! “I'm loving it. I thought I'd picked a course that would be easy for me, but that hasn't been the case! I have had to work a little harder than I'd expected, which has been a challenge in itself managing my time around my work and my life, especially with three children and a newborn!”

Despite the love for the course, there was more than just the time issues making life difficult for Peter. An increased commitment to his study meant a decrease in his clinical working time, as well as being the sole earner while his wife is on maternity leave. This has meant extra purchases such as a clinical digital camera for recording of his case studies an extra burden. This is where a chance meeting at the recent Clinical Innovations Conference gave him the helping hand Peter needed. “There was a discussion at this year's Clinical Innovations Conference about the availability of bursaries for students in the 2011 MSc uptake. I had a discussion with Noam Tamir, Director at Smile-on, about how a bursary would be very useful to a student such as me on this year's course.

“I was later contacted and offered a bursary of £1,000 from KaVo. This bursary is exactly what I need right now and has been absolutely invaluable.”

Peter is very honest about what the KaVo bursary has meant to him. “It has meant that I have been able to buy camera I need for the MSc without having to hold that money - it's just taken some of the pressure off. At the start off the course I had to get the camera and I've been putting it off for as long as possible and now it means I don't have to worry.”

“Contact your local KaVo or Gendex supplier for more details!”

KaVo – Dental Excellence

ESTETICA E80

Rise above the rest with KaVo.

• Outstanding ergonomics and attractive, highly functional designs.
• Innovation at its best.
• State of the art technology reliability and functionality at amazingly low prices.

From as little as £286* per month excl VAT

*Finance is subject to status and for business purposes only.
Dealing with difficult patients

How do we care for our more awkward patients without giving in to their demands and having to care for them too much? Mhari Coxon finds out how to strike the balance

I have a patient who I am very fond of, but our appointment always starts the same way. He will walk in to the room and immediately announce that I am going to be annoyed with him and disappointed at the state of his mouth. Hackles raised, I calmly reply that no, I won’t be annoyed or disappointed with him, as it is his health not mine.

He sometimes even says: “I know what you are going to say, that you are not cross with me, but it must be disappointing to have a patient like me.” After unclenching my jaw, I reply that if there is any disappointment, it is because you feel so guilty at letting me down.

After a few minutes of this, he usually says: “Yes, I know it is my health, and I am only letting myself down, but how can you not care? You are such a hard woman.” I explain that I have more than 1,000 patients whom I treat and I cannot be responsible for each individual’s health, as it would be too heavy a burden for my shoulders. This does not mean I do not have empathy for patients. I do care; just not on the level he would like me to.

Same old score

We then do our usual bleeding score and BPE, followed by plaque score, all of which are in the “just getting away with it” section and have been there for over a year now. Once he sees he is not getting worse he is more relaxed and we go over all his hygiene routine, usually deciding that all is manageable and it is just a case of implementing it regularly.

ITI Education Week, London.
Current Treatment Principles and Concepts in Implant Dentistry

Course details

This six-day ITI Education Week has been designed for clinicians who wish to acquire further knowledge in basic and advanced treatment techniques in implant dentistry through an evidence-based approach. The course will be delivered through lectures, surgical and prosthodontic hands-on workshops, exposure to live procedures and interactive treatment planning sessions.

Topics

• Current principles of bone and soft tissue integration around dental implants
• Patient risk assessment (surgical and prosthodontic aspects)
• Smile design and treatment planning considerations for patients with demanding aesthetic needs
• Advanced treatment planning using radiographs and 3D imaging (lecture and workshops on radiographs and 3D images)
• Prosthodontic principles and loading protocols in implant dentistry
• Basic surgical and prosthodontic workshop (tissue level & bone level implants)
• Guided bone regeneration
• Alveolar ridge preservation vs. immediate implants
• Piezoelectric bone surgery for intra-oral bone grafting and implant site preparation
• Advanced soft tissue management by means of periodontal plastic surgery
• Provisional restoration and final prosthesis in the aesthetic zone
• Implants in periodontal and systemically compromised patients
• Management of peri-implantitis and supportive/maintenance therapy
• Case presentations with interactive treatment planning exercises and case discussions

As a highly intelligent lawyer, he is used to fighting his corner and I have not found a way of breaking this cycle we have fallen into. We discussed it after our last appointment and he said it was his own need to succeed at everything that led him to be hard on himself about his own hygiene. So, after our last maintenance session a few weeks ago I have been looking into ways of dealing with this cycle so we can both progress and I can keep my blood pressure where it belongs.

How to deal with difficult patients

I am loathe to use this as a heading, because I am so fond of this patient and his family. But, it is a tiring start to the day (he is always an 8am patient) and if I can make it easier for both of us, it would be good. I also believe the only way we can make progress is to stop this cycle. So here are a few tips we should avoid:

• Don’t take difficult patients’ behaviour personally. It is often habitual and affects most people with whom they come in contact. This does not mean they

ITI – International Team for Implantology

www.iti.org
are not worth having as a patient.

• Don’t try to cater to them. Appeasing difficult people can feed their insatiable appetite for more. It can lead to what we call a “black-hole client” who will suck all your energy during their visits for very little return. (I bet you are thinking of one now?)

• Don’t fight back or try to beat them at their own games. They have been practicing their skills for a lifetime, and you’re an amateur. Sometimes not responding at all and changing the subject can work very well with this.

Finally and most importantly I think:

• Don’t try to change them. You can only change your responses to their behaviour. While a patient is going through the motions, they will not be responsive to any attempts to change their behaviour. We have to guide them to a state of awareness of a need to change before we can begin to introduce choices for them.

Dealing with overly aggressive people

 Thankfully this is not a daily occurrence in most practices, but it is very unpleasant for those facing it. Abuse of staff should not be tolerated and the principal should always side with their staff in this situation. The best solution, however, is to avoid the confrontation completely.

Stand up to them, but don’t fight. Overly aggressive people expect others to either run away from them or react with rage. Your goal is simply to assertively express your own views, not try to win a battle of right and wrong.

First, wait for the person to run out of some steam. Sometimes writing down their complaint is a good way of defusing them. Then call the person by name and assert your own opinions with confidence.

There are many other types of negative behaviour that we can stop with good patient-management skills.

It is helpful to go on courses from time to time to enable us to deal effectively with this type of issue and it improves our complaints-handling skills if we are all aware of how we deal with certain situations. Ursula Markham’s book How to Deal with Difficult People is great. You could read it and discuss it as a group, with clear outcomes and a chance to feedback. What’s more, you will have completed verifiable CPD, as well as making your working environment easier.

So, next time you look at your day list and see a name that makes you groan, think of how you can break the cycle, so they do not get the result they desire, which stops the behaviour that can be so draining. Go on; give it a go – it just might make your day.

Finding the right path to help more difficult patients

The British Dental Trade Association

The BDTA represents over 130 companies who supply you with all you need to run your practice efficiently.

About the author

Mhari Coxon is a dental hygienist practising in Central London. She is chairman of the London British Society of Dental Hygiene and Therapy (BSDHT) regional group and is on the publications committee of its journal, Dental Health. She is also clinical director of CPDforDCP, which provides CPD courses for all DCPs. To contact her, email mhari.coxon@cpdforcp.co.uk.
Importance of a Diet Diary

A diet diary is an essential piece of evidence in to a patient’s teeth and for the health, says Dilhani Silva


Information about the diet itself is of little value unless it is taken in context with the patient's lifestyle. Only dietary recommendations tailored to the patient’s life are likely to be adopted. The diet record should include all the food and drinks consumed, the amount and the time of eating or drinking. Every morsel eaten and every drop that has been drunk. The diet record should include all the foods and drinks consumed, the amount in readily estimated units and the time of eating or drinking.

Analysis of the diet itself may be performed in a variety of ways. The patient can be asked to recall all foods consumed over the previous 24 hours. This is not very effective, relying on a good memory and honesty, and is unlikely to give a representative account. Relying on memory may be more than 24 hours is too inaccurate.

The most effective method is to keep a written record of their diet for four or five consecutive days, including two working days and two leisure days. The need for the patient to comply fully and accurately. The diet should not be changed because of it being recorded. Ideally the analysis should be performed before any dietary advice is given. Even the patient who does not keep an honest account has been made aware of their diet. If they know what foods to omit from the sheet to make their dentist/oral health educator/dental nurse happy, at least the first step in an educational process has been made.

How to analyse a diet sheet

Highlight sugar rich foods and drinks

Note whether they are confined to meal times or whether they are eaten frequently and spaced throughout the day as snacks.

The number of sugar attacks should be counted and discussed with the patient. Also the consistency of the food because dry and sticky foods take longer to be cleared from the mouth. Sugared drinks taken immediately before bed are highly significant because salivary flow is reduced during sleep and clearance time is greater. Identify foods with a high hidden sugar content because patients often do not realise that such foods are insignificant: ex. Baked beans

• Breakfast cereals
• Tomato ketchup
• And plain biscuits

If the diet sheet shows the main problem for the patient is too much sugar contains drinks and frequent drinks and carbohydrates. The need for the diet for four or five consecutive days, to keep a written record of their diet in readily estimated units and the time of eating or drinking. The patient should be educated in the relationship between caries and high frequency in consumption of sugar.

The dental profession has been aware for over half a century that the frequency of sugar intake is far more significant in the development of caries than the amount consumed at any given time.

Advice based on Diet Diary

- Particularly those containing sugar. It is important to give the same advice as other health professionals such as dietitians and health visitors, who are concerned with other aspects of health, such as obesity. But it is rare that patient opt to have a healthy diet having concerns about their teeth rather than size.

- Dental profession has suggested that plain crisps, peanuts and cheese are tooth-friendly alternatives to sweet, biscuits and confectionery. When reading labels, it can be seen that some nut snacks contain hidden sugars, and this should be pointed out to the patients.
- Should always check and liase with the patients medical condition. Some must have been a told by their health professionals to avoid such foods for other health reasons. Advice always must be balanced and accurate.

- Particularly school children and adolescent require frequent intake of carbohydrates to sustain energy. In such cases it is essential to mention frequent snacks such as pasta, bread and toast, bread sticks fruit and raw vegetables.

- Public has raised awareness of hidden sugar and salt with the current trend towards healthy eating. It is important to be able to identify hidden sugars (eg. Glucose, fructose, dextrose, maltose, lactose) to look for these on food labels.

- Also the relationship with such food can contribute to obesity and heart disease as well as caries and behavioural disorders.

- The use of artificial sweeteners is increasing as the public becomes more diet conscious, since their low calorific value means that they are virtually non-cariogenic and non fattening. Sweeteners can be of synthetic or natural origin (eg. xylitol, a plant extract).

Facts The advice below can elaborate on it more.

*Reduce the amount of sugar.

Check manufacturers' labels and avoid foods with sugar such as sucrose, glucose and fructose listed. Natural sugars (eg honey, brown sugar) are as cariogenic as purifed or added sugars. When sweet foods are required, choose those containing sweetening agents such as saccharin, ascorbic acid and aspartame. Diet formulations contain less sugar than their standard counterparts. Reduce the sweetness of drinks and foods. Become accustomed to a less sweet diet overall.

*Restrict frequency of sugar intakes to meal times as far as possible.

Try to reduce snacking. When snacks are required select safe snacks such as cheese, crisps, fruit or sugar free sweets, such as mints or chewing gum (which not only no sugar but also stimulates salivary flow and increases pH). Use artificial sweeteners in drinks taken between meals.

*Speed clearance of sugar from the mouth.

Never finish meals with a sugary food or drink. Follow sugary foods with a sugar free drink, chewing gum or a protective food such as cheese.

The dietary advice is almost always provided using the health belief model of health education. How ever it is well known that education about the risks and consequences of lifestyle, habits and diet is often ineffective. It is important to judge the patients likely compliance and provide dietary advice which can be used to make small but significant changes rather than attempting to eradicate all the sugar from diet. As the diet improves, the advice can be adopted and extended. Advice must be acceptable, practical and affordable. In this case the patient has already suffered consequences from his poor diet and this may help change behaviour.

The patient must be made aware that damage to teeth continues up to 20min to 2hrs of sugar intake. The statement should correspond with the Stephan curve without difficulty.
CODE is launching a series of one-day seminars in the autumn aimed at helping dentists and managers get ahead with the requirements for Care Quality Commission registration. The seminars, held in Manchester, London, Bredenbury and Buntingham in association with the BDPA, feature leading speakers in dentistry and management and will provide practical help in how to make sure your practice complies.

With compulsory registration for practices in England less than a year away, and examining where you practice is at the moment, and help you to develop an action plan to help you to ensure your practice complies by the deadline.

A place on the seminar costs just £145 including lunch, and each day provides 6.5 hours of verifiable CPD. Delegates booking before August 1st will receive a 5% early booking discount.

The new centre extends over two floors and incorporates free working surgeries and a 5,000 sq ft dedicated education facility. Delegates can enjoy the new open plan learning setting within a friendly and spacious environment and are able to utilise procedures taking place on site. This practical, hands on approach reflects CODE’s relaxed, high quality approach to dental education.

Situated in a convenient location, DARE is an ideal choice for companies or providers looking for an ultra-modern dental training facility in the North of the country.

For further information or to place orders call Jackie or Helen on 07700 772056 or visit: www.dare.dent.co.uk

Snappy Half Price Special Offer

For a limited period, buy an Owandy Visteo system and get an Owandy Cam - Sensor - Full instructions - 24 Months Warranty

The package includes:

- Owandy “Quickvisor” Software - Interface Modem - Storage box
- Sensor - Full instructions - 24 Months Warranty
- Owandy “Quickvision” Software - Interface Modem - Storage box

Owandy are proud to announce a new Digital Intra-Oral X-Ray System. Velopex is pleased to announce a new Digital Intra-Oral X-Ray System featuring unique USB connectivity and both 1 and 2 CMOS sensors. Both sensors have either a hard wearing cable connection: the removable cable is clipped on to the back of the sensor for easy ergonomic shipping in the mouth and the system comes complete with integral positioning device which the sensor can be clipped into. This reduces the bulk of the material in the mouth and spread of radiation when positioning. The cable contains a flexible anti-traction sheath which helps to prevent the cable from being damaged when shipping.

The USB connected system comes with a 5 year cable length between sensor and modern interfaces, The USB system draws power through the USB cable. For a limited period, buy an Owandy Cam system and get an Owandy Cam Intra Oral Camera FREE. Velopex, supported by Velopex, for more information, please call: Mark, Dental Director Sales & Marketing, 07774 044877. E-mail: mark@velopex.com

51.3% of adults ignore oral health advice

Despite the Department of Health’s latest campaign for prevention Delivering better oral health, several studies and other recent oral hygiene advice that patients should “top – not mow” it seems the message is not getting through. A recent survey undertaken by the BDPF shows that 51.3 per cent of adults admit to rinsing with water after toothbrushing. This “top - not mow” advice has been designed to make sure that rinsing with water after toothbrushing will negate the positive effect of fluoride in the mouth and spread of bacteria away.

The scenario changes however if a mouthwash containing fluoride is used as a rinse instead of water. In fact, a recent blinded, randomised study has shown that 100 ppm mouthwash, such as Listerine, even when used immediately after brushing, maintains the fluoride levels obtained from a fluoridated toothpaste.

For information or to book your place call on 0443 872266 or email info@navuse-ihd.com

http://www.navuse-ihd.com
Introducing a dental technology
so advanced, it revolutionises preventive care.
Reliably Formed

Clesta II offers ‘air’ and ‘electric’ operation across a flexible range of chair-mounted and mobile delivery systems. Hygiene-conscious, ergonomic comforts and versatile treatment centres for the demanding environment of a busy practice. Utterly reliable technology supported by Belmont’s unrivalled extended warranties.
It’s a knockout!

For a truly original and hilarious idea for a team day out, why not join B2A for ‘It’s a Knockout’, held this year at Aston University, Birmingham on 3 July?

From the Banana Dash to Human Demolition games, it’s a Knockout is described as ‘a sports day for grown ups’ and will feature many of the games from the classic 1970s TV show. It’s a perfect event to get your team or practice involved in. Teams can vary in size from between six and 10 people at £500 (minimum) sponsorship per team.

The funds raised will be vital for Bridge2Aid’s training programme in emergency dentistry, as CEO Mark Topley explains: ‘Our training programmes this year will give access to simple, pain-relieving dental treatment to almost half a million people in East Africa. But this only possible with funds donated by our ‘Friends of Bridge-2Aid’ and raised by events like ‘It’s a Knockout’. I hope that many practices and teams will join us for what promises to be a great day out having fun and making a big difference to the poor rural communities where Bridge2Aid works.’

Let the fun begin!
The games will start from 11am to 3pm at Aston University’s sports ground. There’ll be a cash bar and barbecue to enjoy, as well as plenty of shower and changing facilities. Spectators are more than welcome to help cheer on their favourite team and looking silly and having fun is definitely compulsory – in fact, extra points will be rewarded to the best-dressed team!

If you’d like to take part, contact us soon to register. There are limited spaces available, and you don’t want to miss out on what will be a fantastic day!

For more information and to register a team, please call the Bridge2Aid office on 01243 780102 or email Naomi at fundraising@bridge2aid.org.

About the charity
Bridge2Aid (B2A) is a dental and community development charity working in the Mwanza region of North West Tanzania. We started full-scale operations in 2004 and work closely with the Tanzanian Government to deliver aspects of their dental strategy. We operate a not-for-profit dental clinic in the city of Mwanza (Hope Dental Centre), and have a community development programme for the disabled community based at Kubimbi Care Centre.

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

The four key aspects of Bridge2Aid’s vision are:
- To provide primary dental care and oral health education to communities in Tanzania
- To equip and further train local health personnel to provide emergency dentistry to rural communities
- To care for and empower the poor and marginalised in Tanzanian society
- To provide opportunities for UK dental professionals and others to use their skills to serve Tanzania, aslocums or participants on the Dental Volunteer Programme (DVP)
Why not sit out le crunch in in comfort for a price you will prefer?

www.stevensseating.co.uk
01243 267 386

STEVENS SEATING LTD
“Give me something that works fast and I might be interested”

Patient, UK

Sensodyne Rapid Relief – rapid* and long-lasting**
relief from the pain of dentine hypersensitivity

The strontium acetate formulation of Sensodyne Rapid Relief forms a deep occlusive plug within the dentinal tubules providing:

• Clinically proven relief1,2
  Works in 60 seconds*1
• Proven long-lasting relief with twice daily brushing2
• A deep, acid-resistant occlusion3,4
• Fluoride to strengthen tooth enamel

The robust occlusion formed by Sensodyne Rapid Relief is still maintained after an acid challenge*

Unoccluded dentine After treatment and a 30 second acid challenge After treatment and a 10 minute acid challenge

In vitro study of dentinal tubule patency following an acid challenge (immersion in grapefruit juice, pH 3.3) applied after dabbing and massaging for one minute with Sensodyne Rapid Relief. Adapted from4.

Recommend Sensodyne Rapid Relief for rapid relief from the pain of dentine hypersensitivity

* when directly applied with finger tip for one minute  ** when used twice daily

SENSODYNE® and THE RINGS DEVICE® are registered trade marks of the GlaxoSmithKline group of companies.