**News in brief**

**Sadly missed**
A dentist from Worcester has been killed in a motorcycle accident. Father-of-two, John Bue from the NHS Dines Green dental surgery on Gresham Road, died in Worcestershire Royal Hospital, following an accident on the A4440. Councillor Margaret Layland, who helped Dr Bue set up his surgery in 2002, said her ‘great friend’ who believed in free healthcare for everyone would be ‘sadly missed’. **LDC chair**
Mick Armstrong, a representative on the British Dental Association’s General Dental Practice Committee, has been elected as chair of the Local Dental Committees for 2010–11. He said: ‘I would like to give the annual conference a bit of life and get dentists united as much as possible under this awkward new contract.’ **Free treatment**
A dentist in Edinburgh is giving free dental treatment worth thousands of pounds to children affected by the Chernobyl nuclear disaster. Biju Krishnan, who runs the Scottish Dental Implant Centre in Edinburgh, has been treating the teeth of 25 Belarusian children from the town of Mogilev in Belarus. The Friends of Chernobyl’s Children organisation have brought the children over for a month’s treatment with Dr Krishnan providing free dental examinations and treatments. He said: ‘The children can have terrible teeth because of the conditions back home – their poor diets and the poor agriculture thanks to the radiation effects – and we have to try and counter that here.’ The average lifespan of those affected by the disaster is 50 years old. **Record deal**
A singing dentist in Richmond, West London is awaiting the release of his debut album after securing a £1 million record deal with SonyBMG. Andrew Bain, began singing in choirs at a young age, went on tour with Cameron Mackintosh’s production of Les Misérables in 1999 and Bill Kenwright’s Whistle Down the Wind in 2002 and signed his million pound contract last July. He currently works two days a week at the Park Dental Clinic in Upper Richmond Road, West. To see him in action, visit myspace.com/andrewbainings.

**Endo Tribune**

**Interesting findings**
A ‘shameful’ lack of IT investment and patient confusion over what the NHS actually offers in terms of dentistry are revealed in Jimmy Steele’s review. **Canal anatomy**
In this case report, Siju Jacob suggests that if you don’t recognise and treat aberrant canal anatomy, it can affect the prognosis of endodontic treatment. **Performing dentistry**
In 2006, when the old NHS system came to an end, the dental associate made way for the dental performer. But what is the difference and has the change been for the better? **First impressions**
Although it takes the whole team makes a new patient feel at home, it’s the receptionist who will first influence a new patient’s opinion of a practice.

**News**

**Professor Jimmy Steele**

The long-awaited independent review into NHS dentistry wants dentists’ pay linked to how many patients are on their books. The Independent Review of NHS Dental Services, looks set to reverse the reforms of the 2006 contract, with dentists being paid for the number of treatments they provide. Critics claimed that this has led to patients tending to have their teeth extracted rather than have fillings or crowns, as it is more profitable for dentists to take a tooth out, than to try and save it with complex treatments such as crowns or bridges.

Before the contract, dentists were paid per procedure, but after it came in they were paid to provide a specific rate of procedures in the coming year.

People in many parts of the UK have had problems accessing an NHS dentist since the new contract came in.

It is hoped that by linking dentists’ pay to patient registration, this will encourage dentists to take on more NHS patients.

Under the recommendations, dentists would have a ‘significant chunk’ of their annual income possibly as much as 50 per cent linked to the number of patients on their books.

Professor Jimmy Steele, author of the report wants to see dentists ‘more explicitly accountable’ for providing high-quality and long-lasting treatments (eg, fillings and root canals). He also wants to see more of a focus on prevention with dentists taking the time to advise patients on preventive care.

Professor Steele said: ‘This review is a vision of a better deal for both patients and dentists. It’s about making sure that patients can see an NHS dentist who will take long-term responsibility for their care.

We have recommended some significant changes to the systems by which dentists are paid in order to support their work with patients to improve oral health, prevent oral disease and provide treatment of the highest quality.’

The report also wants dentists to give a clearer definition of the patients’ rights upon registering with an NHS dentist and for there to be a simpler registration process with dentists, with information on local services made available through NHS Direct or the NHS Choices website.

Patients will still pay NHS charges, which cover about 80 per cent of the cost of treatment, but these may be divided into up to 10 payment bands, compared with the existing three, to lie them more closely to the amount of work done.

Health Secretary Andy Burnham welcomed the review and said access to NHS dentistry is already improving and new NHS dental surgeries are opening up all over the country.

He accepted the recommendations in ‘principle’ and said: ‘From the autumn, many will be asked to pilot the changes that the review has recommended. Recognise that more needs to be done to bring NHS dentistry up to the standards that the patient should expect.’

**Review links pay to patient numbers**

The review has been welcomed by The British Dental Association (BDA), which has called on the Government to work constructively with patients and the profession on its findings.

The BDA has urged the Government to heed the report’s recommendations to pilot properly any reforms it introduces as a result of this report.

John Milne, chair of the BDA’s General Dental Practice Committee, said: ‘The BDA is pleased that this report has been published. Professor Steele and his team have clearly listened carefully to patients, dentists and primary care trusts. We have an opportunity to learn from the difficulties of 2006, and it is vital that opportunity is taken.

The report’s recommendations appear to be far-reaching. They describe a new approach to dental care that dentists hope will mean a move away from the target-driven arrangements that are currently in place. Clearly, the details of how that approach will be delivered will be vital.’

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Embrace Endodontic Success

Mrs ProTaper Universal lies at the centre of most successful endodontic procedures in the UK.*
Lack of IT funding ‘quite shameful’

Professor Jimmy Steele, who led the independent review into NHS dentistry, has called the lack of IT investment into dentistry ‘quite shameful’. However, on the negative side, he found that ‘some patients are not able to access care and added: ‘I am really concerned that some of the best dentists are unable to provide the best care they want to provide.’

He revealed that there was a real issue, since it came in, has been the competence of the PCTs.

‘Where it is done well, you have the local dental committee, commissioners and chief executives fully engaged in the process,’ he said.

He also dealt with the problem of UDA units (units of dental activity) and said: ‘There is unrealistic remuneration for certain procedures and to have the UDA as a sole measure of payment is wrong’.

Another problem with the current contract is that the NHS offer is unclear so ‘patients are confused about charges and what treatments are available on the NHS’.

He also feels there is a problem with the image of dentists and called them ‘fairly unpopular’, second on people’s dislike list only to lawyers and politicians.

To reverse this trend, there needs to be a ‘high level support for dentistry’ and from all political parties and said: ‘That commitment is really important’.

Review links pay to patient numbers

He added: ‘What is important now is that the Government pilots properly the changes it makes and engages fully with the profession and patient groups as we move forward. The BDA looks forward to playing a full part in that process.’

Prior to the report’s publication, Dr Milner speaking at the annual conference of Local Dental Committees in London, prior to the publication of the report.

He revealed that a big reason he took on the task given to him by the Government was that he was ‘very concerned’ about the state of NHS dentistry.

He revealed that researching ‘The Independent Review of NHS Dental Services’ has been difficult and he had to deal ‘over the last six months with some very conflicting viewpoints’.

‘I have had to deal with a profession that is hostile to the reforms and you cannot have a good dental service if you don’t have happy dentists.

I was also dealing with an NHS that was telling me that more money had been put into it but there are fewer patients being treated.

I felt like a man on a tightrope trying to keep my balance and trying to keep my balance for 29 months with some very conflicting viewpoints.

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However, on the negative side, he found that ‘some patients are not able to access care and added: ‘I am really concerned that some of the best dentists are unable to provide the best care they want to provide.’

He also expressed concern about the ‘highly variable commissioning’ that takes place now it is all done at a local level’ and said: ‘There needs to be more robust performance management from the PCTs and better coordination of information and better data and improved use of data.’

One of the core reforms of the 2006 contract was the move to local commissioning. So one of the real issues, since it came in, has been the competence of the PCTs.

‘Where it is done well, you have the local dental committee, commissioners and chief executives fully engaged in the process,’ he said.

He also dealt with the problem of UDA units (units of dental activity) and said: ‘There is unrealistic remuneration for certain procedures and to have the UDA as a sole measure of payment is wrong.’

Another problem with the current contract is that the NHS offer is unclear so ‘patients are confused about charges and what treatments are available on the NHS’. He also feels there is a problem with the image of dentists and called them ‘fairly unpopular’, second on people’s dislike list only to lawyers and politicians.

To reverse this trend, there needs to be a ‘high level support for dentistry’ and from all political parties and said: ‘That commitment is really important’. The Foundation is particularly happy to note the emphasis on prevention and reward for prevention within the system, which will help more of us attain a sound level of dental hygiene to help look after our health.

The review marks a welcome return to continuity of treatment through patient registration and the report’s emphasis on thorough oral health assessments to determine necessary treatment and a strong evidence base for any decisions are pleasing.

The proposed ‘pyramid of need’ approach, addressing advanced care, routine care and emergency treatment, is a sensible plan to ensure effective treatment when required.

We also welcome a commitment to testing any proposals before they are implemented as many of the existing problems with NHS dentistry arise from a lack of thorough groundwork before contracts were introduced.’

Dentists call for consistency

Dentists at the Local Dental Committees’ conference have debated the 2006 contract and called for more consistency from primary care trusts. They also held a vigorous debate on whether the Government should fund the General Dental Council (GDC).

Alasdair McKendrick of Northamptonshire LDC, claimed dentists will no longer be regulating themselves from this October, as there will be more lay members on the GDC than dentists.

The Council currently has 29 council members – 10 are members of the public appointed by the NHS Appointments Commission, and 19 are dental professionals (15 dentists and four dental hygienists and therapists) elected by dental professionals. Under the restructure in October, there will be 12 lay members, eight dentists and four dental care professionals (dental hygienists, dental therapists, dental nurses, dental technicians, orthodontic therapists, clinical dental technicians). A chair will be elected from within the membership of Council (dental professional or lay).

John Milne, chair of the BDA’s General Dental Practice Committee, speaking on the contentious subject of UDA’s (units of dental activity) said: ‘You all know they are corrosive and we need to rid them of them or, if not, see them lose some of their power’.

He also referred to the relationship between dentists and primary care trusts (PCTs) and said: ‘A good relationship between the Local Dental Committees and the PCTs needs to exist.’

Ian Gordon, an LDC representative from Tees put many of the problems of the new contract at the door of the PCTs. He said: ‘It didn’t help that the PCTs were in an embryonic stage when the new contract was brought in. But I also find that you go to all that effort building up a good relationship with both PCTs and you put them to the test when the person you have been dealing with moves on and you have to start all over again.’

There was also a call for all PCTs to be consistent within a Strategic Health Authority region or in their policies towards UDA (units of dental activity) achievement.
NHSDentists in England are calling for extra funding to help them implement the decontamination guidance issued by the Department of Health.

Dentists at the Local Dental Committees’ (LDC) annual conference voiced their concerns over the extra time, extra staff and extra equipment needed to implement HTM 01-05.

The Department of Health produced this guidance in response to emerging evidence around the effectiveness of decontamination in primary care dental practices and the possibility of prion transmission through protein contamination of dental instruments.

The guidance for dentists in England was published online in April.

All NHS dentists have 12 months to implement HTM 01-05, from when they receive the hard copy of the guidance, which should be with all dentists over the next couple of months.

Dentists in Wales will also adopt 01-05 with a few modifications of the terminology. But Scotland has decided not to follow the guidance.

Lesley Derry, head of education and standards at the British Dentists Association (BDA), who spoke at the LDC conference said: ‘At the moment, Scotland has just cleaning protocols in place and this may be less arduous but I don’t think Scotland is getting much of an easier time.’

Under Scottish guidance, all dentists in Scotland have to have a Local Decontamination Unit in place by the end of the year. They are being given grants of around £20,000 to help them do this.

However, a Scottish dentist at the conference revealed that there are currently 55 dental practices in Glasgow facing closure as they are unable to comply with this, as they do not have the space.

Jason Stokes from Norfolk LDC called for the Government to offer dentists in England similar financial help.

‘The Department of Health needs to offer funding to primary care trusts (PCTs) to help fund dentists implement 01-05. If it wants to see more patient safety, we want to see extra funding,’ he said.

While Vijay Sudra of Birmingham LDC claimed that the guidance will create ‘chaos’ and leave dentists with a ‘logistical nightmare’.

Under the guidance, all dentists will have to have an overarching infection control policy. So if a dentist gets a new piece of equipment, he or she will have to show how it will be cleaned.

All practices will have to have a rota in place detailing how all the areas in the dental practices are cleaned. The guidance also stipulates that single use instruments are used wherever possible.

Ms Derry said: ‘These are national guidelines but PCTs will be able to adapt them as they see suitable.’

John Milne, chair of the BDA’s General Dental Practice Committee, also spoke and said he had been in discussion with the Health Minister Ann Keen expressing his concern about the guidance and detailing the problems that dental professionals will have implementing the decontamination guidance.

The full guidance can be accessed online at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089245

DH guidance ‘logistical nightmare’

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* Graphical representation based on SEM photography; for illustration only
A dentist described as the ‘worst in Scotland’ has been struck off from the profession. Andrew Boyd, who practised at the Barassie Street Dental Practice in Troon, Ayrshire, left one man looking ‘like the Elephant Man’.

While another patient was forced to spend £17,000 on private treatment to repair the damage caused by Mr Boyd.

Health campaigners have called him the ‘the worst dentist in Scotland’.

Mr Boyd was accused of not examining patients properly, failing to take x-rays and not recording treatment.

The General Dental Council (GDC) chairwoman, Marilyn Green, said: ‘He omitted to take proper care of his patients on a large number of occasions, and failed to provide the basic diagnosis and treatment of common oral disease which would be expected of a competent dental practitioner. This amounted to the supervised neglect of his patients.’

She added: ‘The committee has to protect the public and maintain its confidence in the profession. Therefore the committee has decided that erasure from the Dentists’ Register is the only appropriate and proportionate sanction in this case.’

Margaret Watt, chairwoman of Scotland Patients Association, said: ‘This dentist is the worst I’ve ever heard about in Scotland. It’s shocking that it took so long for his behaviour to be exposed when he was very clearly endangering patients’ lives.

Bad oral hygiene can cause all sorts of health problems especially if the patient has an underlying health condition such as a heart problem.’

The hearing heard that around a hundred of Mr Boyd’s patients needed ‘immediate treatment’ after going to see him.

Dozens of them suffered from problems with gum tissue and tooth pulp.

Dental experts discovered other patients’ fillings had not stopped their teeth rotting because Boyd had failed to remove decay.

Boyd was removed from the NHS practitioners’ list after a misconduct hearing in 2006.

In 2007, he admitted a series of misconduct charges involving sub-standard dental care and was suspended for five months.

He failed to attend a review hearing in June 2008 and was banned from working for another 12 months.

Mr Boyd did not attend his hearing at the GDC.

Rochdale sees NHS boost

Rochdale is to get five new NHS dentists as part of a £1.3 million plan to improve dental services in the area.

NHS Heywood, Middleton and Rochdale want to open a surgery in Brimrod with four NHS dentists.

A fifth dentist will be based at an existing practice in Littleborough.

It is hoped that the extra dentists will be in place by the end of the year.

All of the dentists will provide NHS treatment and are expected to treat an extra 17,000 patients.

Carole Williams, the Trust’s primary care dental lead, said: ‘We have been working really hard to bring more dental services to the borough and it’s fantastic that we are able to do this before the end of the year.

Access to NHS dentistry has slowly improved over the past two years but these new services will accommodate in the region of 17,000 new patients when at full capacity, significantly boosting our local NHS dental services.’
News & Opinions

Patient left to suffer ‘extreme pain’

A dentist has been accused of leaving a woman to suffer months of ‘extreme pain’, according to a misconduct hearing at the General Dental Council.

Simon Rudland, of Falgrave Road surgery in Scarborough, installed bridges to the patient’s upper and lower mouth between 2005 and 2006.

The woman told the hearing at the General Dental Council (GDC) that the pain was so bad she was unable to sleep at night.

She had a number of further appointments with Mr Rudland but he failed to correct the problem.

He added: ‘They also feel that the contract makes providing appropriate care more difficult, produces more financial risk, alters the management of disease and that patients are less happy.’

Newly qualified dentists don’t find the contract easy to manage, don’t feel their education and skills are fully used or that UDAs measure work effectively.

While dentists outside the GDS withdrew from the GDS because of the introduction of the contract, they found more unrelated disease on new patients than before.’

Smile-on helps deliver better oral health

Smile-on, the learning resources provider, has come up with an innovative e-learning solution to help dental practices implement Government guidance on improving patients’ oral health.

The two-hour programme, ‘Prevention in Practice: Using Delivering Better Oral Health’ was developed by Smile-on at the request of NHS Education South Central (NESC).

It has had input from members of the team that produced the Delivering Better Oral Health toolkit, which was sent to all NHS practices in England in 2007, by the Department of Health.

Dr Gill Davies, specialist in dental public health for Manchester Primary Care Trust, who wrote some of the educational material on the DVD said: ‘It deals with issues such as the best ways of communicating with patients and overcoming opposition within the practice and the perceived barriers to integrating preventive activity for every patient.’

She added: ‘A variety of teaching methods are used, including short film sequences, illustrations of key points and indicators of the sources of the evidence on which the prevention toolkit is based. It is interactive in that it asks questions about attitudes at the start of each topic and then checks on knowledge gained at the end.

It can be watched from start to finish or the user can dip in and out of topics as they choose – the screen is very user friendly and constantly shows the stage the viewer has reached.’

The e-learning package can either be downloaded online or bought as a CD-ROM.

The programme is for all dental professionals from dentists to orthodontists to hygienists.

Each DVD provides two hours of CPD.

For more information on the programme, call 020 7400 8989 or email info@smile-on.com.

Army dentist treats Kenyan villagers

A dentist with the Royal Army Dentist Corps is currently visiting remote villages in Kenya, providing ‘once in a lifetime’ dental care for the villagers.

Captain James Scott, a dentist with the Royal Army Dental Corps, is one of 151 British Army medics, on exercise in Kenya, giving dental treatment, primary health care and inoculations to people in remote locations across Kenya.

Captain Scott has spent four weeks out there setting up temporary mobile dental clinics which provide villagers with their only chance of dental care in their lifetime.

There is such a demand for the treatment that some villagers have walked more than 50 kilometres to be seen in the clinic which opens at 8am and close when it gets dark.

Captain Scott said: ‘Most teeth we have been looking at have tooth decay, so if there is imminent pain, we suggest taking it out because the patients are unlikely to see a dental care soon.

In some cases, we are providing the first and last dental care some of our patients will see.’

Dental expert Anthony Lynn told the hearing that some pain was to be expected because installing bridges was a ‘severe process for the teeth’.

However, he said Mr Rudland was under a duty to investigate the problem, particularly as the patient returned for further consultations.

He said that he thought Mr Rudland did not carry out enough investigations into the cause of pain as there were no radiographs.

The GDC heard that Mr Rudland sold his practice in 2006 and moved to Spain where he is thought to be living in Marbella with his wife. He has not been present at the hearing.

If found guilty, he could be struck off.

The hearing continues.

UDA system ‘bad’

Over 80 per cent of dentists disagree with using units of dental activity as a way of measuring the work they do, according to a recent survey.

The survey carried out by Challenge, a pressure group for dentists, found that 91 per cent of respondents believe that the introduction of units of dental activity (UDAs) to measure activity, has had a damaging influence on diagnosis and treatment planning for patients.

While 80 per cent felt that the new contract did not make it easier for them to give preventive advice and treatment for their patients than previous General Dental Service (GDS) arrangements.

A spokesman for Challenge said that the findings showed that ‘dentists working within the GDS feel that UDAs are a bad system, damage treatment planning and do nothing to encourage prevention’.

He added: ‘They also feel that the contract makes providing appropriate care more difficult, produces more financial risk, alters the management of disease and that patients are less happy.

Newly qualified dentists don’t find the contract easy to manage, don’t feel their education and skills are fully used or that UDAs measure work effectively.

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Filling baby teeth may have ‘no benefit’

An NHS study is looking at treatment options, after research found that filling baby teeth may have ‘no significant benefit’. Around 40 per cent of five-year-olds in the UK have tooth decay and at least one in 10 of these is treated with fillings.

Researchers from Manchester looked at case notes of 50 dentists, which suggests that filling baby teeth may achieve nothing but expose children to the discomfort of an injection and the sound of the drill.

Children receive a wide variation of care on the NHS with some dentists choosing to give a filling with another opting to extract it.

Professor Martin Tickle, of the University of Manchester, found no difference in the numbers of extractions for pain or infection whether baby teeth had been filled or not.

He also carried out a survey of the parents of all five-year-olds living in Ellesmere Port and Chester in 2005, and found only six per cent would want their child to have a filling if they had symptomless decay in a baby tooth.

While a third would want the dentist to monitor the tooth but provide no treatment.

Kamini Shah, honorary secretary of the British Association for the Study of Community Dentistry, said: ‘There are two schools of thought, one being that baby teeth can cause pain and sleepless nights and so dentists should fill.

The other is that actually the evidence around filling baby teeth is questionable.’

Advisers to the NHS are now beginning a study on treatment options to provide dentists with clear evidence-based guidelines.

Experts working for the Health Technology Assessment Programme want to recruit over 1,000 children from across the UK to take part in a study that will compare the outcomes of three treatment options.

They are drilling and filling, no fillings or a painless paint-on tooth treatment that merely seals and contains the decay.

The trial will run for four years from 2011 across England, Scotland and Wales.

Charity appeals for donations

The Dentists’ Health Support Programme made an appeal for more donations at the Local Dental Committee’s annual conference in London.

The charity gives support to dentists suffering from alcohol and drug addiction. It is estimated that one in 10 dentists suffers from an alcohol or drug-related problem.

Brian Westbury, chairman of the Dentists’ Health Support Trust which runs the programme, said: ‘We save the professional and personal lives of these people and every year we take on about 70 new cases.

We inevitably have a growing caseload. Many of these colleagues are helped to a stable condition. None however are truly cured and they may need access to our help and support at any time they feel vulnerable.’

The Trust enables the programme to run a 24-hour service with access to its co-ordinators and UK-wide network of voluntary referees. The Trust pays for the co-ordinators and their expenses but not for the dentists’ treatment, which must be funded privately or through the NHS.

Any donations should be sent to the Trust’s treasurer Michael Stern, 48 Pollard Road, Whetstone, London N20 OUD.
Recession hits BDA Fund

The British Dental Association Benevolent Fund is struggling financially in the current economic climate with more and more people appealing for help.

Ian McIntyre from the Fund said: ‘One of the problems is that beneficiaries are getting younger so they will be dependent on the Fund for considerably longer. The youngest applicant we have had was 24. We are currently helping the twins of a 35-year-old female dentist who recently died. Her husband is a tenant farmer and he has financial problems so they will be dependent on the Fund for considerably longer.’

Applications to the Fund are up 50 per cent on the year before and nearly a quarter of these applicants were below the age of 40.

The Fund operates by giving loans of up to £250,000 to dentists and their families.

However, the recession has hit the amount of money the Fund has tied up in bank dividends and it is ‘facing a reduced income stream combined with an increased demand for help’.

Any donations are much appreciated. For more information, go to www.bdabenevolentfund.org.uk.

Scotland gets advanced treatment

Two dentists in Scotland have opened one of the country’s most advanced treatment centres combining dental treatment and alternative therapies.

Biju Krishnan and Lubino do Rego have opened Lubiju in Edinburgh, which offers some of the most hi-tech treatment techniques and equipment available in cosmetic dentistry.

The pair already run the Scottish Dental Implant Centre open to NHS patients, a specialist facility in Edinburgh, dedicated to providing patients with solutions to missing teeth or loose dentures.

Dr Krishnan said: ‘We’re really excited about the possibilities at the new practice. Scotland has a patchy dental record and we are now at the leading edge of bringing the best new technologies and technology into the country.

We are looking at everything from the most advanced implants and surgical methods, to breakthroughs in needle-free and painless treatments and also the most up-to-date cosmetic dentistry.

The practice has two consulting rooms, an x-ray area which was created using a ton of lead and a Local Decontamination Unit.

It is also fitted out with three treatment suites, each with a designer flat-screen TV on the ceiling, so patients can watch DVDs during longer treatments such as laser tooth whitening.

Each suite is equipped with hi-tech, ceiling-mounted cameras, which can film surgical and cosmetic procedures to be beamed to specialist audiences elsewhere in the practice – or anywhere in the world – for training and teaching purposes.

Lubiju also has its own dedicated massage and complementary therapy treatment room, with staff who provide alternative health advice, relaxation and beauty treatments, non-surgical facelifts and other rejuvenation and detox treatments.

Dr Krishnan said: ‘There is nowhere else in Scotland – and very few centres in the UK – which offer this unique blend of advanced medical treatments and the very best in alternative therapies.’

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PracticeWorks
DCPs storm GDC website

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T
here has been a surge in the number of dental professionals using the General Dental Council’s website, since its relaunch.

Over 2,600 dental care professionals (DCPs) have created accounts on the General Dental Council’s (GDC) website, eGDC, since it was re-launched in April this year, according to figures from the GDC.

This brings the total number of dental professionals who are using the site, first launched last November, to over 7,200.

The eGDC site is designed to make things as easy as possible for registrants to keep on top of registration requirements at the click of a mouse.

It allows users to update their contact details, pay their annual retention fee and, in the future, submit continuing professional development returns.

A spokeswoman for the GDC said: ‘We have made changes to the log-in procedure on eGDC after listening to feedback from site users.

Registering on the site can now be done instantly, meaning there’s no wait for a password letter, providing you have an ID verification code.

If you don’t have your code you can request one on the site, from now on.

If you don’t have your code you can request one on the site, from now on.

BOS Education Day

The British Orthodontic Society is organising the UK’s first National Orthodontic Commissioning Education Day.

The event will be held this September and the day is aimed at individuals or organisations who are directly or indirectly involved in commissioning NHS orthodontic services.

A spokeswoman for the British Orthodontic Society (BOS) said: ‘Whilst the new contractual arrangements of 2009 in England and Wales brought about a number of positive changes, there are still many issues that would benefit from further clarification and guidance.

With this in mind, there is no doubt that shared knowledge between strategic health authorities, primary care trusts (PCTs), orthodontic managed clinical networks and providers is of huge benefit.

After discussion with both commissioners and the Department of Health, the British Orthodontic Society is keen to help facilitate this process and so is organising the day-long event as a parallel session at its annual conference which takes place on Tuesday 15 September in Edinburgh.’

The BOS has already run a number of education days at a local level in the last year and these will form the blueprint for the first national event.

During the day, delegates will learn at first hand about several examples of commissioners and providers successfully working together as part of local clinical networks and there will be good practice to share with those involved with commissioning.

The BOS wants this day to be as inclusive as possible and, with that in mind, has announced that representatives from PCTs, the BSA, the Department of Health, as well as the British Orthodontic Society will give presentations.

The topics to be covered during the day include justification and scope of orthodontics, background and principles of the PBS contract and orthodontic monitoring and BSA reports.

There will also be information on handling practice sales and retirements, referral management, the benefits of local managed clinical networks and dealing with orthodontic tenders and re-commissioning.

Registration for the meeting is free, but places must be booked in advance.

Lunch and refreshments will also be provided free by the British Orthodontic Society.

More information and a booking form is available from www.bos.org.uk.

Bridge2Aid has a ball

Tickets are now on sale for this year’s Bridge2Aid charity ball – a UK charity offering dental and community development programmes in North-West Tanzania.

The Bridge2Aid charity ball will be held on 15 November at the Hilton Metropole Hotel in Birmingham at the 2009 British Dental Trade Association (BDTA) Showcase and is being sponsored by Dentsply.

The Bridge2Aid charity runs a not-for-profit dental clinic, an innovative dental training programme for local health workers, and a community development programme helping the poor and disabled in North West Tanzania in Africa.

A spokesman for Dentsply said: ‘Dentsply has provided continuing support to Bridge2Aid over the years, and is delighted to assist with the organisation of such a highly anticipated event.’

Anne Geralat, processing manager at the GDC, said: ‘We’re hoping DCPs in particular take advantage of eGDC this summer.

They’re fast approaching the 31 July deadline to pay their annual retention fee and eGDC has plenty of extra information about how they can do that.

Some DCPs will also be asked to complete their continuing professional development returns this August and will be able to submit this on eGDC.

The deadline for all DCPs to pay their £96 annual retention fee to remain on the register is 31 July and will be 31 July each year from now on.

The deadline for dentists to pay their fee will still be 31 December each year.

For more information, contact the GDC customer advice and information team on 0845 222 4141 or email customeradvice@gdc-uk.org.

Bridge2Aid, please visit www.bridge2aid.org.

Tickets to the ball cost £42 each.

For further information on Bridge2Aid, please visit www.bridge2aid.org.
Creating perception: building reality

When it comes to considering how to brand your practice, it’s essential you make sure people don’t draw the wrong conclusion about your business. Andy McDougall explains.

‘All that is gold does not glitter; not all those that wander are lost’ J.R.R. Tolkien. In other words, making assumptions can lead to incorrect conclusions and that has never been more applicable than when considering your practice branding. As the practice principal you may be absolutely clear about the brand values of your practice, but if I were to ask a select number of your patients and each member of your team independently, would those same values be reiterated? In the majority of cases, I would suggest they would not. This article seeks to give you some food for thought and aims to help you derive tangible benefits from any investment you make in your brand.

What is brand?

While there are many variations of definition, in essence a brand is a collection of perceptions in the mind of the consumer. The purpose of a brand is to differentiate competing products or services and to highlight what is unique about each. Brand values help you to establish your brand. They provide physical and emotional triggers that create a relationship between consumers and your products/services. In essence, they represent the core values and qualities that sum up your brand and provide the benchmark to measure the behaviour and performance of your products/services. Essentially, your brand values determine how the vision and your promises are delivered to the consumer.

The confusing bit

Branding, marketing, logo: because the terms are often incorrectly interchanged, confusion arises. The Chartered Institute of Marketing, which is the world’s largest marketing body, defines marketing as ‘The management process responsible for identifying, anticipating and satisfying customer requirements profitably.’ That means it is all the activities you undertake to attract and retain customers and encourage them to purchase your goods and services. In contrast, a logo is merely a graphic element designed for immediate recognition that forms one aspect of your overall brand.

What it all means is that while you may have invested a substantial proportion of your marketing budget (and I do hope you have a marketing budget) in establishing a logo and producing practice literature, you may not have determined your position relative to your competition or determined how to achieve consistency between what you say (your brand values) and what you do (the customer’s experience).

‘Brand values help you to establish your brand and how your vision of it is delivered to the customer’

Time to talk about dry mouth?

Approximately 20% of people suffer symptoms of dry mouth, primarily related to disease and medication use. More than 400 medicines including tricyclic antidepressants and antihistamines can cause dry mouth and the prevalence is directly related to the total number of drugs taken.

Ask your patients

Some patients develop advanced coping strategies for dealing with dry mouth, unaware that there are products available that can help to provide protection against dry mouth, like the Biotène system.

Diagnosis may also be complicated by the fact physical symptoms of dry mouth may not occur until salivary flow has been reduced by 50%.4,5

Diagnosing dry mouth

Four key questions have been validated to help determine the subjective evaluation of a patient’s dry mouth.2

1. Do you have any difficulty swallowing?
2. Does your mouth feel dry when eating a meal?
3. Do you sip liquids to aid in swallowing dry food?
4. Does the amount of saliva in your mouth seem to be too little, too much or do you not notice?

Clinical evaluations can also help to pick up on the condition, in particular:

• Use of the mirror ‘stick test’ - place the mirror against the buccal mucosa and tongue. If it adheres to the tissues, then salivary secretion may be reduced
• Checking for saliva pooling - is there saliva pooling in the floor of the mouth? If not, salivary rates may be abnormal
• Determining changes in caries rates and presentation, looking for unusual sites, e.g. incisal, cuspal and cervical areas.

Consequences of unmanaged dry mouth include caries, halitosis and oral infections.

The Biotène patented salivary LP3 enzyme system

The Biotène formulation supplements natural saliva, providing some of the missing salivary enzymes and proteins in patients with xerostomia and hyposalivation to replenish dry mouths.

The Biotène system allows patients to choose appropriate products to fit in with their lifestyles:

• Biotène Oral-Balance Saliva Replacement Gel
• Biotène Oral-Balance Liquid

Hygiene Products:

• Biotène Dry Mouth Toothpaste
• Biotène Dry Mouth Mouthwash.

The range is appropriately formulated for the sensitive mucosa of the dry mouth patient:

• Alcohol free
• Mild flavour

Sodium Lauryl Sulfate (LSL) free.

The Biotène formulation:

• Helps maintain the oral environment and provide protection against dry mouth
• Helps supplement saliva’s natural defences
• Helps supplement saliva’s natural antibacterial system - weakened in a dry mouth.

Samples available from www.gsk-dentalprofessionals.co.uk

A consistent brand
To illustrate what I mean I have taken the three words ethical, effective and caring that, after a good deal of thought, a practice recently decided represented their brand values. Once they had determined what they stood for, their logo was created to visually symbolise those values and they began to establish how they would carry them through to every touch point (every opportunity to interact with a customer whether on the phone, via letter, email and the web, in person, through advertising and literature, etc.).

They took one of the words, caring, and asked every member of the team how he or she could express that value in what they did. The receptionist would ensure that she listened and attended to patients’ concerns and would provide prompt solutions.

The team decided they should introduce a process that regularly asked patients for their feedback, which would be sincerely and swiftly acknowledged. The hygienists wanted to provide some free inter-dental products to encourage patients to take more care of their oral hygiene between visits. The practice introduced free dental check-ups for the children of patients on a plan. And on it went.

The point is that once this practice had established its brand values, it began to work hard on consistently applying them in everything it did.

Definition is vital
In my experience, few businesses can articulate their brand values. Even when the leader’s vision is evident, staff will generally be vague and faltering about what their business is about. The point is that if you can’t articulate your brand values, how do you expect customers and prospective customers to do so? In the absence of your clear communication, your intended audience is likely to draw its own conclusions, which may not be to your advantage.

Perception exists, whether you create it or not. The point of building a brand is to shape perception according to the values you want to instil. A strong brand is not a great logo; it is clarity of communication and experience that leaves everyone absolutely clear about what you stand for, and what they can expect when they engage with your business. The quality of communication is the response that you get.

Perception is reality
The customers’ perception is your reality, so why leave it to chance? Especially when you have probably spent thousands of pounds on creating marketing communications vehicles such as your web, logo, literature, and so on. Even if you have all these things in place, it is never too late to bring the team together to clarify exactly what it is you stand for and exactly how they can behave to deliver a consistent message and experience to patients. As part of your strategic planning process, and in conjunction with creating your business plan, this is one of the most vital and beneficial activities you could undertake.

About the author
Andy McDougall has over 25 years experience of business planning and brings techniques and expertise from a wide range of commercial and competitive business sectors. Andy now delivers business-planning services to help members of the dental community to respond to the dynamics of an increasingly commercial and competitive environment. He helps businesses to reach the next level and to turn around poor performance. To find out more about his business-planning services, contact info@spoton-businessplanning.co.uk or call 07708 982559.

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Abstract
Failure to recognise and treat aberrant canal anatomy can affect the prognosis of endodontic therapy. This case report shows a variation in conventional anatomy in mandibular first molars. A third mesial canal may be present between the Mesio-lingual and Mesio-buccal canal in Mandibular molars. A clinician should be aware of the possibility of this extra anatomy when treating mandibular molars.

Introduction
A comprehensive knowledge of canal anatomy and its variations is essential to ensure consistency in endodontic therapy. Variations from conventional anatomy are encountered occasionally in all teeth. Inability to recognise, detect and treat this additional anatomy can lead to failure of endodontic therapy1.

In mandibular first molars, the normal anatomical pattern consists of two mesial canals and one or two distal canals2. However, a third mesial canal may be occasionally present between the mesio buccal and the mesio lingual.

Table 1: Prevalence of a third canal in the mesial root of Mandibular Molars according to different authors. (Courtesy Navarro et al3)

<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>No. of teeth</th>
<th>Method</th>
<th>Three Canals (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skidmore and Bjornsdol</td>
<td>1971</td>
<td>45</td>
<td>Vitro</td>
<td>0</td>
</tr>
<tr>
<td>Pineda and Kuttler</td>
<td>1972</td>
<td>500</td>
<td>Vitro</td>
<td>0</td>
</tr>
<tr>
<td>Vertucci</td>
<td>1974</td>
<td>100</td>
<td>Vitro</td>
<td>1</td>
</tr>
<tr>
<td>Pomeranz</td>
<td>1981</td>
<td>100</td>
<td>Vivo</td>
<td>12</td>
</tr>
<tr>
<td>Martinez-Berna and Badanelli</td>
<td>1985</td>
<td>1418</td>
<td>Vivo</td>
<td>1.5</td>
</tr>
<tr>
<td>Fabra-Campos</td>
<td>1985</td>
<td>145</td>
<td>Vivo</td>
<td>2.1</td>
</tr>
<tr>
<td>Fabra-Campos</td>
<td>1989</td>
<td>760</td>
<td>Vivo</td>
<td>2.6</td>
</tr>
<tr>
<td>Goel</td>
<td>1991</td>
<td>60</td>
<td>Vivo</td>
<td>15</td>
</tr>
</tbody>
</table>

Case report: Middle mesial canal
Siju Jacob shows why it pays to be aware of the possibility of a third mesial canal when treating mandibular molars
mesio-lingual canal. This is referred to as the middle mesial canal. The middle mesial canal may be confluent or may have a separate portal of exit. The incidence of middle mesial canals varies from 1 to 15 per cent (3). (See Table 1).

This article will illustrate the clinical management of the middle mesial canal.

Case report

A 27-year-old male patient reported to the clinic with chief complaint of food impaction in the right mandibular posterior tooth for the past four months. There was no history of pain. His past medical history was non-contributory.

Clinical examination revealed a large carious lesion in the right mandibular first molar tooth (see Fig. 1). The tooth for the past four months. The patient was recalled two weeks later. The calcium hydroxide was removed (see Fig. 10). The canals were obturated using gutta percha and AH plus sealer (Dentsply DeTrey, Germany) in warm vertical condensation. The access cavity was sealed and the core build up done using a dual cured resin (Luxacore, DMG, Germany) (see Figs. 11 to 15).

The patient was recalled two weeks later. The calcium hydroxide was removed (see Fig. 10). The canals were obturated using gutta percha and AH plus sealer (Dentsply DeTrey, Germany) in warm vertical condensation. The access cavity was sealed and the core build up done using a dual cured resin (Luxacore, DMG, Germany) (see Figs. 11 to 15).

Discussion

The biologic objectives of endodontic therapy include removal of all potential irritants from the root canal space and the control of infection and periradicular inflammation. Complex root canal anatomy can prevent achievement of endodontic goals. It is important to debride, disinfect and obturate as much anatomy as possible. A missed canal can lead to failure of Endodontic therapy 1. Therefore every effort must be made to locate additional canals if any.

An extra mesial canal known as the middle-mesial canal has been documented by numerous researchers 19. The percentage varies from one to 15 per cent. The majority of middle mesial canals will merge with either the mesio-buccal or mesio-lingual canals. Rarely, they may have a separate apical portal of exit.

Numerous techniques enable the clinician to locate the middle-mesial canal. It is important to have an adequately flared access cavity to visualise the anatomy of the chamber. Constricted access can lead to missed anatomy 18.

The use of the surgical operating microscope has vastly enhanced the quality of Endodontic therapy 12. Magnification coupled with coaxial lighting greatly enhances visualisation and the potential to discover additional anatomy.

The use of ultrasonic tips for precise cutting has gained favour among clinicians in the last decade. Ultrasonics in conjunction with the surgical microscope (Microsonics) greatly enhances the clinician’s ability to locate extra canals 17.

Conclusion

Variations in conventional root canal anatomy can occur in any tooth. The middle mesial canal in Mandibular molars is one such variation. Knowledge of anatomical variations and the techniques to discover and manage these variations will significantly enhance the prognosis of endodontic therapy.

References available on request.

About the author

Dr Siju Jacob BDS MDS
maintains a private practice limited to Endodontics in Bangalore, India. In addition, he conducts hands-on courses in Endodontics and Microscopes for general practitioners and Endodontists at his center at Bangalore. He can be reached at desij@gmail.com or through his website, www.rootcanalciname.com.
One versus multiple session endodontic treatment

It is one of the most discussed topics in modern endodontics. Prof. Dr. Liviu Steier explains the key factors for success.

Evidence shows that the number of sessions used to perform a successful root canal treatment does not differ between one or multiple sessions. The only possible post-operative complications with single session root canal treatments are:
1. Post-operative pain.
2. Flare up.

For a better understanding of successful single visit endodontic therapy the following factors are key:
1. Adequate working length control (using electric measurement devices and if necessary x-ray)
2. Mechanical root canal preparation (best results will combine the use of hand and rotary files)
3. Chemical root canal disinfection (using irrigants – advanced devices and technologies)
4. An optimal root canal obturation to avoid apical leakage
5. Coronal sealing to prevent coronal leakage

Each one of this key factors are determined by other factors.

Determinant factors for an adequate working length control:
1. Straight line access
2. Establishing glide path
3. Use of adequate file to correctly bind

Determinant factors for adequate mechanical root canal preparation:
1. Straight line access
2. Establishing glide path
3. Hand-file reshaping to size 25 or 20
4. Determination of the “first file to bind” – “Master apically file”
5. Shaping of the so called “apical capture zone”
6. Adequate use of sequential files protocol either hand or rotary
7. Adequate irrigation and smear layer removal protocol while mechanical shaping

Determinant factors for adequate chemical root canal disinfection:
1. Coronal isolation (rubber dam)
2. Adequate coronal access
3. Adequate shaping protocol
4. Use of irrigation solutions in optimised sequences
5. Optimized irrigant delivery
6. Adequate energising of the irrigants
7. Satisfactory irrigant evacuation

Determinant factors for inadequate root canal obturation (either under filling or incomplete filling):
1. Canals not dry prior to obturation
2. Inadequate straight-line access
3. Inadequate irrigation protocol
4. Excessive enlargement of a curved canal
5. Packing of debris in the apical portion of the canal
6. Skipping of sequential file sizes
7. Inadequate tug back
8. Inadequate master cone selection
9. Inadequate condensation procedures
10. Coronal seal

Conclusion
A trained and experienced operator who follows a strict treatment protocol can manage to perform root canal treatments in one visit alone having in mind the management of postoperative complications. The author needs to acknowledge that not all root canal treatments can be executed as single session.

Useful reading

Dr. med. dent. Liviu Steier
is a visiting professor at the School of Dental Medicine in Florence, visiting professor at Tufts School of Dental Medicine on its endodontic postgraduate programme; and an honorary clinical associate professor at Warwick Medical School. He is also a registered specialist in endodontics (GCD) and Specialist fuer Prosthetik (www.dgzpw.de). He can be reached at
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About the author

Endo Tribune


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Useful reading
Case report: Failure evaluation in endodontics

Dr Hank Willis and Dr Craig Barrington discuss how we can use failed treatments to help us learn from our mistakes

The patient was a 44-year-old female with non-con-}

Temporary sublining for deep cavities where no

The cavity is closed with a cotton wool pledge
dentin from the post. Compare

Root Master

The Routemaster was once just as familiar a sight on London's streets as Ledermix is now on dentists' shelves. And the word, reliable, trusted, indispensable, can justifiably be applied to both. The Routemaster was unquestionably a leader. So we're rather tempted to rename our product Ledermix.

Ledermix Dental Paste

Dentine: Ledermix Dental Cement plus Hardener maybe used as a lining for deep cavities. The canals may be filled with Ledermix Dental Paste (or a mix of Ledermix and calcium hydroxide). The cavity is closed with a cotton wool pledge and a temporary filling.

Ledermix Dental Cement

Ledermix Dental Cement may be used as a temporary sublining for deep cavities where no exposure has occurred if the dentine is hypersensitive. For small pulp exposures, Ledermix Dental Cement may be used as a pulp capping agent.

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Autoimmune "scrubbing" between the roots. Note the striations in the dentin.

Another view of all four canals of the lower first molar in the x-ray. Note the incomplete treatment of the apical anatomy. Note the "black" material on the root on the upper left corner of the picture. That is left over periodontal ligament.

Lower first molar in the x-ray. Note the screw post in the canal. Note the incomplete treatment of the canal system. Compare and contrast the root canal therapy fill vs what actually occurred in reality with the fill.

Initial view of the lower second molar in the x-ray. Staining of the root occurs during the clearing process and this can give the root a "black" appearance that the crown fits the tooth poorly. The crown on this tooth actually fit quite snugly.

Potassium hydroxide 2g. Tricarboxylic acid 0.1% 1.5g. Lactic acid 0.3g. 2. Hardener F (fast setting time) 85% w/w Eugenol. 3. Hardener S (slow setting time). 85% w/w Eugenol. 4. Hardener T (low setting time), 85% w/w Eugenol. 4. Hardener T (low setting time), 85% w/w Eugenol.
Direct view of the distal root of the lower first molar in the x-ray. Note again the incomplete treatment of the canal system.

Side view of the distal root with the mesial root(s) in the back ground.

Here is another direct view of the distal root. The picture was mostly taken to try to capture the “white lines” coming off the post. The source of the white lines are unknown but are demonstrated as they were as this tooth was held at specific angles to allow the light to reflect off of them. It was a feature never witnessed before by this photographer of cleared teeth that seemed interesting.

On examination, teeth 2, 30, and 50 were painful to palpation and percussion. Panoramic and full mouth radiographs revealed large periradicular radiolucencies associated with the lower right first and second molars. These teeth were deemed unrestorable and the patient elected to have them extracted. Additionally, tooth 2 had gross distal caries and needed extraction. Fixed partial dentures utilizing the third molars were discussed as a potential, though far from ideal, treatment option. The patient elected to extract the third molars as well and move toward dental implants to allow the light to reflect off of them. Here is the distal root of the lower second molar in the x-ray again. The striations in the dentin are interesting and was something I had never witnessed before in the hundreds of cleared teeth I have worked with and analysed.

For anxiolysis, 0.25mg Triazolam was prescribed (to be taken PO 60 minutes prior to the extraction appointment) and the patient returned later that afternoon. Then 2mg two per cent lidoc with epinephrine 1:100,000 was administered via IANB, PSA, long buccal, and greater palatine. Teeth 1, 30 and 51 were removed simply. Teeth 2 and 52 were sectioned and the roots were delivered. Finally, 3-0 chromic gut sutures were placed.

Transplanting the teeth
The teeth were transported in a 10 per cent buffered formalin solution. Upon arrival, they were immediately transferred to a hydrochloric acid solution and soaked for 24 hours. From there they were moved to a 95 per cent alcohol solution. They were again soaked for 24 hours, and after that they were placed in methyl salicylate for one hour.

For the photography, the teeth were placed in a glass dish and totally submerged in methy salicylate. They were then back lit with a xenon fibre-optic light source and photographed with a Canon A650 IS camera mounted on a high power dental operating microscope.

A valuable process
Clearing teeth is a valuable process to allow us to evaluate endodontic failures as teeth are left in virtually their true anatomic form yet we can see through them to see what was accomplished or not accomplished in a treatment protocols.

Another view of the failing first molar.

Here is another direct view of the distal root of the lower second molar in the x-ray again. The striations in the dentin are interesting and was something I had never witnessed before in the hundreds of cleared teeth I have worked with and analysed.

Dr Craig M Barrington, DDS is a 1996 graduate of the University of Texas Health Science Center San Antonio. He practices general dentistry in Waco, Texas with his wife, and has particular interests in endodontics and microscope dentistry. Dr Barrington is also a part-time clinical associate professor in the Department of Advance Education in General Dentistry at Texas A&M Baylor College of Dentistry in Dallas. He has lectured to a variety of dental societies and study clubs and has written and co-written a number of articles for various dental journals. Dr Barrington is a member of the American Dental Association, the Texas Dental Association, Omicron Kappa Upsilon, and he is an associate member of the American Academy of Endodontists. To contact him, call 001 208 267 6454 or emailing CraigM.Barrington DDS@gmail.com.

Dr Hank Willis is a 2003 graduate of the University of Washington School of Dentistry in Seattle. He practices general dentistry at his own practice in Bonners Ferry in Idaho and has a particular interest in microscope-enhanced dentistry. He is also a member of the Academy of General Dentistry and the American Dental Association and you can contact him by calling 001 208 267 6454 or emailing hankwillisdds@gmail.com.
The patient presented for endodontic treatment of a maxillary molar. The tooth had developed mild to moderate unprovoked pain, and the referring dentist had prescribed pen/VK five days prior to the treatment visit. The pre-operative diagnosis was necrotic pulp with periapical periodontitis of endodontic origin.

A lesion was visible radiographically at the apical area of the mesiobuccal root. (See Figure 1).

Upon entry, the chamber presented as a curved groove from the mesio-buccal to the palatal. Figure 2 shows debris accumulated in the mesiobuccal orifice (bottom of image), the distobuccal orifice (middle of image), and the palatal orifice is not shown (top of image).

Mesiobuccal roots of maxillary molars are characterized by an isthmus extending palatally from the mesiobuccal orifice. These isthmus areas present with a variety of configurations, and can harbor significant amounts of bacteria and debris. It is imperative to debride these areas as thoroughly as possible, because the isthmus may be in communication with the attachment apparatus, and may be a source of persisting disease after treatment.

Vital cases with inadequately treated mesiobuccal root canal systems may present with vague symptoms of discomfort, and non-vital cases may show lesions which do not resolve or worsen, following therapy.

The dentin ledge covering the mesiobuccal isthmus is removed with a Munce Discovery bur (www.cjmengineering.com). Ultrasonic tips in a variety of shapes and sizes are also ideal for this work. This case demonstrates the use of the bur, and shows the dark furcal dentin surrounded by the dentin shavings (left intact for demonstration purposes).

Within the dark area created by the bur, a small white dot is formed which can be visualised with extreme magnification and lighting. The “dot” is formed by troughing debris collecting in the orifice, or isthmus, area. The next image shows the “dot” becoming more of a “line” as the access is improved. It may be possible to gain entry with a small k-file (06 stainless steel, 08, or 10) at any point along this line.

Figures 7 and 8 show the result of careful development of the “mb2” orifice. In this case, the resulting canal was confluent apically with the primary mesiobuccal canal. This is frequently not the case, and furthermore, this author has retreated cases with persisting disease on the MB root with untreated MB2 canals, despite the canals being confluent after instrumenta-tion. An excellent source for information about the morphology of maxillary molars can be found in an article by Dr John Stropko, Journal of Endodontics, June 1999, “Canal morphology of maxillary molars: Clinical observations of canal configurations.”
In a study of more than 1,700 teeth (1,096 first molars), the operator discovered the MB2 in 93 per cent of maxillary first molars, with 54.9 per cent of those being separate canals. This emphasises the importance of uncovering and negotiating this mesiobuccal root isthmus to maximise debridement.

Obturation of the canals to orifice level is accomplished prior to placement of an orifice barrier (not shown). Final radiographs, as well as radiographs from other cases, demonstrating a variety of presentations of mesiobuccal root anatomy.

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**About the author**

**Dr D Kendel Garretson** is a general dentist practicing non-surgical endodontic treatment only. He resides in the San Antonio, Texas area, and can be reached at onlyendo1@gmail.com.
Choosing wisely

Deciding which materials and products to use in your practice can be a difficult task, but one that has been made easier by Dr Michael Miller, founder of RealityEsthetics. Prof. Dr. Liviu Steier explains

You've just come across a new technology (maybe a new material) that you really like. You're unsure of what to do next - should you buy it? There are lots of questions:

- Could it help/compliment my daily work?
- Who is the manufacturer?
- What are the strengths and weaknesses?
- Where could I get some additional user information and/or tips?
- How does this perform with my colleagues' rating?

A colleague told you some time ago about product evaluators... are they worth looking at? What was the name again...? Yes, indeed that is exactly what could help now... Does this scenario sound familiar? It is 20 years since someone made this dream come true: Dr Michael Miller. He founded RealityEsthetics (www.realityesthetics.com) and not so long ago RealityEndo.

How does it work?

Dr Miller gathered a group of about 20 renownedclinicians. He then spoke to product manufacturers and offered them the chance to have their products tested by the clinicians.

Himm, you may think now: “This sounds awkward! Why would the manufacturers want to have clinicians test, evaluate and rank their products?”

The answer is simple: The feedback received is extremely useful in that it can be implemented in further developments; for example, the evaluation received can be useful for advertising.

What you might be thinking now is that the people carrying out the product evaluations are working for the dental manufacturers. Well, they're not and this is what makes this group so special.

To be accepted as an evaluator, Dr Miller set up a very strict list of criteria. To maintain objectivity, the RealityEsthetics group does not accept any advertisements nor support by third parties or manufacturers. The publication is created by professionals like yourself to benefit professionals like yourself.

Now it is time to have a closer look into the way the evaluations are done.

Carrying out evaluations

Each product evaluation starts with a ranking out of five. Details are then given of the manufacturer and its website. Next, a product's benefits and disadvantages are mentioned – perhaps it's a Gold standard, a new design or a new piece of software. Or maybe it's cumbersome or complex to maintain.

Most of us don't take much care or notice of the information we are given when we purchase a new product, so it's good to know there is a place we can find this. On this website, you can find out what to do if your product, for example, needs a repair.

A detailed product description follows, and because it's created by professional colleagues, all their good and bad experiences, their helpful suggestions and advice are implemented in the specially created section called Use. It is highly accessible and easy to read, interesting, extremely relevant for the daily one not. It's called the "bible of Esthetic Dentistry" by many colleagues for no reason!

Because one day you may need to know about maintenance, RealityEsthetics stores this information for you. Almost everyone prefers first to learn about the essence of a product before reading the details – well here you go!

If you're curious? Just have a look by logging on to www.RealityEsthetics.com.
Case report: Clear root evaluation of endodontic failure

Dr Craig Barrington discusses the importance of follow up in order to see where treatment may have succeeded or failed.

Abstract
Endodontic treatment is classified as therapy by definition. Regimented follow up should be an important part of our clinical actions to evaluate our research perceptions, ability and performance. Sectioning treated roots can destroy anatomy and alter our ability to properly evaluate failures and successes. Clearing teeth is an important technique because it leaves anatomy and obstructions as they were in situ.

Introduction
We perform our clinical processes and it is rare that we are able to truly encounter and see what we have accomplished. Endodontic treatment requires follow up to evaluate success or failure. Although unfavorable, endodontic failures allow us the chance to learn. It is important to know the cause for failure such that we might enable ourselves to prevent the occurrence in future treatments.

This case illustrates a restorative endodontic failure but further evaluation is required to evaluate the cleaning, shaping and obturation.

Case report
A 57-year-old female patient presented initially in 2001 with multiple decayed and problematic teeth. (See Fig. 1). She has a controlled substance problem and has a history of being an unreliable patient. She wears a complete upper denture. Her CC was: “I want to save the rest of my teeth”.

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- Statim complies with EN13060 and the 2006 RKI Hygiene guidelines.

Fig. 1 shows an initial radiographic for NSRCT of tooth #18. The diagnosis was necrotic pulp with acute periradicular periodontitis.

Fig. 2 is of post extraction of 19 and 20 and was taken in 2002 as an initial radiographic for NSRCT of tooth #18. The diagnosis was necrotic pulp with acute periradicular periodontitis.

Fig. 3 demonstrates a working length x-ray. Four canals were located.

Fig. 4 shows an initial post-op x-ray prior to rubber dam removal. The canal system was obturated with System B/Otbara and Kerr’s EWT sealer.

Fig. 5 shows the post op x-ray with build up. Build up material was bonded flowable resin in the canals and composite resin.

Fig. 6 shows an angled post op x-ray.

Fig. 7 shows a follow up x-ray two years later. The patient presented with a fractured cusp, so we placed a stainless steel crown due to financial constraints. Healing of the apical radiolucencies was noted.
Discussion

The biologic objectives of endodontic therapy include removal of all potential irritants from the root canal space to control infection and periapical inflammation. Many complexities in root canal anatomy can prevent achievement of endodontic goals. It is important to debride, disinfect and obturate the prepared system and to protect the treated tooth from coronal leakage. It is only in failure and thorough post extraction evaluation that we are truly able to see if we accomplished any of the required tasks.

In spite of our best efforts, failures in our treatment protocol can occur for multiple reasons and for reasons beyond our control. Although unwelcomed, these moments can be made into opportunities for learning and increasing our endodontic knowledge. This can eventually lead to improvements in our endodontic treatment approach and protocol.

Conclusion

Coronal leakage is a complex and multifactorial entity that is still not fully understood.

Fig. 8 shows the seven-year follow up. Yet again, the patient disappeared but this time for five years. Note the drifting of the roots or both.

Figs. 10 to 12 show other views of the cleared mesial root anatomy complex.

Figs. 13 and 14 show the distal root cleared. The overfill seems to be beneficial to the system.

Fig. 9 shows the extracted and cleared mesial root. Note the space between the canal wall and the gutta percha fill at the red arrow. This could be under prepared canal, under filled, gutta percha shrinkage on cooling or all of the above. Note the other lateral anatomy between the canals. The black stain is hard to indentify. It is either the silver particles in Kerr’s EWT or bacteria growth or both.

Fig. 11 shows the mesial root filled with gutta percha and the gutta percha fill at the red arrow. This could be under filled, gutta percha shrinkage on cooling or all of the above. Note the other lateral anatomy between the canals. The black stain is hard to indentify. It is either the silver particles in Kerr’s EWT or bacteria growth or both.

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Performing dentistry

The year of 2006 not only ended a long cosy affair with the old NHS system, it also marked the death of the dental associate. In the wake of the chaos that ensued arose the dental performer. Neel Kothari discusses the differences and whether the change has been for the better.

Unlike the dental associate, the dental performer now has to work within a very different set of rules that have never been trialled. Like all dentists working under UDA the dental performer has to work within the NHS system. The NHS reforms allowed new procedures for the future, as well as allowing flexibility in working patterns. This current system seems to offer front-line dentists less flexibility, with penalties incurred for not meeting Government set targets, regardless of the quality of the work provided.

For performers joining growing practices, the chances are they are more likely to be seeing patients new to the practice who are likely to need far more work than regular attenders. Even with a quick glance it is clear to see that the foundations of the test period have been built on pillars of sand which may satisfy the masses temporarily, but in the long term may stifle the growth of younger practitioners who will inevitably follow working patterns set by practice owners and PCTs, rather than at a rate which works for them as individuals.

Lack of transparency

Since the dental reforms have taken place, there has been a shocking lack of transparency between principals and performers. With principals in most cases holding onto practice contracts, the UDA values passed on to performers have not always reflected the UDA values given by the PCTs. The importance here for performers lies in the fact that UDA values should be to a certain degree reflect the amount of work expected to be done per course of treatment; for example if a dentist was given a high UDA value perhaps that reflects the high needs of the local area compared with another dentist who has been given a low UDA value in a lower risk area since they would not need to do so much treatment per course. The test period not only does not apply to newly qualified dentists but is clearly not future proof. Many young practitioners looking to relocate now face a difficult time of predicting how reasonable their UDA target is, and rather than having the flexibility of being a professional now face the confines of being a performer.

Lack of control

Dental performers no longer have as much control in this new system compared with the old NHS and as a result, finding a new job can be an absolute nightmare. The old system of paying dentists based on what work they have done not only sounds like common sense, it had the added advantage of enabling practitioners to budget and set targets, regardless of the quality of the work provided.

Many readers will remember back in the early Nineties the phrase ‘second-gear valuation’ where the Government sent estate agents to assign council tax bands for properties and in many cases the estate agents assigned the valuation of a property with just a simple glance (while still in second gear). In dentistry, the current Government has used another crude assignment called the ‘test period’ where UDA valuations are based on work done within an arbitrary period of time.

While for many this transition may pass with little turbulence, for those qualified post-graduates there is no test period and as such, no accurate way of predicting their working habits, so it is little wonder many younger dentists are finding manoeuvring in the new NHS rather tricky.

In the past, this offered a valuable service to the Government, with dentists fronting the set up costs in full, unlike general medical practices where the Government typically paid up-to 70 per cent of the set up costs. The DPA argued that the 2006 contract had resulted in a transfer of financial risk from the NHS to individual practices. Under the new arrangements, the traditional autonomy of dentists had been replaced by a system where PCTs ‘dictate to dentists where they will work, which patients they will see and to whom they must sell their practice in case of ill-health or retirement’. This all amounts to a high level of risk placed on individual dentists, which for some has effectively murdered the leap from associate to principal.

Neel Kothari qualified as a dentist from Bristol University Dental School in 2005, and currently works in Cambridge as an associate within the NHS. He has completed a year-long post graduate certificate in implantology at UCL’s Eastman Dental Institute, and regularly attends postgraduate courses to keep up to date with current best practice. Immediately post graduation, he was able to work in the older NHS system and see the changes brought about through the introduction of the new NHS system. Like many other dentists, he has concerns for what the future holds within the NHS and as an NHS dentist, appreciates some of the difficulties in providing dental healthcare within this widely criticised system.

Neel Kothari, qualified as a dentist from Bristol University Dental School in 2005, and currently works in Cambridge as an associate within the NHS. He has completed a year-long postgraduate certificate in implantology at UCL’s Eastman Dental Institute, and regularly attends postgraduate courses to keep up to date with current best practice. Immediately post graduation, he was able to work in the older NHS system and see the changes brought about through the introduction of the new NHS system. Like many other dentists, he has concerns for what the future holds within the NHS and as an NHS dentist, appreciates some of the difficulties in providing dental healthcare within this widely criticised system.
Trust the system
Andrew McCance insists that there is a straightforward answer to achieving excellent orthodontic results

Orthodontics is a highly specialised field, and one that requires superior expertise. By focusing not just on the dentition, but on the entire skull, orthodontics is simply the most effective and thorough way of achieving a great smile for the patient naturally, and does not adversely affect the patient’s wellbeing.

With the right system, you can augment your treatment list and begin treating an array of malocclusions, while highly skilled and experienced orthodontic specialists ensure that you have all the laboratory support you need. Also, by bringing to bear extremely accurate diagnostic tools, the leading system lets you give your patients the sort of excellent results that will truly set your practice apart.

Carry out research
If you’re interested in orthodontic treatment, ask the following questions of each system:

• Will I get support as and when I need it?
• Will you help me treat every single malocclusion, from mild to severe?
• Will you supply pre-adjustment, pre-activation, and indirect bonding?
• Will you help me treat every single malocclusion that comes my way?

If you don’t get a resounding YES in response to all three, you need to keep looking. The best system gives you everything you need to develop your skills, feel empowered and meet the needs of patients.

With the latest developments, GDPs can tackle any malocclusion, and employ a range of techniques and approaches to help dentists meet the needs of any patient. With appliances like the CODA expansion device and the Final Occlusal Refinement and Detailing device (FORD), you can offer the highest standard of service to your entire patient base.

Complete support
Of course, some procedures are more demanding than others, and you might expect issues such as increased chair time and intricate, demanding work. Fortunately, the leading system provides complete support from diagnosis to completion, with orthodontic experts carrying out vital tasks to facilitate expedient treatment. For instance, the patented CODA expansion device is pre-activated and pre-adjusted in the laboratory then sent to you for fitting.

The best benefits of any treatment system are those that delight both patient and dentist alike. With the fully comprehensive and invisible orthodontic systems available today’s GDP, you can expand your treatment list and give your patients smiles they can be proud of.

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About the author

Dr Andrew McCance
Since qualifying in dentistry from Glasgow University, Dr Andrew McCance has gained a wealth of experience in multi-disciplinary practices. He has held several distinguished positions including senior house dental surgeon at St George’s Hospital, Testing and senior lecturer at Great Ormond Street, developing his expertise through a PhD at University College London. In the mid 1990s, Dr McCance began to develop the Clearstep brace, based on the demands of the 4,000 patients treated annually in his specialist practices. He is currently taking his Clearstep vision to a worldwide audience. For more information on the Clearstep solution, call 01542 557910 or email info@clearstep.co.uk.

References

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Welcoming new patients

It’s essential that your receptionist is highly skilled at nurturing new patients. It will make their experience worthwhile and they’ll want to return to your practice, says Sharon Holmes.

Choosing your receptionist

Your choice of who to place in your reception area needs be based on key skills such as; people skills, approachability, maturity and a financial understanding of what makes a business do well. This is a large package to fill, but so important. By over-looking the obvious simply because the person you have on your desk is reliable, does not mean they are the correct person to be there. Making changes for the right reasons can be uncomfortable for the principal dentist, but right for the patients.

I have experienced this kind of situation so many times which has lead to serious issues with regards to patient complaints due to poor customer care. Very rarely do the patients complain about clinical work, but more about poor communication from both reception and dentists.

From the moment a new patient phones the practice to book an appointment to the end of the phone call, they can tell what kind of relationship they are going to have with the practice. Even if the first call was poorly handled, the patient may come in anyway, due to location and time availability. From my experience, this patient is a complaint waiting to happen and expects their whole experience to be a difficult one.

A happy new patient

When the call comes in, what the patient should hear on the other end is a clear, concise friendly voice which is warm and welcoming. The call should also be answered within three rings. The receptionist should know the dentist’s availability for appointments, the treatments that are carried out and the costs. When this is achieved, I can assure you, you are going to have a happy new patient who has already started to build a relationship with the practice through reception.

The next important step is the reception. The nurse must make the effort to make all members of any dental practice feel welcome and cared for. Working in NHS is far more stressful and time pressured, but each member of any dental practice should make the effort to make all patients feel welcome and cared for. Patients do value the staff that take care of them.

A friendly voice

The next important step is the one carried out by the nurse who is going to meet the patient in reception. The nurse must make sure she calls the patient’s name out just as clearly and in a friendly inviting voice. The nurse should introduce herself by name and invite the patient to follow them through to the surgery where she then introduces the patient to the dentist. Once the dentist carries out a thorough examination and uses all the tools possible such as intra-oral cameras, x-rays, educational charts and finally a treatment plan that explains all costs, the patient will walk away feeling that they have been well cared for and fully informed. Working in private practice, this is always achievable. Working in NHS is far more stressful and time pressured, but each member of any dental practice should make the effort to make all patients feel welcome and cared for.

When the new patient arrives at the practice, the receptionist should know the new patient is due and note his or her name so that on entering reception the patient is greeted on a personal level by surname the receptionist should offer the patient a health questionnaire and enquire as to whether the patient needs assistance or not, this will put across to the patient that the practice has a caring attitude towards all its patients. Once the form has been filled in, it is then the dentist’s responsibility to get the patient into their surgery on time especially on a first visit.

About the author

Sharon Holmes

Originally from South Africa, Sharon Holmes moved to the UK in 2002. She thoroughly enjoys her position as business development manager at the Dental Arts Studio and her role in the dental industry, which has moulded her into a winner in her field. She believes that her position is based on common sense.
NEW CEREC® AC from Ceramic Systems (CEREC®) makes impression free dental practice a reality

The NEW CEREC® AC from Ceramic Systems (CEREC®) enables Clinicians to capture whole jaw arches – quickly and conveniently - without the need for impressions. It combines the NEW Bluecam camera with updated CEREC® 3D software, making it even easier to operate.

Bluecam features high-performance LEDs which deliver optical impressions of unprecedented precision: this ensures the final restoration’s excellent accuracy of fit, speeds up the bonding process and reduces any excess luting cement to be removed. Each exposure triggers a series of measurements which are combined to generate the final image, which is virtually distortion-free even in peripheral areas. It can acquire optical impressions anywhere in the mouth, even those inaccessible to other cameras.

Bluecam delivers razor-sharp images, its built-in shake detection system enhancing overall precision. Its automatic exposure function and extensive depth of field means the entire impression-taking process can now be delegated.

For further information, contact Ceramic Systems Limited on 01952 582950, e-mail colville@ceramicssystems.co.uk or visit www.ceramicssystems.co.uk.

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Miris 2 is a development and improvement based on existing Miris outstanding technology. A radio-opaque, highly filled nano-hybrid composite providing excellent restorations that meet the highest expectations with harmony of light, material and colour; a new way to look at aesthetic dentistry from Coltene Whaledent.

The Miris 2 natural layering concept, which differentiates between younger, adult and older patients, is combined with a new adjusted unique shade guide which shows a combination of enamel and dentin layer that allows an accurate preview of the finished restoration and perfect natural mimicry, brightness and vitality. With optimised handling properties and reduced shrinkage Miris 2 has been kept as simple as possible to use whilst still providing distinctive characterisitc colours and opalescence.

Call Coltene Whaledent on Freephone 0800 289544 or 225/224 for your information pack or to organise a demonstration at www.coltenewhaledent.com.

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You are not unusual if you find that you sometimes com- promise your composite aes- thetic results by using a single shade of composite for the ma- jority of patients. Help is now at hand with GC Gradia Direct.

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lade SRO. StarFlow had the highest compressive strength in CRA testing and was found to be stronger than some “pack- able” composites.

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Using the CEREC system you will produce perfect chairside ceramic restorations. The system allows you to place the new prosthesis in the same visit saving you and your patient time, laboratory fees and ultimately making your business more profitable.

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Seminar Success For Ivoclar Vivadent

An extremely favourable response has been received from those who attended the Ivoclar Vivadent seminars recently held in Dublin and the UK. Many have stated the positive benefits and relevance in attending the workshops, with some expressing an interest to attend future seminars that will be held later in the year on a variety of topics.

A substantial number of delegates who attended the first seminars hosted by the company felt the courses proved invaluable in relation to important aesthetic dentistry topics. Developed to help further strengthen the skills of dental teams by enabling dental practitioners to achieve greater client care and long-term success individually, the courses will continue to run throughout the year at various locations.

Darryl Muff concludes, “It is always invaluable to listen to the opinions of industry professionals who have a wealth of experience from which everyone can draw initiatives.”

For more information on other seminars being run by Ivoclar Vivadent please call 0116 284 1780

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Being the exclusive supplier of R&S products in the UK, Dental Sky has brought together the perfect combination to enable you to place the perfect restoration.

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Step 3: Suprafond micro hybrid composite is perfect for both anterior and posterior regions, Class I to Class V; due to the combination of a superior abrasion resistance and the high translucency of the enamel sheen, it forms a perfect bond to instruments; it stays exactly where you place it.

The lightweight, fully autoclavable handle is ergonomically designed for your ultimate comfort. It incorporates wide, flat buttons that are clearly set out, for ease of use.

For further information or to place your order please call Dental Sky on 0800 284 4700.
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Dry Mouth Gel from GC UK is a medicated gel product that has been specifically developed to help relieve dry mouths. With a unique neutral pH (like more acidic competitor products) it provides ultimate patient comfort combined with an immediate soothing effect.

To make your denture patients more comfortable, allowing time for the soft tissue to adjust particularly after implant surgery, GC has introduced Tissue Conditioner. This all-in-one soft reline and conditioning material is classed as the next generation of acrylic soft reline materials, patented by GC. Another new product within GC’s portfolio is GC Initial IQ; the new one Body, Press-over-Metal and Press-over-Zircon systems.

The British Orthodontic Society has announced today that it is organising the first National Orthodontic Commissioning Education Day in September 2009. The day is aimed at individuals or organisations who are directly or indirectly involved in commissioning NES orthodontic services. Whilst the new contractual arrangements of 2006 in England and Wales brought about a number of positive changes, there are still many issues that would benefit from further clarification and guidance.

A number of education days have already been run at a local level in the last year and these have proved very helpful and popular for all concerned, so form the blueprint for the first national event.

Registration for the meeting is free but places must be booked in advance. Lunch and refreshments will also be provided for by the British Orthodontic Society. More information and a booking is available from www.bos.org.uk.

We are delighted to introduce the Velopex Zephyr 150 Surgery Air Supply. This is the first Compressor designed specifically to be sited within the Dental Surgery – rather than outside in a shed! The neat clean lines and white powder coat finish make this powerful compressor an easy addition to a Dental Surgery, either mounted on a Velopex trolley or sited within cabinet. The low noise signature of this oil free twin head design, makes it suitable for all occasions.

The small capacity holding tank means low maintenance. Whilst the fast cycle twin head pump provides over 150 litres of dry compressed air per minute. This makes one Velopex Zephyr 150 ideal base for a complete surgery air supply.

The Velopex Zephyr 150 Surgery Air Supply is available (until end of July) with the Velopex Aquacut Quattro and trolley for £2,000.00 + VAT, saving of over £1,240 (+VAT) from last price. Speak to your normal Dental Equipment supplier, or call Velopex for more information.

Mark Chapman Director Sales & Marketing Mobile: 07754 044877 E-mail: mark@velopex.com

First National Orthodontic Commissioning Education Day announced

The Velopex Zephyr 150 Surgery Air Supply

For further information please contact GC UK on 01908 218 999.

Velopex Zephyr 150 Surgery Air Supply

For more information on the outstanding benefits Carrie-See PRO™ can offer you, call the dedicated team on 0845 475 9875 or visit www.cariesee.com

Bridge 2 Aid Review

On the 4th of April 2009 a team of 10 from GC UK and Bien-Air employees and 1 dentist flew off to Tanzania to renovate a dormitory in the village of Bukumbi. The team spent two weeks working alongside charity Bridge 2 Aid, to help in their bid to build a sustainable future for the residents of the Bukumbi Care Centre.

Bridge 2 Aid are a charity that strive to provide essential resources for the inhabitants of North West Tanzania all year round, providing the means by which they can not only access basic dental care but are also able to help people within the community, giving them the chance to live a better, healthier lifestyle.

As part of an on-going commitment to raising money for Bridge 2 Aid, Henry Schein Minerva employees and 1 dentist flew off to Tanzania to renovate a dormitory in the village of Bukumbi. The team spent two weeks working alongside charity Bridge 2 Aid, to help in their bid to build a sustainable future for the residents of the Bukumbi Care Centre.

"I am delighted to be using CarieSee PRO™. For the first time we have a tool that can detect caries in a pit or fissure and have a validated reason for leaving it or removing it. The results can be recorded for monitoring decay, without being operator sensitive."

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Aquacut Quattro Installed

Denmark Hill in London, is now firmly on the map as far as...
Fluid Abrasion is concerned! The latest Velopex Aquacut Quattro has been installed in Dr McCarthy’s busy Department in the Dental Institute. This light and airy building provides a superb backdrop for this busy department – which now offers all patients the availability of fluid abrasion: Cleaning and Treating, in a calm soothing environment. Dr Kelleher commented: “I’ve got one in my private practice as well and I’m happy to call myself a user.”

The Velopex Aquacut Quattro contains two chambers, which can accommodate any combination of the 5 Cleaning and Treating media available. The 5µg Treating powder allows the clinician to ablate hard tissue (Composite, enamel and dentin) creating a relatively rough surface – which is ideal for the latest bonding and restorative materials. The 29µg Treating powder gives the clinician a much smoother cut for finer work.

For more information or to ask any questions, please contact Mark Chapman, Mobile: 07500-769-881, jesshop@blackwellsupplies.co.uk or visit www.blackwellsupplies.co.uk.

**VOCO shows its latest innovations on the BDA conference in Glasgow**

High-quality products “Made in Germany” for different indications

Several brand new products for different indications have been presented by VOCO on the British Dental Conference and Exhibition. Such as the non-running, non-dripping syringe based on the innovative non-driping technology (NDT®) especially for highly flowable materials. The new NDT® syringe permits the products to be applied in exactly the desired amount without material waste. This means procedure that is not only safe and hygienic, but also economical.

**New restorative in Gingiva shades**

With Amaris Gingiva VOCO releases the only restorative that permits chair side gingival shade matching for highest standards in aesthetic dentistry. This new material permits the reconstruction of the “red” tissue (Composite, enamel and dentin, i.e. the gingival tissue) with predictible result. Amaris Gingiva provides long-lasting, aesthetic restorations with its low abrasion values as well as its high compressive and transverse strength.


**GlaxoSmithKline’s Talking Points in Dentistry lecture series just keeps getting better!**

GlaxoSmithKline (GSK) is delighted to announce that it has achieved record-breaking attendance figures for its 2009 Talking Points in Dentistry lecture programme. With almost 5000 delegates over the seminar series, the attendance at the Motor-Cycle museum in Solihull was up by 100% totalling 900 delegates alone.

For three weeks, the event aimed at the whole dental practice, visited 9 venues across the UK offering topical evening lectures to the whole practice team. Speakers this year included Philip Ower, Graham Smart and Ashley Latter.

Jeremy Meader, Sales Director Pharmacy and Dental Channels, comments, “The premise of Talking Points has always been to provide further education in an engaging and entertaining manner. Using the positive feedback that we have received from delegates over the years, has meant that Talking Points has grown into the largest dental seminar programme in the UK.”

**New Patient Guide to Periodontal Disease**

It is vital that dental patients are made aware that gum health is paramount in keeping teeth healthy and that effective oral care can maintain gum condition, avoiding the deterioration that eventually leads to the onset of periodontitis.

The leaflet is packed with concise, clear information to help patients identify if their gums are healthy, the causes of gum disease and what to do if they are experiencing any of the symptoms described. The leaflet outlines exactly how dentists will assess gum health and what the treatment options are for controlling gum disease. There is also extremely useful information on preventing the deterioration of gums.

Blackwell Supplies provides a highly effective yet affordable range of oral health care products to dental professionals, including the Waterpik® dental water jet for use as an adjunctive treatment in scaling and root-planing when treating chronic adult periodontal disease.

For more information please call John Jesshop of Blackwell Supplies on 020 7224 1457, fax 020 7224 1094 or email john.jesshop@blackwellsupplies.co.uk.

**Waterpik® Dental Water Jets Now Available Across All Boots Stores!**

The benefits of Waterpik® Dental Water Jet have been documented in numerous clinical studies. Water Pik is delighted to announce that this groundbreaking equipment is now available in over 800 Boots stores across the UK.

Scientifically proven to offer great advantages in a daily healthcare regime, the Waterpik® Dental Water Jet can dramatically improve overall oral health. More and more UK dental professionals are recommending their patients try the Waterpik® dental water jet to see the results for themselves.

Dental professionals can also order Waterpik® dental water jets through their dental wholesaler and make the most of their professional courtesy discount.

Lightweight and cordless, the Waterpik® dental water jet offers many advantages. It is convenient when travelling and its slender shape enables easy storage. The many health benefits of Waterpik® dental water jets include a hygienic mouth, strong and healthy teeth and gingivae, fresh breath confidence and excellent protection against plaque, bacteria, bleeding and a range of periodontal diseases.

For more information visit www.waterpik.co.uk.

**A Tale of Refurbishment**

It was time for a ‘makeover’ of my associate’s surgery, which would mean stripping the walls back to the brick, rewiring, re-plumbing and then replastering the whole room.

My bête noir is exposed pipework, and with careful planning and astute cabinetry placement, I was determined that the plumbing and wiring should be hidden within the walls and plastered over.

The choice of cabinetry had to also work with the decor of the rest of the practice, where we have bold reds and greens with cream and black tiles throughout the treatment rooms.

I was impressed with the elegant Tavom cabinetry range, offered by my local equipment dealer, RPA Dental based in Wigan. Whilst all the Tavom series is designed in Italy, my cabinetry were assembled for me locally at RPA Dental.

Working with Tavom was a real pleasure, and our major refurbishment was successfully completed within two weeks.

For further information please call Tavom UK on 01582 840486 or email info@genusgroup.co.uk, www.genusinteriors.co.uk.

**Exceptional Design, Outstanding Delivery**

Genus provides a cost effective, high quality Design and Build service to the dental market, working closely with dentalists to enable them to develop their own unique vision of a practice. The Genus team uses advanced software to create designs and provides advice on all fixtures and equipment before overseeing the construction phase, to ensure that all runs smoothly.

Alison Telfer of the Glasshouse Clinic in Clapham, London felt that Genus truly understood and followed the brief to deliver a stunning practice design. “Nothing was too big or too small, nothing was a problem. They were amazing.” She praised the way they worked as a team and added, “The design is so exceptional that we’ve had lots of people popping in to have a look and asking about the design. Genus really delivered an outstanding package.”

Genus prides itself on creating top quality surgeries in line with the dentist’s vision, fully equipped to meet the needs of the whole dental team.

For more information please call Genius on 01582 840486 or email info@genusgroup.co.uk, www.genusinteriors.co.uk.
Make Hawaii happen

Inspire creativity and celebrate the ADA's 150th anniversary at its 2009 Annual Session at the Hawaii Convention Centre, Honolulu

ADA invites you to attend the 2009 Annual Session and World Marketplace Exhibition from September 30 to October 4. This isn't any Annual Session. It will make the culmination of a year-long celebration of the ADA's 150th anniversary. The refreshing and energising environment will inspire excitement and creativity as we celebrate the past and look to the future of our profession. And of course, it's never been more important to sharpen your practice management skills and be up to date with today's latest technologies. The ADA Annual Session will help you stay at the top of your game.

Why you should attend
The ADA Annual Session provides practical advice and information by bringing together leaders in dental practice, research, academics and industry.

• Unlock the secrets of running a highly successful practice.
• With more than 180 continuing education courses spanning four days, you'll find plenty of ideas you can take home and use immediately. More than 60 per cent of continuing education course seats are free with your registration.
• Learn from the finest minds in the dental community.
• The ADA Annual Session offers an unparalleled opportunity to select from leading speakers, all in one location, and to learn in the most advanced settings in the dental community.
• Test-drive the latest products.
• Shop at the ADA World Marketplace Exhibition. Discover cutting-edge technology and new products from the hundreds of exhibiting companies.
• Build staff camaraderie.
• With the ADA's inspiring Opening General Session and the fun of Hawaii at night, the ADA Annual Session offers almost endless opportunities for team-building.
• The place for networking.
• More than 200 alumni and professional associations will come together during the ADA Annual Session – the best opportunity to network with peers, make new professional acquaintances, and catch up with old friends.

How to register
Online registration is available at www.ada.org/goto/session.

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About the American Dental Association
Celebrating its 150th anniversary, the not-for-profit ADA is the nation's largest dental association, representing more than 157,000 dentist members. The premier source of oral health information, the ADA has advocated for the public's health and promoted the art and science of dentistry since 1859. The ADA's state-of-the-art research facilities develop and test dental products and materials that have advanced the practice of dentistry and made the patient experience more positive. The ADA Seal of Acceptance long has been a valuable and respected guide to consumer dental care products. The monthly Journal of the American Dental Association (JADA) is the best-read scientific journal in dentistry. For more information about the ADA, visit the Association's website at www.ada.org.
**Classification**

**Valuations:**
purchase, sale, buying in, retirement

**Purchases:**
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