Agency death
A dental insurance company is searching for the family of a dentist in Cheshire who died in the arms of a call girl. An insurance policy held by David Hillary, from Alderley Edge, has produced a payout of about £5,000 for his next of kin. However Dentists’ Provident have been unable to find any of his relatives - and the lump sum remains unpaid. Mr Hillary, 55, lived with his father, Jack, at a dental surgery in Trafford Road, where he had practised for nearly 20 years. His father died from lung cancer just 10 days before Mr Hillary was found dead. An inquest into the dentist’s death found he had been out drinking with a friend before calling the Select escort agency in Sale. He then drank more alcohol and took morphine with the escort until they fell asleep together on his sofa. When the escort awoke in the early hours of the next morning, she could not wake him up. Cheshire coroner Nicholas Rheinberg said that Mr Hillary died from a combination of alcohol and opiates - the combined levels of alcohol and drugs is in his blood. He recorded a verdict of accidental death. Anyone who can help trace Mr Hillary’s next of kin is asked to call Dentists’ Provident on 020 7222 2511.

Charity fundraiser
Staff at a dentist’s surgery in Wigan returned to the 1970s and donned Afro wigs, platform boots and flowery shirts to raise money for the health charity Dentaid. Dentists, dental nurses and a hygienist at Pemberton Dental Practice in Pemberton, raised more than £2,500 for the charity, which provides much-needed dental and oral health care in the developing world. Dr Phil Barlow, from Pemberton Dental Practice, said: “It was a great day. All the staff and patients had a wonderful time, the patients loved it too.”

Amalgam U-turn
The American drugs watchdog, the Food and Drug Administration has reversed its decision and has decided not to warn against pregnant women and children having mercury fillings. It was reversed after a review of around 200 scientific studies the levels released by dental amalgam fillings are “not high enough to cause harm in patients”.

Postcode lottery
Scotland has seen a rise in the number of NHS dental patients, but they are still very much at the mercy of a postcode lottery. The percentage of patients registered with an NHS dentist ranges from 41.5 per cent in Grampian to 78 per cent in Greater Glasgow and Clyde. Throughout Scotland, the number of registrations has increased.

By the end of March more than 5.5m people in Scotland had an NHS dentist, up from 2.9m a year ago.

Health boards are also making improvements with the number of children on the books of NHS dentists.

However six health boards have still to meet a national target to register 80 per cent of three to five-year-olds by 2010-11.

Below the target were West ern Isles (51.4 per cent), Orkney (60.1 per cent), Shetland (68.4 per cent), Grampian (69 per cent), Fife (75.6 per cent) and Highland (78.9 per cent).

This compares to 94.2 per cent registered in NHS Greater Glasgow and Clyde.

Dr Richard Simpson MSP, Labour health spokesman, said the figures showed that an increase in registration with NHS dentists benefits the whole country.

Public Health Minister Shona Robison said: “I am pleased that there have been further increases in both child and adult dental registrations in the last quarter, which indicate that the measures we have taken to improve access are working.

While I recognise one of the factors behind this increase will be the extension of the registration period, there are other factors, such as the record number of dentists in Scotland offering NHS services.

Having said that, we know there are still problems with access to an NHS dentist in certain parts of Scotland and we are continuing to tackle this.”

Forced resignation
A dentist who had a nine-year affair with his dental nurse, forced her to resign from the practice when his wife found out, an employment tribunal was told.

Tartig Drabu, 44, was said to have lavished gifts, including a diamond ring, on Paula Jackson and rented a flat.

The 45-year-old was then forced to resign from the practice in Middleton, Manchester, when his wife Suraya found out.

She said Dr Drabu had offered her £100,000 if she left the practice and dumped her husband.

Mrs Jackson claimed that Dr Drabu had told her she could have anything she wanted and eventually he would leave his wife.

Mrs Jackson, who had started at the practice as a trainee dental nurse, had during the nine-year affair, become practice manager at Langley Dental Group.

She claimed she was “bullied” into quitting her job and sued for constructive dismissal, which Mr Drabu admitted.

The amount of compensation will be fixed later.

Dr Drabu has been suspended by the General Dental Council from working for four months.

It found his conduct was unprofessional, inappropriate and not in the best interests of patients.

Anger management
Anger wells up within us whenever we perceive that we have been wronged, so how do we deal with it?

Due diligence is a time-consuming task, says Hewi Ma of Co-operative Insurance.

Due diligence is a time-consuming task.

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DENTAL TRIBUNE

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Raising money for charity

Two dentists played alongside ex-international rugby player and Strictly Come Dancing star Kenny Logan, in a game which raised £25,000 for charity. Dr Norman Bloom, who has a private dental practice in the West End of London, was joined by his associate dentist, Shane Roiser, who played professionally for the London Wasps rugby team for eight years.

The two dentists played in the London Wasps Legends team with Come Dancing star Kenny Logan against Hartlepool district where they raised £25,000 for the Hartlepool and District Hospice, which provides palliative care and bereavement support.

In another match, the London Wasps Legends team won 41-7 against a combined channel island team in Guernsey.

Dr Bloom said: ‘We won 41-7 alongside ex-internationals Kenny Logan, Andy Reid, Rob Luszczki, Mark Denny and Jonny Ufton captained by ex-Wasps captain Mark Rugby. We also raised over £3,000 for the Wooden Spoon society which raises money for children’s charities.’

Cosmetic treatment

The former world champion boxer, Chris Eubank is spending £50,000 on cosmetic treatment and is hoping it will get rid of his trademark lisp.

Mr Eubank has travelled to Ireland to have the work carried out by dentist Barry Buckley.

The work includes closing the gap between his two front teeth to improve the aesthetic nature of his smile.

Mr Eubank said: ‘I’m here to see the best dentist in Ireland and the U.K. Before long nobody will be able to accuse me of having a lisp.

Dr Buckley is carrying out the work at Clane Hospital, Co Kildare, which will also see all his other teeth slightly lengthened.

Dr Buckley said: ‘We’re getting rid of the gap between his front teeth, adding length to the teeth and widening his smile slightly.

The main purpose of the work is to make his teeth look better. However a Scottish dentist at the recent 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 the 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 Dental Tissue 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 their guidance, all dentists 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 roster 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.

When cleaning instruments and equipment, manual cleaning is still acceptable according to the guidelines but automated and validated processes need to be used where possible.

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

HTM 01-05 gives the Care Quality Commission, the new regulatory organisation for healthcare, the right to inspect all practices and to see if they attain the two standards of essential and best practice.

By 2010, all dental practices in the UK, both NHS and private, will have to register with the Care Quality Commission and will be regulated by this body.

The full guidance can be accessed online at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089247

Call for funding

Dentists in England are calling for extra funding to help them implement the decontamination guidance issued by the Department of Health.

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Underground cinema

A dentist is hoping to build an underground cinema under the garden of his home in Lincolnshire.

Morne Gerber, who works as a clinical director of Advanced Dental in Market Rasen, also wants to build an underground tunnel that connects the current patio outside his home to the soundproof cinema.

The plans for his home in Washingborough also includes the construction of an open air swimming pool.

Architect Mark Henderson said in the plans: ‘Although it is large the house is compartmentalised by small rooms which the owner feels limits his aspirations for a 21st century lifestyle.’

Other plans for the listed building include the construction of a greenhouse and alterations to an outbuilding to create a pool annex.

Dental powder mistake

Police have been left red-faced after they claimed to find a stash of 13 kilos of cocaine with a street value of £500,000 in Devon, only to discover after tests it was dental powder.

Police said it was the largest seizure of a class ‘A’ drug in Devon and Cornwall and arrested five people on suspicion of possession with intent to supply.

However tests then revealed the cocaine was actually benzocaine – a mild local anaesthetic used by dentists to numb gums.

A police spokesman has revealed that no further action will be taken following the raid on the Prince Regent pub in Tiverton.

Police uncovered the stash of white powder following a long-running investigation into a money-laundering operation in Devon.

Approximately 13 kilos of white powder, which they believed to be cocaine, was found after officers raided the Prince Regent pub, in Lowman Green, Tiverton, and an adjoining garage where they found the powder in a holdall.

Police searched nine further properties following the raid.

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News
Xylitol sweetener prevents decay

The British Dental Health Foundation has welcomed research that shows the non-artificial sweetener, Xylitol, helps prevent decay in baby teeth.

The non-artificial sweetener, which acts as an anti-bacterial agent against cavities is already widely used as a ‘safe’ sweetener.

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Swine flu guidance

Dental Protection, the professional indemnity body, has been receiving a large volume of calls asking for advice about what to do about the spread of swine flu.

In response, it has issued a paper highlighting the indemnity and risk management aspects of pandemic influenza, including a section on frequently asked questions with some of the recurring questions that its dental-legal advisers are being asked.

A spokesman for the company said: ‘Dental Protection has had experience of advising and assisting its members in similar situations in other parts of the world, such as members in Hong Kong and Singapore who were badly affected by the SARS outbreak and the C5N1 avian flu epidemic.

This experience heightens our awareness of the kind of issues and risks that need to be considered.’

Dental Protection warns that it is up to dental professionals to act responsibly and said it is in the public interest that everyone should play their part in limiting the spread of pandemic influenza.

Guidance includes:
Taking every reasonable step to maintain your own health and that of those around you.
It is irresponsible to continue treating patients when you have reason to believe that you may be infectious; this may apply to your professional colleagues as well as to yourself.

In such situations you should monitor your own health (including your temperature), take medical advice when necessary and appropriate, and act upon this advice.

It is equally irresponsible to expect or require your employees to attend the workplace and come into contact with colleagues and patients when you have reason to believe that they may be infectious.

The temptation may be greatest when you are already short-staffed, but it must be resisted, warns Dental Protection.

On the other hand, those healthcare professionals that are fit and well can make a valuable contribution by covering for colleagues who are unwell and unable to work.

Those who are in positions of responsibility and leadership – including practice owners, and those with management responsibilities in all branches of dentistry – should plan in advance for a range of possible scenarios so that they know how they would deal with many of the likely contingencies.

This will make it easier to make good decisions under pressure at a later stage. There are also legal considerations for practice owners and employers, according to Dental Protection.

Employers have a duty, amongst other things, to maintain a safe workplace, and to make adequate provision for the health, safety and welfare of their employees.

They also have a legal obligation to provide staff members with appropriate Personal Protective Equipment (PPE).

Team members should wear good quality, well-fitting masks and adequate surgery ventilation and high volume suction will all help to minimise the risks inherent in the dental environment.

The General Dental Council requires all registered dental health professionals to maintain adequate and appropriate professional indemnity at all times, and Dental Protection recommends all its members to ensure that those with whom they work (regularly or in exceptional circumstances) do have such indemnity.

For more information, go to www.dentalprotection.org
Tooth decay caused by multiple medicines

The British Dental Health Foundation claims many oral problems are being caused by people taking multiple medicines.

Scientists are blaming multiple medications for the growing problem of dry mouth syndrome which can lead to tooth decay.

Foundation chief executive Dr Nigel Carter said: ‘Dry mouth affects our saliva levels which can expose the teeth to risks of tooth decay, since saliva is a natural protection against caries.

With advances in healthcare, more and more medicines have hit the market. As more people take multiple medicines, the risk of oral health problems such as xerostomia has greatly increased, especially amongst older people.

Dry mouth increases exposure to the main causes of tooth loss, decay, erosion and gum disease, yet these problems are entirely preventable.

A good oral health routine and regular trips to the dentist, as often as the dentist recommends, will help look after your mouth and quality of life.’

Dry mouth can also be caused by medical conditions such as diabetes and lupus, or natural factors such as ageing and menopausal changes.

There are a wide range of products designed for dry mouth which can help prevent any problems preventing risks of decay and minimising other attendant issues, such as a lack of saliva affecting swallowing.

Products such as gels and sprays can help moisture levels in the mouth, while it is important to brush teeth twice a day with a fluoride toothpaste to prevent decay.

Avoiding sugary foods and citrus acids will minimise risks of dental decay and erosion.

Though sucking sweets and chewing gum can help stimulate the flow of saliva and counteract dry mouth, it is vital to use sugar-free products.

Those with more severe cases may even choose to sleep with a de-humidifier in the room and practice breathing through the nose rather than the mouth.

Alcohol, caffeine and salty foods are on the banned list in cases of dry mouth, while sufferers should drink plenty of water.

Yorkshire carries out fluoride study

Yorkshire and Humber Strategic Health Authority is to carry out a feasibility study into whether fluoride should be added to drinking water in a drive to improve oral health in the region.

The health authority is carrying out the study on behalf of the whole region but at the specific request of primary care trusts in Bradford and Airedale and Kirklees.

NHS Bradford and Airedale Trust believes it would bring benefits for the people, as it will optimise exposure to fluoride and reduce tooth decay.

The trust runs a fluoride varnish scheme for children, which it wants to expand.

Chief executive of NHS Bradford and Airedale, Simon Morritt said discussions with Yorkshire Water had revealed it was not possible to contain water fluoridation to just West Yorkshire.

Because of this, he has asked the health authority to carry out a feasibility study for the entire Yorkshire region.

It is expected to be completed by April 2010.
The General Dental Council is an ‘outward-looking regulator with a real focus on customer service’, according to the watchdog for healthcare regulators.

The Council for Healthcare Regulatory Excellence (CHRE), in its review of the GDC, also found the council had a clear commitment to continuous improvement, and a willingness to innovate.

Among other initiatives, the GDC has demonstrated ‘excellence and good practice’ by encouraging dental patients to expect better standards through a process of educating and empowering them, said the CHRE.

The report by the watchdog said ‘we are impressed with the GDC’s approach and would encourage others to consider such a customer-focused strategy’.

GDC chief executive and registrar Duncan Rudkin said: ‘We welcome the rigour and scrutiny of the review and the opportunity for us to show that we’re accountable. But we’re not complacent. We are keen to do all we can to stay focused on continual improvement.’

The CHRE said it would follow ‘with interest’ the GDC’s progress on revalidation, appraising and assessing fitness to practise panellists, a new ‘risk-based’ approach to education and training, and how it measures and manages its own performance.

The GDC said it would follow ‘with interest’ the GDC’s progress on revalidation, appraising and assessing fitness to practise panellists, a new ‘risk-based’ approach to education and training, and how it measures and manages its own performance.

The GDC will be the first regulator to pilot its revalidation process and the CHRE welcomed the GDC’s stated intent to share the learning from its pilot with other regulators.

The GDC is currently undertaking a major review of its Fitness to Practise work, including a comprehensive and challenging review of how the function is managed and governed.

A strategic review is also planned.

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Gold medal award

Anthony Power, who recently completed his undergraduate dental programme at King’s College London Dental Institute, has won the 2009 University of London BDS Gold Medal. This is the eighth year in succession that a graduate of King’s has been awarded this highly prestigious prize.

The medal is awarded to the candidate who most distinguishes him or herself in the final Bachelor of Dental Surgery exams. Both London dental schools are invited to nominate candidates for the gold medal examination - an oral conducted by six external examiners. Each school selects candidates from students with the highest number of merits and distinctions.

Anthony, who is undertaking his vocational training in the coastal resort of Minehead with the South West Deanery, said: ‘It was both with pride and trepidation that I attended the viva for the Gold Medal on graduation morning. To be told at the graduation ceremony later that day that I had received the award was an unexpected delight, not to mention a great honour. I am very grateful to have studied at King’s for the past 5 years, since the teaching and facilities were wonderful on the whole, and the memories I have will always be cherished. I hope that I can return one day, perhaps as an SHO, to some familiar friendly faces.’

He will receive the medal, with a cheque for £500, at the Institute’s annual prize giving in November.
Chewing robot to test crowns and bridges

Researchers in Bristol have invented a Chewing Robot to study the wear and tear on dental fittings such as crowns and bridges.

The UK spends around £2.5bn each year on dental materials to replace or strengthen teeth.

Researchers at the University of Bristol's department of mechanical engineering in collaboration with the Department of Oral and Dental Science have developed the Chewing Robot to test dental materials.

The inspired invention was shown to the public for the first time at this year’s Royal Society Summer Science Exhibition, the premier annual showcase for scientific excellence in the UK.

Dental fittings, such as crowns and bridges, are made from well-known metals, polymers and ceramics but their dental wear properties are often poorly understood. Clinical trials examining the wear of human teeth are expensive and time-consuming and by the time a new material has been tested, it is often obsolete.

This is why researchers came up with the Chewing Robot which replicates the movements and forces involved in chewing.

The robot is based on a three-dimensional mechanism with six linear actuators that reproduce the motion and forces sustained by teeth within a human mouth.

A human jaw is a powerful and complex piece of natural machinery, allowing a person to chew in many different ways.

The lower jaw and the teeth move with six degrees of freedom, translating and rotating along each of the Cartesian axes.

Dr Kazem Alemzadeh, senior lecturer in the department of mechanical engineering recognised that the Stewart-Gough platforms have been used to provide and control the same six degrees of freedom in aircraft simulators, and so he proposed the chewing robot concept based on just such a platform.

The design and development of the chewing robot was carried out by Daniel Raabe, a PhD student in the department of mechanical engineering at Bristol University.

The robot has the potential to dramatically improve the process of developing and testing new dental materials.

Daniel Raabe said: "By reproducing natural bite forces and movements, the chewing robot can help improve and accelerate the process of developing new dental restorative materials that may someday be found in a person’s mouth."

Fill in your CPD hours online

All dental care professionals registered with the General Dental Council (GDC) before 30 June 2008 and paid the annual retention fee by 31 July this year will receive - along with their Annual Practising Certificate - a letter with instructions on how they can log on to the eGDC website and fill in their annual CPD hours electronically.

A spokesperson for the GDC said: ‘Although we’re encouraging professionals to submit their hours online, alternatively they can submit a return form which will be sent out with the letter this August.

A special telephone helpline and email advice service will go live in August to help with any questions registrants may have in filling out their paper forms or hours online.’

The new online facility will allow professionals to track and record CPD hours over their five-year cycle at the click of a mouse.

If they have previously submitted paper forms, they will be able to edit and add hours from their current five-year cycle online.

Once they’ve entered their hours for this year, the site will tell them how many hours they have left to do.

Registrants need to keep hold of their certificates as proof of carrying out verified CPD.

This is important as the GDC carries out audits at the end of each five-year cycle.

The deadline for professionals to submit their hours is the end of September.

GDC registration development manager, Sarah Arnold, said: ‘As well as submitting your CPD returns, you can also check and update your contact details that appear on the register, pay your annual retention fee by credit or debit card, set up a direct debit and access your annual practising certificate.’

Dental care professionals who registered with the GDC on or after 31 July won’t have to fill in a return form until August 2010.

Good oral healthcare combats obesity

Good oral healthcare could hold the key to combating obesity, according to new dental research.

The Journal of Dental Research found that bacteria in our mouths could play a direct part in causing obesity.

The study was carried out on five hundred women, three hundred of whom were clinically obese.

This found that out of forty kinds of bacteria tested, one species - selenomonas noxia - was present at levels of more than one per cent of total bacteria in 86 per cent of the overweight group.

This bacteria has previously been linked with the development of gum disease.

Further research will now explore the importance of these infectious agents as indicators of and potential causes of obesity.

Foundation chief executive Dr Nigel Carter said: ‘Though this information represents very early stages of research, it is another fascinating example of the potential overall health links related to our oral health.

It is uncertain whether people may become obese due to changes in the bacteria in their mouths or whether these changes occur as a result of obesity. What impact changing the bacterial make up may have on helping to reduce obesity is certainly worth additional research.

There are hundreds of bacteria in our mouths at any one time, contributing to the most common dental hygiene issue - gum disease.

Alongside posing risks of causing tooth loss if left unchecked, gum disease has been linked to heart disease, diabetes and premature births.'
A smooth transaction

Due diligence is a time-consuming subject, says Hewi Ma of Cohen Cramer solicitors, who explains what it actually means and how it affects you when you’re buying or selling a practice.

Due diligence is invariably the most time-consuming stage of a dental practice sale or purchase and one of the most crucial. “Due diligence” means the raising by the buyer’s solicitors of enquiries about the practice and the premises. The buyer’s solicitors send out enquiries at the initial stages of a transaction. The enquiries not only ask for written replies, but also the provision of substantial amounts of documentation from a seller. The replies and documents are scrutinised by the buyer’s solicitors, which then lead to the raising of further enquiries and requests for further documentation.

I have acted for many a Seller who tackles these enquiries with great gusto and fervour providing prompt replies and a well-compiled bundle of due diligence documents, which expedites the transaction to exchange and completion.

At the opposite end of the scale is the Seller who sends through replies and supporting documents in dribs and drabs and whose replies are incomplete and inadequate. This can mean delay, more work and more expense for a Seller.

Don’t be fooled

The Credit Crunch has affected everyone including solicitors. When the bottom fell out of the property market, some commercial property solicitors attempted to move into dental work, but do not be fooled! A low quote for selling a practice may seem like a bargain, but if it sounds too good to be true – it usually is. A solicitor with no experience in dealing with dental practices may quickly find themselves out of their depth, with fees spiralling out of control and a deeply unsatisfied client.

A solicitor with a well-established background in dental practice sales and acquisitions should be familiar with how a practice works and will know the right questions to ask. They should ask you if you are NHS, private or a member of a capitalisation scheme. They will ask if you have any associates, what type of NHS contract you hold – GDS or PDS. If they are asking you the right questions, they should also ask the right questions of a seller (if instructed by a buyer) and will be able to understand and deal with questions raised by a buyer (if acting for a seller).

Enquiries for the seller

When you receive the enquiries from your solicitor, my top tip is to hand it to your practice manager. There will, in most cases, be two parts to the enquiries; property and business.

Commercial Property Standard Enquiries (or CPSEs) ask for information about the property. The vast majority of solicitors for any commercial-property transaction use them. Replies should be sent to you in draft for you to approve and add to if you have any further comments before being sent to a buyer’s solicitors.

Business enquiries are a completely different kettle of fish! At present, there are no standard enquiries relating to a Dental Practice’s business. Our firm and a handful of others (all members of the Association of Specialist Providers to Dentists) have an agreed form of enquiries. This is useful as we know what to expect of one another and the enquiries can be sent to you as soon as a transaction commences although ‘standard’ enquiries are often supplemented by bespoke enquiries relevant to that particular transaction.

Most business enquiries are relatively straightforward although in many cases they are numerous and do take time to deal with properly.

Providing an inventory

One thing you are guaranteed to be asked for is an inventory of all items included and excluded from the practice. The aim is to be thorough but not pedantic. Generally, the main items of equipment are detailed, for example, name, model and serial number, then furniture, computers and fixtures and fittings, a process similar to when you are selling a house. You will not be expected to list things classed as stock or such sundry items like a mop and bucket as in one case I dealt with.

The inventory you prepare will be appended to the Business Transfer Agreement, so it is important that you are happy with it. In addition, be sure to detail the items at the practice, which are not included in the sale, as you wouldn’t want to surrender that rather expensive intra-oral camera you have just purchased.

If your practice works under an NHS contract, you will also be expected to provide up to date UDA figures and a whole copy of the NHS contract itself – not just the signature pages and schedules. NHS contracts do vary and it is important that your solicitor has sight of this. If your Practice runs a capitation scheme you may be asked to provide at least six months’ written reports.

Enquiries relating to staff form a large part of any due diligence enquiries. Under TUPE regulations, the transfer of the staff goes hand in hand with the transfer of the business. You may be required to provide copies of the signed contracts of employment, GDC registration certificates and vaccination records for clinical staff and attendance records.

An inability to provide full and accurate replies to these enquiries may at worst endanger a sale and at the least, it will cause a significant delay.

Enquiries for the buyer

Your part is easy. Instruct “dentally aware” solicitors and sit back, let them do the hard work. Your solicitor should report back to you upon the seller’s documentation.

You will be provided with an inventory and you must ensure that it gives a true representation of what you believe is included in the purchase. If you noted a nice new autoclave when you visited and this doesn’t appear to be on the inventory you must advise your solicitor. Replacement of missing equipment will be a painfully costly lesson.

If your practice works under an NHS contract, you will also be expected to provide up to date UDA figures and a whole copy of the NHS contract itself – not just the signature pages and schedules. NHS contracts do vary and it is important that your solicitor has sight of this. If your Practice runs a capitation scheme you may be asked to provide at least six months’ written reports.

Conclusion

Due diligence is one of the most crucial and fundamental parts of any sale or purchase of a dental practice. For the seller, a speedy and satisfactory response to the enquiries goes a long way to expediting a sale. As for the buyer, you should always instruct a solicitor who knows the right questions to ask and who will persevere until appropriate replies and supporting documentation have been provided.

About the author

Hewi Ma joined Cohen Cramer in 1999 and is a key member of the dental team working on dental practice sale and acquisition transactions. Her particular area of expertise lies in dealing with enquiries before the exchange of contracts, producing practice acquisition reports on purchases and disclosure bundles for sales.

To contact Cohen Cramer Solicitors, call 0113 2440597, email dental.team@cohencramer.co.uk or visit www.cohencramer.co.uk.
**Don’t wait, act now**

Without financial planning, you might not end up with the retirement package you had imagined, says Suzanne Allen who offers some advice.

In the current climate many dentists are wondering if they will ever be able to retire from dentistry. Like them, you may have spent your working life building your practice to provide wealth for you and your family, making good profits, yet they still worry about their finances because they have little or no real understanding of their true personal financial position. Their fears are often not rational and without foundation, but how are they become your financial safety system; they won’t drive the car for you, but they will guide you to your destination. A practice valuer will provide an up-to-date valuation of the practice and help make it fit for sale. The accountant will advise on the tax implications of selling and the tax reliefs available. Financial planners will pull together all the assets and develop a cohesive long-term retirement strategy. This latter specialist ultimately puts you back in control of your finances by taking you through a 3-stage process.

1. **Information gathering and analysis**

This is a fact-finding mission whereby all your financial information is pulled together and your vision for retirement is identified. A net worth statement of all your assets is drawn up. It is quite surprising how much you could be worth! The following table illustrates the asset chart of your practice property rental, etc.

<table>
<thead>
<tr>
<th>Husband</th>
<th>Wife</th>
<th>Joint Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Pension</td>
<td>26,500</td>
<td>26,500</td>
</tr>
<tr>
<td>SIPP - Income Drawdown</td>
<td>18,000</td>
<td>18,000</td>
</tr>
<tr>
<td>Annuity</td>
<td>2,000</td>
<td>2,000</td>
</tr>
<tr>
<td>Bank Interest</td>
<td>1,500</td>
<td>1,500</td>
</tr>
<tr>
<td>State Pension (from age 65)</td>
<td>1,935</td>
<td>1,935</td>
</tr>
<tr>
<td>Practice Rent</td>
<td>8,000</td>
<td>8,000</td>
</tr>
<tr>
<td></td>
<td>58,593</td>
<td>58,593</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tax-free Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Portfolio (CGT)</td>
</tr>
<tr>
<td>ISA Income</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

| Total Net Annual Income | 58,226 | 58,226 | 116,452 |

<table>
<thead>
<tr>
<th>Outgoings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housekeeping Expenses</td>
</tr>
<tr>
<td>Personal Expenses (incl. holidays)</td>
</tr>
<tr>
<td>Children / Grandchildren</td>
</tr>
<tr>
<td>Motoring Expenses</td>
</tr>
<tr>
<td>Life Assurance / Insurance</td>
</tr>
<tr>
<td>Investments</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Outflows</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Annual Income Less Outgoings</td>
</tr>
</tbody>
</table>

But are you confident that a lifetime’s effort will be translated into your desired post-practice lifestyle? There is so much to consider now: has the impact of the global recession decimated your private practices and ISAs? Is there still the same value in making those sources, and how it matches up to your spending needs during retirement.

The second stage therefore is to pull all these income streams together and illustrate where you would be in retirement. It’s surprising how many sources make up your income: the NHS pension, state pension, private pensions, ISAs, cash accounts, the practice's sale proceeds, the practice property rental, etc.

2. **Assimilating the Information**

Dentists have different retirement requirements. Some can’t wait to sell up, some are happy to sell their goodwill yet maintain the property to provide an excellent rental stream, while others cannot let go and still want to keep their hand in. There is no prescriptive formula, which is why a financial adviser is vital to show you the level of retirement income you can expect from all sources, and how it matches up with your spending needs during retirement.

The way to lose that financial fear is to become the driver and take control. When considering your impending retirement, bring in specialists who can make the process easier and take away the worry and pressure – they understand their financial situation; they won’t drive the car for you, but they will guide you to your destination. A practice valuer will provide an up-to-date valuation of the practice and help make it fit for sale. The accountant will advise on the tax implications of selling and the tax reliefs available. Financial planners will pull together all the assets and develop a cohesive long-term retirement strategy. This latter specialist ultimately puts you back in control of your finances by taking you through a 3-stage process.

5. **Creating the solution:**

Having identified the assets and income sources, the most suitable and tax efficient means of securing the income is determined. The following is illustrative of the planning adopted by our 59-year old dentist.

Having chosen to sell his goodwill but keep the property, a strategy was prepared around his retirement vision that gave him flexibility, fitted in with his tolerance to investment risk, and took advantage of available tax breaks.

With the security of the NHS Pension, he wanted to keep his private pensions more actively managed and not be tied into an annuity, so he set up an Income Withdrawal Plan, took the maximum tax-free cash and a flexible income. Yet for his wife, an annuity was appropriate because of the smaller pension fund. Having sufficient cash put aside for emergencies, he was happy to invest his practice goodwill into a joint discretionary managed portfolio with his wife, geared for growth. From this they take income in the form of capital gains each year, entirely tax-free!

This portfolio may also fund their future ISA payments; moving money from a potentially tax-able fund to a more tax-efficient environment. They are also now drawing a tax-free income from their ISAs. By transferring 50 per cent of the practice property into his wife’s name, the tax on her share of the rental income is only taxed at the basic rate. The following table shows how their income comfortably covers their regular expenditure and provides a comfortable surplus for any contingencies, and those extra little luxuries!

This dentist was delighted that he could restructure his investments so that his income would cover his anticipated ongoing expenditure and in future, he and his wife will only be paying a composite rate of tax of less than 15 per cent of their gross income!

**Take control**

You feel in control of your finances when you are in control of them! Waiting until you retire could be too late. If you are planning to retire in the next five years, do so with confidence that you and your family have a level of regular income commensurate with the retirement lifestyle you desire.

**Suzanne Allen**

is managing director of Heritage Financial Advisers, a team of independent, fee-based financial planning specialists dedicated to the dental sector. She has over 12 years experience in the financial-planning industry, having spent half this time working with dentist clients. Suzanne holds a diploma in financial planning and possesses specialist knowledge of pensions, taxation and trusts. Visit www.hfadvisers.co.uk for more information.

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Dental Air has one of the best customer service reputations in the dental industry, and with our fast call out times, it is no surprise that we are the leading supplier of oil-free compressed air packages.

Freephone 0800 542 7575 to book a survey or to receive your FREE ‘Practice Managers Guide’
Saving for school

If you still plan to send your child to a fee-paying school despite the recession, it’s a good idea to start putting money aside as soon as you can. Mark Blakeman explains...

Although the recession continues to bite, private schools being hit hard. Some reports suggest that over 90 schools have already closed, merged or been taken over. It’s a worrying time for pupils and parents alike, with one mother likening the closure of her daughter’s school to “a bereavement”. Equally difficult would be the prospect of moving your child from school if you could no longer afford to pay the fees, which this year have shown an average rise of 5.9 per cent, according to the Independent Schools Census.

If you plan to send your children to a fee-paying school, the key is to start putting money aside as soon as you can. You might be surprised to know that, according to our research it can cost almost half a million pounds to educate two children privately.

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Dentists and are dedicated to helping you plan for a more secure financial future.

To arrange a no-obligation financial review, please call 0800 980 1885.

A tax efficient savings option is to use your ISA allowance, which currently stands at £7,200. ISAs allow your savings to grow free of income tax. Investments can either be made in lump sums or as regular savings, starting at around £20 per month. Up to £5,600 of your ISA allowance can be invested in a Cash ISA. This is an ideal home for money that you will require in five years or less. The remaining part of the allowance could go into a stocks and shares ISA, designed for medium to long term saving.

Alternatively, you can invest the whole of the allowance into a stocks and shares ISA. There are various types available depending on your attitude to risk. For more cautious investors there are with-profits ISAs which invest in a mixture of shares, fixed-interest securities and property. Regular bonuses are added in order to smooth out investment returns.

Savings options

Once you have committed to new investments, make sure you consider their maturity date to ensure that they release funding to coincide with the times when you need to pay the school fees.

Individual Savings Accounts (ISAs)

A choice of funds is available which invest in the UK or overseas shares, fixed interest or property. Your investment in these funds will fluctuate in value in-line with the underlying investments.

It’s worth remembering that, from April next year, the annual ISA investment limit will be increased to £10,000, of which up to £7,100 can be placed in a cash ISA. Those 50 and over will be able to benefit from these new allowances from 6 October this year.

Other investments

If you have the capital available you could invest a lump sum of money. A wise investment could ensure that future fees can be covered from the returns. You should speak to your financial consultant to find a tax efficient and flexible approach that suits your needs.

For longer-term savings, direct investment in unit trusts is another option. This can also be a tax efficient option because investors can use their annual capital gains allowance of up to £10,100 to make tax-free withdrawals. With capital gains tax standing at 18 per cent, compared to income tax at 40 per cent, generating income through capital growth can be beneficial but talk to your financial consultant as this is a complex area.

It’s also worth considering a regular savings plan that can be put into discretionary trusts for children. Managed funds can be used which spread the investment risk across shares, fixed interests and property.

There are other investment options available according to your timescale and attitude to risk. Your attitude to risk will be a key factor in helping you to decide what type of financial planning to undertake. If you are a cautious investor you might want to choose funds with a safer, lower return. More speculative investors might consider higher-risk options.

Trust planning

If you’re in the fortunate position of having parents who can help, they can make tax-efficient contributions to the education of their grandchildren whilst minimising Inheritance Tax liability on their estates. If this could be of benefit to your family talk to your financial consultant to get more information.

Finally it’s worth thinking about how you would continue to pay fees if your personal circumstances change, for example if you are sick, made redundant or die. You might want to ensure your payments are suitably protected to cover you in the event of such unforeseen circumstances.

Take professional advice

There are many ways in which money can be put aside to help pay the costs of your children’s education. Every family will have different requirements so it makes sense to take professional advice from a financial consultant who has a good understanding of the subject and of your own needs. The sooner you start saving the better prepared you will be to cover these costs.

About the author

Mark Blakeman is National Sales Manager for Wesleyan Medical Sickness, specialist providers of financial services and products for dentists. For information, call 0800 980 1885 or visit www.wesleyan.co.uk/dtalk.
Tax-planning checklist

Now that we’re well past the April 5 deadline, it is time to consider what tax-planning ideas and opportunities are available for the 2009/2010 tax year. Thomas Dickson explains in the second of this two-part feature.

There’s quite often a rush at the end of the tax year to make sure you’ve maximised on all the tax savings you can. As always we had pension cheques arriving right up to the end of the tax year and we were submitting ISAs right up till the last working day. However, you’ve actually got 52 weeks before then to arrange your finances and maximise the tax reliefs available. Following on from the points I raised in part one of this feature, here are further ideas that could save you a considerable amount of money.

Capital Gains Tax (CGT)

Capital Gains Tax is now set at a flat rate of 18 per cent of any net gain (gain after expenses) and entrepreneurs relief has also recently been introduced which charges tax at a tapering rate of 10 per cent on certain business gains up to a cumulative lifetime limit of £1m. Although it’s not good news for landlords, buy-to-let properties however have been specifically excluded from this relief.

You can crystallise gains to the extent of the annual allowance which is £10,100 for 2009/2010, but remember you must not buy back the same shares or assets within 30 days.

For any gains made in this tax year the CGT will be payable on 31 January 2011, so if you can wait until 6 April 2010 to sell your investment assets you would not be payable until 2012. Another often-used method to reduce CGT is to transfer assets between spouses before sale to utilise both annual allowances. Reinvestment relief is also available, where the chargeable gain is deferred when the gain is reinvested in a qualifying Enterprise Investment Scheme (EIS).

Estate planning

It’s often said that Inheritance Tax is a voluntary tax. If your estate is likely to be above the nil rate band (£255,000 for 2009/2010) you may need to take some simple steps to reduce the tax bill.

One of the simplest methods of inheritance tax planning is to make full use of each year’s annual exemptions, such as:

- Annual exemption – £3,000 (you can also use £5,000 for 2009/2010 if already used)
- Small gifts exemption max £250 per donee (person receiving the gift) per tax year
- Gifts out of normal expenditure – for example, premium payments to a life insurance policy

Despite some financial costs associated with implementing a will, the benefits from a will or a life insurance policy under trust will often be a simple economic and acceptable way of providing cash on death that is free of Inheritance Tax (IHT) and using the annual and normal expenditure out if income exemptions.

You could also consider a “deed of variation” where an inheritance has been received in the last two years to make the distribution of the inheritance more tax efficient.

If you’re living with your partner, but not legally married, your estate could be left with a large inheritance tax bill as a result. This is because if you leave your estate to your partner and the value exceeds £255,000 then tax will be due at 40 per cent. However, if you marry or enter into a civil partnership this would be exempt.

The other benefit of being married is that if your estate passes to your spouse on death (and the nil rate band is therefore not used) your surviving spouse could inherit the total value of the donation.

Charity gifts

Charities can reclaim the basic rate of tax on every donation. This means that for every £1 donated, the charity can claim an extra 25p in tax. In addition, HMRC will automatically pay your charity a further three pence for every pound donated. This “transitional relief” – to adjust the fall in basic rate tax (from 22 per cent to 20 per cent) – is available from 6 April 2008 until 5 April 2011.

For every £1 donated, your charity can receive 28p, so the total value of the donation is £1.28. A higher rate taxpayer can then claim back the difference between the higher rate of tax at 40 per cent and the basic rate of tax at 20 per cent on the total value of their gross donation.

One of the simplest ideas is to crystallise gains if you are planning a large charitable gift. Transferring assets may also be beneficial for avoiding Inheritance Tax. Lifetime gifts to bare trusts are Potentially Exempt Transfers. No inheritance tax is due on these ‘PETs’ if the donor survives for seven years. If the asset is sold within seven years there may be an IHT charge if the donor dies within that time so don’t spend all the money.

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Researchers find new proteins

Researchers have found two new proteins that may lead to more effective treatment of endocarditis and infections associated with implants.

Endocarditis is an inflammation of the heart valves that can be life-threatening and streptococcus gordonii, a bacterium that exists in the mouth, is one of the bacteria that cause the disease.

To survive in the oral cavity, the bacteria must be able to attach to a surface such as the mucous membrane.

This is done with the help of proteins.

In the mid-1990s, one of these proteins from S. gordonii was identified by a research team in England.

Most antibiotics initially work extremely well, killing more than 99.9 per cent of microbes they target.

But through mutation and the selection pressure exerted by the antibiotic, a few bacterial cells inevitably manage to survive, repopulate the bacterial community, and flourish as antibiotic-resistant strains.

Professor Vern L. Schramm and Ruth Merns, chair of Biochemistry at Einstein and senior author of ‘Transition State Analog Analogs of 5’-Methylthioadenosine Nucleoside Disrupt Quorum Sensing’ tested three transition state analogs against the quorum-sensing pathway.

All three compounds were highly potent in disrupting quorum sensing in both V cholerae and E. coli 0157:H7.

‘In our lab, we call these agents everlasting antibiotics,’ said Dr Schramm.

This study involved three compounds, but Dr Schramm said that his team has now developed more than 20 potent MTAN inhibitors, all of which are expected to be safe for human use.

Once the bacteria are encapsulated, it is extremely difficult to get rid of them.

But with enhanced knowledge of how bacteria fasten to surfaces, it will be easier to find effective strategies to treat biofilm-induced diseases.

‘If we can block this binding with the help of drugs, treatment will be more effective,’ said Professor Davies.

Previously, researchers knew that bacteria that grow in biofilms alter their properties when they settle on a surface.

For example, they become more resistant to antibiotics and antibacterial compounds. These researchers are now investigating how this resistance arises.

Researchers don’t trigger resistance

Researchers have developed a new generation of antibiotic compounds that do not provoke bacterial resistance.

Bacterial resistance to antibiotics is one of medicine’s most vexing challenges.

But a recent study in an edition of Nature Chemical Biology, has revealed that researchers from Albert Einstein College of Medicine of Yeshiva University have developed two compounds that work against two notorious microbes: Vibrio cholerae, which causes cholera and E. coli 0157:H7, the food contaminant.

Now associate professor Julia Davies, and her research team at the Faculty of Odontology at Malmö University in Sweden have found two more and thereby taken a step towards understanding how these bacteria attach to a surface, like heart valve instances.

The two new proteins SGO 0707 and SGO 1487 are found in the cell wall of the bacterium S. gordonii.

The proteins are produced by the bacterium and without them the bacterium cannot fasten to a surface, which is a precondition for its survival.

If bacteria get in the bloodstream, they can bind to the heart valves, where they produce a biofilm and encapsulate themselves.

Oral osteoporosis drugs

Even short-term use of common oral osteoporosis drugs may leave the jaw vulnerable to devastating necrosis, claim researchers.

Researchers at the University Of Southern California, School Of Dentistry have released results of clinical data that links oral bisphosphonates to increased jaw necrosis.

The study is among the first to acknowledge that even short-term use of common oral osteoporosis drugs may leave the jaw vulnerable to devastating necrosis, according to the report in the Journal of the American Dental Association (JADA).

‘Oral Bisphosphonate Use and the Prevalence of Osteonecrosis of the Jaw: An Institutional Inquiry’ is the first large institutional study in America to investigate the relationship between oral bisphosphonate use and jaw bone death, said principal investigator Parish Sedghizadeh, assistant professor of clinical dentistry with the USC School of Dentistry.

After controlling for referral bias, nine of 208 healthy School of Dentistry patients who take or have taken Fosamax, the most widely prescribed oral bisphosphonate, for any length of time were diagnosed with osteonecrosis of the jaw (ONJ).

The study’s results are in contrast to drug makers’ prior assertions that bisphosphonate-related ONJ risk is only noticeable with intravenous use of the drugs, not oral usage.

Professor Sedghizadeh said, ‘We’ve been told that the risk with oral bisphosphonates is negligible, but four percent is not negligible.’

He hopes that other researchers will confirm his findings and thus encourage more doctors and dentists to talk with patients about the oral health risks associated with the widely used drugs.

The results confirm the suspicions of many in the oral health field.

He said: ‘Here at the School of Dentistry we’re getting two or three new patients a week that have bisphosphonate-related ONJ and I know we’re not the only ones seeing it.’
Thinking outside the box

Cardiovascular disease represents one of the leading causes of death in the Western world. With this in mind, it is interesting to note that the American Academy of Periodontology has just informed its members of its new clinical recommendations developed in regards to atherothrombotic cardiovascular diseases, which has been published in the American Journal of Cardiology.

The American periodontologists presented scientific evidence which convinced the cardiologists that they needed to alert their fellow colleagues that they were able to help reduce the risk of cardiovascular diseases in patients suffering from periodontitis.

An important relationship

Here I will make a few points on the interrelation between periodontal and cardiovascular diseases.

Dental plaque may become colonized by periodontal pathogens such as:
- Porphyromonas gingivalis;
- Campylobacter rectus;
- Fusobacterium nucleatum;
- Bacteroides forsythus;
- Prevotella intermedia, Actinobacillus actinomycetemcomitans, for example.

Bacteria and its products reaching the gingival tissue stimulate inflammatory response leading to infiltration of neutrophils, lymphocytes, macrophages and mast cells. Inflammation is a well-established determinant for cardiovascular and periodontal disease.

Dentomycin® Periodontal Gel 2% w/w
Minocycline (as hydrochloride)

Dentomycin abridged prescribing information.

Please refer to the Summary of Product Characteristics before using Dentomycin Periodontal Gel 2% w/w (minocycline hydrochloride).

Presentation: Light yellow coloured gel containing minocycline hydrochloride equivalent to minocycline 2% w/w. Each disposable applicator contains minocycline HCl equivalent to 5mg minocycline in each 0.1g of gel.

Uses: Moderate to severe chronic adult periodontitis used as an adjunctive treatment is particularly effective in breaking down biofilm and helping reduce the vicious circle of periodontal destruction*.

With its pre-filled applicator, Dentomycin is simply and painlessly applied, helping you make a rapid start on managing the condition and minimising its effect.

So you can, by taking early action, step up the fight against periodontal disease and significantly improve the effectiveness of the treatment.

For more information please call 020 7224 1457

Dentomycin

- Inhibits destructive collagenases
- Exerts a positive anti-inflammatory action
- Conditions the root surface
- Promotes connective tissue attachment
- Significantly reduces key periodontal pathogens
- Actively helps the healing process
- Is well tolerated and does not interact with alcohol

Information about adverse event reporting can be found at www.yellowcard.gov.uk

Adverse events should also be reported to Blackwell Supplies, Medcare House, Centurion Close, Gillingham Business Park, Gillingham, Kent ME8 0SB or by telephone: 01634 877525

Storage: 2°-8°C.

Presentation: Disposable applicator in an aluminium foil pouch. Each carton contains 5 pouches. Carton £90.00.

Product Licence Holder: Henry Schein UK Holdings Ltd, Medcare House, Centurion Close, Gillingham Business Park, Gillingham, Kent ME8 0SB. Telephone 020 7224 1457 Fax 020 7224 1694

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References:
(2) Stamm WJ et al (1999), J Infect Dis 179: 1116-1119
(2) Stamm WJ et al (1999), J Infect Dis 179: 1116-1119

How can you win a fight with an enemy that increases in number every day?

When that enemy is periodontitis, with bacteria reproducing at a frightening rate, you need a dependable ally that you can call on at the first sign of the disease. An ally such as Dentomycin Periodontal Gel.

Where pockets are 5mm or more, Dentomycin Perio-Gel, used as an adjunctive treatment is particularly effective in breaking down biofilm and helping reduce the vicious circle of periodontal destruction*.

With its pre-filled applicator, Dentomycin is simply and painlessly applied, helping you make a rapid start on managing the condition and minimising its effect.

So you can, by taking early action, step up the fight against periodontal disease and significantly improve the effectiveness of the treatment.

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Uses: Moderate to severe chronic adult periodontitis as an adjunct to scaling and root planing in pockets of 5mm depth or greater.

Dosage:
- Moderate to severe chronic adult periodontitis as an adjunct to scaling and root planing in pockets of at least 5mm depth. Each disposable application contains minocycline hydrochloride equivalent to 10mg minocycline in each 0.5g of gel.
- Adults – Following scaling and root planing to pockets of at least 5mm depth. Each disposable application contains minocycline hydrochloride equivalent to minocycline 2% w/w. Each disposable applicator contains minocycline HCl equivalent to 5mg minocycline in each 0.1g of gel.

Elevation
It's more likely a combination of factors than one single one that makes a person susceptible to periodontal disease. Fiona Clarke explains

Effective periodontal treatment in practice involves a series of stages; firstly understanding the aetiology and pathogenesis of the disease, early and accurate diagnosis, followed by effective treatment with due consideration of all the associated risk factors. This needs to be followed by timely reassessment and continued periodontal maintenance and monitoring.

When considering the aetiology of a complex disease like periodontitis, we need to consider both the direct cause and factors associated with cause. Within this, we can define two components; risk factors and susceptibility factors. A risk factor is defined as any environmental or behavioural characteristic of an individual that increases the probability of developing a disease. Risk factors such as smoking and poor oral hygiene are modifiable. In contrast, susceptibility factors (often called risk determinants) such as age, gender and genetic make-up cannot be modified.

It is now accepted that bacteria are essential, but insufficient for the development of periodontitis. A susceptible host is a prerequisite. Periodontitis is primarily driven by a bacterial challenge, but a complex interplay exists between the oral bacteria and host which is influenced by a range of risk factors.

Periodontitis is thus described today as a complex disease having a multifactorial aetiology and although bacteria are still believed to be the primary aetiologic agents in periodontitis, often the amount of plaque present does not fully explain the observed severity of the disease. Some patients experience severe periodontal breakdown despite low levels of plaque and conversely other patients have little destructive disease despite widespread build-up of plaque.

So if poor oral hygiene alone cannot account for severe destructive periodontal disease and everyone is not equally prone to the disease, the question then becomes what makes some individuals more susceptible than others. Risk factors which have been reported to be associated with increased susceptibility to periodontitis include the specific bacteria within the microflora, smoking, systemic disease, behavioural and psychosocial factors such as negative life events and stress (figure 1).

Much research has focused around trying to better understand the microbial aetiology of the disease. In the mid 20th century, it was believed that all bacterial species found in plaque were equally capable of causing disease and that periodontitis was the result of cumulative exposure to dental plaque.

This non-specific plaque hypothesis assumed it was the elaboration of noxious products by the entire plaque flora that resulted in destructive disease. Clinical trials have documented the importance of controlling the microbial plaque in the treatment of gingivitis and periodontitis. The association of specific bacterial species generally harmful to the host, but the host response to this attack may be protective or destructive. The varying balance between harmful and beneficial interactions of the host accounts for the wide variety of patterns of tissue changes in patients. It is believed that bacteria can however only account for about 20% of this variation in disease and current evidence indicates that most destruction of the periodontium is host mediated.

**Systemic disease**

Systemic disease can adversely affect host defence systems and therefore act as a risk factor for both gingivitis and periodontitis. Depressed neutrophil number and function (in neutropenia, Chediak-Higashi syndrome, Down’s syndrome and Papillon-Lefèvre syndrome) are associated with severe periodontitis. Diabetes mellitus is one of the strongest systemic risk factors for periodontitis and studies show that diabetic patients are at increased risk of periodontitis, in particular those with poor oral hygiene or poor diabetic control.

Smoke

A positive association between smoking and periodontal disease has been reported in both cross sectional and longitudinal studies. In the past few years increased attention has been paid to this relationship, and smoking is believed to be a significant factor in the development and progression of the disease. In studies in which plaque levels were adjusted between smokers and non-smokers, greater probing depths, clinical attachment loss and bone loss have been reported in smokers.

It has been found that there is reduced gingival inflammation and bleeding in patients who smoke. This may be explained by the fact that nicotine exerts local vasodilatation resulting in reduced blood flow, oedema and clinical signs of inflammation. Smokers are believed to be between two and six times more likely to have severe periodontitis than non-smokers. Several studies have demonstrated that the severity of periodontal disease appears to be related to the duration of tobacco use and amount of daily tobacco.
have a similar response to periodontal therapy as non-smokers. Thus smoking cessation advice and support should be as important in our management of patients as our improvement in the patient oral hygiene and we should acknowledge the important role we have in highlighting this issue to our patients.

**Psychosocial factors** There appears to be an association between periodontal disease and stress. Socially determined behaviours and responses to life circumstances are thought to affect the immune system and thereby health and periodontal disease. Psychosocial factors lead to changes in oral habits and in behavioral responses, such as poor oral hygiene and smoking, and the host’s response to environmental determinants such as stress. Studies suggest stress is a significant risk indicator for periodontal disease and that the impact of negative life events, number of negative life events and being unemployed are all significantly associated with periodontitis and should not be under estimated.

**Genetics** The view that genetic factors influence periodontal disease is not a recent one. In 1950, after reviewing the periodontal status of several families, Denny concluded that susceptibility to periodontal disease is probably heritable. The present theory of disease susceptibility is that it depends upon the presence of a critical number of one or more pathogenic bacteria in a susceptible host. Studies have shown that the number and type of bacteria required to exceed an individual’s critical disease threshold defines host susceptibility, and that this susceptibility is influenced by a number of factors, including genetics.

Initial attempts to define risk factors for periodontal disease have focused primarily on bacterial and immunological parameters while significantly less effort has been directed at defining host genetic factors. Studies on periodontal disease incidence in humans have shown that genetics do not explain population variance in the incidence of *P. gingivalis* or *P. intermedia*, two oral Gram-negative bacteria associated with periodontal disease. We also know that *P. gingivalis* has been demonstrated in many studies to be correlated with periodontitis yet not all individuals are equally prone to bone resorption when they are infected with this bacteria.

Thus, it has been suggested that genetic factors may have more influence on host response to infection than on bacterial colonisation. In order to better understand, classify and ultimately manage the disease it would be useful if we understood how genetic variation in host response could explain the differences which can be observed in disease progression.

We are now beginning to understand that it is more likely a combination of risk factors that predispose a patient to periodontitis and not a single factor and so consideration of all associated risk factors involved in a particular patient’s condition should be considered before treatment commences.

Dr Fiona Clarke graduated from WITS Dental School, South Africa and completed an MSc and PhD at Barts and The London School of Medicine and Dentistry with a special interest in genetic risk factors for periodontal disease. She’s currently working as a clinical perio tutor at Guy’s Hospital and in private practice. Teaching interests include periodontology, local anaesthesia and the use e-learning in dental education.
Keeping up appearances
Hygienist Leah Beckman looks at the long-term compliance and maintenance of dental implants

Today anyone can achieve permanent tooth replacement. Dental implants are the standard of care for patients presenting with lost or missing teeth. As dentistry moves forward in leaps and bounds, the dental care professional must provide the patient as well as other colleagues with the knowledge to be able to maintain these implants.

The most important factor is the regularity and frequency of homecare and the proper use of the appropriate hygiene aids. The patient must also be dedicated to excellent homecare and to maintain regular recare appointments with the dental hygienist at decided intervals usually every three months. At these recare visits, the dental hygienist must provide motivation for the long-term compliance and maintenance of the implants. Good dental health begins with superior dental hygiene.

Regular maintenance
A dental hygienist has the role of providing regular maintenance and professional care of dental implants. The area most prone to damage is the interdental papilla. This mainly results from the fact that it is an area that is difficult to access and keep plaque free.

First, assess the area with a periodontal screening. The interdental papilla around an implant should have the same characteristics as a papilla around a natural tooth. The tissue should be firm, pink in color and plaque free. There should be no swelling or bleeding. There should be no evidence of vertical bone loss upon radiographic examination and no mobility.

The dental hygienist must probe and scale the implant using only titanium or carbon fiber instruments. Metal curettes and probes can scratch the surface of the implant causing increased plaque retention. Today there are also many options for using ultrasonic tips with a Teflon coating such as the piezoelectric tip from NSK. This tip is autoclavable and fits into the piezo headpiece.

Patient education
The role the dental hygienist plays in patient education is of the utmost importance. Without proper patient education, the proper daily homecare cannot be achieved. The dental hygienist must provide the patient with tangible results at each professional prophylaxis appointment that will motivate the patient’s compliance at home.

Homecare starts with the appropriate hygiene aids and the instruction on how to use them correctly. The use of a sonic toothbrush is highly recommended.

Nothing replaces floss
An implant patient should always use special floss with a thicker foam coating. Again, instructing the patient on how to adapt the floss around the implant and under the gingiva main priority.

Ask the patient if they have ever been instructed on how to properly adapt floss and especially teach them how to clean the interproximal areas around the implant.

Keep the implants plaque free.
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Panoramic radiography changed the paradigm of diagnosis when introduced in the early 1960s. The limitations of two-dimensional radiography are:
1. Magnification,
2. Distortion,
3. Superimposition,

Due to this the use is and was limited.

Cone beam technology (CBCT) is a recent introduced technology in dentistry which succeeded to change and continues to change diagnosis, treatment indication and treatment approach – having as such a more comprehensive impact than the introduction of panoramic radiography. Of course on of the most impressive topic is the availability of software for 3D – reconstruction.

It is of great importance to mentione that CBCT provides data at lower cost and absorbed doses than conventional CT.
The author has resumed this article for the purpose of demonstration how CBCT aided tremendous value to routine dental practice.

1. Use of CBCT in endodontics

2. CBCT in periodontics

2.1 CBCT and soft tissue

In 2008 Januario et al published in the Journal of Esthetic Restorative Dentistry (J Esthet Restor Dent 20: 566-574, 2008) a paper called: ‘Soft Tissue Cone Beam Computed Tomography: A Novel Method for the Measurement of Gingival Tissue and the Dimensions of the Dentogingival Unit’. In this paper, the authors described a simple method to diagnose the thickness of the gingiva specially in the anterior aesthetic zone. The scans were performed with an iCAT (Imaging Science International, Inc., Hatfield, Pa, USA). The authors positioned the subject for the scan wearing a plastic lip retractor.

A 28-year-old female patient was referred to our practice for evaluation and treatment planning of the periodontal status. No special remarks regarding medical or dental history. The patient has undergone orthodontic over a couple of years.

The patient was referred for the completion of the diagnostic to take a CBCT at CTdent (2 Devonshire Place, W1G 6HJ, London, see also www.ct-dent.co.uk).

The CBCT confirmed the preliminary diagnosis.

A treatment plan has been elaborated.

2.2 CBCT and hard tissue

Vandenberghe and coworkers researched periodontal bone architecture using 2D CCD and 3D full-volume CBCT-based imaging modalities.

Their investigation concluded that CBCT offered a significant benefit over conventional radiography.

The authors concluded that CBCT can be used to diagnose the bony support as well as surrounding soft tissue and may reveal valuable informations for...
example regarding furcation involvement.

A 55-old human patient was referred to our practice for evaluation, treatment planning and execution. Of major concern was the first upper molars. After performing the routine diagnostic approaches such as BOP, periodontal probing, etc, the patient was referred to CTdent for a CBCT.

Summary

Information provided by this modern technology represents an invaluable milestone in diagnostic, treatment planning as well as evaluation of treatment outcomes especially for periodontal applications, especially in the areas of intrabony defects, dehiscence and fenestration defects, and periodontal cysts, and in the diagnosis of furcation-involved molars.

Conclusion

1. For periodontology, CBCT proves to be superior to 2D imaging for the visualisation of bone topography and lesion architecture as well as for the covering soft tissue.

2. For endodontics CBCT seems to be the most promising applications for diagnosis, treatment planning and treatment evaluation.

CBCT images and 3D reconstructions allow for visualisation and exact measurement of dimensions. Diagnosis built on the combination of clinics and CBCT are a reliable aid in planning and execution of simple as well as advanced dental procedures.

References are available on request.

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 a registered specialist in endodontics (GDC) and Spezialist fuer Prothetik (www.dgzpw.de).

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Panoramic view CBCT image showing the advanced bone resorption at the level of the first upper molars.

The CBCT confirms the class III furcation involvement.

The CBCT centre sent along as 3D reconstruction of the right side.

The CBCT centre sent along as 3D reconstruction of the left side.

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Protecting the root
Prof. Dr. Liviu Steier outlines how best to prevent gingival recession

Root surface exposure as a consequence of gingival recession is a challenge for the dental practitioner. Over the past decade, many procedures have been introduced and presented to prevent and/or treat this complex phenomenon. Most of the treatment approaches consist of mucogingival graft techniques.

Variation in gingival thickness (GTH) has been related to different periodontal ‘biotypes’ (Seibert & Lindhe 1989):
• Thick – flat biotype (quadratic teeth with a broad zone of keratinised tissue)
• Thin – scalloped biotype (slender teeth with a narrow zone of keratinised tissue)

Gingival thickness not only interferes with dental procedures but can advance if left untreated. Among the most common found clinical manifestations are:
• Tooth sensitivity.
• Long tooth appearance

Gingival biotype and natural teeth
As a consequence of this thin biotype, gingiva can recede during life. It is not often that clinical situations like the one below can be seen in practice. Treatment which does not address the primary disease was performed using adhesive filling material to reduce tooth sensitivity and mask esthetics. With time, restorations have to grow and an unpleasant image occurs.

Ericsson & Lindhe demonstrated in an experimental study (1984) performed on beagle dogs, that once metallic strips were inserted subgingivally, recession was more likely to appear in areas with thin gingiva architecture.

Gingival biotype and prosthetics
It is a widely accepted clinical impression that a thin, highly-scalloped gingiva tends to recede from source of irritation, for example, an artificial crown. Margin or microbial irritants (Seibert & Lindhe 1989), and gingival recession often occurs following traumatic, or surgical injury (Claffey & Shanley 1986).


Subgingival elements covered by a thick – gingival biotype assure a predictable esthetical outcome lowering the treatment risks.

Müller et al. (2007) demonstrated that subjects with a thin periodontal phenotype have also relatively thin palatal mucosa not very suitable for harvesting connective tissue grafts. As a consequence, the use of ‘acellular dermal matrix’ derived from donated human skin (AlloDerm – BioHorizons) may be the only treatment alternative in cases of thin gingival biotype.

Soft-tissue grafting
Soft-tissue grafting is performed for different reasons:
1. Changing of the natural gingival biotype by augmentation → a preventive approach.
2. Root coverage → a curative approach in ready installed disease.

Protecting the root

Clinical picture showing a ‘dark margin’ of a PFM crown in a thin gingiva biotype patient having multiple recessions.

Clinical picture demonstrating gingival recession around an implant.

Post-operative pictures

AlloDerm package

Swann Morton surgical blade used for the cervical incision

… placed in sterile saline bath for rehydration

… rehydrated and cut in strip

Tunnel periostome used to raise the flap

A clinical case of generalised gingival recession in a patient with thin gingiva biotype and high muscular insertion.

Picture demonstrating the ‘Treatment Algorithm for Gingival Recession’ (modification of the UCLA approach).

… placed in sterile saline bath for rehydration

… rehydrated and cut in strip

Tunnel periostome used to raise the flap
The Algorithm on page 21 should best exemplify diagnosis and adequate treatment.

Alloderm
Alloderm is an acellular dermal matrix derived from donated human skin. The donor material is deprived of the epidermis and immunogenic cells. It undergoes a final freeze drying and an extensive panel of serology tests and a sterilisation process.

One can say that the Allograft Tissue is transformed into a Regenerative Tissue Matrix consisting of a complex acellular heterogeneous scaffold, containing growth factors binding sites and blood vessel architecture.

It has been demonstrated that due to retained vascular channels the patient’s blood infiltration is facilitated and accelerated - revascularisation can start as early as one week after implantation.

Clinical case
A 29-year-old male was referred for the management and prevention of recession. The medical history was uncomplicated with no special recording in the dental history.

The clinical dental examination proved:
• Thin gingiva biotype
• Temperature sensitivity
• Gingival recessions with tendency to expansion
• There were no signs of inflammation or ulceration.

The initial management was conservative and consisted in cleaning and hygiene instruction. Follow-up a few weeks later showed a clear improvement in oral hygiene. The patient was explained treatment goals and different available treatment options.

The selected and agreed treatment plan was two-fold:
• First to thicken the gingiva using a graft technique (Alloderm)
• At a later stage for complete root coverage a ‘coronally repositioned flap’. Consent was obtained.

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Biologic Solutions
BioHorizons comprehensive Biologic product portfolio offers a wide range of evidence-based regeneration options to ensure ideal site development. Delivering optimal aesthetics and successful implant placement is the goal of our proven hard and soft tissue products.

• **AlloDerm®** - regenerative tissue matrix for use as an effective alternative to palatal tissue for soft tissue augmentation*

• **MinerOss™** - blend of mineralized allograft cancellous and cortical chips that provide an osteoconductive scaffold for bone regeneration

• **Mem-Lok™** - resorbable collagen membrane that is cell occlusive and slowly resorbing to promote clot maintenance and bone formation

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For more information, contact BioHorizons
Customer Care: 01344 752560
Email: infouk@biohorizons.com
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Step-by-step treatment

Preparing Alloderm for use:
The package is opened and the graft is dropped into a sterile saline bath, where it is kept for 30 minutes. The paper back is removed from the graft. It is important to identify the two sides of the graft. The basement of the membrane is rough and does not absorb blood, while the dermal side does.

Preparation of the recipient side
Adequate anesthesia is administered – usually infiltration will suffice.

The surface of the root is scaled and planed. Papillary incisions are made using a Swann Morton blade to a depth of 3-4 mm apically. The papilla is left intact to prevent flap retraction and improve blood supply to the graft during the healing phase.

To lift the tunnelled papillae, a microsurgical papilla elevator is used and a mucoperiosteal pouch (past the mucogingival junction) is created.

The Alloderm graft is cut to fit from the distal of the canine to the mesial of the molar. The graft is inserted into the pouch preparation under the intact papilla using the micro papilla elevator. The graft is then positioned with the connective tissue side facing the bone.

The margins of the graft are fixed to the tooth with Histoacryl glue. No suture needed.

The patient was instructed not to brush the area for six weeks, to start rinsing the mouth with saline solution for seven days. After seven days, disinfection was performed with oral rinse with CHX solution. The patient was seen for postsurgical check up after two days, seven days and six weeks.

After six weeks, a thorough cleaning was performed and the patient instructed to restart regular hygiene. Healing was re-evaluated after three months and the next treatment step scheduled.

Conclusion

Early diagnosis and preventive regenerative periodontal treatment can avoid long-term gingival recession. Patients with a thin gingiva biotype will also lack adequate connective tissue in the palate for transplant. The use of donated human tissue represents a viable alternative technique.

References are available on request.

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Leadership essentials for the ‘rookie’

By Sally McKenzie, CMC

U pon entering your first “real” dental practice either as an associate or as an owner, there is a lot of detail in hand and requisite experience on your resume, it’s likely that one thing became abundantly clear very early on: The learning process had only just begun. There is a whole lot more to a career in dentistry than most young dentists ever imagine.

Almost without warning, many are tossed into leadership roles seemingly overnight. And it’s that part of the job requirement that often leaves new dentists shaking their heads in bewilderment. Certainly, there is a lot to learn as a leader, but here are a few essentials to follow from day one as “The Boss.”

No. 1: Never assume

This is the common pitfall in leading employees: assuming that your staff knows what you want. Spell out your expectations and the employees’ responsibilities in black and white for every member of your team from the beginning. Do not convinces yourself that because they’ve worked in this dental practice for X number of years they know what you want them to do. There is a reason they are there, and they will simply keep performing their responsibilities according to what they think you want unless they are directed otherwise.

For example, your scheduling coordinator may be very experienced in scheduling according to how other dentists want their days shaped, whereas, in fact, be very different from how you want your days scheduled. Give good employees what they want clear direction, and it’s tremendously frustrating for everyone when staff are forced to guess at what you want. So speak up.

No. 2: Staff success = your success

Recognize the strengths and weaknesses among your team members because all employees bring both to their positions. The fact is that some people are much more suit for certain responsibilities and not others. Just because Brandy has been handling insurance and collections for the practice doesn’t mean she’s effective in those areas. Look at results. Brandy may be much more successful at scheduling and recall and would be better suited for those duties. Don’t be afraid to restructure job responsibilities to make the most of team strengths.

Invest in training early and often to build loyalty and ensure excellence.

No. 5: Give feedback often

Along with clear expectations, direction and guidance, employees crave feedback. Don’t be stingy. Give praise often and appraise performance regularly. Employees want to know where they stand and how they can improve. Verbal feedback can be given at any time, but it is most effective the moment the employee is engaging in the behavior that you either want to praise or correct.

Know the numbers

Certainly, it doesn’t take long for any new dentist to realize that just as important as your role as dentist is your role as CEO. It is critical that you understand completely the business side of your practice. There are 22 practice systems, and you should be well versed in each of them. If not, seek out training for new dentists. The effectiveness of the practice systems will directly and greatly impact your own success today and throughout your entire career.

Overhead. For starters, routinely monitor practice overhead. It should break down according to the following benchmarks to ensure that it is within the industry standard of 55 percent of collections.

- Dental supplies 5%
- Office supplies 2%
- Laboratory 10%
- Payroll 20%
- Equipment, insurance and benefits 35%
- Miscellaneous 10%

Salaries. Keep a particularly close eye on staff salaries. These can mushroom out of control and send overhead into the 70-80 percent range in record time. Payroll should be between 20-22 percent of gross income. Tack on 10 percent for payroll taxes and benefits. If your payroll costs are higher than that, here’s what may be happening:

• You have too many employees. More staff does not guarantee an improvement in efficiency or production. It does, however, guarantee an increase in overhead, unless you are hiring a patient coordinator or going in one hour every hour. You exceed your per hour production goal by 5%

This excess could be applied to any shortfall caused by smaller ticket procedures. Unfortunately, you are probably not doing crowns every hour on the hour. Use the formula below to determine the rate of hour production and whether you’re meeting your personal production objectives.

1) The assistant logs the amount of time it takes to perform specific procedures. If the procedure takes the dentist three appointments, she/he should record the time needed for all three appointments.

2) Record the total fee for the procedure.

3) Determine the procedure value per hour goal. Take the cost of the procedure — for example $25 — and divide it by the total time to perform the procedure, 5 minutes. The production per minute value is $4.50. Multiply that by 60 minutes to arrive at $258/hour.

4) The amount must equal or exceed the identified goal. Now you can identify tasks that can be delegated and opportunities for training that will maximize the assistant’s functions.

You also should be able to see more clearly how setup and tasks can be made more efficient. Thus, you’ll be well on your way to achieving your own production goals, whatever those may be.

In your practice, every system directly affects your success, as does every member of your team. Each is an extension of you. Your systems and your team will affect whether you have enough money to pay your bills. They will keep your schedule on track or off. They will tell you what you don’t want to hear when you don’t want to hear it. They will be a source of great joy and satisfaction, as well as anger and frustration. But no matter what, your success as a dentist is dependent upon your ability to lead your team effectively and manage your systems efficiently.

About the author

Sally McKenzie is CEO of McKenzie Management, which provides success-driven management solutions to dentists nationwide. She is also editor of The Dentist’s Networking Newsletter, the world’s first networking e-newsletter from www.champions-implants.com and The New Dentist™ magazine, www.thenewdentist.net. She can be reached at (877) 777-6151 or sallymck@mckenziegmt.com.
Setting yourself free
Simon Hocken shows how you can increase your success with a personal and professional vision

Everything that exists is created twice: once in the mind, then again in the outside world. In fact, nothing can be created without being envisioned first. Just as a mountain climber can hold in mind the image of standing on the peak, hands on hips, or an Olympic runner pictures himself crossing the finish line, the vision begins at the end of the adventure, when your goal has been realised.

Understand your goal
Once you know what you want to accomplish, you can then determine more effectively what has to be done on the way. The most innovative leading coaches in dentistry use this strategy to help principals and their teams reverse-engineer their success, because it facilitates the decision-making process: when you know where you want to be, the decisions you make along the way become so much easier. You simply ask yourself, whenever you reach a fork in the road: which path will take me closer to my goal? The difference a vision makes can be equated to the difference between meandering around a maze, or cruising along the highway.

When it comes to helping a client develop his or her own unique vision, the coach might ask, 'If we met in three years’ time, what would have to have happened, both personally and professionally, for you to be happy with your progress?'

Coaching is all about giving clients the skills, knowledge and confidence to realise their visions – to take the image out of their head, and into the world. With the right marketing structure, and robust, efficient working systems, increased profitability can be reliably achieved – even in the current financial climate. In fact, now is the time to up your game, rather than hunker down; the constructive forward-thinking you do now will put you in a stronger position when the market improves. Otherwise, you could simply find yourself with less of a business!

Make time work
By having the right team around you, you can free yourself up to focus on the treatments you are passionate about. Your coach will also help you make time work for you, not against you, reducing your clinical hours without reducing your profit. With the extra time available, you can monitor your team more effectively, appraise the performance of your business, and respond to new opportunities quickly. You don’t see the captain of the ship sitting with the crew, rowing; he’s the one with the telescope, scanning the horizon, or studying the treasure map, and giving orders.

This efficient use of time lets dentists enjoy a happier home life, with more holidays, more dinner with friends, more visits to the cinema...
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Practice Management

The 10th Dimension... the power of 10

Ed Bonner and Adrianne Morris discusses 10 ways to deal with anger

A
nger wells up within us whenever we perceive that we have been wronged, but how we deal with the situation will determine whether the problem escalates or is resolved. Here are 10 ways to resolve a toxic situation:

1. Take a deep breath... and wait
Breathing calms the body, and by reducing the physical signs of anger, calms the mind. When something has angered you, rather than erupting spontaneously, or sending off an angry letter or email, breathe deeply and then exhale – and the exhalation should be longer and more complete than the in-breath (say, in for seven seconds and out for 10). Repeat this several times. Wait until you are physically calm. Only then should you express yourself. If you cannot reach a state of calm, consider what benefit you are trying to get out of the situation, and take measured, considered action which does not include ranting or sending an invective-filled or vitriolic email or letter which can only inflame and worsen the already fraught state of affairs.

2. Don’t deny your anger, but consider the consequences
Anger should not be suppressed. Doing so and storing it only builds up to a more explosive eruption later. Rather use it and lose it. Anger can be used appropriately or inappropriately. It is appropriate when you use it to achieve a desired outcome. It is inappropriate when the anger uses you, takes over and brings about an unconsidered and unwanted outcome. Think about poor service on an airline: don’t explode at the hostess – ranting and raving will just annoy other passengers and may just get you barred from using that airline in future – rather call the senior purser and voice your complaint in a measured way and you are likely to be offered a better meal, an upgrade, or air-miles.

3. Eat properly... and drink sensibly
Healthy, but not excessive eating, drinking lots of water, enjoying tea, coffee and alcohol but not in excess are all sensible responses to irrational emotion or tiredness. They may also prevent and control stress headaches.

4. Recognise tiredness and stress
One of the most common places we recognise that we are tired and/or stressed is in a car. This is where most arguments between spouses or companions occur. The trigger may be not following the best route, heavy traffic or the poor control of another driver. The consequences of losing your temper may be an insufferable journey or, worse, an accident. You might injure someone, kill or be killed. Rather breathe deeply and wait. Above all, do not drive when tired. Tiredness and stress are equally damaging at work and at home. Rather than get embroiled in a major argument, say you are upset and walk away.

5. Control your environment
As anger specialist Mike Fisher says, ‘Anger thrives in a toxic environment, feeding on itself. If you manage to stay calm at work or in a car, other people will be less stressed and angry, which will in turn help you to control your own anger’. The dental practice environment – working on a tiny cavity on a small object in a small mouth in a small room – is fortunately not conducive to relaxation, but can be controlled by having good equipment, lighting and ventilation and improving the local ambiance.

6. Anger as a justified response to wrong-doing should be proportionate
There are times and situations when it is completely appropriate to be angry, but when for example, one goes into a rant because one your employees has spilled a bottle of varnish, this is disproportionate.

‘One of the most common places we recognise that we are tired and/or stressed is in a car.’

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- Programme memory control
- Micro Motor speed Limiter
- Scaler power control
- Water Bottle A
- Water Bottle B
- Spatula cup filler
- Spatula rinse
- Operating light switch
- Radiograph viewer
On the other hand, becoming apoplectic at the spillage of a bottle of mercury is by no means unjustified!

7. Focus on the issue rather than on the person
When we are angry it is easy to use terms like ‘you always get things wrong when you speak to patients’, but this tends to bring about a response like ‘no, I don’t always, just in this case, but you always say always!’ Focusing on the issue, like ‘Mrs Jones was upset – do you think you could have handled her in a different way?’ will produce a very different and less emotional response.

8. Get help
If one is in a persistently stressed and angry state to the detriment of one’s health, wellbeing, and relationships with others, it is eminently sensible to seek help from a doctor, therapist or coach. Help may come in the form of advice, medication or suggestion for lifestyle change, but someone else is far more likely to see the bigger picture.

9. Join a support group
Examples would be The British Association of Anger Management or Alcoholics Anonymous, or one’s church, mosque or synagogue. Joining a yoga or tai chi group often provides a nurturing community for dealing with lower-level stress.

10. Take responsibility
A problem may be caused by another person, but until you recognise that the greater problem of your excessive response to a negative situation rests within you rather than with others, you are unlikely to improve the situation. As soon as you start to blame others, focus on your own errors or misconceptions that have clouded the picture, and accept responsibility.

It’s in your mind and in your hands!

Adrianne Morris is a highly trained success coach whose aim is to get people from where they are now to where they want to be, in clear measured steps.

Ed Bonner has owned many practices, and now consults with and coaches dentists and their staff to achieve their potential.

If you would like to discuss anything about this article, or a free consultation, or to subscribe to The Power of 10 e-zine, feel free to contact Ed at bonneredwin@gmail.com or phone 077 666 01 558 or e-mail Adrianne (alplifecoach@yahoo.com)

Recommended reading: Beating Anger by Mike Fisher, director of The British Association of Anger Management.

Truly excellent customer service doesn’t happen by accident. It requires a system that dictates how every patient every hour of every day will be treated. And that system is absolutely vital to your practice.

Superior customer service requires a system

Your system for customer service must be one that can be repeated for every patient, every day. You should outline the steps that lead to exceptional customer service so that all employees know what you want to have happen for every patient, every single time.

So just how can you improve the customer service in your office? Here are six of the many recommendations from Levin Group’s Stage III Customer Service curriculum.

1) Give new patients clear instructions for getting to your office. This is easy to overlook. Some patients may become frustrated just getting to your office. Are you on a busy street or an unmarked side road? Will your patients have to pay for parking? If so, does your office validate? Give clear instructions and directions to patients when they call to avoid a negative reaction.

2) Do not make patients wait. When you fail to keep your appointment times with patients, you set the stage for their impression of your customer service — no matter what other positive experiences they had in your office. You ask that they arrive on time so make sure they can be seen on time!

3) Provide your staff members with clear job descriptions. Knowing exactly what is required of staff members will make them less stressed and friendlier to patients. Develop phone scripts so that your staff members are prepared when patients call. This will make for clearer, easier interaction with patients.

4) Be sure to greet patients warmly in the treatment area. Whether they are arriving for a hygiene visit, an evaluation or treatment, patients need to feel welcome. Something as simple as a smile or a handshake is a good beginning toward achieving this goal. Team training is the key, as I discuss in my GP Blog at www.levingroupgp.com.

5) Give patients something to help them remember your office. Pens, key chains, and notepads are just a few of the many mementos you can give your patients to keep your practice foremost in their minds. Giveaways like this don’t constitute great customer service — they merely reinforce it.

6) Think carefully about the specialists to whom you refer. If your patients have a bad customer service experience in a specialist’s office, then it will reflect poorly upon you. Make sure the specialists you work with have the same attitude toward customer service as you do.

Conclusion

Customer service goes far, far beyond simply being nice. It’s about making every interaction with every patient a pleasant experience. By consistently providing high levels of customer service, you are helping protect your greatest investment — your practice. Superior customer service isn’t a luxury. In today’s economy, it’s a necessity.

In this economy, customer service matters more than ever!

By Roger P. Levin, DDS

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Help where it's due?

Could the NHS do more for those who want the best available, yet essential treatment, but are unable to afford it? Neel Kothari finds out

Last week, an 18-year-old patient came in with severe facial trauma, an avulsed central incisor, as well as multiple fractures affecting his alveolar bone and incisor teeth, after falling of his bike at speed. Thankfully his patient still can't get an implant under the NHS. While the public may be led to believe that actual clinical decisions are based on clinically appropriate reasons many PCTs nationally regard the provision of dental implants as 'a low priority treatment' other than in the selected groups due to the availability of more cost-effective treatments.

Scope for treatment

After discussing his case with an oral surgeon and a specialist prosthodontist, it is clear his avulsed tooth is best replaced by a dental implant, so I decided to find out the scope for this treatment under the NHS. After searching through a range of online articles and NHS sources, the conditions under which implant services are available within the NHS are still unclear.

For patients with congenitally missing teeth, as well as head and neck pathology such as cancer, there does appear to be good scope for having dental implants, but if a patient suffers from trauma it is still very unclear as to whether the patient is eligible to get dental implants on the NHS. I decided to contact my local maxilla-facial department to find out more.

In my opinion, this patient would be an excellent candidate for dental implants, so why should he have to pay for this privately if he is eligible for treatment at no cost to him under the NHS? Discussing the case with various clinicians it was clear that they were not the ones deciding on who would and would not provide implants for. Each case has to be approved from senior administrators, which leads me to question how they judge suitability. Of course money matters and the NHS must provide a cost-effective solution, but how exactly do senior managers decide the benefits in terms of quality of life for individual patients needing dental implants?

Unreasonable expectations

Personally, I’m still not absolutely convinced that the NHS should provide dental implants, as I’m sure PCTs do have other areas of high priority, but asking a teenager to pay the full whack for a private implant retained crown (which is clearly the best option for him) is far too much to expect from an average 18-year-old. Surely here the government cannot claim that this would be a private option for ‘cosmetic improvement’ and if the patient does proceed with dental implants, does this not return us to a time where healthcare renews its links with the NHS, the NHS still lives on, even if the public are forced to contribute a wider range of cancer medication as opposed to what the NHS chooses to fund.

How funding is distributed

In my recent interview with Chief Dental Officer Barry Cockcroft, I asked him about how the NHS funds dental implants. Cockcroft replied: ‘We fund it where it’s clinically appropriate in the secondary sector, but at the moment it’s not part of primary care.’

Coughing up

My patient’s mother will probably pay privately for her son. She has enquired whether the NHS could pay for part of their treatment and she could top up the rest. But I have explained to her that she may not have scope for that at present. Whether patients will ever have scope under the NHS to have complex treatments such as implants under the NHS in a part-payment system is yet to be known, but the precedent has been set with drugs used in the treatment of cancer (March 2009). Although this has come under public criticism for introducing a two-tier system within the NHS, the NHS still lives on. We are still left with the question: does the NHS have scope for more cost-effective treatments?

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About the author

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 prostodontics 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 with the changes brought about through the introduction of the new NHS system. Like many other dentists, he has been critical of the future holds within the NHS and as a result he has appreciated some of the difficulties in providing dental healthcare within this widely critised system.
Infection control guidance

HTM 01-05 guidance requires that every practice should be capable of meeting the essential quality requirements. Dental Tribune rounds up some important points.

Health Technical Memorandum 01-05 is intended to progressively raise the quality of decontamination work in primary care dental services by covering the decontamination of reusable instruments within dental facilities.

Patients deserve to be treated in a safe and clean environment with consistent standards of care every time they receive treatment. It is essential that the risk of person-to-person transmission of infections be minimised as much as possible.

Here are some ways this can be done.

Essential quality requirements

• Regardless of the technology used, the cleaned instruments, prior to sterilisation, should be free of visible contaminants when inspected. Instruments should be reprocessed using a validated decontamination cycle including cleaning/washing; a validated steam steriliser, and at the end of the reprocessing cycle they should be in a sterilised state.

• Reprocessed dental instruments should be stored in such a way as to ensure restraint of microbiological recolonisation. These measures should be backed by careful controls on the storage times to which instruments that are less frequently used are subject.

• Practices should audit their decontamination processes quarterly using an audit tool (the use of the Infection Prevention Society/DH audit tool that accompanies this document is strongly recommended).

• Practices should have in place a detailed plan on how the provision of decontamination services will move towards best practice.

Best practice

To demonstrate best practice, further improvements are required in three main areas:

• A cleaning process that should be carried out using a validated automated washer-disinfector. The environment in which decontamination is carried out should be such as to minimise the risk of recontamination of instruments and the possibility of generating aerosols, which may reach patients or unprotected staff. For best practice, the decontamination facilities should be clearly separate from the clinical treatment area. This implies the use of a separate room or rooms for the accommodation of clean (output) and dirty (input) work. In these facilities, the room(s) should be used for this purpose only and access should be restricted to those staff performing decontamination duties. However, plant and equipment not necessarily used for decontamination may be located in these rooms (but preferably in the dirty room) provided it can reasonably be shown that the devices do not conflict with the requirement for a clean environment.

• The storage of reprocessed dental instruments in a simple but carefully designed facility clearly separate from the clinical treatment area is an important best practice improvement. The facility should take account of the need to reduce recolonisation of sterilised instruments and also make the identification/selection of instruments easy. This storage facility will ordinarily be part of the clean area within the decontamination room(s).

For a full report on the guidance, visit the Department of Health website at www.dh.gov.uk.

Postgraduate Dental Education

New Course

MSc in Endodontics

Endodontic treatment is one of the most technically demanding procedures in general dental practice. Growing demand from patients for teeth to be saved rather than extracted has presented a need for further training in this area. The Postgraduate Dental Education Unit (PGDEU) at Warwick Medical School has developed a new MSc in Endodontics to deliver comprehensive and flexible endodontic education.

The MSc in Endodontics has been designed to develop your knowledge and confidence in this complex discipline, enabling you to deliver a high quality service. As a part-time course spread over 3-5 years, it offers you the flexibility to continue working in clinical practice while studying. You will study a wide range of topics from sterilisation and disinfection procedures to tissue regeneration and preventing cross infections.

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Contact Anne Duhig-Reader for further information, quoting reference code: C0908F3

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The PGDEU also offers: MSc Orthodontics, MSc Lingual Orthodontics, MSc Implant Dentistry and a range of short courses.
Safer Handpieces from Bien-Air

To help prevent the risk of cross-infection the Bien-Air Unifix quick-connect couplings are supplied with a non-return valve, designed to prevent infection through the exhaust line. Bien-Air turbines already have a non-return valve incorporated into the water line in the handle of the instrument, but this additional valve provides even more ‘security’.

The Bien-Air range of instruments are designed with safety as a major requirement. All instruments are autoclavable and/or can be cleaned and disinfected to the highest criteria.

SPRAYNET 500 is perfect for cleaning and disinfecting all surfaces and hoses. The surfaces and grip of the handpieces are easily cleaned; screws are concealed to avoid possible areas where debris and germs can accumulate; cleanliness has always been a feature of Switzerland and this has become integral with the design of instruments all of which are manufactured to European Standards. Bien-Air is confident that they provide the highest standards of safety.

For further information please contact Bien-Air on 01506 711 505 or visit www.bienair.com

Tough Infection Control with The Dental Directory

With the release of the updated HTM 01-05 government guidelines and the outbreak of the Swine Flu H1N1 Virus, never before has eliminating the risk of cross infection been so at the forefront of your mind and so paramount for your dental practice.

Topdental also manufacture a range of infection control chemicals, which cover all requirements in a typical dental surgery environment. Items such as surface wipes through to water line treatments are available at competitive prices.

As well as being able to place your order from the comprehensive catalogue, you can also order online at www.topdental.org, you will receive a 5% discount on all on-line orders.

The catalogue also includes over 100 new products including uniforms. Topdental are now the dental distributors for leading uniform manufacturer Simon Jersey.

If you would like to receive a FREE copy of the catalogue and regular offer sheets please telephone: 0800 152 575

ChairSafe - alcohol and alcohol free foam for quick disinfection and cleaning of surfaces

ChairSafe is the new disinfectant foam cleaner from the Kemdent range of cross infection control products. ChairSafe foam is specially formulated to clean sensitive surfaces and equipment, including the leather and synthetic facings of dental chairs. As soon as you try it you will recognise the real benefit of this product.

ChairSafe is an aerosol and alcohol free foam that is suitable, not only for alcohol sensitive materials such as leather, acrylic glass and vinyl but also hard surfaces, inventory and medical products. It is effective against HBV/HIV/HCV/BVDV/vaccinia, bactericidal and fungicidal microorganisms within one minute of application.

Kemdent customers require high quality, value for money products. This foam provides all dental professionals and their patients with the highest possible level of protection. Because its non-drip, it is also economical to use.

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BioSonic UC125

Proven Coltene/Whaledent quality with additional customized operation!

Cross Contamination procedures are an extremely important aspect of the dental surgery so Coltene Whaledent is pleased to launch the new BioSonic Ultrasonic Cleaning Unit 125 which delivers a variety of customized options. The cleaning time cycle can be selected individually, a countdown timer is available to inform the user with the amount of cleaning time remaining, and indicate exactly when the instruments will be ready for sterilisation. The new unit is equipped with a solution tracking function to inform the user how long the solution has been in use, so that mandatory changing of the cleaning solution will not be forgotten. With a simple touch of a button, gassing of the solution, i.e. air
entrapments which hinder the cleaning process, will disappear. A comprehensive range of accessories and solutions in the range of Prima Dental Group are designed to promote easy cleaning. A wide range of Prima Dental Group products are available in single-use, high-quality packaging and can be easily stored in dental practices. Please contact Kerr on 01733 293454 for further information.

Kerr’s Solutions for Infection Control

Have you ever had to deal with staff shortage and busy days, high-risk patients or autoclave breakdown? The new Sterile Oral Health Examination Kit from Kerr is here to help. This pre-sterilised examination kit is also perfect for domiciliary visits.

This small sterile package contains a tray with disposable instruments including a stainless-steel explorer probe, tweezers and mirror. Also included are a patient bib, a napkin, 2 cotton wool rolls and 2 latex-free ‘ear loop’ masks. The sterile examination kits stack neatly for easy storage and are available in compact boxes of 50.

The kit was developed in 1997 by a maxillofacial surgeon who recognised the need for dentists to offer every patient a routine examination using a complete sterile kit. First introduced into dental practices in China the sales have grown to date in excess of 7 million kits per year. Users of this product already claim savings in auto-claving costs making it one of the most cost-effective products that you can buy today.

For further information please contact Kerr on 01755 892292.

Pre-sterilised Burs from Prima Dental Group

With increasing emphasis being placed on infection control within the surgery environment, and in view of the recent well publicised reports regarding the use of dental instruments, Prima Dental Group are proud to offer you the Sterisafe range.

At last a full range of burs are available in pre-sterilised packaging only from Prima. Whether you are looking for diamond, tungsten carbide or steel rotary instruments Prima are able to supply the full complement.

Infection control in safe hands with Prestige Medical

As a leading manufacturer of decontamination equipment, Prestige Medical say that they have made it their business to understand the requirements of HTM 01-05 and are now in a position of being able to provide dental practices with a ‘one stop shop’ for integrated decontamination solutions.

Briefly, the essential requirements (to be in place by January 2010) state that:

1. Effective decontamination, infection control and health and safety policies and procedures should be in place
2. Decontamination equipment should be fit for purpose and validated
3. Chart loggers or printers are required to enable independent monitoring of the equipment
4. Decontamination procedures should be separated from clinical procedures by using either a designated room or a designated area within the surgery with a dirty to clean workflow
5. A log must be kept for each cycle of the equipment used in the decontamination process
6. Practices are encouraged to plan to introduce washer disinfectors which will also improve the cleaning and disinfection of hand pieces.

More information is available from Prestige Medical direct by calling 01254 844 105 or email sales@prestigemedical.co.uk.

Decontamination and Debris Removal for Your Dental Instruments from Dental Sky

Dento-viractis 55 is a versatile combined pre-sterilisation detergent that disinfects whilst cleaning instruments. Dento-viractis has been designed specifically to remove debris from hand instruments and surgical equipment prior to sterilisation. It is particularly useful in the removal of blood and pus. It quickly dissolves proteins due to its enzymatic action. This bactericidal, fungicidal and virucidal product is available exclusively from Dental Sky in either a 2kg or 5kg bucket or 50 unidoses of 15g each. Dento-viractis 55 dissolves quickly and easily saving time and effort.

Competitively priced Dento-viractis 55 is a highly efficient concentrate solution for cleaning and pre-disinfecting dental instruments that is ideal for use in your ultrasonic bath. This grapefruit smelling product speeds up the process of debris removal and is also bactericidal, fungicidal and virucidal.

Dental Sky exclusively supply a complete range of Dento-viractis disinfecting products developed specifically to meet the demands of modern day practice.

For further information or to request you FREE catalogue please contact Dental Sky on 0800 294 4700.

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IPS Empress Direct offers high stability, shade fidelity and excellent modelling and polishing properties. The material’s handling is also exceptional: As the natural dentin is simply replaced by Dentin material and the enamel by Enamel Material, there is no need for a “recipe”. Even the physical properties meet the highest demands, such as an optimum radiopacity and a low sensitivity to light. As a result of the low light sensitivity, enough time is available to design the restorations without pressure.

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For nearly 20 years, IPS Empress has been synonymous with all-ceramics and high aesthetic properties for the reconstruction of dental defects. With the introduction of IPS Empress Direct, the aesthetics of the ceramic are now combined with the convenience of a composite.

IPS Empress Direct is available both in syringes and in Cav-filts.

For more information please call Mark Chapman on 07734 044872, or your normal Dealer.

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NEW Velopex Intra-x

The new x-ray processor for all sizes of intra-oral x-ray film will be arriving over the summer.

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- Simple to position – its compact design means that it can be sighted almost anywhere in the surgery, sterilisation room or office.
- Simple to maintain – making it very user friendly.

The unique film transport system has been designed by our engineers to make ‘lost’ films a thing of the past.

The new Intra-x has a ‘super fast’ facility for rapid processing of endodontic films. This means that a ‘jet’ film is available for viewing in just 2 minutes!
No-Rust Cleaning solution – New Omnisan Forte from PANADENT

Ideal for cleaning and storing all dental equipment, the new Omnisan Forte cleaning solution with benzenthionium kills 99.9% of microorganisms with 50 seconds (undiluted) and 5 minutes at 1:2 dilution (British Standard tests). More concentrated than most leading brands and with up to 10 days lasting action, Omnisan Forte represents outstanding value for money as an every day cleaning solution in the surgery. RRp: £19.50 plus VAT and carriage

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Monobond Plus – one primer for all materials
With Monobond Plus, Ivoclar Vivadent is pleased to announce the launch of a universal primer that helps establish a reliable bond to all restorative materials.

Monobond Plus meets a requirement that is essential for dental professionals: ease of use. The innovative combination of three different functional groups – silane methacrylate, phosphoric acid methacrylate and sulfide methacrylate – enables a strong and durable bond to be established to any restorative material.

Therefore, there is no need to purchase and store different primers for different materials. Uniform reaction time, easy storage
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The children of Musoma

Keval Ashok Shah goes on a life-changing journey to help make a difference in Musoma, Tanzania

After months of anticipation, Tanzania came into view. What better way to define this than with the snow peak of Kilimanjaro, glistening in the moonlight. It was enough to wake us up after the exhausting 14-hour journey from London Heathrow, as we drove along a pitch-black road to an inn in Moshi, where we were going to spend the first night. Nothing prepares you for its beauty, and one can only gawk in wonder at its immense size. The team staring out of the windows were Dr Manny Vasant, Mrs Meena Vasant, Dr Kishor Vasant, Dr Auriel Gibson, Hudson Cook (a builder by trade), Fleur (a dental practice manager) and myself.

On the road

The next day, we visited the town of Moshi, which is situated 70km east of Arusha. What struck me immediately, was the pace... how laidback everything was, compared to London. No one seemed to be in a hurry, and I put it down to the blazing midday sun. After buying much-needed bananas, chocolates and water, we visited Marangu Falls, in the foothills of Kilimanjaro. We stood for a while and took in the sights of the 60-foot cascade dropping into a plunge pool, which led away as a rivulet through a dense jungle that seemed to stretch for miles.

The next we made our way back to the airport to fly to Mwanza, the southern port of Lake Victoria. Looking out of the plane, it was easy to see the devastating impact of human activity on the environment. Hundreds of hectares of forests had been cleared to make way for grazing and farming, evident by myriads of white lanes in the barren land. But that was what it was – barren. I don't know if it was due to lack of rainfall, or overuse... it just seemed like a huge waste, land that could no longer be used by people or animals.

Upon landing, we visited the Hindu Union Hospital, where I witnessed a small portion of the enormous contribution Manny had made to the healthcare in Tanzania. The dental clinic he donated was well up and running, except for a handpiece, that he quickly made a note to fix.

A few more bottles of water, and we began on the three-hour journey to Musoma, with the Serengeti rushing past us on the right as we touched its heart. As darkness fell, the clouds gathered over the heart of the Serengeti, and gave birth to lightning. I could just imagine the horror in the eyes of a wildebeest, as the bolt illuminated a crouching lion with only one thing on its mind.

Arriving at Musoma

Dreams aside, we reached Musoma, to be warmly welcomed by Denis Mahina, Andy Vanzandt, Lizzie Cameron and her parents. Denis, a small man with a big heart, started the Lake Victoria Disability Centre (LVDC), with nothing more than his savings and determination, to improve access to social, economic and educational opportunities for disabled youths in the Mara region of Tanzania. Many articles are constructed by the trainees and assistants (for example, desks, bicycles for the disabled) and sold to help fund the project. The project is otherwise funded by donation and has charitable status. The absence of regular funding is a continual problem.

Andy Vanzandt, a 22-year-old qualified carpenter/joiner from Suffolk, is spending three months in Musoma to teach his skills at the LVDC, and help with its renovation.

Lizzie, a 26-year-old graphic designer from Edinburgh, Scotland, found out about the project, and joined him, to work with the local disabled children and teenagers. She has been living in Musoma for a year now, except for one month this summer, when she returned home to get a job to fund her work and living expenses in Tanzania.

A vibrant and beautiful town, Musoma is situated on the shores of Lake Victoria. Manny and Kishor grew up here, which explains their deep love for the place and its people. Sadly, ever since the 1970s, the town has suffered economic decline. The isolated rural majority across Mara continue to suffer from abject poverty due to an absence of employment opportunities, ill health caused by malnutrition, and shortage of schools and affordable health centres.

Back to school

We planned to work in Musoma for four days, and Lizzie organised our schedule to see and treat the children from the Mwensene Blind School, the Mwensene Deaf and Intellectually-impaired School, and the youth from the LVDC. One in ten people in Tanzania are disabled – 3.5 million people suffer from a visual impairment. This statistic is high because of causes such as catching malaria or meningitis as a baby, unprofessional administration of herbal medicine, mis-

‘What struck me immediately, was the pace... how laidback everything was, compared to London. No one seemed to be in a hurry, and I put it down to the blazing midday sun.’
Blind School

DENTAL TRIBUNE

Inside the clinic

The surgery itself needed a lot of organisation. This was probably the first time that the challenges of health care in the developing world, hit home. Everything that I took for granted working in my cosy clinic in Northampton, had to be arranged – the different types of equipment, nursing staff, the administration, ensuring infection control, and making sure we did not get in each other’s way working in a small room. But Auriel’s determination and Manny’s cool exterior drove me on. At the end of the day, we were exhausted, but very happy that we could slightly improve the lives of these children.

While the first day’s challenge was verbally communicating reassurance to the kids who could not see, the next day’s hurdle was to successfully gesture to those who could not hear. The teachers at the Mwiweseen Defri Blind School taught us basic sign language, but I realised that if you looked into the child’s eyes with an honest willingness to help him/her, that child put all their trust in you. A gentle reassuring hand on the shoulder was enough to put them at ease. The most challenging were the mental handicapped kids, but the headmaster’s kind words and reassurance enabled their compliance. Children who thought had a systemic illness or condition, were referred onto Dr Kishor Vazani and facilitated further treatment.

Whenever school went wrong, we were welcomed wholeheartedly.

Prevention better than the cure

The unseen killers in this part of Africa are malaria and HIV.

The view over the Serengeti

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‘All the little kids rushed to shake our hands or give us a hug…and their smiles got imprinted in my head forever.’

The unseen killers in this part of Africa are malaria and HIV.

The way forward

Denis is planning to arrange an outreach programme to target people in the rural parts of Africa, to get people aware of AIDS and its effects, and to teach abilities and how to prevent them. To raise funds, he is thinking of opening a pizza takeaway service…the first in Musoma. He continues to support his family and build a home to other children who need one. He is the driving force behind the LVDC, and an inspiration to all who know him.

Lizzie has become an angel for the kids in Musoma, a constant provider of joy for them. She continues her work with the local disabled children and teenagers, teaching and caring for them, and always thinking of ways to improve their lives. Sandra aids in her daughter’s work, and manages health care for the children. Gilbert, Lizzie’s dad, a teacher by profession, is in the process of helping in the renovation of his house, and building Dennis’s new home.

Manny and Auriel have put their efforts into creating a medical and dental training centre, adjacent to LVDC. This would aim to train local persons to become adept at recognising disease, and act alongside a trained and experienced dentist. The knowledge and expertise of dentists from the UK would be greatly welcomed in addition to final year dental students from the UK to visit and carry out outreach projects and other research activities within an ‘elective’ framework. In addition to this, Manny is trying to raise money to improve LVDC itself. Donations will allow the construction of dormitories for disabled students from other areas, employment of more staff to teach the necessary communication skills, construction of classrooms, and development of a health outreach programme for the Lake Victoria region.

Upon returning to the UK, Andy Vanzandt plans to continue being involved in projects aimed at reducing world poverty.

‘A better place’

This has been a true example of the power of the individual to make the world a better place; an illustration of a deeper approach to the reduction of poverty through improvement of health care; a case of not following like sheep, doing your own thinking, and taking a initiatives to help others, a shift from the ‘me me me’ psychology to caring more about others who need help.

This trip has strengthened my purpose in life – reduce poverty and conserve what is left of nature. The two can not be separated; if one worsens, so does the other, and vice versa. It has never been enough to just sit back and wait for governments and organisations to make a move. Mahatma Gandhi said: ‘We must become the change we want to see in the world.’

Overpopulation is a basic issue that needs to come first on the agenda of every charity in existence. It cannot be ignored. All our efforts are cancelled out if we cannot control the growth of the human population. No one likes a crowded train or having to fight for jobs…at the rate at which we are going, we will soon have to fight for food and water, a phenomenon already facing millions living in poverty.

It will take all of us to make a real and significant change in this world. And how we live here, affects everything and everyone around us. The fundamental problem is the ‘me, me, me’ psychology and the ‘I want more’ lifestyle.

‘The view over the Serengeti’

The view over the Serengeti

The view over the Serengeti

Survival of the fittest can be allowed in the Serengeti…not in London, New York and Dubai! We have evolved beyond searching for food and shelter in the wilderness. We have evolved beyond…and ignoring the needs of others. As poorer countries develop to give their people basic healthcare, education and nutrition, more resources will be consumed and the environment will have to pay dearly for this. We must change our lifestyle to accommodate this.

It is time to give more, take less and evolve further. It is time to become the change we want to see in the world.

About the author

Keval Ashok Shah

is a community dentist, working in Northampton. He gives special thanks to Lain Scott, and his books ‘The Infections’ and ‘Actions speak louder than words.’ He believes that time is the essence and that we need to act now to make a difference. You can email him on keval.archery@hotmail.co.uk or text/call him on 07826 972189.
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