**White Paper reshapes NHS**

PCTs and SHAs scrapped as GPs take over healthcare; dentistry reverts to centralised control by NHS Commissioning Board

The Coalition Government has set out its reforms for the NHS in a White Paper entitled Equity and Excellence: Liberating the NHS.

In a radical shakeup of the way the NHS is currently run, the White Paper proposes that most of the mainstream health-care services currently looked after by Primary Care Trusts will become the responsibility of GP Consortia, who will assess and commission services.

Dentistry will not fall under this remit however, as there will be an independent NHS Commissioning Board who will be responsible for services such as pharmacy and ophthalmology as well as dentistry. The will see a return to centralised control for dental services, as PCTs and SHAs will fall by the wayside in the proposed reforms.

**Consistency**

Commenting on the proposals, Health Minister, Lord Howe said: “The White Paper proposes that a new NHS Commissioning Board should take over from PCTs the responsibility for commissioning dentistry in order to improve the quality of care for patients and consistency of commissioning.

“The transition to the new system will require careful management at every stage. This will be a challenge, but I have every confidence in the NHS’s ability to manage this successfully.”

“We recently published a consultation seeking views on commissioning for patients and the implementation of the NHS Commissioning Board and now we want to hear the views of healthcare professionals on how the new system should work.”

**The Way Forward**

The White Paper also reiterates the Coalition Government’s commitment to introduce a new dentist contract following consultation and trials. This will be designed in the context of the new commissioning arrangements. I am having ongoing meetings with key representatives of the profession to discuss the way forward.”

“We look forward to more detailed proposals on how the government intends to implement these changes.”

**Impact**

Peter Bateman, chair of the British Dental Association’s Salaries and Benefits Committee, commented on the potential impact of the White Paper for salaried dental services.

He said: “It is essential that special care dentistry and other salaried dental services are included in same dental commissioning arrangements as for general practice otherwise there is a risk that the budget for community services could be lost to dentistry.”
Guidance is ‘confusing’ – Dental Protection

The new local anaesthetic guidance for hygienists and therapists has been criticised as ‘confusing’.

Dental Protection claims that the recent order to amend the Medicines Act 1968 has failed to create a situation that is universally applicable to dental hygienists and therapists (DCPs).

It said that instead it has had the effect of ‘distinguishing between the method of payment applicable to the treatment when it comes to deciding how local anaesthetic and high-content fluoride products (the ‘items’) should be delivered to a patient during their course of treatment’.

The patient group directive was primarily designed for use in NHS settings and the Department of Health now advises that they are not valid for treatment that is provided privately.

Apart from being confusing to the clinical team involved, the situation seems somewhat ‘illogical’, said Dental Protection.

A spokesman for Dental Protection said: “It also flies in the face of DHs long-held view that there should be no negative comparison drawn between NHS treatment and private treatment.”

New guidelines for dental implants

New guidelines for the provision of dental implants and the care of dental implant patients have been drawn up by the Academy of Osseointegration.

Dr Michael Norton (pictured) who runs the Norton Implants surgery in Harley Street in London, was asked by the Academy to form a task force to review their 2008 guidelines.

The new guidelines have been published in the International Journal of Oral and Maxillofacial Implants.

Dr Norton, who runs the Norton Implants surgery in Harley Street in London, said: “The need to represent all the specialities as well as the general dental practitioner was foremost in my mind. To this end I set out to establish a task force with representation from the three main mono-specialities as well as the general dental arena.”

While the document is based largely on the recommendations established by the specialist boards based in the United States, Dr Norton did his utmost to ensure that UK and European guidelines were equally well represented.

The document includes recommendations made by the European Association of Dental Practitioners and The Royal College of Surgeons (Edinburgh). The Faculty of General Dental Practitioners and The European Association of Dental Implantology.

Dentist comes fifth in beauty pageant

A young dentist has come fifth in the Miss Professional beauty pageant.

Jennifer Bate (pictured), who is sponsored by dental products company, Schottlander, has also just been awarded her Diploma of Membership of the Joint Dental Faculty of the Royal College of Surgeons (MIDF) certification.

The 24-year-old, who works at University Hospital in Coventry, has already won the title Miss Charity after raising funds for the Variety Club and Bridge2Aid.

Ms Bate said: “I am passionate about what I do. It is so rewarding to do this work, to be able to free people from pain, and give them a wonderful smile.”
15m steps for cancer charity

Mouth cancer charity the Mouth Cancer Foundation is challenging 1,000 dentists to walk 15 million steps between them to help combat mouth cancer.

Places are filling up fast for the Mouth Cancer Foundation that takes place on Saturday 18th September 2010, in Kensington Gardens, London. In 2009 in excess of £60k was raised which goes to help patients and their families, like mouth cancer survivor Michelle Morton.

Michelle, 26 from Hastings, East Sussex was only 22 when she was diagnosed with Nasopharyngeal Carcinoma in June 2006.

Michelle says: “I had a large tumour that came from the Nasopharynx, down my left nostril. I was treated by my GP for six months for what was thought to be a sinus infection. I was eventually referred to ENT at the local hospital and diagnosed. By this point the cancer had also spread to a lymph gland in my neck. I went through six cycles of high dose chemotherapy (Cisplatin & 5FU), followed by six and a half weeks of Radiotherapy.

“During treatment I dropped to 6stone 10lb and I vomited every day for about three months! The cure is far harder than the disease! I’m feeling REALLY good now. I’m working full time again and I love my life! As far as they’re concerned I’m cancer free”.

“I support the Mouth Cancer Foundation as they helped me so much during my battle with cancer. I want to make younger people more aware of the symptoms and risk factors of Mouth Cancer. It happened to me and it can happen to anyone. We aren’t indestructible!”

Well, Dental Tribune is heading off for its holidays as the hot days keep coming and the kids get off school. But never fear, we will be busy working behind the scenes to bring you all the in-depth news and views as we interview people such as Earl Howe, Minister for dentistry. We also have great features in store for the Autumn including a look at a new mouthguard technology and a chat with a laboratory owner about the future of dental labs and the importance of communication between labs and clinicians.

See you in September...

SEPTEMBER IS...

The entire dental team can get involved in the 2010 campaign focusing on ‘Discover 3 Essentials for an Even Healthier Mouth’.

Practice packs contain educational materials, motivational stickers, patient samples and materials to enable dental teams to create their own display to drive awareness of the 3 Essentials for an Even Healthier Mouth.

The 2010 interactive CPD programme ‘Putting Prevention into Practice’ providing verifiable CPD will be available to download by visiting www.colgateohm.co.uk from 1st September 2010.

If your practice has not previously been involved in Colgate Oral Health Month, please call 0161 665 5881 to register by 20th August 2010.
New regulations for Scottish NHS dentists

New regulations have come into force for NHS dentists in Scotland.

The 2010 regulations consolidate the 1996 regulations and various amending legislation introduced over the years.

It also extends the dental list system to include, for the first time, Dental Corporate Bodies and those working as assistants in general dental practice.

Traditionally, dental lists only included dentists working as ‘principals’ in general practice, whether as practice owners or associates.

All dentists working for Dental Corporate Bodies will be under a duty to join dental lists but inclusion will be voluntary for the Dental Corporate Bodies themselves.

Hugh Harvie, head of dental services (Scotland) for Dental Protection, said: “The 2010 regulations provide a welcome update to the law governing the provision of general dental services in Scotland and are intended to increase the protection of patients and NHS resources alike.

“As a caring profession, the dental profession in Scotland can only welcome any measures intended to protect patients. They widen the existing differences in the arrangements for NHS dentistry north and south of the border, and address some areas of concern in England and Wales.”

“Members in Scotland can be assured of Dental Protection’s continued support to any difficulties in understanding and issues arising from the implementation of the 2010 regulations.”

The 2010 regulations also give the Health Board power to suspend a dentist or body corporate from the dental list in a limited range of circumstances.

Delegates get Rapid Relief at Barcelona IADR event

The IADR in Barcelona was the place to be to find out more about the latest offering in the Sensodyne range.

GlaxoSmithKline, a Gold Sponsor at the event, took the opportunity to showcase its Sensodyne Rapid Relief – a toothpaste designed to offer relief from the pain of sensitivity in 60 seconds.

A spokeswoman for GSK commented: “The product was released in April but the IADR conference was one of the first chances for clinicians to find out more about the product. We were delighted with the response from delegates, with large numbers of delegates coming to the stand at the exhibition to ask for more information, details of the product and supporting clinical studies.”

Dr Soha Dattani, Director Expert Marketing commented: “We are constantly researching and developing new ways to help those that experience tooth sensitivity. We were aware that many are not actively addressing the problem, with sufferers changing the way they consume certain food and drinks or avoiding them altogether to avoid the pain of sensitivity. In response, Sensodyne Rapid Relief has been formulated to provide a quick, easy and effective solution.”

Whipps Cross VT Scheme Prize Winner

Dr Sabina Bidgol, Vocational Trainee based at Chingford Mount Dental Practice, has won the 2010 prize for Best Case Presentation for the Whipps Cross Vocational Training Group. The champagne and prize certificate were presented by Eloise Nutton of Denplan, which sponsored the award.

Dr Bidgol had selected a complex restorative case for her case study which involved multiple dental disciplines including endodontics, periodontics, oral surgery, prosthetics and bridge work.

“I am delighted”, said Dr Raj Gogna, Principal Dentist at Chingford Mount Dental Practice, “Sabina chose a very challenging case and the extensive treatment took several months. She was able to deliver a high standard of treatment and I am very pleased that she managed to achieve such a level of competence”.

“Yes, I’ve really had a fantastic year”, said Dr Bidgol, “My clinical exposure has been extensive and I’m pleased to have been part of the Whipps Cross Scheme”.

Having completed her vocational year, Dr Bidgol leaves Chingford Mount Dental to take up a position as an SHO in Maxillofacial Surgery at The Eastman Dental Hospital. However, she enjoyed working in a broad-based family practice and hopes to return to private practice following her hospital post.
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A quieter month on the political scene followed the Newsnight watching frenzy in April and early May. The health ministry teams have settled in and gradually news has emerged of developments between the Department of Health and the profession.

The Government has started to lower expectations in terms of the economy for the medium term, while speculation regarding where the axe would fall led to forum members making some suggestions on the types of savings that could be made.

Money matters
What do you think is the most wasteful aspect of public spending in dentistry? Could local practices provide dental access services for a lower cost than the politically inspired Dental Access Centres? Should denture repairs attract no patient charge? What about patient charges for pregnant people? What about molar endodontics? This is a zero UDA treatment, so there is nothing to be saved. However, despite our musings, the decisions will be made by politicians who wish to be re-elected, and this certainly makes them choose soft targets, things that do not affect their constituents.

How about the tick-box culture? Still rife near you? Form after form, from agency after agency, are getting under the skin of GDPUK members. As long as you can prove you have filled in every FP17DC form correctly and ticked every box, somehow it doesn’t seem to matter if the treatment fails. And in a latest self-assessment tool, silly questions are posed for which no one will answer “no” to, for example, whether needles are used only once. The same with Health and Safety – no central or simple process proves this has been done, so the clipboarders have to visit again and again to see the same documents.

Techno babble
Dentists on the forum like to have the odd friendly disagreement on topics other than dentistry, ie Apple versus Microsoft, so the pros and cons of the latest iPhone 4 generated some chat. However, like chatting in a sports club, or pub, people’s differing perceptions of the same item or concept can be illuminating.

There have been a number of clinical cases discussed, one being interesting enough to be suggested for a scientific “write-up”. An image of a radiograph was posted showing a bifid lateral incisor, with a dens invaginatus, and the root was dilacerated too. It was possible that one canal was vital and one non vital. Very complex, and it was proposed that it could be best solved using the 22nd element of the periodic table – namely titanium!

Latest events
The LDC Conference was held in Harrogate in mid June, and on the forum, there were discussions about the validity and benefits of the event before it occurred, followed by reports during the event, then dissection afterwards. Overall the view was that Chair Richard Emms’ speech was very well received, and that speech was published in full.

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About the author
Tony Jacobs, 52, is a GDP in the suburbs of Manchester, in practice with partner Steve Lazzaroni at 406 Dental. Tony attended GDC in 1997 which saw him around 7,000 unique visitors per month, who make 50,000 visits and generate more than a million pages on the site. Tony is sure GDP UK is the liveliest and most topical UK dental website.
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Do you dream about success or have nightmares about failure?

Asks Seema Sharma

Are you feeling FAB? 
Are you one of these eternally positive people who knows that as long as people have teeth, you know you have a product people need or want? Even when you think about those who don’t have teeth, you may be upbeat if you are unique, special and different and one of your many niches is dentures and implants? If you use a FAB marketing campaign (less about the Features, more about the Advantages and Benefits of coming to your practice) you are already ahead of the game. If you have to make some tweaks to prepare for the changing environment, perhaps you see this as simply adding to your repertoire of benefits to promote to your patients.

Or are you feeling SAD? 
Are you worrying about the future of your practice? Is the economic downturn starting to bite? Are you fretting about CQC? Does it feel like the PCT is on a different page to you, your team is on a different page to you, your patients are on a different page to you – worse still all three? Does reading the white paper make feel like you will soon die of change fatigue? Are you at the bare bones of costs already, and struggling with how else to cut spiralling costs? Could you do with a PEP talk or better still with peppping up the practice? Are you fretting about the future of your practice? Is the registration is just a few months away, the lack of leadership will show quickly in the plunging morale of the team. Authority and responsibility can be delegated but never accountability. Action without vision is a nightmare. Futureproof your practice. Leadership is less about power and more about empowerment, and there is nothing more dynamic than an empowered team. A good leader will put a full repertoire of skills into action by defining where the practice is going (vision), advising the team what is not working and why a new strategy is required (autocratic), arranging a meeting for a good leader to share their charismatic (participative) and decide who is going to take on which tasks to implement the new strategy (delegation).

Don’t sweat the small stuff. There are 5 kinds of people in this world – people who make things happen, people who watch things happen and people who wonder what happened! Are you a leader, a follower or an ostrich? The decision is yours.

About the author

Seema Sharma qualified as a dentist but gave up clinical practice to pursue a career in practice management and marketing with a particular interest in rural practice management. Seema established Dentabyte in 1996 and will cover the five balancing of the dental and commercial interface in practice.

We believe we have the right people in place to run the whole practice. The leadership is less about power and more about empowerment and vision.

We are more about empowerment, and there is nothing more dynamic than an empowered team. A good leader will put a full repertoire of skills into action by defining where the practice is going (vision), advising the team what is not working and why a new strategy is required (autocratic), arranging a meeting for a good leader to share their charismatic (participative) and decide who is going to take on which tasks to implement the new strategy (delegation).
Meeting face to face

Elaine Halley continues her journey through the online MSc in Restorative and Aesthetic dentistry from Smile-on and the University of Manchester

The clinical cases so far include six whitening cases, simple orthodontics, restoration of the endodontically treated teeth and single tooth indirect restorations. I think we are going to have lectures in the practical techniques but at this point I’m not sure. The current unit’s lectures are mostly about communication, legal record-keeping etc – we have two with Kevin Lewis coming up on Thursday.

After photography, Chris Orr covered treatment planning and shade taking with an eye-crossing exercise in matching values on the computer. All of this with Covent Garden beckoning outside and an ash cloud to disrupt our homeward travel – the joys of CPD.

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The life of a dental editor can be a pretty mundane one. We don’t often get let out, mostly for the safety of the general public. But sometimes an opportunity comes along for us to pack our things and head for foreign climes.

One such opportunity arrived recently when I received an invitation to visit the offices of implant manufacturer Euroteknika, located in a French village just ten minutes from Chamonix, and I wasn’t about to say no!

Euroteknika was established in 1992 by implantologist Guy Hervé. In 2004, the company was acquired by French dental distributor GACD, which allowed the company to develop five ranges of implant systems and maintain its service mission – to offer high quality products with professional service at the best price. In 2010, the company now boasts:

- A new facility of more than 3,000m². This allows the whole of the manufacturing process to be done in-house
- The claim that it is the number one French manufacturer purely dedicated to implants
- A staff of 64, having grown from a staff of six in 2004
- The establishment of Teknika Training in 2009 to allow for various types of training and mentoring to allow first time dentists to place implants and more experienced clinicians maintain their skills
- What does this have to do with dentists in the UK? Well, Euroteknika has developed an exclusive partnership with D2D Implants, the implant arm of D2D Endo.

A winning formula

Dental Tribune looks back at an enlightening visit to implant manufacturer Euroteknika

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After an extremely early start, my fellow colleagues from the dental press and I met John Laugher, head of Sales and Marketing at D2D at the airport for our flight to Geneva where we were met by our French hosts Laurent Dereudre, International Marketing and Sales director and Benoit Fontaine, Sales advisor. Driving to the factory it was hard to understand why everyone didn’t move their business there! Nestled in a little part of France that lies between the borders of Italy and Switzerland under the shadow of Mont Blanc, the area is known for more than just its outdoor pursuits of climbing, parasailing and skiing – it is also home to a thriving micromechanical manufacturing industry, the origins of which lie in clock making.

After a chance to have a coffee, it was time to get down to why we were there; to find out more about Euroteknika and D2D Implants. Laurent gave a series of presentations that provided a background into the company and its aims in the development of five implant systems. Then John Laugher spoke about D2D Implants, the importance of the relationship between the two companies and the benefits that it can bring to UK dentists.

We then had the opportunity to tour the factory, seeing the process from the storage of the titanium bars through to the manufacture of the implants; the finishing and packaging of the products as well as the R&D suite and the order fulfilment area, which uses an innovative electronic system to try to reduce errors.

I am a big fan of getting behind the scenes to see how things are made, so this was a very interesting experience. The processes that the implants must go through are so complex; and the attention to tracking the implants from the batch number on the source bar of titanium to the implant being placed in a patient’s mouth was mind-blowing.

Throughout the time we were in France the Euroteknika team, including managing di-
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All attendees receive a free sample of Bond Bone
rector Alain Veillard, were on hand to answer any question about their implants. I also had the opportunity to speak with John about D2D and how they came to work with Euroteknika.

“The company started as D2D Endo three years ago after the founders, Jason Bedord and Charlie Nicholas, realised that they were often recommending certain products to delegates on their endodontic courses. They decided to put together a range of equipment together that they were happy with - no big sell, the guys can just say ‘this is what we use, it works for us and if you want to buy it you can get it at this price’.

“What’s fairly unique about D2D is that it’s owned by dentists for dentists. Any clinician who has a query about a product can pick up the phone and talk to a fellow clinician about it; this means they will get relevant practical answers from someone who truly understands their needs.”

The formula seems to have worked well for D2D Endo, and last year they teamed up with implantologist Willie Jack to provide the same sort of service on the implant side. “When the opportunity came along to go into the implant side, with Willie Jack (who has been placing implants since 1992) the same sort of system worked. He saw that the market was growing, that more people were becoming aware of implants and he thought ‘well I’m an implantologist, I would like people to have more of their implant work done in the UK by UK dentists’. So, he looked for a system that was competitive in price with the bigger dental implant brands but still offered the same quality and reliability as the well established brands.

“There are so many people selling cheap implant into the UK because dentists want to be able to deliver an implant system at a low cost. The way we’ve approached it is we need to know from a clinical perspective that the products we are offering are 100 per cent reliable. The thing with D2D is that the directors are dentists, they do not want their reputation to be tarnished by any dentists saying ‘look this product that you’ve sold us, it doesn’t do what it’s supposed to do’. We’ve gone with Euroteknika because they represent quality. Also there is about a 40-60 percent difference in price if you compare Euroteknika to the established brands, but as far as we can see they are comparable especially in terms of quality. Not only that but the prosthetics can be up to 80 per cent of the cost of the big brands so if you put all that together it’s a very powerful argument for D2D.

“In the beginning people are used to placing what they have been placing (ie Straumann, Astra, Nobel) because they are good products, they have been on the market a long time and they have all the surgery equipment to do it. So to change systems, well there needs to be a good reason. Those that have taken on board the Euroteknika product have honestly not had one problem. All we have are pluses on the ease of how it works and the ability to match the prostheses. So, the labs like us – they like the prosthetics – the dentists like us because the products are of good quality at the right price. They also like the fact that if they have an issue they can talk to Willie and he can answer them clinician to clinician.”

Ninety per cent of the equipment that clinicians have to place Straumann/Astra/Nobel implants can be used with Euroteknika implants. We also do promotions such as once someone has placed 20 implants we give them a free Euroteknika surgical kit. And from what dentists tell me it is a very good surgical kit! John added: “The relationship between Euroteknika and D2D Implants is crucial as it is a long term partnership. We have got the ability to talk to them at every level right up to the MD about things we’d like to change or things we can get involved in – I think we’ve ticked all those boxes. I think they are prepared to listen, I think they are prepared to change things and it seems to be their aspiration to make us a part of their business. So it really does work, we will help them develop things on the clinical side as we are highly qualified and experienced clinical implantologist, and they are a very good manufacturing company – put the two together and you have a winning formula.”
Recently was able to add implantology to my ever growing list of dental skills after a very insightful day at the UK headquarters of Straumann.

The day was entitled ‘An insight into the world’s leading dental implant company’ and it gave the dental press an chance to get to know the team at Straumann, find out what the company does beyond its implant offerings and hear about its association with the ITI (International Team for Implantology). It also allowed us to have a chance to place an implant for ourselves, though fortunately our patients were nothing more than a small plastic disc.

The event began with a welcome from head of Marketing Vanessa Elwill. Following her was managing director of Straumann UK Stephen Booth. He gave a background to the company, from its beginnings as a family-owned research institute in 1954, through to the present where it is claimed as a global leader in replacement, restorative and regenerative dentistry.

Straumann UK has established itself at its offices in Crawley as not only a base for UK operations but also a first-class training facility for internal and external clients. In the last year there have been 75 courses at the centre and 45 external courses, with more than 1500 delegates.

Stephen also pointed out that Straumann are more than just implants. The product portfolio covers solutions for preserving, restoring and replacing teeth, including: Emdogain – regeneration product in perio; Bone Ceramic – synthetic bone replacement; CAD/CAM – in partnership with Ivoclar Vivadent, this includes the Cadent digital scanner; Digital implant systems and guided surgery; Implant surface technology – Roxolid, SLA Active.

Following Stephen was John Aiken, Straumann CADCAM Sales Manager. John gave further insight into the benefits to labs, clinicians and patients of using digital scanning and CAD/CAM in the design and production of appliances such as crowns, bridges and onlays.

Then it was the turn of Phil Freiberger, clinician and Chairman UK & Ireland ITI Section. He explained who the ITI is as a global association in implant dentistry aiming to promote research, development and education in its field.

It currently boasts 7,500 members and 700 Fellows in its ranks. Education and research is key to the ITI, with study clubs, courses such as the ones run at Straumann and Scholarship programme at the Eastman.

Research-wise it is critical, with investment of CHF1.7m in 2009 alone into 60 different projects at 22 different institutes worldwide. Since 1988 283 research projects have been funded to the tune of CHF32.2m.

After the presentation it was time to play dentist! A few hardy souls sat down under the watchful gaze of the Straumann team and Phil. We were taken through the process of drilling the implant socket, having to be careful not to drill too far. My implant is now pride of place on my desk in the office.

Thanks to Straumann for a wonderful and informative day at their offices, I look forward to the next time!
Aesthetic challenge

Thorough examination and execution of treatment are key to carrying out immediate tooth replacement Dr Riz Syed explains

In our clinics, we often have to deal with patients who require a single implant to replace a failing tooth. Our aim should always be aesthetically driven, in that we should always strive to achieve the most stable aesthetic outcome.

In the aesthetic anterior zone, we are often faced with an aesthetic challenge. Do we extract a tooth and delay the placement of an implant allowing the site to heal before implant placement and try to rebuild any bone and soft tissue loss following the healing process?

Gingival support

The main reason for placing an implant at the same time as extracting the tooth and possibly placing a provisional restoration is to support and maintain the gingival architecture of the failing tooth.

In order for us to place implants in immediate extraction sites, certain protocols have to be followed to achieve a successful outcome:

• Careful patient assessment should be undertaken both clinically and radiographically
• No active underlying pathology
• Gingival form: look at the whether the form is flat or scalloped and determine the marginal position relative the adjacent teeth. This is significant in deciding the degree of marginal discrepancy that may occur
• Gingival biotype: is the biotype thick or thin? We can often determine the biotype by probing the buccal tissue and seeing how much of the probe is visible through the tissue. The thinner the tissue, the higher the chances of soft-tissue recession.

Carrying out extraction

The tooth has to be extracted carefully using periosteum in order to avoid unnecessary trauma to the bone. The socket is then cleaned thoroughly and probed to determine the length of the socket from the soft tissue or bone margin. The ideal option would be to place an implant just a few millimetres longer than the socket to engage in the apical bone to achieve primary stability. Pressure should be avoided on adjacent interdental bone to maintain the papillary between the implant and tooth.

For incisal teeth, the mid-palatal socket is an ideal location for the initial twist drill. The final implant should therefore be placed in more palatal position. The remaining gap between the implant and the buccal plate, if it is less than 1mm, can be filled in with bone. If, however, the gap is larger, bone material should be used to prevent the collapse of the buccal bone and soft-tissue.

The ideal depth of the implant in the majority of cases is three mm below the soft-tissue margin to ensure the biological width is not encroached. In areas where there is a bony wall defect, implants can still be placed at the same time as extraction and guided bone regeneration can also be carried out at the same time. In V-shaped defects, there is often minimal recession compared to U-shaped defects.

Placing an immediate provisional without encroaching on the tissue with a negative contour will help to support the tissues. Although immediate implant placements can result in a successful outcome, there is slightly higher risk of failure. Thorough examination and surgical execution are vital to ensure success.

About the author

Dr Riz Syed qualified at the Royal London Hospital in 1999 and runs referral clinics in Islington and Walton on-Thames. Regularly consulted for complex treatment planning cases, Dr Syed lectures internationally. To contact Dr Syed, visit www.leadingdentalimplants.com.

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All-on-4 can be planned and performed using the NobelGuide treatment concept, ensuring accurate diagnostics, planning and implant placement.
Peri-implantitis: definition, etiology and treatment

By Vavalekas Michail of the Ashman Department of Periodontology and Implant Dentistry at New York University College of Dentistry

Peri-implantitis is an inflammatory process affecting the soft and hard tissues resulting in rapid loss of supporting bone, often associated with bleeding and suppuration. The etiopathogenesis of peri-implantitis is complex and is related to a variety of factors. The peri-implant environment and soft-tissue-implant interface has a major impact on the progression of peri-implantitis.

Patient-related factors include: 1) systemic diseases (for example, diabetes, osteoporosis), 2) social factors such as adequate oral hygiene, smoking, drug abuse, 5) parafunctional habits (bruxism) 4) and previous dental history of periodontitis. In addition to the above etiologies, inorganic factors can also play a significant role in the development of peri-implantitis.

Although restorations of endosseous implants have demonstrated a very high survival rate, one study suggested that over a five-year period, 0 to 14.4 percent of dental implants demonstrated peri-implant inflammatory reactions associated with crestal bone loss.

The treatment modalities are: 1) administration of systemic antibiotics, 2) mechanical debridement with or without chlorhexidine oral rinses or antibiotics, 3) mechanical debridement combined with LASEK decontamination, 4) debridement combined with a flap access and more recently, 5) debridement was combined with guided bone regeneration (GBR) for repairing of osseous defects. GRR has limited predictability and some case series have demonstrated limited bone fill after GRR procedures. There is insufficient evidence to support any one of the aforementioned treatment strategies for peri-implantitis.

Therefore, different treatment modalities for peri-implantitis will be compared from previously published studies.

Points for discussion
One study demonstrated the importance of bacterial plaque accumulation in the development of inflammation around implants (peri-implantitis) while another showed that, if this condition is left untreated and the surface is not decontaminated, it will lead to peri-implant pocketing, alveolar bone loss, and eventually to implant failure. Because there are biologic differences between teeth and implants, the advancement of infection around implants is also different from natural teeth.

The inflammatory cell infiltrate around implants was reported to be larger and extend more apical when compared to a corresponding lesion in the gingival tissue around natural teeth. In addition, the tissues around implants seem to be unable to resist the plaque associated infection and antibiotics may be necessary for the treatment of peri-implantitis.

Bacteria on the implant surface are the target in treating infections around implants and traditional therapeutic approaches have been directed towards implant surface decontamination. Systemic administration of antibiotics were also used in the treatment of peri-implantitis with an immediate reduction of inflammation, bone re-growth and gradual resolution of pocket depth, but a three-month recurrence of peri-implantitis was observed due to bacterial re-colonisation of the implant surface.

To date, there is no reliable evidence that suggests which intervention (chemical agents, mechanical debridement, surgical procedures, lasers or a combination of Guided Bone Regeneration (GBR) with the former techniques) is the most effective for treating peri-implantitis.

Some of the treatment modalities suggested for peri-implantitis are: 1) sub-mucosal mechanical debridement and antimicrobial minocycline spheres (Arestin), 2) mechanical ultrasound debridement without antibiotics, 3) laser ablation (Er:YAG) with mechanical debridement, chlorhexidine, with and without open flap surgery, 4) antimicrobial therapy with open flap debridement, 5) access flap surgery and bone substitute or bone graft.

Furthermore, it was compared the combination of oral hygiene instructions, mechanical debridement and topical application of minocycline microspheres (Arestin) in peri-implant lesions (with bone loss corresponding to no more than three implant threads) to the combination of oral hygiene instructions, mechanical debridement and one per cent chlorhexidine gel application.

The results obtained after a follow-up period of 12 months on sub-mucosal mechanical debridement and antimicrobial minocycline spheres showed that only a
limited reduction in bleeding on probing was achieved and that the mean peri-implant probing depth (PD) remained unchanged (3.9 mm) in the chlorhexidine group. On the other hand, in the minocycline group, the reduction of bleeding on probing was statistically significantly greater than that in the chlorhexidine group, coupled with an improvement in mean peri-implant PD (from 3.9 mm to 3.6 mm). These results suggested that the topical application of chlorhexidine provides limited or no adjunctive clinical improvements when treating shallow peri-implant lesions as compared with using mechanical debridement alone. Moreover, in another study was compared the efficacy of sub-mucosal debridement alone for the therapy of peri-implantitis utilising an ultrasonic device versus hand instrumentation with carbon fibre curettes. He concluded that there was no statistically significant difference reported for the implants treated either by the ultrasonic device or manually scalers between baseline and three to six months regarding reduction in bleeding on probing and radiographical bone loss.

An interesting treatment modality can be the laser decontamination of the implant surface. The use of Er:YAG laser was used alone and compared to the combination of mechanical debridement (using plastic curettes) and antiseptic (0.2 per cent chlorhexidine digluconate) administration for the treatment of peri-implantitis. In both studies the results obtained at six months after therapy suggested that the treatment modalities were equally efficacious in significantly improving peri-implant probing pocket depth (PPD) and clinical attachment level (CAL).

However, at 12 months in both groups, the mean values of peri-implant PPD and CAL was not statistically significantly different from the corresponding values at baseline. Therefore, the efficacy of the Er:YAG laser seems to be limited to a six-month period, particularly for advanced peri-implantitis lesions and the main reason for this result can be found in the difficulty accessing the apical portion of the defect in these lesions.

Treating advanced peri-implant lesions may include an attempt to regenerate as much as possible of the lost bone structure. The efficacy of two bone regenerative procedures for the treatment of moderate intra-bony peri-implantitis lesions were also compared. The defects were either randomly treated either with a combination of access flap surgery and the application of nanocrystalline hydroxyapatite or with a combination of flap surgery and the application of a bovine-derived xenograft (Bio-Oss, Geistlich, Wolhusen, Switzerland) and the placement of a bioresorbable porcine-derived collagen membrane (Bio-Gide, Geistlich, Wolhusen, Switzerland). After two years the evaluation of the study showed that application of the combination of natural bone mineral and collagen membrane seemed to correlate with greater improvements in clinical parameters.

Several treatment modalities have been suggested for treatment of peri-implantitis, however, it was demonstrated in the case series that it was possible, but not predictable, to maintain implants using a treatment modality consisting of surgical cleaning and a systemic antimicrobial treatment for five years. Long-term treatment modalities need to be assessed and there is a need for randomised-controlled studies evaluating treatment of non-surgical therapy of peri-implantitis.

Conclusion
The management of implant infections should be focused both on infection control of the lesion, detoxification of the implant surface, and on regeneration procedures.

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**The management of implant infections should be focused both on infection control of the lesion, detoxification of the implant surface, and on regeneration procedures**.
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Infections should be focused both on infection control of the lesion, detoxification of the implant surface, and on re-education procedures. Treatment options can be surgical or nonsurgical. It was observed that nonsurgical treatment of peri-implantitis was unsuccessful, while the use of chemical agents such as chlorhexidine had only limited effects on clinical and microbiological parameters.

Adjunctive local or systemic antibiotics were shown to reduce bleeding on probing and probing depths and some beneficial effects of laser therapy on peri-implantitis have been shown, but this approach needs to be further evaluated. Despite treatment and re-treatment of lesions, establishing an adequate healthy environment was found to be difficult since inflammation can be still present in a significant number of patients. About the author

Vassilis Michail graduated from the University of Athens in 1986. He continued with the advanced education in Periodontics from "Cattolico" in Italy in 1990 and with the advanced education in Implant Dentistry from "Cattolico" in Italy in 1992. Since then, he has become a full-time office. During the period 2000-2010 he has been an Associate Professor at the Department of Periodontics and Implant Dentistry at the University of Athens. He is currently an Adjunct Assistant Professor at the University of Athens. He is also an Associate Fellow where he got involved in the periodontic clinic and continues with the advanced education in periodontics at "Cattolico" in Italy.
The 30-year old patient had lost tooth 21 in an accident about 15 years previously. Tooth 11 underwent root treatment (Fig. 1). As a result of fear of the dentist, the patient continuously delayed treatment of the two teeth and wore a temporary denture for years. The treatment plan envisaged an implant in position 21 and a crown on 11. Since the incisive papilla was directly in the implant region, cone beam tomography was performed in order to clarify the position of the incisive canal. The width of the bony ridge at position 21 was five mm measured in the sagittal plane (Fig 2).

Treatment
A mucoperiosteal flap was dissected for the implantation with vertical relief distally at tooth 22. As expected, the incisive canal was only slightly palatal to the ideal implant position. The implant site was prepared with the aid of a splint along the buccal boundary of the canal (Fig 3) without perforating the canal. A Straumann® Bone Level Implant (4.1 mm, length 12 mm) could be placed in correct prosthetic position without dehiscence (Figs 4, 5). Because of the thin buccal bone plate and the concavity of the ridge, augmentation was performed with a bone substitute and a collagen membrane, fixed with resorbable pins (Fig 6). At tooth 11, 1mm of crown lengthening was performed on the buccal aspect. The flap was mobilised and sutured over the wound without tension (Fig 7). The sutures were removed ten days later; the wound area healed uneventfully.

After healing the soft tissue over the implant did not yet have the desired convex contour and had a rather uneven structure (Fig 8). Therefore, eight weeks after implantation, a split flap was dissected buccally in region 21 and a connective tissue graft from the palate was inserted (Figs 9-10); in addition, the mucosa was de-epithelialised with a diamond bur in order to smooth the surface. The connective tissue graft allowed volume to be gained buccally (Fig 11). Eight weeks after graft insertion a mini rolled flap was formed over the implant and folded in the buccal direction with a conical gingiva former (Fig 12). At the same time, tooth 11 was prepared for a crown and fitted with a direct temporary. Two weeks later, the impression for the indirect temporaries was taken. In the laboratory, a screw-retained

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Temporary on the implant and a temporary crown for 11 were made using a temporary abutment. The temporaries were fitted (Fig 15); conditioning of the soft tissue began one week later with application of composite to the cervical region of the implant temporary. After conditioning three times, the desired emergence profile was achieved (Figs 14-15). For the final impression, an impression post was customized with composite so that it corresponded to the emergence profile of the temporary (Fig 16).

After taking an impression with polyether a model was made that reproduced the gingival conditions perfectly. The patient, dental technician and dentist had agreed to carry out all-ceramic reconstruction with the Straumann® CADCAM system. The “Wax Up Design” function of the CADCAM etkon™ visual software allows wax patterns to be scanned and zirconium oxide frameworks to be produced that optimally support the veneering porcelain. First, a try-in wax-up was made from resin and tried in the patient; minor esthetic corrections were made. Using a silicon index of the wax-up, the frameworks for crown 11 and the directly screwed implant crown 21 were formed from scannable wax (Fig 17). The modelled frameworks were placed in the 3D scanner and scanned (Fig 18). These data were then sent via the Internet to the milling center. Three days later the frameworks arrived in the laboratory and the accuracy of fit was checked on the model.
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After that, the frameworks were veneered with porcelain and the biscuit bake was tried, in the patient's mouth. The crowns were then completed and fitted (Fig 19). An opaque white composite cement was used for the crown on tooth 11 in order to prevent the dark colour of the abutment from showing through.

Treatment outcome and conclusion
On follow-up two months after insertion, the esthetics were satisfactory and the two crowns harmonised well with the rest of the dentition (Fig 20). The soft tissue in region 21 was similar to the rest of the gingiva in color and texture, and the papillae mesial and distal to 21 were almost completely filled up. In the final radiograph the marginal bone level seemed ideal (Fig 21). The patient appeared highly satisfied with the restoration.

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When we were children, we were excited by surprises because we associated them with gifts and the excitement of celebrations such as a birthday or Christmas. In adult life we come to realise that not all surprises are created to thrill and excite: some life events that descend upon from a clear blue sky create the levels of anxiety and stress which can badly affect your emotional and physical well-being none more so than when your employer informs you that you are required to learn a whole range of new skills in order to keep up with changes in the practice's operations.

Over recent years developments in the dental sector have lead practices to review many aspects of how they operate and this had lead them to introduce new working practices, which has meant that dental team members have needed to develop new skills and approaches to their day-to-day work. The very fact that patient's demands and expectations have changed so much means that we need to complete more openly than ever before with the other providers of goods or services who are competing for the same disposable income that patients could opt to spend on dental care. This in turn places more demands upon the dental team, not least because patients are asking pertinent and stretching questions about their treatment plans.

While it's often impossible to prepare or change situations you have no control over, you do have power over how you respond to and handle these life events. And while there may never be a satisfying answer to why bad things happen to good people, coming to an understanding of the situation and accepting what you can and cannot change can, at the very least help you to:

- Get over unexpected challenges and succeed on the job
- Take charge of your well-being in good and bad times

We can get so wrapped up in our own needs and the desire to have them met, that we miss opportunities to connect with others. The irony is that the more we can see the bigger picture and recognise the needs of others and understand how any required changes meet their needs, the more willingly we will make changes even although at first they are inconvenient and demanding because we can see they are also logical and meaningful.

The accelerated pace of the modern professional practice rising to meet workplace demands can be tough at the best of times. But with an economic crunch adding to the strain on the bottom line and forcing many employees to do more with less, learning to catch, run with and manage unexpected challenges on the job is no longer an option—it's a necessity. From learning to work with your manager, to making the most out of newly assigned job duties, you need to learn to channel workplace challenges into occupational opportunities.
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Back to the Egg; Part II

Kenneth Serota continues his look at the Endodontic Implant Algorithm

Dentist is the most abundant mineralised tissue in the human tooth. In spite of this, research has failed to provide consistent values of dentin’s mechanical properties. In clinical dentistry, knowledge of these properties is pivotal to any number of variables ranging from innovations in preparation design to the choice of bonding materials and methods.

The Young’s modulus (the measure of the stiffness of an isotropic elastic material) and the shear modulus (modulus of rigidity) are diminished by viscoelastic behaviour (time-dependent stress relaxation) at strain rates of physiologic (functional) relevance. The reported tensile strength data suggests that failure initiates at flaws. These flaws may be intrinsic, regions of altered mineralisation, or extrinsic, caused by cavity or post channel preparation, wear, or damage. There have been few studies of fracture toughness or fatigue (1). Finally, little is known about the biomechanical properties of altered forms of dentin subsequent to decay, the influence of irrigants, chemicals and the choice of curing techniques used for bonded restorations (2).

Studies suggest that there are at least two forms of transparent or sclerotic dentin; a form associated with age-related changes in the root. The impact upon tooth strength as a function of these altered forms of dentin is not well understood.

The long-term predictability of residual coronal tooth structure to function in a manner commensurate with the demands of the orofacial ecosystem, may need to be reasserted in light of observations that sclerotic dentin, unlike normal dentin, exhibits no yielding before failure and that the fatigue lifetime is deleteriously affected at high stress levels (3). Mechanisms for energy dissipation and crack growth resistance present in young dentin are not present in old dentin. Restorative methods and techniques, particularly as it relates to ferrule creation for endodontically treated teeth, may need to be amplified to address the fact that fatigue crack growth resistance of dentin decreases with age (4) (Fig 5).

There are primary causes that predispose teeth to fracture and secondary causes that predispose fracture after a period of time (Fig 5). Endodontics is a component of an interdisciplinary process and a chain is only as strong as its weakest link.

Subsequent to any endodontic procedure, intensity of stress concentration and tensile stresses within an endodontically treated tooth will depend upon (1) the material properties of the crown, post, and core material chosen, (2) the shape of the post, (3) the adhesive strength at the crown-tooth, core-tooth, and core-post, post-tooth interfaces, (4) the magnitude and direction of occlusal loads, (5) the amount of available tooth structure and (6) the anatomy of the tooth. Any combination of vectorised stress concentration and high tensile stresses will predispose these teeth to fracture without an adequately engineered restorative design.

Reengineering

Reengineering negative treatment outcomes is a significant part of the contemporary endodontic oeuvre. The presence of apical periodontitis may or may not affect the outcome of initial endodontic treatment (7) however, there is a general consensus that apical periodontitis...
Apical surgical "correction" of intracanal infections may isolate, but not eliminate, the residual microflora of the root canal space. It should therefore be limited to situations where non-surgical retreatment is judged impractical.

With the range of sophisticated equipment and material in the conventional endodontic armamentarium, this is a remote consideration at best. When the etiology is independent of the root canal system, surgery is the most beneficial treatment (80). Non-surgical retreatment may still be indicated in these cases, especially when intracanal infection cannot be ruled out. Time constraints or financial pressures, should never be a factor in making surgery the first treatment choice (Fig 7).

Other options

The variables associated with non-surgical retreatment are myriad and treatment outcome studies in endodontics have been egregiously abused by those wishing to diminish the value of re-engineering natural teeth. Many studies have categorised teeth with caries, fractures, periodontal involvement and poor coronal restorations as negative surgical retreatment outcomes. Thus, the selection of retreatment technique is a critical factor in determining the outcome. For example, if a case requires a surgical intervention, the odds of success may be enhanced by the use of a hybrid surgical retreatment technique compared to a re-irrigation and obturation technique alone (Fig 6).

The premise that non-surgical retreatment should never be a factor in making surgery the first treatment choice (Fig 7) is supported by many studies. In endodontics, this has been argued by previous studies demonstrating that retreatment outcomes may be more influenced by a combination of both procedures than with one or the other (39).

It is interesting to note that while surgical cases may demonstrate higher healing rates than non-surgical retreatment cases initially, four years out there was no difference between the two modalities due to "late" surgical failure. The failure rate for surgical therapy appears to be analogous to the failure rate for retreatment as a function of the size of the lesion treated (92).

Levels of apical resection (93) and the type of root end filling material make a difference in surgical treatment outcome success (94); however, the denin bonded composite technique and the use of compomer materials has not been widely reported. As these techniques dome the resected root face, sealing off the cut tubuli, they may prove to be the most effective retrograde surgical protocols of all. In regard to periapical re-surgery, the literature is unclear.

Other studies have compared periapical surgery and re-surgery over a five-year follow-up period. Using magnification and microsurgical root-end preparations, the positive outcome for primary surgery was 86 per cent and 59 per cent for resurgery.

While others have shown positive outcomes, the positive outcome for primary surgery was 86 per cent compared to 59 per cent for resurgery. The failure rate of surgical therapy appears to be analogous to the failure rate for retreatment as a function of the size of the lesion treated (95). Levels of apical resection (96) and the type of root end filling material make a difference in surgical treatment outcome success (97); however, the use of compomer materials has not been widely reported. As these techniques dome the resected root face, sealing off the cut tubuli, they may prove to be the most effective retrograde surgical protocols of all. In regard to periapical re-surgery, the literature is unclear.
Intra-radicular bacteria and fungi in root filled, asymptomatic human teeth with therapy-resistant periapical lesions: A long-term light

Serota’s paper will be published in a future issue of Dental Tribune U.K. 

References


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Implants

Dental professionals should consider significant incremental benefit to a recommended regimen of brushing twice daily and flossing once daily. Dental plaque removal has for many decades been a routine part of dental care, and has been shown to be effective in reducing the incidence and prevalence of gingivitis.

Mechanical methods of dental plaque removal have for many decades been a routine part of dental care, and have been shown to be effective in reducing the incidence and prevalence of gingivitis. For many patients, this mechanical tooth cleaning is the only way to remove plaque from hard-to-reach areas.

Now, Straumann's pioneering approach encompasses not only dental implants, but also tissue regeneration and digital solutions.

For more information contact Straumann on 01295 651230 or visit www.straumann.com

FREE IMPLANTOLOGY Brochure
Perfectly aesthetic – Colgate Whaledent

Colgate Whaledent would like to offer the new Implantology brochure, which contains information for the dental professional on relevant products for implantology. Including the outstanding Affinis MonoBody the first single-phase impression material with an innovative Affinis surface. "The implantology system for perfect impressions in a moist environment and -Draws New Formula for accurate reproduction of soft tissue structures. This informative booklet gives concise description of Colgate Whaledent quality, precision, made, dental products and clinical images and application.

To obtain your copy call free phone 1800 93868 253/224.
www.colgatewhaledent.com

DENTSPLY enjoys successful exhibit at ISDH and dental therapists in advancing preventative dentistry and looks forward to another successful event in 2011.

For more information please contact your local representative, Freephone +44 (0)800 572 3313 Or visit www.dentsply.de

Dress to Impress with Dental Sky

Dental Sky are proud to be recognised as the sole licensed distributors of Cherokee Uniforms to the dental profession. Cherokee Authentic Scrubs are modern and stylish but still hard wearing and practical with durable easy care fabrics, built on quality and a range of 23 vibrant colours that stand up to fading. For many years Cherokee have been established amongst the leading supplier of uniforms to healthcare professionals and are now the leading supplier of uniforms to the dental profession. Cherokee Authentic Scrubs are modern and stylish but still hard wearing and practical with durable easy care fabrics, built on quality and a range of 23 vibrant colours that stand up to fading. For many years Cherokee have been established amongst the leading supplier of uniforms to healthcare professionals and are now the leading supplier of uniforms to the dental profession.

Dental Sky are also working in partnership with Toolstock freepost, a well established family business based in the UK with a strong reputation for fresh and innovative designs created with comfort and durability in mind. New to the range are the Ultra Lite Eko™ sports styled comfort shirts combining all the reassured comfort and quality with the latest styling.

Dental Sky work very closely with Cherokee and Toolstock to ensure they offer their customers the latest styles and colours and support to encourage a wider range of products from their UK warehouse.

To see the full range of styles and colours please visit www.dentskyly.com or call 0800 294 4700 to request the new full product brochure.

In a randomised, controlled, observer blinded, parallel group six month trial, Sharma et al concluded that for patients with gingivitis who brush and floss routinely, the adjunctive mechanical methods of dental plaque removal have for many decades been a routine part of dental care, and have been shown to be effective in reducing the incidence and prevalence of gingivitis. For many patients, this mechanical tooth cleaning is the only way to remove plaque from hard-to-reach areas.

Utilising a range of models, modified ultrasonic devices and air-water syringes, all patients were instructed on the importance of oral hygiene and the need for daily brushing and flossing.

The results are a treatment which irritates neither teeth nor gingiva – and which delivers smoother tooth surfaces without abrasing the enamel. Everyone benefits, all feel good – patient, practitioner, the whole practice.

For more information: contact Johnson & Johnson on 0800 120 0795

Since Septodont was founded, we have emerged as a company fully focused on a single purpose: to provide dentists with products of superior quality and value.

We at Septodont believe that staying ahead of the competition requires more than just supplying dental products. Septodont is actively involved in research and development projects into Diamond Glass Ionomer Cements.

University and Bristol University Dental School has brought about up-to-date relevant products for implantology. Including the outstanding Affinis MonoBody the first single-phase impression material with an innovative Affinis surface. The implantology system for perfect impressions in a moist environment and -Draws New Formula for accurate reproduction of soft tissue structures. This informative booklet gives concise description of Colgate Whaledent quality, precision, made, dental products and clinical images and application.

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The world’s Number One dental implant professional]

Strauuum

Long recognised as one of the leading providers of dental implants, Straumann has now officially been granted the title of number one provider of dental implant solutions in figures released earlier this year.

Straumann’s success is built on the founding tripartite principles of reliability, simplicity and versatility backed by an unswerving level of over 20 years of clinical research have led to Straumann rightly claiming predictable results in any clinical indication.

Now, Straumann’s pioneering approach encompasses not only dental implants, but also tissue regeneration and digital solutions.

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Helping at Crisis Christmas

Bianca is a senior dental nurse who volunteered in the Dental Service at Crisis Christmas for the first time in 2008.

When I first heard about the Dental Service at Crisis Christmas I wanted to give it a go, as it sounded so rewarding. I signed up in 2008 and was thrilled to be given three days of volunteer work!

I went to the induction meeting where a Crisis team explained how the week is run, what to expect and they also went into what it means to be homeless and the reasons why people are homeless.

I had never worked with or been in contact with homeless people before. I was one of the many people who offers a pound here and there and the most I'd ever done for a rough sleeper was give them a cup of hot chocolate on a freezing night.

Admittedly, I was a little daunted by the idea of coming face to face with these unfortunate people whom we see every day across London, and who seem ignored by our society.

When I turned up on that first chilly morning, I was immediately affected by the warmth of the place. It was buzzing! There were people everywhere – holding steaming cups of tea and coffee, engrossed in wholesome conversations and having a good laugh. I couldn't tell the difference between the guests and the volunteers. Although the building had been set up only a couple of days before, it seemed that this was an old meeting place for good friends.

Our first patient was a young man from Lithuania who was extremely polite and grateful. I wished all my patients to be like him! Another patient was a young professional man who had come to London on a working holiday and lost his job and couldn't find another. He soon became homeless. Another still, was a gipsy who had great travel stories to tell and made everybody laugh.

The dentistry was carried out in a couple of fully equipped vans which weren't much smaller than some of the surgeries I've worked in. We also had heating and a steady supply of chocolate to keep up our energy levels! We were parked next to the makeshift kennels, where guests' dogs were having a Crisis Christmas of their own. They were bathed, fed and given a thorough workout and barked their appreciation regularly. I went in to visit the dogs several times – they were so cute!

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Discovering the H Factor

Dental Protection brings two events to Northern Ireland

Following the success of previous events Northern Ireland, Dental Protection is pleased to be offering two further events in Belfast and Derry.

Responding to feedback from members, Dental Protection is presenting two ‘Discovering the H Factor’ events, which had been a resounding success when they were delivered at venues across the Republic of Ireland earlier in the year.

The events will take place during October 2010 when speakers Hugh Harvie and Brian Edlin will discuss the ‘H’ Factor – human nature – and will explore why it may not be possible to keep all of our patients happy all of the time.

These team-focused evening lectures are designed to help all members of the practice identify difficult patients in advance, in order to adopt techniques and practices to assist them in proactive, as well as reactive, management.

The session will also explore the ethical standards expected by the GDC, and provide examples of situations where litigation could have been avoided.

Be cool this Summer

iPOWER

iPower is an intelligent Power device for the discerning teeth whitening dentist. It saves chairside time and delivers excellent results.

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Teeth whitening with the best in town!

Need to know more? See iPower in action! www.wy10.com

Dates for your diary

Wednesday 13 October – City Hotel, Derry (Hugh Harvie presenting)

Thursday 14 October – Belfast Waterfront, Belfast (Brian Edlin presenting)

The lectures are open to all members of the dental team and cost £60 for DPL members, £50 for DPL Xtra members (practice programme) and £75 for non-members. Accompanying staff members (dental nurses, technicians, receptionists and practice managers) can attend free of charge.

Including 1.75 hours verifiable CPD for all members of the dental team and cost £60 for DPL members, £50 for DPL Xtra members (practice programme) and £75 for non-members. Accompanying staff members (dental nurses, technicians, receptionists and practice managers) can attend free of charge.

The H Factor joins a growing list of prestigious educational events organised by Dental Protection that includes the team-based regional Horizons events, the Premier Symposium organised in conjunction with Schülke and the Young Dentist Conference in association with the BDA and BDJ.

For more information, delegates can visit www.dentalprotection.org/newsandevents/events/hfactor or contact events@dentalprotection.org.
Something to 
Smile about!

SmileGuard is part of the OPRO Group, internationally renowned for revolutionising the world of custom-fitting mouthguards. Our task is to support the dental professional with the very latest and best oral protection and thermoformed products available today.

Custom-fitting Mouthguards – the best protection for teeth against sporting oro-facial injuries and concussion.

OPROshield – a self-fit guard enabling patients to play sport whilst awaiting their custom-fit guard.

NightGuards – the most comfortable and effective way to protect teeth from bruxism.

Bleaching Trays – the simplest and best method for whitening teeth.

Snoreguards – snuggly fitting appliances to reduce or eradicate snoring.

OPROrefresh – mouthguard and tray cleaning tablets.

In 2007, OPRO was granted the UK’s most prestigious business award, the Queen’s Award in recognition of outstanding innovation.

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80% extra protection against future acid erosion

Studies show that the combination of Sensodyne Pronamel daily toothpaste and Sensodyne Pronamel Daily Mouthwash can provide up to 80% extra protection against future acid erosion.* Sensodyne Pronamel Daily Mouthwash is an alcohol free 450 ppm fluoride mouthwash with tri-hydra™ polymers, which help build more protection against acid erosion than standard fluoride mouthwashes.2,4

* compared to brushing with Sensodyne Pronamel daily toothpaste alone

For patient samples visit www.gsk-dentalprofessionals.co.uk

References:

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