Dentists still ‘poor relation’ to GPs

The Sunday Times Rich List claims Dr Hull is personally worth about £45m and said he has a 10% collection of vintage Jaguars.

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Dental Protection takes Horizons programme to Scotland

The indemnity organisation, Dental Protection, is set to take its Horizons programme, on how to manage difficult people, to Scotland.

Dental Protection has run its Horizons series of events in England and Northern Ireland and will now be running it in Scotland.

The programme will be held in four cities in Scotland this year, and two more next year, to allow more dental professionals the opportunity to attend.

The team-focused, evening events will see renowned speakers talk on relevant and practical subjects that will be useful for all members of the practice team.

During October, Horizons will visit Inverness, Aberdeen, Stirling and Dumfries, with events in Glasgow and Edinburgh following in April 2010.

Speakers, including Hugh Harvie, Kevin Lewis (Inverness and Aberdeen) and John Tiemann (Stirling and Dumfries), will be talking at the sessions, entitled The Good, The Bad and The Ugly, which will explore the management of difficult people and difficult situations that arise throughout the practice - from chairside to reception.

Kevin Lewis, director of Dental Protection, said: “We were overwhelmed by the response to last year’s Horizons event, and are pleased to be running another series.”

“Our aim is to bring quality programmes closer to home for more of our members, and in that spirit this same programme has recently been taken to our members in 17 cities all over Australia.”

The evening includes 2 hours of verifiable Continuing Professional Development (CPD) (pending) for all members of the dental team who are GDC-registered.

Tickets cost £60 for members and £75 for non-members. Tickets for DPL Xtra Practices and their staff are priced at £50 per person.

Further information and tickets can be obtained by contacting Sarah Garry on 020 7399 1579 or email sarah.garry@ups.org.uk.


Over 85 per cent of dental practices take part in Colgate Oral Health Month

More than 85 per cent of dental practices in the UK are taking part in this year’s Colgate Oral Health Month, an oral health initiative run by Colgate in partnership with the British Dental Association.

The aim of the campaign is to educate the general public about the importance of oral health and promote communication between dental professionals and their patients.

This year it is focusing on the theme of delivering prevention in practice.

Colgate is offering dental professionals the chance to take part in its 2009 Colgate Oral Health Month CPD (continuing professional development) programme, which utilises Delivering Better Oral Health a toolkit for prevention published by the Department of Health.

“A spokesperson for the campaign said: ‘This toolkit provides the dental team with simple, evidence-based advice to promote oral health to their patients.’

“In order to bring its advice to life, and to engage patients, the CPD programme will show some practical examples of how to deliver prevention in clinical practice.”

“We want dentists to speak to patients in a manner that patients will understand readily, so that they are better able to follow advice on oral health care.”

“Focusing on one key prevention theme and working together as a team, practices are asked to develop accessible, easy to understand oral health messages they can communicate to their patients to help them implement a good oral hygiene routine.”

Practices are invited to submit the messages they’ve conveyed and these will be reviewed by a panel of judges. The winning entry will be developed into a practice waiting room poster, to be included in the Colgate Oral Health Month 2010 practice pack.

This CPD programme offers everyone in the dental team the opportunity to participate and provides four hours of verifiable CPD.

The CPD programme can be downloaded from www.colgate-techn.co.uk.

A road show is also travelling around the UK this month visiting major retailers at selected venues and dental professionals will be in attendance at mobile toothbrushing units giving advice on oral health and demonstrating appropriate toothbrushing techniques.

More than 85 per cent of UK dental practices have registered to take part in this year’s event.

They have each received a practice pack containing educational materials, patient samples, motivational stickers and materials to enable dental teams to create their own display to drive awareness of oral health within their practices.

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BDA calls for action on Steele Report

The British Dental Association (BDA) is urging the Department of Health to take action and start consulting on the proposals put forward by Prof Jimmy Steele in his report on NHS dentistry.

The BDA’s call comes after the NHS Information Centre revealed there has been a small increase in the number of patients accessing NHS dentistry in the six months up to 30 June 2009 and a fall in the number of complex dental treatments carried out between 2003/04 and 2008/09.

John Milne, chair of the BDA’s General Dental Practice Committee, called the continued increase in the number of patients able to access NHS dental care ‘good news for those who are benefiting from it’.

He added: “These reports also highlight a change in the treatment patterns of care provided by NHS dentists, with decreases in the amount of more complicated treatments compared to 2005-06 and 2008/09.

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The Steele behind the Steele Review

Interview: Lisa Townshend speaks to Prof Steele

For the last nine months, the name on the lips of anyone interested in NHS dentistry has been Professor James Steele. Since the announcement of the independent Review into NHS dentistry in December 2008, Prof Steele has been at the forefront of the dental agenda as the lead in the Review process.

Prof Steele graduated in dentistry from the University of Dundee in 1985 and was awarded his PhD in 1994. His research is around oral health in populations and oral health services research. He has been awarded the International Association for Dental Research Distinguished Scientists Award for geriatric oral research. He is also a clinician, working as a consultant in Restorative Dentistry for the Newcastle Hospitals NHS Trusts. Formerly chair in Oral Health Services Research at Newcastle University, he has recently taken up his new post of head of Newcastle Dental School.

Speaking with Prof Steele, he looked back over the Review and explained how he had become involved: “I was contacted in November of last year and I think I might have been interested in the Review, and I think there was a shortlist of people at that time. I'm really not sure how I ended up on that shortlist to be honest. I like to think it was a combination of things. I hadn’t been involved in everything that had gone before, so I think that made it a bit easier as I was coming from a neutral position and I had no ‘baggage’ attached. I had made various comments and observations over the initial reform period, which had been reasonably balanced. In addition, I think an academic background helps when producing documents, writing and analysing etc – so I probably had the right sort of skills. But as to how I was selected is actually a mystery.”

He was keen to praise the support the University of Newcastle had given him during the Review process: “It’s not really something you can turn down – it was a really big task and a really difficult task. It was a quite important thing to do in a sense I was less concerned about the dental school more concerned to make sure that the university understood what it was I had been asked to do and they were broadly supportive.

“Sometimes your natural modesty takes over and you think ‘can I really do this?’ and looked at it and thought ‘well yes I think I probably can do this’. There are a lot of things I can’t do but this was one I could.”

One of the first tasks for Prof Steele was appointing the Review team. “I had a lot of input into the rest of the Review team. There were some really difficult decisions to make because this had to be done quickly – this was my decision. There was a certain amount of momentum coming off the back of the Health Select Committee report and I wanted to maintain that. I wanted to keep the momentum; I wanted to do it relatively quickly. And I wanted to engage widely, but I didn’t want a huge team with dozens of people because we would never have gotten the job done. I was keen to keep the team quite small and compact and have on board people that I knew could deliver.”

Deciding on a team of him and the principal responses, he had then for he had all the bases covered. The Review team finally consisted of himself, Janet Clarke (clinical director, Salaried Dental services, Birmingham; and deputy director, Provider services, Heart of Birmingham teaching PCT), Eric Rooney (consultant, Dental Public Health, Cumbria and Lancashire PCTs) and Tim Wilson (director of Contracting and Performance, NHS Tameside and Glossop). He added: “One of the areas where there had been a bit of an issue was whether I should have a practising dentist on the team, and I had to give that a lot of thought. Initially I was quite keen to do that, but then the more I considered it and thought through the implications, for the team and the individual concerned, I thought that it was not in the best interest of the Review, largely because it would put undue pressure on the one who was doing it. And then the accusation would be that I had only gotten one view of the area. However, in my opinion about ten or 20 practitioners on the team and that would have made the whole thing too difficult. However, the engagement events were focussed towards practitioners and I think in retrospect that they actually gave us a much better opportunity for people to have an input, which we could then take control of and implement in the writing of the Review.”

Prof Steele has admitted that he did have a couple of fixed ideas about things that was going to pan out – and he says that he was proved almost completely wrong. “I did have a few preconceived ideas and whatever I had they were all wrong. Well not all wrong – I knew I’d find quite a lot of anger amongst the profession. Amongst practitioners we weren’t really sure what we would find to be honest, one was to find in the media and that tends to have its own agenda. So wasn’t really sure what we would find there and I wasn’t really sure what I would find in the commissioning world and people’s responses. I didn’t find exactly what I expected from the profession – I think there was a fantastic willingness to engage with the process, a real interest in getting it right and a lot of dentists who were really interested in doing good dentistry. That didn’t surprise me but what perhaps did was the real willingness to engage with the process and to really want to try to improve the system for everybody – not just for dentists but for patients and everybody else as well. And that was good because if I had got to the end and finished the job in a very short time and then finished it back in December it wouldn’t have been much of a Review!”

Discussing the biggest issues which came out of the Review Prof Steele did state that UDAs weren’t the actual problem. “The UDAs end up as a focus of all evil. But it’s not the concept of being paid for a unit of treatment, we always had that. It’s just that in the past we had different sizes of units. The biggest issue is actually the variability of the UDA and one that does concern me. And the way it is grouped together the banding across the system – came up as a bit of a problem.”

“Clearly some dentists have done much better than others and some have benefitted because of the reforms and others not. However, some of the cases that concern me are the really honest guys who are trying to do a thoroughly good job and who it hasn’t really worked for – because of the way their UDAs ended up or their patients or whatever it was and I have a lot of sympathy there. So the UDA was one thing, but actually there was much more.”

“There was an awful lot about the relationship between the dentists and the commissioners and how good or bad that relationship was. In some areas the relationship was absolutely fantastic – there was really good commissioning and it was immediately obvious. In other areas it was a fantastic willingness to engage with the process, a real interest in getting it right and a lot of dentists who were really interested in doing good dentistry. That didn’t surprise me but what perhaps did was the real willingness to engage with the process and to really want to try to improve the system for everybody – not just for dentists but for patients and everybody else as well. And that was good because if I had got to the end and finished the job in a very short time and then finished it back in December it wouldn’t have been much of a Review!”

Of course cynicism about the Review was something Prof Steele was expecting – and got! “I did come across a lot of cynicism about what we were doing and I still come across it. And I think to some extent that’s understandable. We have been through a number of Reviews before and nothing has come of it.”

But I think we are in a different place now we are running out of chances to get it right; so I can understand the cynicism and we really have to get it right now.

“The circumstances in which we have to do this - we are in the middle of a recession, there’s not much money and there is a cut in public spending, so it is a different understanding that now is not the easiest time to be doing it. In a sense though, if you understand that nobody is going to get a lot of money then it makes it a bit easier – not to deliver but it does make it easier to say ‘right this is the situation we are in’. We are in a battle now to maintain our position to be appropriately resourced. We have to use what we have maybe a little bit better. From the point of view of the profession it must make sure that it does maintain what we’ve got because eroding it further could cost dear. And I think we can do a lot with the resource we have if we use it better than we do.”

Prof Steele added: “The feedback we’ve had was pretty positive, but there was a certain amount of cynicism that you might expect. I’ve had the accusation that the Department of Health (DH) was putting all this together, that it was a DHI document - I can assure you they weren’t. What I negotiated with DH at the beginning was for total editorial control of the Review and that was re-assuring. It’s the way the Review team and I stand by everything that’s in the document – nothing has been altered.

“There have been a lot of questions about implementation and I think there is perhaps some frustration that there isn’t more detail of implementation in the Review. I thought it was more important to get the principles clearly set out then the principles clearly agreed by all parties - then the details can be worked on the back of that. In addition, our terms of reference didn’t include implementation, so they were to make suggestions about how we were going to do various things. For these things to work they have to be on firm foundations; sensible, clinical and theoretical foundations for what might work and what might not. Let’s Review the theoretically what patients want and what dentists can deliver and it was done on that sort
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of basis. For that there will be all sorts of detail and the devil is in the detail - detail about setup about the contracts and how they operate and that's fine detail that frankly I don't want to be involved in! But it has to be done and there are people who will do that.

Discussing the recommendations the Review has made, Prof Steele detailed what he thought would be the hardest to implement. "The most difficult for DH is always going to be the thing that implies most resource, so I think the most difficult for them will be the IT; actually I think it could be one of the most important recommendations in the whole thing so that we get our data collection systems and IT properly set up. The one that I think has been most controversial amongst practitioners is the idea of warranties. The point I was trying to make is that this is a principle because it is something that patients say 'well, why not?' and we have to ask the question 'if we can't do that, then why can't we do that?' - there would have to be a very good answer to that. There are situations where you can't guarantee it and there are many situations where we already do because there is a free replacement for some treatment within 12 months. That one will be the hardest to get agreement on, and the hardest to implement will be the one that costs money, so I think that will probably be the IT.

Looking to the future, Prof Steele was clearly excited about his recent appointment to head of Newcastle Dental School, a position that he took over at the beginning of August. "It's been a revelation. The Review now seems years away. I feel like I finished it months ago. So much happened during the period of the Review and it was so intense that it really occupied every minute of my life just about for six months. Then it tailed down a little bit with the presentations and that's all done now. So I've been trying to clear an awful lot of back-up, and the new role has already been really challenging!

"As head of the dental school I have to make the decisions about how we are run. I have to make huge strategic decisions about research direction, our teaching 'manifesto' and our role in the NHS. There's some quite big decisions I've got - I have to manage our budget properly which is quite a substantial I've got dealings with the local trusts which we are part of. Many millions of pounds come into the system every year and I've got to try to make sure that is used fairly. I think we've got a fantastic school here and a fantastic workforce and I've got to make sure that we use everybody to the best of their ability. It's a reasonably big school and it is obviously very expensive to train dentists so I have to think pretty carefully about how we do that."

Training and retaining students and young dentists within the NHS is a matter that has been coming up more often as the issue of access is raised. Prof Steele acknowledged that dental schools have an important role to play in this and commented that it had been raised within the Review. "It's come up in independent think-tanks and one of the consumer associations raise their concerns about dentists being committed for a certain time. There is an issue as the taxpayer pays an awful lot in to training dentists and they quite rightly expect something back. I think that for the most part we do get something back which is good. But I'm very keen to ensure our students recognise that actually they are working for the NHS, that they have a role within the NHS they do - a really important role in the NHS. They provide care within the NHS and in return they have an awful lot invested in their training.

"It's interesting that the students pay fees now - £5000 a year - and I think there's a conception that the fees cover the training. It doesn't come close and I'm not sure they get that. So I'm very keen to make sure they know that they have a huge responsibility to the NHS, that they have a role to play. But it's been a real chalenge and I've enjoyed it so far.

Looking back on the last nine months, Prof Steele wanted to show his appreciation to the people who contributed in the Review process. "I would like to put on record my thanks for the people who contributed out of their own time, and there were many people who emailed in (I tried to reply to all of them but sometimes I was unable to do so because of the volume), people who came along to the engagement events, people who telephoned me or stopped me at meetings or gave me stuff that was important and I didn't have a chance to thank all of them so if they are reading Dental Tribune – Thanks! I tried to make sure that I read everything that I got and that it was a vast amount but I really did try to do that so I would like to thank the whole of the profession for that."

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though there hasn’t been a lot of attention-grabbing news in the world of dentistry through the last few weeks, GDPUKers have still found time to air topics they feel strongly about.

One colleague was able to share a letter he had received from his dental contracts team at the PCT reminding dental colleagues that during the summer months, when the weather is warmer, they may be off work more, but reminding the colleagues that they must still provide cover for patients in pain even if not at the practice. The letter had four signatories, all dental nurses working in the dental contracting department of that PCT. This letter raised ire on the GDPUK forum, but no one ever thinks that this item is the last straw to start any revolt against the unscientific, unreasonable levels of contracting demands placed upon general dental practitioners by the Government, which claims the high moral ground yet bullies the profession.

Some other topics briefly covered at this time were questions about spontaneous pulpal haemorrhage, NTI TSS appliances, the recording of telephone calls and there was longer set of messages when a colleague reported his problems following illness and the wording of his BDA associate contract.

The arrangements should the swine flu pandemic become more serious or widespread were discussed, and there has been guidance given by the GDC as well as other bodies. Colleagues on GDPUK are also knowledgeable about the bird flu and other pandemic arrangements too.

A question was asked about saliva substitutes. Some patients have situations whereby there is no saliva being produced, and as sometimes happens when experts are asked, there are several varying answers, but the overall consensus was that this is a major problem, there is no real substitute, and patients clearly suffer if they have this condition.

There was some discussion about a future course, and perhaps there will be a report in due course on GDPUK, on the role of the state in dentistry. Perhaps this could be the subject of a future textbook, or PhD paper.

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GDPUK round-up
Tony Jacobs shares the most recent snippets of conversation from his ever-growing GDPUK online community

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Call for boys to have HPV vaccine

The British Dental Health Foundation has backed calls by leading cancer researchers for boys to be given the HPV vaccine to prevent them getting mouth cancer.

Leading academics have pointed to the links between the cancer causing human papilloma virus (HPV) in mouth cancer cases, particularly amongst young men contracting the virus via oral sex.

Currently the gardasil vaccine preventing HPV is only given to girls to combat cervical cancer cases.

The British Dental Health Foundation is backing these calls.

Foundation chief executive Dr Nigel Carter said: “Mouth cancer hits some 5,000 people each year in the UK, killing one person every five hours.

“It is time we took action to prevent this hidden killer, which is beginning to affect more and more young people. Expert studies suggest HPV could become a leading cause of mouth cancer so let us be proactive and plan against this threat.”

The government sensibly rose above controversy to give young girls anti-HPV jabs to young girls to curb cervical cancer. Mouth cancer affects far more people than cervical cancer, so surely it is time to widen the programme to boys.”

Speaking at a cancer conference in Melbourne in Australia, British expert Prof. Margaret Stanley of Cambridge University said: “These HPV’s don’t just cause cancer in women. They can cause cancer in the mouth, cancer in the anus and those cancers are very hard to treat.”

“As an anti-cancer prevention strategy, I would have thought immunising boys was a sensible way to go.”

Lemonchase now sole UK distributor

UK distributor Lemonchase is now the sole UK distributor for EC Dental Solutions products.

The company, established in April 2005, aims to offer surgeons and dentists expert advice and the finest in magnification, lighting and ancillary equipment. It is headed up by two faces well known to the surgical and dental communities, Nick Lemon and Mark Chase, who have long specialised in magnification and lighting. They offer a one-stop shop for surgeons needing magnifying loupes and for dentists interested in dental loupes and dental microscopes.

Commenting on the news, Nick said, “We’ve been on the lookout for high quality, sensibly priced consumable products to create a repeat business division of the company. EC Dental Solution’s products fit that brief perfectly and are proving very popular with existing customers and dentists nationwide.”

The range currently consists of premium diamond and carbide burs, high-speed handpieces both fibre and non-fibre optic and hygienist prophy paste in disposable cups. The diamond burs are individually packed, pre-sterilised and can be treated as single use. The high-speeds are compatible with the big handpiece brands such as KAVO, W&H, Bien Air, NSK, Star etc., and due to the move to dental dishwashers and central sterilisation are proving an economic alternative.

Over the next six months the range will be extended to include the following products:
1. Fiber post
2. Dental instruments
3. Fluoride varnish
4. Nano-composite
5. Hygiene scalers and composite instruments

For information on how you can purchase these, go to the industry news pages 26-29.
If you join the ASPD, you'll find no shortage of trustworthy advice on running your practice. Here, some members share their experiences.
Concentrate on quality
You need to keep your eye on the ball if you're to get things right in business, and dentistry is no different, insists Frank Pons

The English physicist Michael Faraday identified concentration as one of the skills essential for success. In every profession, taking care to get things right is vital, and dentistry of course is no different. However, when you are enduring a protracted tax investigation, the costs can prey on your mind. Presence of mind is key, particularly now. Dentistry has been very competitive for several years, but the credit crunch has raised this almost to fever pitch. Dentists are under the greatest pressure to deliver high quality treatment at a reasonable price, but not only that – they must also do so with a smile. Patients are feeling the financial pinch too, and will not put up with anything less than the best possible standard of service.

This has led to many dentists investing in new equipment, new training and possibly extensive refurbishments. One thing that must remain constant is the dental professional’s unerring focus on great results during every single procedure, for every clinical hour.

Concentration all round
Concentration is not confined to moments when you have an instrument in your hand. It also applies to your business planning and management. When your mind is elsewhere, it can be hard to see things as they really are; effective business decisions become harder to make. Opportunities are missed, particularly when opportunities are few and far between.

Looking beyond the practice, dentists need to be making the most of their opportunities investing in their hobbies, spending time with their loved ones, even planning for the future. Even this becomes difficult to do when facing a potentially crippling bill from an accountant or investigation specialist.

Tax investigations have been known to last several years. Imagine how many hours of assistance you will have to pay for during this time, and you will see how the prospect can drive dentists to distraction. The media is full of doom and gloom at the moment, and people are looking to the future with uncertainty. Those dentists in the midst of tax investigations know only one thing for certain: eventually, the investigation specialist will want paying. Even if the tax inspector decides that no extra tax is required.

Protect yourself
Peace of mind is hard to come by in Britain, 2009. However, when it comes to protecting yourself from the expensive fees incurred during a tax investigation, leading providers are offering insurance of up to £75,000. And when the bill from the investigation specialist arrives, you won’t be terrified to open it. With the right policy of Tax Investigation Cost Protection in your corner, you can work, manage and live with a clear head, making the most of your time professionally and personally, and concentrating on the good things in life: clinical excellence, job satisfaction and personal fulfilment.

About the author
Frank Pons is a qualified chartered accountant and tax expert. Frank Pons founded PFP in 1984, the first company to recognise the need for and provide dentists with tax investigations insurance. For more information, contact PFP on 0845 507 1477, email info@fpf.co.uk or visit www.pfpdentist.com. PFP also offers unlimited human resources and employment advice with the HR Plus service.
Blood clots are extremely valuable for initiating healing and regeneration for both soft and hard tissues. Platelet rich plasma (PRP) is becoming more accepted as a way of accelerating and enhancing natural wound healing, and has been successfully used for decades in orthopaedic surgery as well as in dermatology.

**Growth factors**

A variety of proteins and growth factors interact with each other to induce wound repair.

In a once-injured vessel, the platelets will start to stick to exposed collagen proteins and will release adenine diphosphate, serotonin and thromboxane, contributing to the clotting cascade and hemostatic process, as well as to the platelet plug formation. The platelet plug is reinforced by an insoluble protein fibromeshwork as a product of the clotting cascade.

It’s important to note the fact that platelets actively extrude growth factors, such as:

- **Well-researched growth factors**
  1. Platelet-derived growth factor = PDGF
  2. Transforming growth factor-β = TGF-β
  3. Insulin like growth factor = IGF-I

**Under research**

- 4. Transforming growth factor alpha = TGF-β
- 5. Epidermal growth factor = EGF
- 6. Vascular endothelial growth factor = VEGF
- 7. Hepatocyte growth factor = HGF

Here I will attempt to explain a bit about some of the benefits of these well-researched growth factors:

- **PDGF**
  - Proliferative activity on periodontal ligament fibroblast
  - Promotes collagen and protein synthesis
  - Enhances proliferation of bone cells.

- **TGF-β**
  - Activates intracellular proteins
  - Promotes extracellular matrix production for example in periodontal ligament fibroblasts
  - Stimulates the proliferative activity of periodontal ligament fibroblasts
  - Stimulates biosynthesis of type I collagen and fibronectin.

**IGF-I**

- In combination with PDGF will stimulate cementogenesis
- Bone formation, and many more.

It was Marx who in 1998 published a paper on the significance of increased bone formation and bone density after using thrombocyte growth factor. Rutherford et al. (1992) and Anitua (1999) published a paper on platelet concentrates for coating dental implants.

**Commercial systems available for PRP**

- Smart Prep autologous platelet concentrate system (Harvest Autologous Hemobiologics, Norwell, Massachusetts)
- Tisscel system (Baxter Heath corp., Deerfield, Illinois)
- Curasan PRP kit (Curasan, Kleinostheim, Germany)
- Friadent-Schuetze PRP (Friadent-Schuetze, Vienna, Austria)

**How the systems differ:**

1. Cycles of centrifugation
2. Speed of centrifuge
3. Amount of blood to be collected
4. Addition yes/no of bovine thrombin.

I have used the Curasan approach for many years and switched to the PRGF technique almost three years ago. For the purpose of exemplification the latter technique will be briefly described.

As such, based on the technique used, the platelet count as well as the growth-factor content may differ. Differentiation of the above number may occur as well as a consequence of the donor.

The Anitua technique:

- Venous blood (between 10-30 mL) has to be collected in office and drawn into two to six sterile tubes containing an anticoagulant (here 3.8 per cent sodium citrate).
- Centrifugation: Eight minutes at 1800 rpm.
- Three different blood fractions will be identified and isolated by pipetting.
  - Fraction 1 = platelet poor plasma (the above 0.5mL)
  - Fraction 2 = platelet rich plasma (0.5mL)
  - Fraction 3 = platelet concentrated plasma (0.5mL)

**A patient’s growth factors**

Prof. Liviu Steier and Gabriela Steier discuss how growth factors are a valuable addition to regenerative dentistry

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**Regeneration**

**Growth factors**

Prof. Liviu Steier and Gabriela Steier discuss how growth factors are a valuable addition to regenerative dentistry.

**Concept**

Platform Switching

Prof. Liviu Steier and Gabriela Steier look at the benefits of this concept, how best to carry it out and which manufacturers offer the equipment.

**Treatment**

Immediate loading

Dr Devorah Schwartz-Arad discusses a preferred solution in the esthetic zone.

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Pages 11–13

Pages 14–16

Pages 17–21
Fraction 2 = plasma containing a number of platelets (next 0.5ml)
Fraction 3 = platelet rich growth factor (remaining plasma above the buffy coat) – this is the most important fraction.

The platelet then needs activation using 10 per cent calcium chloride (0.05ml per 1ml PRGF).

The coagulation will occur in five to eight minutes (best at 37 degrees Celsius – incubator).


The same study confirmed the absence of leucocytes in all three fractions.

One can use the gained material as follows:

a. Not activated for coating implants before seating
b. Activated:
   1. To be mixed with graft materials
   2. To make membranes.

Strengths of the technique

1. Needle-free approach which drops infection risk for practitioner
2. Duration for the preparation is about 20-25 min
3. Reduced centrifugation time
4. No need of additional bovine thrombin.

Weakness of the described technique

1. Lack of leukocyte might lead to a reduced anti-infective protection
2. High number of pipetting procedures (up to 30)
3. The use of a so-called “open system” implicates high sterilisation criterion.

Conclusion

PRP is a new tissue-engineering application suitable for the clinician. Among the different procedures available, I am describing the approach which in my hands currently works best. The use of the PRP here PRGF technique significantly changed the treatment outcomes in my practice: less complications, better healing and higher predictability of regeneration procedures.

Disclaimer

The author has no financial interests in any of the presented products or systems.
Clinical case study

A 54-year-old female patient presented to our practice requesting rehabilitation of the upper jaw with implant-supported fixed restorations.

The patient had not received dental assistance for the last 12 years and had no medical problems. The patient’s chief complaint was non-satisfactory chewing efficacy. She requested rehabilitation of the upper jaw with implant supported fixed restorations.

Her oral hygiene was adequate so she underwent a rigorous oral hygiene programme for three months. The soft tissue examination revealed no problems; TMJ and muscles showed no acute problems; occlusal assessment revealed a lack of occlusal support; implant assessment showed suspect teeth 16, 15, 12, 22, 25, 26, available bone is moderate to poor; treatment plan includes planned extractions of teeth 16, 15, 12, 22, 25, 26 and a total of seven implants.

Esthetic risk analysis

We explained to the patient the high risks of smoking and it was agreed that the patient would attend a stop-smoking programme. Three months after this, the patient did stop smoking and treatment began.

The following treatment plan was agreed and discussed with the patient:
- Planned extractions: 16, 15, 12, 22, 25, 26.
- Number of implants: seven
- Position of implants: 15, 14, 15, 12, 22, 26, 27.
- Bone graft using: BioOss (Geistlich) and PRGF (Anitua technique).
- Type of prosthetic restoration: single crowns.
- Surgical template: conventional lab-made surgical guide.

Consent was obtained and the treatment started. The first treatment step comprised extractions and the fitting of a temporary restoration. Ten weeks later, impressions were taken, casts were mounted in a semi-adjustable articulator and sent to the lab for manufacturing of a surgical guide. PRGF, implant insertion and bone graft (a mixture of Grafton, BioHorizons and BioOss, (Geistlich) soaked in PRGF) were performed concomitant in local anesthesia. Antibiotic coverage was assured for seven days.

The patient was asked not to wear temporary prosthesis for 10 days and an antibiotic regimen was prescribed.

The second-stage surgery was performed six months later. After a gingival healing/maturation time of 14 days, definitive impressions were taken, bite registered and a face bow made.

After two try-in sessions the definitive restorations were fitted.

The 12-month X-ray proved a stable outcome and it is expected that the patient will come back for rehabilitation of the lower jaw.

Conclusion

Wound-healing deficiencies do not often impose an obstacle in guided bone regeneration (GBR) procedures when associated with implant placement. The use of PRP techniques in medicine go a long way back and its application into dentistry represented a change of paradigm. The author can only anecdotally affirm, based on his own experience, that since using PRP (latest PRGF) techniques, wound-healing problems don’t occurred again and GBR procedures seem to have gained more predictability.

References are available on request.

About the author

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 Specialist fuer Prothetik (www.dgzpw.de).

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Gabriela Steier is a BA from Tufts University Boston. She has conducted extensive research in the field of ozone in endodontics and has co-authored several articles, and textbooks chapters.
Platform switching in dental implants

Prof. Liviu Steier and Gabriela Steier look at the benefits of this concept, how best to carry it out and which manufacturers offer the equipment.

Introduction

The crestal area is the region to suffer initial breakdown when it comes to the implant tissue interface. Adell et al. (1981) first communicated 1.2mm of marginal bone loss from the first thread during healing time, with a continuation of 0.1 mm annually.

As a consequence, Smith and Zarb (1989) established the following as criteria for implant success: vertical bone loss of <0.2mm annually following the first year. This of course is a major issue in the anterior esthetic zone. Since then, clinicians and manufacturers have worked hard to try to improve this condition.

Factors affecting loss

The following factors are among the most discussed to cause crestal bone loss:
1. Surgical trauma
2. Biologic width/seal
3. Microgap
4. Occlusal overload
5. Crest module.

Causes of trauma

Overheating the bone during the drill procedure; extended full-flap raise, Screw-in forces higher than 35 N/cm² are optional causes for crestal breakdown. As such, these factors may only be responsible for bone loss prior to prosthetic load.

Biologic width/seal

This seal starts the day the abutment is mounted and continues for the next six weeks into treatment. Today’s surgical protocols control this fact by adequate three-dimensional implant positioning.

Microgap development

Two-stage implants seem to be prone to microgap development. Even with implant engineering work, it’s hard to control via different improved connections, glue, etc.

Occlusal overload

Crestal bone is mostly cortical bone. Forces occurring at the crestal level are described as shear forces. Cortical bone is highly susceptible to shear forces. Occlusal concepts have been developed specially for implant-supported restorations to address this issue.

Crest module

Implant professionals as well as implant manufacturers have introduced different remedies to address this issue: polished collar, Connective Contour (Astra), Laser-Lok Technology (Biohorizons), for example.

The peri-implant histology

Ericsson et al (1995) reported the following findings:

a. Plaque associated inflammatory cell infiltrate;

b. Implant associated inflammatory cell infiltrate.

As such implantologists addressed more attention to the area.
Serendipity

In the late 1980s, NobelPharma introduced a Branemark 5mm-diameter implant. The prosthetic components used a “standard” diameter. In 1991, Implant Innovations introduced wide diameter implants. Of course not all prosthetic abutments were available. As a result, prosthetic parts from a regular platform have been used.

Long-term observations of this demonstrated a reduced loss in crestal bone height compared to the available standards.

The platform switching treatment concept

The platform is the crestal area of an implant. Let us say as an example that the diameter of the implant is 5.2mm and the abutment measures 3.2mm. The difference of the diameter between the implant and the abutment is the so called “platform switching”.

Manufacturers offering the concept

The concept of platform switching is only offered exclusively by a restricted number of implant manufacturers:

1. Wieland
2. BTI
3. 3I
4. Astra
5. Dentsply – Ankylos
6. Zimmer

Scientific evidence


Conclusion: The findings of the current trial indicate that the use of implants with an enlarged platform can result in better preservation of crestal bone as compared with conventional cylindrical implants when a reduced abutment is mounted.


Conclusion: This study suggests that, in a limited time period of two years, immediately placed implants with subsequent platform switching can provide peri-implant tissue stability.


Conclusion: Results from this study showed the reduction of abutment diameter (for example, platform switching) resulted in a measurable, but minimal effect on Von-Mises stress in the crestal region of cortical bone.


Conclusion: The concept of platform switching appears to limit crestal resorption and seems to preserve peri-implant bone levels. A certain amount of bone remodelling, one year after final reconstruction occurs, but significant differences concerning the peri-implant bone height compared with the nonplatform-switched abutments are still evident 1 year after final restoration. The reduction of the abutment of 0.55mm on each side (5mm implant/4.4mm abutment) seems sufficient to avoid peri-implant bone loss.

Dental holidays in the UK

Can Britain really compete with Europe for dental implants?

The concept of platform switching is only offered exclusively by a restricted number of implant manufacturers.

Conclusion: Platform switching seems to reduce peri-implant crestal bone resorption and increase the long-term predictability of implant therapy.


Conclusion: This proof-of-concept study suggests that immediate loading with platform switching can provide peri-implant hard tissue stability with soft tissue and papilla preservation.


Conclusion: Within the limits of the present study, it was concluded that both CAM and CPS implants revealed crestal bone levels changes after 28 days of healing.

The ITI Consensus Statements and recommended clinical procedures regarding esthetics in implant dentistry (ITI Treatment Guide Volume 1- Quintessence) have to be mentioned here as the authors wish to avoid raising false expectations that only platform switching (a group of prosthodontic and restorative procedures) can lead to predictable results. The authors’ statements in the articles are based on:

1. Long-term results (from evidence to newer surgical approaches)
2. Surgical considerations (from extraction planning to soft tissue stability)
3. Prosthodontic and restorative procedures (from standards for esthetic fixed-implant restorations to location of the implant shoulder)
4. Well-executed esthetic risk analysis performed prior to any treatment planning.

Conclusion: The authors would like to end with questions raised by DM Gardner in an article in NDSM, from APRIL 2005:

• Can implants be placed closer than 3mm from an adjacent implant, while still maintaining interproximal height of bone?
• Can implants be placed less than 1.5mm from an adjacent tooth and still maintain interproximal bone?

The authors’ personal experience is of course limited to one manufacturer, but over time the results are encouraging and many more long-term multicentre studies are needed to obtain evidence.

About the author

Gabriela Steier
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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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In the past two decades, immediate implant placement into fresh extraction sites has gained in popularity and is considered a predictable and acceptable procedure. However, the dimensional changes and esthetic results are controversial. The rationale behind immediate implant placement is, in part, based on observations that it may contribute to bone preservation. Early extraction and immediate placement could lead to a favourable crown-implant ratio, better esthetics, and a favourable interarch relationship.

In this case, the right maxillary canine was scheduled for extraction due to root fracture. Single-tooth replacement through immediate provisionalisation was chosen as the treatment method.

In Fig. 1a, the right maxillary canine was extracted, taking care not to damage the buccal plate and the adjacent papillae. In Fig. 1b, a pre-operative CT scan revealed thin buccal plate in the area of this canine. In Fig. 1c, the canine was atraumatically extracted, taking care not to damage the buccal plate and the adjacent papillae. In Fig. 1d, an implant was immediately placed into the fresh extraction socket without raising a flap. In Fig. 1e, an acrylic resin provisional crown without any occlusal contacts was fabricated and placed. In Fig. 1f, healthy soft tissue around the provisional crown is evident at six months.

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The Dental Company
In 2001, Garber et al. introduced immediate provisionalisation of immediate implants and described the next generation of the immediate implantation technique, which included atraumatic tooth removal with simultaneous root-form implant placement and temporisation in one session. This technique of “Immediate Total Tooth Replacement” allows for the maintenance of the bony housing and soft-tissue form that existed before extraction, while simultaneously establishing a root-form anchor in the bone for an esthetic restoration.

Diagnosis and treatment planning

These are key factors in achieving successful outcomes after placement and restoration of implants inserted immediately after tooth extraction. A socket often presents dimensions that may be considerably greater than the diameter of most implants after extraction. In a histological report, Wilson et al. stated that the horizontal component of the peri-implant defect was apparently the most critical factor relating to the final amount of bone-implant contact. Botticelli states that small defects (1-1.25 mm) may heal with new bone and a high degree of osseointegration and that the placement of a barrier membrane after implant installation does not improve the outcome of healing. Jung et al. concluded that the remaining defect, small enough to be clinically neglected, irrespective of gap size within two mm, does not need any kind of regenerating procedures.

In 1998, this author examined the hypothesis that immediate implants can succeed without primary flap closure. A technique was described that does not require any incisions during immediate implant placement. No barrier membranes were used and the sole grafting material was autogenous bone chips. Clinical osseointegration was achieved with minimal gingival recession and papillae preservation. It was concluded that immediate implant placement in the anterior maxilla can be successful in replacing a single tooth even without primary closure.
The esthetic zone
Preservation of the buccal bone crest after tooth extraction is of major importance in achieving esthetic results and long-term implant survival. However, controversy exists in the literature regarding immediate implantation benefits for preserving the morphological ridge contour. A marked reduction of the buccal bone following implant placement in fresh extraction sockets has been shown in animal studies. For example, Araújo et al. concluded that the bone-to-implant contact established during the early phase of socket healing following implant installation was partly lost when the buccal bone wall remained. However, post-extraction implants. The same surgical procedure included mucoperiosteal full-thickness flaps that were elevated to disclose the buccal and lingual hard tissue wall of the ridge. The same surgical procedure conducted by Bötticelli et al. also concluded that the height of the approximal socket walls may be retained and the reduction of the crestal bone will be limited to the buccal walls of the recipient site.

Bone preservation
The controversy regarding bone preservation has been discussed in several studies. Fickl et al. have shown that the resorption rate of the extraction socket decreases when the periosteum remains in place. A significant lower resorption rate was found in the “flapless groups” with and without the socket-preservation techniques. Furthermore, the flapless technique implementing bone augmentation materials preserves the socket volume better. In their study on dimensional changes of the alveolar ridge contour after different socket preservation techniques, Fickl et al. were not entirely able to compensate for the alterations after tooth extraction. Yet, incorporation of BioOss collagen seems to have the potential to limit but not avoid post-operative contour shrinkage. Treatment of the extraction socket with BioOss collagen and a free gingival graft is beneficial in limiting the resorption process after tooth extraction.

A pilot study in which buccal bone preservation after immediate implantation, using a flap or flapless approach in mongrel dogs was evaluated, has shown that the flapless approach reduces the buccal bone height loss for immediate post-extraction implants. A reasonable explanation could be the preservation of the periosteal vascular network. Immediate post-extraction implants also have a high percentage of bone-to-implant contact.

Immediate loading of immediate implants
The objective of immediate provisionalisation or loading of dental implants is to combine tissue preservation with bone preservation (Total Volume Preservation) that follows immediate placement. This will preserve proper volume and shape of the hard and soft tissues. Immediate provisionalisation also results in fewer surgical interventions and a simpler solution for the patient.

Immediate loading of immediate implants does not impair osseointegration of an immediately loaded implant compared to an unloaded post-extraction implant. The key difference between success and failure of osseointegration of the immediately loaded implants is controlling the micromotion, which is reduced through broad antero-posterior distribution of the immediately loaded implants. Anchorage of the cortical bone, especially in the maxilla, may be necessary to increase implant stability. Recently, this author found that after a mean follow-up of 15.6 months, provisionalisation of immediately placed implants proved a predictable procedure with a high implant survival rate (97.6 per cent).

Histologic observations from different animal and human studies have shown that immediately loaded implants can have a direct bone-to-implant interface without any fibrous tissue formation. Success in immediate placement and loading of implants is based on several clinical parameters.

Therefore, this treatment concept can be applied to everyday clinical practice in properly selected patients who

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have good primary stability and sites with a fully preserved extraction socket with no bone dehiscence. Immediate provisionalization should be proposed only if an appropriate initial insertion torque has been applied to the implant.\textsuperscript{60} Implant placement in extraction sockets combined with immediate function has been widely reported.\textsuperscript{20,25–26}

The esthetic success\textsuperscript{10,26,27} is related to Total Tissue Preservation and to several other parameters, including maintenance or re-establishment of harmoniously scalloped soft tissue lines and natural contours, number of missing teeth, location of missing teeth and the relation to the midline, whether missing teeth are adjacent, etc.

Single-tooth replacement
A single tooth replaced by a single-implant restoration is an increasingly popular treatment option, especially among young patients (Figs. 1a to 1f). A high level of surgical and prosthetic success is achieved with the single-implant restoration.\textsuperscript{5,20} A significant reduction in the number of surgical procedures required, and elimination of the need for a provisional prosthesis between the surgical and prosthetic phases of treatment are among the advantages of the immediate-loading protocol. This procedure has shown predictable clinical success and possible preservation of the existing osseous and gingival morphology. Immediate restoration of implants placed immediately in fresh extraction sites can provide a safe treatment option, with success rates of 94 per cent to 98 per cent.\textsuperscript{20,25}

Atraumatic tooth extraction is essential for successful immediate implant placement and the maintenance of the buccal plate (see Fig. 1c). The most important factors and main prerequisites for immediate loading are sufficient initial implant stability and insertion torque of about 40 N/cm. When a single-tooth implant is immediately loaded, the implant-abutment connection should also be stable; primary stability is fundamental.

Single-tooth replacement does not actually represent immediate functional loading, since clinicians normally prevent any occlusal function of the provisional restoration. Therefore, these types of restorations are classified as immediate provisionalisation only.

A strong advantage of this treatment protocol is immediate placement of the restoration. This eliminates the need for a provisional removable prosthesis and leads to satisfactory esthetic results. Second-stage surgery is unnecessary, and excellent soft tissue healing occurs predictably, with a stable mucogingival junction in relation to adjacent teeth and with preserved interproximal papillae. These clinical outcomes reduce the necessity of further surgical procedures to improve the gingival architecture.

Multiple adjacent implants
Replacement of multiple adjacent teeth with fixed implant restorations in the anterior maxilla is poorly documented. The esthetic results are not always predictable because the mechanism of tissue behaviour in the context of the esthetic outcome is still not fully understood.\textsuperscript{19} The distance of the bone crest from the restoration’s contact point is related to the presence of the interimplant papillae.\textsuperscript{60} This may imply that preservation of this bone crest is imperative for
The effect of immediate implants on non-compromised bone shape and quality (for example, in the maxillary premolar and anterior mandibular regions) is less important. However, it becomes a major contributing success factor when bone shape and quality are compromised (for example, in the anterior maxillary region and posterior regions of both arches). The preservation of alveolar ridge dimensions immediately after tooth extraction has been documented.11

Immediate loading of multiple adjacent implants in a partially edentulous arch could result in success rates even higher than those for single-tooth replacement (Figs. 2a to 2j). This might be due to the distribution of forces among the adjacent implants and the absence of rotational forces that act on a single implant.

As with single-tooth implants, the clinician is advised to eliminate any function of the provisional restoration for the first three to six months, which is the waiting period prior to final restoration.

Tips for success
Several important parameters should be considered for successful implant placement with immediate loading:
• Primary stability is crucial (40 N/cm is recommended). An implant with stability less than 50 N/cm should not be loaded.
• Flapless surgery is preferable in the esthetic zone.
• Gap filling is recommended at the esthetic zone.
• The use of membrane is not necessary.
• Implant placement should be slightly palatal for better esthetics and volume maintenance in the anterior maxilla (with augmentation at the buccal area).
• Rigid fixation is used when more than one implant is involved.
• The provisional crown or fixed partial denture should not be in occlusal contact.

SETTING THE PACE IN ANALGESIA

‘Immediate restoration of implants placed immediately in fresh extraction sites can provide a safe treatment option’

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Tips for success
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• Implant placement should be slightly palatal for better esthetics and volume maintenance in the anterior maxilla (with augmentation at the buccal area).
• Rigid fixation is used when more than one implant is involved.
• The provisional crown or fixed partial denture should not be in occlusal contact.
• Strategic extraction should be considered when it allows placement of longer implants, which leads to better prognosis and prosthetic positioning, especially in the esthetic zone.

References are available on request.
Orthodontic treatment is becoming more accessible, which can only be a good thing for patients. Innovative new systems have enabled general dental practitioners to offer treatment for mild to severe malocclusions, with the close support of experts in the orthodontic field. Thanks to the media, people in the UK are becoming more interested in achieving straight, white smiles. One of the benefits of orthodontic treatment is that it achieves this naturally, using the patient’s own dentition, and the results can be truly life changing. However, orthodontic treatment requires considerable expertise to perform, and can seem daunting to dentists who already spend a great deal of time on continuous study to improve their skills and knowledge.

Straightforward options
Fortunately, the leading system has been designed so that it is organised into a clear structure. This provides GDPs with the most straightforward set of options, and experts are on hand to discuss cases and offer support. When a dentist decides to add orthodontic treatment to his or her treatment list, it is imperative to look at the way the system is organised, since this will impact greatly on the speed and accuracy of treatment.

The leading system is organised into five key elements, with each one addressing a specific area of treatment. Not only does this make the system more intuitive for GDPs, it also promotes appropriate implementation and treatment. It is highly unlikely, with a clear system of processes, for the GDP to miss a crucial stage of the process, and excellent results are facilitated by the step-by-step approach.

Five key elements
The first step is pre-alignment, and in the leading system this part of the process involves the use of the CODA expansion device. This affects expansion in both arches using very light elgiloy wire and soft esther acrylic. Pre-activated and pre-adjusted in the laboratory, the CODA is easy to utilise for the dentist.

The second key element is space closure, which offers the GDP a number of options. Fixed wire and brackets are available, and the laboratory can offer an indirect bonding method to allow space closure either buccally or lingually, but dentists are also able to use an innovative closing spring, which combines a positioning tray in the anterior section, with spring-loaded nickel titanium wire in the buccal section surrounded by acrylic.

The third element is alignment, which uses a set of clear, medical-grade polymer positioners to move teeth incrementally in the desired direction.

The fourth step involves finishing and detailing, with a variety of devices including extrusion elastics, buccal segment settling, the final occlusion refinement and detailing appliance and more.

The fifth element includes the extras, a range of applications for bite opening and anchorage, as well as attachments for gaining a greater purchase on the tooth.

With these five elements, the leading system helps GDPs not only offer orthodontic treatment to patients, but also work confidently, without feeling over-awed by the wealth of options available.

About the author
Dr Andrew McCance
Since qualifying in dentistry from Glasgow University, Dr Andrew McCance has gained a wealth of experience in multi-disciplinary practices. In the mid-1990s, Dr McCance began to develop the Clearstep brace, based on the demands of the 4,000 patients treated annually in his specialist practices. Call 01342 337910 or email info@clearstep.co.uk.
How to give feedback

As a practice manager, you must regularly inform your staff about their performance. Nikki Berryman explains why this is beneficial and how it can be done successfully.

Feedback is a powerful motivator. It is an indicator that the job we are doing is important, it is crucial for learning and development and it is one of the main tools in monitoring performance in ourselves and staff members. Feedback is essentially a way of conveying appropriate, significant information to others and to some degree is a trust-building exercise. It can also be a way of learning more about ourselves and others.

As a practice manager, you must regularly inform your staff about their performance. Whether they are performing well or need to do something better, giving feedback means acknowledging what was done.

A good manager will deliver both positive and negative feedback by:
- Being genuine, honest and open
- Being specific and direct
- By giving encouragement for improvement when feedback is needed
- Genuinely listening to the response
- Giving time for reflection/discussion
- Being consistent.

Start with the positive

Always start with positive feedback, it makes people feel warm, motivated and encouraged and therefore more open to receive negative feedback (if necessary). Show and advise how to turn negative feedback into a positive result, this will give your team member a goal and something to work on rather than focusing too much on what they actually got wrong.

It is important to be very specific and to avoid generalisations, there needs to be as much detail as possible in order for the recipient to use this as a learning process. Make it clear that the feedback has come from you, for example, ‘I thought that...’ This is especially important where negative feedback is concerned as it removes any thought of ‘being ganged up on’. We need to remember that the person to whom you are giving feedback must always be encouraged and given the opportunity to respond.

Negative feedback, if treated appropriately, can be a positive experience. Robert Heller (1998) stated: ‘If you only get positive feedback, it may well not be the whole truth.’

When to give feedback

Meetings can be used to give or receive generalised feedback as to how a system/technique may be working within the practice. Meetings should never be used to offer personal negative feedback. Daily management meetings – 20 to 30 minute sessions at the beginning of each day, to discuss the day ahead and give or receive feedback from the day before.

Team meetings (for example, weekly) – individual teams can organise and run these between themselves. Excellent for improving communication levels between staff members. Sometimes allow people to become more expressive and confident where they wouldn’t normally due to ‘managerial’ presence.

Appraisal – these can used to give feedback as a whole, i.e. how someone is developing within the practice. This is the most commonly used way of giving feedback, but practice managers must ensure that the yearly appraisal is not the only time that feedback is given.

One-to-one – private one-to-one sessions should always be used for sensitive feedback. Positive feedback is also better given in this kind of situation, there are no distractions and people will be able to take in what is being said to use as a learning tool.

End of day – for example, ‘Thanks for coping well with a difficult day’ – simple feedback for a job well done.

Coaching and mentoring - the coach/mentor will be expected to give feedback. Assign each staff member a mentor. This does not necessarily need to be someone who is ‘above’ them in the practice hierarchy. It is about having someone to communi- cate with, to discuss ideas with, to get feedback from.

Coaching sessions – in a business where innovation is built into the culture, coaching is an ongoing process. Coaching sessions with a peer (from inside or outside the business) can provide improved communication and positive feedback.

Points to note

- Feedback must be acceptable and usable
- Focus on the ‘here and now’

‘How can you expect your team members change, develop or improve their performance if you, as their manager, are not giving regular feedback?’

‘If you only get positive feedback, it may well not be the whole truth.’

‘Share ideas – do not lecture

- Learn to listen

- Be specific

- Be personal

- Feedback sessions should be held in an atmosphere of sensitivity and support

Where to start

If as a practice manager you do not feel confident giving feedback, the easiest place to start is of course with positive feedback. It doesn’t have to be over the top, a simple thank you for a job well done will suffice. As you learn to be more confident and as you begin to give more regu- lar feedback it will become easier to give negative feedback where necessary.

The golden rule is: how can you expect your team members change, develop or improve their performance if you, as their manager, are not giving regular feedback?'

This article is an extract from one to be published in the Autumn 2009 issue of Dental Management, which is sent free to all members of the British Dental Practice Managers Association. The BDPMA is the essential forum for dental practice managers and organises seminars on all aspects of practice management. For more information telephone the BDPMA at 01452 888364 or visit www.bdpma.org.uk

About the author

Nikki Berryman is BDPMA membership co-ordinator and practice manager for past 10 years of Pure Dental Health and Wellbeing Centre in Truro, Cornwall. She is also a qualified dental nurse, has a diploma in dental practice management (DipDPM) and a diploma in management (DipMngmnt). She has been married for 14 years and she enjoys running, hiking, cricket (watching, not playing), cooking and spending time with friends on the beach.
Together, guiding the way to long-term oral health

Recommending Oral-B® Power toothbrushes can help your patients reach their long-term oral health goals. That's because the unique small round brush-head design and the oscillating-rotating cleaning action ensure a superior clean in hard-to-reach areas, versus a regular manual brush.

Together, we can make a difference.
Ed Bonner considers
The case for... and against Returnment

What is 'returnment'? Very simply, it is the act of returning to work after one has retired. Now, I know many people whose entire working lives have been devoted to arriving at that magical moment when they clear their desks or instrument drawers or whatever, attend the farewell drinks celebration of their years of diligence and hard work, and wave goodbye for the last time to those they have worked with for so long. With the first installment of their hard-earned pensions about to grace their bank account, they are all set to head for the golf course or bowling green, or whatever it is that Merton, Margate or Majorca is famous for. Just think, never having to worry ever again whether that crown will fit, never having to listen ever again to some ancient biddie complaining about her lower denture rubbing on her gums. The perfect scenario?

Lot to be said for that – having time for the garden, the grandchildren and the geographical locations you have always wanted to visit; having heaps of quality time to spend with your spouse with whom you have spent so many years not spending time. Or even to settle down and write that novel that has been tossed around in the back of your mind for so long. Or learn to play the guitar, easier because your fingers are still supple and loose, or sculpt (dentistry is a form of mini-sculpting). What could be nicer?

But halt awhile! All may not be rosy in the garden of retirement. In the first instance, your spouse will have had about 40 years of being used to not having you under his/her feet, of not having you chattering away at breakfast, lunch AND dinner, of not having to ask if you want tea every three hours, and, perish the thought, of not being asked if they fancied a roll in the hay twice a day.

In the first instance, your spouse will have had about 40 years of being used to not having you under his/her feet, of not having you chattering away at breakfast, lunch AND dinner, of not having to ask if you want tea every three hours, and, perish the thought, of not being asked if they fancied a roll in the hay twice a day.

Then, think about all that knowledge you have accumulated. What to do with it? Let it wither, or put it to some really useful use: teach? You always got on well with young people and would certainly find telling what really works (compared to what the theorists though really worked) quite rewarding. Write your memoirs? Bet you could spin some amazing stories that you have accumulated over the years! Write articles such as ‘The case for... and against...’ for a dental magazine?

Go back to your practice a couple of mornings a week just to keep your hand in on those few patients who truly believed that you walked on water? Take on locums where you can work for a couple of weeks at a stretch in between your trips to golf on the Algarve or ski in Tignes? That would definitely keep you in petty cash and your hand in and you off the street. Whatever you decide to do, do something, unless you literally want to die of boredom after you have completed your 1,000th crossword.

Keep on achieving

It is now an established fact that our minds if left unemployed wither as quickly as our bodies as we age; yet if put to use, can achieve extra-ordinary things. The author of these thoughts has often wondered why great pianists and other musicians, composers, artists and authors live to a grand old age, no matter how dissolve their lives, and has come to the conclusion that it is due to the following factors: (i) they can continue do what they do, and do it well, even if in a modified form; (ii) they have more things to do than time to do them; (iii) they retain their sense of self-worth; (vi) they enjoy the challenge of re-inventing themselves concentrating on using their retained strengths rather than dwelling on their fading faculties; and (v) they become revered role-models providing they retain their sense of humour (Katherine Hepburn said that if you survived long enough, you would be revered – rather like an old building).

Can’t remember who it was who said old age is not for sissies, but it was definitely Norman Vincent Peale who said: ‘Live your life and forget your age!’ The immortal Mae West said something similar: ‘You’re never too old to become younger!’ and there’s nothing that keeps you younger than going back to work when you don’t have to. That’s returnment.

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For Information on training call Elizabeth

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Nobel Biocare are the world leader in innovative restorative and aesthetic dental solutions and offer professionals an outstanding range of effective, easy to use implants that are scientifically proven to be safe and effective.

For further information please call: +44 01885 452 912, or visit www.nobelbiocare.com.

Support Chairs
Ergonomically designed for optimum comfort!

It is universally accepted that maintaining a correct posture whilst at the chairside is essential for operator efficiency, comfort and health. This is particularly important during procedures, where the clinician spends long periods bent over a patient, staying relatively still in order to perform intricate procedures. Poor posture can easily result in back pain, a problem that hasts most Dentists causing discomfort, reduced working hours and possible forced early retirement.

Support Chairs’ Support Stools have been developed for professionals working in sedentary positions, where both body and support the ability to pre-packed drape kits provide a time and cost saving solution for your surgical needs. They contain a comprehensive range of drapes and gowns and feature a detachable traceability label for your records and are currently on offer from £20 per pack.

To place an order or for further information contact Swallow Dental on 01555 656512.

Email: rebecca.jacques@swallowdental.co.uk
www.swallowdental.co.uk

Scottish Dentist July/August edition 09

The Astra Tech Implant System
It’s all in the documentation

You can count on Astra Tech for solid documentation and reliable clinical results. In fact, our Astra Tech system is exceptionally well documented. At Astra Tech, documentation is an integrated and essential part of the quality assurance process.

A comprehensive study programme that began in 1986 now includes more than 300 published, scientific references supporting our products. Due to the consistency of our implant design, the results from those references are in fact applicable for the implants that we are selling and marketing today.

The system has been documented for a range of clinical indications, surgical applications and prosthetic solutions. High implant success and survival rates:
- Maintained marginal bone level i.e. no or limited marginal bone resorption
- The same optimal clinical outcome with one-stage and two-stage surgical protocols
- Predictable results for early loading and immediate loading protocols

The results from our research and documentation are published in scientific journals and summarised in our Scientific Reviews and Documentation Summaries. For more information please e-mail info.uk@astratechuk.com or call 0845 450 0586.

Digital Dental
Looking at Cone Beam Technology! Digital Dental have the range to suit every requirement and budget.

Digital Dental offers a complete range of cone beam digital imaging systems.

As an adjunct to the Gradia system, GC developed a light cured composite for the highly aesthetic reproduction of gingival tissue. GC Gradia Gum is particularly indicated for implant superstructures and for other fixed or removable prosthetics.

GC Gradia Gum allows you to reproduce unlimited natural gingival shades, as the layering technique combined with a variety of modifiers provides endless possibilities.

GC FitChecker II is the perfect material to check the fit of your crowns and bridges, as well as some other restorations. This A-silicone has excellent flow characteristics enabling minute surface detail to be recorded. You can easily identify even subtle misfittings according to the tone and translucency of the set FitChecker II, which has a film thickness of just 15 microns.

For further information please contact GC UK on 01908 218099 or visit www.gecerurope.com.

GG UK Ltd

GC Gradia is a high strength micro-hybrid composite system with the brightness, translucency and warmth in the oral environment, making it remarkably life-like in appearance providing fantastic aesthetics combined with superb physical properties. Gra- dia is the material of choice for inlays, veneers and crowns and bridges.

Digital Dentals
United Kingdom Edition • September 7-15, 2009

26 Implants

Biologic Solutions
The new range of Regeneration products from BioHorizons

BioHorizons are pleased to introduce BioLogic Solutions, their new comprehensive BioLogic product portfolio, offering a wide range of evidence-based regeneration options to ensure ideal site development. This proven hard and soft tissue range is successful in delivering optimal aesthetics and successful implant placement.

BioLogic Solutions follows the BioHorizons history of introducing market leading products based on science and evidence based research. The range comprises Ladderc (dental bone graft), MinerOss mineralised allograft (cortical & cancellous bone chips), Grafton (Demineralized Bone Matrix), Alloderm (Regenerative tissue matrix) and the most recently introduced Mem-Lok (Type 1 Collagen resorbable barrier membrane of bovine origin).

The BioHorizons complete line of Regeneration products provides you with solutions to restore your patients to their intended functionality and appearance.

For more information on BioLogic Solutions please contact BioHorizons on 01344 752560, email: info@biohorizons.com or visit our website at www.biohorizons.com.

NobelReplace™ Tapered
The easy to use solution for a completely natural effect!

The entire range of implants from Nobel Biocare offers dental professionals reliability and quality every time. All products and innovations from Nobel Biocare have been validated through stringent pre-clinical and clinical studies to bring you reliable, state of the art products, like the NobelReplace™ dental implant.

NobelReplace™ Tapered is the most widely used implant in the world and offers high initial stability for all indications, including cases of immediate extraction & implant placement. The multi-range Duo 5D offers a wider selection of fields of view, with four options between 5cm x 5cm and 12cm x 8cm.

You can count on Astra Tech for solid documentation and reliable clinical results. In fact, our Astra Tech system is exceptionally well documented. At Astra Tech, documentation is an integrated and essential part of the quality assurance process.

A comprehensive study programme that began in 1986 now includes more than 300 published, scientific references supporting our products. Due to the consistency of our implant design, the results from those references are in fact applicable for the implants that we are selling and marketing today.

The system has been documented for a range of clinical indications, surgical applications and prosthetic solutions. High implant success and survival rates:
- Maintained marginal bone level i.e. no or limited marginal bone resorption
- The same optimal clinical outcome with one-stage and two-stage surgical protocols
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The results from our research and documentation are published in scientific journals and summarised in our Scientific Reviews and Documentation Summaries. For more information please e-mail info.uk@astratechuk.com or call 0845 450 0586.

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Digital Dental offers a complete range of cone beam digital imaging systems.

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For further information please contact GC UK on 01908 218099 or visit www.gecerurope.com.
Predictable Treatment Results

The rehabilitation of the edentulous maxilla and the mandible always presents a challenge for professionals. The All-on-4 evidence based protocol enables implantologists predictable results in even the most difficult of cases.

The procedure is based on placing two straight anterior implants and two angulated posterior implants to avoid the sinus/sinus lift but at the same time reduce the cantilever. Dental professionals will benefit greatly from the All-on-4 treatment outstanding features including:

- No complicated bone grafting procedures required
- No sinus lifts required
- No nerve repositioning required
- Limited/Shorter cantilevers on posterior implants
- Faster treatment time
- Compatibility with NobelGuide™

Complete rehabilitation of the upper and lower jaw can be costly and time consuming. Practices that offer less expensive, immediate loading techniques will be able to create a better service patients and offer faster, less traumatic procedures and a speedy recovery.

For more information about a world class All-on-4 course date in your area or to find a Nobel Biocare mentor please call: +44 01805 452 912, or visit www.nobelbiocare.com

A plus for any practice

You are your practice’s most important asset and maintaining your health is vital – Sirona’s aim is to design our treatment to improve your health is vital – Sirona’s aim is to design our treatment.

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Innovative Ultrasound Surgery

NSK’s powerful VarioSurg is the first choice for ultrasonic surgery as it is packed with features to help control excising surgical procedures. Strong, precise cutting power is enhanced with TiN (Titanium Nitride) coated bone cutting tips that are available in a wide variety of shapes and sizes, increasing cutting efficiency and leaving a surface that aids bone formation.

 NSK’s VarioSurg employs ultrasonic cavitation of the irrigation solution reducing heat generation, minimizing osseonecrosis and avoiding damage to any surrounding soft tissue.

The VarioSurg is fast becoming recognised as an effective tool for implant dentists, among them Dr. Joe Bhat BDS FDS RCS McLintDent MBD RCSEd, Specialist in Prosthodontics and Oral Surgery, Director of Moor Park Specialist Dental Centre and Fellow of the International Team for Implantology. “I have found NSK’s ultrasonic surgical unit VarioSurg is nonfunctional yet very easy to use and it has certainly revolutionised my way of performing implant surgery”.

 NSK’s VarioSurg is versatile enough to be useful in numerous areas of implant surgery including bone surgery and sinus lifts and periodontal surgery.

For more information contact Jane White at NSK on 0800 6541909.

BioHorizons announce First Ever European Congress

Following the success of their 5th Annual Global Symposium in June, BioHorizons are now delighted to announce the details of their first ever European Congress on 8th – 10th October 2009.

Cascais, near Lisbon, Portugal, is the exciting location for the BioHorizons European Congress and features a comprehensive up- to- date programme of renowned international speakers addressing current trends in implant dentistry and tissue regeneration with a special focus on satisfying and exceeding patient expectations.

BioHorizons is one of the fastest growing oral reconstructive device companies in the world as a result of their commitment to providing the most comprehensive line of evidence-based, scientifically-proven dental implants and tissue regeneration solutions.

Speakers include internationally renowned Maurice Salama, David Garber, Hom-Lay Wang and Marius Steigmann. Please register now to reserve your place at this outstanding educational event.

For further details and to register please contact BioHorizons on 01544 752560, email: info@biohorizons.com or visit our website at www.biohorizons.com

Vital – Still using a membrane?

If you, like most implantologists and periodontists find membranes difficult to handle, then VITAL may be the answer for you. It is a great British product that reliably and quickly turns into bone. Vital is simple to use and sets beneath a flap to create an osseous wall, it is also found in the external periosteal callus of repaired

NEW CEREC AC Bluecam ~ Seen in a new light

Sirona UK has a specialist division of Sirona Dental Systems, which for the last 5 years has supplied and supported CEREC 5 CAS/CAM in the all-ceramic restoration system in the UK.

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

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

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

To find out how the Sirona team can directly support your practice and for a no obligation demonstration please telephone 0845 671 0440 or email: info@sironadental.co.uk or visit www.sironadental.co.uk
femoral fractures in children. Significant improvements in stability have been achieved by providing an increased amount of calcium ions (Ca2+ and PO4 3-) to the transforming media due to compound solubility, accelerating osteogenesis and mineralization. The advanced Brushtite coating increases the blood osteoblast count on the implant surface and accelerates and enhances osseointegration between implant and bone. The implants effectively speed up osseointegration by dissolution and promote recovery by promoting bone formation around the implant. DIO is so confident about their technological advances that they are offering the preferred surface options for their most successful dental implants. The hybrid implants (Bio-Tite II) receive a dual surface treatment consisting of a biocompatible Brushtite coating (Cap) and advanced Brushtite smoothness. For more information, visit the website at www.DIOUK.com. Alternatively, email sales@DIOUK.com or call 0845 123 5996 to speak with a qualified representative.

Introducing SeptProtector for complete surgery disinfection

Eschmann, the first name in infection control, is proud to introduce the powerful SeptProtector, the complete surgery disinfection solution. Microorganisms and bacteria, particularly those distributed by dental turbines can contaminate exposed surfaces and remain active for hours and minutes within the surgery.

The SeptProtector is specifically designed to safeguard against cross-infection risks.

- Reliable, automated, hands-free disinfection of all patient areas
- Protects against microbiol, vi- ral and sporicidal contagions
- Disinfects all exposed surfaces more effectively than manual methods
- Proven broad spectrum Hydrogen Peroxide/Silver Nitrate disinfectant
- Silver Nitrate technology enhances the level and longevity of protection

The SeptProtector utilises the specially formulated Sept-Protectol, which is automatically dispensed at the correct volume for the size of the room. Treatment takes no more than 90 minutes and will not interfere with the usual daily routine. Full protection is achieved after only two treatments, providing protection in areas of normal traffic for several days.

It almost goes without saying that compressed air and suction are key requirements for any practice. Therefore securing their provision in an efficient and economic manner is one of the most important decisions for the business can take.

The unit offers the versatility of a ‘wet’ suction system (the Durr V type) where the functionality separates air and water.

Perhaps the most remarkable features are the sound and size, or rather the lack of them. The new PTS120 is no louder than a standard dishwasher and in size no larger than a fridge, meaning you can get state of the art technology and maximum efficiency all from the size of the room. The new PTS120 is easy to install and operate, it doesn’t require miles of cabling and this helps to keep installation and on-going maintenance costs down.

A great solution, and although we want to shout about it, you’ll agree it’s definitely one that’s on the quiet.

For more information call 01516 526740.
Dental Tribune

United Kingdom Edition - September 7-13, 2009

Industry News - 29

Ledermix: Effective Pain Relief for Endodontic Treatment

Blackwell Supplies is proud to offer Ledermix, the established solution to the pain and inflammation patients experience in cases of pulpsitis. Ledermix combines the antibiotic action of Demeclocycline with the anti-inflammatory action of Triamcinolone and is particularly useful as an emergency measure in endodontic therapy, where it can be used to fill in the root canals between appointments.

Ledermix is available in Combination Kits comprising the Dental Paste and Dental Cement, with Hardeners for fast or slow setting. The Dental Paste contains one third more steroid than the Cement, and is prefilled in the treatment of exposed pulp. In the case of irreversible pulpsitis, the Paste reliably relieves pain until definitive root canal therapy can be carried out.

In small pulp exposure cases, the Cement is excellent as a pulp-capping agent and if the dentine is hypersensitive, it can be used as a temporary sublining for deep cavities where no exposure has occurred.

For a copy of the Summary of Product Characteristics (SPC) please call John Jesshop of Blackwell Supplies on 07971 128077 or email john.jesshop@blackwellsupplies.co.uk.

A Six Hit

It’s becoming increasingly commonplace for dental practices to contain multiple surgeons. The advantages of this strategy are many; it allows dentists and hygienists to work concurrently, it minimises waiting times and allows more flexible

openings times for patients (for example early morning or later evening to fit in with their working days).

This trend has led to a different and more exacting set of requirements for many of the tools and systems within a surgery, and Durr Dental’s VS1200 S suction system is the perfect response.

Durr Dental already provide a range of units (the VS 500 S, VS 600 and VS 900) to suit practices of varying sizes and the VS 1200S is the latest in this range. Like the others, installation and ongoing maintenance are trouble free and low cost. Furthermore, the VS 1200S is made from corrosive free materials and is therefore very extremely durable.

For further information contact your dental supplier or call 01515 526740.

How to score in Endodontics.

Old Trafford, Manchester United (5 Nos) & Stamford Bridge, Chelsea (6 Nos) football stadia are the exciting venues for this amazing learning opportunity. This multi media course is designed for the general practitioner to improve their daily endodontic skills.

Areas covered will include diagnosis, case selection, the latest endodontic instrumentation and the cleaning, shaping and packing of the root canal system in three dimensions with warm obturation techniques and bonded obturation. Dr Rich Mounce, DDS, the widely published US endodontist, will conduct the day which includes refreshments, lunch & complimentary tea during try-ins, and during hydrofluoric acid etching, silanation and even ultrasonic cleaning. The restoration can be picked up and released multiple times in a passive, controlled way with no risk of dropping it.

For more information, go to www.triodent.com or ph 0800-511-2097.

Nothing Compares To Genus Design and Build

Nothing compares to seeing your dreams realised. Genus takes great pride in helping dentists achieve their ambition of cutting edge treatment in a stylish and fully compliant environment, with its celebrated Design and Build service.

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For more information, go to www.triodent.com or ph 0800-511-2097.

Griptab by Triodent

Griptab changes the way in-direct restorations are handled.

Placing crowns, veneers, inlays and onlays can be frustrating because of their size and slippery surfaces. That has all changed thanks to the Griptab by Triodent.

Excellent Oral Health on the Go

Curaprox knows that maintaining an excellent level of oral health is sometimes difficult away from home or when short of time. The Curaprox Travel Care feature offers everything you need for healthy teeth and gums when you're on the move, be it on holiday, business travel or just for your handbag.

Dentomycin for Effective Periodontal Management

With periodontal health a major element in the success of many dental treatments, Blackwell Supplies’ Dentomycin is an excellent adjunctive treatment in the fight against periodontal disease.

Contact keith.morgan@sybronendo.com for full key learning objectives.

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Contact keith.morgan@sybronendo.com for full key learning objectives.

The Handy Travel Sets are available in translucent yellow, green, red and blue include:

- Mini Tube of Curasert Gel Chlorohexidine Toothpaste
- Non staining, contains fluoride and is antibacterial for effective, gentle cleaning
- Tartar Stick – Anatomically shaped with a mineral based surface specifically designed for ease of use
- Toothbrush – Modified G55060 super soft head with detachable handle for folding away

For free samples please email clarie@curaprox.co.uk.

For more information please call 01480 862084, email info@curaprox.co.uk or visit www.curaprox.co.uk.

Dentomycin’s anti-bacterial action helps to maintain the reduction in bacteria levels achieved through scaling and root planning, preventing levels returning to baseline within the typical period of 8 weeks.

Blackwell Supplies is committed to providing high quality, high performance products like Dentomycin to the dental profession and has additionally produced a patient information leaflet ‘How healthy are my gums’ - ‘Help and advice on your oral care’. This important publication is available free to practices and patients and is designed to help promote better oral health and combat periodontitis.

For more information please call John Jesshop of Blackwell Supplies on 020 7224 1457, fax 020 8234 1684 or email john.jesshop@blackwellsupplies.co.uk.

Lemonchase Denal!

Lemonchase, the renowned loupe and lighting specialist, has launched a dental consumables division. Their new range includes low-cost, high quality USA made Wolf Fibre-Optic Handpieces that are compatible with all other brands, including Bien Air, Kavo, W&H, NSK, Midwest & Star. Nicely designed to be self-maintaining, the handpieces are priced at only £560 + VAT - and with the move to dental dishwashers and central sterilisation, they’re proving a very popular and cost-efficient alternative.

Lemonchase are also supplying a full range of KUT pre-shaped individually packaged Diamond Burs at extremely competitive prices.

The company will continue to supply its world leading loupes & LED Lights from Designs for Vision – as used by over half of all USA Dentists.

Lemonchase can be reached on 01892 752505 or Lemonchase.com (or lemonchase-consumables.com for extra on-line savings).

 gravy
The UK’s major event for dental hygienists and dental hygienist-therapists takes place on 16 and 17 October at Bournemouth International Conference Centre, and offers something of interest to all members of the dental team.

Diamond Jubilee

In 1949, 12 dental hygienists established the British Dental Hygienists’ Association, which evolved into the British Society of Dental Hygiene & Therapy. With the society celebrating its 60th anniversary in 2009, this year’s Oral Health Conference & Exhibition will be a special event, complemented by a Diamonds are Forever themed Diamond Jubilee Dinner on Friday 16 October, taking place in the Victorian splendour of the Royal Bath Hotel on the Bournemouth seafront.

Don’t miss a galaxy of learned speakers and the largest ever trade exhibition hosted by the society with more than 50 stands

Eminent speakers

Marina Harris, President of the BSDHT, will open the conference itself on the Friday morning.

Martijn Rosena, a widely respected researcher and co-author of many books, is the first speaker of the conference and will discuss Prevention of gingivitis: fact, future or fantasy?

Edwina Kidd follows, with an important session on caries – what it is and how it can be treated. Entitled: The role of the dental hygienist/therapist in the treatment of caries, this one-hour session is not to be missed.

Annual award

At midday the AGAM takes place – an event all BSDHT members are encouraged to attend. After lunch, the Dr Gerald Leatherman Award will be presented.

Friday afternoon belongs to Phil Ower as he runs two sessions in which he asks: Periodontal therapy at the crossroads – infection or inflammation? This session has been named The Graham Smart Memorial Lecture in honour of a great man who died recently, an ardent supporter of the dental team, and who was scheduled to co-present with Phil.

Day two

Saturday’s lectures commence with Martin Fulford and: Infection control – an update.

The provocatively titled session, Evidence based dentistry – do we care?, comes next with Dr Keith Milsom speaking.

Professor Stephen Flint takes delegates to the lunch break as he discusses drugs and osteonecrosis of the jaw in: Bisphosphonates and dentistry – what you need to know.

Saturday afternoon begins with Making sense of dentine sensitivity by David Gillam with Joanne Rodriguez talking after refreshments on: What is soft tissue management? Why do we need it in dental practices?

The final session has Ewan Macleod presenting: Current developments at the GDC – moving towards revalidation of dental professionals.

Two workshops sessions will take place on the Friday and be repeated on the Saturday. Restorative Materials – are they ready for the 21st Century? is being hosted by Rob McLellan and Hot Topics – what’s hot & what’s not! a core CPD workshop to be facilitated by Andrew Collier.

More information and a booking form can be found at wwwbsdht.org.uk. Reduced rate registration fees are available for booking made by 23 September.
Postgraduate DCP Tutors

Salary commencing at £38,660 pa (pro rata) including London Weighting
Up to six positions based across London

The London Deanery is currently recruiting for Postgraduate Dental Care Professionals (DCP) Tutors.
You will be responsible and accountable to the Postgraduate Dental Dean for the delivery, monitoring and assessment of postgraduate education and the continuing training for the dental team at a local level, as well as needs assessment, mentoring and appraisal of the dental workforce when required. You will be based at one of the postgraduate centres funded by the Deanery and will work in collaboration with other Deanery tutors.
A tutorial background is not an essential requirement for this post, you must however, be fully registered as a DCP with the General Dental Council. You will be enthusiastic with a commitment to continuing professional development, both of yourself and the Dental Team of Nurses, Hygienists, Therapists and Dental Technicians. In return, we offer a bespoke training programme to enhance your personal development in this role.

The post is for either one or two sessions per week. If you are in hospital employment you may be appointed by secondment to the post.
Informal enquiries should be made to Raj Raja Rayan OBE (07739303490/raj.rayan@londondeanery.ac.uk) or Corinne Tapsell (020 7866 3218 or 020 7866 3177/corinne.tapsell@londondeanery.ac.uk)
To apply online, visit our website http://www.londondeanery.ac.uk/var/recruitment/internal-recruitment
Alternatively for general enquiries email ldnrecruit@londondeanery.ac.uk or call 020 7866 3176 during business hours (09.00 - 17.00).
Closing date for receipt of applications and detailed curriculum vitae: 14th September 2009.
Interviews will be held week commencing 21st September 2009.

To apply online, visit our website
www.londondeanery.ac.uk

London Deanery

Postgraduate DCP Tutors

Salary commencing at £38,660 pa (pro rata) including London Weighting
Up to six positions based across London

The London Deanery is currently recruiting for Postgraduate Dental Care Professionals (DCP) Tutors.
You will be responsible and accountable to the Postgraduate Dental Dean for the delivery, monitoring and assessment of postgraduate education and the continuing training for the dental team at a local level, as well as needs assessment, mentoring and appraisal of the dental workforce when required. You will be based at one of the postgraduate centres funded by the Deanery and will work in collaboration with other Deanery tutors.
A tutorial background is not an essential requirement for this post, you must however, be fully registered as a DCP with the General Dental Council. You will be enthusiastic with a commitment to continuing professional development, both of yourself and the Dental Team of Nurses, Hygienists, Therapists and Dental Technicians. In return, we offer a bespoke training programme to enhance your personal development in this role.

The post is for either one or two sessions per week. If you are in hospital employment you may be appointed by secondment to the post.
Informal enquiries should be made to Raj Raja Rayan OBE (07739303490/raj.rayan@londondeanery.ac.uk) or Corinne Tapsell (020 7866 3218 or 020 7866 3177/corinne.tapsell@londondeanery.ac.uk)
To apply online, visit our website http://www.londondeanery.ac.uk/var/recruitment/internal-recruitment
Alternatively for general enquiries email ldnrecruit@londondeanery.ac.uk or call 020 7866 3176 during business hours (09.00 - 17.00).
Closing date for receipt of applications and detailed curriculum vitae: 14th September 2009.
Interviews will be held week commencing 21st September 2009.

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