Survey access is still biggest problem for PCTs

Commissioning survey by the British Dental Association shows growing experience of commissioning staff

Ensuring that people have access to NHS dentists is still one of the biggest problems for primary care trusts, according to a recent survey.

The 2010 British Dental Association (BDA) Local Commissioning Survey found that significant challenges remain for the commissioning of dentistry in England, despite the growing experience of commissioning staff and consensus on priorities.

The research found that access to care remains the top priority for primary care trusts (PCT) dental commissioning leads, with 89 per cent of PCTs naming it as one of their top three priorities: This echoes the findings of research by the British Dental Association in 2009. Quality was next, which appeared in the top three concerns of just over a quarter (28.4 per cent) of PCTs.

The research sought insight into the experience of PCT dental commissioning, staff commissioning and the level of support they enjoyed from strategic health authorities (SHAs), revisiting themes addressed by the 2009 research.

This year’s survey found that 61 per cent receive performance monitoring advice, 46 per cent contracting advice and guidance and 18 per cent receive support with their dental strategy.

The growing experience of dental commissioning staff is noticeable. Less than 10 per cent of those surveyed had been in their role for under a year according to the 2010 survey, while more than a quarter had served for such a short period in 2009.

However, many of the commissioning leads questioned this year said they did not have an adequate workforce.

Almost three-quarters said they needed additional support, with 18 per cent declaring they did not benefit from the expertise of a consultant in dental public health.

The research also identified significant under spending of dental budgets. Just under a fifth (16.4 per cent) of PCTs said they had spent less than 95 per cent of their ring fenced dental budgets. Just under a fifth (18 per cent) said they needed additional support, with 18 per cent declaring they did not benefit from the expertise of a consultant in dental public health.

John Milne, chair of the BDA’s General Dental Practice Committee, said: “This research illustrates the challenges that persist with the commissioning of primary dental care and underlines some of the issues the national commissioning board will face when it assumes its duties.”

He added: “It is clear that whoever is responsible for commissioning dental care must be properly supported and have access to appropriate expertise.”

The experience and knowledge of consultants in dental public health and dental practice advisers are particularly valuable in helping PCTs provide effective care to patients. This study stresses the gradual accumulation of experience by PCTs. Arrangements for the handover of commissioning responsibility must seek to ensure that experience is not lost.”

Under the coalition government, the transfer of responsibility for dental commissioning will pass in 2012 from the PCTs to the national commissioning board.

It is not yet clear whether the board will have regional offices and, if it does, how these will be organised across the country.
Around 9,000 dental practices in the UK are set to take part in this year’s Colgate Oral Health Month. Participating practices have been issued with a pack containing educational materials and motivational materials to promote the campaign’s messages.

The theme for the 2010 campaign is ‘Discover 3 Essentials for an Even Healthier Mouth’, which are brush your teeth twice a day with fluoride toothpaste and replace your toothbrush regularly; avoid sugary snacks between meals and visit the dentist regularly.

Colgate is organising and running a UK roadshow throughout September as part of the campaign. The company aims to use the roadshows to help raise the awareness concerning the importance of good oral hygiene and care standards.

The campaign also contains a CPD programme, which focuses on the theme of delivering prevention in practice based on the principles contained in the Department of Health’s toolkit, Delivering Better Oral Health: An Evidence Based Toolkit (2nd edition, July 2009).

The verifiable CPD, Putting Evidence into Practice, is available to all dental professionals, by downloading the interactive programme from www.colgateohm.co.uk.

Do you have an opinion or something to say on any Dental Tribune UK article? Or would you like to write your own opinion for our guest comment page?

If so don’t hesitate to write to: The Editor, Dental Tribune UK Ltd, 4th Floor, Treasure House, 19-21 Hatton Garden, London, EC1 8BA

Or email: lisa@dentaltribuneuk.com
A dentist in Hull is travel- ling to Morocco to give vital dental treatment to the Berber Tribe.

The tribe of 50,000 has just one doctor and no dentists.

Chris Branfield, from Castle Park Dental Care in Cottingham, has helped to set up the charity to give dental treatment to people in remote parts of the world.

He and seven other dentists will be taking part in the eight- day expedition to treat the Berber Tribe in North East Morocco.

In a Berber village by the Mediterranean Sea, the group of eight dentists will be treating both men and women whose biggest problem is gingivitis (inflammation of the gums surrounding the teeth).

Dr Branfield said: “In ten years’ time, the day will come when the Berber Tribe, its land and its traditions, will be swallowed up into mainstream soci- ety - just as the Red Indians and their culture have been assimilated by the white man. But today, the privilege to experience the tribe in their natural habitat, is available to a very few.”

Money is being raised by Castle Park Dental Care for supplies and materials to help the Berber Tribe and the cost of the trip is being personally met by Dr Branfield.

If you wish to sponsor the expedition, go to www.castleparkdental.co.uk.

Tenth anniversary of the Premier Symposium

T his year, the risk manage- ment conference, Premier Symposium, will be celebrating its tenth anniversary.

It is celebrating the event with a compelling line-up of speakers. Organised by Dental Protection, the leading indemnity organisation for dental professionals in the UK and by schülke, the international name in cross- infection control, this year’s Premier Symposium will take place on Saturday 5 December 2010 at Kings College, London.

A spokeswoman for Dental Protection said: “The opportu- nity to hear well-informed and entertaining speakers in comfortable and spacious surrounds ensures that this meet- ing remains a highlight of the dental calendar.

“The Premier Symposium 2010 will feature a range of topi- cal lectures including the trans- formation of dental care through the use of implants and the risks associated with them, nerve inju- ries, their cause and manage- ment, and the HTM 01-05 guide- lines one year on.”

The programme features the following speakers and lecture topics: Professor Richard Palmer on implants – new risks for old; Professor Tara Renton on nerve injuries – their cause and man- agement, Paul Jenkins on the HTM 01-05 watershed - where are we now; Paul Redmond, talk- ing ‘bout my generation (com- municating across ‘generation gaps’) and Peter Briggs on risks and responsibilities in periodon- tal care.

The event will also include the presentation of the Pre- mier Awards, a series of six risk management prizes presented to dental professionals who have produced original work which aims to improve patient safety.

The event is an ideal practice day out, with team tickets available for DPL Xtra Practice Pro- gramme members, and a chance for all members of the dental team to attend this informative pre-Christmas symposium.

Including six hours verifiable CPD, tickets are now on sale for this year’s Premier Symposium.

The conference was a sell-out last year, and delegates are advised to order their tickets as soon as possible in order to avoid disappointment. Tickets are available from events@den- talprotection.org or telephone 020 7399 1339. Or for more information, please visit the Dental Protection website at: http://www.dentalprotection. org.uk/news/events/events/ premier2010

Tickets for this year’s Sym- posium are priced at £110 For DPL members and £255 for non-members. The team pack- age (available to DPL Xtra prac- tice programme members only) costs £190 for two places, or £280 for three places when booked to- gether. All prices include VAT at the standard rate.

CQC extends opening hours to help dentists prepare

In order to help dentists prepare to apply for registra- tion, the Care Quality Com- mission is extending its national contact centre’s opening hours.

The new hours are 8.30am to 8.30pm Monday to Thursday, from 8.30am to 5.30pm on Friday and from 8am to 4pm on Saturdays. In addition, the Care Quality Commission (CQC) has also published a ‘new system of registration: Guide for pro- viders of primary dental care services’ to help practitioners.

The new guidance provides more information on the applic- ation process, which was refined following a series of pilot projects in June/July of this year.

General dental practitioners will be invited to start apply- ing soon, so that all providers are registered by 1 April 2011 and the CQC expects – from the available data – to register more than 8,500 providers. Due to this expected large amount of applications, dentists will be put into groups with each group given an application window within which to apply. Provid- ers (essentially ‘practices’) will be registered against the new essential standards of quality and safety that apply across the care sector; the British Dental Association has produced den- tal-specific guidance on this.

The CQC’s director, Linda Hutchinson said: “We appre- ciate that this type of regu- lation is very new to the den- tal sector and that people will have a lot of questions. We publish regular updates on our website, but we know that some people would prefer to talk things through over the telephone.

“We want to make sure our helpline is available to an- swer questions at times that are convenient to dentists, tak- ing their working hours into consideration. We’re also work- ing closely with the General Dental Council to avoid any overlap in our actions and to minimise any potential regu- latory burden for providers.”

Ms Hutchinson added: “Ulti- mately, our objective is to pro- tect services and to encour- age improvement in the care people receive.”

The Care Quality Commissi- on will be also writing to den- tists to advise what will happen next and about what further ac- tion needs to be taken.

Smile-on produces learning programme for dental nurses

T he dental education provider, Smile-on, has produced an online/CD-Rom training programme specifi- cally for dental nurses.

DNNET II is a learning pro- gramme produced by Smile-on - available on CD-Rom or online. The comprehensive programme is designed to prepare for the den- tal nursing examinations and for dental nurses studying towards the National Certificate, the NVQ level three in Oral Health Care Dental Nursing or as an update for established nurses.

As a learning package, DN- NET II incorporates dynamic audio and video footage, an- imations and detailed diagrams that immediately make learning more engaging.

The DNNET II programme covers health and safety, in- fection control, oral health education, patient assessment, processing radiography, peri- odontics and restoration, equal- ity and diversity, minor oral surgery, surgical periodontal therapy, orthodontics, commu- nication, prosthetics and endo- dontic treatment.

By using DNNET II, den- tal nurses are given full access to all of the knowledge that they will need in order to pursue a fulfilling career as well as preparing them for their exami- nation after registration at an accredited assessment centre.

For more information on DNNET II call 020 7400 8989 or email info@smile-on.com.
Warning issued over solar powered brush

The British Dental Health Foundation has issued a warning over a new toothbrush that cleans your teeth with solar power.

The Soladey-5 ionic toothbrush from Japan claims to get rid of plaque with electrons that work with saliva to remove it from your teeth.

You can still use toothpaste but Soladey claims it loosens plaque effectively using only electrons. However the British Dental Health Foundation has expressed its concern over the new invention and is advising people to continue using toothpaste.

Chief executive of the British Dental Health Foundation, Dr Nigel Carter, said: “It is absolutely vital that we stick with fluoride toothpaste when brushing our teeth, in order to maintain the good modern day levels of oral health. Good toothpastes, along with a steady brushing action, can remove harmful plaque and bacteria from the mouth, preventing such diseases as caries, gum disease and tooth loss.

“Over the last century, the ingredients in toothpaste have developed to such an extent that it now offers us an exceptional level of protection against oral diseases such as decay and gum disease.”

The addition of fluoride for instance, which became common in toothpaste from the 1970s, helps strengthen enamel and makes the teeth more resistant to tooth decay.

Other important components in toothpastes include antibacterial agents such as Triclosan and zinc, which helps thwart gingivitis. If untreated, it can lead to periodontal disease, the most common cause of tooth loss in adults.

Dr Carter is warning people to be cautious about the new Japanese brush, which is currently in the prototype stage.

The solar-powered brush is the idea of Dr Kunio Komiyama, who is now a professor of dentistry at Canada’s University of Saskatchewan. The brush itself is called the Soladey-J3X.

Dr Carter said: “The components that make up today’s toothpaste are far too complex, for what essentially is a ‘gadget’, to replicate. I’m certain that more tests need to be undergone to see if the brush can do what it claims and, in addition, to measure any potential long-term effects not using toothpaste may have on an individual.

“As we know of, there is yet no substitute for brushing our teeth twice a day with a fluoride toothpaste – and I cannot see that changing.”

The company responsible for the brush is currently conducting a study to determine how teenagers rate the solar powered toothbrush in comparison with a regular toothbrush.

Free research event for dental care professionals

The Faculty of General Dental Practice (UK) will be hosting the second in a series of free research events for dental care professionals.

This free event on 27th November builds on the highly successful introductory event in June 2009, which was aimed to promote research activities among dental care professionals (DCPs).

The Research Day will once again be a collaboration between the FGDP (UK) and the British Society for Dental Hygienists and Therapists, with additional sponsorship from partners in the British Dental Trade.

The programme will focus on the progress made since June 2009 and will include a report of a pilot study into DCP skills usage and plans for a national study of dental hygienists skills usage and job satisfaction.

There will be a series of presentations from DCPs on their achievements in the field of research.

The programme will also include essential information on the opportunities for further progression in research, including presentations on retrospective studies, undertaking a PhD and literature review. Delegates will have the opportunity to take part in breakout group sessions on producing research abstracts and posters; these will be led by DCPs and dentists who have produced and presented research posters and abstracts. They will also take part in research topic selections and literature searching in small groups.

Ken Eaton, FGDP (UK) national research facilitator and leader of the initiative said: “Although the past active involvement in research has not been of interest to the vast majority of DCPs, it has been very encouraging to see the enthusiasm of the small minority who have become involved and the results that they have achieved.

“I am particularly pleased by feedback I have received from DCPs and that the deeper insights they have obtained from research has changed the way in which they treat their patients.”

The Research Day is open to all DCPs who are involved or interested in developing in the field of research.

There is no fee for the meeting and certificates for five hours of verifiable CPD will be provided to delegates.

Registration will be at 10am The Research Day starts at 10.30am and will finish at 4pm.

For further details and to register for the event please contact the Amrita Narain on 020 7869 6750 or email anarain@rceng.ac.uk.
Iain Forster, Managing Director of DIO UK, at the Royal Society of Medicine, London

"How to grow your dental business in an adverse economic climate", as presented by Iain Forster, Managing Director of DIO UK, at the Royal Society of Medicine, on Friday 3rd September to delegates at the Royal Society of Medicine on Friday 3rd Sep -

In his presentation Iain said that it was a good time to be in dentistry, with the population increasing and costs decreasing. He also put a positive spin on the recession saying that companies that promoted heavily during a recession were often the first to emerge from it and the most successful in the following years.

Despite encouraging dentists to promote their services during a recession, Iain urged caution. He said that companies should not over spend and should test marketing methods to determine what worked best for them and focus on those that proved to be most successful. “It pays to start small and build confidence,” he said.

Iain was confident that the economic climate is right for dentists to promote their businesses as the country emerges from recession. He went on to explain that it is however essential that practices remain focussed, targeting those people with whom they already have a relationship before spending too much money looking further afield. He drew a distinction between internal marketing to reach out to the local population, educating their own practice teams and the importance of the Internet; and external marketing that was designed to open up new markets over an extended period. “Internal marketing gives us business next year,” he said. “External marketing gives us business next year”

In closing Iain introduced the new “21st Century Dental Marketing” workshops which help dentists to take advantage of the opportunities they have available to market their businesses in the modern climate. The workshops cover:

• The use of PR and how to do it;
• Best practices for web page layout;
• How to use a CMS system to keep your website up-to-date;
• Pay-per-click (PPC) campaigns

Bringing marketing right up to date Iain urged dentists that they should embrace social media and the opportunities it provides. Twitter, Facebook, LinkedIn and many more all provide unprecedented opportunities for dentists to reach out to a wider market, for little or no cost. Not only are these outlets easy to use they are also essential for those practices who do not want to be left behind as the old marketing techniques are superseded by newer, cheaper, more effective methods.

To book your place on the next 21st Century Dental Marketing workshop, go to: www.dentalmarketinguk.com

Iain is now presenting his lecture as a free online webinar. Delegates can register for the online seminar by going to www.dental-webinar.co.uk or visit http://www.dentala.co.uk/seminars/dentistry-marketingwebinar.html.

DIO Implant is a global supplier of dental implant technology. Established for over 20 years, DIO is rapidly expanding in the UK and has already taken a sizeable share of the market with its combination of high quality, sensible pricing and clear communication. The company’s focus on marketing education is part of its strategy to build effective and profitable business partnerships throughout the dental industry.

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Closure of NHS Direct will affect dental health most, says charity

The chief executive of the British Dental Health Foundation, Dr Nigel Carter, claims it will be people’s oral health that will suffer most as a result of the closure of the medical advice helpline NHS Direct.

“The axing of the 24-hour nurse-led service is set to leave the future of 1,400 nurses uncertain, as well as 15,000 callers a day who rely on its professional advice. The government has said it will replace the service with the new NHS 111 service.

However, Dr Carter claimed this is not an adequate alternative and said: “NHS Direct was a quality service and an essential source of information for the public. Sadly, they have replaced it with a facility which will simply struggle to offer the same standard of assistance.”

The new 111 service will employ fewer qualified nurses and will instead turn to non-specialist ‘call advisors’ who have completed a 60-hour training programme.

“Unfortunately, when looking to slash costs, the temptation is to look to cut staff, their wages or to introduce cheaper employees altogether. This seems to be the case with the 111 service.

‘NHS Direct was a quality service and an essential source of information for the public.’

“Time will tell on how it will be received in the long-run by the public and whether the same standard of advice can be replicated by non-professionals.”

He added: “Regrettably, it will be dental health that will suffer the most. The now abandoned NHS Direct service regularly took more calls related to dentistry than any other area and if you consider on top of that the potential cuts to local PCTs, it leaves us asking just who is going to fill the void in terms of giving qualified information to the public?”

He hopes that people will turn to the National Dental Helpline, which is staffed by fully-qualified dental nurses, who offer free advice at a local-rate number.

NHS Direct, which was formed in 1998, was staffed by nurses and health advisers at 55 sites around the United Kingdom and received around five million calls a year to its core services, as well as an additional five million people who used its online health and symptoms checker.

A trial of the new 111 phone-line is currently being tested in the North East region, with further trials to be carried out across the UK over the coming three years.

The online version of the service is set to remain, in addition to the phone service in both Scotland and Wales.
Lord Howe has had a long involvement with health issues, having been opposition spokesman for health since 1997. Although never a specific responsibility of dentistry, the health system in general has been a part of the general issues surrounding health care. “I have always been well aware of the general issues that the area of dentistry is involved in; it was no accident that my party colleagues and I, in preparing our manifesto, made specific promises about dentistry. As the minister now charged with looking after dentistry, I am very pleased that I have this responsibility.

Key Representatives

“Although I have only been here for a few months I have made it my business to have meetings with key representatives from the profession to bring myself up to speed. I’ve met the BDA twice and I attended a reception in Westminster where I spoke with a number of stakeholders. I have met Prof [Jimmy] Steele informally, and I am due to meet him again within the next few weeks. In addition, I have received a number of invitations to visit dental providers and have already visited a clinic in Cambridge, which was extremely valuable to me.”

The political place dentistry seemed to hold in this year’s General Election shows exactly how much of a key issue for the voters it is. “I think dentistry is as much a priority for us as it is for the public. It’s become more salient as a health issue for the voter than maybe it was a few years ago, we certainly sensed this when we were in opposition.

Dentistry on the radar

“The importance of oral health in terms of how it plays into general health is certainly not lost on us and I hope you will have felt from the White Paper that dentistry is very much on our radar. Of course we have got to work out exactly how the system is configured but we are clear that we want an architecture for the health service that promotes quality, that promotes the prevention agenda and that gives consistency in commissioning services.

Lord Howe is by no means immune to the size of the task facing dentistry in tackling oral health inequalities that still exist around the country, calling it ‘the biggest challenge’. He is keen to see the adoption of a number of approaches to improve the picture in terms of child oral health, many focusing directly on the dental contract. “The statistics that I have seen on children, which is a particular area of concern that I have, are quite encouraging in that oral health in children seems to have improved much over the last 20 years. Yet if you drill down into those figures you do see a pretty horrific picture in terms of those children whose oral health is poor and I think that there are a number of approaches we can adopt to this.

“The reform of the dental contract lies at the centre of this. You will have seen in our election manifesto that we built in an undertaking to reform the dental contract. I have asked officials to take that work forward - obviously it can’t happen instantly but the principles on which a new contract should be built are there.

“There needs to be a pronounced emphasis on prevention and a move away from unintended perverse incentives. Although the current contract was formulated with extremely good intentions - one mustn’t deny its good features - I am afraid there have been some perverse consequences arising from it and I think both dentists and patients have been aware of these.

End of UDAs?

“Does that spell the end of UDAs? We’re looking at all of that. I think that the Steele review had a great deal of information in it which will inform the work we do on modifying the contract; on the whole the Steele review met with a good response. So, I am taking stock of all that before deciding in any detail how we are going to take the reform forward.”

Of course time is a major factor in the reforms and Howe is very conscious of the balance between getting things done and rushing the process. “One can never do things as quickly as one wants because there are so many things that are subject to consultation and detailed work - it can’t be done in a hurry. I can’t tell you that in a year’s time we will be on the brink of a new contract, that would be too soon, because any new contract will have to be piloted, we have to be sure it is going to do what we all want it to do, so we’re looking reasonably far down the track in terms of this Parliament. By the middle of this Parliament I would hope to be very much further with the new contract.”

Centralised control

The biggest topic that has been discussed over recent times is the White Paper and the implications that it will have for dentistry. Speaking of the proposed return to more centralised control over dental commissioning Lord Howe said: “The point of that proposal is that we should first of all have a commissioning mechanism designed to ensure consistency, as I mentioned, and in the standard of consistency. One of the commissioning board’s tasks will be to promote equality and access, and its access to a service that delivers quality that I think lies at the heart of this.

“One can never do things as quickly as one wants because there are so many things that are subject to consultation and detailed work.”

Also I think that it sits more logically with the board as it does with services like Pharmacy and we’re looking at other areas which may more logically sit with the NHS commissioning board, nothing to do with dentistry. How the board configures itself is a matter for them. But I would be surprised if it didn’t consider regional outposts so that services such as dentistry are commissioned with a view to the needs to a local population.”

One of the major fears expressed over the new proposals is what is going to happen in the period between PCT control and the taking over of the reigns by the NHS Commissioning Board. Many practitioners are concerned about how they’re going to be able to interact with their PCTs in the interim period, and Lord Howe was quick to reassure: “This is a very important question and it’s one that we’re looking at across the piece. I would like to reassure practitioners that we are alive to the risks in all of this but we believe it to be manageable and we have time in which to make sure that nothing slips between the cracks, not least dentistry.

“PCPs are clear as are strategic health authorities that they have a very important role to play in making sure that this transition works smoothly. We will be setting up the NHS Commissioning Board in shadow form quite soon, so that by the time it starts its role for real we should have sorted out most of the transfer functions. Of course we don’t plan to abolish PCTs until we are absolutely sure that the transition has occurred. I can understand the anxiety of dentists but I think they need to be assured that I am very much with them on this. I am not going to take risks with the way that NHS dentistry is made available to patients and there certainly will be no hiatus in terms of administration.”

HTM 01-05

Another controversial topic in dentistry is the issue of cross infection control and the HTM 01-05 guidelines. Lord Howe, though reluctant to revisit the guidelines, did say he believed that they needed more clarity: “The current version of HTM 01-05 is going to stay in force as it is, but the messaging has to be clear because there has been a lack of clarity in this. Clearly, patients expect to be treated in a safe environment, and dentists and dental staff expect to work in a safe environment, that I don’t think is a matter for argument.

“Currently the HTM 01-05 guidance sets out two distinctly different things; it sets out essential quality requirements, which practices have to achieve by the end of this year. Now I have looked at this in some detail with CDO Barry Cockcroft’s help and I’m absolutely clear that no self-respecting dentist would wish to do anything other than to meet essential quality requirements and achieve his or her goals; that guidance does no more than reflect existing guidance. The essential quality requirements differ

Lord Howe: I think dentistry is as much a priority for us as it is for the public.

Dental Tribune United Kingdom Edition - September 20-26, 2010

Interview

One Lord a talkin’ exclusively to DT

Dental Tribune recently met with Lord Howe, Parliamentary Under Secretary of State (Department of Health) with responsibility for dentistry, and asked him about his feelings about the current dental system and where he feels improvements could be made.
slightly from the pre-existing guidance that were set out in the BDA infection control document (A12), so I think it’s wholly appropriate that dentists meet those requirements to reduce the risk of transferring infections and the evidence that the requirements have the effect of doing that is also pretty clear.

“The other side of the guidance of course is best practice, which is quite separate. We have been quite deliberate in not setting a timetable for dentists to meet best practice as we know that for many practices this is difficult and for some it isn’t. What we’ve said is that we expect dentists to have a plan to work towards best practice; there is no mandatory timetable involved. The HTM 01-05 guidance is an evidence based document and for that reason I’m not minded to revisit it, other than to obviously update it as time goes on and our knowledge improves.”

Lord Howe definitely seems to be taking dentistry to his heart, especially focusing on the longer-term aspects of improving oral health in children. “What I want to see is us doing a lot better with children’s dental health. We need to find a way through the public health agenda, accessing young mums in particular and getting the right messages across to them. There’s some quite promising work going on in Scotland in this area and we can perhaps learn from that. I just think that improving children’s oral health and getting the young into good habits early on is massively important. When you look at children with poor oral health, you can see it impacts on them adversely throughout their lives. It’s the most damaging way to start your life. So I’m keen to look at ways in which we can help children avoid tooth decay and get them into good habits. It is a long-term challenge, it’s not going to happen in a hurry but I wanted to mention that because it very much permeates the thinking we’re doing on the dental contract and public health planning.”

“I have looked at this in some detail with CDO Barry Cockcroft’s help and I’m absolutely clear that no self-respecting dentist would wish to do anything other than to meet essential quality requirements.”

Lord Howe was born in 1951. He was educated at Rugby School and Christ Church, Oxford, where he read Mods and Greats. After leaving University in 1973, he joined Barclays Bank and served in a number of managerial and senior managerial posts both overseas and in London. In 1987 he was appointed London director of Adam & Co. plc, the Scottish-based private bank, where he remained until 1990.

In 1991, Lord Howe became a government whip in the House of Lords with responsibilities, successively, for transport, employment, defence and environment. Following the General Election of 1992 he was appointed Parliamentary Secretary (Lords) at the Ministry of Agriculture, Fisheries and Food, and in 1993 Parliamentary Under-Secretary of State at the Ministry of Defence, a post he relinquished at the 1997 General Election.

He has been opposition spokesman for Health and Social Services in the House of Lords since 1997. He is an elected hereditary peer under the provisions of the House of Lords Act 1999.

In May 2010, Earl Howe was appointed Parliamentary Under Secretary of State at the Department of Health.
Making things simpler for our customers

Managing Director at KaVo, Sonia Tracey, discusses a change in direction for the dental equipment provider with Dental Tribune

Dental Tribune: Tell us a little about your career.

Sonia Tracey (ST): My dental career started at Ivoclar Vivadent as a territory sales manager. Since then I have worked within the industry and more recently within the medical industry as a field sales manager and later as sales director. I also spent seven years working as the northern sales manager for another well known headpiece manufacturer.

I started at KaVo in June 2007 as public sector manager for the UK and Ireland. In November 2008 I accepted the position of Managing Director at KaVo. It's been a big challenge but an extremely enjoyable one.

DT: I understand that there is some major news from KaVo, can you tell us more about it?

ST: Obviously we've had a couple of really good years and we want to continue to build on that success and improve the products and service we offer to our customers. With that in mind, we have taken the decision to restructure our distribution channels in order to guarantee better flexibility when purchasing KaVo products. Instead of selling direct to the clinician we are going to take our products through their trusted suppliers. We believe that this is the right direction for KaVo to follow.

The dynamics of the dental profession and industry are continually changing, the market is becoming more competitive, for example National Framework agreements are being put in place. In addition the way consumers are purchasing goods has changed - customers are looking to use a single supplier to fulfil all their equipment and consumable needs.

DT: What has made KaVo choose this new strategy?

ST: This decision has not been taken lightly, we have been working on this model for some time and we believe that in order to build on our recent record breaking successes and continue to grow our business that this is the right direction for KaVo to follow.

DT: When will this change go live?

ST: September 2010. It has very much been a work in progress, KaVo have been looking at this model for a period of time and have already used the same go-to-market model very successfully in a number of other European subsidiaries.

DT: Do you think that you were chosen to head up this strategy?

ST: September 2010. It has very much been a work in progress, KaVo have been looking at this model for a period of time and have already used the same go-to-market model very successfully in a number of other European subsidiaries.

ST: We believe that it will provide our customers with greater flexibility and purchasing power. Our goal is to enable us to offer an improved service through their trusted suppliers. Our team of product specialists will still be visiting customers to advise them on their needs within the dental practice.

Of course we will continue to support KaVo products in the market place with technical support.

DT: Do you think that customers are looking to use a single supplier to fulfil all their equipment and consumable needs?

ST: Yes, we can see that purchasing patterns are changing, if we look in the public arena we shop at hyper markets, and we book holidays on line. Consumers are looking for easier purchasing options including one-stop shops, this is no different in the dental profession.

DT: Do you think that KaVo looking to achieve with this strategy?

ST: The main emphasis of KaVo’s policy lies in the total satisfaction of our customers, who represent the key to the success of the company. In line with our motto, KaVo, Dental Excellence, we aim to implement the KaVo vision through our highly trained workforce, our efficient organisation and excellent technical backup from our headquarters in Biberach, Southern Germany.

By fulfilling all applicable customer, statutory and regulatory requirements, we guarantee high quality, environmentally friendly products, reliability and customer satisfaction.

Through our efficient organisation and excellent technical backup from our headquarters in Biberach, Southern Germany.

By fulfilling all applicable customer, statutory and regulatory requirements, we guarantee high quality, environmentally friendly products, reliability and customer satisfaction.

The KaVo Dental Excellence strategy will allow greater market penetration and we believe fulfil the needs of our customers.

DT: How do you think this news will affect current KaVo customers?

ST: Our team of product specialists will still be visiting customers to advise them on their needs within the dental practice.

Of course we will continue to support KaVo products in the market place with technical support.

DT: Do you think that you were chosen to head up this strategy?

ST: September 2010. It has very much been a work in progress, KaVo have been looking at this model for a period of time and have already used the same go-to-market model very successfully in a number of other European subsidiaries.
Teaming up
If you’re buying or selling a share of a practice you’ll need to consider partnership options and the impact it will have on the value of goodwill, says Martyn Bradshaw

Partnership structures within a dental practice commonly fall into one of two types: expense sharing or true partnership. Some practices adopt a hybrid of the two. Under a true partnership, profits are split equally, regardless of the individual partners’ fee, income, or days worked. The risk of inequalities makes this a potentially flawed agreement and is therefore unpopular.

The expense-sharing route, where the principals split either some or all of the expenses, allows for a profit distribution more in line with individual fees produced. A hybrid arrangement may involve the partners taking a percentage of the fees produced as the first layer of income (similar to an associate), with residual profit or loss then split equally.

Goodwill valuations
A goodwill valuation should take account of the partnership structure. If you are considering expense sharing, it is not relevant to simply undertake a valuation on the whole practice and divide it by the number of partners. The valuation should be based on the actual share being purchased, which involves an analysis of the purchaser’s potential gross fees and share of the remaining associate income. An experienced valuer will combine this analysis with a projected profit and loss account for the purchaser to ensure that the structure is financially viable.

Sole-owners considering the part sale of their practice run the risk of devaluing their retained interest at the point of their final exit. However a balanced view is called for, as the partial sale may produce some advantages in the form of raising capital, sharing managerial and administrative duties and not least the opportunity to continue work with similar rates of pay.

Partnerships – dispute prevention and protection
A formal partnership agreement should be written by a specialist dental solicitor (see www.apsd.co.uk) to reduce the likelihood of a future dispute. Partnership protection insurance is recommended to protect dependents and surviving business partners in the event of a partner’s death. This enables surviving business partners to retain control of the business and ‘buy out’ the (non-clinical) dependents of their deceased business partner, without the need to raise finance. Crucially, the deceased’s dependents can offload their inherited business shareholding and release the cash value of the inherited goodwill, for which they have no use. This arrangement should be supported by a ‘cross option agreement’ written into the partnership deed/agreement.
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055/050 CLAIR
How busy is your hygienist book?
Sheila Scott offers eight immediate ways to transform your hygienist’s appointment book

Could your hygiene book be busier? Are you seeing an increase in cancelled hygiene appointments or failed to attend? If you can relate to either of these two questions, the advice in this article could help you to (re)build your hygiene service and ensure greater patient health and practice stability.

I believe the ideal private, preventive-oriented general practice should be keeping a hygienist busy for four out of every five days of general dentistry availability. Here are my eight immediate recommendations for transforming your hygiene appointment book.

1. Communicate the benefits
   Do communicate the benefits of hygiene visits to every patient you see for a regular exam. It’s not enough to suggest patients see your hygienist for a ‘scale and polish’ or a ‘cleaning’ as this does not adequately explain why the appointment is necessary. It is also misleading and unhelpful to indicate that the hygiene appointment is for a ‘clean’ – after all, patients believe they can do this for themselves.

By far the most important part of the hygiene appointment for most patients will be in helping them develop skills and habits that will reduce their chances of developing gum disease, tooth decay, heart disease, etc., and I believe it’s the job of dentists and hygienists to communicate this information every time they see a patient.

It doesn’t have to be complicated, your message could be: ‘You do have signs of damage in your mouth from bacterial plaque. I recommend you see Natalie, our hygienist, for regular appointments to help you work on the skills you need to control this plaque damage at home – this will help you stay dentally healthy and reduce your chances of developing dental problems later.’

2. A consistent message
   Please don’t change your communication of what your focus is without letting your whole team know, particularly your hygienist. Ideally, call a team meeting to discuss how your hygienist helps preventally compromised patients in their appointments, and fine-tune your communications to reflect the actual pattern of advice given in the appointments.

3. Involve reception
   Make sure your reception team has some good verbal communication for discussing the impact of broken, cancelled or failed hygiene appointments with patients. It’s not good for your patients or your professional standing to just let your patients cancel their appointments or fail to book them.

Your receptionist should have your blessing to tell patients that hygiene appointments can be more important for some patients than their dental visits – because hygienists help patients prevent dental problems – which might reduce their risks for treatment in the future. For example, if a dentist has recommended a hygiene visit then the receptionist can suggest to the patient that they would also benefit from some help in either treating gum problems or preventing them.

4. Stock what’s recommended
   If your hygienist recommends a patient uses a certain brush, paste, mouthwash, floss or interdental aid, please make sure you stock these. It doesn’t matter if the local shops sell your preferred electric toothbrush for less than you buy them for (in which case I’d suggest going to the shop and buying a dozen and selling them for the same price). You should be stocking recommended items as the practice needs the whole team to play actively.

5. Hygiene & cosmetic dentistry
   If you’re a provider of regular crown and bridgework, or cosmetic dentistry, don’t include in the cost of a hygiene visit to each course of treatment and offer a ‘free’ hygiene visit after the treatment. For example: ‘Now you’ve spent this money on your treatment, Mrs. X, I’d like you to see our hygienist so that she can show you how to look after it in the best possible way. If we can help you keep this new tooth free of plaque, it should last much longer and your mouth will be healthier in the long term.’

6. Focus on children
   Why not develop a programme for all children in the practice, where they see your hygienist for a ‘family skills and habits’ appointment at least once a year – perhaps in the holidays? Full-priced hygiene appointments can be immensely valuable – and great fun for competing siblings, if the focus is on who is best at removing every last bit of (disclosed) plaque. In addition, a parent should be encouraged to supervise and coach each one to do this well at home.

7. Work as a team
   Make sure dentists and hygienists ‘huddle’ together to discuss individual patients, their suggested patterns of hygiene appointments, response and any changes to advice or treatment etc. Don’t let your hygienist work in isolation. Improving patients’ dental health is a team game and the game needs the whole team to play actively.

Practices can organise for almost all patients to benefit from hygiene visits and increase profits while doing so; however, the game requires focus and good communication with patients.

* Data from patient questionnaires provided by Sheila Scott

About the author
Sheila Scott has dedicated the last 20 years to helping dentists and their teams grow and prosper. See her website www.sheilascott.co.uk for more details, or contact her on 01535 862950.
Following the rules

Chris Hindle looks at how measures flowing from the Health and Social Care Act 2008 will affect dentists and their business plans

As a solicitor dealing predominantly with the commercial affairs of dentists, I am acutely aware of the concerns in the dental profession, which flow from the Health and Social Care Act 2008 and the measures being introduced. The Act contains 175 sections, 15 schedules and provides for the introduction of further regulations, codes of practice and guidance to be published by the Secretary of State if required.

Subsequently, there have now been 28 published regulations setting out certain essential and politically correct standards of quality and safety that dentists are required to acknowledge. The outcomes are apparently meant to be helpful by providing dentists with prompts to help them comply. On top of all this, there is written guidance to help interpret the regulations.

The main objective of the Act is a sweeping one: to protect and promote the health, safety and welfare of people who use the health and social care services (s.5 (1)).

The Care Quality Commission

In order to provide services all dental practices, NHS and private, have to be registered with the newly created, integrated regulatory UK public body, The Care Quality Commission (CQC), by 1 April next year. Thereafter, they can look forward to compliance monitoring.

Eager dentists can enrol from 1 October, although there is some suggestion that the CQC still doesn’t know what it wants from dentists to facilitate this. At least doctors are more fortunate as they have a year longer to register. There are harsh potential penalties for not registering, with fines of up to £50,000, 12 months‘ imprisonment, or both.

Under Section 86 of the Act, dentists could be issued with fixed penalty notices for non-compliance and there will be powers for the CQC to take enforcement action if practices are not up to scratch; practices may even have to have their own registered managers.

Practitioners can seemingly take no comfort at all, considering one of the stated aims of the CQC, which is a commitment to reducing bureaucracy and unnecessary regulatory burdens - to avoid duplication and promote “joined up care”. They seem to be doing the reverse of the statement: they think that by saying what they are not going to do will fool us, and that nobody will notice when they go on and do exactly the opposite.

Local decontamination units

One of the main issues for primary care dentists is, of course, the requirement to have on site their very own Local Decontamination Unit (LDU) - a sterile unit for the decontamination of reusable dental equipment. The 95-page best practice advice booklet, A Health Technical Memorandum, gives full details.

“Concerns that dental practices might have to close, due to the cost of creating LDUs or because of a lack of available installation space, appear unfounded.”

Incidentally, this is only part of a suite of nine such useful memora nda, comprising assorted core health subjects. The LDU issue is an important one and seems in part to have originated in 2001 with The Glennie Report, which reviewed the sterile service provision across the NHS in Scotland.

There is of course a question mark as to the effectiveness of LDUs; the sterile environment is inevitably moved into the non-sterile environment of the surgery where there is no effective control over what happens to it. Nevertheless, one of the preferred objectives behind LDUs is to try and counter the risk of the human variant of CJD/mad cow disease being caught from re-usable, steel dental instruments; add to this further concerns about passing on MRSA and hepatitis B – one can hardly deny a highlighted need for patient safety.

Negative impact?
Concerns that dental practices might have to close, due to the cost of creating LDUs or because of a lack of available installation space, appear unfounded.

Undoubtedly, the work of the CQC has created a new range of work for some manufacturers and also those eager to advise dentists on their new responsibilities – best-practice advisers and CPD providers, to name a few.

Published information on Wikipedia about the CQC does not help inspire confidence. A recent staff survey identified that 86 per cent of them have no confidence in the executive team and 82 per cent thought it unsafe to speak up and challenge what they were doing. The high-profile CQC Chairman, the Baroness Young of Old Scone, resigned her post at the beginning of the year in an apparent breakdown with Labour Ministers; raising serious questions about Lady Young’s confidence in the Government and the Health Service.

The future

It does seem that despite the change in government and the promise of less bureaucratic interference and state control in all our lives, this is an area where the influence of the ‘Nanny State’ continues to dominate. Looking to the future, one also wonders how far compliance with the new quality rules, aside from pleasing patients, will be used as a pre-requisite to qualify dentists to undertake NHS work and indeed also qualify them for membership of organisations such as Denplan and Practice Plan. Compliance will certainly help all those bodies, private and public, in determining who they favour.

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www.practiceplan.co.uk

About the author

Chris Hindle qualified as a solicitor in 1991 and is a partner with Leeds-based specialist dental lawyers, Cohen Cramer. He has extensive experience acting for clients who are buying and selling property and of landlord and tenant matters, including drafting leases and landlord consents. He acts for clients in the acquisition of development sites and retail/industrial estates. To contact him, email Chris.hindle@cohencramer.co.uk.

Practice Management United Kingdom Edition · September 20-26, 2010
Delivering patient experience

If you have focused your team on delivering the best possible experience to patients, your business is sure to flourish, says Lesley Bailey.

We know that word-of-mouth referrals will always be your strongest marketing tool and that patients will only recommend your services to others if they have enjoyed a positive experience at your practice. So my next question to my clients is: ‘What score would you give yourself for your customer care when one is low and 10 is high?’

I allow a few moments, as they ponder the answer to this question before reminding them that it is only their patients who can provide the answer and that to try and judge it from their own perspective is actually a waste of time.

So before I encourage my clients to invest any money in marketing their practice, we assess the level of service being delivered to ensure it is consistently excellent. In this way we can ensure money invested in marketing provides the best possible return and that the business grows organically through increased word of mouth referrals.

Step one: benchmarking

Therefore, the first step to take before beginning any marketing project is to benchmark the current level of patient care. There are a variety of ways to do this. Try assessing the first impression new callers have when they contact your practice or ask your patients informally to comment upon your service and care and establish whether there is any aspect of their experience that could be improved upon. Or you can undertake more structured patient satisfaction surveys – I recommend all these methods are used to assess your service levels. Limitations in practice resources can make it almost impossible to find the time to carry out mystery caller and patient surveys, but I always urge my clients to find the means to carry out this vital benchmarking exercise. The results can often be surprising and provide important business intelligence to help you develop your patients’ experience.

Step two: develop your patient experience

You will need to act upon any areas as which patients have identified for improvement and work with your team to create a consistently excellent experience for each and every patient when they call or visit your practice. Don’t forget, your patients will not judge you necessarily upon the quality of the dentistry you provide for them – in fact they will take that as a given. They will also judge you on your professionalism, efficiency, warmth and many of the small human gestures that develop rapport and illustrate the value you place upon them. The surroundings, facilities, printed material and in fact anything which patients see and hear or feel will create an impact.

A neutral experience

Try assessing the first impression new callers have when they contact your practice or ask your patients informally to comment upon your service and care and establish whether there is any aspect of their experience that could be improved upon. Or you can undertake more structured patient satisfaction surveys – I recommend all these methods are used to assess your service levels. Limitations in practice resources can make it almost impossible to find the time to carry out mystery caller and patient surveys, but I always urge my clients to find the means to carry out this vital benchmarking exercise. The results can often be surprising and provide important business intelligence to help you develop your patients’ experience.

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Patient Quality Measures
Is your practice compliant?

Are you waiting to find out when the Care Quality Commission* inspect your practice?

Have you addressed all 28 CQC outcomes?

Your compliance with Clinical Governance and Patient Outcomes will be questioned with the introduction of the Care Quality Commission*, HTM 01-05 and the increase in PCT practice inspections.

Would you like to know how you would fare when your practice is inspected and have the opportunity to take corrective action?

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The assessment will take approximately four hours of your Practice Manager’s time depending on the number of surgeries and we will require access to all areas of your practice. A report will be dispatched to you confirming the results of our assessment. If you have an inspection imminent then we suggest that you arrange your DBG assessment at least one month before the inspection to allow you time to carry out any recommendations if required. Following the assessment you may wish to have access to the DBG Clinical Governance Package with on-line compliance manuals.

For more information and a quote contact the DBG on 0845 00 66 112

*England only.

www.thedbg.co.uk

Please Note: Errors and omissions excluded. Any prices quoted are subject to VAT. The DBG reserves the right to alter or withdraw any of their services at any time without prior notice.
lasting opinions about the experiences we have.

**Step three: gather management information**

Let us suppose you have benchmarked your current levels of patient satisfaction and that you have reviewed and refined the experience you will provide systematically to every patient who calls or visits the practice.

The next step is to ensure you have a system in place to record each enquiry and the referral source for each new business opportunity.

There is little point in investing in a variety of marketing opportunities if you do not record the response you receive from each activity. Your front of house team must ensure they record each new enquiry, the reason for their call, secure a contact point if possible and find out how the enquirer heard about the practice.

You can analyse this information to establish the ratio between enquiries and consultations and assess the effectiveness of the front of house team in communicating effectively with new patients and motivating them to make an appointment.

This system may be developed further by tracking the patients as they attend, ensuring they have been referred to the dental hygienist and if they are proceeding with their prescribed treatment. More than 25 per cent of a dentist’s revenue can be lost because patients do not proceed with treatment. Few practices have the time, skill or resource to address this aspect of their business and don’t invest in finding out why patients don’t go ahead with their dental treatment.

**Step four: measure your return on investment**

Few practices work out the return on investment in marketing. Here is a simple method to establish whether the practice has made money on a marketing activity.

For this example we will assume a gross profit margin of 65 per cent - you must measure returns on profit and not on gross revenue.

If you invest £2,000 on a large glossy full-page advert, you will need to generate £3,077 worth of income to break even, £5,077 income x 65 per cent gross profit = £2,000.05 gross profit or sufficient revenue.

Many practice teams forget that their most important target market is their existing patients - these individuals have already bought into your products and services so the first part of your plan should include marketing internally to existing patients.

**Step five: set a budget and develop a marketing plan**

If you do not already allocate a marketing budget, consider the sum of money you are prepared to invest in the development of your business. This amount will depend upon the current status of your business, but in a steady state practice, I usually recommend around two per cent of gross income.

Carry out an analysis on your local marketplace, including your competitors and how you compare. Decide who your target market is as a cover all approach rarely works.

Many practice teams forget that their most important target market is their existing patients - these individuals have already

Finally your plan should include some activity to “the rest of the world”, le direct mailing, radio advertising or PR.

A small fortune

One of the most valuable lessons I have learnt is that sometimes the most effective marketing is the least expensive.

Certainly, if you have focused your team on delivering the best possible experience to patients, your business will grow organically.

The investment you do make in marketing will pay dividends as new patients joining your practice through marketing will become great advocates of your business.

**About the author**

Lesley Bailey is a partner in Yes! Results, a business that offers a range of patient communication services to dental and other businesses. For more information about how Yes! Results can help you maximise your revenue and profit through effective communication with patients visit www.yesresults.co.uk or call 08456 45 50 12 or email info@yesresults.co.uk to find out more.
Small things make big difference
Dental Tribune’s Laura Hatton discovers there’s more than meets the eye in the small world of ToothVille

Gummy Bear attacks? Scuba divers treating root canals? Decorators performing tooth whitening sessions? Sound like an ordinary day at the dentist? Invite the miniature world of ToothVille into your waiting room and your ordinary day will be just that - not forgetting meeting with the builders to discuss that cavity restoration. In hindsight, the incredible world of ToothVille should have been partnered alongside Colgate Oral Health Month, which runs this month; with the campaign fast becoming a regular date in the dentistry calendar, ideas on how to inform and educate both children and adults on maintaining good oral health always need to be revamped.

Two Passions
Being a keen photographer, London-based dentist Dr Ian Davis (pictured, bottom right) has combined his two passions of dentistry and photography to create ToothVille, a world of model mouth moulds where various dental treatments are carried out by miniature figurines. Inspired firstly by the artwork of Slinkachu (www.slinkachu.com) and the thought of what it would be like if teeth were large, Ian has created a storm of creative inspiration for the dental world using the power of these little men. The ToothVille sculptures include decorators carefully whitening a set of teeth, scuba divers carrying out root canal treatments, emergency teams rescuing broken teeth and workmen guarding teeth

Having placed pictures along corridors and throughout his waiting room, Ian has also produced a book, mainly aimed at the younger generation, although adults also can’t seem to put it down! The picture book, aiming to inspire prevention in all areas of tooth decay, begins with the least invasive treatments of Cavity Preparation and Restoration and leads onto emergency dentistry, before embarking on photographic images of miniature model scuba divers recreating root canal treatments. Whilst tiny workmen defend another set of teeth from sugar attacks the book comes to an end with further photographs, carried out in pure ToothVille style, recreating the invasive treatment of an implant; the final destination that all teeth want to avoid!

Originally spurred on by his photographic hobby, Ian’s passion for combining dentistry and photography under one roof is certainly becoming that of a business, and with the British Dental Trade Association on 14-16th October, we will hopefully see a display of the iconic ToothVille series on public view.

Small things
The main purpose of ToothVille is to visually show how ‘small things make a big difference’, the small things being brushing and flossing, the big things being saving your teeth - and with more than 80 per cent of dental practices taking part in this year’s Colgate Oral Health Month Campaign, the introduction of these miniature creations into practice waiting rooms could definitely help encourage the theme of the 2010 campaign - ‘Discover 5 Essentials for an Even Healthier Mouth’:
1) brush your teeth,
2) avoid sugary snacks, and
3) visit your dentist regularly.

Making Patients Smile
With the miniature workmen as visual metaphorical representations of the ‘small things’ in dental care, the models are fast becoming a useful way of conveying the message of maintaining good oral health. In response to ToothVille, Ian said: “ToothVille is quirky and makes the patients smile in the waiting room”.

If this is the response that every dentist wants, then surely ToothVille is the way to get that perfect smile.

Photos of the ToothVille series are available for sale at www.toothville.co.uk

Patients at Ian’s surgery are experiencing a waiting room quite unlike any other; children and adults alike are being drawn into the unique world of ToothVille, describing the experience as anything from ‘amazing and funny’ to ‘quirky’. From laughing and gigling as they see the Gummy Bear attack, to cringing at the implant photographs, ToothVille “demystifies the treatment”;

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Future models of ToothVille will see regular sugar attacks (as these seemed to go down rather well with all ages!) and further creations will be modelled on orthodontic treatment and tooth loss. Like existing ToothVille models, future photographs of the moulds will visually demonstrate different treatments, casting a brighter light on orthodontic treatments and expressing how tooth loss can be avoided, and in serious cases, repaired. Even though Ian is continually focused on improving the models that he has already created, the “icing on the cake” would be to publish a children’s book, providing the younger generation with a chance to understand dental health in an entertaining and interesting way.

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The bigger picture

Dr Koray Feran looks at how restorative dentistry has progressed in the past few years and compares some of the materials on the market

Over the past five years or so I have noticed a gradual, but distinct consensus across the disciplines, so that the procedures we are carrying out are backed up with stronger evidence. We seem to have developed a much better understanding and agreement of the treatments we carry out for our patients. Of course, there are still gaps, but we are all heading in the right direction.

Behind the scenes

I have great admiration for the unseen supporters of our profession and underpins the success of what we do in our practices. Not enough recognition is given to such people by our profession. The John McLean Memorial symposium, which was organised by Dr David Winkler just before the European Academy of Aesthetic Dentistry meeting, took place on May 26 in London and offered a tribute to one such man, who gave us glass ionomers and dental ceramics.

While the materials we have now are excellent, I'm sure somewhere there is always a team of people who feel they can do better! However, although we are continually provided with better materials, the techniques adopted by practitioners must be skilful and consistent enough to utilise the optimum properties of these materials: If you take clinical shortcuts, no material will save you for very long!

The greatest advances

I would have to say that the greatest advances have been seen in postgraduate education that are continually striving to create better materials and more efficient equipment. This requires an intricate knowledge of chemistry, biology, electronics and material science.

Although it may sometimes seem overwhelming, the huge choice of materials and equipment available to us is a minor miracle and underpins the success of what we do.

As far as one particular item is concerned, the profession has put a lot of faith in zirconia and especially CAD/CAM manufactured zirconia restorations. The material itself is pretty tough and easily the most durable ceramic we have at our disposal; however, the problems experienced with adhesion of veneering porcelain and cement to this material – as well as its degradation over time when exposed to the punishing oral environment – is still a subject for intensive debate.

I hope that the problems are ironed out and we can keep zirconia. However, some very experienced practitioners around the world are finding a greater cumulative failure rate of zirconia-based restorations as years go by, so this might be one technology where I would recommend not putting all of your eggs in one basket just yet.

How patients benefit

One would hope that through better knowledge and acquisition of more advanced skills, more of us are in a position to assist our patients with the problems they face. The use of stronger aesthetic materials that bond better to teeth will hopefully mean less frequent revision being necessary during the patient’s lifetime and greater reliability of our treatment. However, again it must be stressed that this will only occur if the clinical techniques and control with which these materials are used is of a high standard.

As for the future, who knows? I would like to see a drive towards better 5-D documentation, such as digital impressions and digital studies of dynamic mandibular movement to assess occlusal function and balance in larger restorative cases.

I would also like to see an improvement of communication and workflow between clinicians and laboratory technicians and to hopefully see an increase in the compactness of some of the equipment we use such as curing lights, implant motors, piezoelectric devices, x-ray sensors and apex locators, for example, which take up such a huge amount of room in our surgeries.

Of course we all await the advances in genetic engineering that will allow the growth of new teeth. Maybe not during the next five years...although you never know.

About the author

Dr Koray Feran qualified in 1989 from Guy’s Dental Hospital, winning the Final Year Prize for overall excellence and the SJ Kaye Prize in Oral Medicine and Pathology. He remained at Guy’s for two separate House Surgeon appointments in Prosthetic Dentistry and then Oral and Maxillofacial surgery until 1991 when he went into general practice in North London. After completing the Master of Science degree in Periodontology from Guy’s Hospital, he obtained a (Restorative Dentistry) Fellowship in Dental Surgery from the Royal College of Surgeons of England. He has since been in practice dedicated to quality dental care, having a special interest in multi-disciplinary cases that require detailed planning and co-ordination of several specialist branches of dentistry. For more information or to refer to Koray, contact The London Centre for Implant and Aesthetic Dentistry on 020 7224 1488, koray@korayferan.co.uk or by visiting www.korayferan.co.uk.
The first week as a maxillofacial surgery senior house officer (SHO), as the majority of past and present SHOs will tell you (and the ones that don’t are lying!) is a scary business. The learning curve at first seems impossibly steep and suddenly being required to function in a hospital environment is an overwhelming and daunting prospect. It doesn’t matter how much you prepare beforehand, there is no substitute for getting in there and experiencing the job first-hand.

I can vividly remember feeling completely shell-shocked, crawling into bed fully clothed and curling up into a ball after my first day on-call. My legs hurt. My brain hurt. I wondered just what I’d got myself into. Eleven months on and looking back, it’s incredible to see how far my colleagues and I have come compared to the startled rabbits we were in August 2009 when we started!

Of course, we by no means know it all and it would be ignorant of us to think that, but gaining an understanding of how a maxillofacial department works, enables us to follow the right pathways and ask the right people to manage most situations.

An important skill

Working as part of the maxillofacial team is probably the most important skill to master early on. “Teamwork” always seems to be a buzzword thrown around a lot in the workplace environment, but within the hospital setting I’ve seen first-hand how essential it is. Everyone in the department—SHOs, middle grades, consultants, receptionists, secretaries, nursing staff, theatre staff, technicians, etc., all work together to provide continued care to the patient. As soon as one part of the team fails to carry out their role, the system begins to break down and places additional strain on the others.

The SHOs in particular are frequently involved in communication between staff members and it’s absolutely paramount in keeping the cogs of the department system running smoothly. As soon as communication breaks down theatre lists can be delayed, important investigations are omitted and most significantly the patient’s management suffers.

The duties of an SHO vary hugely depending on the unit.
you work within, though typically, you’ll involve working on consultant clinics, pre-assessing patients for theatre, conducting your own minor oral surgery lists, ward duties and of course, being the dreaded SHO ‘on-call’ for the department, which tends to be the most demanding, exhausting and exciting part of the job – you never get the same day twice! Knowing when you are out of your depth is vital.

There’s no shame in calling your registrar if you’re stuck, and all the team members (nurses in particular) have a breadth of knowledge and can be an invaluable source of information – remember they have seen years of SHOs come through the department, making the same mistakes; filling out X-ray forms incorrectly, struggling with cannula, fainting in theatre...

First point of contact
Being the on-call SHO means being the first point of contact for the department. Receiving referrals from other hospitals, A and E departments, walk-in centres, GPs and GDPs across your region, one of the most important skills to master early on is to attain a thorough history over the phone to assess the urgency and appropriateness of the referral to assess whether a patient is fit for transfer. The nature of referrals varies widely and often depends on the department you work in. From my experience from working in a busy city centre hospital in the North East of England, a significant volume of referrals tend to be for facial trauma (frequently including facial lacerations, zygoma, mandible and infra-orbital floor fractures to the more severe complex poly trauma cases).

Adrenaline rush
It’s a unique chance as a dentist to be truly on the medical ‘front line’ and there’s never a dull day when a potential neck stabbing, road traffic accident, shooting, or airway compromising swelling could be coming your way the next time the phone rings. The dreaded ring tone will be etched in your brain and it’s an amusing phenomenon watching a room full of SHOs jump in unison as soon as it rings!

There will be times when you feel exhausted and tempted to dropkick the on-call phone across an overflowing A and E department at 4am on a Saturday night as the revellers begin to roll in, and you sometimes will be on shifts where you feel totally overwhelmed.

For me, the major stresses came not so much from the nature of the work, but the sheer volume. You have to constantly reassess the tasks that need to be done and more importantly prioritise who must be treated first – something which can be really tricky when A and E staff start breathing down your neck about patients who are close to ‘breaching’, but you’ve got to put your patients interests first rather than work to targets.

Learning curve
There are times when it’ll feel like the worst job in the world, but equally there are times when your shift ends and looking back you can’t believe what you’ve managed to achieve and what you’ve learnt. Nothing beats the job for hands-on surgical experience. You’ll pick up some fantastic skills in examining patients, facial suturing, dento-alveolar surgery and so on, as well as other, slightly more bizarre skills, like the ability to go from fast asleep to running down the corridor in 10 seconds flat and being able to present a ward round of patients coherently to a room full of consultants after being awake all night closing lacerations. I’m just concerned I’ll find going back to dentistry a little dull in comparison...

About the author
Sarah Armstrong qualified from Newcastle University in 2008 and is currently working as a maxillofacial surgery senior house officer at Newcastle General Hospital.

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An Evidence-Based Endodontic Implant Algorithm: Back to the Egg; Concluding Part

Kenneth S. Serota, DDS, MMSc

An increased uniform amount of coronal dentin significantly amplifies the fracture resistance of endodontically treated teeth, regardless of the post system used or the choice of material for the full-coverage restoration*. A recent article by Coppede et al demonstrated that friction-locking mechanisms and the solid design of internal conical abutments provided greater resistance to deformation and fracture under oblique compressive loading when compared to internal hex abutments*. These two "seemingly" disparate observations define the inherent continuum between natural tooth engineering and the principles of engineering necessary to orthobiologically replicate the native state.

The use of a ferrule or collet and a bonded or intimately fit post-core to restore function and form to an endodontically treated tooth is analogous to the use of a long, tapered friction fit interface with a retaining screw (Morse taper), to secure an abutment to a fixture. In both cases, the role of contact pressure between mating surfaces to generate frictional resistance provides a locked connection. This has been shown to affect the long-term stability of crestal bone support for the overlying gingival tissues and maintain a healthy protective and esthetic periodontal attachment apparatus*

Human symmetry

The Roman architect Vitruvius’ (Marcus Vitruvius Pollio) description of the perfect human form in geometrical terms was a source of inspiration for Leonardo da Vinci, who successfully illustrated the proportions outlined in Vitruvius’ work ‘The Architecturae.’ The result, the Vitruvian man, is one of the most recognised drawings in the world and is accepted as the standard of human physical beauty. Vitruvius theorised that the essential symmetry of the human body, with arms and legs extended, should fit into the perfect geometric forms: the circle and the square. However, Leonardo da Vinci recognised that the circle and the square were only tangent at one place, the base. Observe the insert in Fig. 8. The stabilising platform for the human outlined form begins at that tangent; the intersection is graphically analogous to the structural configuration of platform switching.

In geometry, an oval is a curve resembling an egg or an ellipse. Architects and engineers have used smooth oval curves to support the weight of structures over an open space literally since the second millennium BC. These arches, vaults and domes can be seen in buildings and bridges all over the world; the most perva- sive example being the keystone arches used by the Romans for aqueducts and mills.

An arch directs pressure along its form so that it compresses the building material from which it is constructed. Even a concrete block is readily broken if you hit it on the side with a sledge. But under compression forces from above, the block is incredibly strong and unyielding. Many will remember the weight bearing tripod experiments from grade school where an egg acts as one of three supporting legs of a square section of wood bearing books as the load. The structure could support over sixty books, almost twenty pounds, before breaking the supporting egg. One need only look at the root tunnel and coronal tooth structure of a multi-rooted tooth and it becomes apparent that strength of the tooth form is dependent upon an arch form for its integrity (Figs 8 & 9).

Optimal engineering

Is it possible for this natural feat of engineering to be biomimetically replicated to the design parameters of osseointegrated implants? There are a number of paradigms that continue to fuel debate in the dental clinical and scientific communities pertaining to the optimal engineering predicates for implant design. These include smooth vs. rough surfaces, submerged vs. non-s submerged installation techniques, mixed tooth-implant vs. solely implant-supported reconstructions, Morse taper abutment fixation vs. a butt-joint interface and titanium abutments vs. esthetic abutments in clinical situations where esthetics is of primary concern.

The cone-screw abutment has been shown to diminish micro-movement by reducing the burden on designs wherein the osseous trabecular framework is carried by the tapered section of the abutment, and in certain combinations of the parameters, the pretension in the screw may become zero. This tapered abutment connection provides high resistance to bending and rotational torque during clinical function, which significantly reduces the possibilities of screw fracture or loosening.

Biomechanics

The seed of a tree has the nature of a branch or twig or bud. It is a part of the tree, but if separated and set in the earth to be better nourished, the embryo or young tree contained in it takes root and grows into a new tree, Isaac Newton.

Pressure on the cervical cortical plate, micro-movement of the fixture-abutment interface (FAI) as well as microfoka leakage and colonisation at and within the FAI are some of the pathologic vectors associated with osseous remodeling, both crestal and peripheral to dental implants*

Occlusal considerations engineered into fixture design should enable optimum load distribution for permanent load stability during functional loading, reduce functional stress transfer to the interfacial tissues and enhance the biologic interaction of interfacial tissues to occlusally generated stress transfer conditions*

Future modifications to implant biomechanics should focus on designs wherein the osseous trabecular framework retaining the fixture will adapt to the amount and the direction of applied mechanical forces, cope with off-axis loading, compensate for occlusal plane to implant height ratios differences as well as adjusting to mandibular flexion and torsion*

In this new era of implant driven treatment planning, fixtures should be engineered to support single crowns with canti-levers instead of implant/implant or implant/teeth connections for a span of any degree. These engineering design iterations will minimise high-stress torque load at the implant abutment interface and obviate areas with degrees of bone insufficiency.

The goal should be to biomimetically replicate the natural state to the greatest degree (Figures 10a and 10b) in regard to load bearing capacity.

Measuring success

Stable crestal bone levels are the yardstick by which treatment success and health are measured in the orodental ecosystem, whether it relates to natural tooth retention, restorative or replacement rehabilitation. It is therefore surprising that the treatment outcome standards for
osseo-integration accept crestal bone remodeling and resorption of up to 1.5 - 2mm during the first year following fixture placement and prosthetic insertion 11.

The concept of “biological width” outlines the minimum soft tissue dimension that is physiologically necessary to protect and separate the osseous crest from a healthy gingival margin surrounding teeth and the peri-implant environment.

Tarnow’s seminal study on crestal bone height support for the interdental papilla clearly showed the influence of the bony crest on the presence or absence of papillae between implants and adjacent teeth 12. Twenty years later, logic dictates that anticipated early crestal bone loss and diminished, albeit continual loss, during successive years of function, should have been engineered out of the substitution algorithm for peri-implant tissues 13.

Platform switching: By default or by design
‘There is no logical way to the discovery of elemental laws. There is only the way of intuition, which is helped by a feeling for the order lying behind the appearance,’ Albert Einstein.

Platform switching theorises that by using an abutment diameter of a lesser dimension than the periphery of the implant fixture, horizontal relocation of the implant-abutment connection will reduce remodeling and resorption of crestal bone after insertion and loading.

The concept implies that peri-implant hard tissue stability will engender soft tissue and papilla preservation. Maeda et al reported that stress levels in the cervical bone area peripheral to a fixture were reduced when a narrow diameter abutment was connected in comparison to a size commensurate with the fixture diameter 12.

The authors concluded that the biomechanical advantage of shifting stress concentrations away from the cervical area will diminish their impact on the biological dimension of hard and soft tissue extending apically from the FAI (Fig 11a, 11b and 11c). The inherent disadvantage is that it shifts stress to the abutment screw with the potential for loosening or fracture.

Baggi et al detected neutrophilic infiltrate in the connective tissue zone contacting the implant-abutment interface. The facility by which platform switching/shifting reduces bone loss around implants has been investigated by Lazzara et al 12. The authors hypothesised that, if the abutment diameter matches that of the implant, the inflammatory cell infiltrate is formed in the connective tissue contacting the microgap created at the FAI. If an abutment of narrower diameter is connected to wider neck implant, the FAI is shifted away from the outer edge of the implant, thus distancing inflammatory cell infiltrate away from bone. Hypothetically, less crestal bone loss is expected and an increased implant/abutment disparity allows more stable peri-implant soft tissue integration.

Type II bone quality was approximated and complete osseous integration was assumed. It was concluded that the Ankylos G/X implant based on its platform...
switched and subcrestally positioned design demonstrated better stress based performance and lower risk of bone overload than the other implant systems evaluated.

**Essential features**

Platform switching, together with a stable implant-abutment connection are increasingly accepted essential implant design features required to reduce or eliminate early crestal bone loss. A bacteria-proof seal, a lack of micro-movement due to a long friction grip tapered channel and minimally invasive second-stage surgery without any major trauma for the periodontal tissues are also important factors in preventing cervical bone loss.

A preconfigured platform switched design has a significant impact on the implant treatment in esthetic areas as not only is the tissue biotype preserved, but it has been shown to be enhanced by osseous generation over the collar of the fixture (Figs 12a and 12b).\textsuperscript{22}

The endodontic implant algorithm parallels the question, which came first, a chicken or the egg as an example of circular cause and consequence. It could be reformulated as follows: ‘Which came first, X that can’t come without Y, or Y that can’t come without X?’ An equivalent situation arises in engineering and science known as circular reference, in which a parameter is required to calculate that parameter itself. This is the essence of foundational dentistry.

Nature wisely created a structure that could harmoniously interoperate hard and soft tissue, act as the portal of nutrition and communication for the body and be the gatekeeper on guard and in function throughout our lifetime. As such, our role is to ensure that however we reengineer nature, we must adhere to its rules, its logic and its fundamentals.

**The best evidence**

This is not an easy task, as filtering out the range of evidence from a wide range of sources, presenting clear, comprehensive analyses and incorporating patient experience is a Herculean task. In many ways, this is analogous to Alice’s Adventures in Wonderland as so much of what we do grows ‘curiouser and curiouser’ as each new innovation demands that we go through the looking glass and determine what Alice found there.

References


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**About the author**

Kenneth S Somia, DDS, MSc graduated from the University of Toronto, Faculty of Dentistry in 1973 and was awarded the George W Stetler Memorial Key for Excellence in Periodontics. He received his certificate in Endodontics and Master of Medical Sciences Degree from the Harvard- Forsyth Dental Center in Boston, MA. The founder of ROOTS – an online educational forum for dentists from around the world who wish to learn cutting edge endodontic therapy, he recently launched IMPLANTS (www.implants.com) and www.kwsonline.org to provide a clear understanding of the endodontic/implant algorithms in foundational dentistry.
SAFE
- Strong, flexible medical grade polymer tips
- Single patient use
- Uncoated & Non Cutting tips

EFFECTIVE
- Creates fluid hydrodynamics
- Improves debridement and the disruption of the smear layer and biofilm

SIMPLE
- Very simple clinical technique
- Intuitive Device
- Ideal in practice when portability is required
Comprehensive Dentistry and Occlusion

Q. Why is the Dawson Academy so well known for occlusion? The reason Dr. Dawson became so well known for occlusion was well! He made a complex subject logical and straightforward. Secondly, the title of Dr. Dawson’s series was actually “The Concept of Complete Dentistry”. Complete dentistry from the simplest filling to complex implant treatments, but as people are keeping their teeth longer more people are suffering the effects of occlusal disease - particularly worn teeth. While dentists have become familiar in dealing with teeth, periodontal and more recently smile problems, they are much less familiar with how to deal with occlusal problems. Consequently, occlusion became the cornerstone of the series.

Q. How does this all fit with modern dentistry? Patient expectations, materials, etc. have changed. John Cranham, Clinical Director, has done a fantastic job in blending Dr. Dawson’s timeless principles with cutting edge research, materials and philosophy.

The “Big Picture” system is our 4 Steps to Predictable Dentistry. Firstly, we need to visualise where the teeth need to fit in the face. Then we need to transfer this vision to mounted models to produce a diagnostic wax-up. This allows us to produce the matrices we need to ensure minimal but adequate preparation and to provide excellent temporary restorations, the third stage of the process. Once these are approved it then becomes a predictable and stress-free process to produce exceptional final restorations, the fourth part of the process.

Q. So do you just deal with restorative dentistry? Absolutely not! Since the cosmetic wave hit dentistry a number of years ago and everything needed a porcelain veneer there is now a move away from this and much talk of minimally invasive dentistry and orthodontic options. Well, forty years ago Dr. Dawson was talking and writing about just this. He outlined his treatment options in a specific sequence: Reshape, Reposition, Restoration or Surgical. Once we have decided where the teeth need to go to fulfil our functional and aesthetic goals we can then apply the treatment options in the above order. Sometimes teeth can simply be reshaped to fulfil the requirements i.e. equilibration. If the teeth are in good condition but in the wrong place, repositioning (orthodontics) is usually the most appropriate option. Only once these two options have been considered should restoration be contemplated. Commonly, complex treatment requires a combination of two or more options. If these treatment options are applied in this order, you will truly able to solve your patients’ problems whilst providing as little dentistry as possible.

Dr. Dawson also had another rule that sat over everything he did - the WIDIOM rule (Would I Do It On Me?). If you wouldn’t accept the treatment yourself, why give it to patients? I’m sure that many good dentists have applied this rule in their career. However, it takes a wise man to point out the obvious. This is why we talk of Dr. Dawson’s timeless principles.
Growing pains

Getting a new team of people to respect you takes patience as you learn to reward them, praise them, lead and motivate them, says Sharon Holmes

I have been in management for 25 years and sometimes forget how painful it can be. Recently we incorporated two new practices into the Dental Arts Studio; I had a feeling we may meet with some resistance, but I hadn’t anticipated just how painful it was going to be for everyone involved, particularly one of the new practice teams.

After much clenching of teeth and a few sleepless nights, it occurred to me that perhaps the team from one of the new practices was worried about being separated from their departing principal dentist. To overcome this problem, I had to establish trust in them, to enable me to pass on our vision of what we want the Dental Arts Studio to represent.

Future vision

To encourage them to follow our lead I realised that I had to set the scene for them and make them feel comfortable; I had to create a reliable and attractive vision for the future that they would respect and believe in.

As managers and leaders we should never forget that staff look to those in leadership roles for confidence, a sense of calm and direction. The most important thing to remember is to make good decisions when under pressure; with confidence you have done the necessary work needed for these decisions to be right.

To make a judgment without investigating the implications can lead to serious disharmony among your staff.

One can never determine the outcome of investing in a new practice; this is something that should be exciting and a challenge - as I have now realised, it is exciting for the purchaser, but not so much for the team left behind.

Best customer care

We took over two practices at the same time and the second practice was a challenge to start with. Dr Simon and Dr Sally had lots of time in the initial takeover and this team has thrived well. They have taken on board all the training that has been put their way. They have only been with us since April and we have seen a massive desire within the team; they want to achieve the very best possible customer care.

Not only have we had to train the whole team in customer care and deportment, but we have had to train them in our management infrastructure: with regards to administration; this is a challenge being faced by both practice managers on a large scale. We have been developing our administration system over seven years now and it is comprehensive, but very effective. This means dealing with stressed staff. The training, however, must continue until they are able to work single-handed without too much micromanagement.

You have to show patience and you have to continually encourage your team as they grow into the new systems put before them. It is not only about systems and progress; it is about giving your new team the time they need to adjust.

A happy environment

Creating a good atmosphere is not only easy, it is also essential. For your team to respect you, you have to learn to reward them, praise them, lead and motivate them. Deal with issues head on - don’t ignore friction as it does not go away, otherwise this will be the undoing of your team.

It is difficult when you are responsible for a team of people you did not choose and you may not like. In return, they may not like you and on top of this you have to do your job well. This might seem like a rather tall order, but as a manager you have been given a trusted and privileged position. You are a manager – so you must manage.

Not very long ago I met a nurse at a dental function and most of our conversation was based on how miserable their practice manager was; as a result, the staff were too frightened to approach her on practice issues to such a degree that the staff were unable to self-develop. I asked her why they did not approach the principal dentist and she sadly informed me that he was not interested as she did a good job with the administration.

To note to self: I never want to be described as “miserable”. My motto is and always will be, to lead by example. A good manager is there to help the team grow and develop, even if you have a larger team to manage. You could utilise part-time staff to cover for people to go on courses to further their self-development.

As Peter F Drucker says: ‘Management is doing things right; leadership is doing the right things.’

About the author

Originally from South Africa, Sharon Holmes has worked in the field of dental practice management since 1992. She received hands-on training from the first dentist who employed her in 1992, which gave her a broad experience in knowing what’s involved in providing dental treatment. Arriving in the UK in 2002, she took a post in a mixed NHS and private practice in Wimbledon, eventually taking over its management, converting it to a fully private practice. In 2005, she moved to London City Dental Practice where after 18 months, was responsible for managing four practices in the group. The London City Dental Practice is now part of a mini co-operative group called the Dental Arts Studio, of which she has been instrumental in its creation. She holds the position of operations director and manages every aspect of the group alongside her principal dentists.
**Why learn occlusion?**

Dr Lawrence Murray presents a compelling case for finding out more about occlusion and its relationship with patient care.

Oclusion touches on every aspect of dentistry and it is one of the most important factors in determining the longevity of our restorations, it is amazing how long any crown will last if it is not in occlusion with a tooth on the opposite arch.

**Pressure**

There is a pressure today for everyone to have perfect teeth and as dentists we frequently place crowns or veneers to achieve the aesthetic improvements the patients desire, it is well documented that patients are less willing to accept problems from elective treatment than treatment necessitated by pain.

Patients arrive with worn or chipped teeth and many practitioners are encouraged by the patients desire to quickly restore the lost tooth substance without always looking at what caused the tooth loss in the first place. ‘Patients arrive with worn or chipped teeth and many practitioners are encouraged by the patients desire to quickly restore the lost tooth substance without always looking at what caused the tooth loss in the first place.’

**Case Study**

This 52 year old lady was referred to me by a local practitioner, she had been to see a ‘cosmetic dentist’ but was unhappy with the treatment that was offered, she was also given no explanation as to how or why her tooth loss had occurred. She was advised that she needed full coverage metal ceramic crowns to provide the necessary strength to prevent the restorations fracturing.

A full history was taken and the patient stated that she was aware of grinding her teeth, had headaches and neck aches and had a disturbed sleep pattern. A full occlusal examination was taken, study casts mounted on a Denar mark 11 articulator using a sliding facebow transfer and centric relation record. A large deflective contact was identified on a molar and there was a large maximum InterCuspal Position (MICP) Centric Relation (CR) discrepancy.

A hard acrylic splint was constructed and adjusted so there were even simultaneous posterior contact and no anterior contact in CR, immediate anterior contact on excursive movement allowing posterior disclusion. This is called mutually protected occlusion and after two weeks she reported that she was free from headaches and neck aches for the first time in many years.

Stabilised joint position

She wore the splint for three months until there was no further adjustment needed as her joint position had stabilised. I then equilibrated her teeth to establish even posterior contacts and smooth anterior guidance within the limitations caused by the loss of the canine cusp on the left side. A diagnostic wax up of the proposed new anterior occlusion was then copied and composite temporaries placed on the teeth.

These were placed to ascertain if the new occlusal pattern was acceptable to the patient, they are also useful in that if they fracture or fall off it indicates that some aspect of planned prescription is incorrect. These were adjusted on two occasions and were in place for three weeks; impressions were taken and mounted in (MCP) which was now coincident with (CR). Then a custom incisal table was constructed for the articulator based on the guidance established on the temporaries, thus enabling us to recreate this in the final restorations. Five teeth (11,21,22,25,24) were prepared for feldspathic veneers. Care was taken to keep the preparations in enamel and it was not necessary to involved the unaffected incisors as we felt we could achieve a good result with the minimum of tooth loss.

Five veneers were cemented using standard protocol and final excursive movements adjusted to ensure smooth and immediate disclusion.

Delighted patient

The patient was delighted with the result both aesthetically and that she had lost her headaches, neck aches and had an uninterupted sleep pattern.

I would like to thank Naomi Greaves for the beautiful porcelain work.

There are many courses that can teach the preparation and cementation of veneers but few that can teach the manual skills needed to be able to fabricate and adjust splints, there are even fewer that teach practitioners how to equilibrate on actual patients as it is very different to doing a model exercise. The International Partnership for the Study of Occlusion (IPSO) is one of these and it was with them that I learned my occlusal training, they have been teaching in the United Kingdom since 1986 alongside and after a one year hiatus they are back with their three-day introductory course in Mansfield in November.

Further details for this course are available from Crystal Walsh at The Academy of Clinical Excellence. Tel: 0815 201 1515.
Mr W was referred to the Kent Implant Studio wishing to replace his upper left central incisor. The patient was wearing a partial denture which he was unhappy with, and did not like the idea of a conventional bridge. The patient was medically fit, healthy and a non-smoker.

After discussions with the patient and the referring dentist, it was decided the tooth would be replaced with an implant supported crown.

There was a buccal defect apparent. The history of the tooth was a trauma incident (cricket bat) which led to the tooth fracturing and needing endodontic treatment around 30 years ago. The tooth subsequently needed an apicectomy. The apicected site was apparent with a soft tissue area apical of the previous tooth. There was also a buccal defect present 12mm from the edge of the ridge. Ridge Mapping clearly indicated a bony defect of at least 12mm in height. Soft tissue analysis showed 8mm of defect at the edge of the ridge narrowing to the shape of the previous tooth. There seemed to be a height defect buccally compared to palatally of around 2mm. These measurements were confirmed during the reflection of the flap during surgery. If an increase in width was needed, ridge widening could be considered, however, the defect on ridge mapping measures 1mm at crestal level; a difficult procedure considering this case. There also seemed to be a buccal height defect, which cannot be corrected with ridge widening.

Therefore, augmentation was the proposed option. This could be either guided tissue regeneration with the use of bovine/irradiated bone or grafting procedures using intra-oral donor sites. The defect was of height and width, and a J shaped bone graft would be of more use: therefore the ideal site for a donor would be the Ramus. As the patient was missing both his wisdom teeth, either side could be considered. As the ID canal was more clearly visible on the OPG and identifiable throughout on the right hand side, the right Ramus was the more ideal site.

A ramus graft was obtained from the right ramus as planned and positioned in the upper left central incisor area. Three months were allowed for bone healing, and subsequently an implant length of 14mm and width 4.5mm (Ankylos B14).

Primary stage impressions were obtained (an impression at the stage of implant placement). six months were allowed for implant integration, and subsequently the implant was exposed using a small ‘H’ shaped incision, with the incision point more palatally, thus allowing a buking effect of the gingivae buccally.

The already chosen abutment with the correct angle (22.5 degrees) was fitted and an already constructed temporary acrylic crown was fitted. The crown was adjusted at the gingival margins so to define the final contouring of the gingivae. The final restoration was fitted after three weeks of gingival healing.

The patient was delighted with the end result, and was surprised the treatment was not painful and that he was able to fully function the next day after all the stages. The patient was returned to the referring dentist for routine care.

‘The patient was delighted with the end result, and was surprised the treatment was not painful and that he was able to fully function the next day after all the stages’

Aesthetic Zone needing Augmentation
Dr Shushil Dattani presents an interesting case

Dr Shushil Dattani BDS, MFDSRCS, DipImpDent RCS (Eng)
Principal of the Kent Implant Studio and Kent Smile Studio in Maidstone, Shushil qualified from the Royal London in 2000, after which he completed a two-year programme and membership to the Faculty of General Dental Practice at the Royal College of Surgeons. He is accredited with a Diploma in Implant Dentistry at the Royal College of Surgeons of England and is a member of the Association of Dental Implantologists, the American Academy of Cosmetic Dentists and regularly trains and attends courses around the world including the pioneering American and British Cosmetic Dentists. For more information or to refer to the Kent Implant Studio please call 01622 754 062
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Developed and designed with advice from the surgeons, the Surgi XT Plus brings a new dimension of control to the dental surgeon with the surgical microscope's unique presentation. Consequently using MFS facilitates easier and more convenient handling with the Surgi XT PH, and the new industry-standard utilising conventional grinders which require hydration prior to placement.

Manufactured exclusively for the scientific community, the OsteoBiol range includes a choice of Genos granules for traditional bone regeneration

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Manufactured exclusively for the scientific community, the OsteoBiol range includes a choice of Genos granules for traditional bone regeneration procedures; and Puffy for joint extrusion alveolar regeneration and periodontal defects. Both of which are also available in a choice of porostic or squared derived options. The range also includes Evolution Membranes, in a choice of thicknesses to suit different applications. Christians report that using OsteoBiol products is easier and more convenient than using similar materials made from other available products.

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The long way down

Four exciting abseil events with Bridge2Aid to challenge yourself with this autumn

Tanzania is 4,500 miles south from the UK – that's a long way down from here! This autumn, however, we'd like to ask you to travel not quite as far to make a big difference to our work.

Pick one (or all!) from the following and by travelling a little you can make an impact on the lives of thousands of people in the Mwanza region of Tanzania, giving them access to safe, emergency dentistry. Imagine hanging 50 metres above the ground while controlling your own descent at some of the most impressive sites around the UK...

26 September – Mersey Ventilation Shaft: The 50m Mersey Tunnels Ventilation Shaft located in Birkenhead provides an exhilarating abseil with fantastic views across the River Mersey.

2 October – Walsall Art Gallery: This iconic building in Walsall, West Midlands provides an exciting 30-metre abseil in the heart of the town.

3 October – Carlisle Civic Centre: The Civic Centre abseil located in the centre of town provides a great view of Carlisle in Cumbria and an exciting abseil.

To take part
• Choose your challenge
• Send your registration form to Long Way Down, Bridge2Aid, PO Box 649, Chichester, PO19 9JB
• Pay £20 registration fee
• Raise £100 minimum sponsorship, we'll give you support.

The fee includes rental and preparation of the venue, qualified and professional instructors, all equipment, registration and management on the day.

If you'd like to travel a little way to help people a long way away, contact us now by emailing fundraising@bridge2aid.org or calling 01243 780102.

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

The four key aspects of Bridge2Aid’s vision are:
- To provide primary dental care and oral health education to communities in Tanzania
- To equip and further train local health personnel to provide emergency dentistry to rural communities
- To care for and empower the poor and marginalised in Tanzanian society
- To provide opportunities for UK dental professionals and others to use their skills to serve Tanzania, as locums or participants on the Dental Volunteer Programme (DVP).
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Dental Tribune United Kingdom Edition September 20-26, 2010

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Comparably to Corsodyl Mint Mouthwash in –

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Product Information: Corsodyl Mint Mouthwash (clear, chlorhexidine digluconate 0.2%), Corsodyl 0.2% Mouthwash (alcohol free) (clear, chlorhexidine digluconate 0.2%). Indications: Plaque inhibition; gingivitis; maintenance of oral hygiene; post periodontal surgery or treatment; aphthous ulceration; oral candida. Dosage & Administration: Adults and children 12 years and over: 10ml rinse for 1 minute twice daily or pre-surgery. Soak dentures for 15 minutes twice daily. Treatment length: gingivitis 1 month; ulcers, oral candida 48 hours after clinical resolution. Children under 12 on healthcare professional advice only.

Contraindications: Hypersensitivity to chlorhexidine or excipients. Precautions: Keep out of eyes and ears, do not swallow, separate use from conventional dentifrices (e.g. rinse mouth between applications). In case of soreness, swelling or irritation of the mouth cease use of the product. Side effects: Superficial discoloration of tongue, teeth and tooth-coloured restorations, usually reversible; transient taste disturbances and burning sensation of tongue on initial use; oral desquamation; parotid swelling; irritative skin reactions; extremely rare, generalised allergic reactions, hypersensitivity and anaphylaxis. Legal category: G3L. PL Numbers and RSP excl. VAT: Mint Mouthwash: PL 00079/0312 300ml £3.99, 600ml £7.82. Alcohol-free PL 00079/0608 300ml £4.08. Licence Holder: GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. Date of preparation: May 2010.


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