Exciting times ahead?

DCPs must now legally invest in building their skills through CPD. Sounds like the perfect chance to boost your career, but the change is also a little daunting. Mhari Coxon explains

S
o, change is finally here. As of the August 1, 2008, every Dental Care Professional (DCP) registered with the GDC must complete 150 hours of Continuing Professional Development (CPD) over five years. Fifty of these hours must be verifiable, while the other 100 will be made up of unsupervised development, reading Dental Tribune UK, for example.

From talking to colleagues and friends, there are mixed feelings about this enforcement. I personally am looking forward to developing my clinical skills and improving the quality of care for my patients, as well as keeping up to date with the most recent evidence.

Attending lectures and courses is something I have always enjoyed. It can boost my motivation for my career, and allows me a chance to catch up with colleagues and discuss our profession. I have often been the only hygienist in a practice so haven’t always had a fellow colleague to talk about daily clinic.

Dental trade companies support meetings and show you the latest products. There is almost always something new to take from a meeting and add to your practice.

Last-minute nerves

Some hygienists and therapists, through family commitments and other restraints, have not been able to attend courses previously not an option. The skill list for nurses will be extended more and we await the final guidance on their future.

Choosing skills to develop

In May this year, the GDC took consultation regarding Scope for Practice for all dental professionals. The paper was designed to look at what skill groups we would expect each group to have upon qualification, and what other skills could be developed as a postgraduate. A team of professionals, representing all DCP groups, formulated a proposal and the paper was open to all professional and the public for comment.

Since the consultation closed, it has been made clear that, once suitable training has been completed, dental hygienists and therapists will be able to perform tooth whitening under prescription of a dentist. Dental nurses, again with suitable training, will be able to take impressions and make vacuum trays. The skill list for nurses will be extended more and we await the final guidance which is due out in the autumn.

Planning for the future

What I see emerging is a real opportunity for the team to be utilised and make the day-to-day running of practices more efficient and cost-effective. For example, one rainy lunchtime, we were hypothetically planning the future for our practice. We could see a new client being interviewed by the nurse and a full dental history, lifestyle and diet assessment, and medical history be taken. The client would then move in to the clinical environment and have their consultation with the dentist. The nurse would take impressions if necessary, and chart the patients bleeding and plaque score. They would take a sample of bacteria and document what was seen under the microscope, disclose the patient, take digital photographs and discuss oral hygiene with the patient, giving them a tailored hygiene kit to take home. Diet assessment sheets could be given if deemed necessary, and an appointment organised for their first hygiene visit. I could introduce myself briefly and give the client some literature to read before their first hygiene visit.

Obviously, if this is to be a reality, detailed training would be required. But we could all see how our clinical day would be improved as well as expanding the quality of care for our new clients.

The client would feel valued as they were asked for information, the dentist would have more time to devote to high-skill treatment, the nurse would have a more involved and interactive role and the hygienist would get the client who has already improved their oral hygiene, enabling a more comfortable first cleaning session. All round, a good improvement.

Of course, this is all a pipe dream but now, you can see why continuing development becoming compulsory could actually be just what the profession needs. I genuinely believe this is a great time to be in dentistry and our profession will go from strength to strength.

Choose your training

There will be more courses available to DCPs now and, as well as completing the compulsory elements; you will be able to choose training that will benefit your particular practice environment. So, don’t see this compulsory addition to your working time as a chore, enjoy developing yourself and boosting your enthusiasm for your chosen career.

For more information on CPD requirements, visit www.gdc-uk.org/CurrentsRegister/CPDrequirements

About the author

Mhari Coxon is a dental hygienist practising in Central London. She is chairman of the London British Society of Dental Hygiene and Therapy (BL- DHT) regional group and is on the publications committee of its journal, Dental Health. She is also clinical director of CPDforDCPs, which provides CPD courses for all DCPs. To contact Mhari, email mhari.coxon@cpdfordcps.co.uk.
Dr Zaki Kanaan argues the case that when it comes to implants, treatment should be kept as simple as possible.

T he old adage goes that if 10 dentists were to treatment plan a case you will get as many varying opinions. There is nothing wrong with this for simple general restorative cases, but when planning for implants, it is wise to opt for the simpler option. The following case highlights the point that proceeding with a more complicated plan may have been due to a poor final result, as well as an unpredictable long term prognosis and outcome for a young patient.

History and Presenting Complaint

This young gentleman presented for an opinion, after being recommended by a hygienist. She was concerned about, what she felt was a large treatment plan that was recommended to her son by another respected dental centre.

Her son, a student on his gap year, had lost his upper right lateral incisor root, through a skiing accident. A provisional acrylic crown was bonded to adjacent teeth as an emergency measure and the centrals were splinted at this visit (Fig. 1, 2, 3, 4). The upper centrals were also traumatised during the accident, with periapical radiographs exhibiting significant infrastructural bone loss at various levels (Fig. 5). The upper right lateral and central had also been root treated shortly after the accident and all teeth have been symptomless since.

Treatment Plan by Another Dental Centre

The initial suggested treatment plan included the extraction of the upper right lateral and central incisors and the upper left central incisor, with the provision of an immediate partial acrylic denture. This would have been followed by the placement of an implant supported bridge with implants in the upper right lateral incisor and upper left central incisor positions. Although this is a viable option, it would have lead to the extraction of 3 important teeth in the smile zone of this young gentleman. This treatment plan was accepted by the young gentleman and his parents, but fortunately, due to a waiting list for the implant phase of treatment, this treatment plan had still not been carried out.

My Proposed Treatment Plan

A view to the fact that the traumatised centrals have been asymptomatic, with no apical changes since the accident, I suggested leaving the centrals alone with no treatment initially. I recommended the extraction of the upper right lateral incisor, with the immediate placement of an implant.

A provisional tooth would have also been provided. A final abutment and porcelain crown would then be fitted after the healing phase. It is important to inform the patient that further treatment may well be required on the central incisors. Staging the treatment in this way will minimise the risk of losing soft tissue architecture. This treatment plan was accepted.

Surgical Phase

The patient attended for treatment and was given an Arnica 200c pillule (a small succussion pill, coated with the remedy) to take preoperatively. Arnica is a homeopathic remedy that I routinely use for all elective surgical procedures. It has been shown to help reduce bruising and swelling associated with surgery and I have noticed a marked difference in both patient reported symptoms, as well as clinical symptoms, including the speed of healing. A 50 second Chlorhexidine pre-surgical rinse was carried out prior to administration of local infiltration anaesthesia. A flapless surgical technique was utilised by using a size 15c micro-blade into the denugingival sulcus around the upper right lateral incisor root. The root was then gently andatraumatically elevated using periosteotomes, taking care not to stress or damage the fragile buccal plate. The resulting socket was inspected, especially for the integrity of the buccal plate. A nice instrument to do this with is the AstraTech™ measure gauge. It has a blunt, hemispherical end, which gives good tactile feedback and can also be used to measure the length of the socket. It can also be used to give visual feedback on the direction of the imminent osteotomy site preparation. Socket curettage was carried out to ensure it is free from any granulation tissue. The buccal plate, although thin proved to be intact and ended approximately 5mm below the labial gingival level. The initial pilot drill used was positioned with a slight palatal inclination and position to the previous root apex, to avoid perforating labially. The site was prepared using a standard sequence and saline, with special attention to avoid the thin buccal plate of bone during preparation. A 3.3 x 10mm NobelBiocare™ Tapered Groovy implant was torqued into position with an initial stability of 20Ncm and ensuring that a tri-channel in the long axis is positioned mid-buccally. The initial stability of 20Ncm is not enough to immediately restore an implant. If immediate loading has been planned, you should always have a contingency plan of good primary stability of the implant is not achieved. The implant head was placed 5mm apical from the anticipated final labial gingival margin (adjacent dentogingival level can also be used as a guide if needed). There was a 2.5mm space between the buccal plate and the implant. A narrow healing abutment was placed and the void was filled with a mixture of BioOss™ (Geistlich) and autogenous bone harvested with an AstraTech™ Bone Trap. It was my usual protocol to fill voids that are approximately 1.5mm or more. No sutures were needed.

Restorative Phase

12 weeks later, open tray impressions were taken and custom shade matching was carried out. It is important to take a photo of the contralateral tooth for comparison (Fig. 7) and a discussion with the patient about whether to copy this tooth needs to be communicated with the lab, especially if there are any unusual characteristics. In this case the upper left lateral had a mesio-buccal rotation and the patient wanted a slight element of rotation with his new tooth. Due to the depth of the implant head it was decided best to use a goldadapt abutment. This was covered with a layer of opaque porcelian to help mask any possible metal shine through as much as possible. This was torqued down to 20Ncm and the access filled with GP and Syntip provisional composite. It was also decided to make a Lava crown with an opaque core (3M ESPE). The Lava crown was tried in and approved by the patient for shade and form before being cemented with temporary cement.

It is often the case that the embarrasement between a canine and a new crown is increased, as it was here (Fig. 9). This can easily be remedied by bonding some composite to the mesial of the canine, as was done in this case, which reduces the embarrasement giving a more aesthetic result, which was to the patient’s satisfaction (Fig. 10).

It is always advisable in aesthetic situations such as this, to condition the tissues by providing

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