Trends in endodontics: views from the specialist practice

Marita Kritzinger talks to Julian Webber, leading endodontic specialist from the Harley Street Centre for Endodontics in London

Q: What inspired you to pursue a specialist career in endodontics and how did you achieve it?

JW: When I first qualified, I wanted to further my education on an MSc programme in the United States. My mentor at that time was Richard Mitzman, an American-trained and very gifted restorative dentist. He had completed a DDS at the University of Southern California, Los Angeles, and had a thriving practice in London.

He persuaded me that what London and the UK needed was an American-trained endodontist rather than another American-trained restorative dentist. I took his advice and went on to complete an MSc in endodontics at the Northwestern University Dental School, Chicago, Illinois, USA in 1978. I am proud to say that I am the first Englishman to have accomplished this.

Q: What advice would you give an undergraduate student considering specialising in endodontics?

JW: Endodontics demands a high standard of clinical skills. Use your time wisely to master these skills and your postgraduate training will be worthwhile. Read as much of the literature as you can, both current and historic. Make sure your course achieves a specialist career in endodontics.

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Q: What is the most valuable thing you learned during your studies?

JW: As an undergraduate, an inquisitive mind spurred me to do the best I could. Birmingham University, where I did a BDS in 1974, was one of the first degrees in the country to integrate all the various disciplines in dentistry into ongoing modules pursued through all the clinical years. This taught me a lot about treatment planning which has always been one of the most important considerations in my practicing career. Planning the treatment is more important than the treatment in many instances. Take time with your treatment plan, and the treatment will always go smoothly.

As a post-graduate student at Northwestern, I learned clinical skills that, at that time, were not available in the UK. I learned to be the best and reach for the pinnacle of clinical excellence. This is something I still adhere to today.

Q: What resources do you use the most in your everyday work?

JW: I am an avid journal reader and on a monthly basis read the International Endodontic Journal (IEJ), the Journal of Endodontics (JOE), Oral Surgery, Oral Medicine, Oral Pathology, Oral Radiology and Endodontology (OOO). I always buy the new edition of the major endodontic textbooks and devour these as soon as received. For my lectures, I find PubMed a fantastic resource for literature that I may have missed.

Q: How many conferences do you present at or attend in a year?

JW: I travel at least once a month, attending or presenting courses. I have just returned from Australia and New Zealand where I gave lectures and hands-on courses. As I write this, I am in the airport lounge on my way to Siberia, Russia to present some more.

The most important conference for anyone interested in endodontics is that of the American Association of Endodontists. The next meeting is in April 2009, in Orlando. The European Society of Endodontology always has a great biennial meeting. The next meeting is in October 2009 in Edinburgh, Scotland.
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There is no excuse for poor technique anymore. Single-use instruments are a potential concern in terms of finances so the simple solution would be a single file technique to prepare canals. I particularly like Ghassan Yared’s recent article in the IEJ. He is using only one hand file and an F2 ProTaper to prepare his canals. I am doing the same, so watch this space...

Q: What is your recipe for running a successful practice?

JW: Surround yourself with good people and pay them top dollar. I have the greatest practice manager who does everything for me. Debra ensures that my mind is only on the clinical side of things. Make your staff feel special. This creates a happy environment. A happy environment is good for patients who can feel the vibes – it relaxes them.

Q: What are your professional goals for the next five years?

JW: I am 56 now, so the next five years may well be the last of my career. I would like to endorse a product that could make a difference to the future of clinical excellence, and I am working with various groups on this.

Q: Is there still a future for endodontics amid the rise of implant dentistry?

JW: Absolutely. What people don’t realise is that well-restored, single tooth endodontics is as successful as well restored single implants. Implants are an option when all else fails or the tooth is unrestorable and peri-odontally unsound. Too many teeth are taken out when good endo could suffice.

Q: Is there any new development in dentistry that you are particularly interested in?

JW: Endodontics at a conventional level gets easier and easier as new rotary instruments become available to prepare root canals. Filling root canals three dimensionally is now simplified.

Q: What do you enjoy most about your job?

JW: I enjoy working in the perfect environment (it should be, because I designed it all). Taking time to complete every case without needing to rush. The name it has given me within the profession is now synonymous.

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• Utilise the best of modern technology. Don’t cut corners.

• Have a paperless digital office.

• Make all patients feel special.

• Take time to explain things to them.

• Write treatment plans and stick to quotes if a fee is presented.

• Always do the best clinical work you can.

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Colleagues go on half day implant courses and then consider themselves as implantologists. I see many implant failures and litigation in implantology is on the increase. The obsession will wane when patients understand that tooth retention is more worthwhile. After all, you wouldn’t have a leg amputated if it broke? There will always be a place for endodontics and I will always strive to champion our wonderful specialty.
There is a lot of media coverage at the moment regarding what might be defined as a ‘commonly recognised cancer’. We can all identify with those cancers that figure in the public media. Breast cancer and cervical cancer have a relatively high incidence and are well known, but just how aware is the general public of mouth cancers?

Many dental journals highlight the issue of the general dental practitioners’ involvement in the detection of mouth cancer, as part of a routine dental examination. It is clear that the majority of practitioners do carry out basic patient screening to detect suspicious soft tissue areas, but just how easy is it to spot the initial signs or symptoms of oral cancer?

So what is oral cancer?

Oral cancer cannot always be readily or easily identified, and it can prove difficult for clinicians to determine exactly which abnormal tissues should cause the most concern. Let’s first remind ourselves of some basic facts.

The oral mucosa consists primarily of two layers: the epithelium and the stroma.

The epithelium – referred to more completely as stratified squamous epithelium – consists of basal, intermediate and superficial squamous cells. The stroma is separated from the epithelium by the basement membrane. The stroma consists primarily of connective tissue – mostly collagen. It also contains capillaries (See Figure 1). Note that a surface layer of keratin of varying thickness can also be present although it is not shown in this picture. Certain types of oral mucosa are naturally keratinised while others can become keratinised as a result of chronic irritation or because of other disease processes.

Squamous cell carcinoma is the most common of all oral cancers (usually accounting for approximately 90 per cent of all cases), and can form within the soft tissues of the mouth, lips and tongue. Pre-cancerous epithelial lesions usually initiate from below the surface of the tissue at the basement membrane, and can remain hidden from view until they reach the surface (See Figure 2). It is essential that discovery and intervention be made during the very earliest of dysplastic progression.

Oral squamous cell carcinoma can progress from oral pre-malignant lesions, and can involve hyperplasia, and dysplasia and may ultimately evolve into what is termed as carcinoma in situ. To overlook the initial signs of any suspect lesions can allow these to develop into the more advanced stages of cancer.