**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 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 allows you to present at/or attend in a year?

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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 (JEO), 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 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 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, Florida. The European Society of Endodontology always has a great biennial meeting. The next meeting is in October 2009 in Edinburgh, Scotland.

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.

He persuaded me that what London and the UK needed was an American-trained endodontist rather than another American-trained restorative dentist. He 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 inspired you to pursue a career in endodontics and how did you achieve it? JW: Endodontics is an exciting and challenging specialty that 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 allows you to present at/or attend in a year?

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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 IJE. 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: 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 a future for endodontics amid the rise of implant dentistry?

JW: Absolutely. What people don’t realise is that well-repaired, 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 periodontally unsound. Too many teeth are taken out when good endo could suffice.

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.

Julian Webber

Julian Webber has practiced endodontics in central London since 1976 and opened the Harley Street Centre for Endodontics in October 2002. He lectures extensively in the UK and has travelled abroad on many occasions to lecture to major world dental and endodontic societies. Through his various workshops and hands-on courses, he has helped to train many general dentists in the skills of modern endodontic technique. Dr Webber has been president of the British Endodontic Society and the American Dental Society of London. He is an active member of the American Association of Endodontists currently serving on various committees. In addition, he is a fellow of the International College of Dentists and editor in chief of Endodontic Practice Journal, a clinically orientated endodontic publication with a worldwide readership. Visit www.roottreatmentuk.com or contact info@julianwebber.com

Jun Webber Interviewed by theobearce ‘Mastering Excellence in Endodontics’ in London on Friday October 17. The seminar will be held at the Royal College of Physicians and offers delegates seven hours of credits (CPD). Although those attending the optional hands-on course the following day will earn them for 11 hours.
Oral cancer screening – its place in the general practice

With incidences of mouth cancer on the rise, Dr David Bloom and Dr Jay Padayachay from Senova Dental Studios look at how using the Velscope can help in its detection

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