**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 he 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.

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 in your everyday work? JW: For my lectures, I find 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.

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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 do so!
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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.

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: Does orthodontics amid the rise of implantology have a future?
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.

About the author
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 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.

For further information, visit: www.roottreatmentuk.com or contact info@julianwebber.com

Watch this space...
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 keratinized while others may 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 serious and even life-threatening cancers.

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