Fish oil helps gum disease

In an article in the Journal of the American Dental Association, researchers from Harvard Medical School and Harvard School of Public Health found that dietary intake of polyunsaturated fatty acids (PUFAs) like fish oil shows promise for the effective treatment and prevention of gum disease. The study involved more than 9,000 adults who participated in the NHANES between 1999 and 2004 who had received dental examinations. The NHANES study also collected extensive demographic, ethnic, educational and socioeconomic data, allowing the researchers to take other factors into consideration that might obscure the results. These findings are encouraging in that they suggest it may be possible to attain clinically meaningful benefits for periodontal disease at modest levels of n-3 fatty acid intakes from foods.

Happy Birthday X-Ray

On 8th November the cyber world celebrated the birthday of Wilhelm Conrad Roentgen, who accidentally discovered an X-Ray in 1895 during an experiment with cathode rays, the medicinal world has benefited greatly from his discovery, and can now see what’s under the skin. An X-Ray (or X-radiation) is a form of electromagnetic radiation, generated inside a high-voltage vacuum tube. Electrons from a cathode ray reach an anode and collide with it, creating an electric current which made it possible to see through objects, even people, for the first time. Just a week after his accidental discovery, Roentgen took the first X-Ray photo of his wife’s hand - wedding ring, bones and all.

Dentists Saving Lives

A new national health organisation called the American Academy for Oral Systemic Health (AAOSH) has been formed. The newly inaugurated AAOSH will bring together medical professionals from all fields and try to eliminate the tunnel vision that can exist between medical specialties. In addition, advanced dental techniques and systems for treating periodontal disease and tooth decay were shared, as well as an emerging program. The new organisation has 50 founding members and anticipates rapid growth as more and more professionals absorb the data that demonstrates the relationship of mouth health to body health and vice versa.

CQC fee consultation finally hits the headlines

CQC dominates profession and politics as consultation opens and questions are asked in Westminster

The Care Quality Commission (CQC) has launched a consultation on the fees it proposes to charge providers of health and adult social care. These fees intend to cover CQC’s work in registering providers and monitoring their compliance with essential levels of safety and quality.

The British Dental Association (BDA) has warned that the proposed fees for registration with the CQC will hit practices and patients hard, adding financial concerns to the worries already expressed about the administrative burden CQC registration will create. The consultation sets out proposals to simplify fees and put in place a single long-term scheme that will cover all providers registered now and those who will be registered from April 2011. It proposes a framework for how fees will be charged based on principles such as fairness, simplicity and proportionality.

The consultation document outlines our three main proposals for:
• categories and bandings for fees, including fee amounts
• a single annual fee that incorporates registration and variation fees
• streamlining the payment date for annual fees

The announcement of the proposed fees comes just months after figures from the NHS Information Centre revealed that dentists’ expenses are increasing by 76 per cent a year and soon after the General Dental Council revealed significant increases in its fees for registration.

John Milne, Chair of the BDA’s General Dental Practice Committee, said: “Dental practices are already facing soaring expenses. Registration fees at the levels set out in this consultation will serve only to exacerbate the problems dentists across England are already facing. The ability of practices to invest in the staff and equipment that deliver patient care will be further harmed by the imposition of such exorbitant fees.”

Word in Westminster

The consultations, however, are not being accepted quietly. Dentists across the country have been canvassing MPs to scrap CQC registration and in Parliament this week a series of questions on CQC were raised in the House of Lords.

Questions on the functioning of the CQC were voiced by Lord Cobyn, Conservative Peer and Vice-Chair to the All-Party Parliamentary Group (APPG) for Dentistry towards Earl Howe, the Parliamentary Under Secretary of State with responsibility for dentistry, and further questions were targeted with regards to the assessment the CQC have made of the benefit to the public.

Responding to the written questions, Lord Howe stated that the CQC’s role of regulating safety is not covered in full by other regulatory bodies. He also noted that it is up to the CQC to determine whether recently redundant Dental Reference Officers have a role to play in the regulation of dental practices, and whether the fees set by the CQC must be approved by the Secretary of State for Health.

The consultation runs until January 2011. A further consultation will be carried out in 2011 before providers of NHS primary medical services.

Smile-on are organising a webinar on the issue of CQC hosted by Raj Bhattar on December 1st. Email info@smile-on.com for more information.
GDC to review its Standards and Scope of Practice

The General Dental Council (GDC) has begun a review of its ‘Standards Guidance’ and ‘Scope of Practice’. It has been five years since the GDC published its ‘Standards Guidance’ and replaced its previous guidance document, ‘Maintaining Standards’. The move to ethical principles was a significant change in direction at the time, however, in the last five years the landscape of the regulatory world, and the GDC itself, has changed.

The GDC now registers the entire dental team – dentists, dental nurses, orthodontic therapists, dental hygienists, dental therapists, dental technicians and clinical dental technicians – and has more than 52,000 dental professionals on its registers.

The aim of the Standards Review is to go back to square one. The GDC will be asking registrants, patients and other stakeholders what level of detail they would find helpful, what they think of the current standards, what works, what doesn’t and what’s missing. The review will take place throughout 2011 and will include consultations, focus groups, a working group and GDC staff attending events across the UK to hear directly from those affected.

Anyone who wishes to make any comments directly to the GDC on the current guidance can do so here (standards@gdc-uk.org).

The GDC is hoping to produce the new guidance in early 2012.

Running alongside Standards, the ‘Scope of Practice’ review will evaluate the effectiveness of the current document, which outlines the role of each member of the dental team; it also summarises what additional skills they might go on to learn.

A call for feedback on ‘Scope of Practice’ will be launched at the end of January 2011 and will be available on the GDC website (www.gdc-uk.org). The forum will ask registrants to give their views on the document, stating whether they think the dental team work together more effectively; they can also lead feedback on what skills may need to be added or amended for each of the seven registrant groups.

Oral health study wins SGH funding

A grant of more than £300,000 has been awarded to a study that will investigate the effect of social deprivation on oral health in outer north-east London. The project, which beat off competition from eleven other proposals to secure funding from the Shirley Glassman Hughes Trust Fund, will investigate whether people living in deprived communities define oral health differently from their peers living in less deprived areas. It will also assess whether individuals’ concepts of oral health affect the way that they care for themselves and what barriers exist to individuals accessing care and adopting healthy behaviours.

The study will consider the populations of Enfield, Waltham Forest and Barking and Dagenham, and use patient concepts of oral health to ask whether deprivation can explain why some individuals engage in behaviours such as smoking, excessive alcohol consumption and irregular visits to a dentist, which increase their risk of oral diseases.

It will assess the strengths and shortcomings of the way oral health services are provided, providing evidence on how to adapt existing structures and develop new services and interventions that overcome barriers to care. It will also provide evidence to underpin models of commissioning care.

Professor Liz Kay, Chair of the Trustees of the Fund, said: “Despite an overall improvement in the oral health of the UK over the past four decades, a persistent and unacceptable gap exists between those with the best and worst oral health persists.”

Understanding why we have this gap is crucial to addressing this situation. The trustees hope that this piece of work can make a significant contribution to expanding that understanding and helping to develop practical tools to address it.

The project will be led by Dr Russ Ladwa (pictured), Dean of the Faculty of General Dental Practice at the Royal College of Surgeons of England in London. It will be hosted by the Institute of Dentistry at Barts and The London School of Medicine and Dentistry.

Thanking the trustees, Dr Ladwa said: “The award of this grant represents a great boost to research in primary care. The FGDP(UK) will work in collaboration with the host institution, Barts and The London SMD, Queen Mary University of London, which has a tradition of research in health inequalities.

Both the Institutions are delighted to be given the opportunity to carry out research that will provide evidence to develop cost effective models of delivering prevention and treatment in primary dental care.”

EAO announces the winners of its 2010 Research Competitions

The winners of two coveted research prizes, awarded annually by the European Association for Osseointegration (EAO), have been announced.

The EAO Clinical Research Prize for 2010 has been awarded to Maurizio Tonetti from Italy and the EAO Basic Research Prize to two winners, Pascale Habre-Hallage from Lebanon and Ulricke Kuchler from Austria.

All three winners were awarded their prizes at the 19th Annual Scientific Congress of the EAO which took place in Glasgow from 6-9 October 2010.

Each winner received a Diploma from the EAO and a prize of 2,000. The 18 finalists had earlier been selected from nearly 500 abstracts submitted to the EAO Congress.

Maurizio Tonetti and his team won the EAO Clinical Research Prize for their study: “Immediate vs delayed implant placement in anteriors: The TIMING trial”. The multi-centre study, co-ordinated by Maurizio Tonetti and his team from the University of Bologna, was conducted in the populations of Redbridge, Waltham Forest and Barking and Dagenham, and used patient concepts of oral health to ask whether deprivation can explain why some individuals engage in behaviours such as smoking, excessive alcohol consumption and irregular visits to a dentist, which increase their risk of oral diseases.

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Dental surgeon David Smith, Chair of the Standards Committee, said: “The reviews of both of these documents could result in a radical redesign of the GDC’s guidance for registrants and it’s therefore extremely important that we hear from everyone who’ll be affected and make the right changes. The standards are the main ethical guide that we expect dental professionals to apply to their everyday work. This is a significant piece of work for the GDC and one that we anticipate will have a positive impact on dental professionals and therefore on patients.”

Smile 4 Life in Lancashire

Health minister Lord Howe has visited Lancashire to launches a new scheme aimed at improving the oral health of children.

Teaming up with local primary care trusts, Lancashire County Council aims to tackle the county’s poor record on tooth decay.

Dental experts will visit pre-schools providing advice to youngsters and their carers on brushing teeth, making regular trips to the dentist and eating more healthily.

Lord Howe said that the Smile4Life scheme should help the NHS to achieve its goal of improving children’s oral health.

 Tooth decay in children is a serious problem,” he revealed. “It can cause a great deal of pain and discomfort, and treating it is very costly for the NHS.

“Focusing on prevention is not only better for the children, but is also a better use of NHS resources. I am delighted to see the local authorities and the NHS taking innovative action to address this very important local health issue, and I hope others will follow suit.”

A number of new dental practices have recently opened in Lancashire to reduce the number of people on waiting lists for an NHS dentist.

Janice Nicholson, head of dental commissioning at NHS Central Lancashire, recently announced that dentists in Leyland and west Lancashire are now opening their doors to patients who are prepared to travel from central Lancashire in a further attempt to improve access.

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Editor
Lisa Townend
Tel: 020 7400 8959
lisa.townend@dentaltribune.com

Managing Director
Sam Volk
Tel: 020 7400 8960
sam.vol@ dentaltribune.com

Advertising Director
Ellen Sawle
Tel: 020 7400 8960
ellensawle@dentaltribune.com

Clinical Editor
Liviu Steier
Tel: 020 7400 8960
liviu.steier@dentaltribune.com

Design & Production
Zoe Syrle
enquiries@dentaltribune.com

Editorial Assistant
Laura Hatton
Laurahatton@dentaltribune.com

Production Assistant
Neve Day
neveday@dentaltribune.com

Subscribe to Dental Tribune
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Editorial Office
Dental Tribune UK Ltd
6th Floor, Treasure House, 10-21 Hatton Garden, London, EC1N 8BA
Editorial comment

The most cynical of you will be no doubt thinking it’s no bl**dy use anyway

Now, the most cynical of you will be no doubt thinking ‘no bl**dy use anyway, they’ll do what they want no matter what we say’ but a public consultation does have the advantage of being just that, public.

I am well aware of the strength of feeling against the CQC and the confusion and resentment that has been created, and I am also aware of how some quarters are using their right to protest by canvassing their MPs to investigate the necessity of extra regulation.

All stakeholders should have their say and at least make their sentiments known, if only to be able to say to yourself that you have. Who knows, someone may even be listening.

Snap-On Smile

In recent years, the number of people opting for cosmetic surgery has increased and continues to be popular with people who desire to improve the aesthetic appearance of their smile. Now, for those who fear needles and worry about drilling, a new treatment is available in the UK: The Snap-On Smile.

The Snap-On Smile does exactly what its name suggests; it fits onto the original teeth, much like false nails are placed over the top of nails.

Fitting over the teeth, the Snap-On Smile gives the illusion of a perfect smile, without the need for surgery. Patients who opt for this treatment can select a colour shade and choose the shape of the teeth.

For those who are worried about drilling and needles, and don’t want to pay hundreds or even thousands of pounds for treatments, such as veneers or dental implants, the Snap-On Smile would seem like a perfect option.

To make the Snap-On Smile photos and impressions are made of the patients’ teeth and in about four weeks the Snap-On Smile lab creates the smile.

Images courtesy of Pearl Dental Clinic

Contact us on 020 7400 8967 quoting DTUK10 to get your early booking discount.
Mouth Cancer News Update

With Mouth Cancer Action Month in full swing, the national press is full of news related to head and neck cancer, highlight ing the condition to the general public. Here is just a taster of the latest news...

MCF benefits from new restaurant
The Mouth Cancer Foundation, will be supporting four charities this autumn. Sunny and Kammi Dhow have created a venue which provides people with fine food and excellent service, whilst making a difference.

Sunny said “I have decided to support the Mouth Cancer Foundation not simply because of the horrific experience my family and I went through. The feeling of being helpless, as Mum fought mouth cancer, was truly awful. Therefore, if I can be of help in terms of raising awareness or fundraising, then I am only too happy to help. The experience has left a deep scar on my family and we want to try and make something positive of this awful situation. It only seemed right to name the children’s restaurant, who was not only an inspiration to me but to everyone who met her.”

Long term, India’s plans to make annual financial contributions to the Mouth Cancer Foundation and also plans to raise funds through the restaurant.

Key breakthrough in HPV-related mouth cancer
New research has shown that cancer patients with the Human Papilloma Virus (HPV) have a greater chance of survival from mouth cancer than those whose cancer is HPV negative.

The new study found that monitoring cancer tumours for the HPV can help health experts predict a patient’s survival chances.

Conducted by Dr Angela Hong from the University of Sydney, the research monitored 198 patients suffering from mouth cancer after they had surgery or radiotherapy.

Dr Angela Hong said: “Our study reveals that there is a group of patients with advanced oropharyngeal cancer, that those with cancer caused by HPV had a significantly better chance of survival than cancer which was not caused by HPV. And this beneficial HPV effect was seen regardless of the type of treatment they had.

Following the patients for a period of three years it was found that those with HPV positive cancer were four times less likely to die than those who were HPV negative.

Another discovery was that cancer was three times less likely to recur at the primary site in patients with HPV positive cancer.

Social inequalities pose mouth cancer risk
New research has revealed that an individual’s social background could heighten their risk of mouth cancer.

Speaking at the launch of Mouth Cancer Action Month 2010, at the House of Commons this week, clinical senior lecturer in dental public health at the University of Glasgow, Dr David Conway, highlighted that those with a “low social economic status” were faced with significantly increased risks of developing the disease.

Drawing on his recent, award winning research, ’Socioeconomic Risk Factors Associated with Upper Aerodigestive Tract Cancer’, Dr Conway explained that the socio-economic inequalities had proven to be an independent risk factor.

The study measured socioeconomic groups by education, occupation and income, and found that those with lower levels of formal education, lower incomes and unemployment history were at greater risk of developing head and neck cancer, highlighting the need for continued research on socioeconomic inequalities and how they can influence positions within society.

Concluding with a quote from George Orwell’s The Road to Wigan Pier, Dr Conway said: “Economic injustice will stop the moment we want it to stop and no sooner, and if we genuinely want it to stop the method adopted hardly matters.”

Dental experts warn against home whitening treatments
Dental experts have warned against home teeth whitening treatments, which have become increasingly popular in recent years.

Experts have urged members of the public to avoid home whitening treatments, which are often recommended by people with no dental training on internet sites. Many sites suggest using home treatments containing ingredients such as hydrogen peroxide, ash and baking soda.

A call to action
Seema Sharma calls on Dental Tribune readers to support her as she walks 60 miles for charity, from Baroda to Bhurach!

“At the end of this month I will be packing my walking shoes to walk 60 miles of the 241 miles between Indian Friendship Walk for charity, led by Jill Beckingham (wife of the British deputy high commissioner and master of ceremonies, Peter Beckingham). Jill is retracing the steps of Mahatma Gandhi’s Salt March of 1930 to raise funds and awareness for Door Step School, one of which have a British Indian connection. She is aiming to raise funds for the three charities already supported by her Foundation:

- Apnalaya - An NGO founded in 1972 to help children living in slums towards a better life, Apnalaya strives to achieve this through urban community development projects in Mumbai. Its role is one of empowerment: of encouraging ordinary men and women to believe in themselves and in their abilities to change their lives for the better.
- Door Step School – is an NGO established in Mumbai, India in 1988 and later expanded to Pune in 1989. It was started with the aim of addressing literacy and unemployment among sections of society. Door Step School provides education and support to the often-forgotten children of pavement dwellers, slum dwellers, construction site workers for education. This increase can be adjusted to consider smoking, alcohol and poor diet, all increases were disregarded for education. This increase can be adjusted to consider smoking, alcohol and poor diet, all increases were disregarded for education. This increase can be adjusted to consider smoking, alcohol and poor diet, all increases were disregarded for education. This increase can be adjusted to consider smoking, alcohol and poor diet, all increases were disregarded for education. This increase can be adjusted to consider smoking, alcohol and poor diet, all increases were disregarded for education. This increase can be adjusted to consider smoking, alcohol and poor diet, all increases were disregarded for education. This increase can be adjusted to consider smoking, alcohol and poor diet, all increases were disregarded for education. This increase can be adjusted to consider smoking, alcohol and poor diet, all increases were disregarded for education. This increase can be adjusted to consider smoking, alcohol and poor diet, all increases were disregarded for education. This increase can be adjusted to consider smoking, alcohol and poor diet, all increases were disregard...
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In these days of single-use files, the CMA system provides good value for money without compromising the need for well-instrumented root canals.

Dr Graeme Fisher BDS, Preston
Regarding Revalidation

Dentist Denis Toppin is on the Council of the GDC and is also Chair of its Revalidation Working Group. Most of you will probably be familiar with the term revalidation by now, although it's likely you hear most about it in relation to doctors and the General Medical Council. The General Medical Council has recently confirmed medical revalidation in the UK is expected to start from late 2012, after numerous delays. Although the GDC doesn’t plan to introduce revalidation for dentists until 2014, and at a later date still for DCPS, the GDC has just launched a 12 week consultation on the issue and is encouraging as many of its registrants as possible to have their say. The consultation can be found on the GDC website at www.gdc-uk.org

For those of you who are less familiar with revalidation and what it will mean for dentists, I’d like to take this opportunity to explain a little bit more about it. Revalidation will provide, for the very first time, a way of checking that dentists carry on meeting the GDC’s standards after they have first joined its registers. The GDC’s Fitness to Practise proceedings are reactive rather than proactive; they assume that dental professionals meet its standards unless the regulator receives information which suggests otherwise. With patient protection in mind, this is no longer good enough. Our research has shown that patients believe and expect that dental professionals’ compliance with standards is already checked by the GDC regularly. Dentists now have to bring reality into line with patient expectations.

The structure

A standards and evidence framework will set out the standards dentists must meet under the framework of good governance, governance and leadership, communi-

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

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For more information and a quote contact the DBG on 0845 00 66112

*England only.

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About the author

Dennis Toppin, a returning Registrant member to the Council of the GDC, was born in Glasgow where he returned to study and work. He qualified as a dentist in 1977 from the University of Glasgow and has been working in general dental practice ever since. He developed an interest in dental education through his involvement in Dental Vocational Training as a Vocational Trainer, Adviser and Regional Adviser and through lecturing undergraduate dental students clinical practice in restorative dentistry. He also teaches on numerous postgraduate courses and also a Master’s programme in Education. He was a member of the Scottish Dental Practice Board for the maximum six year period. He currently holds a part-time post of Assistant Director of Postgraduate General Dental Practice Education with NHS Education for Scotland.

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Judging panel announced

A team of leading dentistry experts has been revealed as the judging panel for the 5M ESPE Student Dentistry Awards 2010-2011.

This panel of influential industry figures and esteemed academics will select the UK and Ireland’s most innovative students and award them with funding to support their studies.

The awards panel includes Dr Amarjit Gill, President of the British Dental Association; Edward Attenerborough, President of the British Dental Trade Association; Professor Trevor Burke, from the University of Birmingham and Professor Nairn Wilson, Dean and Head of King’s College London Dental Institute.

There are three categories in the 5M ESPE Student Dentistry Awards 2010-2011 – the Award for Innovation, the National Award for Innovation and the Award for Interrelated Studies. Funding ranging from £300 (554 EUR) to a bursary worth £3600 (4130 EUR) is available to be won.

Speaking about the announcement of the judges, 5M ESPE’s commercial manager Steve Foster said: “We are delighted to have such a strong panel judging our awards programme that supports the future of UK and Irish dentistry.

“As leading industry figures, the judges’ shared experience will ensure that the very best dental students are recognised for their abilities.”

On his appointment to the panel, Dr Amarjit Gill said: “An awards programme such as this offers real support to talented young dental students.

“I am very much looking forward to reading the entries and meeting the winners.”

For more details on the awards programme, visit 5M ESPE’s new dedicated student website at www.5mespe.co.uk/dentalstudents.

‘Best Dental Plan Provider’!

Denplan is extremely proud and excited to have been voted ‘Best Dental Plan Provider’ at this year’s Health Insurance awards.

The glittering awards ceremony took place at the Grosvenor House Hotel in London on the 21st October. Denplan were thrilled to accept the award - especially as it’s the first time this category has been featured.

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Gary continued: “Denplan has been at the heart of dental care for nearly 25 years and is dedicated to preventive care. That’s why we tailor our corporate products to suit both companies and employees to ensure that both get the very best value and service, and we’re delighted that our efforts have been recognised in this area.”

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- Practice Accounts

L-R: David Sawyer, Gary Williams and Host Patrick Bailey
Mitigating the effect of VAT increase

Michael Lansdell discusses how dentists can best address the inevitable increase in costs for every type of dental practice, as VAT goes up.

A major weapon in the Government’s armoury to battle the national deficit, announced in the Budget, is a proposed rise in the standard rate of VAT from 17.5 per cent to 20 per cent from January 2011.

Although health services are exempted from Value Added Tax (VAT), the cost of many of the essential materials, equipment and sub-contracted activities which service dental practices are not, and so any rise in this tax will add to the financial burden of running a dental practice. This increase in practice overheads comes at a time when many are already committed to additional expenditure on autoclaves and decontamination facilities to ensure compliance with HTM 01-05.

In recent years, many practices have expanded their activities to include non-health related cosmetic treatments such as tooth whitening or botulinum toxin injections, as well as selling toothbrushes and dental hygiene products, and these procedures and products are not VAT exempt nor zero-rated.

The present threshold for compulsory VAT registration is a turnover of £70,000, and this means that if the gross income from any practice activity not officially recognised as health care exceeds this figure, then the practice must register for and charge VAT on this aspect of its services, and any changes to the rate of VAT will automatically apply.

Dentists who are in any doubt about which activities in relation to dental services qualify for VAT exemption, should consult VAT Notice Number 701/57 for Health Professionals.

The obvious first step is to bring forward any projected major expenditure or purchases, such as refurbishment, new IT, sterilising or other surgery equipment to before the deadline, and so reduce the VAT burden by 2.5 per cent.

However, principals and managers should be aware that the Government has introduced measures to counter businesses paying in advance, or pre-paying invoices at the old rate, for goods or services to be supplied after the January 2011 when the new rate comes into force.

These measures provide for a supplementary VAT charge of 2.5 per cent to be levied in cases where the customer can...
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Given the recent changes, dentists operating as sole traders might wish to consider incorporating, as this often provides a legitimate means of saving tax in other areas - paying a reduced rate of Corporation Tax, for example. Limited companies comprised one of the few sectors of the economy to benefit from the Coalition’s first budget, when the previous administration’s announced increase in Corporation Tax was reversed, and replaced with a reduction, with further decreases to follow. Corporation Tax is already significantly lower than the top rate of Income Tax, and incorporation could yield substantial fiscal, financial and personal benefits for dentists in the appropriate situation. Owners of small companies (profits under £500,000) will pay almost 10 per centless corporation tax under the new Government, whilst bigger companies will pay up to 15 per centless.

Although the latest figures indicate that the economy is improving faster than expected, personal and family spending remains constrained by existing debt, and there is still on-going pressure on wage increases and uncertainty over employment, meaning it may be some time before the amelioration has an impact on retail dentistry. With other tax changes also in the pipeline, this could be a good time to discuss your situation with a professional for some new ideas on business efficiency - monitoring cash flow, for example, planning for the rise in VAT or identifying areas where expenditure could be reduced. When times are hard, experience has proved that intelligent austerity today is always the foundation for greater success tomorrow.

The one piece of unalloyed good news is that Mervyn King and the Bank of England have pledged to kept interest rates at the present historical low for as long as possible, so if you do have to borrow, loans are cheaper than they have ever been. For more information please www.lansdellrose.co.uk.

Principals and managers should be aware that the Government has introduced measures to counter businesses paying in advance, or pre-dating invoices at the old rate

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About the author

Michael Lansdell was brought up in South Africa, receiving his honours degree there in 1991. He completed his training with international accounting firm Deloitte in 1994, and went on to become a founding partner of Lansdell & Rose Chartered Accountants (SA) a year later. Based in Kensington, London, Lansdell & Rose deal only on a long-term retained basis, exclusively with owner managed clients, general dentists and doctors, and specialising in the incorporation of dental practices. As a client focused team, they look for sustainable long-term solutions for their clients that maximise profits, minimise tax and build wealth.
Implant Tribune

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50 years of osseointegration

Dental Tribune looks back at the recent Nobel-Biocare symposium celebrating 50 years of osseointegration in the UK and Ireland

Who could believe in just 50 years ago marked the beginning of developments into osseointegration in the UK? It was only a short 28 years ago that Per-Ingvar Brånemark conducted an experiment where he used a titanium implant chamber to study blood flow in rabbit bone. When it became time to remove the titanium chambers from the bone, he discovered that the bone had integrated completely with the implant that the chamber could not be removed. Brånemark called the discovery 'osseointegration'. Not until years later, when using a similar titanium chamber in the upper forearms of volunteers did the realisation of this could be of benefit to humans occur to Brånemark.

In dental medicine, the implementation of osseointegration started in the mid-1960s as a result of the work of Prof Brånemark. In 1985 Brånemark, who was at the time Professor of Anatomy at the University of Gothenburg, placed dental implants into the first human patient - Gosta Larsson. This patient had a cleft palate defect and required dental care. Gosta Larsson died in 2005, with the original implants still in place after 40 years of function.

In the mid-1970s Brånemark entered into a commercial partnership with the Swedish defense company Bofors, to manufacture dental implants and the instrumentation required for their placement. Eventually an offshoot of Bofors, Nobel Pharma, was created to concentrate on this product line. Nobel Pharma subsequently became Nobel Biocare.

Brånemark spent almost 50 years fighting the scientific community for acceptance of osseointegration as a viable treatment. In Sweden he was often openly ridiculed at scientific conferences. His university stopped funding for his research, forcing him to open a private clinic to continue the treatment of patients. It took until 1985 before the worldwide scientific community started to really accept Brånemark's work. Today osseointegration is a highly predictable and commonplace treatment modality.

Symposium

To mark 50 years of osseointegration in the UK and Ireland, Nobel Biocare organised a two-day symposium at the Royal Institute of British Architects in London, with an international list of renowned speakers. The main topics covered at the invitation only event included The Compromised Patient, Immediate Loading, Implant Surfaces and Aesthetics. Each day started with a keynote speaker who set the tone for the day's sessions. Friday's keynote speech was entitled Prosthodontics at a Crossroads and was presented by Dr George Zarb, recently retired as Professor and Head of Prosthodontics at the Faculty of Dentistry, University of Toronto following a distinguished 40-year academic career.

Dr Zarb discussed the drive to be more adventurous with implants and what they can do for patients and the need to temper that drive to ensure that cases are chosen appropriately. He also looked at the development of materials and techniques and how the concerns of patients are driving the refinements to the implant techniques.

The first session, chaired by Prof Naira Wilson, was devoted to The Compromised Patient. First to speak was Prof Ashraf Ayoub, Head of the Biotechnology & Craniofacial Sciences Section of the Dental School and Director of Dental Research at the University of Glasgow. His presentation, The application of dental implants in compromised bone foundation, looked at bone grafting methods using both autogenous and substitute materials. His presentation included visual illustrations of some case examples of bone grafting and implant placement.

Bioglass

Prof Robert Hill was next to speak on Bone substitutes and their application to implant dentistry with a special emphasis on Bioactive Glass. Prof Hall, Chair of Physical Sciences in Relation to Dentistry at Barts and the London Medical School, discussed various bone substitute materials including phosphates, hydroxyapatites (natural and synthetic), biophysics and bioactive glasses. With autogenous bone being the gold standard, substitute materials were rated by cost effectiveness, ease of use and similarity to own bone. He then looked in depth at Bioglass and the benefits and challenges created by it.

The session ended with a presentation from Prof Mark McGurk on The Rehabilitation of patients with oral cancer. Head of Department of oral & maxillofacial surgery at GKT Dental Institute, Prof McGurk discussed some of the complex issues surrounding the use of implants in people recovering from oral cancer. He emphasised the need to identify patients where rehab will make a difference and looked at modern trends in cancer therapy. He pointed out that surprisingly few patients are suited to implant therapy and looked at cases where it had been successful.

Albrektsson

Session two was chaired by Dr Edwin Scher and looked at Implant Surfaces and Biological Responses. Prof Tomas Albrektsson
Di Silvio, senior lecturer at King’s College London. With her expertise lying in cell biology and cell material interaction, *The Biology of implant surfaces – new and improved*, Dr Di Silvio’s presentation took a close look at biocompatibility and the effects of surface modification. She also discussed stem cell technology, and its possible use in tissue regeneration.

The final session of the day looked at immediate loading and was chaired by Dr David Harris. The first speaker, Dr Marco Esposito (Senior lecturer in oral & maxillofacial surgery, Editor of the Cochrane Oral Health Group and Director of Postgraduate courses in Dental Implantology at The University of Manchester), discussed Immediate and early loading: the scientific evidence. He looked at the concepts behind evidence-based practice, randomised clinical trials and systematic reviews, leading up to a presentation of data from an updated Cochrane review.

It was then the turn of Dr Alon Preiskel to discuss Immediate loading: a prosthodontic perspective. Always a controversial topic, Dr Preiskel examined both patient and prosthodontic factors in determining whether immediate loading is appropriate.

**Keynote**

The second day’s sessions began with a keynote speech from Dr Bertil Friberg, specialist in oral surgery and emergency dental care, involved with the Bränemark Dental Clinic in Gothenburg, Sweden, Dr Friberg discussed Clinical Considerations and Current Concepts in Osseointegration. This presentation covered developments over the last 25 years in treatment techniques and oral implant components.

With sessions covering CAD/CAM Dentistry and Aesthetics, culminating in a post symposium meeting with the developer of the NobelActive Implant, Dr Ophir Fromovitch, the speakers included:

- **Dr Andrew Dawood**
  - CAD/CAM Dentistry and Aesthetics

- **Dr Marco Esposito**
  - The concept of immediate loading

- **Prof Michael Fenlon**
  - The role of implant prosphodontics

- **Dr Tidu Mankoo**
  - Anterior implant aesthetics: The keys to success

This symposium was a very fascinating look into the past, present and future of osseointegration and implantology. May the next 50 years of osseointegration be just as interesting!
The use of the Er:YAG in laser-assisted broken abutment screw treatment

Dental implants are a functional and aesthetic solution to partial and total edentulism. Although the overall success rate of implant dentistry is very high, more than 90 per cent of the treatment modality is not free of complications and dental implants occasionally fail. The chronic loosening or fracturing of implant screws continue to be a problem in restorative practices and generally are challenging to remove. This report describes and demonstrates the management and technique used for the removal of fractured screw fragments and the successful utilisation of the Er:YAG laser as an important auxiliary tool.

Introduction - the problem
Success in implant-supported prosthetic replacement of teeth will be due to a combination of appropriate placement criteria (receptor site quality, implant stability, osseo-induction), appropriate (non-excessive) loading and prevention of bacterial contamination.

The failure of dental implants is due not only to biological factors, such as unsuccessful osseo-integration or the development of peri-implantitis, but it may also result from technical complications.1,2 Dental implant complications may be considered under the following main categories:

Early
- Failure/inadequate surgical preparation
- Failure of osseo-integration
- Peri-surgical infection

Late
- Implant overloading, leading to bone loss
- Peri-implantitis
- Soft tissue complications
- Fracture of mechanical components and aesthetic/phonetic considerations

Failures of implant-supported restorations result from technical problems and can be divided into two groups: those relating to implant components, and those relating to the prosthesis.3,4,5,6,7,8,9,10,11 Technical problems related to implant components include abutment screw fracture.8,12

The abutment screw fracture presents a rare, but quite unpleasant failure and can be a serious problem13,14,15,16,17 as the fragment remaining inside the implant may prevent the implant from functioning efficiently as an anchor.18 The primary reason for screw fracture is undetected screw loosening which can be due to bruxism, an unfavorable superstructure, overloading,19,20 or malfunction.21,22,23 Fractures of the implant abutment or of the abutment screw have been observed as a consequence of screw loosening and undetected micro-movements of the abutment under functional loading and consequently, it is advised that the repeated loosening of an abutment screw should alert the clinician to possible significant contributing causes.

However, the behaviour of the implant/abutment joint components with respect to critical bending force is still unclear.24,25 Studies show that implant abutment failure occurs when lateral forces exceed 570 Newtons for abutment with a joint depth of at least 2.1 mm and 530 Newtons with a joint depth of at least 5.5 mm.26

Recommendations
The number, position, dimension and design of implants, as well as the design of the prosthesis are critical factors to be considered during the treatment planning phase.15,24,25,26 To withstand high bending stresses, implants should be as long and as wide as possible, used in adequate numbers, and be positioned such as to allow axial loading.25,26,27 Implant components are known to fracture...
more frequently in the posterior region and in partially dentate patients compared to completely edentulous patients. 24, 25

Retightening an abutment screw ten minutes after the initial torque applications should be routinely performed, and increasing the torque value for abutment screws above 30 Newtons can be beneficial and increasing the torque for the abutment, implant stabilization and to decrease the possibility for the abutment, implant stability loss. 26

Proper case selection, excellent surgical technique, placing an adequate restoration on the implant, educating the implant patient as to the importance of maintaining meticulous oral hygiene, and evaluating the implant both clinically and radio-graphically at frequent recall visits 27, reinforcing periodic maintenance of the implant.

A procedure for using dimples inside the abutment screw cylinder above the screw, and filling the holes with elastic impression material, will prevent the den-tal prosthesis from loosening. 28

• Using the correct fixation screw
• Replacing loose screws instead of retightening them
• Immediate investigation; looseness of the prostheses is detected by the clinician or patient 29, 30

Fragment retrieval

The method is extended to grasp the broken fragments or screw, are determined according to the location of the fracture abutment-above or below the head of the implant. If an abutment screw fractures above the head of the implant, an explorer, a straight probe or haemostats might be successful. The tip of the instrument is moved carefully in a counter-clockwise direction over the surface of the screw segment until it loosens.

If the screw fracture occurs below the head of the implant, other methods are required. There are several available implant repair kits:

• DENTSPLY Friadent’s IMZ® TwinPlus Implant System1 (DENTSPLY Friadent, Germany)
• ITI® Dental Implant System (Institut Straumann AG, Switzerland), consists of drills, two drill guides and six manual tapping instruments. (figs 8)
• DIO® Removal Kit Replace (Nobel Biocare™, Yorba Linda, California, USA)
• Certain 8-Screw Removal Kit (Biomet 3i™, Florida, USA)

The application of these systems is to permit a hole to be drilled into the centre of the broken screw and drive a removal wedge into the hole that engages the broken screw so that the reverse torque is applied by removing the instrument.

If no thread damage has occurred and the screw has not “bottomed out” or torqued into a seating stop, then the force necessary to remove the screw may be minimal. 31 If none of these systems is available, another method for broken screw retrieval is suggested (Fig. 9). The removal procedure: after the prostheses or abutment is removed, the screw hole is vigorously flushed with an air-water spray from a 5-way syringe. Pressurised air is applied to dry the screw hole, and a drop of mineral oil (delivered on the tip of an explorer) is introduced into the screw hole. A sharp #4 round bur in a high-speed hand piece is activated and lightly applied to the exposed side of the fractured screw.

The objective is to have the spinning bur’s blades contact the metal surface of the screw so that the screw will spin itself out of the hole. When repeated several times, the screw can be backed out and retrieved easily with forceps. 32 If this technique fails, a slot can be created using a surgical drill, on the head of the fractured screw, and then a screwdriver is used to back out the broken abutment screw. Sometimes just a gentle touch with the drill to the head of the broken screw will be enough to back it out. If the hexagonal head of the screw is stripped, it should be filed away completely using a round carbide bur or heat-sensitive bur, then the implant should be straightened, and a new abutment may be rotated into the implant.

Case study

This clinical report describes a situation in which a fractured implant abutment screw was successfully retrieved by using the Er:YAG laser as an auxiliary tool, and the advantages of this 2,940 nm wavelength versus the 2,940 nm wavelength.

DIO Implants (UK) and Biocomposites Support Racing Team at Silverstone

A team including Peter Fairbairn, the principle implant dentist at the Scarsdale Dental Clinic in Kensington, South West London was indulging in its favourite pastime with the help of DIO Implants (UK) and Biocomposites Ltd. The two companies supported the racing team which took part in the Britcar 24-hour race at Silverstone, held on Saturday and Sunday 2/3 October, 2010.

Peter has been racing in motor sport for many years although this was the first time he’d taken part in a gruelling 24-hour event. Akin to the Le Mans 24-hour race, this the fifth Britcar GP event at Silverstone and James Tucker, the event organiser, said that it was becoming more popular each year.

In addition to all the engineers and pit crew in the team, Peter was accompanied by his fellow drivers: Paul McLain who set the car up; Tony Littlegood, technical advisor for Porsche; and Mike Quinn, a seasoned racing driver whose grandfather founded luxury car manufacturer Jaguar. Each driver took it in turns to take the wheel between each pit stop (around 90 minutes), from 4:30 pm on Saturday through the night until the same time on Sunday.

The race started badly for the team with a crash in the first hour of the race; whilst heading for the pits the Porsche was hit by another car at speed, rendering the GT2 un-drivable. It was due to the skill and ingenuity of Peter’s team and their ability to work under pressure that the crippled car was launched back into the race after three hours of repairs. Despite this early setback they powered on to finish in a creditable 39th place. The data then used to finish in a creditable 39th place. Despite this early setback they powered on to finish in a creditable 39th place. Despite this early setback they powered on to finish in a creditable 39th place. Despite this early setback they powered on to finish in a creditable 39th place.

Over the last 22 years Peter has been on the world stage speaking about implants and synthetic graft materials and regularly contributes to dental journals. He has lectured at the British Academy of Cosmetic Dentistry annual forum (2005 and 2006) and the European Society of Cosmetic Dentistry Forum (2006) and is a regular speaker for the Association of Dental Implantology (ADI).

Further editorial information from: Steve Jordan The Words Workshop Ltd Tel: 01908 695500 Fax: 01908 690099 E-mail: steve@thewordsworkshop.co.uk Web: www.thewordsworkshop.co.uk

All dental implant business enquiries to: Iain Forster Managing Director DIO Corporation Ltd (UK) Tel/Fax: 0845 123 5996 E-mail: info@DIOUK.com Web: www.DIOUK.com Web: www.Dental.co.uk

For information on The Next Generation of fully synthetic materials please contact: Robert Teague Sales Director (Dental) Biocomposites Ltd Tel: 01782 738580 Fax: 01782 538598 E-mail: rmt@biocomposites.com Web: www.biocomposites.com
Examination
A 36-year-old male presented for treatment, reporting the detachment of an implant-supported crown in the region of the upper left central incisor. The patient stated that the implant and crown had been placed four years earlier and that looseness of the crown had occurred on two occasions during this period. On both occasions, the screw had been retightened with no further investigation.

Clinical examination of the patient revealed a missing tooth at the location of #9 with no sign of an implant (Fig. 1). The patient brought the abutment, crown and broken screw with him (Fig 5). Radiographic examination of the area showed the presence of a root-form cylindrical implant, consistent in appearance with a 1.5mm long, 5.75 mm diameter abutment with an internal hex. The apical part of the screw remained threaded into the implant, but had fractured at the level of the hexagonal neck. Although the implant was osseointegrated, there were radiographic signs of peri-implantitis with some crestal bone loss having occurred (Fig 2).

Treatment options
The treatment options available were: 1) retrieve the fractured screw, or 2) remove the old implant and insert a new implant in one sitting. Following discussion with the patient and evaluation of the possibilities for success, it was decided to try and retrieve the fractured screw. Treatment would involve the use of the Er:YAG laser to perform the following, based upon accepted research:

- The flap incision,
- Ablation of granulation tissue around the implant,
- Remodelling, shaping and ablation of the bone,
- Detoxification of the infected surfaces of the implant,
- Ablation of granulation tissue (if any exists)
- Decortication for GBR technique
- Granulation Tissue Removal: Laser: Wavelength: 2,940nm (Er:YAG), 1,500-micron sapphire tip, in non-contact mode; 500mJ per pulse at 17Hz. Total power: 8.5Watts.
- Bone Surgery: Laser: Wave length: 2,940nm (Er:YAG), 1,500-micron sapphire tip, in non-contact mode; 450mJ per pulse at 20Hz. Total power: 9Watts.
- Detoxification of the implant: Laser: Wave length: 2,940nm (Er:YAG), 1,500-micron sapphire tip, in non-contact mode; 150mJ per pulse at 20Hz. Total power: 3W.
- Decortication for GBR technique: Laser: Wavelength: 2,940nm (Er:YAG), 1,500-micron sapphire tip, in non-contact mode; 500mJ per pulse at 17Hz. Total power: 8.5Watts.

A V-shaped incision was made with the Er:YAG laser. An intrasulcular incision was made (after anaesthesia) at the buccal and palatal side of the implant, together with two vertical relieving incisions; one at the mesial side of tooth #8 and the second at the mesial side of tooth #11 (Figs 4, 5).

The buccal and palatal flaps were lifted and the area explored (Fig 6); there was granulation tissue around the neck of the implant. The granulation tissue was ablated using the laser (Fig 9). Vaporisation of granulation tissue (if any exists) after raising a flap is efficient with the Er:YAG laser, offering a lower risk of overheating the bone than that posed by the current diode or CO2 lasers, and often obviates the need for hand instruments. Results from both controlled clinical and basic studies have pointed to the high potential of the Er:YAG laser and its excellent ability to effectively ablate soft tissue without producing major thermal side-effects to adjacent tissue has been demonstrated in numerous studies.

The broken hexagon slot was straightened, using a round diamond bur and the head of the implant was rendered smooth. A slot was created with a surgical drill on the head of the fractured screw, and a screwdriver was successfully used to unscrew the broken abutment screw (Figs 7, 8). The Er:YAG laser was aimed at the surface of the exposed implant for the purpose of decontaminating the infected exposed surfaces, without damaging them. Studies have shown that Er:YAG laser energy effects on bone include bacterial reduction. Follow ing this, all accessible bone surfaces were exposed to laser energy to ablate necrotic bone and to shape and remodel the surface, in accordance with established clinical protocols. Decortication of the buccal bone was then performed (Fig 10).

The purpose of decontamination is to encourage bleeding, providing progenitor cells to the site. A new abutment was then inserted into the implant (Fig 11). All spaces between implant and existing osteotomy site were filled with a xenograft bone substitute (Bio-Oss®, Geistlich Biomaterials) and covered with an absorbent biayer membrane (Bio-Gide®, Geistlich Biomaterials) (Figs 12, 15). The mucoperiosteal flap was re-positioned and sutured with silk 3-0, paying particular attention to primary closure of the flap (Fig 14).

Post-operative instructions
The patient was prescribed Clindamycin 150mg x 50 tabs to avoid infection. He was also given Motrin 800mg x 15 tabs for pain. Instructions were given to rinse with Chlorhexidine 0.2% for two weeks x three per day.

Management of complications and follow-up care
The following day the patient reported moderate pain and moderate swelling. There was no tissue bleeding and the site was closed. The flap was showing signs of attachment and was healing nicely. At ten days postop the patient returned for inspection and removal of sutures. The swelling had resolved; there were no signs of fistula and healing was progressing well. After five months the soft tissue was completely healed without complications (Figs 16, 17). The soft tissue had healed over the bone and there were no bony projections observed under the soft tissue. The prognosis is excellent.

Conclusion
The use of osseointegrated implant-supported prostheses in the replacement of missing natural teeth has become an accepted clinical protocol in dentistry. Success in this area is enhanced through correct diagnosis, treatment planning and maintenance; however, complications often occur, which may be significant and compromise the long-term success of the implant abutment and associated prosthesis. The management of such complications has given rise to several techniques to address failings, such as component fracture and bacterial contamination.

The Er:YAG (2,940nm) laser can be employed as an auxiliary tool for the purpose of decontamination of infected implant surfaces and it has been shown to be effective and safe. The use of the 2,940nm wavelength for these procedures presents many advantages over conventional methods, including enhancing the surgical site and less bleed-
ing during the operation, providing the practitioner a better field of visibility and reducing patient discomfort during its use. In addition, anecdotal claims have been made that post-operative effects such as pain and swelling are less pronounced.

A summary of possible serious complications associated with implant placement has been given, together with a report of a clinical case in which the use of the Er:YAG laser has been shown to be beneficial in the management of the consequences of a fractured abutment screw.

References available on request to Lisa@dentaltribunuk.com
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Implant Tribune

**Implant retained mandibular over-dentures**

Willie Jack presents a case study which describes an alternative method that gives an immediately loaded solution in 24 hours.

In each of our practices how many patients do we have who struggle to cope with loose and unstable mandibular dentures? Many patients are not regular attenders as they have discovered there is little that we can do to help them; endless repairs and relines do not make a significant difference and so they try all sorts of denture pads & adhesives every day.

Dentists often view denture work as a difficult and generally unrewarding part of daily clinical life. How often do we see (with dismay!) a very familiar patient’s name listed on our diary for yet another ‘case’ and wonder how much benefit we can offer them? The first implant case I did in practice was a two-implant lower denture case as I was advised that this type of case would be easy to start with.

Surgically these cases can be straightforward, but the angle of the anterior mandible compared to the denture tooth position often makes for an awkward connection to the implants. In addition there are further challenges:

The bar & clip method of retention can be time consuming, complicated and costly. As the denture is processed indirectly obtaining an accurate fit is technically sensitive. The press-stud type ‘Locator’ is a common denture abutment today, which gives an excellent degree of retention; these stand-alone implants must wait till they are fully integrated before the denture can be connected to the abutments.

Looking for ways to make over-denture treatment quicker, simpler and give better value for money, I came across Cendres & Metaux’ new ‘SFI Bar system’. This is a method of placing an adapter type abutment into your usual implant system and connecting a bar chairside at the time of implant placement. You can then pick-up the gold clip onto the bar position in the denture with cold cure acrylic.

**Case study**

The first case that I treated with Euroteknika’s Aesthetica+ implants and the SFI bar was a lady who came to see me who was happy with every aspect of her dentures except the stability and retention of her lower denture. When I examined her I could see that she had sufficient bone for implant placement, as is often the case in the anterior mandible. However the alveolar ridge and the denture bearing area was clearly going to cause a problem with any conventional denture. What this lady did not have was time: she had a family wedding within a month! I am normally reluctant to give any guarantees about the timing of implant treatment, but with only one month before the wedding it made me think that the SFI system may be an ideal solution in her case.

The patient’s denture was adequate and so we decided to use this as the template as well as the final denture so we could start her treatment earlier and keep the cost down. Her treatment was planned to start early one day and to finish the end of the same day! When she arrived on the day of treatment, we took her denture to our on-site prosthodontics laboratory so our technicians added more acrylic on the lingual aspect, bulking it out for strength. Then they made a large opening just lingual to the tooth positions from the first premolar positions left to right, but ensuring that the acrylic removed was above the alveolar ridge. It is important to ensure that the sites...
of both canine teeth are visible in the mouth when the denture is seated.

The patient was prepared for implant surgery with pre-operative chlorhexidine mouth-rinse, analgesics, antibiotics and infiltration local anaesthesia. The denture was seated in position and from the Aesthetica+ surgical kit we used the very sharp ‘point-drill’ to identify the canine sites at the limit of the anterior part of the denture slot. By punching through the mucosa we could also mark the alveolar bone; then this was removed and a small full-thickness flap opened from just distal to each mark and with a midline relieving incision. I prefer to place a midline relieving incision in these cases as if they are distal to the sites it is possible to make an incision too close to the mental foramen & nerve. The second drill is the 2.2mm twist drill to 6-8mm depth, and then the orientation is checked by re-seating the denture over the direction/depth gauge indicator.

When happy with the orientation, the site is further prepared with the 2.8mm & 3.5mm twist drills. The Aesthetica+ regular platform implant to be placed is 12mm in length and 4.1mm diameter with a 4.8mm collar. These implants are Straumann compatible surgical and the 4.8mm collar is compatible with Straumann regular neck prosthetics; they are better able to maintain marginal bone levels by the Euroteknika designed Micro-Threads which are synchronous with the main threads. Once in place the denture is again re-seated to check that the first implant is sited correctly and that it will still be possible to place the second implant in the optimal site.

As both implants are being fully seated the final insertion torque is measured and then a reading is taken using the Osstell resonance frequency system. These give an understanding of the primary stability of the implants and will allow the clinician to make a decision as to whether to immediately load or not. We are aiming for a minimum of 35Ncm final insertion torque and an ISO of at least 60. In this case the implants were very firm and so, after closing the site with 6/0 mono-filament suture, we chose the appropriate height SFI abutments and torqued them to 35Ncm. We now come to the slightly fiddly aspect as the system: measuring and cutting the bar to the length which matches exactly the distance between the two implants. With typical Swiss efficiency C&M have developed a very precise measuring abutment which allows the length of the bar to be calculated and then cut. When cut the bar is slotted into the bar ends which are then fitted into the abutments and torqued to 20Ncm.

The denture is tried in over the bar and if it is too close it is adjusted to give a uniform clearance. The gold clip is cut to fit the bar and then left with a spacer between the bar & clip.

The denture is re-seated allowing the horizontal slot on top of the gold clip to be tacked to the buccal and lingual aspects of the denture with cold cure acrylic. The patient is asked to close together in occlusion so that the correct occlusal position & vertical height is maintained. When the acrylic has set, bite registration material is added into the remains of the denture opening, giving a ‘ceiling’ to the denture, before it is carefully removed from the mouth. The patient is then discharged until later on the same day.

In the dental lab an analog of the bar is seated inside the gold clip and the denture is based over the analog bar. It is a simple yet exact process of adding more acrylic to seal the clip into the denture, processing this and then removing the gross lingual excess and polishing the denture. Later that same day, the patient arrives back to have the denture fitted. There was no doubt that the fit & retention was exceptional, but to allow for some swelling of the tissues it meant that some acrylic had to be removed, especially buccal to the implants & bar. When the patient returned in seven days for removal of the sutures her response was that she had no pain and while she had been cautious with her diet, she had been able to eat many different foods that she had not been able to up to that point.
Literature review

These types of treatments are associated with a high success rate, although it has been suggested that clinical & radiographic evaluation must be maintained over the long term. (COOPER et al 1999) Some authors report no indications of worsening of the clinical or radiological state after 10 years (MEIJER 2004). Patients’ expectations of a two implant retained over-denture may be too high compared with what can be delivered; it must be remembered that the prosthesis is still the same size as their previous denture, still removable and not completely immobile in function. (ALLEN et al 1999) Other authors report a considerable benefit compared to conventional dentures (RAGHOEBAR et al 2000) and patients report that they have a better chewing & biting function than their previous conventional dentures (BAKKE et al 2002). Some patients have noticed that their chewing force is so much greater that – if they have an opposing denture – it is this other denture which is the limiting factor in functional aspects compared to conventional dentures. (MEIJER et al 1999) Some patients have noticed that their chewing force is so much greater that – if they have an opposing denture – it is this other denture which is the limiting factor in functional terms (FONTIJN-TEKAMP ET AL. 2001) I have even noticed that the opposing denture fractures after provision of an implant retained over denture in the mandible.

In some cases I am making the implant denture itself in chrome to prevent fracture (SHOR et al 2007). In relation to bone quality and healing times, it has been suggested that this type of treatment can allow the implants to be loaded within two weeks of placement. (PAYNE et al 2003)

References

Geri atric dentistry has raised its awareness due to longer life expectation. Patients with previous history of edentulism and midterm life expectation can request and expect today higher chewing efficacy as well as higher levels of self confidence when socialising. This can be achieved with implant supported dentures. Primary focus is based on the lower jaw due to muscular insertions, minimal suction performance achievable and higher risk of mobilisation.

Schwartz- Arad (2005) re searched the long term success of implant supported over dentures and concluded: “Implant survival rate was 96.1 per cent (112/285 did not survive) and total 10-year cumulative survival rate was 95.6 per cent (maxilla, 85.5 per cent, mandible, 99.5 per cent).”

The edentulous lower arch presents unique challenges, especially when it is in a state of advanced atrophy. Most common, clinical situations still present sufficient remaining bone height in the interforaminal region.

This article aims to familiarise the readership with telescopic technology. The telescopic or double crown technique consists of two crowns, one fixed (cemented) and a second one mounted in the denture. The telescopic crown system acts as a retention unit. The telescopic crown system acts as guiding plane for the RPD when removing and reinserting the RPD.

Two major double crown systems most common used are:

1. The conical crown system
2. The parallel sided crown system

The conical crown system

Retention is gained using available spring tension of outer crown covering a cemented inner crown. Ideal taper degree of 6° has been described for precious alloys (achieving a retention force of 5-10 N).

The reduction of the taper degree may increase retention force while a higher convergence angle decreases it. This is of importance since multiple retainers are used allowing for adequate values to be easy handle (for the patient) and not at the expense of retention loss while chewing.

The parallel sided crown system

Retention in parallel sided crown relies on the friction gained through opposing surfaces of both inner and outer crowns and it is mandatory to achieve a clear fit between both crowns to reach the desired retention force.

When considering current available materials and technology to manufacture telescopic crown retention, Reuer et al. (2010) concluded: “Primary teeth crowns showed higher retentive forces than crowns made from gold alloy.” Weigel et al. described adhesion between primary crowns made out of zirconia and secondary ones manufactured in galvanoforming approach.

CadCam technology has successfully entered the telescopic crown arena and will have a huge impact in advancing it in the future.

Benefits

Benefits of telescopic double crown technique for the retention of removable partial dentures include:

1. The telescopic crown system acts as a retention unit
2. The telescopic crown system assures the needed rest of the RPD
3. The telescopic crown system acts as guiding plane for the RPD when removing and reinserting the RPD
4. The telescopic crown system represents a resistance unit for the RPD
5. Ease to treatment plan when compared to other devices
6. High foresighted planning: in an event of implant failure – chair side extension and continuation of function guaranteed. The more units the higher the long term success rate
7. Simple access to oral hygiene
8. Higher freedom of implant placement (position, etc.)

Disadvantages

1. Patient needs preoperative explanation of aesthetics when RPD out of the mouth
2. Costs could be high as it is a fact that that best retention values achievable only with high precious alloys (a taper degree of 5-6 guarantees adhesion values of 5-10 N) – alternative materials are zirconia primary crowns and galvanoforming secondary ones. The combination of the telescopic crown system with implants to support and retain dentures is a procedure with adequate history in implant retained prosthodontics. The author’s case presents a clinical case using the implant abutments as primary and gal- vano formed secondary copings.

Case presentation

A healthy 75 year old female patient (nonsmoker) with a history of 16 years of edentulism was referred by her general practitioner complaining from reduced stability and insufficient retention of her mandibular denture. No medical impairments were notified.

Radiographic examination proved a remaining mandibular height in the symphysis region of more than 12mm.

The patient was informed about the treatment options (fixed bridge on 4-6 implants vs removable over denture on two or four endosseous implants). Benefits and disadvantages were explained, postoperative compliance and oral hygiene requirements explained and discussed.

Treatment decision was taken based on patients desire to easy maintain oral hygiene. After financial evaluation and acceptance of agreed treatment a written informed consent was obtained.

Once full diagnosis was gathered and mounted study casts obtained implant position was elaborated and a surgical guide manufactured. Four Biohorizons Maestro implants (external hexlock) were inserted under local anaesthesia, in the interforaminal region according to classic protocol and excellent primary stability registered. The wound was sutured and the patient requested not to wear prosthesis for eight days.

Standard postoperative treatment was composed of analgesics and chlorhexidine 0.2 per cent mouth rinses, but no antibiotics. Healing concluded at no complications. The lower denture was soft lined at suture removal.

The second stage surgery (reentry) was performed three months later. A working cast was created two weeks later using an alginale impression and a custom open-tray manufactured. The two piece implant transfer system was used for the open try impression.

The upper jaw cast was mounted in to the articulator using a face bow. The lower bite registration rim (created on the master cast) was used to three dimensionally mount the lower arch into a semi adjustable articulator. Abutments were delivered by the dental laboratory for try in and pick up impression. Prior to the...
impression a second bite was registered for verification purposes. Secondary copings were performed using galvano forming. Try in with wax mounted acrylic teeth proved the correctness of all treatment steps.

The delivery session has been documented and is presented in this paper.

The clinical pictures were taken at the delivery session.

Authors' conclusions

A possible loss of retention has been discussed in the literature due to possible mechanical wear of the copings. With tapered construction the blockage of the parallel walls occurs just short before definitive set. This contributes to a reduced material wear. After having restored multiple cases of lower jaw edentulism with implant supported either removable or fixed prosthetic devices over the last two decades, one of the major benefits the author has come across was the soft tissue condition during the years of compliance. Soft tissue in bar restored cases tends to become hyperplastic closing the gap to the bar and impairing regular oral hygiene.

In cases of implant retained RPD with telescopic crown retention oral hygiene was easy to be maintained and no changes from baseline, associated hard tissue values were always stable.

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The implant registration splint is used as a transfer and positioning key for the abutments (primary copings as well).

About the author

Dental. Liviu Steier, FICOI, FRSM, FANG, F1ADF Liviu Steier received his Dr med. dent. (PKD) in 1982. He is Specialist here Prosthesis and Specialist in Endodontics (GDC-UK). He is Honorary Clinical Associate Professor at University of Warwick, and course director of the MSc in Endodontics. He maintains private practices in 20 Wimpole Street, London.

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EMS Swiss Instrument Surgery MB6 with unique spiral design and internal instrument irrigation for ultralow temperature at the operative site.

Clinical picture showing the vestibular aspect of the methyl methacrylate based denture.

Clinical picture showing the double crowns (secondary copings) mounted in the denture base.

Clinical picture showing the double crowns (secondary copings) mounted in the denture base.

Clinical picture proving optimal gingival condition prior to delivery.

Clinical picture proving optimal gingival condition prior to delivery.

About the author

Dr. med. dent. Liviu Steier, FICOI, FRSM, FANG, F1ADF

The implant registration splint is used as a transfer and positioning key for the abutments (primary copings as well).

The implant registration splint is used as a transfer and positioning key for the abutments (primary copings as well).

Clinical picture of the abutments screwed in place having the screw accesses closed.

Clinical picture of the abutments screwed in place having the screw accesses closed.

Claw-like copings in place serving as primary crowns (telescopic) retention.

Claw-like copings in place serving as primary crowns (telescopic) retention.

OPG demonstrating ideal healing conditions of the implants.

OPG demonstrating ideal healing conditions of the implants.

At the end: a satisfied, happy and self-confident patient!
Learning Curve

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Have you ever noticed that patients who introduce constraints into the timing that you have proposed for their treatment often create additional problems that go well beyond the clinical aspects of their dental treatment?

Take the case of a patient who arrived for an appointment some 25 minutes early and announced that she wanted to be seen immediately, rather than be kept waiting. The receptionist explained that other patients were booked in before her and asked politely if she wouldn’t mind waiting her turn. The patient stormed out of the reception area and chose to stand at the entrance to the practice, complaining about the service to other patients coming in and out.

Quite alarmed by what was going on, the receptionist informed the practice owner of the problem and suggested that it might be better to get this patient in as soon as practically possible. The dentist reluctantly agreed.

Split personality

On entering the surgery, the patient’s behaviour altered dramatically. She became apologetic and explained that she was very nervous. The consultation continued normally and the patient explained that she did not like the discoloured restorations in her front teeth and wondered what could be done.

The dentist agreed to write to her within the next two or three days once the results of the radiographs had been studied. The patient discussed the various options and the costs in the letter including the provision of four crowns, but suggested that veneers would be the ideal form of treatment. Strangely, there was no reply from the patient.

Several weeks later, the receptionist noticed a picture of the patient in the local paper standing outside an electrical store. The story reported how she had apparently been provided with a cheaper washing machine than she thought she had ordered. The retailers, not wishing to receive any bad publicity, had agreed to upgrade the washing machine as a sign of goodwill. The paper proudly boasted that they had resolved the matter through their intervention.

A letter of reply was drafted and forwarded to the patient. Unfortunately the patient was not prepared to discuss the matter and had by now contacted a consumer affairs programme on local television. As it happens, neither the television station nor the local newspaper chose to run the story.

Find out more

Attention seeking behavior was displayed by the patient from the moment that she had unreasonably demanded not to be kept waiting. Even though the reason may not have been initially obvious, you might want to discover a little more about the patient who behaves in this way before you become too involved in their treatment.

Watch out for another Learning Curve from Dental Protection in future editions of Dental Tribune UK.

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A new evidence emerges about denture plaque and biofilms, the indication of an increased risk to denture wearers in the development of oral and systemic diseases is an issue that needs to be discussed.

At the FDI’s Annual World Dental Congress, held recently in Brazil, GSK-supported a timely symposium dedicated to the importance of denture and oral hygiene in denture wearers and its potential impact on their oral and systemic health.

Key messages from this symposium included:
• Unclean dentures are a chronic source of potentially harmful bacteria and fungi that may be associated with oral and systemic diseases.
• Dentures need to be cleaned daily with effective antimicrobial and antifungal agents.
• Dental professionals play an important role in educating patients and helping them improve their oral and overall health.

An international panel of experts was chaired by Professor Claudio Fernandes, Prof of Prosthodontics, Fluminense Federal University at Nova Friburgo, Brazil. Prof Fernandes highlighted the growing edentulous population globally, the resultant oral health implications, and the role of dental professionals in dealing with associated issues. He commented: “Dentists must take a look beyond how dentures are fitting and functioning; dentures must integrate into patients’ health. If they are fulfilling their function, we are really restoring health for patients.”

The speakers and their key points:
• Dr Zvi Loewy, VP of Dental Care R&D at GSK, and on the faculty of New York Medical College and Drexel University, US, looked at Edentulism: Public Health Impact. Prevalence of denture wearing patients ranges from 12 per cent to 65 per cent globally. Studies show an increased risk of certain systemic diseases in denture wearing patients, which has an impact on the public health system.
• Dr Steven Offenbacher, OralPharma Distinguished Professor of Periodontal Medicine, Chairman of the Department of Periodontology, School of Dentistry, University of North Carolina at Chapel Hill, US, presented on Strategic Approaches for Denture Wearing Based on Periodontal and Prosthodontal Research. He detailed the importance of edentulism in systemic diseases; not as a major cause, but more as a risk factor. He reiterated that dentures carry high levels of many infectious organisms. Denture wearing is associated with increased risk of several systemic diseases including COPD, heart diseases, atherosclerosis, hypertension and diabetes. “Basically research suggests that patients need to do a better job at cleaning dentures on a daily basis and we as clinicians need to be very careful that we are reducing the source of infection in the mouth.”

The symposium was very well attended and well received by the delegates. One delegate commented; “this symposium was outstanding and made my trip worthwhile!” Another delegate said; ‘the symposium was very interesting and it brought together research experts from all over the world to help delegates understand better the importance of good oral health in denture wearers, and the need for healthcare professionals to focus on it.”

The speakers and their key points:
• Dr Angus Walls, Professor of Restorative Dentistry and Director of Research, School of Dental Science, Newcastle University, UK, discussed Implications of Oral Health and Nutrition on Systemic Health. Dietary changes associated with the loss of teeth can result in an unhealthy diet, low in fruits and vegetables and with increased fats and sugars. Denture stability is key to improving confidence in chewing ability, and is one of the parameters necessary to help patients improve diet and quality of life. The use of denture adhesives may help to stabilise the dentures or help improve masticatory efficiency. Evidence shows that as edentulous patients’ nutritional intake declines, the function of the immune system and body repair is suppressed; perfect conditions for the development of oral and systemic diseases.
• Dr Wenyuan Shi, Chairman and Professor of Oral Biology, UCLA School of Dentistry, and Professor of Oral Biology, UCLA School of Medicine, US, discussed Microbiology of Denture Patients, and reiterated the deep connection between microbiology and dental diseases. Between 65-80 per cent of denture patients have stomatitis caused by Candida albicans and Candida glabrata, and other pathogens present on dentures are implicated in respiratory and GI infections. He advocated the elimination of microbial pathogens on dentures as very important.
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Are you having a laugh?

Glenys Bridges looks at ‘radiators’ and ‘drains’ as a way to laugh your way through the day

As I am increasingly hearing how practices are struggling with the impact of the current financial downturn, it brings to mind the words of Ella Wheeler Wilcox’s “Laugh and the world laughs with you, weep and you weep alone”. The advice in her words is as potent in today’s troubled times, as they were 117 years ago, which is sure proof that their underpinning philosophy is sound.

In some of the dental teams I have met laughter is a natural, spontaneous part of their team culture. This is usually due to the blend of personalities involved life coaches often categorise people as ‘drains’ and ‘radiators’. They consider that productivity and energy are directly linked to the balance of drains and radiators in the team. So how can you identify the balance in your team?

The radiators have a ‘cup half full’ mentality; these people put the life into the saying ‘smile and the world smiles with you’. Their optimism is infectious because they are able to make people feel good about themselves. They radiate their energy and enthusiasm like rays from the sun. They are inquisitive and playful but focused too.

The drains on the other hand are people who one way or another leave you feeling diminished after you’ve been with them. You know the feeling - you started off a conversation bright and positive and you came out of it dull, negative and frustrated.

When working through difficult times it is important to ensure any drains in your team are not allowed to pull the rest down. The more difficult the times you are working through the more important it is to allow the radiators to radiate. If you want to be problem focused, think badly of yourself and everyone else, look for the cloud in every silver lining and surround yourself with drains.

The sad things about drains is that seldom realise they are a drain. It is not as though they gain from the energy; they drain energy from others and they drain their own energy too. One cure for the problems they bring could be found in laughology. Laughter can raise the spirits more than anything else. It has proven psychological and physiological benefits. This is surely

why at this time when the world is in the doldrums, one of the boom businesses are the Comedy Clubs, where people can spend an evening of laughter to build up their reserves, before they going back out into the real world. Why should this be the case? Well this is what we know:

• Every time you have a good hearty laugh, you burn up 5 1/2 calories
• Laughing increases oxygen intake, thereby replenishing and invigorating cells. It also increases the pain threshold, boosts immunity and relieves stress

The teams that laugh together are the ones who will come through the current problems in the best shape. Laughter breaks up boredom and fatigue, fulfils human social needs, increases creativity and willingness to help, improves communication and breaks up conflict and tension, so go on; when appropriate have a good laugh.

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Island mentality vs European view
Do we yet think as Europeans or are we still an Island?

When meeting a dentist to discuss new equipment, many have had hanging tube delivery systems for years and do not want to change. When the advantages are explained many take a leap of faith and try the whipcord system (balanced arm configuration) where the tube is retracted by a spring-loaded arm over the unit. While dentists can see the advantages, the fact that the patient is hemmed in or made to feel claustrophobic by having the delivery arm over the top of them, puts them off from converting from their beloved hanging tube system. One option is to mount the unit over the cabinet, avoiding the arm having to hover over the patient. It also means the dentist does not have to get up to move the arm to allow the patient to allow the patient to enter or leave the chair or stoop to reach the hand pieces resulting in back problems. It is the over patient delivery that is associated with the whipcord system that puts us off the European style of delivery. Most of the delivery systems we supply are balanced arm and most dentists would not go back to hanging tubes. From our point of view, and experience the reliability also seems to be better, as the tubes last longer, not being bent or trodden on. Hanging hoses get dirty, stepped on, have a concentrated bend where the tube bends towards the patient causing it fail sooner. The Balanced arm supports the hose and to some degree the hand piece, not only this but also the light bend that on the hanging hose is removed or smoother and the hoses seem last longer as a result.

The other thing that we seem to be reliant upon as a nation, are air driven motors. They are great little workhorses; in some cases never seeing the oil can for years! But the other option an electric motor has the advantage in that it tries to keep up with demand, so cutting rates can be much higher. Unfortunately putting an electric motor on a unit driven by an air foot control can loose much of the speed control afforded by an electric foot control, losing many of the advantages of fine speed control and electric motor can offer. The transducer used to convert air pressure signal to an electric speed control can stick slightly and you get an “all or nothing effect”. Electric foot control cables on the other hand can be susceptible to damage from being trodden on, with the advent of Bluetooth technology the wireless foot control is becoming more common, offering the dentist a finer degree of control, and with it reliability without the cables to trip over.

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So if you’re thinking about replacing equipment, why not consider these options? It could breathe fresh air into your whole working environment and in the long run many keep pennies in your pocket!
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For information on the Kent Implant Surgery and other dental professionals who would like to be involved in the Kent Implant Surgery may contact Dr Mike Mikrozid on 01453 872 266 or email john.jesshop@blackwellsupplies.co.uk.
TENED is awarded the if communication design award 2010 for the EasyTouch user interface.
In addition to the if Gold Award, the entirety of the design of the TENED treatment center from Sirona, the center's innovative user interface has now been awarded the prestigious award for outstanding communication design.

Bensheim/Germany August 3, 2010: Another distinction for TENED. After the treatment center was awarded as the first dental product ever to be awarded an if Gold Award in 2009, it has now also been awarded the if communication design award. The innovations and design of Sirona products have been distinguished several times in recent years.

For further information please contact
Sirona Dental Systems 0845-017 5040 info@sironadesigns.co.uk

Sirona: The innovations and design of Sirona products have been distinguished several times in recent years.

19. 91% of clinicians trialling SDR® plan to use the product in their practices.
A survey of dentists using the new bulk-fill, flowable composite base, SDR® (Smear Dentin Replacement), has revealed that 91% of clinicians plan to use the material on a daily basis in their practices.

SDR is the revolutionary new way for clinicians to save time, making posterior direct restorations simpler and quicker to place. Over 1200 new users in the UK and thousands of users worldwide agree that the first flowable, bulk-fill composite base significantly reduces the time and effort spent in the placement of Class I and II restorations.

Excellent internal cavity adaptation and reduced air bubbles mean that with SDR® clinicians can place direct restorations simpler and faster than before and the standard of my clinical work has vastly improved. From the clinicians’ perspective, the results are very promising.

5.0x magnification, along with five working distances from 500mm to 300mm; perfecting posterior restorations.
Dr Arik Quarshie of the West of Scotland Dental Surgeon, is delighted with the many benefits he is experiencing with his new EyeMag Pro Loupes, “The EyeMag Pro Loupes and illumination unit has been a complete blessing with regards to my clinical work. I can appreciate the margins so much better than before and the standard is immediately improved. For simple procedures such as examinations, to complex pre-patience, the EyeMag Pro Loupes have literally been eye-openers.”

Nuvec offers a comprehensive service including a survey of the client’s needs, full installation, training and prompt aftercare.
For more information please call: 01435 872 266 or email: nuvecinfo@ltd.com
www.nuvec.co.uk

EasyTouch is the treatment system’s control panel. The dentist can use EasyTouch to call up the entire range of TENED functions and to control patient communication on the unit directly. A wireless foot control can also be used to operate all functions hands-free without causing a break in the hygiene chain during treatment.

The award will be presented on September 3, 2010 at BMW Welt in Munich, Germany. TENED and the EasyTouch user interface was designed by the Dremelstad-Pui Design and Konstruktion.

For more information please visit TENED’s website, www.teneds.de

 patrioc.com

30 Industry News

DENTAL TRIBUNE
United Kingdom Edition • November 15-21, 2010
Clinical Innovations Conference 2011 Dates Announced
Be inspired and innovated by fantastic speakers and sessions

Once again the Clinical Innovations Conference 2011 will be held in the fantastic surroundings of the Royal College of Physicians. Smile-on has announced that it will be held on Friday 6th and Saturday 7th May 2011. The event, which is organised by Smile-on in association with the AOG and The Dental Directory, looks set to be another inspiring and an essential date in dental professionals’ diaries.

Last year’s the Clinical Innovations Conference saw some of the world’s leading educators in aesthetic and restorative dentistry share their expertise on a wide range of relevant subjects through several live demonstrations with enthusiastic clinicians from around the world. 2011’s conference is aiming even higher, putting together a fantastic line up of speakers and hands-on sessions to create a truly motivating learning experience for dental professionals of all abilities.

“I have found the conference to be well organised and very professional with excellent speakers, which is of course the most important thing!”

Dr. Sara Abdulla Alnoor Aljily is a GDP from Madina Dental Centre in Doha, Qatar, and was one of the attendees and commented: “I heard about the Clinical Innovations Conference through Smile-on’s regular email updates. I decided to take part in this extraordinary gathering to widen my experiences and knowledge which I believed did really happen.

“I have found the conference to be well organised and very professional with excellent speakers, which is of course the most important thing! Attending the conference has been a great experience and has helped update my skills. I’ll definitely be putting these skills to good use when I go back home.”

The event succeeded in inspiring and motivating attendees, helping to raise standards in dentistry and enhance practitioners’ enjoyment of their chosen profession.

The 2010 conference saw a very high turnout and clinicians are encouraged to reserve their place early to avoid disappointment.

The confirmed speakers for next year’s event are:

- Tif Qureshi
- James Russell
- Nasser Barghi
- Wyman Chan
- Raj Rayan
- Trevor Burke
- Julian Satterthwaite
- Wolfgang Richter

Delegates will also have the opportunity to earn up to 14 hours of verifiable CPD at the event.

For more information about the event call 020 7400 8989 or email info@smile-on.com

For further information and samples contact PeriProducts on 020 368 1989, by email info@periproducts.co.uk or alternatively visit our website: www.retardex.co.uk

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Our natural reaction to bad breath, is to turn it into good breath.

The Retardex oral health range has got everyone talking about bad breath – because it doesn’t just mask the problem with mint or other flavours, it eliminates the root cause of bad breath.

Unlike other mouthwashes, the alcohol-free Retardex range contains anti-bacterial and oxidising ingredients that actually destroy the odour-causing Volatile Sulphur Compounds (VSC). Developed by dental professionals, a single 30 second rinse with Retardex oral rinse is clinically proven to eliminate bad breath for at least 8 hours.

As you’d expect, the Retardex range is also highly effective at preventing plaque formation and bacterial growth that causes gingivitis and caries. So for real fresh breath confidence, recommend the daily use of Retardex oral rinse, toothpaste and spray.

Give your breath the all-clear.

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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. Sock 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 discolouration 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: GSL. 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.