Fluoridation rage gains momentum

Hampshire councillors are fighting fluoridation

Southampton City councillors are backing an NHS proposal to fluoridate water in the area but Hampshire councillors have given it their backing.

The proposal was backed by Southampton City councillors - 26 votes to 18 - that fluoride be added to water in some parts of Southampton and South West Hampshire, in a move that will affect 195,000 people.

Andrew Mortimore, public health director at Southampton City Primary Care Trust, said: ‘We hope that local people take confidence from the decision taken by the city council to back the proposals. We hope also that even more Southampton residents will now express their support for the proposals for fluoridation currently being consulted on by South Central Strategic Health Authority.’

He added: ‘We are delighted by the fact that elected councillors who represent Southampton, which makes up the majority of those who would benefit from fluoridated water in the proposed scheme, have decided to support water fluoridation. We appreciate the thoroughness with which the issues were examined and believe this is an example of local democracy at its best.’

However, Hampshire councillors vetoed the plan, just hours after. Southampton councillors had given it their backing.

Hampshire County Council decided unanimously that it did not support the proposals.

Councillor Ken Thornber, leader of Hampshire County Council, said: ‘The Southampton City Primary Care Trust wants to improve the oral health of specific communities in Southampton, but their proposals will impact on people in south-west Hampshire which does not have the same problems of poor dental health.

There may be some benefit to some children living in the affected area, but there is also a strong possibility that children with otherwise healthy teeth may develop a degree of fluorosis.’

He expressed concern that it is not fully understood if there are other health effects to a population that has fluoride added to drinking water.

London

Hundreds of millions of people around the world are currently benefiting from this public health measure, which for the past 60 years has saved many millions of teeth from decay, from fillings and from needing to be extracted.’

He added: ‘The degree of human discomfort and pain that has been avoided is almost in calculable.’

Commenting on the public consultation being run by South Central Strategic Health Authority (SHAs), Lord Hunt said: ‘Rightly, fluoridation is a matter of public decision following public consultation. My family and I are fortunate to live in Birmingham, where the water has been fluoridated for 45 years. From my personal experience, I would strongly commend fluoridation to the people of Southampton.’

Baroness Cumberlege claims that during more than 20 years of involvement in health issues she has seen ‘few public health measures as measurably successful as fluoridation’.

Fair play?

So does the Government need to re-think the funding strategy to keep NHS dentists alive and kicking? Neel Kothari is back with his views.

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News in brief  News and opinions  Practice management  DCPs  Education

Hard times

There are hard times ahead for dentists, predicts the chair of the BDA’s General Dental Practice Committee. Lester Elliman claims that due to the credit crunch, the picture for dentists is back on treatment due to the economic uncertainty of the times. He warned that ‘in the short term this will probably not affect most practices unity but in the longer term, if it continues, there will be a considerable impact’. He also expressed concern over how banks will respond to requests for any funding and said: ‘Despite the Chancellor’s pleas there is little evidence that banks are being more open handed. How will a bank respond given that in many areas the patients are simply not attending so UDA targets cannot be met?’ He added: ‘These are truly disturbing times!’

BDA Awards

The Prior’s Dental Practice in Penkridge, Staffordshire, was awarded the Good Dental Practice Scheme Practice-of-the-Year Award at the third annual British Dental Association (BDA) Honours and Awards Dinner in London last month. The award, open to all members of the BDA Good Practice Scheme, recognises outstanding commitment to patient care by the whole dental team. The winning general dental practice is also a specialist referral centre for orthodontics, endodontics and prosthodontics. The evening also featured presentations to individuals by the BDA in recognition of service to dentistry and the BDA, along with a range of awards presented by the BDTA and dental care professional associations. Read the full story next week.

Photography course

Dental professionals can now benefit from more effective treatment monitoring and medicolegal protection with a newly launched clinical photography course. The course of five days advice on selecting the right camera for your needs, setting it up for clinical use and taking the perfect shot in eight clinical areas. The clinical photography course is on CD-ROM or online, and provides two hours of continuing professional development (CPD). Smile-on has also introduced the three module programme Communication in Dentistry: Stories from the Practice, and has a new series of Webinars. For more information call 020 7400 0989 or email info@smile-on.com.

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Scottish dental access crisis

MPs are calling on the Scottish Health Secretary to deal with the lack of NHS dentists in Scotland.

Orkney, Grampian and Caithness have the lowest level of NHS dental cover, according to MSPs.

Orkney MSP Liam McArthur claims that the situation on the islands had reached crisis level.

Dental Tribune moves ‘leaps and bounds’

Dental professionals from small practices are choosing to read Dental Tribune, over any other dental publication according to a recent survey by the British Dental Trade Association (BDTA).

The Dentist Readership Survey by the BDTA, found that a total of 66 per cent of DT readers are from small practices and half of the dental professionals who read Dental Tribune (DT) say they read it regularly.

While 57 per cent of DT readers look at the news first.

More than half of DT’s readers are aged between 55 and 44.

This makes DT, the second preferred choice for people in this age group.

Penny Palmer, editor of DTUK said: ‘We have only been in the market for two years and are already moving leaps and bounds compared to other stalwarts in the market that have been around for years.’

The survey found that BDJ and BDA News are the dental publications that attract the highest number of readers.

A total of 96 per cent of dental professionals believe that dental publications enable them to keep abreast of what is happening in the dental industry. While 77 per cent read dental publications to gain information on the newest techniques.

Empty rooms ‘a crying shame’

The practice three dentists and a hygienist and five nurses. The practice is open six days a week and some evenings.

Credit crunch hits ADP

The credit crunch has forced the company ADP to cancel its plans to run a new NHS dental surgery in Tunbridge in Kent.

NHS West Kent, the regional primary care trust (PCT), revealed back in June that a new £500,000 deal had been signed with ADP to provide dental care to 6,000 patients in the town.

However the PCT has now revealed that the company has been forced to pull out.

A spokesperson for the PCT, said it was ‘clearly disappointed’ that the company had withdrawn and that staff were doing ‘everything possible’ to help affected patients.

He added: ‘As soon as NHS West Kent became aware of this potential issue we took steps to alleviate the inconvenience that this will cause.’

The PCT has temporarily awarded contracts to a range of local dentists in the short term to ensure patients have access to treatment while the formal tendering process is completed.

That process will now begin again next month and the PCT hopes a successful bidder will be selected by June next year.

Fluoridation rage gains momentum

She pointed to ‘reports by the Royal College of Physicians in 1976, the University of York in 2000, the US Task Force on Community Preventive Services in 2002 and the Australian National Health and Medical Research Council in 2007’ that found evidence that fluoridation reduces tooth decay.

She added: ‘Importantly, children in fluoridated areas have fewer fillings and extractions and are less likely to need a general anaesthetic for decayed teeth to be removed. Equally important is the fact that they experience less pain, discomfort and anxiety.’

Commenting on concerns posed by anti-fluoride campaigners over the safety of water fluoridation, Lord Hunt said: ‘When the debate about whether or not to fluoridate Birmingham’s water was taking place in the early 1960s, there were dire predictions from anti-fluoridation campaign groups that people would be seriously harmed, that teeth would turn brown and that no teeth would be saved from decay.

However, he claimed none of these “scare stories” actually came to pass in reality.

The public consultation, on whether to add fluoride to water in parts of Southamptom and South West Hampshire, will close on Friday 19 December.
Leader of Hampshire County Council, Ken Thornber has admitted that he has doubts on whether drinking fluoridated water is safe. He also raises the subject of fluorosis.

Why, he asked, should children with otherwise healthy teeth be at risk of developing some fluorosis for the sake of just a few others who may benefit? He does have a point. For while there is plenty of evidence that fluoridation keeps decay, fillings and extractions at bay, nobody seems keen to roll out much evidence on the safety and efficacy of fluoridation. This was the very question Dental Tribune put forward to Dr Barry Cockcroft only recently, and he remains passionately confident on the issue. Indeed, the other day he even pulled out information related to a recent study by The York Review looked at 700 papers and there was not one link between fluoridation and general health issues – there really is no evidence that any damage is done and that is a fact. And on fluorosis he is equally as vehement.

Impossible NHS access

Forking out for expensively equipped, empty dental rooms is ludicrous. So what does this say about NHS dentistry? While it is great that a PCT in Cornwall is providing fantastic dental facilities, what is the point when there are no NHS dentists to fill them? A dentist told Dental Tribune last week that under the new contract he gets paid the same amount of money for doing either one filling or ten fillings. ‘There is just no incentive to work in NHS dentistry any longer’, he said. Point taken…

When it comes to pushing through fluoridation, the UK remains at war

He said: ‘I spent 20 years working as a dentist in a fluoridated area and I never had to do a cosmetic procedure related to it - you would have to drink loads and loads of water to get it anyway.’ With first-hand experience Dr Cockcroft also has a point. So when it comes to pushing through fluoridation, the

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Or email: penny@dentaltribuneuk.com
A row has broken out between the British Medical Association (BMA) and the British Dental Association after the BMA called for dentists to be banned from calling themselves ‘Dr’.

It follows a ruling by the Advertising Standards Authority (ASA) that ordered a dentist to stop calling himself ‘Dr’ in his advertisements, unless he had a medical qualification or a PhD.

Dr Jonathan Fielden, chairman of the British Medical Association’s consultants committee, believes dentists should be banned from using the term to protect patient safety.

He said that patients have a right to clarity and to be secure in the knowledge that the person treating them is competent and qualified to do so.

He added that it could mislead patients into thinking they are medically qualified when they are not.

Dentists are not banned from calling themselves doctor but they can face penalties if it is judged that they are not being clear enough about their qualifications. The ASA says that if a dentist refers to himself or herself as ‘Dr’ without making it obvious that they are not doctors, it is a clear breach of advertising laws.

However, the British Dental Association claims using the term does not confuse patients and just brings Britain into line with the rest of Europe, where the term is commonly used. ‘We believe that dentists should be permitted to use the courtesy title ‘Dr’ should they wish to,’ said Peter Ward, the chief executive of the British Dental Association (BDA).

He added: ‘The General Dental Council has no objection to the title and its use is becoming widespread.’

‘In virtually all other European states and other English speaking countries throughout the world dentists are given the title and we support harmonisation with professional colleagues from overseas.’

He claimed that calling dentists in the UK ‘Dr’ could remove confusion for patients and dentists from abroad. ‘Many patients in this country, both UK nationals and those from abroad, address their dentist as ‘Dr’ and many dentists and patients from abroad are confused by the fact that dentists in Britain are not referred to by the title,’ he said.

The Department of Health (DH) claims that the title of ‘Doctor’ is not a protected title, so dentists don’t have to be a medical practitioner to use it.

A DH spokesman added, however, that there was a provision in the Dentists Act 1984 which stops dentists from using any title or description to suggest a qualification that they do not possess. However, it is up to the General Dental Council to enforce that rule.

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Are dentists who call themselves doctors causing confusion?
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Guilty dentist launches appeal

A dentist who was found guilty of urinating in a surgery sink has launched an appeal in the High Court against being struck off by the General Dental Council.

Alan Hutchinson, who worked at Branch Road Dental Practice in Batley, Yorkshire was struck off the register after a General Dental Council (GDC) tribunal last April. The GDC also found him guilty of using dental instruments to clean his ears and fingernails.

Mr Hutchinson denied all the charges except the allegations of routinely not wearing gloves, due to a latex allergy. He has asked a judge to rule that he was denied a fair trial.

Robert Francis QC, for Mr Hutchinson, argued that erasing Mr Hutchinson’s name from the register was ‘disproportionate.’ He claims the evidence against the dentist was ‘inconsistent and incredible’ and should never have been accepted by the GDC’s professional conduct committee.

Dental nurse Claire Pygott, who had worked with Mr Hutchinson for 16 years, told the tribunal in April, how she could smell urine coming from the sink after about three weeks. She told the tribunal that she also saw Mr Hutchinson ‘tucking something’ into his trousers in March last year. Ms Pygott told the tribunal she was too embarrassed to raise the matter with Mr Hutchinson, claiming he is ‘a very intimidat- ing and manipulative man’.

The initial complaint was made by an unnamed woman patient, who told North Kirklees Primary Care Trust, that Mr Hutchinson had refused to wear gloves while he removed her wisdom tooth. However during the tribunal, Mr Hutchinson claimed he was cleaning his teeth at the sink.

At the appeal, Mr Francis said the evidence did not support the findings and there had been an abuse of process. He called allegations ‘improbable’ and criticised the findings as ‘unsafe, if not perverse’. Mr Francis said suspension for a period, subject to review, would have been an adequate sentence.

The appeal continues.

Free Oral cancer checks

Dentists up and down the country have offered free oral cancer screening checks following the launch of Mouth Cancer Action Week.

The Dental Healthcare Centre in Fairfield, in Stockton offered free cancer checks to anyone, even those not registered with the practice.

The Tarporely Dental Centre in Chester, also offered free screening checks. Dr Jason Hopkins of the centre in Chester claimed he had offered the free sessions to help spread awareness of the disease.

He said: ‘Anyone can get it. People need to be more aware of the symptoms, such as ulcerations that do not heal and red or white patches in the mouth.’

In the north east of England, Newcastle and North Tyneside Primary Care Trusts and Northumberlarn Care Trust put on free sessions all week. Oral health promotion teams were also at the sessions giving oral health advice and information on the risks posed by excessive drinking and smoking.

Deborah Howe, part of Newcastle PCT’s oral health promotion team, added: ‘One of the main problems in mouth cancer treatment is simply that people wait far too long before going to see a health professional when they think something might be wrong.’

• Mouth cancer is a relatively unknown disease and the consequences of not having a check can be fatal.
• Every year 1,600 people die from it, and the chances of having mouth cancer are greatly increased by smoking and drinking.
• If the cancer is detected early, the survival rate is 90 per cent, so a visit to the dentist can be potentially life saving.

Advanced training for UK dentist

A dentist in the north east of England has become the first in the UK to graduate from an international advanced training programme in America.

Dr Ken Harris, who runs Riveredge’s centres in Sunderland and Newcastle, has just returned from Seattle after graduating from the Koos Centre.

The Koos Centre offers internationally recognised training programmes to dentists from around the world.

Mr Hutchinson denies all charges

NHS dentist for Swindon practice

The group’s area manager Ruth Coleman said ‘Her appointment reflects our continued commitment to the NHS to provide the people of Swindon with affordable dental care of the highest standard. The places are being offered on a first come first served basis.

Clyde House practice, is part of the Dr Michael Frain LTD group, Wiltshire’s largest NHS dental care provide.

Orthodontic nurse wins Nurse Prize

An orthodontic nurse from Guildford Orthodontics at Eastcake Clinic in Guildford, has won the TOC Orthodontic Nurse Prize 2008.

Lauren Smoothy Ian Grobler, principle of Guildford Orthodontics was awarded the TOC (The Orthodontic Company) prize at the British Orthodontic Conference which was held in Brighton.

Ms Smoothy won the prize for her portfolio project entitled ‘Orthodontic Oral Hygiene Motivation – The Orthodontic Nurse’s Role’.

Dr Mari du Toit of Guildford Orthodontics, said: ‘The project was based on a case study which proved that motivation by the orthodontic staff can significantly improve the oral hygiene standard of a patient.’

The competition was open to all dental nurses currently working in orthodontics in hospitals, community, specialist practices and general practices.

Prosthetic dentistry prize

Dr James Field from the School of Dental Sciences at Newcastle University has won this year’s Schottlander BSSPD (British Society for the Study of Prosthetic Dentistry) Prize.

Dr Field won the award for the advancement and knowledge in prosthetic dentistry for his paper ‘Perceived barriers of General Dental Practitioners in the North-East of England to the provision of implant-supported over-dentures’.

Dr Brian Schottlander, who gave the award, praised the BSSPD and called it ‘the repository for a great deal of knowledge in removable prosthodontics.

He added: ‘How it keeps that knowledge intact in passing it on to the prosthodontists for the future is one of the challenges that it faces as patients’ needs and expectations change.’
GDPUK round-up

This week the media whips up the profession in protest on alleged stories of NHS manipulation, but there was also time to talk clinical and to reminisce on the past.

This autumn, the media has been full of stories about dentistry, and these always encourage GDPUK members to rise to the bait and give their opinions. The Sun, The Daily Mail and Sky News have all had words over alleged manipulation of NHS arrangements, but the conspiracy theorists among us believe the stories were orchestrated by the Department of Health (DH), and that it always has a plan ready to scupper any goodwill the dental profession cultivates.

In addition, the media storm that followed the great global financial crisis made colleagues aware of the ultimate ownership of Associated Dental Practices, ADP, and there was much speculation on what had happened, and what the outcome will be for those practitioners and patients when the dust settles from the Icelandic implosion. Usually the GDPUK readers consider themselves well informed by the knowledge of their colleagues, but in this case, there was only speculation and almost everyone remains in the dark on this topic.

Moving on, a number of clinical cases were discussed, and it continues to amaze what infinite variety of problems and comic incidents occur in our practices. One colleague was discussing whether he should consider attempting root treatment on a non-vital, but long-term symptom-free tooth for his wife, a tooth which definitely needs a crown. The pitfalls were fully expounded.

The type of tooth preparation needed to provide porcelain veneers in a severe-wear-case patient also created debate on a clinical line, and there were marked differences of opinion.

Another severe-wear case was of interest, and the member seeking advice posted images to aid the discussion. Yet another innovation at the GDPUK forum is the ability to embed video clips within the forum posts, but no one has yet used these to illustrate a clinical case. I might use this myself to announce the GDPUK 2008 awards for best post, top member and so on.

Some other topics outlined more simply included:
- Can a patient drive after having relative analgesia?
- Is seniority pay still around?
- Which treatment is guaranteed successful?
- How young can a tooth be bleached?

Nostalgia for the good old days encouraged me to look back at old record cards in my own practice. I commenced practice in 1980, but older cards told me an NHS exam fee was around seven shillings (£0.75) in the mid 1960s, and by 1980, this had risen to eight shillings. A scaling was 12/6d, and fillings just over 14/6d each. Medical history was blissfully unrecorded on those days, and one correspondent talked about leaving dental school before air-rotors had found their way there. He went on to reminisce about other interesting concepts brought left on the web. If you’re feeling inspired, log on to the forum to read more at www.gdpuk.com – you’ll be welcome.

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About the author

Dr Anthony V Jacobs started the GDPUK emailing list in 1997, and the group membership is now just under 2,000. The list is read in all corners of the UK dental profession. Dr Jacobs is now in partnership with Dr Stephen Lazarus, practicing at 406 Dental in Manchester and has a long-term commitment to continuing professional development, both for himself, and for the profession in general through his mailing list. He has been a member of the British Dental Association (BDA) since 1975, and is presently chairman of the Bury and Rochdale Oral Health Advisory Group, as well as vice chair of the Bury and Rochdale Local Dental Committee (LDC). Dr Jacobs also sits on the committees and helps to organise the annual conference of Local Dental Committees.
No show charges to hit the Welsh

The Welsh Assembly Government is looking at introducing a ‘discriminatory charge’ for patients who miss dental appointments.

The proposal was put forward by a task and finish group, which recently reviewed the current dental contract.

The idea has received universal support and, if implemented, could eventually be extended to other areas of the NHS, including hospital outpatient appointments.

Stuart Geddes, director of the British Dental Association in Wales, claims his own practice lost up to three weeks’ worth of appointments in one year and said: ‘Charging is the only sanction that would be in any way effective’.

Jonathan Davies, policy and public affairs manager for the Welsh NHS Confederation, said: ‘Reasons for non-attendance may vary and are not always the patient’s fault.

However, simply forgetting to turn up for, or failing to cancel an appointment for reasons of apathy is increasingly unacceptable.

The idea of introducing a discretionary charge in these cases may well help improve the current situation.’

Edwina Hart, Minister for Health and Social Services, said: ‘At the end of last year I announced a review of the dental contract and the establishment of a task and finish group to look at a range of issues to improve the way in which the contract works.’

She added: ‘The Review Group completed their work in July and submitted their Report. It concluded that the dental contract is broadly a workable system, and one which, with amendment, can be further improved.’

After consultation, the group found there was strong support for proposed national guidance on termination and transfer of dental contracts and the need for help in the upgrade of dental surgery equipment to meet new statutory requirements.

The current review of Units of Dental Activity as the sole contract currency was also seen as a key area.

‘There is a sub group of the main Review which continues to work on these complex issues and I look forward to seeing their final report and implementation proposals,’ said Mrs Hart.

The Welsh Assembly Government will also be looking at consolidating and strengthening the Community Dental Service (CDS) as part of its commitment to refocus provision of dental services to provide a new emphasis on public health.

The Review Group recommended revised guidance on the role of the CDS and for the care of the vulnerable in society, including children from deprived areas and those people with special needs.

This guidance was published at the end of October and will strengthen provision of dental services for those most in need and support the development of the CDS.

The CDS is also delivering the National Child Oral Health Improvement Programme – Designed to Smile – which is at the centre of the National Oral Health Action Plan for Wales.

The first phase of the Designed to Smile programme concluded last month, and is already providing tooth-brushing programmes in well over 100 schools.

This will be rolled out steadily across the two super pilot areas covering North Wales, Bridgend, Rhondda Cynon Taff, Merthyr Tydfil, Cardiff, and the Vale of Glamorgan areas. A number of schools in Swansea are also participating in the programme.

Mrs Hart added: ‘While the review of the dental contract and the subsequent consultation on its findings clearly shows that the dental profession wants to work with the current system there is still of course much to do. While we have stabilised NHS dentistry in Wales and built foundations for the future, we now need to ensure that the dental contract is working as well as it possibly can and delivering benefits to the public and those working in the dental profession.’

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Dental students treat patients

The first cohort of dental students at Lancashire’s graduate entry dentistry programme have begun their second year of intensive training and are now treating patients on the NHS allocation list.

The 32 second-year students on the University of Central Lancashire’s BDS Graduate Entry Dentistry programme are now based in one of four brand new dental education centres situated in Carlisle, Accrington, Morecambe and Blackpool.

Lawrence Maar, head of the School of Dentistry, said: ‘The students have now started seeing patients who are currently on the NHS allocation list, under the close supervision of their tutors. They will be carrying out simple routine treatments and emergency care, including scale and polishes, fillings and simple tooth extractions.

Research has shown that most dentists stay in the area in which they trained and so we hope to be able to provide more qualified dentists for the north-west and help allay the current shortage.’

Since the students started in September 2005 they have had to develop their skills on simulators as well as learning the theory of dental practice.

The first year was based at the new £1.25m dental school in Preston, which was the first purpose-built dental school in the UK for over a century.

They have also had to pass 15 exams since January to ensure they are ready to see real patients.

Their clinical training will be supplemented by further lectures, some via video links with the School of Dentistry in Preston, Lancashire.
The Sceptic presents

The case for... and against

Solo practice – making it on your own

Everyday in life is a balancing act, including deciding what kind of practice setting will make for a satisfying dental career. For some, the choice of solo practice offers advantages over a group or academic setting.

The advantages

Being one’s own boss is usually thought of as the biggest advantage to solo practice. The flexibility to set working time to fit one’s own schedule, especially the ability to shift hours around as children grow, make it possible to attend plenty of school concerts, netball games, and soccer matches. Patient scheduling is completely within your own control, and staffing is entirely at your discretion.

Anyone who has employed and worked with associates will know their ability to throw hissy fits. Rather than face the prospect of hiring another, you may choose to work alone, supported by your nurse and front-desk staff, and feel comfortable as your practice hums along.

There is no board of directors to convince; no manager to persuade; no partners to get to buy into a new paradigm. You choose which insurance plans you want to participate with and which ones seemed to be more trouble than they’re worth. You get to design a filing system that works for you, the software, and even shop for the computer hardware yourself. There is a sense of ownership that would take years to develop. After all those years working as part of a team, even shop for the computer hardware yourself. There is a sense of ownership that would take years to develop – if it ever did – had you gone into a group practice instead.

Best of all, of course, is the intensity of the one-on-one patient relationships you enjoy. They come to see you, and you are the dentist they get. Over the years, your patients become your friends, deepening the joy of caring for them.

The case against

The flip side of constant availability is the illusion of indispensability. Each weekend out of town becomes a hassle; every vacation requires a negotiation. And none of those days off come with pay. The opportunity cost of time away from the surgery is significant for everyone who is self-employed, as is the overall financial risk of the business endeavor.

But the issue that probably keeps more dentists away from solo practice than any other is the perceived professional isolation. Think about it: throughout dental school and your early jobs when you yourself were an associate in someone else’s practice, you were always surrounded by colleagues. Study groups, teaching conferences, patient rounds in the hospital – you never had to think twice about bouncing random questions off your peers. ‘What’s the dose of amoxicillin?’ ‘Should I refer this patient?’ ‘What do you think about this OPG?’

The further along you get in your training, the less you tend to ask questions, but even as an attending you are still surrounded by colleagues. You are never completely alone – until you choose to be by going into practice by yourself. After all those years working as part of a team, how do you keep from getting lonely without any other colleagues around?

You have to strike a balance in your life. You have to make it on your own and let us have your views.
Doom or boom?
Sarah Gwilt of Essential Money offers some tips to beat the credit crunch

The credit crunch has turned the financial world upside down. We all know that Halifax Howard has been rescued by the black horse and part of the Bradford & Bingley has been nationalised. But is the future as gloomy as the press would like you to believe? Although good news doesn’t sell newspapers, however the markets always work in cycles – what goes up must come down and go up again. Here are some tips as credit crunches:

• Limit your cash savings to £50,000 with each organisation, as you are protected under the Financial Service Compensation Scheme, and beware of groups: organisations such as HBOS, Bank of Scotland, Birmingham Midshires, Halifax & Intelligent Finance are one organisation, so save a maximum £50,000 within the group as a whole.

• If your mortgage rate is expiring with your current lender over the next eight months, look at securing a new rate now as rates may get worse. If you have savings and tax-bill funds, you may benefit from an offset mortgage.

• Any outstanding balances on credit cards? Secure 0 per cent balance transfers for up to 15 months (set up charges vary between 2.5 per cent to 3 per cent). Reduce the balance by setting up a standing order as there are no guarantees these schemes will be available in the future.

• Consider a stocks and shares ISA. The people who have made the largest stock-market gains in the past are those who hold their nerve when the markets fall.

• Review your utility charges – websites such as uswitch.com will compare your current provider with the market. Consider fixing your gas and electricity charges. British Gas has a fixed-price plan until 2012.

• Have you started any life insurance policies prior to 2006? Several life-insurance companies have reduced their rates, so contact your financial adviser to see if they can re-broke your plan(s).

Good times ahead?
Stock markets and property prices are falling, there will be great opportunities ahead. Start planning today so you can maximise your future gains. These cycles on average only happen every 15 to 20 years, don’t miss out.

If you want to start or increase a buy-to-let portfolio, there are some factors you will need to bear in mind. Lenders need a minimum deposit of 15 per cent and the rental income must at least cover mortgage payments on an interest-only basis.

Sarah Gwilt
Sarah Gwilt is a Mortgage Associate at Essential Money Limited, and won Mortgage IFA of the Year 2005. She is recognised as one of the most experienced advisers in the dental market and advises lenders on structuring mortgage products to attract dental clients. For more information please call 0121 685 5060 or email thomas@essentialmoney.co.uk or visit www.essentialmoney.co.uk.
Complying with the code

As you know, there is no shortage of dental products, services and special offers available to satisfy your needs. But are the products and supply companies really as good as they sound? Do they meet your demands for high quality standards?

The British Dental Trade Association is the body, which represents manufacturers, wholesalers and distributors of products and services to the dental profession in the UK. It was formed in 1923 and now has in excess of 125 members. All BDTA members comply with the BDTA's Code of Practice which ensures that the highest standards of self-discipline are enshrined in the conduct of members. It demonstrates members’ commitment to providing high quality, effective dental goods and ancillary services and also accurate, fair and objective information to you.

Because equipment in the dental surgery represents a major capital investment and consumables are a vital part of daily treatments, it is important that you use companies who can provide products of an appropriate standard, a reliable service, properly trained professionals to deal with your enquiries and continued support. With patients demanding higher standards of treatment than ever before, you can be confident that you are meeting their needs and delivering the best possible service by using BDTA member companies.

BDTA Dental Showcase

BDTA Dental Showcase is the UK’s market leading dental exhibition, organised by the British Dental Trade Association annually. The three day event attracts more than 12,000 members of the dental team and well over 520 exhibitors. Showcase is a great opportunity for you to see the latest products, materials, technologies, equipment and services all under one roof. You can also take advantage of the complimentary daily seminars covering the core CPD subjects recommended by the General Dental Council which were introduced to this year’s event and were attended by over 2,000 visitors. Internet and mail order purchasing have many advantages but BDTA Dental Showcase enables you to benefit from face to face interaction with manufacturers and suppliers, gain hands-on experience of new products, develop fresh contacts and of course take advantage of the many Showcase special offers! There is a real balance between business, education and fun as you will see from the pictures, so why not plan a trip to the event in 2009?

The next BDTA Dental Showcase takes place at the NEC, Birmingham on 12-14 November 2009.

Picture gallery from this year's event is available www.dentalshowcase.com.

Working in harmony as a complete dental team

The term ‘dental team’ has been used extensively over the past few years. The size of the dental team as a whole and the roles of the team have changed greatly and the implementation of the statutory register for dental nurses, technicians and other dental care professionals has meant that the concept of the team approach has become more widely accepted.

It is now recognised that all members of the team, including suppliers and manufacturers – a group which is often forgotten – have a role to play in the development of dentistry in the UK. Working together creates synergy and cooperation which allows this common goal to be achieved.

Forming relationships with patients is accepted as a necessary part of the dental care and treatment process but how much emphasis is placed on members of the dental team fostering strong relationships with each other? Developing long term relations with your suppliers, for example, means they have a better understanding of your needs and can meet your requirements more effectively. It also means that you are likely to be more satisfied and saves you the time of seeking and recruiting new suppliers and establishing new accounts.

The associations representing the various members of the dental team have also recognised the long term benefits of working together. The BDTA meets with representatives from the DLA, BDA, BADN, BDPM, DPA, DTA and BSDHT on a regular basis which helps align the views of the trade and the profession.

One of the key projects the BDA and BDTA have worked together on is the development of BDA MasterClass, a first-class management educational programme for dentists. The programme has been developed to support the profession during this period of change and offers business guidance to help you gain the most from your dental practice. Whether you are a practice owner who wants to take your business in a different direction but you’re not sure how, or you just want some reassurance that your practice management skills are up to the job this course can help.

To find out more e-mail: masterclass@bda.org or call 020 7563 4131 and quote DT December.

What is the BDTA?
The BDTA represents and supports manufacturers and suppliers of dental products, services and technologies to the benefit of members, the dental profession and the public.
Help your team earn 20 hours of CPD with the BDTA Certificate – Introduction to Dentistry Course

The BDTA Certificate: Introduction to Dentistry is a ten-module course designed to raise the level of understanding of those new to dentistry, new registrants and those who supply and provide a service to the dental industry. Written by specialists, it is an ideal self-learning or supervised training programme for your dental nurses, practice managers and receptionists who want to learn more about dentistry.

Relevant staff within BDTA member companies are required to undertake the Introduction to Dentistry course within two years of commencement of employment. So when you use a BDTA member company you can be confident that you are dealing with people who are knowledgeable about the industry meaning that you benefit from a more efficient and professional service.

The majority of students who undertake the course feel they have acquired a solid understanding of the basics of dentistry and as a consequence, their confidence to perform their job noticeably increases. It also provides 20 hours of CPD.

For further information on the BDTA Certificate: Introduction to Dentistry, visit www.IntroductionToDentistry.co.uk or contact Maggie on 01494 782873.

Adding value to dentistry

To stay in practice and remain profitable, means developing a team of well qualified, and nowadays registered, staff who can deliver a quality service to patients at an affordable price. This applies whether the practice is NHS, private or a mixture. It is more important than ever to ensure you add value to the practice and, especially in periods of economic downturn, that you receive the best return from your suppliers. Here are just a few ways that BDTA members add value to your business:

High standards
BDTA members are committed to providing the same high standards of quality as you are, when treating patients. The maintenance of high standards is a goal for all who work in healthcare. BDTA members share this aim and by choosing them you will add value to the services you provide for patients.

Service
BDTA members provide excellent levels of customer service, minimising surgery downtime and giving you the confidence needed to operate a busy dental practice. Even in the best run practice things can go wrong and there is nothing more frustrating than sitting on your hands, because of equipment failure, while patients are clamouring for attention.

Research and development
It is sometimes said that any member of the dental team who has been away from clinical dentistry for as short a period as five years, will find it difficult if not impossible to return to seeing patients, such is the pace of development in ideas and technology. Looking back over the past few years, there can be few areas of dentistry, from computers to composites, from radiography to laboratory services, from orthodontics to oral hygiene, where the pace of change has not accelerated.
Adding value to dentistry

When you deal with a BDTA member, you benefit from more than just the clinical freedom to choose from a wide range of dental products and services. **BDTA members...**

- are committed to providing the same high standards of quality as you are, giving you peace of mind when treating patients.

- provide exceptional levels of customer service, minimizing surgery downtime and giving you the confidence needed to run a busy dental practice.

- research and develop new materials, equipment and technologies providing you with more choice and the ability to treat patients more efficiently and effectively.

- provide courses and seminars to support you with the adoption of these innovations within the dental practice.

- are actively encouraged to train their staff ensuring they have the relevant dental knowledge to understand the ever changing needs of the dental team.

Check if your supplier is a BDTA member and search for products and services of member companies on our website [www.bdta.org.uk](http://www.bdta.org.uk)
John Davis receives The British Dental Trade Association Award for outstanding contribution to the dental industry

The British Dental Trade Association is delighted to announce that the award for outstanding contribution to the dental industry has this year been awarded to John Davis.

Described as an inspiration by his peers, John Davis is a gentleman who hardly needs introducing to anyone involved in the dental industry, an industry to which he has devoted much of his life’s work.

Having seen active service as a fighter pilot during World War II, in 1955 he re-established his father and uncle’s company, J&S Davis alongside his wife Hilde. From the humble beginnings of making deliveries using his daughter’s pram, John transformed the company into one of the most respected within the UK dental trade. In 1982 he went on to acquire Claudius Ash, the oldest and one of the largest dental retail companies in Europe. By the time he retired from full time dental trading in 1991, the company was turning over £15 million and had 150 employees.

John is a man of vision who was able to identify the potential of products and services long before they became common practice. Decades before cross infection became a major concern, he introduced Dry Heat Sterilisers and the concept of disposable dental sundries. He also pioneered the 24-hour turn-around dental handpiece repair service, which was then widely adopted by other companies.

John’s accomplishments are not constrained solely to the area of business. He is also known for having demonstrated a ceaseless commitment to charitable work.

John co-founded the British Dental Health Foundation and set up The Cordent Dental Trust. Through Cordent he encouraged UK dental trade contributions to the Phelophepa Mercy Train in South Africa and helped establish the Pankey Organisation in the UK. He was also President of the British Dental Trade Association on two separate occasions, showing a particular awareness of the need to cultivate relations with the smaller, newer companies in the industry.

He was one of the first non-dentists to be awarded the fellowship of the International College of Dentists.

Tony Reed, Executive Director of the British Dental Trade Association, comments, “John has been an inspiration to many. His hard work in both the business and charitable sides of the industry spanned almost 40 years which is a remarkable commitment. Many congratulations to John on winning this much-deserved award.”

The award was presented to John Davis at the BDA Awards and Dinner on 20 November 2008.

The BDTA website can help you

The BDTA is a primary source of information on dental suppliers and brands. When you are trying to source a particular product or replace a piece of equipment, rather than searching aimlessly through the internet, you may find it useful to search the BDTA website www.bdtroad.org.uk.

A search facility has been added to the BDTA website making it even easier for you to search for contact details, products, services and brands of BDTA member companies simply by typing in a keyword. The contact details of over 125 suppliers can be found on the site. Almost 120 product categories are detailed in the product locator under major sections – surgery equipment, surgery sundries, laboratory equipment, laboratory sundries and services. 560 brand names are listed on the website alongside the name of the BDTA member that can supply the product and a link to their website.

The BDTA website should be the first point of reference when you are searching for dental suppliers and products. The website is regularly updated to enable you to access accurate information when you need it.

Check it out for yourself at www.bdtroad.org.uk

Looking for a supplier?

For a full list of BDTA member companies and their contact details visit www.bdtroad.org.uk and click on members directory. Alternatively contact Keri at the BDTA on 01949 781185 to request the latest copy of the BDTA members directory. Remember to quote DT December.

Adding value to dentistry continued from overleaf

BDTA members research and develop new materials, equipment and technologies providing you with more choice and the ability to treat patients more efficiently and effectively as they increasingly ask about alternative treatment options and new products.

Education

BDTA members provide courses and seminars to support you with the adoption of these innovations within dental practice. The GDC requires that registrants should only carry out procedures for which they have been adequately trained and this extends to the use of equipment and materials. It also helps to be familiar with how they work and why.

Dental equipment, materials and services are not pieces of flat-pack furniture that can be assembled with the aid of multi-lingual instructions. You and your team need training in how to use them. This will be provided by your BDTA supplier. Added to the requirement to practise evidence-based dentistry is the requirement for your patients to be properly informed of the choices available and to give their consent to any procedures. Increasingly nowadays they have picked up information from the internet or the popular press about the latest ideas in healthcare. By taking advantage of BDTA members’ courses and seminars you can be better informed to give your patients sound advice.

Training

BDTA members are actively encouraged to train their staff ensuring they have the relevant knowledge to understand the ever changing needs of the dental team. This includes effective and timely response to your queries.

BDTA training courses are available to assist in this process and provide benchmark training standards within the dental industry. The BDTA is also a source of information and advice on training, educational and career issues within the dental industry.

We want to hear from you

E-mail your name, occupation, GDC no and address to kerijakimain@bdtroad.org.uk to register in advance for a complimentary ticket to BDTA Dental Showcase 2009, 12-14 November, NEC Birmingham. The first 100 people will receive a BDTA branded mouth mirror and the chance to win a BDTA Certificate: Introduction to Dentistry training package for your practice. You have until 31 December 2008, so hurry!
Motivating the motivator

Keeping up enthusiasm in a job can be hard sometimes, but we still need to offer a quality level of care no matter what. Mhari Coxon offers some ideas to help you stay motivated

This last month the clinic has been busy. I’m not complaining – what with the credit crunch in full flow, I’m happy that people are still coming for treatment. My colleague has also just left, and now I’m the only hygienist in my practice, and am well aware of the appointment book filling up weeks in advance. To top it all off, my personal life is busy too.

When life is busy like this, it is easy to get a little lax and decide to skip some things to keep on time and make life easier. We can get tired and de-motivated just like everyone else. After all, we need motivation as well as providing it.

Under pressure

This week, a client was my motivator. She had an aggressive periodontal condition and it took several sessions of root surface debridement and a lot of good home hygiene to get her stabilised. When she first attended, as is common with active periodontal cases, she was suffering from a strong oral malodour. She had not mentioned it in her initial interview, and, as she was already motivated to improve her oral health, I chose not to mention it. In this incidence, it was not necessary to use it as leverage.

This visit was for her maintenance appointment and was booked on a particularly busy afternoon and she was my last client of the day. I had just seen three demanding patients in a row, which had left me a little drained and I was conscious of running late.

I carried out the usual run through of the medical history, dental health, stress levels, oral hygiene routine and was seriously considering skipping a bleeding score and not disclosing for a plaque score to make my life easier.

An unexpected boost

Then my patient said that she just wanted to thank me for everything. She was so pleased that I had helped her to stabilise her disease, but was most pleased that the bad breath had gone. She and her friends had been aware of the odour and it had affected her social life quite badly. She had stopped going on dates and avoided large groups where she would need to be close to someone to be heard. She was a receptionist in a large office and she felt self-conscious most days.

Since our completion of initial treatment, she has been speed dating, has joined a dating agency and is enjoying her social life again. She felt this was largely due to the treatment I had carried out and she just wanted to let me know what a difference I had made in her life.

I went from being a shrunken husk of a hygienist rushing to get home, to bursting with energy and enthusiasm. I may even have had a wee tear in my eye. Needless to say I did do that bleeding and plaque score and she was doing well.

Realistically, most clients are busy and although they appreciate what we do, they might not have the time or the notion to boost our motivation by saying thank you.

Maintaining the motivation

One way to help keep your care consistent for your clients is to work out what will be involved in an appointment with you. Will you always disclose? (I would say yes to that). What about pocket charting? Once a year? Anything over 4mm measured each visit? There is no end to the information we can document, but there is an end to the appointment.

In our practice, we use a protocol system so we have a clear guide to how we care for the patients. This helps us to monitor the quality of care we give our patients.

Another tool to help keep yourself motivated might be to join a hygienist discussion group. Try visiting www.hygienist.co.uk, a website set up by hygienists to interact with other peers. It is free to join and can be a great way to discuss your clinical dilemmas or just have a chat. A big advantage is that you can log on at any time of the day and spend five minutes if that is all you have to spare. There are other professional websites available so it is worth a look.

Whatever method you choose, remember that you are human. It’s all right to lack enthusiasm sometimes, but we still need to deliver a quality level of care. That is what makes us professionals – and great ones at that.

Mhari Coxon

is a dental hygienist practising in Central London. She is chairman of the London British Society of Dental Hygiene and Therapy (BS-DHT) regional group and is on the publications committee of its journal, Dental Health. She is also clinical director of CPDforDCP, which provides CPD courses for all DCPs. To contact Mhari, email mhari.coxon@cpdfordcp.co.uk.
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At the Dental Arts Studio, our infrastructure is made up of sound practice policies and procedures to guide and direct all staff in their daily duties, creating a streamlined routine for both the nurses and the dentists.

Each member of staff should be given a job description at the onset of employment, which immediately explains what is expected of them. They would also have had a full induction to the practice, which settles them in.

Noticing individuals
Recognising each team member’s role and their importance within the team, builds up a healthy respect among staff. Those who are treated with respect will in return offer respect. As a practice manager, you should adopt a ‘lead by example’ attitude in managing your team.

Communication is another key factor that can either make or break a team. When you are giving your team instructions, remember to talk to them and not at them. There’s nothing worse than feeling that you are being spoken down to, especially when the practice manager may be younger than the dentists or more senior nursing staff.

Remember – communication is not just about talking, it is also about listening. Staff must also feel that they can approach you and not feel that you are dismissing them when you’re busy. This could cause a breakdown in the practice, which will eventually affect all of your staff.

Learning to say thanks
At the Dental Arts Studio, we have a ‘Staff Member of the Month’ programme, whereby we reward our staff with a gift voucher for a beauty treatment. We present awards during staff meetings, and we offer our thanks and appreciation. I have seen the difference this makes to the winning staff members.

Always take the time to say thank you to your staff for the contribution they make. Even when you have a tough day and have had to lean on staff for support, you must find time to thank them.

We have recently introduced regular meetings into our weekly agenda. Every morning, the reception staff at the Clapham Junction practice meet at 8.30am, and the practice manager sets the agenda for the day.

Mid-week, a staff meeting is held for all the dental receptionists and dental nurses. A separate mid-week financial meeting is held with the dentists. You’d think with all these meetings in place, the practice would run like clockwork... well, as often say, expectation can lead to disillusionment...

‘Shosholoza’ as we say in Africa... Go forward!

To go forward successfully, it’s essential to have a happy dental team. To create and mould a happy dental team takes a sound infrastructure with regards to practice management, which in turn takes time, dedication, perseverance and a lot of self-discipline, says Sharon Holmes.

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ment. These are all baby steps leading towards GOING FORWARD!

The staff are not always keen to participate in meetings, so it is extremely important you make these meetings meaningful and educational. I have also found that if you let the team help you create better systems, they feel involved and as though they have achieved a goal if the system works.

Is everyone listening?
If you find yourself having to repeat yourself over and over again as staff are not doing what you are asking of them, you need to take a constructive approach and analyse why they are not listening to you.

If someone is not sure of what they are doing, take the time to go through the process with them again and give them tools to help them to achieve what you have set out. Sometimes it may take “micro-management” for a while. For example, we have lab books in the surgery and also in the reception area.

The lab books in the surgery let nurses know where their lab work has been sent and when it is due back. The nurses look at this lab book every day to ensure that the work due has been delivered.

For some reason though, the nurses don’t make use of this tool. If you are aware of this and lab work is continually late, the situation may need monitoring. For a period of time, you should keep tabs on the treatment that has taken place during the day and ask the nurse to show you they’ve written up their lab book at the end of each day.

This may sound petty and painful but I ask myself, which is worse – an angry patient or a nurse who knows they are being monitored. If the nurse still does not respond at this point, you need to take a closer look at the person’s attitude and decide what is best for the practice and the team.

Horses for courses

Over the years, I’ve learned that not all people are like-minded and at work you are going to have a different mix of employees. Some people can deal with directness, while others are more sensitive and require a more gentle approach.

There is nothing more worthwhile than seeing a member of staff flourish and it makes me proud to know that perhaps I had a small part to play.

Remember – a happy team is a productive team. As Winston Churchill once said: ‘Never give in, except to convictions of honour and good sense’.

Always remember to applaud your staff for their hard work.

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Originally from South Africa, Sharon Holmes moved to the UK in 2002. She thoroughly enjoys her position as business development manager at the Dental Arts Studio and her role in the dental industry, which has moulded her into a winner in her field. She believes that her position is based on common sense.
The effects of enlarged adenoids on a developing malocclusion

By Dr Derek Mahony and Dr Kevin Williams

Abstract

This article reviews upper airway obstruction caused by hypertrophied adenoids and the possibilities of a subsequent malocclusion. Early diagnosis, and treatment, of pathologica conditions that can lead to the obstruction of the upper airways is essential to anticipate and prevent alterations in dental arches, facial bones and muscle function. Correct nasal breathing facilitates normal growth and development of the craniofacial complex (Fig. 1). Important motor functions such as chewing and swallowing depend largely on normal craniofacial development. Any restriction to the upper airway passages can cause nasal obstruction possibly resulting in various dentofacial and skeletal alterations. Upper respiratory obstruction often leads to mouth breathing (Fig. 2). Habitual mouth breathing may result in muscular and postural anomalies, which may in turn cause dentoskeletal malocclusions (Fig. 3, 4). Hypertrophy of the adenoids, and palate tonsils, are one of the most frequent causes of upper respiratory obstruction (Fig. 4). Philosophies regarding the treatment of adenoid hypertrophy range from dietary considerations to dentofacial orthopaedics, change of breathing exercises, and surgical procedures.

Introduction

The aims of this article are to highlight the skills and tools that assist the clinician in identifying upper airway obstruction; to improve the diagnosis of adenoid hypertrophy; and to improve the classification and treatment of associated malocclusions.

The methodology used in this literature analysis consists of a thorough review of narrowly-tailored research and journal articles. The paradigm explored in each article involves upper airway obstruction, adenoid hypertrophy and malocclusion. The results and conclusions stemming from these analyses are summarized in Table 1.
The research in this area is expansive, but largely inconsistent. Thus, the cause-and-effect relationship of adenoid hypertrophy and malocclusion must be carefully examined on a case-by-case basis. Regardless of the various researchers' conclusions, one theory remains common—that airway obstruction caused by adenoid hypertrophy and malocclusion are related. The degree of that relationship and what it affects is still under debate. This paper attempts only to highlight the positive existence of this relationship and its possible effects regarding dentofacial growth and development.

### Basic facial growth and development

Developments in the understanding of human craniofacial growth have stemmed from histological and embryologic studies, radiographic cephalometry, correlation of growth and facial anomalies analysis of surgical interventions, animal research and other science fields. Despite these studies, we are still waiting for a definite consensus regarding the controlling mechanism of craniofacial tissue.

Postnatal facial growth is influenced by genetic and environmental factors. Most facial growth and development occurs during the two childhood growth peaks. The first growth peak occurs during the change from primary to permanent dentition (between five and 10 years of age) and the second growth peak occurs between 10 and 15 years of age. The study of the early years of life shows that by the age of four, 60 per cent of the craniofacial skeleton has reached its adult size. By the age of 12, 90 per cent of facial growth has already occurred. By age seven, the majority of the growth and development of the maxilla is complete and by age nine, the majority of the growth and development of the mandible is complete. Proper facial growth is affected either positively or negatively, early in life, by the sequential occurrences of four major factors:

- The cranial base must develop properly.
- The maxillary complex must grow down and forward from the cranial base.
- The maxilla must develop in a linear and lateral fashion.
- A patent airway must develop properly.

The relationship between the naso-maxillary complex and the cranial base is significant for aesthetic reasons and proper facial, bone, muscle and soft tissue support. To allow proper downward and forward rotation of the mandible, the maxilla must be adequately developed, in width, for acceptance of the mandible. Any limitation on mandibular rotation may affect the relationship of the condyle to the glenoid fossae (in the temporal bone) resulting in multiple TMI problems. An improper airway will affect the global individual growth. The simultaneous growth of these factors is not nearly as significant as how these factors interrelate during facial growth and development. For example, the basic design of the face is established by a series of interrelated factorial developments. The naso-maxillary
complex is associated with the anterior cranial fossae. The posterior boundary of the maxilla determines the posterior limits of the midface. This structural plan is beneficial to facial and cranial development. The basic structural format of facial growth and development is dependent on, and governed by, the interrelation of multiple functionally and anatomically independent patterns of development. These functional matrices include a phenomenon of bone displacement and movement that the maxillary forward and downward movement equaling mandibular growth upward and downward. The displacement and growth phenomenon is responsible for the spatial relationships necessary for functional joint movement resulting in the final result of facial growth. Additionally, muscle adaptations affect dentoalveolar development. The integration of the musculoskeletal system affects respiration, mastication, deglutition, and speech.

This basic understanding of facial growth and development is relevant as atresial tissue enlargement coincides with major facial growth, for example, they occur simultaneously. Facial growth may be restricted by abnormal development of adenoidal tissue resulting in abnormal swallowing and breathing patterns (Fig. 5).

Adenoidal growth and development

Adenoidal tissue is normally present as part of the Waldeyer’s tonsillar ring in the form of a nasopharyngeal tonsil (Linder-Aronson 1970). The Waldeyer’s ring is the system of lymphoid tissue that surrounds the pharynx. This system of tissue includes adenoids and pharyngeal tonsils; lateral pharyngeal tonsils; lateral pharyngeal bands; palatine tonsils and lingual tonsils (Fig. 6). Tonsils and adenoids have disparate embryonic origins and cytology even though they are both part of Waldeyer’s ring. Bacteria may play a role in adenoid hyperplasia. Specifically, different pathogens such as Haemophilus influenza and Staphylococcus aureus, have been associated with lymphoid tissue hyperplasia. The adenoid lymphoid structures are lined with ciliated respiratory epithelium which is normally distributed throughout the upper and posterior nasopharynx walls. During the presence of disease, the distribution of the dentritic cells (antigen presenting cells) is altered. The result is that there is an increase in dendritic cells in the crypts, and extracellular areas, and a decrease in surface epithelial dendritic cells.

Lymphoid tissue is normally not apparent in the early infant stage of life. Marked symptoms of adenoid development are most common in the childhood age range of two to 12. During adolescence, a decrease in adenoid size is noted as current with the growth of the nasopharynx. Occasionally adenoid tissue present in adults and when it is noted it is usually in an apathetic condition. The cause of the involution of the Waldeyer’s ring is still under investigation. The imbalance in the relationship between the enlargement of the nasopharynx/nasopharyngeal airway and the concomitant growth of adenoid tissue can result in reduced patent nasopharyngeal airway and increased nasopharyngeal obstruction.

The growth of adenoidal tissue as demonstrated by a bell curve, peaks at near age six and also begins involution at or near this age as well (Fig. 7). Facial growth is coupled with adenoidal growth. As the cranial base forms the roof of the nasopharynx, a close examination of the growth and development of the craniofacial complex becomes significant for evaluation of the size and configuration of the nasopharyngeal airway. Any abnormal development regarding this craniofacial complex may affect the nasopharyngeal airway. Abnormal adenoidal growth that occurs during childhood, may consume the nasopharynx and extend through the posterior choanae in the nose. This excessive adenoidal growth usually interferes with normal facial growth and can result in abnormal breathing patterns, congestion, snoring, mouth breathing, sleep apnea. Eustachian tube dysfunction/obits media, rhinonasal, nasal deformities, swallowing problems, reduced ability to smell and taste, and speech problems. Theoretically, many clinicians believe the blockage should be removed as soon as possible through a surgical procedure called adenoidectomy. However, according to a study conducted by Ivas and Lowinger one-third of child study patients, with traditional adenoidectomies, were ineffective with intranasal extensions of the adenoids obstructing the posterior choanae. For this segment of the study population the “powdered-shaver adenoidectomy” was effective in the complete removal of the obstructive adenoid tissue ensuring postural patency.

Upper airway obstruction and mouth breathing

During normal nasal respiration, the nose filters, warms and humidifies the air in preparation for its entry into the body’s lungs and bronchi. This nasal airway also provides a degree of nasal resistance in order to assist the movements of the diaphragm and intercostal muscles by creating a negative intrathoracic pressure. This intrathoracic pressure promotes airflow into the alveoli.

Correct normal resistance is 20–55 cm H2O/L/sec and results in high tracheobronchial airflow which enhances the oxygenation of the most peripheral pulmonary alveoli. In contrast, mouth breathing causes a lower velocity of incoming air and eliminates nasal resistance. Low pulmonary compliance results. According to blood gas studies, mouth breathers have 20 per cent higher partial pressures of carbon dioxide and 20 per cent lower partial pressures of oxygen in the blood, linked to their lower pulmonary compliance and reduced velocity.

Contributing factors in the obstruction of upper airways include: anatomical airway constriction, developmental anomalies, macrognathia, enlarged tonsils and adenoids, nasal polyps and allergic rhinitis. However, for purposes of this paper the focus shall be on enlarged adenoids as the major contributing factor. There are numerous studies that link adenoid hypertrophy with nasopharyngeal airway obstruction to the development of skeletal and dental abnormalities.

Airway obstruction, resulting from nasal cavity or pharynx blockage, leads to mouth breathing which results in postural modifications such as open lips, lowered tongue position, anterior and posterior inferior rotation of the mandible, and a change in head posture. These modifications take place in an effort to stabilize the airway. As previously discussed, facial structures are modulated by postural alterations in soft tissue that produce changes in the equilibrium of pressure exerted on teeth and the facial bones (Fig. 8). Additionally, during mouth breathing, muscle alterations affect mastication, deglutition and posture. These and other muscles are relied upon.

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Malocclusion – the issue still in debate

Dentofacial changes associated with nasal airway blockage have been described by CV Tones in 1872 as adenoid facies. Tones considered this based on his belief that enlarged adenoids were the principle cause of airway obstruction and resulted in noticeable dentofacial changes.1 Tones reported that children, who were mouth breathers, often exhibited narrow V-shaped dental arches9 (Fig. 9). This narrow jaw is a result of mouth breathers keeping their lips apart and their tongue position low. The imbalance between the tongue’s pressure and the muscle in the cheek, result in cheek muscles compressing the alveolar process in the premaxillary region. Simultaneously, the lower jaw posture back (Fig. 10). These two multiharmonic actions have been termed the compensatory theory.10 Tones’s views were supported in the 1950s by numerous leading orthodontists. These supporting clinicians reported nasal airway obstruction as an important etiological agent in malocclusion. Rubin advocated that in order for these patients to fully be assessed they must be thoroughly evaluated by both a rhinologist and orthodontist.11 Malocclusion is the departure from the normal orientation of the teeth in the same dental arch or to teeth in the opposing arch.12

Airway obstruction, coupled with loss of lingual and palatal pressure of the tongue, produces alterations in the maxilla. The position of the tongue also plays an important role in mandibular development. The tongue placed downward can lead to a retrognathic mandible; and an interincisal space can lead to anterior occlusal anomalies.13

Additionally, maxillary changes can be viewed in the transverse direction, producing a narrow face and palate often linked with cross bite; in the anteroposterior direction, producing maxillary retraction; and in the vertical direction causing an increase in palatal inclination as related to the cranial base and excessive increases of the lower anterior face height. The most commonly found maxillary retractions are cross bite (posterior and/or anterior), open bite, increased overjet, and retroclina-

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Clinical

and Linder-Kronzon’s findings were in agreement with the significant correlation between changed mode of breathing and diminished mandibular/palatal plane angle (ML/NL) found in adenotonsilomised children.14

Several authors have taken the position that alleged faces are not consistently found to be associated with adenoids, mouth breathing, nor a particular type of malocclusion; and that there is no cause and effect relationship between adenoids, nasal obstruction/mouth breathing and malocclusion.

Proponents of this position believe that the V-shaped palate was inherited and not acquired through mouth breathing. Hartsook (1946), on a review of literature related to mouth breathing, concluded that mouth breathing is not a primary etiological factor in malocclusion. Additionally, Whitaker (1911) found that in a study of 800 children, who underwent adenoidectomy or tonsillectomy only 30 per cent had dental anomalies that needed orthodontic intervention. There is some suggestion that adenoids and hypertrophied tonsils are a consequence of a thyroid hormone deficiency. This hormone deficiency acts as a catalyst for activating the organism’s defense mechanisms, which include hypertrophy of lymphoid tissue.15 Another orthodontic clinician, Vig, took the position that without documented total nasal obstruction, any surgery or other treatment to improve nasal respiration is empirical and difficult to justify with an orthodontic point of view.1,17

Nasal respiratory evaluation

The relationship of airway obstruction and dentofacial structures/malocclusion is still the subject of investigation and controversy amongst orthodontists. The correlation between functional problems and morphologic characteristics is yet to be solidified. Regardless of varied opinion in this area practitioners should observe each patient carefully.

Suggested protocol

As the patient enters the room, facial and head posture should be noted to see if the lips are closed during respiration. Signs of allergic rhinitis should be noted, as well as histories of frequent colds or sinusitis. Assessment of family history for allergies is important. Sleep history should be evaluated: sleep apnoea, loud snoring, open-mouth posture while asleep.

Patient is asked to seal their lips – difficulty breathing through nose should be noted. One nostril can be occluded and the response noted – same procedure on the other side. (Fig. 11)

The evaluation of nasal airway patency is complicated, especially when the possibility exists that airways may clinically appear inadequate but be quite functional physiologically. Lip separating or an open-mouth habit is not an infallible indicator of mouth breathing. Often complete nasal respiration is coupled with dental conditions that cause open-mouth posture.16

Adenoid evaluation

Nasopharyngeal space and the size of adenoids have been evaluated using different methods of assessment:

1. Determination of the roentgenographic adenoid/nasopharyngeal ratio (a lateral cephalometric xray)
2. Flexible optic endoscopes (Fig. 12)
3. Acoustic rhinometry
4. Direct measurements during surgery.

Direct measurements are considered to be the most accurate because space can be assessed in three directions.12 A lateral cephalometric radiograph is an added valuable diagnostic tool for the orthodontist in the evaluation of children with upper airway obstructions18 (Fig. 15).

Treatment of nasal obstruction

Adenoidectomy with or without tonsillectomy is indicated if hypertrophied adenoids (and tonsils) are the cause of upper airway obstruction.19

Powered-Shaver Adenoidectomy – Adenoidectomy coupled with Endoscopic Visualization technique allows for better clearance of obstructive adenoids. The end result is more reliable restoration of nasal patency.20

Conclusion

The effect of adenoids on facial expression, malocclusion and mode of breathing has been a topic of debate and investigation by practitioners in the field for the last one hundred years. A review of the literature exposes several theories.

A healthcare provider, with a practice philosophy based on prevention of malocclusion development, cannot ignore the early years of the patient’s growth cycle. By age twelve, 90 per cent of facial growth has already occurred. This is the age when many practitioners begin orthodontic treatment.1 This is the age when 80-90 per cent of craniofacial growth is complete, so most formation and/or deformation has occurred.21 To wait until 90 per cent of the abnormality has occurred, before beginning treatment, is not consistent with a preventive philosophy. Interceptive measures must be initiated sooner. Early intervention requires an acceptance of a multidisciplinary approach to total patient health. An integrated approach to patient evaluation, diagnosis and treatment is most effective. Primary care physicians, dentists, allergists, otolaryngologists, and orthodontists must all work together for early prevention and management of young patients with increasing nasal airway resistance.

After diagnosis, a comprehensive risk benefit analysis regarding early intervention must be considered. Although hereditary and environmental factors must be considered, the unifying goal is the promotion of proper nasal respiration throughout a child’s early years of facial growth.

Figure 15 (a–f) shows the before-and-after treatment results of a young girl who had adenoids removed, and then underwent maxillary expansion before full-fixed braces. She was treated as a second opinion against the removal of four premolar teeth to relieve dental crowding.

References

1. Maltiar, SE, Anselmo-Lima, WT, Valema, FC and Matsumoto, MA, Skeletal and Ocular Characteristics in Mouth-Breathing Pre-


LOGOS JUNIOR Sprido

- THESI 2 chair with 4+2 programs
- LUNA operating light
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B - MULTIMEDIA PACKAGE
- VIDEORCAM 2 SYSTEM with intra-oral camera
I t's never too long before a group of dentists start talking shop. As an NHS dentist, I've noticed that the introduction of the new contract, much of this shoptalk has been about the system, rather than the work done within it. Some dentists appear to have been minimally affected, but others are struggling with providing vast quantities of work and are still not meeting their targets.

In May 2006 the BDA asked PCTs across England for factual information about their PDS arrangements. The information concentrated on the amount of dental care commissioned by the PCT, contract values, numbers of contracts taken up and numbers of contracts dispute. For those PCTs that responded, we can see that average UDA values vary staggeringly across the country, from £14/UDA in Durham and Chester-Le-Street to £65/UDA in Sheffield West. Apart from the matter of fairness, this begs the question of whether the Government can be sure that this is the right number of treatment bands should be, but I think we can all agree three is not the magic number.

Diminishing trust

Many dentists have lost faith in the Government’s ability to fairly allocate funding across the UK and see this system as a massive oversimplification of what is actually needed to provide dental healthcare. Nothing epitomises the failures of the new contract more than the effect it has on those people who require dental healthcare the most. As I sift through the numerous reports on the working patterns of NHS dentistry, we are constantly made aware that access has not improved, less complex dentistry is being carried out and there are financial incentives to under treat.

Dentists have now been put in a tense position when taking on new patients. On the one hand, dentists need to meet their targets, regardless of how unrealistic these might be. On the other hand, a few high-risk patients can absorb much of the dentist’s time for little reward. Instead of a clear set of workable guidelines, what we are faced with is a variety of murky solutions that cast a dark shadow over the core ideals of the new contract. As a profession, we can all see the need to realistically define the amount of work a dentist should provide per course of treatment. Unless the profession can see transparency and fairness in the new contract, it will be difficult to stop the current erosion of faith in the NHS.

Changes to work patterns

Since the introduction of the new NHS contract, it has become clear that the working patterns of many have changed. When we look at the management of high need patients, we can see that what is being provided can vary considerably between dentists, practices and even postcodes nationwide. As a result of the changes, community dentistry and secondary dental care have become swamped with an increase in referrals of patients needing complex treatment. The Health Select Committee has been concerned that this could have an adverse effect on those patients who have been traditionally treated in these settings. Little has yet been done to return patients back to primary dental care. Dentists who refer high need patients not only free up much of their time to chase targets but also in many cases are able to claim for the full course of treatment without providing it themselves, as directed by the Department of Health’s (DH) Factsheet 15: Referrals to other practitioners. While all high trust environments are open for abuse, by placing targets on treatment, this has also placed limits on capacity and many feel they simply do not have the capacity to meet their UDA targets.

Testing the water

Many in the profession argue that the commissioning of dentistry through the UDA system needs to be re-investigated by the DH. It was clear that the old GDS charging system needed simplification for the benefit of patients and dentists needed a system where they could provide clinical care with unbiased judgment rather than that dictated by the NHS. There was certainly no question that reform was needed, but given its importance, surely by now the DH must regret not piloting these reforms first.

Like it or not, there is a clear link between the way dentistry is funded and the type of treatments dentists are able to provide. Much of the initial promise of this new contract has now faded and what we are left with is more than just a few teething problems. But there is still much about the new contract that, with reform, could improve dentists’ working lives and the patient’s dental experience. The simplification of the charging system is in essence a good idea. I also see certain aspects of the new contract, such as being able to now charge for small posterior composites on the NHS and having the freedom to see patients more regularly if I feel it is necessary. But I, like many others, feel uneasy simplifying the system into bite-sized pieces. NHS dentistry had eroded to just that. By only having three bands, even a layperson can see that turning corners will be tight and a squeeze will be felt. We would all have different opinions on what the right number of treatment bands should be, but I think we can all agree three is not the magic number.

So with a few modifications, we must hope that this system can deliver dentistry with a better degree of fairness. For this to happen though, the Government must urgently take into consideration the concerns of the profession and patients. Let us hope that it hears the recommendations of dentists, patients and MPs and not only has the desire to change, but also the funding.
KaVo ESTETICA E80 T/C

The KaVo treatment unit ESTETICA E80 with its innovative suspended chair concept can be optionally adapted to the everyday needs of the dental practice. Both the dentist’s and assistant’s elements are provided with a configuration and an ergonomically perfect instrument layout ready for the future. The new AL 762 motor with optional endo-function, and the possibility of integrating the surgery motor SL 550, makes additional, expensive instruments superfluous. The integral communication system ERGOnom 4 connects the ESTETICA E80 to the practice system and delivers information directly to the treatment area. USB interfaces at both the dentist’s and the assistant’s elements enable USB suitable equipment to be connected to the unit at any time.

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For information or to arrange a visit from a KaVo Equipment Specialist, regarding the full range of KaVo products and services including dental units, handpieces, imaging products, surgery planning, cabinetry and flexible finance please contact us on Freephone 0800 218020.

Dental Art

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Prices and designs are available from A-dec dealers and an example of the cabinetry available can be viewed at select A-dec showrooms. Please contact A-dec for more details on 02476 559091.

The BOS reviews some annual highlights

On Reflection

2008 saw The British Orthodontic Society’s (BOS) Chairman Dr Iain Lathborn address a Parliamentary Health Select Committee at the Houses of Parliament as it continued its strong political lobbying to petition for a more sustainable, fair and consistent orthodontic provision across the country.

The BOS Annual Conference took place between 14-16 September 2008 and attracted a substantial number of members to Brighton.

Each year, an outstanding contributor to the world of orthodontics is invited to give the Northcroft Memorial Lecture at the Conference. This year was no exception when Dr Nigel Harradine, Chair of the BOS’ Chairman Elect presented a perceptive address on ‘self-ligation: past, present and future’.

On the International front, the BOS will attend the 7th IOC Symposium during the 14th European Orthodontic Society (WFO) and will be hosted by the Australian Society of Orthodontists.

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Heka Dental are inviting Dentists to visit Wonderful Copenhagen to see their fantastic design and production facilities, as well as their beautiful city. They will be arranging several trips a year, which will normally run from Thursday morning to Saturday afternoon. During which time their guest will have an opportunity to visit their factory as well as enjoy some of the delights of Wonderful Copenhagen. If Dentists order a Heka Dental package before or during the trip, their visit (including flights, hotel, lunch and dinners) will be free. If they do not, they will only pay for the flight and hotel.

Incorporating the latest Treatment Centre Technology, Heka Dental’s UNCIC is the ultimate embodiment of feedback from patients, dentists, dental technicians and service engineers.

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Heka Dental equipment is available in the UK from Dental Services Direct, telecom 01586 277278 or visit www.heka-dental.dk for further information.

100th Aseptico Unit

Velopex the UK Distributor for the Aseptico range of portable dentistry products have just installed the 100th item from the extensive range, a Transport II Mobile Surgery Unit.

Secure Your Future with CEREC

One tried and tested method of raising revenue whilst trading in difficult times is to offer your patients something that they cannot necessarily get from other dental practices locally which has a real advantage for the patient. This is achievable with the CEREC CAD/CAM System from Sirona Dental Systems Ltd.

CEREC is proven to increase profits plus it adds the ‘wow’ factor to any practice. CEREC enables you to provide your patients with same day crowns, bridges etc without the expense and inconvenience of waiting for the laboratory to construct the prosthesis. The finished prosthesis is immediately aesthetic, exhibiting excellent strengths and the margins are superb too. CEREC accurately captures the occlusal contacts saving you from making any further adjustments.

Using CEREC allows you to produce perfect chairside ceramic restorations in the same visit whilst saving you and your patient time, laboratory fees and ultimately making your business more profitable.

To find out how the Sirona team can directly support your practice and for a no obligation demonstration of the CEREC 3D system telephone 0845 071 5040 or email: info@sironadental.co.uk or visit www.sironadental.com

Another exciting new chair for dental services direct

When the time comes to buy a new dental chair the variety can be daunting. You’ll need to consider things like; patient comfort, ease of use, the ability to incorporate other equipment such as monitors and handpieces and what type of upholstery you would prefer.

Dental Services Direct have a wide selection of chairs and delivery packages from many major manufacturers and their experience and understanding of the dental trade can help make your decision swift and painless. Their exclusive agreements with both Anacor and Heka combined with packages from Anthos, Belmont, and DentalEZ mean there is some to suit every budget.

For further information on the TR Series and all other available chairs contact your local Dental Services Direct sales office: Scotland & the North 01442 269301; Scottish 01442 269350, South 0845 260 550, South West 0845 260 550.
The handpiece of the R&S Ultrasonic Scaler is cast from titanium alloy to ensure sound mechanical function and durability.

The scaling tips are designed to ensure easy cleaning of the tip from cream and are available in an assortment of patterns so subgingival tartar is now easy to eliminate. Replacement tips are competitively priced from just £19.95 + VAT, in a range of 5 patterns for ease of use. The lead wire of the R&S Scaler is made from silica gel, it is soft, flexible and most importantly, durable.

With electric-magnetic controllable water, the R&S Ultrasonic Scaler is easy to use and will not drain your patients making the whole scaling experience more comfortable for you and your patients.

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Sident Dental Systems’ NEW Teneo Treatment Centre offers many exceptional innovations and is designed to reduce the operator’s workload, leaving them free to concentrate on the patient instead.

It offers clinicians simple and intuitive operation via its EasyTouch user interface, wireless foot control for optimum flexibility without cable clutter, intuitive and dynamic seating via the HUGO stool, and an array of patient communication and entertainment tools.

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Highline bespoke healthcare storage solutions, from Support Chair, are the ultimate answer in mobile storage systems.

Available in a choice of nine formats they are extremely versatile and meet the exact storage requirements for each and every individual. Probably the reason why Highline cabinets are becoming so widely used in clinics, surgeries, laboratories and treatment rooms.

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Supported by the Australian Physiotherapy Association, the Bambach Seat is available in a range of 10 vinyl colours, 16 hard wearing leather as well as 5 pure new wool to perfectly match your décor.

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For further information please contact Bambach directly on 020 8522 5100.

Oral probiotic counteracts bleeding gums by interacting with the immune system

A new study confirms that the oral probiotic marketed by Sunstar as GUM®PerioBalance in the UK and produced by BioGaia containing Lactobacillus reuteri Prodentis reduces gingivitis (inflamed gums). The study also shows that the Lactobacilllus reuteri Prodentis can interact directly with the human immune system to reduce inflammation.

Professor Tveitman says “The importance of this study is not only that it supports earlier findings that L. reuteri Prodentis can be effective in the treatment of gingivitis, but also that it points towards an extended mechanism of action beyond the ability of fighting off pathogens. Our immune system involves mediators that promote inflammation when they are “turned on”. Our results suggest that these mediators can be down-regulated by L. reuteri Prodentis.”

In the study, 42 subjects with moderate gingivitis were randomly assigned to receive either chewing gum containing Lactobacillus reuteri Prodentis. The number of bleeding sites was reduced in both groups taking Prodentis chewing gums, by 85%.

For more information about GUM® PerioBalance visit www.sunstargum.co.uk. The product is available for dental wholesalers including Dental Shop, visit www.dentalshop-wholesale.com.

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Luke Barnett began his career in Technical Dentistry and specialised in dental ceramics. He set up his own business in 1985, now a state of the art facil-
ity in Watford, Hertfordshire. Luke is on the Sub Committee and Board of Examiners with the BACD and the Laboratory Com-
mittee Board of Directors, and a sustaining member of the Amer-
ican Academy of Cosmetic Den-
tistry.

Whilst being passionate about general Crown and Bridgework, his approach to cosmetic dental treatments in-
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Children’s Practice Benefits with PracticeWorks

Toothheary Ltd, located in Richmond upon Thames is a state-of-the-art dental practice dedicated to the treatment of children. It adopts the funda-
mental philosophy of making each visit fun, eliminating worry and promoting optimum and lasting oral health.

 Principals Dr. Cheryl Lee Butz and Dr. Nicole Sturzen-
baum began developing the highly anticipated practice back in 2006. Having already es-
tablished a successful child-
ren’s practice in Germany, Dr. Butz was amazed there were few private, child-focused den-
tal practices in England.

Incorporating the best possi-
ble external materials, the prac-
tice needed the same high stan-
dards internally. The practice decided on the BACD’s Integrated Den-
tal Practice Management Soft-
ware from leading providers PracticeWorks as it was the per-
fert solution to accommodate the logistics and legal issues of a child-only practice.

B4 is the perfect choice for the next generation practice as the software allows all appoint-
ment books, clinical charting and notes, accounts and med-
ical records to be stored cen-
trally and access easily elimi-
nating any added stress.

IDH Celebrate 10-Year Milestone

Integrated Dental Holdings (IDH) would like to congratulate the Keighly team reaching their 10-year milestone. Being com-
mitt ed to professional stan-
dards, achieving results and above all teamwork are just some of the qualities that have helped the Keighly team achieve this monumental success.

As one of the UK’s leading dental groups with 2 million pa-
tients and a network of over 250 practices nationwide, IDH offer outstanding resources and sup-
port with patient-focused prac-
tices and always offer superb service.

This is an incredible accomplish-
ment and IDH would like to thank the team for all their ef-
fort and dedication. They have worked extremely hard and have constantly provided qual-
ity service all these years. IDH look forward to celebrating the new 10 years with the team.

With over 1500 profession-
also including over 850 dentists, IDH has a support infra-
structure and facilities like no other dental group. No one will work harder to ensure these high standards are delivered.

To find out more about IDH, please call Gemma Bradshaw on 01204 799 751 or email: info@integratedden-
tal.co.uk.

To sit in comfort everyday, please contact Evident on 0800 5121111 or visit www.evident.co.uk.

To find out more about IDH, please call Gemma Bradshaw on 01204 799 751 or email: info@integratedden-
tal.co.uk.

For more information please contact Paterson Health Group on 01594 855007 or e-mail sales@paterson.ltd.uk.
The unique Florida Probe® will speak volumes about your practice...

Elegant, yet ergonomically designed, the Florida Probe® is the complete electronic probing and charting system which enables a single operator to complete a simple or comprehensive periodontal exam in less than 10 minutes. The results are recorded by computer as well as “spoken” so the measurements do not have to be called out to another person. And as an added bonus, the patient’s current exam data is compared automatically to their last Florida Probe exam clearly indicating where treatment is needed.

The probe exerts a constant pressure so no matter who operates it, dentist or hygienist, the same pressure is applied ensuring accuracy and reproducibility between users. Exams can be customised to record all or any of the following: medical history, risk assessment, recession or hyperplasia, pocket depth, bleeding, suppuration, furcations, plaque, mobility, MGJ and diagnosis.

The probe is the most accurate and consistent available. Precision is within 0.2mm, depth range is 0 to 11mm (up to 13.2mm with the special long tip probe option). The Florida Probe software offers patient education videos and handouts, a risk assessment summary, print-outs of the periodontal chart and much more. Now available in the UK exclusively from Clark Dental, the Florida Probe gives the patient a unique experience, enhancing treatment acceptance. And gives you and your practice, precise and accurate information no matter who uses it.

Call Clark Dental today on: 01268 733146 to arrange an in-practice demonstration and find out more about the “talking probe” - it’s well worth listening to!

Clark Dental, 6 Victory Close, Fulmar Way, Wickford, Essex SS11 8YW
Tel: 01268 733146 Fax: 01268 769209 E-mail: clarkdental@aol.com
Dental Tribune special offer

Boost your skills while on holiday as part of a Jon Baines study tour. What’s more, Dental Tribune has organised a very special offer exclusive to readers.

If you’ve ever wanted to visit the beautiful country of Vietnam, there’s no better way to enjoy it than on a Jon Baines study tour. The particular trip to Vietnam combines cultural experiences, visits to places of professional interest as well as a number of specialist dental visits and lectures from Dr Ashok Sethi, which contribute to your annual CPD requirements. What’s more, partners are welcome and the tour is tax deductible due to its professional nature.

What to expect

To give you an idea of what to expect, the tour begins in Hanoi, where you will take a walking tour of the Old Quarter, followed with a visit to a dental hospital and the first of Dr Sethi’s lectures. The next morning you drive through the Red River Delta, and then back to the hotel for the second of Dr Sethi’s lectures. From Hanoi you will depart for Halong Bay, and board the floating hotel Emeraude for a cruise around the bay. In the evening you fly to Hue, Vietnam’s former capital, where Dr Sethi will give a lecture entitled ‘What treatment options do our patients have?’

The next day begins with a lecture on ‘Decision making for predictable outcome’, after which you take dragon boats on Hue’s Perfume River, to Emperor Ming Mang’s mausoleum. From Hue, you drive to Danang to view the Cham Museum and then to the fishing town of Hoi An, continuing south to Ho Chi Minh City. The next day you drive deep in to the lush surrounds of the Mekong Delta, then returning to Ho Chi Minh City for a farewell meal, before flying home or on to the Cambodia extension (see below).

Cambodia extension

If you have extra time, the two-day extension to Cambodia takes you to the awe-inspiring Angkor temples and the refined Victoria Angkor Resort. You will also take a boat ride out to Lake Tonle Sap, with its floating homes.

Tour details

The tour departs on January 31 2009, returns on February 13 2009 and costs £2,750 per person (fully inclusive). A single supplement costs £580.

Dental Tribune special offers

Readers of Dental Tribune who wish to break up the journey home, are being offered one free night of accommodation at the InterContinental Grand Stanford Hotel in Hong Kong’s Kowloon Bay. The offer includes airport hotel transfers. Or, if you’d rather spend your free time in Cambod-
Howard Cohen & Co, members of the ASPD, are proud to introduce new member of their Dental Team

Howard Cohen & Co are delighted to welcome Mr Sunil Abeyewickreme who is joining their busy and expanding Dental Division.

Mr Abeyewickreme qualified as barrister in 2004. He has previously been employed by the BDA to advise their members on general legal issues but specialising in Employment Law. He is joining Howard Cohen & Co as part of their specialist team offering advice and assistance to dental practitioners on:

- Employment Law
- NHS Contracts
- Associates
- Expense Sharing and Partnership issues
- Industrial Disputes

Howard Cohen & Co, members of the ASPD, are a Leeds based national solicitors practice providing a comprehensive range of legal services to the Dental Profession in all parts of the Country.

ASPD members offer professional, objective and practical advice and services, based on experience within the industry, to dental practices and other businesses within the dental sector. ASPD members include solicitors, accountants, banks, financial advisers, valuers and sales agencies, insurance brokers and leasing and finance companies.

For more information please contact: Sunil Abeyewickreme

CALLFREE 0800 542 9408
or visit www.howardcohen.co.uk
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Septodont has dedicated 75 years of innovative product development and manufacturing exclusively to the Dental profession. Our production expertise has earned the approval of Dental professionals on 5 continents and from 150 government health agencies, making us the world leader in local anaesthetics.

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