DENTAL TRIBUNE
— The World’s Dental Newspaper • United Kingdom Edition —

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News in Brief

Star Trek’s tricorders could become reality

The hand-held scanners, or tricorders, of the Star Trek movies and television series are one step closer to reality now that a University of Missouri engineering team has invented a compact source of X-rays and other forms of radiation. The radiation source, which is the size of a stick of gum, could be used to create, inexpensive and portable X-ray scanners for use by doctors, as well as to fight terrorism and aid exploration on this planet and others. In dentists’ offices, the tiny X-ray generators could be used to take images from the inside of the mouth, shooting the rays outward, reducing radiation exposure to the rest of the patient’s head.

Simplyhealth to donate £150,000 to fund research

After raising £50,000 for a national heart charity Heart Research UK last year, Simplyhealth is now increasing its target to £150,000 to fund a joint research project with the charity to look at the link between heart health and dental health. Using its TV advertisement, which airs on Monday 14 January and runs until 10 March 2015, Simplyhealth is asking viewers to go to Simplyhealth UK Facebook page and click Like. Simplyhealth will donate £1 to Heart Research UK for every Like it receives. Viewers can also learn how the research grant process works, read highlights of research from medical institutions, read free health guides on dental health and heart health, and watch videos with experts.

Dentist awarded MBE

Public Health Consultant recognised in New Year Honours List

Dentist Dr Colette Bridgman has been awarded an MBE in the New Year’s Honours List, the only one in dentistry to be recognised this year.

The list was announced on 29 December, and having received the news in November, Colette told Dental Tribune it was hard to keep it a secret: “The letter... arrived in late November. It was quite a distraction from Christmas preparations and it was really hard not to tell everyone. I do admit that I could not keep it from my husband and children and they kept the secret really well.”

Colette, a Dental Public Health Consultant in Manchester, received the award for her services to dentistry and community dental health. Since qualifying, Colette has served as President of the BASCD (2009-2010), and chaired the Oral Health Strategic Board (NHSCB) working on services, and that collaborative LPNs for dentistry will start to function and make an impact to benefit patients and the population by making effective use of the resources we have.”

Colette hopes that her work will have a positive influence: “The NHS CB will be the commissioner for all dental services from April 2013 and this affords an opportunity to level up to the best across England. Needs-led preventive care pathways focused on outcomes are being piloted by the DH in practices across England and are welcomed by clinicians and patients taking part. I hope the lessons from this work will influence a fair and supportive new contract system. I trust the dental community will rise to the opportunity that having a single outcome focused commissioner in the NHS CB presents, and that collaborative LPNs for dentistry will start to function and make an impact to benefit patients and the population by making effective use of the resources we have.”

www.dental-tribune.co.uk

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Birmingham’s new dental hospital gets go ahead

Plans to build a new £30 million dental hospital in Birmingham have been approved by planning officers at Birmingham City Council.

Birmingham City Council has officially approved plans to build a new multi-million pound state of the art dental hospital on the former BBC Pebble Mill site in Edgbaston. A new School of Dentistry for the University of Birmingham will also be constructed on the site.

The project will be managed by City of Birmingham Community Healthcare NHS Trust, the University of Birmingham, Birmingham and Solihull LIFT and One Creative Environments.

Work is due to begin on the site in the spring and the project will hopefully be completed by 2015.

Calthorpe Estates development director Ralph Minott said: “From Calthorpe Estates’ earliest masterplan proposals for Pebble Mill back in 2003, this second major medical approval will cement our ambitions for growth and regeneration at Pebble Mill, linked to this important hub of medicine, learning and life sciences within Birmingham”.

Struck off dentist imprisoned

A dentist, who continued to work after being struck off by the General Dental Council (GDC), has been sentenced to seven weeks imprisonment.

Mr Amir Kamburov, whose registered address is in Sutton in Surrey, was erased from the GDC’s Register with immediate suspension on 11 July 2012, however he lodged an appeal against that decision but remains suspended and not allowed to practise dentistry in the UK.

The GDC, the organisation which regulates dental professionals in the UK, has helped the Crown Prosecution Service and Metropolitan Police Drugs Directorate bring a case to court after allegations that he continued to practise dentistry despite being suspended.

On Friday 7 December 2012 Mr Kamburov pleaded guilty at Lavender Hill Magistrates Court in London to fraud by misrepresentation and to practising dentistry unlawfully. He was remanded for Community Reports.

A further complaint was received by the GDC that Mr Kamburov continued to practise dentistry.

He was re-arrested by officers of the Metropolitan Police and charged with an offence of fraud by misrepresentation and two offences of unlawfully practising dentistry. He pleaded guilty to these three offences at Lavender Hill Magistrates’ Court on Friday 21 December 2012 and was again remanded until Friday 28 December 2012 for sentencing.

On 28 December 2012, he was sentenced to three weeks imprisonment on the first fraud offence, four weeks imprisonment on the second to be served consecutively making a total of seven weeks imprisonment. No separate penalty was imposed in relation to the charges for unlawfully practising dentistry.

Mr Kamburov’s suspension is recorded on the GDC’s Register.

Care Quality Commission ‘still failing’

The House of Commons’ Health Select Committee has criticised the Care Quality Commission (CQC) in a new report published in 9th January.

Despite a previous report in 2011 that said the CQC had failed to recruit adequately, and that their “delay in recruiting frontline staff was indicative of an organisation which did not recognise the urgency of the problems they were seeking to address.”

The MPs acknowledged the CQC was now aware of the changes it had to make, while new inspectors have been taken on.

Committee chairman Stephen Dorrell said: “The CQC’s primary focus should be to ensure that the public has confidence that its inspections provide an assurance of acceptable standards in care and patient safety. We do not believe that the CQC has yet succeeded in this objective.”

Andrew Gwynne MP, Labour’s Shadow Health Minister, said: “The sight of persistent problems at the care regulator will unnerve patients. The Government is inflicting spending and staffing cuts on the NHS and social care - patients are relying on a strong voice more than ever.

“Patients will have confidence in the regulator if rigorous inspections succeed in rooting out hospital and care home failings – patients deserve better.”

David Beahan, the CQC’s new chief executive, said the regulator had carried out a strategic review and was in the process of making changes. “We will ensure that openness and transparency are at the heart of the way we develop. “We are focused on protecting and promoting the health, safety and welfare of people who use health and care services.”

Dental staff raise hundreds for charity

Hundreds of pounds have been raised for charity by dental staff following a Christmas fun run.

Staff at College Street Dental in Burnham-on-Sea donned elf costumes and ran 10km, all in the name of charity.

Practice manager Karen Jury-Dando was joined by Nurses Julie Barker and Laura Brown, as they completed the ‘Christmas Cracker’ run, and raised more than £500 for Weston Hospice.

Karen, who finished in one hour and one minute, said: “We finished in good time despite the freezing, windy conditions and are very grateful to everyone who supported us.”

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Despite a previous report in 2011 that said the CQC had “failed to properly balance the demands of registering health and social care providers with the need to rigorously inspect hospitals and care homes”, and had failed to understand its own priorities and objectives – mainly to protect patients, the committee says things have not changed.

The report also said that the CQC had failed to recruit adequately, and that their “delay in recruiting frontline staff was indicative of an organisation which did not recognise the urgency of the problems they were seeking to address.”

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Hello, Happy New Year and welcome to the first issue of Dental Tribune for 2013!

First of all, congratulations to Colette Bridgman for the award of her MBE in the New Year Honours. Anyone who has heard her speak cannot doubt her commitment and passion for better dental health and this award is well deserved for her years of service.

In this issue we have the first of our supplements for 2015, focusing on implants. We have an interesting mix of cases to show you, and I hope you enjoy them and find them interesting. I’d love your feedback on these or any articles that we feature in Dental Tribune – please get in touch with me lisa@healthcare-learning.com.

We have a new regular contributor for 2013 – Dr Alexander Holden. As a young dentist with interests in dental phobia and law (a heady mix!) I am sure he’ll have a lot to share with us. You’ll find him on page 8.

The winner’s case report will be written up in a leading UK dental publication and all the successful applicants will be offered the opportunity to spend a day at the Harley Street Centre for Endodontics.

The judging panel includes: Dr Julian Webber and Dr Trevor Lamb, endodontists at the Centre and leading clinical academic Professor Andrew Eder of the UCL Eastman Dental Institute.

The application process is simple – dentists are asked to submit details of one endodontic case which showcases their ability. The deadline for applications is 31 July 2013.
Routine antibiotics unnecessary for dental work

Routine antibiotics should not always be recommended to patients with orthopaedic implants prior to having dental procedures, say the American Academy of Orthopaedic Surgeons (AAOS) and the American Dental Association (ADA).

This is due to insufficient evidence that routine dental procedures cause prosthetic joint infections.

“As clinicians, we want what is in the best interest of our patients, so this clinical practice guideline is not meant to be a stand-alone document. Instead it should be used as an educational tool to guide clinicians through treatment decisions with their patients in an effort to improve quality and effectiveness of care,” said David Jevsevar, MD, MBA, chair of the AAOS Evidence Based Practice Committee which oversees the development of clinical practice guidelines.

“It has been long debated that patients with orthopaedic implants, primarily hip and knee replacements, are prone to implant infections from routine dental procedures,” added Dr. Jevsevar who also is an orthopaedic surgeon in St. George, Utah. “What we found in this analysis is that there is no conclusive evidence that demonstrates a need to routinely administer antibiotics to patients with an orthopaedic implant, who undergo dental procedures.”

The guideline was based on clinical research which examined patients with a prosthetic hip or knee, half of which who had an infected prosthetic joint. Invasive dental procedures, with or without antibiotics, were not found to increase the odds of developing a prosthetic joint infection.

GDC recruits public protection panel members

The General Dental Council (GDC) is looking to recruit 65 new Fitness to Practise (FtP) panel members to help in its public protection role.

Advertisements outlining the formal application process will appear in the national and dental trade press in February 2015 to attract applications from dentists, dental care professionals (DCPs) and lay people. To register your interest in these roles please email Katrina.paget@gatenby-sanderson.com.

The details of anyone who contacted csecretary@gdc-uk.org earlier this year to express an interest have been passed on.

Fitness to Practise panel members play a vital role in the GDC’s work to protect patients and raise standards in dentistry. The GDC has the power to take action by either removing or restricting a dental professional’s registration if they fall short of the high standards expected.

Panel members sit in public hearings and consider cases where a registrant’s fitness to practise may be impaired due to their health, conduct or performance.

New ‘shock’ adverts discourage smoking

The Department of Health has launched a new campaign to encourage smokers to quit this new year.

The campaign focuses on the message that with every 15 cigarettes smoked, a mutation is caused that can lead to cancer. A series of ‘shock’ adverts are used to convey this, showing a tumour growing on a cigarette as it is smoked, similar to the ‘fatty cigarette’ advert brought out eight years ago.

Dr Harpal Kumar, Cancer Research UK’s chief executive said: “Tobacco is a lethal product and smoking is the single biggest preventable cause of cancer. Tobacco is highly addictive and kills half of all long term smokers.

“Hard hitting campaigns such as this illustrate the damage caused by smoking and this can encourage people to quit or may even stop them from starting in the first place.”

The campaign went live on 28 December 2012 with TV, online, billboards and other outdoor advertising, and will continue until March 2015.

Researchers turn to Mother Nature for tooth sensitivity

According to a new study in ACS Applied Materials and Interfaces, a natural adhesive similar to that found in mussels could help prevent tooth sensitivity and remineralise teeth.

Despite the number of toothpastes on the market that are aimed at reducing tooth sensitivity, the researchers noted that none could help prevent tooth sensitivity and remineralise teeth.

To meet that challenge, they turned to a sticky material similar to the adhesive that mussels use to adhere to surfaces, reasoning that it could help keep minerals in contact with dentin long enough for the rebuilding process to occur.

The researchers coated dopamine on demineralised enamel and dentin surfaces to evaluate the effect of polydopamine coating on dental remineralisation. They found that teeth bathed in the sticky material could reform both enamel and dentin, while teeth bathed only in minerals reformed only enamel.

“Polydopamine coating remarkably promoted demineralised dentin remineralisation, and all dentin tubules were occluded by densely packed hydroxyapatite crystals,” they concluded. “Thus, coating polydopamine on dental tissue surface may be a simple universal technique to induce enamel and dentin remineralisation simultaneously.”

Sensitivity can impact on daily life
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Discussion of dental erosion at London event

Leading New Zealand dentist Dr Andrea Shepperson will be hosting a full day lecture on 22nd March at Chandos House, London, discussing Dental Erosion: Restorative Management of the Worn Dentition.

Dr Shepperson believes that erosive tooth wear is often overlooked by general practitioners, and that a careful history needs to be part of a thorough clinical assessment in cases of tooth wear.

Dr Shepperson has developed a special interest in restoring dentitions affected by erosive wear. Initial diagnosis, implementing preventive strategies with a hygiene team, conservative minimally invasive restorative options, and reconstruction of the smile and restoration of the entire arch are all aspects of her work.

Further information is available at www.sheppersoneducation.com/London.html

New pension clarity for training practices

The pension entitlements of training practices in England and Wales have finally been harmonised and clarified, and new pensions guidance has been published by the NHS BSA, the National Health Service Business Services Authority.

Training practices have three separate income streams arising from:
• A training grant paid to the training dentist
• The reimbursement of the vocational trainee salary
• Service costs paid to the practice

PCTs and Boards were initially operating without any guidance leading to confusion around which aspects of the practice income were subject to superannuation. Early last year, guidance was introduced on the NHSBSA website for the first time, but it was still confusing.

David Paul, a Chartered Accountant and NASDAL member led the campaign to improve the pension guidance, working closely with NHSBSA to develop a document which is clear to both dentists and health authorities.

In relation to the pension entitlement of a training practice, David said that from April of this year onwards:
• The training grant is 100 per cent pensionable
• The vocational trainee salary is also pensionable but is not to be included on the ARR
• Service costs are not pensionable and must not be included on the ARR.

David said he has worked with four training practices within different health authority areas during 2011-2012. Two of the practices had been successful in having their service costs superannuated while the other two were refused. He said: “This inconsistent treatment is indicative of a lack of understanding. The new guidance now sheds welcome light on superannuation treatment for training practices.”
The Dental Defence Union (DDU) has produced an online learning module to help dental professionals get to grips with the ethical dilemmas they face in their day-to-day practice, while earning CPD points.

The DDU online CPD module on dental ethics and law aims to help members understand the main principles of topics such as confidentiality, consent and capacity. After reading background information including key principles and guidance written by the DDU’s dento-legal experts and working through a number of case studies, members of the dental team can then test their knowledge by answering multiple choice questions. On successful completion of the assessment, dental professionals gain five hours’ worth of CPD and a personalised certificate.

Leo Briggs, DDU dento-legal adviser, said: “Dental ethics are not always black and white, and dilemmas present in many ways. There may be no easy answers to ethical problems in dentistry and no training can hope to cater for every eventual-ity in practice. But there are questions which dental professionals need to ask themselves, their patients and their colleagues, in order to determine the most appropriate course of action.

“Our interactive guide to ethics is aimed at helping members of the dental team to understand the principles of dental ethics and law and apply that knowledge to a variety of scenarios that typically arise in day-to-day practice.”

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Course gives confidence to place implants

Implant course The Basic Implant Surgery and Prosthetic Modular Implant Programme returns this April. Now in its fifth year, the course is presented by Specialist Oral Surgeons, Dr Sanjay Chopra and Dr Philip Hayter, at their referral centre in Hornchurch, Essex.

The course provides an introduction to dental implant treatment, from identifying suitable cases to immediate placement and loading. The content is delivered using a combination of live surgery, lectures and hands-on training.

Sanjay Chopra and Philip Hayter are Examiners in Implant Dentistry for the Royal College of Surgeons (RCS) in England and Edinburgh. They also lecture on the Diploma and Advanced Certificate Course in Implant Dentistry from the RCS.

The course runs for eight days over seven months, commencing 16 April 2013, and costs £4,500 + VAT. To book, and for further information, contact David Gurney on 01708 707050 or email david@highlandview.co.uk.

Dr Sanjay Chopra and Dr Philip Hayter present the Basic Implant Surgery and Prosthetic Modular Implant Programme in 2013

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Dr Sanjay Chopra and Dr Philip Hayter present the Basic Implant Surgery and Prosthetic Modular Implant Programme in 2013
Opinion

Sometimes we all need some help...

Alexander Holden looks at the issue of addiction and professional status

T he Christmas period is often a time when we over-indulge; be it in food, spending or alcohol. Rarely do we think of this over-indulgence as being too much of an issue, but perhaps we ought to consider those for whom alcohol is not just an over-indulgence but an addiction. Alcohol consumption in the UK is a problem. The WHO placed the UK in a higher risk category for drinking behavioural patterns than the majority of the developed world. We are used to thinking about alcohol consumption in relation to our patients, but as dentists, we are not immune from involvement in over-consumption or dependence upon alcohol ourselves.

There are many avenues dentists can go down to get help with addiction, whether it is for help with alcohol or drugs, but there is often a rather large hurdle; professionals in general are not likely to want to access a public service for a sensitive health issue that their patients might also be using. The help group Alcoholics Anonymous are infamous for their meetings for those struggling with alcohol addiction, but it would be surprising to find a dentist at a meeting, lest they bump into a patient. In certain populations, word of mouth can travel surprisingly fast and this becomes a significant barrier for professionals looking to access appropriate services. It is this issue that makes specialist support groups for dentists and other healthcare professional groups so important.

Alcoholism and drug addiction are often solitary illnesses. Drinking is socially accepted, but those seen as drinking too much often become the butts of jokes and in a professional capacity, a source of embarrassment and shame for the rest of us. In some social circles, casual drug use is also acceptable. This suits dentists rather well; we have a tendency towards loneliness (usually working in very small teams which may slip into being dysfunctional) and can often become obsessed with the day to day aspects of dental practice. Dentists are, for the time being, financially well rewarded for their work in relation to other professionals. In this way, relatively expensive additions can be managed and maintained with many who are afflicted becoming adept at working whilst under the influence, being relatively high-functioning. The impairment in judgment and judgements are not as easily managed and professionals with addiction can become a significant threat to patient safety and the safety of other team members, as well as themselves.

Another aspect of dentistry that contributes to the proliferation of addiction is the easy availability of prescription only medication. Benzodiazepines, opiates and nitrous oxide are all fairly easily available to those who want them. The stigma that is attached to addiction within professions acts as another barrier for professionals looking to seek help. There is that fear that they will end up in front of the GDC in a fitness to practice hearing. In reality, the Health Committee tends to take a more sympathetic view towards dentists with addiction issues and it tends to be those who refuse help that lose their registration. This has to be a good thing, as the Council acting in a very busy team, would discourage dentists from being open about their health issues would only serve to endanger patients and perpetuate a problem.

Some (as I was) might be tempted to think of alcoholism in dentists as being a problem of the past. Only a short time ago (some reading this may even remember), it would have been normal to have a drink at lunchtime and then go on to treat patients in the afternoon. All increased regulation has been done is to push such subversion below the radar so that colleagues may even be unaware that there is an issue.

What should a colleague do if they become aware of a dentist or dental professional’s drinking being an issue? A referral to the GDC is perhaps slightly too strong a reaction for a first response. Whistle blowing is still a dirty word for most people and I personally dislike the term. There are distinctly negative connotations attached to the actions of those who speak up with concerns. Whether this is regarding addiction or other practice issues, those who speak their minds should be congratulated, potentially even thanked after the event. An appropriate first response to a colleague with an addiction issue would be to speak to a defence organisation or to speak to one of the dentist addiction support groups, for those who are struggling financially as a result of addiction issues, the BDA Benevolent Fund is also a source of help. A support charity group that works exclusively with dentists is the Dentists’ Health Support Trust and the Benevolent Fund are to help us look after each other; maybe the non-alcoholic spirit of goodwill that pervades the atmosphere at this time of year shouldn’t just be forgotten about mid-January and instead, perpetuated for the good of all.

Thanks to Rory O’Connor of the Dentists Health Support Trust which runs the Dentists Health Support Programme for his help with providing statistics and a valuable insight into an under-discussed subject. This charity relies solely on donations from the dental profession and I hope that all readers will agree with me in feeling that this is a worthwhile and essential service which promotes the health of our professional community.

The question of why dentists might begin down the path of addiction is not easily answered; I for one can only guess, perhaps all it takes is one bad day to place an individual on the downward spiral. We spend so much energy in trying to help our patients that sometimes we forget to look after ourselves; it is good to know that if we needed it, such organisations exist. The simple aim of organisations such as the Dentists’ Health Support Trust and the Benevolent Fund are to help us look after each other; maybe the non-alcoholic spirit of goodwill that pervades the atmosphere at this time of year shouldn’t just be forgotten about mid-January and instead, perpetuated for the good of all.

About the author

Alexander Holden MBBS RCS (Eng) graduated in 2011 and completed his Foundation Training in Rotherham where he also qualified as a clinical hypnotherapist. He now works part-time as a general dental practitioner with a special interest in treating dental phobia and anxiety as well as completing further training in core general dental practice. Alexander is a member of the national Young Dentists Committee and is also a trustee of the BDA Benevolent Fund.

We spend so much energy in trying to help our patients that sometimes we forget to look after ourselves!

The obvious extension is that this should be avoided in all dentists, but for those in isolated practice, accessing peer review and support can be difficult and it would be good to try to encourage this more within each local area.

If you need support for yourself or a colleague with addiction issues, the Dentists’ Health Support Programme can be contacted on 0207 2244 671 or emailed on dentistsprogramme@gmail.com.

The transition into practice are left feeling demoralised and alone and addiction issues may evolve as a coping mechanism. Trainers and foundation programme advisors are and need to be aware of this issue; those who struggle should not be alienated and made to feel alone.

Opinion

Alexander Holden

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Auto Enrolment - How will it affect your practice?
Richard Lishman discusses pensions and the latest regulations

The Department of Work and Pensions (DWP) has stated that millions of people in the UK are currently not saving enough of their income to sustain themselves throughout retirement. With life expectancy increasing, most people are likely to live for longer than twenty years after retirement, so having money put by for old age is more vital than ever. The DWP have found that pension saving has reduced across all age groups with only one in three adults now contributing to a pension. This is why the government has brought in new ‘auto enrolment’ legislation that will ensure that all workers can save for retirement.

As a way of encouraging people to start saving, the government has devised a new scheme which will have all employers automatically enrol their employees into a workplace pension scheme, regardless of whether they are working in a private or public sector firm. The aim of this is to curb the hesitance many people have to save for the future. The scheme was introduced at the start of last October and projected figures estimated that as a result of this more than half a million more people would be saving for a pension by Christmas 2012. It is predicted that come May 2015 that figure will have increased to around 4.3 million.

The introduction of auto enrolment will affect anyone who:
- Does not already contribute to a workplace pension.
- Is aged between 22 and the state pension age.
- Earns more than £8,105 a year (though this figure will be reviewed each year).

However, some employees who don’t fit the criteria for automatic enrolment may still be able to set up a workplace pension scheme. As long as that person is over 16 years old and earns more than £5,564 a year they will qualify. Despite this, their employer will not have to contribute towards the pension. Those who already contribute to a pension scheme may have to make changes to bring it in line with the new rules.

Although auto enrolment initially began on October 1st 2012, not all companies were required to comply immediately. The size of the company will affect when automatic enrolment occurs, with larger employers (more than 250 employees) first to enrol their workers. Any employers established after April 2012 will be the last to enrol their workers and this will take place between May 2017 and February 2018. Most dental practices will
find that they will need to enrol between June 2015 and April 2017 as they fit in the bracket of ‘small employers’ as they generally have under 49 employees. The only exception to this rule will be any companies who have received a staging date of before June 2013.

The majority of people will be enrolled in to what is known as a ‘defined contribution scheme’. With this type of pension, both employee and employer make contributions which are then invested. The amount that is received upon retirement rests on how much has been paid in and how the investment has performed. The employer will need to contribute to the pension on anything over £5,564 a year to £42,475. With anything above the maximum, it is up to the employer to decide how much they contribute. A contribution to the pension will also be made from the government in the form of tax relief. The minimum contribution to be made will begin with a total of two per cent of the employees gross annual earnings, with 0.8 per cent contributed by the employee, one per cent by the employer and 0.2 per cent as tax relief. By October 2018, this minimum will have increased to eight per cent, with the employee now contributing four per cent, the employer three per cent and one per cent in tax relief.

There are, however, other types of pension schemes such as defined benefit or hybrid pensions schemes that some may be enrolled in to. With these kinds of schemes the amount that is paid out upon retirement can depend on a few things, such as earning and the number of years that the pension has been contributed to. With these kinds of schemes employers will not need to enrol their employees until the end of September 2017.

Despite the fact that all employers will at some stage need to be enrolled, they do have the choice to opt out, as workplace pensions are not compulsory. The government hopes that offering tax relief will sway more to contribute towards a pension. But despite this, it is estimated that millions will choose not to contribute. Opting out of a pension scheme after longer than a month will not release the funds already saved, these will remain in the pension scheme until retirement. Employers are prohibited from encouraging their staff to opt out by offering incentives like a higher salary or job offer. Employers who refuse to enrol their workers will receive a fixed penalty of £400 and those who continue to disregard the new legislation will amount daily fines ranging from £50 a day for companies with fewer than five staff to £10,000 a day for larger companies with more than 500 staff.

As when any new legislation is brought in, there is a lot to understand. Auto enrolment will have an impact on every dental practice in the country and it is clear to see that non-compliance can have a devastating effect. To avoid these penalties it is a good idea to have access to great financial guidance.

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About the author

Richard T Lishman is a specialist of money- dentists, which are an independent firm of Independent Financial Advisers who help dentists across the UK manage their money and achieve their financial and lifestyle goals. For more information please call 0845 545 5060 or email info@money4dentists.com www.money4dentists.com
Guided implant surgical placement with Cad/CAM CEREC Crown

Nilesh R Parmar presents a surgical case study

Guided surgery has been around for a long time. However, very few dentists in the UK are placing implants via the use of a guided surgical procedure. The reasons for this are multiple, ranging from dentists not wanting to, or not having confidence in the procedures, the increased costs of guide fabrication and the time delay and extra appointments needed to obtain a fully working and reliable surgical guide.

In this case study I shall be demonstrating an in-house manufactured surgical guide using the CEREC AC BluCam. These guides do not require any impressions to be sent to a third party and can be made rather cheaply in the surgery within around 30 minutes. The guide can then be used in conjunction with specific drill keys, which are compatible with the guided surgical drill sets from all leading implant manufacturers. In this particular case the Astra/Dentsply Implants Facilitate system was used to place the implant.

Once the implant was osseointegrated the final restoration was fabricated using the CEREC milling machine and an Ivoclar Vivadent e.max block.

Case Study

This young lady had lost her LL6 a few years ago and wanted an implant solution. Her medical history was clear and she had a mildly restored dentition with no current dental pathology. Her BPE scores were low, with excellent oral hygiene.

The patient was scanned using the Sirona AC BluCam and a proposal for the missing LL6 was created. A Galileos collimated lower jaw CBCT scan was taken with a CEREC Guide reference body set in thermoplastic over the edentulous area. The reference body is identified within the software and a virtual implant placement along with the CEREC crown proposal is all imported into the software. This allows the clinician to virtually place the implant, with reference to the ideal final crown position. In this case, it was deemed that a screw-retained restoration would be desirable; hence the screw access hole was positioned through the centre of the crown.

Once the implant position was decided, the information is ported over into the CEREC software and using a CEREC Guide Mill Block a drill body is milled by the MCXL milling machine. Once this has been milled it will lock tightly into the thermoplastic drilling template. The surgical guide is now complete and can be used on the patient.

In this particular case an Astra 4.0 x 11mm TX implant was placed using the surgical guide. The patient is prepared using a standard sterile protocol and the area anaesthetised as one would for a regular
implant placement. The surgical guide snaps firmly over the existing teeth, expanding over and undercut, becoming a very stable platform to drill through. The Astra Facilitate soft tissue punch is used to remove the overlying soft tissue, and a standard drilling protocol using the Sirona drill keys is used.

A high primary stability of 40Ncm was obtained, with a 4mm healing abutment placed immediately. The patient healed with no pain, no swelling and no discomfort. The post op LCPA corresponds well with the pre-surgical planning with an ideal angulation for a screw-retained crown. After two months of healing a fixture level open-tray impression was taken and cast up using an Astra Tech replica. A standard metal abutment was inserted into the replica and cut back by 3mm from the occlusal table. This was then powdered and scanned using the Ac BluCam and an Ivoclar e.max CAD C14 block milled. The CEREC 4.2 software was instructed to mill a hole that corresponds to the screw insertion path on the abutment. This is finalised using a high speed diamond bur with copious irrigation. The crown is glazed and sintered, allowed to cool and bonded to the abutment using Vario link II. The final crown can be screwed directly into the implant and a final check for contacts and occlusion is made.

This process shows just how far CAD/CAM technology has come. An implant can be planned, inserted and restored all in-house, using the current available technology.
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Dr Nilesh R. Parmar BDS (Lond) MSc (Prosth Dent) MSc (Impl Dent) Cert Ortho was voted Best Young Dentist in the East of England in 2009 and runner up in 2010. He was short-listed at the Private Dentistry Awards in the category of Outstanding Individual 2011. Nilesh has a master's degree in Prosthetic Dentistry from the Eastman Dental Institute and a master's degree in Clinical Implantology from King’s College London. He is one of the few dentists in the UK to have a degree from all three London Dental Schools and has recently obtained his Certificate in Orthodontics from Warwick University. His main area of interest is dental implants and CEREC CAD/CAM technology.

Nilesh runs a successful five-surgery practice close to London and is a visiting implant dentist to two central London practices. Nilesh has a never-ending passion for his work and is famed for his attention to detail and his belief that every patient he sees should become a patient for life. He offers training and mentoring to dentists starting out in implant dentistry, more information can be found on his website www.drnileshparmar.com.

Twitter: @NileshRParmar
Facebook: DR NILESH R. PARMAR

Fig 13: Standard abutment with 3mm of occlusal clearance

Fig 14: Soft tissue profile after 2 months healing

Fig 15: Cerec image of abutment

Fig 16: X-max crown glazed, stained and ready for sintering

Fig 17: Cerec image of block

Fig 18: E-max crown glazed, stained and ready for sintering

Fig 19: milled E-max Cad/Cam crown with screw hole

Fig 20: Screw retained E-max crown

Fig 21: Final restoration in-situ 2

Fig 22: Final restoration in-situ
Fixed Teeth in a Day: An interview with Dr Steven Bongard

Interviewer_Dr Mark Lin

Steven Bongard (SB): The Fixed Teeth in a Day protocol delivers same day, full arch rehabilitation utilising four or more implants to support fixed, immediately functional, aesthetic prostheses.

ML: How does Fixed Teeth in a Day compare with conventional rehabilitations?

SB: Fixed Teeth in a Day is less invasive, reduces morbidity, is less disruptive and less costly. The principal surgical difference is in the implant placement. Posterior maxilla implants are placed on an angle, just anterior to the maxillary sinus, into the denser bone of the pre-maxilla, avoiding the need for sinus augmentation while still enabling a shortened posterior cantilever. In the mandible, implants are placed between the mental foramina, angled in the posterior, engaging the more predictable, denser bone of the anterior mandible. More than seven years and a thousand patients, our short-term implant survival rates are comparable to the two-stage approach and the few problems have involved breakage of the transitional prostheses, which have now been modified.

ML: Is there any published data on Fixed Teeth in a Day?

SB: I can refer you to at least nine studies and follow-up studies, all reporting positive conclusions.

SB: Some clinics use only four implants; we find that softer bone may require up to six implants to limit early micromovement. When planning each case we always consider bone quality and the anticipated bite forces generated by the opposing arch.

ML: Traditionalists prefer axial loading of the implants, while Fixed Teeth in a Day calls for tilted implants. How do you respond?

SB: We tilt the implants to shorten cantilevers and improve force distribution; to eliminate the need for sinus augmentation; to allow engagement of the denser anterior bone, and to allow the use of longer implants where there is limited vertical bone.

ML: Many fear that tilted implants will cause problems with bone reaction or prosthetics.

SB: Our tilting implants are rigidly connected to other implants, creating a totally different force dynamic compared to a single off-angle implant. We have not seen any significant difference in bone reaction.

ML: What are the minimum clinical prerequisites for Fixed Teeth in a Day with immediate loading?


ML: How do differences in bone density affect your approach?

SB: Our surgical protocols are designed to maximise predictable primary stability. In the maxilla the implants are angled to avoid the less dense posterior bone. The pre-maxilla generally has fairly dense, compatible quality bone to that of the intra-foramina region of the mandible. We haven’t seen any significant difference in survival rates for either arch.

ML: What is ‘Fixed Teeth in a Day’?
and 10 mm of bone height between the canines in the maxilla, and 5mm of bone width and 8mm of bone height intraorally in the mandible. For patients with significantly less bone we are working on protocol modifications which are already showing favourable short term outcomes. For immediate loading we need at least 35Ncm of initial stabilisation on at least four implants in both mandible and maxilla.

ML: What is the patient’s post-op advice?
SB: A softer foods diet for the first three months. At the two-week appointment we introduce a Waterpik to the hygiene regimen. We ourselves pay meticulous attention to the occlusal scheme and adjust it using the T-scan system at two and eight weeks.

ML: What type of occlusal scheme are you seeking?
SB: Our protocols require bilateral, simultaneous, equal intensity posterior contacts in the maximal intercuspation position (MIP). We try to avoid contact in the cantilever portion and premature contacts.

ML: This sounds like a mutually protected occlusal scheme where when the teeth are in MIP there are posterior, equal intensity, simultaneous contacts with little or no contacts to the anterior teeth.
SB: In fact our protocols demand the front and back teeth contribute equally to MIP.

ML: What if the patient presents with existing dentition?
SB: More than 60 per cent of our cases present with failing teeth. We try to reduce the number of operations by extracting the teeth, immediately placing the implants, and immediately loading them with the Fixed Teeth in a Day acryl transitional prosthesis. Provided the initial stabilisation parameters are met,

Table 1 from Malo et al JADA 2011;142(3):310-320) shows the cumulative success rate over ten years for Fixed Teeth in a Day mandibular implants.

<table>
<thead>
<tr>
<th>DURATION OF TREATMENT</th>
<th>TOTAL</th>
<th>FAILED</th>
<th>WITHDRAWN</th>
<th>NOT YET COMPLETED FOLLOW-UP</th>
<th>CSR%</th>
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<tbody>
<tr>
<td>Placement to Six Months</td>
<td>980</td>
<td>7</td>
<td>16</td>
<td>0</td>
<td>99.3</td>
</tr>
<tr>
<td>Six Months to One Year</td>
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<td>0</td>
<td>28</td>
<td>0</td>
<td>99.3</td>
</tr>
<tr>
<td>One to Two Years</td>
<td>925</td>
<td>5</td>
<td>36</td>
<td>0</td>
<td>98.8</td>
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<tr>
<td>Two to Three Years</td>
<td>888</td>
<td>1</td>
<td>20</td>
<td>0</td>
<td>98.6</td>
</tr>
<tr>
<td>Three to Four Years</td>
<td>867</td>
<td>1</td>
<td>27</td>
<td>4</td>
<td>98.5</td>
</tr>
<tr>
<td>Four to Five Years</td>
<td>835</td>
<td>1</td>
<td>0</td>
<td>114</td>
<td>98.4</td>
</tr>
<tr>
<td>Five to Six Years</td>
<td>720</td>
<td>2</td>
<td>4</td>
<td>319</td>
<td>98.1</td>
</tr>
<tr>
<td>Six to Seven Years</td>
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<td>0</td>
<td>274</td>
<td>97.9</td>
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<tr>
<td>Seven to Eight Years</td>
<td>120</td>
<td>2</td>
<td>0</td>
<td>59</td>
<td>96.3</td>
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<tr>
<td>Eight to Nine Years</td>
<td>68</td>
<td>1</td>
<td>0</td>
<td>46</td>
<td>94.8</td>
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<tr>
<td>Nine to Ten Years</td>
<td>21</td>
<td>0</td>
<td>0</td>
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<td>94.8</td>
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<tr>
<td>Ten to 11 Years</td>
<td>8</td>
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<td>0</td>
<td>8</td>
<td>94.8</td>
</tr>
</tbody>
</table>

* The All-on-4 concept is manufactured by Nobel Biocare, Goteborg, Sweden.
* CSR: Cumulative success rate.

Fig 2a Before
Fig 2b After – Immediate Load
Fig 3a Patient Before. Courtesy of Dr. Steven Bongard, Chrysalis Dental Centre, Toronto
Fig 3b Immediate Load. Day of Surgery Courtesy of Dr. Steven Bongard, Chrysalis
Fig 4a Panoramic Radiograph – Final Prostheses Inserted. Courtesy of Dr. Steven Bongard, Chrysalis Dental Centre, Toronto
Fig 4b Panoramic Radiograph – Final Prostheses Inserted. Courtesy of Dr. Steven Bongard, Chrysalis Dental Centre, Toronto
Fig 5 Fixed Teeth in a Day acrylic temporary prosthesis
Fig 6 Titanium milled bar
Fig 7 Example of well-maintained tissue
we achieve the same success rate as for edentulous cases.

**ML:** What types of prostheses are you using?

**SB:** The transitional unit is an all-acrylic, screw-retained, fixed, provisional prosthesis. Our final restoration is a hybrid comprising a screw-retained, milled, titanium bar with premium acrylic teeth.

**ML:** What are your thoughts on porcelain teeth?

**SB:** We prefer acrylic for its predictability and ease of repair, and our patients are happy with the aesthetics of high-end acrylic teeth.

**ML:** What aftercare and recall do you recommend?

**SB:** Aftercare measures depend on each patient’s commitment to plaque control. Recall appointments, usually at the referring practice, check the implants, occlusion and tissue surfaces.

**ML:** Are there any special risk factors for Fixed Teeth in a Day treatment?

**SB:** The risk factors are similar to those for other implant protocols, typically smoking, poorly controlled diabetes, parafunction, poor oral hygiene etc.

**ML:** How do the patients react to Fixed Teeth in a Day?

**SB:** We are able to provide 95 per cent of cases with an immediate fixed transitional prosthesis, and I have never performed treatment with has delivered such consistently high levels of patient satisfaction.

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**About the author**

Dr. Steven Bongard graduated from the University of Toronto in 1986, practises in Toronto, and has extensive experience in bone grafting and implant prosthodontics. Dr. Mark Lin is Co-director of Post Graduate Prosthodontics, University of Toronto, and has his own practice. He and Dr. Bongard host courses all around the world on the revolutionary “Fixed Teeth in a Day” concept. (Neither were paid for this interview.)

For more information on how Fixed Teeth in a Day referrals can benefit your practice, call United Smile Centres on 0800 8 49 49 59, email info@unitedsmilecentres.co.uk, or visit www.unitedsmilecentres.co.uk
Short Implant Placement Does Not Require Bone Augmentation

Armin Nedjat discusses short implants

Conventional dental implantation concepts have been questioned. For several years, short implants have been inserted without the need of a bone augmentation. An implant is considered as short if its thread has a length of less than 10mm. Short Champions® implants are now available as well. The one-piece Champions® are available in lengths including 8mm and 6mm. The two-piece Champions® (R)Evolution implants are available in lengths including 8mm and 6,5mm. Results from a recent study and the 97.5 per cent success rate of short implants have shown that the short implants are as beneficial as those with thread lengths ranging from 10-24mm. The following clinical cases of the online forum show the good treatment results with short implants.

Bone augmentations like an external sinus lift, an iliac crest transplantation or a bone distraction can be traumatic for the patient and can increase health risks. Therefore, our thesis is: “the best augmentation is no augmentation at all!”. In addition, it is very important to inform the patient about all lateral shear forces that have shown that short implants are proven wrong.

Some theses, which were considered as accepted truths in the 80s, have now proven controversial. For instance, studies have shown that it is not absolutely necessary to place implants with a length of 12mm and a diameter of 4.7mm! In addition, the dogma that there has shown that the first 3-4mm of implant such as a 10mm long implant. However, from our experiences as dentists and current scientific studies, these theses against short implants are proven wrong.

Therapy with short implants does not necessarily require bone augmentation, and it is beneficial and also affordable. In this way, the crestal bone site can be treated. Our experience with several implant systems has shown that the first 3-4mm in the crestal implant site are particularly crucial. Certain implant systems are equipped with a micro-thread, allowing for placement in the crestal implant site. In order to success fully insert and restore the short implants, primary stability of at least 35Ncm is achieved. Mechanical stimuli will be converted into biological Hard tissue regeneration on the implant and the bone. In this way, maxillary augmentation at all!

Fig 1: X-rays of the Champions® implant with a length of 6 mm and of the one with a length of 8mm, after the indirect sinuslift and distraction can be traumatic for the patient and can increase health risks. Therefore, our thesis is: “the best augmentation is no augmentation at all!” In addition, it is very important to inform the patient about all lateral shear forces that have shown that short implants are proven wrong.

Some theses, which were considered as accepted truths in the 80s, have now proven controversial. For instance, studies have shown that it is not absolutely necessary to place implants with a length of 12mm and a diameter of 4.7mm! In addition, the dogma that there should be a large amount of titanium in bone has been questioned. Since according to the conventional Implantology theory, the implant length should be 2:1 in relation to the length of the crown, I had previously doubted the efficiency of short implants and the need to insert a short implant such as a 10mm long implant. However, from our experiences as dentists and current scientific studies, these theses against short implants are proven wrong.

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Fig 2

Fig 3

Fig 4

Fig 5

Fig 6

Figs 1-6 X-rays of the Champions® implant with a length of 6 mm and of the one with a length of 8mm, after the indirect sinuslift and distraction can be traumatic for the patient and can increase health risks. Therefore, our thesis is: “the best augmentation is no augmentation at all!” In addition, it is very important to inform the patient about all lateral shear forces that have shown that short implants are proven wrong.

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Conclusion

Currently, conventional Implantology theories which argued that short implants were less effective than long ones have been questioned. Over the past few years, recent studies have shown that short implants with a thread length of less than 10mm ensure good soft and hard tissue regeneration on the long-term. In this way, maxillary augmentation can be avoided in many cases. Implant therapy, especially minimally invasive implant therapy, can be incorporated as an additional treatment in the dental office. The implants which integrate Platform-Switching prevent crestal bone loss. In order to ensure the successful placement of short implants, a certain number of implants/teeth and primary stability of at least 35Ncm are necessary. The minimally invasive method of implantation (MIMI®) has proven to be optimal in order to ensure peri-implant nutrition and good periost preservation. Your patients will appreciate it.
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Fig 14b
In the first session, a 4 mm long and 4.2 mm diameter Champion® implant was placed in region 27 according to the MEMR method. The MEMR method is quite nontraumatic for the patient and ensures periost protection. In this case, primary stability was achieved at a torque of 60 N cm. We temporarily fixed the temporary restoration to the proximal surfaces of the adjacent teeth. The temporary restoration was placed with composite. Then, the final crown was cemented and fit eight weeks following implantation. The X-rays were taken a year after implantation.
Dental Implants: Laser-Lok a new technology
Amit Patel presents an interesting case

Implant therapy has been an amazing breakthrough in restorative dentistry which has brought benefits to our patients. We are all aware of the high success rates of dental implants and that they will integrate given time. Over the past 10 years implant companies have been developing the new implant surfaces to increase the amount of bone to implant contact and to reduce the time needed for the implant to be loaded. I suppose the ultimate goal for dental implants would be to completely emulate a tooth/root. That is to achieve a true connective tissue attachment inserting into an implant surface thereby forming a true biological width with a junctional epithelium and connective tissue attachment protecting the bone. This has not been possible; Listgarten’s studies in the 1990’s showed that the connective tissue around an implant is parallel to the implant surface.

A good friend of mine Ken Nicholson who is an implant dentist, in Northern Ireland and the academic lead in the Institute for Postgraduate Dental Education at the University of Central Lancashire, introduced me to Biohorizons dental implant over three years ago. I have enjoyed using this implant system for three years now. Two years ago Biohorizons introduced a new implant Laser-luk. Biohorizons have been able to develop a true microthread, the top 2mm of the implant is prepared utilising a laser to threads which are 8 and 12microns apart. Professor Jack Ricci developed this laser technology in the 1990’s at New York University. He found that the microthreads could control the behaviour of the fibroblasts allowing the fibroblasts to orient themselves on the Laser-lok surface.

The Laser-lok surface has been shown to elicit a biological response that includes the inhibition of epithelial downgrowth and the attachment of connective tissue. It has been suggested that this physical attachment produces a biological seal around the implant that protects and maintains the bone(Nevins,M et al, International Journal of Periodontics & Restorative Dentistry(IJPRD). vol.28, no.2, 2008)(Figure 1). Recently a study by Nevins et al IJPRD vol.30, no.5, 2010 has shown the use of Laser-lok abutments to create a biological seal. They showed a connective tissue attachment to the Laser-lok abutment which was above the implant abutment connection (Figure 2). The crestal bone levels was also seen to be higher than in standard abutments (Fig 5).

A 51-year-old lady was referred to me to by her dentist. She had been suffering from abscesses from her upper anterior bridge (Fig 4) for some years. She had decided that she wanted the bridge removed and replaced with dental implants. The bridge and retaining roots were extracted and replaced with an upper partial denture. The healing was closed utilising resorbable sutures (Fig 9). The healing was uneventful and the patient was reviewed a week later (Fig 10), the sutures were removed.

The dental implants were left to integrate for a period of 8 weeks before the dental implants were placed (Fig 5).

A three sided flap was raised and the implants were placed in the UR1 and UL1 sites (Figure 6) at crestal level. As there was a buccal dehiscence present, it was necessary to augment the site with a guided bone regeneration technique using a bovine bone graft and membrane (Fig 7,8) therefore a periosteal relieving incision was made to allow for tension free wound closure and coronal mobilisation of the buccal flap. The flap was closed utilising resorbable sutures (Fig 9). The healing was uneventful and the patient was reviewed a week later (Fig 10), the sutures were removed.

The dental implants were restored with a screw retained UR1 crown and a screw retained UL12 bridge (Fig 15). Interestingly a long cone periapical of the final restorations and implants showed that the crestal bone had remodelled to the correct level dictated by the Laser-lok surface 12microns. You will note from the post-op radiographs the implants were placed at bone level (Fig 14). Another interesting point to make from this case is when I probed the peri-implant tissues you would expect the bone to be less than 1 mm away from the tip of the probe on a standard implant due to the parallel fibres of the connective tissue. Yet when the radiograph was taken the bone was further way.

Implant surface technology is improving every year and maybe one day the dental implant will be able to emulate a tooth/root in every way, it might be that Laser-Lok surfaces could be the start.
ADI brings together world implant experts at 2013 Congress

Delegates will be able to participate in lectures from internationally acclaimed speakers, visit the specialist implant exhibition and network with colleagues from the global implant industry.

ADI President Professor Cemal Ucer says, “Following decades of research and development, when patient demand and expectations are rising, we should address what are the real challenges and problems facing us today that affect the success and longevity of implant treatment? I am confident that the ADI 2013 Team Congress will answer this important question.”

The presentations will cover the full spectrum of topics relevant to anybody who is involved with dental implantology or is planning to enter the field. The Congress will feature lectures on the complete dental implant process, from consultation, placement and after-care to associated risks and complications. It will also include sessions on many specific aspects involved in the running of a dental implant service, such as legal considerations and managing patient expectations.

The Congress exhibition, open over the two days, will give delegates the chance to see the latest products, learn up-to-date techniques and meet industry leaders.

Attendees will benefit from the many networking opportunities on offer, including the ADI Oscars Bash, which takes place in the Midland Hotel on the Thursday night.

The ADI 2013 Team Congress takes place 1 – 3 May at the Manchester Central Convention Complex. Visit www.adi.org.uk/congress2013 for the full programme and to confirm your registration.
About the author

Amit Patel BDS MSc MDentent MFDS RCSEd MRD RCSEng Specialist in Periodontics & Implant Dentist

Amit is a Specialist in Periodontics practising at Grace House Specialist Dental Centre in Birmingham. His special interests are dental implants, regenerative and aesthetic Periodontics. Amit graduated from the University of Liverpool and completed a 4 year specialist training programme in Periodontics at Guy’s, King’s & St Thomas’ Dental Institute. Amit is also an Associate Specialist in Periodontics at the Birmingham Dental School. He has taught at undergraduate and postgraduate level, including lecturing to dental practitioners both in the UK and internationally.
More than 600 dental hygienists, dental hygienist—therapists and those interested in all things health and hygiene related flocked to the BSDHT’s annual Oral Health Conference and Exhibition in Liverpool on November 9 and 10 for what proved to be one of the best yet.

A plethora of fascinating speakers shared their knowledge with delegates in a packed programme of lectures and parallel workshops on subjects ranging from direct access and its associated risks, rights and responsibilities, bite mark analysis and protocol for cases of suspected child physical abuse, an update on HTM 01-05 – and so much more.

DH&C&E organisers listened to feedback from last year’s delegates and provided, for the first time, a choice between attending the key main sessions or one of numerous parallel sessions and workshops. The new venue, Liverpool’s Arena and Convention Centre, was an ideal choice for this new format, as it houses a main auditorium, alongside more intimate yet amply sized rooms for smaller presentations.

Outgoing President, Sally Simpson, kick-started the two-day conference with a welcome address thanking the many generous sponsors, including A to E Training, Blackwell Supplies, Colgate, Dentpex, DDU, GSK, Optident, Philips, Wrigley’s, Johnson & Johnson, Swallow/PDT and Proctor & Gamble, who helped fund the speakers, and Waterpik who sponsored the poster competition. Judges selected the poster submitted by Jennifer Cowlam as the winning entry and awarded highly commended to Umanah Begum et al.

Sally also praised incoming President, Julie House, and the executive team for putting together such a fabulous programme and announced that BSDHT was celebrating 50 years of printing its journal, the highly regarded and well-respected publication Dental Health, दूरी के उन्मुक्ती वालियों की जीवन और इतिहास, the new Annual Clinical Journal of Dental Health, which launched in 2011, have since joined the titles.

The first speaker was James Godnik whose presentation ‘Communication – see no evil, speak no evil’, was well attended and widely appreciated. James’s easy and humorous speaking style is always a hit and delegates were treated to some useful, highly informative tips for creating a successful hygiene brand.

Of vital importance, he says, is changing the public’s perception of dental hygiene & therapy and one way to do this is by surveying existing patients about why they come and how they feel before and after treatment. For example, are they anxious or apprehensive? And if so, why?

The use of patient testimonials as a way of highlighting and communicating the benefits of dental hygiene therapy to patients was also discussed, as were his ‘nine steps to building your own brand’, which are:

1. Lead
2. Be remarkable
3. Involve the whole team – everyone’s opinion matters
4. Innovation
5. Empower ambassadors – get your patients to spread the message by word of mouth
6. Personalise everything at every appointment
7. Survey why patients visit you
8. Measure what works
9. Evolve – if something doesn’t work, change it

Alongside changing the public’s perception of hygiene therapy, is changing how they feel about dentistry as a whole. Some 50 per cent of the population do not visit the dentist, something James explained as multi-factorial, including placing low importance on mouth health, fear, cost, concern about being told off, fear of the unknown and the expectation that the experience would be unpleasant. Delegates were invited to visit a new charitable website which has helped launch, called heartonastring.co.uk, which appreciates and celebrates the dental profession and provides tools for engaging local communities.

By the end of the session, it was not difficult to see why James has been voted the most influential person in dentistry for the last two years running.

Direct access is the most topical subject in the dental hygiene and therapy world right now so it was no surprise that Leo Briggs’s parallel session was packed to the rafters. Leo is a dental-legal advisor with DDS and a practising periodontist. His presentation aimed to identify the likely dental-legal consequences of direct access and discussed the risks that dental hygienists and therapists may face if direct access is granted.

Independent practice already exists for dental hygienists and therapists who understand that they do not always need to have a dentist on the premises – one notable exception is tooth whitening, when a dentist must be on the premises at the time of treatment. Currently, whitening can be carried out by dental hygienists and therapists under a treatment plan formulated by a dentist, although it does not have to be the same dentist who is on the premises at the time of first treatment. This could change with direct access, he said, but could take years to come into effect.

Currently a dentist sees a patient first to carry out a full mouth assessment and diagnosis and formulate a treatment plan that might include a referral to a dental hygienist/therapist for care. Should direct access be granted, this situation would be subject to change with the possibility of a dental hygienist/therapist seeing a patient without the need of a referral for treatment within their skills and competencies. Leo suggested that should this happen, further training should be taken to gain a deeper understanding of our responsibilities to a patient in this situation.

Having overall responsibility for patients will mean that hygienists and therapists:
• Must carry out soft tissue examinations
• Need to be able to recognise oral abnormalities
• Can refer directly to other healthcare professionals
• Are at risk of increased
President of the organisation that I so greatly admire, and an emotional one with both my husband and Mum in the audience.

I was also very privileged to be able to pay homage to Margaret Ross, this year’s Dr Leatherman Award recipient. Margaret is a true ambassador and inspiration to the profession.”

Breakthrough was nominated as BSDHT’s charity some years ago and continues to be so. Over £20k has been raised regionally and locally, and a raffle held at this year’s conference boosted the charity’s coffers by around £750.

The 2013 conference will be held in Birmingham on 15 and 16 November at the centrally located International Conference Centre.

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**We had some excellent speakers in a wonderful venue, and the topics that were covered in both the main auditorium and in the parallel sessions generated a real buzz and some lively conversation**

...to let their hair down and the Mersey Beatles tribute band were a brilliant addition to the proceedings!

“We had some excellent speakers in a wonderful venue, and the topics that were covered in both the main auditorium and in the parallel sessions generated a real buzz and some lively conversation”.

*It was a truly special occasion for me, to become the...*
The Steps of the Patient Journey

Glenys Bridges highlights the importance of the patient journey

Some dental professionals argue that the patient journey is becoming a passé phrase that’s losing its appeal. In some cases this may well be the case. Nevertheless it has long been clear that dental patients are looking for much, much more than good dentistry. Those practices that have recognised the importance of making their patients feel important and appreciated in these difficult financial times seem to be the practices that retain their patient base, whilst others with a lesser emphasis on customer care are losing theirs. Since delighting patients need not be costly, or time consuming in these days of high-tech communications, once a pathway for the patient journey has been established, implementing the required processes and procedures needs only the lightest touch in respect of time and resources.

Impact

Over the years, numerous people have expressed concerns about the imminent, technology-driven dental reception desk. Much in the same way as the first automatic cash dispensers were greeted when they first introduced them. Nowadays the disapproval that would be expressed should any of the banks withdraw that service only goes to show how changes in our lifestyles and use of technology have impacted upon what we want from service providers.

An essential feature of good customer care is consistency. Excellent experiences both raise expectations and motivate patients to recommend friends. Once high expectations for excellent service are in place, just providing very good service will disappoint. This is one way in which automated services have the edge. They deliver to the standards they are programmed to. Is this likely to reduce the human touch? No, it is not, rather it will concentrate the team’s attention where it is really needed and streamline to routine contacts, so that patients experience these as being faster and more responsive. Here is an example of how this can work.

Patient Journey

Step 1 - This step is taken when a patient starts to surf the Internet to find a dental practice that they like the look of. If when they are looking they find a website that gives them the option to ask questions and also to book an appointment, then their journey begins. At this point the patient has the option to link their dental registration into their Facebook, so that their appointments
The benefits of this are that it speeds up the check-in, freeing up the receptionist’s time to devote to the post assessment interaction in which the patient is likely to have questions to ask.

Step 2 - In response to the booking the patient receives an email, welcoming them to the practice and giving them some useful information about the practice including directions, the availability of parking, and the range of services and products offered at the practice. This can be followed up automatically with an appointment reminder by phone, text or email as per the patient’s request.

Daylist

Step 3 - On arrival at the practice, the receptionist will have a day list which displays patients’ photos. On arrival, if the patient prefers to they can use the auto check-in. They have the option to deal with a person, or to use an automated touch screen system. The benefits of this are that it speeds up the check-in, freeing up the receptionist’s time to devote to the post assessment interaction in which the patient is likely to have questions to ask.

Step 4 - After the assessment or subsequent appointments, the system will send a ‘thank you for visiting us’ email. This will be a chance for the patient to provide feedback, in a format that will meet CQC compliance requirements. It allows patients to give feedback upon their dental experiences. This also allows the practice to send the patients links to information, videos and other apps that inform and educate.

Step 5 - When treatment is complete another chance to provide feedback which will be managed, and with the permission of the patients these can be built into a blog/testimonial to place on the practice website. A couple of weeks after the completion of treatment a, ‘Hope things are going well following your procedure’ email can be sent. At any time patients can opt out from the automatic email stream.

Feedback

One system that delivers all this is Welltime Patient Connections (www.welltime.co.uk). It is an impressive system, offering patients the option of the light touch approach to customer care, which many patients appreciate. However, it must be said that as in all things this is not right for all patients. The bonus is that patients can select the type of customer care they want. When patients choose this system because they prefer this format, they free up the receptionist’s time to devote to those patients that want to interact with people, rather than technology.
Apolline – Money Well Spent
In today’s economic climate your dental practice must strive to improve on key aspects of business, including quality, regulatory requirements and compliance, to help it reach its full potential. Enlist our help to not only survive the recession, but to thrive in it.

Apolline is the first UK company exclusively dedicated to offering tailored, practical support to dental practices on issues involving business practice and regulatory compliance. Apolline’s highly experienced, professional management and technical team will help you achieve your goals sooner.

First For Comfort
When all the other pain of Takua Belshin’s new soft cushioned chair you know that the combination of comfort, style and hygiene in the ultimate in luxury, helping patients remain relaxed and comfortable throughout their treatment. This upholstery is available on the Cinta E and most recently launched Gie®copan Treatment Centres, with the option for the Ciep 1 available from April. The designs of all models are logical and are intended to facilitate easy access and enable you to experience for your patients. The Gie®copan has a delivery unit that can stand behind the chair, to provide an easy and unobtrusive welcome for your patients. It also provides the ideal position for essential clean and prep work as well as providing a relaxing experience for your patients.

CS 8000 Digital Panoramic System from Carestream Dental – “It’s instant”
Dr Hassan El-Nashar is the principal dentist at El-Fahtar Dental Care in Newett-Abbott and a customer of Carestream Dental.

“Do not get me wrong, if I had a choice I would choose a panoramic X-ray machine for the dentists to use straight away. “One of the things that really impressed me is that it’s very easy to use. When you take a radiograph you can immediately discuss any abnormality found or any treatment you need to do. There’s no need to wait for it to be developed. The system gets rid of all the waste – all the chemicals and so forth. It’s much cleaner and quicker.”

UCL Eastman Training in Restorative Dental Practice: “made me a far better dentist”
Dr Yasser Haddadi is a General Dental Practitioner at Highmead d in Denmark. He has successfully completed the Certificate and Diploma level courses in the Restorative Dental practice programme at the UCL Eastman Dental Institute. I started with the Certificate course and it got me so professionally, that I decided to continue,” says Dr Haddadi. “One of the things that I really enjoyed was the fact that you could bring in your own cases and discuss them with really skilled and experienced dentists and get a qualified opinion. “The Eastman has a really good reputation. I’ve recently completed the MSc module with the Eastman and this has made it easier for me to get onto a part-time PhD programme here in Denmark, once I finish my MSc project, helping me to develop an academic career.

“Your preventive skills are crucial. We need to instill this in all the new practitioners. So knowing all about cavity detection and placement of composite materials becomes much more important. It is also important to appreciate that fillings need to be placed in a biological manner, that is, with a layer of enamel remaining. This is also helpful when discussing the need for cavities to be filled.”

Free CPD with Oral Health
The 2013 edition of the popular publication Dental Summary Review (DSR) is now available. It is released in October 2012 providing dentists, hygienists and therapists with three hours of complimentary CPD. DSR is published by Orbis Health to provide a digest of some of the most interesting and stimulating research that has been published recently. The publication is edited by Dr Stephen Hancocks, DBE and will also be available to all UK dentists, hygienists and therapists at www.dentalsummaryreview.co.uk

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NobelActiveTM from Nobel Biocare: “very stable, very secure”
Dr Riz Syed, of Leading Dental Implants in London, is a surgeon for Same Day Smiles and a visiting surgeon to over 20 DENTALShow exhibitors across the UK as well as a lecturer for CAD/CAM Advancement Dental Congress.

“NobelActiveTM is a very stable implant, especially for immediate extraction and placement and its ability to adapt to the surrounding bone. Prosthetically, NobelActiveTM offers a very secure lock with a built in platform shift and a choice of restorative options.

“NobelActiveTM is available in 3.0 mm diameter, especially for insertion in narrow situations. I get great results and I see absolutely no problems or failures. It is my implant of choice! I am not afraid to put it in the most compromising situations. With NobelActiveTM you can safely and securely proceed with immediate load.

NobelActiveTM is also available in 4.3 mm diameter, especially for situations where more bone support is required. I use NobelActiveTM in all types of situations: in very compromised bone. Prosthetically, NobelActiveTM offers a very secure lock with a built in platform shift and a choice of restorative options.

Farrel Bradley Design – A comprehensive and automatic service.
With extensive experience working in the dental sector, Roger Gullidge Design is an architectural design service which has, over the years, developed exactly what the modern dentist looks for in a practice.

Director and Senior Designer Roger Gullidge has been creating outstanding dental practices for over twenty years. Offering services from concept feasibility to project management, Roger Gullidge Design offers comprehensive projects for a wide variety of clients: from small practices to large teaching hospitals and private clinics.

Roger Gullidge Design is a specialist design and project management consultancy specializing in the dental sector. Call 0273 978442 for more details or visit www.rogergullidge.com

Sirona
ChairSafe AlcoFree free from disinfectants.
CharSafe AlcoFree alcohol-free is available in a 500ml spray, as well as a 220ml bottle in 14, 2, 5, 10, 15, 20ml containers with the new Kemdent range of durable and economy concepts. CharSafe is made with an active ingredient that penetrates into the soft wall of bacteria, fungi and the envelope of viruses. It attracts the phospholipid membrane, altering its structure to make a leaky hole in the bacteria, causing it to burst.

CharSafe AlcoFree is free from disinfectants, and is very safe to use. It has been shown to be used for daily disinfection of surfaces close to the patient/frequently touched surfaces (e.g. dental chairs, door handles, and work surfaces).

For more information on the full range of Kemdent disinfecants, ChairSafe, P fiscalSafe and InstrumentSafe visit the Kemdent website www.kemdent.co.uk

For further information on special offers and to order contact Ciep on 0833 770151 or visit our website www.kemdent.co.uk

Sirona
For more information about the fantastic new CPD tracking app, make sure you visit www.cpdmobile.co.uk and download the app for free.

Life is better when you knock out a tooth!
For more information about the new app, visit www.options.dentalshow.co.uk

Tavom UK has long established an “Outstanding Cabinetry with Fantastic Quality and Price!” reputation. They offer a complete range of wall cabinets, wall shelving systems, and counter tops from the most renowned manufacturers. Tavom UK can provide you with the best quality cabinets at the best price. With over 36 years of experience servicing the dental market, Tavom UK is the leader in providing excellence in cabinetry for the dental market.

UCL Eastman Dental Institute, London, January 21st-27th, 2013
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Dental Tribune
United Kingdom Edition
January 21-27, 2013

With BKH Coaching
The 2013 edition of the popular publication Dental Summary Review (DSR) is now available. It is released in October 2012 providing dentists, hygienists and therapists with three hours of complimentary CPD. DSR is published by Orbis Health to provide a digest of some of the most interesting and stimulating research that has been published recently. The publication is edited by Dr Stephen Hancocks, DBE and will also be available to all UK dentists, hygienists and therapists at www.dentalsummaryreview.co.uk

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"What I like about NobelActiveTM is that it’s a very stable implant, especially for immediate extraction and placement and its ability to adapt to the surrounding bone. Prosthetically, NobelActiveTM offers a very secure lock with a built in platform shift and a choice of restorative options.

"I use NobelActiveTM 3.0 mm in narrow spaces, especially for missing lateral. I get great results and I see absolutely no problems or failures. It is my implant of choice! I am not afraid to put it in the most compromising situations. With NobelActiveTM 3.0 mm I have been successful with placing implants into sites where before patients were sent to the orthodontist in order to open smaller spaces. It also means less hassle and delays for the patients."
Sidel Dental Systems

Sidel Dental Systems, an independent, family-owned company with more than 13 years of experience working exclusively in partnership with Sidel, to promote the world’s premier brand of high tech dental equipment and support their many loyal customers, whom we buy Sirona equipment from Sidel Dental Systems you not only get the best price and exclusive Special Offers, but also you get access to the best sales support in the UK. Sirona Specialties, Sidel Dental Systems offer the choice from the complete range of Sirona Treatment Centers, 2D and 3D digital and film based x-ray apparatus – including the very latest Orthos 3G digital panoramic machine, their extensive range of Sirona handpieces, and auxiliary items including Sirona intraoral SROBiOx and DACI sterilisation units. Wherever possible potential clients are invited to visit The Courtland. Sidi’s state-of-the-art training and showroom facility in Chertsey, where they will be able to see the complete product range in action. Finally Sidel will undertake a complete Project Management Service, including installation and post installation service support, to enable these dreams to become reality.

For further information call Sidel Dental Systems on 01922 562900 or email j.cowell@sided.co.uk.

2 Years Warranty

Sidel’s extensive range of handpieces designed for use in the new Treatment Centres have a warranty of choice for all their customers and in the event of repair or repair may be a key factor in the decision making process. Tukarle Belmont are so confident in the quality and reliability of their products that you need to ensure that your business has a 5 year extended warranty policy to cover your Sirona Chucks, Units and Operating Lights. A reputation for reliable, the company feels that the extended policy will give you confidence the product and offer additional peace of mind. Stephen Price, Director said, “Having taken the time to research what equipment is most suitable for their practice it’s reassuring to know that their choice is covered under the terms of the manufacturer’s warranty. Our chairs are one of the most popular choices for dental teaching hospital facilities, such as 250 treatment centres in Guy’s hospital alone!” For full details on their warranty policies, please contact our team on 0114 209 6251, email: info@kemdent.co.uk

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For more information on this release please contact:
Michelle Hurd, AB Communications, Tel: (020) 8399 0703, E-mail: michelle@ab-comms.com

UCL Eastman Training in Restorative Dental Practice:

“made me a far better dentist”

Dr Yasir Haddad is a General Dental Practitioner at Holmewood in Denmark. He has successfully completed the Certificate and Diploma level courses in the Restorative Dental Practice programmes at the UL Eastman Dental Institution. “I started with the Certificate course and it gave me so much knowledge that I decided to continue, says Dr Haddad. “One of the things that really made me think was the fact that you could bring your own cases and discuss them with really skilled and experienced dentists and get a qualified answer.” The Eastman has a really good reputation, he says, and one of the best hospitals in the world. “The Eastman has made it easier for me to go onto a part-time PGD programme here in Denmark, once I finish my MSc project, helping me to develop an academic career.”

“I would definitely recommend the course because it’s really opened up not only new career pathways for me but also made me a much more contented and skilled dentist, and far better dentist than I was”

For further information, please contact Victoria Banks, Programme Administrator, on 020 7065 1251, email: v.banks@ucl.ac.uk or visit www.ucl.ac.uk/eastman/pgd

An Invitation To Lunch

Oral-B’s popular ‘lunch and learn’ sessions are CPD accredited so all team members can earn 1 hour of verifiable CPD in the comfort of their own practice. The meetings are ideal for those who want to learn more about the latest developments in power brushing and toothpaste including clinical support and the latest advancements. Surgeries for patient and personal use will also be available. Oral-B will endeavour to work on or the most convenient day for you and will provide presentations and/or a presentation focusing on clinical data behind their products. As the presentation takes place at lunchtimes Oral-B will provide lunch for all team members. Access to the Internet has led to an increased interest and awareness amongst consumers regarding matters of oral hygiene, and it is hoped that these informal weekly lunchtime meetings about Oral-B products and clinicians questions they might have in a relaxed environment with as little distraction as possible to their normal working day. These events are popular so early. To request a lunch and learn demonstration you will need to contact your local Oral-B sales representative for more information. If you do not have Oral-B products please call 01922 562900. A member of the customer service team will put you in contact. As demands high, reps will allocate appointments on a first come, first served basis.

An oral appliance for children with snoring

Sirona’s Airway Management System is a Class IIa medical device, available in two sizes, for use in the assessment of sleep-related breathing disorders in children aged 3 to 14 years. The Airway Management System is designed to support the investigation of functional nasal airflow. It is an active medical device with a non-invasive approach to maintaining adequate nasal airflow and facilitating REM (rapid eye movement) sleep with the aim of improving the patient’s sleep quality. The system consists of a nasal mask, an upper airway therapy unit, and a medical air compressor. The nasal mask is placed on the infant’s or child’s nose and positioned using an adhesive bandage. The system is connected to the upper airway therapy unit, which is connected to the medical air compressor. The medical air compressor is connected to a compressed air installation or a compressed air cylinder. The system is designed for quick and easy transport, allowing the device to be used at home and in hospitals. The system has been tested in clinical trials and has been approved by the relevant regulatory authorities in several countries. The device is designed to be used in combination with other therapies, such as continuous positive airway pressure (CPAP), to improve the patient’s sleep quality and reduce the risk of sleep apnea. The Airway Management System can be used in children with snoring, obstructive sleep apnea, or other sleep-related breathing disorders. It is recommended for use in conjunction with other therapies and should be used under the supervision of a qualified healthcare professional. The system has been shown to be effective in improving sleep quality and reducing the risk of sleep apnea in children. The Airway Management System is a medical device and should only be used for the intended purpose. It is important to follow the manufacturer’s instructions for use and to consult a qualified healthcare professional before using the device. The Airway Management System is not suitable for children under the age of 3 years.

For more information please contact: Sirona Dental Systems Limited 0845 071 5041 info@sironadental.co.uk

Industry News

Earn points with the Big Heart Party

The Big Heart Party will have a special guest, Heart Your Smile. Chris Brown, Event Director of the Dental Directory, said: “We are thrilled to have the Big Heart Party as a special guest at the Big Heart Party this year. The Big Heart Party is an annual event that brings together the dental community to raise awareness and funds for important causes. The Big Heart Party is known for its fun and engaging atmosphere, and it is always a highlight on the dental calendar. This year, we are excited to have Heart Your Smile as a special guest at the event. Heart Your Smile is a dental charity that focuses on providing oral health care to children and families in need. The Big Heart Party supports Heart Your Smile by providing a platform for the charity to raise awareness and funds for its important work. The event will feature a variety of activities and attractions, including a silent disco, live music, and a variety of other entertainment options. Attendees can earn points for participating in various activities, and these points can be redeemed for prizes. The Big Heart Party is a great opportunity to have fun and make a positive impact on the community. We look forward to seeing everyone at the event.”

For more information or to register for the event, please visit www.facebook.com/bigheartparty.

Sidi’s another Kazakhstan move

Sidi’s Kazakhstan operation continues to grow, with a new office opening in Almaty. The move is part of Sidi’s ongoing expansion in the region, where the company already has a significant presence. The new office will allow Sidi to further increase its footprint in Kazakhstan, offering a range of products and services to local health authorities and medical professionals. Sidi’s Kazakhstan operation is growing rapidly, with a number of new contracts secured in recent months. The company has been successful in securing contracts for hospitals and clinics across the country, and is now looking to expand its operations further. The new office in Almaty will allow Sidi to offer a more comprehensive range of products and services to customers in the region. Sidi’s Kazakhstan operation is run by a local team of experienced professionals, who have a deep understanding of the local market and are well-placed to provide support and guidance to customers. Sidi is committed to delivering high-quality products and services to its customers in Kazakhstan, and the new office in Almaty is a key part of this commitment.

For more information please contact: Sidi’s Kazakhstan team on +7 7172 712 121, email: info@kemdent.co.uk
the journal of

The Young Dentist Endodontic Award 2012

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| user report |
| feature |
| feature |

more people to learn their

AIDS because it empowers

In-Home HIV Test is a

kit, said “The OraQuick
to wait days for results,” the
doctor’s office or the need

but without the trip to a

health professionals use

the first do-it-yourself test
can identify the antibod-

zine, OraQuick, the first

day

6,000 cases have been di-
said: “Larry’s passing is a

and raise awareness about

Health Foundation, Dr Ni-

Dallas, died of tongue can-
cancer

battery.

charged with four counts

wound. Collazos has been

subsequently kissed the

migrants. A woman com-

ing his services towards im-

25 Clinical Tips

| comment |
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wants to offer an

opportunity to educate and

warn dentists and patients

about the risks of HPV

and genital warts.

Now is the

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