End of the line for tobacco displays

New legislation came into effect on 6 April to protect children from being the target of tobacco promotion and to help people quit smoking

From April all large shops and supermarkets in England had to cover up cigarettes and hide tobacco products from public view.

Evidence shows that cigarette displays in shops can lure young people to start smoking. More than eight million people in England still smoke – it is one of the biggest preventable killers causing more than 80,000 deaths each year. Nearly two-thirds of current smokers say they started smoking before they were 18.

Up until now, every time parents do their weekly shop their children are exposed to tobacco, making it a normal part of everyday life. Statistics show:

- Five per cent of children aged 11-15 are regular smokers
- More than 380,000 children under 16 try smoking each year
- 59 per cent of smokers say that they were smoking regularly before the age of 16

Covering tobacco displays will protect children and young people from the promotion of tobacco products in shops, helping them to resist the temptation to start smoking. It will also help and support adults who are trying to quit.

Health Minister Anne Milton said: “We cannot ignore the fact that young people are recruited into smoking by colourful, eye-catching, cigarette displays. Most adult smokers started smoking as teenagers and we need to stop this trend.

“Banning displays of cigarettes and tobacco will help young people resist the pressure to start smoking and help the thousands of adults in England who are currently trying to quit.”

Jo Butcher, programme director of health and well being at the National Children’s Bureau, said: “National Children’s Bureau welcomes the end of tobacco displays.

“Children and young people tell us that outside influences make it even more difficult for them to choose healthier lifestyles. A yet to be released National Children’s Bureau health survey has found that more than one in four young people felt they needed more information about the health effects of drugs, alcohol or tobacco.

“It’s essential that we create a culture that promotes and protects public health and tobacco legislation is a significant factor in making this happen.”

Cigarettes and all tobacco products will have to be out of sight except when staff are serving customers or carrying out other day-to-day tasks such as restocking. Those responsible in shops not complying with the law could face fines up to £5,000 or could face imprisonment.
Children call for smoke-free homes

A new hard-hitting campaign, highlighting the shocking truth behind second-hand smoke recently hit our TV screens.

The New TV and radio adverts will show that smoking by a window or the back-door is not enough to protect children from second-hand smoke, with the health of second-hand smoke is invisible. This contains harmful cancer-causing toxins and poisons that are unknowingly damaging children across the country every day.

Millions of children in the UK are exposed to second-hand smoke that puts them at increased risk of lung disease, meningitis and cot death. It results in more than 500,000 GP visits, 9,500 hospital visits in the UK each year and costs the NHS more than a staggering £25.6 million every year.

The only way to completely protect people from second-hand smoke is to make homes and cars entirely smoke free. As the campaign launches, a new survey reveals that children who want smoke free lives. The survey found:

- 88 per cent of children wish their parents wouldn’t smoke in front of them at home
- 82 per cent of children wish their parents wouldn’t smoke in front of them in the car
- 78 per cent of the children wished their parents wouldn’t smoke in front of them
• 44 per cent of children said cigarette smoke made them feel ill
• 42 per cent of children said cigarette smoke made them cough

Health Secretary Andrew Lansley said: “We all know smoking kills but not enough people realise the serious effect that second-hand smoke has on the health of others, particularly children.

“This campaign will raise awareness of this danger and encourage people to take action to protect others from second-hand smoke.

“This is just one part of our wider strategy on tobacco. We need to do more. That is why we will end tobacco displays in large shops. We will also be consulting on plain packaging this spring.”

Chief Medical Officer Professor Dame Sally Davies said: “Second-hand smoke can cause a range of serious health problems for children and adults. Smoking damages our lungs, causes cancers and is now the biggest risk for cot death. Parents who smoke need to do more. That is why we will end tobacco displays in large shops. We will also be consulting on plain packaging this spring.”

Consultant Paediatrician at the Royal Surrey Hospital Dr Charles Godden said: “I see children every week with conditions which are made worse by second-hand smoke. Most parents would be horrified to know that every short car journey where an adult has been smoking would result in breakdown products of nicotine in their child’s urine.

“This shows exactly why we should all make our homes and cars smoke free and that children need protection from exposure to second-hand smoke.”

Smokers can order a new NHS Smokefree kit by texting POISONS to 65818 or by visiting nhs.uk/smokefree for facts, tips and tools to help them on the way to a smoke free future.

Nominations open for Principal Executive Committee

The nominations process for the new BDA Principal Executive Committee (PEC) has opened. The new committee, which will replace the current Representative Body and Executive Board, will assume overall responsibility for BDA policy and governance. PEC members will also be the legally responsible directors of the Association.

The Committee will consist of 15 members, 12 of whom will represent geographical constituencies and three who will be elected on a UK-wide basis. All members will be elected in spring 2012. Seats will then be subject to a revolving cycle of elections starting in December 2014, when a third will be subject to fresh elections.

Those interested in standing for election are invited to submit a completed nomination form and personal supporting statement by Friday 25 April 2012. Members will have the opportunity to hear from prospective candidates at a series of ‘speed dating’ style events at the British Dental Conference and Exhibition which takes place in Manchester between 26-28 April, and will receive ballot papers, where required, at the end of April.

Encouraging applications, BDA Chief Executive Peter Ward said: “The BDA occupies a unique position in UK dentistry. Members of the new Principal Executive Committee will be working in the interests of their professional colleagues, taking on the governance and stewardship of the Association and overseeing the next stage of its development. They will inherit resources, reputation and research and will help shape the future of the BDA and the dental profession.

“I encourage all members who feel passionately about the future of the organisation and UK dentistry to think seriously about standing for election to the PEC.”

Further information on the Principal Executive Committee and the election timetable, is available at: http://www.bda.org/pec Nominations forms are also available via the above link.

Make an exhibition for yourself in Manchester

Delegates at the forthcoming British Dental Conference and Exhibition can plan their visit to the exhibition element of the event using an innovative new online bookings system that allows attendees to reserve time with exhibitors.

For the first time ever, visitors can book time with exhibitors that they wish to meet at any time within advance of the event, using a simple online bookings system hosted on a BDA-managed British Dental Conference and Exhibition microsite. The system also allows delegates to plan the conference sessions that they intend to attend, thereby creating a personalised schedule for the event that can be downloaded to Outlook diaries.

The exhibition is expected to feature more than 140 exhibitors, including equipment suppliers, product manufacturers, service providers and trade associations. The meeting reservation facility has been introduced in response to feedback from exhibitors and visitors and aims to help busy delegates maximise the value of their visit by allowing them to schedule all of the key appointments they need.

Linda Stranks, Director of Marketing and Membership at the BDA, said: “Some delegates are happy to peruse the exhibition and find inspiration as they explore, but others visit the exhibition with a very specific aim – researching the purchase of a particular piece of equipment, for instance.

“This new tool will help delegates to tailor their British Dental Conference and Exhibition experience to create a bespoke schedule that ensures they get the time they want with exhibitors when they want it, to fit around the conference sessions they are planning to attend.”

The 2012 British Dental Conference and Exhibition takes place at the Manchester Central Convention Complex from 26-28 April. For full details, visit: www.bda.org/conference.

Action group seeks DA evidence

A group of dental hygienists have formed a campaign group in order to influence the future of dental access to patients.

Key DCs are hoping to encourage fellow DH&Ts to help influence the future of their profession.

The Direct Access Action Group is campaigning for direct access to patients for dental hygienists and plans to keep colleagues in the loop as to what this will mean for them, the profession as well as for patients.

The Office of Fair Trading (OFT) is currently re-examining arrangements for dental hygienists and NHS dentistry markets are working well for patients and this includes an investigation into how patients currently access dental care including access to dental hygienists.

To take part, visit www.fae c.ca.org.uk or follow @DAActionGroup on Twitter and take a few minutes to fill out a brief survey that even takes a very short journey. Go to www.surveymonkey.com/s/HK8C56P or email the group at directactiongroup1@gmail.com.
Metformin tablets

According to a new study, Metformin Prevents the Development of Oral Squamous Cell Carcinomas from Carcinogen-Induced Premalignant Lesions, published in Cancer Prevention Research, Metformin may protect against oral cancer.

Metformin is the most widely used treatment for patients with type 2 diabetes, and according to the study authors, scientists have noticed that “metformin reduces the growth of HNSCC (Head and neck squamous cell carcinoma) cells and diminishes their mTORC1 activity by both AMPK-dependent and -independent mechanisms.”

According to a report, J Sivil Goolnik made the top spot for the second year running, a big achievement and in recognition for the Heart Your Smile campaign which he founded last year; aiming to bring positivity back to the dental profession.

Congratulations also go to Dean of the Peninsula Dental School and Dental Tribune editorial board member Liz Kay, number four in the list. Other notable names familiar to DT readers include Mhari Coxon (5), Elaine Hallie (11), Nik Sisodia (25), Wyman Chan (55), Julian Webber (58) and Susie Sanderson (49).

Thoughts are now also turning to the upcoming events prominent in the dental calendar: the Dental Awards (April 20), BDA Conference and Exhibition in Manchester (April 26-28) and the Clinical Innovations Conference in London (May 18-19). I will be attending all three events — if you see me come over, say hi and let me know your thoughts on Dental Tribune.

Do you have an opinion or something to say on any Dental Tribune UK article? Or would you like to write your own opinion for our guest comment page? If so don’t hesitate to write to: The Editor, Dental Tribune UK Ltd, 4th Floor, Treasure House, 19-21 Haddon Gardens, London, EC1 N8.

Or email: lisa@dentaltribuneuk.com

Metformin tablets

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Or email: lisa@dentaltribuneuk.com
**MyFaceMyBody Awards**

The MyFaceMyBody Awards have been organised to celebrate and award those who have made a difference in the cosmetic sphere. Celebrating in style, The MyFaceMyBody Awards will be delivered in the form of a masquerade ball and held at The Landmark Hotel, London on the 3rd November 2012.

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New information to help improve patient outcomes

Dentists can learn how to stay out of trouble by signing up for one of nine dento-legal lectures being held throughout the UK in May and June this year.

UK-wide dental defence organisation MDDUS is co-hosting a series of educational sessions that will provide top tips on how to avoid dento-legal pitfalls that could lead to patient complaints, claims of clinical negligence or referral to the GDC.

MDDUS has teamed up with dental equipment providers Wright Cottrell to host the lectures which kick off on Wednesday, May 23 in Newcastle with further dates in Manchester, Leeds, Liverpool, Inverness, Aberdeen, Glasgow and Edinburgh, before concluding in Dundee on Thursday, June 21.

The lecture will feature MDDUS Head of Dental Division and adviser Aubrey Craig, who has long experience helping MDDUS members deal with professional difficulties.

He says: "Being on the receiving end of a claim, complaint or referral to the GDC is an expensive, time-consuming and stressful experience."

"Every year at MDDUS, we assist members who find themselves in such situations and these lectures will draw upon our considerable experience in this area to provide delegates with practical advice on how to avoid professional difficulties."

Wright and W&H will also lead a session unravelling the mysteries of the national decontamination guidelines. This will enlighten dentists to the realities of what is expected and arm them with the know-how to achieve a fully compliant practice.

W&H Northern Territory Manager Claire Wilson will present the sessions in England, with Scottish Territory Manager Raymond Baxter hosting the Scottish ones.

In addition, the Scottish dates will also feature George McDonagh, Clinical Adviser for the NHS in Scotland, who will share his unrivalled knowledge of decontamination procedures that he has accrued from his 20 years' experience in the industry.

Robert Donald, non-executive director of MDDUS and well-known Scottish dentist and magazine columnist, welcomed the CPD-accredited evening road-show initiative.

He says: "Staying out of trouble with the GDC and decontamination compliance are hot topics for all UK dentists. The collaboration of MDDUS and W&H in providing practical advice and support to our members is a very positive step indeed and I would encourage my colleagues to attend."

"To book your place at one of the lectures or for further information, contact Karen Walsh at kwa@mddu.com. Tickets cost £30 with a light buffet available from 6pm and the programme commencing at 6.30pm."

Dates and venues for lectures (all dates 2012):

- Wednesday, May 25: St James' Park, Newcastle
- Wednesday, May 30: Mandec, Manchester Dental Hospital
- Thursday, May 31: Weetwood Hotel, Inverness
- Wednesday, June 6: RGP of Edinburgh, Edinburgh
- Wednesday, June 21: Wright Cottrell offices, Dundee

Wheelchair controlled by remote control in mouth

The Tongue Drive system, which is a wireless device that enables people with high-level spinal cord injuries to operate a computer and maneuver an electrically powered wheelchair simply by moving their tongues, is getting less conspicuous and more capable.

An inconspicuous dental retainer, which the user blows into or sucks through a straw, contains a tiny magnet attached to the roof of the mouth and is covered with a material and vacuum-molded inside a standard acrylic.

When in use, the output signals from the GDC are wirelessly transmitted to an iPod or iPhone. Software installed on the iPod interprets the user's tongue movements by determining the relative position of the magnet with respect to the array of sensors in real-time. This information is used to control the movements of a cursor on the computer screen or to substitute for the joystick function in a powered wheelchair.

Ghovanloo and his team have also created a universal interface for the intraoral Tongue Drive System that attaches directly to a standard electric wheelchair. The interface boasts multiple functions: it not only holds the iPod in place, but also has a simple switch controlled by sucking or blowing through a straw.

The researchers plan to begin testing the usability of the intraoral Tongue Drive System against the state-of-the-art head mounted displays. In the near future, the research team hopes to test the usability of people with high-level spinal cord injuries.

In recent months, Ghovanloo and his team have recruited 11 individuals with high-level spinal cord injuries to test the headrest version of the system at the Atlanta-based Shepherd Center and the Rehabilitation Institute of Chicago. Trial participants received a clinical tongue piercing and tongue stud that contained a tiny magnet embedded in the upper lid. They repeated two test sessions per week during a six-week period that assessed their ability to use the Tongue Drive System to operate a computer and navigate an electric wheelchair through an obstacle course.

“During the trials, users have been able to learn to use the system, move the computer cursor quicker and with more accuracy, and maneuver through the obstacle course faster and with fewer collisions," said Ghovanloo. “We expect even better results in the future when trial participants begin to use the intraoral Tongue Drive System on a daily basis.”
The UK launch of ‘Periodontal Disease and Overall Health: A Clinician’s Guide’, supported by an educational grant from Colgate, took place at Chandos House, London. A host of attendees representing a wide range of educators, periodontists and those with a shared interest in medicine came together to hear about the most contemporary thinking behind what the dental and medical literature suggest is an association between oral and systemic diseases.

Dr Anousheh Alavi, Scientific Affairs Manager, Colgate UK & Ireland, opened the proceedings introducing Dr Fotinos Panagakos, Colgate Director of Clinical Research. Dr Panagakos, who is based in the US, shared insight into the 18 chapters, which delve into the sciences behind diabetes mellitus, atherosclerosis, adverse pregnancy events, respiratory diseases, osteoporosis, rheumatoid arthritis and cancer, looking at risk factors in common with periodontal disease such as inflammatory processes. The book then logically follows with a discussion of the steps needed for comprehensive co-management of the diseases by both dental and medical caregivers.

The editors, Drs Robert J Genco and Ray C Williams, assembled this textbook working with a number of internationally renowned authors. In their overview they set out clear goals for this textbook stating “Much research is focused on understanding how periodontal disease increases the risk for systemic diseases. It is not yet clear what impact the biofilm in the oral cavity might have on distant sites and organs, or the role of the inflammatory response is not fully understood. Some of the chapters in this textbook review the biological plausibility for periodontal disease as a risk for systemic conditions. The overall goal of this textbook is to present the emerging and compelling evidence that periodontal disease is a risk for several systemic conditions and to look at the role of oral health in contributing to overall health. This book also seeks to provide the reader with a guide to patient management in which dentistry and medicine work together.”

This textbook will be provided in hard copy to UK and Irish dental libraries, and available to all dental professionals to download as a PDF from www.colgate-professional.co.uk.

The outcomes of a dental pain study comparing the efficacy and tolerability of a novel single-tablet combination of ibuprofen and paracetamol with that of an ibuprofen/codeine combination and a paracetamol/codeine combination using the dental biphasic pain model. This comparison relates to cumulative pain relief over 12 hours following a single dose. *The nuromel fast release tablets (both 200mg and 500mg) provide: • Stronger pain relief • and is effective for longer than TWO tablets of an Ibuprofen + codeine combination*
Discussing dental nurses

In the third part of this four-part interview, Neel Kothari talks to Susie Sanderson about dental nurses

NK: I wanted to ask about dental nurses. Nurses are amongst the lowest paid of the dental team and they’ve suffered a huge rise in costs – registration fees, compliance with CPD and other rules and regulations. Have they seen good value for money and are these relations. Have they seen good CPD and other rules and regulation fees, compliance with huge rise in costs – registration team and they’ve suffered a the lowest paid of the dental N...
The receptionist role in CQC compliance

Glenys Bridges highlights the need for team work

Irrespective of where your practice is located, the new culture of healthcare is one of the whole team working to meet required care standards. Inspectors will visit practices to ensure that each member of the team, irrespective of whether or not they are a GDC registrant have the training and resources required to provide safe, high quality dental care and services.

When it comes to defining the receptionists’ role to ensure compliance with healthcare regulations, there are several essential requirements. For each of these the Provider and Registered Manager must develop policies and procedures. To name but a few, these include procedures for: blending NHS and private services, communicating about and collecting patient’s fees, data security, equality and diversity, patient safety, consent, confidentiality, child protection, risk assessment, the Mental Capacity Act, Information Governance requirements and many more. Irrespective of whether it is delivered in-house or by external trainers, training and preparation for each of these complex aspects needs to be delivered to ensure practice policy and procedures shape the services delivered to patients, rather than simply filling-up a folder on a shelf in an office.

High quality and customer care sits at the core of care quality standards. Service with a smile is a significant first step toward creating a welcoming environment. However, a smile alone is not enough to create a perception of competence. Intelligent reception services are developed with in-depth understanding of patients’ needs for information about all aspects of their treatment. Care quality standards specify the need to collect information so that patient satisfaction levels can be monitored. Then to go on to use the information gathered, to evolve systems and procedures to meet the needs identified by patients, the practice team and regulatory bodies.

Historically, the training and development needs for reception staff have been side-lined. In the current regulatory climate it would be naïve of practices to overlook the need for their reception teams to be fully involved in developing care standards. Even although they are not GDC registrants in their own right, unless receptionists are fully involved in setting and meeting the practice’s standards of quality and care, the hard work of clinical teams will fail to reach their full potential.

Service with a smile is a significant first step toward creating a welcoming environment.

About the author

Glenys Bridges is an independent dental team trainer. She can be contacted at glenys.bridges@gmail.com

Digital imaging can be so simple: Ergonomically and anatomically perfect placement of the sensor, imaging with lowest dose, images with excellent image quality available within seconds, intuitive diagnostics and comfortable post-processing of the data in the practice workflow. USB or Ethernet operation – the choice is yours. Sirona offers the right solution for each use case: The XIOSPLUS intraoral sensor system – as flexible and individual as your dental practice. Enjoy every day. With Sirona.

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In whose interests?

Andy Acton warns about an offer that’s too good to be true

O
ne fine, sunny afternoon, there I was relaxing on the sofa at home when a complete stranger knocked on my door and told me he had someone who would love to buy my house.

Surely this is all too good to be true?

Of course this story isn’t true because my Mum always told me to never answer the door to strangers! You may be surprised to learn however, that many, many principals have sold dental practices on this basis. It might be a cold call from another dentist, corporate player or a dental broker but whatever way the initial contact is made, it is a recipe for disaster.

Whilst it is very flattering to get a direct approach, this is never the way to get best value for your business. How do you know the ‘real market value’ other than what you have been told? How many other good quality buyers are really out there? How much is the person who made the approach being paid by the buyer? Who else could fund the purchase?

A knock on the door could well spark your interest, but from here on in you need to be looking after your own interest and not be guided by someone who may purport to be looking after you, but is actually being paid by another party. In this scenario – who are they actually looking after? In business, the person paying the bill will get looked after first. Anyone who claims to be acting for the seller of a practice yet is being paid by the buyer, has a clear conflict of interest – and in my opinion there is no doubt on this. If you sign an Authority

A ‘direct approach’ is never the way to get best value for your business

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DO engage the services of an independent firm to liaise with the Banks on your behalf – will ensure proposal is packaged for best chance of a positive response and also to negotiate best terms.

DO ensure you provide an accurate summary of your current position including all savings and existing borrowing.

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Frankly Speaking

‘A knock on the door could well spark your interest, but from here on in you need to be looking after your own interest and not be guided by someone who may purport to be looking after you, but is actually being paid by another party’

with a client to sell their practice you have a duty of care to achieve the best deal you can for that client and act with integrity.

You may be aware of the mantra in online marketing that “if you’re not paying for an online service, you’re not the customer; you’re the product.” This has recently been in the news with the way that Facebook and Google use your data. The quote applies equally well to the sale of a dental practice – if you aren’t paying them then you can be sure that someone else is!

The true market for the sale of practices is far from the stories being spread by the ‘direct approaches’. Last year FTA Finance, the leading arranger of finance for dentists in the UK, arranged £109 million worth of finance for dentists – this blows away the myth that there is no one out there with any money. Last year a practice in Essex had 12 offers of which some were above the asking price – and no one is buying dental practices? This particular practice was initially marketed to 975 dentists who were actively looking for a practice that matched the profile of this one.

I would also strongly advise that you pay for selling your practice too. In this way there is no doubt you are the client, you are receiving the service and if you work with a reputable firm you should also end up with more in your pocket. If we go back to my house which I was offered £55,000 for, if I had checked the true value I would have found out it was worth £65,000. A good agent would also have found me a buyer at that price, but charged me a fee – say 2.5 per cent. End result is I get £65,575.

The only real loser from selling as a result of a direct approach is the seller. The buyer pays you £55,000 – if there is an agent of any sort involved they may get between £5,000 and £25,000 so the true cost to buyer is £40,000 to £60,000 (which is still below the market value). The buyer and agent are delighted and you are left feeling hard done by and slightly embarrassed; but only if you know about it.

Whilst this may read like a piece of fiction, in my experience so many dentists do sell for tens of thousands of pounds less than they could have.

A direct approach can sound very convincing and to seek a second opinion may well cost you nothing – so why wouldn’t you? You have worked hard all your life to build value into your business - you owe it to yourself to sell it for what it is worth.

About the author

Andy Acton is a director and co-owner of Frank Taylor and Associates – the leading independent valuers and sales agents to the dental profession. Its sister company, Loan Hunter, provides financial solutions to the dental industry. Andy is a regular contributor to the dental media and has also delivered many lectures across the UK.

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Best of British

Dental Tribune speaks with DLA Chief Executive Richard Daniels about the organisations latest campaign to promote British dental laboratories

Following the launch of the British Bite Mark last month, the Dental Laboratories Association have had an incredible response from UK dental laboratories wanting to be part of the DLA's first ever campaign direct to the public. To date there are now 277 dental laboratories that have signed the declaration of compliance to the British Bite Mark with several hundred still waiting.

Speaking to Dental Tribune Richard Daniels, Chief Executive of the Dental Laboratories Association made it clear why he felt the campaign was necessary and what he hoped the outcome of the campaign would be.

Outsourcing

“The launch of the British Bite Mark was deliberately made in March on the back of the announcements from some dental bodies corporate that they were looking to review their procurement processes in 2012. Whilst on the face of the procurement changes there was nothing to suggest a desire to move towards outsourcing work to dental laboratories in the Far East, it was clear from the pricing structures that the DLA should be concerned that this is the ultimately where the path could lead. Equally the subsequent enthusiasm by some dental practices to use dental lab outsourcing agents over their usual dental laboratories, provided greater reason to start a campaign that provides transparency to the patient.”

It seemed appropriate to ask Richard why he felt there was a need for a campaign of transparency that effectively could by-pass the dentist in terms of offering patient information.

“The British Bite Mark campaign is like any other ‘Made in Britain’ campaign’, its aim is to provide the patient with an informed choice about their purchase, far from by-passing the dental practice, the campaign is going to actively embrace those dental practices that use registered British Bite Mark dental laboratories, over the coming months we will have information packs that dental practices can use free of charge to promote the fact that they use a British Bite Mark dental laboratory to their patients.

Since 2004, the Dental Laboratories Association has proactively lobbed against custom made dental appliances manufactured overseas, the Dental Tribune asked Richard if he felt that there really was sufficient danger to the patient that justified the British Bite Mark as an essential tool for patients when making decisions with their dentists over their prescription. Richard replied: “This campaign isn’t necessarily moment only dental laboratories operating in the UK and the EU have the possibility of a competent authority visiting the manufacturing dental laboratory to ensure appropriately trained professionals are operating in the lab and that CE marked materials are being used.

“The truth of the matter is that there are good and bad labs everywhere in every country, the comforting thought for patients here in the UK is that there is a significantly higher chance of them getting found out here in the UK than anywhere else in the world and the easiest way of getting this message across is with an easily identifiable logo, that instantly offers patients peace of mind.”

When discussing the British Bite Mark campaign and its objectives, it is clear that Richard thinks the DLA have got it right, both for the patient and for the DLA membership. Dental Tribune asked Richard if he had received any resistance from the membership following the launch of the British Bite Mark, he said: “in all honesty, I have received three complaints, understandably all from members who have a commercial interest in dental laboratory outsourcing, but as I have said to them and anyone other party that has enquired, my mission is not to say that British dental laboratories are best or that dental practices that use overseas dental laboratories are bad but merely to manage a campaign states the facts, facts that the patient and for that matter many dentists should be aware of when choosing a manufacturer of custom made dental appliances. In my opinion, dental laboratories that carry the British Bite Mark should be proud, dental practices that use British Bite Mark dental laboratory’s should be proud and we want to help them promote the fact to their patients, frankly if the DLA don’t promote British dental technology, who is?”

"In my opinion, dental laboratories that carry the British Bite Mark should be proud, dental practices that use British Bite Mark dental laboratory’s should be proud and we want to help them promote the fact to their patients, frankly if the DLA don’t promote British dental technology, who is?"
Tripping over triple trays

David Hands and Neil Photay shed some light on the pitfalls of using triple trays and how they could end up costing more than they are worth.

The use of triple trays are becoming more common in the surgery to take an impression of prepared teeth (as well as opposing teeth) for the dental laboratory to prepare a fixed prosthesis such as a crown or bridge. With a thin, pliable mesh separating the impression material, the trays are used to simultaneously register the upper and lower bite. They tend to be seen by dentists as a cost-effective solution for taking impressions, but your dental technician may take a different view.

To prepare restorations of the highest quality and perfect fit, laboratories need to accurately register the patient’s bite. There is a very fine line between a perfectly fitting crown and one that causes the patient irritation — the difference can be a matter of millimetres. There are so many different techniques and products that a dentist can use to ensure they are taking impressions as accurately as possible, but in my opinion using a triple tray is not one of them.

Triple trays' main downfall is that an impression of only four or five teeth is able to be taken. This makes it almost impossible for the technician to get a clear idea of the arrangement of the patient’s teeth, making it extremely difficult to create suitable restorations for them. Imagine being asked to cook a stranger their perfect meal, without being told which ingredients they don’t like! Essentially the chef is working blind, and this is the challenge dental technicians are faced with when they are sent impressions that are constructed using triple trays.

Along with the correct bite, technicians must also be able to assess the size and shape of the preparation margin and also of any adjacent teeth. The only way to do this effectively is to use stock trays which enable the dentist to take an impression of the full upper and lower arches. This really helps technicians to visualise for themselves how the patient’s bite, teeth and margin are formed.

‘There are so many different techniques and products that a dentist can use to ensure they are taking impressions as accurately as possible, but in my opinion using a triple tray is not one of them’ being told which ingredients they don’t like! Essentially the chef is working blind, and this is the challenge dental technicians are faced with when they are sent impressions that are constructed using triple trays.
awkward to use. I frequently have to ask dentists to retake their impressions after receiv-
ing a model which shows that the patient has bitten through the tray into the mesh. Avoid-
ing this can be tricky and a lot depends on how much mate-
rial needs to be used and how deep the outside of the tray is. Having said that, with the right technique triple trays can be successfully used for small inlays but I would avoid using them for anything more complex, such as bridgework.

Another word of warning: triple trays may at first ap-
pear to be the cost effective method of taking impressions but my experience tells me otherwise. With their lack of consistency and inability to take an impression of full upper and lower arches, im-
pressions frequently have to be retaken. This involves rescheduling appointments at great inconvenience to both the patient and the den-
tist, costing time and, ulti-
mately, money.

Dental Technology schools heed a warning regarding tri-
ple trays as a source of inac-
curacy and therefore a higher rate of device failure. Some even go as far as refusing to work on triple tray impres-
sions at all.

Most laboratories will re-
fuse to fabricate any bridge work on triple tray impres-
sions, and rightly so, as the functionality of the bridge cannot be created or checked. If working only on the quad-
rant, the excursions of the full arch cannot be replicated which is essential information for the technician to have. In-
evitably dentists may have to grind bridgework chair-side and create any guide planes by sight and feedback from the patient. Surely the cost of extended chair time is more than the cost of taking full arch impressions.

It can be very easy to be-
come accustomed to using the system that you have done for years and it is under-
standable why at first cli-
nicians might be loath to switch their impression tray. Never-
theless, I do believe that by using full arch stock trays, practitioners will benefit from more accurate restora-
tions, a smoother service and an easier relationship with their laboratory. Likewise, the patient will receive an excel-

more features, more benefits, more time, more support, all of which can help you achieve more patients and more profits.

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Ultra Suction Denture Stabilisation System

Mony Paz and Ted J Carson discuss suction dentures

Ultra Suction system increases the retention of mandibular complete dentures. There retentive capacity in comparison to conventional dentures has been positively demonstrated via retention tests and clinical observation.

A clinical study published in the EDA Journal (Jan. 2010 Vol. 56) shows a significant improvement in denture retention after the application of the Ultra Suction system. The aim of this article is to familiarise the clinician with the materials and methods through a comprehensive installation process.

Ultra Suction works on a simple mechanical principle: Suction. Two tiny one-way valves, embedded into the lingual or palatal aspect of the denture base, draw air from beneath the denture via two channels, collectively open to a retention chamber (Fig A).

As the wearer bites firmly, the air trapped between the mucosa and the denture is expelled through the valves. Under negative atmospheric pressure, the diaphragms seal off the valve inlets. The pressure difference, i.e., the lower pressure beneath the denture exerts a pull and draws the denture closer to the borders. The result is a better fit to the tissue and an improved resistance to dislodging forces (Fig B).

The documented dental literature teaches us that the supporting soft tissue under a well-crafted maxillary complete denture is subjected to ~80mmHg of negative atmospheric pressure. This is the suction level experienced by upper denture wearers. Ultra Suction valves have been developed to generate the same negative force when applied to the mandibular dentures or palatless maxillary dentures.

‘Ultra Suction works on a simple mechanical principle: Suction’

The system is commercialised as a full kit with illustrated mounting instructions. The components may be used for upper or lower dentures, on completely new dentures or fitted on existing dentures during the rebase/reline pro-
System Components
The spacer bar is used to create a retention chamber. Made of malleable metal, the bar is designed to sit intimately against the ridge. It can be easily bent, burnished and adapted to almost any alveolar ridge. (Fig D).

Valves
Two one way valves designed to expel the air from beneath the dentures. The central hole in the valve body is described as the inlet, and the valve cover as the exhaust (Fig F).

Processing Caps
As their name suggests the caps are fitted onto the valve bodies before the instillation procedure. Their role is to protect the valves. They are removed only after the polishing stage (Figs G and H).

Diaphragms
Two diaphragms and two spares come with the kit. These tiny plastic discs seal the inlet under negative atmospheric pressure and release the pressure under resting conditions, at the rate of 10mmHg per 15 seconds (Fig I).

The service key has two extremities. The upper part is used to grip, close & open both the valve covers and the processing caps. The lower part is a slightly larger replica of the valve and may be used as a gauge for depth and diameter (Fig J).
Ultra Suction Technique

The following sequences of images display us through the instillation process starting with two light body vinyl polysiloxane impressions loaded on special trays. In Figs 1 and 2, the impressions were boxed with particular attention to preserving accurate borders and to encompass the tuberosity protuberances.

Yellow stone was used to pour the casts from the impressions and after setting, the cast models were trimmed (Figs 3-4).

On the ridge, the location of the spacer bar was pencil designed, making sure that the bar stopped at least 1cm short of the end of the denture (Figs 5-6). The bar was stabilised using two or three small drops of cyanoacrylate and any under cuts were blocked-out (Figs 7-8).

Hard base plates were prepared on top of the spacer bars (Figs 9-10), followed by bite blocks (Fig 11). After bite registration, the casts were mounted on an articulator (Fig 12) and teeth set-up for try-in was carried out (Figs 15-14).

In this case study the Agar flasking technique and cold cure acrylic was used. However, all other flasking and packing techniques are acceptable. Each model was packed in a two part flask (Figs 15-16). The spacer bar remained on the model and any under cuts were blocked-out (Fig 17). Cold cure acrylic poured in (Fig 18).

After polymerisation and de-flasking, the bars were removed from the dentures by digging prudently to prevent damage to the walls of the retention chamber (Fig 19-22).

The dentures were then trimmed and polished (Fig 25). It should be noted that if the valves are mounted before polishing the dentures, there is a high risk of ending up with protruding valve covers, which is not a favourable outcome in terms of patient comfort.

At the chosen lingual site, the location of the valves was drawn with a felt marker between first and second premolar, with the centre of the valve preferably 1-1.5mm above the highest point of the retention chamber (Figs 24-25).

The cavities for the valves were prepared with a round bur (Fig 26) intermittently using the gauge side of the service key for guidance ie, depth and diameter (Figs 27-28).

Processing caps were then placed in the valves to protect the core from being filled with self cure acrylic and then tried in (Figs 29a-30).

The cavities were then trimmed and polished before washing the dentures. The valves were rinsed and the valve body inspected (Figs 35-36). Each valve was rinsed and the valve body inspected (Figs 35-36). The valves were installed with cold cure acrylic (Figs 51-52). Soft rubber cylinder points were used to remove excess material and to polish around the valves (Fig 53). The dentures were given a final sheen (Fig 54).

The processing caps were then removed and the valve body inspected (Figs 55-56).

A simple and efficient recall system developed by Fred Carson consists of a computerised patient database and a recall postcard printed on both sides (Figs 44-45). The patient's last visit was entered into the records. Six months later a pop up window displayed the names due for check-up. A postcard was sent. Most patients responded positively to this follow up.

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During the biannual visit, dentures were checked for their fit to the supporting tissue, followed by a general examination of the oral cavity. On this occasion, calculus deposits were removed from...
around the retention chamber and the air channels were thoroughly cleaned (Fig 46).

The valve covers were opened over a receptacle of water to avoid losing the components. The valves were cleaned and the diaphragms replaced. Patients were instructed to clean their dentures and the valves on a daily basis. Patients who had manual dexterity were given the service key, together with spare diaphragms and were instructed to perform routine maintenance in between the biannual visits (Figs 47-51).

Discussion

Ultra Suction system appears to increase considerably the retention of complete dentures in both clinical observations and statistical findings. Their retention capacity is superior to that of conventional dentures. The decrease in the rate of applied negative force by 10mmHg per 15 seconds, attributed to the design of the diaphragms, suggests that we may have a more tissue friendly denture than we first thought. It is well known that the supporting tissue is subject to -80mmHg under conventional maxillary dentures, which caused an increase in epithelial width in the palate and attached gingival, and a decrease in the epithelial width in the alveolar mucosa in most, if not all, complete denture wearers. The response is directly related to the functional demands of the tissue. In view of this documented evidence, it would be responsible to conclude that Ultra Suction’s negative force is less invasive that that of conventional dentures.

References

7. Implant strength & fatigue testing done in accordance with ISO standard 14801.

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Introducing the Laser-Lok® 3.0 implant

Laser-Lok 3.0 is the first 3mm implant that incorporates Laser-Lok technology to create a biologic seal and maintain crestal bone on the implant collar. Designed specifically for limited spaces in the aesthetic zone, the Laser-Lok 3.0 comes with a broad array of prosthetic options making it the perfect choice for high profile cases.

- Two-piece 3mm design offers restorative flexibility in narrow spaces
- Implant design is more than 20% stronger than competitor implant
- 3mm threadform shown to be effective when immediately loaded
- Laser-Lok microchannels create a physical connective tissue attachment (unlike Sharpey fibers)
As dentistry continues to evolve, new technologies and materials are continually being offered to the dental profession. Throughout the years, restorative trends and techniques have come and gone. Some material developments have transformed the face of aesthetic dentistry, while other initial concepts have phased out and died. Today all-ceramic restorations continue to grow in the area of restorative dentistry, from pressed ceramic techniques and materials to the growing use of zirconia, and new materials that can be created from CAD/CAM technology. This article will explore new uses for the all-ceramic material, known as lithium disilicate, and the use of a digital format to design and process this material in new and exciting ways. An overview of the material and unique clinical procedures will be presented.

Introduction

Embracing proven alternative solutions and transforming traditional methods can be challenging to dental restorative teams facing increasing patient demands while being tasked with delivering high-strength restorative options without compromising the aesthetic outcomes. Traditionally, dental professionals have used a high-strength core material made of either cast metal framework or an oxide-based ceramic (such as zirconia or alumina). This approach has two disadvantages.

Compared with glass-ceramic materials, the substructure material has high value and increased opacity but may not be aesthetically pleasing. The zirconia core (with a 900 to 1,000 MPa flexural strength) is less than half of the cross-sectional width of a restoration; it must be completed with a veneering material with a flexural strength in the range of 80 to 110 MPa (depending on delivery method). The veneering material tends to chip or fracture during function. Also, such restorations depend significantly on the ability to create a strong bond interface between the dissimilar materials of oxide-ceramic and silica-based glass-ceramic, a bond that is not difficult to create. However, the quality of the bond interface can vary substantially because of the cleanliness of the bond surface, furnace calibration, user experience and other issues.

In today’s industry, monolithic glass-ceramic structures can provide exceptional aesthetics without requiring a veneering ceramic. Greater structural integrity can be achieved by eliminating the veneered ceramic and its requisite bond interface. This has been resolved through the development of highly aesthetic lithium-disilicate glass-ceramic materials.

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Compared with glass-ceramic materials, the substructure material has high value and increased opacity but may not be aesthetically pleasing. This is especially an issue in conservative tooth preparations when the core material will be close to the restoration’s exterior surface.

The other disadvantage is that although the high-strength material has great mechanical properties, the layering ceramic with which it is veneered exhibits a much lower flexural strength and fracture toughness. The zirconia core (with a 900 to 1,000 MPa flexural strength) is less than half of the cross-sectional width of a restoration; it must be completed with a veneering material with a flexural strength in the range of 80 to 110 MPa (depending on delivery method). The veneering material tends to chip or fracture during function. Also, such restorations depend significantly on the ability to create a strong bond interface between the dissimilar materials of oxide-ceramic and silica-based glass-ceramic, a bond that is not difficult to create. However, the quality of the bond interface can vary substantially because of the cleanliness of the bond surface, furnace calibration, user experience and other issues.

In today’s industry, monolithic glass-ceramic structures can provide exceptional aesthetics without requiring a veneering ceramic. Greater structural integrity can be achieved by eliminating the veneered ceramic and its requisite bond interface. This has been resolved through the development of highly aesthetic lithium-disilicate glass-ceramic materials.

The 70 per cent crystal phase of this unique glass-ceramic material refracts light very naturally, while also providing improved flexural strength (360 to 400 MPa). This gives more indications for use and the ability to place tooth restorations, and adhesive bonding techniques are needed for load sharing with the underlying tooth. This has been resolved through the development of highly aesthetic lithium-disilicate glass-ceramic materials.

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With a monolithic technique (Figs 1 & 2), most restorations built from lithium-disilicate materials can be completely fabricated. This approach provides high strength and aesthetics but requires surface colourants for the final shade. When in-depth colouration is needed, a partial layering technique may be employed. Although no longer a purely monolithic structure (Figs 3 & 4) because the restoration maintains a large volume of the core material, the resulting restoration should reasonably maintain its high strength. However, no evidence supports this.

**Aesthetic options**

If covering or masking underlying tooth structure is part of the treatment plan, the restorative team can imagine doing so in an aesthetic way. The ceramist can make that vision a reality with IPS e.max (Ivoclar Vivadent) by using a very high opacity ingot. Ingot opacities available for IPS e.max include high opacity (HO), medium opacity (MO), low translucency (LT) and high translucency (HT). The MO ingot can be used as an anatomic framework material if restorations must be fully layered. LT ingot can be employed with stain and glaze methods or hybrid layering techniques, which have been used for years with IPS Empress Aesthetic (Ivoclar Vivadent). The HT ingot is meant for stain and glaze techniques.

Choosing one of these four different aesthetic options depends on the preparation and the technique to be used in order to match the adjacent dentition or restorations. In addition, the laboratory can select the processing choice that is appropriate for the selected restoration. IPS e.max includes press and CAD/CAM options because lithium disilicate can be pressed from ingot form or milled from a block form. If the CAD/CAM option is used, the technician will design the restoration digitally rather than perform a full wax-up and invest/press.

**Preparation options**

If LT or HT ingots will be needed, then dentists can have flexibility with their preparations because of the translucent margins. This is the situation with partial preparations (for example inlays, onlays and veneers) – the margins can be placed wherever clinically proper. IPS e.max’s translucency enables dentists to place the margins virtually anywhere on the restoration, blending seamlessly with the natural dentition.

Dentists can use a traditional preparation of 1.0 to 1.5 mm reduction (for example a full-crown preparation) if they need more opaque materials (for example HO and MO). Because the resulting restoration will have a slight opacity, the margins will be equi-gingival or slightly sub-gingival. In either case, the material will be fully layered to create the final restoration. IPS e.max provides the choice of using traditional or creative preparation designs.

**Cementation options**

Because lithium disilicate can be fully light-cure bonded or cemented using a self-etching primer with conventional resin-cement techniques, IPS e.max also provides options for cementation. Conventional self-etching primer cement is ideal for full crowns. For partial and veneer preparations for which adhesive protocol will be used, full light-cure bonding is preferred.

**Case study**

A 42-year-old female presented with discoloured teeth that had been repaired with veneering ceramics. When in-depth colourant was applied, the dentists decided to mask the underlying tooth structure with IPS e.max. The ingot was trimmed to match the adjacent natural dentition. IPS e.max's high translucency and acceptable esthetics provided the clinicians with the perfect result.
Various composite restorations placed throughout the years (Fig 5). A lingual amalgam restoration in tooth #12 and composite restorations in teeth #25, 21, 11 and 15 showed recurrent decay that was diagnosed with digital X-rays. She possessed a negative medical history and good oral hygiene with resultant periodontal health and asymptomatic teeth. Treatment options of zirconia or porcelain-fused-to-metal crowns or CAD/CAM all-ceramic restorations were discussed with the patient.

Ultimately, CAD/CAM all-ceramic restorations were tested. When proper prepa-ration and occlusal design considerations are followed, properly placed CAD/CAM-designed and -milled restorations have been extremely successful. The patient made a preparation appointment, during which the existing restorations were removed, and teeth #25 to 15 were prepa-red for all-ceramic veneer restorations, following accepted CAD/CAM glass-ceramic preparation guidelines (Fig 6): adequate clearance, rounded internal aspects, and equi-gingival butt-joint margins were ensured. Once the preparations were completed, conventional impressions were taken and poured in high-quality, laser-reflective dental stone.

**Laboratory communication**

The dentist is to the dental technician what the architect is to the builder. Each has a primary role in indirect restorative dentistry, which is to imitate natural function and aesthetics perfectly and translate that into a restorative solution. The communication between the clinician and technician entails a thorough transfer of information, including functional components, occlusal parameters, phonetics and aesthetics, and continues throughout the restorative process, from the initial consultation through treatment planning and provisionalisation to final placement.

The primary and conventional communication tools between the dentist and technician are:

- Photography
- Written documentation
- Impressions of the patient’s existing dentition
- Clinical preparation
- Opposing dentition

This information is used to create models, which are mounted on an articulator to simulate the mandibular jaw movements.

**Traditional indirect restorative process**

The indirect restorative process involves the following steps:

1. The clinician prepares the case according to the appropriate preparation guidelines, takes the impressions, sends these and other critical communication aspects to the laboratory, and the laboratory receives all the materials from the dentist.
2. Then, the impressions are poured, models mounted, and dies trimmed.
3. Appropriate restorations—layered, pressed, milled, cast, or combinations—are made.

However, as restorative dentistry shifts further into the digital era, clinicians must change their perceptions and definitions of the dental laboratory. Traditionally, a laboratory is the site that receives and processes patient impressions and returns the completed restorations to the clinician, who adjusts and delivers them to the patient. Similar to how the Internet has transformed the communication landscape, the possibility of using CAD/CAM-restoration files electronically has spurred evolutions in the way dental restorative teams perceive and structure the dentist–laboratory relationship.

**The digital process**

When the E4D LabWorks system (D4D Technologies) was introduced in 2008 (Fig 7), it was the first computerisation model to present a real 3-D virtual model accurately and account for the occlusal effect of the opposing and adjacent dentition automatically. It enables the user to design 16 individual, full-contour, anatomically correct teeth simultaneously. The device condenses the information from a complex occlusal case and displays it in a user-friendly format that allows clinicians with basic knowledge of dental anatomy and occlusion to modify the design. Once this has been completed, the information is sent to the automated milling unit.

The innovation of digitally designed restorations meant that some of the more me-
Mechanical and labour-intensive procedures (for example, waxing, investing, burn-out, casting and pressing) involved in the conventional fabrication of a restoration were essentially automated. The dentist and technician had a consistent, precise method to construct functional dental restorations.

A file is created within the design software for each patient. The operator can input the patient’s name or record number and selects the appropriate tooth number(s) to be treated. Each tooth’s planned restoration is checked (for example, full crown, veneer, inlay and onlay). Lastly, additional preferences include material choices and preferred shade. System defaults that can be set ahead of time or changed for each patient are preferred contact tightness, occlusal contact intensity and virtual die spacer, which determines the internal fit of the final restoration to the die/preparation. All this information can be entered prior to treatment or changed at any time if the actual treatment differs from what was planned.

When the images of the preparation, provisional restorations and opposing dentition are captured, the computer has all the required information for preparing the working models, preparation and opposing model. The real 3-D virtual model is then shown on the screen and can be rotated and viewed from any perspective (Fig 8). In designing the restoration, the first step must be to define the final restoration’s parameters digitally. This is achieved by employing the opposing and adjacent teeth for occlusal interproximal contact areas and, finally, the gingival margins of the preparation.

Using input and neighbouring anatomic detail as a basis, the software will place the restorations in an appropriate position—but not to the clinically ideal location. Instead, the operator relies on his or her knowledge of form and function and experience to reposition and contour the restoration. As the crown’s position and rotation are fine-tuned, the software’s automatic occlusion application will readjust each triangular ridge and cusp tip—and the restoration’s contours, contacts and marginal ridges—employing the preferences and bite-registration information. The virtual restoration adapts all parameters in relation to the new position. Instantaneously, the position and intensity of each contact point is illustrated graphically and colour mapped, where it can easily be modified based on the operator’s and clinician’s preferences. Through a variety of virtual carving and waxing tools, customisation and artistry are also possible. These tools can be used to adjust occlusal anatomy, preferences and contours, reflecting actual laboratory methods. Each step in the process is updated on the screen; therefore, the effect of any changes is immediately apparent. For this case, three files were loaded into the computer software for restoration design. Scans of the preparations, provisional restorations and opposing dentition were joined to form a composite file that represented the patient’s oral situation accurately (Fig 9). Once the final virtual restorations have been completely designed (Fig 10), the milling chamber with the predetermined shade, opacity and size of the IPS e.max block is loaded, an on-screen button is pressed, and an exact replica of the design is produced in ceramic in a short time.

Glass-ceramics are categorised according to their
chemical composition and/or application. The IPS e.max lithium disilicate is composed of quartz, lithium dioxide, phosphorus oxide, alumina, potassium oxide, and other components. These powders are combined to produce a glass melt, which is poured into a steel mould, where it cools until it reaches a specific temperature at which no deformation occurs. This method results in minimal defects and improved quality control (owing to the translucency of the glass). The blocks or ingots are generated in one batch, based on the shade and size of the materials. Owing to the low thermal expansion that results during manufacture, a highly thermal, shock-resistant glass-ceramic is produced.

Next, the glass ingots or blocks are processed using CAD/CAM-milling procedures or lost-wax hot-pressing techniques (IPS e.max Press; Fig 11). The IPS e.max CAD blue block is based on two-stage crystallisation: a controlled double nucleation process, in which the first step includes the precipitation of lithium-metasilicate crystals. Depending on the quantity of colourant added, the resulting glass-ceramic demonstrates a blue colour. This ceramic has superior processing properties for milling. After the milling process, a second heat-treating process is performed in a porcelain furnace at approximately 850°C, at which temperature the metasilicate is dissolved and the lithium disilicate crystallises. This results in a fine-grain glass-ceramic with approximately 70 per cent crystalline volume incorporated into a ceramic with 70 per cent crystalline volume lithium-disilicate crystals that are approximately 0.5 μm. The final-stage crystallisation gives the restoration its superior mechanical and aesthetic qualities. In this stage, the glass-ceramic contains approximately 70 per cent volume lithium-metasilicate crystals that are approximately 0.5 μm. The final-stage microstructure of lithium disilicate gives the restoration its superior mechanical and aesthetic qualities. In this stage, the glass-ceramic contains approximately 70 per cent volume lithium-metasilicate crystals that are approximately 0.5 μm.

The laboratory process
Once designed and milled, the IPS e.max ceramic restorations are then prepared for final aesthetic adjustments. After the milling stage has been removed, the technician defines surface texture and occlusal anatomy using diamond and carbide burs, care-fully avoiding any alteration to the perfected occlusal and interproximal contacts. Afterwards, restorations are rinsed to remove surface debris and dried. Then, the milled blue restorations are placed in a conventional ceramic furnace for the crystallisation process. These restorations were digitally designed with an incisal cut-back design that will allow a minimal application of translucent ceramics to mimic the incisal effects found in nature. Contoured to final anatomic shape, the restorations are further aesthetically improved by subtle colouring and glazing.

Restoration placement
Next, five per cent hydrofluoric acid (IPS Ceramic Etching Gel, Ivoclar Vivadent) was applied for 30 seconds onto the internal surfaces of the glazed restorations. Then, they were rinsed and dried. This was followed by a silane coupling agent (Monobond-S, Ivoclar Vivadent), which was also placed for a minute onto the internal surfaces, and then air-dried. For the final cementation, Variolink Veneer (Ivoclar Vivadent) was used. After excess cement had been removed, final light-curing was done. The occlusal contacts were then reviewed and excursive pathway freedom was confirmed. Owing to the correct capture and alignment of the bite-registration information, few adjustments were required.

Conclusion
IPS e.max is about restorative options. Dentists and technicians now have a material with which they can do anterior or posterior restorations. With four different opacities or translucencies available, a variety of creative aesthetic options can be accomplished in a restoration. Dentists and their laboratory ceramists now have the opportunity to be more creative for their patients (Figs 16–18).

Editorial note: A complete list of references is available from the publisher.
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Cause for concern

Mark Phillips discusses when, how, and to whom dental professionals should raise concerns

For many dental professionals, the enjoyment of working in a practice comes from the teamwork involved in ensuring patient satisfaction. But team working can bring its own challenges, particularly if a colleague’s behaviour gives cause for concern.

A large, successful dental practice recruited two new staff members to help cope with an increasing patient register. The practice had an excellent reputation for providing a high standard of care and didn’t want to see this be affected by the increasing demand for its services so it engaged a new dentist and nurse to work alongside one another.

Within the first month the dentist and nurse had formed an excellent working relationship, but soon after, the dentist had to take an extended period of leave due to illness and the nurse was allocated to work with a new dentist who was brought in to cover. They also quickly established a good working relationship, but after a few weeks, the nurse began to notice the dentist was starting to speak rather abruptly to patients and had on one occasion, lost his temper with a patient who was needle phobic but required a local anaesthetic to undergo a procedure. When the nurse attempted to speak to the dentist about the incident she was given short-shrift and told to mind her own business.

The dentist’s behaviour continued to be of concern until one day the receptionist witnessed him pouring alcohol into his tea in the kitchen. When questioned, the dentist’s response was “everyone’s allowed a drink once in a while”. The dentist worked at the practice for a total of seven months and during this time, a number of colleagues had witnessed inappropriate behaviour. Although the staff had discussed their concerns informally among themselves, these weren’t taken any further. On one occasion, another dentist at the practice pulled his colleague aside and attempted to discuss his behaviour. The dentist put his temper down to stress. Concerns about his behaviour were subsequently taken to the practice manager, who in line with the practice’s sickness policy offered the dentist a course of

‘Although the staff had discussed their concerns informally among themselves, these weren’t taken any further’

Is a colleague’s behaviour causing you concern?
counselling and some time away from work. Neither of these offers were acted upon and eventually, because of the potential risk to patients, the practice manager was forced to alert the GDC to his concerns and the dentist was asked to leave the practice.

A sensitive subject
The DDU recognises that it can be difficult to raise concerns about a colleague, particularly those in a position of authority. The fear of victimisation and bullying may be all too real but this is often not the case. In instances where behaviour may be putting patients at risk, you have a legal and ethical duty to say something. The GDC guidance on raising concerns states that: “The duty to put patients’ interests first and

- the problem is so severe that the GDC clearly need to be involved (for example, issues of indecency, violence or dishonesty, serious crime, or illegal practice)
- there is a genuine fear of victimisation or a cover-up?"

Will I be protected?
Under the Public Interest Disclosure Act 1998 (PIDA) those working in NHS or private practice and those who are self-employed and contracted to provide NHS services, will be protected if they raise concerns about potentially illegal or dangerous practices, as long as you have acted in good faith and in the first instance, followed local level procedures. In addition, the GDC’s guidance in Principles of Dental Team Working makes clear that those who employ, manage or lead a team must support team members who raise concerns (paragraph 5.5).

Finally, the DDU advises you to remember that your duty to raise a concern should override any apprehension you may have about doing so, and that you should take steps to resolve issues at a local level, where appropriate, before contacting the GDC. Dental professionals who are unsure whether to raise a concern in the workplace should contact their defence organisation for advice.

The GDC guidance on raising concerns states that: “The duty to put patients’ interests first and act to protect them must override personal and professional loyalties.” The GDC adds that if you fail to raise a concern that potentially puts patients at risk, you could be risking your registration.

When and how – the regulations
The action that you take will depend on the type of concern that is raised. If the concern is about poor performance that does not pose an immediate risk to patients, this can be raised at a local level through Practitioners’ Advice and Support Schemes for dental professionals. You may also want to raise a concern with your manager or employer but this may not always be appropriate, particularly if they are the subject of the concerns. In such cases, concerns can be raised with your local PCT or NHS hospital trust.

There are however circumstances when you should contact the GDC. This is advisable in instances when:
- taking action at a local level would not be practical
- action at a local level has failed

References:
1. & 2. GDC Principles of raising concerns at work, page 6, p.1.1; page 8, p.3.6

About the author
Mark Phillips has worked predominantly in NHS dental practices as an associate and principal for 25 years prior to joining the DDU. He continues to work one day a week as a clinical demonstrator in the Prosthetic department and has recently been appointed Chairman of the Dental Undergraduate Admissions Panel at GKT.

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Feature 25
Effects of bruxism

Pav Khaira discusses treatments for bruxism

If ever there was an appropriate time for raising awareness of bruxism, the parafunctional grinding and clenching of teeth, and the problems it causes, this could be it.

As a dentist with a special interest in migraine and pain management, Pav Khaira of the Migraine Care Institute says the condition is becoming increasingly common as the economic crisis takes its toll on the nation’s health.

“I think bruxism is definitely becoming more common,” says Pav. “The symptoms and fallout of bruxism that we see are more common too, such as frequent headaches and migraines, and increased facial pains.”

Decades of new cases arrive in his practice every month and between 80 and 90 per cent of patients show some signs of at least some historic bruxism, he adds.

Many of the new patients presenting with these issues may have always suffered from bruxism to some extent, but found that their symptoms are increasing as their stress levels rise along with debt or job security worries.

“As my point of view stress is a modifier to bruxism, not a driving force,” adds Pav. “And it is a complex subject that highlights biodiversity. It’s like a threshold. For some people, as their stress drops below the threshold, their symptoms will resolve. But other people always seem to be above their threshold, even if their stress levels are low.”

For many patients, arrival in a migraine and pain management practice might follow months or years of shuttling between different medical practitioners in search of help. A lack of knowledge about bruxism throughout the medical education system is to blame for that, suggests Pav. “It’s not about a lack of empathy, it’s about a lack of knowledge,” he adds.

In general practice there can be gaps in knowledge about bruxism, or where to send sufferers, according to Pav. “If I see somebody who has really crooked teeth, I send them to my orthodontist. If I’ve got somebody with ragging toothache and I can’t do the root treatment I send them to my endodontist.”

“Quite often people say, I’ve had a clicking jaw joint for several years, and it was really painful for four or five months. But then it settled down by itself. But of course it didn’t settle down by itself. Something happened and you have to try to get to the bottom of it.”

Sometimes, asking the right questions can open the floodgates of medical history. If a patient feels they are finally being listened to after years of migraines or jaw pain, they may have a lot to say. “Sometimes it turns out that the problems stem back to an old whiplash injury from five, ten, 15 or even 20 years earlier,” says Pav.

“You need to understand that a problem won’t just go away. You need to understand that if a patient gets pain free, does that mean you can stop the treatment? Well, it might be. But if the patient gets pain free, does that matter?”

To make sense of all the information gleaned without being overloaded, it is important for practitioners to change their mind set, says Pav: “You can’t just have the floodgates of medical history. To treat the condition effectively and efficiently, practitioners must take the time to make the fullest diagnosis possible.”

To the patient about whether they have ever had jaw popping and clicking, locking jaw joints, any sinus pain, any ear pain, any joint pains elsewhere. I also do a very in-depth analysis. I talk to the patient about whether they have ever had jaw popping and clicking, locking jaw joints, any sinus pain, any ear pain, any joint pains elsewhere. I also do a full muscular examination, a full ligament insertion examination.”

This process is used to tease as much information from the patient as possible.

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ferring from between 15 and 18 migraines a month. After treatment both patients were happy, even though the frequency at which they suffered the migraines had remained constant. The improvement had been in the duration of the migraines: instead of suffering for up to two days each time, the migraines were lasting for an hour and could, literally, be slept off.

To treat bruxism effectively, practitioners must be open-minded about issues such as occlusion, says Pav. “The fact is that occlusion is not the driving factor in a lot of these issues. It can sometimes be a modifying factor but it is not a driving factor. That is not to say that doing something consciously will not give pain relief, but it is still not the driving factor,” he insists.

“What a lot of dentists say is that, if your teeth do not fit perfectly where your jaw joints and muscles harmoniously want to contract, your muscles will fight to find a comfortable position. The theory is that if you remove these interfer-ences from your bite, you let the patient close their mouth correctly and their problems go away. My take on this is actually the other way around: if you suffer from bruxism you are going to clench and grind your teeth, no matter what. And there is strong scientific evidence to support this. Sometimes your teeth will get in the way, which will exacerbate the pain. Sometimes by harmonising the bite you can get resolution of these symptoms, but that doesn’t make it the driving factor.”

Pav’s treatment model assumes that patients are suffering a neurological phenomenon, rather than an anatomical one. He achieves considerable success in treating patients with the NTI-tss occlusal splint. This small device fits over the front teeth, which according to conventional wisdom should prevent clenching and grinding. “When you fit an NTI-tss you have no interferences at the back of the mouth, so if the argument is correct the drive for clenching and grinding your teeth should have disappeared. So how do I explain the scratches that appear on almost 100 per cent of the NTI-tss devices that I fit over time? The bite is not the driving factor.”

“People need to realise that NTI-tss is part of a philosophy. The device itself is the easiest way to deliver that philosophy, but it is not the only way to do it,” says Pav. While some dentists fear, incorrectly, that the device can overload the jaw joint, Pav says that a success rate of over 90 per cent means that patients like the NTI-tss a great deal.

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