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 cigarette displays. Most adult smokers started smoking as teenagers and we need to stop this trend.

Evidence shows that cigarette displays in shops can lure young people to start smoking. More than eight million people in England are trying to quit 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 300,000 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.

“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 be fined up to £5,000 or could face imprisonment.

Call 01903 875787 or visit EschmannDirect.com for details

EschmannCare FIVE year warranty protection now comes as standard with Little Sister products...

And, when you buy from EschmannDirect, the first two years of ServicePlan cover that protects your EC5 warranty are included.
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. The health threat 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 are demanding 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 can have 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 choose to smoke need to think about the effect it has on their family.

“Giving up smoking or making sure you have a completely smoke free home and car is the only way to protect your family.

“If people do want to quit there is excellent support and advice available. Get in touch with your local stop smoking service, GP or pharmacist or visit nhs.uk/smokefree.”

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 even a 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 23 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 are passionate 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 Nomination 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 want to see at any time within in 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 about: 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 DCPS 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 complaints and plans to keep colleagues in the loop as to what this will mean for them, the profession as well as for patients.

The group would like the help of all DH&TS in collating evidence of their current perceptions of the Direct Access issue.

To take part, visit www.fac.chemeng.ox.ac.uk/pec or follow @DAActionGroup on Twitter and take a few minutes to fill out a brief survey that even a very busy practice could do.

Go to www.surveymonkey.com/s/HLBSC6EP or email the group at directactiongroup1@gmail.com.
Editorial comment

Big congratulations to those who found themselves with a place in the top 50 most influential people in dentistry, as voted for by members of the profession.

James 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 returning to DT readers include Mhari Coxon (5), Elaine Halley (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!

Metformin may lower risk for oral cancer

According to a new study, Metformin Prevents the Development of Oral Squamous Cell Carcinomas from Carcinogenic-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 Silvio Gutkind, PhD, chief of the Oral and Pharyngeal Cancer Branch of the National Institutes of Dental and Craniofacial Research at the National Institutes of Health, and colleagues induced premalignant lesions in laboratory mice; they then studied the effect of metformin on progression of these lesions to oral cancers.

The scientists found that metformin reduced the size and number of carcinogen-induced oral tumoral lesions in mice and significantly reduced the development of squamous cell carcinomas by about 70 per cent to 90 per cent.

In surgery treatment for caries prevention

In surgery treatment for caries prevention

Metformin tablets

Metformin tablets

According to a new study, Metformin Prevents the Development of Oral Squamous Cell Carcinomas from Carcinogenic-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 Silvio Gutkind, PhD, chief of the Oral and Pharyngeal Cancer Branch of the National Institutes of Dental and Craniofacial Research at the National Institutes of Health, and colleagues induced premalignant lesions in laboratory mice; they then studied the effect of metformin on progression of these lesions to oral cancers.

The scientists found that metformin reduced the size and number of carcinogen-induced oral tumoral lesions in mice and significantly reduced the development of squamous cell carcinomas by about 70 per cent to 90 per cent.
Dental plaque may trigger blood clots

Dental Protection in the Dock – it’s a sell-out

MyFaceMyBody Awards

Aesthetic Awards list
• Best Inj ectable Anti-Ageing Treatment
• Best Cosmeceutical Product
• Best Body Reshaping procedure including semi-invasive as well as take home devices
• Best Skin Tightening Treatment (take home or professional) includes Micro-needling, skincare, skin peels and also Laser treatments
• Dental Awards

Best tooth whitening Product
• Best Dental Hygiene Product - Floss, Electric, Mouthwash
• Most Innovative Treatment or Service
• Clinic Awards

Best Customer Experience
• Best Clinic
• Best Clinic Team
• Best Non-Surgical Makeover (Facial Aesthetics, body reshaping or smile transformations - vitamin, meso and fillers)

Television Awards
• Best Documentary or Televi sion Series
• Best Online Information Resource
• Best Beauty Ambassador

MyFaceMyBody is a television and online resource for consumers seeking advice on hundreds of beauty and cosmetic treatments. It allows people to access information, learn about treatments, follow the latest procedures and discuss them via our social media channels.

The MyFaceMyBody Awards and the masquerade ball and held at The Landmark Hotel, London on the 3rd November 2012.

Dental Protection in the Dock – it’s a sell-out

150 dentists and lawyers assembled at the Mermaid Theatre Conference Centre in Puddle Dock, to attend the first ever Dento-legal Study Day organised by Dental Protection. The delegates either had an interest in working in this area of dentistry or were already doing so and wanted to hear from the UK’s leading provider of indemnity, 70 per cent of UK dentists are already Dental Protection members.

In addition to cases of clinical negligence, the revelation that the GDC has allocated 1200 hearing days in multiple venues for 2012 confirmed that their interest was well founded. Members of the fifty strong team of dento-legal advisers already supporting Dental Protection were on hand to share their experiences with delegates on a one-to-one basis.

The Dento-legal Study Day included presentations from experienced dentists and lawyers including Raj Bhatia, who discussed the ethical dimension of dento-legal cases and how professional conduct can complicate the management of complaints and claims. Anne Green, a barrister from Radcliffe Le Brasseur described the crucial and central role of the GDC’s Investigating Committee and Melanie Bowles, Head of Claims Management for MPS, discussed the law of negligence and explained how a ‘breach of duty’ is described and the process of analysing whether or not a breach has caused any loss.

Kevin Lewis, Director of Dental Protection said: “With the unprecedented case load currently being experienced in all three DPL offices, it is reassuring see such a high level interest from dental colleagues and other who are interested in working in this challenging area of dentistry. Since its inception over a century ago Dental Protection has always taken pride in the quality of its service to members. The same is true today and events like help to ensure that the same service will be available in the future.”

Speakers Hilary Firestone and Melanie Bowles take questions from the audience.
The CQC Compliance File

£499.00 (+£10 p+p)

Dental Support UK are the dental leaders in providing on-going and contracted help and assistance in matters relating to Health and Safety and Employment Law compliances to hundreds of Dental Practices throughout the UK. We are pleased to announce the release of our much requested and completed file: "The CQC Compliance File"

The CQC Compliance File is your complete answer to the nightmare of CQC compliance, which complies fully with the CQC requirements.

All policies, protocols and procedures are all ready supplied and written for your practice and in most cases all you need to do is sign the document and then enforce it's requirements.

It's that simple!

For more information on our packages or to request YOUR copy of "The CQC Compliance File", contact Dental Support for this latest innovation in "off the shelf" assistance.

Alternatively you can purchase online through our web site.

Are you ready for your CQC Inspection?

See our range of Services that will help you.

Health and Safety Package
£675.00 per year

Our Health and Safety Package is by far our best selling product as this involves a personal visit to your practice and provides you with a hands-on account in all aspects of Health and Safety, Cross Infection and HTM 01-05 compliance.

All for just £675 per year.

Employment Law Package
£675.00 per year

One of our experts will assess your practice. They will draft personalised documents for your business and guide you through the complicated employment legislation. Employment Law Advice Line support, 24 hrs a day.

All for just £675 per year.

Legionella Risk Assessment
£249.00 (normal price £399)

Our Legionella Risk Assessments are fully Compliant with the Health and Safety Commissions, Approved Code of Practice and Guidance L8 Document; "The control of Legionella bacteria in water systems."

FREE thermometer with every Legionella Assessment.
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 Cordtoll 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 can be 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 GDP-accredited evening roadshow initiative.

He says: “Staying out of trouble with the GDC and decontamination compliance is hot topics for all UK dentists. The collaboration of MDDUS and W&H in providing practical advice and support in addressing these important issues 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 kwalsh@mddus.com. Tickets cost £50 with a light buffet available from 6pm and the programme commencing at 6.30pm.

Dates and venues for lectures (all dates 2012):

• Wednesday, May 23: St James’ Park, Newcastle
• Wednesday, May 30: Mandec, Inverness
• Tuesday, June 12: Drumossie Hotel, Inverness
• Wednesday, June 13: The Marcliffe Hotel, Aberdeen
• Tuesday, June 19: MDDUS offices, Glasgow
• Wednesday, June 20: RGP of Edinburgh, Edinburgh
• Thursday, June 21: Wright Cordtoll 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.

The newest prototype of the system is supported by the National Institutes of Health, National Science Foundation, and Christopher and Dana Reeve Foundation.

The newest dental appliance contains magnetic field sensors mounted on its four corners that detect movement of a tiny magnet attached to the tongue. It also includes a rechargeable lithium-ion battery and an induction coil to charge the battery. The circuitry fits in the roof of the mouth and is covered with an insulating, water-resistant material and vacuum-molded inside standard dental acrylic.

In recent months, Ghovanloo and his team have also created a universal interface for the introral Tongue Drive System that attaches directly to a standard electric wheelchair. The interface boasts multiple functions: it not only holds the gismo, but also interprets incoming data and delivers it to the iPod, connects the iPod to the wheelchair, charges the iPod, and includes a container where the dental retainer can be placed at night for charging.

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 recruited 11 individuals with high-level spinal cord injuries to test the headset 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 half. 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 introral Tongue Drive System on a daily basis.”

In preliminary tests, the introral device exhibited an increased signal-to-noise ratio, even when a smaller magnet was placed on the tongue. That improved sensitivity could allow additional commands to be programmed into the system. The existing Tongue Drive System uses a headset interpreter commands from seven different tongue movements.

The ability to train the system with additional commands as many commands as an individual can comfortably remember – and having all commands available at the user’s command would simplify the user experience.

The researchers plan to begin testing the usability of the introral Tongue Drive System by able-bodied individuals soon and then move on to able-bodied individuals to test its usability by people with high-level spinal cord injuries.
The UK launch of ‘Periodontal Disease and Overall Health: A Clinician’s Guide’ a textbook, 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. Nousheh 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 text book 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. Likewise, 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.

Two Nuromol tablets provide:

- Stronger pain relief
- and is effective for longer than TWO tablets of an Ibuprofen + codeine combination*

Nuromol does not contain actives known to cause addiction

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 Impression pain model. This comparator relates to cumulative pain relief over 12 hours following a single dose.

1 This nuromol allowed ODE dose in the UK is 1000mg paracetamol plus 20mg codeine.

References:
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 costs fair?

SS: This is one of those circular issues. We know from our research that a significant proportion of practices pay their dental nurses’ regulation costs, and by that I mean not just the GDC fees but also the CPD fees. Now that’s fine, but of course it just gets recycled into the expenses of the practice so the wages bill looks bigger, profit is smaller and so their wages are then suppressed for longer. So it is a circular problem – without a doubt it is a cost.

Pay freeze

The Department of Health has been told by the Treasury and by the Secretary of State that there’s a pay freeze on public sector workers. Dentistry gets an amount of money which the Department of Health think that they can contribute to the expenses of running dental practices, plus an efficiency saving, which at the moment is currently expressed by improving prevention through fluoride varnish. So in real terms, in order to achieve the efficiency saving, dentists are doing more for the same money, and their expenses are not being fully met. In effect, a pay cut.

Step too far?

So you’re absolutely right, it’s potentially a real expense to the dental nurses ultimate.

Fifteen years ago, dentistry was a very paternalistic profession. The dentist decided what they were going to do, issued instructions, people ran round them, made them coffee, put their metaphorical slippers on for them and kept quiet in the surgery. I think we can take some credit for developing the whole dental team.

 NK: It seems that if you’re a full time nurse, that’s great, but it seems that there are large numbers of people who are concerned about the cost. For instance, I can pick out three nurses from my own experience who have come back from maternity and have said, can’t I afford to go back into the profession?

SS: Yes, and it isn’t just dental nurses either who struggle with it. Part time dentists still have to pay the full annual registration fee. They also pay a significant proportion of the full BDA membership at the moment. When we first started having on-call rotas, and it was a 1990 contract that brought out of hours responsibilities in, huge rows erupted about ‘well I only do one day a week, why should I do the same amount of on call cover on the rota as my friend who works seven days a week and works all night?’ It was a similar problem.

And actually when you talk to dental nurses (perhaps not the youngsters, but certainly nurses who have been around for longer), they actually quite like the requirement to do CPD and they find it empowering

NK: I think there’s probably a compromise in my own mind – and again it’s not BDA policy, because BDA policy is that the whole team should be regulated as it stands at the moment – but perhaps there should be a mandatory regulation for anyone who has an extended duty qualification and does anything to and with patients directly, rather than just standing and being under instruction all the time, and perhaps there should be a voluntary regulation for dental nurses as well.

SS: What do you think?

N K: I think has been really good for the profession, because it’s challenged the dentists’ perception of paternalism.

 NK: So to sum up I suspect it probably is value for money, in terms of the empowerment of the profession of dental nurses – although it may not be appreciated as such. And just saying my last sentence highlights something new: profession of dental nurses? So it has established professional behaviour and it has established a voice and a role politically, representationally and also parochially as well.

SS: I think the dental nurses – the dental nurses need to be represented in patient care, because it’s not just about the dentist and the nurse, it’s about the patient care in a practice and the nurses had a role in the success, the sustainability, the morale, the improvement in patient care and a practice and had a significant part to play. Now the minute that happened, the whole dental team became worth something; it had a value, self-worth, esteem responsibility and the enjoyment of that responsibility.

And actually when you talk to dental nurses (perhaps not the youngsters, but certainly nurses who have been around for longer), they actually quite like the requirement to do CPD and they find it empowering.

SS: That’s quite interesting.
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 naive 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.

`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`
In whose interests?

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

One 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 for £35,000 and assured me this was an excellent price. He then proceeded to tell me that in the current market there is almost no one out there with any money and the buyer he has, by chance, has the money available to purchase it right away. Furthermore, it wouldn’t cost me a penny to sell my house because the buyer was going to pay this stranger. 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 are really 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 of the bank to undertake your own research of the local area and find out why the current owner is selling. Do the purchase.

The true market for the sale of practices is far from the stories being spread by the ‘direct approachers’. Last year FTA Finance, the leading arranger of finance for dentists in the U.K, 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 £35,000 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 £65,375.

The only real loser from selling as a result of a direct approach is the seller. The buyer pays you £35,000 - 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-founder of Frank Taylor and Associates – the leading independent valuers and sales agent in 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.

Tel. 08456 125354
Email: andy.acted@ft-associates.com
Frank Taylor and Associates @franktaylorass
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 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 ensure appropriate trained professionals are operating in the lab and that CE marked materials are being used.

“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?"

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 ensure appropriate 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 it 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?"
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.

‘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’

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.

Triple trays can also be
awkward to use. I frequently have to ask dentists to retake their impressions after receiving a model which shows that the patient has bitten through the tray into the mesh. Avoiding this can be tricky and a lot depends on how much material 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 appear 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, impressions frequently have to be retaken. This involves rescheduling appointments at great inconvenience to both the patient and the dentist, costing time and, ultimately, money.

Dental Technology schools heed a warning regarding triples trays as a source of inaccuracy and therefore a higher rate of device failure. Some even go as far as refusing to work on triple tray impressions at all. Most laboratories will refuse to fabricate any bridge work on triple tray impressions, and rightly so, as the functionality of the bridge cannot be created or checked. If working only on the quadrant, the excursions of the full arch cannot be replicated which is essential information for the technician to have. Eventually, 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 become accustomed to using the system that you have done for years and it is understandable why at first clinicians might be loath to switch their impression tray. Nevertheless, I do believe that by using full arch stock trays, practitioners will benefit from more accurate restorations, a smoother service and an easier relationship with their laboratory. Likewise, the patient will receive an excellent restoration quickly and hopefully without having to return to the practice for a repeat impression.

By taking full arc impressions, dentists won’t have to extend patient chair time.

‘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’

R4 Practice Management Software GIVES YOU MORE AND KEEPS ON GIVING

CONSTANTLY IMPROVING
CONSTANTLY DEVELOPING
CONSTANTLY DELIVERING

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

...and there’s still more to come

For more information or to place an order please call 0800 169 9692
email sales.uk.csd@carestream.com
or visit www.carestreamdental.co.uk

Carestream Dental
© Carestream Dental Ltd., 2012.

FEATURES OF R4
- R4 Mobile
- Direct link to PIN pad
- Patient Check-in Kiosk
- Care Pathways
- Communicator
- Steritrak
- E-Forms
- Patient Journey
- On-line Appointment Booking
- Text Message and Email reminders
- Clinical Notes
- Appointment Book
- Digital X-Ray
- Managed Service
- Practice Accounts
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 atmospherc pressure, the diaphragms seal off the valve inlets. The pressure difference ie, 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 relase/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 installation 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 1 cm short of the end of the denture (Figs 5-6). The bar was stabilised using two or three small drops of cyanoacrylate and any undercuts were blocked-out (Fig 7-8).

Hard base plates were prepared, making sure that all other flasking and packing techniques are acceptable. Each model was packed in a two part flask (Figs 9-10). The spacer bar remained on the model and any undercuts were blocked-out (Fig 11). Cold cure acrylic poured in around the valves (Fig 33).

The 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).

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 (Figs 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.

The valves were installed with cold cure acrylic (Figs 31-32). Soft rubber cylinder points were used to remove excess material and to polish around the valves (Fig 35). The dentures were given a final sheen (Fig 34).

Ultra Suction is a simple and efficient approach to retention. For check-ups, a postcard was sent. Most patients responded positively to this follow-up.

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 the high point of the retention chamber, drilling is done at an obtuse angle.

Each valve was rinsed and dried thoroughly to ensure a smooth placement of the diaphragm into its housing (Figs 39-40). The perforated cover was fitted and tied up using the service key (Figs 41-43).

Preventative Maintenance

Practitioners were encouraged to recall their patients every six months. This shows that the clinician cares, thus increasing patient loyalty and also income stream.
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 retentive 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.

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 a 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. This is especially an issue in conservative tooth preparation 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 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.

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 restorations using traditional cementation techniques, while also having strength and aesthetics.
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 colourants are 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. Ingots opacities available for IPS e.max include high opacity (HO), medium opacity (MO), low translucency (LT) and high translucency (HT). 7

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, on-lays 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 subgingival. 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-curebonded or cemented using a self-etching primer with conventional resin-cement techniques, IPS e.max also provides options for cementation. Conventional selfetching 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

In today’s industry, monolithic glass-ceramic structures can provide exceptional aesthetics without requiring a veneering ceramic

GRACEY CURETTES AND EVEREDGE THE MOST EFFICIENT COMBINATION FOR ALL YOUR HAND SCALING NEEDS

H U-FRIEDY - THE ORIGINAL MANUFACTURER OF GRACEY CURETTES!

STANDARD GRACEY CURETTE – The Gracey curettes combine a unique offset blade with 9 different shank designs to be used on specific tooth surfaces, thus improving adaptation and deposit removal. Also referred to as Finishing Gracey Curettes.

AFTER FIVE GRACEY CURETTE – Designed for instrumentation in deeper periodontal pockets. Elongated terminal Shank (3mm) provides better clearance around crowns, and superior access to root contours and pockets 5 mm or more in depth. Thinner blade permits easier subgingival insertion.

MINI FIVE GRACEY CURETTE – Designed with the same elongated terminal Shank (3mm) and thinned blades as the After Five Gracey Curettes. 50% shorter blade for access to smaller roots, narrow pockets, furcations, and developmental grooves.

For more information on our products please:
- call us on 0770 318 6612 or 0770 318 6474
- visit our website www.hu-friedy.eu
- e-mail us on info@hu-friedy.eu
- contact your regular Dental Dealer.
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 preparation 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 prepared 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 and teeth #25 to 15 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. The impression is 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 means 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 manufacturing, 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 70 per cent crystalline volume incorporated into a glass matrix.

With two crystal types and two microstructures during processing, the IPS e.max CAD material demonstrates distinctive properties during each phase. The intermediate lithium-metasilicate crystal structure promotes easy milling, without excessive bar wear, while maintaining high tolerances and marginal integrity. In the blue stage, the glass-ceramic contains approximately 40 per cent 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-disilicate crystals that are approximately 1.5 μm (Figs 12-15).

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, carefully 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).
Champions® Implant System

(R)Evolution in Implantology and Prosthodontics: MIMI® Method (Minimally Invasive Method of Implantation)

Dr. Armin Nedjat said, “I have developed the Champions® implant system, a reliable and innovative implant system that can be routinely used in the day-to-day work of dental offices. More than 2 800 dental offices and clinics are ‘Champions,’ and they performed more than 50,000 implantations last year. Do you want to be a new ‘Champion’ too?”

Advantages
- Suitable for MIMI® - Win-Win situation for patients and dentists
- Patient friendly
- More efficient procedure for the dentist
- Champions® implants: a wide range of innovative implants and accessories, which can be used for many indications
- High quality at affordable prices
- Excellent primary stability
- Optimal immediate loading
- Excellent prosthodontic restorations
- Innovative solution and successful treatment
- Made in Germany with great precision and of the highest quality materials
- Free MIMI® marketing
- Free forum for all Champions® customers
- Champions® surface – rated one of the best (studies on demand)

One-Piece Implants
Champions® Square-Shaped Implants
- Ø 3.0 · 3.5 · 4.5 · 5.5
- Thread lengths: 6 · 8 · 10 · 12 · 14 · 16 mm
- Zircon Prep-Caps
- WIN & Titanium Prep-Caps
- Ø 2.5 · 3.0 · 4.0
- Thread lengths: 8 · 10 · 12 · 14 · 24 mm

Two-Piece Implants
- Free loan of the surgical kit
- Inner cone with integrated ‘Hexadapter®’
- Micro-close connection < 0.6 μm
- Price VAT included:
  - Healing Cap (with implant): 0 €
  - Customizable and glueable titanium abutment: 23 €
  - Implant Analog Set: 23 €
  - Impression Coping: 10 €

Q: I have developed the Champions® implant system, a reliable and innovative implant system that can be routinely used in the day-to-day work of dental offices. More than 2,800 dental offices and clinics are ‘Champions,’ and they performed more than 50,000 implantations last year. Do you want to be a new ‘Champion’ too?“

Dr. Armin Nedjat said, "I have developed the Champions® implant system, a reliable and innovative implant system that can be routinely used in the day-to-day work of dental offices. More than 2,800 dental offices and clinics are ‘Champions,’ and they performed more than 50,000 implantations last year. Do you want to be a new ‘Champion’ too?"

Advantages
- Suitable for MIMI® – Win-Win situation for patients and dentists
- Patient friendly
- More efficient procedure for the dentist
- Champions® implants: a wide range of innovative implants and accessories, which can be used for many indications
- High quality at affordable prices
- Excellent primary stability
- Optimal immediate loading
- Excellent prosthodontic restorations
- Innovative solution and successful treatment
- Made in Germany with great precision and of the highest quality materials
- Free MIMI® marketing
- Free forum for all Champions® customers
- Champions® surface – rated one of the best (studies on demand)

One-Piece Implants
Champions® Square-Shaped Implants
- Ø 3.0 · 3.5 · 4.5 · 5.5
- Thread lengths: 6 · 8 · 10 · 12 · 24 mm
- Zircon Prep-Caps
- WIN & Titanium Prep-Caps
- Ø 2.5 · 3.0 · 4.0
- Thread lengths: 8 · 10 · 12 · 14 · 24 mm

Two-Piece Implants
- Free loan of the surgical kit
- Inner cone with integrated ‘Hexadapter®’
- Micro-close connection < 0.6 μm
- Price VAT included:
  - Healing Cap (with implant): 0 €
  - Customizable and glueable titanium abutment: 23 €
  - Implant Analog Set: 23 €
  - Impression Coping: 10 €

Champions® Implant System
(M)MIMI® Method (Minimally Invasive Method of Implantation)

Dr. Armin Nedjat, Developer of the Champions system / CEO
Tel.: +49 151 / 15 25 36 92
armin@championsimplants.com

Fanny Rougnon-Glasson, Tel.: +49 151 / 15 25 57 18
fanny@championsimplants.com

www.champions-implants.com
Incl. online-shop & about 120 videos (instructions & implantations)
Several clinical cases online!
Incl. online-shop & about 120 videos (instructions & implantations)
Several clinical cases online!

OUR OFFER FOR YOU
The Champions® can be fully integrated into the treatment services offered in regular dental offices. You can smile again!
We have a special offer for you: the Surgery Kit for one-piece and two-piece Champions® implants for € 500 instead of € 700!

OFFER FOR NEW CUSTOMERS
- If a turnover of at least 50 implants is reached within 6 months, the surgical kit will be your property.
- You can choose 20 implants, which you can keep for two months. You will only have to pay the used implants.
- Should you require further information, you can contact our Service team. You can also go to our Web site to find our offer for new customers and also further information at:
www.champions-implants.com

Courses about the minimally invasive implantation method (MIMI®) and the Champions® implant system

Continuing education in Mallorca
The course starts on Wednesday at 2:00 P.M. and ends on Saturday afternoon
June 13 – June 16, 2012
The courses will be taught by Dr. Armin Nedjat, an experienced Dental Implantology specialist. He has placed and restored more than 20,000 implants.

Courses will be presented in a friendly and relaxed atmosphere, please arrange your flight schedule. For transfers, please give us your flight arrival time.

Course participants: minimum 3, maximum 10
Course fee € 3,200 (VAT excluded)

The course includes 5 nights in a double-room, breakfast included, transfer to the dental office, day rate, lunch, coffee break, 2 dinners, course script, A3 Certificate, incl. for accompanying person.

Discount
Save € 200

Medilas Opal
diode laser 980
by Dornier MedTech

4 999 €
Recommended by VIP-ZM

www.champions-implants.com
Incl. online-shop & about 120 videos (instructions & implantations)
Incl. online-shop & about 120 videos (instructions & implantations)
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 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...
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) 5 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.

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.
Seeking release from the daily grind

Pav Khaira discusses treatments for bruxism

I
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.”

Dentists in the UK report seeing more and more patients with severe symptoms of bruxism. For many patients, arrival in general practice is the earliest stage of seeking release from the daily grind.

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.

“From 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 shutting 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 raging toothache and I can’t do the root treatment I send them to my endodontist. Where do you send patients who’ve got these types of problems? There is no set speciality,” he says. “I’m not one of those people who say you can cure bruxism. But you can manage it; you can manage the signs and the symptoms, and often you can get the patient completely comfortable. There are some patients who are absolute monster clenchers and grinders, and somebody has to help them. You can’t just leave them.”

As well as substantially improving quality of life for patients, successful management of bruxism can also save them from future dental problems that might necessitate invasive and expensive treatment. “Bruxism can cause extensive damage in the long term,” says Pav.

To treat the condition effectively and efficiently, practitioners must take the time to make the fullest diagnosis possible, Pav believes: “We do a very in-depth history, 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.

“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 on its own. It is vital to remember that being pain free and having an improved quality of life is the ultimate goal for most patients. Pav relates a story of two recent female patients, both of whom had been suf-
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 occlusally 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 interferences 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, occluding the teeth 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.

Taking diagnosis and treatment of bruxism to a new level

GrindCare measure

GrindCare Measure is the ideal tool for dental professionals who seek to:

- present hard facts to patients denying to be bruxers
- sell a treatment plan based on clinical facts
- manage risk when planning reconstruction work or
- measure the effect of a chosen treatment

GrindCare Measure is the first ever tool for accurately measuring whether and how often your patients grind their teeth. Within just 3-5 nights of use, GrindCare Measure identifies and quantifies the patients’ grinding pattern.

GrindCare clinic

GrindCare Clinic is a breakthrough solution for reducing grinding and clenching.

GrindCare records the activity in the temporalis muscle via a small electrode that adheres to the temple. Each time the patient grinds, the device transmits a mild electrical impulse that stimulates a conditioned reflex in the jaw muscles, instantly interrupting the grinding.

Actually reduces teeth grinding

Clinical studies have shown that GrindCare can reduce grinding by at least 50% in just 3 weeks. By reducing the grinding activity, GrindCare helps reduce the accompanying symptoms.

For more information, please contact:

Prestige Dental
Tel: 01 274 721 567
email: info@prestige-dental.co.uk
www.grindcare.com

The elexxion Pico Laser is easy to operate and is battery powered. The Laser has been installed at the UK’s First elexxion Pico Laser system rapidly removes bacterial bio-film leaving all internal surface areas thoroughly clean & disinfected.

Highly Economical: Each 500gth tub of Alkazyme-W allows for up to 100 service applications. Safe to use Non-toxic and fully biodegradable.

Alkazyme-W 500gth concentrate is available from all dental supplies sundries. For comprehensive product information on Alkazyme-W www.alkapharm.co.uk

The AOG – Do Dentistry: Do Good

Dr Garry McMahon is the Dr ArmourBite® is the perfect choice for all your patients, and when it’s effective and easy to use. The ArmourBite® is the perfect choice for all your patients, and when it’s effective and easy to use.

To learn more about Oralign and The Dental Director’s fantastic range of infection control products, speak to your Dental Director Representative, call 0800 505 566 or visit www.dentaldirector.co.uk

For more information on R4 from Carestream Dental please call 0800 169 9692 or visit www.carestreamdental.co.uk

For comprehensive product information on Alkazyme see www.alkzyme.com

www.alkazyme.com

www.alkazyme.com

www.alkazyme.com

www.alkazyme.com

www.alkazyme.com

www.alkazyme.com
Dental Gateway – Join the reimbursement revolution
Post vacancies for charge Dental Gateway has revolutionized recruitment in the UK with a quick, convenient and cost-effective service for dental professionals.

The UK’s only dedicated dental recruitment website, Dental Gateway allows you to successfully post your vacancies for charge. You can post your roles to the right credentials and experience. You can also post any number of vacancies at no charge. Once satisfied that you have found a suitable candidate, simply purchase credit to contact your preferred candidates.

CS Plates can be scanned in any order and the system does everything for you, the next patient.

The transition from film to digital imaging is simple and cost-effective with CS Plates. The new CS plates allow for improved infection control whilst hosing up both, both. The automatic tooth texture function helps you especially when inserting implants into hard bone. This function allows you to have ideal implantation by allowing for improved infection control whilst hosing up both, both.

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

Top five reasons why a Waterpik Water Flosser should be part of your daily hygiene routine

1. Rosema study

2. It can clean between teeth, as well as deep below the gum line where other toothbrushing methods can’t go.

3. Patrons can say goodbye to bleeding or swollen gums and bad breath with the Waterpik Flosser. Waterpik products are widely available in Boots stores and selected Lloyds Pharmacies.

4. Studies have shown the Waterpik to be twice as effective as dental floss for removing plaque in interdental spaces and reducing inflammation.

5. Patrons get a fantastic, clean feeling thanks to the Waterpik Flosser’s pulsation and pressure action, which dislodges bacteria and debris from teeth.

CS7000: intelligent X-ray scanning

Simply ‘Scan & Go’ with the new CS7000.

The CS7000 from Carestream Dental is ideal for general dentistry and small and large practices alike.

CS7000 delivers images of high quality in digital intraoral plate technology from Carestream Dental. It couldn’t be easier to use.

Next, place the exclusive softplate in the CS7000 unit and high quality images are automatically sent to your practice. It’s that simple.

dbg360 – the accreditation package that works with you

With dbg360, practices can build a custom package to address their specific needs, with options available in engineering, data protection and IT compliance. If you feel your practice staff could benefit from on-site training in a particular area, dbg360 offers a number of workshops. “A great variety of training and Safety courses, with CPD certificates available to download at any time upon completion. Hygienic equipment could be used as a template to incorporate into your own program,” can be arranged.

The dbg360 package also includes the price of membership with dbg and all of the exclusive services this training. Additionally, all dbg360 customers will gain access to the unique Virtual Compliance Office, an indispensable online tool designed to offer even more compliance support and much more. And with all of these features included at a fixed price over 3 years, dbg360 is exceptionally cost-effective.

Stay compliant with “essential standards”, save time and save money by making dbg360 an effective part of your practice.

For more information on how dbg360 could help your practice, call 045 066 112, or visit www.thedgh.com

Philips Zoom DayWhite 6 per cent HP with ACP is compliant with the new whitening products in the European Union (EU) containing more than six per cent hydrogen peroxide. Philips has announced the introduction of the latest product to add to its range of teeth whitening innovations – Zoom DayWhite 6 per cent HP with ACP. This is an at-home teeth whitening formula, designed to be dispensed by a dental professional, in the form of custom-fit trays into patients’ mouths. The trays are worn twice a day for 15 to 30 minutes depending on the advice of the dental professional, and will patients noticeably whiten within two weeks. Zoom DayWhite 6 per cent contains Ammonium Calcium Phosphate (ACP), which when combined with the whitening gel and the enamel to provide enamel protection, improved faster and shine, with reduced sensitivity. The product provides patients with a healthy white smile and patients who have experienced less feedback to their original tooth colour after six months.

An additional benefit for dental professionals is the product’s patented dual-barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology, which provides guaranteed gel stability through its barrel syringe technology.
April 16-22, 2012
United Kingdom Edition

Dental Tribune UK
Editorial Board

Dr Neel Kothari
BDS Principal and General Dental Practitioner

Dr Stephen Hudson
BDS, MFPGD, DREP
General Dental Practitioner

Mr Amit Patel
BDS MClin Dent MFDS RCS Eng MBBS MRCP DENTAL
Specialist in Periodontics & Implant Dentist Associate Specialist Birmingham Dental Hospital

Professor Nick Grey
BDS, MD, PhD, MDS, RD, FDS, FRCP, FHEA
Professor of Dental Education, National Teaching Fellow, Faculty Associate Dean for Teaching and Learning School of Dentistry, Manchester

Professor Andrew Eder
BDS, MSc, MFGDP, MBBS, FDS, FHEA
Director of Education and CPD, UCL Eastman Dental Institute

Mr Raj RajaRayan OBE
MA(Clin Ed), MSc, FDSRCS, FFGDP(UK), MRD, MGDS, DRD

Dr Trevor Bagg
BDS, MDS RCS (Eng), FDS RCS (Ed), FFGDP (UK)
Practitioner in Private and Referral Practice

Rahesh Chana
BRE, BRT, PETC, Dip DHE
President, BADT and Deputy Principal Hygiene and Therapy Tutor, Barts and The London School of Medicine and Dentistry

Dr Stuart Jacobs
BDS MSH (U Ind)
Full-time Private Practitioner

Shaun Howe
BDS Hygienist

Dr Richard Kahan
DS MSc (Laud) DLS RCS (ENG)
Endodontic Specialist

Mrs Helen Falcon
Postgraduate Dental Dean, Dental School, Oxford & Wessex deaneries

Professor Liz Kay
Dean of the Peninsula Dental School, Plymouth

Pum Swain
MBA LGDI FLAM MCM BADN® Chief Executive

Mr Raj Rattan
Associate Dean, London Deanery

Dramatically less traumatic
for you, your patients and
their dentition

FenderWedge
protects and separates
during tooth preparation

FenderWedge
FenderWedge protects the tissue and separates the teeth, simplifying the following application of a matrix. It can be applied buccally or lingually for optimal access and vision. Available in four color coded sizes.

Luxator Extraction Instruments
Luxator Periotomes are specially designed periodontal ligament knives with fine tapering blades that compress the alveolar bone, cut the membrane and gently ease the tooth from the socket. The whole operation is performed with a minimum of tissue damage.

Visit us! Dentistry Show Stand K31

Dramatically less traumatic
for you, your patients and
their dentition
Dental Practice Valuations and Sales

Are you considering selling your practice?
- Independent Valuations
- Professional Sales Agency

Experts in Sales to: Body Corporate / Associates / Partnerships / Open market sales
Speak to one of PFM’s experienced valuers to find out how experience, independence and a personal service can achieve the highest price for your practice and help you with your exit strategy.

Contact Nick Ledingham, BSc, FCA
Tel: 0151 348 8400
Email: mail@moco.co.uk
Website: www.moco.co.uk/dentists

_.Assistance with Buying & Setting Up Practices
- NHS Contract Advice
- Tax Saving Advice for Principals and Practices
- National Coverage

Please contact:
Nick Ledingham BSc, FCA
Tel: 0151 348 8400
Email: mail@moco.co.uk
Website: www.moco.co.uk/dentists

Geoff Long FCA
We can reduce your tax bill if you:
- Own a profitable Dental Practice & Pay Corporation Tax
- Own your Practice Freehold
- Want immediate access to your Pension Pot Tax Free

Call us on 01438 722224 or email office@dentax.biz

STAND OUT FROM THE CROWD

Choose a first class dental specialist accountant, with unrivalled expertise and over 30 years’ experience dealing with:
- Tax savings – Chartered Tax Advisor
- Buying and selling a practice
- Incorporations
- NHS Superannuation
- HMRC Investigations

FREE CONSULTATION
Book your free initial meeting at our Thame office.

WWW.DBS.ORG.UK
01844 260111

Whatever your management role.....
you can find a qualification to benefit you and your practice. UMD Professional’s range of qualification courses are accredited by the Institute of Leadership and Management and provide a practical management training pathway for dentists, DCPs and practice managers.

ILM Level 3 Certificate in Management
designed for senior nurses and receptionists and now managers taking their first steps in management

ILM Level 5 Diploma in Management
for existing practice managers and dentists

ILM Level 7 Executive Diploma in Management
for dentists and practice business managers, and accredited by the Faculty of General Dental Practice as part of the FGDPI Career Pathway

For full details, course dates and venues contact Penny Parry on:
020 8255 3076 penny@umdprofessional.co.uk

www.umdprofessional.co.uk

Contact
To advertise call
Joe Ackah on
0207 400 8964
Evolution in action

The original LED turbine just got even better!

Unbelievable Value:

Buy four W&H Synea Handpieces & receive the least expensive FREE*

Synea offers an unbeatable range of handpieces to meet the needs of our customers. This range includes W&H’s revolutionary range of LED handpieces.

But not all LEDs are the same - and we want our customers to have the best. So we are pleased to announce that W&H has raised the bar once again! Improved positioning of the LED source at the head of the handpiece ensures accurate bright illumination of your treatment site. The new LED+ also has an unparalleled Colour Rendering Index (CRI) giving colours a supremely natural feel. And Synea has a small head too, so your daylight quality light will not be obscured by your handpiece.

Contact W&H today to see things more clearly with Synea LED+.