The TV ‘Truth’ about dental professionals?

Screening of Dispatches documentary prompts rallying call from dental organisations

Channel 4’s programme ‘The Truth about your Dentist’, the newest addition to the Dispatches series, has claimed dentists are misleading patients about their rights to NHS treatment.

According to Channel 4, the programme exposes dentists who are waiting until patients are in the chair before telling them they must pay hundreds of pounds for private treatment, which should be available on the NHS. Dispatches also reveals that children’s teeth are being neglected under the NHS and that cost-cutting dentists are outsourcing lab work to countries such as China where there are little or no checks on safety or quality.

The programme, aired on 23rd May, plans to expose dentists who have been overcharging and misleading patients who have sought treatment from the NHS.

Commenting on the documentary, Kevin Lewis, Director of Dental Protection, said: “The word on the street is that this expose reveals yet another investigative journalist doing the rounds of different dental practitioners and comparing what is recommended or more pertinent in this instance, offered.

“The traditional version of these media “Rentalopol” outings would reveal that ten dentists can come up with 11 treatment plans. The former was evidence of one form of synapsus-based dentistry (natural variations in clinical opinion), while the latter is evidence of an entirely different version of the genre. History tells us that you get more variation in clinical decision making if any kind of reward gets mixed up in the thinking process. This may take the form of real money, or virtual money (such as UDAs), or performance “targets” of the kind that robbed hospital managers of any semblance of rational behaviour as they desperately tried to manipulate their results in relation to waiting list targets.

“The timing of the Dispatches programme, due to be screened just a few weeks after the extraordinarily confused, one sided and emotive anti-dentist piece by John Naish in the Daily Mail (April 22nd) suggests that there may have been an extensive briefing of the media by Department sources, over and above the “Dear Colleague” letter from the CDO, linking the results of the Adult Dental Health Survey to the 2004 NICE guidelines on dental recall intervals. Perhaps this was timed to coincide with (and add weight to) the Government comment in mid April advising patients to disregard any advice from dentists to attend for six monthly checkups. It does all have the fragrance of a bit of orchestration.”

Dr Susie Sanderson, Chair of the BDAs Executive Board, said: “Dentists are highly trained, caring professionals whose first priority is their patients. Each practitioner is expected to do what they feel is best for the individual they are caring for and, accordingly, treatment plans will be developed in consultation with that patient. Effective communication between patient and practitioner is essential and the BDA strongly encourages this process so that a mutual understanding of what treatment involves and what it will cost is achieved.

“In the rare instances where misunderstanding or problems do occur there are formal procedures for resolving them, via either primary care trusts, the Dental Complaints Service or the General Dental Council.”
The British Dental Health Foundation, in association with Wrigley, has announced a new project to help improve oral health in local communities. The project is inviting bids from oral health education teams across the UK to access a new charitable fund to help boost their important work, especially in disadvantaged communities.

The Oral Health Education Project forms part of the Foundation’s fortieth anniversary celebrations later this year and Wrigley’s own centenary celebrations in 2011. The project combines the expertise of the British Dental Health Foundation, with a generous charitable donation of £100,000 from the ‘Wrigley Tooth Fairy Fund’.

The project was announced at this year’s National Smile Month campaign which started on Monday 15th May.

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, said: “Both the Foundation and Wrigley are celebrating major milestones this year and we wanted to mark the occasion with a new and significant project to boost oral health.”

“With the generous support of Wrigley, we have been able to establish this fund to help support the crucial work that oral health educators undertake, especially in disadvantaged communities and regions of known poor oral health. The fund is good news, especially in a period when oral health education is likely to be affected by the slow-down in public spending.”

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Editorial comment

So we are looking forward to yet another round of the nation’s favourite pastime, ‘dentist bashing’. A one-hour long investigation into the greedy underhanded dealings of dentists stealing money from the patient’s wallet, all to a backdrop of a high speed drill and patients’ fears and wrapped up for some early evening TV.

But what makes dentists such a prime target for these types of reports? Whether it is the Daily Mail, bbc.com, Channel 4 or the latest blog by a disgruntled patient, dentists come across as evil money grabbers who care little for patients or ethical treatment.

Some blame the fractured nature of the profession, which makes it easy to hide in your surgery and pretend it’s someone else’s problem. Others just reel off a list of names which have been brought before the GDC FTP committees for inappropriate treatment, misconduct, fraud, embezzlement and other misdemeanours and say dentists are all the same. Then there is the group that say dentists need to communicate better with patients, be absolutely clear about what treatment is being offered and whether it is NHS or private care.

For me, I think it might be a mix of all three, added to the fact that clinicians are also trying to juggle the demands of running a practice with trying to actually practise what they have trained to do. Even the life of the tabloid hack doesn’t seem so bad now.

Have you got the Smile Factor?

Dunmurry Dental Practice is helping to spread the message of good oral health by organising an Open Day for National Smile Month.

Showing that they have the smile factor, Dunmurry Dental Practice is organising an open day on Friday 27th May at their multi-award winning Practice – inviting the public and existing patients to come in, see around our new facilities, meet the dentists, get oral hygiene advice, participate in kids activities and enter a prize draw. In addition there will be a limited number of free consultations and the opportunity for new patient to register with the Practice.

Dr Philip McLorinan said: “We are delighted to get involved in National Smile Month and to give a little bit back to our patients and the community. A good oral healthcare routine can help guard against all sorts health conditions such as diabetes, heart disease and strokes. By promoting good oral healthcare in a fun, imaginative and non-threatening way we hope to persuade more people of the importance of taking care of their teeth.”

For more information on National Smile visit www.smilemonth.org

NEW LISTERINE® ZERO™
Highly effective yet alcohol-free for a less intense taste

LISTERINE® ZERO™ is alcohol-free yet retains the LISTERINE® brand’s 4 essential oils. So it has a softer taste but kills up to 49% more plaque bacteria in vitro than other alcohol-free daily mouthwashes. And there’s the added benefit of 220 ppm fluoride with high uptake for extra enamel protection. When patients want a less intense, alcohol-free mouthwash, why not add LISTERINE® ZERO™ to their oral care routine?

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Do you have an opinion or something to say on any Dental Tribune UK article? Or would you like to write your own opinion for our guest comment page? If so don’t hesitate to write to:
The Editor,
Dental Tribune UK Ltd,
4th Floor, Treasure House,
19-21 Hatton Garden,
London, EC1 8BA
Or email: lisa@dentaltribuneuk.com
**Showcase 2011**

The BDTA has announced that the following professional dental associations will be sharing the pavilion at Showcase 2011:

- BADN
- BACDT
- DPA
- DLA
- IFTA
- BDPMIA
- BADT
- BSDHIT
- BACD
- BDTA

The pavilion will be located just inside the entrance of the hall and will contain a hospitality and lounge area.

Tony Reed, Executive Director of the BDTA, said: “The pavilion was a great success last year with representatives from the associations commenting that being located together on one stand communicating a positive message of working in partnership. Visitors who attended the event in groups, also commented that they were pleased that they could visit their respective associations in one location of the hall. We are delighted to be able to offer this facility to our fellow associations again this year.”

Alongside the pavilion, the Knowledge Hunt will once again run at this year’s Showcase. All members of the dental team who attend Showcase will be able to take part in the ‘Knowledge Hunt’ which will provide one hour of verifiable CPD if the pass mark is achieved for answering 50 questions about products/services available at Showcase.

The questions will be published in the official Show Guide for the event and participants will need to search for the answers by visiting the exhibition stands and talking with stand representatives.

“We know that visitors come to Showcase to see what’s new and gain knowledge so we are always looking for ways to deliver education in different formats to appeal to people with varying learning styles. The knowledge hunt at Showcase is a practical way of gathering information as you walk around the exhibition and provides one hour of CPD which is of value to all members of the team.” Tony Reed added.

BDTA Dental Showcase 2011 takes place between 20-22 October 2011 at the NEC, Birmingham. To secure your free of charge entry to the show, register for your ticket at www.dentalshowcase.com, call the registration hotline on +44 (0) 1494 729959 or text your name, address, occupation and GDC number to 07786 286 276. Advance registration closes on 17 October 2011. On-the-day registration: £10 per person.

**Bizarre uses for a toothbrush...revealed!**

A nationwide survey has discovered that toothbrushes are used for far more than an aid to keep our smiles pearly and white.

The research, commissioned by the British Dental Health Foundation as part of the 35th anniversary of National Smile Month (May 15 – June 15), questioned more than 1,000 people in order to try and provide an insight into some of the UK’s oral health habits and routines.

The national survey uncovered that more than four in every five of us go on to reuse our old toothbrushes for another purpose.

Results showed that four in ten people use an old toothbrush for scrubbing bathroom tiles, making it by far the most popular activity. Almost a third (28 per cent) of us use our past toothbrushes to assist in cleaning more than a quarter (26 per cent) use them to give an extra glimmer to our jewellery and roughly one in every five (18 per cent) of adults use the versatile oral hygiene product to shine shoes.

More uses included cleaning bikes, computer keyboards, toilets and tooth seats, fish tanks and finger nails. A clean sweep all-round!

Results from the comprehensive survey found that the age of the owner plays a significant role with toothbrushes more likely to be used as a toothbrush after it is too old to care for the teeth and gums.

Those of us over 75 are three times more likely to re-use their toothbrush for a different purpose than those between the ages of 16 and 34 and twice more likely than those between 55 and 44.

Additionally, women are a third more likely to reuse their toothbrush for chores and other uses than their male counterparts.

“Bizarrely, other uses for the oral hygiene product ranged from women who admitted to using it to apply their hair dye to those who use the object as a hair chopstick while some men who choose to use an old toothbrush to clean the dog’s teeth or give the golf clubs a sharp polish.”

**How safe is that medicine you are taking?**

A recent report has stated that drug consumption continues to rise around the world, and that Africa alone remains to have the largest and best developed pharmaceutical market, with drug spending reaching US$2.68b in 2009. However, there is a problem as consumers can be easily led to believe that prescription drugs that have been recommended by their doctor are safe and that anything ‘natural’ is unlikely to work.

Against the backdrop of the continuing rise of pharmaceutical drug consumption throughout the world, there have been persistent warnings from both the International Narcotics Control Board (INCB) and the South African Medical Nutritional Institute (MINI), the latter issuing an urgent call to consumers to be much more cautious and conscious with regards to the medicines they purchase and use.

There continues to be a blind faith towards orthodox medicine, even though prescription drugs can in fact be lethal. According to a study in the Journal of the American Medical Association, in the United States alone prescription drugs kill more people every year than traffic accidents and Adverse Drug Reactions (ADRs).

The fact remains that some medicines have adverse side effects that have not been detected prior to their approval, and people will continue to respond differently to treatments and there can be no sure answer as to how some medicines will react with others.

Undetected side effects are also included in the ‘natural’ or non-prescription category of medicines; Simply labelling a product as ‘natural’ doesn’t automatically mean it is safe.

**General Dental Council prosecutes suspended registrant**

A London-based dentist has been successfully prosecuted by the General Dental Council (GDC) and ordered to pay a total of £10,015 for the illegal practice of dentistry.

On Thursday 4 May 2011 Mr Young Jun Suh, of Camberwell Dental Surgery, 214 Coldharbour Lane, London pleaded guilty at Tower Bridge Magistrates’ Court to practising dentistry while not registered, contrary to Section 58 of the Dentists Act 1944.

The GDC’s Interim Orders Committee suspended Mr Suh’s registration in September 2009 and that suspension is still in place.

He has been fined £4,000 and ordered to pay a £15 victim surcharge. He has also been ordered to pay £6,000 towards the GDC’s costs.

The Magistrates told Mr Suh: “You have blatantly disregarded the interim order for suspension for a period of a year.”

Chief Executive of the GDC Evlynne Gilvarry said: “We are committed to taking action against people who practice dentistry illegally, whether they’ve been removed from our register or never gained the qualifications to register in the first place. They are a risk to the people they treat and we will do everything we can to ensure public safety.”

**United Kingdom Edition**

Showcase 2011

How safe is that medicine you are taking?

General Dental Council prosecutes suspended registrant
You’ll never look at toothpaste the same way again...

Introducing Oral-B PRO-EXPERT
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The first and only toothpaste with a breakthrough formulation of stabilised stannous fluoride and polyphosphate. The combination amplifies its antimicrobial, anti-sensitivity and acid erosion benefits. 15 years of research and over 70 clinical studies have helped validate this latest toothpaste innovation.

To learn more, visit us at www.oralb.co.uk/professional
Outstanding Achievement for Denplan Chairman

Denplan is extremely excited and proud to announce that its Chairman, David Phillips, has been recognised with a special honour at this year’s Dental Awards.

The Dental Awards are organised by The Probe magazine and developed to recognise and reward the very highest standards in UK dentistry and oral healthcare. David was thrilled to receive the award for Outstanding Achievement at the glittering awards ceremony, which took place at the Lancaster House Hotel in London on the 6th May.

Keith Hemmingway, Chairman of The Dental Web, presented David with the award and spoke of David’s ‘glittering career’, both in the UK and overseas. He also praised David for his work with the GDC, WHO, Oasis and Denplan, as well as his tireless dedication to the profession and his family. David was described as ‘a rather special and intriguing individual’ and the team at Denplan could not agree more.

Steve Gates, Denplan Managing Director, said: ‘I could not be happier for David, who certainly deserves this prestigious award. He is a real character and entirely devoted to the dental profession and to Denplan. His achievements truly are outstanding and long may his involvement continue’.

Judith Hann shares her experiences

Members of the British Dental Editors Forum (BDEF) gathered together at the RAF Club in Piccadilly at the end of April for an evening of networking, discussion and an informative presentation by one of Britain’s leading science journalists and broadcasters, Judith Hann.

Judith is known to millions for the 20 years she spent presenting BBC’s Tomorrow’s World as well as other programmes on technology, health, food and the environment. The topic for the evening was Publicising Science and Health Care in the 21st Century and Judith drew on her wealth of experience in the media to add to the debate.

She openly shared examples of times when broadcasts didn’t go according to plan, explained the need to make contact with national publications and highlighted the importance of joining together with industry peers to create a united voice on subjects affecting the industry at large.

The event provided an opportunity for BDEF Chairman, Ken Eaton, to officially launch this year’s Young Dental Writers Award and announce that the ceremony will be taking place on 14 September 2011. Ken explained that the initiative was growing in popularity each year and encouraged BDEF members to nominate young writers for this year’s award.

Only one toothpaste provides clinically proven non-stop 12 hour protection against bacteria...

For a healthy mouth recommend NEW Colgate Total.
Neel Kothari discusses the contribution of mouthwashes to oral health

**Mouthwashes: help or hindrance?**

Neel Kothari

**Agency (FDA)** seem to disagree strongly imply that patients may 'kills 99.9 per cent of bacteria' and effective for gum problems' and (a fact often omitted) and often out severe periodontal disease. halitosis.

actual effectiveness at combating containing mouthwash and the dryness when using an alcohol have been raised about the effects of alcohol-free ranges. Whilst the risk of mouth cancer has been much debated, concerns have also been raised about the effects of alcohol-containing mouthwash - especially on waking up, for instance the slogan 'bleeding gums are bad'. At first glance this seems hard to argue against, but if we look at when people actually trichosan etc; but how effective are these products when stacked up against thorough cleaning? Are they actually needed or helpful in the presence of poor cleaning or as a substitute for good oral hygiene. Whilst the 'help' that they claim to offer to families is usually advertised, perhaps mouth washing post brushing (hence rinsing of fluoridated toothpaste) for a high caries risk child may actually be a hindrance.

On a different note, it is worth questioning whether the terminology used by mouthwash brands helps or hinders the population's ability to maintain their own oral hygiene. Many of the studies used by the mouthwash manufacturers point to improvements when looking at mouthwashes being used as an adjunct to decent oral cleaning, but there is very little evidence supporting the use in the presence of poor cleaning or as a substitute for good oral hygiene. Whilst the 'help' that they claim to offer to families is usually advertised, perhaps mouth washing post brushing (hence rinsing of fluoridated toothpaste) for a high caries risk child may actually be a hindrance.

**Child ranges**

Many leading manufacturers are introducing children's ranges of mouthwash, again with much of the same rhetoric around killing bacteria and carefully worded implications surrounding preventing oral health problems. Many of the studies used by the mouthwash manufacturers point to benefits of improved oral health, all of a sudden this state-

Treating, all of a sudden this state-

**Whole of development of oral cancer**. The authors also state that the risk of acquiring cancer rises almost five times for users of alcohol-containing mouthwash who neither smoke nor drink, with a higher rate of increase for those who do. Whilst this was disputed by Yinka Ebo of Cancer Research U.K, who concluded that "there is still not enough evidence to sug-

**It is worth questioning whether the terminology used by mouthwash brands helps or hinders the population's ability to maintain their own oral hygiene**

of development of oral cancer”. The authors also state that the risk of acquiring cancer rises almost five times for users of alcohol-containing mouthwash who neither smoke nor drink, with a higher rate of increase for those who do. Whilst this was disputed by Yinka Ebo of Cancer Research U.K, who concluded that “there is still not enough evidence to suggest that using mouthwash that contains alcohol will increase the risk of mouth cancer”, many brands have now introduced alcohol-free ranges. Whilst the risk of oral cancer has been much debated, concerns have also been raised about the effects of dryness when using an alcohol containing mouthwash and the actual effectiveness at combating halitosis.

Leaving the content of the products aside, what exactly is their contribution towards oral health? Of course many brands heavily promote clinical studies that clearly point to improve-

ments in gingival health, but these tend to be for patients with-

out severe periodontal disease (a fact often omitted) and often slogans such as ‘nothing is more effective for gum problems’ and ‘kills 99.9 per cent of bacteria’ strongly imply that patients may be able to effectively self treat. The US Food and Drugs Agency (FDA) seem to disagree see their gums bleed, ie during brushing and interdental clean-

ing, all of a sudden this statement takes a different turn. Could these sorts of messages hinder our patients from decent gingival brushing when cleaning? And if, so do the benefits of using a mouthwash outweigh the risks of poor tooth brushing?

**Why use it?**

So why do we all use mouthwash? Well I often use mouthwash during the day, but mostly to freshen my breath either after lunch or if I am in a rush. Many people use mouthwash after brushing their teeth, but in the process however wash off much of the proven benefits of their fluoridated toothpaste. Others purposefully buy mouthwash on the basis of improving their breath, especially on waking up, to get rid of the so called ‘morn-

ing breath’. A panel compiled by the FDA reported that bad breath in the morning is something most people have, but it doesn’t indi-

cate an oral disease. According to the panel, most people can solve their breath problems by rinsing their mouths with water, brush-

ing their teeth, flossing, or simply eating breakfast.

Now of course, this doesn’t detract from the many of the ad-

vances made with anti-plaque and anti-gingivitis agents such as with chlorhexidine, essential oils, and anti-gingivitis agents such as Walgreen Co Johnson & Johnson, and CVS Corp to stop making untrue claims that their mouth rinse products can reduce plaque above the gum line, promote gum health, and prevent gum disease. The com-

peting products effectiveness in preventing gum disease, but according to the FDA no such benefit has been demonstrated.

On a different note, it is worth questioning whether the termi-

nology used by mouthwash brands helps or hinders the population's ability to maintain their own oral hygiene. Consider for example the slogan 'bleeding gums are bad'. First glance this seems hard to argue against, but if we look at when people actually
May 6-7, 2011 saw the eighth annual Clinical Innovations Conference held in association with Smile-on, the AOG, Dental Directory, ESCD and FGDP (UK). The event, held at the prestigious Royal College of Physicians in London, saw more than 350 delegates come through its doors to find out the latest thinking in aesthetic and restorative dentistry.

The conference was opened by some welcoming words from Smile-on CEO Noam Tamir, and AOG president Pomi Datta. Then it was the turn of Dr Nasser Barghi to commence the lecture programme, with his presentation titled All Ceramic Restorations in 2011: different ceramic systems and their clinical indications.

Dr Barghi discussed various restorative solutions for patients and how technology has progressed to such an extent that there aren’t too many bad products to choose from. He was passionate in his ‘love’ of zirconia, making it his material of choice for his restorations. He was able to show many case studies to show the different solutions clinicians have at their disposal to illustrate many of his points. Themes in his presentation included:

- **Adhesion: cement or bonding?** Discussing surface treatment when looking at adhesion
- **Veneers:** his preference for ceramic veneers; indications for no-prep veneers. These include:
  - No discoloration
  - Presence of diastema
  - No rotation
  - Presence of proportion
- **Learning from failures:** Dr Barghi commented that his definition of an expert was a person with failures. Acknowledging that these were not a preferred thing in practice, he thanked the ‘luxury’ of being in academia which gave him the chance to be experimental with techniques
- **Being in control:** he was very passionate about dentists remaining in control of their restorations. Commenting that he always looks at the scans which his dental laboratory have taken from his impressions (he’s not convinced with digital impression taking, not just yet!) so he can ensure that what is going to be milled is what he is expecting for his patients

My favourite piece of advice Dr Barghi gave in his presentation was this: ‘Remember the golden rule of dentistry – if it is your patient, repair it; if it is someone else’s patient, replace it!’

After such a start, it was going to take something special to follow. Luckily, next up was Dr Wyman Chan, discussing Latest techniques in teeth whitening processes. Showcasing his new ‘Jumpstart’ technique, Dr Chan gave a demonstration of the system that he has devised over many years of research and development.

The first thing that struck me was the emphasis on patient safety and the precautions taken to ensure that the process was entirely pain-free for the patient. This was paramount, Dr Chan commented, to ensure that the home regime prescribed by the clinician would be adhered to because the patient knew it wouldn’t hurt.

The other thing that struck me, and this is the innovative thing about the Jumpstart system, is that there is no use of whitening trays or bright cumbersome lights; the whitening gel is painted onto the teeth and a small thermal
diffuser is attached to the lip retractors to help the gel to permeate the tooth structure. The use of a light is just a gimmick, Dr Chan commented, it is the heat, not light that allows the gel to work.

After doing the Jumpstart whitening (which was only 20 minutes), Dr Chan then had the ‘patient’ a willing dental therapist volunteer, perform two home whitening sessions using his take home kits. Again not using trays, he asked the patient to put the special retractors which also hold the diffuser on and paint the gel on her own teeth.

I’ve never been a fan of the concept of tooth whitening, figuring that bleach is not something I want anywhere near my teeth! But after Dr Chan’s lecture, and seeing for myself what can be done in a safe manner even by someone like me, I am a total convert.

With there being so many fabulous lecturers to choose from, it was impossible to see and hear them all. Other presenters included:

- Dr Julian Satterthwaite: Management of failing dentitions
- Dr Julian Webber: Single File Reciprocation, Shaping the Future of Endodontics
- Prof Edward Lynch: Top Tips for Successful and Aesthetic Clinical Dentistry
- Dr Peet van der Vyver: Making Magic with Matrix Systems
- Dr Wolfgang Richter: Composites - Facts and Fiction
- Drs Tif Qureshi & James Russell: Pre-align then Design – the Simplification of Cosmetic Dentistry for all

A first for the Clinical Innovations Conference, the Friday also saw the London Deanery’s annual DCP Conference held alongside its delegate programme. This event was a vibrant meeting, and was a perfect complement to CIC’s innovative ethos. Attendees were treated to a range of subjects including mentoring, communications, decontamination and medical emergencies. The presenters included:

- Dr Sue Morgan: Mentoring in the Workplace
- Dr Mike Clarke: ‘Now that shouldn’t have happened – can I phone a friend?’ Risk Management in Dentistry – a DCP guide
- Dr Mike Wanless: Effective communication to develop rapport
- Dr Sandra Smith: Getting to grips with the latest dental decontamination guidance known as HTM 01-05
- Dr Joe Omar: Medical Emergencies: ‘How Can I Help’

The Friday evening was a chance to get together and party the night away with fellow delegates, sponsors and speakers at the annual Charity Ball, organised by Smile-on and the AOG. A night of fine dining and fantastic entertainment at the five-star Millennium Hotel in Mayfair, the event did make for some delicate heads in the morning!

Fortunately, the Saturday line-up was enough to get even the weakest of constitutions out of bed. Saturday’s speakers included:

- Dr Eddie Scher: Failure in implant dentistry
- Dr Peet van der Vyver: The Benefit of Magnification in Dentistry
- Dr Jason Smithson: Simplified posterior restorations – simple, easy and predictable
- Dr Raj Rattan: The Future Direction of the NHS
- Dr Trevor Burke: A Pragmatic Approach to the treatment of tooth wear
- Dr Bob McLelland: Preparing for Perfection
- Dr Liviu Steier: Advanced Biofilm Management - Reality Check. From single vs. multiple sessions Root Canal Treatment to full mouth disinfection in Periodontal Treatment
- Dr Jason Smithson: Direct Composite Restorations: Advanced Concepts for the 21st Century Composite restorations which require little occlusal adjustment and have firm proximal contacts
- Dr Nasser Barghi: Different Ceramics, Different Bonding, a very unique participation course
- Dr Peet Van Der Vyver: Management of Curved Root Canals using Modern Endodontic Equipment and Techniques

A knowledgeable exhibition was also there to compliment the speaker programme, giving delegates the opportunity to speak with product experts on a one-to-one basis.

An event enjoyed by attendees, speakers and sponsors alike, Clinical Innovations Conference 2011 was considered a fantastic success. Look out for news of next year’s Conference, coming soon!
Family Interference
Dr Mike Ostrofsky discusses how a little bit of knowledge can adversely affect treatment

Elderly patients are often accompanied to a consultation by well-meaning adult children. These children, themselves parents, especially those with some medical knowledge, often second guess treatment. They often want second opinions from others not related to dentistry. These “others” do not know the full extent of a dentist’s or dental specialist’s training and background, and they then take over treatment. This is very often to the detriment of the patient, leading to expensive, unnecessary and harmful results.

Case report
An elderly lady living with a carer in a retirement home, was brought in by her daughter, who is a pharmacist. Her son, an ENT Surgeon, lives overseas. The main problem was a painful swelling of her face, present for 10 days. She had been eating a full upper denture which was now uncomfortable. The only significant medical problem, apart from early dementia, was that she had been a smoker for many years, but had given up 20 years ago.

The extra oral examination revealed a oedematous swelling of the right side of the upper lip and cheek. There was also a swelling of the buccal sulcus around the 16 area where there was a root present. A panorex x-ray demonstrated the presence of a root in the 16 area. A radiolucency was visible above the apex and extending into the maxillary antrum. Clinically the lesion was suspicious for a malignant neoplasm, but as there was an inflammation from the 16, irritated by the denture it was decided to treat the patient with antibiotics for a week and then to reassess for possible biopsy.

Now the interference kicked in. The daughter, unknown to me, decided to take her mother to head and neck surgeon for a second opinion, who decided to remove the submandibular lymph node under GA. He had diagnosed the lesion as lymphoma and was making arrangements for the lady to undergo chemotherapy thereafter. It was now that I was informed by the daughter of what was to take place. Apart from the fact that both the daughter and the head and neck surgeon had not spoken to me about the second opinion, my fear was that the chemotherapy would lower the lady’s resistance to infection and that the roots should be removed. Reluctantly the head and neck surgeon and the ENT son allowed me to be present in theatre at the time the lymph node was to be excised, so that the roots could be removed. To my horror the large ulcer in the mouth had not healed, but in fact had enlarged. The head and neck surgeon still thought that the ulcer was related to an infection from the tooth roots. However, I insisted that some tissue from the ulcer be sent away for histopathological examination. The Pathologist confirmed that was in fact a lymphoma.

Had there been no family interference, I would have biopsied the lesion under local anaesthetic and made the diagnosis. The patient would not have had to undergo a procedure to remove a lymph node and neck dissection and could have been referred on for the chemotherapy. Interference in treatment by members of the family often leads to an adverse outcome.

About the author
Dr Mike Ostrofsky B.D.S., M.Dent (MFOS)(Wits) is a Maxillo Facial and Oral surgeon in practice in Cape Town. He holds an appointment as a part time senior consultant in the departments of Maxillo Facial and Oral surgery at the University of the Western Cape and at No 2 Military Hospital. He has been in private practice for 35 years and his main interests are in implantology, endodontic surgery, TMJ surgery and dento-alveolar surgery.
So, what do we know about implant dentistry?

This April saw the Association of Dental Implantology UK Team Congress held in Manchester. With the theme of 'What we know, what we think we know and what we think we don’t know about implant dentistry', the event saw more than 650 delegates come together to hear world-class speakers discuss the latest topics within implant dentistry.

It was interesting to see the sector breakdown of delegates – whilst more than 50 per cent of the attendees were clinicians, there was an even spread across other registered and non-registered groups. The one exception being dental nurses, which seems to show the changing views of the importance of teamworking in dental practice, especially in the more complicated areas of dentistry. This course of was complimented by the extensive dental implant team programme which ran alongside the plenary session. The attendee breakdown is as follows:

- 356 clinicians - 53.5%
- 43 technicians - 6.5%
- 43 hygienists - 6.5%
- 167 nurses - 25%
- 48 practice managers - 7%
- 8 students - 1%

The speaker line-up itself was a global who’s who of implantology, with figures such as Tomas Albrektsson and Michel Magne taking to the podium. The team programme played host to names such as Ashley Latter, Louise Fletcher and Simon Wright, discussing topics ranging from team approaches in implant dentistry to medical emergencies, HTM01-05 to sinus lifts.

Plenary speakers included:
- Prof Tomas Albrektsson MD PhD ODhc: How learning from past errors can guide the future of dental implants
- Mr Michel Magne MDT BS: Aesthetic dentistry today - a distinctive approach to nature
- Prof Mauricio Araújo DDS MS: PhD: Management of the alveolar socket
- Prof Clark M Stanford DDS PhD: Integrating the process predictable aesthetics into clinical practice
- Dr Stephen L. Wheeler DDS: Immediate implant placement: is it safe and predictable?
- Prof Joseph Kan DDS MS: Implant papilla management in the aesthetic zone
- Mr Oliver Brix MDT: Oral Harmony: a systematic way to success
- Dr Stephen S Wallace DDS: Latest strategies and techniques for maxillary sinus augmentation
- Assoc Prof Tara Aghaloo DDS MD PhD: Bone grafts for site development - the past, the present and the future
- Prof Torsten Jemt DDS Dr/PhD: Long-term experience of dental implants - clinical development and biological response

Dental implant team programme speakers included:
- Ms Anita H Daniels RDH: The team approach to implant dentistry: a blueprint for success and The role of the dental hygienist in implant treatment
- Mr Ashley Latter: Ringing the changes: turn every patient enquiry into an appointment
- Miss Helen McCvicker: Asepsis for dental implants: the theory and Asepsis for dental implants: the practical
- Miss Louise Fletcher: Effective communication with patients
- Miss Helen Batty and Dr David Speechley BDS DMI RCS Edin PGDip Implant Dentistry: Advanced surgical techniques, instruments and preparation
- Miss Helen Frost, Miss Amy Miller and Dr Simon Wright BDS PGDip FDS RCS: Dental Implant Dentistry: Medical emergencies in implant dentistry
- Miss Helen Batty: HTM01-05 and implant dentistry
- Miss Kara Moody: Sinus lifts

Sitting alongside the congress was an extensive exhibitor’s area, where delegates could discover the latest technologies on offer to make their...
Implant dentistry easier and more predictable. With more than 500 implant systems available worldwide and with this number growing, delegates were finding it helpful to speak to the teams behind some of the systems available in the UK. Representatives of the largest implant companies in the UK were there, including Astra Tech, Biohorizons, Nobel Biocare and Straumann. Other emerging systems were also on show, including Bicon, d2d Implants, DIO Implants, Implantum and Southern Implants.

ADI’s stand was prominent in both size and busyness, with many of the organisation’s staff and officers on hand to help with queries and showcase the many services and benefits ADI can offer its members. The main highlight of the stand was the launch of the association’s new online education resource Ark.

Ark comprises 15 individual courses, each covering a core topic within implant dentistry and is designed to meet the complex educational needs of today’s learners. It has been designed to incorporate a flexible approach so that learners can access individual modules or the whole course, and can access the learning at their own time and preference of learning opportunities: online, directed reading, study days and experience-based learning through mentoring.

Speaking at the congress, ADI President Dr Stephen Jacobs was delighted at the success of the event: “This is turning out to be a fantastic event. The speakers have really kept to the remit of reflection within the subject of implant dentistry.

“There really isn’t a lot that’s new in implantology. Of course, with the advances in technology the accessibility for patients has improved as well as the predictability of the implant components.

“This year’s congress has been two years in the planning and I was delighted that every speaker we invited to take part was able to accept except one who could not make it.”

Dr Jacobs was keen to stress the importance of mentoring when developing the skills needed as an implant clinician, both in terms of patient safety and the clinician’s own needs. “Mentoring can often be more stressful for the mentor! The relationship between mentor and mentee is extremely important; it needs to be right.

“In a field such as implant dentistry mentoring is a fundamental facet to becoming competent, a patient’s well-being is paramount when performing this kind of treatment and the clinician needs to have confidence in their skills. Mentoring helps give that confidence.”

The congress was a vibrant and exciting event which delegates seem to thoroughly enjoy. Comments from attendees included: The congress exceeded my expectations - wonderful accessible venue, superb audio visuals, world class speakers, friendly sociable delegates, excellent standard of catering. All in all, the best dental convention I have attended.

Outstanding - best ever in all respects.

A very professional and organised congress - excellent overall and excellent speakers.

Very good event!

The best ever done by ADI.

ADI President Elect, Professor Cemal Ucer will host the next ADI Team Congress in 2013 with the theme How long do implants last? Complications, risk management and prognosis. Save the date!
Bone Harvesting—nice and easy
Dr Hohl and Dr Petersen discuss bone harvesting

The desire to use bone from your own body to build new bone in another place is almost as old as humanity itself. We call this procedure autologous bone grafting.

In the case of autologous bone grafting the bone is removed from the same organism that the graft is to be incorporated into.

The body's own bone cells have the greatest potency for rebuilding of bones and are the gold standard in oral augmentation surgery. Donor areas are: the tuber maxillae, the retromolar space, the chin region or the iliac crest, the ribs or the shin. Gaining the required quantity is sometimes elaborate (large surgical interventions, in patient stay) and afflicted with particular problems, especially when it comes from regions far away from the oral cavity (eg the iliac crest). The extraction of autologous bone grafts from the retromolar space find the best acceptance with patients.

Particularly in implantology lateral augmentations are necessary in more than 75 per cent of cases. These augmentative measures mostly require low bone volumes of less than 0.5mg. If the decision is made intraoperatively, that the patient's own bone must be used, this situation the question is raised of whether implantation and necessary augmentation of the crestal jaw line can occur synchronously.

It was planned for the patient to have autologous bone adhered in the region of the 051 vestibular. Hereby the right retromolar space and the right tuber area were considered as donor areas. The patient could be assured preoperatively that an extraction defect of bone extraction would only involve few complaint symptoms. Interoperatively the crestal incision was begun in the areas 031 and 041. After forming a minimally invasive mucoperiosteal flap, in particular region 051 showed strong vestibular atrophies. Initially implant drilling was carried out and the bore shaft was extended using bone condenser, ie the peri-implantational bone was condensed. Subsequently, the implant bodies were inserted. Here it became obvious that the implant was 2/3 exposed on its vestibular side in region 051. Both implants were primarily stable. After measuring the missing bone volume, a stab incision was made in the right retromolar. Then a conventional implant drill was driven through

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the gums and drilled precisely 9mm deep. When withdrawing the drill the bone meal was already able to be retained. Additionally further spongios bone was extracted with a mini-excavator.

The transplant bone was able to be adsorbed into the implant body in an ideal manner. Finally a thin collagen membrane was applied for complete coverage. The soft tissue defects were closed with absorbable materials. The stab incision in the retromolar was glued with cyanoacrylate. In regions 031/041 the wound closure was carried out using absorbable suture material and horizontal mattress stitches.

Finally, as a provisional restoration, a Maryland temporary prosthesis was affixed, which additionally ensured a good soft tissue stabilisation. A digital volume tomography (DVT) was produced in order to evaluate the removal defect and document the augmentative result.

Summary

Autologous bone grafting represents the gold standard in augmentation surgery. Particularly with implant operations it is often only shown intraoperatively that a small quantity of autologous bone is needed for augmentation. In this situation quick reaction is often indicated. The retromolar space is frequented most often for this purpose. As the patient should have the least possible discomfort due to the bone extraction, minimally invasive procedures are the means of choice.

The technique presented above is a new method which is impressive due to its minimally invasive and simple characteristics. The shown procedure is especially ideal for augmentation planning with volumes up to 0.5mg. Of course larger bone volumes can also be extracted using this minimally invasive method. Soft tissues can be closed discreetly and so that they are hardly noticeable to the patient using adhesive techniques. Minimally invasive procedures in implantology can be perfectly planned and executed by including modern 3-D-diagnostics (DVT).

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Figs. 1 & 2_Initial situation in region 031, 041. State 3 months after the removal of the teeth 31, 41. In region 031 the vestibular lamella has completely collapsed.
Fig. 3_Noticeably visible three wall bone defect in region 041 vestibular.
Fig. 4_After drilling the implant shafts, region 031 showed to be significantly atrophied.
Fig. 5_The implant shafts are dilated using condensers and the paraperiimplantational bone is condensed.
Fig. 6_Final implant insertion in the regions 031, 041. In region 031 it is visible that a vestibular augmentation must take place.
Fig. 7_The implant body in region 031 must be vestibularly covered with autologous bone over approx. 2/3 of its surface.
Fig. 8_Farcomolar stab incision with an 11 scalpel.
Fig. 9_A conventional implant drill is used to drill directly in the area of the linea obliqua through the stab incision. A “two spade drill” is excellently suited to bone extraction.
Fig. 10_Bone excavation via simple shaft drilling with the conventional “two spade drill”.
Fig. 11_Additional bone excavation by hollowing out the shaft drill hole in the linea obliqua with the excavator.
Fig. 12_Implants and autologous bone augmentation in situ. In order to achieve this result it was only necessary to drill into the retromolar!
Fig. 13_Covering the implants and augmentations with a simple collagen membrane.
Figs. 14 & 15_Augmentation of the retromolar extraction region is flushed with cyanoacrylate. Today the patient only incurs a minimal extraction defect.
Figs. 16 & 17_The soft tissue in the implant region is closed with absorbable suture material. The neighboring teeth 43, 42, 32, 33 are lingually cauterised.
Figs. 18 & 19_Insertion of a Maryland provisional prosthesis, directly after the augmentation-implantological intervention.
Fig. 20, 21, 22_DVT of excavation defect.
The concept of “platform switching” in implant dentistry: A literature review—Part I

Virgil Koszegi Stoianov, Romania reviews the latest literature

Over the last decades, osseointegrated dental implants have proven to be highly predictable and largely accepted as a treatment modality for the rehabilitation of partially and completely edentulous jaws.

Being considered the most aesthetic and functional alternative to missing teeth, dental implants are used as prosthetic supports and expected to withstand complex occlusal load. However, they also have to confront the effects of additional factors such as oral microflora or elevated parafunctional forces.

Several factors such as implant design and surface, implant abutment interface or connection, bone architecture, prosthodontic restoration type and loading conditions may have effect on bone modelling and remodelling around the implants.

The generally accepted criterion for implant success is that less than 0.2mm of alveolar bone loss per year should occur after the first year in function. What is overlooked, however, is that the implant therapy success is determined after the first year of service because most of the bone loss occurs during the first 12 months following abutment connection.

Therefore, the 2mm loss of crestal bone over the first year might be considered a normal characteristic of a healthily functioning implant. The loss of crestal bone and soft tissue may have important implications for aesthetic implant restorations, which are reliant on healthy and constant soft tissue dimensions over time. The aesthetic replacement of teeth has become an important standard for implant dentistry, leading to further research regarding the factors contributing to crestal bone loss around two stage implants (Fig. 1).

Bone adaptation under loading conditions

Bone is a tissue that changes its mass and internal architecture adapting itself to the loading conditions. According to Wolff’s law, every change in the form and function of bone is followed by modifications in its internal architecture and external conformation. The dimensions and orientation of trabeculae are adaptable in accordance with changes in loading trajectory vectors and, when equilibrium is found, trabecular patterning represents the average regime experienced by the bone.

Mechanical stimuli affect bone response and exert influence on the replication and differentiation of mesenchymal cells toward the osteoblast lineage.

Frost’s theory

Frost stated that bone mass changes when absolute peak strains induced inside the bone fall either below or above the physiological window estimated between 200 and 1,500 microstrains.

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SPMP09095 REV A APR 2009
The application of this theory (Fig. 2) to dental implant rehabilitation explains bone resorption at the crestal level of loaded implants, a condition that may occur because of the stress shielding effect, due to both the solid metal structure of the implant and the implant design. These features can play a role on load transfer to the bone, reducing strain magnitude under the lower physiologic threshold and, thus, promoting osteoclast resorption at the crestal level.

Implants with a slim design at the crestal level, for example, demonstrate a wide bone formation, corroborating Frost’s theory.

Effect of implant geometry

Implant design consists of the combination of the implant body three-dimensional geometry, presence of threads, thread design, surface topography and surface treatments that may affect strain stimulation of peri-implant bone.16

Finite element analysis is reported that tapered implants present a better mechanical performance than cylindrical implants to avoid punching stresses.21, 22 It has been demonstrated that threads and their location on the implant body have a role in the load transferring pressure patterns to the bone.23

The outcome of comparative clinical research on different implant systems have reported analogous marginal bone loss per year (1–5), even if smooth surfaced implants with a conical collar have demonstrated higher bone loss than self-tapping and standard implants.29, 30

In this respect, marginal bone loss might be primarily related to the smoothness of the implant surface, leading to stress protection, and thus, to bone resorption (bone shielding).31

Effect of the implant surface on the peri-implant bone

Surface microgeography plays a primary role in facilitating biological interactions between bone precursor cells and implant. Rough implant surfaces facilitate high osteoblast adhesion levels24, and since osteoblasts are spread on implant surfaces, the roughness seems to induce osteoblasts toward synthesis and the release of biological factors affecting the tissue response at the interface. Surface roughness is a crucial factor affecting bone apposition at the interface and improving the interface resistance because of better mechanical interlocking.

However, increased bone mass around rough surfaces may also be attributed to a lower bone remodelling level during the early stages of implantation, as reported in a comparative research study between plasma sprayed and smooth surfaced implants.25, 26

A poor implant design like smooth machined coronal part could be related to a reduction in mechanical interlocking between implant and crestal bone, acting like a stress shield and inducing crestal bone loss.27, 28

The stability of the peri-implant cervical bone around the neck of the implant and the absence of resorption are the key to maintaining gingival papillae and bone in the anterior region.

According to reference literature, several changes should occur after abutment connection. Bone resorption of approximately...
Preliminary evidence suggests that anticipated bone loss occurring around two-stage implants, following loading, or surgical stage two, may be reduced or eliminated when implants are restored with smaller-diameter abutments on larger platforms.\(^5\)

The interface between abutment and implant, or the microgap, is subject to micro movements and bacterial seeding, and, if it lies at or below the crest of the bone, prompts osseous resorption for these reasons. Bone preserving techniques such as platform switching have been utilised for more than ten years (Fig. 5).

The answer to these questions may be of an important support in choosing the implant system, able to switch the platform, which can face high implant–aesthetic demands.

Is the concept of platform switching a bone preserving technique, and, if so, is it reproducible?

Is this concept alone able to preserve bone?

Is the platform switching concept evidence based?

Materials and methods

The aim and objectives of this review have been to examine the scientific validity of claims that platform switching concept improves implant performance, being a bone preserving technique.

These claims have been analysed against historic back-ground, findings and conclusions of published implant studies.

A literature search of paper published in reference journals in the English language was performed by computer using the National Library of Health.

PubMed search for the key words “implant platform switching concept” ended in 10 and Google Scholar in 5,110 results for the same key words in 0.07 seconds.

These results show an ever-growing interest in this subject which is very challenging for the peer reviewed literature to keep up with.


Table 1

<table>
<thead>
<tr>
<th>Type of implant</th>
<th>Bone mean bone loss (mm)</th>
</tr>
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<tbody>
<tr>
<td>Laser welded A</td>
<td>&lt; 1 micron</td>
</tr>
<tr>
<td>Laser welded B</td>
<td>&lt; 0.3 micron</td>
</tr>
<tr>
<td>Laser welded C</td>
<td>&lt; 0.6 micron</td>
</tr>
<tr>
<td>Alumin. milled A</td>
<td>&lt; 0.3 micron</td>
</tr>
<tr>
<td>Alumin. milled B</td>
<td>&lt; 0.5 micron</td>
</tr>
<tr>
<td>Alumin. milled C</td>
<td>&lt; 0.7 micron</td>
</tr>
<tr>
<td>Alumin. milled D</td>
<td>&lt; 1.0 micron</td>
</tr>
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Table 2

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<thead>
<tr>
<th>Site</th>
<th>No. of implants (173) Astra</th>
<th>Mean marginal bone loss (mm)</th>
</tr>
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<tbody>
<tr>
<td>Mandible</td>
<td>80</td>
<td>0.56</td>
</tr>
<tr>
<td>Mandible</td>
<td>93</td>
<td>0.70</td>
</tr>
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</table>

Table 3

<table>
<thead>
<tr>
<th>Type of implant</th>
<th>Size of the microgap (micron)</th>
<th>Mean bone loss after 3 months (mm)</th>
</tr>
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<tbody>
<tr>
<td>Laser welded A</td>
<td>&lt; 1 micron</td>
<td>0.67</td>
</tr>
<tr>
<td>Laser welded B</td>
<td>&lt; 0.3 micron</td>
<td>0.96</td>
</tr>
<tr>
<td>Laser welded C</td>
<td>&lt; 0.6 micron</td>
<td>1.21</td>
</tr>
<tr>
<td>Alumin. milled A</td>
<td>&lt; 0.3 micron</td>
<td>1.31</td>
</tr>
<tr>
<td>Alumin. milled B</td>
<td>&lt; 0.5 micron</td>
<td>1.37</td>
</tr>
<tr>
<td>Alumin. milled C</td>
<td>&lt; 0.7 micron</td>
<td>2.26</td>
</tr>
<tr>
<td>Alumin. milled D</td>
<td>&lt; 1.0 micron</td>
<td>2.27</td>
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Table 4

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<tbody>
<tr>
<td>Results</td>
<td>This data confirm the important role of the microgap between the implant and abutment in the remodeling of the peri-implant crestal bone.</td>
</tr>
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</table>

Platform switching seems to reduce peri-implant crestal bone resorption and increase long-term predictability of implant therapy.

Table 5

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<tr>
<td>Results</td>
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Table 6

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<th>Multiple-Stage Restoration in the Posterior Jaws: Maintenance of Marginal Bone Levels with Reference to the Implant-Abutment Microgap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Results</td>
</tr>
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</table>

With an overall mean margin of bone loss of only 0.65mm from the microgap the data of this study is in close agreement with numerous studies on the Astra Tech System.

The finding that some of the implants have demonstrated bone above the level of the microgap cast doubt on the theory of bio-logic width, with regard to the influence of the location of the implant-abutment microgap which requires re-evaluation.
There is an association between bone and soft tissue preservation around implants with direct influence on aesthetics. Some authors have proposed different methods to maintain supporting bone: improved implant micro-geometry and implant surface treatment, improved implant abutment connection (elimination of bacterial reservoir, absence of movements under bending forces) as well as the use of wide implants with smaller-sized abutments (platform switching concept).

An alternative in preserving marginal bone levels around implants is the platform switching concept that refers to the use of a smaller diameter abutment on a larger diameter implant platform.

This connection shifts the perimeter of the implant-abutment junction (IAJ) inward towards the central implant axis. Lazzara and Porter demonstrated that the inward movement of IAJ also shifts the inflammatory cell infiltrate inward and away from the bone implant interface, creating a horizontal biologic width that will limit bone resorption around the coronal aspect of the implant.

From a biomechanical perspective, stress in the bone is concentrated around the crestal region because of the difference in modulus of elasticity between bone and implant, as demonstrated in photo-elastic and finite element analysis studies. Peak bone stresses occurring in marginal bone have been hypothesised to cause bone micro-fracture and may lead to bone loss. The issue of whether platform switching may affect peak bone stresses in the marginal bone has not been demonstrated yet.

The original criteria established for assessing implant success and survival identified marginal bone levels as an important indicator for measuring the response of the peri-implant tissues to functional loading.

More recent studies have considered the effect of stresses established in bone by the direct influence of non-passive prosthetic work to be a causative factor in marginal bone loss.

Another more recent explanation of marginal bone loss is the theory of establishing the biologic width directly related to the position of the implant-abutment microgap and its associated microbial flora.

In addition, some studies have shown that certain designs in the geometry of implant coronal part may contribute to bone loss, while other studies have indicated that such bone loss can be prevented by incorporating a biologically stable connection and a more retentive surface on the implant collar.

Prevention of horizontal and vertical marginal peri-implant bone resorption during the post-loading period is fundamental in maintaining stable gingival levels around implant-supported restorations. It has been demonstrated that peri-implant marginal bone loss is time-related with significantly more acute bone loss during the preloading period than in the following loading phases (two years after surgery) and also during the first year after loading (six months to one year after surgery) than in the second one (one year to two years after surgery).

Aesthetic outcomes cannot be attributed to a single parameter. They are the result of a number of important factors, especially in the aesthetic area.

Both biologic width and the integration of platform switching concept are of utmost significance in preserving a stable marginal bone level around implant neck. It is important to understand mainly the meaning of biologic width. Hence, the stable bone serves as a support for the soft tissue determining the long-term aesthetic and functional treatment, the outcome stability being ensured in this manner.
The following points should be noted:

- The use of a single post for temporary and final prosthesis work
- As long as the frequent replacement of parts is not avoided, repeated destruction of the connective-tissue attachment of the biologic width occurs increasing the risk of bone resorption

A special implant and abutment design (a ledge and integration of the biologic width/tapered shape of the post) facilitates nonsurgical lengthening and thickening of the peri-implant soft tissue.

This leads to the establishment of a wider and more resistant zone of connective tissue. A micro-rough and nano-rough titanium surface extending to the implant shoulder in conjunction with the platform switching concept provides osseous integration along the entire length of the implant.

A fine thread optimally distributes the masticatory forces in the region of the implant neck, avoiding further bone loss in this region.°

Possible interactions amongst factors contributing to peri-implant bone loss

These factors include:

- Surgical and anatomical considerations such as mucoperiosteal flap design, thickness of buccal and lingual cortical plates of bone remaining after osteotomy preparation, bone quality, healing technique submerged or nonsubmerged, early unintentional cover screw exposure by mucosal dehiscence and amount of keratinized Gingiva
- Patient risk factors such as medical and pharmacological status, habits including cigarette smoking, poor oral hygiene, excessive alcohol consumption, mucosal erosive pathology like lichen planus, previous or present periodontitis (chronic or aggressive);
- Biologic width related factors such as level of the micro-gap, platform switching and implant-tooth or implant-implant distance
- Implant design including geometry, surface, length and diameter
- Biomechanical factors including time of loading, type of loading, type of prosthesis, habits like bruxism

Flap design

It was reported in the literature long time ago that, whenever a mucoperiosteal flap is reflected about a tooth, some crestal bone resorption will occur. Similarly elevating a flap to place a dental implant will lead to crestal bone loss and there is evidence suggesting a direct relationship between size of full thickness flap and the resulting post-op bone loss.

Other studies reported no statistically significant differences using more traditional histological evaluation of retrieved specimens after 12 weeks of site healing. Becker reported the same magnitude of difference in buccal vertical implants bone loss as Jeong, one millimeter less for flapless approach.

Alveolar bone thickness

The main blood supply for buccal alveolar bone is supplied by vessels in the overlying mucoperiosteum and is greatly affected by elevating a full thickness flap to facilitate placement of a dental implant. Studies suggest that if residual facial bone thickness is less than 2mm and/or if dehiscences or fenestrations of facial bone occurred during osteo-

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my preparation, consideration should be given to augmenting facial bone thickness with GBR procedures.35, 36

Premature exposure of an implant cover screw through the overlying mucosa may result where mucosal tissues fail to achieve primary closure, or are too thin to avoid dehiscence, or have been traumatised with the transitional prosthesis. It was reported in the literature that patients with prematurely exposed cover screws suffered 3.9 times greater bone loss than nonexposed ones.37

Quantity of keratinised tissue
Adequate keratinised tissue may be more important around implants than natural teeth for several reasons: supracrestal collagen fibers are oriented in a parallel rather than in a perpendicular configuration adjacent to transmucosal surfaces of implants38, providing less resistance to local trauma and microbial penetration. Periimplant mucosa may have a reduced capacity to regenerate itself due to compromised number of cells and poor vascular supply.39

Oral hygiene, smoking, alcohol abuse
Patients with poor oral hygiene and/or existing periodontal disease experience greater periimplant crestal bone loss than patients with good oral hygiene and stable periodontal status. Both current and lifetime cigarette are associated with deterioration in bone quality and impaired wound heal-

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Smoking has been shown to be one of the most significant factors predisposing to implant failure. Individuals who use alcohol in excess may have inadequate nutrition including vitamin deficits which may compromise initial site healing.

**Diabetes**

It is well known that diabetic patients are at higher risk for developing periodontitis and are also more prone to infection. It is very likely that performance of dental implant will be affected as well. Poor metabolic control in diabetic patients increases the risk of peri-implantitis.

**Biologic width**

Crestal bone remodeling to establish “biologic width” or soft tissue seal in peri-implant mucosal tissues is considered to be an important factor contributing to early crestal bone loss with all types of endosseous dental implants (Fig. 4). Factors known to affect this crestal bone loss include the level of micro-gap in relation to the bone crest, platform switching achieved either by implant body design and/or use of an abutment smaller in diameter than the implant body and tooth-implant or inter-implant horizontal distance. Another factor with deleterious effect on crestal bone resorption is considered to be the repeated removal and re-placement of abutments because of disruption of the soft tissue seal.

**Level of the micro-gap**

The connection between implant body and prosthetic abutment is termed “micro-gap” and, in most cases, it is susceptible to microbial seeding and micro-movements between the parts during clinical function. Both micro-gap and micro-movements may lead to localised inflammation and associated crestal bone loss if the micro-gap is within a minimum distance from the alveolar crest. Biologic width around the neck of a dental implant constitutes a mucosal seal intended to protect the underlying bone. It is formed apically to the micro-gap and requires a minimum of about 1.5mm of fibrous connective tissue between bone and epithelial attachment of the gingival sulcus of the implant (Fig. 5).

**Platform switching**

This design feature can be created in an implant body or achieved by the clinician using a compatible abutment of a narrower diameter than the implant platform. It can be acquired even with the healing abutment in case of nonsubmerged approach. The purpose of platform switching is to create a horizontal component for the total linear distance between micro-gap and bone crest required for biologic width and eventually to shift...
the stress concentration away from the cervical bone-implant interface.51

Generally, the horizontal component created by platform switching is around 0.5mm (Fig. 6), sufficient to result in significantly less radiologically detectable crestal bone loss in humans.51, 52 Not only does this concept reduce the risk of peri-implantitis in the future but also has the benefit in the aesthetic zone of providing better soft tissue support.59

**Implant-tooth or inter-implant distance**

For single tooth dental implants, a minimum horizontal distance of 1.5mm must be left between the implant and the two approximating tooth root surfaces in order to avoid crestal bone loss after biologic width accommodation. When two implants are placed side by side, the crestal bone loss that occurs between them has a more complicated aetiology. A clear tendency for increased inter-implant vertical bone loss occurs as the distance between two implants decreases below 5mm.54, 55

First and foremost, inter-implant crestal bone loss will be affected by the horizontal distance between the two implants which should be minimum 3mm (Fig. 7). It will also be influenced by the level of micro-gap, biologic width, and whether platform switching was used or not. Histological data from animal experiments using 2-piece, moderately rough surface, submerged implants, showed that vertical inter-implant bone loss decreased from 1.98mm for a 2mm inter-implant distance to 0.23mm for 5mm inter-implant distance.56

**Conclusion**

Significant differences in marginal bone loss have been identified between implants with platform switching and implants without platform switching only in the first year after loading. It may be concluded that the platform switching concept represents a bone preserving technique. Preservation of crestal bone around dental implants cannot be attributed to a single parameter. That is the result of a number of important factors, especially in the challenging aesthetic zone.

It is important to understand the mechanism that permits the implant-abutment connection to maintain a seal against the bacterial ingress before and after loading due to absence of micromovements. An appropriate understanding of the importance of biologic width and the use of platform switching concept in the routine treatment is of real support in maintaining a more stable marginal bone level around implants.

This stable marginal bone as a support of the soft tissue is determinant for the long-term aesthetic stability. Further neutral clinical studies are required to demonstrate the importance of micro-gap, biologic width and platform-switching in crestal bone preservation around dental implants.

For the support I thank: Dr Mazen Tamimi, Private Practice, Amman, Jordan, Dr Rainier Valentin, Private practice, Cologne, Germany, Dr R. & M. Vollmer, Private practices, Wissen, Germany

Editorial note: The literature list can be requested from the author.

**When two implants are placed side by side, the crestal bone loss that occurs between them has a more complicated aetiology**
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Art and science of remembering
Glenys Bridges discusses techniques to hold on to your memory

I always have trouble remembering three things: faces, names, and - I can’t remember what the third thing is...

We often hear people say they have a memory like a sieve. Most of us would like to have a better memory. The good news is that there are a number of easy techniques we can use to improve our powers of recollection.

The ability of dental professionals to remember names, faces, facts and figures will have a massive impact on how they are valued by their colleagues, their profession and their patients. In many ways we judge the worth and intelligence of others based upon their ability to retain information. Some people have amazing recall of numeric information; in fact some of us can remember the phone numbers of all our friends and family, but can never remember where we put our keys! Memory theorists summarise memory as being the processes of registering, storing and retrieving information. They recognise that we use our visual, aural and kinaesthetic senses in this process. To improve the power of memory we need to determine which of these senses is your dominate sense so that you can make good use of your strengths, whilst working to develop areas of weakness.

In his book, Moonwalking with Einstein: The Art and Science of Remembering Everything, Joshua Foer offers these tips for memory improvement:

Visualise Techniques
If your dominant sense for learning and remembering is visual; link names to visual cues, such as a person’s name is Mary, picture her dressed as Mary Poppins, or picture someone called Tom as Tom Jones. Wherever possible blend the key words you want to remember to pictures or places.

Memory Guru Tony Buzan offers this technique in his mind mapping process when you can see the links between events or ideas, as they are set out in linked boxes.

Aural techniques
If your dominant sense for learning and remembering is aural. You could use mnemonics to create a memorable sentence as a memory aid. For example, children learning music often use Every Good Boy Deserves Fun to remind them of the notes of the treble clef. This can be applied to anything from shopping to tasks, to ‘to do’ lists. Then by voicing the mnemonic aloud, you redouble the ability to recall the information when needed.

Emotional links
When your dominant sense for learning and remembering is kinaesthetic it is important to recognise that we remember what has the greatest meaning to us. In many cases, the reason someone has really good recall is linked to their interest in the subject. The reason is simple; if you are interested in something you are far more likely to remember lots of details. Our brains divide memory into two sections, working-memory and long-term memory. This is such an effective system that it is mimicked by computers.

Some people say that our memory deteriorates with age. This may well be true, but as in all things, the use it or lose it principles apply. You have to begin to lose your memory, if only in bits and pieces, to realise that memory is what makes our lives. Life without memory is no life at all, just as intelligence without the possibility of expression is not really intelligence. Our memory is our coherence, our reason, our feeling, even our action. Without it, we are nothing.

About the author
Glenys Bridges is managing director of the Dental Resource Company and has provided training for dental teams since 1992. For more information, visit www.dental-resource.com or call Glenys Bridges on 0121 241 6693.

Art and science of remembering
Glenys Bridges discusses techniques to hold on to your memory

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Mentoring in practice – a rewarding expansion role for all team members

Mhari Coxon provides some insight into the art of mentoring

At the time of writing I am working with a wonderful young dental team, helping them to develop their treatment paths for patients, enabling them to offer a wider range of excellent care in a cost effective manner by utilising the existing team members. This will see the dental nurses doing more and more and walking beside each patient, supporting them on their journey through treatment to health and happiness in their dental care. The role will not be purely assisting and coordinating the patient, but will have clinical elements which will be reviewed throughout the patients treatment and beyond into the patients long term maintenance plan.

The nurses are excited and enthusiastic to be more clinically involved in the patients care and have more personal development in their career path. This new way of working will ease the burden on the hygienists/therapists and allow at least one of them to pursue other more of the aesthetic anterior work that she is enjoying developing. The dentist, still the all important centre of this method of working, will also have more freedom to develop and attend courses and improve his enjoyment of his working day.

Sound too good to be true? It is not as unattainable as some might think and I truly believe it will be a big part of future dental care plans. The key element here in building this blended line of care for patients is the empowerment of the team to implement this type of care. And the tutors I am using? In this particular case we

have a nurse with a fantastic impression taking ability who will work with the others, including the hygienist therapists, to improve overall quality of impressions taken to the prescription of the dentist. Another nurse, still studying, will be able to support in the theory development and academic understanding behind the care plans they are developing. The hygienists and therapists will support in the nurse’s development of an oral health programme and fluoride therapy again all under the prescription of the dentist. The dentist will share his excellent photographic skills and develop all team members with and support the hygienists and therapists as they expand their skills into whitening for patients. The receptionist will share her experience and communication skills to help everyone to listen better and interview more effectively.

Using mentoring in practice, with all the technology available to us now, need not be a drain on clinical time. It is true that some things are better learned in a peer group outside of practice. It is also equally true that, with good guidance and implementation, the team developing together can bring something unique and attractive to the practice in terms of the relationship of the team, the quality and consistency of care for the patients and the recommendation that comes from those two things.

For some, mentoring comes naturally. For others confidence can need a boost. The most important tool in this is communication. It is also essential that the mentor has kept up to date with which ever aspect of practice that they wish to mentor in. By supporting any mentoring with theoretical work, you can often find the mentor learning too! With a positive attitude from all involved, both parties gain in terms of career skills and confidence and the quality of work in practice tends to improve too as everyone is aware of the standard they are aiming for. There is also a personal sense of satisfaction that is gratifying for all involved.

If mentoring is something you might be interested in but you worry you don’t have the right abilities then the Faculty of General Dental Practitioners has a wonderful one year distance learning certificate course, which would give you the tools and the peers to work with to build this skill group into your life. The course is approximately one year long and is mainly distance learning, with only three face to face study days in London. There is a good level of computer literacy needed; otherwise anyone with any qualification related to dentistry can apply. For those looking to develop their career pathway further in the future, the course counts as 30 postgraduate credits.

The cost of the course is reasonable but high to some DCPs relative to their pay scale. This has been considered and there are two 50 per cent price places available to DCPS for the course starting in September. The forward thinking practice I am sure could see how this skill coming into their mix could allow better implementation of new skills in practice and work in developing a strong, confident workforce, who in turn develop a strong, healthy practice. And, if you needed more persuading, once they start the course, if all future development has a clear aim and objective, gives the opportunity to feedback, and is documented; then you have a tidy number of verifiable CPD points for the team too.

Mhari Coxon is a dental hygienist and therapist and is chairman of the BSDHT regional society of Dental Hygienists and Therapists (BSDHT) regional group in east London. She is the current UK chair of the Professional Group of Dental Hygienists and Therapists (PGrDHT) and has written the standards of practice document for the emerging role of Dental Therapists. She is also clinical director of CPD for allied dental professionals. For more information visit www.fgdp.org.uk/professionaldevelopment/dentalhygienists/mentoring.aspx.
Moving the dental world from analogue to digital - 3Shape’s success story continues
by Bernhard Moldenhauer & Matthias Diessner, DTI

O n occasion of Scandefa, a major dental fair in Scandinavia, DTI recently visited the 3Shape headquarter in the heart of downtown Copenhagen, to learn about the company’s new products and future strategies. The historical building right next to Kongens Nytorv square and the Royal Danish Theatre features light and airy rooms, a perfect environment for a young, passionate and ambitious organisation driven by the quest to develop the best technological solutions in 3D Scanning and CAD/CAM.

Often called “The Google of the Dental Industry,” 3Shape was launched 11 years ago in a one room apartment by two young and ambitious graduate students from the Technical University of Denmark and Copenhagen Business School - Tais Clausen and Nikolaj Deichmann. At that time Tais was finishing his master thesis on a groundbreaking 3D scanning technology and Nikolaj was finalising his Master of Finance and Economics. Knowing each other from common friends they joined forces to participate in the prestigious Venture Cup business plan competition, organized by McKinsey, in which they finished 2nd. Throughout the competition they were constantly discussing how the technology could be commercialised so the idea of launching 3Shape was born.

Initially they approached companies in the hearing aid industry with the idea to develop a quality control system for hearing aid shells and earmolds. Similar to a dental restoration, the devices need to be custom fit to the patient’s hearing canal and they’re traditionally made by taking an ear impression that is then manually sculpted, cut and used to make a mould – a time consuming, manual procedure.

“When we had these first meetings we realised that we could actually create a mass customisation production system. So instead of just checking the quality we decided to go directly for changing the workflow completely, from a manual process where you spend several hours of shaping the hearing aid shells to a completely digital workflow,” Deichmann said.

3Shape digitised the whole manufacturing process by introducing a 3D scanner for ear impression taking, a management software, a CAD software that is needed to simulate the position of all the electronic components, which need to fit along with the shell into the patient’s ear by taking minimal space and a CAM software for controlling the manufacturing equipment. They developed the system for one specific hearing aid manufacturer but retained all rights to sell the technology to others. There were only six companies controlling approximately 90 per cent of the global hearing aid market and within a period of three years all of them went from a completely manual to a completely digital production. Today about 90 per cent of all hearing aid devices are produced by using 3Shape’s technology.

Tais and Nikolaj were always aware of the 3D scanning technology’s enormous potential so they soon looked at other industries, such as the dental laboratories, where the manufacturing processes are similar to the hearing aid industry. In 2004 3Shape began to receive an increasing amount of requests from dental companies that were interested in the technology.

“We quickly decided that if we wanted to replicate our success in the hearing aid industry we needed to go for the full solution to have a very user-friendly system that the dental laboratories would adopt. So we went to a lot of labs, small ones and big ones, and tried to figure out how we could optimise the processes instead of just finding a better way to make zirconia copings. From the very beginning our vision was to achieve a complete switch from analog to digital,” Deichmann explained.

3Shape introduced its first 3D dental scanner and CAD/CAM software for virtual restoration design at IDS Cologne 2005 and the system became a raving success. In the following years the company extended and enhanced their dental lab product range by continuously listening to and involving their customers from the early stages of the product development process.

“Perhaps the most important lesson we have learned is that successful innovation is only successful if it moves and is guided in directions that truly

From right to left: Nikolaj Deichmann (CTO), Tais Clausen (CTO) and one of the in-house developers at 3Shape.

3Shape headquarters in Copenhagen.

benefit professionals in their daily work,” pointed out Tais Clausen, CTO and spearhead of the 3Shape development team.

Today CAD/CAM has conquered the dental labs and clinics, ensuring high profitability by maintaining top level quality through standardised and controlled treatment and production processes that are also beneficial to the patient. In Germany, traditionally an early adopter of new technologies, nowadays approximately 82 per cent of all ceramic restorations are already produced by using CAD/CAM technology. The question today is no longer if CAD/CAM will endure in the industry, but rather when all dental professionals will be taking advantage of it,” Clausen said.

After having conquered the dental lab industry, 3Shape leveraged the proven technologies also to the dental clinics. “We did an analysis of all existing scanning systems on the market and defined what we like and what we don’t like about them. We wanted to do a system that incorporated all the advantages and eliminated all the drawbacks of the existing systems. Our solution really needed to be faster, easier, more accurate and more reliable,” Deichmann said.

At the opening day of the International Dental Show 2011 in Cologne, 3Shape launched its newest achievement, the TRIOS intraoral impression-taking solution, which aims at revolutionising the work in the dental practice. Their booth was literally flooded by dentists to try the TRIOS 3D scanner in sleek and elegant design, seldom seen in dental clinical equipment.

One of the TRIOS 3D scanner’s notable features is that it does not require dentists to apply spray or powder to coat the patient’s teeth, making scanning an easy, fast and patient-comfortable process that doesn’t ruin scan accuracy by adding material to teeth surfaces. In addition it can scan any materials, such as metals, semi-transparent materials and skin. It only requires minimal amount of training for use in clinical practice from day one. The scanner captures over 5000 2D images per second, which is 100 times faster than a conventional video camera. Dentists who witnessed the presentations at IDS stated that the “impression-free” dental practice seems to be just around the corner.

An open communication interface allows the dentists to send the scanning data by internet directly to the lab of their choice where the technician can start designing the restoration solutions immediately using 3Shape DentalSystem software or the appropriate interface to third party software. The TRIOS communication software also includes a tool to visualise the technician’s solutions for the patient, for example on an iPad, while the patient is still in the chair, which is especially important for anterior cases.

The system is designed to give dentists best quality restorations and treat more patients...
and solutions are born from the union of cutting edge technology with the latest trends in the industry and in the markets. 3Shape Product managers and key developers have regular meetings with distribution partners around the world to keep each product in a top-of-the-class position. During the whole life-cycle, the products are developed in close collaboration with partners who understand and gather the needs of their customer base and the market.

3Shape headquarters in Copenhagen
But even with 10 years of outstanding history behind it, 3Shape never stops looking ahead. The company believes that the age of fully digital dentistry is only a few years down the road, even if there will always be some smaller dental practices who will still go the traditional way.

About 3Shape
Branches of 3Shape’s customer support service are operative in Copenhagen (Denmark), New Jersey (USA) and Shanghai (China), virtually covering any time-zone. The very close collaboration between the customer support and the development team allows for unprecedented level of efficiency and responsibility to partners’ call for help typically available in 12 among the world’s major languages.

3Shape is a privately-held company headquartered in Copenhagen, with the market’s largest team dedicated to scanner and software development for the dental segment based in Denmark and Ukraine, production facilities in Poland, and Support Offices in New Jersey, USA and Shanghai, China. For further information regarding 3Shape products, please refer to www.3Shapedental.com.

Rather than spending time and money on chairside milling, it handles a wide range of indications and produces quality 3-D data that can easily be realised by any lab.

Generally, digital data are controllable, predictable and available any time by requiring only minimal space. This guarantees that the dentist own and can use patient data without limitations and can potentially export virtual setups to other systems such as for appliance manufacturing.

Surprisingly, 3Shape is the only major dental company that goes by a non-exclusive basis. All products are designed as plug-and-play solutions and feature open interfaces for connection to third-party applications.

3Shape has been recognised three times as Ernst & Young’s Entrepreneur of the Year in the Innovation category in Denmark. This prestigious award recognises innovation, leadership, state-of-the-art products, international network and clear strategy to pursue continuous growth.

Today 3Shape’s development team counts more than 100 developers of 22 different nationalities, with a least 50 PhDs among them. All products benefit of dental practitioners and patients alike – the very philosophy embraced by EMS.
In addition, QuickWhite have launched their new ‘LowCost’ whitening for both in the UK at Ramsgate, therefore making support so much easier and quick. coagulation and ultimate cutting for the ultimate price of £4100 inc vat. Sales 3.5w 810nm diode laser and the famous Dual 8w 810nm+980nm for ultimate

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Due to the sloped neck of this dental implant, Astra Tech recommends that

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Nobel Biocare, a worldwide leader in the areas of dental restorative and aesthetic technology, was proud to exhibit its products at the Clinical Innovation Conference in London this May at the Royal College of Physicians. Delegates attending the popular event were able to speak to Nobel Biocare’s representatives and discover more about the company’s range of innovative products and educational programmes to support them, including an all-in-one cost effective solution for deep caries, NobelGuide® - state of the art 3D rendering and CAD/CAM technology to help create the final prosthetic solution for your patient. For further information call Nobel Biocare on 0208 756 1030 or visit www.nobelbiocare.com

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PowerWave Cordless Laser from QuixiLase

The implant design meets a clinical need: it facilitates immediate loading, reducing the need for an extraction, a provisional implant in the same surgical appointment, and optimizing implant position to maintain marginal bone support and aesthetics. ‘The sloped design lets the implant engage more easily rather than letting the anatomy adapt to the implant design; this works particularly well for placement in the aesthetic zone’ says Professor Dr Wilfried Wagner, of the Johannes Gutenberg University Mainz, Department of Oral and Maxillofacial Surgery, Germany.

Due to the sloped neck of this dental implant, Astra Tech recommends that dental professionals who use this product have extensive implant treatment knowledge.

Sensitivity Relief

Sensitivity Relief

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On Thursday 12th May 2011 the launch of National Smile Month kicked-off to a smiling start, as members of the dental press, dental professionals and sponsors gathered together in the beautiful surroundings of the Houses of Parliament.

Signalling the start of the UK’s largest oral health campaign, this year celebrating its 55th anniversary, National Smile Month promises to be a successful event.

Many leading figures from the world of dentistry were at the launch and sponsors, Oral B, Listerine, Wrigley’s, silver sponsor Macleans (GSK) were proud to be sponsoring National Smile Month for the first time.

Dr Carter opened the event, thanking the room for all their support that the event and the BDHF had received; he also thanked the involvement of Smile-on in the event with regards to the development of the website, www.nationalsmilemonth.org.

Daniel Davis, President of the BDHF, then took centre stage, welcoming the crowd that had gathered. He spoke warmly of the passion that the BDHF has for the nation’s oral health, and emphasised how people need to be confident of their mouth and that a smile should be part of everything you do.

Representatives from the main sponsors were on hand and added their personal thanks and welcome at the event; Adrian Toomey from Wrigley’s also announced the launch of the Tooth Fairy Fund, a new project which will sponsor local healthcare.

Working on last year’s campaign, ‘Teeth4Life’, which was a huge success, featuring hundreds of events, activities and displays all across the UK, Dr Carter said that he hoped that this year’s campaign will put a smile back on people’s faces.

Dr Carter said: “Many might underestimate it but a smile can be a very influential feature. It can shape our lives, our relationships and careers and be a very powerful show of emotion, yet not everyone has the confidence to do so. Those who are not happy or are self-conscious about their teeth could be missing out on showing off their very own ‘Smile Factor’. Others are being held back by poor oral well-being and its impact on their general health. This year’s campaign is designed to challenge those perceptions and get you smiling again.

“Getting people to talk about their teeth and dental habits is vital in our goal of improving the state of oral health not only in the UK but worldwide. We have had a tremendous response to the campaign, particularly in the last couple of years, but we must work harder to ensure this year’s National Smile Month can build on that success.”

Welcome to the Smile Factor

What’s Missing?

Three global titles from the Dental Tribune International portfolio are coming to the UK. Published quarterly, each of these glossy, clinically-focused titles aims to bring you the latest developments in the fields of implantology, endodontics and cosmetic dentistry in a clear, easy to read format.

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