Out of the frying pan...

... and into the fire, as agreement is cancelled between DPA and CODE; DPA now looking at rescue options

Following recent events surrounding the ‘merger’ of CODE and DPA, a new twist in the association’s future development has occurred. According to statements released by CODE and the DPA, the proposed CODE DPA ‘merger’ has been cancelled.

In a statement released by CODE, the ‘rescue plan’, which had been offered by GDPA Ltd with CODE’s support as a long-term solution for the financial stability of DPA, has been turned down by DPA members: “The members decided to keep the DPA as a mutual, primarily because in their opinion CODE wasn’t political enough.”

Paul Mendlesohn, CODE CE said: “I found the concept of successfully developing a sister association, as I have done with CODE, very exciting. I am not politically inclined myself, but it would have been fascinating to build a new political team that could continue to make an impact in dentistry, and to be the alternative choice for dental professionals.”

Following the wishes of DPA members the DPA Council cancelled the Association Management Agreement (AMA) and further withdrew the Transfer Agreement, two days before the Special General Meeting in April.

Although the AMA had been cancelled, acting Chairman Reginald Short went ahead with the Special General Meeting that had previously been arranged to discuss the CODE transfer. In a DPA statement, Mr Short explained that this was: “to enable members to air their views and the Council to explain their decisions.”

During the meeting members accepted that despite the draft figures showing losses in 2011 and the current balance sheet deficit, “they still wanted the association to continue to be independent.”

The DPA Council has invited alternative rescue bids and one has already been received. The deadline for this is the 14th June. A new date for the AGM has also been arranged, and will be held July 7th. Interested parties should send their proposals to Reg Short by email before the 14th June.

GDPA Ltd will respect the wishes of members and not make a new rescue offer.

For further information or to send a DPA rescue proposal email: rwj.short@virgin.net.
Vitality Show visitors tell DCS their views on dental professionals

A snapshot survey carried out by the Dental Complaints Service (DCS) at the Vitality Show in London has revealed insights into the way patients view their dental professionals.

Staff from the Service, which helps resolve complaints about private treatment, were at the show to remind patients that the first step if a problem arises is to talk to their dental professional.

Nearly 500 people took part in the short survey over the four days of the show and of that number there was a fairly even split between NHS (49.8 per cent) and private dental patients (40.8 per cent).

Although just under a quarter (25.5 per cent) of the survey’s respondents said they had had problems with their dental treatment, DCS staff were encouraged that the vast majority (84 per cent) said they would feel confident asking their dentist about their treatment.

Head of the DCS, Hazel Adams said: “Good communication between patients and professionals can make a big difference to problems arise. We always advise patients to speak to their dental professional first to try and resolve any concerns, before seeking our help. I was pleased to see that of the people that took part in our survey, 77.5 per cent said they feel confident enough to speak to their dentists if they had a problem with their treatment.”

The DCS has a leaflet ‘Making a complaint about private dental treatment – a guide for patients’ that can help people through the complaints process and can be ordered online at www.gdc-uk.org

There are four key principles to the work of the DCS, which is funded by the General Dental Council:

• The service is free
• It is independent of the NHS
• It will treat people fairly, whatever their background or circumstances
• It does not take sides

For more details about the service and what it can help with log on to the website www.dentalcomplaints.org.uk

Study warns of killer bugs

In the past studies have highlighted how thin layers of bacteria can cover the surface of dentures, making them potentially harmful. However, a team of scientists have suggested that by putting false teeth in a microwave oven for three minutes can in make them safe.

The research was carried out by a team of scientists from Brazil, who also identified that by soaking dentures in a germicidal mouthwash solution of two per cent chlorhexidine gluconate for 10 minutes could also make them safe.

According to the study led by Karen Tereza Altieri, a dentist at the Araquara Dental School at the Universidade Estadual Paulista in Sao Paulo, either method is “sufficient to disinfect dentures coated with the toughest MRSA biofilms for up to a week.”

“To our knowledge, we are the first investigators to report the effectiveness of this method in killing MRSA,” she said in a report.

Scientists have suggested that simply leaving dentures in a glass overnight may not be enough to keep them clean.

MRSA, full name Methicillin Resistant Staphylococcus Aureus, is a bacteria resistant to some antibiotics and according to scientists usually found on false teeth, scientists said.

According to reports, the new method of cleaning has already been adopted by experts in the US.

The study has been published in the Journal of the American Dental Association.

Dentists’ confidence dips in Lloyds TSB commercial healthcare confidence index

Business confidence among both NHS and private practice dentists has taken a downward turn as they prepare for the prospects of a new NHS contract and continued economic uncertainties, according to new research.

The latest twice-yearly Lloyds TSB Commercial Healthcare Confidence Index shows that the short term confidence of dentists has fallen 20 points, since the first survey in October 2011.

Once again, the outlook of GPs was the least positive of the three primary healthcare providers researched, followed by pharmacists and then dentists, whose previously positive score suffered the biggest fall in confidence.

The findings are based on a combined ‘Confidence Index’ drawn from responses to a number of questions, canvassing primary healthcare providers opinions on overall business confidence and outlook for the future profitability of their businesses.

Where any figure greater than zero represents a positive outlook, figures below indicate a negative one (the maximum value achievable is plus 100) and minimum value achievable is minus 100, GPs registered minus 62, an overall shift of minus 1 to an even less confident position.

This compared to minus 42 for pharmacists - an eight point uplift - and a 12 point fall of minus 58 for dentists, indicating that GPs are still far by the most uncertain of the likely impact of forthcoming NHS reforms, while pharmacists are the only group heading towards a more positive outlook.

Dentists’ collective long term confidence (looking ahead over the next five years) fell three points to minus 67 since the last survey.

Dentists were split on whether NHS practices would remain the most profitable with 26 per cent saying they would, 53 per cent saying not and 41 per cent uncertain. A surprising 47 per cent of those undertaking NHS work said they had experienced some ‘claw back’ in the last year and over half (55 per cent) expressed doubt that the new contract will be adequately funded. Only 29 per cent of all dentists believe they will still be working to an NHS contract in ten years’ time.

Ian Crompton, head of healthcare banking services for Lloyds TSB Commercial, said: “Pharmacist confidence has improved to a degree, GPs have maintained the most uncertain but dentists really seem to have lost confidence since our first survey in October 2011.

‘Back then, they stood out as the only group among their healthcare peers who had any positivity about the short term future of the profession. “The Health & Social Bill may now have passed but the debate has clearly unsettled NHS dentists who are facing their own contract changes and private dentists are still feeling the impact of the economic downturn.”

More than 50 per cent of private dentists who responded to the survey admitted that they may be encouraged to take on NHS work, having seen an increasing number of requests from their private patients. Despite this, when asked outright if they would take on NHS work, 69 per cent said that they would not.
Editorial comment

Last week saw this year’s BDA conference and Exhibition occur in Manchester. From a networking perspective, it was a great opportunity to meet up with colleagues across the profession and catch up with the latest happenings in dentistry; in addition to some great speakers. My favourite lecture was the presentation entitled Fighting the Tide of Communicable Disease and Avoiding Infection – Experiences from the Cruise Industry by Medical Director for Carnival UK (Cunard and P&O) Kate Bunyan. Anyone who was there I’m sure will never forget the thought of people counting how many toilet rolls are used in cabins to keep an eye out for spikes in usage!

One ‘highlight’ was the speech by Parliamentary Under Secretary of State for Quality (Department of Health) Earl Howe, outlining the changes in dentistry and what is to come over the next few years. He discussed many issues surrounding piloting and the analysis of the first tranche of data from the pilots as well as the commitment to reducing the inequalities in child oral health across the country. It was very much the kind of thing we have heard before, but I’ll tell you what he was a lot easier to listen to than Mr Lansley!!

Small change = big change

Just knowing that 70 per cent of the world’s population has no access to the simplest of relief from oral pain; leaving millions of people to suffer daily from preventable pain; leaves many of us feeling we want to do something about it – but what? How can we make a difference to such a terrifying statistic?

Bridge2Aid believe that together everyone can make a difference – just £1 at a time. They are asking practices to offer their patients a chance to add £1 to their bill. For every £120 you raise, you will have given access to emergency dental care to a whole village – allowing people to live pain-free, and, for many, giving them the chance to return to work to support their families. As the money will be put towards training local East African health workers, you know that your fundraising is making a long-term difference, and is not just a quick-fix.

Bridge2Aid will send you all of the information you need to get started, and the posters and reception information stand that will help you tell your patients what you are doing. These should be enough to get your patients on board, without the need for your receptionists to take time out of their busy day to explain the scheme.

It really is as easy as that. Your practice will get the opportunity to make a sustainable difference to thousands of people, and your patients will see that as a team you have decided to support such a great cause – bringing you real business benefits.

For more information visit www.bridge2aid.org/b2a/
Parents are biggest providers of alcohol to kids, reveals Drinkaware

Children as young as 10 say their parents are who they are because of alcohol, while half (50 per cent) of those who have had a drink report it was their parents who supplied them with the alcohol the last time they drank.*

The publication of these findings coincides with the launch of Drinkaware’s new ‘Mumtank’ - a team of mums with expertise ranging from health and child psychology, to education and parenting. The Mumtank will provide parents with practical advice on how to tackle the thorny issues around kids and alcohol. Members include Mumnet co-founder Carrie Longton, TV’s Dr Sarah Jarvis and Super-intendent Julie Whitmarsh from Devon & Cornwall Police.

The research also shows that while 85 per cent of parents agree it is important to talk to their kids about alcohol, a third (52 per cent) admit that there are many things they do not know about the effects of alcohol on children. Many parents allow their children to drink from an early age - with data showing that the average age at which the child had drunk alcohol, the average age at which parents first allowed their child to have a drink was 13.8 years old. Of the 10-17 year olds polled who had drunk an alcoholic drink, the majority (55 per cent) had been with their parents the last time they drank alcohol.

Research by Drinkaware also found:
• 45 per cent of parents worry that their child’s friends have a greater influence on their child’s drinking behaviour than they do
• More than two thirds (67 per cent) of 10-17 year olds say they have never felt encouraged to drink alcohol.

Based on the outcomes of this new research, and drawing on their collective expertise and experience, this summer the Mumtank will produce a practical and thought-provoking set of resources for parents, which will seek to involve them in the debate and offer advice and guidance on children and alcohol.

This resource will form the centrepiece of Drinkaware’s parenting campaign this year, which offers advice and tips to parents on how and when to talk to their children about alcohol, in an age appropriate way, between the ages of 8-17. Further advice can be found at drinkaware.co.uk/parents

* When asked about the last time they were drinking, 50 per cent of 10-17 year olds who have had a drink say their parents gave them the alcohol.

Outstanding achievement award for BADN Chief Exec

BADN is proud to announce that the Dental Awards 2012 Outstanding Achievement Award was presented to Chief Executive Pam Swain at the black tie Dental Awards dinner held at the Lancaster London Hotel in April, hosted by comedian Mitch Benn.

The Dental Awards, now in its 48th year, is organised by Purple Media Solutions Ltd and is sponsored by The Dental Web, Dentsply, Software of Excellence, Waterpik, Weighley, Beverly Hills Formula and Practice Plan. Each of the winners of the 18 awards received a beautiful, specially designed glass trophy.

Pam was born in Fleetwood in 1958 and later attended Fleetwood Grammar School and Blackpool & Fylde College. In 1976 she spent one year in Vienna, as an au pair and part time student at Vienna University studying “Deutsch für Ausländer”. She worked briefly for the Home Office Research Unit in London and moved to Brussels in 1979, working for CPC Europe Ltd and at Hilton International’s European Office, in Personnel and then in Marketing. From 1982 to 1987 she worked at the NATO Headquarters in Brussels, both for the International Staff in the Electronic Warfare section and for the International Military Staff in the Operations Division.

Pam moved to Bermuda in 1987 where she worked in the Investment Department of the Bank of Bermuda, completing three quarters of the American Institute of Banking exams and evening courses in investment banking, effectiveness training and small business management. In 1990 she took a year’s sabatical in the US, training as a holistic therapist at the Massage Institute of New England in Boston, and obtaining the American Massage Therapy Association’s qualifications. Upon her return to the UK in 1991, Pam ran her own part time therapy business until her Association workload made that no longer possible.

More recently, she obtained a Master’s in Business Administration (MBA) from the Open University and a Licentiate in Management from City & Guilds (LCGI). She is also a Fellow of the Institute of Association Management (IAM) and a Member of the Chartered Management Institute (MCMI).

As well as Chief Executive of BADN, Pam is Editor of the ‘British Dental Nurses’ Journal’ and was Registrar of the Voluntary National Register until it closed in 2005. She has worked for the Association for 20 years this summer and has been instrumental in both raising the profile of dental nurses and the Association and in obtaining professional status for dental nurses and recognition of their vital role in the dental team. Pam became President of Blackpool & District Soroptimists in April 2012.

“I am delighted and extremely honoured to receive the Outstanding Achievement award”, said Pam. “It has become something of a cliché, at times like this, to accept an award on behalf of a team - but BADN is very much a team. Not just the head office, or Council, but all the dental nurses throughout the country who support their profession through BADN’s membership.”

Twenty years ago, when I started working for ABDSA (as the Association was then called), dental surgery assistants were very much the Cinderellas of the dental team; today, dental nurses are registered dental professionals and their vital role in the delivery of dental care is widely recognised. We may still have some way to go, but we’ve come a long way in the last 20 years and I’m looking forward to the next 20!”

A film produced by Dr Rayner was shown to MPs Steve Webb and Angela Eagle to see what their thoughts were on the subject.

According to a report, Mr Webb said that the idea of a tax was “worth looking at”, while Ms Eagle claimed that although tax could have a role in tackling obesity, it could help tackle a problem that will only keep expanding.”

D irector of the University of Oxford’s health promotion research group, Dr Mike Rayner, is urging the government to introduce a tax on unhealthy foods and drinks to encourage people to eat more healthily.

Dr Rayner believes that a “fat tax” (as it has been referred to), could help tackle obesity and help raise funds. He told the BBC that children are offered hundreds of billions of pounds every year and that a 12p tax on soft drinks could prevent several thousand deaths each year.

“There’s evidence to show that manipulating food prices can encourage healthy eating. So why are we so reluctant to change the way we tax food?” Dr Rayner was quoted in one report. I don’t think whether it’s hot or cold, whether you got it from a takeaway or a shop, I’d like us to tax all unhealthy and sugary products and see if it works. And in so doing we can tackle a problem that will only keep expanding.”

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CWRU researchers find joint failures potentially linked to oral bacteria

De Nahil Bassada, chair of the Department of Periodontics at the dental school, said the objective of the study, “Identification of Oral Bacterial DNA in Synovial Fluid of Patients with Arthritis with Native and Failed Prosthetic Joints,” was to see if the bacteria has been linked to the joint. The pilot study’s findings were reported in the April issue of the Journal of Clinical Rheumatology.

These study participants had both natural and artificial joints. Researchers extracted samples of their synovial fluid, which is much like oil that keeps a door from squeaking. These patients also had signs of periodontitis or gum disease and underwent exams where dental plaque was obtained for the study.

Plaque build-up from the bacteria, associated with gum disease, breaks down the walls of the pockets around the teeth. The inflammation process from the bacteria acts like a gate that gives bacteria access to the blood stream. Once in the blood, the oral bacteria have induced inflammation in remote sites where the bacteria has been linked to heart, kidney and cancer diseases and premature births and fetal deaths.

Because these bacteria cannot be found with routine lab tests, detection of bacteria in the plaque and fluid was done through a process called polymerase chain reactions and DNA sequence analysis of specific genes (16S-23S rRNA). This is a sophisticated DNA tracking procedure.

Five of the 36 patients (14 per cent) showed direct DNA links between the bacteria in the fluid and plaque from the mouth. The breakdown in patients was: one from a rheumatoid arthritis (RA) patient with a failed natural joint and one RA patient with a failed replacement joint; two osteoarthritis (OA) patients with failed artificial joints and one OA patient with a failed natural joint.

Bassada said researchers will continue exploring the oral health link in a larger study.

Transforming care for people with dementia

The British Dental Association (BDA) has welcomed a reminder from the Welsh Government to Local Health Boards (LHBs) that funding allocated for dentistry must not be diverted to fund any other type of healthcare.

Minister for Health and Social Services Lesley Griffiths has written to LHB Chairs to remind them that budgets allocated for spending on general dental services contracts and the Designed to Smile programme should be used as intended, and that any underspends on these budgets should not be diverted to shore-up other services. The letter expresses concerns that some LHBs are not maintaining improvements to dental services and that access for patients remains problematic in some areas.

The BDA has also applauded the letter’s confirmation that the dental budget will remain ringfenced until at least March 2014-15 and the renewal of a commitment to develop Community Dental Services in Wales to help with the aim of ensuring vulnerable patients have access to appropriate care. The letter notes the lack of investment in GDS services in deprived areas and the responsibility LHBs hold providing or securing services for society’s most vulnerable groups.

Stuart Geddies, BDA Director for Wales, said: “We welcome the Minister’s clear statement that dental budgets designated for primary care are to be used solely for developing dental services in this area. The BDA has been concerned for some time that some health boards appear to be setting on funds earmarked for dentistry, rather than commissioning services where they are urgently needed.

“ar a country where some people are struggling to access dental care and we are fighting oral health inequalities, it is simply unhelpful that money intended to improve dental services should be diverted. Local health boards need to sit up and take notice of this letter and strive to deliver the care their populations require.”

“The Minister’s letter also provides a timely reminder to the Boards of the need to invest appropriately in Community Dental Services. As the BDA has consistently pointed out, vulnerable patients in Wales need to be afforded some political priority to ensure that they are getting the care they need. We are delighted to see that our message has been heard and that boards are being reminded of their duty to invest appropriately in the care of these patients.”
Dentist with a distinguished army career assumes Presidency of BDA

Frank Holloway, (pictured), a retired army dentist based in Surrey, was installed as the 126th President of the British Dental Association (BDA). Dr Holloway, the first armed forces dentist to receive this honour since 2005, was presented with his chain of office and made his inaugural speech as BDA President at the opening of the 2012 British Dental Conference and Exhibition at the Manchester Central Convention Complex.

Dr Holloway gained his Bachelor of Dental Surgery degree from Bristol University in 1969 and his Licence in Dental Surgery from the Royal College of Surgeons in the same year.

After five years in general practice in the UK, he worked for the US Army in Bavaria as a civilian dentist. Three years later he joined the British Army, subsequently working in Germany, Texas, Cyprus, the Outer Hebrides and occasionally in England. Frank achieved the rank of Colonel and completed his regular army service as Commandant of the Royal Army Dental Corps, Commanding Officer of the Defence Dental Services Training Centre and Principal Dental Officer of the Home Counties region. He spent the last five years of his career treating new recruits and recently retired after 53 years in the army.

In 1986/87 he did an MSc in conservative dentistry at the Eastman Dental Institute London, after which he taught and ran a referral service for six years. He was then selected for command posts but maintained his clinical involvement and started a long association of activities with the BDA. Frank has been a member of the BDA’s Armed Forces Committee since 1998 and was elected its chair in 2004, a post he had held to date. He has also been a member of Representative Body since 2006.

He has represented the BDA nationally on the British Medical Association’s (BMA) Armed Forces Committee since 1998, and is also on the BMAs Co-ordinating Group.

Dr Holloway said: “It is a great honour to become President of the BDA and I look forward to serving my fellow professionals in this capacity.

“I look forward to being an ambassador for the profession, both in the UK and abroad, during my term of office.”

Married to Carole, he has two daughters. Away from dentistry Frank enjoys hill walking, golfing and gardening.

Genix healthcare to give new smiles for African children

National corporate social responsibility agenda Genix has partnered with Lionsraw, a UK based movement which harnesses the passion of football fans, taking them to World Cup events and European championship whilst doing charitable work during their stay.

In 2010 Lionsraw took more than 150 fans to the World Cup in South Africa and at the same time built an orphanage, sports changing rooms, a pre-school, toilet blocks with more than 50 toilets and ran football schooling for thousands of African children. Since then it has continued the legacy to maintain these facilities and provide critical help for the long term.

This week Genix Healthcare dentist Roberto Gil Marques De Suza will join Lionsraw on its latest mission to Africa. He joins a team of six people on an intensive four-day programme visiting two schools of 200 and 1100 children with an official Zulu chief opening. He will also visit a new orphanage built by Lionsraw and assess the oral care needs of 200 orphans.

During the trip Roberto intends to formulate a plan of what is needed to facilitate a long term care programme and provide items such as toothbrushes, holders and toothpaste for each child.

Jon Burns, Founder of Lionsraw, said, “This support from Genix Healthcare is truly fantastical and an essential building block in our mission to support a healthy and sustainable community. These children have no understanding about oral hygiene whatsoever and have never even seen a toothbrush. This incredible generosity from Genix Healthcare will start to address vital problems with gum disease in many children who are still growing teeth. Life threatening disease in these areas is very common and so the provision of simple items such as individual holders will help to minimise infection.”

Stan Nelson-Jones, Clinical Director at Genix Healthcare said, “Genix Healthcare is very committed to support the fantastic efforts of Lionsraw. It is extremely humbling to learn what these children have to endure, just to have basic schooling and even running water. Genix has a long standing commitment to support education through football so when we were approached by Lionsraw it was a very appropriate extension to our existing corporate social responsibility agenda. We look forward to learning about Roberto’s trip and how we can formulate a successful support plan for the long term.”

Conversation on CPD continues

The General Dental Council (GDC) has published a discussion document as part of a big conversation on Continuing Professional Development (CPD) in dentistry.

The document, which is called “Maintaining Quality and Impact of CPD in Dentistry”, sets out some key issues being considered as part of the on-going CPD review by the GDC.

These include the potential to:

• introduce a learning outcomes element to future CPD requirements
• embed personal development planning into a future scheme
• introduce mandatory CPD declarations every year

The document was launched at the recent (17 April 2012) National Conference on CPD hosted by the GDC and attended by more than 80 dental stakeholder representatives. The event was addressed by almost 20 key players in the world of dentistry and CPD, including the Chief Dental Officers for England and Northern Ireland and representatives from various Postgraduate Dental Deanseries and professional associations.

Registrants and other key stakeholders are invited to enter into the conversation on the future of CPD through discussing the issues contained in the document with their teams, peers and colleagues. These views can then be shared with the GDC via its dedicated CPD Review email inbox CPDReview@gdc-uk.org

The document is for discussion purposes only and does not necessarily represent GDC policy.

The GDC’s current CPD requirements can be found on the website www.gdc-uk.org.

The GDC has published a discussion document regarding CPD

Unit supports doctors and dentists to retirement

The London Deanery has launched a new unit to support the professional development of doctors and dentists at all career stages and specialties working in the capital.

The Professional Support Unit, led by London Deanery, provides services, offers an expert shared service of resources, separate from employing organisations to support the professional development of the medical and dental workforce in London.

It will support clinicians develop as professionals and individuals. It will help doctors and dentists throughout their careers, whether this is enabling to meet the challenges offered by new roles to accessing coaching and personal development planning, to support with clinical placements and return to practice schemes.

London Deanery launched the unit in response to the need for better support for clinicians throughout their careers, to enable them to realise and sustain their potential, manage their talents and maximise their contribution to quality healthcare delivery. It is hoped the unit will be able to give support to responsible officers to meet the medical revalidation challenges that are due to take place later this year.
Looking for world class speakers, a variety of clinical topics and a host of hints and tips to take to your practice? Then look no further than the Clinical Innovations Conference!

A major event in the dental calendar, Clinical Innovations provides unparalleled presentations and an opportunity to learn from the very best in their chosen subject, including masterclass.

Now in its ninth year, the conference will be held in the Millennium Gloucester, Kensington in London on Friday 18th and Saturday 19th May. Organised by Smile-on and the AOG in conjunction with The Dental Directory, the event meets the GDC’s educational criteria and delegates who attend both days will gain 14 hours of verifiable CPD.

Speakers
Delegates will be spoilt for choice with a top line-up of speakers, including:

Professor Nasser Barghi: Head of the aesthetic dentistry division in the Department of Restorative Dentistry at the University of Texas, San Antonio. Prof Barghi has presented more than 650 educational courses and empirical workshops in more than 30 countries. A prolific writer, he has also written more than 250 articles. He is a member of the American Academies of both Esthetic Dentistry and Fixed Prosthodontics, and the International Association for Dental Research.

Dr Basil Mizrahi: A graduate of the University of the Witwatersrand, South Africa (1989), Dr Mizrahi operates a full time referral private practice specialising in Complex Rehabilitation and Aesthetic Cases and Dental Implants. After qualifying with an MSc in Dentistry with a major in Periodontics in 1993, he left South Africa in 1995 to specialise for three years full time in Prosthodontics and Implant dentistry at Louisiana State University, USA. He is an honorary Clinical Teacher at UCL Eastman Dental Institute and also runs hands-on “Advanced Aesthetic and Restorative Dentistry” courses. Basil publishes and lectures extensively both nationally and internationally and is on the Editorial Board of Quintessence International and is a diplomat of the American Board of Prosthodontics.

Dr Richard Kahan: Based in Harley Street, Dr Kahan is the senior visiting lecturer on endodontology at the Eastman Dental Institute and a member of the Editorial Board for Dental Tribune UK. A highly regarded lecturer nationally, his other interest is dental IT inte-
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Offer valid from 1st April – 30th June 2012.
This offer is not to be used in conjunction with any other offer.
Vouchers are not transferable and a cash alternative is not available.
Offers valid for dental professionals residing in the United Kingdom only.

DFT Conference
Running simultaneously on the Friday, the Conference plays host to the London Deanery Dental Foundation Training conference. A fantastic opportunity for FDs and trainers to get together in a non-clinical but still highly educational setting, delegates will benefit from a tailored programme of speakers to compliment their ongoing training.

Backed by the lecture programme is a group of supporting companies who will also be exhibiting at the conference. These include companies from across the dental market such as The Dental Directory; Sirona; DMG; Hu-Friedy; Kavo; Morita; NSK; Software of Excellence/GURU; Dental Imaging Company; and SybronEndo. With a wide range of products and services on offer, delegates are sure to find what they need.

Charity Ball
The Clinical Innovations Conference is not just about lectures. The Friday night sees a chance to party at the AOG Clinical Innovations Charity Ball. For the third year running, attendees can relax, network and let their hair down at this charitable event known for its wonderful food and lively entertainment. There are still places available at this not to be missed event, see http://www.clinicalinnovations.co.uk/charityball.php for more details.

For more information and to book a place, call Smile-On 020 7400 8889 or email info@smile-on.com or visit www.clinicalinnovations.co.uk.

Professor Gianluca Gambarini: A world renowned lecturer, Prof Gambarini has lectured in universities all over the world and is the author of or has contributed to hundreds of books and articles. He has been the keynote speaker at major national and international endodontic congresses, including those of the AAE, IFEA and ESE. He is currently working with manufacturers to develop new technologies and clinical procedures for root canal treatment.

Mr Amit Patel: A Specialist in Periodontics, Mr Patel practise at Grace House Specialist Dental Centre in Birmingham. His special interests are dental implants, regenerative and aesthetic periodontics. He has taught at undergraduate and postgraduate level, and lectured both in the UK and internationally.

Dr Nilesh Parmar: One of the few dentists in the UK to have a degree from all three London Dental Schools, Dr Parmar runs a successful five-surgery practice close to London and is a visiting implant dentist to two central London practices. He has Master’s degrees in Prosthetic Dentistry and Clinical Implantology and is currently studying for his third MSc in Orthodontics. His main area of interest is in dental implants and CEREC CAD/CAM technology.

Ms Mhari Coxon: With more than 20 years’ experience in dentistry in the UK, in a variety of practice and hospital environments, Ms Coxon currently works as Senior Professional Relations Manager for Philips Oral Healthcare and clinically as a dental hygienist. Mhari is a keen writer and a regular contributor to Dental Tribune; as well as being a sought-after speaker who has lectured extensively both in the UK and overseas.
Finding the right coach for your practice

Chris Barrow discusses the benefits of the right business coach

There’s no doubt that dental business coaching has achieved a much higher profile in recent years. Most people are aware of the profession, but they may be less certain of exactly what it entails, how long it lasts and what the benefits are. Broadly, there are two types of business coaching: quantitative and qualitative, and the length of the contract very much depends on the relationship with the client.

An example of a quantitative relationship could be a dentist wishing to increase their profits by 50 per cent. Once they reach that point, the target has been achieved and the contract fulfilled. Other targets could include a conversion from NHS to private, or to get some senior team members, or to increase their intuition, which is usually very accurate. When bravado and ego get in the way, it always goes wrong.

A business coach becomes part of the team, and importantly, a team member with the experience that the dentist does not yet possess. Whatever the business venture, whether it’s a dental practice, florist or pub, it’s going to be a good idea to have someone around who’s got a 10 to 15 years’ head start.

There’s a fantastic quotation attributed to North American Indians, ‘wisdom enters through the wound’. In other words, if you’re going to open a business, you need a battle-scarred veteran on side; someone who’s run their own business, do you really want implants, do you really want grossing £4,500 a day doing tactical implementation, or very specific connections. A qualitative relationship can go on for quite a long time, whereas quantitative relationships tend to last in the region of two or three years.

The benefits of business coaching can be the difference between success and failure, or a ‘turnaround’ out of a difficult situation or problem. Ultimately, the ideal business coaching strategy is more profit, less time at work and happier people (team, patients, suppliers and family).

‘Happier people’ above all should mean a happier dentist. Dentists have got the second highest rate of suicide of any of the other professions, and the highest rate of alcoholism. The reason being that a lot of dentists are unhappy people; part of the business coach’s role is to try and get them as happy as they can be.

When appointing a business coach, it’s imperative to check their formal coaching qualifications, to ensure that they have been trained in the formal procedures of how to conduct a coaching relationship, as well as to read testimonials from their clients. However, it’s not only about qualifications and experience; it’s also about ‘the magic’. If you don’t feel good about each other, then no amount of qualification or experience will make any difference. The coach and the client are effectively interviewing each other and the dentist has got to ask him or herself - does it feel right? Am I enjoying myself?

A lot of it is intuitive. I think that’s why women generally make better business owners than men, because they follow their intuition, which is usually very accurate. When bra-vado and ego get in the way, it always goes wrong.

As for fees, it’s a cliché but you really do get what you pay for. There are coaches who will work for £500 a day, £2,000 a day or £5,000 a day. You’ve got to ask yourself, what is it that you want and what are you paying the extra for? Let’s face it, if you want to be a dentist who is grossing £4,500 a day doing implants, do you really want £2,000 a day or £5,000 a day? Surely, you want to hire a coach that charges £4,500 a day because they know what that feels like. They understand that conversa-tion and know how to look someone in the face without blinking and say ‘that’ll be £4,500 please’.

In the mid-1990’s, there were probably three UK dental business coaches. Nowa-days, there are a huge number to choose from. Also during that time, the demographic of dental practice ownership has changed. Previously, practice principals were between 45 to 60 years old, now people start buying practices at 35.

Specialisations have also begun to creep into coaching in the same way that you get specialisations in dentistry. There are those who focus on areas such as marketing, team training, financial controls and management, social media marketing, treatment coordination, front desk and telephony, and so on.

Dentists need to determine if they need general business advice from a strategic perspective, or very specific tactical implementation, or both. Take a good look round the marketplace to see what’s available and decide if individual help is needed or a blended solution from more than one provider.

As with any business, a dental practice is at its most productive when principals surround themselves with the right people in the right roles and delegate accordingly. How can you move to the next level if you can’t see the bigger picture? Having a skilled team in place – including a business coach - is the difference between being down in the trenches and sitting in a hot air balloon with a clear view all around you.

About the author

Chris Barrow has been a consultant in the dental profession for seven-teen years. He is the co-founder and Managing Director of the BKH Group of Companies and runs Chris Barrow Live at BKH. He is a high-end business and coaching expert in to take advanced business coaching to the next level. Contact Chris at chris@bkhgroup.co.uk for more information about Chris Barrow Live at BKH please call 0161 820 5466 or email Chris Barrow at chris@bkhgroup.co.uk. You can also stay in touch with the Barrow Kwong Hing Group? Connect with us here Facebook: www.facebook.com/bkhgroup; YouTube: www.youtube.com/BarrowKwongHing; LinkedIn: www.linkedin.com/company/barrow-kwong-hing-group; Twitter: Chris Barrow @ChrisKbhk; Dr Al Kwong Hing @AlkHongHing
New coating for implants could prevent premature failure

A team of MIT chemical engineers has developed a new coating for implants that could help them better adhere to the patient’s bone, preventing premature failure.

The coating, which induces the body's own cells to produce bone that fixes the implant in place, could also be used to help heal fractures and to improve dental implants, according to Hammond and lead author Nick Shah, a graduate student in Hammond’s lab.

Artificial hips consist of a metal ball on a stem, connecting the pelvis and femur. The ball rotates within a plastic cup attached to the inside of the hip socket. Similarly, artificial knees consist of plates and a stem that enable movement of the femur and tibia. To secure the implant, surgeons use bone cement, a polymer that resembles glass when hardened. In some cases, this cement ends up cracking and the implant detaches from the bone, causing chronic pain and loss of mobility for the patient.

“Typically, in such a case, the implant is removed and replaced, which causes tremendous secondary tissue loss in the patient that wouldn't have happened if the implant hadn't failed,” Shah says. “Our idea is to prevent failure by coating these implants with materials that can induce native bone that is generated within the body. That bone grows into the implant and helps fix it in place.”

The new coating consists of a very thin film, ranging from 100 nanometers to one micron, composed of layers of materials that help promote rapid bone growth. One of the materials, hydroxyapatite, is a natural component of bone, made of calcium and phosphate. This material attracts mesenchymal stem cells from the bone marrow and provides an interface for the formation of new bone. The other layer releases a growth factor that stimulates mesenchymal stem cells to transform into bone-producing cells called osteoblasts.

Once the osteoblasts form, they start producing new bone to fill in the spaces surrounding the implant, securing it to the existing bone and eliminating the need for bone cement. Having healthy tissue in that space creates a stronger bond and greatly reduces the risk of bacterial infection around the implant.

“When bone cement is used, dead space is created between the existing bone and implant stem, where there are no blood vessels. If bacteria colonize this space they would keep proliferating, as the immune system is unable to reach and destroy them. Such a coating would be helpful in preventing that from occurring,” Shah says.

It takes at least two or three weeks for the bone to fill in and completely stabilize the implant, but a patient would still be able to walk and do physical therapy during this time, according to the researchers.

The MIT team can control the thickness of its film and the amount of growth factor released by using a method called layer-by-layer assembly, in which the desired components are laid down one layer at a time until the desired thickness and drug composition are achieved.

The researchers are now performing animal studies that have shown promising results: The coatings lead to rapid bone formation, locking the implants in place.

Dental implant firm files for bankruptcy

According to reports, Voxellogix Corp, a seven-year-old US teeth-replacement company, has filed for bankruptcy protection in San Antonio.

President of the corporation and dental specialist, Dr Stephen Schmitt, who replaces missing and damaged teeth, said the company had been “hurt” by the down economy in the last few years. As a result it “lacked the financial resources it needed to grow”.

The company was part of the emerging field of digital dentistry that uses three-dimensional models and other computer-designed aids to improve teeth replacement. While full replacement costs at Voxelogix started at about $40,000, the company said its treatment can result in lower costs compared to conventional dental methods.

The report stated that Voxelogix filed for bankruptcy protection Tuesday under Chapter 11 of the bankruptcy code, meaning it can seek reorganisation. Schmitt said he was uncertain, however, if it would return to business.

Nobel Biocare Catalog 2012 available online

Nobel Biocare has released its new Product Catalogue 2012 with up-to-date content, illustrations and detailed product information.

The new Nobel Biocare Product Catalog 2012 is an informative and fundamental reference point for navigating through Nobel Biocare’s comprehensive assortment of products and solutions. The updated catalogue allows for accurate and efficient ordering of all Nobel Biocare’s implants, prefabricated and individualized prosthetics, and components for guided surgery.

Highlights of the new product catalogue include: Recently launched products such as NobelClinician Software for digital diagnostics and treatment planning now also for Mac; NobelActive 5.0 for safe implant placement in areas with limited space, and NobelReplace Conical Connection and NobelReplace Platform Shift designed to optimize aesthetic outcome through enhanced soft tissue preservation while maintaining the benefits of the well-proven tapered implant body.

XiVE - now on Facebook too

Implant System Fanpage provides a platform for users. Exchange mutual experiences, ask for tips from colleagues or find out about innovative concepts – now, the XiVE implant system makes this possible for its users on its own Facebook fan page.

A centre stage of the XiVE fan page are all the topics around implantology: What new practical concepts are there? What new tips can colleagues give for issues of primary stability or immediate loading, for instance? These are only some of the aspects that interest practitioners and that they would like to discuss. The new XiVE fan page provides a platform for just this purpose.

You can share your own experience with the implant system – the XiVE Experience
A 59-year-old male patient was looking for a new fixed restoration for his maxilla. His case history showed no general disease. The patient had been fitted with telescopic model casting prostheses in the maxilla and mandible.

Owing to the periodontally insufficient anterior residual teeth in the maxilla (teeth #12, 11, 21 and 22), the prosthesis could no longer be supported. After losing the residual teeth, the patient wanted a fixed implant-based restoration of the maxilla.

The residual teeth of the mandible showed the following findings. Tooth #48 was impacted and displaced. Tooth #45 showed mobility (Grade 3) and was periodontally insufficient.

The anterior residual teeth #33 to 43 presented with increased probing depths on the canine teeth and increased mobility (Grade 2).

The treatment strategy for the maxilla included, as a first step, a conservative periodontal therapy of the anterior residual teeth for strategic preservation and fixation of the existing prosthesis until implant insertion.

Afterwards, the residual teeth were removed and a bilateral sinus floor augmentation was performed in a two-stage procedure. Following 3-D planning, eight endosseous implants were inserted with the CAMLOG Guide System in a flapless procedure, and the prosthetic restoration was realised using a telescopic bridge.

In order to ensure accurate transferability, the fixation must be performed under radiological control in the identical position as the one for the implantation.

In the mandible, tooth #45 was removed and the other teeth were treated with conservative periodontal therapy, the mandibular posterior teeth were replaced and realigned. Teeth #43 to 33 received re-veneering of the removable denture.

The planned minimally invasive flapless procedure for implant insertion requires a unique fixation for the preparation of radiological materials. The fixation is facilitated by temporary implants in a suitable position.

In order to ensure accurate transferability, the fixation must be performed under radiological control in the identical position as the one for the implantation.

The scan template is fabricated...
Atlantis™ crown abutment is an efficient, effective and aesthetic alternative to traditional cast abutments for single-tooth, screw-retained restorations. Like Atlantis™ patient-specific CAD/CAM abutments for cement-retained restorations, the Atlantis crown abutment is uniquely designed from the final tooth shape for more natural aesthetic results and available for all major implant systems. It is also precision-milled from a solid blank of biocompatible zirconia, which eliminates the need to cast with precious metals.

What’s more, because porcelain is applied directly to the Atlantis crown abutment, it can be easily retrieved, if needed, and the time and cost of preparing a separate coping is recaptured. Atlantis crown abutment is available in five shades, including a new translucent zirconia in white. It can be placed in all positions in the mouth and is covered by a comprehensive warranty.

To guide all drills by the sleeve geometry from the start, the drilling sequence is performed in succession from the nine to the 11mm drill and finally to the 15mm drill (maximum implant length).

The CAMLOG Guide offers a sleeve system. As opposed to multi-sleeve systems, a single sleeve inserted into the surgical template is adequate for guidance during all drilling sequences and implantation procedures. The implants can be inserted through the sleeves. To guide all drills by the sleeve geometry from the start, the drilling sequence is performed in succession from the nine to the 11mm drill and finally to the 15mm drill (maximum implant length).

The CAMLOG Guide offers a sleeve system. As opposed to multi-sleeve systems, a single sleeve inserted into the surgical template is adequate for guidance during all drilling sequences and implantation procedures. The implants can be inserted through the sleeves.

Editorial note: The case was first published in C Mairoana & M Beretta (eds.), Manual of Oral Implantology (Edizioni Italia Press, 2010) and is reprinted here with kind permission.

A complete list of references is available from the publisher.
Fig 16, Transversal view at 14
Fig 17, Transversal view at 13
Fig 18, Transversal view at 12
Fig 19, Surgical template with ball retention elements at positions 21, 15 and 25 for stable positioning of the template during drilling procedures. Careful cleaning and disinfection are mandatory before placement.

Fig 20, Ball retentions on temporary implants for stabilisation of the temporary prosthesis, fixation of the scan template during cone-beam scan and positioning of the surgical template during the drill procedures.

Fig 21, The gingival punch is guided through the sleeves into the mucous membrane. The punch has no depth stop.
Fig 22, A vapolet is used to cut out and remove the punched gingival islands after removing the template.
Fig 23, Excavated implant locations 26 and 27.

Fig 24, The template is mounted again. Start of the CAMLOG Guide drilling sequence with the pilot drill followed by drills of the appropriate lengths depending on the implant length (region 23).

Fig 25, Guided insertion through the sleeves utilising the CAMLOG Guide insertion tool.

Fig 26, The sleeve dimension allows for bone-condensing and bone-spreading procedures through the sleeve (here, osteotome for vertical bone condensation).

Fig 27, Implant in first quadrant in situ.
Fig 28, Post-op panoramic radiograph.

Fig 29, Healing after one week post-op. The patient had neither complaints nor post-op swelling.

Fig 30, The surgical template is set back on its fabrication model. The analogue plaster reamers are used to create the cavity for the lab analogue through the sleeve.

Fig 31, Implant positions on the plaster cast.
Fig 32, Mounted lab analogues together with the insertion posts are secured to the sleeves with wax. The lab analogues are fixed into the plaster cast.

Fig 33, Cast with lab analogues in place. The transfer of the analogue into the correct position through the sleeve of the surgical stent.

Fig 34, A 0.5mm thick thermoformed splint is drawn over the abutments. The thermoformed copings perform the space-making task for passivation when cementing the interim restoration.

Fig 35, Long-term temporary appliance in the articulator.
Fig 36, PEEK abutments in situ.

Fig 37, Long-term temporary appliance cemented in situ in terms of early treatment eight weeks post-op.

Fig 38, Impression with closed impression posts.
Fig 39, CAD/CAM-fabricated zirconia abutments bonded to CAMLOG Esthomic inset abutments.

Fig 40, CAD/CAM-fabricated zirconia abutments after one year in function.

Fig 41, Occlusal view before treatment.
Fig 42, Radiological situation before treatment.

Fig 43, Occlusal view two years after final prosthetic restoration.
Fig 44, Occlusal view two years after final prosthetic restoration.

About the author
Dr Claudio Cacaci is a specialist in oral surgery and implant dentistry. He studied at the Dental School in Munich and worked in the Department of Maxillo-Facial Surgery and the Department of Oral Surgery and Implant Dentistry in Munich. In 1997, he founded a private dental clinic with Dr Jan Hajtó in Munich. In 1998, he established the Private Training Centre for Implant Dentistry (F.I.O.I.) in Munich. He is the founder of the Munich Study Group for Implant Dentistry and a member of various national and international study groups and dental associations. Dr Cacaci is author of the book Check-list – Implantology and contributing author of the book Manual of Oral Implantology. Since 2009, he has worked in a group practice specialising in implantology and periodontology in Munich.
Champions® Implant System

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

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

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- Optimal immediate loading
- Excellent peridontal restorations
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Courses about the minimally invasive implantation method (MIMI®) and the Champions® implant system

Continuing education in Mallorca

The course starts on Wednesday at 2:00 P.M. and ends on Saturday afternoon

- June 13 – June 16, 2012

Course content

- Theory: Presentation of the Champions® implant system and the MIMI® method · Practice: Live surgeries with one-piece and two-piece Champions® implants.
- The course includes 5 nights in a double-room, breakfast included, transfer to the dental office, day rate, lunch, coffee break, 2 dinners, course script, A3 Certificate, incl. for accompanying person.

Course fee € 3 200 (VAT excluded)

Course participants: minimum 3, maximum 10

Please arrange your flight schedule. For transfers, please give us your flight arrival time.

The courses will be presented in a friendly and relaxed atmosphere, and dentists will be able to incorporate Implantology as an additional treatment in their dental office.

The courses will be taught by Dr. Armin Nedjat, an experienced Dental Implantology specialist. He has placed and restored more than 20 000 implants.
Keep it safe and simple

Dr Armin Nedjet examines the principles of Champions

For almost two decades, MIMI®, the Minimally Invasive Method of Implantation, has been known as a beneficial, patient-friendly and periosteum-protecting surgery surgical method. (Don’t confuse the MIMI® method with Mini implants, which are made from titanium, grade five, and have an implant diameter that is smaller than 2.9mm). The Champions® implant system, which is inserted according to MIMI®, has been proven very successful in recent years. However, this implant system can also be inserted according to the classical implantation method, and if necessary, augmentations can be performed. The implants themselves are made from titanium, grade four, by a well-known German manufacturer. The surface of the Champions® are made from the best material on the market, according to several studies in Germany, for example at the university clinic in Cologne, and the United States.

According to recent clinical studies, the old argument, “The more titanium in the bone, the better it is”, has been proven wrong. In fact, the peri-implant nutrition plays a major role. There are very few complications associated with the MIMI® treatment, which is very beneficial for patients: thanks to MIMI®, the periosteum, which nourishes the bone, is very well protected.

Primary stability at a torque of 40Ncm can be achieved with a one-piece 3.5mm-diameter “Classic” Champions® implant (slightly conical end), with the 3.5mm-diameter “New Art” Champions® or with 3.5mm-diameter two-piece Champions® (R)Evolution® implants.

In some cases, you can extract teeth that cannot be peri-odontally preserved and insert implants in the same session. Patients with one-piece Champions®implants, for example for single front teeth, are provided with a fixed temporary restoration before the final prostodontic restoration is fitted eight weeks after implantation. If there are more than four fixed teeth/implants, the final prostodontic restoration can even be fitted within the first 14 days post-surgery and splinted/passively fitted (eg with Implantlink Semi). In the two-weeks critical: when fitting fixed prostodontic restorations, the temporary restorations should not be removed in the second to eight weeks post-surgery.

When two-piece Champions® (R)Evolution® implants are inserted, the implants can be transferred to Secondary Osseointegration Stability independently from temporary restorations without any problems. Two-piece Champions® (R)Evolution® implants are indicated for smaller units (one- or three teeth), and one-piece Champions® are indicated for larger units (four or more implants/teeth). Dental surgeons prefer to work with two-piece Champions® (R)Evolution® implants since they can avoid many of the problems associated with temporary restorations. The whole treatment (without the need of special high-tech material) is easily affordable for most patients.

• Figs 1-3: Case Study
Tooth 54 and tooth 56 of the 50-year-old patient could not be preserved. After local anaesthesia, the teeth were gently extracted, and one-piece Champions® were inserted. You can see the bone “plateau” between the previous tooth roots in the bifurcation area. This type of immediate implantation has many advantages, just one surgery session is necessary, and in the long-term, there is no loss of soft or hard tissue.

• Figs 4-7
With the bone condensing conical triangular drills, we pre-
Laser-Lok 3.0 is the first 3mm implant that incorporates Laser-Lok technology to create a biologic seal and maintain crestal bone on the implant collar. Designed specifically for limited spaces in the aesthetic zone, the Laser-Lok 3.0 comes with a broad array of prosthetic options making it the perfect choice for high profile cases.

- Two-piece 3mm design offers restorative flexibility in narrow spaces
- Implant design is more than 20% stronger than competitor implant
- 3mm threadform shown to be effective when immediately loaded
- Laser-Lok microchannels create a physical connective tissue attachment (unlike Sharpey fibers)

Introducing the Laser-Lok® 3.0 implant

Laser-Lok 3.0 is the first 3mm implant that incorporates Laser-Lok technology to create a biologic seal and maintain crestal bone on the implant collar. Designed specifically for limited spaces in the aesthetic zone, the Laser-Lok 3.0 comes with a broad array of prosthetic options making it the perfect choice for high profile cases.
guessed that implants should always have an inter-implantary distance of two-three mm or of two-three mm to adjacent teeth, this has been proven wrong by hundreds of studies and long-term documented cases. When the implants have achieved primary stability, bone does not have to first grow on the titanium. Thanks to the MIMI® technique, bone remains well-nourished. There-fore, you only need an inter-implantary distance of one mm and a distance of 1mm to the adjacent teeth.

Patients need to be well informed about all aspects of implant treatment, including the benefits of one-piece implants for single tooth gaps. Temporary restorations and cements should be fitted to avoid lateral shear forces and micromovements in the first two to eight weeks post-surgery, and patients should be aware of the importance of their compliance with their dentist’s instructions. The case described is an example of how successful and reliable immediate implantation can be if special techniques and materials, which protect the periosteum, are applied.

‘Patients need to be well informed about all aspects of implant treatment, including the benefits of one-piece implants for single tooth gaps’

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Ridge preservation and GTR with a xenograft and resorbable collagen membrane

Prof Nart provides a case study

The most predictable way to maintain the width, height and position of the alveolar ridges is to perform ridge preservation at the time of tooth extraction. This procedure requires an intra-socket osseous graft and the use of a membrane and should reduce the morphological changes in alveolar bone (Lekovic et al. 1998; Wang et al. 2004). In a six-month animal study, Araújo and Lindhe demonstrated that the placement of a biomaterial in an extraction socket may modify the remodeling and ridge resorption that occurs following tooth extraction. They observed that there was an average of 55 per cent of ridge resorption in natural healing and only 12 per cent in the grafted sites (Araújo & Lindhe 2009).

The materials and the surgical techniques in use today simplify ridge preservation before implant placement and enable clinicians to ensure the functional and aesthetic outcomes of the implants and subsequent restorations more predictably. Various natural and synthetic bone graft materials are available for the clinician to use for ridge preservation. Bone grafts in general are divided into four major categories: autogenous, allografts, xenografts and alloplasts. Although the gold standard is the autogenous graft, studies have proven the reliability and functionality of using either an allograft or xenograft, which avoids the creation of an additional surgical site for bone harvesting. In addition, there is rapid resorption of autogenous grafts, which is much slower with mineralised allografts or xenografts (Artzi et al. 2000; Vence et al. 2004; Irimaios 2006).

The use of barrier membranes has become a standard of care in guided bone regeneration and for alveolar ridge preservation and/or augmentation. The membrane excludes fast growing cells - epithelial and connective tissue cells

Recent study shows* bacterial contamination on 70% of bib holders: Use a hygienic, disposable bib holder with each patient!

* Study Uni Witten/Herdecke on file with DUX Dental

For more information please visit www.duxdental.com
The surgical technique was established initially, membranes made of expanded polytetrafluoroethylene (ePTFE) were used. Although clinical and experimental studies found excellent treatment results using ePTFE membranes, wound healing complications with infection sequelae arose following the exposure of membranes. Therefore, clinicians and researchers have advocated the use of biabsorbable barrier membranes (Grill et al. 1995).

Successful regeneration is possible, provided that cell exclusion and space maintenance prevails for the time needed for repopulation of the site with progenitor cells. This period may vary between three to 12 months for bone regeneration in edentulous areas. The structural integrity of implanted biabsorbable barrier membranes needs to be preserved for an adequate period to allow maturation of the newly formed tissue under the membrane-protected space.

The purpose of the present case report is to evaluate clinically and histologically a ridge preservation using a xenograft and resorbable collagen membrane following tooth extraction.

Case study
A 40-year-old female patient was selected for this case report. Other than localised periodontal disease around a right temporary mandibular second molar, she had no systemic disease. The patient was referred for extraction of this molar. The reason for the extraction was type III mobility and the radiological image.

Surgical treatment
Following administration of local anaesthesia (4 per cent articaine and 0.001 per cent epinephrine), the tooth was elevated and an atraumatic extraction was performed. A full-thickness mucoperiosteal flap was elevated to expose both the labial and lingual aspects of the alveolar ridge. The extraction socket was then curedtted to remove all the soft tissue. A combined two- and three-walled bony defect of 6 and 5 mm and a fenestration of the buccal plate were observed (Figs 3 & 4). A ridge preservation technique was performed using a xenograft material (a blend of granules of...
The use of a bone substitute can avoid bone harvesting from a donor site, thus reducing patient discomfort post-operatively.

Post-operative care
The patient was given 600mg ibuprofen every eight hours for the first four days and 500mg amoxicillin every eight hours for the first seven days and 10ml 0.20 per cent chlorhexidine gluconate rinses for 50 seconds twice a day (1-0-1) from the day of the operation until day 14 after surgery was prescribed. A toothbrush with extra soft bristles was recommended. The use of a bone substitute can avoid bone harvesting from a donor site, thus reducing patient discomfort post-operatively.

Clinical and histological analysis (Figs 14 & 15)
Clinically, xenograft particles were well integrated into the alveolus, and the regenerated area was easily distinguishable from the original bone tissue. The new bone formed was firmly attached to the bone graft particles.

Discussion
The aim of this case report is to evaluate guided bone regeneration after tooth extraction with a xenograft material. The use of a bone substitute can avoid bone harvesting from a donor site, thus reducing patient discomfort post-operatively.

In a randomised clinical study, Barone et al. (2008) compared extraction-only treatment to ridge preservation with xenograft (cortico-cancellous porcine bone) and collagen membrane. Seven months after tooth extraction, a greater horizontal width reduction of the residual alveolar ridge (8.1mm versus 6.5mm) in the extraction-only group was observed. A reduction of vertical ridge height was also observed. These findings were in agreement with previous studies (Iasella et al. 2005). Deproteinised bovine bone has proven to be a highly biocompatible and osteo-conductive material that acts as a natural scaffold for bone formation, and has a low
Often times, compromises have to be made when developing impression materials. Because normally the rheological properties of stability and good flow characteristics would stand in each other’s way. DMG’s Honigum overcomes these contradictions. Thanks to its unique rheological active matrix, Honigum yields highest ratings in both disciplines. We are very pleased to see that even the noted test institute »The Dental Advisor« values that fact: Among 50 VPS Honigum received the best »clinical ratings«

Table 1: Histological and histo-morphometric evaluation of the xenograft as an alveolar bone graft material.

<table>
<thead>
<tr>
<th>Time (months)</th>
<th>Membrane</th>
<th>New bone (%)</th>
<th>Residual particles (%)</th>
<th>Connective tissue (%)</th>
<th>Inflammatory response</th>
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<td>Nbo</td>
<td>46.3</td>
<td>10.1</td>
<td>22.9</td>
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</tr>
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<td>Collagen</td>
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<td>18</td>
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<td>20</td>
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<td>Li, 2009</td>
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<td>25.6</td>
<td>35.4</td>
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</tbody>
</table>

The efficacy of a xenograft as an alveolar bone graft material may be the result of a combination of factors: its osteo-conductive capacity, the increase of mineral content in the grafted area necessary for bone formation and its density in order to provide stability to the graft and to persist for many months (Barone et al. 2008; Artzi et al. 2006).

The histological analysis revealed that in all samples there are residual particles of the xenograft, including studies at nine months (Artzi et al. 2000). According to studies, the volume of residual bone graft material may vary between 16 and 50 per cent. The volume of new bone formation varies between 25 and 46 per cent (Table I).

Histological and histo-morphometric studies have observed that the formation of new bone and the resorption of the xenograft particles is a slow and gradual process. In a nine-year study of a sinus elevation with a xenograft, Traini et al. (2007) observed an increase in bone formation over time, a decrease in the narrow spaces and a slow resorption of the biomaterial. Sartori et al. (2003) presented a case of a sinus augmentation with a xenograft and histo-morphometric evaluation after ten years; he observed that the absorption of the xenograft is slow but constant. He saw a resorption of 5.6 per cent per year for the first two years and a significant decrease in the next eight years, with an average rate of resorption of 0.58 per cent per month.

According to several studies, once the xenograft is in contact with mineralised bone, it acts similarly to the host bone, providing a biologic support for dental implants (Haas et al. 1998). The success of implants placed in regenerated areas of up to 40 per cent of xenograft residual particles seems to be similar to those placed in native bone (Carmagnola et al. 2005).

Conclusion

The ridge preservation technique limits hard-tissue resorption following tooth extraction. A xenograft with a resorbable collagen membrane has been proven to be a clinically successful means of restoring a bone defect. The histological examination confirmed the presence of newly formed vital bone almost completely surrounding xenograft particles throughout the biopsy samples.
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Managing a dental practice

Jane Armitage discusses management qualifications

For several years I have been approached by other practice managers, some new to the profession, some not, some having the qualification and others without little or no academic training. I don’t mind answering any questions they may have and I will share the knowledge I have gained over my 40 years in the profession with anyone. However, what does concern me is how many contacts I have from colleagues who tell me they know very little about the job and in some areas don’t even know where to start.

This I find frightening. How can a manager be expected to lead a team of nurses who are enforced to be qualified, or working towards a qualification, having not had any academic training themselves? In these days of governing bodies’ expectations of quality, how can this be allowed to happen?

It is time that we as a profession look at this role and see where it can be improved.

Currently, the estimated figure of qualified practice managers stands at 20 per cent, which is appalling. I’m not saying that you should only lead a practice if you have management qualifications in dentistry, but what I am saying is I feel there should be a tiered level of training that all managers should be enforced to study; specifically if they wish to manage a dental practice.

Legislation
With legislation forever changing, I would imagine that managing a dental practice without any knowledge of dentistry would be quite difficult to come to grips with. Managing a bank is one thing, but managing a dental practice is another thing entirely!

I therefore believe we need a minimum level of compulsory academic training for those involved in the admin side of our profession.

Learning the principles is the basis of a good manager and this will help with the daily running of the practice, whilst helping transform the stress and worrying of “if you’re doing it right!” The manager should be confident that the protocols and procedures they put into place are correct.
I understand that courses are expensive, but surely it’s cost effective knowing that you have a trained qualified manager leading the team and that you can leave the principle to get on with what they have trained for. With training it will surely be a win/win scenario for everyone.

The role of the practice manager

When it comes to defining the role of a practice manager, I believe the answer will be different depending what part of the country you are in.

Sometimes the practice manager is a nurse who one minute will be taking x-rays and the next minute they will be interviewing someone; or it could be a receptionist who is a qualified nurse, but finds themselves in the role of the receptionist, nurse and practice manager! Or maybe it’s a qualified manager with training in management but not specific to dentistry? Last but not least, maybe the practice manager is one of the 20 per cent of qualified dental practice managers within the UK.

I really feel for the many individuals out there who are struggling whilst trying to pretend they know exactly what is required, when really they need to be in the position that if the CQC do make a visit they won’t need to bother the principal to make sure everything is in place.

Please don’t think that I am underestimating many of my colleague’s ability to manage a dental practice; what I am asking for is formal training that leads to a qualification covering all aspects of managing a dental practice; it really should be something that is looked at to ensure everyone with the title ‘practice manager’ has had the correct foundation training. Because how can you expect qualified nurses who have been enforced to maintain CPD to take instructions from a manager who does not have to possess any formal qualification and who doesn’t even have to do CPD to maintain their role?

‘With legislation forever changing, I would imagine that managing a dental practice without any knowledge of dentistry would be quite difficult to come to grips with’

Should there be a certain level of training that managers should be forced to study?

About the author

Jane Armitage, Practice Manager of the Year 2005-2009. Jane Armitage is an award-winning practice manager and has almost 40 years industry experience. She is currently a practice manager for Thompson & Thomas, and holds a Vocational Assessor award. She is also a BDA Good Practice Assessor, BDA Good Practice Regional Consultant, and has a BDA Certificate of Merit for services to the profession.

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Dental implants: it’s not as easy as it looks

A few months ago, I was on a course listening to a lecture from a very well known specialist, a true leader and innovator in his chosen speciality. He was discussing the complexity of his speciality and how many years were needed before one can become truly proficient, he went onto say “…it’s not like placing dental implants, where you can go on a weekend course and learn all you need. To treat these kinds of cases requires years of training and experience.” I was a little taken back by his attitude towards implant dentistry; in fact I would go as far to say that I find comments such as these quite belittling. They usually come from dentists who have never placed nor attempted to restore implants before.

Don’t let the implant companies fool you; it is a challenging and demanding area of dentistry. It encompasses both the surgical and the restorative envelope and to be a good implant dentist one must be a good surgeon, a good communicator, a good restorative dentist, a good prosthodontist, the list goes on and on. Yes, anyone can place dental implants without too much trouble, but that’s akin to me saying that anyone can stick an orthodontic bracket on a tooth, yes that’s true, but just because you can do that, doesn’t mean the final result will be a good one.

Below is a typical multi-disciplinary implant case which I have treated. The aim is to show that implant dentistry is not just about making a hole and putting a screw in, there is a great deal of planning and preparatory work carried out before this can happen.

This lady has suffered with TMJ pain ever since a nasty fall in a local shop a few years ago. She has limited opening and is very nervous about her teeth. She recently lost her UR23 and came to see me for an implant solution. As you can see from the initial photos she was over closed with an almost traumatic bite in the UR23 region. Her lower incisors were heavily worn and sensitive, with a number of occlusal issues. Her medical history was clear and she was a non smoker. After a long discussion we arrived at the following treatment plan:

1. Full case diagnosis with articulated study casts and wax ups
2. Assessment of the UR23 edentulous area with a CBCT scan
3. Augmentation the UR23 implant sites with a piezo surgery device
4. Carry out implant placement under iv sedation in the UR23 area
5. Restoration of the occlusal vertical dimension with composite build-ups
6. Develop favourable soft tissue outline using a partial denture and fixed temporary bridges
7. Fabricate and fit a permanent 2 unit e.max bridge

The patient needed some pre-implant surgery to reduce the height of the bone crest in the UR23 region coupled with opening/restoring of her OVD to create sufficient space to accommodate the implant-abutment/ceramic restorations. The necessary height was judged using a Galileos...
scan and virtually placing the implants and abutments with a CEREC over-lay. This enabled me to assess how much height would need to be obtained by reducing the bone height and increasing the vertical dimension.

An interesting incidental finding was a previous silver point root filling in her UL7 and it appears to have exited her maxillary sinus. The patient was unaware of this, and has never had any symptoms from this tooth. The CBCT was sent to a Consultant Oral Maxillo-facial radiologist who recommended leaving the UL7 alone and only investigating it if the area becomes symptomatic. If the UL7 needs extracting in the future, re-alignment of the silver point filling in the future, re-alignment of the silver point filling in the future, re-aligning the UL7 alone and only investigating this area.

Once she was sedated, she was much calmer and managed to maintain a very reasonable level of mouth opening for the duration of the surgery. Two Astra Tech Osseospeed TX implants were placed achieving very high primary stability.

The area healed without complication and after 2 months a 2 unit composite temporary bridge was made.

The patient was delighted with the final result and will be seen by me every 6 months for examinations and regular hygiene visits.

As can see, this is just a brief synopsis of what was carried out, making the hole and placing the implants is only part of the overall treatment. It's not as easy as it looks....

**About the author**

Dr Nilesh R. Parmar B.D.S. M.Sc. M.I.C. M.I.C. was voted Best Young Dentist in the East of England in 2000 and runner up in 2010. He was short-listed at the Private Dentistry Awards in the category of Outstanding Individual 2011. Nilesh has master's degrees in Prosthetic Dentistry from the Eastman Dental Institute and a master's degree in Clinical Implantology from King's College London. Nilesh is one of the few dentists in the UK to have a degree from all three London Dental Schools and is currently studying for his 3rd MSc in Orthodontics. His main area of interest is in dental implants and CEREC CAD/CAM technology. Nilesh runs a successful 5 surgery practice close to London and is a visiting implant dentist to two central London practices. Nilesh was voted the 8th Most Influential Person in UK dentistry by Dentistry Magazine 2012, the youngest person in the Top 10. Nilesh regularly speaks for national and international meetings including The Dentistry Show 2012 Future Dentist Conference, the IDA in Japan and for Sirona in Germany and the USA. His direct and easy-going presentation technique makes him a sought after speaker in Europe. Nilesh has a never-ending passion for his work and is famed for his attention to detail and his belief that every patient he sees should become a patient for life. He offers training and monitoring to dentists starting out in implant dentistry. More information can be found on his website.

www.dentaleshiparmar.com

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‘One of the benefits (or some might say downsides) of implant dentistry is that it can take months before the implants are ready to be loaded’

**NILESH R.PARMAR Surgical Instrument Kit**

**Fig 1** Initial presentation

**Fig 2** Lack of vertical space

**Fig 3** CBCT image

**Fig 4** CBCT image to show silver point filling into sinus

**Fig 5** Implant placement

**Fig 6** Closure of implant site

**Fig 7** 2 unit composite temporary bridge, note the restoration of the vertical dimension

**Fig 8** Soft tissue profile after 2 months with the temporary bridge removed

**Fig 9** Atlantis Zirconia abutments

**Fig 10** 2 unit e.max bridge

**Fig 11** Abutments in situ

**Fig 12** Final bridge cemented in place

**Fig 13** Occlusal view of temporary bridge

**Fig 14** Final bridge at fit, note soft tissue profile

When I first started placing dental implants in practice, I wasn’t sure which instruments I would need. Yes, I had placed implants in hospital, and was aware of the retractors, elevators etc. that were used, but that was all I knew. So when I told my local rep I wanted to buy some surgical instruments I was a little bit confused by the variety. Over the years, and on my travels, I have picked up instruments of all shapes and sizes, some are fantastic, and some are useless. Recently, I have been asked by dentists who are new to implants, to send me pictures of my surgical kit so that they could duplicate my chosen instruments. This had developed into me forming a partnership with Hu-Friedy to design and produce my own Implant Surgical Kit. **The NILESH R.PARMAR Surgical Instrument Kit is comprised of 31 instruments in 2 cassettes which are everything a dentist needs for simple to moderate implant cases.**

We elected to place the implants under IV sedation. Although this lady wasn’t an especially nervous patient, she struggled to maintain a normal opening for any length of time.

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The Dental Directory is the UK's largest full service dental dealer. The Dental Directory is proud to announce that its one-day course on dental stabilization with Phil Broughton will be on the road in May 2012.

Cat-Hup with Phil and the BioTreat system in Manchester - 11 May - London - 25 May - Limerick City - 28 May

The first portion of the day will cover a number of important implant topics, including stabilization and clinical considerations, plus an overview of the BioTreat® system. After a short break, delegates will take part in a practical programme focused on implant placement, while after lunch hands-on sessions will focus on prosthesis.

Speaker Phil Broughton graduated from Liverpool University and has completed an advanced dental restoration course. Phil has continued to push himself clinically, now being the implantologist at the Aystanabt Dental and aesthetic clinic in Manchester.

Visit our website: www.thedbg.co.uk or visit: dbg.dental

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The aim of the course is to increase knowledge of restorative options available to the practitioner, for both general practitioners and specialists.

Astra Tech Familiarisation Course for restorative clinicians and dental technicians who want to provide patients with implant based restorative dentistry – gain five hours CPD

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President of the London Section Michael Frankl, of the prestigious Lotus Clinic in London. Dr Michael Frankl, who has been involved with laser for a number of years, said of the Claros unit: “It’s been great – it’s amazing what it can do!”

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Qudent have introduced a new alginate mixer to their product range. The Pulsar DB11 alginate mixer represents a triumph in technology, streamlining, compact style design with a minimalistic casing making it lighter and more resistant to impact.

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Smile-on impresses delegates at the BDA Conference and Exhibition 2012

This year’s BDA conference was another great success, with thousands of delegates in attendance. The many training and education opportunities that the conference offers include the innovative online Core CPD and QCs programmes, and webinars in different areas of dentistry. Smile-on was this year’s main sponsor of the Dental Product Zone, which also saw a host of other new products such as the popular MSc course in Restorative and Aesthetic Dentistry, and partners with the University of Central Lancashire to provide the UCLan. 

Smile-on would like to thank all delegates who visited the stand and helped make the day a tremendous success.

For more information call 020 7420 8989 or email info@smile-on.com.

Implants, oral hygiene and patient compliance at the BDA Conference 2012

Water Pik stood out from the crowd of hundreds of companies in attendance this April at the British Dental Association Conference in London. Water Pik, Inc’s director of professional and clinical affairs, Deborah Lyle, gave an enlightening lecture on key areas of concern when maintaining proper oral hygiene with the presence of implants. Attendees at the lecture learned how just 20 per cent of today's implant patients are currently using manual floss regularly, and other studies have shown there is little evidence when we find a root planing necessary to benefit patients with gingivitis.

One study has shown a Waterpik® Water Flosser to be twice as effective at reducing gingival bleeding as manual floss. Mry Lyle points that dentists, hygienists and therapists must gain personal understanding of their patients in order to properly and effectively offer advice, recommending that dentists look into the relevant CPD course on patient coaching at www.waterpik.co.uk/professional/index.html.

Deborah Lyle and Water Pik would like to thank all who attended, and very much look forward to seeing everyone again at next year’s event.

To learn more about the Waterpik® Water Flosser and the other products in the Waterpik® range go to www.waterpik.co.uk
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