Public ‘need more education’ on dental products

The British Dental Health Foundation survey reveals some worrying statistics about the public’s dental product education.

A study undertaken by the British Dental Health Foundation (BDHF) has revealed that although dental products may be commodities that find their way into everybody’s shopping trolley, only a quarter (26 per cent) of people understand what ingredients they are made from and their purpose.

The findings, which have been published by the British Dental Health Foundation as part of this month’s National Smile Month campaign, worrying revealed that 55 per cent of people failed to understand the ingredients that were contained in their dental products and a further 44 per cent only partly understood what was contained in them.

Participants were also asked if they felt it was important that the manufacturers’ product claims had been independently tested to check they are clinically proven and not exaggerated; the results indicated that half the people questioned felt that independent testing was important and less than a quarter of the people felt that such testing was ‘extremely important’.

Out of the remaining participants, 20 per cent were indifferent to independent testing, whilst the remaining felt such means were unimportant.

The survey also revealed that approaching three quarters (72 per cent) of people did not always believe the product claims made on dental products.

The Foundation believes the issues are connected and has announced plans to publish a glossary of common ingredients and their purpose to help educate and inform consumers.

Dr Nigel Carter, Chief Executive of the British Dental Health Foundation, said: “The Foundation has a long track record of helping to educate the public on all aspects of oral health issues. For nearly 20 years, the have been evaluating consumer oral health care products to ensure that manufacturers’ product claims are clinically proven and not exaggerated – an issue which is considered important by nearly three quarters (74 per cent) of consumers.

“The survey revealed a worrying statistic: only one in ten people under-stand the nutritional content of the food they are buying.

The survey also showed worrying statistics about the public’s dental product education.

“Providing consumers with more information about ingredients is a natural extension of our charitable work in this area. When you glance down the ingredients list of a typical toothpaste or mouthwash it is easy to see why people may have some difficulties. Even common ingredients like water may sometimes be described in terms that not everyone will understand such as ‘aqua’.

“We hope our new glossary of common ingredients will help more people to make an informed choice about which products to buy and how it can help their oral health. Consumers can also find a list of approved products on our website at www.dentalhealth.org,” said Dr Carter.
Editorial comment

M y stars – June already! If anyone knows where this year has gone can somebody please tell me!

The issue with tooth whitening seems to be rumbling on, with the BDA reportedly now having written to the Department for Business, Innovation and Skills, the body responsible for trading standards. The letter calls for talks to address the inconsistencies in the current situation and the way in which differing trading standards offices are enforcing the rules governing tooth bleaching products. Dental Tribune’s Laura Hatton has written an interesting article on the latest situation in this issue – go to pages nine and ten for more!

Also the Dispatches programme has roused much interest in dental circles, even if it does seem to only be in dental circles! DT has taken a retrospective look at the programme – pages 11-12 is the place to look.

Finally, let me know what you think on any issues relating to dentistry (or rugby for that matter – I love a good sports convol) get in touch and we may contact you for an opinion piece! Email me lisa@dentaltribuneuk.com, I’d love to hear from you.

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GDC announce Deputy Chair

The General Dental Council (GDC) has announced that Derek Prentice has been elected as Deputy Chair of the GDC.

Derek, who has been an appointed lay member of Council since 1999, is currently the managing director of a consultancy company and previously held a number of executive appointments, including assistant director with the Consumers’ Association and president of the Bureau of European Consumer Unions.

Derek has also held a number of non-executive positions within NHS bodies and is currently a trustee of The British Home – which is an independent charity that provides specialised nursing and social care for people with long term medical conditions and severe disabilities. He will hold the post of Deputy Chair of the GDC until a permanent Chair is elected by the GDC in September this year.

Derek said: “I am pleased to take up this position and I look forward to working with my fellow Council members and the Executive as we tackle the challenges facing the General Dental Council in the months ahead.”

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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, EC1N 8BA
Or email: lisa@dentaltribuneuk.com

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Group Editor
Lisa Townshend
Tel: 020 7400 8979
Lisa@dentaltribuneuk.com

Editorial Assistant
Laura Hatton
Tel: 020 7400 8981
laura.hatton@dentalt Tribuneuk.com

Clinical Editor
Liviu Steier

Advertising Director
Joe Aspis
Tel: 020 7400 8969
Joe@dentaltribuneuk.com

Design & Production
Ellena Harris
Tel: 020 7400 8961
Ellena@dentaltribuneuk.com

Dental Tribune UK Ltd
4th Floor, Treasure House, 19-21 Hatton Garden, London, EC1N 8BA
New Chief Dental Officer for Wales

The Chief Medical Officer for Wales, Dr Tony Jewell, has announced that David Thomas has been appointed as Wales’ new Chief Dental Officer.

Mr Thomas qualified as a dentist in Cardiff in 1976 and was appointed as Deputy Chief Dental Officer to the Welsh Government in 2010. Later in 2010 he was named Acting Chief Dental Officer (CDO) following the retirement of the previous CDO, Dr Paul Langmaid.

Thomas has taken up the role with immediate effect and is responsible for providing high quality and professional advice to Welsh Government Ministers in relation to dentistry policy, the practice of dentistry and the promotion of good oral health.

In a press release issued by the Welsh Assembly Government, Dr Jewell said: “I am pleased to announce the appointment of David Thomas as our new Chief Dental Officer for Wales.

“David brings to the role a background in community dentistry, dental public health as well as a record in academia, in both a management and research role. He has published widely in academic dental journals and has been involved in the management of Dental Postgraduate Education.

“I would like to thank David for his work as acting Chief Dental Officer since the retirement of Paul Langmaid, and look forward to working with him in his new role.”

Ancient teeth raise questions

DT USA: Eight small teeth found in an Israeli cave raise big questions about the earliest existence of humans and where we may have originated, Binghamton University anthropologist Rolf Quam says. Quam is part of an international team of researchers, led by Israel Hershowitz at Tel Aviv University, that has examined the dental discovery and recently published joint findings in the American Journal of Physical Anthropology.

Excavated at Qesem cave, a prehistoric site near Rosh Haain in central Israel that was uncovered in 2000, the teeth are similar in size and shape to those of modern man, Homo sapiens, which have been found at other sites in Israel, such as Oafreh and Skul – but they’re a lot older than any previously discovered remains.

“The Qesem teeth come from a time period between 200,000 and 400,000 years ago when human remains from the Middle East are very scarce,” Quam says. “We have numerous remains of Neanderthals and Homo sapiens from more recent times, that is around 60,000 to 150,000 years ago, but fossils from earlier time periods are rare. So these teeth are providing us with some new information about who the earlier occupants of this region were as well as their potential evolutionary relationships with the later fossils from this same region.”

The teeth also present new evidence as to where modern man might have originated. If the remains from Qesem can be linked directly to the Homo sapiens species, it could mean that modern man either originated in what is now Israel or may have migrated from Africa far earlier than is now thought.
Alcohol-related hospital admissions top one million

The number of admissions to hospital in England related to alcohol has topped one million, according to The NHS Information Centre’s annual report, Statistics on Alcohol: England 2011.

Statistics show there were 1,057,000 such admissions in 2009/10. This is up 12 per cent on the 2008/09 figure (945,500) and more than twice as many as in 2002/03 (510,800).

Of these admissions, nearly two thirds (65 per cent) were for men. Among all adults there were more admissions in the older age groups than in the younger age groups.

New prescriptions data shows that alcohol dependency cost the NHS £2.41 million in prescription items in 2010. This is up 1.4 per cent on the 2009 figure (£2.38 million) and up 40 per cent since 2005 (£1.72 million).

There were 160,181 prescription items issued for alcohol dependency per 100,000 of the population.

Regionally, the figures for prescription items per 100,000 of the population were highest in the North West (515 items) and North East (410 items) and lowest in London (150 items).

The data on alcohol related hospital admissions and new data on prescriptions is published in the report, along with previously published information from a range of sources about drinking behaviours and health outcomes in England.

The NHS Information Centre chief executive Tim Straughan said that the "report shows the number of people admitted to hospital each year for alcohol related problems has topped one million for the first time. The report also highlights the increasing cost of alcohol dependency to the NHS as the number of prescription items dispensed continues to rise."

"This report provides health professionals and policy makers with a useful picture of the health issues relating to alcohol use and misuse. It also highlights the importance of policy makers and health professionals in recognising and tackling alcohol misuse which in turn could lead to savings for the NHS."

Help make dental history

A project to build a comprehensive living history of dentistry, the John McLean Archive, is seeking participants from across the UK to help make dental history. Participants are required to take part in the project’s next witness seminar in October; and to take part in an ongoing series of oral history interviews across the UK.

The second witness seminar for the project, which will take place at the British Dental Association’s (BDA’s) London headquarters on 26 October 2011, will focus on changes in dentistry since 1948. Discussion is expected to concentrate on topics including the introduction of the NHS, payment and contracts, developments in equipment and evolution of private practice. Participants in the project’s first witness seminar, which took place in March and looked at the development of the regulation of dentistry, included past Presidents of the BDA and General Dental Council, three former deans of dental schools and a former dean of the Dental Faculty of the Royal College of Surgeons of Edinburgh.

It was chaired by Professor Nairn Wilson, Dean of King’s College London Dental Institute. Deliberations from each of the witness seminars will be published and placed in the John McLean Archive via the BDA Museum’s website: www.bda.org/museum.

Volunteers are also being sought to carry out oral history interviews with dentists and dental care professionals across the UK. The transcripts of these interviews, which will focus on different aspects of the development of dentistry, will also be published as part of the project.

Volunteers must have a connection to dentistry, good listening skills and an interest in history. Volunteers selected to take part will receive training in oral history and the use of the recording equipment that will be used in the interviews.

Individuals interested in participating in either strand of activity contact Sophie Riches, the John McLean Archive project co-ordinator at the BDA Museum. Telephone 020 7585 4549, email sophie.riches@bda.org or visit the BDA Museum stand at the 2011 British Dental Conference and Exhibition.

Could bullying be linked to dental appearance?

According to a report published in the latest issue of BDA’s Dental Journal (BJD), one in eight adolescents with prominent, or irregular shaped teeth have experienced bullying, with a negative impact on their self-esteem and quality of their oral health.

The authors, hospital-based orthodontic specialists, found that the children, aged between 10 and 14 years, were at an increased risk of being teased or bullied by their peers if they had certain dental features: these included maxillary overcrowding; a cleft lip, with or without a cleft palate; an overjet and a deep overbite (ie prominent teeth).

The specialists also expressed concern that psychosocial factors are not considered when assessing a child’s need for orthodontic treatment; although they acknowledged that the relationship between the shape of teeth, self-esteem and bullying is a complex one.

“Currently the severity and need for orthodontic treatment within the UK is judged on occlusal [bite] and aesthetic impairment without consideration of psychosocial factors,” warn the authors of the British Dental Journal report.

Commenting on the report’s findings, the British Dental Association’s Scientific Adviser, Prof Damien Waldmsley, said: “As studies show that having well-aligned teeth can influence our ability to make friends and progress in our careers, it’s not surprising that young children pick up on society’s ideal of what is perceived to be attractive early on.”

“Because prominent or irregular shaped teeth can affect a child’s self-esteem, or make them the subject of teasing or bullying at school, it’s important that these factors are taken into account when referrals for orthodontic treatment are considered.”

Bullying in schoolchildren - its relationship to dental appearance and psychosocial implications: an update for general dental practitioners, by J Seehra, JT Newton, and AT Dhiabiase, was published in the British Dental Journal, volume 210, No 9, May 14, 2011.
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A £10 on the day registration fee will be charged to visitors who do not secure tickets in advance. Advance registration closes 17 October 2011.
"Change is here to stay"  

Some of the brightest young minds in medicine and dentistry have gathered in Birmingham to discuss the impacts of changes to the National Health Service and how Wesleyan Medical Sickness can aid young doctors and dentists.

Wesleyan Medical Sickness’ Junior Advisory Board is made up of a select group of doctors, medical and dental students from across the UK. The group, the first of its kind in the financial services sector, provides insight into issues affecting young medical and dental professionals, ensuring Wesleyan continues to serve their needs through out their career.

Sally Lovell, Student Liaison Manager at Wesleyan, said: “Understanding our customers is an important part of what Wesleyan Medical Sickness does. The Junior Advisory Board provides a vital insight into the needs of young medical and dental professionals, meaning we can continuously improve our products and services.”

The Junior Advisory Board complements Wesleyan’s main Medical Sickness Advisory Board, which is made up of eminent members of the medical and dental profession, including Professor Parveen Kumar, past president of the British Medical Association and current president of the Royal Society of Medicine.

Dr Ben Attwood, president of the Junior Advisory Board and a registrar junior doctor working at Oxford Deanery, added: “I’ve been a policyholder with Wesleyan Medical Sickness since I was a medical student. I think there are a variety of pressures facing junior doctors and dental students these days and I think the members of the Junior Advisory Board can offer a unique insight into their wants and needs.

“There has been a huge increase in medical student debt by the time people qualify, as well as pressure in the early years trying to find a job. Those jobs are no longer for life and there’s absolutely no guarantee you will be able to follow the specialty you’d like to do or pursue it in the place you’d like to work. This can be really challenging for young graduates, which is why they need support from organisations that have an understanding of what they are going through. This is where we on Wesleyan’s advisory boards can help.”

The meeting was held at Wesleyan’s head office in central Birmingham. The Junior Advisory Board meets in Birmingham

Dean honoured at Brescia

The Dean of King’s College London, Professor Nairn Wilson, has been honoured by the University of Brescia with the conferment of the title of Cultore Dell’A坐在elle delle discipline Odontostomatologiche – the University’s equivalent of Visiting Professor, during his attendance at the most successful ninth Anglo-Italian Colloquium held in Brescia between 5 and 8 May.

Regarding his new title, Professor Wilson said in King’s College London press release: “I am deeply honoured to have had the title of Cultore Dell’A坐在elle delle discipline Odontostomatologiche conferred on me by the University of Brescia. This is a tremendous accolade, which I will greatly treasure. I wish the highly successful, long-established collaboration between the Dental Institute and the Dental School of the University of Brescia every success in the future.

I will endeavour to attend the special celebrations being planned for 2012 to mark the tenth anniversary of the launch of the now truly international annual Anglo-Italian Colloquium.”

An honest British Smile for start of 2011

In a letter to the Dental Tribune, Dr Ben Attwood, president of BDA, said: “The work to change our logo and adjust our messaging represents us entering a phase when we will honour and continue all that has been achieved at Bukumbi, whilst actively pursuing expansion of the DVP and emergency dental training, which has become the larger part of what we do. While our targets are ambitious, we have all been overwhelmed by the support shown by the profession and look forward to the next phase of B2A.”

Showcasing a new logo and a stronger message that stretches throughout the world, B2A demonstrates their commitment to the future. With B2A Founder Dr Ian Wilson returning to the UK, the dental charity will be taking leaps and bounds forward over the coming months and years and calls on the profession for their ongoing support to help in their quest to free the world from dental pain.

To find out how you can support B2A further or for more details on their Dental Volunteer Programme contact Ruth Bowyer, Visits Administrator, on 07748 645006 or email her at Ruth@bridge2aid.org. Alternatively visit www.bridge2aid.org to download an application form.

The members of the Wesleyan Medical Sickness Junior Advisory Board, Michelle Baker, Kristina Kauermann, Holly Morgan, Nia Chapera, Ben Attwood, Emily Taylor, Aannah Busuttil, Kyle Gibson, Natalie Crawford and Kieran Zucker.
Lansley at the BDA

Not at the BDA this year? Couldn’t get to Secretary of State for Health Andrew Lansley’s speech on dentistry? Don’t worry, Dental Tribune has the highlights...

The welcome: As you all know we are in the middle of a listening exercise, so we can ensure that the reforms and the modernisation of the NHS, to take the views of the clinicians, patients and the public, so we can absolutely make sure that we have a legislative framework and a structure of modernisation that supports the objectives that we all subscribed to. When we talk about putting the patients at the heart of what we do or focusing on outcomes and evolving the responsibility to those clinicians who have care of patients – that is the basis of the agreement.

I have been Shadow/Secretary of State for seven years, and this experience has given me the view that there is a very chequered history of dental reforms. With regards to the listening exercise on the Health and Social Care Bill – whilst the Bill itself does not directly affect what we’re doing in relation to dental contracts we will of course in the future introduce legislation to reform the contract and the charging system for dentistry. So we do have to be sure that the reformed dental contract is a good fit with the NHS structures that are being developed through the health and social care bill and in particular the new commissioning arrangements.

NHS Commissioning Board: We intend that the new NHS commissioning board will commission all dental services, and I think I’m right in saying that this is very broadly welcomed. Some primary care trusts have worked innovatively and constructively to commission better services. But I also know that the different approaches taken by different PCTs has been frustrating for everybody, especially dental professionals.

Sir David Nicholson will be the Chief Executive of the new NHS Commissioning Board was recently here in the North West meeting dentists to discuss how they thought commissioning could be developed to support the objectives that we have of putting the patients at the heart of the NHS, to take the views of the profession. And that core consistency offers real opportunities to the patients, to exercise real choice in relation to dental services.

The constructive engagement we had with the dental profession and indeed with the BDA, for which I and my colleagues are very grateful, has contrasts sharply with the atmosphere of hostility and anger that had developed at the previous dental reform programme. I think there are important lessons of dentistry that we can learn from a whole NHS modernisation programme. We are working with clinicians on dental reform whereas previously reform was imposed on the profession.

More than anyone else, you the clinician, know what is right for your patients and I want to engage with you as it’s how we take forward the reforms of dentistry and it is how we are taking forward wider reforms across the National Health Service.

The changes we are making are essential, but it’s vital that we take the clinicians with us for the long term benefit of patients. We have to develop a system be it in dentistry or wider healthcare, that will measure success by outcomes and tells us to what extent we are improving the health of individuals and the wider population, not just how process indicators have been achieved.

Dental public health: At either end of the age spectrum, the overall oral health in this country is amongst the best in the world. The recent Adult Dental Health Survey and Child Dental Epidemiology programme results shows that around 70 per cent of adults were free of active tooth decay and that nearly 70 per cent of children who suffered from tooth decay, do suffer from tooth decay, do suffer from tooth decay, do suffer from tooth decay. That’s great news, and it tells us we’re right to be seeking to use dental contract reforms to move clinical practice in the direction of continuing care and prevention. But it also shows that the 50 per cent of children who suffer from tooth decay, do suffer from tooth decay, do suffer from tooth decay. That’s great news, and it tells us we’re right to be seeking to use dental contract reforms to move clinical practice in the direction of continuing care and prevention. But it also shows that the 50 per cent of children who suffer from tooth decay, do suffer from tooth decay.

Registration – to reassure patients that they have guaranteed continuity of care and to clearly divide the responsibilities of dentists and their patients.

Capitation – to take the perverse incentives of an activity based system out of the NHS, to focus on good oral health and preventative work and to really for the first time get dentists off the treadmill.

Quality – providing high quality services to patients is a key aim of all our NHS reforms. Measuring quality can be difficult but it is an essential element of the pilots. Finding out if we can really identify how quality indicators help us ensure that we can improve the outcomes of all the patients.

The constructive engagement we had with the dental profession and indeed with the BDA, for which I and my colleagues are very grateful, has contrasts sharply with the atmosphere of hostility and anger that had developed at the previous dental reform programme. I think there are important lessons of dentistry that we can learn from a whole NHS modernisation programme. We are working with clinicians on dental reform whereas previously reform was imposed on the profession.

So by taking responsibility for all dental services in one place, with the NHS commissioning board we have a greater opportunity to integrate primary and secondary care dental services and to bring a far greater degree of consistency to dental commissioning.

Under our proposals, local authorities, through their health and well-being boards, will need to produce joint strategic lead assessments. So the commissioning board will then develop services that do respond to locally identified leads, at the same time bringing consistency across the country in for the profession. And that core consistency offers real opportunities to the patients, to exercise real choice in relation to dental services.

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Here in the North West the extraction of teeth is the biggest reason why children are subjected to a general anaesthetic. We need to focus our services more on prevention, both for children and adults, whilst at the same time maintaining the good oral health of that majority.

This coalition government has made a clear commitment to improve the oral health of children, this does not only mean dentists, we need to work across the spectrum, in education, social care and the wider medical fraternity, proactively tackling the inequalities on oral health.

I know that my colleague Freddie Howe has been impressed when he has visited schemes, where everyone - local authorities, dental practitioners, consultants and health visitors - have come together to really tackle oral health promotion. And I would like to take this opportunity to give my thanks to the people that are leading this vital work and schemes that support them.

**Access to dental services:**

You may be aware that the latest data on dental access was published yesterday; when the coalition government came to power a year ago access to NHS dentistry has increased to 651,000 and it is a credit to all of you and the NHS that this has been achieved at a time when we are also moving forward rapidly with changes of the NHS.

Access is a really significant issue and we all know that. We want to see access improved further. But it is important, vital, that people have access to a high quality, lead-based, outcome-focused service, one that offers patients an excellent experience, one that offers prevention and a reasonable financial award and a satisfaction of knowing you have improved people's lives and knowledge that you are offering value for money on the NHS.

As a government, we can take pride for that being achieved; I think even more importantly as a profession I know you will take pride and care in delivering it.

**The future:**

My aim, I believe yours to, is to work to create an NHS dental service that is the envy of the world, that helps build on and maintain improving oral health of the majority of the population, whilst seeking out and tackling inequality, and finding that minority where we have not yet achieved it.

I believe that our contract reforms, taken together with NHS modernisation, will give dentists working for the NHS more complete working lives, reduce the burden of bureaucracy and the inconsistency of commissioning, that many of you have complained about in the past.

The fact that we are today here, at this conference, a matter of weeks away from the start of piloting the new NHS contracts, very much reflects the engaging commitment over the last year between the profession and ourselves. I want to say thank you to the BDA for that engagement. I think it's been constructive and positive, immensely helpful and I thank you all for it.

**Lansley:** “It is important, vital, that people have access to a high quality, lead-based, outcome-focused service”

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**DT**

• Were you at Mr Lansley’s speech? What were your thoughts? Email Lisa@dentaltribuneuk.com
Tooth whitening products have been at the centre of much speculation and discussion throughout Europe for many years. The view as to whether whitening products fall into the category of cosmetics or are in fact a “medical device” remains a divided and undecided one between the UK and Europe.

During recent years several cases that went to court backed by scientific papers failed to change the opinion of the UK courts and the fact remains that in the UK under the 1976 Cosmetics Directive Council directive 76/768/EEC provides in Annex III, part 1, n°12 a, whitening products do not fall under “medical devices” and therefore cannot exceed a stated dose of 0.1 per cent hydrogen peroxide. Following a House of Lords Judgement in June 2001, all tooth whitening products are considered to be cosmetics and not medical devices. The Cosmetic Directive does not require CE marking.

One argument that has been brought to the retailers’ attention from one dental supplier is that the commonly used concentration of 10 per cent carbamide peroxide releases about three per cent of hydrogen peroxide; however, using a product with 0.1 per cent available hydrogen peroxide is unlikely to be an effective tooth whitening agent. As a result, many UK products have about three per cent or more and so are currently, under the legal requirements, illegal.

With this in mind, the recent whitening issue that has come to light is once again causing grave concern for dentists throughout the country.

Earlier this year in January 2011, a patient complained to a dentist about their tooth whitening treatment; the issue was brought to the attention of the Trading Standards Authority (TSA), and the Trading Standards Officer informed the dentist to stop offering tooth whitening and forced his dental supplier to stop selling tooth whitening products altogether: the case is threatening to reach the courts.

The consequence of this situation has resulted in a sudden suspension from dental suppliers in supplying whitening products. However, the ‘blind eye’ and the distribution of prescription whitening treatment has continued. It would seem that it all comes down to interpretation.

Speaking to Chris Wilson, City Trading Standards Manager, he was only able to say on the current situation that: “Our inquiries are continuing and we cannot comment further until legal proceedings have been completed.”

With no clarity regarding the situation, the position that dentists are finding themselves in is an alarming one; as they must consider whether to continue providing the popular cosmetic treatment or to cease using it.

Speaking to Dr Wyman Chan, a dedicated teeth whitening dentist from Smile Studio, London, it was noted that the UK is the only country in the world where it is essentially illegal to practice tooth whitening because anything which has a percentage of hydrogen peroxide of more than 0.1 per cent is classed as illegal.

Speaking on the origins of the law, Dr Chan pointed out that originally the regulation under the EEC Cosmetic Directive was designed to regulate substances provided to patients for treatment it is a case of the products are prescribed to patients and NOT supplied to patients.

To solve the confusion and the issue that dentists are being confronted with on a daily basis, Dr Chan believes that the ideal situation would be for a Trading Standards Officer to take him to court to present a test case. Currently, the law can be interpreted differently, as Dr Chan has experienced, and Trading Standards Officers have the power to read into the law as they see fit; this means varying results for dentists across the country if they are brought to the attention of the Trading Standards Authority.

As Dr Chan argues, if the dispute of the law is taken to court, there would be no more doubts and whitening products can be reclassified to their correct field.

With the threat of the above case looming over many dental practices and dental suppliers, could it be that tooth whitening will soon be a forgotten treatment? Considering that according to a poll of dentists of the American Academy of Cosmetic Dentistry (AACD), whitening is a trend that will continue to rise throughout 2011: This current case could not have come at a more inappropriate time. The poll recorded that AACD members performed an average of 77 whitening treatments last year, and 57 per cent said that they expect this number to increase.

Dental Tribune looks at the current whitening debate

We’re prescribing, not supplying

“When tooth whitening products are provided to patients for treatment it is a case of the products are prescribed to patients and NOT supplied to patients.”

As Dr Chan explained, tooth whitening products do not fall into the category of an OTC oral hygiene product.

Delving further into the debate, into yet another area of the law that remains grey and obscure, Dr Chan stressed that when tooth whitening products are provided to patients for treatment it is a case of the products are prescribed to patients and NOT supplied to patients.
that they expect this number to increase.

Quoted on the CODE website, Paul Mendlesohn said of the situation: “This messy legal situation has been going on for too long, whilst we can understand that it may take years for Europe to sort out its mistake, we can take a simple national action now for a local solution. The national coordinating authority for local authority regulation called LACORS could solve out this problem easily by informing Trading Standards to take low-key approach as they did in 2004 and subsequently withdrew in 2006.

“Encouraging LACORS to take action should be our main focus; we must lobby LACORS directly and indirectly. “It is my view that should there be prosecutions, dentists will stop providing tooth whitening altogether. But the huge patient demand for this effective, minimum intervention treatment will open the floodgates to its provision by non-qualified therapists, many of whom will use unsuitable or untested products.

“This poses a huge risk to the health of the public, which in turn could bring a substantial cost to the NHS for remedial treatment.”

Dental Protection said on the situation: “On the information currently available to Dental Protection from the members involved, and from our discussions with the dental materials distributors and from discussions it would appear that Trading Standards’ interest lies primarily in pursuing supply companies rather than individual registered practitioners.

“We have also checked the position with the relevant contact person within Local Government Regulation (formerly “LACORS” the Local Authorities Coordinators of Regulatory Services), as part of the Local Government Group, which is the local government central body responsible for overseeing local authority regulatory and related services in the UK.

“We are assured that the underlying position in terms of the legislation, regulation and co-ordination of the approach to the supply of these products is actually unchanged.

“The national coordinating authority for local authority regulation called LACORS could solve out this problem easily by informing Trading Standards to take low-key approach as they did in 2004.

“Many dental professionals have expressed concern about unregistered individuals providing tooth whitening from unregulated premises. On the 5th May 2011, BBC Breakfast TV and Radio 5 live ran a story highlighting the dangers of seeking tooth whitening treatments from unregistered individuals and reported that the GDC had successfully prosecuted the director of a national chain of tooth whitening salons.

“The Chief Executive and Registrar of the GDC appeared on these programmes and confirmed that in the view of the GDC, tooth whitening amounted to the practice of dentistry.

“In view of the recent publicity surrounding the provision of tooth whitening by unregistered individuals it is possible that Trading Standards’ actions are targeted at these individuals and supply companies rather than registered dental professionals, although this remains a matter of conjecture based on recent events.”
Did Channel 4 Dispatch the truth?

*Dental Tribune* looks at the latest programme to highlight NHS dentistry

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**S**o, *The Truth About Your Dentist* has been aired and become the topic of many a conversation between colleagues in the dental practice.

The Channel 4 Dispatches programme was broadcast last month and attracted a combined viewing of approximately 1.1m people between the original broadcast and +1. Despite the original misgivings of many within the profession, the programme was not the dentist bashing one-sided affair that was expected – in fact may dental professionals have said that it has helped to draw attention to some of the flaws of the Unit of Dental Activity (UDA) remuneration system.

*Dental Tribune* has spoken to some of the dentists who appeared on the programme, as well as receiving comment from dental professionals.

**No sensationalist negativity**

Dr Gareth McAleer, dental practitioner and contributor to the Dispatches programme, commented: “There were several dentists involved in the making of the programme. We wanted to make sure there was none of the sensationalist negativity often seen with other programmes; this is often because the profession doesn’t get involved in the making of programmes such as these and so there is often only one side presented.

“In my opinion there seems to have been a lot of research done in the beginning; first the filmmakers called a number of practices, and then chose practices to send mystery shoppers to. As the research progressed, it was obvious to the filmmakers that they were indeed on to something.”

Dr McAleer was full of praise for his dental colleagues who agreed to be part of the programme and give the profession a voice: “It was great that the dentists who came onto the programme didn’t hold back explaining the problems of the system – this gave the programme balance. There was a lot of negativity from certain members of the profession before the programme came out – they didn’t give it a chance.

**Honesty and integrity**

“The reason the dentists featured were chosen were because they came across with a depth of honesty and integrity, showing that not all dental professionals were like those who had been filmed in their practices. This was to let the public see that although there are some dentists who are not wholly ethical, there are plenty out there who are.”

Dr McAleer also gave his opinion about the current state of NHS dentistry: “I believe the government needs to listen to what dentists are telling them; we told them in 2000 that the system would fail, and if they don’t listen to dentists now, that there needs to be a completely new system implemented for NHS dentistry to work, then it is a criminal waste of time and money piloting a system that simply isn’t designed to deliver complex or time-consuming dental care, such as molar endodontics or prolonged periodontal gum treatments, let alone additional time for important areas such as prevention.”

Kilcoyne said that all comments given at interview were his own personal opinion and done in isolation to other parts of the programme, so until it was broadcast he wasn’t sure if, or what, would be included in the final programme.

“Whilst the adverts for it focussed on the title, *The Truth about Your Dentist* several days beforehand, the expectation was that this would highlight dentists as being the worst culprit for the continuous problems that beset NHS dentistry in England. However whilst the programme raised concerns whether some dentists offered everything the NHS contract requires, an equally strong theme was the failings of the existing UDA system itself, which simply isn’t designed to deliver complex or time-consuming dental care, such as molar endodontics or prolonged periodontal gum treatments, let alone additional time for important areas such as prevention.”

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Terrific statistics
Dr Kilcoyne continued: “I was really pleased the programme directors left in my comments about the terrific statistics which show the third commonest reason for people in England, we must avoid some public criticism for doing this.”

“Thus whilst I then think prevention needs to be provided to a higher standard than we ever had with over treatment or two and a loose CoCr dentists since this is what is thought to attract audiences. The undergraduate element was understood and used in investigative journalism. The dentists recorded were ‘bending the rules’ but the dentist pronouncing on their conduct could have been more balanced and discussed the role of the NHS contract in encouraging such behaviour.

‘Feedback from colleagues is that the programme was unbiased for RCT and patient with perhaps two or three failing crowns and a broken filling or two and a loose CoCr dentists since this is what is thought to attract audiences.’

Having watched the programme, dentist lan Gordon said: “It is often uncomfortable for a profession to be subjected to journalistically scrutiny. It takes real courage to be interviewed for a programme such as Dispatches, there is always the risk of being misrepresented.”

To avoid this, the programme was balanced and discussed the contribution has been generally favourable, in that it was considered professional, provided some balance and the presentation was truthful and accurate. I have received no direct feedback on the programme from patients but 1 have contact. I also make requests for your help from patients experiencing dental problems! I understand that feedback from the dental environment is the public perception of the programme was balanced and discussed the contribution has been favourable and much discussed on Facebook (apparently) but they expressed concern that the programme provided an unbalanced view.”

Right up to the point when the Coalition criticised the contract, with good reason, for all its failings. He listened but never acted to improve the contract. In fact, in de-plussing, he evoked the future more, and less more dealing with dental care. In the future, we need to stop patients accessing the dental service. Deskilling, supervised neglect, gaming, PCT inflexibility... it was all obvious.

“However change is at least three years away, three years of the same contract, UDA and tariff. The programme is unfair, but other than that the gaming was dealt with very well. This is more rare than many are prepared to admit.

Agressive stance
“I feel that those who are providing for example scales privately rather than on the NHS should not have signed the new contract. You cannot have your cake and eat it, and I feel the PCTs should have taken a more aggressive stance in the past to stamp out this gaming. I hope now that this is stamped out, and the practices that are doing this realise that instead of hiding behind the lack of knowledge of the public, they become open and honest about what is funding the treatment and how.

He added: “I am also concerned that the concept of full lists is being used to stop patients accessing the service. There is no registration, but you must have a full list. If a patient needs a dentist you need to take them on as a patient. This is the reason why I refused to sign the contract and converted in 2005. But in any event you cannot do this without a prescription. The title of the programme was unfair, but other than that the gaming was dealt with very well. This is more rare than many are prepared to admit.

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Make or break social marketing

Rita Zamora explains how to thrive in a digital ‘word of mouth’ world

Word of mouth has forever changed. It used to be that a friend would recommend your practice to another friend, and you’d likely receive a new patient referral. Today, on the internet at our fingertips, potential patients have evolved to become voracious researchers. This appetite for volumes of information before making purchase decisions has made it more important than ever for you to change the way you’ve marketed—both on and offline.

Patients researching a dentist will not only expect you to have a website, they will also want to see what other information is available about you. In fact, they may even want to know what their friends, and the friends of their friends, also think of you. Consider for a moment how important ratings and details have become in the book and travel markets. People not only want to see photos of the hotel they are considering, they may also want to see video, comments from recent travelers, and they may search out several other sites to compare information.

This high level of research is not only being done by those “seeking out the best deal”, MarketTools recently revealed a study indicating affluent visitors with annual incomes of more than $75K are most likely to research products online before buying (45 per cent). While the power of personal recommendations and word of mouth will live on, consumers now want to view as much information as possible before making decisions about buying everything from hotel rooms to healthcare.

Now is an ideal time to consider whether your website needs remodelling. Does your website represent your practice and your brand? Does your website appear properly on mobile devices? In a recent study by Tecmark, almost 15 per cent of UK web traffic is of mobile origin. Mobile internet usage continues to skyrocket. It’s vital your website be positioned well for this growing market. Imagine someone referring their friend to your practice during a conversation at a coffee shop. Their friend pulls out their smartphone to Google you on the spot... If your website isn’t findable, functional or viewable, your inability to be researched may hurt your chances of gaining a new patient.

Remember that upon referral, potential new patients want to be able to find you easily. They may also want to know what to expect when they see you, sitting in your dental chair, receive treatment, or settle their bill. Expect when they see you, sitting in your dental chair, receive treatment, or settle their bill. They will not only expect you to have a website, they will also want to see photos of the hotel they are considering, they may also want to see video, comments from recent travelers, and they may search out several other sites to compare information.

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Remember that upon referral, potential new patients want to be able to find you easily. They may also want to know what to expect when they see you, sitting in your dental chair, receive treatment, or settle their bill. With that said, it is important for you to have a good website, plenty of photos, and video with tours of what to expect in your practice ... In addition,
be sure you have reviews/testimonials in a variety of online locations (again, to make yourself easily found in Google search).

Most importantly, if you aren’t already on board, research what you need to get your practice on Facebook. The Facebook platform has replaced ambient noise, which used to be filled by television or radio in many homes. Often, users of the enormously popular social network will have Facebook open and readily available throughout the day on their computer or their phone. It has already become a great source of testimonials and powerful, amplified word of mouth for many practices.

Make or break marketing
With that said, understand that without proper systems in place (primarily word of mouth in your office) your Facebook efforts may fail. Social marketing is not a “build it and they will come” tactic. For example, a traditional magazine adver- required you to build your ad, pay for it and then sit and wait for it to work. Social media marketing requires ongoing effort—like maintaining a garden. You’ll always need to tend to it or it will die.

Practices well versed in referral marketing strategies, those who understand what it takes to make traditional word of mouth succeed, will likely find Facebook a remarkable opportunity. On the other hand, those practices looking for fast fixes, immediate floods of new patients, or those who practice on-and-off “when we have time” marketing will be quickly disappointed in social marketing.

It’s happening already. Check out Facebook, and you’ll find dozens of abandoned dental practice pages. Pages were created, and for whatever reason were left ignored. Most commonly I hear, “We just don’t have time”, “We don’t know what to say”, “If it didn’t work”, etc. Here are a few successful traditional word of mouth marketing elements that will also help you sustain your social media efforts:

- Have a plan in place: Identify your goals and objectives
- Communicate well
- Be sociable, friendly and personable (yet you don’t have to abandon privacy).
- Be yourself—authenticity is in
- Make one specific person in your office responsible for regularly maintaining and monitoring your efforts (it helps if they are people oriented, motivated—and for social media, have good web 2.0 skills)
- Be patient

Social marketing efforts will build results for the long term. As with referral and traditional word of mouth marketing, your returns will reflect the effort you invest. Consider the theory of inviting referrals and the same applies to asking patients to “like” you on Facebook. Talk to your patients, make yourself easily found in Google, and ensure your web presence portrays you properly. Place your focus on building quality relationships in highly visible online communities and you are sure to succeed in today’s digital word of mouth world.

Mobile phones can be at the centre for sound monitoring

About the author
Rita Zamora is an international social media marketing consultant and speaker. She and her team actively co-manage dozens of dental practices’ social media programs. Her clients are located across the United States and internationally. She has been published in many professional publications. Rita is also Honorary Vice President to the British Dental Practice Managers Association. Learn more at www.DentalRelationshipMarketing.com or email rita@rita-zamora.com.
What should have been a simple task has turned into a frustrating task. Several calls made to different bodies gave me different answers causing me to be confused as to the correct process to apply for Enhanced CRBs for our dental care practitioners and providers; confusing me rather easy to do these days with all the changes that are going on as well as trying to run successful dental practices! Not one person gave me a complete rundown as to how to apply for Enhanced CRBs for dental care providers in one go outside of CQC!

You would have thought that I would have learned my lesson when trying to implement the Medical Device Directives into the group! It is so important to source the correct person to talk to when dealing with any new implementations if you are not sure of what you are expected to do in the first place.

To make the application process easier for those of you who are still in the process I will break it down in point format what it is that you have to do to apply for Enhanced CRBs for general dental practitioners and providers.

Also be aware that any criminal record checks that were carried out prior to 2006 are no longer valid. You get two types of CRBs. The CRB that all dental care providers are required to have are ENHANCED CRB’s due to working with vulnerable people. I believe that some PCTs are carrying out the CRBs on behalf of their practices and are charging a fee, so it is worth making a call to them to find out. However, some may not as they are now short staffed due to cuts in staffing numbers and can’t handle the extra work load.

As you know, if you are a proprietor or in a position of responsibility, such as a

Make us better, not bitter
Sharon Holmes discusses how to make applications for Enhanced CRBs easy

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Applications for an Enhanced CRB check can take up to six weeks.
Becoming compliant can seem like a challenging mountain to climb for people in senior roles.

If you are an NHS practice you can call your PCT and they can inform you of the umbrella company that they use as you would be reassured they are reputable and that the fee will be fair. You could also use a recommend company from a reputable source as I have done.

You can go onto the Home Office web site homeoffice.gov.uk/crb and search umbrella company and it will bring up a list of recommended umbrella companies which are best to use.

It is much less complicated and simple to apply for E CRBs for general dental practitioners and providers as opposed to proprietors and personnel in senior roles.

Step by step all you need to do is:

1. Only a registered CQC manager can call the umbrella company as they have had an Enhanced CRB carried out already therefore you have clearance.

If you are an NHS practice you can call your PCT and they can inform you of the umbrella company that they use as you would be reassured they are reputable and that the fee will be fair. You could also use a recommend company from a reputable source as I have done.

2. You need to have your Enhanced CRB number at hand as they will ask you for this.

You can go onto the Home Office web site homeoffice.gov.uk/crb and search umbrella company and it will bring up a list of recommended umbrella companies which are best to use.

3. Once you have called the umbrella company they will send you out an information pack as well as the application forms that you have applied for.

Make sure that you carry out an audit beforehand so that you apply for the correct amount of forms to avoid delays due to errors and to make sure you collect the correct fees if your associates/hygienist are paying for their own CRBs to be done.

4. The umbrella company will apply for your CRB checks through the Criminal Records Bureau.

5. The application takes approximately six weeks although some are going through within three weeks.

6. The applicant will receive their Enhanced CRB to their home address therefore they will have to bring a copy to the practice so it can be kept on file.

As for the rest of your complaints and the elements required on the forms to avoid delays due to errors and to make sure you collect the correct fees if your associates/hygienist are paying for their own CRBs to be done.

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Motivational interviewing

Mhari Coxon discusses trying a different approach to changing your patient's habits

My main role as a hygienist is education of patients to prevent dental disease. I used to use the advisory model of giving information out in large paragraphs to patients without finding out if they were ready for this change. I now use motivational interviewing to great success in my clinical day and in my home life too.

This form of interviewing is free and not scripted. Scripts have their place but it is my feeling that we all have amazing, genuine people skills that would be stunted if we try to conform to a set learned vocabulary. I personally believe that this is health care and ethical selling at its best as it is genuine. We are listening and then forming the best way forward for the individual at that point. Once the connection is there the initial sell (of health and elective treatment), reselling and future selling is very simple. It doesn’t even feel like selling.

Communication is key

By incorporating effective communication techniques into daily patient interactions, all the team can increase treatment uptake and decrease complaints. More importantly, as clinicians we can positively and effectively impact patient health outcomes without increasing the length of visit—a win-win situation for both parties, and indeed the goal of healthcare.

Motivation is key to change, and can be influenced by social interactions and the clinician’s style and can be modified

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Motivation is key to change, and can be influenced by social interactions and the clinician’s style and can be modified. When selling treatment, if the patient is not motivated to change or ‘buy’ then you will not close your sale and run the risk of appearing pushy. It is the team, and in particular the three nurses, who will develop motivation and interest from the patient.

Motivational interviewing (MI) is a cognitive–behavioural technique that aims to help clients identify and change behaviours and opinions. This form of influencing is subtle but very effective and will grow the trust required for patients to return and recommend. Essentially we are using the patient’s ownership and awareness of health developing as a tool to treatment uptake. We need to understand the patient’s journey to treatment acceptance to be able to guide them.

The Nuts and Bolts Questions – opening the conversation – permission to communicate

We have to decide whether the patient is interested in communicating before we launch into education about treatment and health. I have put some examples below that will help you to decide what we want to ask.

Do you mind if we spend a few minutes talking about your ________________?

What do you know about ________________?

Are you interested in learning more about ________________?

Miller and Rollnick conclude that MI has five basic principles:

• express empathy
• avoid argument
• support self-efficacy
• roll with resistance
• develop discrepancy

Empathy is sincere – and successful – when a patient acknowledges that he or she has been seen, heard, and accepted as a person.

Barriers to empathy include:

• Using medical terminology
• Confusing sympathy with empathy
• Feeling that it takes too much time
• Effective empathy can be exhibited by:
  • Greeting the client on neutral territory; ie the waiting room
  • Keep on an even eye level with maintained eye contact
  • Avoid physical barriers
  • Reflective speech - Repeat in-

Incorporate effective communication techniques into daily patient interaction

‘Motivation is key to change, and can be influenced by social interactions and the clinician’s style and can be modified’

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BA678UK KaVo fitting with light £479 £429
BA678LS Sirona fitting with light £479 £429
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BA675L “S” Medium Head
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BA670LN NSK fitting with light £484

BA685L “S” Mini Head
BA685UK KaVo fitting with light £479 £429
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formation in patients own language
- Share experiences/anecdotes (where appropriate and never in a prolonged way)
- Accept patients thoughts and feelings
- Reserve judgement
- Use ‘hear’ ‘see’ ‘tell’
- Open and closed questions
- Closed questions often lead to yes/no responses and the question/answer trap
- Open Questions usually allow the clients to tell their story and they permit a better understanding of the issues.

Avoid argument
Patients can be uncomfortable or nervous and this can result in
- Aggressive behaviour
- Derogatory comments
- Negative listening
- You feeling STRESSED!!!!!!

Only when it is the client, not the clinician, who voices arguments for change can progress be made. The goal is to “walk” with the clients (ie, accompany clients through treatment) not “drag” them along (ie, direct clients’ treatment).

This does not mean we should not provide advice and support, rather that we should not dictate our opinions to the patient.

Roll with resistance
Adjusting to resistance is similar to avoiding argument in that it offers another chance for the clinician to express empathy by remaining nonjudgmental and respectful, encouraging the client to talk, and to stay involved.

The clinician should avoid evoking resistance whenever possible, and divert or deflect the energy the client is investing in resistance toward positive change.

The simplest approach to responding to resistance is with non-resistance by repeating the client’s statement in a neutral form. This acknowledges and validates what the client has said and can elicit an opposing response. This simple reflection is very effective.

You can also defuse resistance by helping the client shift focus away from obstacles and barriers. This method offers an opportunity to affirm your client’s personal choice regarding the conduct of his own life.

Develop discrepancy
Separate the behaviour from the person and help the client explore how important personal goals (eg, good health, fresh breath, straight teeth, and whiter smile) are being undermined by current patterns.

This requires the clinician to listen to the client carefully about values.

The questions below are ways of evoking change in the patient. This is an important phase of discussion and can increase treatment uptake as well as improving health.

1. What would you like to see different about your current situation?
2. What makes you think you need to change?
3. Why are you concerned about your health situation/appearance?
4. What things will be different if you don’t change?

Try throwing these open questions into conversation with your patients then listen, without interruption to the answers. See if you can spot the internal discussion the patient has as they decide how they feel about things and decide if they are ready to change, have treatment, and alter their behaviour.

About the author
Mhari Coxon is a dental hygienist practising in Central London. She is chairman of the London British Society of Dental Hygiene and Therapy (BSDHT) regional group and is on the publications committee of its journal, Dental Health. She is also clinical director of CPDforDCPs, which provides the CPD courses for all DCPs. To contact her, email mhari.coxon@cpdfordcp.co.uk.
Undoubtedly, digital volume tomography has significantly expanded the range of dental imaging diagnostics. Just as Paatero ushered in a new era of dental radiology at the end of the 1950s with the development of the ortho-pantomograph and the resulting introduction of panoramic view imaging, 3-D processes will, in turn, replace panoramic view imaging.

Although digital volume tomography has to date been mostly used for pre-implantological planning and in reconstructive surgery, now other dental disciplines are beginning to appreciate the value of this process. It is in orthodontics, endodontics, dental surgery and periodontics that digital volume tomography represents a significant improvement of the possibilities of imaging processes. Its significance in the current domain, pre-implantological diagnostics, can be assessed as even greater.

Available digital volume tomographs
Digital volume tomographs (DVTs) have been on the market for a good decade, and the number of suppliers of such devices has increased dramatically.

When observing the device market, two clear trends are evident: the trend towards an all-in-one device (also called dual use) and the trend towards DVTs of various volumes.

All-in-one devices
In addition to offering 3-D diagnostics, the majority of DVTs available on the market also provide the option of producing panoramic view images (real images, not reconstructed from a data record) and sometimes even lateral cephalogram. These devices thus cover the entire range of dental large-scale diagnostics—in contrast with the first generation, which only offered the DVT option.

The DVTs of today’s generation are often similar in design and appearance to traditional DVTs.

The position of the patient with these and other frame devices is typically standing or sitting, while the once dominant supine patient position of the first-generation device is passé, except for that required by one DVT manufacturer.

Use of an X-ray phantom in dental 3-D diagnostics in digital volume tomographs
Dr Georg Bach, Christian Müller & Alexander Rottler discuss 3-D diagnostic techniques

“The position of the patient with these and other frame devices is typically standing or sitting, while the once dominant supine patient position of the first-generation device is passé, except for that required by one DVT manufacturer.”
Various volumes
The first-generation devices featured very large volumes that required time-consuming reworking of the immense data record for problems beyond large and reconstructive surgery in order to be able to evaluate the relevant data and/or regions in a target-oriented manner. Today, numerous manufacturers offer devices with small and medium-sized volumes. Three types of devices are available:
• small volume (4 x 5 cm) for oral surgery and dental procedures
• medium-sized volume (8 x 10 cm and higher) for oral surgery and reconstructive surgery
• large volume (18 x 20 cm and higher) for oral surgery and reconstructive surgery

Problems with small and medium-sized volume devices
Small- and medium-sized volume devices are generally used for preimplantological diagnostics, oral surgery, and orthodontic and endodontic procedures. The limited volume size requires careful device setting and patient positioning so that the relevant structure is accurately captured.

For new users and those who only take volume tomosgrams once in a while, this correct setting can pose difficulties, which was our motivation for developing a DVT phantom that can be used for training purposes and for direct preparation of an image with a patient.

The DVT phantom and its application
The DVT phantom is an X-ray phantom that depicts a medium-sized mandibular and maxillary dental arch with the teeth positioned in ideal dentition.

The phantom, which consists of a mandible and maxilla, is mounted on the individual bite or positioning support of the respective device.

Barium sulphate is added to the plastic teeth so that they are visible in the X-ray image. These teeth are made by the manufacturer especially for X-ray applications. The DVT platform is then mounted on the device with the original bite support instead of a patient. The device setting can be done in two different ways:

a. The desired volume is pre-set using the device programme and then manually fine-tuned.

b. The device is manually set directly upon the region to be captured with the aid of the light visors.

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‘Time-consuming and tedious setting (aiming) of the DVT on a patient who is already in the device is likely to be uncomfortable for the patient’

Using the DVT phantom for training and practice

With the aid of the DVT phantom and the abovementioned setting techniques, new users, who are training to become dentists or dental technicians, can learn how to set the device for the regions to be examined, generate one or more individual images using the preview function and check whether the setting was correct. In the event of incorrect settings, a better image can immediately be generated. In this manner, there is a direct learning curve. Using the DVT phantom for preparing a patient image Time-consuming and tedious setting (aiming) of the DVT on a patient who is already in the device is likely to be uncomfortable for the patient. This is where pre-setting the device with the aid of the DVT phantom comes in handy. The desired region is captured with the phantom and, if needed, is checked with the preview function. Then, the phantom is removed and the patient is positioned in the device.

Generally, only one device setting for the patient’s body size and small fine-tuning are required before the image is set.

How to obtain a DVT phantom

The DVT phantom can be produced in co-operation with practising dental technicians. The plastic teeth containing barium sulphate are available on the market and a phantom can be made in the manner described above.

An easier option is to send a DVT positioning aid of your device to dtcmfreiburg@aol.com or through www.dtcmfreiburg.de.

Master Dental Technician Christian Müller will then mount a prepared DVT phantom on your positioning aid. Industrally manufactured plastic teeth containing barium sulphate (SR Vivo Tac/SR Ortho Tac, Ivoclar Vivadent) will be used, which are then incorporated into a mandibular and maxillary model made of transparent plastic.

We hope that the fascinating field of 3-D diagnostics will establish itself quickly in dentistry and remain an imaging procedure that significantly expands upon the hitherto range of dental X-ray diagnostics in the long term.’

This article was first published in the international edition of Cosmetic Dentistry Issue 3, 2010

Captions

Figs. 1a & b_DVT phantom (the maxillary sinus floor and alveolar nerve of the mandible are simulated with radiopaque wire structures).

Fig. 2_DVT phantom in a DVT (Kodak 9000 3D, small volume) fixated on the original patient biting aid.

Fig. 3_Device settings: with the aid of the light visors, the volume is placed on the region to be captured (here region 26 and the maxillary sinus floor).

Fig. 4_DVT phantom image of the maxilla with the DVT phantom.

Fig. 5_DVT phantom image of the mandible with the DVT phantom.

For more information or to subscribe please call Joe Aspis on 020 7400 8969 or email joe@dentaltribuneuk.com

Dr Georg Bach Katharinastrasse, 56 79098 Freiburg/Breisgau, Germany E-mail: doc.bach@t-online.de
In 1985, Prof Werner Mörmann, Dr Marco Brandsttini and their team laid the foundations for a new treatment system consisting of optical impression-taking, CAD and numerically controlled milling.

This new concept motivated large numbers of clinicians and prompted them to carry out their own follow-up investigations.

Today, CEREC is one of the most closely scrutinised dental procedures, a fact reflected in more than 250 clinical studies and approximately 6,500 longitudinal studies of restorations.

Long-term observations indicate that adhesively bonded restorations fabricated using the first versions of the CEREC system (CEREC 1 and 2) achieved higher survival probability rates (according to Kaplan–Meier) than conventional layered ceramic restorations. CEREC restorations with service times in excess of 20 years still display a degree of clinical excellence, which is normally attributed to metal-based restorations.

On the basis of this extensive long-term experience, there are convincing reasons for recommending CEREC-fabricated inlays, onlays, partial crowns, veneers, anterior crowns and posterior crowns as an alternative to conventional metal-based restorations.

Immediate treatment stabilises enamel
The goal was to deploy CAD/CAM technology to create immediate all-ceramic restorations chairside without the need for temporaries. Clinical experience has demonstrated that provisionally restored inlay cavities have a significant, negative influence on the integrity of the enamel. In the course of chewing simulations, cracks occurred in the oral and vestibular enamel surfaces. In addition, spalling was observed at the enamel margins. Such defects did not occur in cavities that had been treated immediately using chairside CEREC inlays. The conclusion was clear: the immediate treatment of the tooth cavity with chairside inlays and the elimination of the need for a temporary restoration reduce the risk of enamel cracking and marginal spalling.

The micromechanical bond between the ceramic inlay and the hard tooth tissue stabilises the cavity walls. In combination with the adhesive bond, the stabilising effect of the immediate CEREC restoration on the residual tooth obviously offsets the consequences of wider adhesive gaps, as evidenced in long-term clinical findings.

High-strength CEREC crowns
So far, long-term investigations have concentrated almost exclusively on CEREC crowns made of feldspar ceramic materials. At the School of Dentistry, University of Michigan, we set out to investigate the material suitability of lithium disilicate (LS2, IPS e.max CAD, Ivoclar Vivadent) for full contour, monolithic crowns. Our aim was to utilise the enhanced flexural strength of LS2 (560–400 MPa) in order to withstand the chewing forces in the premolar and molar regions.

The full crown preparation included 2.0 mm functional cusp reduction, 1.5 mm occlusal reduction in the central fissure in combination with rounded shoulders and axial reduction of 1.2 mm. Using the CEREC 5 system, 62 crowns were created for 43 patients and then placed with the aid of dual-cure luting cement. There was a small degree of sensitivity reported in the first week post-operatively. This had subsided by the third week and there were no reports of sensitivity at the one- or two-year recall evaluation.

After two years of clinical service, there were no clinically identified cases of crown fracture or surface chipping. Clinical monitoring revealed a positive long-term survival prognosis. Although two years in situ is a relatively short period of time, the survival rates are on par with those obtained in similar studies of ceramic crowns (Fig. 1).

‘After two years of clinical service, there were no clinically identified cases of crown fracture or surface chipping’

‘This new concept motivated large numbers of clinicians and prompted them to carry out their own follow-up investigations.’

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Fig 1. LS2 crowns after the two-year recall visit.
‘Our products function like the pieces of a puzzle’

The increasing significance of digital dental technology was already on everyone’s lips long before IDS 2011. As the focus of this year’s show, digital technology is clearly going to reshape the world of dentistry by becoming part of day-to-day work at dental practices and laboratories.

Dental Tribune Online spoke to Jost Fischer, Chairman and CEO of Sirona, whose vision is to put digital dental technology in everyone’s mouth, literally.

With more than 1,000 m², Sirona had a strong presence at IDS 2011. What was your experience of this year’s show?

Mr Jost Fischer: IDS 2011 was absolutely fantastic! The spirit of the visitors, our staff and distribution partners was unbelievably high. It absolutely showed that the economy in Germany is doing well, which for us as market leader is always a very good sign.

You introduced a large number of new products at IDS. Which of these is your personal favourite?

I consider all of our products my favourite. Everything we do makes sense and is a vital contribution to Sirona’s success. At the end of the day, what is important to us is that our customers invest not only in a product or device, but also in their future.

We are an innovator in our industry and continuously strive to improve. Our systems are upgradeable, meaning that additional features and future technologies can be added on. Furthermore, every single one of our products integrates into the digital workflow of the dentist or laboratory technician. Sirona products function like the pieces of a puzzle. All our offerings fit into this concept.

Which products were launched at IDS?

A major product we launched at IDS is the ORTHOPHOS XG 3D, a machine that can be used as a 2-D and a real 2-D machine. We think that the XG 3D is going to be the breakthrough in 3-D imaging in the general practitioner’s office.

Not only specialists, but also GPs will be able to take 3-D images.

We also introduced SINIUS, a new treatment centre. SINIUS is the star of our new efficiency class. This unit saves the dentist compact, very design oriented and, according to the feedback we have received thus far, very appealing to female dentists.

In our instrument division, we launched SIROBoost, a powerful turbine that allows for uninterrupted workflow.

In our CAD/CAM division, we gave visitors a preview of our new software CEREC 4.0, which will be launched this summer. It offers a new interface and additional features, more fun, creativity and ease of use. We have already received enthusiastic feedback on our preview model from the CEREC community and intend perfecting the software over the next few months.

And finally, as patient marketing is a very important aspect of dentistry today, we launched an integrated face scanner. Thanks to the integration of a 3-D scanner into GALILEOS, X-rays and surface anatomy scans can be taken simultaneously. The result is a lifelike depiction of the anatomical structures of the face, teeth and bones. This accurate image of the patient’s face assists the dentist in planning treatment and makes it easier for the patient to understand the treatment proposal.

Two Sirona products, InEos Blue desktop scanner and CEREC and InLab Biogeneric software, were named amongst the 2010 WOW! winners for 2010’s most innovative tools in the dental laboratory industry by the Journal of Dental Technology. Did these products still create a buzz at IDS?

Both products were very prominently exhibited at IDS 2011 and did not only receive the honours of this award, but also the approval of the market. InEos was developed for dental technicians and they love it! It is intuitive, and scanning with this device is fast, precise and efficient. It has met with great success and is a cornerstone of our lab offerings.

The CEREC Biogeneric software is the most intuitive software out there. It analyses the patient’s individual dentition as basis for the restoration, which will consequently have a perfect, natural fit. With it, we have eliminated the need for a tooth library. The method is extremely simple: with a single click of the mouse, the user is able to create crowns, veneers, inlays and onlays, as well as anatomically sized bridges.

What activities is Sirona involved in regarding giving back to the community?

We take our social responsibility very seriously. Giving back to the community is an important part of Sirona’s activities. We believe that we have a responsibility towards the needy and thus engage in corporate-wide and local activities. For example, we supported clinics in Peru, Tanzania and Ghana with equipment donations. Some of these activities are a joint effort between Sirona and our distribution partner Henry Schein, such as our support of the largest non-profit organisation SCO Family of Services in New York, for which Henry Schein and Sirona held a combined charity event.

We also set up a relief fund immediately after the catastrophe in Japan. The purpose of the fund was to provide support and aid to colleagues affected by the disaster. About 8,200 was collected through fundraising events at Sirona’s Bensheim and Salzburg locations, as well as at IDS. Sirona subsequently increased this donation to 20,000.

What is Sirona’s vision of dentistry of the future?

Certainly, we see digital dentistry, including CAD/CAM, becoming central to the dental office. We have worked hard to make this happen over the past years and are well on our way. If you were to fast-forward five years, you would most likely see CAD/CAM and digital dentistry in every office, certainly in the more developed countries. That’s what we believe in, and it would be a great reward for Sirona to be the top brand driving this development.
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A lot going on at BDA!

Dental Tribune recalls the product launches and profiles of the BDA conference and exhibition in Manchester

Quite apart from the events happening in the meeting rooms and main lecture hall of the BDA Conference, the exhibition was proving a great success. The number of new launches and notable news was staggering, especially bearing in mind the fragile nature of the UK economy at present.

Two companies were very prominent at the exhibition: Oral-B and Denplan. Oral-b, Diamond sponsors of the event, sponsored the plenary programme, the OCP theatre, the directional signage, delegate bags, catering areas and massage areas. The company also hosted two conference seminars and an update lunch. With such prominence, it was clear that the company really had something to shout about.

And it really did – the professional launch of the company’s newest innovation – the Pro-Expert toothpaste. This product has been slowly coming to the profession’s attention since its ‘soft’ launch in January, but this was the first time that dental professionals at large were able to experience the paste for itself.

The all-in-one Oral-B Pro-Expert toothpaste derives its deliverable benefits against gum problems, plaque, caries, calculus formation, dentinal hypersensitivity, staining and bad breath from the evolution of its two main active ingredients; stabilised stannous fluoride and polyphosphate.

Dental professionals were able to try Pro-Expert for themselves in specially-provided booths dotted around the exhibition hall.

‘Dental professionals were able to try Pro-Expert for themselves in specially-provided booths dotted around the exhibition hall’

The Dental Directory/Practice Plan – the companies announced a re-launch of their partnerships that give Practice Plan member dentists significant savings on their purchases from Dental Directory and a whole host of other benefits too!

Dental Plan – recognising a need for training in the business aspects of running a practice, the Dental Plan has launched the Dental Business Academy; a consultancy and training service to help practices do what they do best: give great patient care.

Dentsply – There was much excitement around the Dentsply stand as they showcased their new products: AirFloss and DiamondClean. Dubbed the ‘iPod for the bathroom’ DiamondClean is Sonicare’s latest in its sonic powerbrush range. Although the handle looks the part, it is the brush head which sports the real innovation – a new diamond-cut tufa formation. The diamond bristle field has anchor free tufting, allowing for 44 per cent more bristles than Philips’ Standard sized ProResults brush head, providing both superior plaque removal and whiter teeth. AirFloss is the company’s newest product to compliment the brush range, and features microburst technology – a rapid burst of air and water droplets to thoroughly fill up the interproximal area and force biofilm out. It also features an ergonomic handle and a slim angled nozzle designed for easy access to all areas of the mouth.

Hobson, the company provides ortho appliances designed to be a more affordable solution to straightening upper and lower teeth from three-three. With courses and study days planned across the country, this appliance is aimed at GDPs who want to provide something a little more affordable for their patients.

Phillips Sonicare – At the breathtaking venue of Cloud 23 in Manchester’s Deansgate Hilton, Sonicare launched two new products: AirFloss and DiamondClean. Dubbed the ‘iPod for the bathroom’ DiamondClean is Sonicare’s latest in its sonic powerbrush range. Although the handle looks the part, it is the brush head which sports the real innovation – a new diamond-cut tufa formation. The diamond bristle field has anchor free tufting, allowing for 44 per cent more bristles than Philips’ Standard sized ProResults brush head, providing both superior plaque removal and whiter teeth. AirFloss is the company’s newest product to compliment the brush range, and features microburst technology – a rapid burst of air and water droplets to thoroughly fill up the interproximal area and force biofilm out. It also features an ergonomic handle and a slim angled nozzle designed for easy access to all areas of the mouth.

Smile-on – Discussing the latest educational and practical resources in its portfolio, the team from Smile-on were on hand to help dental professionals find a CPD solution right for them and their teams. The team were also available to discuss the educational bursaries available for its innovative flagship online MSC in Restorative and Aesthetic Dentistry, in partnership with The University of Manchester.

Tandex – The 80-year-old Danish company has launched the new adjunct to its flexi range of interdental brushes – the Fleximax. With all the usual features of the flexi range of non-slip grip and ergonomic design, Fleximax features a longer handle to make accessing hard to reach areas easier for those with mobility issues or orthodontic anchorage.

Waterpik – the Waterpik but wish it wasn’t quite so bulky? Well, the company has designed a more compact ergonomic product more suited to British bathrooms and patients. Called Waterpik Nano Flosser, it is designed to be powered from a shaver socket and be smaller so it does not take up too much space; yet it still features the company’s two special tips and three pressure settings.

Jawbreakers – The charity launched at the company’s base in Tanzania, with founders Ian and Andie Wilson, is building a school for the children of a village. The charity is aimed at GDPs who want to make a difference to kids and their teams. The team find a CPD solution right for them and their teams. The team were also available to discuss the educational bursaries available for its innovative flagship online MSC in Restorative and Aesthetic Dentistry, in partnership with The University of Manchester.

The University of Manchester.

Oralign Ltd – Founded by dentists Lester Eillman and Ross

Dental Plan

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Bridge2Aid – The charity discussed the changes happenning at its base in Tanzania, with founders Ian and Andie Wilson handing over the reins and returning to the UK after nine years, and the launch of a new logo and website designed to take the charity on to the next phase.

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Dental Plan is aimed at GDPs who want to provide something a little more affordable for their patients.

Phillips Sonicare – At the breathtaking venue of Cloud 23 in Manchester’s Deansgate Hilton, Sonicare launched two new products: AirFloss and DiamondClean. Dubbed the ‘iPod for the bathroom’ DiamondClean is Sonicare’s latest in its sonic powerbrush range. Although the handle looks the part, it is the brush head which sports the real innovation – a new diamond-cut tufa formation. The diamond bristle field has anchor free tufting, allowing for 44 per cent more bristles than Philips’ Standard sized ProResults brush head, providing both superior plaque removal and whiter teeth. AirFloss is the company’s newest product to compliment the brush range, and features microburst technology – a rapid burst of air and water droplets to thoroughly fill up the interproximal area and force biofilm out. It also features an ergonomic handle and a slim angled nozzle designed for easy access to all areas of the mouth.
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COURSE ANNOUNCEMENT
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