Food labelling consultation

Keeping track of what you eat and choosing healthier foods could be made easier thanks to a UK-wide consultation launched by Secretary Andrew Lansley. UK health ministers want to see all food manufacturers and retailers use the same systems to show on the front of packs – how much fat, salt and sugar, and how many calories is in their products. Around 80 per cent of food products sold in the UK already have some form of front-of-pack labelling. But different retailers and manufacturers use different ways of labelling which can be confusing for consumers. If the biggest seven supermarket chains used the same labelling for their own brands, it would cover around 50 per cent of the food sold in the UK and encourage others to adopt the scheme, Health Secretary Andrew Lansley said: “Being overweight and having an unhealthy diet can lead to serious illnesses such as cancer and type 2 diabetes. We need to do everything we can to help people make healthier choices. Offering a single nutrition labelling system makes common sense, it should help us all to make healthier choices and keep track of what we eat.”

New Chair of CCDAS

Deborah White, associate professor and director of education at the School of Dentistry at Birmingham, has been elected as the new Chair of the British Dental Association’s Central Committee for Dental Academic Staff (CCDAS) for the 2012/14 triennium. She was Vice Chair of CCDAS in the last triennium. Deborah joined the University of Birmingham in 1998 as a part-time researcher and joined the staff full-time in 1999. She completed her PhD in 2000 and, as head of dental public health, has research interests in dental epidemiology and health services. She undertakes clinical teaching and clinical work in the salaried services in Birmingham. Deborah has been a BDA accredited trade union representative, firstly for the salaried services and more recently for university staff. In her spare time she enjoys walking, gardening and swimming. The Chair of CCDAS will be supported by Jeff Wilson, the newly elected Vice Chair. Jeff is a senior clinical lecturer in restorative dentistry at Cardiff University Dental School.

MSc blog

All smiles

NSM launches at Houses of Parliament

Taking the plunge

Ken Harris takes his first MSc steps

Clinical

Use your head

Paw Khaira discusses pain relief

Cosmetic Tribune

Straight teeth in less time

Nick Simon looks at the options

May 21-27, 2012

Vol. 6 No. 13

DENTAL TRIBUNE

The World’s Dental Newspaper • United Kingdom Edition

Published in London

£70m NHS dental fraud claim

The government has announced that under the current dental contract system an estimated £70m was wasted on dental fraud in a year.

Figures published by NHS Protect, the lead on tackling and identifying crime across the health service in England, show dental fraud may have cost the NHS £75.1 million in 2009-10.

The government has committed to introducing a new dental contract system that will focus on improving the quality of care patients receive, increase the availability of NHS dental care and promote good oral health. Part of this process will include reducing the risks of dental fraud before it becomes a problem and proactively analysing data on dental contract claims to spot irregular or suspect claim activity.

The government will work with NHS Protect to tackle the current problem of contract fraud by:

- changing how some dental treatments are recorded to prevent fraud
- undertaking a further analysis of dental fraud to help identify weaknesses in the system
- developing an awareness programme of dental fraud risks, including workshops with local anti-fraud staff to help spot dental fraud activity
- moving to a new single way of working for managing all NHS dental services

Health Minister Lord Howe said: “This shows the current dental contract system is not fit for purpose and needs to change to ensure NHS funds are protected and used to benefit patients.

“IT is totally unacceptable that some NHS dentists have abused the system for personal gain. Fraud of any kind will not be tolerated and any allegation of fraud is taken seriously.

“We believe dentists should get paid for the quality of care they provide rather than simply for the number of treatments. That is why we are currently piloting this approach with dental practices ahead of introducing a new dental contract to make sure we get things right and minimise the risks of fraud.”

Barry Cockerott, Chief Dental Officer said: “The vast majority of dentists behave ethically and provide high quality dental care to their patients. Action needs to be taken against the small minority who behave dishonestly and submit fraudulent claims.

“We are working closely with NHS Protect to raise awareness of fraud risks to help prevent and deter fraudulent activity.

“I would also urge colleagues in the profession and patients to report any suspicions of fraud or corruption to NHS Protect on their confidential dental fraud and corruption reporting line or to their PCT.”

Reducing the risks of dental fraud and corruption will help to ensure that public funds are not lost to a dishonest minority of dentists. Action will be taken against those who attempt to take valuable NHS resources for personal gain.

“As the lead organisation in tackling NHS fraud, NHS Protect will effectively coordinate investigative and intelligence resources and take swift action where suspicions of fraud are found. We will also seek the recovery of any NHS funds lost through the actions of fraudsters.”

Under the current contract the most common types of fraud include submitting false claims for patients who did not exist, claiming for patients who did not visit the dentist and submitting claims for more expensive treatment than was actually delivered.

To view the NHS Protect report visit www.nhsbsa.nhs.uk/5630.aspx
All smiles at National Smile Month launch

I
t was all smiles in the House of Commons on 15 May, when national charity the British Dental Health Foundation launched the UK’s largest annual oral health campaign.

The British Association of Dental Nurses (BADN) are lobbying HMRC for tax relief on CPD costs - following correspondence between BADN Chief Exec Pam Swain and Exchequer Secretary to the Treasury, David Gaulke MP, in which Mr Gaulke states that:

*HMRC do not accept that all training expenses incurred by the employee will now qualify for tax relief. ……… expenses must be incurred exclusively as an intrinsic part of the performance of duties………… On the basis of the information provided (BADN briefing note to Mr Gaulke)…… the CPD training referred to does not have the characteristics mentioned above …….. No deduction is due for the costs of continuing professional education. That is so even if participation in such activities is compulsory, and failure to do so may lead to the employee losing his or her professional qualifications, and/or their job."

“Dentists, hygienists, therapists and technicians who are self-employed or business owners are allowed tax relief on their CPD costs. However, HMRC is refusing to acknowledge that CPD expenses for dental nurse employees are in fact ‘incurred exclusively as an intrinsic part of the performance of duties’” said BADN President Nicola Dober. “This is blatantly unfair, as tax relief on CPD costs is denied to those most in need of it. BADN are calling on other dental professional associations and the GDC to support this campaign in order that tax relief on CPD costs is afforded to all registered dental professionals.”

Dental nurses (and other members of the dental team) are encouraged to visit the BADN website www.badn.org.uk, download the form letter together with supporting documents, and send it to both Mr Gaulke and their local MP.

To register for free ‘Smileys’, or for more information about the campaign, visit www.smilemonth.org

BADN campaign for tax relief on CPD costs

The Department of Health’s Transition Risk Register from November 2010, which was a statement of potential risks of NHS changes, will not be published, following Cabinet agreement and a final decision made by the Secretary of State for Health.

The Secretary of State for Health sought the Cabinet’s views on the exercise of the Ministerial Veto in relation to the Information Tribunal’s ruling that the Transition Risk Register should be released. He did so as part of a full commitment to act in accordance with the provisions of the Freedom of Information Act, which makes specific provision for the exercise of such a veto.

The Coalition Government is committed to the Freedom of Information Act and has extended it to all academic schools through the Academies Act; and to the Association of Chief Police Officers, Financial Ombudsman Service, and the Universities and Colleges Admissions Service through secondary legislation. In addition, the Protection of Freedoms Act, which gained Royal Assent on 1 May, provides for the extension of the FOI Act to over 100 companies wholly owned by public authorities.

Risk Registers are a vital part of Government policy development. Ministers and officials should be able to deliberate sensitive policy formulation, in expectation that their views are not published at a time when it would prejudice the development and delivery of policies. If such risk registers were regularly disclosed, it is likely their form and content would change, and they would no longer be the effective internal management tools they are intended to be.

In light of the interest in this case, and in line with the Government’s commitment to be more transparent by opening up Government information, the Department of Health has published a document that sets out key information relating to the areas of risks in the original Risk Register. It also sets out the mitigating actions that have taken place since November 2010 and which are planned in the future. But it protects the language and form of the Risk Register.
New award for young dentists

The Harley Street Centre for Endodontics is launching the Young Dentist Endodontic Award 2012. Marking the 10th Anniversary of the centre, the award is open to any young dentist who graduated in the last three years, whether they are in their Foundation Year or just starting out on their career. Applicants are invited to submit a case report of their best endodontic treatment so far. An application form can be downloaded from: www.roottreatment.com.

Julian Webber, founder of the Harley Street Centre for Endodontics, said: “We hope this award will inspire and encourage young dentists to develop skills in one of the most complex of primary care procedures. While endodontics is taught at dental school and practised by new graduates during their Foundation training, acquiring the confidence to carry out the procedure as well as managing patients is challenging.”

In addition to national recognition, there are five outstanding prizes. First prize is the new WaveOne Endodontic Motor, handpiece and accessories kit, from Dentsply UK and the second prize is a Morita Root ZX apex locator from Quality Endodontic Distributors (QED). Three further runners up will win a pair of endo-benders from SybronEndo.

The winner’s case report will be written up in a UK dental publication and all successful applicants will be offered the opportunity to spend a day at the Harley Street Centre for Endodontics.

The award will be presented at an event at the Royal Society of Medicine in October this year to celebrate the 10th Anniversary of the Harley Street Centre for Endodontics. The judging panel includes Dr Julian Webber and Dr Trevor Lamb, endodontists at the Centre, and Prof Andrew Eder, dean of the UCL Eastman Dental Institute. No names will be on the case reports so the judging can be undertaken anonymously.

The application process is simple - dentists are asked to submit details of one endodontic case which showcases their ability. The deadline for applications is 2nd September 2012.

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In surgery treatment for caries prevention

• Clinically proven caries efficacy
  – 33% reduction in dmfs
  – 46% reduction in DMFT

• Quick and easy application

• Temporary light tint for visual control

Applying fluoride varnish containing 22,600 ppm F is a recommended intervention in ‘Delivering Better Oral Health – An evidence-based toolkit for prevention’

Duraphat 50 mg/ml Dental Suspension. Active ingredients: 50mg Sodium Fluoride equivalent to 22.6mg of Fluoride (22,600ppm F). Indications: Prevention of caries, desensitisation of hypersensitive teeth. Dosage and administration: Recommended dosage for single application: for milk teeth up to 62.5ml (1/5.5mg Fluoride), for mixed dentition up to 0.4ml (19.5mg Fluoride), for permanent dentition: up to 0.75ml (71.65mg Fluoride). For caries prophylaxis the application is usually repeated every 6 months but more frequent applications (every 3 months) may be made. For hypersensitivity, 2 or 3 applications should be made within a few days.

Contraindications: Hypersensitivity to colophony and/or any other constituents. Ulcerative gingivitis. Stomatits. Bronchial asthma. Special warnings and special precautions for use: If the whole dentition is being treated the application should not be carried out on an empty stomach. On the day of application other high fluoride preparations such as a fluoride gel should be avoided. Fluoride supplements should be suspended for several days after applying Duraphat. Interactions with other medicines: The presence of alcohol in the Duraphat formula should be considered. Undesirable effects: Oedematous swelling has been observed in subjects with tendency to allergic reactions. The dental suspension layer can easily be removed from the mouth by brushing and rinsing. In rare cases, asthma attacks may occur in patients who have bronchial asthma. Legal classification: POM. Clinical licence number: PL 0009/0042. Product licence holder: Colgate-Palmolive (UK) Ltd, Guildford Business Park, Midleton Road, Guildford, GU2 7HC. Price: £22.70 each/10 (9ml tube). Date of revision of text: July 2009.

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Editorial comment

Last week saw the launch of this year’s National Smile Month Campaign in the Houses of Parliament.

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Or email: lisa@dentaltribuneuk.com
Dentists raise money for children’s cancer ward

In December 2003, 15-year-old Robbie Anderson set up a Trust to improve the quality of life for young people spending long periods of time on the children’s cancer ward, where he too was a patient.

As explained on The Robbie Anderson Cancer Trust website: “Robbie knew his cancer was terminal, but even that knowledge didn’t deter him.” Robbie passed away in December 2004. Robbie’s parents and members of the dental profession were setting off on an epic journey to the exotic principality of Monte Carlo to raise funds and awareness of the needs of children and young adults suffering with cancer. The trip, however, will also be carrying out one of Robbie’s wishes, which was to go to Monte Carlo and place a bet on the number eight on a roulette table! All the participants are self-funding the drive and all money raised will go towards funding the age appropriate cancer facility at Leicester Royal Infirmary.

Donations and sponsorship are desperately needed for the facility to become a reality. The Robbie Anderson Cancer Trust is proud to be supporting University Hospitals Leicester in their campaign to provide a unit in Leicester that will make a significant difference to the lives of all young people fighting cancer.

For those of you wishing to make a donation to this worthwhile fund or to find out more information visit www.robbieanderson.org.uk/index.php/donations-contact-us or www.robbieanderson.org.uk/index.php.

Energy drinks responsible for irreversible damage to teeth

A recent study published in the May/June 2012 issue of General Dentistry, the peer-reviewed clinical journal of the Academy of General Dentistry, found that alarming increase in the consumption of sports and energy drinks, especially among adolescents, is causing irreversible damage to teeth—specifically, the high acidity levels in the drinks erode tooth enamel.

“Young adults consume these drinks assuming that they will improve their sports performance and energy levels and that they are ‘better for them than soda,’” said Poonam Jain, BDS, MS, MPH, lead author of the study. “Most of these patients are shocked to learn that these drinks are essentially bathing their teeth with acid.”

Researchers examined the acidity levels in 15 sports drinks and nine energy drinks. They found that the acidity levels can vary between brands of beverages and flavours of the same brand. To test the effect of the acidity levels, the researchers immersed samples of human tooth enamel in each beverage for 15 minutes, followed by immersion in artificial saliva for two hours. This cycle was repeated four times a day for five days, and the samples were stored in fresh artificial saliva at all other times.

“The type of testing simulates the same exposure that a large proportion of American teens and young adults are subjecting their teeth to on a regular basis when they drink one of these beverages every few hours,” said Dr. Jain.

The researchers found that damage to enamel was evident after only five days of exposure to sports or energy drinks, although energy drinks showed a significantly greater potential to damage teeth than sports drinks. In fact, the authors found that energy drinks cause twice as much damage to teeth as sports drinks.

One of the researchers, Dr. Bone, recommends that her patients minimize their intake of sports and energy drinks. She also advises them to chew sugar-free gum or rinse the mouth with water following consumption of the drinks. “Both tactics increase saliva flow, which naturally helps to return the acid levels in the mouth to normal,” she said.

Also, patients should wait at least an hour to brush their teeth after consuming sports and energy drinks. Otherwise, says Dr. Bone, they will be spreading acid onto the tooth surfaces, increasing the erosive action.

Source: www.agd.org

Leaflet and poster on NHS dental services and charges now available

Details of NHS dental services and new charges are outlined in a new leaflet and poster. The leaflet describes how NHS dental services in England work, including how to find an NHS dentist, what treatment to expect and how much it will cost. The poster shows the charges to pay from April 2012 depending on the treatment needed.

The NHS dental services in England (540k) leaflet includes information on:
http://www.dh.gov.uk/health/files/2012/04/20/0000136-Dental-Poster-v1_TAGGED.pdf

- Free NHS dental treatment or help with health costs
- Treatments provided under the NHS

- NHS dental charges
- How to find an NHS dentist
- How often to visit the dentist
- Dental appliances
- Urgent NHS dental treatment and care out of hours

The NHS dental charges from 1 April 2012 (640k) poster includes details of:
www.dh.gov.uk/health/files/2012/04/20/0000896-Dental-Poster-v1_TAGGED.pdf

- Charges for each complete course of treatment
- Charges for referral for a course of treatment
- Treatments that are free
- Where to find information on free dental treatment or help with health costs

iNSkills – a pathway to a brighter future

A new unemployment of the under 25s surpasses the 1m mark, Neil Sikka, of Barbi- can Dental Care, has created an initiative that will provide training and real job prospects.

Working in conjunction with Tower Hamlets, the local college and other practices in the City and Canary Wharf, Neil’s iNSkills initiative will provide disadvantaged youth of Tower Hamlets and Newham the opportunity to learn and work within the dental world. After an 18-month period, candidates will graduate with an NVQ Level 3 qualification in Dental Nursing.

Neil Sikka states: “Within the Square Mile there are some of the most successful businesses and the richest people. But just outside, is Tower Hamlets and Newham, the poorest borough in the Capital. We wanted to create a scheme where we could offer people the chance of training, work and, more importantly, career development.

In the pilot scheme, launched in January 2012, trainees will be recruited from the borough of Tower Hamlets. Depending on the success of the initiative, it could go national.

Tower Hamlet Council’s Skillsmatch – the outreach team with established links in the community - will be responsible for sourcing, screening and mentor- ing the trainees throughout the duration of the course. Tower Hamlets College will provide the training on a day-release basis and students will gain work experience and valuable on-the-job training in selected for the other four days. Students will benefit from a mentor- ing scheme to ensure their performance is maintained.

Neil has been responsible for recruiting other practices to the scheme. The Dental Surgery in the Corn Exchange and Smile Im- plant Centre, both agreed to involved in the inaugural launch. Each practice will take on a minimum of two trainees, and the College have a ‘earn as you learn’ element, where students will be paid for their working and college time.

Neil concludes: “We are very excited about iNSkills. Initial in- terviews are being arranged and candidates will have to be the right fit of candidates. We are very commit- ted to recruiting, developing and empowering our students and we are confident that iNSkills will be a success.”

Leaves are caused by a combination of factors, including:
- The climate and soil conditions
- The age and variety of the tree
- The amount of sunlight and water available

This cycle was repeated four times a day for five days, and the samples were stored in fresh artificial saliva at all other times.

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- Where to find information on free dental treatment or help with health costs
Adding LISTERINE® Total Care to your patients’ daily prevention routine finishes the job started by mechanical cleaning

Communicating the value of a three-step daily prevention process – brush, floss and rinse – to patients in an effective manner will help to keep the message resonating between appointments, improving their commitment to better oral health.

Following mechanical cleaning with a mouthwash that will lower the bacterial burden in the mouth is an extremely important part of achieving the ultimate in oral care at home, and something that patients need to understand is their responsibility. You can help patients do this by promoting a partnership approach that clearly and concisely presents the benefits of combining daily prevention with regular hygiene appointments.

Brushing and flossing/interdental cleaning are pivotal to oral hygiene. They displace and dislodge plaque bacteria that can cause gingivitis and periodontal disease from the tooth surface. But bacteria from other areas of the mouth can recolonize on teeth quickly.¹

Using LISTERINE® after mechanical cleaning destroys bacteria effectively, killing up to 97% of them in vivo.²

This lowers the bacterial burden in the mouth and in plaque that reforms.³ And when used for six months, LISTERINE® can reduce plaque levels by up to 52% more than brushing and flossing alone.⁴

The LISTERINE® Total Care range

The LISTERINE® Total Care range ensures that there is an effective adjunct to help reduce plaque bacteria and manage biofilm in every patient. Plaque biofilm is the main cause of gum disease, and plaque formation begins immediately after brushing. LISTERINE® has broad antibacterial effects against a wide range of species of germs, killing them by destroying their cell walls and inhibiting their ability to multiply.

In addition to containing the LISTERINE® four essential oils – menthol, thymol, methyl salicylate and eucalyptol – which have antibacterial properties and kill plaque bacteria, LISTERINE® Total Care products offer various levels of fluoride and other benefits to suit patients’ needs.

Recommended LISTERINE® as the final step in your patient’s daily regime, to finish the job started by mechanical cleaning

For more information about the LISTERINE® Total Care range of mouthwashes, or for free samples†, please contact Johnson & Johnson Ltd on 0800 328 0750.

† As long as stocks last. Free samples can only be sent to dental practice addresses (no home addresses).

Finish the job. Finish off with Listerine.
Donated materials save teeth in rural Uganda

Patients in rural Uganda have potentially avoided extractions and kept more of their own teeth thanks to DENTSPLY glass ionomer materials. The company donated materials to the Teeth for Life project organised by DENTaID and Christian Relief Uganda.

Project leader Barbara Koffman, who has been visiting Uganda since 1996 to run free dental pain relief clinics, says donations make a big difference to people with little or no access to dental care.

“When I first went to Uganda, I found a government clinic with very little in it, just two or three forceps and a mouth mirror without a handle,” says Barbara.

She developed a mobile clinic, staffed by volunteer dentists, hygienists and nurses to give hygiene instruction alongside clinical care.

On the most recent trip, in February and March, a small drill and the DENTSPLY GI material made a big difference. “Rather than take painful teeth out, we were able to restore them,” says Barbara. “We are very grateful for any help we are given.”

The next visits to Uganda will be leaving on 1st June and 6th September. Any qualified staff wishing to volunteer to help – with partners attending as helpers – can find out more at www.dentaid.org

CEO of DPA takes legal action over unfair dismissal

Leeds-based solicitors Cohen Cramer has been instructed by Derek Watson, former CEO of the Dental Professionals Association (DPA), in his unfair dismissal claim following the proposed transfer of DPA assets.

After taking independent legal advice on behalf of the members, Derek Watson advised the DPA’s Council that the transfer was unlawful, requiring a majority vote of DPA members. The proposed transfer went ahead and shortly afterwards, Derek was suspended for gross misconduct and subsequently dismissed despite having an exemplary employment record.

Derek Watson said “I am devastated, having worked for the DPA and its members for seven years, by Council’s decision to instantly dismiss me following my advice on their legal obligations regarding the transfer of DPA assets. I am still hoping for, and working towards, a positive solution for the Association and its members.”

Cohen Cramer, specialist lawyers to the dental profession, have submitted a claim to the Employment Tribunal. “No employee should have to tolerate the kind of treatment described by Mr Watson. We are pursuing a number of claims with both the DPA and CODE to address this situation”, says Sarah Leyland, Head of Dental Employment Law.

Derek Watson

Shaeena Loughnane, Bridge2Aids UK Manager said: “We are really pleased that A.P McCoy has agreed to become a patron. He has been a supporter of our work for many years now, showing an interest in the work that we do and helping raise much needed funds for Bridge2Aid.”

A P McCoy OBE joins Bridge2Aid as new patron

B ridge2Aid are delighted to announce that A P McCoy OBE joins us as a new Patron. A P McCoy won BBC Sports Personality of the Year in 2010 and has been British Jump Racing Champion Jockey every year since 1995/96.

The previous winner of the Cheltenham Gold Cup, Champion Hurdle, King George VI Chase and the Grand National had this to say of his involvement with Bridge2Aid: “I am delighted to be a patron of Bridge2Aid as I have been aware for some time of the invaluable work the charity does. My dentist has been involved with Bridge2Aid for several years, and we have tried over the years to support him and his practice with their fundraising efforts.

“Bridge2Aid provides support which is not built on one-off aid, but on a sustainable approach to the communities they serve. I admire the passion and dedication the charity’s staff and volunteers bring to their work, qualities which are not out of place in National Hunt racing, of course; as well as their commitment to training and long-term investment in people.

“I really do feel that together we can make a real difference to people’s lives in one of the poorer parts of the world and urge you to support them in whatever way you can”.

A P McCoy OBE joins Bridge2Aid as new patron

King’s hosts first conjoint in Orthodontics under the Royal College of Surgeons of Edinburgh

K ing’s College London Dental Institute hosted the first conjoint in Orthodontics on 25-26 April 2012 under the auspices of the Royal College of Surgeons of Edinburgh.

Previous successful arrangements had been in place for the previous four years allowing a conjoint MClinDent and MRD examination in the restorative specialties. This conjoint, in the era of major governance frameworks, was one of the new style conjoint arrangements. In the Orthodontic specialty, the Membership in Orthodontics is assessments were closely intertwined with the assessment for the Master of Science in Orthodontics. The conjoint arrangement offers major advantages for all those involved, exposing candidates to a rigorous and robust assessment process yet supporting the candidate experience.

The examiners represented both organisations and had a broad experience in examination of all aspects of specialist knowledge. They all adapted well to the combined process with major positive outcomes from this unique integration.

The examinations were organised by Fraser McDonald, Professor of Orthodontics at the Dental Institute. He said: “In the days of professional leave restrictions and constraints in health service financial rewards in all employing authorities, this seems the only way forwards to ensure objective specialist evaluation. It can only help support the basis of having independent bodies approving specialist knowledge.”

The examiners included (shown in the picture, back row from left to right) David Tresson, Alan Jones, Fraser McDonald, Dirk Bister, Jeremy Breckon, and Nigel Taylor (front row from left to right): Samantha Hodges, Anna Gibilaro, Margaret Collins, Robert Evans.

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Taking the plunge

Ken Harris takes the first steps towards gaining an MSc

A long with the news of my upcoming 50-year reunion came the realisation that I am actually in the twilight of my career, much to my children’s glee, and their regular quips about my advancing years (and receding hairstyle) seem all the more appropriate these days. Should I go gently into that good night or should I try to raise the enthusiasm to rage a little more against the dying of the light?

One thing I’ve learned after 50 years in dentistry is everyone’s an expert. The adverb of the evidence-based dentistry movement, possibly driven by government and perhaps fuelled by dry-fingered academicians (OK, I’m prepared to concede myst) has often been given short shrift by the army of general practitioners such as myself who is working in the ultimate “in vive” laboratory. After all, we’ve all been there and done that, even if for many of us the T-shirt no longer fits.

It is a truth universally acknowledged (at least by wet-fingered dentists) that an academic dental colleague in possession of a “learned” opinion must be in need of a soap box. I was bombarded by posters from a well-known high street bank, (and we think we have an image problem) urging the public to consider the world of opportunity out there. Useing an example about Holland exports (although I’m lost as to what relevance the fact that Holland exports more soy sauce than Japan has), one piece of advice caught my eye. Tucked away at the bottom of the poster was the suggestion that we need to invest in education in order to be ready for the new opportunities coming our way. Hmmm... Hallowed path

My academic career was stopped in its tracks back in 1982 when my application for a house job at Newcastle Dental Hospital was unceremoniously rejected, and I went straight into practice instead. There was no vocational training in those days. I had given up any thoughts I would ever tread the hallowed academic path when I discovered a whole load of “interesting” stuff on the internet and it seemed that post graduate education was available online. I have never seen the attractions of technology for technology’s sake, preferring the more intellectual pursuits of a good book or a stimulating conversation (or so I tell myself) and my usual scepticism held me back. But I soon discovered that you could sign up for an MSc in almost any branch of dentistry with guaranteed success if you had both a pulse and a credit card (with the latter being most important).

Two years ago I first noticed the MSc in restorative and aesthetic dentistry at the University of Manchester; a highly renowned establishment. I was looking for a course with serious aspiration and the confidence in itself to challenge its delegates; I was also looking for a university with the courage to set the bar high enough to gain respect within the academic community at large! After a recommendation from my old friend Elaine Halley, who had signed up at the outset two years ago, I decided to take the plunge. I thought people would praise me for my open mind and the willingness to take up a new challenge, yet when I told my family, my friends, and even my patients, they could scarcely disguise their amuse-ment! Only one of my friends, who actually has 37 watch-es (almost as many as Nigel Saynor) said he recognised a kindred impulsive spirit, and congratulated me on my decisiveness.

Consequently, I now find myself reading about the influence of air abrasion on Zirconia ceramic bonding; unusu-al, I’m sure you’ll agree, but it’s more unusual given that I’m sitting on an exercise bike at the very swanky Biltmore Hotel in Miami, while everyone else is relaxing by the pool! This MSc thing is starting to take over my life I’m afraid... maybe I should be very afraid?

Is there really no time for relaxing?

Ken Harris graduated from the dental school of the University of Newcastle upon Tyne in 1982 and passed MFGDP(UK) in 1996. He maintains a fully private practice with branches in Sunderland and Newcastle upon Tyne specialising in complex dental reconstruction cases based upon sound treatment planning protocols. He is one of only two Accredited Fellows of BAAD, holds full membership of BAOD and remains a sustaining member of AACD. He is currently UK Clinical Director for the California Center for Advanced Dental Studies and the only UK Graduate and Mentor of the Kois Center in Seattle.

About the author

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The importance of a professional advisor
Alun Rees provides his top 10 tips to finding and working with an accountant

One of the phrases that I find myself using when I write analysis reports for my clients goes along the lines of: “Practice ownership can be a lonely place; being a medical professional has unique innate pressures, having to make immediate decisions with patients that are awake and where you have a finite time to complete procedures produces even more pressure.”

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Organisations that I advise say that one of the important things they do is to ensure that all their clients have advisers in place rather than to presume. It’s vital for them to know exactly what they are able to assist them so they have to understand the breadth and depth of the adviser’s talents. In turn, the adviser, like all professionals, need to have a network of back up people who can be relied upon when and if the problems become really complex.

1. Find the most successful dentists working in a similar manner to how you wish to work and ask them who they use. Research three or so and be prepared to interview them (and vice versa).

2. Ensure the accountant is fully qualified; anyone can set up a business and call themselves an accountant without so much as a GCSE in maths. You’re looking for a chartered or certified accountant, check that they are what they say they are by visiting their professional body’s website.

3. Get to meet them, and ensure

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So let’s start with the money and Rees’s Top Ten Tips to finding and working with an accountant.

Get used to the idea that you have to have an accountant and that you are going to have to pay them for what they do; any accountant worth their salt will save you more money than they cost and will also prevent premature grey hair!

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3. Get to meet them, and ensure
that you respect the way they operate that you feel some empathy with them and that you know you can trust them. There's more to this than a brass plate and a firm handshake. In spite of their reputation they do have personalities.

4 Sort out your questions before you meet your prospective accountant, take as many as you can and ensure that they are welcomed - you're the client, they are the ones with the knowledge and expertise and should welcome your input.

5 Do they understand your business? They don't have to be "specialist" dental accountants but they must know and understand the background economy in which you are working and appreciate the changes that will affect your business.

6 Make sure that you are 100 per cent open with them and that you can be trusted too. If there are any skeletons in your cupboard, or even if you think there might be, make sure they know so that there are no surprises down the track. You wouldn't want to operate in the dark, why should they?

7 Sort out their fees. Cheap is not always good. How do they operate, fixed fee or hourly rate? Some accountants can’t and won’t give you a quote up front - they simply tell you what the hourly rate for whichever member(s) of staff will be involved in preparing your accounts and roughly how many hours will be involved. They’ll know soon enough if you’re short of cash to pay them and will probably be proactive in helping you spread the cost, perhaps on a monthly standing order. Don’t haggle - unless you’re the sort of dentist who happily knocks their own fees down (and if you are then give me a call and I’ll put you right) then ask yourself how well disposed you are towards haggling patients.

8 Can they do everything that you will want of them? Are they happy to do your tax returns? Will they produce monthly management accounts for you and the bank if required? Will they advise on incorporation and handle the process without fuss? Will they advise you regularly on changes in legislation that will affect you?

9 How can you help them? How do they want the information from you? Will they send a bookkeeper to show you and your business manager exactly what records to keep, how they should be kept and when they should be submitted? Will they help train you? Will they show you how to prepare budgets? Remember the less work that you have to give them the better all round and the lower the bills. Files of invoices in date order and numbered to correspond with bank statements, cheque books make an accountant heart glow and helps them feel far better disposed towards you than a cardboard box full of paper in no particular order.

10 Timing. My own particular bugbear. If your year-end is (for instance) the end of October then your records ought to be with the accountant within a fortnight of the year-end. They, for their part should have written and let you know that your books are expected, that there is time put aside for the work and who from the firm will be dealing with it. You need to know your tax bill well in advance to be prepared.

It’s not what you earn that matters, it’s what you keep that counts, and for that a good accountant is essential.

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About the author

Alun Rees trained at Newcastle University and started his career as an oral surgery resident, before working as an associate in a range of different practices. With this solid foundation, Alun went on to launch two practices in the space of just 15 months, a challenge in the toughest economic conditions. After years of hard work, Alun finally sold his award-winning business in 2005. Alun’s background and experience give him a strong understanding of what others go through to build a successful practice. He has seen many different approaches and learned his own lessons in the real world. Alun now runs Dental Business Partners to offer specific and specialised support for dentists, by dentists. He has served as a media representative for both the BDA and BDHF and is an agony uncle regularly featured in the media, and has featured on BBC2, Sky TV and various radio stations.

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Dental Hygienists Sarah Murray and Christina Chatfield discuss Direct Access and the importance of having your say on this controversial issue

Sarah Murray (SM): So Christina, Dental Health Spa is five years old this year; what’s on the agenda?

Christina Chatfield (CC): Hopefully to see a change in the way that patients can access hygiene services would be great. I suppose in my naiveté five years ago I thought that Direct Access was around the corner because of the strong recommendation from the Office of Fair Trading (OFT) to remove the ‘under prescription’ rule. This recommendation came about because of a super complaint made by the Consumers Association (WHICH) in 2005. The OFT report did make a number of recommendations, one was to allow registered professionals with the GDC, other than dentists, to set up and manage the business of dentistry; hence independent practice was born. It is a tough and challenging working environment which any dentist will tell you and it is no different for me but it’s certainly not Direct Access.

Here we are, nearly a decade on and the OFT are relooking at the issue of Direct Access and diagnosis. All I want to do is treat patients within my scope of practice, and provide my patients with an accessible, high quality service. I am sure many dental hygienists/therapists want what I want - to be recognised for the importance of having your say on this controversial issue

Unfortunately the ‘under prescription’ rule still stands - a patient cannot see a dental hygienist or therapist to have their prevention and oral hygiene needs met without a dentist’s permission. However, they can take a copy of their treatment plan to any clinician of their choice. My experience, which is shared by many of my colleagues, is that very few patients are given an in-depth treatment plan, a diagnosis or even an accurate BPE.

SM: BPE has been around for nearly 25 years and is taught as part of the undergraduate training, irrespective whether the student is studying BDS or hygiene/therapy; they are taught together. All the students’ learn this in their second year, so it gives them ample time to consolidate this and use it as a diagnostic and treatment tool. When our competency is constantly questioned, it should be noted that as our scope of practice has changed over the years, so has the robust core training programme that underpins our profession.

CC: Sarah, with such a simple diagnostic treatment tool that’s been around for 25 years, why in the most recent Adult Dental Health Survey, are perio disease levels still so high?

SM: Well I think people have ‘white coat syndrome’ and get nervous about seeing their dentist. In a survey by the British Dental Health Foundation for last year’s launch of National Smile Month, it was stated that people were more frightened of their dentist than they were of snakes and spiders. Patients are customers at the end of the day, who want fresh, white teeth and healthy gums, and they feel that hygienists and therapists can provide this and are (as a professional group) possibly seen as less threatening.

CC: I agree with you, the Adult Dental Health Survey also said that 12 per cent of the population do not go to the dentist due to dental anxiety, so, this core group do not receive any oral cancer screening, any prevention advice or smoking cessation advice. Why then, in the 78 per cent that go to the dentist, is the level of periodontal disease so high? One might question if the BPE, the very simple diagnostic tool that we are all taught, may not be being used accurately or widely enough.

SM: It is true to say that students know how to carry out a BPE, what pressure to put on the probe (25g of pressure), they know about angulation and they are aware of operator variables, so it is being taught and used in dental school, but do patients know the uptake of this after they leave. Is it being used? Is it accurate? Do we know how many hygienists get a BPE from their dentist in their treatment plans? How many of the teams actually calibrate with their therapists to ensure intra and inter operator accuracy? In terms of a clear diagnosis, other than a dentist saying the patient has gum disease – how many times are you advised whether it is chronic or aggressive - you are often left to decide this for yourself. Evidence is the key thing here and whilst we all have knowledge of this, do we memorise the treatment plans or accurate diagnosis we don’t have the evidence. This is why we are asking that dental hygienists and therapists help us collate the evidence that we need to support this. Our survey seeks to establish the evidence surrounding referral practice for dental hygiene treatment. Please complete our Survey Monkey questionnaire. Even if you are happy with the status quo, we want your views. Join the 300 who have already completed the survey. You are asked to give your GDC number for validation purposes only this data will be collated without reference to the participant.

Go to www.surveymonkey.com/w/HK856E or go to www.bsdt.org.uk and click on Direct Access Action Group survey on their front page.

The GDC is also asking for your views please take time to fill out their survey, https://response.questback.com/thegeneraldentalcouncil/yyrulknku/

Change won’t happen if you say nothing at all.

About the authors

Sarah Murray teaches dental hygiene and therapy at Barts and The London School of Medicine and Dentistry, in addition to teaching at the University of Essex. She believes that both dental hygienists and therapists have the skills and abilities to undertake Direct Access for patients acting in the patients’ best interest.

Christina Chatfield, a dental hygienist, is clinical director and owner of Dental Health Spa Ltd in Brighton. She has more than 20 years’ experience in practice and qualified from Huddersfield in 1992. She is currently studying a two-year Diploma in Periodontology at King’s College Dental Hospital in London.
Six Month Smiles - straight teeth in less time

Nick Simon explains how GDPs can offer patients a great smile in just six months

The Six Month Smiles Short-term Orthodontic System is a system that allows GDPs to meet the needs of patients who have crooked or spaced teeth in an average of just six months, using clear braces and tooth coloured wires. The system, like aligners, is cosmetically focused – it is not a replacement for traditional orthodontics. The goals of treatment are not as comprehensive but it provides a much needed alternative for adults that aren’t interested in conventional orthodontic treatment.

The short treatment times associated with the Six Month Smiles System are possible for two primary reasons:

- Cosmetically focused treatment goals
- Unique and specific brackets and wires

The short-term orthodontic brackets are pre-positioned at the Six Month Smiles case processing facility and placed in clear bonding trays. This makes bracket placement extremely easy and precise. Additionally, the orthodontic wires have shape memory and work in conjunction with the pre-positioned brackets to gently guide the teeth into their new position. As the arch-wires return to their original shape via their shape memory, the overall symmetry of the smile is dramatically improved as the teeth are straightened. The Six Month Smiles System utilises tooth coloured arch wires and clear brackets, both of which are very patient-friendly because they are barely visible. These inconspicuous appliances, together with the short treatment times, overcome the usual objections patients have when considering traditional orthodontic therapy.

Within the dental community and among orthodontists, braces are widely recognised as the most effective and efficient method of straightening teeth, giving the most predictable result.

Fig 1 The patient’s smile before treatment showing crowded and crooked teeth.

Fig 2 The same patient with a brace fitted. Note the tortuous route taken by the fixed wire.
Many treatments are possible using the Six Month Smiles System. It can be used to:

- Alleviate crowding, overlapping, rotated teeth and high canines
- Correct anterior crossbites
- Alleviate crowding, over-lapped, rotated teeth and high canines
- Close spaces
- Treat open bites of dental-vestibular cause
- Level the gingival zeniths
- Treat deep bites
- Over-erupted teeth destined to be replaced with implants to increase the bone available for placement
- Provide rounded arches, free of crowding, for future veneer preparation

However, Six Month Smiles is not generally used to treat the following conditions:

- Correction of molar relationships and posterior bite discrepancies
- Large open bites and those of skeletal origin
- Bilateral cross bites

Offering Six Month Smiles treatment has many advantages for dental practices. Most importantly, it is a treatment that patients are keen to have and many of your current patients would most likely benefit from it. It also helps to promote further cosmetic dentistry - veneers require significantly less preparation when placed on aligned teeth compared to crowded teeth. It is typically more economical for the patient than conventional orthodontics and, for dentists, it is an enjoyable and satisfying treatment to perform.

Six Month Smiles offers regular clinical training, through two-day hands-on seminars. Even GDPs with no previous orthodontic experience can leave a seminar with the confidence and knowledge needed to select the proper cases and treat them appropriately. Advanced level training and clinical support are also on offer together with a complete package of marketing materials, tools and accessories.

You can learn more about Six Month Smiles at www.SixMonthSmiles.com.
Today's patients expect restorations that are both functional and aesthetic. Unlike yesteryear’s, today's patients have better knowledge of the advanced materials available and state-of-art equipment. Consequently, they have high expectations when designing their smile and other procedures to achieve optimum results. The specialist’s main aim is to achieve complete oral rehabilitation in the most conservative manner.

When choosing a treatment option, dentists and technicians must satisfy both the clinical criteria and the patient's expectations. To design the optimal outcome for a patient during aesthetic enhancement, the dentist must seek to create a symmetrical and harmonious relationship between the lips, gingival architecture and the positions of the natural dentition.

Case report
A 27-year-old patient visited our practice with the chief complaint of attrition in the lower front teeth and generalised discoloration of all the teeth. He also complained of reduced visibility of the lower anterior teeth along with blackish discoloration of the gingiva.

Examination and treatment plan
Clinical examination revealed attrition of the lower anterior teeth up to the level of the mid-third of the coronal tooth structure in relation to teeth #31, 32, 41 and 42. All the teeth were discoloured and extrinsic stains due to the patient's seven-year history of tobacco chewing (as reported by the patient) were present.

Overall gingival asymmetry was observed. Generalised pigmentation of the gingiva was also observed (Figs 1, 2). It was decided to treat the patient in four phases.

Phase 1: Preliminary phase
Impressions were taken and study models were prepared. An OPG was taken. Oral prophylaxis was done. The patient was recalled after two days for further treatment.

Phase 2: Surgical phase
The second phase entailed a laser-assisted gingivectomy and laser-assisted endodontic sterilisation.

Gingivectomy
Lasers offer increased operator control and minimal collateral tissue damage. The fine tip of the diode laser can be manipulated easily to create!
ate the gingival margin contours required to perform the aesthetic crown lengthening procedure. The surgical site was anaesthetised and the biological width was determined.

A 980nm diode laser with a 400μ cable was used for the surgical procedure. The amount of gingival tissue to be incised was outlined. Initial incision for the laser-assisted gingivectomy was similar to that of using a blade with an external bevel approach. The distance of the incision from the coronal marginal gingiva is based on the pocket depth and the amount of attached gingiva. The gingival chamfer is achieved and the initial cut is made slightly apical to the pocket depth measurement. A slow, unidirectional hand motion is used, moving the tip at an external bevel towards the tooth structure. Caution is necessary, especially near the root structure, because of a possible laser - hard tissue interaction, which could harm the tissue. During the course of surgery, care was taken to maintain the biological width and to preserve the attached gingiva (Figs 3, 4, 5).

The access cavity was prepared according to the traditional method. The rotary instruments were used along with the ProTaper files for cleaning and shaping the root canals.

Sterilisation

A 980nm diode laser with a 200μ cable was used for sterilisation of the canals along with regular chemical disinfectants. The advantage of laser sterilisation to a conventional irrigant regime to provide sterilisation is that while irrigating solutions have a limited depth of penetration, the laser beam transmitted through the tip of a fibre is emitted in a lateral direction and has an effective penetration depth of more than 1,000μm. This was followed by obturation and coronal access restoration with composites. The patient was recalled after one week for further treatment.

Phase 3: Aesthetic phase

The third phase entailed laser-assisted depigmentation and laser-assisted bleaching.

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**Depigmentation**  

The diode laser was used at 2W, continuous wave in a defocused mode. This causes a reduced depth of penetration, ablating only the superficial epithelium, which primarily contains the melanin pigments, leaving behind a carbonised layer. Only a surface anaesthetic spray was used for this procedure.

**Bleaching**  

Laser light has the unique property of being absorbed by the chromophores. These emissions can be added to the bleaching gel, which are capable of absorbing laser energy and thus inducing and promoting a fast, safe and effective reaction. Check and tongue retractors were positioned and a dry operatory were maintained.

The gingival protection material was applied along the margin of the gingival covering approximately 1mm from the tooth surface in the cervical region. The bleaching gel was applied to teeth #41, 21, 12 and 22. Each tooth was then irradiated for 30 seconds in the same sequence, constantly moving the tip of the laser, so that the laser energy was not directed at one place (at 1W). Fluoride gel was applied to each tooth at one place (at 1W). Fluoride gel was applied to each tooth at one place (at 1W). The gingival protection material was then removed, the occlusion was adjusted and contours were checked.

The patient was recalled after six days for the cementation of the crowns. Excess cement was removed, the occlusion was adjusted and contours were checked.

The final result showed that the definitive restorations and the soft-tissue procedures had restored the normal form, function and harmony of the oral cavity, while keeping the patient’s functional and aesthetic concerns in mind.

**Conclusion**  

Dental lasers promote patient compliance through the non-invasive nature of treatment, faster recovery time and reduced post-operative discomfort. The use of laser reduces chairside time and improves operator efficiency and thereby reduces fatigue.

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**About the author**

Dr Kirpa Johar

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**DENTAL TRIBUNE** United Kingdom Edition  
May 21–27, 2012

**Cosmetic Tribune**
A female student of 20 years of age was referred for a consultation regarding replacement of her failing resin bonded bridge (Fig 1). She gave a history of having congenital absence of the maxillary right lateral incisor tooth. Fixed appliance orthodontic treatment had been used to create adequate mesio distal space for a bridge pontic. The space measured 7.5mm.

There was a deficiency of the labial plate in the 12 site and the patient complained of a dark appearance at the gingival zenith of the bridge pontic. The bridge had repeatedly decemented and had a poor fit where excess cement was present and possible proclination of the bridge retaining tooth 11 had occurred (Fig 2).

Treatment options were discussed, including a further resin bonded bridge, a removable partial denture or an implant retained crown. Poor long-term success rates for resin-bonded bridges with failure rates of up to 75 per cent after six years can be expected.1 The patient and her parents decided to proceed with the implant option.

Initially study casts were fabricated and an in-house cone beam CT scan undertaken (Gendex i Cat) to achieve a 3D image of the proposed implant recipient site. The scanned zone was minimised to reduce the radiographic exposure to the patient.

The scan result confirmed a narrow ridge, but adequate width for placement of a narrow platform 3.5mm NobelReplace Tapered Groovy implant with simultaneous guided bone regeneration using a xenograft (Bio-Oss and Biogide Membrane) (Fig 3).

We planned to use the new NobelReplace Tapered Groovy implant with a conical connection. This is a combination of the successful Replace implant with a different platform connection based on the NobelActive implant, which is designed to provide a tight coronal seal and a platform shift which gives good aesthetic results by reducing the microgap. With a platform shift concept, designers aim to move the implant abutment interface away from the periphery of the implant thus attempting to maintain good bone levels. When possible, it is intended to place the conical connection implant slightly sub-crestal to allow bone deposition coronal to the implant platform.

We find the NobelReplace Tapered Groovy Implant easy to place and have confidence in achieving good primary stability with the tapered implant profile.2

A surgical guide was fabricated to allow angulation of the implant for a screw retained crown. Whenever possible, I use screw retained crowns to prevent the necessity of cement with the potential risk of cement extrusion on cementation and also to facilitate retrievability.

A crestal incision with buccal flap elevation with no relieving incisions was used to minimise the risk of compromising the blood supply to the mucoperiosteum. Confirmation of a narrow ridge was made and osteotomy preparation undertaken up to 3.5mm diameter and 10mm length (Fig 6).

A Nobel Replace Tapered Conical Connection implant was inserted at 35Ncm torque achieving good primary stability. The coronal 2.0mm of

Philip Pettemerides presents a case using the new Nobel Biocare conical connection implant

Fig 1

Fig 2

Fig 3

Fig 4

Fig 5

Fig 6

Fig 7

Fig 8

′I find the NobelReplace Tapered Groovy Implant easy to place and have confidence in achieving good primary stability with the tapered implant profile′
weeks later. The Nobel-Procera CAD-CAM technique was employed whereby our laboratory, Fusion Dental in Newbury designed the framework, scanned the resin tem-
plate and forwarded this to the Nobel Biocare facility in Stockholm. The feldspathic ceramic was built up expertly by Eva Forst directly onto the Zirconia. This material gives good biocompatible results and excellent aesthetics (Fig 8). The screw access hole can be almost invisible with matching composite resins. The use of ceramo-metal restora-
tions can be an aesthetic issue with mandibular resto-
rations when it can be difficult to mask the metal of the screw access hole.

A balanced aesthetic result was achieved with a gingival zenith matching that of the contra lateral tooth. Colour and texture of the peri-implant gingival tissues was con-
sidered good although further maturation of the labial tissue is expected to occur. There was a slight loss of mesial papilla pre im-
plant placement but due to good interdental crestal bone levels (Fig 9) on the adjacent teeth, I expect full papillary infilling to be restored within the next six months as per Dennis Tarnow’s study. The patient and her parents were pleased with both the functional and aes-
thetic result.

I feel we have achieved a good result very simply, using the latest offering from Nobel Biocare, based on sound biomechanical prin-
ciples and bio-compatible materials.

References
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About the author
Philip Pettemerides BSc BDS Dip Imp Dent graduated from the University of Sheffield in 1978 and is the principal dentist at Edgar Buildings Dental Care in Bath. His many member-
ships include Executive Committee Member of the British Academy of Aesthetic Dentistry. Philip achieved the Certificate, Advanced Certificate and Diploma in Implant dentistry with distinction from the UCL Eastman Dental Institute, and trained in the All-on-4™ under the guidance of the concept’s founder, Paulo Malo, in Lis-
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Fig 9

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There was a time not so very long ago when dentists looking for advanced education, especially in the field of cosmetics, really had no choice but to travel to the USA. Times have changed!

At the recent eighth Annual Conference of the British Academy of Cosmetic Dentistry (BACD), more than 30 excellent lecturers, nearly all from the UK and Europe, delivered a meeting that was described by the delegates as “the best one ever”.

What is the secret of the success of a major seminar? Balance - balance between subjects and ideas and between approach and execution. Variety - most delegates were general practitioners; therefore, a conference concentrating on a single theme would not have been appropriate to everyone present.

The theme of the meeting was “Minimal intervention”. How can we produce the best possible results while doing the least amount of damage? The days of aggressive crown and veneer preparation are over. This seminar highlighted the use of composite resin and minimal or no-preparation full or additional veneers.

And there was more! The meeting offered lectures and workshops on numerous subjects to help build better practices, as well as seminars on photography, practice management, marketing and team-building for clinicians and all dental team members.

Who was speaking? There were too many to list therefore apologise to those not mentioned! Amongst the well-known clinicians who shared their experience and learning was Dr Mauro Fradeani, who lectured on the opening day of the three-day conference. This outstanding clinician explained in detail the choice and protocols demanded for the production of metal-free ceramic restorations.

Dr Sanjay Sethi, who is passionate about minimal intervention but requires the very best aesthetics for his patients, stressed that all dentistry must follow strict ethical guidelines.

Prof Trevor Burke expanded on the theme of “Do no harm” and encouraged practitioners to make the best possible use of remaining tooth structure as a framework for building reliable restorations.

For Dr Federico Ferraris adhesion is the key! Whether using direct or indirect procedures the avoidance of microleakage is paramount in producing excellent longevity.

Dr Joerd van der Meer spoke about digital impression, a technology that is improving rapidly and opening exciting possibilities.

In his lecture, Dr Jason Smithson explained that warm
composite undergoes better monomer conversion, leading to stronger posterior composite fillings, and described his technique in detail.

Our dental trade partners supported the conference with an exhibition that featured more than 40 companies supplying a variety of products from further educational material to high-technology equipment.

Let’s get back to balance - this time I am referring to the balance between work and play! Delegates enjoyed many treats during the meeting, including entertainment during the Opening Ceremony, a drinks reception featuring traditional Turkish dancing and a Gala Charity Dinner, during which a substantial sum was raised to support Bridge2Aid, a charity working amongst the underprivileged in Africa. Balance is important. This year, there were few American accents. Next year, there will be more. It is valuable to consider trends and treatments from both sides of the Atlantic to be able to form a balanced view of the international future of dentistry and make decisions about where we want to place ourselves in this.

If you missed this meeting, you missed what delegates described as “The best BACD meeting ever!”

Make sure you come to the next one!

### Honigum. Overcoming opposites.

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As patients get older, anterior teeth commonly show wear, chipping and discoloration. These changes are the result of a number of factors associated with ageing. There is increased awareness of these unattractive teeth and the desire to have a more youthful appearance. Because of the recent media attention on changing one’s appearance with veneers, there is a much greater demand for cosmetic dentistry procedures.

Over the years in the practice of dentistry, I have developed products and techniques that have improved my practice significantly. However, it was not until I took on an associate, who had been in practice for 18 years that I became aware that these were new and innovative ideas to him, as well as to other dentists he knew.

I have been placing veneers for more than 25 years and developed a technique that can make a single veneer blend so naturally that it’s undetectable. Various nuances in technique make preparing and bonding veneers quick and easy.

I have a CEREC machine that works especially well for a single veneer. Six or eight veneers can be done on the CEREC, but this is then rather time consuming. Two or three cases of the same number of teeth could have been prepared, impressions taken and sent to a laboratory in the same period. It is more cost effective to use a laboratory but you have to have the best laboratory available to you if you expect perfect results.

Feldspathic porcelain is the only material that will look natural. Pressed ceramics will look more opaque, somewhere between a porcelain-fused to metal restoration and a natural tooth. For patients requesting brilliant white, feldspathic porcelain can work well too and one can adjust the colour by the bonding composite used under the veneer.

Very little shade adjustment can be done under pressed ceramic porcelain. Flowable composites work the best and come in many shades, which makes shade adjustments easy. The flowable composite by Kerr has the right consistency for veneers and with OptiBond Solo the company offers the strongest bonding agent.

The preparation requires only a little more than 0.5mm of reduction so that it does not go through the enamel, if possible. The bond is the best on enamel. There should be the same reduction over the total facial surface for the laboratory to make a perfect veneer. Cut three or four depth grooves of 0.5mm then remove the enamel to the grooves.

If instant orthodontics is the treatment plan, some teeth may need to be reduced more and others less. Run the preparation interproximally from gingival to incisal to hide the margin visually, but do not break the contact point. The gingival margin should be at the gingival crest or a little below. It should have a chamfer for ease of finishing, precluding any chipping at the margin. Some dentine will show through at the gingival margin because the enamel is less thick there. If there is room, insert a thin piece of gingival braid, which can be left there during the impression. Reduce the incisal by approximately 1mm so the finish line is on the lingual, and round the incisal-facial junction so that there are no potential fracture lines in the veneer.

When the veneers come back from an excellent laboratory there should be little or no adjustments necessary before bonding them to the teeth. Etch them with hydrofluoric acid gel for at least three minutes. Rinse them thoroughly, neutralise them with a baking-soda slurry and then rinse them thoroughly again. Dry them with a dry air source until a chalky appearance is visible on the interior of the veneer. Ceramic primer is then applied for one
minute. Dry until it is chalky again and apply another coat of ceramic primer. Leave the primer on while the teeth are etched with phosphoric acid gel for 50 seconds. Rinse thoroughly and dry the teeth and veneers until a chalky appearance shows on both.

Turn the operatory light off and then apply bonding to the teeth and the veneers. Place the flowable composite onto the veneers one at a time for placement. Place all of the veneers and ensure they are correctly situated. With two hands, hold the distal two veneers (teeth #5 and #6) in place leaving a space only large enough for a curing light to shine in between. Shield the rest of the veneers with your hand so that the light will not set any of the other composite except the interproximal space between veneers #5 and #6. Cure for only two seconds. Now cure the distal of veneer #5 for two seconds.

Move your hands to veneers #6 and #7, shielding the rest of the veneers and holding veneer #5 and #6 in place, leave just enough room to cure the space between #5 and #6 for two seconds. Repeat the same process for the rest of the veneers, moving from #7 to #8 and so on, until all of the interproximal spaces have been cured for two seconds each, including the distal of the last veneer on the other side.

Now cure the centre of each veneer for two seconds and then the lingual incisal of each for two seconds too. If cured for longer than this, it is very difficult to remove the excess composite and much time is consumed in the process.

The first step in removing the excess composite is the use of a Bard-Parker #12 scalpel. With a palm grasp and...
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Re-establishing a physiologic vertical dimension for an over-closed patient

Dr Derek Mahony presents the first article of this two-part series

The term neuromuscular occlusion has become associated with certain limited methodologies that are used to obtain a muscle-compatible occlusal relationship. In reality, there are several different approaches that can be used to determine a “neuromuscular” maxillo-mandibular relationship, even with a fully edentulous case. Within each method, however, the common basis for all muscle-oriented approaches involves first determining the resting length of the masticatory muscles.

Historically, opening the bite has been considered hazardous and/or foolishly by many dentists and with good reason. Arbitrary opening of the bite, especially when accomplished strictly on an articulator, can result in a difficult, uncomfortable and unappreciative patient. Some dentists have recommended against ever opening a bite, perhaps after an especially troublesome experience with a patient.

In spite of the risks, there are some advantages associated with opening an over-closed bite. The identification can be traced back at least 70 years to an ENT physician, Dr J B Costen.19 Dr Costen discovered, perhaps quite by accident after referring many of his symptomatic, edentulous patients to a local dentist for new dentures, that many returned with their head and ear pain symptoms greatly relieved. His publications were positively received at the time, several studies have subsequently evolved the current array of neuromuscular registration methods presently in use. At the same time, several studies have demonstrated that a muscle-determined position, although similar, is not identical to centric relation.

Common signs and symptoms of over-closure

When asked, over-closed patients often report symptoms such as frequent headaches, dull pain of the elevator muscles and pain or stiffness in their neck muscles. Ear stuffiness, tinnitus and/or vertigo are also commonly reported. A more subtle symptom, less often reported, is frequent gastrointestinal distress in various forms that has no clear, identifiable cause. This may also be accompanied by a report of difficulty in chewing and/or swallowing. An over-closed patient will usually report several, but not all, of the following symptoms:

1. Frequent headaches with no identifiable cause
2. Ear stuffiness with no indication of ear pathology
3. Difficulty in chewing tough foods
4. Difficulty or discomfort in swallowing
5. Frequent gastrointestinal distress
6. Vertigo
7. Tinnitus
8. Persistent dull pain in masticatory elevator muscles
9. Neck pain or stiffness
10. Possible increased wear of incisor teeth

Under examination, a number of signs indicating over-closure may appear.

These include:
1. A measured freeway space greater than 5mm
2. EMG or visual identification of a tongue-thrust swallow
3. The appearance of less than fully erupted molars
4. A deep curve of Spee
5. One or more posterior edentulous spaces
6. Lingually tipped mandibular molars
7. EMG identification of elevator muscle hyperactivity at rest of more than 2.0 microvolts average (or 2.2 microvolts RMS)
8. Worn and shortened teeth (there is no scientific evidence that human teeth “grow out” in response to wear in the way that elephant’s teeth do)
9. Horizontal skin creasing and saliva weeping at the corners of the mouth
10. A so-called “Shimbashi” measurement (in centric occlusion) of less than 16mm from the cemento-enamel junction of the maxillary central incisor to the cemento-enamel junction of its opposing mandibular tooth
11. Long-term chronic internal derangement of the TM joint(s)

However, patients rarely seek dental treatment for any of these objective signs. Instead, they are more likely to seek rehabilitative treatment for headache, jaw-ache, ear-ache, difficulty in chewing/swallowing or for purely aesthetic reasons.

In other cases, they are unaware of their condition, apparently due to their excel lent adaptability. In the over-closed patient the “reason” for treatment, either cosmetic or functional, is often depend ent on his/her individual adaptability than on the dental condition present. While some signs simply indicate the “progress of the destruction” that a pathological maxillo-mandibular relationship fosters, other signs may indicate a successful adaptation.

1. Freeway space > 5mm (if pain level is low, it is an adaptation, otherwise it is not)
2. Tongue thrust swallow (if full arch tongue thrust, usually a successful compensation)
3. The appearance of less than fully erupted molars (tongue inhibition of natural eruption)
4. A deep curve of Spee (often associated with one or more missing molars or a deep anterior overbite with retroclined upper incisors)
5. One or more posterior edentulous spaces (leads to deep curve of Spee)
6. Lingually tipped posterior teeth (tongue thrust during swallowing, restricted maxillary arch)
7. Hyperactivity of elevator muscles at “rest,” (an adaptation, successful if no elevator muscle pain)
8. Worn/short teeth, abfractions (ground off) (not a successful adaptation)
9. Skin creasing at corners of mouth (may appear as an aesthetic problem only, not an adaptation)
10. Saliva weeping at corners of mouth (an aesthetic and functional problem, not an adaptation)
11. CEJ (cemento-enamel junction) to CEJ in C.O. < 16mm. (less than the normal adaptive range)
12. Internal derangement(s) of the TMJ (if no degeneration, may be a successful adaptation)

Maxillo-mandibular bite relationships

Centric Occlusion (CO = habitual)

The maxillo-mandibular position of maximum intercus- pation is most often the dental treatment position, primarily by default. This is of necessity whenever single tooth preparations or small restora tions are involved, since they must fit within the patient’s existing occlusal scheme.

Fig 1 BioJVA* testing for normal TM joints

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*TMD = Temporomandibular Disorder

**CO = Centric Occlusion

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United Kingdom Edition

Costen.1-3 Dr Costen discovered, perhaps quite by accident after referring many of his symptomatic, edentulous patients to a local dentist for new dentures, that many returned with their head and ear pain symptoms greatly relieved. His publications were positively received at the time, several studies have demonstrated that a muscle-determined position, although similar, is not identical to centric relation.

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The maxillo-mandibular position of maximum intercus- pation is most often the dental treatment position, primarily by default. This is of necessity whenever single tooth preparations or small restora tions are involved, since they must fit within the patient’s existing occlusal scheme.
It is only at times of major reconstructive, orthodontic and/or surgical treatments that the option of opening a bite or establishing a new maxillo-mandibular relation may present itself. However, many clinicians still prefer to “play it safe” and retain the existing habitual (CO) maxillo-mandibular relationship, even during major rehabilitative procedures.

By definition, the use of centric occlusion as a treatment position excludes re-establishing a proper vertical dimension in an over-closed patient’s. However, if the patients condition is actively deteriorating this may not be a safe option at all, as the continued physiologic breakdown may lead to failed dentistry and/or a flare up of craniofacial pain.

Centric Relation (CR)
The concept of centric relation has a very long history and was originally devised, at least in part, to accommodate the use of articulators during prosthodontic treatment.

Although we now know that the jaw doesn’t function like a hinge, originally it was convenient to make that assumption when using articulators to make prostheses. Today, one clear difference between centric relation procedures and strictly muscle-oriented methodologies is the priority given by CR methods to evaluating the function of the temporomandibular joints. Typically, centric relation operators give first priority to establishing stable joint function, while muscle-oriented (neuromuscular) approaches tend to focus almost exclusively on muscle comfort, position and/or stability secondary to muscle function. In the extreme, it is simply assumed that creating “happy muscles” will automatically provide good or at least adequate joint function. In a more practical view, both joint function and muscle function are seriously evaluated and, when indicated, a compromise is sought to provide both joint and muscle compatibility. This represents an approach that bridges the gap between strict CR and rigid MC approaches.

Muscle-related Centric (MC)
Consequently, a variety of methods have evolved to capture and establish a muscle-related centric position, while maintaining favorable joint function.

Requirements of proper Neuromuscular Occlusion (NMO)
The first step in all approaches to NMO requires inducing relaxation in the masticatory musculature, however, there is no rational excuse for not evaluating TM joint function prior to beginning the process. This can be accomplished quickly and easily with Joint Vibration Analysis (JVA see Fig 1), or with more expensive and invasive imaging such as MRI. Muscle relaxation can be aided by Ultra-Low Frequency TENS (ULF-TENS, see Fig 2), an Aqualizer, soft music or any other technique that reduces the resting hyperactivity of the masticatory muscles. Surface electromyography (see Fig 5) is useful for making a quantitative determination whether relaxation has occurred or whether resting muscle hyperactivity still exists. Needles and/or fine wire electrodes not only make relaxation less likely, they record a more localised signal that is less representative of overall muscle activity.

There are several methods currently used for selecting the treatment vertical. Each has its own rationale and advantages, but all of them benefit from objective diagnostic aids to ensure the best compromise between optimum joint, muscle, and tooth function.

- The TScan range is distributed in the UK by Indent Systems. For further information please contact Indent Systems on 01932 562800, email mike@indentsys.co.uk or visit www-indentssystems.com

* The second part of this article will appear in issue 14

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* The second part of this article will appear in issue 14
Use your head for pain relief cure

The very first step to treating patients with suspected migraines is the easiest one to remember, says Pav Khaira. “As dentists, we are not allowed to diagnose migraines and headaches, or to give them a classification,” says the dentist, who has a special interest in migraines and pain relief.

Any dentist considering increasing the focus on pain relief offered by their own practice must keep this in mind, he says. “Whatever they do has to be done in conjunction with a GP or neurologist, or whoever the patient’s medical specialist is. That is very important. One of the first questions I ask patients when they come in to my practice for the first time is ‘Have you seen a doctor?’”

No resistance
Pav insists that keeping the patient’s doctor informed of any dental treatment is vital, and he would not provide treatment to anybody who refused him permission to contact their doctor. “But I’ve never had any resistance. I explain that I am not allowed to diagnose this kind of thing and that they have to be monitored by one of my medical colleagues. They are very, very happy with that if it offers them the prospect of being pain free,” he says.

Exclusion criteria are used to confirm that the patients are indeed suffering from migraine. “It’s a tick box process,” says Pav. “If they answer yes to x number of questions, and if the symptoms are not attributable to any other pathology, then they are classed as suffering from migraines.”

The involvement of doctors

The patients of all dental practitioners could benefit if more attention was paid to pain relief and conditions such as migraines, says Pav Khaira.

Could migraines be the answer?
Migraine sufferers don't tend to put formal classifications on their level of headache. Migraine sufferers often, due to the nature of the condition, suffer in silence. But being released from the debilitating pain of constant headaches can lead to enormous improvements in their quality of life. Migraines most commonly affect women, but sufferers can be from any walk of life.

Migraine sufferers often, due to the nature of the condition, suffer in silence. But being released from the debilitating pain of constant headaches can lead to enormous improvements in their quality of life. Migraines most commonly affect women, but sufferers can be from any walk of life.

Pav has recently encountered a patient in his teens, who was in such frequent pain that he was only attending school on average twice a week. The problem had been ongoing for three years, with the obvious implications such pain has on education. "If we can get him out of pain he can go back to school and get on with his life," says Pav.

The second instalment of this article will look at how migraine and bruxism issues manifest themselves in the mouths of patients.

If you understand the anatomy of what is going on you can really help. I'm not saying you can solve 100 per cent of cases, but you can offer pain relief to a lot of these patients and they are very grateful for it.

Careful examination can, in conjunction with the proper training, throw light on other issues too, says Pav: "It can help explain some of the more bizarre pains and sensitivities patients are having... when you understand this approach you can diagnose a lot of them. And that includes sensitivity of teeth, facial pains and neuralgias. If you understand the anatomy of what is going on you can really help. I'm not saying you can solve 100 per cent of cases, but you can offer pain relief to a lot of these patients and they are very grateful for it."

Migraine sufferers often, due to the nature of the condition, suffer in silence. But being released from the debilitating pain of constant headaches can lead to enormous improvements in their quality of life. Migraines most commonly affect women, but sufferers can be from any walk of life.

Pav has recently encountered a patient in his teens, who was in such frequent pain that he was only attending school on average twice a week. The problem had been ongoing for three years, with the obvious implications such pain has on education. "If we can get him out of pain he can go back to school and get on with his life," says Pav.

The second instalment of this article will look at how migraine and bruxism issues manifest themselves in the mouths of patients.

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Big Bite from The Dental Directory

Promotions and offers from The Dental Directory are back, taking another chunk out of prices on selected oral health products just in time for National Smile Month. The Dental Directory’s bi-monthly Big Bite promotional newsletter catalogues in bulk, offering pages of promotions and reduced prices. The Big Bite continues today in its commitment to providing extremely competitive pricing, as well as its usual range of terrific products.

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84 Industry News

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Dr M Booyens is principle at Dental Surgery, Heybridge, and recently invested in a Kavo Primea 1058 dental unit, and Belmont Phot-X W-Mounted X-Ray: “I am a long-time user of The Dental Directory and have always been very pleased with the service I have received. Their rep, Daren Hare, was especially helpful and highly recommended the KaVo unit and Belmont Phot-X system, which I am very pleased with. All-in-all, a very good service.”

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Dr Powell said of the elexxion Pico Laser: “The laser can be used in a wide range of treatments and endodontic work where it can sterilise the root canal. The laser energy is indicated for both periodontal work and endodontic work where it can sterilise the root canal. The laser energy is indicated for both periodontal work and endodontic work where it can sterilise the root canal. The laser energy is indicated for both periodontal work and endodontic work where it can sterilise the root canal. The laser energy is indicated for both periodontal work and endodontic work where it can sterilise the root canal. The laser energy is indicated for both periodontal work and endodontic work where it can sterilise the root canal. The laser energy is indicated for both periodontal work and endodontic work where it can sterilise the root canal. The laser energy is indicated for both periodontal work and endodontic work where it can sterilise the root canal. 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smart dental compressor solutions from Absolute Air & Gas offer free five-year warranty. Ekom, the leading European manufacturer of oil- free air compressors for the medical and dental markets, is launching a range of smart cabinet- based compressors in the UK & Ireland, which come packed with a one-year’s warranty as standard. Our expert solution means that its cabinets – available from Absolute Air & Gas – don’t require routine maintenance less than 50 dB(A). The 3kW Ekom DK50S2 6V air compressors cover single to multiple surgeries, are endorsed for their high-quality, functionality and offer a reception product that meets the most stringent demands of the medical industry, including TRAG2012 and medical air standards if required. With a working pressure of 6-8 bar, the continuously-rated DK50 & DK50 2V compressors feature Siemens electric motors, a range of tank solutions (from 50 litres to 3000 litres), and an innovative control system designed exclusively from Nuview, Carl Zeiss dental loupes are precision engineered for optimal clarity. Dr Fiona Knight of Sensodyne Dental, Fareham was particularly impressed with the Carl Zeiss Eyemagn Pro loupes: ‘I’ve been using Carl Zeiss loupes for some time now, but this is the first time I really looked at how much the loupes have improved.’ The sales team from Nuview were especially helpful – they even came out to visit the practice. Designed specifically for the dental profession, Carl Zeiss dental loupes are a benchmark for design and function. Precision optics allow optimal visualisation of the treatment area, giving practitioners the means by which to deliver an elevated level of care.

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