Dental associations speak up over whitening debate

Could this be the call for reclarification on whitening products?

The British Dental Association (BDA) has already expressed concerns that any supply problem could mean patients seek whitening treatments from non-dental professionals, which is illegal and dangerous.

The BDA would like to see the previous low-key approach to enforcement around the supply of whitening products to dental professionals previously advised by Local Government Regulation (LACORS).

The BDA is aware that the current investigation by trading standards officers to maintain the low-key approach to supply of whitening products to non-dental professionals previously advised by LACORS and taken by trading standards re-instated.

A full examination must take place before any bleaching procedure.

Informed patient consent is paramount and patients must have alternatives and risks thoroughly explained.

Before and after photos must be taken and retained throughout the course, and following completion of treatment.

Any products supplied for home use by a dental practice must meet Scientific Committee on Consumer Products (SCCP) guidelines.

There should be a commitment by the trade not to supply beauticians or the public direct.
have you got what it takes to help make decisions about whether a doctor is fit to treat patients? that is the question being asked by the general medical council which has embarked on a major recruitment campaign to find medical and non-medical panellists who will sit in judgement at its fitness to practise hearings. it is the first campaign for new panellists in five years.

the panellists have a vital role in protecting patients and making sure proper standards of conduct and behaviour are maintained within the profession. they have to make independent decisions in cases where the doctor faces serious allegations which could affect their registration as a doctor.

the panellists hear evidence, decide whether the allegations are proved, whether the doctors’ fitness to practise is impaired, and if so what action is required.

there are normally three panellists for each hearing and each panel must include at least one woman and one man. they are expected to make challenging and complex decisions which protect patients and maintain proper standards of behaviour in the medical profession. they are expected to make challenging and complex decisions which protect patients and maintain proper standards of behaviour in the medical profession.

as most hearings take place in manchester, the GMC is keen to hear from candidates who live within commutable distance of manchester, although the GMC also wants to hear from suitably qualified candidates who live throughout the UK. the new panellists are being recruited to replace those whose terms of office are due to expire next year.

the GMC is holding a series of sessions where those considering applying can learn more about the role of panellists and the work of the GMC. Candidates interested in attending one of the sessions should contact panelapplications@gmc-uk.org for further details.

although in formal terms these are not public appointments, the recruitment process will be carried out in line with the guidance issued by the office of the public appointments commissioner and an independent assessor will monitor the process to ensure consistency and that it is accessible and fair for everyone who applies.

the closing date for applications is 19 June 2011. candidates can obtain further information about the posts and apply online at https://jobs.gmc-uk.org.
Editorial comment

If there is one thing that fries my circuit boards, it’s seeing something that supposedly is about the whole NHS (or even healthcare in general) but has no mention whatsoever about dentistry!

Case in point – I received an email newsletter from a law firm who specialises in the healthcare industry – promoting their presence at the next month’s NHS Confederation Annual Conference and Exhibition. ‘Hmm this sounds interesting’ I thought, and proceeded to look up the conference programme and details.

Well there was no need to get excited, because dentistry does not seem to be invited to this auspicious event! There were no speakers on dentistry, no mention of it in the commissioning presentations or workshops, and no one making their presence known at the exhibition (one point to note, the General Medical Council have a stand at the exhibition...).

If anyone happens to be going (it’s in Manchester if you’re interested) and is flying the flag for dentistry, let me know how it goes. One other bit of news that had me rolling my eyes was the ‘shock’ revelation by the Financial Times and then the BBC that the CQC are experiencing staff shortages to the tune of nearly 500 people, 133 of those being inspectors.

Now, that may be a ‘duh’ moment, but it does raise concerns about the Commission’s ability to inspect dental practices in the first year of registration for dental practices.

I have been in contact with a CQC spokeswoman to ask this very question, and when I know, you’ll know.

Join the loo queue

King’s College dental students have recently starred in Water Aid’s ‘Join the Loo Queue video’, a light-hearted and warming video of people queuing for the toilet, which was filmed all around the world.

However, besides the humorous ‘how many people can you fit in a port-a-loo’ shot, the video brings home some serious messages, showing how more than 40 per cent of the world’s population are living without a toilet and that one in eight people live without safe water. As a result, 4,000 children die every single day. One message that the video conveys is that the government could help 100 million people out of this crisis.

The video, which accompanies the Loo Queue petition that will be happening during the Glastonbury festival this summer, is a display of solidarity with those who have been waiting their whole lives for a safe, clean place to go to the toilet.

Watch the video at www.wateraid.org/loojqueue and sign the petition to call on the government to address this injustice by committing to lifting 100 million people out of water and sanitation poverty by 2015!

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*Demonstration illustrating reduction of plaque bacteria 12 hours after toothbrushing with Colgate Total vs stannous fluoride toothpaste.

Researchers uncover therapies for dry mouth

According to a recent report, researchers from the University of Louisville are closer to helping millions of people who suffer from dry mouth.

Douglas Darling, Department of Oral Health and Rehabilitation, University of Louisville School of Dentistry, and his team have identified a protein sorting mechanism used by the salivary gland.

Patients who have suffered damage to their salivary glands due to radiation therapy, prescription drugs or Sjögren’s Syndrome (an immune system disorder defined by its two most common symptoms: dry eyes and a dry mouth), could be of benefit to the scientific discovery.

Salivary glands have multiple secretion pathways: One pathway takes proteins to the salivary duct; other pathways carry different proteins into the blood or to form a supportive matrix for the cells. Transport along these pathways occurs by sorting the proteins into vesicles (hollow membrane sacs) that carry their “cargo” to the correct destination.

It was believed that cargo proteins were moved into the forming vesicles by attaching themselves to sorting receptors. However, Darling and his team have discovered a completely new approach, which suggests the reason no salivary sorting receptor protein has been found is that it may not exist.

According to a report, Darling’s new model, says that the salivary cargo protein, Parotid Secretory Protein (PSP), selectively and directly binds to a rare lipid, a type of fat molecule called PtdIns(3,4)P2, which is present only in certain cell membranes; it is also only present on one side of the membrane.

Darling also found PtdIns(3,4)P2 can flip to the inner part of the vesicle membrane - giving PSP the opportunity to bind it.

The next step is to identify ways to test the potential protein sorting mechanism.

The study, Parotid Secretory Protein Binds Phosphatidylinositol (3,4) Bisphosphate appeared in the Journal of Dental Research.

Third of children in Birmingham have tooth decay

New figures that have recently been released reveal that a third of children under the age of five in Birmingham have either missing teeth or tooth decay.

Although Birmingham Community Healthcare Trust has been encouraging children to take better care of their teeth and gums by using giant toothbrushes, the statistics show that the amount of people visiting their dentist has dramatically decreased.

It was reported that health experts have attributed the high rates of decay and obesity to poor diets that are full of sugar and fatty foods.

Quoted in the news release, Jasmin Frater, a postnatal coordinator for the under-fives programme, said that oral health care should start from a very early age and parents need to take responsibility for their children’s oral health.

Dental dilemma

It has been reported that Liverpool’s A&E and dental department, which provides an emergency service performed by student dentists, is attracting thousands of young people as they choose to visit the dentist there instead of registering with a regular NHS dentist.

Last year alone more than 6,000 patients attended the unit, costing the NHS more money than if they had visited ordinary dentists.

The Liverpool Primary Care Trust (PCT) investigated the issue and found that patients were visiting dental hospitals as an alternative to other care. It is believed that patients prefer to visit dental hospitals because the care is free and there isn’t the hassle of having to register.
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Tobacco Amnesty

A Tobacco Amnesty which has been supported by TV doctor Hilary Jones has seen hundreds of smokers ditch their old cigarettes in favour of healthier E-Lites electronic cigarettes.

According to reports, the pioneering initiative took place on World No Tobacco Day. By binning their old cigarettes in exchange for one of E-Lites' revolutionary new disposable electronic cigarettes, the event gave commuters at Liverpool Street Station in London an opportunity to try smoking without tobacco or tar. The report stated that E-Lites replicate a smoking experience, by not only being a realistic-looking device, but by turning a pure nicotine solution into a vapour that is inhaled like a cigarette.

E-Lites director Adrian Everett was quoted as saying: “The response on the day was astounding and far beyond our best expectations. People were fascinated to find that there’s now a credible alternative to real cigarettes that is healthier, cheaper and unrestricted for use in public places. The interest in our Tobacco Amnesty proves beyond doubt that smokers who are struggling to stop, or simply don’t want to quit, are open to new ideas, and just as VHS videotapes have been overtaken by DVDs and digital downloads, we believe E-Lites will render cigarettes out-dated before too long.”

Islanders lose their dentist

5,000 islanders who are about to lose their dentist have been calmed about to lose their dental practice. Mr Owen is expected to be the last to leave the practice in October when there will be a press briefing to tell everyone all about it. .

People across the islands have began receiving letters informing them about the situation. The business, which is contracted to the NHS and run from a dental surgery in St Olaf Street leased from NHS Shetland, has not been brought by a new buyer. For the moment, patients seeking emergency treatment are advised to contact the Montfield clinic or NHS 24.

Nearly half of population admit skipping bedtime brush

Nearly half of the population (47 per cent) has admitted to regularly skipping brushing their teeth at bedtime putting their oral health at risk.

Women are the most likely to break one of the three golden rules for clean and healthy teeth, with nearly six out of ten (59 per cent) regularly skipping brushing their teeth at bedtime, compared to just over a third of men (35 per cent). In contrast, relatively few people skip brushing their teeth in the morning with just one in ten people starting the day without looking after their teeth.

The findings have been revealed by the British Dental Health Foundation as part of its National Smile Month campaign, which has been running since 1972. The survey – which looked at the nation’s brushing habits – also found that over a quarter of the population (28 per cent) have admitted to not brushing their teeth for 24 hours and around one in seven people (15 per cent) have not cleaned their teeth for more than two days.

During National Smile Month, the Foundation seeks to remind everyone of the three golden rules for good oral health: brushing for two minutes twice a day using a fluoride toothpaste; cutting down on how often you eat and drink sugary foods and drinks; and visiting your dentist regularly, as often as they recommend. Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, said: “Anyone who regularly skips brushing their teeth – morning or night-time – is storing up oral health problems for the future such as tooth decay and gum disease – the biggest cause of tooth loss often resulting in the need for bridg- es, dentures or implants. Gum disease has also been linked to other medical problems such as heart disease, strokes, diabetes and respiratory disease.”

“Good oral health cannot be maintained by brushing once a day as each brushing session has a specific purpose. Brushing first thing in the morning coats the tooth’s enamel with fluoride to strengthen and protect the tooth surface against acid attacks throughout the day.”

“Brushing last thing at night removes the deposits which have built up from eating and drinking during the day, as well as removing plaque – the cause of gum disease. The last brush of the day also coats the teeth with fluoride, which is not washed away through eating and drinking, and continues to protect the tooth’s surface further during sleep,” advised Dr Carter.

I am Tubulite Barbie

Dhru Shah, dentist and founder of website dentinal tubules and Mark Ohorn, consultant in online and social media marketing, came up with an idea to run a competition for dental professionals to take pictures of the website’s #Iamatubulite badge in weird and wonderful places. The prize was a free place on Mark’s next Social Media Kick-start course, worth £250.

Mark commented: “I set up the competition #tubulite badge to find the best, most fun, most exotic, most daring and most creative photo people could take of their badge. We had many entries including Dhru Vader wearing a badge and photos of the badge on the moon (thank goodness for Photoshop huh?), but the final winner was chosen for sheer entertainment and creativity.

And the winner was Rachel Webb, a trainee dental care assistant. Her photo (left/right/delete as appropriate) saw toy icon Barbie getting involved in the tubulite trend.

For more information go to www.dentinaltubules.com.

Waterpik® has been supporting competitions like this since 2008. A recent competition asked dental professionals to submit their best shot of a dental professional, with the winning photo being published in Dental Tribune. The prize was a free place on Mark’s next Social Media Kick-start course, worth £250.

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Tobacco Amnesty
In order to address the need for dental instruments in developing countries, the BDTA is pleased to announce that the instrument amnesty will be returning to Showcase 2011. The BDTA is linking up with Dentaid, the dental charity striving to improve the oral health of disadvantaged communities around the world, to encourage the dental team to donate their unwanted hand instruments at this year’s exhibition.

There is a severe shortage of dentists in developing countries and the ones that are working are drastically under-resourced. The level of care they are qualified to offer is significantly higher than their equipment allows; no light, no drill, no suction, difficult working conditions and very importantly, only a limited range of instruments.

Recipient dentists are always delighted with the equipment provided but some have been known to literally weep with joy when they have opened the box of instruments provided with the surgery, highlighting just how important these hand tools really are for day-to-day dental care.

Andy Jong, Dentaid’s CEO said: “Since developing the portable dental chair and portable instrument kit, Dentaid has experienced a big surge in orders from charitable projects and hospitals with community oral health programmes. This year’s instrument amnesty is a great way for the dental team to help us meet the demand and reach many more remote places with improved oral health care.”

It is likely that there is a huge selection of instruments sitting in the bottom of cupboards in dental practices across the country not being used. The highly successful instrument amnesty last took place at Showcase in 2005 where over 10,000 instruments were collected. It returns to this year’s event as a way to once again replenish the diminishing stocks and enable Dentaid to continue its important work.

Bring your instruments with you to BDTA Dental Showcase 2011 and please ensure your instruments have been properly sterilised and then donate, along with details of your practice, to the Dentaid stand during the exhibition.

BDTA Dental Showcase 2011 takes place between 20-22 October 2011 at the NEC, Birmingham. To secure your free of charge entry to the show, reserve your ticket at www.dentalshowcase.com. For further information on Dentaid, visit www.dentaid.org.

B2A announce 2011 Golf Tournament

The Bridge2Aid (B2A) 2011 Golf Tournament is on! The team are delighted to announce their hugely popular and now annual Golf Tournament will be held at Hankley Common Golf Course, in Farnham Surrey on August 30th, 2011.

Voted the 50th best golf course to play in the UK by Golf World Magazine and soon to host the Open Championship prequalifying competition in June, Hankley Common provides the perfect setting for Bridge2Aid’s Tournament this summer.

Starting the day with a light breakfast, followed by 18 holes and topped off with a delicious three course lunch, prize giving and a special auction with a round of Golf at the prestigious Loch Lomond up for grabs - this year’s Tournament is set to be the best yet!

If you’re a budding golfer, keen to host a day out for your team or simply looking to support the dental charity, there are now 25 teams available to book in one of Surrey’s finest golf courses.

A team of four can be booked now for just £488. For more information on the day or to book your team contact Stuart Thompson now on 01483 304944. Alternatively for more information on the course go to www.hankleycommon.co.uk.

Derbyshire dentists complete CQC registration

Derbyshire dentists can celebrate National Smile Month in style, as all 126 NHS practices in the area have now successfully signed up with the Care Quality Commission (CQC).

Keith Mann, head of Primary Care Contracts for NHS Derbyshire County, was quoted saying that: “It was a very positive sign that dentists across the county are committed to improving NHS dental services and offering patients the best possible standards of care.”

According to the report, the trust is continuing to operate the dental helpline, which provides information and advice about dental services and oral health matters in the area.

Register now for the 3 day smile design course
A new report has revealed that 60 per cent of European doctors are using Wikipedia for their work. 500 GPs across Europe were interviewed for the report, which examined how regularly doctors accessed the internet for both professional and personal reasons. According to one report, the statistic jumps to 69% when analysing the number of European GPs using social media sites for professional use outside of just Wikipedia (including Facebook, LinkedIn, YouTube, Twitter).

The issue that needs debate here is whether this is a surprise to patients and doctors alike, as it is clearly a forum that GPs do refer to,” said Damian Eade, Director at Insight Research Group, who spearheaded the research. “The report is certainly not saying Wikipedia, and other social platforms, are not exceptional fonts of knowledge for the public.

But should it be a sensible and reliable place for medical professionals to turn to?” Surprisingly the report also highlighted that throughout Europe the social web wasn’t only used by young doctors: the report revealed that around 75 per cent of doctors in the 51-60 age groups had stated that they regularly used Wikipedia for professional use.

The report also suggests that the internet is fast becoming a regular part of a patient’s visiting to their doctor. Half of the doctors interviewed stated that they recommend specific websites for patients to visit following their consultations; a further 87 per cent were known to have advised certain sites for patients with regards to seeking background and educational information on their condition; 70 per cent searched the internet for additional support and advice and 69 per cent used the web for more information regarding treatment and medication.

One report suggested that the report has reinforced the view that we have entered the era of the ‘ePatient’ - where the web has become a trusted tool for not only daily tasks, but also health-related matters. However, as Damian Eade stressed: “Whether it’s researching illnesses, sharing experiences, making recommendations or providing moral support for other patients around the world, the social web has re-invented health advice, and we need to make sure the right advice is on hand for people.”

WYTEN Technology gets new management team

This week heralds a new senior management team at Wyten Technology as the company begins selling products direct to dental care professionals in the UK as well as expanding its business into USA.

Benjamin Mak is promoted to chief executive officer. His responsibilities will include overseeing the continuing growth in the UK market and expansion plans in the new global markets. Previously chief operations officer at Wyten Technology, Benjamin has been with the company since its inception. Previously holding senior managerial positions in industries as diverse as engineering, logistics and wholesale supply, Benjamin brings a wealth of experience and skills to the company. Benjamin has been thoroughly instrumental in the establishment of Wyten Technology as a leading, innovative supplier of dental products.

Lisa Roche assumes the role of international sales and marketing manager at Wyten Technology where she will be responsible for developing a direct sales structure for the product range. Lisa holds more than 30 years’ experience in the dental industry working with market leaders including Discus Dental and Nobel Biocare.

Melonie Prebble becomes international clinical development manager at Wyten Technology where her role will encompass clinical advisory and practical training, key customer support and team development. Boasting 20 years’ experience in the dental industry, Melonie is a renowned national speaker in the field of comprehensive care, dental hygiene and team building and a regular contributor to eminent dental journals. She previously chaired the British Dental Hygiene Association London region.

“Dr Wikipedia will see you now…”

GPs are seeing a rising use of Wikipedia for professional information gathering.

On the site, the online encyclopaedia, confirms that: “…Wikipedia is written collaboratively by largely anonymous internet volunteers who write without pay. Anyone with internet access can write and make changes to Wikipedia articles... users can contribute anonymously, under a pseudonym, or with their real identity, if they choose.”

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30 Years of Charity and Education

The AOG is Britain's under-funded dental organisation. Its recent holding of a joint conference of formal lectures and workshops with the Faculty of General Dental Practice (UK) and the Indian Dental Association in Delhi in February 2011, was followed by a joint international conference in May, were visible indications of the high esteem in which it is held internationally. The activities of the group, however, are not restricted to weighty professional issues; its social events are also a chance for guests to meet friends old and new, and contribute to AOG's charitable work.

A recent focus of the philanthropic aspect of the AOG is its support of the Chitrakoot Project charity, named after the region in central India where the Project gives primary dental care to children and the poorest families in around 500 villages across the area. Treating over 40,000 cases of dental problems, in addition to oral cancers or cleft palates, and carrying out cosmetic work such as prosthetic rhinoplasties are just some of the procedures carried out by volunteers, whose assistance can save lives in many cases.

As well as delivering vital and sometimes life-saving oral care to people unfortunate enough to have no other access to dental professionals, this worthy venture is also valuable experience for some of the AOG's younger members who want to gain a familiarity of operating in a remote area of the world where access to dentistry can be limited.

Next year's project, in February, is linked with the CIC international conference in Capetown and the long standing association in Musoma, Tanzania. Members and friends depart during Easter mid-term for Kilimanjaro to open a new facility for disabled people in Musoma which is just 50 miles from the Serengeti Safari park. Those on a shorter vacation return to UK whilst the rest amble through South Africa, tasting the splendid New World wines and ending in Capetown where the AOG/Smile-on Clinical Innovations conference is being held between the 23rd and 25th of February 2012. Charity, fun and education are the themes of any AOG international tour.

Not for nothing is the organisation's motto 'towards the greater good!' Naturally, a large number of the AOG's members wish to 'give something back' and perform good works with the destitute of the third world, which many of them have a strong connection to either through being born there or having relatives there.

A similar charitable spirit is embodied in the AOG's social events, the proceeds from all of which go to worthy causes. Over £90,000 was raised in one campaign that had also kick started the Chitrakoot project, whilst over £100,000 was raised in one night after the Japanese tsunami earlier this year. The dental trade also enthusiastically supports the AOG, due to its members having a strong connection to either the destitute of the third world, such as a 'hucking bronco,' a bouncy castle, and a petting zoo. The great and the good of dentistry tend to gravitate there with shorts, T-shirts and flip flops. Those who book tickets in advance online can save themselves money with a lower entry fee.

Since its formation in 1981, the AOG has grown to become one of the largest dental community groups in the UK. One of the largest dental community groups in the UK. As well as its aforementioned charity projects, the AOG has alliances with other bodies in Britain and abroad that allow it to provide financial and educational help and guidance to its members; this comes in the shape of a free newsletter and a variety of discounts on educational courses and dental materials and consumables (primarily, a 16.5% reduction on products and services from the Dental Directory). The AOG will be 'Dentalghar’s' UK social networking hub.

To learn more about the AOG, or to join, go to www.aoguk.org

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Gone FISH-ing
Elaine Halley catches up on another month as MSc student

Following another catch-up stint of 5am starts I am bang up to date with my lectures again and trying to get the next assessment in on time. The lectures in this Unit 5 Complex Treatment have so far been of a very high standard. The Unit is led by Eddie Scher, who obviously has a vast experience in teaching general practitioners of different levels of experience, and his style is well suited to our varied group of students.

There have been some interesting new additions to the technology: We now have ‘poll questions’ where the lectures can ask a general question of the audience, which pops up on the screen and we are asked to give a response anonymously and in real time. This gives the lecturer real-time feedback from his audience. It seems as though one of the toughest things about delivering a webinar lecture is that you have no easy connection with the people you are speaking to.

The downside of the poll questions is that for these lectures which were announced at short notice, there were only ever eight or nine live attendees (of which two or three are usually the lecturer and smile-on support!) and so only a handful were answering the questions.

My guess is also that sometimes a student can log onto the lecture and then be distracted by home life (or even a patient) and so they are shown as an attendee but are not actually watching. I was watching them all back recorded and I must admit it was a further encouragement to watch them live if possible to be able to share in the interactivity. To Smile-on’s credit, we now have the dates for lectures going into July and so diary organisation should be much easier.

The fast lane
So, what have I learnt so far and who have I listened to? We had a very interesting and fast-paced lecture on assessing the complexity of a case including risk assessment by Maria Retzepi. This was based around the ITI SAC Classification of risk. This was followed by the Biological oral medicine with the very clear message to investigate any single lesion of unexplained origin which is present for more than three weeks. We have also had an update on medical emergencies, but I couldn’t get it to play back (I know I said I was up to date but I am technically if I can’t watch it! It has, of course, been fixed so Sam beckons next week sometime!) We’ve had patient communication including consent and treatment planning letters and Eddie gave us another evidence packed lecture on the philosophy of dealing with complex cases and the consequences of managing them appropriately.

The assignments have taken a new twist too – apparently named FISH as an acronym of Eddie and Fiona Clark – maybe I’ve spelt that wrong? Oh, it must be Fiona and SCIter – I think? Anyway, these are interactive treatment planning cases where

‘My Endnote software is bulging at the seams – as are my pdf folders with the reading articles!’

Considerations of Tooth Loss by Cemal Ucer from the University of Salford. This, again, was packed full of information and with my newly motivated scientific-I’m-an-MSc-student hat on, I was desperately scribbling down references left, right and centre. My Endnote software is bulging at the seams – as are my pdf folders with the reading articles!

One technical hitch I had with this lecture was that in the recording the slides were slightly ahead of the narrative – I’m not sure if this was due to my low speed connection on the farm in the hills, or some technical gremlin. The speaker did keep me amused by typing comments in the chat bar without seeming to lose a beat of his serious lecture style, and because of my delay the comments appeared first and then a few minutes later he was furiously typing. Well, it’s the small things that keep me amused...

Professor Crispian Scully gave us a sobering update on we are supplied lots of clinical information including x-rays and photographs and we have to answer specific essay questions based around our treatment plan and supplying evidence for our suggestions. I am finding the supplying of evidence is becoming much more of a habit now – I can happily lose hours on Pubmed searches and reading literature and often have to force myself to get down to the business of answering the question – and I had better get back to this now as it is 10 per cent of the marks for this unit – every little percentage counts is my philosophy!

Our assignments have taken on a new twist!
Doubtful disputations, Romans 14, v. 1
Ray Goodman discusses how to deal with business disagreements

Dentists who jointly own or manage a dental practice with the intention of returning a profit have effectively formed a business partnership, in exactly the same way as traders in any other sphere of commercial activity. However, unlike most entrepreneurs in other areas, many dental practitioners work together on something of an ad hoc basis, without having a legally binding partnership agreement in place. Experience has shown that allowing this kind of relationship to develop, perhaps almost unnoticed between friends or colleagues can lead to problems in the future.

De facto, legally recognised business partnerships can occur by default even without signed agreements, and dentists need not be wary of inadvertently forming associations with can be so interpreted, as potential disputes may be difficult to resolve and provoke rancour, expense and stress even when there has been initial goodwill on both sides.

A detailed partnership

Dentists are notoriously busy, and usually preoccupied with treating patients, clinical paperwork or PCT red tape, and specific business arrangements with work colleagues are easily, and all too often, taken for granted. This laissez faire approach, however comfortable at the time, is fraught with risk; a brief time-out to draw up a detailed partnership document will make no difference to day-to-day relationships but may save possibly endless, and always costly, disputes from arising in the future if circumstances or attitudes change.

Partnerships which have evolved as a result of informal professional association and without a detailed legal agreement, are covered by the Partnership Act of 1890, which necessarily is intended to apply to any form of business association, the unforeseen accidents of life can all too often intervene to provoke disarray or unexpected conflicts of interest.

Complications

In the case of a disputed dental partnership, the practice’s premises, assets and equipment would have to be sold and the business terminated, with all the additional complications for the remaining partner(s) of dealing with staff redundancies and compensation payments, cancelling contracts and assuming responsibility for any liabilities such as debts or overdrafts. The business’s tax position could also be compromised, and even if the practice was salvageable much goodwill would have been lost.

Partnership Act

Specific to dentistry are NHS Primary Care Trust (PCT) contracts, which may stipulate that should a contracted partner die or leave the practice during the contract period, then the contract or leave the practice during the contract period, then the contract will be automatically terminated. This contract proviso is also included in the Partnership Act. Whilst it is possible to prevent this happening, the procedure is costly and time consuming, and without a legally binding agreement in place a disappointed partner is powerless placed to cause disruption by simply issuing a notice of dissolution. It is also worth noting, from another perspective, that in the present economic climate PCTs are seizing every opportunity to re-negotiate dental contracts in their own interest.

If a partner should decide to leave the practice before reaching retirement age, through ill health, changed family circumstances or for career ambitions for example, a partnership agreement should cover the division, entitlement and responsibilities of each individual. It is a matter of financial capital, assets, debts, other liabilities and payment of any tax outstanding. Such an agreement will also include directions on how to deal with a partner who is under performing, and the procedure for expanding the partnership.

Business Security

Nothing delivers greater peace of mind than certainty. A properly constituted partnership agreement is the strongest guarantee of business security, as it unequivocally sets out the rights, obligations and responsibilities of each partner in the event of a disagreement or an unexpected shift in the status quo. The mere existence of the agreement is a powerful disincentive for aberrant conduct, and it offers an ever ready reference to resolve a dispute should it ever be required.

However harmoniously colleagues normally work together, inevitably over time there may be occasions when disagreements occur or unforeseen events arise. A partnership agreement provides a means of positive, impartial resolution when such disputes do arise, and is especially valuable at times of major upheaval, such as a death, retirement or a change of business focus.

The advantages of having such an agreement in place cannot be overstated, as those who have suffered the expensive consequences of disputes within less formal business associations will quickly testify. A specialist dental law firm, such as Goodman & Gal, will have the industry knowledge to draft an agreement which precisely suits your own practice’s circumstances.
Income protection provides you and your dependents with protection should serious illness or incapacity affect your ability to work and cause you financial hardship. It provides you with a regular tax-free income. Income protection can cover employed or self-employed dentists. The market has a variety of income protection policies for dentists, all with their own criteria, features, and incentives. Some of the important options to consider when looking for a policy are:

1. **Do I need it?**
   If your answer is no or maybe, then you need to ask yourself some further questions:
   - If you fell ill, will you still receive a percentage of your income indefinitely?
   - If not, and you are a part of a couple, could you pay the bills and live off your partner’s income indefinitely?
   - If not or you are single, do you have savings you could live off indefinitely?

2. **Amount**
   Most providers will only insure you for a percentage of your income, typically 50 to 60 per cent of your income. So, for example, if your net income is £100,000 per annum, you would be covered for £60,000 or £5,000 per month. The insurer may also have a maximum amount that may be insured per month, so even if £5,000 per month is the 60 per cent limit, they may have a limit of £4,000 on their criteria.

3. **Pay-out amount**
   The amount the policy would payout depends on the type of cover you have selected or been recommended. You can either get a fixed payout, so if for example you insure yourself for £2,000 per month it will pay-out £2,000 per month until you are able to return to work. Other...
policies would payout £2,000 per month for the first six months, then drop to 50 per cent of the insured amount, ie £1,000 per month, after a further six months it will then drop to 50 per cent of the insured amount, ie £600 per month. This is quite an important factor to consider when reviewing an Income Protection policy.

Will £600 per month be sufficient to cover your outgoings should you have a long term illness?

4 Term of cover
The insurer will also have a maximum age at which they will insure you to, typically 55 or 60. Obviously the longer the cover, the higher the premium.

5 Cost
The cost of a policy can vary hugely; the cost is based on your gender, occupation, general state of health, age, whether you are a smoker and level of cover required.

6 Fixed or reviewable premiums
The monthly premium for the policy can either be fixed, which means that the premium will be fixed for the term of the policy or reviewable premiums which would be reviewed every few years to ensure that the premiums are market related.

Reviewable premiums tend to be cheaper, however they may be increased in the future.

7 Occupation definition
It is very important to ensure that your income protection policy has an ‘own occupation’ definition. This will insure that should you be unable to work as a dentist due to accident or illness, it will pay out. There are other policies which will not pay out if you can do a ‘suited occupation’. For example if you can’t work as dentist but as a nurse, then it won’t pay out as you can do a ‘suited occupation’. The other definition is ‘activities of daily living’ this means that if you can do three out of five daily activities then they won’t pay out either. The daily activities would be disclosed in their policy schedule.

8 Deferred period
A deferred period on an Income Protection policy would pay out the benefit after a deferred period as chosen by you when you set up a policy. These can be from 0 weeks to 24 weeks; a typical deferred period is three months. A deferred period could also coin-
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*vs a regular manual toothbrush.
cide with an existing Locum Cover policy, in this case it would normally be deferred for 12 months. The longer the deferred period the cheaper the monthly premium.

9 Income protection policies with an investment attached to it
There are income protection policies that have an investment attached to it. The idea is that the investment portion will grow and provide a lump sum payment at the end of the term of the policy. These policies may be slightly more expensive than a standard income protection policy, due to the investment portion incorporated into the policy. In 2012 the Financial Services Authority (FSA) may be changing the rules on these types of policy arrangements, i.e. protection and investment, insurers may have to drop the investment portion of these policies; further guidance is still being sort from the FSA. In addition, should you cancel this type of policy you may forfeit some of the gains on the investment. It is best to get guidance from an IFA before cancelling any of these policies.

10 Tax implications
The amount paid out by the insurer will normally be paid tax free, in line with current legislation. The idea is that the investment portion will grow and provide a lump sum payment at the end of the term of the policy. These policies may be slightly more expensive than a standard income protection policy, due to the investment portion incorporated into the policy. In 2012 the Financial Services Authority (FSA) may be changing the rules on these types of policy arrangements, i.e. protection and investment, insurers may have to drop the investment portion of these policies; further guidance is still being sort from the FSA. In addition, should you cancel this type of policy you may forfeit some of the gains on the investment. It is best to get guidance from an IFA before cancelling any of these policies.

11 Amount of times you can claim
With most income protection policies there are no limits to the amount of times you can claim on the policy. The amount paid out by the insurer will normally be paid tax free, in line with current legislation. The idea is that the investment portion will grow and provide a lump sum payment at the end of the term of the policy. These policies may be slightly more expensive than a standard income protection policy, due to the investment portion incorporated into the policy. In 2012 the Financial Services Authority (FSA) may be changing the rules on these types of policy arrangements, i.e. protection and investment, insurers may have to drop the investment portion of these policies; further guidance is still being sort from the FSA. In addition, should you cancel this type of policy you may forfeit some of the gains on the investment. It is best to get guidance from an IFA before cancelling any of these policies.

12 Income protection when taking out a bank loan
When taking out a new bank loan for practice purchase, some banks will insist on having Income Protection as a condition of their loan. Whether the banks require a policy or not, it is still good advice to have one in place to cover you in the event of accident or illness.

13 Interesting facts
Employment and support allowance is just £91.40 per week (1). That’s less than 20 per cent of the average UK salary (2). Should you have been off work due to illness, you may have to drop the investment attached to it. The idea is that the investment portion will grow and provide a lump sum payment at the end of the term of the policy. These policies may be slightly more expensive than a standard income protection policy, due to the investment portion incorporated into the policy. In 2012 the Financial Services Authority (FSA) may be changing the rules on these types of policy arrangements, i.e. protection and investment, insurers may have to drop the investment portion of these policies; further guidance is still being sort from the FSA. In addition, should you cancel this type of policy you may forfeit some of the gains on the investment. It is best to get guidance from an IFA before cancelling any of these policies.

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Labour market statistics - September 2010 (1)

• More than 2.6 million people are claiming benefits from the State due to incapacity.

• More than 2.2 million people in the UK have been off work due to long term sickness.

• Statutory Sick Pay is £81.60 a week for up to 28 weeks.

• If you have been off work for six months, you have an 80 per cent chance of being off work for five years.

Labour market statistics - September 2010 (2)

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For many practice principles the words ‘employment law’ is enough to make their blood run cold. It’s a complex and often frustrating area, but there are many things you can do to ensure that you avoid any pitfalls. The following information has been designed to help you through every stage of the employment process, including how to advertise for and appoint the best possible candidates for your practice.

Getting the advert right
When a position becomes available, the first thing you need to do is advertise for a new member of staff – and often very quickly. This is easier said than done, as getting your advert wrong can be a costly exercise when paying for placement in local newspapers.

Therefore, it’s worth spending some time putting together a short list of criteria for the role. What skills and attributes do you consider important and which would be more of an added bonus? Some practices consider qualifications and experience the most important factor, as training takes time and money. Others hold customer care and loyalty in higher regard as the rest can often be learned on the job.

Deciding what is right for you and your practice is important, as your criteria can then be put across in the job advert to reduce the risk of unsuitable candidates. It can also be a useful reference point when looking at CVs and later, during the interview process.

References
According to the October 2010 Equality Act, all references should provide factual, provable information only. A

It’s worth bearing in mind that your advert actually forms the basis of a job agreement, so making sure it is accurate and not misleading is essential. For example, if you advertise a role at £15k per annum and then only offer the candidates the right calibre of candidate, or you could simply say ‘competitive salary’.

Interviewing skills
On a scale of 1-10, most interviewers only rate around 3½ to 4½. So, if you’re going to be in a clinical role, don’t be afraid to ask them clinical questions or to perform a basic clinical task. You could even ask them to take part in a trial day, to give you a better idea of how well they gel with the team and deal with patients. However, it’s important to avoid questions which can get you in trouble legally. Asking about a candidate’s marital status, whether they have children, their religion or sexual orientation is a strictly no-go area. So too is asking about their sickness absence in a previous role.

It’s estimated that around 50-60 per cent of people continue worrying is the fact that around 60 per cent of people continue to lie in their interviews, so it’s important not to take them at their word.

Now, I’m not saying that all your candidates are lying to you, but if computer skills are a necessary requirement of the role, don’t be afraid to set during the interview stages. If they’re going to be in a clinical role, don’t be afraid to ask them clinical questions or to perform a basic clinical task. You could even ask them to take part in a trial day, to give you a better idea of how well they gel with the team and deal with patients. However, it’s important to avoid questions which can get you in trouble legally. Asking about a candidate’s marital status, whether they have children, their religion or sexual orientation is a strictly no-go area. So too is asking about their sickness absence in a previous role.

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£12k, this could be seen as false advertising and candidates could raise a grievance. Therefore, it’s a good idea to put a salary range in place instead as this will usually attract the right calibre of candidate, or you could simply say ‘competitive salary’.

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person’s employer has a duty of care, not only to the employee, but to the potential new employer. Therefore, you should not give any opinion about an employee’s performance or level of skill—even if it’s all positive.

Unfortunately, this does not really help you when trying to appoint your own team members, but it’s important to be seen to treat all your employees the same and to be fair to all parties at all times. Usually a reference will consist of confirmation of the employee’s dates of employment and their job title only.

Redundancies and dismissals

Redundancies are sometimes a necessary course of action when workload has diminished significantly. However, you need to have evidence to show that this is the case. You cannot, therefore, make a team member redundant if you’re not happy with their work. It’s also worth bearing in mind that, in redundancy cases, if an employee has been with you for more than two years, they are entitled to compensation.

If you are dismissing a member of staff you need to ensure that you have documented evidence of fair process. If you have given the employee fair warning and the opportunity to rectify the problem, you can then undergo a consultation with them to explain why you are planning to let them go and your reasoning behind the decision.

There should then be a short period of no more than 48 hours before another meeting is held. This is to hear the employee’s thoughts and any ideas or suggestions they have and they are entitled to bring a representative to this meeting such as a work colleague or trade-union representative. It’s a good idea to give any ideas some serious consideration, but you are not obligated to take them up. If, after this meeting, you decide to let the employee go, you can hold a dismissal meeting to formally give notice. The employee then has the right to appeal to bodies such as the Defence Union, but this does not happen in the vast majority of cases.

You’re not alone

Hopefully the information above has given you some useful ideas and guidance. Recruitment and employment law is a complex topic, but please don’t feel like you are alone. You can not only get valuable advice from bodies such as www.direct.gov.uk, but some payment plan specialists also offer training courses on the topic. These can not only provide helpful information, tailored to your specific needs, but can also offer verifiable CPD, so why not check them out? So, please don’t feel overwhelmed and there is also no reason not to make recruitment and employment law work for you.

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Retail is detail
Jonathon Fine discusses the finer features of your dental practice

Attention to detail can turn an average dental practice into an outstanding dental practice from the patients' perspective.

Ask any retailer from ASDA to Agent Provocateur and they will confirm that one of the principal key drivers in retailing success is getting the detail correct. From the opening hour’s signage to credit card processing, from the team’s uniform to the vernacular sales assistants use when speaking to customers: it all conspires to generate a successful purchase.

As customers, we are continually collecting and simultaneously evaluating information. We are searching for clues that either reinforce our buying motivation or, just as critically, reduce it. Curiously, we often experience a huge sigh of relief when we discover that the retailer is not living up to our perceived understanding of their proposition. The sense of relief is driven by the fact we can stop processing the vast amount of multi-level information (sight, sound or scent) we are being hit with and simply accept the fact that this particular retailer is not right for us. We are quite pleased to move on.

How many times have you been motivated by a real need, marketing, or simply opportunity and entered a new retail environment with an expectation that has been shattered in a matter of seconds by a dirty or foul smelling environment, slovenly staff, poor lighting, or perhaps vast amounts of threatening signage? These are the obvious conditioners to our perception of the retailer and will have a massive impact on buyer behaviour. However, in all honesty, these types of problems belong to a retailing world of the 1970’s. And thankfully these types of conditions would be most unusual to come across today. The conditioners that affect buyer behaviour today tend to be subtler.

Typical Conditioners
- The location of the unit: next door to an Indian takeaway as opposed to next door to Boots
- Signage and packaging: how well does the signage communicate the retailer’s core proposition to its target customers? Do customers understand what is being sold?
- The welcome: how easy is it to find the entrance and how welcoming is it? What are you presented with first in terms of smell? Many supermarkets pump a chemical into their air management system that makes the air smell of baking bread, which research tells us makes us hungry (hungry shoppers buy more) or the universal fact that every supermarket’s first aisle is fresh fruit and vegetables, designed to communicate a halo of goodness and freshness over the entire 65,000 different products that are sold in a typical large supermarket
- What can you hear? Have you ever sat in a hotel dining room and listened to some screeching female vocalist belt out a love song in an extreme American accent whilst you are trying to eat breakfast? It’s incongruous, but worse it really spoils breakfast. Or how about PA systems operators in regional retail is detail

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money matters

are you retail-savvy?

airport? So how does this detail translate to the world of dentistry?

Are dentists indeed retail-savvy? Is it important? The accepted view is that UK dentists are becoming very retail-savvy. There are countless examples of the so-called ‘dental spa’ with very un-dental type names being over represented in certain segments of the dental market. Make no mistake, dentists are and will become skilled retailers, however the detail point goes way beyond the ‘packaging’ of the practice.

Take 10 minutes out to try this little 10-point test: Put yourself in a prospective new patient’s shoes, visiting your practice for the first time:

2. Does the signage communicate the type of dentistry you provide? eg pain free, no needles or cosmetic, etc. Does it say new patients are welcome? Does it tell you the opening hours and does it tell you where to park?
3. On entering what can I hear? As a new patient I am naturally stretching to see if I can hear the dreaded drill. Instead, I hear a soundtrack from some birds tweeting gently in the background, along with some running water.
4. How do the people who work in the practice look? Could it be a tanning parlour, a Toni & Guy or an NHS waiting room? Not uniformed or uniformed, or maybe in scrubs? What is your overall conclusion of the team: frumpy, happy, young, senior, mainly female, gentle, professional, sloppy, dim, exciting...
5. Does the receptionist step out from behind the counter to welcome the new patient or does she simply look up and say: “Hello, where did you park? Please fill your registration number in here” (which is what my expensive dentist’s receptionist always does).
6. How are the toilets? Check them out at about 4.30pm, you might be shocked. Dirty toilets translate as dirty dentist, transmitting disease.
7. What is the range of magazines and how thumbed are they? People are perpetually thinking about cross-infection.
8. How is the clinical team addressed by staff? Is it Dr Brown or Gordon? Both could be correct depending on your practice’s positioning, but that is not always the reason first names are used. The captain of a BA 747 is always referred to as ‘captain’ by cabin crew, as it is critical his leadership is never compromised through familiarity.
9. What items are sold to me in a passive way through point of sale devices as I am waiting for the treatment session is over? How is payment handled? Do I feel like the value has been re-inforced so I leave contented?
10. What happens when the treatment session is over? How is payment handled? Do I feel like the value has been re-inforced so I leave contented? Not applying the ‘retail is detail’ rule to your practice will hurt your bottom line. In fact, you will find that applying this rule plays a vital role in keeping your team focused on who is the most important person in the practice...

The accepted view is that UK dentists are becoming very retail-savvy.

“the accepted view is that UK dentists are becoming very retail-savvy”

Jonathan Fine is Director of Mar
line-patients. He has...
The ultimate goal - clean canals

Michael Sultan discusses the challenges of getting root canals clean

Nowadays dentists have such a wide range of exciting gadgetry at their disposal to help prepare root canals quickly and easily that sometimes the biological focus of treatment is somehow overlooked.

Of course, the latest NiTi systems can certainly help improve efficiency in the surgery, but they don’t necessarily help us achieve our ultimate goal – clean root canals. Even if the post-treatment radiograph does reveal a beautiful shape, without fully disinfected canals, the treatment will fail.

When we look closely at the complex structure of the canal systems in cleared teeth it is immediately evident that it is impossible that our files can even come close to cleaning the intricate shapes. It doesn’t matter which NiTi system we use or how cleverly we can manipulate a rigid stainless steel file - we are just deluding ourselves. For this reason, irrigants are the weapon of choice for eliminating bacteria that are harboured in the intricate channels of the root canal systems. The irrigants work in inflamed teeth by dissolving the organic pulp tissue and in infected teeth by killing and removing bacteria. This is further enhanced by opening up tubules and removing the smear layer using chelating agents. The files are merely making space for our irrigants to get in.

The importance of a rubber dam cannot be overestimated. The rubber dam is a brilliant tool to prevent the inhalation of files, protect the airways and maintain a clean, dry area in which to treat the patient. It is also vital for medico-legal reasons and moreover ensures that the irrigants stay in the tooth and are not swallowed. If a rubber dam is not being used the only thing the tooth is being irrigated with is probably saliva. Some studies have shown that the success rate of teeth treated under rubber dam is double those that are poorly isolated.

Sodium hypochlorite is the irrigant of choice for disinfecting root canals. The solution works by dissolving pulp tissue, killing the bacteria and flushing debris away to prevent canals from becoming blocked during instrumentation. This, in turn, helps prevent ledging and other procedural errors so that the canals can be thoroughly cleansed. Sodium hypochlorite also happens to be a very cheap solution. Also recommended is chlorhexidine solutions (two per cent): This, like sodium hypochlorite, is strongly anti-microbial but cannot dissolve pulpal tissue; it is also expensive. The concentration of bleach that is used varies from country to country.

A complete range of irrigants for root canal treatment

Gluco-Chex 2.0%
Chlorhexidine digluconate 2% – an antibacterial dental preparation for rinsing the root canals. It is more efficient than sodium hypochlorite in destroying such microorganisms as E. faecalis which are often responsible for unsuccessful endodontic treatment.

Chlorax 2% or 5.25% (Sodium Hypochlorite)
Chlorax dissolves organic matter. It has cleaning properties and has a bleaching effect on tooth and hard tissue.

Endo-Solution EDTA
Endo-Solution is used during mechanical preparation of the root canals. The preparation supports widening and cleaning of the root canal, removes the smear layer and exposes the dentinal tubules.

Citric Acid 40%
Citric Acid 40% removes the smear layer from the root canal walls, allowing precise penetration of root canal sealer.

Isopropyl Alcohol
Reduces the surface tension enabling Sodium Hypochlorite to penetrate the tubules.

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to country. In Scandinavia the issue of toxicity and possible problems with bleach have led practitioners to err on the side of caution and concentrations of 0.5-1 per cent are traditionally used. In the United States on the other hand, dentists tend to use concentrations of 5.25 per cent, arguing that this is the most effective solution as a tissue solvent. In the United Kingdom we generally use 2.5 per cent but can increase effectiveness by either heating it or using ultrasonics. The bleach can be warmed in a bottle warmer and its effect is further increased by constantly flushing the solution through the canals rather than just letting it sit passively in the canals.

Nickel Titanium instruments can lead us to falsely assume that we have fully prepared the canal. However, often the walls have not even been touched due to the files staying very centred. The speed at which the canal system is prepared also means that our irrigants may not have had sufficient time to be effective. The optimum soaking for this should be half an hour to ensure that theissues are fully dissolved and the bacteria are killed - no matter how quickly the canals are prepared with the NiTi files. Recently a new file system has been launched - the SAF (self adjusting files). These are hollow files shaped as a thin metal lattice that are very flexible and prepare all the walls especially in very irregular shapes. Sodium hypochlorite is continuously pumped through the files as the walls are being prepared and the published data is very promising. The manufacturers recommend four minutes preparation per canal.

No matter which system is used it is important to remember that sodium hypochlorite is a very toxic fluid. If it is extruded out of a canal under pressure it can cause severe complications. There have been recent cases of severe hony necrosis and nerve damage but even small amounts can cause pain, bleeding and marked bruising.

If a hypochlorite accident occurs the patient will get sudden pain and bleed profusely. The best plan of action in this situation is to remain calm and if necessary top up the local anaesthetic. The canal should be rinsed out with saline and the contents aspirated to dilute the irritant. Antibiotics may be indicated as well as analgesics and ice packs for the bruising.

As previously mentioned, high concentrations of bleach are used to dissolve tissues. Obviously, the higher the strength of the bleach, the higher the danger it potentially poses to the patient. But for the bleach to be effective it needs to be placed within 2mm of the apex and so precautions have to be taken. I always inject bleach slowly, under low pressure, always ensuring that the needle is moving so that it doesn’t become jammed. I am always very cautious with short teeth and immature teeth with open apices and tend to place a rubber stop on the needle so that I always know where I am.

As is the case in all treatments, prevention is always better than cure. I advocate the use of sodium hypochlorite as the only effective way of disinfecting root canals, but it must be used with care and caution to avoid problems from occurring.

No matter which system is used it is important to remember that sodium hypochlorite is a very toxic fluid.
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While the public and some scientists continue to claim that dental amalgam causes health problems, other scientists and the FDA concluded that clinical studies did not establish a causal link between dental amalgam and health problems.2,3 This case report will discuss the entrapment of amalgam particles.

Case report

Recently, a 50-year-old Caucasian male presented to the VA New Jersey Health Care System Dental Service at East Orange seeking dental care. The patient came to our facility exploring, among other things, the viability of a dental implant in the region of tooth #30.

The patient gave the following dental history. Approximately three years ago, his right mandibular third molar (#32) was scheduled for an amalgam-alloy core buildup following root canal therapy. A crown lengthening procedure using reflected, full-thickness buccal and lingual flaps was performed.

While the flaps were reflected, an alloy core buildup was performed. The foreign bodies visible in the radiographic images are most likely amalgam alloy particles that either became trapped in the apical portion of the flap or in the interstitial tissue.

Comprehensive oral and maxillofacial examination included an intraoral and extraoral exam, full-mouth periapical X-rays and a panoramic radiograph. Among other clinical findings, the panoramic radiographs revealed incidental foreign bodies, most likely amalgam, embedded in the soft and/or hard tissue of the oral cavity due to iatrogenic treatment (Fig. 1).

The patient consented to explore the feasibility of a dental implant in the region of tooth #50 and, at the same time, explore the region of #32 in order to determine the orientation and proximity of the foreign bodies to critical anatomical landmarks.

For that study, a cone-beam CT (CBCT) 3-D scan of his lower jaw was obtained utilizing an i-CAT™ CBCT (Imaging Sciences International, Hatfield, PA.). Inherent in the acquisition of the 3-D volume of information is the ability to explore the precise location of the foreign bodies.
Using CBCT to explore the amalgam pieces in the region of #32 revealed scattered pieces entrapped under the oral mucosa outside the alveolar cortical plates, both lingual and buccal to tooth #32. It was also noted that the crown-to-root ratio of tooth #32 was much compromised and the tooth should be considered for extraction.

By using the i-CAT 3-D CBCT, precise 3-D software was employed to visualize the bone in three dimensions from different viewing angles (Fig. 2). It was revealed that some of the amalgam foreign body fragments were resting on the buccal side of the jaw bone on the right side, while other foreign fragments rested on the lingual side of the jaw bone under the lingual undercut (Figs. 3a–c).

As no soft-tissue inflammation and/or bone remodeling has occurred, following a professional dialogue between the restoring dentist and the oral surgeon, the amalgam foreign body fragments incidentally observed in this case were left intact, posing no medical risk or interference in our proposed dental treatment plan for a dental implant in the region of tooth #30. Nevertheless, continuous follow-up was strongly recommended.

Conclusions
Fortunately, following careful assessment, our patient did not experience symptoms associated with the amalgam remnants embedded under the oral mucosa, as has been reported in some cases in the literature. This case also demonstrates that restorative procedures and simultaneous full-thickness flap elevation, especially those involving amalgam restorations, ought to be reconsidered.

When the patient was seen by the oral surgeon for extraction of the adjacent tooth #31, the surrounding areas were evaluated as well. The patient wished to leave #32 alone, despite recommendations for extraction, so no further actions were taken at the time with regard to exploration of amalgam foreign bodies because they were asymptomatic.

This report also attempted to provide justification for the use of CBCT scans in order to visualize abnormalities from a 3-D perspective, ultimately facilitating case management.

While outcome assessments in this area of dentistry are difficult, the authors believe that it is justified from a diagnostic perspective, and what’s more, with renewed interest in mercury toxicity from amalgam fillings, the use of a CBCT scan to visualize amalgam foreign bodies and possible bone remodeling may offer invaluable information regarding treatment protocols.

References

Authors
By Dr. M. Almog, DMD; Samuel Melcer, DMD; Rachel Berley, DMD & Kenneth Cheng, DDS

Fig. 1
Fig. 2
Fig. 3
Fig. 4
Fig. 5

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Improved diagnostics with Cone Beam Technology
A look at one practice’s choice of CBCT

Dr Dzulietta Kiworkowa of the Elektoralna Dental Clinic in Warsaw has recently installed the New-Tom 5G Cone Beam CT unit in her practice. Here she tells us about the advantages of having a high spec digital imaging system when performing dental diagnostics.

As a practice we offer a very high standard of treatment. As much of what we do is reliant on effective diagnostics, we were concerned that our previous CBCT equipment was not living up to our expectations, particularly with regards to its use with implants and orthodontics.

We had heard about the New-Tom Cone Beam Scanner and were told by colleagues that it is one of the most advanced systems currently available on the digital market. We had worked with another system before this but had been frequently forced to refer patients to other practices because our equipment did not have cephalometric capabilities. We went ahead with the purchase of the NewTom 5G and we can now take superb quality cephalometric images, which have significantly improved our diagnostic ability.

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We use the NewTom 5G in our clinic on a daily basis for implantology, root canal treatment, dental surgery, orthopedics and laryngology as well as gnathic and facial surgery. The equipment has made such a difference to our diagnostics, particularly with regards to periodontics and endodontics, and it helps us to carry out precise and effective root planning. We have noticed a considerable improvement in image quality and resolution and the fact that we can control the exposure settings with the ‘Smart Scan’ technology is most helpful as we are able to control the, already quite low, doses of radiation making it far safer for our patients. The flexibility of the system makes it ideal for all our diagnostic needs as we can choose whether to take a traditional, panoramic, cephalometric or detailed TMJ image.

The positive feedback that we have received since installing the unit has definitely justified our purchase! The various specialists with whom we work are more than satisfied with the quality of the images we produce and thoroughly enjoy working with us. In addition to this our patients feel confident that we are doing our best for them by using such high tech equipment. I would absolutely recommend the NewTom CBCT unit to other dental practitioners as the range and quality of the images is outstanding and the flat panel sensor technology and low radiation dose make it ideal for the detailed, high resolution images demanded by first class dental diagnostics.

When we purchased our CBCT equipment we were extremely satisfied with the service we received from NewTom, as it seemed that the company’s focus was very much on making sure our needs as customers were met. The firm sent out highly qualified technicians to install the system and all our staff were instructed in its use. The time they gave us proved invaluable as we got to grips with the operation of the equipment far faster than we would if we had been forced to wade through instruction manuals! In addition to this the support and aftercare offered by NewTom were first rate and we have every confidence that the helpline staff will answer any queries or problems we have with the equipment immediately and efficiently.

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