FDA use shock tactics for tobacco

According to an American newspaper, the federal government have unveiled a new plan designed to shock customers with images of tobacco's impact: images will include sick smokers exhaling through a tracheotomy hole, smokers struggling for breath in an oxygen mask and even smokers lying dead on a table with a long chest scar. The report stated that in the most significant change to U.S. cigarette packs in 25 years, the Food and Drug Administration released nine new warning labels that depict in graphic detail the negative health effects of tobacco use.

Beginning from next year, cigarette cartons, packs and advertising will feature these and six other graphic warnings.

The tobacco companies, several of which are challenging the new rule in court, refused to comment on the starting images that will now have to dominate half of the front and back of each carton and pack and 20 per cent of each large ad.

Hospital stay causes oral deterioration

A study titled ‘The impact of hospitalization on oral health: a systematic review’ has uncovered how oral health deteriorates during hospital stays.

The study suggests that oral health deteriorates during hospitalisation and is associated with an increased risk of hospital-acquired infections and reduced quality of life. The background of the study was to research how poor oral health of hospitalised patients is connected with an increased risk of hospital-acquired infections and reduced life quality.

The researchers reviewed the evidence on oral health changes during hospitalisation using five before and after studies recorded between 1998 and 2009 in the UK, USA, France and Netherlands; the data suggested deterioration in patients’ oral health following hospitalisation, and that there was an increase in dental plaque accumulation and gingival inflammation.

The images are deliberately designed to disgust and unnerve all ages, and the FDA hopes that they will reduce the number of smokers by 215,000 by 2015.
Holding the key to their success
David Bridges provides advice on how to make progress with difficult patients

Like many colleagues, I am an avid user of the internet. I spend a lot of time browsing a wide range of dental and associated sites researching the latest news, trends, politics and general ‘stuff’. I’m also a frequent visitor to many dental and associated sites, literally, from around the world. Sometimes, a post appears that, at first sight, seems quite innocuous yet can make you stop, think and re-evaluate your approach and beliefs.

Just this week, I read a post from a colleague on a hygienist website that had just such an effect on me. This hygienist related a tale about the practice she was in. A patient of the practice that she had seen a number of times before that year, had returned for another three monthly visit. The patient had long-standing severe periodontal disease with a BPE of 4’s. She’d previously asked this patient to book longer appointments in order for her to carry out the proper treatment that his condition dictated, but to no avail. Repeatedly, he would only book twenty-minute routine visits.

Eventually, it appears the constant reinforcement of advice from our colleague might have finally achieved the desired effect.

This time, (at yet another twenty minute appointment), he decided to engage and asked what the recommended treatment actually entailed. He wasn’t interested in a specialist referral – he didn’t want to spend the money that he said he had – could our colleague do the treatment?

Despite the fact he claimed to “use my purple tepe every day”, his plaque score was 100 per cent. Our colleague disclosed the patient, showed him in a mirror and recorded the score. She then went through her suggested treatment plan. She planned for initial one-hour appointment first, followed by a subsequent forty-minute appointment at a later date. The slightly longer appointment was to allow six point charting with plaque and bleeding indices, disclosure, OHI, delivery of LA and root face debridement of one half of the mouth. The second appointment was to treat the other half of the mouth. All well and good. Perfectly reasonable.

Despite the fact he claimed to “use my purple tepe every day”, his plaque score was 100 per cent. Our colleague disclosed the patient, showed him in a mirror and recorded the score. She then went through her suggested treatment plan. She planned for initial one-hour appointment first, followed by a subsequent forty-minute appointment at a later date. The slightly longer appointment was to allow six point charting with plaque and bleeding indices, disclosure, OHI, delivery of LA and root face debridement of one half of the mouth. The second appointment was to treat the other half of the mouth. All well and good. Perfectly reasonable.

However, our patient baulked at this on cost grounds and said he would only book and pay for two thirty-minute appointments “and that’s your lot!” Despite sharing the fact he had £1000 to spend on specialist treatment, he apparently didn’t want to spend it on the proper, initial non-surgical therapy.

Our colleague instructed reception to book the patient in at the end of a session for these twenty minute appointments so that, if necessary, she could run
that we think we should have feel guilty if we haven’t done all every last bit of value out of insulate ourselves. We beat ourselves up and who seemingly won’t help them—perhaps especially, for those mile’ for our patients even, and we often try to ‘go the extra way. Remaining friends and with all replies documented.

In my reply, I said that I informed my patients that in this situation they have three options.

1. Do nothing - i.e. we agree to part company
2. Carry on as we are but inform them that it is compromised treatment and the consequences of that
3. The ideal treatment plan with appropriate appointments, times and fees including the review appointments

All delivered in a non-judgmental way. Remaining friends and with all replies documented.

Hygienists are generally, as a group, a particularly caring lot and we often try to ‘go the extra mile’ for our patients even, and perhaps especially, for those who seemingly won’t help themselves. We beat ourselves up and worry about how we can squeeze every last bit of value out of inadequate treatment times and feel guilty if we haven’t done all that we think we should have during that compromised appointment. The extra pressures of HTM01-05 and CQC and the near pandemic absence of adequate chairside support help compound these feelings.

Later in the week, whilst reflecting on the theme of the story, I came to the conclusion that it was essentially one of ‘ownership’.

Firstly, we as clinicians need to make sure that we do not assume ownership of our patients’ problems. This is exactly what was happening in the story above. We need to feel confident in setting out our stalls and maintaining our principles in order to help give ownership of the problem back to the patient. It is only when a patient finally accepts that they alone hold the key to the success or failure of the treatment of their problems that we can begin to make progress with these more difficult people.

Secondly, practices need to take ownership of the fact that they are responsible for providing their clinicians with the best possible environment and managerial support in order for them to perform at their peak. The ability of practices to provide great equipment together with good managerial, clinical and full-time chairside support can make a massive contribution in assisting their staff feel more confident in dealing with these more difficult patients.

Thirdly, and perhaps most importantly due to the sometimes insular nature of the dental hygienist’s job, is the realisation that we too can also take ownership. Ownership of the situation we find ourselves in. We can help ourselves deal with it by reaching out to fellow professionals for help, advice and support beyond our immediate vicinity, making use of the rich communication, education and research resources that the Internet has to offer.

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In March of this year, *Science Daily* published a story warning of the possibility of increased pathogen accumulation on orthodontic appliances. The story soon went national and the popular media were quick to warn readers about the dangers faced by the nation’s brace-wearing youth.

In fact, what the media were keen to play up as the latest ‘health hazard’ stemmed from a significant piece of research from the Eastman Institute, which highlights the importance of instilling a rigorous oral health care routine in orthodontic patients. Dr Jonathan Pratten and colleagues conducted research designed to ascertain the types and growth of microbes on removable retainers. The study confirmed the presence of potentially pathogenic microbes on over 50 per cent of the retainers studied, using a control group of patients without orthodontic appliances.

The theory behind the research was that the constant removal from, and replacement in, the mouth makes retainers susceptible to transmission of microbes. The study revealed that Staphylococcus was present on 50 per cent of retainers and Candida on 66.7 per cent. Both microbes were also found on the tongue and interior cheeks of those subjects. Although the risk to healthy individuals from these microbes is minimal, those patients with compromised immune systems could find themselves in danger of severe infection. The implications for children with underlying conditions such as Cystic Fibrosis, in whom Staphylococcus can cause debilitating and often life-threatening chest infections, are therefore serious, and this study provides further evidence for the importance of better cleaning of removable appliances and the effective removal of biofilm in orthodontic patients.

Other studies have shown that fixed appliances do not increase the risk of levels of peri-odontal pathogens. A 2009 study examined Actinobacillus actinomycetemcomitans (AA), Porphyromonas gingivalis (PG), Prevotella intermedia (PI), Tannerella forsythia (TF), Eikenella corrodens (EC), Fusobacterium nucleatum (FN), Treponema denticola and Campylobacter rectus (CR) in 190 adolescent orthodontic patients and concluded that ‘Orthodontic treatment with fixed appliances does not increase the level of these pathogens.’

**Microbes**

**Pharyngitis**

**Bacteria**

**Porphyromonas gingivalis**

**Actinobacillus actinomycetemcomitans**

**Treponema denticola**

**Fusobacterium nucleatum**

**Eikenella corrodens**

**Orthodontic patients should have a rigorous oral health routine**

**The brace debate**

Deborah Lyle discusses whether orthodontics pose an increased threat of infection?

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with patients requiring some form of orthodontic intervention. Compliance in adolescents is notoriously low because of a lack of discipline and self-awareness. It is therefore vital that practitioners consider every method of patient education when dealing with younger patients.

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Moving your practice to prevention based dentistry as best practice – Part 1

Mhari Coxon discusses how to increase profit and client loyalty

Warning – this is not an evidence-based clinical abstract. This is an article based on more than 15 years of experience in practice growing and developing, providing a preventative regime that empowers both your team and the client in a profitable manner. Those who have the perfect preventative based practice can thankfully stop reading now (that doesn’t include me you know, there is always room to improve).

Changing attitudes in dentistry

Dentistry has been a “see the problem - name the problem - fix the problem” profession for a very long time. We were conditioned that way while in our safe institutions and find it hard to move to a preventative approach to our health care when we transition to general practice and the time constraints and attitudes that come with it.

With growing evidence showing common sense links with our systemic health (if you had an inflamed, suppurating, bacteria covered area on your arm the size of an egg you would expect to feel ill so why would it not be the same for the same size lesion in the mouth?) and our oral health, we as a profession, need to improve our prevention led practice. This is clearly best practice.

“But we do it already” I hear us all cry. “You are reinventing the wheel Mhari!” If this was the case then the incidence of periodontal disease and caries in the population would be decreasing, as would the incidence of litigation against dental professionals in relation to periodontal issues and undiscovered caries. It is not easy to look at what we are not doing and seek to improve but it is the only way we, as clinicians and as practices can develop and progress.

Building on the right foundations - The initial consultation

The first time your patient spends time in your practice will affect how they feel about treatment and how happy they will be at the end of treatment. How much information you glean from them can determine the level of success with each client. In my opinion, supported by its success in our practice, a short interview in a non dental environment can be very useful before the patient even sets eyes on the dentist. Our receptionist, oral health advisor, hygiene...
ist and nurse can all carry out this short interview and are trained to listen and repeat to show that the patients’ wants, needs and concerns are being understood and will be presented to the dentist. Our patient’s feedback to us is that they feel happier knowing that they have someone who knows how they feel to support them.

How many times have you been to see a consultant or specialist and forgotten all the things you wanted to ask. “White coat syndrome” can happen to the best of us so why should our patients be immune? Using staff to provide a supportive and informative role can make the patient happier and your day as a dentist more rewarding. Not to mention the happy staff you will have working for you.

Examples of questionnaire questions:

1. When was that last time you had any dental treatment?
2. What was your main reason for your visit today?
3. Do you feel you have good dental health?
4. Do your gums bleed?
5. Are you sensitive to hot/cold/sweet?
6. Do you have any worries about your mouth or treatment?

Big up your team

It is difficult to appreciate the role of preventative treatment as a patient and it is vital that you convey that importance and the skills of your team if you want to have a success with that client’s behavioural change and treatment acceptance. Do you think saying “you have some gum problems and the hygienist will see you for a scale and polish” conveys a preventative message? Does that show that the patient has to make a commitment to their treatment by supporting with their home routine? Or does it make it sound as though the patient has a “problem” that you have “named” that the hygienist will “fix” and so the cycle continues. Our principle talks about the gums and bone as the foundation to any dental work and without solid foundations he can’t work. He also explains how the biggest health benefit we can give patients is their oral health assessment and advice programme which always follows an examination and is precursor to any further treatment.

If you as “The Dentist” are telling them they need this then they will feel it has some value and are more likely to be open to advice from your team.

Communication about prevention

So, how do we change our pa-

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Perio Tribune is the most prevalent chronic inflammatory disease of humans¹ and a major cause of adult tooth loss, impacting negatively upon oral health, function, speech, nutrition and quality of life². However, we are only now beginning to comprehend the full impact of periodontitis upon general health. Periodontitis is significantly associated with systemic inflammation, with all cause mortality³, and with an increased relative risk for several other chronic inflammatory conditions, including cardiovascular disease⁴, rheumatoid arthritis⁵ and type 2 diabetes⁶. Successful periodontal intervention improves tooth retention⁷, improves diabetes control, and reduces the systemic inflammatory burden. Periodontitis, and its prevention, matters.

Changing the focus: Wellness not repair

The "repair model", identifying current disease and fixing it when it breaks has pervaded dental training and practice since the beginning of the last century. This surgical mentality dates back to the days when periodontitis was considered ubiquitous and simply a bacterial infection consequent upon plaque accumulation. We now know that periodontitis requires a susceptible host and that we all vary in our susceptibility from the 10 percent who are immune to the 10 percent who are highly susceptible. We know that host factors are the major determinants of disease, outweighing plaque by a ratio of 80:20 in relative importance. The new medical approach, “wellness” aims to identify those patients most at risk of developing disease in the future and to engage them in individualised preventative care programs. Its validity is supported by the work of researchers such as Axelsson⁸ who demonstrated unequivocally that common dental...

**“Tell me I’ll forget, show me, I may remember, but involve me and I’ll understand”**

Liz Chapple explains how a risk based approach to periodontal management is the foundation for preventive treatment planning, patient empowerment and motivation, and medico legal protection.

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eases like caries and periodontitis are preventable provided a risk-based approach to prevention is adopted at a patient level.

There are moves afoot... In 2000, the American Academy of Periodontology stated that a periodontal risk assessment should be an integral part of all dental and periodontal examinations. In 2010 the NHS incorporated the concept that risk should underpin patient care into the proposed new dental contract and made it the driver in the pilots for recall periods and care pathways. But predicting periodontal risk is not straightforward: how do we assess it?

We know the risk factors

Susceptibility and risk for disease vary greatly from one individual to another, and major factors that place individuals at risk have been identified. Factors known to influence the onset, clinical presentation, and rate of periodontal disease progression include smoking, poorly controlled diabetes, poor oral hygiene, extent and severity of existing alveolar bone loss, positive family history, proportion of probing pocket depths > 5 mm, age, gender, and gingival bleeding. The number of missing teeth is also a valuable predictive variable, while certain aetiological microorganisms may also be indicators of risk.1

Where we assess risk factors, our assessment is subjective: Although most clinicians collect the information required for risk assessment, tools for quantification of risk previously have not been available. Consequently, as currently performed, risk assessment consists of identifying the risk factors an individual patient may manifest during the history and examination taking process, and then making a

subjective, qualitative judgment as to the magnitude and role these factors may be playing in the disease process. The evidence shows, however, that these subjective evaluations of pocket depth measurements, bleeding and plaque scores can be hard for patients to remember and understand. Success depends on the clinician’s ability to demystify periodontal risk, even when performed by expert clinicians, are of questionable value due in part to the complex effect of interactions among risk factors.20

Patient motivation: knowledge is power

Patients are becoming increasingly interested and involved in their own care and want more and better information about their oral health status.3

"Patients are becoming increasingly interested and involved in their own care and want more and better information about their oral health status."

We have to do more than tell patients that their oral health is not good. We have to justify our actions to them so they are influenced to change their behaviour. The new technology should provide this feedback to help motivate them to take an active role in their own care and see evidence of their success in the reduction of disease.

Shifting the focus to Wellness

An alternative model of patient care is therefore proposed: the "Wellness model" which is patient rather than clinician driven. Patients are comprehensively assessed when they are well (i.e. prior to the development of disease) and their risk of developing oral diseases is quantified using accepted clinical measures. The patient is then provided with evidence-based and personalised information using objective risk prediction models to help them take greater responsibility for maintaining their own "wellness" and prevent disease developing in the future.

PreViser Risk Prediction

PreViser risk and disease assessment technology has the potential to facilitate the shift in focus from repair to wellness. PreViser is unique in that it is a clinically validated4 oral risk prediction and disease scoring technology, performed online within the dental practice and designed to provide immediate patient feedback. It adds just 3-4 minutes to a routine examination.

Routinely collected information from each patient is entered into the software whilst the patient is in the chair, and transmitted securely over the internet to the USA. Here a mainframe server utilises a scientifically validated algorithm to return, within seconds, a risk score (scale 1-5) and a disease score (scale 1-100). This, together with treatment plan guidance based on the patient’s presentation, is provided in personalised reports for the patient and clinician.

The clinician report includes inputted data for future reference and storage on the patient’s clinical record. The patient report contains a visual display of the patient’s risk and disease scores, explanatory text about periodontitis and the patient’s role in its management.

Both risk and disease scores are objective, reproducible and sensitive to minor changes. Repeat assessments may be performed at any point in the treatment or recall cycle, and a graphical display of changes in risk and disease scores is automatically provided enabling you and your patient to track treatment effectiveness and outcomes.

PreViser:

• Facilitates risk factor identification and correction (both systemic and local risk factors)
• Educates patients about why they are susceptible and what their role is in managing their risk factors and their disease
• Provides personalised biofeedback to help motivate them to take an active role in their own care and see evidence of their success in the reduction in scores
• Reduces the risk of medico-legal claims because no patient with disease at magnitude or uninformed about their health status and role in its management

More information and a month’s free trial of PreViser can be accessed at www.previser.co.uk or by calling 07725125291.

References


About the author

Liz Chapple is Director of Oral Health Innovations (OHI) Ltd, a joint venture with the University of Birmingham. Profits from the sale of PreViser and my dentalScore are donated to the Oral and Dental Research Trust and to a scholarship at the University of Birmingham Dental School.
Tandex: An ‘Open Door’ approach to business for 80 years

Janni Theilvig has worked for Danish company Tandex for 15 years, and has been its Managing Director for three. With extensive experience in every single part of the company, Janni is the person to talk to if you want to know about Tandex, and she is eager to explain the company ethos:

“I like to think of Tandex, and of myself, as having an ‘open door’ policy. I encourage staff and members of the public to come to me with any ideas, praise or criticisms they feel will help improve our products. In fact we base a great deal of our research on the customer feedback we receive from dental professionals and other product users.”

It’s obviously a system that works, as this year sees Tandex celebrate its 80th anniversary, as well as receive continued acclaim both in Denmark and the UK.

Janni’s connection with Tandex was first established in 1994 when her father Ole and his partner Henrik Andersen bought the already well-established company. Janni herself first joined Tandex in 1996, initially on a three-month contract, and worked her way up through administration to the role of Managing Director. She has, over the years, done a little bit of everything for the company, from answering phones and collecting customer feedback, to working in the factory and packing deliveries.

It is this experience that makes Janni the boss she is today, and she seems to have a remarkable empathy for her staff and her clients.

By concentrating on what customers want, Tandex is able to produce reliable and effective products. The latest product from Tandex, the FLEXI Max interdental brush, is no exception. Already well known for its superb range of interdental brushes, including the popular Tandex FLEXI, the company has included the FLEXI Max in its range to meet the needs of people who find interdental cleaning difficult, including those with manual dexterity problems. The FLEXI Max’s long handle and angled head make it easy to use for people of all ages; as well as those with orthodontic appliances in place, it retains the same soft touch grip and colour coding as the Tandex FLEXI. It is an ideal addition to the range, which also includes toothbrushes, toothpicks, den-

STERITRAK - tracks your instruments through the sterilisation process

Steritrak is another solution from Carestream which helps you achieve full CQC compliance and gets rid of the need for multiple paper log books and the pressures of ensuring information is updated regularly and kept secure.

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Carestream Dental
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begun in 1931, when busi-
tures, and the SOLO interspace

ture brushes and interdental
gel, and the SOLO interspace

ture brushes and interdental
brush.

They have certainly come a
long way from the company’s
found its niche. Interdental brushes may have
been initially designed for the
wide interproximal gaps found
in patients suffering from peri-
odontitis, but once it was firmly
established that such devices
could be utilised in every pa-
tient’s oral health care regime,
Tandex were quick to develop
products that could be used by
any patient of any age.

Since Janni’s appointment
as MD, Tandex have continued
to go from strength to strength
and now have an excellent cus-
tomer base in the UK. To en-
sure that things are running
smoothly at this end of the line,
Tandex employs a special team
dedical professionals to rep-
resent the company at dental
shows, help collate that all-
important customer feedback,
and assist in the design proc-
ress. Rachel Pointer, a dental
hygienist, has been instrumen-
tal in developing new products
for the Tandex range, and Janni
holds her and her team in the
highest regard.

“It’s the work of profession-
als like Rachel that really helps
Tandex to continue to grow.
With first-hand experience of
using these products in the
surgery, she can advise us on
what does and doesn’t work for
patients and this is an inval-
uable part of the development
process.”

The emphasis placed on the
abilities and welfare of its staff
is definitely one of Tandex’s
biggest selling points. The over-
all impression one gets when
speaking to Janni is that this is
a company that cares, about
its customers, its products and
its staff. Some of the Tandex
employees have been with the
company for over thirty years
and their loyalty inspires Janni
herself to keep striving for per-
fection and pitching in where
needed, even if that means don-
ing work gear to spend a day
on the factory floor.

Tandex’s dedication to qual-
ity and customer care is obvi-
ous, and it is this that drives the
company:

“As a small company we are
in an excellent position to lis-
ten to every piece of customer
feedback and we use this feed-
back when designing new
items. The most important
things for me are that our prod-
ucts are of the highest quality
and our employees look for-
ward to coming to work in the
morning. After all, if you don’t
enjoy your job, you can’t do
your best work!”

From the quality of its
products, it is easy to see how
Tandex has accumulated 80
years excellent service to the
dental industry and, with the
enthusiasm shown by Janni
and her staff, it is easy to see
how it will continue to thrive in
the future.

For more information on
any of Tandex’s range of prod-
ucts for better oral health,
please visit www.tandex.dk

References

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A complete range of irrigants
for root canal treatment

Gluc-O-Chex 2.0 %
Chlorhexidine digluconate 2 % - 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 %
Chlorax dissolves organic matter. It has cleaning properties and has a bleeding 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.