Innovative probe unveiled

A leading dental implant provider has launched a pioneering new instrument that can significantly improve the consistency and quality of periodontal measurements.

Implantium has partnered with Professor Iain Chapple, Head of Periodontology at the University of Birmingham, to design and deliver a new double-ended force measuring probe. Inconsistent probing pressure is a major source of measurement variation and discomfort for patients. However, the new UB-WHO-CF15 Probe creates a standardisation of probing pressure, which not only improves the consistency and quality of periodontal measurement, but also reduces patient discomfort.

The double-ended instrument combines a World Health Organisation (WHO) C-type end for screening periodontal disease, with a 15mm graduated end to enable detailed measures of probing pocket depth, recession, and attachment levels. Its design also enables effective washer-disinfection and autoclaving.

Jason Buglass, Director of Implantium, explained: “It is a real challenge to achieve consistent measurements with perio probes. Professor Chapple’s new probe is a big step forward from previous instruments. By producing consistent measurement forces, more relevant comparisons can be made over time, in both the fields of research and standard monitoring.

Jason Buglass, Director of Implantium, explained: “It is a real challenge to achieve consistent measurements with perio probes. Professor Chapple’s new probe is a big step forward from previous instruments. By producing consistent measurement forces, more relevant comparisons can be made over time, in both the fields of research and standard monitoring. The design is ergonomic to reduce the risk of repetitive strain and the calibrated forces make it more comfortable for the patient.”

“Two work alongside someone as experienced and highly-respected as Professor Chapple has been a real pleasure. We believe the final product will be of genuine interest to the industry, and at a cost of just £85 + VAT, is an extremely cost-effective solution too.”

Professor Thomas Dietrich, Head of Oral Surgery at the University of Birmingham, commented: “I generally think that this is a major advancement in perio. It’s a simple, but great idea, and it will vastly improve measurement quality.”

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 stunning 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 stays cause oral deterioration

A study titled ‘The impact of hospitalisation 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 213,000 by 2015.

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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 forums - I like the opportunity to make contact and discuss various subjects of interest with peers and colleagues, 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 hygiene 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 an initial one-hour appointment first, followed by a subsequent forty-minute appointment at a later date. The slightly longer first appointment was to allow six point charting with plaque and bleeding indices, disclosure, OHI, delivery of LA and root surface debridement of one half of the mouth. The second appointment was to treat the other half. Perfectly reasonable.

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

‘It appears the constant reinforcement of advice from our colleague might have finally achieved the desired effect’

However, our patient baulked at this on cost grounds and said he would only book and pay for twenty-three 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...
over and do the proper job. On the way home, she started thinking ‘...why should I?’ but still showed signs of caring beyond the call of duty whilst asking us, her forum friends, how we would deal with this situation if faced with it ourselves. Essentially, she was asking about two options. Would we try to do the treatment in the time allotted by the patient or do what we could and leave the rest?

Nine colleagues including myself replied. We all offered similar advice which distilled down to:

1. Offer options
2. Explain pros and cons of each option
3. Document the reply and deliver the chosen treatment

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 pressure 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, 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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About the author

David Bridges RDH
David has over 25 years’ experience as a dental hygienist in general practice. Over the last few years, in addition to periodontal disease, he has become interested in Minimal Invasive Dentistry (MID), particularly Cariest Management By Risk Assessment (CAMBRA). Together with friends and colleague Tim Jones RDH, he has set up an information website - www.dentalvillage.co.uk - which provides information and resources regarding CAMBRA. David and Tim also write online and in print on hygiene-related subjects and present across the UK on courses prevention. They have even played [in all senses!] with video. See Dentalvillage UK on YouTube!
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.

Microbes

This study is in addition to the research already done into the pathogenic implications of orthodontic use, notably a Turkish study from 2006, which was developed to investigate instances of caries in orthodontic patients. The study concluded that *Actinobacillus aegyptius* (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 risk of levels of periodontal pathogens.” Other studi...
ies have reported different findings. Studies from 2004 and 2005 indicate that periodontopathogenic species increase significantly within 28 days of bracket placement and are markedly higher in comparison to patients without orthodontics. A 2006 study by Amezquita et al further suggested that there are significantly more periodontopathic and superinfecting bacteria three months after bracket placement, which results in more inflammation and bleeding on probing. The study advised that: “Special attention should be paid to oral hygiene methods in orthodontic patients.” The evidence clearly points to the need for a solid oral hygiene routine for orthodontic patients.

Discipline
The problem that many dentists face is that orthodontic patients are primarily children and teenagers, with an estimated 66 per cent of twelve year olds 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.

Praticing the importance of oral hygiene to teenagers. For the growing importance the public has of hospital-acquired infections is important to be aware of other potential ‘hidden reservoirs’ of harmful bacteria which can be introduced to environments where we know they can cause problems.”

Make it fun
With younger children however, the answer to inducing effective oral health care is to make it as fun as possible. As well as emphasising the importance of brushing morning, night and after every meal, it is vital that patients understand the efficacy of interdental cleaning. Many younger patients, as well as those with manual dexterity problems, can find flossing difficult however, so different methods may need to be employed.

Posing a threat
Preventative care is the key to successful treatment and health management with both removable and fixed orthodontic appliances and despite the media furore, with proper management, there is little evidence to suggest that orthodontics pose any real threat to patients. The important message to pass on to patients is one of good oral hygiene: if patients look after their retainers, their retainers will look after them.

About the author
Deborah M. Lyle, RDH, MS, Deborah received her Bachelor of Science degree in Dental Hygiene and Psychology from the University of Bridgeport and her Master of Science degree from the University of Missouri - Kansas City. She has 18 years clinical experience in dental hygiene in the United States and Saudi Arabia, with an emphasis in periodontal therapy. Along with her clinical experience, Deborah has been a full time faculty member at the University of Medicine & Dentistry of New Jersey, Forsyth School for Dental Hygienists and Western Kentucky University. She has contributed to Dr Esther M. Wilkins’ 7th, 8th, 9th and 10th editions of Clinical Practice of the Dental Hygienist and the 2nd and 3rd edition of Dental Hygiene Theory and Practice by Darby & Walsh. She has written numerous evidence-based articles on the incorporation of pharmacotherapeutics into practice, risk factors, diabetes, systemic disease and therapeutic devices. Deborah has presented numerous continuing education programs to dental and dental hygiene practitioners and students and is an editorial board member for the Journal of Dental Hygiene, Modern Hygienist, RDA, and Journal of Practical Hygiene and conducted several studies that have been published in peer-reviewed journals. Currently, Deborah is the Director of Professional and Clinical Affairs for Waterpik, Inc.

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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 undiagnosed 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, hygien-
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 sound 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 patient’s mind and get them to accept the advice and treatment they need? There are many ways to do this and it is important to use them all when appropriate.

What’s Missing?

Three global titles from the Dental Tribune International portfolio are coming to the UK. Published quarterly, each of these glossy, clinically-focused titles aims to bring you the latest developments in the fields of implantology, endodontics and cosmetic dentistry in a clear, easy to read format.
can make all the difference. It doesn’t need to be a long session, you just have to fine tune how you talk and listen to patients. Some good basic rules are:

- If you ask a question, RE-ALLY listen to the answer...and don’t interrupt!! (harder than it sounds, I know)
- Ask about the patient’s knowledge about the topic you wish to discuss. This can open up the discussion in a non-confrontational manner
- Be positive...but realistic about their treatment needs
- Ask the patient if what you have said makes sense to them. Are you sure they understand the message you are trying to convey?
- Praise the talents of your team. “Sell” their care to your patient and watch as your treatment acceptance increases with little effort

A picture speaks 1000 words

Every working environment is different and has restrictions, but preventative dental care is very cost effective and time friendly so we do not have an excuse as a profession. For those with good budget to change the practice dynamics, you will save time and increase compliance with the addition of a microscope in practice. This should be linked to a live screen so the patient can see what you see. Taking a sample of your patient’s plaque and showing them what is growing there can make a difference with their treatment acceptability appointment booked.

• Ask the patient if what you have said makes sense to them. Are you sure they understand the message you are trying to convey?
• Praise the talents of your team. “Sell” their care to your patient and watch as your treatment acceptance increases with little effort

So to summarise:
- Use your team to glean information and discuss patients needs, fears and expectations
- Question the patient gently to develop conversation about their health
- Emphasise the importance of prevention in dental health and the benefits of this
- Show your patients what is happening
- Be positive, explain that they can make a difference with their home routine
- “Sell” your team and their part in preventative care in the practice

Obviously, if the patient is immediate pain or risk then this should be dealt with. Otherwise resist carrying out treatment until the preventative routine has been introduced.

Part 2 will look at the information and direction your team need from that first appointment to support your treatment of the patient. For any questions please email me at mhari.coxon@cpdfordcp.co.uk.

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Periodontitis is the most prevalent chronic inflammatory disease of humans and a major cause of adult tooth loss, impacting negatively upon oral health, function, speech, nutrition and quality of life. 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 mortality, and with an increased relative risk for several other chronic inflammatory conditions, including cardiovascular disease, rheumatoid arthritis and type 2 diabetes. Successful periodontal intervention improves tooth retention, 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. The solution was thought to be to eliminate plaque, hence the perception of peri as a plaque and calculus removal function. We now know that periodontitis requires a susceptible host and that we all vary in our susceptibility from the 10 per cent who are immune to the 10 per cent 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 Axelsson who demonstrated unequivocally that common dental dis

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‘This surgical mentality dates back to the days when periodontitis was considered ubiquitous and simply a bacterial infection consequent upon plaque accumulation’
eases like caries and periodontal diseases 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.¹⁰

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 perio and:

- help the patient to appreciate that they are different to the majority of the population due to their increased risk level
- convey the severity of their condition and its implication for their oral and general health
- emphasise the patient’s role in reducing their risk and managing the disease
- provide personalised data which the patient can monitor that your and their efforts are improving their health

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 (ie 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 validated¹¹ oral risk prediction and disease scoring technology, performed online within the dental practice and designed to provide individual patient feedback. It adds just 3-4 minutes to a routine examination.

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- Reduces the risk of medico-legal claims because no patient with disease is left uninformed about their health status and their 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 Dental Score are donated to the Oral and Dental Research Trust and to a scholarship at Birmingham Dental School.
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-

It is 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.”

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

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 products for better oral health, please visit www.tandex.dk.