Patient swallows toothbrush

A recent report has told how a 24-year-old was repeatedly turned away by doctors as she tried to convince them that she had swallowed her 9 1/2-inch toothbrush. According to reports, it took two visits to two separate hospitals in northern Israel before Bat-El Panker, 24, of Kiryat Yam, was able to convince a doctor that she had in fact accidentally swallowed her green, white and orange toothbrush while brushing her teeth. The report said that the toothbrush had slipped down her throat as she bent over to drink some water whilst the brush was still in her mouth. According to reports, the plastic toothbrush did not show up in X-rays, which lead doctors at the first hospital to send her home. “I begged for another exam, I knew I’d swallowed a big toothbrush, but no one believed me,” she said that the toothbrush had slipped down her throat as she said that the toothbrush had slipped down her throat. The report then highlighted some areas for improvement.

The OFT study found that patients have insufficient information to make informed decisions about their choice of dentist and the dental treatments they receive; it also stated the complexity of the complaints process for patients, instances of potential pressure selling by dentists of dental payment plans and the need for accurate and timely information for patients. The OFT is calling on NHS commissioning bodies, the General Dental Council and the Care Quality Commission to be proactive in enforcing existing rules which require dentists and dental practices to provide timely, clear and accurate information to patients about prices and available dental treatments.

The report also raised significant concerns about continued restrictions preventing patients from directly accessing dental care professionals, such as hygienists, without a referral from a dentist. The report considered these restrictions to be highly unjustified, and the OFT have responded by urging the General Dental Council (GDC) to remove restrictions preventing patients from making appointments to see dental hygienists, dental therapists and clinical dental technicians directly, as soon as possible.

The OFT report also highlighted concerns with the current NHS dental contracts in England and stated how it is extremely difficult for new dental practices to be established and how successful dental practices, which offer a higher quality of service to NHS patients, are prevented from expanding. As a result, the OFT has urged the Department of Health to redesign the NHS dental contract to facilitate easier entry into the market by new dental practices and allow successful practices to expand.

John Fingleton, OPT Chief Executive said: “Our study has raised significant concerns about the UK dentistry market which need to be tackled quickly in the interest of patients. All too often patients lack access to the information they need, for example when choosing a dentist or when getting dental treatment. We also unearthed evidence that some patients may be receiving deliberately inaccurate information about their entitlement to NHS dental treatment, and we expect to see robust action taken against such potential misconduct by dentists.

“This study has also highlighted that the current NHS dental contract in England may well not be working in the best interests of patients, and that regulations unjustifiably restrict patients from getting direct access to dental care professionals like hygienists. Reform in both these areas is needed without delay.”

In response to the report, Dr Susie Sanderson, Chair of the BDA’s Executive Board, said: “Where patients do have concerns about their care, it is clearly important that they have an effective complaints process. This is helpful for dentists and patients alike and dentists support the goal of making the process as simple as possible.”

“Also crucial is the development of a new dental contract which is already under way in England. In piloting and designing those new arrangements Government must ensure that it provides clarity about what the NHS offers and properly supports practitioners in providing the kind of modern, preventive care that our patients deserve.”

Dr Nigel Carter Chief Executive of the British Dental Health Foundation (BDHF) said in response to the OFT report: “Whilst we welcome the report and the fact it recognises the need for change in certain areas, some of the findings are extremely difficult for new dental practices to be allowed to expand.”

The OFT report also highlighted concerns with the current NHS dental contracts in England and stated how it is extremely difficult for new dental practices to be established and how successful dental practices, which offer a higher quality of service to NHS patients, are prevented from expanding. As a result, the OFT has urged the Department of Health to redesign the NHS dental contract to facilitate easier entry into the market by new dental practices and allow successful practices to expand.
From strength to strength – Clinical Innovations Conference 2012

The ninth annual Clinical Innovations Conference has been hailed a ‘fantastic success’ from delegates and organisers alike. Dental Tribune was there...

The Clinical Innovations Conference 2012, organised by Smile-on and the AOG and in association with The Dental Directory, was a fantastic success, boasting world-class speakers, cutting edge topics and practical advice for the many dental professionals in attendance.

Held last month at the Millennium Gloucester Hotel in London, the event saw more than 400 visitors from across the country come together for the two-day event.

As befits one of the leading aesthetic and restorative conferences held in the UK, delegates were able to expand and develop their understanding of ideas and techniques with help from some of the top names in the field. For the first time, the event included a London Deanery DFT Conference, running alongside the Clinical Innovations Conference, providing more variety and attracting a number of additional practitioners.

The event began on the Friday, with world-renowned Dr Nasser Barghi speaking on ‘All-Ceramic and CAD/CAM Restorations in 2012: Clinical Steps’, to a highly attentive audience. Always a popular speaker, Dr Barghi’s look at restorative materials and the best indication for each was both practical and entertaining.

After the coffee break the conference split into two streams; Dr Wyman Chan and Dr Anthony Roberts. Dr Chan gave a lecture on ‘Modern Bleaching Techniques’. As a dedicated tooth-whitening dentist, Dr Chan focused on bleaching techniques and the science behind the products he uses, as well as running a live demonstration alongside his lecture, with his dental nurse.

Simultaneously, Anthony Roberts spoke about ‘The Periodontal Jigsaw: Putting it all Together’. Looking at what a measure of success in periodontal treatment might mean for both clinicians and patients, Dr Roberts discussed RPE charting and the journey of diagnosis. He also explained the clinician’s role as motivator, communicator and educator in addition to their clinical capacity for the best treatment for patients.

The afternoon continued the high standard of speakers, with Richard Kahan giving an enthusiastic talk on ‘New Horizons in Endodontic Diagnosis and Treatment Planning’.

Comparing the dental and medical industries, Richard highlighted the issue that dentistry has a far smaller range of tests to use when diagnosing a patient’s complaint. In fact, the only truly objective test is an X-Ray. This is not however, a totally reliable tool, as its limitations can affect the results shown. If an X-Ray does not show a specific problem that does not necessarily mean there is nothing wrong – if a lesion for example is limited to cancellous bone, an X-Ray will not show it at all.

In effect, an X-Ray gives a ‘shadow’ of the tooth structure, so a 2nd and 3rd dimension is needed for an accurate diagnosis. The Limited Volume Cone Beam Computed Tomography (CBCT) gives this, and allows for a reliable and immediate diagnosis; preventing the possibility of working on the wrong tooth and causing more problems than existed originally.

Nasser Barghi, Mhari Coxon and Fraser McCord then separated the conference into three streams, speaking on ‘Bonded All Ceramic Restorations in 2012’, ‘Effective Biofilm Management’ and ‘Diagnosis of Complete Denture Problems’ respectively.

Fraser McCord took over the lectures to discuss the best techniques for diagnosing problems with complete dentures. He was quick to establish five main areas where problems arise;

- Support (resistance to movement towards the tissues)
- Retention (resistance to movement away from the tissues)
- Stability (resistance to movement along the axis of the natural tooth)
- Retention (resistance to movement away from the tissues)
- Appearance
- Miscellaneous

‘Visitors were able to expand and develop their understanding of ideas and techniques with help from some of the top names in the field’

To diagnose each, Dr McCord recommended a hands-on approach, tracing the dentures while in the patients’ mouths to find where problems could be occurring.

Dr McCord concluded his lecture with a few pointers to aid success with complete dentures. The first was that practitioners should ensure they use the suitable diagnostic treatment with confidence and competency. Patients’ expectations should also be kept realistic and the dentures should be age appropriate, helping them to look as natural as possible. Finally, good communication with the tech...
According to Professor Gambarini, the best treatment is the one that achieves the most appropriate results. This is because the success of endodontic treatment depends on the patient's requirements. As a great believer in the importance of working with 3D technology, he illustrated the impact of new and existing patients using the technology to improve their practice and to support their use.

The first day concluded with Professor Gianluca Gambarrini lecturing on ‘Clinical Endodontics: Concepts and Techniques’. Discussing the benefits of cone beam technology, he illustrated the importance of using 3D images to diagnose patients’ complaints.

The London Deanery DFT Conference was the second annual conference for London Dental Foundation dentists, and the second time it has been held in the UK. The conference proved to be a popular edition, with many delegates already penning the 2013 date in their diary. Next year, the tenth anniversary of the Clinical Innovations Conference, will be held 17-18 May 2015. See you there?

In the evening, the event hosted its third annual Charity Ball, where hundreds of delegates dressed to impress. Attendees were greeted by a champagne reception, and were able to relax and enjoy a sumptuous three-course meal, followed by a live entertainment in the form of a variety of complicated endodontic problems. As a great believer that the ‘Anatomy dictates instrumentation’, he showed that success of endodontic treatment can only be achieved if the most appropriate tools and techniques are adopted for each case.

As the Conference split into three sessions again, Professor Gambarini returned to the theme of ‘Clinical Endodontics: Concepts and Techniques’. Simultaneously, Ajay Kakar lectured on ‘Non Surgical Management of Periodontal Disease’, Sandeep Senghera discussed ‘Treating Your Patients and Business to the Latest in Technology’, and Dr Nasser Barghi spoke about ‘CAD/CAM Zirconia’ to MSc students.

Dr Senghera’s presentation was a practical look at marketing your practice to new and existing patients using the technology that many use daily in their personal lives — smartphones, social media etc. Likening the patient base to a bath with water running in and draining out, he emphasised the need to ensure patients are retained with smart recall processes and timesaving strategies for patients such as online appointment booking.

John Moore then took over the speaking to explore ‘Digital Dentistry and the Advantages for Cosmetic Treatments’. Primarily discussing how his practice is using the CEREC system to their advantage, Dr Moore showed how clinicians can use CAD/CAM in their practices to fulfil patients’ requirements.

Dr Barghi returned again in the afternoon to repeat his popular lecture on Bonding from the previous day, while Dr McCord’s lecture was ‘An Update on Impression Techniques for Complete Dentures’.

Dr Nilesh Parmar looked at Dentistry in the 3rd Dimension’. Discussing the clinical applications for CBCT in various branches of dentistry, Dr Parmar used many case examples using the technology to illustrate how, in his words, it ‘changed my working life’.

The Clinical Innovations Conference 2012 came to a close on the Saturday afternoon, with Dr Amit Patel speaking on ‘Peri-implantitis – a Future Timebomb’. With the growing trend of placing dental implants, cases of peri-implantitis and peri-mucositis will inevitably increase.

Dr Patel discussed the process of the inflammation and the reasons for it, looking at prosthesis design. He discussed his preferences for screw-retained restorations and looked at therapies for managing the inflammation.

Feedback from the event has been fantastic, with many delegates already penning the 2013 date in their diary. Next year’s event, the tenth anniversary of the Clinical Innovations Conference, will be held 17-18 May 2015. See you there!
Rerwarding innovation

Dental Tribune looks at the first Clinical Innovation Award finalists

The first ever Clinical Innovations Award, a fantastic new prize designed to showcase the best, most innovative products on the market today, was held this year at the Clinical Innovations Conference Charity Ball. The Clinical Innovations Conference, now in its ninth year, has become one of the leading conferences in aesthetic and restorative dentistry in the UK. The conference itself brings together top international thinkers who present the very latest developments in dentistry.

In keeping with the theme of the lectures, these conferences have become the backdrop for companies to expose the genius of their innovative products. Smile-on and the AOG invited the dental industry to nominate their most innovative product to be judged by a panel of experts.

There was a fantastic range of entries, some of which were described as "breathtakingly brilliant", others of which were defined as "superbly practical"; all were distinguished as having innovation at the heart of their solutions.

The judging panel consisted of a number of esteemed dental professionals, as well as members of a number of key journal editorial boards. As the award ceremony got underway, the judges were keen to comment on the variety and excellence of all the products short-listed, which had given the panel "great admiration" for all the companies involved. With such a strong short-list, picking a final three was tough, and the judges were particularly interested to examine innovation for dentistry as a profession – not just in the product itself.

With such a strong line-up of potential winners, the winner of the inaugural Clinical Innovations Award really had to stand out above the rest and after much careful deliberation, Dean of the London Deanery Mrs Elizabeth Jones announced the winners.

The winner was the Morita Veraviewepocs 3D R100 X-Ray machine and according to the judges it was a cut above the rest:

"This is an amazing development. No one thought anyone could achieve it. The field of vision in the right trough providing accurate information has been almost impossible with rotational devices. This is a technological breakthrough of increasing an 80mm diameter cylindrical field of vision to 100mm triangulated field of vision – to simulate the shape of the triangulated mandible, now includes the missing anatomy without exposing other tissue. This improves accurate detailing and will enhance patient safety when diagnosis and treatment planning is undertaken."

Launched in March 2012 the Veraviewepocs 3D R100 is the latest model in the Veraviewepocs 3D series of combination panoramic, cephal & cone beam CT devices. It re-defines the concept of 3D imaging with a unique Reuleaux Triangular FOV which more accurately matches the shape of the patients' jaw. The R100 FOV in-
cludes relevant anatomy that would be imaged with a 100mm circular diameter cross section but excludes irrelevant tissues outside the jawline. Not only was it previously considered impossible to achieve anything other than a circular cross section, but by achieving this, the X-ray dose to the patient is comparatively lower by around 15 per cent. With such powerful implications for enhanced patient safety, the R100 is the deserving winner of the first ever Clinical Innovations Award.

The highly commended award went to W&H with its entry the Proface light probe. Despite all the years of research in the field, detecting caries remains difficult. Where previous caries detection devices have generally been chemical based leaving stains, the Proface light probe was commended for its innovative approach that, while not perfect, provides the right approach to ‘evidence’ in knowing when to stop treating.

This new innovation allows direct visual identification of the caries-infected areas, thereby enabling selective treatment during caries excavation due to the ease of detecting the caries. Proface enables simple identification of the extent of a carious lesion allowing the clinician to ensure that subsequent excavation is minimally invasive and leaves healthy tooth structure intact. It also allows the clinician the confidence of knowing that they have eradicated the entire caries.

The commended award went to NSK S-MAX PICO HANDPIECE. In the modern era of micro cutting and magnification, this handpiece reduces the size of its head to allow wider visibility and better access to the posterior regions of the mouth where mouth opening is restricted, or in children and patients where mouth opening is limited. This handpiece has the smallest neck and head size yet developed in dentistry and the NSK’s S-Max pico ultraminitri cut turbine has been specifically developed for minimally invasive (MI) procedures. The technical specification of this handpiece’s cutting ability for such a small head is impressive. This is minimalistic functional art in action.

Finalists for the award were:
- The Carestream CS7600, the world’s first Intelligent Image Plate System
- COMPONER from Coltène/Whaledent, Direct Composite Shells that represent a completely new class of veneers
- Tri Plaque ID Gel from GC UK, a gel that allows you and your patient to identify areas of plaque in three easy steps
- Propoints from Smart Seal, the only obturation product to use hydrophilic polymers which absorb water and expand laterally within the root canal, creating a 3D mechanical seal
- TEPE Angle from TePe, designed to provide improved access and cleaning. A TePe Angle clip strip also offers a novel way of displaying the entire range in dental practices
- The Nano Water Flosser with the Plaque from Waterpik, which has been described as the “pinnacle of modern Water Flosser technology.”
- A piezo scaler developed by Ti-gons W&H that provides the patient with temperature-controlled irrigant spray thus avoiding irritation, even for sensitive teeth

Smile-on and the AOG would like to congratulate all the winners of the Clinical Innovations Award, and would like to thank everyone who helped make the Clinical Innovations Conference such a resounding success.

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flawed and out of date. The Steele Review, which was commissioned by the last government, has already addressed the concerns raised around the 2006 NHS Contracts and a replacement proposal is already being piloted. The results of this will be used to help shape the future of the way NHS dentistry is delivered.

“The recommendation for the GDC to require that private practices display a pricing structure is irrelevant. A dentist should provide a patient with a treatment plan, and as each patient’s plan is different, fixed pricing will lead to confusion and the possibility of disappointed patient expectations.

“The report suggests that patients should be given direct access to dental hygienists and therapists. And whilst supporting this recommendation, as we believe it may facilitate a better understanding of oral health and encourage new patients and more referrals to the dentist, it must be done under caution.

“This report should not be taken as central advice as the government of dentistry in the UK and if taken in isolation it does not deliver a satisfactory solution for the patients or the dental health profession. The findings of the OFT report need to be included and reviewed as a part of the education, research and change which needs to happen to deliver the best quality dental care.”

David Worskett, Chair of the Association of Dental Groups (ADG) said: “The Association of Dental Groups, which represents the larger corporate providers of dentistry in the UK and supports many of its key conclusions.

“In particular, ADG members, who account for some 10 per cent of NHS dentistry, support provision of clearer pricing information and are pleased to have been able to reach agreement with the OFT on ways of extending and improving this.

“The ADG supports the OFT’s emphasis on choice and competition in dentistry. Members welcome the emphasis in the report on improving entry to the market for new providers and the support the OFT gives to increasing tendering. Long-term contracts facilitate investment and continuity of patient care but must not prevent commissioners from tackling poor quality. The OFT’s recommendations to the sector and to the Department of Health have the potential to improve quality for patients and help to drive up standards, particularly when taken in conjunction with the new NHS dental contract, which addresses many of the worst problems identified by the OFT in the current arrangements.

“Clinical opinion in the UK remains divided over the issue of direct access to some dental services and the ADG believes that it is clinical considerations that should determine whether to go down this route. The ADG therefore awaits with interest the work already being undertaken by the GDC on this.

“It is of course vital that improvements are driven out of UK dentistry and the OFT is completely right to draw attention to the worst types of abuse. ADG members already have very high standards of clinical and corporate governance designed to prevent abuse and protect patients.

“However it is welcome news that the level of abusive practices is put into perspective by the very high levels of professional concern and in practice there is already considerable choice and competition on the high street, bringing real benefits to patients. The ADG agrees with the OFT that the overall assessment of the market does not require or justify a referral to the Competition Commission.”

**GPs draw the line at CQC reg fee payment**

According to a recent report, it has been agreed by the local medical committee’s conference that GP practices should not have to pay for CQC (Care Quality Commission) registration.

North Yorkshire GP Brian McGregor said in the report that GP practices were “already subject to oversight from 28 organisations and the CQC would become the twenty-ninth as of next April.”

Dr McGregor won support for his demand that registration should not impose any expense on practices.

He said: “It’s a bit like medieval times, giving a piece of silver to the axeman to ensure the sweep was sure. The ultimate cost of registration should not fall on GPs.”

The report also quoted Gloucestershire GP Steve Avis, who said he did not want his GP practice to become a stark environment, “with plastic flooring replacing carpet in a bid to meet CQC standards.”

GPs are also concerned about the CQC’s registration process which they believe to be overly bureaucratic.

According to the report, the conference called on the CQC to “modernise, streamline and simplify its processes.”

It has been agreed that GPs should be spared the fee to register with CQC.

**All smiles as professor scoops Lifetime Achievement Award**

The former dean of Dundee Dental School and chair of the Dental Schools Council, Professor William Saunders has received the first ever Scottish Dental Lifetime Achievement Award paying tribute to his commitment to the dental industry in Scotland.

Professor Saunders has made a substantial contribution to dentistry in Scotland over many years and has been pivotal in the development of undergraduate, postgraduate and postgraduate teaching. He also sits as a council member of the Royal College of Surgeons of Edinburgh.

Four of Scotland’s top dental professionals were nominated for the award - Professor Saunders was up against Dr Graham McMurtry from Glasgow, Edinburgh’s Dr Jim Bremner CBE and Dr Hew Matheson CBE. Fellow industry professionals voted online making Professor Saunders the clear winner.

He received the accolade at an evening drinks reception during the inaugural Scottish Dental Show at Glasgow’s Hampden Park on Thursday 24 May. BBC sports pundit Chef Young, who entertained guests with dental tales and football anecdotes, presented the trophy.

Bruce Osley, editor of Scottish Dental magazine, organisers of the Scottish Dental Show and Scottish Dental Lifetime Achievement Award 2012, said: “Professor Saunders fellow professionals admired his continued commitment and his exceptional academic work making him a worthy winner of the first Scottish Dental Lifetime Achievement Award.

“Employing more than 10,000 professionals in Scotland, dentistry is a significant industry and Professor Saunders influential work can ensure that the country continues to produce the very finest graduates.”

The award was one of the highlights of the Scottish Dental Show, where more than 100 exhibitors representing the cream of the UK dental trade have been showcasing the latest innovations, product developments, services and launches.

Created by the Connect Publications, a subsidiary of Scotland’s largest book publisher Connect Communications and the publishers of Scottish Dental magazine, the free event, is provided to up to 12 hours of verifiable CPD through speaker sessions and hands-on workshops. The Minister for Public Health, Michael Matheson MSP officially opened the show.

**Dentist to clean shark’s teeth**

Richard Howarth, a 45-year-old dentist from Fife, has been invited to dive in a shark-infested tank! Richard, who has been invited to do the charity event at the Blue Planet Aquarium, Manchester, will be cleaning the teeth of a shark named Storm, an 11.5ft Sand Tiger Shark who weighs in at a staggering 50 stone!

For the challenge Richard, who is taking specialist training before spending half an hour in the chilly shark infested tank, will be equipped with a toothbrush so he can clean Storm’s 46 razor-like teeth!

Richard hopes to raise £2,000 through this challenge for the charity Dental Mavericks and their work to end the daily dental pain for Moroccan kids. The money will help buy a solar powered dental chair so that more conventional dental care can be provided rather than just extractions and fillings for the charity Dental Mavericks and their work to end the daily dental pain for Moroccan kids.

Richard Howarth, who is a member of the Dental Mavericks Charity, is travelling to Morocco in September for eight days to treat children in severe dental pain with no access to dental care. Richard said: “The idea for this crazy dive came from a pensive moment. I think they find it funny that I spend my life helping patients who are anxious and fearful. And for me to immerse myself in the tank then the tables would be turned.”

Richard has been invited to do the charity event at the Blue Planet Aquarium, Manchester from 10am to 11am on 8 June 2012.
Editorial comment

The news today has been dominated by the Office of Fair Trading’s report into dentistry and the recommendations that they have made. People from all areas of the profession have been making their cases in a variety of media – radio, TV, newspapers etc – aiming to downplay what many have called the sensationalising of the report.

Yet again the drum of evil – radio, TV, newspapers etc – has been beaten by the Press, aiming to drown out the fact that the majority of those who responded (and that was 3450 people) are actually satisfied with the dental care they receive.

Statistics, as we all know, can be twisted to prove anything. In my post-graduate days as a green and grateful marketing assistant for a firm selling telephone systems, I had to ring local businesses to find out about their systems for a university-based project. Treated as a loathsome cold calling salesperson, I had to take the figures from the nine companies who bothered to talk to me and make a presentation out of them. With the use of the times by five principal and some lovely pie charts, I made a fantastic presentation that bore no resemblance to the true situation of the telephone system usage of the city’s local businesses.

Sound familiar? Thought so.

Dental training needs ‘urgent consideration’

The recent Health Select Committee report on Education, Training and Workforce Planning highlights a failure to adequately consider the dental issues that must be tackled, the British Dental Association (BDA) has said. This must be addressed urgently, the BDA believes, by proper consideration of how changes might affect dentistry and what must be done to support dental training.

The report, which notes a lack of vital detail in plans for the reform of the training and education of healthcare workers, has nonetheless failed to pick up properly on warnings in the BDA’s submission to the Health Select Committee inquiry, meaning that the issue of how the training of dentists and their teams will be paid for is still unclear. Detailed assurances that dental practices will not be expected to pay for training, a scenario that would be completely unacceptable, are urgently required, the BDA believes.

Dr Judith Husband, Chair of the BDA’s Education and Standards Committee, said: “This report reminds us that the Government’s plans are still lacking in important detail and require significant further development. Disappointingly, differences between medical and dental training remain unacknowledged and dental-specific issues have not been addressed.

“The BDA has been pressing for clarity on these issues. That they continue to be unresolved is a source of frustration and anxiety for dental practice owners. Dentists need to see a bold, unambiguous statement from Government that confirms that they are not to be landed with a huge financial burden for training future generations of the profession.”

The regime that shows plaque bacteria no mercy

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

Using LISTERINE® after mechanical cleaning destroys oral bacteria effectively, killing up to 97% in vivo. This lowers the bacterial burden in the mouth and in plaque that reforms. And when used for 6 months, LISTERINE® can reduce plaque levels by up to 52% more than brushing and flossing alone. In addition, LISTERINE® Total Care products offer various levels of fluoride and other benefits to suit patients’ needs.

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

References:
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5._places_destroy_dislodge_displace_destroy
Buying smarter could save NHS £1.2bn

New ways of buying supplies and medical equipment could save the NHS £1.2 billion to reinvest in patient care, Health Minister Sir Mark Walport announced today.

The NHS has been asked to ‘raise its game’ when purchasing goods and services, such as gloves and sutures, catering and energy, to save at least £1.2 billion over the next four years.

The Department of Health, working with the NHS Supply Chain, has also established a £500 million cash fund to enable the NHS to bulk buy large equipment such as:
- CT scanners
- MRI scanners
- ultrasound machines
- gallium-68 PET scanners
- cancer treatment technology

Thanks to this fund, £1 million has already been saved through orders that have been placed in advance via NHS Supply Chain with suppliers.

Traditionally, the NHS has struggled to make the most of its buying power as there was very little knowledge between local hospitals about their equipment needs. This fund allows the NHS to benefit from the savings of bulk buying expensive medical equipment via NHS Supply Chain.

Health Minister Simon Burns said: “This is an important development in healthcare. The NHS Supply Chain, has selected the membership of panel members’ experience, to help them save even more money that can be reinvested in patient care.”

The recommended life of the majority of equipment, such as CT and MRI scanners is ten years, after which it either needs updating or replacing because of wear and tear. There are over 200 of these large scale items that will need replacing over the next four years, if the NHS is to adopt efficient and effective procurement planning and management.

By having the cash fund available, the NHS Supply Chain are able to secure better bulk buys deals for the NHS with suppliers. As equipment is purchased by trusts, payment for it will go back into the fund, effectively replenishing it for future use.

Andy Brown Managing Director of Business Solutions for NHS Supply Chain said: “This important development will allow NHS Supply Chain to group together the purchasing power of the NHS for this vital equipment, make large commitments with suppliers and bring improved planning to the management and replacement of this equipment across the NHS and with suppliers.”

Procurement plays a valuable role in driving improvement in so many areas. Better procurement means these savings can be reinvested to benefit patients. Our ambition is to put in place a world-class procurement system in the NHS that is responsive to modern suppliers. This will enable the NHS to adopt existing innovations and stimulate new ones that will benefit patients and taxpayers.

In addition, hospitals are now being asked to drive forward improvements through a series of actions, more transparent and ensuring they buy equipment and services, including:
- Publish the details of all contracts over £10,000
- Appoint a board executive to be accountable for procurement performance
- Regularly audit procurement

These actions in Raising Our Game will be taken forward immediately, whilst the strategy for developing world-class procurement will be published later this year.

It is vital that we have procurement that is not only better, but is world class. As a first step, Raising Our Game sets out the actions that the NHS must take immediately. It should be focused on outcomes, not just cost, and must be responsive to creative ideas from suppliers, procurement specialists, clinicians and managers.

Transforming procurement in the NHS could enhance quality and value and the strategy for delivering this will be published later this year.

Trade a smile for a ‘smiley’

Want to take part in National Smile Month? Struggling for ideas? Budget too tight? Make the BDHF smile and they can help.

Campaign organisers the British Dental Health Foundation, has enlisted the number one contributors to the BDHF smile and they can help.

“Grand Tour” to benefit Dentaid

Elizabeth May is a specialist in Special Care Dentistry currently working for the Somerset Primary Care Service. She plans to celebrate her retirement in June with a “Grand Tour”, in aid of Dentaid, visiting each of the county’s ten clinics in turn – about 200 miles – backpacking with a lightweight tent.

Starting on June 28th, the route will take her from her home in the Mendips to Frome, Yeovil, Chard, Taunton, Wells, Bridgwater, Burnham-on-Sea, Wells, Glastonbury and home, covering about 25 miles per day, using many of the long distance footpaths in Somerset.

She writes: “Dentaid’s aims sum up many of the areas of dentistry in which I have been involved – the wider aspects of delivery of care to populations; issues of access and reaching out to the more vulnerable; prevention and education.”

Sponsorship donations to benefit Dentaid will be much appreciated and can be made at www.justgiving.com/elizabeth-may1

Membership of Information Governance Review Panel announced

Fiona Caldicott, Chair of the independent Information Governance Review Panel, has selected the members of the panel who will conduct the review. The aim of the Review is to advise on how to achieve a better balance between protecting and sharing confidential personal information.

The members of the Review, entitled ‘Information: to share or not to share?’ have been drawn from patient and volunteer groups, clinical and local government professionals. Further information is available at www.Caldicott2.dh.gov.uk

Dame Fiona Caldicott, Chair of the Review, said: “I am delighted that the individuals who we invited to participate in this work have accepted enthusiastically. They will play a crucial role in ensuring we have effective communications with groups or individuals whose support we need if our recommendations are to be realistic and likely to lead to constructive and acceptable improvement. The breadth of panel members’ experience will guarantee us the necessary insights to identify the appropriate balance between sharing and protecting information.”

The full list of panel members is:
- Dame Fiona Caldicott, Chair
- Dr Alan Hassey, GP
- Dr David Wrigley, GP
- Sir Nick Partridge, Chief Executive, Terence Higgins Trust
- Professor Martin Servers, Chief Executive National Voices
- Caroline Tapster, Former Chief Executive Hertfordshire County Council
- Sir Mark Walport, Director Peoples hefty
- Sir David Wrigley, GP from the Clinical Commissioning Group

Terry Daffer, Director of Adult Social Care, Stockport Council and ADASS
- Janet Davies, Director of Nursing, RCN
- Professor David Haslam, President BMA
- Professor Richard North, Chair of the Health Protection Agency
- Dawn Monaghan, Chief Executive Terence Higgins Trust
- Sir Mark Walport, Director Peoples hefty
- Sir Nick Partridge, Chief Executive National Voices
- Professor Martin Servers, Geriatrician, University of Portsmouth
- Caroline Tapster, Former Chief Executive Hertfordshire County Council
- Sir David Wrigley, GP from the Clinical Commissioning Group

For further information please visit www.smilemonth.org or call 01788 539792

www.Caldicott2.dh.gov.uk

So far the campaign has generated an excellent response. It is extremely pleasing to see such a variety of organisations taking part in this year’s campaign.

“We hope by making so many ‘smilies’ available free of charge that more organisations will come forward and help us spread the messages of National Smile Month. All you need to do is make us smile!”

Submit your offers to make the BDHF smile by 5pm on Friday 8 June at the following places to be in with a chance of winning:

- www.smilemonth.org/page/competition
- Facebook fan page – ‘National Smile Month’
- Twitter – @smilemonth, @Daviddavid_BDHF
- Email – pr@dentalehealth.org

For more information please visit www.smilemonth.org or call 01788 539792

She writes: “Dentaid’s aims sum up many of the areas of dentistry in which I have been involved – the wider aspects of delivery of care to populations; issues of access and reaching out to the more vulnerable; prevention and education.”

Sponsorship donations to benefit Dentaid will be much appreciated and can be made at www.justgiving.com/elizabeth-may1
The key to a healthy smile lies in the infant and toddler years

Leading experts in toddler feeding and dental health have united to highlight the importance of diet, positive feeding habits and good oral health routines in the early years, as part of National Smile Month (20 May-20 June). Around a quarter of a million children starting primary school across the UK will already have tooth decay and the Infant & Toddler Forum (ITF) and British Dental Health Foundation are working together to raise awareness about how to avoid this wholly preventable problem.

Those who learn good habits from an early age are more likely to carry them into adulthood, and the ITF – specialists in food and feeding in the under threes – has produced a sheet of simple tips to help families take positive steps towards their toddlers’ good dental health. Endorsed by the Foundation, the practical, evidence-based advice includes tips on how to care for children’s teeth – including diet, bottle-feeding, tooth brushing, fluoride and medicines.

Advice around what and what not to eat can also be confusing; the UK Royal College of Surgeons Dental Faculty recently reported that half of five year olds show signs of enamel erosion caused by fruit, particularly citrus fruits and encouraged schools to ban fruit juice and to offer milk and water instead.

Judy More, paediatric dietician and member of the ITF, says: “It is important to give young children the opportunity to learn to like water as a drink by offering it. Fruit juice, like other sweet drinks, causes tooth decay when drunk frequently throughout the day. If fruit juice is given as a drink it should be well diluted; for example one part juice to about six to ten parts water and served in a glass, cup or beaker, not a bottle.

“Sweet food, sweet drinks and fruit juices should only be given at four occasions throughout the day (eg three meals and one snack) to minimise the times teeth are exposed to sugar and acid. Water and milk are the only drinks that should be offered between meals and snacks.”

Dr Nigel Carter, Chief Executive of the Foundation says, “Educating children from an early age can reap huge benefits, as the development of a good oral healthcare routine begins at a young age.”

For more information on protecting toddlers from tooth decay, download the ITF’s free ‘Protecting Toddlers from Tooth Decay’ Guidance & Tips sheet for families or Factsheet for professionals working with parents.

For further information about National Smile Month and to view resources supporting the campaign visit: www.smilemonth.org

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*The Dental Advisor, Vol. 23, No. 3, p 2-5
A long career dedicated to the dental nursing profession- Jean Smith

Diana Wincott MBE pays tribute to M Jean Smith MBE: Following the Second World War there was great difficulty in recruiting suitable dental chairside staff. There was no formal training available, pay was poor and the term ‘Attendant’ often deterred suitable applicants from entering the work.

The Dental Nurses and Assistants Society of Great Britain and Northern Ireland, established in 1940, sought to influence and act to secure proper training and pay for their members and protect the character and status of dental nurses. It was in this environment that the young Jean Smith found herself. Jean passed the National Examination in 1945 at the Leeds centre. At that time the Panel of Examiners consisted of six dentists.

In 1948 Jean replied to an advertisement for a Secretary to the Dental Nurses and Assistants Society who urgently needed a new secretary; the advertisement stated that, unless someone came forward at once, the society would cease to function. Fortunately Jean Smith was appointed!

Jean made a huge commitment to her work and succeeded in increasing the number of courses, candidates and examiners, ensuring that the professional status of dental nurses was promoted. She became widely recognised as the figurehead of the profession.

Then in January 1954 the British Dental Association and the British Dental Nurses Association agreed to form a Joint Committee.

Recommendations on pay and conditions for dental nurses in General Dental Practice were issued in an advice sheet and in 1964 a National Voluntary Register was established. Jean Smith administered the register and became the first registrar.

Succeeding years were occupied with ever increasing workloads and emerging issues of fluoridation, dental health education and post qualification courses. It became clear that there was a need to look at creating an improved career structure for dental nurses within the dental team; this was pursued with the BDA and representatives from Area Health Authorities and the Department of Health.

Jean’s style was always calm and considered. She was able to read a situation and make timely judgements for the benefit of the profession and it is through Jean’s considerable contribution that we now call ourselves a profession. This service to dentistry was recognised in 1975 when Jean was awarded the MBE in the Queen’s Birthday Honours. (pictured)

In 1978 the Association was officially entered onto the records as a Trade Union. Pay negotiations continued with the BDA and through the Whitley Council. In 1985 a campaign was launched and MPs approached to support a fair wages resolution. Jean prepared the submission made to the Nuffield Foundations research into the Training and Future Role of Dental Nurses.

Jean was determined to get proper recognition for Dental Nurses and in 1980 applications were made to the GDC to set up a group of stakeholders to standardise their training and education. The Dental Nurse Standards and Training Advisory Board was set up in 1981 and the National Voluntary Register was taken under the auspices of the GDC.

A report was prepared and published in 1984 outlining, for the first time, the role and training objectives for dental nurses. It is widely acknowledged that much of the work in developing this document was undertaken by Jean and three other dental nurse representatives.

Jean Smith retired from the Association on 31st December 1985 but continued to work for the Examining Board and in the development of Occupational Standards.

Jean Smith’s impact on the Dental Nursing Profession is without equal. She leaves a daughter Jennifer, granddaughters Diane and Joël and great granddaughters Natalie, Hannah, Isobel and Alexandra.

BDA PEC membership announced

The results of the elections for seats on the British Dental Association’s Principal Executive Committee (PEC) have been announced. Voting for the elections finished on Wednesday 25 May and has been followed by the counting of ballot papers.

The successful candidates and the geographical constituencies they have been elected to represent are:

- Dr Martin Fallowfield (England, East)
- Dr Judith Husband (England, East Midlands)
- Dr Graham Stokes (Wales)
- Dr Susie Skandaren (Scotland)
- Dr Gemma Barlow (Northern Ireland)
- Dr Paul Blaylock (North East/ North West)
- Dr Victor Chan (Scotland)
- Dr Rusu Ladwa (England, London)
- Dr Nigel Jones (England, South West)
- Dr Eddie Crouch (England, West Midlands)
- Dr Mick Armstrong (England, Yorkshire and Humberside)
- Dr Philip Henderson (Northern Ireland)

BSDHT announce first accreditation awards

The British Society of Dental Hygiene and Therapy (BSDHT) have announced the first awards under their new education Accreditation Scheme, which was launched at the Oral Health Conference & Exhibition at Bournemouth in November 2011.

The scheme aims to ensure a consistency of quality and standard for Continuous Professional Development educational material used by its members.

The BSDHT President, Sally Simpson, and BSDHT Accreditation Lead, Michaela O’Neill, presented the first three Awards at the recent Dentistry Show in Birmingham.

The awards were received by Caroline Thompson on behalf of GSK, for their Talking Points in Practice sessions on:

- Acid Erosion
- Dentine Hypersensitivity
- Gingivitis and Periodontal Disease.

Exciting volunteering opportunities with B2A

Bridget2Aid are delighted to offer a new and exciting opportunity for volunteers in Dodoma, Tanzania. This is a new area for our Dental Volunteer Programme and after successfully piloting in January, they are now filling spaces for a second trip on the 2nd-12th October 2012.

Dodoma, as illustrated on the map, is located inland and the geographical difference to Mwanza will offer returning volunteers the chance to experience something completely new. Even as the capital city of Tanzania, Dodoma is under resourced and under developed with great dental needs within a long distance of the city centre.

Government officials in Dodoma requested our assistance, and following the pilot, we are confident that DVP will continue to work well in this location.

At the moment Bridge2Aid have a limited number of places left available for this trip so if you are interested in joining them, please contact the visits team for more information visits@bridge2aid.org.
No longer a sensitive subject
Eric Peterson discusses sensitivity and whitening

The popular accessory nowadays is not just the handbag, the shoes, or the Chihuahua; it’s the pearly white smile to boost appearance and self-esteem. In fact, tooth whitening is one of the fastest growing in the dental market, boasting an estimated value of £600 million according to the Academy of General Dentistry.

This growth has allowed teeth whitening to become more accessible for patients and there’s a solution to suit all budgets; in-office procedures, dentist-prescribed at-home treatments, strips and gels. But a common factor of this cosmetic procedure is that the patient will almost certainly experience some level of discomfort through sensitivity. This pain can often be so excruciating that the patient either stops treatment halfway through or dismisses this procedure altogether in search for a less painful option.

And it’s not just after teeth whitening, dentine hypersensitivity affects one third of the adult population at some point in their lives. This can be anything from a mild twinge to having severe discomfort that lasts for several hours or even days. Be it a result of teeth whitening or if they are simply sensitive to heat, cold, sweetness, acidity or brushing, by educating patients on how to deal with dentine hypersensitivity you can help them achieve a whiter, brighter, “pain-free” smile.

Explaining the causes and symptoms of sensitive teeth
Many people can be confused about the causes of their sensitive teeth so it’s important to make them aware of all the common factors and put them at ease. Generally, when the hard enamel is worn down or gums recede the dentine tubules become exposed; the causes and symptoms will differ for every patient, from eating or drinking foods and hot or cold beverages to touching teeth or exposing them to cold air.

The pain associated with dentine hypersensitivity can even affect the eating, drinking, and breathing habits of patients, so it’s ideal to start by informing them that sensitive teeth are relatively common and not usually a health concern.

- Check which toothpaste they use – Highly abrasive ingredients found in toothpastes can add to the discomfort, as they continue to wear away the enamel. Patients should steer clear of highly abrasive toothpastes, especially after in-surgery treatment, as they can damage the teeth and gums, removing the lustre of the teeth and dulling an otherwise beautiful smile.

Using tartar-control toothpastes can cause teeth to become sensitive and should be avoided. There are many types of toothpaste available on the market specifically formulated...
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Text Message and Email reminders
Clinical Notes
Appointment Book
Digital X-Ray
Managed Service
Practice Accounts

Raising awareness of sensitive teeth
By helping your patient’s combat sensitive teeth you will be making a dramatic improvement to their life, enabling them to enjoy hot and cold foods and drinks again.

Nominate a “sensitive teeth” expert in the practice or hold a “sensitive teeth” day/week/month; you’ll be surprised at how many patients will come forward to end their fight against sensitive teeth. Leave flyers/brochures on sensitive teeth around the practice, in reception or in the waiting room, and patients will feel more inclined to tackle the subject.

‘By helping your patient’s combat sensitive teeth you will be making a dramatic improvement to their life.’

Eric Peterson is founder of the whitening toothpaste Beverly Hills Formula. For more information on the Beverly Hills Formula products please call +353 1842 6611, email info@beverlyhillsformula.com or visit www.beverlyhillsformula.com.

About the author
How hand hygiene impacts hospital infection rates

A study published in BMJ, which coincided with the World Health Organization's SAVE LIVES: Clean Your Hands campaign on the 5 May 2012, reveals that the campaign played a significant role in reducing rates of some healthcare associated infections in hospitals across England and Wales.

The purpose of the study was to evaluate the impact of the Cleanyourhands campaign on rates of hospital procurement of alcohol hand rub and soap, report trends in selected healthcare associated infections, and investigate the association between infections and procurement.

Bedside alcohol hand rub, materials promoting hand hygiene and institutional engagement, regular hand hygiene audits, were installed from 1 December 2004 and rates for each trust of hospital procurement of alcohol hand rub and liquid soap and levels of Staphylococcus aureus bacteraemia (methicillin resistant (MRSA) and meticillin sensitive (MSSA)) and Clostridium difficile infection for each trust was obtained.

The results found that combined procurement of soap and alcohol hand rub tripled from 21.8 to 59.8 mL per patient bed day; procurement rose in association with each phase of the campaign. Rates fell for MRSA bacteraemia (1.88 to 0.91 cases per 10,000 bed days) and C difficile infection (16.75 to 9.40 cases); however, MSSA bacteraemia rates did not fall.

Increased procurement of alcohol hand rub was independently associated with reduced MRSA bacteraemia, but only in the last four quarters of the study and the publication of the Health Act 2006 was strongly associated with reduced MSSA bacteraemia.

The study concluded that the Cleanyourhands campaign was associated with sustained increases in hospital procurement of alcohol rub and soap, which the results suggest has an important role in reducing rates of some healthcare associated infections. National interventions for infection control undertaken in the context of a high profile political drive can reduce selected healthcare associated infections.

The study can be found at www.bmj.com/content/344/bmj.e3005

The WHO's SAVE LIVES: Clean Your Hands campaign is part of a worldwide effort to improve hand hygiene amongst healthcare workers, in order to prevent infections, such as Staphylococcus aureus infection, meticillin resistant (MRSA) and meticillin sensitive (MSSA) and Clostridium difficile that are often life threatening.

Patients contacted over infection concerns at dental practice

Nearly 1,000 patients at a dental practice in Aberdeen have been contacted by NHS Grampian due to concerns regarding their infection control procedures.

According to a report, the patients at the Bridge of Don Dental Clinic and Research Centre in Silverburn Crescent, Bridge of Don have been sent advisory letters after an inspection in March found that infection control procedures at the practice, including those for instrument decontamination, did not meet national standards.

A spokeswoman for NHS Grampian said in a report: “The letter reassures patients that the risk of infection is low. However, any patient who remains concerned can contact NHS 24 helpline 08000 28 28 16 between 8.00am and 10.00pm where they can get further advice about health concerns including for blood borne viruses such as hepatitis B, C and HIV.

“Letters have been sent to patients registered at the independent practice between January, when it opened, and 10 April, the date of a follow up inspection which found infection control procedures were satisfactory and now followed national standards.”

She added: “Dr Xenofon Gkouzis is the only dentist now working in the practice. He is registered in the UK with the General Dental Council and is authorised to treat NHS patients in Grampian. This incident is not related to him.”

Dr Maria Rossi, consultant in Public Health Medicine at NHS Grampian, said: “We are working closely with local and national experts and have concluded there is a low risk of infection to patients. As our priority is always for the safety and welfare of patients, we felt it was important to write to inform them of this incident. The letter emphasises that no action is required by the patient, but tests will be available if anyone remains concerned having read the letter and after calling the helpline.”

Ray Watkins is Consultant in Dental Public Health at NHS Grampian. He added: “While this is an independent practice, it is expected to comply with national infection control standards. We are unable to confirm that these standards were adhered to prior to April 10 when at a follow-up visit, procedures were found to be satisfactory.

“The practice has co-operated with the investigation, and will continue to be monitored.”
By now, all dental practices must comply with the essential requirements of Health Technical Memorandum 01-05 Decontamination in Dental Practice (aka HTM 01-05). If they do not, they are in breach of CQC Regulation 12, Outcome 8. HTM 01-05 was produced in response to emerging evidence around the effectiveness of decontamination in primary care dental practices and the possibility of prion transmission through protein contamination of dental instruments.

In brief, the essential requirements of HTM 01-05 are that:

- Regardless of the technology used, the cleaned instruments, prior to sterilisation, should be free of visible contaminants when inspected with a magnification device. Instruments should be reprocessed using a validated decontamination cycle including: cleaning/washing (in terms of manual cleaning, this includes having a written protocol, a validated steam steriliser, and at the end of the reprocessing cycle they should be in a sterilised state).
- Reprocessed dental instruments should be stored in such a way as to ensure restraint of microbiological re-colonisation. These measures should be backed by careful controls on the storage times to which instruments that are less frequently used are subject.
- Practices should audit their decontamination processes quarterly using an audit tool (the use of the Infection Prevention Society/DH audit tool that accompanied the document was strongly recommended).
- Practices should have in place a detailed action plan on how the provision of decontamination services will move towards best practice.

Continuing to raise clinical governance awareness

Considering that last bullet point in more detail, it is implicit in the guidance that merely meeting the essential requirements of HTM 01-05 is not an end in itself. Instead, practices should continue moving forward with decontamination and aim towards best practice – effectively shooting at ever narrowing goalposts.

By definition, I cannot tell you in detail what best practice is. It will continue to evolve over time as more effective processes are discovered and as better decontamination equipment is produced. Also, you may be close to achieving best practice now or you could be a long way off it.

In moving towards best practice, you may wish to consider some or all of the following upgrades to your practice:

- The use of an automated (HTM 01-05) washer-disinfector
- Separate facilities for decontamination clearly separated from the clinical treatment area. This implies the use of a separate room or rooms which should be used for the purpose of decontamination only and to which access should be restricted to those staff performing...
ing decontamination duties

- Organisation of the reprocessing area into a dirty/clean workflow system with best practice being dirty and clean areas as separate rooms, each with a door and individual air supply and extraction

- Provide suitable storage for instruments, which reduces exposure to air and a possible risk of further contamination

- Minimise worktops – which means less clutter and less to clean – and replace them with glass, so that patients can see immediately that the surgery is clean

To keep abreast of decontamination best practice, I suggest you link up with your PCT, that you always read Dental Tribune and Infection Control Tribune and that you keep an eye on dentistry websites. Also, check out the decontamination equipment manufacturers for new products, liaise with dentistry colleagues and visit the appropriate trade and association stands at shows.

An action plan for best practice

Decontamination best practice cannot simply be a wish list – you need to draw up an action plan for achieving it. At the moment, no timescales have been set for practices to achieve best practice. This makes developing an action plan with targets as to when things will be achieved rather tricky. Bear in mind that you will, at some stage, need to show this action plan to a member of your PCT and talk them through it – so it needs to be based on sound thinking, not guess work.

Let’s take the example of separating decontamination rooms. There are many dental practices that use the same room for patient treatment and decontamination and this meets HTM 01-05 essential requirements at this time. The principals or owners of these practices need to decide how they can work towards a separate and controlled decontamination room (or clean/dirty rooms). If it’s merely a question of utilising an unused room or erecting partitions, the timescale for achieving it could be relatively short and will depend on when the finance is likely to be available.

In, for example, a listed building or premises where you are already short of space, the only solutions may be to move or rent/purchase additional premises. Clearly, this will likely be a longer-term aim.

For something a little easier to build into your action plan, consider the purchase of washer-disinfector. You will need to investigate what models are available, which will be most suitable, how much it will cost and what the installation requirements area. You will also need to consider how, where and when your staff can be trained to use it and how much this will cost. They may well also need training in the use of instrument rotation systems and working in a designated decontamination room.

Although you should check whether your PCT has funds available for the purchase of washer-disinfectors, in England there was no central funding for meeting HTM 01-05 essential requirements and there is certainly none at this time for moving towards decontamination best practice. By contrast, the Scottish Government has made funds available for decontamination improvements, for the maintenance of decontamination equipment and even provided grants for when a practice needs to relocate.

Sample test processes and procedures to evidence the level of compliance

Finally, don’t forget to maintain the daily and weekly checks of equipment and the quarterly checks specified in the Infection Prevention Society/DH audit tool.
Most equipment-associated infection is due to inadequate cleaning and disinfection. The most effective stage of any decontamination procedure is thorough cleaning.

Medical devices heavily loaded with microbiological material will be more difficult to sterilise than one lightly contaminated and must therefore be thoroughly cleaned to reduce organic material or bio- burden before disinfection and sterilisation. Washer-disinfectors are the safest and most reliable option.

Automated processors, eg washer-disinfectors and ultrasonic cleaners, improve the quality of the decontamination process and offer the safest, most reliable option, providing they are suitably monitored and maintained.

Decontamination is done most simply in a disinfectant which both cleans and disinfects in one stage. In a washer-disinfector the items are first cleaned by rinsing in cold water and then washed in water at less than +70°C. The water temperature then increases to between +85°C and +95°C, for one to three minutes, providing thermal disinfection of the load. At the temperature range of +85°C - +95°C, pathogenic bacteria are inactivated or killed, but bacterial spores survive. In order to ensure inactivation of viruses, particularly hepatitis virus which is relatively heat tolerant, it is now recommended that the water temperature during the disinfection phase should be just over +90°C.

Disinfection is generally a less lethal process than sterilisation. It eliminates virtually all recognised pathogenic microorganisms but not necessarily all microbial forms (eg bacterial endospores) on inanimate objects. Disinfection does not ensure overkill, and therefore disinfection processes lack the margin of safety achieved by sterilisation procedures.

Cleaning and disinfection of instruments should be carried out as soon as possible after use. Dried biological material is much more difficult to remove than fresh deposits. Blood, with its content of iron, acid and sodium chloride, is corrosive.

The type B-cycle
Sterilisation is defined as the use of a physical or chemical procedure to destroy all microbial life, including large numbers of highly resistant bacterial endospores. The sterility requirement for medical products means that the theoretical probability that a living organism will be present on an object after the sterilising process is equal to or less than one in a million, so-called Sterility Assurance Level (SAL) = 10^-6. Sterilisation may be achieved by various methods: heat, chemical and ionising radiation. The simplest method is heat sterilisation. There are two methods: dry heat sterilisation, ie use of dry heat, usually a hot air oven or autoclave, in which moist heat (steam) is used.

Regardless of the method, the result of sterilising procedures depends on the number of microorganisms and other biological material present on the article before inactivation and the resistance of microorganisms to the sterilisation process. The result of steam sterilisation is also influenced partly by the kind of material the items are made of, and partly by the shape of the items. It is important to note that packaging material itself is a porous load (paper, textiles) and should be handled as such. All packaged/wrapped goods require sterilising in steam-autoclave processes with pre- and post-vacuum cycles.

Another factor which influences the result of the sterilising procedure is the way in which the chamber is loaded as well as whether the items are packaged and the shape of the package. The goods should not be tightly packed: the steam must be allowed to penetrate all parts of the goods. Residual moisture in the packaging material after sterilisation will act as a potential pathway for microorganisms to penetrate the package.

Steam sterilisation
Saturated steam under pressure is by far the quickest, safest and most efficient and most reliable medium, known for the destruction of all forms of microbial life. The brief exposure to steam destroys the most resistant bacterial species and heat is rapidly achieved because of mass heat transfer as the steam condenses.

In order for the steam to condensate within the whole load to be sterilised, virtually all air must be evacuated during pre-treatment. This can only be achieved with several (at least three (3)) pre-vacuum pulses. So called B-cycle in accordance with EN 13060.

In steam sterilisers with pre- and post-vacuum processes (ie B-cycle), the sterilisation process is composed by three main phases: pre- treatment, sterilising and post-treatment. During pre-treatment the air is expelled by a number of pulses of vacuum and the introduction of steam. The temperature increases successively, up to the degree at which sterilising is to take place. The actual sterilisation period, which is called holding time, starts when the temperature in all parts of the autoclave chamber and its contents (the load) have reached the sterilising temperature.
temperature. The temperature should then remain constant, within specified temperature band, throughout the whole sterilisation phase (plateau/holding time). In the post-treatment phase, either the steam or the re-vapoured condensed water are removed by vacuum to guarantee the condensed water are removed post-treatment phase, either (plateau/holding time). In the whole sterilisation phase temperature should then remain constant, within specified temperature. The temperature should then remain constant, within specified temperature band, throughout the whole sterilisation phase (plateau/holding time). In the post-treatment phase, either the steam or the re-vapoured condensed water are removed by vacuum to guarantee the condensed water are removed post-treatment phase, either (plateau/holding time).

An area of contact will not be properly cleaned and disinfected.

Two different metals will cause corrosion. Corrosion is a common problem. When in the same fluid, instruments and other articles made of different metals may corrode, and corrosion destroys sharp and delicate instruments. Corrosion pits will also make the surface rough, which increases the possibilities of microorganisms to attach themselves to the instruments. Mixing different types of metal in a liquid solution will result in an electrochemical cell and cause corrosion – this is often the case during cleaning, ultrasonic bath and washer disinfectors when using aluminium trays and instruments in stainless steel or when cleaning carbon burs and burs made of stainless steel in the same liquid container. However, in daily dentistry we call this rust and blame the manufacturer for poor material – the actual problem is clinical routines!

Don't make it too heavy. Metallic weight is another decisive in decontamination and sterilisation. The heat energy from the ultrasonic waves in the ultrasonic bath and/or the water in a dishwasher or washer disinfectors as well as the saturated steam from the steriliser shall be concentrated on the instruments that are to be processed. A load that is too heavy lessens the effect of disinfection and sterilisation. The steam sterilisers that are most frequently used in dental clinics are adapted to loads of 4.0–4.5 kilos. A stainless steel tray with instruments for endodontic procedures has a weight of approximately 1.5–1.7 kilos! This will be an important issue to consider when using trays made out of stainless steel.

Steam sterilisation of hollow instruments (with long, narrow lumina) and porous objects always requires several (at least three (3)) pre-vacuum pulses to a defined, pre-set, vacuum level.

Fewer instruments, better control. The type of equipment and the type of procedures in use at the clinic will to a very high extent determine the safety margin of decontamination. A very important issue, that is often foreseen, is the logistics of instruments. A common problem in many dental offices is an overload of instruments, which will contribute to a more difficult and time demanding procedure to keep track of all instruments and to make sure that storage and sterile as well as packaging/wrapping conditions are maintained.

An item heavily loaded with microbiological material will be more difficult to sterilise than one lightly contaminated. The most effective stage of any decontamination procedure is thorough cleaning and this should accompany or precede all disinfection procedures. The effect of cleaning, disinfection and sterilisation is affected by the design of the cassettes/trays being used. Shadow effects may easily ensue from the use of solid cassettes so that instruments are not being properly cleaned, neither in washer disinfectors nor in ultrasonic bath.

Fastened but free. Instruments should be free and fastened on trays so that ultrasonic waves, water jets and steam can reach every part to clean and inactivate efficiently during the whole procedure of disinfection and sterilisation. Even if fastened the instruments must be free and have no contact points/areas with the locking device.
Rationalisation of the handling of instruments is a good way to improve practice and economy. Often instruments made of stainless steel are supposed to be extremely strong and fit for using for almost any amount of time. But the truth is that all kinds of instruments can be harmed both by mechanical, thermal and chemical influences. Dental instruments are made of different parts and of different kinds of metals and alloys, even in the same instrument.

It is important to maintain the tenability of the instruments with careful handling. They are not to be thrown in the process of decontamination. The instruments should be processed in trays, holders or stands so as not to clash against each other. They should also be in contact with each other as little as possible when washed, disinfected and sterilised.

Reduction of the number of articles and save time and money. To have fewer instruments in use means that it will be easier and safer to locate goods that should be re-sterilised and re-disinfected and that there will always be current information on which instruments that are needed in the surgery.

Higher security will be a result from always having the right materials and instruments in the treatment area.

The time in need for handling sterile goods can be reduced, usually to half the time.

Good control of and minimising the number of instruments and materials result in less costs and gives the conditions of safer handling, decontamination and disinfection.

A tray system should facilitate the handling of instruments through the whole hygienic circle. Evaluations of effective tray systems have shown reduced time for handling the instruments at disinfection and sterilisation.

Rationalisation of the handling of instruments during all parts of work - from preparation to sterile keeping - gives the staff liberty to work with quality improvement and to take a greater part in the treatment of patients. Rationalisation of the handling of instruments is thereby a good way to improve practice economy.

Fig 11 Evaluation of the handling of instruments with effective tray systems has shown substantially reduced time.

Fig 12 Rationalisation of the handling of instruments is a good way to improve practice economy and quality.

Dr Mikael Zimmerman is one of the founding members of AESIC – Association in Europe for Safety and Infection Control in Dentistry. He is also a member of the subgroup for dental professionals within Strama - the Swedish strategic programme against antibiotic resistance.

About the author
Infection control is continually neglected in dental education

DTT’s Ben Adriaanse interviews Dr Hans de Soet, microbiologist and expert in infection control

In 2009, a group of microbiologists established the Association for European Safety & Infection Control in Dentistry (AESIC), an organisation that promotes European collaboration for shared knowledge and uniform legislation on infection control and dental hygiene. This March, AESIC and ACTA, an academic centre for dental education in the Netherlands, organised a conference in Amsterdam with the theme “Harmonising dental infection prevention guidelines in Europe.” During the conference, steps were taken towards establishing a collaborative working group to collect and share dental infection control guidelines in Europe. Dental Tribune Netherlands spoke with Dr Hans de Soet, microbiologist and expert in infection control at ACTA, and chairperson of the event.

Dental Tribune Netherlands: Dr De Soet, what are your thoughts on the conference in Amsterdam?
Dr Hans de Soet: It was a successful conference. Last year’s European Oral Microbiology workshop, we sensed a need for harmonisation in dental hygiene and infection control. Apparently, there are substantial regulation differences among European countries: in some, these regulations are set up as laws, while in other countries they are merely stipulations. The way in which these guidelines are enforced also varies.

I did not observe any fundamental differences. There are, of course, some minor variations. For example, in some countries gloves can be used more than once. Generally though, the regulations are quite similar.

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The conference offered lectures on the current situation in the Netherlands, Ireland, Scotland, Germany and Sweden. What is the most noteworthy regarding the current situation in these countries?

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The goal of the conference was to establish a European working group. What activities will this group undertake?
The working group is not primarily concerned with formulating European regulations. We are mainly interested in sharing our thoughts on patient safety. We can all benefit from sharing our knowledge at an academic level and performing research using data from all over Europe. The ultimate goal is to give infection control the place it deserves in academic research programmes.

Once we have finished mapping the current state of infection control, we can determine whether it is possible to formulate regulations at a European level.

The goal is that the risks are difficult to prove, and on a relative scale few cases can be linked to poor oral hygiene. In our opinion, however, every case is one too many.

The Lancet published a case about an 82-year-old Italian patient who died of Legionella infection after seeing a dentist. The Netherlands has never seen a serious case like this, but if infection control is neglected, we just might. As I indicated, the smaller education budgets force universities to make certain choices. Unfortunately, microbiology is not a priority for most dentists.

By the way, AESIC does not confine itself to infection control alone. We also discuss infection treatment. Antibiotics are too easily prescribed, even when not necessary or desirable. Students should also be taught the alternatives in infection treatment.

You indicated that infection control in the Netherlands is of a relatively high standard. Does this mean that other countries could benefit more from a European working group?

There is room for improvement for us as well. The regulations for infection control in dentistry are not mandatory in other countries. The situation in the UK is not ideal either, in that all local authorities perform their own research and establish their own regulations, owing to apparent political goals, but focuses on science.

Infection control is currently a hot topic in Dutch dentistry, owing to the strict enforcement of equally strict regulations. How does this compare with the rest of Europe?

By comparison, our regulations are well developed: they are extensive, clear and realistic. Although some dentists regard them as too strict, they are actually more flexible than those of some other countries. For instance, Dutch dentists are not obliged to publish an annual record of their activities with reference to patient safety. Dutch regulations are also unique in that they are developed by an independent party.

Regulations also require enforcement. How does foreign regulation enforcement differ from that in the Netherlands?
The Dutch situation is very good, partly because of its well-functioning government-owned monitoring agency. The England monitor is of high standard as well, especially compared with most other European countries. Often, patients need to file a personal complaint before any action is taken against a dental practitioner.

The Lancet aims to anticipate new developments, enabling it to steer manufacturers in a certain direction. For instance, few dental chairs are equipped with an automatic drainage cleaning system. Were such a system to be made compulsory, manufacturers should be able to anticipate this at an early stage.

Dental manufacturers are probably hoping for very strict regulations on infection control, thus forcing dental practitioners to make large investments in this field. Some companies may think like this, but those that join AESIC adopt a responsible stance, demonstrating their passion for dentistry and their willingness to achieve optimal infection control. We sincerely value their contributions. Aside from that, conferences like this one need funding and we need commercial parties in that respect as well.

How close are you to establishing a European working group?

We have now inventoried the main similarities and differences between the regulations in European countries. In doing so, a practical problem immediately became apparent: The Netherlands is the only country that has translated its regulations into English. Also, they are often split up into various reports, rules and regulations. We have now decided to take one set of regulations as starting point and compare it with those of other countries. This could be done by students.

Another important project is to develop an educational curriculum that clearly states our minimal requirements for infection control knowledge for all dental professionals. We will also investigate how to get funding for collaborative research in our focus area.
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Protein contamination in the dental surgery

Peter Bacon discusses surface cleaning and disinfection

A s the dental profession is only too well aware, in-depth cleaning and disinfection processes within the dental practice are of paramount concern, not only in relation to CQC and HTM01-05 compliance, but also with regard to staff and patient well-being – which the compliance guidelines are there to ensure and protect.

Protein contamination in the dental surgery is an obvious area for serious concern, since residual protein contamination on surfaces can harbour pathogens.

Blood has the potential to carry and transmit viruses such as HIV, HBV and HCV. The risk of transmission of communicable blood-borne viruses might be considered to come only from high risk areas such as accidental sharps injuries, but greater research and advances in the sphere of microbiology now provides evidence that many microorganisms can survive on a variety of surfaces, making the danger of disease transmission from contaminated surgery surfaces or equipment a genuine threat to patients and staff. In addition, an increasingly mobile population including greatly increased economic migration has resulted in a resurgence of diseases such as TB, which are associated with overcrowding and poor standards of general health.

In order to overcome the potential issue of surface decontamination and the prevention of transmission of pathogens, dental practices must have rigorous infection control policies which establish clear protocols for cleaning and disinfection and document the practice’s adherence to the procedures laid down.

Decontamination is defined as a reduction in the risk of contamination to a level that is acceptable, ie controlling the number of microbes in an environment. Within a dental surgery, both cleaning and disinfection are required but although the terms are often confused they are not the same thing. Cleaning involves physical removal of soil matter from surfaces while disinfection is inactivation of pathogens. Cleaning must take place before disinfection to ensure that bacteria, proteins and other contaminants are removed from surfaces before disinfection takes place, unless a suitable single stage process is in use.

Decontamination of a specific area is aided by the use of commercially available products and many of these agents are based on alcohol. In dentistry, alcohol has been widely adopted as a disinfectant for many years and its efficacy in this role is well documented.

The widespread use of alcohol as a disinfectant in dentistry has been largely driven by its low cost and quick drying properties, where its rapid drying is perceived as beneficial in achieving a short turn-round time between patients. However, rapid evaporation of alcohol based products also means that by the time the treatment of a surface has been completed, most of the alcohol has evaporated from the wipe or surface, so the areas wiped at the end of the process will be neither cleaned nor effectively disinfect.

A fact frequently overlooked, but one that is highlighted by the HTM 01-05 guidelines, is that alcohol is not effective as a cleaner, particularly where protein based soils are present as is likely to be the case in medical and dental environments.

Section 6.57 of HTM01-05 states: Evidence suggests that the use of commercial bactericidal cleaning agents and wipes is helpful in maintaining cleanliness and may also reduce viral contamination of surfaces. Care should be taken in the use of alcohol wipes, which – though effective against viruses on clean surfaces - may fix protein and biofilm. However, the careful use of water with suitable detergents, including those CE-marked for clinical use, is satisfactory provided the surface is dried after such cleaning.

NOTE: Alcohol has been shown to fix blood and protein to stainless steel. The use of alcohol with dental instruments should therefore be avoided.

Some of the limitations of alcohol are as follows:

- **Protein fixation**:  
  - Materials incompatibility (particularly PMMA)  
  - Rapid evaporation  
  - Flammability

If we consider the ideal properties of a combined disinfectant and cleaning agent, most “experts” would agree that the following would be a reasonable, though not exhaustive list:

- Excellent cleaning action
- Broad spectrum microbiocidal action – some microbes present in the oral cavity present challenges than others, for example TB
- Non-toxic – or at least selectively toxic
- Short contact time – driven by time pressure and the need for short turnaround between patients
- Stability – some agents have a very short shelf life
- Ease of use – no complicated making-up requirements
- Competitively priced

As stated in HTM 01-05, alcohol does not clean effectively but will disinfect clean surfaces, therefore, a two-stage process is required when using an alcohol based disinfectant.

1. Clean to remove physical soil ing
2. Disinfect with alcohol to inactiv ate pathogens

This process however is less than desirable from an operational point of view due to the additional time required to carry out two procedures between each patient as well as the additional cost of buying two products and the additional inventory required.

Therefore we have seen in recent years a growing demand for water based combined cleaners and disinfectants. The ideal solution is a carefully formulated water based product that can both remove soiling and disinfect in a single process, greatly reducing the time taken and providing an effective solution.

The properties required in such a combined cleaner and disinfectant would be:

- Broad spectrum efficacy
- Wide surface compatibility
- Effective cleaning
- CE marked Class 2a (required if a product is to be used to disinfect medical devices)
- pH neutral
- Two-year shelf life
- Low residue
- Supplied in all formats (ready to use, concentrate and wipes)

The ability to deliver all the required features and their associated benefits in a single product will answer the demands of the market and provide a means of ensuring complete compliance with current guidelines.
Treatment of gingival hyperpigmentation

Drs Prabhuji, S Madhupreetha and V Archana discuss using the diode laser for aesthetic purposes

The colour of the gingiva is various among different individuals and it is thought to be associated with cutaneous pigmentation. It depends on the vascular supply of the gingiva, epithelial thickness, degree of keratinisation of the epithelium and the presence of pigmented cells.

Oral pigmentation is the discolouration of the mucosa or gingiva. It can be either due to physiological or pathological conditions. Melanin, a brown pigment, is the most common pigment associated with the etiology of oral pigmentation.

Gingiva is the most common site of pigmentation in the oral cavity. This hyperpigmentation is seen as a genetic variation in some populations independent of their age and sex. Hence it is termed as physiological or racial gingival pigmentation. Melanosis of the gingiva is frequently present in dark skinned ethnic groups as well as in different medical conditions. Although pigmentation of the gingival is completely a benign condition, it is an aesthetic problem in many individuals.

Gingival pigmentation is the discolouration of the mucosa of the gingiva. It is seen in dark skinned ethnic groups as well as in different medical conditions. Although pigmentation of the gingiva is completely a benign condition, it is an aesthetic problem in many individuals.

Gingival depigmentation is a periodontal surgical procedure in which the gingival hyperpigmentation is eliminated or reduced by different techniques.

Gingival depigmentation
Various depigmentation techniques have been employed with similar results. Selection of a technique should be based on clinical experience and individual preferences.

The various methods include gingivectomy, gingivectomy with free gingival autografting, electrosurgery, cryosurgery, radiosurgery, chemical agents such as 90 per cent phenol and 95 per cent alcohol, abrasion with diamond bur, Nd:YAG laser, semiconductor diode laser and CO2 laser.

One of the most common techniques for depigmentation is the surgical removal of undesirable pigmentation using scalpels. In this procedure, gingival epithelium is removed surgically along with a layer of underlying connective tissue. The denuded connective tissue then heals by secondary intention.

Laser ablation of gingival depigmentation has been recognised as one of the effective techniques. Different lasers have been used for gingival depigmentation including carbon dioxide (10.600nm), diode (810nm), Neodymium: Yttrium Aluminium garnet (1.064nm) and Erbium: YAG (2.940nm) lasers.

The diode laser was introduced in dentistry a few years back. The diode laser is a solid-state semiconductor laser that typically uses a combination of Gallium (Ga), Arsenide (As), and other elements, such as Aluminium (Al) and Indium (In), to change electrical energy into light energy. It also can be delivered through a flexible quartz fibre optic handpiece and has a wavelength of 810nm. This energy level is absorbed by pigmentation in the soft tissues and makes the diode laser an excellent hemostatic agent. It is used for soft tissue removal in a contact mode. The power output for dental use is generally around two to 10 watts. It can be either pulsed or continuous mode.

The present case series describes simple and effective depigmentation techniques.

‘One of the most common techniques for depigmentation is the surgical removal of undesirable pigmentation using scalpels’

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Fig 1 Pre-op situation
Fig 2 Use of the FOX diode laser to treat gingival pigmentation
Fig 3 Immediate post-op situation

Fig 4 One week post-op
Fig 5 Three months post-op
Fig 6 Pre-op situation

Fig 7 Use of the FOX diode laser to treat gingival pigmentation
Fig 8 Immediate post-op situation
Fig 9 One week post-op
using A.R.C. Fox™ (semiconductor diode laser), which have produced good results with patient satisfaction.

Case report one
A 22 year old female patient visited the department of Periodontics, Krishnadevaraya College of Dental sciences, Bangalore with the chief complaint of “blackish gum”. The medical history was non-contributory. Intra-oral examination revealed generalised blackish pigmentation of the gingiva, however it was healthy and completely free of any inflammation.

Considering the patient's concern, a laser depigmentation procedure was planned.

Procedure
Diode Laser (A.R.C. Fox™) with wavelength of 810nm was selected for the procedure. No topical or local anaesthesia was given to the patient. Melanin pigmented gingiva were ablated by diode laser vaporisation with a flexible hollow-fibre delivery system with a non-contact, air cooling handpiece, under standard protective measures. The procedure was performed on all pigmented areas. Remnants of the ablated tissue were removed using sterile gauze dampened with saline. This procedure was repeated until the desired depth of tissue removal was achieved. Analgesics and chlorhexidine 0.2 per cent mouthwash were prescribed.

Case report two
A 24 year old female patient visited the department of Periodontics, Krishnadevaraya College of Dental sciences, Bangalore with the chief complaint of “blackish gum”. The medical history was non-contributory. Intra-oral examination revealed generalised blackish pigmentation of the gingiva, however it was healthy and completely free of any inflammation.

Considering the patient’s concern, a laser depigmentation procedure was planned.

Procedure
The depigmentation was performed identically to the first case. Analgesics and chlorhexidine 0.2 per cent mouthwash were prescribed.

Results
No post-operative pain, haemorrhage, infection or scarring occurred in first and subsequent visits. Healing was uneventful. Patient’s acceptance of the procedure was good and results were excellent as perceived by the patient.

“The diode laser is a solid-state semiconductor laser that typically uses a combination of Gallium, Arsenide and other elements”
Why improving your practice is a mystery – part nine

Jacqui Goss asks: Who are you?

Okay, pop quiz time! In July 1978 a single was released which was an edited version of the album track of the same name and reached number 18 in the record charts. The title of the single was the same as the album released a month later and included part of the name of the band. That’s correct, it’s *Who Are You* by The Who.

My point? Well, here I want to discuss why and how you should make yourself as visible and memorable as you can. Don’t worry, I won’t advocate you donning fancy dress and parading down the high street – which must surely be banned by GDC rules. And, in any case, I’m using the ‘royal’ you – your practice, your practice team and you.

**Patient journey**

I’ve written before about how your team should work to ensure each person enjoys a ‘wow’ patient journey. But the benefits of that great experience in terms of the opportunity for patients to share it with friends and family, will be lost if they can’t remember who you are. You may think you’re memorable but believe me you’re eminently forgettable! Don’t take it personally. As soon as patients have their foot out of the door they’ll probably begin forgetting the name of your practice, most likely failing to recall the name of the dentist or hygienist they saw and certainly putting out of their minds the names of nurses and front of house (FoH) staff! I offer no science to support this, only empirical evidence based on making telephone calls to patients when I’m commissioned to undertake satisfaction surveys.

So, how do you counter this collective and, presumably, selective amnesia? Quite simply, your name (by which I mean the practice name and appropriate team member names) should go everywhere. Logo and nameplate design is not my department but I do know they should be distinctive, memorable and repeatedly visible. I’ve quite often walked in to a dental practice (and other establishments) and seen nothing to reinforce the knowledge that I’m in the correct place. Look around your practice – does my comment ring true? There are, of course, many places to put your practice name and or logo – leaflets, posters, mugs, pens and so on.

**Name calling**

Turning to the FoH team, which is my department, there are several ways they can reinforce the name of the practice, the names of the clinical staff and their own names. The most obvious is for the information to be on their clothing. However, this may not be obviously visible to the patient as they approach the reception area (they may not be wearing their reading glasses) so have nice large nameplates on the desk or counter as well. FoH staff should get in the habit of introducing themselves. This is vital on the telephone but also useful in face-to-face contact. As well as the “who are you?” benefits I’m discussing...
here, it also prevents patients having to make awkward references such as: “The girl on reception said...” or “Can you lend me your pen, er, miss?”

Now for some clinical staff name reinforcement. Foul staff should say something similar to: “Right Mrs Goss, your appointment is with Doctor XXXX in five minutes and her nurse, XXXX, will collect you when she is ready.” They can actually be a bit more sophisticated. If the dentist or hygienist in question is a recent addition to the practice team how about: “Okay, Mrs Goss, your appointment is with XXXX our new hygienist, whom I’m sure you’ll like.”

If your practice offers, say, cosmetic treatments, what about: “Now Mrs Goss, your appointment is with our cosmetic dentist, Mrs XXXX, and her nurse, XXXX, will come for you in just a few minutes.” No harm in other patients overhearing that you have a cosmetic dentist!

Of course, XXXX the nurse should subsequently say something like: “Hello Mrs Goss, I’m XXXX and Mrs XXXX is ready for you now.”

Reminders Don’t let patients leave without something reminding them where they’ve been and who they’ve seen. Even with SMS and email reminders, the old appointment reminder card system is still valid and should be used. You may also consider a system whereby patients get a reward or recouping a friend. If so, you’ll need to give them something they can pass on – similar to a business card, perhaps.

There is an almost endless choice of corporate gifts as potential giveaways. I favour things that are likely to be retained and, preferably, kept where they are easily visible.

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‘There is an almost endless choice of corporate gifts as potential giveaways. I favour things that are likely to be retained and preferably kept where they are easily visible’
The art of listening

Mhari Coxon discusses how using your ears can lead to success

In general practice we can often feel we don’t have time to listen to our patients. And can we really be bothered anyway? I mean, they do go on a bit don’t they?

And yet, if we don’t listen actively we run the risk of missing out on treatment and by default money. Yes, I said it, listening can make you money! Listening well can help you to identify the patient’s wants and needs and work these into the treatment options you offer them. And it can’t just be one team member that does this. For optimum results it needs to be the whole team.

Here are some simple tips that can get you listening actively quickly and simply.

Shut up!
No really, ask a question and then do not talk again until you are absolutely sure the other person is finished talking. It is amazing the extra insight you will gain by trying this. When we interrupt two things may happen. They will either persevere and talk for a long time because of it, or they will clam up altogether.

Ask permission
When you want to discuss something with a patient, stopping smoking, changing diet, adding a new oral hygiene product to their routine; ask permission to start the conversation. Rarely the patient will say no. When they do, respect that. It is so hard to do but DON’T talk to them anyway. They will see the respect you gave their wishes and be much more receptive to you as a person, and in the long run, your advice.

Take note
A great way to show you are listening well is to write down what the patient is saying. It doesn’t have to be word for word but writing in their choice of words then repeating these back to them can really show the patient has been heard and understood. All of us, regardless of background or circumstances, value being listened to and understood.

Make a questionnaire with open questions on it
To help the whole team get into the swing of active listening make your questionnaire have open questions in it instead of closed. An open question requires more than a yes or no answer. For example: What was it that made you decide to book for your visit today? Open questions can help lead the pa-
To help the whole team get into the swing of active listening make your questionnaires have open questions

That way you can compare how you communicate and listen now with the listening you will develop as a habit over time. The results should be pretty conclusive that this is the best way to work with patients for their patient centred care pathway.

Build it up one patient at a time per day over a week or so, then look back and reflect on the benefits as well as measuring which listening sessions went best.

We are all individuals so learning a way of doing this that works for you is important too.

Good luck and remember - we have two ears and only one mouth for a reason.

Mhari Coxon has 20 years experience in dentistry, working as a nurse, receptionist, oral health advisor and ultimately hygienist in a variety of practice environments. She is passionate about her profession. At present, she works as Senior Professional Relations Manager for Philips Oral Healthcare and clinically as a hygienist in central London. From Chairing the London BSDHT for 3 years, and working as an MD, Mhari excels at maintaining and co-ordinating a team and utilising skills, decentralising leadership and developing self sufficiency in members. Throughout her career Mhari has developed hygiene protocols and plans in practices which have contributed to the team's success. Mhari is Clinical Director for CPD hilaroDent Ltd, a training company offering motivational and interactive development courses to the dental team. As a keen writer, Mhari is on the Publications Committee of Dental Health, the British Society of Hygienists and Therapists (BSDHT), Journal, has a conversational column in Dental Tribune and writes articles for many other publications and online sites. As a speaker Mhari has presented regionally, nationally and internationally for many groups including Talking Points in Dentistry, the British Orthodontic Society Specialist group, the BSDHT, BDA, 039 the International Symposium of Dental Hygiene, the dentistry shows and many others. In 2006 she was the Probe Awards hygienist of the year, and was highly commended in 2010. 2011 saw her as hygienist in the Dentistry Top 50 most influential people in the UK.

The art of listening

In general practice we can often feel we don’t have time to listen to our patients. And can we really be expected to do this? I think we can.

Re-read those notes

It is not easy to remember each patient so always take a minute to re-read your notes. Remembering that their son was doing his driving test, that they hate the sound of the slow speed, dread the 3in1; these little touches mean so much to your patients and will keep them coming back.

Share – unless asked not to

Share the information received with all the team so there can be continuity in conversations with the patients. Obviously, if the patient tells you something in confidence and asks you not to share this again respect their wishes. The only time this does not stand is if the information could pose a risk to others.

Try it out a bit at a time

Learning any new skill can be tiring, and can make us run late! So, try out listening in this way to one patient in your morning list, then on one patient from your afternoon list.

Mhari Coxon

About the author

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Dento-Viractis 55 is a ready-activated biological enzyme based detergent/disinfectant for dental practices. It is highly effective against a wide range of microorganisms including multidrug-resistant and antibiotic-resistant bacteria, viruses and fungi. It is particularly useful in the removal of blood and body fluids. It is designed to be added to autoclaves or ultrasonic baths in the ratio of one part Dento-Viractis 55 to five parts water. It is also used to disinfect surfaces and instruments before sterilisation. Dento-Viractis 55 can be used in combination with other disinfectants to enhance the effectiveness of the disinfection process.

**Sterilisation**

Sterilisation is a process that eliminates or destroys all forms of life from a material. There are several methods of sterilisation, including autoclaving, ethylene oxide gas sterilisation, dry heat sterilisation, and chemical sterilisation. Each method has its advantages and disadvantages, and the choice of method depends on the type of material being sterilised and the specific requirements of the user.

**Optima**

Optima is a comprehensive decontamination system that is designed to be highly effective against a wide range of microorganisms, including multidrug-resistant and antibiotic-resistant bacteria, viruses, and fungi. It is particularly useful in the removal of blood and body fluids from surgical instruments and devices. Optima is designed to be used in combination with other disinfectants to enhance the effectiveness of the disinfection process.

**W&H Lisa 500**

W&H Lisa 500 is a highly effective decontamination system that is designed to be highly effective against a wide range of microorganisms, including multidrug-resistant and antibiotic-resistant bacteria, viruses, and fungi. It is particularly useful in the removal of blood and body fluids from surgical instruments and devices. W&H Lisa 500 is designed to be used in combination with other disinfectants to enhance the effectiveness of the disinfection process.

**Dento-Viractis 55**

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**W&H 24-seven**

W&H 24-seven is a new website which offers a range of services to dental practices. It is designed to be highly effective against a wide range of microorganisms, including multidrug-resistant and antibiotic-resistant bacteria, viruses, and fungi. It is particularly useful in the removal of blood and body fluids from surgical instruments and devices. W&H 24-seven is designed to be used in combination with other disinfectants to enhance the effectiveness of the disinfection process.

**ChairSafe**

ChairSafe is a range of disinfectants that are designed to be highly effective against a wide range of microorganisms, including multidrug-resistant and antibiotic-resistant bacteria, viruses, and fungi. It is particularly useful in the removal of blood and body fluids from surgical instruments and devices. ChairSafe is designed to be used in combination with other disinfectants to enhance the effectiveness of the disinfection process.

**Viractis 55**

Viractis 55 is a ready-activated biological enzyme based detergent/disinfectant for dental practices. It is highly effective against a wide range of microorganisms including multidrug-resistant and antibiotic-resistant bacteria, viruses and fungi. It is particularly useful in the removal of blood and body fluids from surgical instruments and devices. Viractis 55 can be used in combination with other disinfectants to enhance the effectiveness of the disinfection process.
For more information, contact The Dental Directory on 0800 585 586, or contact Johnson on 0800 328 0750. For more information about the Listerine Total Care range contact Johnson & Johnson on 0800 585 586, or visit www.johnsonandjohnson.com.

The Dental Directory supports the Clinical Innovations Conference
The Dental Directory was pleased to be a sponsor of the 4th Clinical Innovations Conference 2012, which took place on 18th, 19th and 19th May at the Millennium Gloucester Hotel & Conference Centre in London’s Kensington.

Now in its ninth year, Clinical Innovations has become one of the leading events in the aesthetic and restorative dentistry sector in the UK. The educational nature of the event meant it represented 14 hours of verifiable CPD. A number of delegates attended to hear a panel of world class presenters lecturing and workshops, keeping the audience informed about global developments in dentistry. Speakers included Professor Nasser Borghi, Dr Rohidn Kahan and Dr Nicole Parmar.

The Clinical Innovations Conference also featured the AGD Charity Ball, held for the third year and the first CIC Innovation Award. Delegates enjoyed the very best in entertainment and food.

For more information, contact The Dental Directory on 0800 585 586, or visit www.dentaldirectory.co.uk.

Sirona redesigns website and starts focusing on social media
Sirona’s corporate website has been given a new look and provides quick, user-friendly access to content, products and services. At the same time, Sirona is focusing more on social media networks and internal and external dialogue with clients and interest groups.

The corporate website of Sirona will feature a new design and even more content. All the information about the company, its products, services and offerings can be found quickly. As well as redesigning the website, Sirona has also extended its presence in social media. Sirona will be actively using various activities on the social media networks Facebook, Twitter, YouTube and Google+.

Dr Jorgen Sorensen, Vice President Marketing at Sirona, explains: “Digital social networks have facilitated something which we of from Marketing and Sales could only dream of just a few years ago: direct dialogue with users, interested dentists, dental technicians, trade partners and patients who now participate in discussions with the users with genuine added value was a precondition for ongoing and relevant communication in social networks. We can now reach new customers in social media and intensify this dialogue through our own websites. Contact details for further information: Bellagio: +44 (0) 20 7907 0720, Cirkus: +31 (0) 21 640 6160, Dutchland: +31 (0) 901 405 0951.

Further your education with Sirona’s key Skills 3
Smile-on are delighted to announce the launch of their new key Skills 3. Smile-on’s Key Skills 3. Record Keeping will be a vital part of the MPGD team and is a must-read addition to dental education.

The Key Skills 3 qualification will enable you to increase your understanding of the importance of keeping full, precise and legible records. You will also be able to demonstrate your understanding on the importance of high quality record keeping and the potential pitfalls and dangers of poor record keeping.

Smile-on’s key Skills programme is a valuable and user-friendly learning scheme divided into seven sections covering topics beneficial to you and your entire practice.

Team. Medical emergencies, infection control, radiography, team training, risk management and preventing infection. The guidelines are all covered in a straight-forward format, which will help you for your continuing education seamlessly around your daily practice.

Smile-on wish to help you on your educational journey and all the information you need to develop your skills. The new version of the Key Skills 3 Launch will add an existing successful scheme, continuing to help you provide better treatment and care within practice.

For more information (call 01243 740 816), or email info@smile-on.com.

Imran Akgun training for the team with Mihir Cooray
Implementing change successfully Straight Talk Seminars are thrilled to announce that they have recently teamed up with Mihir Cooray BDI, who was voted 5th in the Dentistry Top 10, and have 20 years’ experience in a variety of different areas within the dental sector. Mihir Cooray has an excellent reputation as a dental, numeric, behavioural, oral health advisor and hygienist, and also as a highly respected speaker. When you are giving free implementation lectures at all future Imran Akgun courses, motivating the team to put their dental skills into practice. The service will cover: Communication with the team • Communication with patients • Change management • Costing options • Marketing strategies. Straight Talk Seminars provide practical tools and online training courses for the Imran Akgun - an innovative appliance that uses opposing forces to straighten crooked teeth and requires no surgery or braces. For further details, please visit www.straight-talk.seminars.co.uk.

Ismail Kacir with Eponite Bis-GMA
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![Graph showing pain intensity over time]

The outcomes of a dental pain study comparing the efficacy and tolerability of a novel single tablet combination of ibuprofen and paracetamol with that of an ibuprofen/codeine combination and a paracetamol/codeine combination using the dental impaction pain model. This comparison relates to cumulative pain relief over 12 hours following a single dose.

* The maximum allowed OTC dose in the UK is 1000mg paracetamol plus 25.6mg codeine.

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Nuromol 200mg/500mg Tablets (film-coated) Essential information  Refer to the SmPC for full details.

Active ingredients: Each tablet contains ibuprofen (200mg) and paracetamol (500mg). Indications: For the temporary relief of mild to moderate pain associated with migraine, headache, backache, period pain, dental pain, rheumatic and muscular pain, pain of non-serious arthritis, cold and flu symptoms, sore throat and fever. This product is especially suitable for pain which requires stronger analgesia than ibuprofen or paracetamol alone. Dosage instructions: Adults over 18 yrs. One tablet to be taken up to three times per day with water. If needed, dose may be increased to two tablets three times a day. Leave at least six hours between doses. Maximum of 6 tablets per 24 hours. To minimise side effects it is recommended that patients take Nuromol with food. If symptoms persist, worsen or if the product is required for more than 3 days, the patient should consult a doctor. Elderly: The lowest effective dose should be used for the lowest possible duration. The patient should be monitored regularly for gastrointestinal bleeding when using a NSAID. Contra-indications: Known hypersensitivity to ibuprofen, paracetamol or any other excipients. History of hypersensitive reactions associated with acetylsalicylic acid/NSAIDs. History of, or an existing gastrointestinal ulceration/perforation or bleeding, defects in coagulation, severe hepatic failure, severe renal failure or severe heart failure. Do not give: in concomitant use with other paracetamol-containing products, in concomitant use with other NSAID containing products, including cyclo-oxygenase-2 (COX-2) specific inhibitors and doses of acetylsalicylic acid above 75 mg daily, during the last trimester of pregnancy. Side effects, precautions: The risk of paracetamol overdose is greater in patients with non-cirrhotic alcoholic liver disease. Immediate medical advice should be sought in the event of an overdose, even if the patient feels well, because of the risk of delayed, serious liver damage. Caution is required in elderly patients and in patients with certain conditions: respiratory disorders, cardiovascular, cerebrovascular, renal and hepatic impairment, gastrointestinal bleeding, ulceration and perforation, SLE and mixed connective tissue disease. Serious skin conditions and impaired female fertility may occur. Warnings for use: do not give to patients who have taken ibuprofen or paracetamol in the last 6 hours; do not give in combination with paracetamol or NSAID containing medicine. Common side effects: abdominal pain, diarrhoea, dyspepsia, nausea, stomach discomfort and vomiting, increase in amino-transferrase, gammaglutamyltransferase, blood creatine, blood urea, liver dysfunction. Recommended retail price: (ex. VAT): £2.08, £2.33 and £2.94: £5.83. Supply classification: P. Marketing authorisation holder: Reckitt Benckiser Healthcare (UK) Ltd, Slough, SL3 6UJ. Tel: 0500 455 456. MA number: PI 00063/0519. Date last revised: September 2010.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Reckitt Benckiser Healthcare (UK) Ltd on: 0500 455 456.

NUROMOL and the target device are trademarks.

Further information: For replacement leaflets or enquiries concerning this product, please contact our Medical Information Unit via email: info.mio@reckittbenckiser.com

References
1. AB Data on file: Study No. NL0811.2010. • Two Nuromol tablets compared with two tablets of Ibuprofen 200mg and Codeine 12.8mg.