Help for migraine sufferers

According to a recent report, the National Headache Foundation in the US has designated June as National Migraine Awareness Month. According to experts, dental problems can cause 95 per cent of migraines, but fortunately due to advances in dentistry, the trouble behind migraines could be revealed by looking to the mouth for answers. “We can tell how your teeth meet within a hundredth of a second, which teeth meet first, which teeth meet hardest, whether your balance is left or right, so it’s very important because all that information goes into the brain headache center and helps produce the headache,” explained Dr Gary Andreoletti, a migraine through his practice. In a recent report. The Migraine Research Foundation says in that the employees lose more than $13 billion each year as the result of those who miss work due to headaches.

Free nursery milk

Plans to secure the future of a fair and cost effective way to offer free milk to all nursery children was set out today by Public Health Minister, Anne Milton as she launched a consultation on how the scheme operates. Figures show that the Government is spending up to 92p for a pint of milk through the scheme while most consumers can pick up one up for 45p - almost half the price. The current nursery milk scheme has been running since the 1940s and the Government is committed to continuing to provide free milk for all nursery children. But analysis shows modernising the operation of the scheme could save up to £20 million each year. In its current form, the legislation covering the scheme provides for full reimbursement of the cost of the milk. While childcare providers are encouraged to seek value for money, there are cases where this is not happening. Around 1.5 million UK children under-five in 55,000 childcare settings receive free milk. The consultation will seek views on the price, access, voucher schemes, supply and claims procedures. Public Health Minister Anne Milton said: “Milk has many benefits to children’s health and is important for their development – we are committed to continuing to provide free milk for all under-fives.”

The ‘perfect’ smile

Primary school children take part in NSM

The Queen’s Birthday Honours List for 2012 has been published, recognising outstanding service and achievement across the UK, and once again the dental world has gained some well-deserved recognition.

Dr Nigel Carter, Chief Executive of the British Dental Health Foundation has been awarded an OBE in Queen’s Birthday Honours. The award recognises Dr Carter’s services to dental and oral health. Dr Carter has been Chief Executive of the British Dental Health Foundation since 1997, and was previously Chairman of the Dental Library in Europe. Dr Carter said: “It is a tremendous honour to have been nominated for this OBE. This award recognises not only me but also the work of British Dental Health Foundation and I am very proud of what we have achieved over the last 40 years.

“Dentistry has made great strides over the years and patients have benefitted greatly from the innovations and improvements in treatments. There is still however an important role to be done through education. Not only to improve oral health but also to help people gain a better understanding of associated diseases including mouth cancer. Our aim is to spread the word on the benefits of good oral hygiene as far as we can. We are currently planning to roll out the concept of National Smile Month to as many countries as we can.”

John Siebert, President of the British Dental Health Foundation said: “We would like to congratulate Nigel on his OBE. It is very well deserved and a testament to his hard work, time and passion that he has dedicated to the British Dental Health Foundation.

Overseeing the Foundation’s work including National Smile Month and Mouth Cancer Action Month, Nigel works with health departments, representatives of major health, cancer, dental and medical organisations. Nigel is also Trustee and treasurer of the Royal Society for Public Health and takes a strong interest in Public Health, the current NHS reorganisation and the social determinants of health.

Dr Carter said: “It is a tremendous honour to have been nominated for this OBE. This award recognises not only me but also the work of British Dental Health Foundation and I am very proud of what we have achieved over the last 40 years.

“Nigel is a great advocate for the dental health profession, and has helped to shape and challenge the way we think about oral health in this country. Thanks to his work with the Foundation, many more people have benefitted from having better oral health and therefore less treatment.”

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The services of Roger Fabey, the British Dental Association’s (BDA) Head of Library and Knowledge, have also been noticed, he has been awarded with an MBE. The award was made in recognition of Roger’s services to dentistry and dental information. He was expected to be presented with his award later this year.

Peter Ward, the Chief Executive of the BDA, said: “Everyone associated with the BDA is thrilled that Roger’s services to dentistry have been recognised in this way. The BDA is justifiably proud of its library and the contribution it makes to the advancement of the profession. Roger’s years of dedicated service have played a major part in its successes and he can be justifiably proud of his contribution to dentistry.”

Roger commented: “I am naturally delighted with this honour but also regard it as recognition of the excellent staff that help run the BDA’s Library, which is undeniably the best dental library in Europe.”

A CBE was also awarded to Professor Irene May Leigh, OBE, Lately Vice Principal for Research and Head of College of Medicine, Dentistry and Nursing, University of Dundee. For services to Medicine.

All smiles for Birthday Honours

BDHF Chief Executive receives award; BDA librarian also honoured
NHS 111 delayed

According to a recent report, the government has announced a delay in the rollout of the NHS 111 number in England. The free one-stop number for patients with urgent, but not life-threatening symptoms was planned for April 2015; however, the Department of Health has said that areas can now have more time to introduce the service.

The delay has been welcomed by doctors’ leaders, who had reportedly expressed “serious concerns” about the introduction of the service. Nursing leaders and the union Unison has also expressed reservations about plans for the service, and there were concerns that NHS services could be placed under further strain if more time had not been given to introduce the service.

The delay will mean areas will have up to six extra months in which to introduce NHS 111 – taking the deadline to October 2015. Those areas which already have the service will continue to run it.

Commenting on the decision by the Department of Health to extend the NHS 111 rollout - Nick Chapman, NHS Direct Chief Executive, said: “NHS Direct believes that the Department of Health’s decision to allow further time to plan and implement these national changes to the urgent and emergency care service is the right one. It will allow for greater clinical engagement and ensure that the service is the best it can be for patients. The decision to allow an extension means that the period of transition from the 0845 46 47 service to the new NHS 111 service is likely to be spread over the next 15 months, rather than over the next 9 months.

“As we understand it, the next step is for local commissioners who want an extension to make an application to the Department of Health. We won’t know until these applications have been made how many areas will request an extension, and what implications that may have for the 0845 service and NHS Direct staff.”

GP patient survey: dental statistics revealed

The GP Patient Survey is a quarterly survey of GP adult patients, which is managed by Ipsos MORI on behalf of the Department of Health. The main results of the latest Survey for 2009/10 Q4 were published on 17th June.

For the first time, for 2009/10 Quarter 4 (January to March), dental questions were included in the survey, of about 400,000 adults were asked to complete questions about access to NHS dentistry in the previous two years. Participants in the survey were asked if they had tried to obtain an appointment with an NHS dentist and if so what was the type of appointment and had they been successful. Patients who hadn’t tried to obtain an NHS dentist in the previous 2 years were asked to select one reason why they hadn’t tried.

The results from the survey responses are presented here at national (England), Strategic Health Authority (SHA) and Primary Care Trust (PCT) level.

Main results:
- 147,600 completed dental questions were received, of 460,000 that were distributed (response rate of 57 per cent).
  - Results are available at National (England), Strategic Health Authority (SHA) and Primary Care Trust (PCT) level.
- 59 per cent of adults in the survey tried to obtain a consultation with an NHS dentist in the two year period before March 2010
- 92 per cent of respondents who tried to obtain an appointment were successful. Eight per cent were unsuccessful. These percentages exclude those who didn’t remember the outcome.
  - Respondents who have tried more recently are more successful, 95 per cent of respondents trying within the past three or six months were successful.
  - For 78 per cent of adults the last appointment sought was for routine dentistry; 18 per cent were seeking an urgent appointment and two per cent didn’t remember the type of appointment sought.
  - 81 per cent of the most recent appointments sought were with the dental practice previously attended. In these cases the successful percentage was 95 per cent.
  - North East SHA had the highest percentage of the adult population seeking an NHS dental appointment in the last two years.
  - North East SHA had the highest percentage of the adult population seeking an NHS dental appointment in the last two years.
  - The most frequent reason for not trying for an NHS dental appointment in the last two years:
    - 41 per cent of respondents did not try to get an appointment with an NHS dentist in the last two years.
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Dentist gets ‘locked-in syndrome’

A recent report in a national newspaper has covered the story of a dentist who suffered a near fatal stroke after performing a particularly grueling tooth extraction.

According to the report, 33-year-old Andy Davies began to suffer headaches and neck pain before eventually admitting himself to hospital in Birmingham in November 2011. Doctors quickly discovered that the dentist had torn an artery in his neck causing a bleed on his brain stem; however, the stroke was so severe he experienced ‘locked-in syndrome’, a condition which left him unable to move, speak or even breathe without aid from a ventilator. According to the report his only way of communicating was through his eyes.

Doctors at Birmingham’s Queen Elizabeth hospital fought to save Mr Davies’s life after the stroke, which was believed to be caused by the tooth extraction. He was then put into an induced coma to allow his body to cope with the massive trauma he had suffered.

However, the story has proved to be a miraculous one, and after some difficult months, Andy is slowly regaining strength and movement; he has even started to learn to sit and talk again. Doctors caring for him have been amazed at his recovery. He is currently being cared for at rehabilitation centre called Moseley Hall, in Birmingham, although his funding is due to run out in the next few months.

According to the report, Andy qualified at Birmingham University in 2002 and was the first dyslexic to qualify as a UK dentist. Since then he has worked for the NHS in general dental practice in Birmingham where he met his wife Emma.

Emma, a teacher was quoted saying in the report: “We were told that if Andy survived he would be left with ‘Locked in Syndrome’ which would leave him unable to communicate or move with no prospect of any independent life. We were told to prepare for the worst and that people didn’t recover from such situations.”

She added: “No one is quite sure what caused the stroke although Andy thinks the trigger was the tooth extraction which may have damaged the artery and caused it to split later.”

Cycle Slam is huge success!

On St George’s Day, former England rugby international and World Cup winner Lawrence Dallaglio and England cricketer legend Freddie Flintoff embarked on the cycle ride of their lives.

The Dallaglio Flintoff Cycle Slam 2012 (supported by Virgin Media) began at the ancient birthplace of the Olympic Games, Olympia in Greece, on 23rd April. The journey stretched over 22 days, and took them through Italy, across France and into the Swiss Alps, ending in London on 18th May.

Dr Alyn Morgan, endodontist at U Dentistry in Ilkley, joined Freddie and Lawrence for the last of the five stages of the ride. He undertook this massive challenge in order to raise donations for three fantastic charities – the Dallaglio Foundation, the AF Foundation and Virgin Unite.

A huge congratulations to Alyn and everyone else who took part in this incredible point in the previous two years was ‘I stayed with my dentist when they moved from NHS to private’ which was mentioned by 21 per cent of adults. The next reason ‘I didn’t think I could get an NHS dental appointment’ was 18 per cent of responses.

Further breakdown of these figures can be found in the summary tables below, and also a copy of the dental questions used in the Survey.


The Cycle Slam team

The Cycle Slam team
A study carried out in Sweden has suggested that poor oral hygiene is associated with increased cancer mortality. The study, The association of dental plaque with cancer mortality in Sweden. A longitudinal study, was carried out to find out whether the amount of dental plaque was associated with premature death from cancer.

For the study, 1,950 randomly selected healthy young Swedes were followed up from 1985 to 2009. According to the authors, all subjects underwent oral clinical examination and answered a questionnaire assessing background variables, such as socio-economic status and smoking. Causes of death were recorded from national statistics and classified according to the WHO International Classification of Diseases. The results showed that:

- Of the 1,390 participants, 4.2 per cent had died during the follow-up. Women had died at a mean age of 61.0 (±2.6 SD) years and men at the age of 60.2 (±2.9 SD) years.
- The amount of dental plaque between those who had died versus survived was statistically significant (p<0.001). In multiple logistic regression analysis, dental plaque appeared to be a significant independent predictor associated with 1.79 times the OR of death (p<0.05).
- Age increased the risk with an OR of 1.98 (p<0.05) and gender (men) with an OR of 1.91 (p<0.05). The malignancies were more widely scattered in men, while breast cancer was the most frequent cause of death in women.

The study concluded that poor oral hygiene, as reflected in the amount of dental plaque, was associated with increased cancer mortality. For the article on the BMJ website, visit http://bit.ly/Kvr0Ma

Just those few facts make for interesting reading for the dental practice looking to engage with potential and current patients via social media, as well as those who find LinkedIn invaluable for networking with peers and colleagues.

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London, EC1 8BA

Or email:
lisa@dentaltribuneuk.com
Recommendations on how to distribute funding for local authorities to spend on public health have been published by an independent group of experts - the Advisory Committee on Resource Allocation (ACRA).

For the first time, from 2013, public health funding will be ring fenced and protected with local authorities taking the lead for improving health. This will help to drive up local efforts to maintain and improve the public’s health and wellbeing.

The Department of Health has committed to ensure that no local authority will lose out under the new grants for 2015-16. So local areas will either receive equivalent funding or be better off under the new funding arrangements.

Alongside the recommendations, the Department is also publishing more information on:

- A health premium incentive that will target areas with the worst health outcomes and most need, rewarding local authorities if they improve the health of the local population
- Further information on the ring-fenced public health grant

“We are committed to all areas of the country seeing a real terms increase in public health spending, above what PCTs were spending locally. Today’s announcement confirms this.”

Every area of the country is different and has contrasting needs. The interim recommendations published by the independent Advisory Committee on Resource Allocation today provide a solid basis for local authorities to begin planning for next year.”

Under the plans for the health premium incentive, local authorities will be rewarded for the progress they make. Disadvantaged areas will see a greater incentive if they make progress, recognising that they face the greatest challenges.

The Secretary of State asked ACRA to develop a formula for the distribution of public health funding to local authorities across England to help support their new responsibilities.

The Department will now actively engage with health professionals, local authorities and public health leaders for their feedback before publishing the final formula later in the year.

Dental practice teaches children how to get that ‘perfect’ smile

In support of National Smile Month a team from Perfect 32, an NHS and private dental practice in Beverley, visited children at Walkington Preschool and Walkington Primary School to teach them the best way to keep their teeth for life.

National Smile Month 2012 ran until June 20th and was led by the British Dental Health Foundation. This year’s focus was on the vital importance of looking after your mouth in order to keep both your mouth and body healthy. Brushing your teeth for two minutes twice a day, drinking and eating less sugary snacks and visiting your dentist regularly are simple measures that can be taken to maintain overall health. Significant scientific evidence has proven the systemic links between the mouth and the body, with research clearly linking gum disease to heart disease, diabetes, strokes, pneumonia and premature and low birth weight babies. Millions of school days are also lost every year because children are suffering with oral health issues.

As well as offering educational advice in a fun way to 40 reception children with visuals and games, including a ‘good food, bad food’ interactive quiz and a ‘Smile for the Camera’ station, the team also had plenty of balloons, stickers and dental goodies to give away. The afternoon ended with a full school assembly with 264 children in attendance to listen to the National Smile Month message.

Practice manager, Nicki Rowland, said: “This is the fourth year that we have visited children to promote good dental health and we always have great fun despite the serious message we are relaying to the children.”

“This year the children dressed up in clinical clothing and masks to look like dentists and had their photographs taken with the campaigns smile-on-a stick logo, which was very funny. We also got very messy learning good brushing techniques using bright blue disclosing tablets and at one point the floor was covered in clinical gloves that the children had blown up and decorated as The Queen!”

Huw Teven (age five) said: “We played a game and gave good food to the tooth fairy. I now know how to check if my tooth brush is worn out. I really enjoyed the afternoon.”

Dr Nigel Carter, chief executive of the Foundation, said: “We are delighted that Perfect 32 has joined the many dental practices, schools, health professionals and community groups promoting good oral healthcare under the umbrella of our National Smile Month campaign.

“A good oral healthcare routine can help guard against all sorts of oral and general health conditions from bad breath and decay to gum disease, which has been linked to a number of more serious health conditions such as diabetes, heart disease and strokes.”

“Dentists must resist PCT bullying”

Dentists across England must resist the bullying tactics of Primary Care Trust dental commissioning staff, British Dental Association (BDA) General Dental Practice Committee (GDPC) Chair Dr John Milne has urged.

Speaking at the 2012 Conference of Local Dental Committees (LDCs), Dr Milne told delegates that he was appalled at suggestions that some PCTs were challenging perfectly acceptable treatment patterns in an attempt to claw back money, using a veiled threat that practitioners might be referred to the General Dental Council (GDC) as a stick with which to beat them.

Dentists who find they face such threats, Dr Milne added, must report the situation to the BDA so that this unnecessary aggressive stance can be resisted.

Dr Milne also, though, reiterated the responsibility that all dentists have to practise professionally and ethically, warning that the small numbers of practitioners who make inappropriate claims are creating problems for the vast majority of the profession that does the right thing.

Dr Milne said: “We have heard from practitioners working in a number of primary care trust areas that commissioning staff are adopting an unreasonable, bullying stance towards dentists with the motive of clawing back money. That is unfair, unhelpful and unacceptable.

“Dentists must not be cowed by such practices. The small number of inappropriate treatment claims that are submitted by practitioners absolutely must be tackled, but they must not be used as an excuse to persecute practitioners who are working professionally, ethically and appropriately.”

“GDPC will not accept such actions by PCTs and urge dentists to inform the BDA if this happens to them.”
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A real fundraising drive

In December 2005, 13-year-old Robbie Anderson set up a Trust to improve the quality of life for young people spending long periods of time on the children’s cancer ward, where he too was a patient.

As explained on The Robbie Anderson Cancer Trust website: “Robbie knew his cancer was terminal and that he was in the final stages of his battle with a rare form of childhood cancer. Robbie’s future didn’t deter him. Facing his second (and last) Christmas in hospital, he set about fundraising for a large plasma TV screen for his ward. He wanted the children on the oncology ward to be able to do what everyone else was doing – playing games and watching Christmas films with their families, something many of us can take for granted. On December 24th it was fixed to the wall in the Day Room. Sadly, ten weeks later, Robbie passed away.”

Cancer is a battle that must be fought on all fronts - the psychological fight is in many ways as important as the physical care and Robbie’s time in hospital was made so much worse by the lack of any facilities for his age group.

“The focus was on much younger children, down to infant-sized tables and chairs in the Day Room and not much else but Disney DVDs to watch. While his life hung in the balance he was placed in either a room with Mr Men mobiles hanging from the ceiling or in a crowded six bedded ward decorated with cartoon characters. Robbie lived in a hospitalised TV’s on tables battled for space with life-saving blood products and chemotherapeutic machinery. There was absolutely no privacy for parents or their children; this, coupled with the sense of being in a nursery, Robbie found hard to bear.”

It was then that Robbie decided to set up a trust to improve the quality of life for young people fighting cancer.

His Trust, which continues to support the Children’s Oncology Ward at Leicester Royal Infirmary, aims to work towards providing a facility where all children are treated in age-appropriate surroundings, with a particular focus on teenagers. The proposed unit will cost £1.4 million to build but will be a centre of excellence with clearly defined spaces for each age group.

And this is where you, the reader, come in. In July, Robbie’s parents and members of the dental profession will be setting off on an epic journey to the exotic principality of Monte Carlo to raise funds and awareness of the needs of children and young adults suffering with cancer. The trip, however, will also be carrying out one of Robbie’s wishes, which was to go to Monte Carlo and place a bet on the number eight ball on a roulette table! All the participants are self-funding the drive and all money raised will go towards the funding the £1.4 million age appropriate cancer facility at Leicester Royal Infirmary.

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

For those of you wishing to make a donation to this well worthwhile fund, please visit http://www.robbieanderson.org.uk/index.php/donations-contact-us. You can also find out more information at http://www.robbieanderson.org.uk/index.php.

OK to limit pre-dental procedure antibiotics

The incidence of infective endocarditis among dental patients in Olmsted County, Minn. did not increase after new guidelines called for giving preventive antibiotics before dental procedures only to those at greatest risk of complications, according to independent research published in Circulation, an American Heart Association journal.

Infective endocarditis is a bacterial infection of the heart lining, heart valve or blood vessel. Although rare, it can occur when bacteria enter the bloodstream through breaks in the gums during periodontal procedures or oral surgery. It can cause death if untreated. A common group of bacteria that cause this infection is viridans group streptococci (VGS).

Patients with a heart weakened by certain congenital defects and acquired conditions, including those with prosthetic heart valves, can be more susceptible to the infection. People with normal heart valves develop the infection less often.

In 2007, the American Heart Association changed its guidelines, recommending patients take antibiotics before invasive dental procedures only if they are at risk of complications from infective endocarditis. This includes patients with artificial heart valves, transplanted hearts with abnormal heart valve function, previous infective endocarditis and people born with specific heart defects.

Before 2007, antibiotics were given to many more people, including those with many types of congenital heart defect or acquired cardiac condition. Antibiotics also were given for a wider range of procedures, including operations performed on the mouth, throat, gastrointestinal, genital or urinary tract.

In the first US study examining VGS-related infective endocarditis rates after the guidelines changed, investigators found a slight decline in the number of patients diagnosed.

To compare infective endocarditis rates, researchers analysed local hospital discharge records in the Rochester Epidemiology Project and national rates using the Nationwide Inpatient Sample. Olmsted County was used because of its unique medical records-linkage system that encompasses all residents of the county.

From Jan 1, 1990 to Dec 31, 2010, 22 patients in Olmsted County, Minn., were diagnosed with the heart infection. These patients represent two to three of every 100,000 people in the United States before updated guidelines, and one of every 100,000 after the updated guidelines.

The percentage of Olmsted county dentists following the new association guidelines represented the percentage of dentists using them nationally, researchers said.

Among other limitation, the lack of diversity in Olmsted means these results may not hold true for non-Caucasian populations.

New Smile Director for Oral B

Dr Uchenna Okoye (pictured) has been appointed as the new Smile Director for Oral-B. Her role will involve raising awareness of oral health issues in the consumer media. She will also act as a technical expert to field queries from journalists.

Commenting on her appointment Uchenna explained, “A large amount of the work I do could be prevented through good oral hygiene. As professionals we all strive to give our patients the advice and tools they need to look after their teeth between appointments. This message, however, needs to be reinforced through consumer media.”

With up to 50 per cent of the population not regularly visiting a dentist Oral-B spokeswoman Jane Kidson explained: “It is essential that we extend the reach of our message beyond the prac-
Comment regarding Bridge the Gap news piece, printed in Issue 14 2012.

Following a news piece by Bridge the Gap, regarding the General Dental Council (GDC) monitoring standards, a member of the GDC has written to Dental Tribune with their response:

I am writing in response to an article that appeared in the May 28 – June 3 2012 edition of Dental Tribune, entitled GDC “failing to monitor standards breaches”.

I would like to take this opportunity to correct some of the misconceptions I feel readers will have been given by this piece and I hope you will publish this letter in the next possible issue of the magazine.

The General Dental Council does in fact know why dentists are being struck off our registers. This information is made publicly available on our website and in past annual reports. In addition we are currently further improving our systems to help aid us in our understanding of the types of complaints we receive.

We supplied the Dental Law Partnership, the group of solicitors behind the ‘Bridge the Gap’ campaign, with a wealth of information when they made their Freedom of Information request. Unfortunately they took one sentence from a letter answering a very specific set of data out of context.

They asked for information about the classification of hearings results by a specific part of our ‘Standards for dental professionals’. We do not record our information in this way but that does not mean we do not analyse data we hold.

Your sincerely,
Neil Marshall, Director of Regulation, General Dental Council

GDC response to ‘Bridge the Gap’

According to a recent study, The effects of home-use and in-office bleaching treatments on calcium and phosphorus concentrations in tooth enamel, an in vivo study, bleaching gels do not alter calcium and phosphorus concentrations on the enamel surface.

Researchers from São Leopoldo Mandic Institute and Research Center in Brazil conducted the study to determine the effects of dental bleaching. They examined the changes in calcium and phosphorus concentrations in enamel after the use of home-use and in-office bleaching treatments inside the mouth.

To carry out the study the researchers applied four bleaching agents (10 per cent and 20 per cent carbamide peroxide [both recommended for home use], 58 per cent and 55 per cent hydrogen peroxide [both applied in the dental office]) to the enamel of 80 participants, who were divided into four groups of 20.

The authors evaluated the subjects’ teeth both before and after the treatments by collecting samples from enamel of incisors before (baseline), during (seven, 14 and 21 days) and after (seven and 14 days) the bleaching treatments. They analysed calcium and phosphorus concentrations by using a spectrophotometer. According to a recent report, the evaluation was done using enamel microbiopsies, which is a method of collecting samples from enamel without causing any injuries to the dental structure.

The samples were then individually analysed by using the Friedman test and the Kruskal-Wallis test, followed by the Dunn test (α = 0.05). The authors noted that there were no statistical differences between the evaluation results, regardless of which bleaching gel was used, for determining the concentration of either calcium or phosphorus.

The authors concluded that home-use and in-office bleaching gels did not alter the concentrations of calcium and phosphorus on the enamel surface in vivo.

The study has been published in the current Journal of the American Dental Association (June 2012, Vol. 142:6, pp. 580-586) and can be found by visiting http://bit.ly/Kbwu1c.

“Bleaching does not damage enamel surface”

Gap in missing teeth market filled by implants

Consumer interest in dental implants has doubled in the last year according to the latest data from WhatClinic.com, a worldwide search engine for medical clinics and services. More than 150,000 people from the UK used the website to research local private dental clinics in the last month, and 2,500 of these were interested in dental implants, up 105 per cent from the same period last year. (27 April – 27 May 2011 vs 29 April – 29 May 2012)

Increasing consumer awareness and more affordable prices are driving demand for the procedure which has traditionally been seen as the preserve of the rich and famous. Of the 555 UK clinics listing dental implant prices on WhatClinic.com, 15 per cent now quote between £1,000 and £1,500 and seven per cent quote between £500 and £1,000 for the procedure. The average price quoted however, is still £1,860, just £10 less than it was a year ago.

With an estimated 27 million British adults missing at least one tooth (57 per cent of the adult population), implant dentists have a considerable market to service. Even though implants are available on the NHS, they are only provided in cases which are deemed medically necessary, leaving private treatment the only option for most patients interested in the procedure.

Carden King, CEO of WhatClinic.com said, “It is clear that dental implants are increasingly popular with UK consumers who see the procedure as a permanent solution to replacing lost teeth. The benefits of the procedure, such as an enhanced ability to chew food, protecting remaining teeth and improving self-esteem are making them a hit with consumers all over the UK.”
TV star shows off “Rolls Royce teeth”

Comedian Crissy Rock is proudly showing off her new set of “Rolls Royce teeth” after enduring years of agony and embarrassment.

Crissy, who is also one of the stars of the hit TV show Benidorm, saw her teeth destroyed after she took chemotherapy-based drugs for vulval cancer in 2003.

Her teeth crumbled causing her to have all of them removed and she went on to have dentures fitted while living in Spain during the filming of Benidorm.

She said: “I spent £10,000 having dentures fitted with a Spanish dentist, but the result was devastating; When I saw my teeth I cried. They looked like something out of a joke shop. It was a real botch job that left me looking like Hannibal Lecter.”

Crissy resolved to get her teeth looked at again after appearing on ITV’s I’m a Celebrity...Get Me Out Of Here last year during which she had to remove her dentures as she prepared to jump out of a helicopter.

Now, after four months of treatment with dentist Barrie Semp, of The Smile Centre in Manchester, Crissy is proudly showing off what she has dubbed the “Rolls Royce of teeth” which cost £20,000 to fit.

Crissy said: “My teeth have been individually handmade and tweaked to look a bit worn and slightly crooked to appear more natural. Even the gums look real.

“For years I couldn’t bite into an apple and had to check restaurant menus for things I could eat. These new teeth are rock solid and I can eat whatever I want. They have given me my dignity back as well as a nicer smile.

“They have already made a huge difference, not just to my mouth but to my life.”

Barrie Semp said: “The problem with Crissy’s teeth was that she had them fitted abroad and there was no after-care. Also the dentistry work she had done was very poor and had completely failed. It was a total mess.

“Each new tooth has been handcrafted with faint cracks and imperfections to make them look very real. The gum work is also hand-stained to blend in with the patient’s gum colour, so it looks as if the patient’s natural teeth are growing from the natural gum.

“Crissy can eat anything she likes now and can even jump out of a helicopter with-out having to take her teeth out.”

Gum disease associated with women’s hormones

Women, keep those toothbrushes and dental floss handy. A comprehensive review of women’s health studies by Charlene Krejci, associate clinical professor at the Case Western Reserve University School of Dental Medicine, has shown a link between women’s health issues and gum disease.

Across the ages, hormonal changes take place during puberty, menstruation, pregnancy and menopause. Krejci found female hormones that fluctuate and menopause. Krejci found female hormones that fluctuate and menopause. Krejci found female hormones that fluctuate and menopause.

Her overview of the literature was reported in the article, “Women’s Health: Periodontitis and its Relation to Hormonal Changes, Adverse Pregnancy Outcomes and Osteoporosis” in the May issue of Oral Health and Preventive Dentistry.

The case Western Reserve University periodontist reviewed 61 journal articles with nearly 100 studies for a collective answer on whether hormones have a relationship to gum disease and specific women’s health issues like preterm labor, bone loss, and the side effect of hormonal replacement therapy.

“There’s definitely a gender-specific connection between women’s hormones, gum disease, and specific health issues impacting women,” Krejci said.

“Although women tend to take better care of their oral health than men, the main message is women need to be even more vigilant about maintaining healthy teeth and gums to prevent or lessen the severity of some women-specific health issues,” Krejci said.

In addition to the brushing and flossing daily regimen, Krejci recommends visiting the dentist at least every six months, and more if there are any gum problems found or women suffer from bone loss or are pregnant.

She added that it is widely known that hormones cause some women gum problems during pregnancy. Women already susceptible to gum disease before being pregnant, she advises, need to make sure that these oral problems are treated.

Although women were once downsized from seeing the dentist while pregnant, she said that scaling and planning of the roots of teeth to eliminate some gum disease is now recommended during pregnancy for women. Severe gum disease requiring surgery is still generally postponed until after the baby’s birth.

Gum disease begins with the build-up of bacterial plaque on the teeth and under the gums. Untreated it can cause irritation and inflammation during which harmful and toxic byproducts are released. These toxins erode the bone that anchors teeth and cause breaks and bleeding in the gums.

Collaborating with Krejci on the study was Nabil Bissada, professor and chair of the Department of Periodontology at Case Western Reserve University School of Dental Medicine.

B2A appear on BBC News

Bridge2Aid were delighted with some great coverage on BBC Breakfast news, when Founder and Clinical Director of B2A Ian Wilson was interviewed regarding the launch of their pilot project in Rwanda. Also featured, was one of their volunteers Clare Roberts, who was preparing to leave on a DVT trip, she is currently in Tanzania.

Over the years Bridge2Aid has developed its expertise in treating and training people in deprived rural areas of Tanzania and now the charity is about to start work in Rwanda, a country that has only 11 qualified dentists; the dentist per patient ratio is only one dentist per 800,000 people.

Volunteer British dentists have spent several years working through B2A helping people with severe toothache and dental problems in Tanzania and the dentists are about to embark on another journey into a part of Africa where many residents have never seen a dentist.

One volunteer is Clare Roberts, who was interviewed for the coverage on BBC.

Speaking of the future trip, she said: “Primarily it’s the lack of equipment and the actual environment you’ll be working in - it’s very basic.

“You have to make do with no running water or electricity. And the patients themselves are going to be very different.

“There’s a language barrier and they may not be used to receiving dental treatment, so there’s all sorts of things that make it a big challenge.”

Unlike dental practices in the UK, the dental surgeries in Africa have little up-to-date or high-tech dental equipment and appliances, but that doesn’t deter the volunteers, who make it their mission to help train local health workers who can carry on treatment once the volunteers have returned home.

B2A hope that this will create a long-term, sustainable dental healthcare system.

Ian Wilson, the founder and clinical director of Bridge2Aid explained the reasons behind the charity during the BBC interview: “If you’re in pain, you can’t function. So if you’re a subsistence farmer in rural Tanzania, you can’t work properly, you can’t therefore generate that small, less than a dollar-a-day income to survive as a family, to put your kids through school.

“So there’s a social impact in terms of people being able to function and there’s an economic impact that can really have a significant effect on a village community.”

Bridge2Aid plan to work with the Rwandan government, as well as two charities which already have a track record in the small central African state: Umubano, which is run by volunteers from the UK’s Conservative Party, and Survivors Fund.

The BBC interview can be found at http://bbc.in/L4hpyz and the original BBC interview can be found at http://bbc.in/MerNih.
Expand your “cosmetic” dentistry
Dr Oliver Harman discusses the innovative MSc in Restorative and Aesthetic Dentistry

Dr Oliver Harman from The Harman Dental Clinic in Royal Tunbridge Wells, is one of the two dentists in the UK to pass the BACD Fellowship Examination, and began the MSc course at the beginning of the year.

“I have just completed the introduction to the Smile-on MSc course, and have so far found it to be an excellent grounding in 21st century dentistry,” he says. “For someone who has been practising for 26 years it has been extremely useful, and it gives a really good overall picture. Technology has developed dramatically in the past few years, and the course offers a very up-to-date and progressive set of lectures, at the cutting-edge of the dental industry.”

Positive approach
When discussing what features of the course he found most beneficial, Dr Harman is finding the eLearning approach to be very positive. “I definitely prefer the webinars live, as I feel it adds something to the lecture. Generally the format works very well and is a realistic method of learning for busy dental professionals. The online aspect provides the fantastic privilege of allowing me to continue working while studying.

This is particularly relevant to dental professionals fairly advanced in their careers, as it is more challenging to attend traditional courses regularly with great commitments to their families and practices. The online format allows for more mature clinicians to revisit mainstream education and training without making too many sacrifices.

“The speakers are also very good, and include some of the leading names in the field. I like that the lecturers aren’t limited to Manchester University, enabling the presentations to provide brilliant exposure to a wider faculty than you would normally have access to.”

When talking about why he wanted to take the MSc in Restorative and Aesthetic Dentistry, Dr Harman is very passionate about the controversies surrounding the concept of “cosmetic dentistry”

“Within the dental industry at the moment, there are some very conflicting views about what the term ‘cosmetic dentistry’ covers. Unfortunately, I think many practitioners have formed their opinions based on some of the pretty terrible examples of so-called ‘cosmetic’ work in the past.

“As far as I’m concerned, ‘cosmetic dentistry’ is not a separate entity in practice. In all my work I aim to complete treatments giving my patients a beautifully crafted smile, which functions properly, looks great, is painless and lasts a lifetime. It’s not necessarily ‘cosmetic’, it’s just good dentistry.

“The MSc in Restorative and Aesthetic Dentistry enhances my mainstream knowledge of modern techniques, providing an updated platform for my work. I put a lot of emphasis on keeping up with new advances within the field worldwide, but I think it is very important to have a basic understanding of the progress within the UK.

Bridge the gap
“Along with a few colleagues, I wish to help bridge the gap between the widespread views of ‘cosmetic’ dentistry. Though I have just begun the course, I think it will be a tremendous help to knowing and fully understanding the literature and evidence-base behind the work I do – an invaluable benefit both in practice and for the clinical case studies and articles I frequently write.

“With so many contradictory ideas of ‘cosmetic dentistry’ within the dental community, it is no wonder the general public don’t really understand the term. In order for practitioners to know what we mean, we need to define the term ourselves first. We need to ensure what we’re teaching, learning and trying to achieve is the same for everyone – hospital workers, general practitioners and members of the public.”

Solid framework
The MSc course from Smile-on and the University of Manchester is split into seven units, incorporating webinars, lectures, residential sessions and a dissertation to end. The online resources can be accessed repeatedly, at a convenient time to the practitioner, and from a familiar environment. Including access to advice and guidance from some of the experts at the forefront of aesthetic dentistry, the course provides a solid framework for dental professionals to develop and improve the standard of service they offer their patients.
Advanced thinking in dental ceramics

‘Bringing it all together’ - BACD Conference, 22nd-24th November 2012

The British Academy of Cosmetic Dentistry (BACD) will hold its 9th Annual Conference on 22nd-24th November 2012 at the Manchester Central Convention Complex. Entitled “Cosmetic Interfaces: Bringing It All Together”, the event will feature a selection of international and home-grown speakers representing some of the leading names in dentistry.

Among the speakers at this year’s BACD Conference will be Dr Mamaly Reshad, a prosthodontist with many years’ experience working both in the UK and abroad, and Dr Anas Aloum, an American Board Certified prosthodontist working in Dubai. In their speech to delegates, Drs Reshad & Aloum will explore the use of ceramic materials in cosmetic dentistry and will guide delegates on how to use ceramics for the best aesthetic outcomes.

“Right now there are tens of types of ceramics on the market,” said Dr Reshad. “They all have different thicknesses, colours and translucencies. This means they all have different properties. If you don’t know how to mix and match them and use them in the right place then they won’t look right, and in some cases you can even cause fractures.”

Dr Aloum added: “At the end of the presentation, the audience will know when, where and how to choose the best material for each clinical scenario. In our talk we will guide delegates on how to make the best use of ceramics by picking the right material for the clinical situation. By following our guidelines delegates will not only place ceramics that ‘look nice’, but importantly, they will also place ceramics that last.”

This will be the first year Dr Reshad and Dr Aloum have presented to the BACD Conference, and they are very much looking forward to the event.

“Having spent the last 10 years living and working in California I’ve been quite involved with the AACD in the US,” says Dr Reshad. “When BACD President Tif Qureshi invited us to attend this year’s event we really couldn’t say no! It’s a great opportunity to present in front of such a strong and prestigious organisation.

“A recurring theme of this year’s Conference will be bringing together different aspects of dentistry to show how you can be both ethical and conservative in your approach while also providing high quality aesthetic treatments. I think that’s a great thing because right now the way the industry’s going we are moving away from drilling teeth and becoming more conservative, so this makes the BACD Conference extremely relevant to the modern dental professional.

“The thinking is now all about the long term. You can easily marry aesthetics, longevity and biology together if you have the right concept and technique. You just need to understand that it’s a fine line you’re treading. You’ve really got to visualise the end right at the beginning of the treatment. If you do that you’re not going to get lost.”

With so many advances in modern dentistry the BACD Conference gives the ideal opportunity to learn from some of the leading names in their respective fields. Drs Reshad and Aloum, events such as the BACD Conference are a great way of sharing valuable lessons for the betterment of the profession:

“If you look at some approaches to dentistry, the patient comes in, you drill the teeth down and you stick whatever you want on top because the technician will have the space to do whatever he or she wants. The problem is the moment you drill the teeth down they become so weak the teeth won’t last. Though they might look nice to start with, in five-six years they’re going to have things falling off, teeth might crack away, there might be leaking and decay – all things that can be avoided with the right approach.

“Our talk goes hand in hand with the general theme of the Conference I think. We specifically talk about the material aspect and what materials are available to us today – what they can or cannot do. We use a simple decision-making system to show clinicians how they can easily decide on which material to use based on the desired result. For instance delegates will be able to follow the decision making process that shows them ‘if I use X ceramic I will get Y result’ or ‘if I compromise in A and B I will get benefits in C and D’.

There are all sorts of factors involved in the decision-making tree designed to help delegates decide what to use and when. We will look at the material, how to choose the material, how to handle the material and how to apply it properly to get the best aesthetic result. Whoever sits in this lecture will be able to understand and apply the most advanced thinking in dental ceramics that is available to us today.”

“There are all sorts of factors involved in the decision-making tree designed to help delegates decide what to do and when’

With such a strong line-up of internationally recognised speakers, the BACD’s 9th Annual Conference is already set to be the biggest and best Conference yet. With feedback from previous events including comments such as “Everything was amazing”, and “I really enjoyed the lectures and the content was excellent”, book your place today to ensure you don’t miss out one of the highlights of the year.

Contact info
For further information about the British Academy of Cosmetic Dentistry, call 0207 612 4166, fax 0207 182 7123, email suzy@bacd.com or visit www.bacd.com
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When was the last time you searched your name or practice name on Facebook? If it’s been a while, you may want to do so today. I’m beginning to see several unfortunate situations where practices have a multitude of business pages, community pages or places that the practice, dentist or manager is completely unaware of.

Even if you have no interest in Facebook, I encourage you to sit down with someone on your team who is Facebook-knowledgeable and search for your name and practice name. It’s important to understand that Facebook accounts, pages, or places represent you, your practice and your reputation.

In one situation, the dentist’s team had created a personal profile for the dentist, as well as several Facebook pages. The dentist was unaware of this and even worse the profile had begun to accumulate patients as friends. Needless to say, this alone creates a risky situation.

With regard to multiple pages or places, note that multiple Facebook properties can cannibalise your “official” page. In addition, you may have patients leaving comments (good or bad) on other pages or places that you are unaware of.

How are these pages created? Facebook auto-generates community pages, often in the case where someone has typed in your practice or doctor name as their “employer” in their personal profile. Ask your team members to ensure their employer information is linked to your “official” Facebook business page. You can recognise community Facebook pages by their unique profile images, often a briefcase represents a company or what looks like a plus sign within a circle for a dental or medical practice (note the generic logos of these auto-generated pages are often blue and white in colour).

Regarding Facebook places, these pages may be generated via the action of someone “checking in” at your practice via a mobile phone. This could be created by either a patient or team member. 

Rita Zamora discusses how Facebook pages can represent you, your practice and your reputation.
While Facebook can be fun and taken lightly, it's important to be well informed about this platform. Invest in team training or consulting when needed.

Remember that your online reputation, whether on Facebook or other online platforms, is your responsibility. Take time today to ensure your Facebook presence is representing you well.

Author info

Rita Zamora is an international social media marketing consultant and speaker. She and her team currently co-manage dozens of dental practice social media programs. Her clients are located across the United States and internationally. She has been published in many professional publications. Rita is also Honorary Vice President to the British Dental Practice Managers Association. Learn more at www.socialrelationshipmarketing.com or email ritazamora@gmail.com.

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Jan was presenting, and over coffee in the break we got a few nuggets of information that helped immediately. We liked Jan’s presentation style and decided to take the Dawson Modules. What that gave us was the ability to formalise and simplify the examination, diagnosis, planning and treatment stages. With both myself and Jim taking the course it made things so much easier to put the theory into practice.

The difference this course has made to my daily working practice has been fantastic, not only has it given me the ability and confidence to take on bigger and more complex cases but it has afforded me the opportunity to practise the kind of dentistry that I wanted to do. Dawson took a scary, often daunting subject, broke it down into understandable concepts and rebuilt it in a simple and logical fashion.

This kind of dentistry has increased patent referrals and uptake in treatment acceptance. I have a much greater level of satisfaction for myself in knowing that the treatment I have provided has been of the highest standard.

I cannot recommend the Core Curriculum of learning enough for any dentist or technician who wants to raise their standards and produce the kind of results that many practitioners can only dream of. Be careful though, once you’ve opened the box there’s no going back, but can you afford not to?

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When you arrive at your practice tomorrow, sign some blank cheques and give them to your front of house (FoH) team. Hand over your credit cards, car keys and iPad as well, if you wish. Now spend the day in your treatment room as usual. Do you feel any different from normal? Are you nervous that your money is being wasted, that practice profits are being squandered?

If your FoH team is not very much ‘on the ball’ and you’re not totally confident that they are you should feel similar nervousness every day – regardless of whether you physically hand them your valuable possessions. Your FoH staff are the portal which leads to practice profits, you shouldn’t overlook this otherwise you’re effectively handing them blank cheques.

They must treat every patient as though their wages depend on it, every enquiry as if it’s the only one for months. The knowledge and skills required for FoH (and all dental practice) staff to communicate brilliantly with patients and enquirers can be taught (I know, I do it) and learned (I know, I’ve seen it). What’s more difficult is instilling the passion, desire, drive, fervour (call it what you will) to perform brilliantly every day and every moment of every day.

There are, of course, ‘sticks’. Against this background of high unemployment, companies are finding it relatively easy to impose pay and conditions on workers that would have been unacceptable just a few years ago. But do you want staff constantly in fear of losing their job?

Let’s look at ‘carrots’ instead. One is a current buzzword, empowerment. If your staff (not just the FoH team) know the financial circumstances of your practice, they’ll appreciate how vital their role is in maintaining and (hopefully) increasing profits. Oh, sorry, did you fall off your chair at the thought of telling them how much you earn?

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g8% of patients would prefer their dentist to use the new dentaLase rather than a scalpel, retraction chord or electrosurge during treatments.
When you're sitting comfortably, please consider these arguments. Surprisingly, perhaps, it's not just accountants and book-keepers who understand figures. Your staff have loans, mortgages, credit cards and bank accounts. They make purchases daily and balance their own "books" - even if only on the back of an envelope. They appreciate that income minus expenditure equals profit (or loss).

They know if things are going well or not. They may have seen the "profits down, costs up" headline in dentistry publications or on websites when the latest NASDAL statistics were released earlier this year. They notice your car is now three years old. They notice the holiday brochures you now bring in for self-catering cottages in Derbyshire, not five-star safaris in Kenya. They know the size of your book and the size of cheques handed over by patients.

They know times are tough. They have spouses, partners, family members and friends who are out of work or cutting back. They watch the news, read newspapers, notice high street stores closing.

So, what am I suggesting - that you post the practice accounts on the staff notice-board? No, I'm not. That would probably break confidences in terms of who earns what and, in any case, different people will put different interpretations on the figures.

Instead, I suggest you sit down with your practice manager (and possibly your accountant) and come up with some meaningful performance indicators that can be discussed at monthly staff meetings. For example, on average, how many new patients do you need each month to replace the numbers that are leaving? What percentage of patients on the plan from 40 to 50, profits will be up by just over one per cent by the end of the year. That means recruiting X patients to the plan per month. If you currently have 1,864 patients on the plan and can increase this to 2,000 within two months, they'll be a reduction in the administration fee the practice is charged - resulting in £XXX extra profit.

Don't assume that these performance indicators will be what the Full team want! Suggest them at a team meeting and ask for feedback. They may prefer different measures, some of which could seem "off the wall". How often does the dental supplies representative call? Less frequently than previously could be a bad sign. How many packages are being sent to the lab? Fewer than in the past suggests a reduction in the more expensive treatments. It might simply be a question of monitoring how often the telephone rings.

If these sound silly, be aware that the definitive survey of commercial construction in London and a measure of future office supply is under-taken quarterly by Drivers Jonas Deloitte - somebody walks around with a clipboard counting cranes on the capital's skyline.

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They just aren’t interested

Alun Rees discusses some reasons as to why you may be ‘short of work’

H
g on the list of problems I hear when working with a prac-
tice owner is that they are “short of work”. If these are
just the ones that have chosen to work with me then it’s
reasonable to assume that the problem is widespread and,
from what I see, affects all sorts of practices whether ful-
ly NHS or 100 per cent private.

The little phrase “short of work” can cover a multitude of
reasons and my first job is to find out what it really
means. Being a coach means
is to find out what it really
means. Being a coach means

With the words “You only
have one chance to make a
good impression” ringing in
our ears we make sure that
every avenue of choice is ex-
plored for the new guests in
our practice.

But what of the “old” (now
there’s a derogatory word if
ever I heard one) patients?
Familiarity breeds contempt,
and dental practices don’t es-
cape from this; just because
you have seen the patient 10
times over a five or six-year
period and know them clini-
cally through their notes and
X-rays, doesn’t mean they
know you enough.

People will only do busi-
ness with people that
want it enough they will find
a familiar menu in a burger
joint: “I know what’s on it so I
don’t need to look.”

Get somebody else in the
practice to talk (but what I
really mean is listen) to them,
this isn’t the place to extol the
virtues of treatment coordina-
tors, care nurses or whatever
the fashion is calling them this
year, but their use as a lis-
tening point is proven beyond
doubt. Tell the patient about
recent advances in dentistry and
changes in the practice and
show them some of the work
that you have been doing
(by that I mean results or
before and after views, not
the blood and engineering pic-
tures that make some implan-
tologist websites need a view-
ing warning!)

Just because the word isn’t
appropriate for them doesn’t
mean that they can’t carry the
value of it out into the wide
world of their friends and
family...and you do tell them
how much you would value
it if they were to refer friends
and family don’t you?

“They won’t pay”
It was ever thus. I have been
around long enough to re-
member being told by my
first principal that when the
NHS patient charge rose from
£8 to £9 in 1981 that was the
drop in the ocean for the NHI
in 1995 my patients would leave me in
droves. Way wrong on both
counts. So what makes you
think they won’t pay? They say
they 1) don’t have the money
or 2) they don’t perceive the
value of it that is do you?

If it’s the former and they
want it enough they will find
a way, eventually and with your
help, to make it happen. If the
latter, then you and your team
need some training in the
communication methods that
you are using. Do you and they
truly believe that what you are
offering is the very best that
you can do, is the most appro-
appropriate and will enhance the
patient’s health and qual-
ity of life? If not then the pa-
tient will know, the team will
know and you will end up hat-
ing what you are doing.

Avoid discounting, how-
ever tempting it might be, it’s
a slippery slope that leads to
frustration and no practice or
individual can stay healthy by
trying to offer treatment to pa-
tients at a price that doesn’t
make a profit - it’s a simple
law of nature. A loss leader is
still a loss.

Finally are you trying too
hard to “sell”? People have an
aversion to being “sold” any-
thing but those same peo-
ple are eager to buy benefits.
They want to buy things that
make them happy; in dentistry
that might be the knowledge
that their teeth will last until
die, that their smile will give
them self confidence or that
their mouth is as healthy as
the rest of their body. Remember
whatever it is that they buy
they will only buy it from
people who they know, like,
and trust.

Still “short of work”?

‘Familiarity breeds contempt and dental
practices don’t escape from this; just be-
cause you know them clinically through
their notes and X-rays, doesn’t mean they
know you’

With the words “You only
have one chance to make a
good impression” ringing in
our ears we make sure that
every avenue of choice is ex-
plored for the new guests in
our practice.

but what of the “old” (now
there’s a derogatory word if
ever I heard one) patients?
Familiarity breeds contempt,
and dental practices don’t es-
cape from this; just because
you have seen the patient 10
times over a five or six-year
period and know them clini-
cally through their notes and
X-rays, doesn’t mean they
know you enough.

People will only do busi-
ness with people that
want it enough they will find
a familiar menu in a burger
joint: “I know what’s on it so I
don’t need to look.”

Get somebody else in the
practice to talk (but what I
really mean is listen) to them,
this isn’t the place to extol the
virtues of treatment coordina-
tors, care nurses or whatever
the fashion is calling them this
year, but their use as a lis-
tening point is proven beyond
doubt. Tell the patient about
recent advances in dentistry and
changes in the practice and
show them some of the work
that you have been doing
(by that I mean results or
before and after views, not
the blood and engineering pic-
tures that make some implan-
tologist websites need a view-
ing warning!)

Just because the word isn’t
appropriate for them doesn’t
mean that they can’t carry the
value of it out into the wide
world of their friends and
family...and you do tell them
how much you would value
it if they were to refer friends
and family don’t you?

“They won’t pay”
It was ever thus. I have been
around long enough to re-
member being told by my
first principal that when the
NHS patient charge rose from
£8 to £9 in 1981 that was the
drop in the ocean for the NHI
in 1995 my patients would leave me in
droves. Way wrong on both
counts. So what makes you
think they won’t pay? They say
they 1) don’t have the money
or 2) they don’t perceive the
value of it that is do you?

If it’s the former and they
want it enough they will find
a way, eventually and with your
help, to make it happen. If the
latter, then you and your team
need some training in the
communication methods that
you are using. Do you and they
truly believe that what you are
offering is the very best that
you can do, is the most appro-
appropriate and will enhance the
patient’s health and qual-
ity of life? If not then the pa-
tient will know, the team will
know and you will end up hat-
ing what you are doing.

Avoid discounting, how-
ever tempting it might be, it’s
a slippery slope that leads to
frustration and no practice or
individual can stay healthy by
trying to offer treatment to pa-
tients at a price that doesn’t
make a profit - it’s a simple
law of nature. A loss leader is
still a loss.

Finally are you trying too
hard to “sell”? People have an
aversion to being “sold” any-
thing but those same peo-
ple are eager to buy benefits.
They want to buy things that
make them happy; in dentistry
that might be the knowledge
that their teeth will last until
die, that their smile will give
them self confidence or that
their mouth is as healthy as
the rest of their body. Remember
whatever it is that they buy
they will only buy it from
people who they know, like,
and trust.

Still “short of work”?“
Improving practice performance
Amanda Atkin explains how to achieve excellent teamwork

You cannot put a price or value on the factors that drive team performance. This is because most people remain with an employer because of the quality of life and satisfaction they derive from being part of a rewarding and balanced working environment. Great dental practices owners recognise these attributes as 'X' factors of the business world and work to improve them.

Such factors include:
• Motivation – every dental team member is unique; therefore the motivation to perform better will be different for each person. You should identify what motivates each team member and provide opportunities that encourage their interest and performance.

‘Make sure you have a vision for how you want your practice to operate now and in the future. Communicate your vision to the team so that they are directing their energies toward a common goal’

• Setting goals – make sure you have a vision for how you want your practice to operate now and in the future. Communicate your vision to the team so that they are directing their energies toward a common goal. They will feel they are truly a part of the practice and this will enhance their performance.

• Praise – take advantage of large and small opportunities to praise your team for work well done. Your recognition of their good performance means a lot and it is important that you acknowledge their efforts.

• Feedback – be lavish with praise but selfish with criticism. Offer constructive feedback that makes your team feel respected and valued.

• Management – be available as a resource to your team. They should feel comfortable to approach you with questions and concerns and not feel as if they are imposing on your time. They should be able to depend upon you for guidance and as a model of what excellent performance is all about.

Don’t underestimate the value of having regular, well-run team meetings. These can pro-
vide the ideal opportunity to:

• Identify the risks of poor performance by individuals or the team
• Discuss the value and benefits of an open and accountable working environment
• Make everyone feel comfortable and confident about raising concerns to do with patient safety or other risks

• Commit to dealing with concerns fairly and professionally and protecting those who raise a genuine concern
• Understand the importance of a ‘safety valve’ when the usual channels of communications do not work, for whatever reason

Whatever the size of your practice team, it is unlikely that everyone will perform at his or her best all of the time. Frequently, below par performance will be brought to the attention of the practice manager or practice principal by another member of the team. If a practice team member raises a genuine concern about the performance of a colleague, they should be supported and protected from adverse consequences or reprisals.

For junior members especially, it is a brave step to confront such issues and they must know they are not at risk of losing their job. If they act in good faith, it should not matter if they are mistaken or if there is an innocent explanation for their concern. However, if someone maliciously makes an accusation known to be untrue, disciplinary action should be taken.

It is in the interests of all practices that concerns can be raised openly and dealt with fairly and professionally. Concerns may be raised verbally or in writing and the latter will sometimes be anonymous. Anonymous concerns can be difficult to investigate and it is impossible to protect the person who raised the concern and provide them with feedback.

The relevant individual(s) should be interviewed to assess what action, if any, should be taken. This could result in an informal review of their performance or a more detailed investigation of the circumstances that led to the concern being raised. It is imperative that a record is kept of each stage of the investigation and that individuals are given as much feedback as possible, as and when appropriate.

Where poor performance is identified and personal development may be needed, an appraisal interview should be conducted. This is a positive process and is not part of a disciplinary procedure. However, areas where the employ-
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It’s a small world after all

Mhari Coxon examines the evidence and best practice

So, I am back and nearly recovered from an amazing adventure to Europaero 7 in Vienna. Believe it or not this was work for me. It was a chance to spend time with my colleagues and the other hygienists around Europe who work for Philips Oral Healthcare as professional relations manager and to meet other colleagues from the sales and marketing teams we work alongside. It was also an opportunity to watch many of the key opinion leaders and drivers from the UK present too. And believe me they did us proud. It is great to see our professors being held in such high regard by our peers in different countries. The UK as a research base is up there with the best of them.

What was also amazing was seeing so many people from other countries speak. In particular for me Monique Stokman was wonderful. She is a hygienist from the Netherlands who has a PhD and is also a trained epidemiologist. She presented such a great lecture on oral manifestations and lesions and so happy to share her knowledge with others.

Mark Ide and Nicola West presented after with a great look at evidence base and sensitivity. It was incredibly insightful.

‘Making yourself look at what you are doing day to day and justifying it is important to ensure we are practising best practice in our clinical lives’

There was a good healthy dollop of controversy, with some showing that the evidence for calculus removal is thin at best, and others causing an uprising with the systematic review that shows flossing is not effective in preventing dental disease unless carried out by a professional. One delegate could not control herself and said – so I can’t take the calculus or teach them to floss...what exactly is my role then? And that is exactly the point.

Before you all get typing to the editor to complain:
1 These are not my views - I am merely reporting to you
2 These lectures are made to get a reaction, good or bad

Making yourself look at what you are doing day to day and justifying it is important to ensure we are practicing best practice in our clinical lives. We have to piece together the puzzle using the scientific evidence, clinical experience, the tools available to us and minding the patient’s wishes. No one solution fits all and it is good to have your beliefs challenged in our profession. Doing the same thing and wishing it is important to ensure we are practising best practice.

The other thing that overwhelmed me was the sheer number of academic posters presented. Yes, there were a large number of academic bodies responsible for these, but equally there were many from regular general practice clinicians too. This simple piece of analysis, either a small new piece of research, a review of current research on a topic, or a case study placed as a poster gave access to all sorts of conversations and in-

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Go Direct
To Enjoy Complete Confidence
1. Make your title catchy – short, sharp, and effective

2. Put the title in a big heading

3. Make sure your abstract is concise and matches the one under your conclusion

4. Put your conclusion under the title

5. Have A4 copies of the presentation available for people to take and digest before the conference, you know how busy these things can be.

6. Make sure you imprint your personality in your poster – papers have to be dry and correct, posters less so.

7. Put a picture of yourself and a contact email or address on your poster. You never know who is looking and what opportunities it could bring.

8. If it is being judged, read and re-read the judging criteria as this varies from group to group.

9. Make it relevant to people.

10. Make it look good and don’t be stingy with the figures, graphs and pictures.

And so, here are my simple top tips to putting a poster presentation together. I intend to present three in the next year as my own personal target. I shall publish them in this column too.

1. Make your title catchy – short, sharp, and effective

2. Put the title in a big heading banner so they can see it from distance

3. Make sure your abstract is concise and matches the one you submitted originally

4. Put your conclusion under your title and again at the bottom in order. This will draw the reader in (Thanks to Martin Ashley for that top tip – looking out for your regular Dental Dealer.

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Reconstruction of an Atrophic maxilla using six dental implants

Dr Avik Dandapat presents a case presentation

Presenting complaint: Mrs X attended our clinic in 2011. She was a lady in her 70’s whom had recently lost the upper retainer teeth on her partial chrome denture. She was extremely distressed with her new full upper denture and wanted a more long term solution.

History of complaint

Over the last five years she had worn a partial chrome denture retained by three teeth – these teeth had progressively deteriorated and were recently extracted by her GDP; they had added to the existing chrome denture making a very bulky and heavy upper full denture.

Medical history

Apart from suffering from Bell’s palsy and having a distinct lack of facial muscular function related to the left side, the medical history was unremarkable.

On examination

Extra Oral: TMJ appeared sound and no pathology detected on examination

Lymph nodes: Clear

Muscles of mastication: Appeared normal and with functional limits

Facial muscles: Exhibited atrophy on the left side and the reduced function of the following muscles

Depressor Anguli Oris
Mentalis:
Zygomaticus Major and Minor

The most distinct element we observed was when the patient smiled only the right side of the muscles used in smiling were functional. However the patient was aware of this and understood that we would work in harmony with the current Neuromuscular function.

There was also an obvious loss of maxillary bone and support to the soft tissues and an decreased OVD was also present. All of these issues were corrected by the use of a well-constructed full denture replacing these areas and supporting the soft tissue.

Intra-Oral examination

Soft tissues were clear and free from any pathological signs

Dental Examination: Lower dentition was stable, Oral hygiene was good and BPE no more than 1. Heavily restored molars and another eight remaining teeth present.

On discussion

After the examination we discussed with the patient the various forms of treatment available and also potential levels of investment required for these options listed below:

1. A Complete upper denture
2. A Upper denture retained by four implants and
splayed with a bar

3. A screw retained hybrid bridge on six dental implants replacing facial support and utilising prosthetic replacement of tissue support but with no grafting or sinus work

4. A full hard and soft tissue reconstruction with hip grafting and up to eight dental implants and a cement retained bridge

After discussion the patient opted for the screw retained prosthesis based on six dental implants and a cement retained bridge

Initial special tests carried out

1. Impressions
2. Face bow record
3. Photo graphs
4. Study models and new temporary denture made to correct OVD, bite and to evaluate tissue support required
5. CT Scans of upper jaw with correct prosthetics in position to study hard tissue relationship to correct tooth position. And to ascertain degree of bone volume/density present. (Fig 1)

Surgical considerations

In such cases my approach is firstly to ascertain the corridor of bone that lies between the medial wall of the maxillary sinus and its position. In order to gain this information one must be familiar with the manipulation of the CT scan image.

Often RAW data is needed to draw the correct cross sectional curve along the desired axis of implant placement. Pre-formatted scans on some software platforms may not allow the operator to manipulate this curve. The corridor of bone exists in most patients and can accommodate a longer implant fixture whereby the cervical implant head can lie distal to the apex of the implant hence negating the need of a sinus graft hence the implant is placed more distal in the arch. For inexperienced implant dentists a surgical guide to triangulate this position exactly is an absolute requirement. In practice this area can be marked out as the zygoma has a distinct curvature on exposure of the maxillary jaw.

Where the curvature or bulbosity starts is usually the position of the medial wall of the maxillary sinus; by using osseotomes, drills and reconfirming this position can be achieved in two ways. Perforation into the sinus via the lateral wall and palpation of the medial wall and mark points at 5.6,11mm - or by intra oral X-rays and check the ostotomy site for perforations during surgery. I recognise these are not ever as accurate as a CT guided stent and the author would always recommend a bone supported stent in these cases as opposed to a soft tissue supported guide.

The other consideration is the space along the horizontal plane to place four or up to six implants. Although there is a lot of literature relating to “all on four” technique the author prefers, where possible, to place six implants simply because if a failure occurs (current accepted two in every 100 or two per cent will fail) there is a backup of still making a final prosthesis on five or four implants if equally spread squared arch form.

Healing

After placement of the six dental implants a post-operative OPG was taken and the denture relined with soft reline material over the healing abutments placed. In this case I opted for transmucosal healing as we achieved high levels of primary stability on all the implants. In this case the distal implant on the right side entered the sinus space and we performed a summers lift. The patient was allowed to heal for a period of five months with the temporary relined denture.

Prosthetic protocol

After the healing period all implants were checked using a periostest to measure osseointegration. The readings were as follows:

- UR3 Implant = -7.0
- UR2 Implant = -6.9
- UR1 Implant = -5.0
- UL1 Implant = -8.0
- UL2 Implant = -5.0
- UL5 Implant = -6.0

All implants had osseointegrated well and showed no pain, mobility, infection, loss of bone or exposed titanium intra orally.

We then carried out the following sequence for restoration:

1. Fixture head impressions linked in a special tray. Using

Often RAW data is needed to draw the correct cross sectional curve along the desired axis of implant placement
Fig 3f floss and GC pattern resin to link impression screws

2. Try-In of the multi-angled screw retained abutments with lab made positional jig to parallel the abutments

3. New impression of the multi-angled abutments and x-ray verification of correct seating. Again these are linked using GC pattern resin and also a verification jig made by the lab to verify accuracy of model prior to metal framework construction

4. The denture was relined again over the new abutments

5. Metal framework try-in - screw retained and checked for passive fit using the Sheffield test. Re-verification of the midline, re-bite registration, a new face-bow record, intra-oral and extra oral photography to give the technician sufficient data to make the teeth, and an idea of degree of soft tissue support was required

6. A Hybrid Acrylic-Composite prosthesis was then placed and checked intra-orally for aesthetics, lip support and bite. I had decided to provide a balanced articulation type of the occlusal scheme

7. Final fixation of the prosthesis and detailed written and oral instruction given to the patient. One must consider cleanable spaces and your lab must understand this and allow for the patient to be able to clean the spaces underneath the area around the implant heads. We provide a waterpik and review the hygiene habits at three, six and 12 months post placement

8. The screw holes were then filled with cotton wool followed by flowable composite

9. Post-operative follow ups at three, six and 12 months with regular dental checks on lower dentition and follow-up x-rays yearly to determine bone levels after baseline OPG were taken.

**Author info**

Dr Avik Dandapat qualified from Birmingham University then went on to complete his MFGDP(UK), the Diploma and Advanced certificate in dental implantology from The Royal College of Surgeons of England in 2006 in Cohort 3 of the course. Avik has been an ADI mentor for the past eight years and a mentor for both Ankylos and DIO Implant systems. Avik actively lectures at various FGDP(UK), ADI members forum, Ankylos implant members forum and is active ADI study club lecturer in dental implantology. At present Avik runs two practices in Reading, Berkshire and 121 Harley Street, London and his focus is solely on implant and reconstructive dentistry. Currently Avik is studying toward his MSc in Implant dentistry from Manchester University. Thanks to my Lab - Medimatch UK - www.medimatch.co.uk and the Dental Implant Manufacturer: DIO Implants
The Dental Wellness Trust: helping orphans in Croatia

The Dental Wellness Trust recently travelled to Croatia to visit two orphanages and deliver much-needed oral hygiene supplies and education to underprivileged children. Diane Rochford, a hygienist and member of the British Dental Bleaching Society, was among the DWT team who made the journey.

“‘It’s quite basic - there’s no comparison between their unit and the practices we’re used to in the UK’”

“I went to Nazorova orphanage in Zagreb, which was for about 70 children, ranging from babies to about 12 or 15 years of age,” Diane recalls. “It also had facilities for some of the mums if they needed to be there. It sounds a bit funny because you think ‘orphanage - no parents’ but if the mums are subject to abuse from husbands, or are living in poverty, it means they can stay there with their babies.”

The orphanage has a dental unit and the dentistry is contracted by Zagreb University. “It’s quite basic - there’s no comparison between their unit and the practices that we’re used to in the UK,” says Diane. “Although the lady who treats the children there also does dentistry for special needs children.”

The Dental Wellness Trust brought some toothbrushes while Dr Hrvoje Starcevic, the trip organiser, had received donations from Croatian businesses. These gifts included toothpaste and protective caps for the toothbrush heads. “We also took some models - model teeth - and used them to demonstrate technique to the children because obviously they don’t speak English and we don’t speak Croatian!” says Diane. “It was quite surprising how quickly they picked it up - they’d put the brushes in their mouths and started giving circles straight away. It was really fun.”

Some of the children had reasonably good teeth, but others weren’t so lucky. “There were a couple that I was helping and they had a lot of decay,” Diane says. “Maybe because they weren’t brushing, or maybe because of their diet - I don’t know how long they’d been at the orphanage or what their history was. But they were probably about six or seven years old and their teeth were quite grossly decayed.”

Diane enjoyed the visit, which was her first experience of charity activity of this kind. “The children were intrigued and quite excited,” she says. “They thought it was a lot of fun and a bit different. No one was frightened. Some of them were a bit shy to start with, as most children would be, but generally once they got going it was absolutely fine. They were quite excited, and dived for the brushes and the toothpaste! We took five sets of teeth models and the children were practically snatch ing them off us because they wanted to play with them, so they were really good. There were a lot of smiles on faces!”

During the visit, Diane was accompanied by Dr Linda Greenwall, founder of the DWT and Chair of the BDBS, as well as Dr Starcevic and some members of staff from the orphanage. The Trust also visited a second orphanage in Croatia called Dom za odgoj i mladezi, which is located in Zadar. “I didn’t go to that one, but Linda did,” says Diane. “It was an all-boys orphanage with children ranging from seven to 18 years of age and a number of them had suffered abuse during their lives.”

Initially Diane had some concerns about making the trip, thinking that she might find it quite emotional. On the contrary, she says, “You feel that you’re doing good and it’s a nice feeling. It’s great to be able to help in this way and it’s important for people like us to get involved. There are a lot of projects and a lot of people in need. There’s a lot more to be done - more good that needs to be done.”

Dr Greenwall is passionate about the work of the Dental Wellness Trust and is continuing to make a difference to the lives of others. “Linda already knew Dr Starcevic because of the BDBS’s involvement with his annual Aesthetic Dental Moment Congress in Croatia, teaching dental bleaching techniques,” says Diane. “Education really is essential, whether it’s for maintaining high standards of dentistry or helping children to clean their teeth properly for the first time.”

“We’ll also be looking to find ways for the DWT to follow up with the orpanhanges,” she continues, “including the possibility of Dr Starcevic taking toothbrushes and toothpaste to them on a regular basis. We do a lot of follow up in our day-to-day work in dentistry - we place a lot of emphasis on that. It’s all very well to go into places like these orphanages, but what happens after you leave? And we’re going to need more help from the industry to make sure that follow-up happens.”

Contact info
If you would like to volunteer or if you are a company wanting to demonstrate corporate responsibility by making a donation or gifts in kind, please visit www.dentalwellnesstrust.org or call 020 7207 7070 or email info@dentalwellnesstrust.org.

The DWT visit the orphanage

The children learn about oral health

Handing out goodies like toothbrushes and toothpaste
An inspirational day for all
A look back at James Hull Associates’ annual conference

The Board Members of James Hull Associates held the second Annual Clinical Conference in April 2012, at the Royal Garden Hotel in Kensington, London. The day commenced with a warm welcome from Board Member Steve Byfield, who introduced all those in attendance to the exciting day ahead. CEO Bryan Magrath then gave a complete overview of JHA, showing the progress of the corporate so far, and how we hope to improve in the future.

A surprise appearance from motivational speaker Ashley Latter provided an excellent kick-start to the lectures, looking at communication between the professional and the patient, and how this can affect the patient’s decisions. Ashley had the audience working in pairs to put his ideas into practice, concentrating on showing genuine interest in the patient to gain their trust and put them at ease.

The conference then divided into two programmes – Treatment Planning and Periodontal Care – enabling practitioners to attend lectures relevant to their personal role in practice. The Treatment Planning programme began with Dr Trevor Ferguson continuing the communication theme with his presentation entitled “my patients can’t afford that…” His speech was based on how clinicians can discuss treatment options and fees with their patients, without feeling uncomfortable. Dr Dermot McNulty took over the speaking to further expand on this point, speaking about how we can develop the complex communication skills required in the modern profession.

In the afternoon, Dr Nicola Price Lecerf took to the stage, to speak about treatment planning in the NHS. She discussed the delicate issues of gaining patients’ trust and offering the best procedure for them, while balancing the financial cost of the long and sometimes difficult process. Nicola gave several amusing anecdotes from her personal experience to illustrate this.

In the adjacent suite, the Periodontal Care programme was opened by dental hygienists Sharon Tozer and Ann Gilbert. A highly enthusiastic Sharon was quick to establish prevention as the best way to achieve excellence in hygiene care. Also discussing the importance of communication, Sharon highlighted that professionals have a duty to listen to their patients in order to offer the best possible service. She went on the show the changes in the hygienist’s role over the years, and how vital it is that hygienists work with the dentists and other members of the dental team, to achieve the best results for the patient. Ann Gilbert reiterated this point, and continued on to...
discuss the importance of CQC training for compliance and a high standard of patient care. She also spoke about the idea of self-employed professionals working as a micro-business, utilising their profits.

Dr Maggie Jackson took over the lectures after a short coffee break, speaking about the issues associated with dental implants. Presenting case study images, Maggie explored past and current techniques in periodontal practice, and achieve a long-lasting solution for the problems caused by bone loss. After lunch Dr David Cohen led on from this with his lecture entitled “Differential diagnosis in peri-endo lesions”, considering how to distinguish between cases that need periodontal or endodontic attention. Again using case studies to accompany his explanations, David explored the overlaps in the classification of different diseases, and how the patient’s symptoms don’t always indicate the correct problem.

The last lecture of the Periodontal Care programme brought Dr Geoff Pullen to the podium, discussing the need to consider cases strategically and realistically. His message was to tackle treatments systematically, be completely honest with the patient and most of all, don’t worry!

At the end of the day, practitioners had the opportunity to put their burning questions to the speakers, and gain additional answers and information where required.

‘At the end of the day, practitioners had the opportunity to put their burning questions to the speakers, and gain additional answers and information where required.’

The Clinical Conference was designed to aid all members of JHA dental team in providing top quality care to all their patients. If you attended the day we hope you gained all the inspiration and motivation to raise the standard of service you offer, and we look forward to seeing you again next year.

Many thanks to all those who put time and effort into making this such a successful event!

Contact info
For more information about James Hull Associates’ dental practices call 02920 772 930 or visit www.jameshull.co.uk

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6th July 2012
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Royal College of Surgeons of England

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Heeulit Lloyd
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The day will cover:

- Information on vulnerability, signs of abuse and neglect and action to take in cases of suspected abuse.
- Oral Health issues for vulnerable people
- Care Planning Commission
  - Outcome 1: Respecting and involving people who use services
  - Outcome 2: Consent to care and treatment
  - Outcome 4: Care and welfare of people who use services
- Outcome 7: Safeguarding people who use services from abuse

- GDC statement on Child Protection and Vulnerable Adults, (expansion of standards for Dental Professionals principle 1.8)
- “Delivering Better Oral Health” for older patients

At the end of the day, practitioners had the opportunity to put their burning questions to the speakers, and gain additional answers and information where required. Attendees then had a couple of hours to rest, refresh and dress up for the evening gala dinner and awards.

Everyone returned to the Royal Garden Hotel dressed in their finest, and were greeted by a champagne reception. A lavish three-course meal ensued, with the JHA awards following. The awards were presented by Derek Turner COO, and the winners were as follows:

- Best Practice of the Year – Elgin
- Practice Manager of the Year – Claire Mitchell
- Receptionist / Coordinator of the Year – Carolyn Hayes
- Dental Nurse of the Year – Gemma Tomkinson
- Dentist of the Year – Stephen Davies
- Hygienist / Therapist of the Year – Hilary Brown
- Best Support Employee of the Year – Rhys Jones (H&S at the support centre) and Daniel Pearl (ICT service desk team leader)

A huge congratulations to all!

The Clinical Conference was designed to aid all members of JHA dental team in providing top quality care to all their patients. If you attended the day we hope you gained all the inspiration and motivation to raise the standard of service you offer, and we look forward to seeing you again next year.

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Debbie Lewis

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The day will cover:

- Information on vulnerability, signs of abuse and neglect and action to take in cases of suspected abuse.
- Oral Health issues for vulnerable people
- Care Planning Commission
  - Outcome 1: Respecting and involving people who use services
  - Outcome 2: Consent to care and treatment
  - Outcome 4: Care and welfare of people who use services
- Outcome 7: Safeguarding people who use services from abuse

- GDC statement on Child Protection and Vulnerable Adults, (expansion of standards for Dental Professionals principle 1.8)
- “Delivering Better Oral Health” for older patients

At the end of the day, practitioners had the opportunity to put their burning questions to the speakers, and gain additional answers and information where required. Attendees then had a couple of hours to rest, refresh and dress up for the evening gala dinner and awards.

Everyone returned to the Royal Garden Hotel dressed in their finest, and were greeted by a champagne reception. A lavish three-course meal ensued, with the JHA awards following. The awards were presented by Derek Turner COO, and the winners were as follows:

- Best Practice of the Year – Elgin
- Practice Manager of the Year – Claire Mitchell
- Receptionist / Coordinator of the Year – Carolyn Hayes
- Dental Nurse of the Year – Gemma Tomkinson
- Dentist of the Year – Stephen Davies
- Hygienist / Therapist of the Year – Hilary Brown
- Best Support Employee of the Year – Rhys Jones (H&S at the support centre) and Daniel Pearl (ICT service desk team leader)

A huge congratulations to all!

The Clinical Conference was designed to aid all members of JHA dental team in providing top quality care to all their patients. If you attended the day we hope you gained all the inspiration and motivation to raise the standard of service you offer, and we look forward to seeing you again next year.

Many thanks to all those who put time and effort into making this such a successful event!

Contact info
For more information about James Hull Associates’ dental practices call 02920 772 930 or visit www.jameshull.co.uk
To learn more about Pricewatch and The Dental Directory’s fantastic range of infection control products, speak to your Dental Directory preferred dealer.

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Spring has sprung with 20 per cent discount on Grahamade Gardner.

Grahamade Gardner is celebrating the onset of spring by offering a very attractive 20 per cent discount on the Virtual Compliance Office (VCO) promotion which will be running for the next three months.

For more information please contact Victoria Banks, Programme Administrator, on 020 7950 1251, email v.banks@ucleast.co.uk or visit www.ucleast.dept/spd.

The Dental Directory is one of the best-known names in the dental directory business, but it has new, exciting products offering an alternative to traditional print. The Dental Directory is launching its latest Pricewatch catalogue from 1 July. The discount spotlight will be shining on a range of well-known brands to bring savings to practices around the UK.

Coltene, GC, Septodont, Sybron, DENTSPLY, Heine and Aalbach products will all feature in the catalogue, along with other big name products and The Dental Directory’s Unicord and Classic ranges.

To learn more about Pricewatch and The Dental Directory’s fantastic range of infection control products, speak to your Dental Directory preferred dealer.

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Group Editor
Lisa Townshend
Tel: 020 7400 8870
Lisa@dentaltribuneuk.com

Publisher
Joe Appu
Tel: 020 7400 8880
Joe@dentaltribuneuk.com

Design & Production
Ellen Natle
Tel: 020 7400 8870
ellen@dentaltribuneuk.com

Design & Production
Rachel Harrison
Tel: 020 7400 8851
rachel@dentaltribuneuk.com

Dental Tribune UK Ltd
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Course Announcement

Multi-System Implantology Certificate Course at Trafford General Hospital, Manchester

Recognised by University of Salford

Applications are invited for a hospital based “certificate” year course (one day a month) starting on 7th November 2012.

This unbiased multi-system clinical course in its 20th year is designed to teach practitioners how to incorporate implant treatment to their practices safely with the back up of three most documented implant systems according to the FGDP/GDC Training Guidelines: Astra, Nobel Biocare and ITI/Straumann, the market leaders in implantology for their unique indications, predictability, research and documentation, are taught step-by-step during the year course. Each participant will have the opportunity to place implants in their patients under supervision. The course has been granted approval by the FGDP (UK) for accreditation towards its Career Pathway.

Course Contents and Benefit
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- Certification for three major implant systems and GBR techniques
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- Become an ITI member (with complimentary 1st year’s subscription) (worth £20)
- Receive complimentary editions of five ITI Treatment Guides (worth £150)

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