It’s not all white!
Whitening salon offers raises registrant issue and patient safety

Following an advertisement placed recently on Groupon by Star-smile, a company who are offering whitening treatments that are performed by non-dental professionals, the question of patient safety has once again been brought into the limelight.

On their site Star-smile claim they “offer the same professional service and treatment as a dentist but at a fraction of the cost,” they also claim to provide a health check of the patients teeth and provide aftercare; however, they are neither dentists nor dental professionals. During the treatment video that is displayed on the Star-smile website, the ‘technicians’ are constantly in contact with the teeth and mouth; however, although stated as part of their procedure, there was no ‘health check’ either before or after treatment.

In addition to this, Star-smile also claimed how one of the ‘highlights’ of the treatment was that the procedure and the technology were recommended by the British Dental Association. Further problems begin to emerge as Star-smile make it clear in the FAQ section of its website that tooth whitening is not provided by GDC registrants, saying: “We are not dentists, our teeth whitening procedure is a cosmetic treatment carried out by fully-trained Star-smile technicians.”

In light of the advertisement the BDA wrote to the General Dental Council (GDC) to ask them to take action to ensure patient safety is upheld.

Stuart Johnson, Chair of the BDA’s Representative Body said: “This advert is very concerning in that it encourages the public to get tooth whitening done by non-dental professionals. The GDC’s recent campaign sought to warn the public against tooth whitening being conducted illegally by unregulated individuals, and highlighted the fact that the procedure should only be undertaken by a dentist.

The BDA wants patients to feel completely safe and know that they are being treated by a registered professional who is fully trained to undertake this procedure. We’ve called on the GDC to take action on this matter!

The law currently states that under the Dentists Act 1984 it is an offence for non-registrants to practise or be prepared to practise dentistry. However, it has been noted by the GDC that several companies which produce tooth whitening products maintain that: since tooth whitening products are covered by the European Council Directive on Cosmetic Products 76/768/EEC, their agents are carrying out a cosmetic procedure and not practising dentistry.

A statement from the GDC on non-registrants who carry out tooth whitening stated: The Council is aware and concerned that tooth whitening is being carried out in a growing number of salons, clinics and shopping centres by non-GDC registrants and indeed is being offered to people in their own homes. It is also aware that the standard of treatment being offered is far below that which is required by its registrants. For some time the Council has been exploring different approaches to tackling this problem with a view to ensuring that such procedures are only carried out by registered individuals and in suitable locations. Given the legal complexities involved, however, this has been a lengthy process.

Dental Tribune was unable to contact Starsmile for their take on the issue.

We are not dentists, our teeth whitening procedure is a cosmetic treatment carried out by fully-trained Star-smile technicians’


Give your views on CQC

The government is seeking the public’s views on a number of proposed changes to regulations for the Care Quality Commission registration system, which has been operated by the CQC, has highlighted several issues with regards to the regulations. Proposed changes to the regulations have not functioned as intended initially, whilst others have had a lack of clarity or impose an “unjustified burden” on providers. In seeking the views of the public and working bodies, it also asks respondents to identify any further issues that should be taken into consideration as part of a wider review which will begin later this year.

The consultation document, which is available online, states: “The proposals include changes to both the regulation of healthcare and adult social care services that, subject to consultation responses and the Parliamentary process, could be made swiftly and that we plan to start to implement in 2012.”

The 56-page proposal is followed by an eight page question-listing bodies, asking respondents to identify any further issues that should be taken into consideration as part of a wider review which will begin later this year.

The initial review of the regulations aims to:

(a) Consider opportunities for streamlining the existing requirements, reducing the burden of regulation
(b) Consider issues that have emerged with the practical operation of the registration system by CQC
(c) Correct oversights in the drafting of the regulations and possible unintended interpretations of the regulations that have come to light following implementation
(d) Tackle issues it was not possible to resolve in advance of the regulations being made
(e) Ensure consistency across the regulatory system
(f) Ensure that the requirement to register appropriately reflects the risks to those receiving care

The proposal also states that the government needs to have the relevant skills and experience, rather than those being held by each individual partner. The proposal will remove a regulatory burden on providers and allow business flexibility.”

In direct response to dentistry, the consultation document proposes to make the regulations clearer with regards to the terms Medical and/or dental services. As the proposal states: the regulations are not consistent in the use of the terms “medical” and “dental” and whether or not the term medical includes dental. We propose to amend the regulations to make this clearer.

The consultation document and the questionnaire can be found at www.dh.gov.uk/en/Consultations/LiveConsultations/DH_126222

£100,000 helps deprived areas

Twelve organisations have successfully bid for funding from a new charitable fund which will help nearly 20,000 people to improve their oral health.

The British Dental Health Foundation established the ‘Oral Health Education Project’ earlier this year to support the work of local oral health promotion teams across the UK and the project has been made possible by a generous charitable donation of £100,000 from the ‘Wrigley Tooth Fairy Fund’.

The twelve organisations which will receive funding are: NHS Nottingham City will start a project to develop oral health education materials and guidance for primary school teachers and pupils in Key Stage One.

Buckinghamshire Primary Dental Service (Milton Keynes Primary Care Trust) will begin a project to support elderly and vulnerable in-patients five Buckinghamshire hospitals whose oral health is affected by their medical conditions such as strokes and head injuries.

NHS East London and the City (Hackney, Newham and Tower Hamlets) project targets parents of children under the age of one to reduce dental decay and increase the use of dental services.

South Tyneside NHS Foundation Trust will conduct a series of week-long Dental Health Road-shows, funded by the Wrigley Tooth Fairy Fund, for more than 1,000 children, carers, parents, guardians and teachers in special schools to a local dental practice, and fund pupils to help integrate oral health into the school curriculum. The project will also help to link all schools to a local dental practice and support teachers at Teeside University Dental School to gain training and work experience during the project.

Northern Devon Healthcare NHS Trust’s project seeks to improve oral health in Ilfracombe, Devon, which has only one NHS Dental Practice and limited current oral health education and promotion activity.

Peninsula Dental School supported by NHS Plymouth, will train up 24 ‘Oral Health Ambassadors’ to work in children centres across Plymouth.

Heart of England NHS Foundation Trust will begin a project which will help to raise the profile and promote the importance of good oral health in a deprived area of North Solihull called Smiths Wood. The area currently does not have a dental practice, and funding from the Wrigley Tooth Fairy Fund will help to create a regular and sustained presence in the ward by training volunteers, developing resources for Health Visitors and encouraging access to dental services.

The funding will also help NHS Sheffield increase the long-term use of dental services by children in Sheffield, allowing them to help train up to 40 health visitors and provide resources to help offer assessments to children at the age of one, two and three. Children in four deprived areas of Sheffield will be provided with vouchers to encourage visits to dentists.

A community project by Healthy Living Network Leeds and supported by NHS Leeds, will help educate 600 children and their families in Leeds about good oral health. The project is supported by volunteers and the Wrigley Tooth Fairy Fund will enable the organisation to continue their charitable work with 60 children’s centres across the city.

US non-dentists ‘illegally blocked from whitening’

According to a recent report, a dental board in North Carolina sent 42 letters instructing non-den-tists to stop providing teeth whitening services, telling them that they were practising dentistry illegally.

The actions of the Dental Board were taken to court and a decision was made by Chief Administrative Law Judge D Michael Chappell that the North Carolina Board of Dental Examiners had in fact violated the law by trying to block non-dentists in the state from providing teeth-whitening goods or services.

Teeth whitening services are offered by dentists in offices and as home kits, whereas non-dentists tend to offer the treatment in salons, shopping centres and retail stores.

In the original complaint, which was made in 2010, it was alleged that there were at least six cases when the Dental Board threatened or discouraged non-dentists who were considering opening teeth-whitening businesses.

The complaint also alleged that the Dental Board sent at least 42 letters instructing non-dentists – mall owners and property management companies – stating that teeth-whitening services offered in malls are illegal.

One report stated how it was alleged that the Dental Board’s actions reduced the availability of teeth-whitening services in North Carolina, and that the Dental Board’s conduct constituted an anticompetitive conspiracy among the dentists on the Dental Board, in violation of federal law.

It was ruled that the Dental Board did not have the authority to order non-dentists to discontinue providing teeth whitening goods or services.

As a result of their actions they have been ordered to send follow-up letters to the non-dentists and barred from engaging in the same anti-competitive conduct in the future.

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Editorial comment

It is so hard to believe we are in the summer already!

And yes, although the weather recently makes that statement seem a little amusing, you cannot deny the Gregorian calendar and it is telling me categorically that it is summer.

With that in mind, Dental Tribune will be taking a little break while we kick back, sip a little something cool and tall and watch the kids dip their toes in the clear waters of some golden beach. Ok, I’ll be in the Isle of Wight, but I do have a very vivid imagination!

We will be back in September with some great features lined up, including a look at a man who had a powerful influence on how dentistry in the UK developed, especially in the field of Max-Fac surgery.

In addition, look out for an interview with award winning author Michael Young about dentistry, writing and our old pal Genghis.

See you in September.

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September is Colgate Oral Health Month

At the British Dental Conference and exhibition held in Manchester, Colgate, in partnership with the British Dental Association, announced the 2011 Colgate Oral Health Month initiative. The theme for 2011 is focusing on ‘The Importance of a Good Oral Care Regime for a Healthy Mouth’.

Research carried out following Colgate Oral Health Month 2010, showed that 90 per cent of respondents from participating dental practices rated the Colgate Oral Health Month initiative to be very good or quite good. These recipients also considered the Colgate Oral Health Month practice packs to be ‘very important’ to the overall initiative.

Colgate Oral Health Month 2011 will run throughout the month of September, and Colgate is once again looking to partner with the dental profession by providing Colgate Oral Health Month 2011 practice packs. These practice packs will contain educational materials, motivational stickers, patient samples and materials to help dental teams drive the awareness of the initiative within their own practice through creating practice displays.

‘Patients Perception and Understanding of Prevention’ will be the theme of the Colgate Oral Health Month 2011 verifiable CPD programme. To participate, visit www.colgateprofessional.co.uk from 1st September 2011 and download this interactive programme.

Register Now!

Dental practices who participated during 2010 will automatically receive this year’s practice pack by the end of August. If your practice has not participated before, or your practice details have changed, please contact the Colgate Oral Health Month registration line on 0161 665 5881 by 19th August 2011. Please note that one pack per practice will be delivered at the end of August, subject to availability.

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The entire dental team can get involved in the 2011 campaign focusing on ‘The Importance of a Good Oral Care Regime for a Healthy Mouth’.

Practice packs contain educational materials, motivational stickers, patient samples and materials to enable dental teams to create their own display to drive awareness of the Colgate Oral Health Month Campaign.

The 2011 CPD programme ‘Patients’ Perception and Understanding of Prevention’ providing verifiable CPD will be available to download by visiting www.colgateprofessional.co.uk from 1st September 2011.

If your practice has not previously been involved in Colgate Oral Health Month, please call 0161 665 5881 to register by 19th August 2011.

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Do you have an opinion or something to say on any Dental Tribune UK article? Or would you like to write your own opinion for our guest comment page? If so, don’t hesitate to write to: The Editor, Dental Tribune UK Ltd, 4th Floor, Treasure House, 19-21 Hatton Garden, London, EC1 8BA. Or email: lisa@dentaltribuneuk.com

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SEPTMBER IS...

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Your Partner in Oral Health

www.colgateprofessional.co.uk
Dentist caters for special needs

Public Health Minister Michael Matheson has launched a dental service for children with special needs.

In an attempt to remove any fears children with special needs may have, particularly those with autism, Bridgeton Health Centre’s paediatric dental service has been re-designed especially for this purpose. The new design means the centre is calming and child-friendly, and is full of picture books and talking books.

The books play a vital role in the service, as they put the children as ease and allow them to become familiar with the staff, surgery and the dental experience.

The Glasgow centre’s re-developed service is the brainchild of two NHS Greater Glasgow and Clyde staff, Lyndsay Overstone, senior dental officer, and Debbie Connelly, health improvement senior for oral health.

Mr Matheson said: “During the past decade there has been an increasing trend in the percentage of five year olds in Scotland with no obvious dental decay. However, we must continue to do more, particularly to accelerate the improvements in more deprived areas and address the barriers to good dental health for children, to enable us to improve the future oral health of the nation.

“That’s why I’m delighted to be in Bridgeton, Glasgow to launch this innovative new service. I want to thank everyone involved in this project for bringing it to fruition and for the support of staff and parents for making these changes a reality. Through their efforts we are already seeing great improvements in that trip-to-the-dentist experience for children with special needs in this part of the city.”

Ms Connelly said: “Children with autism have difficulty understanding and relating to other people, as well as taking part in everyday family life. And a trip to the dentist can be terrifying for them.

“Children with this condition like routine and find unfamiliar settings very daunting. And in a new environment they tend to experience a sensory overload as they cannot process the sheer volume of new information. Not only is this upsetting for them it is also incredibly distressing for their parents too.”

With the children solely at the heart of this service, questionnaires are also sent to the parent or carer before the visit, allowing the dental staff to tailor the experience to the children’s particular needs.

“For example, if we know in advance what a child’s favourite cartoon character we can arrange in advance to have this playing when the child enters the room, providing instant distraction so the child is relaxed,” Ms Connelly added.

Are computers replacing your memory?

A new study has found that the brain fails remember information as well if the person knows that the information they wish to remember is saved somewhere on a computer. What the study has suggested is that people tend to remember where the information they require is saved, and not what the information is about.

What isn’t yet clear is how these changing memory patterns may change the brain in the long run.

The author of the study, Betsy Sparrow, an assistant professor in the department of psychology at Columbia University in New York City, was quoted saying: “I think [technology] might hurt the type of memorisation that we usually think about, like remembering the name of an actress, but I think there might be some benefits, too.”

“If you take away the mind set of memorisation, it might be that people get more information out of what they are reading, and they might better remember the concept,” she explained.

Sparrow and her co-authors point out that the ways people rely on computers for information is countless: “People automatically think of using a search engine and computers and smart phones to find information they don’t know. It’s as if we’re using those devices as external memory sources, and we wondered if by doing things this way people wouldn’t remember as well,” said Sparrow.

To conduct the study, the researchers designed four experiments. All of the study volunteers were college students. Experiments consisted of trivia questions, identifying words and evaluating the effect of memory when the participant knew that their answers had been saved or not.

Results of the study were published online in Science.

Dental services deteriorate

An urgent survey of the dentists who treat society’s most vulnerable patients has been launched amidst fears that services are being allowed to deteriorate meaning patient care will suffer as a result.

The British Dental Association (BDA) has issued a questionnaire to salaried primary care dentists across England that seeks to gather information on whether cuts are being made to staffing, facilities and services. The survey follows reports of such cuts from attendees at this year’s BDA Accredited Representatives Conference that were echoed at a recent meeting of the BDA’s Salaried Dentists Committee (SDC).

Dr Peter Bateman, Chair of SDC, said: “The feedback we’re getting paints a picture of dental care for vulnerable people being allowed to falter, with staff and equipment not being replaced and some services and facilities even being allowed to close. If this is an accurate picture it will be a significant concern. I urge all colleagues in salaried services to respond to this survey so that we can build a fuller, accurate picture of what is happening across the country.

“Salaried primary care dentists treat vulnerable patients who are often unable to speak up for themselves. If promises that front-line patient care will not suffer are being broken then we must speak up on their behalf to ensure their care is protected.”
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BDA helps to develop next generation

Presidents and Vice Presidents of the Dental Students’ Societies from the UK’s 16 dental schools last week attended a one-day workshop at the British Dental Association’s (BDA’s) London headquarters.

The 2011 BDA Annual Council of Presidents Meeting, which took place in July, was designed to hone attendees’ leadership skills, helping to prepare them to take on responsibility in their careers, and develop a professional network of peers from across the UK. It provides practical advice on professional leadership and career development and allows delegates to quiz senior figures from the dental profession about their own professional development and factors influencing dentistry.

Speakers at the event included Dr Simon Galiier, Managing Director of Baxi Partnership Healthcare (and former President of the Manchester Dental Student Society), Dr Janine Brooks MBE of the National Clinical Assessment Service (NCAS), and BDA Chief Executive Peter Ward. BDA Student Committee Chair Martin Nimmo and BDA President Kirpal Benawra also addressed delegates.

Peter Ward said: “It’s a huge privilege to attend this day which serves as a reminder of the energy and verve of the cohort of bright young people currently training to become dentists. It’s important that the profession invests in its future by harnessing, developing and encouraging the aspirations and abilities of these individuals and I am proud that the BDA was once again this year able to host this day. Leadership skills are a vital component of a dentist’s career development and clinical leadership is becoming increasingly important in the dental profession.”

The research reflects a shifting landscape for primary care trusts (PCTs), in which more than a quarter (28 per cent) of those questioned said that their commissioning functions had merged with those of other PCTs. Although a very small proportion of respondents (eight per cent) of those questioned reported that clustering had had a negative impact on their ability to respond to local needs, most did not, reporting no change or a positive impact or saying that they did not know what the effect of clustering had been. Half of those questioned said that clustering had improved their ability to manage contracts.

Pilots for a new dental contract also received a largely positive verdict, with 79 per cent of those surveyed stating they believed a new contract based on capitation and quality would increase the quality of care patients receive. More than half (55 per cent) of respondents also believed that such a contract would improve the oral health of the local population for which they are responsible.

The survey did uncover concerns about funding issues, however, with 21 per cent of those surveyed reporting cuts of as much as more than four per cent to their budget for salaried primary care, and 16 per cent reporting smaller decreases in the budgets for hospital dentistry. Further details of the survey are available at: www.bda.org/Images/local_commissioning_pct_survey_2011.pdf

Mouth cancer survivor steps out

Mouth Cancer Survivor Louise Holtaway, 49, a self-employed Mortgage Broker from Bury St Edmunds, is taking part in the 6th annual Mouth Cancer 10km Awareness Walk for the third time this year.

Louise was diagnosed with Mouth Cancer in September 2008. Louise first noticed white patches along the left hand side of her tongue but she like many people just thought it was nothing to worry about. A few months later Louise found that she had got an ulcer in the same area and assumed it was just an everyday ulcer that would go away. However, it did not go way and became more painful. After being pushed into going to see the doctor, the doctor took one look at the problem area and referred her for a biopsy. A month after being diagnosed Louise underwent surgery to remove a part of her tongue as well as a neck dissection to remove lymph nodes.

The Mouth Cancer Foundation 10 km Awareness Walk takes place at 15:00 on Saturday 17th September 2011, in Hyde Park, London and this year the charity is hoping more than 1,000 people will step out and make a difference.

The walk, which is growing year on year, is designed to increase awareness and through fundraising allows the charity to provide support for mouth cancer patients and carers. People travel from all over the world to support the walk, which has raised in excess of £154,000 over the last five years. There will be FREE mouth cancer screening on the day, plus prizes available for top individual and team fundraisers.

Louise said: “The Mouth Cancer Foundation has been a saving grace for me! Through their support group I have been able to interact with other people in a similar situation as me. It is great to know that I am not alone and there is help and support out there. The main reason that I am doing this walk is to raise awareness of mouth cancer. I had such a great time last year and can’t wait to meet up with people that I met last year.

“I found it unbelievable the amount of people who did not know about Mouth Cancer when I told them about my diagnosis,” Louisa added.

The Founder of the Mouth Cancer Foundation Dr Vinod Joshi said: “The Mouth Cancer 10K Awareness Walk is a great opportunity for mouth cancer survivors, their families and friends, the public and health professionals to come together and stand up against this debilitating disease.”

To take part in the FREE Mouth Cancer Foundation 10 K Awareness Walk visit www.mouthcancerwalk.org
Dentistry couple bridge the gap

A husband and wife dentistry duo who met at university have hit the books together for a second time 12 years later to bring specialist skills to their practice.

Nigel and Alice Kirk have enrolled onto pioneering postgraduate dental courses at the University of Central Lancashire (UCLan), which will enable them to offer a range of specialties of dentistry at Nigel’s practice in York upon course completion.

Nigel, who has already gained a Masters in Clinical Restorative Cosmetic Dentistry from UCLan’s School of Postgraduate Medical and Dental Education, is now studying for his second Masters degree in Aesthetic Dental Implantology at the University.

His wife Alice is a sedation lead for the Salarter Dental Services across North Yorkshire as well as working in Nigel’s practice. She is currently undertaking an MSc in Oral Surgery at UCLan.

The couple first met in 1999 at the University of Birmingham’s School of Dentistry where Alice was two years ahead of Nigel in her studies. They finally got together when Alice taught at the School and Nigel was in his final year.

Alice commented: “We met whilst training to begin our careers and now all these years later we’re studying together again. It means we’ll have a good range of services to offer to our patients and hopefully stand out as a practice”.

Nigel heads up a fully private dental practice in the centre of York and is a member of the joint dental faculties of the Royal College of Surgeons.

He said: “I undertook my first Masters degree in restorative dentistry at UCLan and I liked the set-up of the courses, especially the flexibility of them, which allows me to fit the course into my daily working life.

“Very few people in the country have a Masters degree in both restorative dentistry and dental implantology; two very closely integrated subjects. Consequently I think I will have much more to offer to both my patients and referring dental practitioners.”

Alice added: “The profession of dentistry has changed an enormous amount over the last few years. With much more emphasis in the media on the appearance of peoples’ teeth in programmes such as 10 Years Younger; patients expect more and as a dentist you must have the training to under-take more complex procedures.”

“Because of these changes we have to be able to show that we are committed to moving with the times and are continually developing and expanding our knowledge.”

Both Nigel and Alice in will graduate in 2012. They say that studying together again has been a positive and beneficial experience.

Alice said: “We both know exactly what the other is going through and when and when one of us needs to get an assignment done we are respectful of this. Although we are doing different courses, we still can help each other knowing how the University works and can give each other advice.”

Nigel added: “My Masters’ courses have given me the confidence to undertake much larger and more complex treatments. My practice is now moving away from general dentistry and leaning towards a lot more referrals and treatments that I wouldn’t have undertaken without the advanced training I have received.”

NHS Lanarkshire won finalist award in Athens

A poster featuring NHS Lanarkshire’s oral health resource for secondary schools was shortlisted for the Bright Smiles – Bright Futures Award, at the 23rd International Congress of the International Association of Paediatric Dentistry (IAPD) held from 15th to 18th June 2011 in Athens.

The competition aimed to showcase individual organisation’s creativity in implementing a preventive oral health community programme serving children.

Two DVDs were produced for the resource. The first DVD combined interviews, cartoons, quizzes, documentaries and the opinions of the young stars of the DVD on oral health and nutrition. Video clip from the DVD is available from the following website: http://ipsmmedia.org.uk/video-solutions/case-studies/case-study-smile

The second DVD was adapted for use with pupils that have additional support needs using Makaton – a method of communication using signs and symbols.

There were also two A4-size colour brochures. One contained teaching materials for three oral health sessions, while the other was a set of worksheets with practical ideas for activities to reinforce the learning.

The resource was launched to all schools in Lanarkshire in October 2009. Special needs establishments were given a Makaton version of the DVD.

Tornado blows woman’s braces 100 miles away

An interesting discovery has been made by a man, who whilst walking along a beach in Massachusetts, found a bag containing some dental aligners that had been blown 100 miles by a tornado!

Rick Maurice came across the bag containing the braces whilst he was enjoying a stroll along a beach on Tuckernuck Island, off Nantucket. Fortunately the bag was labelled with the dentist’s name, which meant that Mr Maurice was able to track the owner down.

The owner of the aligners, Tammy Lamy, had originally put the braces in wardrobe of her Brimfield home; however, when a tornado struck on 1st June the bag was blown away and was eventually swept out to sea and found by Mr Maurice over a hundred miles away.

According to a report, Dr Scott Smith, the Springfield dentist whose name was on the clear bag containing the aligners, said that he was amazed by the journey the aligners had made.

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15 years and counting

Dental Tribune speaks with DPAS’ Quentin Skinner and Andrew Warren as the company celebrates 15 years of dental plan provision

DPAS was born on a sunny day in the summer of 1996 when Quentin Skinner was looking to establish a gap in the market for practices who wished to keep their practice identity independent but still be able to avail themselves of the services of a plan provider. Quentin and his friend and former colleague Andrew Warren set about establishing Dental Payment and Administration Services (DPAS).

Quentin explained: “When I founded DPAS I structured it specifically to be a boring business - when I first set it up it was called Dental Payment and Administration Services Ltd and that was specifically chosen to be particularly descriptive of our role as an administrate sub-contractor for dentistry. Of course, it was also a bit of a mouthful and so it started to be shortened to DPAS; in fact for a long time I was just about the only person who called the company by its full name!”

Passionate
Both Quentin and Andrew are passionate about the company being a support to dental practices by maintaining the collection of plan payment as their core function and not becoming a controlling influence. Quentin said: “The name Dental Payment and Administration Services Ltd was never meant to be a boring business - when I first set it up it was called Dental Payment and Administration Services Ltd and that was specifically chosen to be particularly descriptive of our role as an administrate sub-contractor for dentistry. Of course, it was also a bit of a mouthful and so it started to be shortened to DPAS; in fact for a long time I was just about the only person who called the company by its full name!”

Although the way we do things has evolved, I like to think that as a company we haven’t evolved basically because we remain true to the core values that we set up”

Change as constant
One thing that has remained a constant in the life of DPAS is change. Dentistry has seen many changes - in provision and collection of plan payment as their core function and not becoming a controlling influence. Quentin said: “The name Dental Payment and Administration Services Ltd was never meant to be a boring business - when I first set it up it was called Dental Payment and Administration Services Ltd and that was specifically chosen to be particularly descriptive of our role as an administrate sub-contractor for dentistry. Of course, it was also a bit of a mouthful and so it started to be shortened to DPAS; in fact for a long time I was just about the only person who called the company by its full name!”

So for 15 years I have religiously tried to ensure that we keep our focus on being a payment and collection company... although the way we do things has evolved, I like to think that as a company we haven’t evolved basically because we remain true to the core values that we set up.”

Although the way we do things has evolved, I like to think that as a company we haven’t evolved basically because we remain true to the core values that we set up”

Change as constant
One thing that has remained a constant in the life of DPAS is change. Dentistry has seen many changes - in provision between NHS and private care, in customer spending and expectations as well as in technology and materials that are available to clinicians. They way the company has evolved
with the market is something that Andrew is proud of: “I am excited by the fact that DPAS is a very black and white business, that we do what we said we were going to do on the tin and we do it well. This we know from our customers telling other customers – that’s how we grow. And that’s where we’ve evolved – we’ve been building up that reputation all the time. We can sit here very relaxed and comfortably: we have great retention, our customers are comfortable to come to us, we’re comfortable with our customers, and we go in a very sort of orderly manner.

“We have also evolved in ourselves, for example I’ve changed the title of our sales force from the words sales to consultancy; we want to grow in a certain way and with the right people. What with changing the title of our sales team away from sales into consultancy, it’s enabled us to hopefully dental practices to realise that by booking an appointment with us doesn’t mean to say they’ve got to sign a piece of paper, it means to say that we’re going to help them decide whether the NHS is the viable position for them, and many a day we advise dentists to take a slightly different course of action from what they were going to do. We’re not confined and we don’t have the problem of constant target making to try and make our business work. And because we don’t, we grow faster.”

Location

A unique feature of DPAS is their location. Based on a country estate in Tisbury, a small Wiltshire village that dates back to the 8th century, the sleepy rural surroundings hide the driving ambition to deliver for their customers a high quality service. Heavy investment in areas such as print and mailing as well as IT infrastructure and patient registration software keeps the company at the cutting edge of customer service, in tranquil surroundings that certainly help to keep the stress levels down when the next wave of practice conversions comes in! Yet it is still less than a two-hour train journey into the heart of London.

The tranquility of DPAS’s headquarters was a perfect backdrop to the company’s anniversary celebrations; held on a sunny day in July (much like the day Quentin came up with the concept for DPAS). Lord, Ladies, clinicians, friends and colleagues joined DPAS staff for a celebratory lunch on the central lawn of the premises. Andrew welcomed guests, and then paved the way for a presentation by Quentin, who gave a short history of the company, thanking those who have been supportive of the DPAS dream over the years. He also put in to context the current situation in dentistry, piloting, the unstable position of PCTs, UDAs and the ongoing recession. He commented that the ‘swing towards private dentistry is still inevitable’, showing that in the next 15 years plan providers such as DPAS will continue to be very busy indeed.

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Focus on your finances
Richard Lishman explains why it is vital to review your pension and investment fund analysis

With a fluctuating global market and with the Coalition Government making constant changes to the financial system as a result of the economic downturn, it becomes essential to watch your finances. For example, the latest plan proposed by the Government is to tax those earning more than £55,000. It is therefore especially important to keep reviewing your pension and investment funds to prevent them from going stale.

A regular review plan of your pension and other investments can ensure you are setting aside enough money and are saving this revenue in the best methods possible. There are some types of investment that can offer the potential for financial growth, whereas others can provide you with an income. There are even types of investment that can offer a mixture of these. The investment you choose is very personal and dependant on what you want to achieve. However, many investors are not very clear about their objectives. There are two main areas to consider before you make your financial decisions:

- The length of time you want to invest for: The time frame you decide to take. For some people, it does not matter how unstable their portfolio is as long as it grows over time. In addition, it is worth thinking about whether you want to leave some of your savings to heirs or would prefer to spend it all before your death.
- The most tax-efficient methods of investing: This can potentially increase the money you retain from your savings and investments tax. For example, pension plans are long-term investments and one of the most tax-efficient investment options around because the contributions receive tax relief based on the amount you earn. There are less stable options that also offer tax reliefs to encourage investors to participate. For instance, the Enterprise Investment Scheme (EIS).

Some investors have a tendency to hold bad investments too long; therefore, when choosing the most suitable investment option for you, seeking independent financial advice is invaluable. This can ensure that you will invest in a reputable company and be confident that your choice of investment is the most suitable for you.

Reviewing your investment funds becomes even more important if your financial circumstances change, as this can affect your investments. For instance, if you have had a gap in your employment for any reason, the pension you have saved may not be enough to provide for you in your retirement. Changing lives, expectations and situations may call for a change in your investment strategies, but this can also be the result of a shift in attitude in regard to your finances, meaning that you may become more cautious or more adventurous in your financial decisions.

To check up on how much your investment fund has grown, and for your own records, it is also vital you acquire an annual statement. This will help you to identify any shortfalls or performance issues in relation to your investment fund. It is also essential that professional fund managers prepare a Good Investment Policy Statement (IPS) tailored to the individual investor. An IPS will help guide any investment decisions and solidify the aims and objectives of the investor, as well as laying out a plan of how these aims are going to be met and how the investment will be managed. This policy should be written up and kept with your financial records and then annually reviewed, evaluated and updated where necessary. As the risk tolerance of your investment funds is likely to change over time (and perhaps your investment goals will alter as well) your policy statement needs to be kept updated and reflect this shift in viewpoint.

It is also essential you balance the risk with reward: the greater the potential reward, the greater the chance of a serious loss. It is necessary to make a decision on how much risk you are willing to take. For some people, it does not matter how unstable their portfolio is as long as it grows over time. Nevertheless, your IPS should include a plan of action that can be undertaken in the event that something does not work out. For example, if interest rates fall below one per cent. This way, you will be secure in the knowledge that, no matter the problem, you will be able to see it through.

It is important that professionals seek out the best financial planning options to diversify their investments and to make certain that their investment options are the most appropriate for them. Money4dentists has 55 years of experience in providing the very best independent financial advice, specifically for the dental profession. Their dedicated team of advisers have the most advanced software available to help you with your finances, and can help ensure that you are making your money work for you.
How much is a washing machine? What about a car tyre? Or a pair of Christian Louboutin shoes? I suggest most people have some idea about the cost of most things – except dental treatments. I know of no dental practices with a window display showing a set of false teeth with a £750 price tag or advertising braces from £1500. The website www.cosmeticdentistryguide.co.uk promises information about the cost of dental implants but only gives a heavily qualified price of £600.

On www.privatehealth.co.uk the cost of an implant in the UK (based on the Branemark system) is given as £2,000, excluding the crown.

With members of the public having little experience and knowledge to go on, are you surprised that the cost of your implant treatment plans will come as a (unwelcome) shock to most patients?

It doesn’t get better if the patient decides to go home and think about it. With equally little knowledge of the cost of specialist dental treatments, friends and relatives are likely to express similar shock at the price. “You could buy a (insert consumer product/holiday/item of furniture) for that!” will be a typical reaction. And someone is bound to Google ‘implants UK’ and see headline figures of £655, £495, £440 and so on.

So if you don’t want lots of proposed treatment plans to bite the dust, what’s the answer? It comes in two forms – the provision of information and the employment of a patient coordinator.

If you expect a patient to spend £000s for a life-changing treatment such as implants you need to do more than scribble the cost on the back of an appointment card. The best dental practices I deal with give their patients an excellently presented treatment plan. Enclosed in a posh looking (but not necessarily expensive) folder, a comprehensive treatment plan may run to several pages. Each stage of the proposed treatment is itemised with the dental terminology explained in layman’s language. For example, when first mentioned, periodontitis is followed by ‘gum disease’ in brackets. There may be a reference to it being commonly referred to in the practice as ‘perio’. That way, when the receptionist asks if a patient has arrived for a perio appointment, the patient will understand.

Even when you avoid dental jargon, you still need to consider the words used. Describing a dental implant as a ‘small screw made of titanium, which is inserted into the jaw bone while the patient is under local anaesthetic’ sounds scary just writing it! Try instead: ‘an artificial replacement for a tooth root’.

By all means include images but they should be of the problem and the anticipated solution, not the process. On YouTube there are animations and videos of all sorts of medical procedures for everything from breast enhancement to knee joint replacement. Informative they may be but the visual effect of seeing drills going the jaw for a dental implant tends to draw comments such as: ‘that looks scary’, ‘ouch, that must hurt’ and ‘I hope I never have that done’.

Include the costs on the treatment plan – broken down for each stage and totalled. Why not itemise labour and materials separately? I haven’t seen this on a treatment plan yet but it could usefully make the patient aware that some costs (laboratory charges, cost of the implant fixture and so on) are outside the

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In the treatment plan pack, why not include a printed leaflet giving general information about dental implants? Written in easily understood language (use the Plain English Campaign website to help you), it should answer many questions patients will have. It may also get passed to friends and relatives and result in referrals.

And now for the patient coordinator:

Here is part of my report of a conversation I had with a potential implant patient, while acting as a remote patient coordinator for a practice:

She is well aware that the treatment is something that she has to have done but she resents being in that position. She has the money to proceed but keeps focusing on what else she could do with it. She has no issues with the practice. Last year she was going to go ahead with the treatment because she was in frequent pain. However, the pain has subsided and with it her resolution to proceed...

The treatment was costed at £25,600 – a significant potential income for a practice. It took me seven attempts over four days to speak with her, which I eventually did by ringing her mobile phone.

Lack of space prevents me detailing the full range of duties of a patient coordinator. However, in relation to treatment plans they should discuss these with patients a day or two after they leave the practice. A phone call in the evening will find most patients relaxed but with queries (and possibly concerns) about the plan – having discussed it with relatives and/or friends.

The patient coordinator should answer queries (being conversant in the procedure is an obvious must) and allay any concerns. This is not a pure sales role but the patient coordinator must put across all the benefits to persuade the patient to proceed with what is, after all, clinically necessary treatment.

If you’re sceptical about the value of a patient coordinator, the conversion rate over a three-month period was 44 per cent in one of my practices and 35 per cent in another. On average, uptake in treatment increases by at least 25 per cent. Practices referred these patients to me because they appeared to be undecided.

About the author

Jacqui Goss is the managing partner of Yes!RESULTS. By using Yes!RESULTS dental practices see an increase in treatment plan take-up, improved patient satisfaction and more appointments resulting from general enquiries. Yes!RESULTS turns good practices into great practices.

Jacqui Goss
Managing Partner, Yes!RESULTS
Ashton House
Sale
Chesterfield M55 8HE
Tel: 01626 844006
Mob: 07795 542617
Email: jacqui@yesresults.co.uk
Website: www.yesresults.co.uk
Twitter: @Yesresults

Prices for most things are made clear—however, dental costs aren’t and can come as a shock to patients.

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Veronica Zamora
BioHorizons Corporate Headquarters
2300 Riverchase Center
Birmingham, AL 35244 USA
Tel: +1 205 986 7927
Fax: +1 205 967 3181
Email: vzamora@biohorizons.com

Chris Netherclift
BioHorizons UK
17 Wellington Business Park
Dukes Ride, Crawthorne
Berkshire, RG45 6LS
Tel: +44 1344 752560
Fax: +44 1344 777023
Email: cnetherclift@biohorizons.com

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Jacqui Goss
Managing Partner, Yes!RESULTS
Ashton House
Sale
Chesterfield M55 8HE
Tel: 01626 844006
Mob: 07795 542617
Email: jacqui@yesresults.co.uk
Website: www.yesresults.co.uk
Twitter: @Yesresults

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Prices for most things are made clear—however, dental costs aren’t and can come as a shock to patients.
Depending on the anatomical situation, the lateralisation of the inferior alveolar nerve may be one, or perhaps the only, solution to manufacture a fixed prosthesis for a patient with a free-end situation.

**Problems**
If a patient with conservable residual dentition in the anterior mandibular area with a free-end situation requires an implant-supported restoration, problems may arise regarding the route of the inferior alveolar nerve. If the route of the nerve runs too far toward the crestal bone, or if there are already signs of atrophy in the crestal part of the jaw, a restoration with a common implant may be difficult, or even impossible.

Here are several solutions for this problem.

One solution is the use of short implants (<10mm). The minimum length of common implant systems is 7–9mm. Therefore, the bottom line for a conventional implant should be calculated with a safety margin of 2mm, provided that there are approximately 9–11mm of crestal bone. As observed in the mandible, the survival rates of 8mm long implants are similar to the survival rates of longer implants (Grant 2009).

Another alternative is a vertical augmentation with autologous bone or allogenic materials. With respect to resorption, the long-term prognosis is controversial. Schlegel states a resorption rate of approximately 50 per cent after five years. Moreover, this solution must be excluded for those cases in which atrophy of the jaw bone is not due to insufficient crestal bone, but to the crestal route of the inferior alveolar nerve (Fig 1). This method requires the usage of pelvic bone, which implies a second surgery site.

Probable rates of long-term complaints in this area are partially stated as 11 per cent (Cricchio 2005).
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This technique carries the important risk of temporary or even permanent irritation of the nerve, which may lead to anesthesia, hypesthesia or paraesthesia. Several studies have considered this risk.

In his 1992 study Rosenquist demonstrated that 12 months later sensory disorders could not be observed in all 10 patients (26 implantations). Peleg’s 2002 study did not show any permanent disorders either. Jensen’s 2005 study reached the same results, and he also agreed with the figure stated by Watzek. The interesting retrospective study by Kan 1997 is the only one that compares both surgical techniques, the “displacement of the foramen” and the “lateralization of the inferior alveolar nerve”. He analysed 21 surgeries (64 implantations) after 10 to 67 months. He found out that sensory disorders occurred significantly more often in cases of displacement of the foramen (66.7 per cent) compared to the lateralization of the nerve (33.3 per cent).

These results show that in this regard, lateralisation is less risky. The implant survival rate stated in the above-mentioned studies is between 93.8 per cent and 100 per cent. Kan describes for example another probable complication, ie a fracture of the mandible at the operation site.

The mandible is weakened by the removal of the buccal corticales, and by the crestal implantation at the same time, and thus there
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Adapting with nature

‘We observed temporary irritations of the mental nerve appearing as paresthesia in 90 per cent of our own patients. These irritations disappeared completely within eight weeks.’

We observed temporary irritations of the mental nerve appearing as paresthesia in 90 per cent of our own patients. These irritations disappeared completely within eight weeks.

Clinical procedures

Diagnosis

Thorough clinical and radiological examinations are crucial preparations for this surgical procedure. In addition to the conventional OPG (panoramic radiography) (Fig 2), a three-dimensional examination using CT (computer tomography) or DVT (digital volume tomography) images, and their evaluation with the appropriate software, is absolutely necessary. Therefore it is possible beforehand to get a three-dimensional image of the route of the inferior alveolar nerve in the mandible. Figure 5 shows an evaluation using Med-5-D software.

The positioning of the buccal bony window should be especially considered when planning the surgery. After having prepared the buccal bony window and the implant cavity, it is of great importance to preserve enough bone in the buccal area of the implant, in order to guarantee sufficient primary stability.

Operative procedures

After carrying out an insertion of the jaw ridge and the preparation of the mucoperiosteal flap, the mental foramen can be shown. This is important and enables orientation when positioning the lateral bone incision. The horizontal incision line starts approximately 5–5mm distal of the foramen. The incision depth depends on the route of the inferior alveolar nerve distal from the foramen. Piezo surgery is recommended for the preparation of the bone incision and the latter preparation of the inferior alveolar nerve because it guarantees maximum safety for the soft tissue, while at the same time the risk of nerve irritation can also be reduced.

After the removal of the buccal corticall the nerve can be...
prepared in the cancellous bone.

Usage of the diamond-coated part of the Piezo device is recommended for this procedure. After preparation, the nerve will be encircled with ethiloop silicone slinga.

The preparation of the nerve is followed by the insertion of the implant. In order to obtain sufficient primary stability, there must still remain enough bone in the buccal area after the preparation of the cavity. If there is not enough bone left, the buccal bone lamella may break during insertion, which might endanger the primary stability of the implant. The preparation of the counter corticalis is also suggested, provided that the implant is long enough. A previously manufactured—by means of 3-D diagnosis—orientation template, can be used for the bucco-lingual and mesio-distal positioning of the implant.

The nerve can be repositioned directly on the implant (in this case a CAMLOG Screwline, 4.5 x 13mm, was used, Fig 10 and 11) without taking any further measures. Some authors (Rosenquist, Friberg) state that the contact with sharp thread edges often causes chronic irritation. Use of implants with a low incisive thread is therefore recommended in order to avoid nerve irritation. After repositioning the nerve the buccal cavity will be filled with bone chips, which were obtained by grinding the buccal compact bone. Afterwards, the cavity will be covered with the collagen membrane, which will be fixed with membrane nails. The wound is carefully closed with successive single interrupted sutures. After a waiting period of three months, the fixed prosthetic restoration can be done. During this time the operative site should not be irritated.

**Discussion**

The lateralisation of the inferior alveolar nerve offers patients the possibility of obtaining a fixed prosthesis in the mandible, provided that they have a conservable anterior residual dentition and a free-end situation.

This is sometimes the only feasible procedure to help patients obtain a fixed prosthesis, especially in those cases where there is only very little residual bone height depth left due to the route of the inferior alveolar nerve rather than atrophy. Other advantages are the fixation in the pre-existing bone, and the one site surgery, which make augmentative procedures unnecessary. This also avoids the disadvantages of other procedures for example the risk of resorption. The evaluation values for implant survival rates are similar to those for standard implantations. However, there are two reasons that might advise against a lateralisation of the inferior alveolar nerve: (i) the complicated surgical technique requires a skilled surgeon and (ii) the risk of nerve irritation.

Patients have to consider six-eight weeks of lasting paresthesia of the mental nerve, and the possibility of a permanent paresthesia cannot be excluded. It is therefore of utmost importance to inform the patient in detail beforehand. A rather rarely-occurring complication is a mandibular fracture in the area of the bony window. In 10 of the 11 lateralisation surgeries carried out in the authors clinic, the function of the mental nerve was completely recovered within 0-8 weeks. In one case, one patient still suffers from permanent pa-
From the patient’s perspective
Dr Götz Grebe and Dr Melanie Grebe discuss design, implementation and prosthetics

The cases presented in this article differ in level of difficulty in order to illustrate that navigated implant placement is the procedure of choice for many cases. We also wish to demonstrate that template-guided navigated implant placement is advisable not only in very complex cases. From the very first time the patient presents to the dental office, the focus of the entire team contributing to the treatment is on thinking and acting from the patient’s perspective and his or her foremost wish to receive a treatment that is safe, not time-consuming, and associated with as little pain as possible.

The advantages of case planning with the NobelGuide software (Nobel Biocare) in combination with template-guided navigated implant placement include:

- backwards planning
- pre-surgical planning in the dental laboratory
- maximal certainty of the diagnosis
- minimally invasive intervention
- evaluation of complications ahead of time, to the extent possible
- optimal prosthetic preparation (Figs. 1–5)

As a concept, navigated implant placement can even be utilised for the purposes of patient marketing, mainly through word-of-mouth communication, as will become evident in case II.

Teamwork

The dental laboratory is an important partner in the team working with the NobelGuide software.

One of the earliest steps, the preparation of the X-ray templates defining the later prosthetic targets in detail, is carried out in the laboratory. During the planning phase, the results can be discussed by means of NobelConnect, an Internet-based network of all participating specialists, and the necessary decisions concerning the fine-tuning between surgery and later prosthetic requirements can be made.

Accordingly, the resulting case designs were developed on the basis of teamwork and are therefore supported by the entire team. The NobelGuide team always includes the dental technician, the prosthetic expert, the surgeon, the patient, and, if applicable, the radiologist recording the 3-D images. The advantages of integrating 3-D diagnostics, 3-D planning and 3-D templates outweigh the disadvantages, such as increased radiation exposure and associated costs, which are the ones most mentioned.

The definite advantages of this approach include certainty of diagnosis, precise surgical implementation, avoidance of angular deviations at depth during the surgery, expansion of the range of indications, and prevention of clinical and prosthetic complications to a large degree, especially in the application of NobelActive implants, as is described below. The NobelActive implant system was developed for experienced surgeons in order to be able to attain high primary stability even in compromised bone and under difficult conditions.

Two new tools – NobelClinician and Nobel Connect – enable even better networking between the participating team partners for collaborative purposes by granting each partner access to the current state of the case—from 3-D planning to the insertion of the implant restoration—through a dedicated software interface. This facilitates communication, especially if team members do not work in the same locale.

After taking the history and arriving at a clinical diagnosis, the 3-D analysis is performed and the results are discussed to determine the treatment plan. NobelGuide, being both a surgical and a prosthetic system, is advantageous in that it allows a temporary restoration to be fabricated by the dental laboratory prior to surgical intervention, provided this is needed and indicated. The laboratory can utilise the drilling template made in a centralised industrial production facility to transfer the planned implant positions to a model such that the temporary restoration can be fabricated without

“The dental laboratory is an important partner in the team working with the NobelGuide software

...
the risk of transfer losses.

Case I: Lateral tooth restoration

The first case presented concerns a 75-year-old female patient and documents a situation that is commonly encountered. The plan was to treat tooth #14 with a single crown and place a bridge on two implants. Furthermore, teeth #23 and 24 were each to receive single crowns and, in addition, an implant bridge on three implants was planned (Figs 4a–f).

In this case, what made the use of NobelGuide so attractive for patient, dental technician and surgeon?

Easier handling

Owing to the exact 3-D design with NobelGuide, the surgeon was able to proceed despite the reduced amount of available bone. A sinus lift was not necessary. It was possible to place all five implants without having to generate a flap, minimising the post-operative consequences such as pain, swelling and the formation of haematomas. Moreover, it allowed the impression for preparation of the master model over teeth and implants to be taken in the same surgical session (Fig 5). The dental laboratory contributed to the production of the X-ray templates early in the planning phase, was familiarised with the case and involved in the discussion about the desired implant positions. The benefits for the patient included a safe operation, since the surgeon planned the entire operation beforehand and thus expected a predictable result.

A difficulty in the present case was the relatively soft quality of the bone. Under these circumstances, NobelActive is beneficial for the experienced surgeon since it rotates into the bone much like a compression screw, which allows good primary stability to be attained.

The NobelActive implant

The TiUnite surface of NobelActive implants affords osseointegration down to the level of the implant shoulder rather than just below the implant shoulder owing to the biological width of at least 1mm as is customary for conventional implants. This is associated with significant advantages for the aesthetics of the red-white transition. The gingiva is more stable and resection is less pronounced, which leads to the volume being maintained. This effect is of crucial importance for the success of an implant treatment in the anterior region, where aesthetic appearance is extremely significant.

Ceramic-veneered and screw-retained implant bridges made of titanium

For dental management of the final restoration, CAD/CAM-fabricated Procera Implant Bridges with screw retention at implant level were produced.

The available framework materials for this purpose are zirconium-oxide ceramics and titanium. Titanium was selected in the present case (Figs 6 & 7).

Additional advantages of this technique are:

• screw-retained abutment and bridge (Fig 8)
• tension-free framework
• bridge construction and implant are made of the same material
• very high quality milled titanium material
• no problems with chipping
• bridges are aesthetically pleasing and easy to remove
• no gingival irritation is caused by a cement gap, since there is no such gap (Fig 9)

Screw-retained bridges and milled titanium are very popu-
Implant Tribune

lunar forms of management today. Their production in the dental laboratory is no longer fraught with the earlier difficulties of cast titanium restorations, such as an alpha case layer. Accordingly, the veneering with titanium ceramic materials, made by VITA in the present case, has become much simpler. In a template-guided implant placement procedure, the axes are aligned such that the screw retentions can be implemented later exactly according to plan. This makes the work much easier and improves the quality of the restorations. Consequently, implant restorations can be achieved that are attractive to the patient owing to their reasonable pricing and high quality aesthetic appearance.

In this case, the master impression was taken during the surgical session. With respect to the skull, the models were mounted in an articulator by means of face-bow transfer via the impression posts. The natural teeth were treated with NobelProcera Crowns Alumina, which is another CAD/CAM-based method for fabricating allceramic dental restorations. For this purpose, a framework coping and the implant frameworks were tried-in at the subsequent session. At the third session already, the tooth-borne crowns were incorporated and the finished implant bridges were tried-in during the same session. The definitive incorporation of the final restoration was only effected after a healing time of three months though. Owing to this specific surgical and prosthetic protocol, no additional session for try-in was required, which the patient considered very convenient (Fig 10).

Case II: Management of upper and lower jaw
It was easy to conclude from the initial situation of this case that the patient, a 65-year-old male, had eschewed visiting a dentist for a long time. Accordingly, the teeth were in need of much dental work (Fig 11). Following a comprehensive diagnostic work-up, all teeth had to be removed, since they could not be conserved (Fig 12). The patient was phobic and well aware of the poor condition of his teeth but had not perceived an adequate treatment option for his needs in the past. Talking to an acquaintance, he had been made aware of the availability of surgery with a template without “cutting” and detailed pre-surgical planning on a PC in order to minimise the attendant risks. By his own account, he would not have made the decision to have classical surgery. For the surgeon, the outcome obtained in this case would not have been possible without this technique except with much difficulty and significantly more surgical effort and trauma.

Procedure according to treatment plan
It is very convenient for the treatment team to be able to proceed according to a detailed plan. Each member of the team is aware of all tasks and when they need to be addressed. In particular, the prosthetic pre-surgical planning, which is of great importance, attains a completely new function as it can be compared, in a quality management approach, to the final result obtained after the treatment is completed in order to determine the degree to which the plan was actually implemented. Following radiological digitalisation of the patient by means of a double-scanning procedure and conversion to virtual 3-D models, the surgeon can start to design the implants. In the present case, we planned to place six implants in the lower and eight in the upper jaw (Figs 13a–n). The transitional dentures required after extraction of the residual teeth also served as

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scanning templates (Fig. 14).

Surgery

In cases of a large number of implants to be placed, our team likes to implement a two-stage implant placement procedure. The lower jaw implants are inserted on the first and the upper jaw implants on the subsequent day. The patient was not subjected to general anaesthesia. It was possible to treat the phobic patient only with local anaesthesia without any problems. The surgical template used in combination with a specifically matched surgical kit allowed for exact transfer of the 3-D computer planning to the patient’s mouth (Figs 15 & 16). As in the first case, Nobel Active implants were inserted, which afforded good primary stability even under the strongly reduced bone conditions present in this case. This is owing to the special surface and the design of the implants. Following surgery, fixed temporary bridges, which had been fabricated ahead of time based on the existing planning, were inserted (Fig 17).

Procera Implant Bridge

As before, the definitive form of management selected in this case was a NobelProcera CAD/ CAM restoration. There were some particularities to take into account in the management of both the lower and the upper jaw. The true quality of the teamwork of dental office and laboratory becomes evident in the smooth production of very sophisticated rehabilitative restorations that can be fabricated without complication and incorporated into the stomatognathic system of the patient without any difficulties.

As part of the production of the restorations for the lower jaw, the terminal molars (teeth #56 and 46) were fabricated as titanium single tooth crowns and screw-retained at implant level (Figs 18 a & b). It was thus possible to take into account the 5-D twist of the arching lower jaw bone such that tensions at the level of the distal implants were prevented, which might otherwise have caused bone loss or even implant loss. We only splinted interproximally in the lower jaw, between teeth #55 to 45 (Fig 19). A distant cantilevered pontic substituting for teeth #56 and 46 was not used in this case, as implants #45 and 55 were only NobelActive implants with a diameter of 5.5mm. The Procera Implant Bridge Titanium on multi-unit abutments from teeth #55 to 45 was veneered completely, including gingival regions using VITA titanium ceramic was produced. The bridge was designed to allow all-ceramic NobelProcera Crowns Alumina to be cemented to them. For this purpose, the framework was veneered with a gingiva-coloured ceramic material and opaquer was attached in the region of the stumps by firing (Figs 21 & 22). In the next step, the single crowns were prepared (Fig 25). After completion of the entire restoration, the basic framework was screw-retained in the mouth (Fig 24) and the aesthetic Procera alumina crowns were cemented in the mouth using conventional cement (Durelon, 3M ESPE; Fig 25).

Accordingly, the patient’s restoration was still conditionally removable in the dental office, since the crowns covering the screw channels remained removable. This is advantageous for the patient in that the aesthetic appearance of the upper jaw can be improved even further, while no screw channels are visible. This resulted in an excellent aesthetic appearance at the red-white transition (Figs 20 & 27).

Conclusion

In this article we have demonstrated a dental team being able to offer treatment based on a one provider concept that starts with a 3-D diagnostic work-up, allows for template-guided navigated implant placement, keeps in stock all implant and prosthetic components (as typifies the concept of Nobel Biocare), and offers numerous advantages, including:

- application of a broad range of different techniques from a single supplier
- only a single supplier needs to be contacted
- implant and prosthetic components as typifies the concept of Nobel Biocare
- interfaces match
- materials match
- final result has a high precision
- generous solutions if difficulties are encountered
- custom-made designs for special needs

Approaching the planning and implementation of an implant restoration from the patient’s perspective and his or her needs will always cause the treatment team to place safety very high up on the list of its priorities. Based on the reliable NobelGuide concept, the success of the team becomes a matter of planning. To have...
A high clinical evidence of grafting procedures from extraoral autologous donor sites like from the iliac crest in difficult bone loss sites is still the practice in oral or oral-maxillofacial surgery. However, the invasive surgery combined with a prevalence of patient morbidity and suffer is an issue to discuss the persisting legitimation of this procedure. Since the appearance of reliable bone substitute materials with or without any autologous bone added, the positive results concerning longterm stability of regenerated bone even in difficult cases have become very predictable.

This article will point out in case report the reliability of alternative and less invasive techniques for 3-D bone reconstruction in the mandible and question the necessity of iliac hip grafts for intraoral bone augmentation.

Materials and methods
A female patient aged 48 years old with a severe and advanced periodontitis in the maxilla

and the mandible came into our clinic with the desire of a complex treatment plan with an implant retained denture in both jaws. This case report will pinpoint the treatment of the mandible. A CBVT was revealing massive bone loss in height and width in the mandible arch from canine to canine and apical cyst at tooth 23, 26 and 28 (Figs 1 & 2). According to our protocol we started with an initial scaling and HELBO®-Laser decontamination prior to the surgery to decrease the number of pathologic germs and post op infections. Tooth 18 and 19 in the left mandible were intended to maintain until the finalisation of the prosthetics to give some comfort during temporisation with an immediate denture that was placed post op. Preoperative the patient received 1,200mg of Clindamycin. The patient despaired the surgery of tooth removal and ridge augmentation pursued under general sedation.

After nasal intubation and local anaesthesia the bridge in the lower was removed and the remaining teeth despite from 18 and 19 as mentioned before (Figs 3 & 4). After full flap preparation with crestal incision, releasing incisions and exposure of the mental nerve exit, the volume of the severe bone loss was revealed as well as the minor soft 3-D alveolar ridge reconstruction in a case with severe bone loss tissue conditions due to inflammatory tissue proliferation (Figs 5 & 6). The success of 3-D bone augmentation is bonded to primary wound closure and tensionless flap adaptation. Thus, the periodontium is dissected with a scissor from the epiosteal connective tissue before augmentation procedures to reduce bleeding and guarantee a flap flexibility without compromising soft tissue and nutritive blood vessels.

For bone augmentation a bone block was harvested via ultrasonic surgery from the retromolar region distal from 52 of the right mandible (Piezotome II, Acteon France).

This bone block was divided into two halves. One was used for two “bone shields” to create a mold for the grafting material and the mandible came into our clinic with the desire of a complex treatment plan with an implant retained denture in both jaws. An allograft bone was harvested from extraoral iliac crest in difficult cases with severe bone loss tissue conditions due to inflammatory tissue proliferation.

‘Since the appearance of reliable bone substitute materials with or without any autologous bone added, the positive results concerning longterm stability of regenerated bone even in difficult cases have become very predictable’.
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Postoperative the patient continued with 1,800 mg Clindamycin, Ibuprofen 600 mg and a decongestant enzyme based medicine (Bromelain-Pos®, Ursapharm, Germany).

The next day the patient had an expected cheek swelling but was not suffering from pain, after 10 days the sutures were removed. However, six weeks later a membrane exposure of the non resorbable membrane was evident, but due to the fact that this is tolerable when the patient is instructed to maintain oral hygiene and re-called once a week, the success of the outcome was not threatened (Fig 11a). The titanium pins and the titanium reinforced membranes were removed after four months.

Eight months after augmentation the 2-D aspect of the CBVT showed clear evidence for entire ridge reconstruction of the deficient sites (Fig 11b) with osseosynthesis screws in position. To emphasize the efficiency and predictability of this technique the pre-op scan of region 28 (Fig 12a) and the reconstructed bone eight months later (Fig 12b) show clear an increase in bone height and width. The well vascularized bone was used to insert four dental implants (4 x 5.75 x 13 BEGO Semados®, BEGO, Germany) for a later bar-retained denture, the healing time is estimated with eight weeks (Fig 15) and was not completed before publication, here my apologies to that.

Discussion

3-D bone augmentation in cases with severe bone loss can be accomplished also with a less invasive surgical protocol than the iliac hip graft. The morbidity can be dramatically reduced with the use of ultrasonic devices. Regarding the donor site, which may be favoured with the retromolar region, patients have close to zero complains if a single incision procedure is performed. Allograft materials may enlarge the volume of the augmentation material and in addition to that the success of beta-TCP is not to be questioned. Regarding the long term stability the regenerated bone is superior to pure autologous bone from the iliac crest, which resorption rate is much higher compared to introral bone or beta-TCP. Reduced pain and postoperative complains should be reduced and enlarges the number of patients willing to undergo oral augmentative procedures.

About the author

Prof Dr Marcel A. Wainwright
DDS, PhD Dental-specialists Kaiser-swerther Markt 25–27
40474 Dusseldorf, Germany
E-mail: Weinrecht@t-online.de
www.dentalspecialists.de

Univeridad de Sevilla
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Chasing a dream
Sharon Holmes gets back to reality...

Going home on the train one evening a fellow passenger sitting opposite me was engrossed in his book entitled *Mastering The Art Of Running*. I thought to myself how nice it was to read such a book! Why is there no such book called *Mastering the Art of Dental Practice Management!* If only…

So I felt compelled to write an article of encouragement for all practice managers or principal dentists who manage practices. If I have moments of fatigue surely there must be others who feel just like me at times.

I have come to surmise much to my dismay that there is no such thing as a "perfectly run dental practice". If you think there is you are going to drive yourself crazy; I have been chasing that dream for years.

The one process in practice management that I find I am most sensitive to is untoward incidences, because normally these are due to negligence. Accidents are manmade; they don't just happen although they most certainly are not planned. However no matter how many practice protocols you have in place you cannot predict what could go wrong in the future.

When a major incident occurs you have got to carry out an investigation to get a full picture of what actually occurred and where the turning point was when it all went wrong.

Too many times I have found staff battle to be honest for fear of blame or retribution for being a grass or a snitch. I don't look at an untoward incident as blame. I look at it objectively to establish why it happened even though there are practice policies and procedures in place. It's normally a chain of events that will lead to failure.

Once I have all the necessary information in front of me I work out what went wrong, who was accountable and establish whether negligence was involved or a weak practice procedure which was not concise enough. Once I have all these involved made clear to me I meet with each one to understand their thinking of what went wrong. Through this I am able to determine what the 'cause' was. Sometimes it is a lack of understanding or just plain negligence due to not taking responsibility for what appears to be wrong. It's the scenario of anybody's, somebody's and nobody's job. When the explanation starts 'but I thought', I know I'm in for tool box talk with the whole team.

We therefore call an urgent staff meeting where a 'tool box' talk takes place openly. We discuss what went wrong, what we have learned from the incident and we then re-write a policy if it was not concise enough and if a policy does not exist for the incident that occurred we create one by agreement as to what should be expected. This should be done as a team effort then those who created the policy could be held to account in the future.

You have to keep all records for CQC as all regulated activities must be evidence based. If it is a serious incident, such as a death, you need to report this to them immediately. All staff are required to sign an attendance list stating that they have attend a meeting and that they now understand what is required of them in the future. Your policies should be discussed frequently to keep them up-to-date and to establish what should be expected. This should be done as a team effort then those who created the policy could be held to account in the future.

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As Winston Churchill once said; However beautiful the strategy, you should occasionally look at the results.
Snoring and the dentist’s role
Neel Kothari discusses ways to help patients with snoring issues

Whilst dentists most commonly treat conditions related to dental diseases, we are also in an ideal position to screen for and treat a range of sleep related breathing disorders, such as snoring and mild obstructive sleep apnoea. Whilst many of our patients are able to adapt to these conditions in the milder forms, for others these sleep related breathing disorders are a source of great distress and in reality may have more serious medical and social implications, both for the person who snores and/or for the sleeping partner.

Snoring and obstructive sleep apnoea are chronic conditions termed “sleep related breathing disorders”. Snoring is primarily caused by restricted air flow as we breathe. In a small number of cases the restriction occurs in the nose or as a result of an enlarged uvula, but more commonly snoring comes from the back of the throat in the area known as the oro pharynx or hypo pharynx.

During sleep the tongue drops back and the muscles below the jaw relax. This leads to a restriction of air flow. As the air passes through the smaller aperture its velocity increases and the soft tissues vibrate, giving rise to the snoring sound. The snorer has to work extra hard to overcome the air resistance, often depriving the individual of vital oxygen. This places a strain on the respiratory and cardio vascular systems.

In the case of obstructive sleep apnoea, the airway is temporarily cut off with total collapse of the tissues. Breathing momentarily stops. The carbon dioxide levels rise and the oxygen levels fall until the body’s natural emergency recovery kicks in, the pulse quickens and with a gasp the breathing recommences. This cycle of events is often described by the sleeping partner as: “the breathing stops and there are terrible pauses and delays followed by a choking gasping sound. This cycle is repeated throughout the night.” To the sleeping partner it can be most distressing, noisy and alarming. Few can tolerate this and often in desperation retire to another room. For the sufferer they may temporarily wake up, regain their breath and then go back to sleep.

Dr Simon Ash, consultant orthodontist at Whipps Cross University Hospital has considerable experience working within a multidisciplinary team helping patients with sleep related...
breathing disorders and says: “We all know that a disturbed night’s sleep is very debilitating. The unfortunate patient may report poor sleep quality being continuously drowsy and tired and all of these symptoms should sound alarm bells to the dentist. Guides to diagnosis include looking for factors that make the condition worse such as weight gain, lying on the back during sleep and the taking of muscle relaxants which includes alcohol. Factors that give relief to the symptoms such as weight loss, avoidance of alcohol and postural changes in sleeping position will not only help in treatment but also support the diagnosis... A sleep study undertaken by the chest physicians is undoubtedly the conclusive acid test.”

Dr Ash’s management of obstructive sleep apnoea consists of a multi-disciplinary team ranging from fields including chest medicine, ENT and Orthodontics or a dentist with appropriate training and skills. Several methods of treatment are available, most importantly changes in life style, less alcohol, weight loss and increased exercise; however Dr Ash believes that surgery, such as laser assisted uvulopalatoplasty should be the last resort, as it may lead to scarring, restricted space and is generally excruciatingly painful over the weeks in the recovery period.

Dr Ash says: “We must be careful to ensure that dentists work with the medical physicians and within their limits, thus whilst dentists should screen patients and ask two very simple questions, ie “do you snore” and “do you feel sleepy and drowsy during the day” we are really not the best health care professionals to actually diagnose sleep apnoea. Remember there is obstructive sleep apnoea and Central sleep apnoea and perhaps even other variants. If there is pathology causing an obstruction in the airway, dentists would not be best placed to diagnose this.”

Of the non-surgical approaches, the Continuous Positive Air Pressure (CPAP) appliances are the gold standard, normally prescribed by the chest physicians. These devices consist of a close fitting face mask covering the mouth and nose, connected by a flexible hose to an air pump which delivers air under a set pressure. This device forces air through the restricted airway during sleep. Whilst CPAP is effective, the discomfort and inconvenience it causes to the patient means that many find CPAP to be intolerable and prefer to suffer the consequences than wear the mask.

The most effective alternative or complementary treatment to CPAP is treatment using mandibular advancement dental appliances. These appliances work by holding the jaw forward in the recovery position during sleep and it is here where dentists with appropriate training are ideally placed to assist our specialist colleagues in the management of these conditions. In the next article I will be looking in more detail about some of the options that are used to treat snoring, such as mandibular advancement splints, how they work and what options are currently on the market.
No clasps please! A further attachment solution

Ulrich Heker and Chris Thomas

In this last article we looked at telescopic or double crowns and their application in the production of removable dentures. Here we will consider another alternative - attachments - that also make use of precision milling.

Attachments are elements for linking removable prosthetics with existing teeth (abutment teeth). These require crowns in order to accept the attachment. They can be used with removable prosthetics and with crown and bridge techniques.

They comprise a primary element that is permanently cemented in the oral cavity and the secondary component that is firmly linked with the actual prosthesis. Attachments are particularly applicable when it proves impossible to produce parallel abutment teeth simply. The attachment is used to create a bridge between misaligned abutment teeth such that a secure insertion becomes possible.

Types of attachments

Attachments are divided into two groups, intracoronal attachments (within the crown of a tooth) and extracoronal attachments (exterior to the tooth crown).

Both types are available either as prefabricated attachments or as they are manufactured commercially and are then simply 'assembled' by the technician. They can be obtained in a wide variety of shapes, sizes and materials.

Alternatively, there are bespoke attachments, which are wholly prepared in the laboratory, though sub-units can be incorporated during construction.

Whether prefabricated or bespoke, an attachment is always made of a male and female part. Both parts slide together during the insertion of the prosthesis and result in a firm connection. Attachments are elements that are manufactured commercially and are then simply 'assembled' by the technician. They can be obtained in a wide variety of shapes, sizes and materials.

Advantages:

- No solder or glued connections (apart from with RSS attachments)
- Patient-friendly insertion and removal of the prosthesis
- Precision calibration of friction settings
- Ease with which female components can be interchanged in practice
- Longevity and robust functionality as there are no complicated mechanics
- Easily adapted to the local space constraints and therefore no reduction of the prosthesis aesthetics; more graceful than double crowns
- Abutment teeth are coated in ceramics in contrast to telescopic solutions
- Price advantage over telescope crowns with 5 or more crowns

Manufacturing

Bespoke attachments require a high level of competence in milling and casting methods; however, they can be adapted to nearly all situations. If you compare the costs of prefabricated standard-sized attachments versus the bespoke attachments, (taking account of the work involved), then the cost difference is negligible.

As with any crown or bridge, the work on an attachment begins with the preparation of the abutment teeth. The individual abutment blocks are taken into account when determining the alignment direction for the attachment. The alignment direction is determined in exactly the same way as for the planning of individual small bridges. Circumstances permitting, it is beneficial to create a bit more space on those dental surfaces where the attachment is to be fixed to bring the male components as close to the tooth axis as possible to avoid the creation of damaging lateral forces.

In order to protect the attachment from overloadings by tension and pressure forces, each component is protected from these forces via a stress breaker: this avoids breakage of the male element or expansion of the female one.

A horseshoe-shaped depression is milled into the crown(s), which has vertical grooves milled at either end. This prevents movement of the attachment along the sagittal axis. The ledge of the milled horseshoe depression is able to absorb axial pressure and distribute it over the crown block. The stress breaker then fits as you either pay more for the parts with one or the labour with the other.

I've worked almost exclusively with ROD attachments over the past 15 years. The ROD attachment is an extracoronal connective element, which impresses through its simple functionality and longevity. The male part is supplied as a modelling accessory and is cast together with the abutment crown. The female component is made from a Teflon wear-resistant synthetic cap, which is available in three different frictions. Additionally, the adhesive strength can be adjusted via the length of the female component.

Each piece of dental technical work requires meticulous planning and this is particularly the case with combination work. You need to take into account the number of abutment teeth, their condition, the required interlocking and last but not least, the number of required attachments.

The final casting of the preparations is no different to that for larger bridge work. The milling model is produced as usual then based on the model. The optimal alignment position for the attachment is determined such that the rods on the male attachments are aligned parallel to one another.

Bridge with male Parts of Rod attachments

‘Bespoke attachments require a high level of competence in milling and casting methods; however, they can be adapted to nearly all situations’

Complete work with inserted CoCr Coating
Collage of separating attachment in case of diverging abutment teeth

snugly into this milled groove and rests on the ledge.

The grooves and ledges are already incorporated during wax modelling and are pre-milled with special wax mills.

The cast crowns then proceed to the first fitting and the coping impression in the dental practice. The crowns are returned to the lab with the over-impession from which the master model is created. The abutment crowns are shaded with ceramics. Due to the expected oxidation during the firing of the ceramics, it is only possible to mill and polish the surfaces afterwards.

It is a great help at this juncture if the dental positioning has been established previously.

After firing, the crowns carried by the attachments are transferred with a key to the milling plate (made out of plaster of Paris or an appropriate holder).

The milling plate now determines the position of the attachment. All the milling surfaces previously cast in wax are then milled and polished. All milled planes are now absolutely parallel.

The Teflon female component for each tooth is shortened as required, to fit the attachment’s length and is applied to the male component.

Undercuts are filled with wax. Here the female attachment cap also acts as a spacer – so do not interchange!

Further casting proceeds as usual and the work is ready for the production of the model cast. The casting of the grooves, ledges and attachment components must be bubble-free.

As with the production of telescopes, the handling of the model and the casting materials require considerable experience in order to get a really good fit of the stress breakers and the base of the cast.

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The insertion of the female components (usual colour yellow) into the cast is facilitated by a special tool which is included in each package. Insertion of the female component into the model cast should be possible using light pressure. If it is too loose, then it will fall out later: if too tight, then the whole model could be lifted or the patient cannot remove the prosthesis. The walls of the female part should be parallel, sitting completely within the model. Otherwise the model casting needs to be reworked.

The conversion of the wax model into methacrylate does not require any special effort; however, one should not forget to protect the attachment from unwanted intrusion of the resin by blocking with wax.

The housings for the female components are coated with composite, rendering the attachment invisible.

It is advisable to have a notch close to the attachment, in the resin of the prosthesis, where the patient can find a hold with a fingernail for easier removal of the prosthesis. Small beads of clear plastic applied to the prosthesis can fulfil the same objective.

Generally, rot attachments and similarly constructed attachments require a bordering gap in order to incorporate an extracoronal attachment.

If the construction requires an attachment point in a still-complete dental row, then a groove-shoulder attachment can be used.

These are intracoronal horseshoe-shaped elements that are attached to the oral side of the crown (hiding them from view) to which the matching interlocking denture with mirrored elements can attach (see article 1 in this series). The secondary construction, as well as a stress breaker, is made of high-quality gold alloy that is soldered with the model cast to guarantee a perfect and tension-free fitting (Note: you cannot exchange the male component within R55).

Conclusion

Ninety-five per cent of all attachment work can be completed with the two attachment types described here.

Attachments are particularly applicable when it proves impossible to produce parallel abutment teeth. The attachment is used to create a bridge between misaligned abutment teeth such that a secure insertion of a prosthesis becomes possible. They can be a cost-effective alternative to double crowns. They are aesthetically attractive and user-friendly solutions for the patient.

“Excellence is the result of always striving to do better”

-Pat Riley

Collage of a so called R55 Attachment

Close up of Rod Attachments female Part

Close up of Rod Attachments male Part - Typical individual attachment

‘As with the production of telescopes, the handling of the model and the casting materials require considerable experience in order to get a really good fit of the stress breakers and the base of the cast’
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Using hypnosis in dentistry

Mohan Lal Photay discusses how to make any patient your ideal patient

How do you set about making someone your ideal patient when the first thing they say when they walk in is “I hate the dentist”? The clinical smile team composing of receptionist, nurse through to the dentist have been conditioned to hearing this for so many years that they begin to believe it. For so many years I have heard a response like “I know” or “yes, not the most pleasant of experiences” or “I understand” yet there is a way to respond to this type of reinforced negative belief. When you read further it will become clear that it is only this negative belief that keeps you and your patient from sharing a more pleasant experience.

I am Mohan Lal Photay (BSCH) 1998 and I trained at the Birkbeck College UCL in Clinical Hypnotherapy. I have treated dental phobia patients using such techniques as EMDR, reframing and NLP techniques to name just three. Prior to this I managed a dental laboratory from 1977. My time now is spent furthering the uses of hypnosis in dentistry.

Reframing

When a patient brings a negative belief or a negative learnt attitude into the surgery you have to gauge whether it is worth challenging or reframing. Challenging the belief could be considered confrontation al and should only be undertaken if you are skilled in the technique. My first gambit would be to ‘reframe’. Reframing, as the name applies, is akin to changing the frame around a picture. Deciding which frame to use to achieve the desired outcome is the role of the framer.

In conversational hypnosis reframing is a simple method used to change someone’s mind. Reframing is actually a technique that comes from NLP (Neuro Linguistic Programming), and it does not require the person you are talking with to be in a trance.

First you should not enforce or strengthen their belief by offering in any way an acceptance in what they say. Next, watch your language. More importantly practice on how you put together the words that form your next sentence. Your words should create pictures; this is the most important part of the reframing. The better the picture your words create the more effective the reframe.

Now, when the patient says ‘I hate the dentists’, look at the patient with a half-smile and say “and yet how will you feel when you walk out with a smile”. The next stage is important as you should remain motionless without changing your stance, gaze or smile, wait for the patient, who will know they are supposed to give a response. They will question their own statement for validity. Once they question their statement they cannot continue to feel the same way or continue to hold the same belief pattern they arrived with.

As a result they will either strengthen (unlikely) or they will modify (most likely event) the statement. When the patient responds with something like “that would feel good” this is where you need to reinforce their fledgling belief by changing your stance (open), gaze (full and warm) smile (sincere) and saying ‘I am pleased and I will do my best to give you the smile you will smile about. Shall we start?’

Practice reframing; for example if you hear a colleague muttering “she is always mixing the alginate wrong” look at them and say “Always?” Once again the original statement is under scrutiny. When the reframe occurs take it as your queue to offer a way to show the nurse how to mix consistently good alginites.

Anxiety

Remove anxiety and you remove bias, anxiety states and beliefs you help with overcoming many phobias, anxiety states and beliefs you are likely to encounter as a dentist.

Anxiety is spent furthering the uses of hypnosis in dentistry and I will do my best to give you the smile you will smile about. Shall we start?”

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Anxiety

Remove anxiety and you remove pain. This is not a utopian goal as there are examples of people who have overcome anxiety to such an extent that they can remove themselves from the situation while the dentist performs the treatment. One technique used by some patients who have overcome anxiety is the visualisation of their favourite place of relaxation.

This does not require the patient to be in a trance-like state. Talk to the patient and ask them if time allowed, where they would be relaxing. Ask them about their holidays or special moments. While you are listening, watch the patient’s face carefully. Tell the patient to go to their favourite place of relaxation in their mind; if they need help finding their favourite place, mention to them how their face lit up when they were telling you about their holiday in Spain. Repeat what they told you about their favourite place, making sure you infuse as much positive imagery into the scene as you can.

When establishing and creating the patient’s favourite place, use of anchors is a must. Establishing anchors at this stage will be of profound help when you need immediate relaxation. Anchors are established by a gentle squeeze of the shoulder when the patient gives a positive response or when a patient enters their favourite place of relaxation. Practice use of anchors, as the use of anchors is one of the most powerful techniques to help with overcoming many phobias, anxiety states and beliefs you are likely to encounter as a dentist.

When the patient is able to go to their favourite place of relaxation ask them to go there in their mind. Help them with encouraging suggestions and remember the more visual the pictures the better. One thing they will notice is that while they were in their favourite place of relaxation, time seemed to pass quickly. This pseudo progression of time helps the clinician to treat while the patient is relaxed.

A thorough understanding of the techniques of NLP, hypnosis and visual direction can help the dentist introduce some calm into the dental procedure. Patients who are taught self-hypnosis and the concept of the favourite place can become some your best patients.

Further reading, as a first book I would recommend the ever popular Hartland’s Medical and Dental Hypnosis (Paperback), author David Waxman.

Contact Information

For more information please contact Mohan via email at mlp@dentalserve.net
COURSE ANNOUNCEMENT
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FOR FURTHER INFORMATION: Professor T.C. Ucer, BDS, MSc, PhD, Oral Surgeon, Oaklands Hospital, 19 Lancaster Road, Manchester M6 8AQ.
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