A positive change

General Dental Council changes again

The Department of Health has announced changes to the constitutions of the General Medical Council and the General Dental Council. The changes mean reducing the size of both the Councils to 12 members and moving towards an appointed (rather than elected) Chair. The move, which was announced last month, aims to improve the effectiveness and efficiency of the two councils.

Initially the proposal had been for a reduction from 24 to eight members, and that both chairs should be appointed rather than elected by the governing councils from within their membership.

The Chairman will cease to be elected from among the members and will in future be appointed by the Privy Council for an indeterminate term. The amended Orders have now been laid in Parliament.

General Dental Council Chair Kevin O’Brien said: “The changes in our governance structure, due to take effect in October 2013, will further enhance the GDC’s ability to respond effectively and in a timely way to a rapidly changing regulatory environment. A key priority for me as Chair of the Council will be to oversee a smooth transition so that important work already underway at the GDC and aimed at improving our performance is not interrupted.”

These changes are just some of the ways in which the GDC is trying to improve its performance, as was pointed out in its review of performance in 2011, which was recently published by The Council for Healthcare Regulatory Excellence (CHRE).

The report, which investigates the ways in which the GDC has been actively trying to improve, noted the GDC’s “changes to its established processes, as well as its new processes, policies and systems to enable the [GDC] to become a more effective regulator”. Although the CHRE added that “the GDC has demonstrated that it meets most of the Standards of Good Regulation for fitness to practise”, there was also a list of measures to be taken to improve the function of the GDC.

In relation to the GDC’s other functions, the report commend the GDC for reviewing its continuing professional development scheme and developing a new ‘outcomes-focused’ regime for dental education and training.

The CHRE noted that further work is needed to improve the timeliness of progression of Fitness to Practise cases and quality of decisions.

Chief Executive Evlynne Gilvarry said: “We welcome this report and the acknowledgement of the progress we have made over the past year. We agree with the CHRE on the further measures necessary to increase the rate of progression of fitness to practise cases and to bring about further necessary improvements in the handling of cases.”
Cross-generational orthodontic treatments on the rise

The number of cross-generational orthodontic treatments is on the rise, according to the British Lingual Orthodontic Society (BLOS). Members of the society are reporting more instances of parents and children embarking on treatment together and sharing advice on their braces, their hygiene and their diet, as well as going to the practice together for shared appointments.

Tania O'Dowd and her daughter Hannah are an classic example of the new trend. They have lent their brace-free smiles to a new leaflet produced by the British Lingual Orthodontic Society (BLOS). The leaflet highlights why lingual braces are such an attractive method of teeth straightening, for both patients and professionals.

Angela Aulkur is a member of the BLOS committee and she is currently treating a mother, father and daughter from the same family. “The mother brought the daughter for an appointment and decided she would opt for lingual braces while her daughter had conventional braces. Then when they both had treatment without anyone knowing, he decided to have lingual braces too!”

Lingual braces have all the advantages of fixed braces but are conveniently placed behind the teeth to remove any potential for embarrassment.

Research carried out over the last few years also shows that lingual braces are have other benefits. Buccal surfaces are considered to be more caries prone than lingual surfaces. Furthermore, lingual brackets are shaped to fit the morphology of the teeth and seal almost the entire surface. One study completed in 2012 on groups of young people shows that lingual treatment is less damaging to the health of the teeth.

The researchers analysed for white spot lesions (WSL) and the number of WSL that developed or progressed on buccal surfaces was 4.8 times higher than the number of WSL that developed or progressed on lingual surfaces. In short, decalcification was nearly five times more likely and over 10 times worse with a labial appliance than a lingual one.

The other significant difference is in what is achievable with lingual appliances compared to clear aligner systems. Research published last year showed the difference between what was planned and what was achieved with lingual appliances was minimal.

Raz Parmar, Chairman of BLOS, commented: “Many of our members are seeing the same trend of parents and children going into treatment together.”

Walking the footsteps of saints

Keith Pearson, President of the British Orthodontic Society is raising funds for research which will be targeted at finding the evidence base for the value and importance of orthodontic treatment to patients, both young and old. This will directly benefit all those in clinical practice, for in the years to come pressures will mount on the funding of such treatment, particularly within the NHS.

Keith, who is an Orthodontic Specialist in practice in Beckenham, Kent, is currently walking as a ‘pilgrim’ along the way of St James to Santiago de Compostela for a total of nine days and covering 180km to reach Santiago de Compostela where the European Orthodontic Meeting is being held later in June 2012.

The BOS has been in communication with Keith during his walk and in one of his more pensive missives he reports: “Walked all day Sunday. High winds and cold temperatures. Stayed in Moinesca overnight. Walked on to O, Cebeiro mainly uphill all day and in driving rain, totally soaked looking like a drowned rat tonight.”

Another entry reads: “Overnight in O, Cebeiro a very small village built almost entirely of granite and considered to be one of the wettest and windiest in Spain! Tuesday. Slightly less arduous in that the weather has improved but still overcast and cold but only drizzle today. Overnight in a rectory just outside Sarria, home cooking and absolutely wonderful, I might even come back here!”

He also reports: “Wednesday a very long day made easier by the sunshine at last! Tonight in Portominar, a town which was rebuilt, having been transported up the valley which was later flooded to create a huge reservoir. Tonight’s accommodation not too good as the room resembles a large garden shed with integral shower cubicle, but at least it’s a bed for the night.”

Consultation on a new adult safeguarding power

The Department is consulting on a new adult safeguarding power. As stated on the Department of Health website:

“Our aim for adult safeguarding is to ensure there is a clear legal and policy framework, enabling the most effective local arrangements and practices to protect adults at risk of abuse and neglect.

“We have based our approach to new safeguarding interventions with reference to the Law Commission’s recommendation that new legislation ‘should not include any new compulsory or emergency powers unless Government decides that such powers are needed’.” (Recommendation 41, page 122, Adult Social Care: Law Commission No 520).

“We do not want to intervene in people’s lives unnecessarily. However, we are aware of the strong feeling from some that a specific power of entry in the circumstances set out in this consultation could give an opportunity to offer timely information and advice, and ensure that people who are unable or unwilling to ask for help can have their voices heard.

“Through this consultation we are seeking evidence from your experience as to whether this would be an effective, proportionate and appropriate way to support the duty to make enquiries proposed in the draft Care and Support Bill.”

The consultation will run from 11 July until 12 October 2012. Comments received after 12 October 2012 will not be considered.

Please submit your comments by email to safeguarding-consultation@dh.gsi.gov.uk or by post to: Quality and Safety Team, Department of Health, 12 Wellington House, 155-159 Watersloo Road, London SE1 8UG.

To download the Consultation on New Safeguarding Power PDF visit www.dh.gov.uk/health http://www.dh.gov.uk/health/2012/07/safeguardingadults/.

- Smile-on and KSS Deeney have come together to produce Vulnerable Patients, an eLearning resource which addresses the role of dental, other healthcare professionals, and carers in safeguarding the welfare of vulnerable adults and children. Featuring 1.5 hours of CPD, this programme will help dental professionals identify potential signs of abuse and neglect and understand what to do when you suspect abuse. The programme also gives guidance on how to treat vulnerable patients in practice and the issues surrounding treatment consent and hygiene instruction.

For more information call Smile-on on 020 7440 8800 or email info@smile-on.com.
Editorial comment

As you read this issue of Dental Tribune, the biggest event on earth will be in full swing in London and other places across the country. Oh yes – the Olympics are here! And while we cheer on our respective countries we all get to involve ourselves in the highs and lows of competitive sport, as well as become world experts in sports that two weeks ago we had never even heard of! Let’s hope for a fantastic Games and the chance to show the world how great we are! (Come on Team GB! – Ed)

Moving back to matters closer to the surgery – congratulations to Anna Bradley, who has been confirmed as the Chair of Healthwatch England.

The role, which also comes with the honour of being a non-executive Director of the Care Quality Commission, was taken up by Ms Bradley on the 16th July.

Healthwatch is the new consumer champion for health and social care in England. It will exist in two distinct forms – Healthwatch England, at national level, and local Healthwatch, at local level.

Healthwatch England will be a national body representing the views of service users and the public. It will use these views to influence national policy and provide advice to Monitor, the NHS Commissioning Board, the Secretary of State and English local authorities, as well as providing leadership and support to local Healthwatch organisations.

BADN dental nursing conference

The 2012 National Dental Nursing Conference - the last before the end of the five-year CPD cycle for those dental nurses who registered before August 2008 - will be held at the Blackpool Hilton on 24 November 2012.

The new one day format is being trialled in accordance with dental nurses’ responses to the BADN’s recent survey. “Holding a one day Conference allows us to keep the cost down” said BADN President Nicola Docherty. “This year, with generous sponsorship from the BDTA, the Conference registration fee is less than £50 for BADN members, and offers 4.5 hours of verifiable CPD.”

“Topics include the core subjects of decontamination, medical emergencies and radiography, as well as oral cancer, hypnotherapies, communication skills, special care, the end of the cpd cycle and, of course, the keynote address by GDC Chair Kevin O’Brien.”

The Conference registration fee also includes lunch, refreshments and a pre-lunch Zumba session.

Also in accordance with the survey results, there will be no Presidential Dinner this year. Instead, delegates can join Nicola and other BADN Council members at an informal dinner at iconic fish and chips restaurant Harry Ramsden’s just beneath Blackpool Tower the evening before Conference.

For more information, visit www.badn.org.uk/conference where there is a link to the on line registration.

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Dental Tribune United Kingdom Edition  ·  July 30 - August 5, 2012

News 3
The DLA awarded for their initiative

The British Society for Dental Hygiene and Therapy are pleased to announce that registration for their flagship Annual Oral Health Conference & Exhibition is now open.

The 2012 event takes place at the Arena and Convention Centre (ACC) in Liverpool on 9th and 10th November.

This year’s event will include an impressive array of speakers from across the dental profession, with presentations, workshops, and a range of parallel sessions, all on subjects sure to be of interest to dental hygienists and dental hygienist/therapists, as well as other members of the dental team.

Located on Liverpool’s waterfront, and overlooking the River Mersey, the ACC is close to landmarks such as the Albert Dock, Tate Gallery, and many of Liverpool’s historic buildings, including the Liver Building - all within a UNESCO World Heritage site.

Sally Simpson, BSDHT President, said: “This year’s conference will be our first in the ACC at Liverpool and I’m sure everyone who visits this fantastic location will be very impressed by the state of the art facilities there. Delegates will experience an even wider choice of topics all directly relevant to and tailored specifically for dental hygienists and dental hygienist-therapists.”

To register for the event go to www.bsodht.org.uk.

BDA PEC Chair calls for high-quality care and professionalism

The recently-elected leader of the UK’s dentists, Dr Martin Fallowsfield, has pledged that the British Dental Association (BDA) will champion high-quality care, promote professional values and speak out forcefully on behalf of the profession.

Speaking in his first interview since being elected Chair of the BDA’s Principal Executive Committee (PEC) Dr Fallowsfield asserts his belief in the importance of all dentists being able to provide patient care in an environment where they are able to put patients’ interests first, free of concern about whether the system that is funding the care provides adequate resources for the treatment that is needed.

Dr Fallowsfield also argues that the significant contribution non-NHS dentistry makes to improving oral health in the UK deserves greater recognition, stressing the evolving aspirations and values of patients as a driving force for the different expectations many patients have of their dental care today.

Putting patients first, Dr Fallowsfield contends, is the behaviour that entitles dentistry to consider itself a profession. It is this belief in values and standards, he says, that lifts dentists above the level of artisans to their professional status.

The interview also sees Dr Fallowsfield discuss a range of other issues including the importance of the BDA’s trade union function, the findings of the recent Office of Fair Trading report into the UK dental market and the long-term nature of the challenge facing the PEC. The interview is available to read or listen to at http://bit.ly/LKri4M

New dental clinic to open at University of Central Lancashire

The University of Central Lancashire (UCLan) is launching a new dental clinic on its Preston campus – and dental professionals are invited to visit the new facility on a special open day on 9 August.

The UCLan Dental Clinic (UDC) will open in September. It will be fully equipped to meet both treatment and teaching requirements.

Dental services can be provided to students, staff and their families via the Denplan capitalisation scheme, at favourable prices. Dentists with special interests will offer personal treatment options or refer cases to the qualified dentists following the UCLan Postgraduate Masters programme.

Endodontic, periodontic treatments and advanced restorative procedures including implants will all be available. These high quality services will be offered at prices that compare favourably to the high street prices.

Announcing the launch of the clinic, Simon Crean, Dean of the School of Postgraduate Medical and Dental Education said: “This is an exciting development for UCLan – as well as for dental education in the northwest region. An on-campus clinic will give students and staff access to first class dental services and allow our dental students an amazing opportunity to develop their clinical skills without leaving the university.”

“Hope as many of our colleagues across the dental profession take the opportunity to come and visit this special site before our official launch in September.”

Paul Walsh, Clinical Director of the UCLan Dental Clinic said: “Our clinic will provide the full range of dental services one would expect from a first class dental surgery. We hope that once our colleagues from local clinics see the levels of expertise, service and patient care we can provide, they will be happy to refer patients to UDC. We are as committed to providing a service to the local community as we are to improving dental education in the UK.”

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Smile-on and Tempdent understand the need for flexible learning to fit around the busy lifestyles of dental nurses and practices.

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Giving a smile on Facebook

A man from Hove has reason to smile after a dentist in Brighton fitter him with new teeth for free, following their search for a worthy patient on Facebook.

David Bryant, a member of the charity Blind Veterans UK, was nominated for a new set of teeth, after the Brighton Implant Clinic decided to search for somebody who deserved a new smile.

After filtering through hundreds of applications, the dental practice decided on David, who was nominated by two colleagues and a patient. David’s hard work and commitment to ex-servicemen who have lost their sight in conflict earned him the opportunity to smile with confidence again.

“After visiting David at work and seeing how he interacted with patients and staff, it was apparent that he is a much-loved character,” said Bruno Silva, dental surgeon at the Brighton Implant Clinic.

“At the beginning of the year we ran a competition via Facebook for one lucky winner to win a brand new set of teeth, in the form of an all-on-4 procedure, a treatment that ranges in cost from £6,500 to £15,000. After sorting through hundreds of stories, one man caught our eye.”

David started to lose his teeth 15 years ago because of an accident and had very few top teeth left, and friends and family felt that David had low self-esteem due to his appearance.

David’s treatment consisted of extractions and all-on-4 implants. After a straightforward procedure and pain controllable with paracetamol, David left the clinic with new teeth, and above all, a new lease of confidence.

“I used to always avoid smiling,” said David. “My teeth were in a really poor state before my treatment, which meant I didn’t smile like I wanted to.

“I’m overwhelmed to have been nominated for implants and I can’t stop looking in the mirror at my new teeth,” he added.

Dental fillings cause “anxiety, depression, and social stress” in children

A New England Research Institutes study has discovered that composite dental fillings could be associated with impaired social behaviours in children.

The paper found that dental fillings that may release bisphenol-A (BPA) were associated with impaired social behaviours in children. According to the press release from NERI, associations were stronger when the composite fillings were on chewing surfaces where degradation of the plastic over time may be more likely. No adverse psychosocial outcomes were observed in children who had fillings made without the plastic materials.

“Dental Composite Restorations and Psychosocial Function in Children” was published in Pediatrics on July 16 2012.

BPA is used to create bisGMA – traditionally the main source monomer for composite dental fillings. Either a combination of BisGMA and other materials, or amalgam (silver coloured fillings containing mercury) are commonly used for dental fillings.

Researchers at the Harvard School of Public Health and New England Research Institutes studied dental fillings in 554 children aged six or older as part of a randomised trial of amalgam. They found that with increasing amount and duration of exposure to bisGMA fillings over five years follow-up, children reported more anxiety, depression, social stress, and interpersonal relation problems. The researchers say this finding is consistent with laboratory research showing social problems related to early life exposures to small amounts of BPA, but they add that additional studies are needed to confirm these findings.

Scientists ‘find’ anti-cavity molecule

A dentist from Austin, Texas, has put together a selection of poems about lips and smiles of patients that visit his dental surgery.

The collection of short poems, which is called Reflections On A Smile, Poems To Passion, is by Lester Sawicki.

According to report, the poems offer interesting thoughts and ideas of lips and smiles and the many moods that they present.

Having worked with mouths for more than 50 years, dentist Lester Sawicki started to look at his patients’ mouths and their smiles in a humorous and mystical way, rather than simple a mouth from a dentist’s point of view.

According to one report, Sawicki now sees the dental world in more ‘complex terms’ thanks to seeing smiles in his dental surgery in a new light. The book is now available from Amazon.

The molecule, named Keep 52, is reportedly able to destroy Streptococcus mutans, the bacterium which is instrumental in the development of dental caries.

However, even though the molecule is a potential breakthrough in preventing dental cavities, it has yet to undergo human testing.

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Dentists get Olympic fever!

Overseas athletes competing at London 2012 will receive free dental care at a specially constructed Polyclinic at the Olympic Park.

The move may come as a welcome relief for some of the athletes taking part, as the clinic will aim to carry out and complete work they may not have access to in their own country.

Top athletes may be putting their oral health at risk though frequent consumption of energy drinks, leading to the possibility of tooth decay and dental erosion. However, if they are receiving dental treatment while at the Olympic village, The National Dental Plan, run by the British Dental Health Foundation, believe it could help them to maintain a high level of performance.

Karen Coates, a Dental Advisor at the British Dental Health Foundation said: “Looking after your oral health not only has great benefits for your mouth, but also for your overall health too.

“Athletes are in a great position to begin with, as people who exercise are less likely to develop tooth-threatening problems that could lead to gum disease. Many other links between good oral health and good overall health have also been made, including diabetes, lung diseases and heart problems. However, too many sports and energy drinks, athletes are at risk of dental erosion.”

One dentist at the heart of the Olympics fully understands the pressure an athlete's teeth are under. Dr Kulnal Dattani will be the leading practitioner for athletes at the Rowing and Canoe Sprint Village at the London 2012 Olympics, after volunteering to be involved. He said in the Chesham and Buckinghamshire Examiner: “I thought it would be a once in a lifetime thing and it will be an amazing journey. It’s incredible and I will see the Games from a different angle.”

Dr Dattani told the Examiner about 40 per cent of the athletes referred for treatment over the course of the Games. He said: “Toothache is one of the worst pains you go through so I’ve got to make sure I treat them as soon as possible and relieve them of their pain. They’ve got to be on their game.”

However, with the participating athletes representing the height of fitness you may have presumed the Olympic organizers might have taken advantage of the country’s excitement by promoting a healthy lifestyle. Therefore it is a little surprising that the chief sponsor of the games is McDonald’s, the world’s leading fast food outlet.

It is not just the effect fast food has on our bodies that is concerning. Less healthy foods can also have detrimental consequences for oral health. Periodontal disease affects 19 out of 20 people. In a study by Case Western Reserve University, 12,000 Americans were examined to discover how lifestyle can affect oral health. Researchers found that regular exercise and healthy eating reduced the prevalence of gum disease, highlighting the importance of a healthy lifestyle.

A similar study was carried out earlier this year in Japan, looking at the relationships between eating habits and periodontal condition in university students. The analysis found that overweight students who frequently consumed unhealthy foods and ate foods that could be scopolylized were at a higher risk of developing gum disease. Carter noted: “One of the key ingredients to good oral health is a balanced diet.”

To put it simply, the more you eat unhealthy foods, the more oral damage is produced.

A positive investment in driving down infections

Almost £8m is being invested in driving down HIV infections and providing information to improve people’s sexual health. Public Health Minister Anne Milton recently announced.

The money will go to the Terrence Higgins Trust and FPA (Family Planning Association) over three years and builds on previous work funded by the Department.

The latest figures show that the largest increases in STIs were seen in men who have sex with men.

The funding will mean:

- the Terrence Higgins Trust and their partners receive £6.7 million to prevent HIV in men who have sex with men and people from African communities, the groups most affected by HIV in England; and
- FPA will receive £1.15 million for their comprehensive specialist sexual health information service for the public and health workers.

There are nearly 100,000 people living with HIV in the UK yet a quarter of them don’t know they have it - meaning they’re more likely to pass it on and are harder to treat. In 2010, there were around 5,000 new diagnoses in men who have sex with men - the highest number ever reported in one year.

Public Health Minister Anne Milton said: “Sexually transmitted infections can lead to serious health problems.

“One in twenty gay men and one in twenty black African men and women in England are HIV-positive and in London this rises to one in every seven gay men.

“This money will help the Terrence Higgins Trust and FPA reach out to these communities. They will use a range of approaches including social media to encourage more people to come forward for testing.”

Sir Nick Partridge, Chief Executive of Terrence Higgins Trust said: “England has a strong record in HIV prevention and we are proud of the part we have played in this, but the stakes – and potential gains – have never been higher. It’s within our grasp to significantly reduce the rates of new infections by working together with local authorities, clinical services and most importantly the communities most at risk of HIV. Our plans are exciting, ambitious, but achievable, and we’re proud to have been entrusted with this work.”

Julie Bentley, Chief Executive, FPA said: “FPA has delivered factual, accessible, and high quality sexual health information to the public and healthcare professionals for many years. We are delighted to have won this contract which is evidence of how respected and trusted our sexual health information continues to be.”

Titanium implants may corrode

Titanium medical implants used in bone-anchored hearing aids and dental prostheses, may not be as robust as commonly believed, according to new evidence from scientists at the University of Birmingham.

Collaborative research led by Dr Owen Addison in the Biomaterials unit of the School of Dentistry has found evidence to suggest that in environments where there is no significant wear process, microscopic particles of Ti can be found in the surrounding tissue.

This can potentially be pro-inflammatory and affect the performance of the device scientists say in a research paper published today (Wednesday July 25) in the Journal of the Royal Society Interface.

Globally, more than 1,000 tonnes of titanium (Ti) is implanted into patients in the form of biomedical devices every year. Metallic prostheses, fixation and anchoring devices are used extensively for orthopaedic, craniofacial and dental rehabilitation and their effects on the body are widely perceived to be predictable following initial implantation.

For this study, tissue was obtained from patients undergoing scheduled revision surgery associated with bone-anchored hearing aids (BAHA) at University Hospitals Birmingham NHS Trust. Soft tissues surrounding commercially pure Titanium anchorage devices were investigated using microfocus synchrotron X-ray spectroscopy at the Diamond Light Source (Oxford, UK).

The results showed, for the first time, a scattered and heterogeneous distribution of Ti in inflamed tissues taken from around failing skin-penetrating Ti implants, the authors report. Wear processes and implant debris were unlikely to be major contributors to the problem, they concluded.

“In the absence of obvious macroscopic wear or loading processes, we propose that the Ti in the tissue results from micro-motion and localised corrosion in surface crevices.”

The development of peri-implant inflammation may result in the premature loss of the implanted device or the require- ment for additional surgery, although there were no cases in the study to which Ti could be linked.

“The results showed, for the first time, a scattered and heterogeneous distribution of Ti in inflamed tissues taken from around failing skin-penetrating Ti implants, the authors report.”

DPC taster day

This is a taster day designed as an introduction to a nationally recognised qualification in mentorship for the registered dental care professional (DCP). This will suit all DCP’s who have or wish to develop a role in team training and development and is an ideal stepping stone for those who are considering teaching and/or mentoring as a career.

Julie Bentley, Chief Executive, FPA said: “FPA has delivered factual, accessible, and high quality sexual health information to the public and healthcare professionals for many years. We are delighted to have won this contract which is evidence of how respected and trusted our sexual health information continues to be.”
Defining an organisation
Alun Rees discusses business success

"It’s a very personal thing, but throughout my career – from my time as a teacher, to my time as a banker – I have seen just how important culture is to successful organisation’s... Culture is difficult to define, I think it’s even more difficult to mandate – but for me, the evidence of culture is how people behave when no one is watching... Our culture must be one where the interests of customers and clients are at the very heart of every decision we make; where we all act with trust and integrity. But it’s not just about how we behave towards our customers and clients. It’s also about how we work together with our colleagues, because if you have to deliver for customers with 150,000 colleagues around the world, as we do, you better be able to work as a team. As far as I’m concerned, if you can’t work well with your colleagues, with trust and integrity, you can’t be on the team. Culture truly helps define an organisation."

Fine words and there is no one who can dispute them. It’s the sort of statement that a leader in any business or organisation should be making. However when you discover that the words were spoken last year by Bob Diamond the recently ex-CEO of Barclays Bank whilst giving the Today Business Lecture in 2011 your opinion might change.

I am old enough and have enough memory of my ‘right-on’ days to retain a suspicion of Barclays because of their involvement with South Africa in the years before the end of apartheid. In recent times the stories of Mr Diamond’s “compensation package” and bonuses have made me wonder what he actually did - but like many I wondered, with just a hint of jealousy, what I would do with so much money.

His appearance a couple of days ago before a committee of MPs, each of whom seemed to have a separate agenda resulting in most of them missing the target, apart perhaps from having their voices recorded for posterity, made me reflect on Mr Diamond’s name. Bob Diamond or perhaps Diamond Bob could have been a dark suited card sharp on a Mississippi river boat, a small revolver concealed in his sleeve for settling arguments without debate. Or perhaps it’s more redolent of Las Vegas where he might have fronted a mob owned casino. If the latter then his appearance before the committee this week is reminiscent of Al Pacino’s Michael Corleone in...
Godfather II facing down the federal inquisitors investigating organised crime.

To return to Mr Diamond’s talk; my grandmother had many wise sayings, one was “Fine words butter no parsnips”. The modern equivalent amongst those of us seeking to be ethical professionals is “Walk the Talk”. Both of these are comparable with “the evidence of culture is how people behave when no-one is watching”. Yet in a more profound context the perception has become that the culture of the organisation is wanting, to say the least, because of the actions of a few individuals.

I speak about, consult on and coach what I know, and that is dentistry and people. We are constantly being encouraged by business pundits and gurus to be authentic, honest and sincere. Sadly the cynic in me is reminded of the words of Groucho Marx who said: “To be successful you can fake that you can fake all you need is sincerity; once you can fake that you can fake anything.”

One of the first things I attempt (I admit I don’t always succeed) with clients is to get them to work out what they truly want to do with their lives. Yep it’s that “vision” thing again. Until they know their destination I can’t help them to find their own road, but one thing I truly know is that until they have a dream, a desire, an aspiration they will go around in circles or worse they will wander down someone else’s path because “it seemed to have worked for them.”

Unless those dreams are congruent with their conscience, unless they are doing what they do for the right and therefore ethical reasons they will end up disappointed and frustrated. Ultimately they will need to confront their own version of Diamond Bob’s time of reckoning even if it’s only by facing their children or by staring into their own eyes in the mirror every day.

I often come across this lack of consistency when I talk about the subject of sales and selling in professional life – it seems that as long as it’s said to be “ethical” and “low-key” then it’s OK. What I find is that people have been on sales courses and have learned the words, the techniques of rapport and closing and so on without working out exactly what it is they are trying to achieve for the greater good of the patient.

That’s where “selling without the S-word” came from - a challenge from a client to encourage his team to (whisper it) “sell” without them realising that’s what they were doing. It takes high quality leadership (another overused and poorly understood word) to ensure that the culture of a business is imbued with that “trust and integrity” that Bob Diamond mentioned, if you’re not a leader that can be trusted 100 per cent or whose integrity can be called in to question then don’t be surprised when your organisation performs poorly.

Until every team member from cleaner to principal is doing what they are doing for the long-term benefit of the patient and truly understand and embrace that, until they truly walk the talk then success will be an illusion.
Antimicrobial Prescribing for General Dental Practitioners - book review

Antimicrobial prescribing can be a hazy subject, but a new book released by the FGDPUK, Antimicrobial Prescribing for General Dental Practitioners, aims to help de-fog this imprecise topic.

Throughout the book, authors general dental practitioner Dr Palmer, senior clinical lecturer Dr Longman, senior medicines information pharmacist Ms Randall, and Dr Pankhurst, a specialist in oral microbiology, all aim to improve the standards of patient care by providing a clear and systematic evidence-based set of guidelines. The purpose of the book is undeniably to provide GDPs with clear advice and help de-fog this imprecise topic.

The authors then follow up on this section and go on to describe the contentious issue of administrating antimicrobials to prevent infection. In this section Antimicrobial Prescribing for General Dental Practitioners highlights the difficult ethical and medico-legal issues, affirming it is not always easy to identify over usage. It might have been as tute to have added a specific straightforward manner when and where prescribing the agents might be useful.

As well as being an essential reference tool, Mr Ladwa said: “This is a very timely book. I was at a talk this morning on the non-surgical treatment of periodontal disease, where the speaker talked about the over-prescription and misuse of antimicrobials. As a profession we need to ensure that antimicrobials are only prescribed when necessary and in the right dosage.”

Speaking at the launch, Dean of the FGDPUK (UK) Russ Ladwa said: “This is a very timely book. I was at a talk this morning on the non-surgical treatment of periodontal disease, where the speaker talked about the over-prescription and misuse of antimicrobials. As a profession we need to ensure that antimicrobials are only prescribed when necessary and in the right dosage.”

Although as being an essential reference tool, Mr Ladwa also said that the book provided practitioners with a useful opportunity to review how they work: “As a practitioner for over 50 years I found through reading this book at least three changes I need to make when prescribing.”

The authors have reviewed all of the available data and guidance, and consulted widely with professional bodies and specialist groups to provide a consensus on best clinical practice. The guidance gives clear, simple and practical advice on when to prescribe, what to prescribe, for how long and in what dose.

Editor Nikolaus Palmer said: “This book was produced to complement the BNF and provide general dental prac-
A powerful practice-builder

Michael Sultan discusses CPD in dentistry

CPD is a vital part of modern dentistry, and like it or loathe it, it is something that we all need to do. As registered dental care professionals, we have a duty to keep our skills and knowledge up to date in order to give patients the best possible treatment and care. This not only helps reassure patients about the standard of treatment they are going to receive but also benefits our everyday working lives as it enables us to keep our skills fully up to date with the latest techniques and evidence-based thinking.

Given the importance of CPD both to my work as an endodontist and as an employer, I was interested to read over the GDC’s latest study exploring what registrants, stakeholders and providers think about mandatory CPD in dentistry. The survey, which can be found in full on the GDC’s website, received more than 6,000 responses in total – the results of which were then analysed and expressed in total – the results of which were then analysed and compiled into a substantial and rather enlightening report.

Among the many findings of the study, the report found that 65 per cent of all registrants generally do CPD outside of working hours. It is perhaps unsurprising then, that the report also found that online learning is generally the preferred learning style of over half of all GDC registrants.

From my own perspective, one of the key findings of the study revolves around the thorny issue of cost. According to the report “cost of CPD was an important factor for dental nurses because of their low wages and the fact that some employers paid only for a part of or none of the CPD their nurses were required to do.” When I read this, I was quite frankly shocked that some practices don’t cover these costs. At EndoCare it is our policy to arrange and pay for all necessary staff CPD. The reason for this is that CPD is just so vital in allowing us to provide the very best levels of patient care. In my experience it can also be a powerful motivator, and helps add to staff satisfaction, making for a far more positive working environment.

We should remember that relative to dentists, nurses don’t earn that much, so to place the same CPD cost burden on them as on dentists seems cruelly unfair. It should be the duty of every practice therefore to take an active interest in the education of their staff, and provide the required courses as necessary.

CPD is vital part of modern dentistry

From a practice’s perspective, this shouldn’t be seen as “just another cost” either, as the benefits CPD can bring can extend far and beyond the obvious educational gains. Take CPR for instance. As we know, medical emergency training is part of the core CPD requirement, but it’s something we all take part in as an arm of our work. Forcoursessuch as these we will normally pay for a trainer to come in so people can come to work every day.

With a happy, highly motivated, highly trained workforce, the practice can only benefit as a result.

First, there is the obvious function that it allows our team members to complete their compulsory CPD requirement. Secondly, and just as importantly, it helps us to build up a far better team spirit. Anything we do together as a team helps produce a better atmosphere and ultimately a better practice. It’s short-sighted then to say to nurses “you’re on your own, you have to pay for it yourself”, as if anything, compulsory training sessions such as CPR are an excellent excuse to get together – normally followed by food and wine!

In my opinion it is our duty to train our nurses, and it’s unfair to expect them to pay for it. As a profession we often get too caught up in our own little “bubbles” and forget to look at the bigger picture as a result. We should remember that people don’t just come to work for the money (if they do then we shouldn’t employ them), people come for a sense of worth, for education, for purpose. From a financial sense, it seems only fair that we pay for our nurses’ CPD, but from a wider perspective as well these sorts of things give our employees something tangible they can take away from their job. They give our staff an extra reason to come into work every day.

The report also found that online learning is generally the preferred learning style of over half of all GDC registrants.

Michael Sultan discusses CPD in dentistry

CPD is a vital part of modern dentistry

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Endodontic retreatment

Dr Brett E. Gilbert discusses how to achieve success the second time around

Retreatment has been shown to have a success rate of 92 per cent. However, as research methodologies move towards higher levels of substantiation, clinicians must rely on the best current evidence available to gain insight into the expected outcomes of their treatment. The highest level and best current evidence we have on the clinical success of endodontic treatment comes from a meta-analysis of the literature.

A meta-analysis done in 2007 by Ng et al. provides a thorough review of endodontic success rates from a variety of classical outcome studies. They found a weighted pooled success rate of 68 to 85 per cent, with at least one year of follow-up. This review considers the strictest of criteria for determining that a tooth has been healed, and includes many studies that were completed prior to the clinical use of dental operating microscopes and other advanced armamentaria.

When considering treatment for a tooth that has not been healed successfully with root-canal therapy, there are significant challenges to address to be able to attain complete healing of the diseased tooth. The armamentarium and techniques available today allow us the ability to disinfect the root-canal system properly after initial treatment has led to post-treatment disease.

The success rate of retreatment has been shown to be in the range of 80 per cent healing. Phases III and IV of the Toronto Study showed such a healing rate four to six years after non-surgical retreatment. In a systematic review by Torabinejad et al. comparing non-surgical retreatment to endodontic surgery, it was demonstrated that non-surgical retreatment had a success rate of 85 per cent versus 71.8 per cent for endodontic surgery after four to six years.

The presence of pretreatment apical periodontitis is one factor that has been shown to decrease the success rate. Micro-organisms are the most critical aetiology of post-treatment disease, as they are present within the root-canal system of a previously endodontically treated tooth owing to a combination of stubborn endodontic techniques, iatrogenic treatment issues and restorative failure. Intra-radicular bacteria are the primary aetiology of post-treatment disease and eradication of these bacteria is the primary goal of retreatment procedures.

The bacteria present in the initial infection of a root canal differ markedly from the bacteria infecting a previously treated tooth. Pretreatment flora is polymicrobial with equal numbers of Gram-negative and -positive bacteria. Post-treatment bacteria are predominantly Gram-positive and they have been shown to be able to survive in harsh environments and to be resistant to many treatment methods.

There are high numbers of Enterococcus species, Entero- cocci faecalis, for exam-
ple, has been shown to be a common isolate in 27 to 77 per cent of teeth with post-treatment disease. A contaminated canal space may result from incomplete cleansing initially or subsequent leakage into root-canal spaces following root-canal treatment. Once present inside the canals, E. faecalis has a variety of characteristics that allow it to evade our best efforts to eradicate it from the root-canal system, including the ability to invade dentinal tubules and adhere to collagen. It is also resistant to calcium hydroxide application inside the canal system, which is an inter-appointment treatment technique used to help remove micro-organisms and their by-products, such as lipopolysaccharides, from the canal space. E. faecalis’s resistance of calcium hydroxide action arises from its ability to pump hydrogen ions from a proton pump. The hydrogen combines with the hydroxyl ions of calcium hydroxide and neutralises the high pH value.

E. faecalis is also able to resist calcium hydroxide by being part of a biofilm. The protection of bacteria within a biofilm matrix prevents the contact of the bacteria with irrigants and medicaments, and allows communication between bacteria to aid in survival capabilities. The presence of E. faecalis is well documented; however, its role in post-treatment disease has yet to be proven definitively. Its survival mechanisms, however, shine a light on the persistent capabilities of these bacteria, and our clinical techniques must be focused on the challenge of eliminating them.

Iatrogenic issues encountered during the initial root-canal treatment may be the cause of intra-canal bacterial infection. These issues may include perforation, incomplete cleansing and shaping.
inadequate canal enlargement, missed canals, ledging, canal transportation, over-instrumentation, as well as obstruction of the canal by debris or separation of instruments. Failure to use or using too small a volume of an appropriate irrigant solution, such as sodium hypochlorite, is an iatrogenic error.

Full-strength six per cent sodium hypochlorite been shown to be highly antimicrobial and able to dissolve tissue and disrupt bacterial biofilm. These qualities in an irrigant are ideal for the debridement of residual bacteria and tissue debris. The use of a rubber dam to isolate the treatment field is the standard of care for endodontic treatment. Failure to use a rubber dam may be a fundamental contributor to post-treatment disease. The following case illustrates the ability to overcome prior or incomplete treatment to achieve successful healing (Figs 5a–c).

Clinical example
Restorative failure is a common cause of post-treatment disease. Failure to place an effective permanent access restoration in a timely manner can allow for bacterial entry into the root canal system by coronal leakage. Submarginal leakage on a crowned tooth can also allow bacterial entry to occur.

Decay in a previously treated tooth is another source of bacterial contamination. Structural damage to a tooth by trauma, cracking or fracture may provide an entry point for bacterial contamination of the canals. Our patients are responsible for their own oral health and must commit to effective oral hygiene.

The use of a dental operating microscope and ultrasonic instruments allows clinicians to uncover all existing canal anatomy properly to ensure that they are able to cleanse the root-canal system completely. The following clinical case (Figs. 4a & b) illustrates the extent of the canal space left untreated in the initial root-canal therapy by not opening the mesiobuccal canal adequately and not locating and cleansing the hidden second mesiobuccal canal.

Thereby greatly improving the ability to retrieve canals (Figs. 6a–c). A heat source such as a System B tip (Axis, SybronEndo) is efficient for the removal of gutta-percha and resin materials from the coronal third. Hand and rotary files can remove root fillings and shape canals to appropriate working lengths. Current NiTi rotary files are highly flexible and resistant to separation and allow us to mechanically enlarge the apical third of root canals safely and efficiently without alteration of the natural canal morphology, which allows effective irrigation to reach the complex anatomical root canal. Bacteria are able to hide and resist debridement.

Once the canals have been located and instrumented, the ability to irrigate becomes essential to successful treatment. The irrigant solutions target the bacteria we are trying to eliminate. While sodium hypochlorite is a potent and proven antimicrobial and tissue dissolver, two per cent chlorhexidine has been shown to prevent the adhesion of E. faecalis to dentine. EDTA 17 per cent is often used as an effective smear layer removal agent. Therefore, mechanical debridement and canal instrumentation provide a pathway for copious chemical irrigation deep into the canal.

Passive ultrasonic irrigation allows clinicians to place an irrigant solution into the pulp chamber and activate it as it is carried down to the apical end of the root canal. The IrriSafe tip from Satelec (Acteon; Fig. 7) is a non-cutting ultrasonic file that is placed into each canal and is moved up and down in the canal for three cycles of 20 seconds. Passive ultrasonic irrigation has been shown to irrigate lateral canals better at 4.5 and 2mm from the working length of canals as compared with needle irrigation alone. It has been demonstrated that passive ultrasonic irrigation can remove dentine debris in a canal up to 5mm in front of where the tip extends apically in straight or curved canals. This evidence shows that an effective flow of irrigation can assist in the cleaning of teeth in which canal alteration occurred during the initial root-canal treatment.

The following silver-point case (Figs. 8a–c), with a large distal post and apical transportation in the mesial root, demonstrates the successful healing of post-treatment disease when proper disinfection has been accomplished. This case illustrates the reason that retreatment is the primary treatment option for post-treatment disease.

Once debridement and disinfection have been completed, appropriate...
obturation methods are used to seal the canal spaces. The warm vertical technique using gutta-percha or resin with an appropriate sealing agent provides a thorough seal of the well-cleansed and shaped canal spaces. The final restoration must provide a proper seal of the pulp chamber to prevent coronal microleakage.

Current evidence has demonstrated that we can retreat previously endodontically treated teeth properly and successfully. The literature has also shown that specific bacteria, such as E. faecalis, are able to survive inside a previously filled canal. The use of a dental operating microscope, ultrasonic instruments, irrigants, rotary NiTi files and appropriate obturation materials increases our ability to attain healing after retreatment. As we continue to strive to maintain healthy natural teeth for our patients, endodontic retreatment should be the primary option for patients with post-treatment disease.

A complete list of references is available from the publisher.

About the author

Dr. Brett Gilbert received his D.D.S. and Certificate of Endodontics from the University of Maryland. Dr. Gilbert has a private practice limited to Endodontics in Niles, Illinois. He is currently on faculty in the Department of Endodontics at the University of Illinois at Chicago. College of Dentistry and on staff at Resurrection Medical Center in Chicago. Dr. Gilbert is a Diplomate of the American Board of Endodontics and lectures nationally and internationally on clinical endodontics.
Large periapical lesion management

Dr Nuria Campo discusses decompression combined with root-canal treatment

Most periapical lesions occur as direct sequelae of chronic apical periodontitis, usually after pulp necrosis of a tooth. The affected tooth is non-responsive to thermal and electrical pulp tests. Periapical lesions often develop slowly and do not become very large. Patients do not experience pain unless there is acute inflammatory exacerbation. These lesions are often diagnosed during routine radiographic exams. Some periapical lesions become large and, in cases of large radiolucencies, they may be diagnosed in the absence of any patient complaint.

Sometimes, symptoms such as mild sensitivity, swelling, tooth mobility and displacement may be observed in these cases.

Large periapical lesions are often associated with anterior maxillary teeth, probably due to traumatic injuries. These lesions could be classified as granulomas, pocket cysts (also called bay cysts) and true cysts. Granulomas are usually composed of solid soft tissue, while cysts have a semi-solid or liquefied central area usually surrounded by epithelium. Pocket cysts have an epithelial lining that is connected with the root canal, and true cysts are completely lined with epithelium and not connected with the root canal.

According to Nair’s research, based on serial sectioning and strict histopathological criteria, the prevalence of pocket cysts to be six per cent, whereas that of true cysts is nine per cent. Previous studies without serial sectioning that reported ranges from six to 55 per cent are proven to contain a great margin of error. The differential diagnosis of large periapical lesions is still a controversial topic. Periapical radiographs, contrast media, Papamichaelou smears and albumin tests have proven to be inaccurate in establishing a preoperative diagnosis. Only once the post-operative biopsy has been taken, can a diagnosis be established.

There is evidence that CBCT scans may provide a more accurate diagnosis than biopsy. To obtain an accurate reading, the entire lucency must be scanned for the most lucent or least dense areas. If the least dense area of the CBCT scan shows positive grey-scale values identified as solid tissues, diagnosis will be consistent with granuloma. If it shows negative grey-scale values identifying a semi-solid or fluid-filled central area, diagnosis will be consistent with a pocket or a true cyst. Real-time ultrasound imaging and ultrasound recently demonstrated that they are capable of establishing differential diagnosis as well.

There is widespread agreement that most granulomas may heal after non-surgical root-canal treatment (NSRCT), but there is no consent regarding this in the case of periapical cysts. In Nair’s opinion, based on indirect clinical evidence, it appears that pocket cysts heal after non-surgical root-canal treatment (NSRCT), but there is no consent regarding this in the case of periapical cysts.

Case report

A healthy 39-year-old male patient with recurrent palatal swelling and buccal abscesses was referred to our practice (Fig 1). He had had these symptoms for the last two to three years owing to trauma sustained while working with machinery. An RCT on tooth #9 had been performed following the incident. One year later, the tooth presented with apparent brown discoloration according to the patient.

At the initial examination, tooth #9 was found to be non-vital (non-responsive to cold or electrical stimuli), and teeth #7, 8, 10 and 11 had a cold pulpal response within normal limits. Radiographs revealed a large cyst-like periapical lesion that appeared to be centred above the left upper central incisor (Figs 2 & 3). A panoramic radiograph (Fig 4) confirmed the full ex-
tent of the lesion, which appeared to involve the floor of the nasal sinus. The history of repeated palatal and buccal abscesses suggested a through-and-through osseous defect.

The diagnosis was apical periodontitis in tooth #9.

The following treatment options were considered:

• decompression combined with RCT; and
• surgical removal of the lesion with RCT on tooth #9 and possibly teeth #8, 10 and even 7 and 11 owing to the great risk of damaging nervous and vascular supply during surgery.

The patient preferred the most conservative approach and treatment was performed in four appointments over five months.

Management sequence

1 During the first visit, the previous root-canal filling (gutta-percha with a plastic carrier) was removed (Fig 5). There was a lot of gutta-percha in the pulpal camera. This and remains of necrotic pulpal tissue could have been the cause of the brown staining of the tooth. Persistent purulent content from the canal was noted. A Ca(OH)2 paste (Ultracal XS, Ultradent) was placed in the root canal as interim medication (Fig 6). Once the buccal encapsulated tissue was removed (Fig 7), copious drainage was also obtained from the buccal abscess.

2 After one month, Ca(OH)2 was replaced because the canal could not be dried even after shaping and cleaning with copious amounts of 5.25 per cent sodium hypochlorite. A vestibular incision was made and a page 18

![Fig 5 Previous root-canal filling (gutta-percha with a plastic carrier)](image1)

![Fig 6 Ca(OH)2 root dressing](image2)

Fig 5

Fig 6

- There is widespread agreement that most granulomas heal after non-surgical root-canal treatment (NSRCT), but there is no consent regarding this in the case of periapical cysts.

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plastic cannula was inserted into the lesion, obtaining purulent drainage. Thereafter, the cannula was prepared and sutured to the mucosa (Figs 8 & 9), and the patient was instructed to irrigate through the lumen of the cannula with 3ml of 0.12 per cent chlorhexidine on a daily basis for four weeks (Fig 10), consistent with the protocol described by Brøndum and Jensen.5

Two months after the last visit, complete drying of the canal space was achieved but, owing to the extent of the lesion, it was decided to replace and maintain the Ca(OH)2 for two months in order to determine whether this would effect healing as evidenced in the pattern of the lesion.

Two months later, healing appeared to be underway (Fig 11a) and the canal was dry. The root-canal filling was performed with gutta-percha and AH Plus (DENTSPLY DeTrey) and composite were placed to seal the access (Fig 11b).

The patient was recalled at eight months and was asymptomatic and there was no swelling or abscess at either the palatal or buccal surfaces. Normal pulpal responses have been maintained in teeth #7 to 11 since.

Healing of the lesion still appeared to be in progress, owing to the reduction in the size of the lesion. The trabecular pattern at the borders of the lesion had been restored (Fig. 11c) and the periodontal ligament around tooth #9 was almost fully recovered (Fig. 12). We plan to recall this patient on a yearly basis until the lesion is fully healed.

Discussion

The management of large periapical lesions is the subject of prolonged debate. The treatment options range from RCT or NSRCT with long-term Ca(OH)2 therapy to various surgical interventions, including marsupialisation, decompression with a tube and surgical removal of the lesion. These treatment options can also be combined.

Long-term drainage is important in the conservative management of these large lesions. One method is to drain through the canal on a daily basis until the canal becomes dry.

Fig. 8 Modified print tip used as cannula

Fig. 9 Sutured plastic cannula

Fig. 10 Flat-tipped needle with Luer-Lok syringe for irrigation

Fig. 11a After five months of intermittent medication, healing appeared to be underway

Fig. 11b Root-canal filling and coronal sealing

Fig. 11c Eight-month recall periapical radiograph

Fig. 12 Eight-month recall panoramic radiograph
from the apical focus. There is no standard protocol for the length of time for which the tube should be left in. Some clinical cases, however, have reported five-week to 14-month-periods, with periodical reshaping if necessary.

The literature offers evidence that the majority of these cyst-like lesions heal after conventional RCT over multiple appointments. Çaliskan6 reported 74 per cent complete healing and 9.5 per cent incomplete healing in an in vivo study of anterior teeth with large periapical lesions ranging from seven to 18mm. The treatment combined long-term canal drainage with Ca(OH)2 dressing and non-surgical RCT. Several case reports7-9 have demonstrated that long-term decompression involving a tube combined with interim Ca(OH)2 dressing and RCT is also successful.

Decompression is favoured because fewer visits are necessary compared with root-canal drainage. Furthermore, it is much more conservative, especially in comparison with surgical removal of the lesion with the risk of damaging the nervous and vascular supply of adjacent teeth and other anatomical structures, such as the nose and maxillary sinus floor. Even if surgical removal is still necessary later, the lesion will predictably have shrunk in size by such time and present less difficulty and less risk of damage to other teeth or vital structures.

With complete informed consent, the patient may prefer more immediate therapy and select surgical enucleation without delay in conjunction with the conventional endodontic therapy of the responsible tooth and usually the adjacent ones involved in the lesion. It is important to remember that microbes initially caused the lesion and continue to maintain the immune response and thus the apical periodontitis.

...{

"Decompression is favoured because fewer visits are necessary compared with root-canal drainage. Furthermore, it is much more conservative."

The length of time required for healing in these cases ranges from eight to 14 months. Follow-up on the process of healing should be done every six months for four years.

There are also large periapical lesions of nondental origin, such as non-dental cysts (e.g. naso-palatal cyst) and neoplastic entities. If there are doubts regarding the dental origin of the periapical lesion, the first choice of treatment is the surgical approach.

This case has illustrated the healing of a large periapical lesion with a minimally invasive approach. However, every case requires an individual approach depending on the patient’s cooperation, preferences, availability and proximity to the surgery, as well as the dentist’s professional training and technical skills.

...{

About the author

Dr Nuria Campo received her degree from the University of Barcelona in 1997. She is a self-trained endodontist. Dr Campo co-organised the Roots Summit IX in Barcelona. ncampob@gmail.com www.microendodoncia.wordpress.com es-es.facebook.com/microendodoncia

‘Decompression is favoured because fewer visits are necessary compared with root-canal drainage. Furthermore, it is much more conservative.’

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Editorial note: A complete list of references is available from the publisher.
Intentional replantation: A viable treatment option for specific endodontic conditions

Prof Naseem Shah, Dr Ajay Logani & Dr Abhinav Kumar

Intentional replantation is defined as the purposeful extraction of a tooth in order to repair a defect or cause of treatment failure and thereafter the return of the tooth to its original socket. Any tooth that can be atraumatically removed in one piece is a potential candidate for intentional replantation.

However, specific indications include:

- all other endodontic non-surgical and surgical treatments have failed or are deemed impossible to perform
- limited mouth opening that prevents the performance of non-surgical or peri-apical surgical endodontic procedures
- root-canal obstructions
- restorative or perforation root defects that exist in areas that are not accessible via the usual surgical approach without excessive loss of root length or alveolar bone
- Contraindications may include:
  - long, curved roots
  - advanced periodontal diseases that have resulted in poor periodontal support and tooth mobility
  - multi-rooted teeth with diverging roots that make extraction and reimplantation impossible
  - teeth with non-restorable caries

In order to provide the best long-term prognosis for a tooth that is to be replanted intentionally, the tooth must be kept out of the socket for the shortest period possible, and the extraction of the tooth should be atraumatic to minimise damage to the cementum and the periodontal ligament.

The periodontal ligament attached to the root surface should be kept moist in saline, Hank's Buffered Salt Solution (HBSS), Viaspan or Doxycycline solution for the entire time the tooth is outside the socket.

We have documented three clinical cases to exemplify the potential of intentional replantation as a viable treatment option in select endodontic cases.

**Case I**

A 14-year-old male patient presented with a separated Lentulo spiral extending 4.5mm beyond the apex of the mesiobuccal root canal of tooth #46 (Figs. 1a-d). The tooth was badly broken and the instrument tightly screwed into the root canal. All efforts to remove the spiral were futile, and we were concerned that it would fracture at the apex.

Apical surgery was ruled out because accessibility to the mesiobuccal root would have been limited. We decided to replant the tooth intentionally and discussed this treatment option with the patient, who agreed to our proposal. Since the tooth was badly broken, we planned to reinforce its core with a post in the distal canal prior to extraction.

Once we had obtained adequate anaesthesia, the tooth was extracted atraumatically with an extraction forceps. We did not use surgical elevators and took care that the heaks did not go beyond the cementoenamel junction (CEJ), as this may have damaged the cementum and the periodontal ligament.

Following extraction, we kept the tooth moist by immersing it in Viaspan. With the breaks of the forceps, we held the tooth by its crown and cut the clot. The socket was filled with tricalcium phosphate in order for the tooth to be 2-5mm higher than before. This helped in planning a good post-endodontic restoration.

The tooth was carefully reinserted into its socket and brought into occlusion with digital manipulation and patient bite force. The tooth was stabilised in its socket with a sling suture. The patient was re-evaluated after seven days, and the sutures were removed.

**Case II**

A 22-year-old male patient presented with a history of trauma to his maxillary anterior region. Clinical examination revealed an Ellis Class III fracture of tooth #12, with the fracture line extending to the root palatally. Once the mobile fragment had been extracted, we realised that the fracture line extended 2-5mm sub-crestally. In order to bring the apical end of the fracture line to a supra-crestal position, we considered two options: orthodontic extrusion and intentional replantation. The patient did not accept orthodontics as an option owing to the extended treatment time required.

Once the tooth had been atraumatically extracted, it was kept moist in Viaspan,

*Fig 1a Tooth #46 with a fractured Lentulo spiral pushed past the apical foramen in the mesiolingual canal.*

*Fig 1b Tooth replanted after removal of the fractured instrument (apicoectomy and retrograde MTA obturation).*

*Fig 1c Clinical photograph of tooth #12 showing the PGG.*

*Fig 1d Six-month follow-up.*
We inserted tricalcium phosphate in the apical 3-4mm of the socket and reinserted the tooth with a 180° rotation to bring the deep fracture line to a more accessible labial side. The tooth was then splinted with fibre reinforced composite for a period of three weeks.

The root-canal treatment was completed at a later date, and the facial surface was built up with composite. We decided not to proceed with the crown immediately after stabilisation to prevent loading of the tooth. The patient was recalled periodically for follow-up.

Case III
A 23-year-old female patient presented with pain in her upper right anterior tooth. There was no history of trauma, and clinical examination revealed a deep palato-gingival groove (PGG) with respect to tooth #12 (Figs 2a–e). The intra-oral peri-apical radiograph revealed a peri-apical radiolucency. We decided to extract the tooth, seal the groove and then replant the tooth. After adequate anaesthesia had been obtained, the tooth was extracted with all the necessary precautions and immersed in Viaspan. With help of the forceps, it was then held by its crown. The PGG was debrided with the tip of the ultrasonic scaler and sealed with glass-ionomer cement (GIC). The socket was then gently curetted and the tooth reinserted. Sutures were placed in the minter-dental area and endodontic treatment was completed one week later. The apical 4-5mm of the root were sealed with MTA, and the rest of the root canal was back-filled with thermo-plasticised gutta-percha. The patient was re-evaluated after seven days.

Discussion
Intentional replantation in dentistry has been performed for more than 10 centuries and was used extensively to manage odontalgia. In 1561, Pare recommended its use when a healthy instead of a diseased tooth was mistakenly extracted! In 1712, Pierre Fauchard* replanted a tooth and reported it to be stable on follow-up. Several steps in the replantation were debated, for instance the need for amputation of root apices, immediate or delayed replantation, root-canal obturation before or after replantation, removal or preservation of periodontal ligament cells and the goal of ultimate healing—bony ankylosis or ligament repair. It was in 1881 that Thompson presented the treatise on the replantation of teeth and emphasised the importance of peri-cemental tissues for treatment success. Later, Fredel in 1887 and Schell in 1890 addressed the role of periodontal ligament cells with regard to external root resorption after replantation.

As the replantation technique became increasingly refined, it was used as an easy alternative for failing root-canal treatment and hence evoked sharp criticism for the technique of replantation per se.

There are many reasons for an adverse outcome of a replantation: the tooth can fracture during extraction and may be completely lost; peri-cemental tissues can be damaged, reducing the likelihood of reattachment; infection; external root resorption; and ankylosis. Therefore, it is extremely important to understand that intentional replantation should be the last choice, selected only when all the other options of treatment (non-surgical and surgical) have been exhausted. Replantation can be a treatment of choice in cases in which
Intentional replantation has a better prognosis when the extra-oral time is kept as short as possible and trauma to the periodontal ligament and cementum is minimised. It is advisable to perform routine endodontic treatment intra-orally before the tooth is extracted to minimise the extra-oral time. It is also suggested that a team of two dentists work in tandem to prevent prolonged treatment time, thus improving the chances of success. The use of elevators should be avoided, and the breaks of the extraction forceps should not go beyond the CEJ. The cortical bone integrity should be maintained, and the tooth should be extracted as atraumatically as possible.

The medium in which the tooth is kept moist plays an important role. Saline, HBSS, milk, Viason, to name a few, are widely used. Viason is used for organ transplantation and preservation. Owing to its anti-oxidant activity, the solution keeps the periodontal ligament moist and reduces the likelihood of surface resorption.

We generally use ultrasound tips to prepare the root-end and the debridement of the PGG. It conserves the tooth structure and produces significantly less smear layer compared with burs. Commonly used root-end filling materials are amalgam, Intermediate Restorative Material (IRM), Super EBA, GIC, Dia- ket, composite and MTA. The sealing ability and marginal adaptation of MTA have been proven to be superior and not adversely affected by blood contamination. In addition, MTA promotes deposition of new cementum and stimulates osteoblastic adherence to the retro-filled surface.

In two of our cases, tricalcium phosphate was placed in the apical few millimetres of the socket. This was done in order to bring the defect supragingivally so that the integrity, aesthetics and prognosis of the case were improved. Tricalcium phosphate is an osteo-conductive material that acts as scaffold for bone growth and is gradually degraded and replaced by bone.

A palato-gingival groove is a developmental anomaly that results in the interlocking of enamel and Hertwig's epithelial root sheath. PGG can vary in depth, length and complexity, cause new development of periodontal defects. Mild grooves terminate at the CEJ, whereas moderate grooves continue apically along the root surface. A treatment option for a PGG terminating close to CEJ is to expose the groove surgically and to seal it thereafter. As presented, the groove extended beyond the apex in Case III. Here, the defect was sealed extra-orally and the tooth replanted. GIC was used to seal the PGG, as it chemically adheres to the tooth structure and has a good sealing ability and antibacterial effect.

After replantation, the tooth was splinted for ten days. The splint enabled physiological movement of the tooth to prevent ankylosis. Endodontic treatment was completed one week after replantation in order to prevent inflammatory resorption and ankylosis and to allow splicing of periodontal fibres, which limits the seepage of potentially harmful root-filling materials into the traumatised periodontal ligament. Final restoration of the tooth was delayed to avoid loading and to ensure that proper healing of periodontal ligament took place.

In recent years, several bio-modulators, such as enamel matrix protein, hydroxyapatite and plateletrich plasma, have been used in intentional replantation cases to improve the success rates. Guided tissue-regeneration techniques can also be employed along with these supplements to further improve the likelihood of success.

We conclude that intentional replantation is a viable treatment option in carefully selected cases in which all other treatment options have been exhausted.

We would like to acknowledge the assistance of Dr Akanksha Gupta and Dr Nikhil Sinha.
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Dino Charalambous advises to take action now and save money on your life insurance ladies (and gents)

No - this is not a special offer at your local supermarket, it is the reason why everybody needs to review their protection arrangements.

The European Union has issued a Gender Directive for all countries in the Europe.

Do engage the services of an independent firm to liaise with the Banks on your behalf – will ensure proposal is packaged for best chance of a positive response and also to negotiate best terms.

Do ensure you provide an accurate summary of your current position including all savings and existing borrowing.

Do ensure your CV is up to date with particular focus on any past Managerial experience.

Do expect the Bank to want you to put down a contribution towards the purchase.

Do undertake your own research of the local area and find out why the current owner is selling.

According to research by HMRC, premiums for women are expected to increase by 15 per cent* due to this new legislation.

As a simple illustration, if you get a quote for life cover and the premium is £50 now, after the 21st December 2012 it will be quoted at approximately £57.50 (15 per cent increase), if the policy is in force for say 50 years, this will mean that you will be paying an extra £2,700 over the term of the policy, so by taking action now you can potentially save lots of money in the future. (Imagine what you could do with that £2,700!)

You can also fix your premiums so that they would not change over the term of the policy, thereby saving additional money.

Equality does not always have an advantage – This new directive means that women will bear the brunt of the increase as they have been cheaper to insure than men in the past.

There have been many articles written in the financial magazines about the pros and cons of this new directive from the EU, men and women are physiologically different and should be assessed differently. However right or wrong we feel about it, the new rules come into effect from 21 December 2012.

You also have a new requirement of tax life companies have to pay. Insurance companies will have to adjust to these new requirements and premiums are expected to increase across the board irrespective of gender. These new requirements come into effect from the end of the 2012, some are predicting premiums to increase between 10 and 15 per cent just on this legislation alone.

So taking into consideration the increases above for ladies and gents, you can see that the premiums are expected to increase substantially.

Where can I get appropriate cover? Switch on your TV and you can see adverts from furry animals, tenors, men in lissousines and many more. They are all promoting credit cards to mortgages, life cover to pet insurance. You input your details into their webpage and Hey Presto, you have about 50 choices to choose from. HOWEVER there is a significant difference between the internet and a Specialist Dental IFA. Is the internet policy appropriate for you as a dentist? Do you know the critical differences in the policies to cover you as a dentist? Sometimes the cheapest quote is not the correct policy for your profession.

Some people are driven purely by price and think that the cheapest premium is the best, or that all policies are the same.

In addition, policies taken out over the Internet are - EXECUTION ONLY – in other words they are Non Advised (you chose the policy), so in the event of problems with a policy claim you have no recourse to compensation, whereas with a Specialist Dental IFA you would have
a recourse to compensation by the Financial Services Compensation Scheme.

Walk into any bank and you are sold anything from an ISA, Pension to Life Cover - banks tend to normally only offer one insurer and these tend to be much more expensive than what you could get from a Specialist Dental Independent Financial Adviser (IFA).

A Specialist Dental IFA will source and recommend an appropriate policy and make sure that you have the correct cover in place. An IFA will also advise you on putting the policy in trust and tax planning advantages, an internet application will not provide any of this type of advice.

When selecting an IFA for protection you need to ensure that they have Whole of Market access for protection and not a Panel of Insurers. The difference between the two is that a Whole of Market Adviser can access the Whole of the Market for products, whereas an Adviser who has a Panel of Insurers may only be able to access four or five insurers. A Whole of Market access IFA will ensure that all the insurers have been researched and you have been presented with the best options for your individual situation.

Next steps....
The clock is ticking now... Why put off till tomorrow what you can do today?

It would be prudent to get the process moving now to arrange cover. Applying for Life Insurance, Critical Illness Cover and Income Protection is not normally a straightforward process. You have to meet up with the IFA, complete the applications forms, submit them to the insurer, a doctor’s report or Nurse Examination may be required. The Doctor may hold on to the report for a month before returning it to the insurer. If the policy is put into Trust, you would need the Trustees to complete the Trust forms and return them to the insurer.

Market conditions will also affect the application process, the summer holidays and the expected rush of applications before the December 2012 deadline will slow down the processing of applications by insurers.

Forewarned is forearmed - Buy now.... Save

‘Some people are driven purely by price and think that the cheapest premium is the best, or that all policies are the same’

About the author
Dino Charalambous works for Frank Taylor and Associates and is a Specialist Dental IFA with access to the Whole of the Market for protection and provides a personalised service for his clients. Where possible, he likes to provide face to face interviews so as to get a full understanding of his client’s requirements. Dino will take charge of your application and chase it to the end so that there is less hassle for the client. The Dental sector is his main focus as he has worked with many Dentists over the past eight years and has an insight into the sector as most of his friends are Dentists! Dino’s contact details are 08456 123 424 or 07939 457 589 or email: dino.charalambous@ft-associates.com. FTA Finance Ltd is an appointed representative of IN Partnership the trading name of The On-Line Partnership Limited which is authorised and regulated by the Financial Services Authority. For an informal chat, please call Dino Charalambous on 07939 457 589 or 08456 123 424 or get in contact by email dino.charalambous@ft-associates.com.

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DT
It pays to check the benefits

Richard Lishman discusses insurance policies

It is at times like these, when everybody is watching their pennies that it can really pay dividends to look at familiar things in a new and more objective light.

For instance, in the modern world we all tend to pay for lots of different kinds of insurance. Some is compulsory, such as car insurance or professional indemnity cover. But other policies will be voluntary, and despite our assumptions these don’t necessarily offer good value for money.

Many of us will have private medical insurance policies, for example. These often cost between £150 and £200 per month, not an insignificant amount. But we comfort ourselves that we will be covered should we suddenly need, say, a major operation. But is that cover all it is cracked up to be?

A colleague is about to undergo a relatively major operation to cure a painful problem with his back. He has opted to pay privately to avoid the long delays in getting the problem sorted on the NHS, and is paying for the operation from his own funds rather than through an insurance policy.

There were sharp intakes of breath around the office as we began to calculate the cost of surgeons, nurses, a general anaesthetic, the operating theatre and the various other expenses that would be involved. We were all surprised to find that the procedure will cost around £2,000.

While this is not spare change, it does on the surface appear to represent pretty good value for money, and it is a sum that could be easily made available from a self-insurance route.

If the monthly insurance premiums that would go to a medical insurance policy were simply paid into a bank account instead, sufficient funds would be available for a significant operation every year – and the savings would be earning interest too.

Looking into this, the most expensive operations, such as having a particular organ removed, seem to come in at less than £10,000. This might account for around four years of self-insurance savings – but would hopefully be a very rare and infrequent procedure.

This isn’t a call to tear up insurance policies. But it is important that anybody considering a private medical insurance policy be more aware of the costs involved in taking an alternative route, and the possible attractions of a ‘pay as you go’ alternative. Sometimes moving against the herd can provide a more efficient means of travel.

Richard Lishman of money4dentists, which are a specialist firm of Independent Financial Advisers who help dentists across the UK manage their money and achieve their financial and lifestyle goals. For more information please call 0845 345 5060 or email info@money4dentists.com.
“A career path change and discovering my passion”
by Moiz Mohammed

My first experience of the Dawson academy was a BDA lecture in Birmingham, where I first met Ian Buckle and was impressed with both his knowledge and enthusiasm. I had studied previously under well respected speakers, Bill Comcowicz and Roy Higson, so my knowledge of occlusion was already at a respectable level.

The Dawson academy however brought something very new to my career progression. In 2009 I undertook the first set of four modules for the core curriculum and found that importantly all the fragmented pieces of knowledge that I had were able to come together so that I could finally start to implement the concepts of complete dentistry into the practice. The course offers a pragmatic and systematic approach from carrying out a comprehensive examination through to treatment planning and implementation. From 2010 onwards I have successfully completed a significant number of cases, from full mouth rehabilitation to complex implant work.

To change a career path is no easy task. Having worked for many years I struggled to apply the principles that I had learnt. Focusing on the approach of a systematic diagnosis and treatment plan I began to approach my treatment decision making in a different way. I used the three dimensional approaches taught by Dr Buckle and started to visualise and create plans in the diagnostic wax up phase myself rather than expect a technician to guess where the teeth should go and what they should look like. This alone improves clinical and diagnostic skills and coupled with the additional modules of anterior restoration and equilibration helps to make important treatment decision making in the planning phase rather than start treatment with no concept of how it will conclude- an unfortunate error many of our profession have made and are still making.

At this transitional time, Dr Buckle is there to help. He encourages bringing models and helping with the treatment making decisions, while always insisting that all the records are as accurate as possible. Poor records mean all further stages are compromised. Unlike many of the restorative gurus out there, Dr Buckle is always approachable.

This course has truly changed my practicing career and I am now doing the kind of dentistry I could only have imagined a few years before. I have since gone on to the advanced set of modules and slowly have gained the confidence to tackle complex and difficult cases.

The Philosophy of the Dawson approach really emanates from Peter Dawson himself, possibly the most important figure in the advancement of complete dentistry, and Ian Buckle, along with John Craneham, Glenn Dupont, Dewitt Wilkinson and Andrew Cobbley (to name a few) have brought this philosophy forward. They teach with a passion and desire to spread their knowledge as Peter Dawson would have wished when the academy was first set up.

Firstly, they have implemented an effective treatment planning process. Based on the severity of the condition for each individual patient, the Dawson approach is to honour the tooth so that patients with financial issues can receive optimum care over the long-term. The focus of the programme is to integrate a comprehensive treatment planning process into their practice. Suggestions will be given on how to implement this. A chance find on a temporary crown course gave us that solution.

In the same way, the Dawson approach is to ensure that the all the records are as complete as possible. Those who have experienced this will understand the difference this course has made to my daily working practice. I have made completely predictable dentistry. The Dawson Academy UK has made a massive difference to how I do my dentistry making it now completely predictable.

Ian Buckle is there to help. He encourages bringing models and helps with the treatment making decisions, while always insisting that all the records are as accurate as possible. Poor records mean all further stages are compromised. Unlike many of the restorative gurus out there, Dr Buckle is always approachable.

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For further information on this introductory course, basic Core Curriculum of learning and team events, please contact:

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New NobelReplace® combines the well-proven NobelReplace® tapered implant body, which transfers the shear stress to the bone, with a secure internal conical connection that gives a tighter seal to the screws and better overall surface finish, resulting in higher soft tissue stability and Maintaining the integrity. It also provides maximum restorative flexibility, as it is suitable for use with standard abutments and individual CAD/CAM NobelProsthesisTM abutments. The amalgamation of the popular NobelReplace® implant and conical connection with platform shifting increases soft tissue volume and maintains the ease-of-use that clinicians have come to expect with NobelReplace®. The second new implant NobelReplace® Platform Shift Platform incorporates the easy-to-use element of the internal tri-channel connection together with the benefits of platform shifting. The tri-channel connection offers accurate and predictable abutment placement, as exact positioning can be one of only three set positions. It provides tactile feedback and ease of alignment. NobelReplace® Platform Shift features an improved soft tissue interface, which maximises soft tissue volume, creating more natural-looking aesthetics. For more information, contact Nobel Biocare on 079 706 3309, or visit www.nobelbiocare.com

Receive the service you deserve with Roger Guilgud Design

Karen Hall; of Baron & Hall Dentistry in Harwich, first met Roger Guilgud during a recent trip to the Dental Exhibition, where she presented him with a set of plans asked for an opinion on the spot. “From that first meeting, I have always found Roger to be insightful, candid, presenting the negative aspects of a project with the same honesty and emphasis as the positive,” says Karen. “He’s bright, knowledgeable and with an eye for detail that will be matched and in some cases, outstripped, by his.”

Karen was pleased to see that Roger had widened the burden by dealing tirelessly with local councils, planning authorities, moulding teeth to encompass her functional and aesthetic demands of the project. “I think that the course is very good at concentrating my mind on the important things,” says Karen. “I find it useful and interesting topic so far being ‘basic science’, which has provided a good foundation to the course. I am happy with the progression of the MLS, and I also hope to focus and organise my learning from the. There is a 20 per cent discount on new posts and for the direct application into the tooth. The innovative MSc programme is specially designed to enhance your current knowledge and skills in aesthetic restorative dentistry. With easy access to the online course, you can acquire your MSc from the comfort of your own home,” and with no reservation to do so.

For more information about the online MSc in Restorative and Aesthetic Dentistry go to www.smile-on.com/msc,

Dental TRIBUNE

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For more information or to register, please contact The Registry Officer, on 020 1450 1932 or web@smile-on.com, dcpbites@eastman.ucl.ac.uk

www.ucl.ac.uk/eastman/depts/cpd

DCEP Bites for GDPs – credits only

‘DCP Bites’ is the ideal solution for busy GDPs who need a flexible approach to CPD.

Dental nurses, therapists and therapists assistant find it difficult to fit in the required CPD around their busy lifestyle, with a few spare moments between patients or the occasional lunch break. To resolve this, ‘DCP Bites’ offers a range of convenient CPD in a series of 30-minute slots that can be completed anywhere and at any time. For as little as £5.75, CPD pods can be downloaded on to core or study subjects, including oral health, decontamination, communication and endodontics. Each fastening and entertaining podcast provides a convenient method of accessing relevant and up-to-date information. Some of the podcasts are additionally supported by video clips. Pods can be played on most MP3 players. After each application for credit, GDPs are sent the application

To register, go to: www.dcopubs.com or contact UCL Eastman GDP at dcpbites@eastman.ucl.ac.uk

Grahame Gardner have been trading since 1906 and offering a very attractive 20 per cent discount on certain stock items. This promotion will run for the month of July and is available in all Grahame Gardner stores. The website www.grahamegardner.co.uk has been updated to show the reduced prices and entering code DENT012 at the checkout. Alternatively call 016 255 6328 to speak to a sales representative. Offer expires on 31st July 2012.

For further information, please call Grahame Gardner on 020 7224 0999 or visit www.endocare.co.uk

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COURSE ANNOUNCEMENT
MULTI-SYSTEM IMPLANTOLOGY CERTIFICATE COURSE AT
TRAFFORD GENERAL HOSPITAL, MANCHESTER
Recognised by University of Salford

Applications are invited for a hospital based “certificate” year course
(one day a month) starting on 16th November 2011.
This unbiased multi system clinical course in its 20th year is designed to teach practitioners how to incorporate implant treatment to their practices safely with the back-up of three most documented implant systems according to the FGDP/ GDC Training Guidelines: Astra, Nobel Biocare and ITI/Straumann, the market leaders in implantology for their unique indications, predictability, research and documentation, are taught step-by-step during the year course. Each participant will have the opportunity to place implants in their patients under supervision. The course has been granted approval by the FGDP (UK) for accreditation towards its Career Pathway.

COURSE CONTENTS AND BENEFIT
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• Clinical practice support and advisory service
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FOR FURTHER INFORMATION: Professor T.C. Ucer, BDS, MSc, PhD,
Oral Surgeon, Oaklands Hospital, 19 Lancaster Road, Manchester M6 8AQ.
Tel: 0161 237 1842  Fax: 0161 237 1844  Email: ucer@oral-implants.com
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Product Information: Corsodyl Mint Mouthwash (clear, chlorhexidine digluconate 0.2%), Corsodyl Original Mouthwash (pink, chlorhexidine digluconate 0.2%) Corsodyl 0.2% Mouthwash (alcohol free) (clear, chlorhexidine digluconate 0.2%) Indications: Plaque inhibition; gingivitis; maintenance of oral hygiene; post periodontal surgery or treatment; aphthous ulceration; oral candida.

Dosage & Administration:
Adults and children 12 years and over: 10ml rinse for 1 minute twice daily or pre-surgery. Soak dentures for 15 minutes twice daily. Treatment length: gingivitis 1 month; ulcers, oral candida 48 hours after clinical resolution. Children under 12 on healthcare professional advice only.

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Keep out of eyes and ears, do not swallow, separate use from conventional dentifrices (e.g. rinse mouth between applications). In case of soreness, swelling or irritation of the mouth cease use of the product.

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