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 recently, 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 Gilmarry 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

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 provide a 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 Auluck 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 were seeking treatment with no one 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.”

The vital funds brought in by Keith’s Herculean effort will make a significant contribution to future orthodontic research. There is still time to applaud Keith’s motives - and his stamina, by donating to The BOS President’s Fund. Please visit www.justgiving.com/KeithPearsonsWalk. Alternatively cheques can be made payable to BOSF and sent in an envelope marked for ‘The President’s Fund’ BOS Head Office, 12 Bridewell Place, London EC4V 6AP.

Anyone who would like to contact Keith about the walk, or the President’s Fund can do so by emailing to pearson$k@
aol.com. He will report back about his walk and the amount of money raised at the end of June.
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, hypnодodontics, 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 at the evening before Conference.

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

...
The DLA awarded for their initiative

This year the Dental Laboratories Association were shortlisted finalists for the CBI’s Trade Association Forum in the categories: Magazine of the Year for the DLJ and Commercial Initiative of the Year for their Medical Devices Directive implementation folder. The awards dinner took place in Plaisterers Hall in central London and was hosted by the former Top Gear presenter and ‘Fair Fuel’ lobbyist Quentin Wilson.

The DLA were located on table 20 out of 20, which as a sign didn’t suggest that they would be successful on this occasion, thankfully despite the table location, initial concerns were unfounded!

The DLA were announced winners of the Trade Association Forum Commercial Initiative of the Year Award 2012, for the MDD Folder; the DLA were awarded the prize because of the quality of the product and its importance subject area to the membership, the DLA were also successful due to the fact that by introducing a product revenue stream, the DLA were able to hold membership fee’s over the past two years.

Richard Daniels, DLA Chief Executive said: “I am absolutely delighted that we have won this category, developing products with the DLA has been a huge gamble, as we were introducing a new concept to the membership in terms of their relationship with the DLA, but the figures speak for themselves and now to have our peers positively recognise the challenge we had is a real credit to the team in the office and the Exec Board who made the decision to go down this line.”

Barbara Hibbert, the DLA’s recently elected President said: “I’m only in to my second week and I’m collecting awards on behalf of the DLA! It is absolutely wonderful, this award is a reflection of how well the Exec Board and the office staff work together – I’m very proud!”

Whilst the DLA didn’t have the Magazine of the Year, they did come second with a Highly Commended award, which was also a fantastic achievement given the fact that they were up against some huge organisations some of which are based in the publications and media profession.

BSDHT 2012 Oral Health Conference open for registration

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.

The UCLan Dental Clinic (UDC) will open in September.

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

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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 practitioners are invited to visit the new facility on a special open day on 9 August.

Putting patients first, Dr Fallowfield 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 Fallowfield 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/LeKrtH

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Dr Fallowfield 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.

Speaking in his first interview since being elected Chair of the BDA’s Principal Executive Committee (PEC) Dr Fallowfield 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.

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Endodontic, periodontic treat-ments 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, Sally Simpson, BSDHT President, 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 Vaidh, Clinical Direc- tor 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 we will have the confidence 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 region.”

From L to R Steve Taylor BIDST President, Richard Daniels DLA Chief Executive, Quentin Wilson Holt, Barbara Hibbert DLA President, James Whitehurst Director WFM, David Brown BACD/FP President.
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Giving a smile on Facebook

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.

David's teeth before and after

A man from Hove has reason to smile after a dentist in Brighton fitted him with new teeth,

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.

A sonnet full of smiles

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 56 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.

Scientists ‘find’ anti-cavity molecule

A molecule that can eliminate tooth decay bacteria in seconds.

The molecule, which is believed to be able to help protect teeth for several hours, was reportedly discovered by researchers at the University of Chile.

Several reports have suggested that the molecule could be added to oral care products, such as toothpastes and even sugar free chewing gum to help prevent dental cavities.

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.
Dentists get Olympic fever!

O verseas 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. "I am pleased to have won this contract for revision / rescue surgery and are scenarios which can 'impact on patients' well-being and economically on the health service overall,' the authors conclude.

Titanium implants may corrode

Titanium medical implants used in bone-anchored hearing aids and dental prostheses, may not be as robust as previously thought. Runny nose, sneezing and a hot feeling in the surrounding tissue. Microscopic particles of Ti can be found. Although 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 latest figures show that the largest increases in STIs were seen in men who have sex with women.

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 from African communities, the groups most affected by HIV in England; and

• FPA will receive £1.13 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 more difficult to treat. In 2010, there were around 5,000 new diagnoses in men who have sex with men. The researchers think this is because 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 organisers must 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 diets can also have detrimental consequences for oral health - periodontal disease affects 19 out of 20 people. In a study by

A positive investment in driving down infections

A lmost £3m 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 Olympic Stadium

The Olympic Stadium in the surrounding tissue. Metal and dental rehabilitation and their effects on the body are widely perceived to be predictably 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 heterogenous 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 tissues 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 revision / rescue surgery and are scenarios which can ‘impact on patients’ well-being and economically on the health service overall,’ the authors conclude.

"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.’

DCP taster day

T im Ives is presenting a one day course specially for DCP’s who are interested in mentoring. The first one is in Leicester on 11 August 9am - 4pm at the Preepul Centre, Orchard Avenue, Leicester. This is designed as a taster day for a nationally recognised qualification in mentorship and is a real bargain for £40.

This is a taster day designed as an introduction to a nation- ally 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.
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

‘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”’

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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 mature, consensual 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 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 FGDP(UK), Antimicrobial Prescribing for General Dental Practitioners, aims to help de-fog this imprecise topic.

Throughout the book, authors general dental practitioners 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 GPs with clear advice on antimicrobial prescribing in an attempt to explain the often complex decision making process and therefore assist treatment planning and patient care.

Although the book is comprehensive, it manages to provide a clear overview of the basic principles of prescribing, whilst covering specialised subject areas concerning antimicrobials. The structure of the book is presented as a guide that is split into 15 distinct sections; from prescription writing to antifungal therapy, the authors have managed to develop a distinctive portal where they can advise dentists on the importance of antimicrobials and how they can be a valuable tool in the treatment of infections.

However, even though the individual chapters are presented in a clear and straightforward manner, this style of writing can come across as a little abrupt and combined with the lack of photographs, illustrations or patient case studies has resulted in Antimicrobial Prescribing for General Dental Practitioners occasionally becoming a little too text heavy.

In the first section, Prescription Writing, with the authors discuss simple guidelines regarding how to fill out a prescription; from general advice on which pens to use, quickly and effectively convey the management of the viruses. The authors state the choices of antimicrobials that practitioners should be aware of, through a first, second and third choice system, thus vastly simplifying the decision-making process. The chapter explains where the use of antimicrobial prescribing would be unwise, which is a practical addition.

The authors then follow up on this section and go on to describe the contentious issue of administering 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 a tute to have added a specific case study at this venture, concerning over prescription, to further illustrate this controversial topic. However, helpfully the book does describe in a straightforward manner when and where to prescribe, the agents might be useful.

The final section of Antimicrobial Prescribing for General Dental Practitioners illustrates the cases where oral health threatens the health of the rest of the body, particularly where the immune system is at risk. The guidelines clearly state how to target this serious issue, alleviating any confusion for the reader. The layout is different in this chapter, and the authors divide the differing medications and their subsequent doses in separate text boxes to give a clear and concise picture.

Vastly simplifying the process of antimicrobial prescribing in a clear and succinct set of guidelines, Antimicrobial Prescribing for General Dental Practitioners should be prescribed (no pun intended) to anyone looking to refresh their understanding about antimicrobial prescribing.

The Faculty of General Dental Practice (UK) launched Antimicrobial Prescribing for General Dental Practitioners, at the British Dental Conference and Exhibition in April.

Speaking at the launch, Dean of the FGDP(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.”

As well 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.

"Although the book is comprehensive, it manages to provide a clear overview of the basic principles of prescribing, whilst covering specialised subject areas concerning antimicrobials" - Georgia Posner

Book Review

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A powerful practice-builder

Michael Sultan discusses CPD in dentistry

CPD is a vital part of modern dentistry, 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 website, received more than 6,000 responses 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 levels of patient care. In my experience it can also be a powerful motivator, and helps add to levels of patient care. In my experience it can also be a powerful motivator, and helps add to levels of patient care. In my experience it can also be a powerful motivator, and helps add to levels of patient care. In my experience it can also be a powerful motivator, and helps add to levels of patient care.

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 a team. 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.

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.

With a happy, highly motivated, highly trained workforce, the practice can only benefit as a result.
Post-operative root-canal treatment 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 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 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.

Without apical periodontitis, a ten-year success rate of 92 to 98 per cent has been shown for both initial and retreatment root-canal therapy. With the preoperative presence of apical periodontitis, there is a decrease in the success rate to 74 to 86 per cent over the 10 years. From this, it is evident that endodontic healing is attainable through retreatment procedures, allowing us to maintain our patients’ natural teeth.

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Intra-radicular bacteria are the primary aetiology of post-treatment disease and eradication of these bacteria is the primary goal of retreatment procedures. The intraradicular bacteria present in the previously treated tooth are persistent and resist removal methods. Bacteria are able to hide and survive in canal ramifications, deltas, irregularities (lips) and dentinal tubules.

Figure 2 shows the complex root-canal anatomy pre-supporting substrate for intraradicular infection. The potential substrates that are found inside the canal and help the bacteria survive can include untreated pulpal tissue, the presence of a biofilm and tissue fluid. This may be present in the canal owing to a poor coronal or radicular seal and microbial proliferation. The presence of a poor seal, bacteria and substrate for their growth results in ideal conditions for persistent inflammation and disease.

The bacteria present in the initial infection of a root canal differ markedly from the bacteria infecting a previously treated tooth. Post-treatment flora is polymicrobial with equal numbers of Gram-negative and -positive bacteria. Post-treatment bacteria are predominantly Gram-positive and 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, Enterococcus 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.20 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 3a–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 substrates. 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.

Failure to use or using too small a volume of an appropriate irrigant solution, such as sodium hypochlorite, is an iatrogenic error.

Endodontic ultrasonic tips are highly efficient at removing core build-up material, paste fills, posts and silver-point fillings, as demonstrated in Figure 5. These instruments allow clinicians to conserve root dentine by providing excellent visibility under a dental operating microscope, without alteration of the natural canal morphology, which allows effective irrigation to reach the complex apical root-canal anatomy where 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,22 two per cent chlorhexidine has been shown to prevent the adhesion of E. faecalis to dentine.23 EDTA 17 per cent is often used as an effective smear-layer removal agent.24 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 (Ac-teon; 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.25 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.26 This evidence shows that an effective flow of irrigation can assist in the cleansing 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 micro-leakage.

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.

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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 pulpal 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 exacerba-
tion. These lesions are often diagnosed during routine radiographic exams. Some periapical lesions become large and, in cases of large radio-
lucencies, they may be diagnosed in the absence of any patient complaint.

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

Large periapical lesions are often associated with an-
terior maxillary teeth, probably due to traumatic injuries. These lesions could be clas-
sified 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 cen-
tral area usually surrounded by epithelium.1 Pocket cysts have an epithelial lining that is connected with the root ca-
nal, and true cysts are com-
pletely lined with epithelium and not connected with the root canal.2

According to Nair’s3 research, based on serial sec-
tioning and strict histopatho-
logical criteria, the prevalence of pocket cysts to be six per cen-
t, whereas that of true cysts is nine per cent. Previous studies without serial section-
ing that reported ranges from six to 55 per cent are proven to contain a great margin of er-
or. The differential diagnosis of large periapical lesions is still a controversial topic. Per-
iapical radiographs, contrast media, Papainuloaou smears and albumin tests have proven to be inaccurate in establish-
ing a preoperative diagnosis. Only once the post-operative biopsy has been taken, can a diagnosis be established.

There is evidence1 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 semisolid or fluid-filled central area, diagnosis will be consistent with a pocket or a true cyst. Real-time ultrasound imaging and ultrasound recently demon-
strated that they are capable of establishing differential di-
gnosis as well.4

There is widespread agree-
ment that most granulomas may heal after non-surgical root-

![Fig 3 Periapical's composition showing the full extension of the lesion](image-url)

There is evidence that CBCT scans may provide a more accurate diagnosis than biopsy. There is evidence that CBCT scans may provide a more accurate diagnosis than biopsy.
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 (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...
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 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).

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.

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.
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 periodic reshaping if necessary.

The literature offers evidence that the majority of these cyst-like lesions heal after conventional RCT over multiple appointments. Çalışkan 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 18 mm. The treatment combined long-term canal drainage with Ca(OH)2 dressing and non-surgical RCT. Several case reports 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 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.

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 non-dental 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.
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:

1. All other endodontic non-surgical and surgical treatments have failed or are deemed impossible to perform
2. Limited mouth opening that prevents the performance of non-surgical or peri-radicular surgical endodontic procedures
3. Root canal obstructions
4. 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
5. Teeth with non-restorable caries
6. Advanced periodontal disease that has resulted in poor periodontal support and tooth mobility
7. Multi-rooted teeth with diverging roots that make extraction and reimplantation impossible
8. 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 reimplantation 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 mesiolingual 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 mesiolingual 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 cemento-enamel 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 heaks of the forceps, we held the tooth by its crown and cut the clots. 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.

**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.**

**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 overextended Lentulo spiral. Thereafter, we performed a 5mm Class I root-end preparation with an ultrasonic tip, at the apical end of all three canals.

A retrograde filling was done with mineral trioxide aggregate (MTA). The extraction socket was then irrigated with normal saline and gently suctioned to remove blood and ensure 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,
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 stabilization 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 anesthesia 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.

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...
a surgical approach can be difficult, for example on the lingual root of a mandibular molar, or in cases in which a surgical approach would be very invasive, such as the removal of thick bone from the buccal aspect of a second mandibular molar.

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, JRBSS, milk, Viaspan, to name a few, are widely used. Viaspan 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 ultrasonic 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 represents the infolding of enamel and Hertwig’s epithelial root sheath. PGG can vary in depth, length and complexity, causing varying degrees 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.

• Editorial note: A complete list of references is available from the publisher.
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Buy now.... save later

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 an Union not to discriminate against males or females when underwriting their insurance policies. This is not only for Life Insurance but all policies, including car insurance.

The deadline date is 21 December 2012; insurance applications have to be in and the policy on cover before this date - any applications still in progress after this date will be assessed with the new rules.

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 due to this new 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 suits 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 Later

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

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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 clients’ 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 Author- ity. For an informal chat, please call Dino Charalambous on 07939 457589/08456 123 424 or get in contac- t by email dino.charalambous@ ft-associates.com.
It pays to check the benefits

Richard Lishman discusses insurance policies

It is at times like these, when everybody is watch-
ing 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 poli-
cies will be voluntary, and de-
spite our assumptions these don’t necessarily offer good val-
ue for money.

Many of us will have pri-

vate medical insurance poli-
cies, for example. These of-
ten cost between £150 and £200 per month, not an ins-
ignificant amount. But we comfort ourselves that we will be covered should we sud-
denly need, say, a major op-
eration. But is that cover all it is cracked up to be?

A colleague is about to un-
dergo a relatively major opera-
tion 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 ins-
urance policy.

There were sharp intakes of breath around the office as we began to calculate the cost of surgeons, nurses, a general an-
aesthetic, the operating theatre and the various other expenses that would be involved. We were all surprised to find that the pro-
cedure 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 avail-
able 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 inter-
est too.

Looking into this, the most expensive operations, such as having a particular organ re-
moved, seem to come in at less than £10,000. This might ac-
count 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 in-
surance policies. But it is impor-
tant that anybody considering a private medical insurance pol-
icy be more aware of the costs involved in taking an alternative route, and the possible attrac-
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tive. Sometimes moving against the herd can provide a more ef-
ficient means of travel.

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It pays to check the benefits

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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.

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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.

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“A career path change and discovering my passion”

by Moiz Mohammed

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 courses, 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 find a simple solution to what seemed to be simple problems. When Jim and I started working more closely in the practice together, we very quickly understood 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 making decisions 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 Cranham, Glenn Dupont, Dwitt Wilkinson and Andrew Cobbli there are a few that 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.

Callum Graham Principle Dentist
at Toothdoctor Larne/Larne Healthcare near Glasgow

Member of ADI, BACD, IJTC, SAAD
I am the Principle dentist of “Toothdoctor” in Larne and have developed a referral service for IV sedation, implants and advanced restorative dentistry. My educational achievements have been to complete The Dawson Academy Core Curriculum in 2011 which has allowed me to assess, diagnose and treat simple and complex treatment plans with confidence and predictability. I have attended extensive seminars and courses in Europe and the UK, most recently Germany with Sinusa, a implantology course in Italy.

Jim Forrest Dental Technician
ToothDoctor

"An eye opening course and a fantastic experience that has supplied me with the knowledge and the tools to communicate with like minded technicians and dentists."

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

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CQ 20:1 L Micro-Series contra-angle handpiece, which is also available in a cordless version. This new system is equipped with an internal irrigation system for greater comfort with one file size.
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