Government launches consultation on local fluoride consultations

Consultation to focus solely on process; not pros and cons

Water fluoridation hits the headlines again as the government launches a consultation on the consultation process for fluoridation schemes in the UK.

Public Health Minister Anne Milton launched the consultation, which is exclusively on the process by which local authorities carry out consultations and decision-making on new and existing fluoridation proposals – not on the pros or cons of fluoridation itself.

These changes are prompted by the abolition of Strategic Health Authorities, which currently carry out this role, and means local authorities will be given new responsibilities and powers to improve the health of their communities.

This will mean ensuring local people’s opinions on fluoridation are considered before decisions are made to adopt, change or end fluoridation programmes.

Public Health Minister Anne Milton said: “Decision-making on public health issues should be made at the local level where they understand what is needed and where the community’s voice can best be heard.

“We want to hear as many views as possible about how this process should work when local authorities get their new powers next year – I encourage everyone to take part.”

Strategic Health Authorities currently have the responsibility for considering changes to fluoridation in local areas, but this consultation is about how this power is taken over by local authorities.

It will seek views on a range of processes related to making local decisions including how public views are considered and how joint decisions are made in areas where water supply covers more than one local authority.

The consultation will be open for responses from 4 September to 27 November. Any person, business or organisation with an interest is encouraged to respond.

Link to consultation: http://consultations.dh.gov.uk

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an unsurprising move, Health Secretary Andrew Lansley has been relegated to leader of the Commons in today's Cabinet reshuffle. Lansley, who was the thinker behind the contentious reforms to the NHS has been replaced by former Culture Secretary Jeremy Hunt, who was described as a “strong reformer” by the Prime Minister.

Speaking outside No 10, Mr Hunt said he was “incredibly honoured” to take over as Health Secretary. “It is a huge task and the biggest privilege of my life,” he told the BBC. Hunt, a contemporary of Cameron’s and Boris Johnson’s at Oxford University, has had a difficult year. Following a near-scandal over his management of Rupert Murdoch’s bid for control of BSkyB, it was revealed that his aide was in close contact with the news corporation. Indeed, he was one of the few people allowed to be called a “friend” in parliament by the Speaker.

However, it seems Hunt is back in favour with the Prime Minister after Lansley was dropped by Cameron, supposedly over his failure to communicate his NHS reforms. A year after his “sack me or back me” ultimatum to the Prime Minister, where he warned Cameron he would rather quit the Cabinet than abandon the controversial health reforms, Lansley has been radically demoted.

In March this year, Lansley had said about the reforms “Some people say we should be a bit more flexible. I would have to say that although there is some action there needs to be ‘Provision of clear, accurate and timely information. The government warned such dentists that not permitting anyone to be ‘doing so deliberately is in breach of their NHS contract.’ A new Stop the Rot campaign has since been set up to hinder this worrying trend. The Primary Care Trust for the region is encouraging people to go to the dentist by working hard to ensure that there are no waiting lists for dental patients wanting to go to an NHS dentist, a new health and wellbeing centre in the area has created a further 2,500 places.

However, Lansley out in radical cabinet reshuffle  

He was also the vice-chairman of the health scrutiny committee said it is the high prices of dental treatment, and the lack of information available about NHS treatments that is scaring people away. He said: “We have NHS dentists available, but in a lot of cases the charges are ridiculous. It’s £17.50 for a filling, £206 for root canal treatment, so it’s no wonder that people are going up and down with no teeth. It’s a choice between putting food on the table or going to the dentist.

It has become endemic over the past 10 years or so, that people don’t want to go, even though sometimes those specialists can spot something that might save your life.

“We need to get advertisements out showing the places that are available at surgeries.”

Just over half of people registered with dentist as revealed in new survey

In a new survey carried out by the Blackburn with Darwen Local Involvement Network, it has been revealed that only 56 per cent of respondents in Darwen are registered with a dentist. This shocking statistic is teased with the fact that on average, children in this area have more than two rotten teeth by the age of five.

A new Stop the Rot campaign has since been set up to hinder this worrying trend. The Primary Care Trust for the region is encouraging people to go to the dentist by working hard to ensure that there are no waiting lists for dental patients wanting to go to an NHS dentist, a new health and wellbeing centre in the area has created a further 2,500 places.

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Government response to OPT

There has been a report published as a response by the government to the recent study by the Office of Fair Trading’s market study of the private and NHS dental markets in May 2012. The study was prompted by complaints to Consumer Direct and the OPT’s concerns patients’ ability to directly access dental care professionals. The purpose of this study was to examine whether the UK dentistry market is working well for patients. The issues were considered within the context of both NHS and private dentistry.

The OPT gave five recommendations to address its concerns:
• Provision of clear, accurate and timely information for patients
• Direct patient access to dental care professionals
• Reform of the NHS dental contract in England
• Simplification of the complaints process
• Development of a code of practice for sale of private dental plans

The government response begins by stating that the recent report, and were particularly pleased that ‘this market study shows that dental patients have a high level of satisfaction with the services provided by their dentists’. The government agreed with the OPT report with regards to patient care, claiming that there needs to be ‘Provision of clear, accurate and timely information for patients’, particularly with regards to prices and dental treatments. The report goes on to share the concerns of the OPT that some dentists have been denying their patients treatment on the NHS by not providing enough information. The government said warned such dentists that not permitting anyone to be ‘doing so deliberately is in breach of their NHS contract.’ A new Stop the Rot campaign has since been set up to hinder this worrying trend. The Primary Care Trust for the region is encouraging people to go to the dentist by working hard to ensure that there are no waiting lists for dental patients wanting to go to an NHS dentist, a new health and wellbeing centre in the area has created a further 2,500 places.

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It should be as simple as possible. With this in mind the government is changing their patient leaflet by updating any information about the complaints procedure and ‘the opportunity to give feedback on practices on NHS Choices.’ The government also want to consider whether there can be any synergy created between the current private and NHS complaints systems.

The OPT recommended that the government developed a new system for the sale of private dental plans. As a result of the report, the government are looking into setting up a code of practice to avoid the miss-selling, or pressurised sale of a private dental plan; in particular the report has highlighted that there should be clear penalties for dentists who do mislead patients.

The government surmises that although there is some action needed to be taken, particularly with regards to direct access. The government will look into designing new dental contracts, and increasing transparency for dental patients, however, on the whole, the government concluded that ‘the vast majority of patients are happy with their dental treatment and that the majority of dentists behave ethically.’

Foundations Trio Give Miles of Smiles for Mouth Cancer Walk

Three employees of the British Dental Health Foundation are planning on embarking on a trek and a six-week walk for a mouth cancer charity.

David Arnold, 29, David Westgarth, 27 from Rugby and Doychin Satutov, 22, who lives in Coventry are taking part in the walk on 22nd November in Hyde Park in London to raise hundreds of pounds for research into mouth cancer.

David Arnold, Senior PR and Press Officer at the Foundation is hoping that the walk will get more people talking about the disease and also help to raise awareness about the risks and different symptoms of mouth cancer.

David said: “Events such as the Mouth Cancer Awareness Walk, along with annual campaigns such as November’s Mouth Cancer Action Month, really do help to get this hidden problem and place it in the spotlight.

“By taking positive action in similar fashion to recent breast and testicular cancer campaigns, we can put mouth cancer firmly in the news agenda. In highlighting key risk factors and symptoms, along with information about self-examination and oral screenings we can potentially save thousands of lives.

“The five-year survival rate of mouth cancer patients is just 50 per cent. But early диагnosis gives patients a 90 per cent chance of survival.”

If you would like to support any members of the British Dental Health Foundation on their Mouth Cancer 10km Awareness Walk, please contact them by telephone on 01788 559 792 or by email at pr@dentalhealth.org.
Editorial comment

It has been a very tumultuous time in the political sphere for dentistry. As the Cabinet waves goodbye to Andrew Lansley as Health Minister, it says hello to Jeremy Hunt.

In addition, there are the various consultations around dentistry including looking at the process of fluoridation scheme planning, views on the CQC (that should be a good one!) and the continuing piloting process.

Traditionally the last quarter of the year is busy not just politically but in terms of conferences and other events. I’m sure that many a glass of enamel-friendly wine will be consumed as the issues around the profession are debated. Please join in the process – not only by adding your voice to the consultations but by letting Dental Tribune know what you think! Email me at lisa@dentaltribuneuk.com.

Fact sheet

The General Dental Council (GDC) has produced a new fact sheet for patients across the UK to help them understand what responsibility their dental professional has to make sure their indemnity or insurance is up to date, ensuring that patients’ rights are upheld.

Indemnity and insurance is a way for dental professionals to ensure patients have a way to claim compensation if something goes wrong with the treatment they’re having.

The new fact sheet guides patients through what is expected of their dental professional as well as what to do if something goes wrong. The guideline asks questions such as what should I ask my dental professional and what happens if something goes wrong?

Chief Executive of the GDC, Evlynne Gilvarry said: “We are working to increase the current, substantial protections for patients, by seeking powers to require proof of insurance or indemnity as a condition of being registered to practise as a dentist or dental care professional. We expect to have these powers by October 2013.”

The GDC can stop dental professionals working in the UK if they are found not to have indemnity or insurance and the new powers being sought will mean dental professionals not only have to have insurance before they can practise but declare they have it every year after that.
Coconut oil could help the fight against tooth decay

The natural antibiotics in digested coconut oil have been found to attack the Streptococcus mutans bacteria which cause dental caries. Scientists at the Dublin based Athlone Institute of Technology (AIT) say that coconut oil could be added to commercial dental products as a marketable antimicrobial. The AIT team tested the antibacterial abilities of the oil in both its natural state and once it had been treated with enzymes to help replicate the process of digestion; the coconut oil was then tested against Streptococcus mutans, the most common bacteria found in the mouth. Researchers discovered that the coconut oil which had been treated with enzymes hampered the growth of the common bacteria vastly.

Previous research had shown that other enzyme-treated foodstuffs, including milk, had inhibited the growth of the Streptococcus bacteria, leading to scientists investigating what other foods might be similarly affected. Further research is now planned into looking at how coconut oil reacts with the Streptococcus bacteria at a molecular level. Scientists aim to discover what other types of bacteria and yeasts the oil affects, the testing group at AIT found that enzyme-modified coconut oil was detrimental to Candida albicans, a yeast known to cause thrush.

This groundbreaking discovery could greatly aid the dental hygiene world. Dr Damien Brady, who led researchers at AIT’s Bioscience Research Institute said “Dental caries is a commonly overlooked health problem affecting 60-90% of children and the majority of adults in industrialised countries. Incorporating enzyme-modified coconut oil into dental hygiene products would be an attractive alternative to chemical additives, particularly as it works at relatively low concentrations. Also, with increasing antibiotic resistance, it is important that we turn our attention to new ways to combat microbial infection.”

The work also adds to our knowledge of antibacterial activity in the gut. “Our data suggests that products of human digestion show antimicrobial activity. This could have implications for how bacteria colonize the cells lining the digestive tract and for overall gut health,” explained Dr Brady.

“Our research has shown that digested milk protein not only reduced the adherence of harmful bacteria to human intestinal cells but also prevented some of them from gaining entrance into the cell. We are currently researching coconut oil and other enzyme-modified foodstuffs to identify how they interfere with the way bacteria cause illness and disease,” he said.

The researchers in AIT’s Bioscience Research Institute are presenting their work at the Society for General Microbiology’s autumn conference at the University of Warwick.

Dental workers’ charity trek

A Durham based dental practice team completed a 26km walk along the historic Hadrian’s Wall to raise thousands of pounds for Help for Heroes.

The team at Durham City Smiles finished the achievement, and managed to raise an impressive £1,500 for the military charity. Help for Heroes provides direct, practical support to wounded, injured and sick service personnel, veterans, and their families. The charity is important to dentists Graeme Dentith and Stuart Cox, who both come from Royal Navy families.

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Graeme Dentith, principal dentist at the practice, said: “The trek along Hadrian’s Wall was really tough, but completing it and raising over £1,500 for Help for Heroes in the process is a fantastic achievement.

“We’re very grateful to everyone who has supported and sponsored us – it really has made a huge difference.”

Graeme said the camaraderie of the team kept them going through the punishing condition.

“We set off at 10am from Walltown Quarry with a little apprehension of what was to follow, but we kept our spirits up as a team, even when our energy levels were flagging,” he said.

“It was a real test of endurance for all of us, but there were lots of smiles and camaraderie, not to mention the stunning scenery which took us through the sweeping countryside along the Roman wall.

“We paused briefly at the Roman Fort of Housteads for lunch before our final descent to Chollerford where we enjoyed dinner and well-earned pint!”

The extra pains of mouth cancer

Being diagnosed with mouth cancer is a harrowing experience. Not only will the sufferer have to endure aggressive surgery, which often results in the loss of teeth and supporting structures, additional treatments such as radiotherapy and chemotherapy are common, and also have an unfortunate effect on a patient’s oral health.

People who have had treatment for mouth cancer unfortunately need further expensive dental treatment to restore their teeth which are damaged by the harsh cures for the disease, unlike sufferers of other types of cancers, who do not always have the same financial issues for follow up treatments.

A petition has been created by Dr Chetan Trivedy urging ‘the government to review the current NHS dental charges by including an exemption category for patients who have had treatment for mouth cancer.’ As it stands, patients are able to claim their dental treatments on the NHS, a disparity Dr Trivedy wishes to highlight, stating “There is clearly a financial inequality for patients with mouth cancer to pay for the postoperative and reconstructive phase following their cancer treatment.”

Thousands of patients have been found to be conning the NHS in Scotland. New information has shown that over 15,000 cases where dental patients have received free treatments they were not eligible for. Counter Fraud Services (CFS) investigators have obtained £538,000 back, however the problem has been found to be far greater than first realised.

It has been estimated that the Scottish NHS loses up to £110 million every year through fraud, including false claims for free treatments and staff dishonesties. The number of people who received free treatments they were not entitled to has vastly grown over the last three years.

In 2009-10, there were 4994 incidents detected and £152,000 recovered. In 2010-11, there were 5258 incidents detected and £175,000 recovered, and, in 2011-12 there were 5598 incidents detected and £211,000 recovered.
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### Link between alcohol and cancer

Scientists have known for 50 years about the links between drinking alcohol and certain types of cancer, however there is new research explaining the effect the beverage has on people.

The report was first recounted during the American Chemical Society annual meeting in Philadelphia.

The human body metabolizes the alcohol in beer, wine, and hard liquor into several substances, including acetaldehyde, a substance with a chemical backbone that resembles formaldehyde - a known human carcinogen, according to lead author Silvia Balbo, PhD, a research associate at the University of Minnesota.

“We now have the first evidence from living human volunteers that doses of ethanol consumed after alcohol consumption damages DNA dramatically,” Balbo stated in a press release. “Acetaldehyde attaches to DNA in humans in a way that results in the formation of a ‘DNA adduct.’ It’s acetaldehyde that latches onto DNA and interferes with DNA activity in a way linked to an increased risk of cancer.”

### Damage caused by electronic cigarettes

A recent study conducted by the University of Athens has found that electronic cigarettes can still cause irreparable damage to the lungs, despite being promoted as a safer alternative to cigarettes.

Researchers at the university conducted a study involving eight non-smokers and 24 smokers, 11 of whom had normal lung function, 15 had asthma or chronic obstructive pulmonary disease (COPD).

Applicants used an electronic cigarette for ten minutes, after which their airway resistance was tested. The researchers found that the devices caused an increase in airway resistance for around ten minutes in both non-smokers and smokers with normal lung function, but not in smokers with COPD or asthma, suggesting that electronic cigarettes, which work by delivering nicotine through a vapour, might still be damaging.

The findings were presented at the annual congress of the European Respiratory Society (ERS). “We found an immediate rise in airway resistance in our group of participants, which suggests e-cigarettes can cause immediate harm after smoking the device,” said author Prof Christina Grafius, who chairs the ERS Tobacco Control Committee. She added: “More research is needed to understand whether this harm has lasting effects in the long term.”

### Dentist sues patient over internet blogging

A dentist is suing a former patient after he blogged online what the dentist felt were unfair and defamatory comments. Dr Mo Salah, of Dental Dynamics in Portland filed the lawsuit for $300,000 of Dental Dynamics in Portland.

Salah has complained that the blogs caused ‘damage to his reputation, loss of profits and emotional distress.’ Bailey has since removed the posts, out of fear for the safety of himself and his family, however Salah is continuing with the lawsuit.

### Dentist information website launched for Indian market

Dr Priya Patel is launching a website in India called ‘dentistmum’ to provide information and raise awareness of dental issues and oral cancer amongst the Indian population. Although Dr Patel was born and raised in the UK, she says ‘I am an Indian at heart’.

The dentist, who owns the Village Dental Practice in Stevenage and also teaches postgraduate dental students at the Royal College of Surgeons in London and overseas dentists studying for their equivalency exams, decided to launch dentistmum.in after learning of the alarming statistics surrounding oral health in India: for example, 40-50% have never visited a dentist; nearly 70% suffer from dental diseases; only 55% of the population uses toothpaste; and 90% of oral cancer cases in India are attributed to the habit of chewing tobacco and gutka. In addition, the dentist to population ratio in rural areas is just 1:250,000.

Dr Patel is working hard to develop the dentistmum website and the launch is set for early September. ‘I am loading it with content on a regular basis and marketing the website by raising awareness on social media channels and by contacting bloggers in India to help spread the word,’ said Dr Patel, who admits that she is not internet savvy and is learning as she goes. She intends to travel to India once the website has launched to raise further awareness.

‘Ultimately even if only one person is successfully diagnosed and treated for oral cancer because of my website I will be very happy.’

If you are interested in contributing to Dr Patel’s website she can be contacted on e-mail: priya.patel@dentistmum.co.uk and you can also follow her on Twitter: @dentistmum.

### Spray-on teeth

Spray-on teeth are being developed by scientists at King’s College London and Imperial College London.

The spray contains a type of calcium and helps repair damage to the teeth enamel and may help repair any exposed dentin.

The developers say the product blocks tiny tubes in the dentin, which can reduce sensitivity.

The spray is held a few millimetres from the teeth and projects a dry powder — the action of the powder hitting the teeth also acts as a mild abrasive, helping to remove stains.

“Sprays allow more accurate and consistent delivery of the drug or treatment, and allow it to be used in the relatively sterile environment of a spray can,” Sam Shuster from the Newcastle University said.

[http://www.kcl.ac.uk](http://www.kcl.ac.uk)
New appointment at IndepenDent Care Plans

IndepenDent Care Plans (ICP) are experiencing a sustained period of growth in their business, working with more and more dental practices who want to introduce new dental plans to their patients or indeed switch from other providers where current service levels are not met.

At a time of financial pressure on both dental practices and their patients, IndepenDent Care Plans are pleased to experience continued success in providing a service to dentists that helps increase additional regular income whilst providing their patients with a dental plan they can budget for.

As a result of the current growth, the company are also bucking the trend of staff support levels by increasing their Business Development team to support practices introducing, converting and developing their patient dental plans.

Therefore ICP are delighted to announce that Wayne Mayhew has joined the IndepenDent team as our new Business Development Consultant, bringing with him a wealth of experience in both the Dental & Healthcare sectors.

Wayne Mayhew is very experienced working with Dental practices and in particular with Dental Plans, having previously worked for Isoplan where he enjoyed developing fantastic and successful relationships with many Dental Practice teams.

Mayhew will provide business development support and advice, including guidance on marketing, conversion management, banding rate assessment and team training needs, helping practices to implement and grow their patient plans.

Gary Moore, Business Development Manager for ICP said “We feel Wayne is a great acquisition to the team and furthermore cements IndepenDent Care Plans growth in the market whilst providing Principal Dentists with a further option as their preferred Plan Provider.”

Care Quality Commission survey

The Care Quality Commission is seeking feedback from health and social care staff. The CQC claim that ‘our job is to check whether hospitals, care homes and care services are meeting government standards’.

The website shows the latest reports on whether government standards are being met, which includes encouraging both patients and health workers to share their experiences or report a specific concern.

The questions included in the recent survey include:

• ‘Overall, how well do you think CQC is ensuring that all providers meet the essential standards of quality and safety?’
• ‘Overall, how well do you think CQC is ensuring that all providers are supporting quality improvement in health and social care?’
• ‘How clear are you about what you need to do in your role to ensure that your organisation is meeting the essential standards?’
• ‘Are you aware of CQC’s process for raising a concern about quality of care (whistle-blowing)?’

These questions are worthy of dentists and dental health workers time since the Care Quality Commission have just started regulating primary dental care for both private and NHS services, publishing up-to-date information assessments received on their websites.

Australia promises $4B for dental care in rural areas

The Australian Department of Health and Ageing has announced a six year dental package for low-income citizens in rural areas. Three million children are now eligible for the government- subsidised dental care, as well as one million low-income adults and pensioners, according to Tanya Plibersek, Minister for Health.

The package includes the following:

• $2.7 billion for 3.4 million Australian children who will be eligible for subsidised dental care
• $1.5 billion for 1.4 million additional services for adults on low incomes, including pensioners and concession card holders, and those with special needs
• $225 million for dental capital and workforce to support expanded services for people living in outer metropolitan, regional, rural, and remote areas

The $4 billion package is in addition to the $315 million announced in the 2012-2013 federal budget. It will replace the Medicare Teen Dental Plan and the Chronic Disease Dental Scheme (CDDS).
Does your continuity plan hold water or will it be powerless to help when the rains come?

Linda Young discusses contingency plans for dental practices

The last two British summers have been memorable for many businesses in the UK for a number of reasons: London 2012, Her Majesty The Queen's Diamond Jubilee celebrations, floods, riots, fuel shortages, storms and power blackouts were just a few of the events that disrupted businesses across the length and breadth of the country.

Whilst it is possible to predict when and how some man made events are likely to cause disruption to your practice, a natural disaster cannot be predicted and so poses a real challenge to businesses. What can a business do to plan for the unknown; the ‘What if’ scenario?

No Plan

Over the years I have worked in businesses that have had to temporarily cease trading for a variety of reasons, all of which were beyond their control. A very cold winter froze the locks of one business’ only access door, which meant that nobody could get into the premises. There was no continuity plan and no one knew what to do! The staff, including me, arrived for work totally unaware of the problem; we were left standing outside in the bitter cold. The locksmith didn’t arrive until midday. We didn’t arrive until midday. We were left standing outside in the bitter cold. The locksmith didn’t arrive until midday.

The situation was beyond the control of either the business owners or the staff. The staff, including me, arrived for work totally unaware of the problem; we were left standing outside in the bitter cold. The locksmith didn’t arrive until midday.

Gale force winds blew part of the roof off a relatively new building in which I was working. People working beneath the damaged roof were moved. The engineers could not access the roof area until the high winds subsided. The staff affected continued their shifts ‘working from home’. The ability for these people to remotely connect to the main servers had been part of that business’ continuity plan, resulting in negligible disruption to service levels.

Computer hardware and software failures, theft and server down times regularly can cause disruption to services for both staff and customers alike. Even the biggest company can get this wrong, look at NatWest’s recent experience! Having good backup systems in place will pay dividends.

Personnel

Losing personnel through illness poses a serious risk to the smooth running of a practice. Episodes of contagious viral illnesses unfortunately cannot be avoided, but can reduce staffing levels to the point where only a basic service can be delivered. It is not only your own staff who might be affected by a ‘flu epidemic; remember that the availability of agency staff will also be reduced. Keep details of all staff, their skills and past experience in the plan; these skills could be called upon to help out in an emergency.

Many practices have a lottery syndicate of which the nurses and receptionist are all members. What would happen on a Monday morning if the syndicate had won on the Saturday night? If the win was substantial then I doubt they would report for work!

Virtual

If using a ‘virtual receptionist’ service appeals to a practice, and both premises could be affected by the same event; too far apart may cause a logistical problem for staff, patients and suppliers alike. A practice can’t set up shop in the spare room in someone’s home even in the short term, so consider a reciprocal arrangement with another practice. The short notice change in location can be overcome by ensuring good communication with patients and suppliers, and perhaps the provision of a bus shuttle service for the patients, which would have to be agreed with the transport provider and, of course, noted in the continuity plan. Test the service appeals to a practice, and the patients’ needs.

‘Making continuity planning part of the way a practice operates helps prepare for ‘business as usual’ in the quickest possible time’

People with a contingency plan and its providers are fully documented in the contingency plan. Test the service regularly to ensure connectivity to the appointment book and that it meets the practice and the patients’ needs.

Finding suitable contingency premises is essential, but can be a dilemma! Choose the contingency premises with care; too close to the practice and the patients’ needs.

Making continuity planning part of the way a practice operates helps prepare for ‘business as usual’ in the quickest possible time. This is preferable to dealing with the disaster should it ever happen. Having a tried and tested plan helps protect the practice against the impact of a man made or natural event, or disaster.

There are plenty of online sites eager to share their ideas.
on how to draw up a plan. The time invested in collating all the information required for the plan at this stage could be one of the best investments a practice has ever made. The things that seem to be very simple now, when the practice is operating without any problems, could be insurmountable in the event of a crisis.

Level of detail
There are no hard and fast rules as to how long or short a continuity plan has to be. The level of detail in the plan is down to the continuity plan manager, who should never assume that everyone will still be around or be able to remember the essential processes, telephone numbers etc. So that your practice can continue to function without its premises and / or key personnel ensure that all the day to day activities and processes are all documented, and that they are all reviewed regularly.

At the same time think about processes that would only come into force if the continuity plan were activated.

Testing
Once the plan has been written and carefully checked think about testing it. Don’t be complacent and think that once the plan has been written it cannot be changed. To assume this is to take a big risk. Even the simplest and smallest of plans will have some amendments. Make sure the plan is kept up to date by reviewing it, even down to the smallest detail. Test the plan on a regular basis, combining this with a team building exercise. Make the testing scenario as realistic as possible, change the theme each time it’s tested from loss of premises, to people, to services and technology. Look at the impact of short-term losses to the medium and longer term. Keep a diary of the outcomes of each test so that key information that arises during each test isn’t forgotten about and can be built into the plan to improve the process.

Success
This article is not meant to be about how to write a practice continuity plan: it’s about thinking outside the box; thinking around all those decisions that will have to be made and which will make the difference to a plan, and your business’ ability to carry on trading.

Success in a crisis isn’t about good luck: it’s about good management continuity planning. Good management of anything involves planning, organising, implementing, controlling and finally reviewing.

About the author
Linda Young was the Information Security Manager and continuity plan holder for an international company for over 20 years. She is currently writing a practical resource manual to be published in 2013, which is designed for dental practices looking to improve their team’s management skills.

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Training day

Jane Armitage looks at staff training

Each year we close the Practice and have a full days training session. This might seem a bit harsh but during this day I will ensure that we have a full day of learning, set with aims and objectives.

This year our Investors in People review was due so we had our review on the same day as this saved disruption at a later date.

Staff meetings are held on a regular occasion but quite often you don’t have everyone’s undivided attention as they are usually held around lunchtime so can quite often become shortened.

At the start of the year I will choose a suitable date and close the appointment book with the exception of one surgery so we can continue to see any emergency patient that may contact on the training day.

I will then contact the mandatory training companies (ie Cross Infection Control, CPR) and allocate a time for the training to be carried out.

Appraisal forms are given out and a time set for the appraisal during the training day. Peer reviews are scheduled for the dentists during the training day.

Contracts are reviewed and updated with any pay increase and given out on the same day.

BDA Good Practice is discussed.

The Partners and I will meet and discuss the business plan for the coming year and see what we require to ensure we reach our goal. This can then become a working tool in our days training.

Identifying the needs of the business and ensuring you meet them usually includes the involvement of team members. It’s of little use you having a goal and not sharing what you need to do to achieve it.

The day will start with an in-depth staff meeting, in the past we have also asked speakers to attend to cover various subjects, ie Health & Safety, Significant Events anything that I feel will be of benefit to the staff. We will also look at everyone’s roles and ensure we have current first aiders, fire marshalls etc, quite often these rules get overlooked especially if a person leaves and held these extra duties.

CPD logs are hours are checked and new CPD folders are given out for the coming year.

I purchase a CPD folder from a Company that can be used by all members of the team. This I find such an easy tool to use. The staff are provided with individual folders containing sufficient verifiable CPD, I understand that mandatory CPD is the individuals responsibility however I feel this is an investment in your staff.

During the lunch break I book a lunch & learn from a rep.

It’s surprising how quickly the day goes and how much groundwork you have covered.

To take a day out needs to benefit the Practice, I believe quality is something that should be expected and delivered at the highest level. Training days may sound expensive but what you gain from a whole days experience outweighs the negative side.

Jane Armitage, Practice Manager of the Year 05,06,07,09

Jane Armitage is an award-winning practice manager and has almost 40 years industry experience. She is currently a practice manager for Thompson & Thomas, and holds a Vocational Assessors award. She is also a BDA Good Practice Assessor, BDA Good Practice Regional Consultant, and has a BDA Certificate of Merit for services to the profession. PM of the year 2005,06,07,09 BDA Certificate of Merit for services to the profession. UK Outstanding achievement award 2011.

Readers can contact janearm@btinternet.com
Eviden that new biomimetic controlled-release capsules may help in gum disease

Scientists are trying to open a new front in the battle against gum disease, the leading cause of tooth loss in adults and sometimes termed the most serious oral health problem of the 21st century. They described another treatment approach for the condition in a report here today at the 244th National Meeting & Exposition of the American Chemical Society, the world’s largest scientific society.

“Our technology uses controlled-release capsules filled with a protein that would be injected in the pockets between the gums and the teeth,” said Steven Little, Ph.D., who reported on the research. “That’s ground-zero for periodontal disease ‘gum disease’ the place where bacteria breed and inflammation occurs. The capsules dissolve over time, releasing a protein that acts as a homing beacon. It guides immune cells to the diseased area, reducing inflammation, creating an environment that fights the disease process and even could create conditions favorable for gum tissue to regrow.”

Little and colleagues, who are with the University of Pittsburgh, have evidence from laboratory experiments with mice stand-ins for humans in early research of this kind that cannot be done with actual patients that the approach does foster healing and regrowth of gum tissue damaged by periodontal disease.

A bacterial infection causes periodontal disease. It first appears as mild tenderness and bleeding of the gums. It leads to inflammation and, if left untreated, can damage the gums so that they recede and lose their attachment to the teeth. It may progress even further and damage bone and other tissues that hold teeth firmly in place. Surprisingly, gum disease has a number of deleterious effects outside the mouth, with some studies linking inflammation in the gums to an increased risk of heart disease, stroke and preterm delivery in pregnant women.

Treatment includes scal-
Improving periodontal health in style

Dr Fotinos Panagakis, Colgate Director of Clinical Research

A number of key decision makers and specialists in periodontology, dental public health & restorative dentistry came together recently to review the latest additions to the wealth of clinical evidence in periodontology, dental public health & preventative behaviour data from the recent Adult Dental Health Survey. Dr Alavi also shared his perspective of the hierarchy of evidence base, from systematic reviews to consensus of experts, in line with the ranking of evidence in the Department of Health publication: Delivering Better Oral Health, a study looking into the “Prevalence of Periodontitis in Adults in the United States: 2009 and 2010,” evaluates the prevalence, severity and extent of periodontitis in the adult US population using information from the Health and Nutrition Examination Survey. Lead author Paul Eke used information from a sample of 3,742 adults 50 years and older with one or more natural teeth of the civilian non-institutionalized population. Attachment loss and probing depth were measured at six sites per tooth on all teeth (except the third molars). The study is important because it is the first national probability sample that has employed a full-mouth periodontal examination protocol versus previous partial mouth examinations.

Of the sample presented, 47.2 per cent, representing 64.7 million adults, had periodontitis distributed as 8.7 per cent, 30.0 per cent and 8.5 per cent with mild, moderate and severe periodontitis respectively. For adults 65 years and older, 64 per cent had either moderate or severe periodontitis. These estimates are far higher than previous national estimates. Periodontitis was highest in males, Mexican Americans, adults with less than high school education, adults below 100% Federal Poverty Levels, and current smokers. This survey has provided direct evidence for a high burden of periodontitis in the adult U.S. population, especially among adults 65 and older.

This information implies that despite America having almost twice the number of dentists per person as in 1948, still more needs to be done to increase oral care and dental education, partially due to the less affluent areas of the country.

Global Oral Care partnership

Colgate is pleased to announce a global partnership with OMRON, a worldwide leader in innovative sensing and control technology for the manufacture of medical and home healthcare products. OMRON, based in Japan, are a leading innovator in their field, and produced the first Japanese components for X-ray machines in 1955. OMRON has continued to develop and break ground in healthcare products, including innovative blood pressure monitors during the 1970s and developed the first digital thermometer in 1985.

Unilever Global Oral Care

This unique partnership combines OMRON technology, with the oral care expertise of Colgate, to provide the next generation of electric toothbrushes. Colgate will launch this new and innovative range of products in the UK. Colgate is a leading innovator in electric toothbrushes, with the Oral-B 4000 Electric Toothbrush, launched in the UK on the 6th October, ExCel London.

Perio prevalence in US reported in study

A study looking into the “Prevalence of Periodontitis in Adults in the United States: 2009 and 2010,” evaluates the prevalence, severity and extent of periodontitis in the adult US population using information from the Health and Nutrition Examination Survey. Lead author Paul Eke used information from a sample of 3,742 adults 50 years and older with one or more natural teeth of the civilian non-institutionalized population. Attachment loss and probing depth were measured at six sites per tooth on all teeth (except the third molars). The study is important because it is the first national probability sample that has employed a full-mouth periodontal examination protocol versus previous partial mouth examinations. Of the sample presented, 47.2 per cent, representing 64.7 million adults, had periodontitis distributed as 8.7 per cent, 30.0 per cent and 8.5 per cent with mild, moderate and severe periodontitis respectively. For adults 65 years and older, 64 per cent had either moderate or severe periodontitis. These estimates are far higher than previous national estimates. Periodontitis was highest in males, Mexican Americans, adults with less than high school education, adults below 100% Federal Poverty Levels, and current smokers. This survey has provided direct evidence for a high burden of periodontitis in the adult U.S. population, especially among adults 65 and older.

This information implies that despite America having almost twice the number of dentists per person as in 1948, still more needs to be done to increase oral care and dental education, partially due to the less affluent areas of the country.

To reduce inflammation at the gums, Little and colleagues designed injectable controlled-release capsules containing a protein encased inside a plastic-like polymer material. The polymer is already used in medicine in dissolvable sutures. After the capsules are injected, the polymer slowly breaks down, releasing the protein encapsulated inside. The protein, termed a chemokine, is already produced by the body’s existing cells in order to summon specialised white blood cells to a specific site. Scientists previously tried to keep those cells, termed lymphocytes, away from the gums so as to block inflammation from occurring in the first place.

“It seems counterintuitive to lure in a lymphocyte, which is traditionally thought of as an inflammatory cell, if there’s inflammation,” Little pointed out. “But remember that a certain level of natural inflammation is required to fight off an infection. Inflammation is inherently a good thing, but too much of it is a bad thing. That’s why we aim to restore the immune balance, or homeostasis.”

Little’s team injected the capsules into mice and discovered evidence that disease symptoms are dramatically reduced and that proteins and other substances involved in regrowth of gum tissue had appeared. Little said that this finding offers encouragement that the treatment could not only rebalance the immune system, but also prompt growth of lost gum and bone tissue in the mouth.

The researchers acknowledged funding from the Arnold and Mabel Beckman Foundation, the Wallace H Coulter Foundation and the National Institute of Dental and Craniofacial Regeneration of the NIH (1R01DE21058-01).

This research was presented at a meeting of the American Chemical Society.

Source: American Chemical Society http://portal.acs.org/portal/acs/org/content
Protocol building for effective periodontal case management in general practice

Mhari Coxon discusses why having a protocol is vital

One way to ensure that the advice, assessment, diagnosis and treatment path remains at a consistently high standard in practice is to build a protocol which the whole practice will work to. This also makes induction training for new staff members robust and in keeping with CQC guidelines. The protocol is a map for anyone to refer to which will add re-assurance and weight to their own conclusions. The secret to success within general practice is to be consistent in your delivery. Protocols really help this to happen.

What should go in your protocol?

Well, if I am honest, as much or as little as you feel appropriate. If you have several dental professionals working on periodontal cases in your practice, for example three part-time hygienists and a specialist periodontist who comes in once a month, then you would need a detailed protocol as they will undoubtedly have different opinions on what is right and not and what should be advised or used and not. The initial mapping of the protocol can take longer the more dental professionals are involved but this example is purely assessing for risk in relation to periodontal treatment.

---

**Tobacco Use:** This is THE most significant risk factor for gum disease

Please circle if you now or have ever used

<table>
<thead>
<tr>
<th>Cigarettes</th>
<th>Cigars</th>
<th>Pipe</th>
<th>Chewing Tobacco/Paan</th>
<th>Snuff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount Per day</td>
<td>Used for How Many Years</td>
<td>If you quit, when did you quit?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Heart Attack/Stroke:** Untreated gum disease can increase your risk of heart attack or stroke

Do you have any other risk factors for heart disease or stroke? (please circle)

None Family history of heart disease Tobacco Use High Cholesterol High Blood Pressure Medications: A side effect of some medications causes changes in gums

Have you ever taken the following medications?

None Anti-Epileptic Medications Calcium Channel Inhibitors Cyclosporin

---

**Genetic:** The tendency for gum disease to develop can be inherited

Has anyone on your side of the family had gum problems (eg mother, father or siblings)?

Yes No

---

**Diabetes:** Diabetes are more prone to gum disease. If left untreated, gum disease makes it harder to control their blood sugar. When gum disease is eliminated, diabetics may improve their blood sugar control and make diabetic complications less likely. Any family history of diabetes?   Yes No

Have you had any of these warning signs of diabetes?

None Frequent urination Excessive thirst Excessive hunger Weakness and fatigue Slow healing of cuts Unexplained weight loss

---

**Rheumatoid Arthritis:** The causes of gum disease and RA may be related. One doesn’t cause the other, but when one is present the other is more likely to be going on. If your gums are inflamed you may be at increased risk for developing RA.

Have you ever been diagnosed with Rheumatoid Arthritis?    Yes No

If you have rheumatoid arthritis, emerging research suggests that eliminating any gum disease and then keeping it at bay can lessen the crippling effects of arthritis.

---

**Special Concerns for Females:**

Pregnancy: Tell us if you are planning to become pregnant. Gum disease can make it up to eight times more likely that you will have a pre-term low birth weight baby. You can greatly reduce the likelihood of having an adverse pregnancy outcome by finding out if you have any gum disease and then doing whatever is necessary to eliminate it before you get pregnant. It is also important to make sure your gums are inflammation free while you are pregnant.

---

**Osteoporosis:**

Do you have osteoporosis?    Yes No

The following are risk factors for osteoporosis: Post-menopausal, Family history of osteoporosis, Early menopause, Rheumatoid Arthritis, Inadequate exercise, Smoking

Do you have any other risk factors for osteoporosis?    Yes No

Have you ever been tested?    Yes No

---

‘The protocol is a map for anyone to refer to which will add re-assurance and weight to their own conclusions’
Please note that the wording of these questions is to ensure they are easy to understand for the patient and easy to answer. The risk assessment questionnaire is useful in more than one way. It is extremely useful for gathering information to aid diagnosis and categorisation of a patient. It is also a subtle tool for moving the patient from pre-contemplation to contemplation regarding their gum health. This, combined with a little open question session, can create a non-confrontational opening to discussion and advice and education sessions.

BPE guidelines and a guide to care - see www.bsperio.org.uk for full details.

Careful assessment of the periodontal tissues is an essential component of patient management. The BPE is a simple and rapid screening tool used to indicate the level of examination needed and to provide basic guidance on treatment need. Please note; the BPE does not provide a diagnosis.

How to record the BPE

1. The dentition is divided into six sextants: upper right (17 to 14), upper anterior (15 to 25), upper left (24 to 27), lower right (47 to 44), lower anterior (43 to 35), lower left (54 to 57).

2. All teeth in each sextant are examined (with the exception of 3rd molars).

3. For a sextant to qualify for recording, it must contain at least two teeth. (If only 1 tooth is present in a sextant, the score for that tooth is included in the recording for the adjoining sextant).

4. A WHO BPE probe is used (World Health Organisation probe). This has a “ball end” 0.5 mm in diameter, and a black band from 5.5 to 5.5 mm. Light probing force should be used (20-25 grams). - you can calibrate your probing using an electric scale to measure 10 probe movements and take the mean number. You can also invest in a set of pressure sensitive probes if you want of be gold standard.

Probing
The probe should be “walked around” the sulcus/pockets in each sextant, and the highest score recorded. As soon as a code 4 is identified in a sextant, the clinician may then move directly on to the next sextant, though it is better to continue to examine all sites in the sextant. This will help to gain a fuller understanding of the periodontal condition, and will make sure that furcation involvements are not missed. If a code 4 is not detected, then all sites should be examined to ensure that the highest score in the sextant is recorded before moving on to the next sextant.

BPE Scores

0 No pockets >5.5 mm, no calculus/overhangs, no bleeding after probing (black band completely visible)

1 No pockets >5.5 mm, no calculus/overhangs, but bleeding after probing (black band completely visible)

2 No pockets >5.5 mm, but supragingival calculus/overhangs (black band completely visible)

3 Probing depth 5.5-5.5 mm (black band partially visible, indicating pocket of 4-5 mm)

4 Probing depth >5.5 mm (black band entirely within the pocket, indicating pocket of 6 mm or more)

5 Furcation involvement

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- Implant design is more than 20% stronger than competitor implant
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- Laser-Lok microchannels create a physical connective tissue attachment (unlike Sharpey fibers)

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Periodontal Disease

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- broader spectrum of antibacterial action2 with greater overall activity than metronidazole or tetracycline
- conditioning of the root surface3 and enhanced connective tissue attachment4
- improved healing through inhibition of degradative collagenases5
- effective treatment of chronic periodontitis which has been associated with cardiovascular diseases6,9


Information about adverse event reporting can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Blackwell Supplies, Medcare House, Gillingham, Kent ME8 0SB or by telephone: 01634 877525.

About the author

Mhari Connon has 20 years experience in dentistry, working as a hygienist and then as an oral health adviser and later as an associate hygienist in a variety of practices in the South East of England.

She is passionate about the importance of oral health, and present, she works as Senior Professional Relations Manager for Philips Oral Healthcare and clinically as a hygienist therapist. It is important that the patient is aware of the importance of their role in stabilising any disease and has ownership of their condition before referring on.

When to refer

If a specialist is at hand, there can be a temptation to refer on to them quickly. In some cases this is entirely appropriate.

In others it can send a mixed message to the patient about the work they have had with either the GDP or hygienist/hygienist therapist. It is important that the patient is aware of the importance of their role in stabilising any disease and has ownership of their condition before referring on. They should also value the clinician who will be carrying out their maintenance regime as that is the person who will support them in ensuring they keep themselves at a high level of oral health.

My lovely Professor Barry Ely, sadly no longer with us, used to say three strikes then refer. So, have three goes at RSD with OHI, and if there is still no improvement then refer on. This would be done within a three - four month period and will not be detrimental to the patient in almost all cases. If you see rapid deterioration, then you would refer on and seek advice at the soonest possible opportunity.

Other things that could be put in your protocol:
- A guide to an oral health education session
- Recall interval guide

The list I have developed here is just a general example for you and could form the template for debate within your team and provide the bones for your final structure to ensure quality, consistency and best practice.
A look at Europerio7 in Vienna

Prof Peter Eickholz

United Kingdom Edition September 10-16, 2012

Insights into the latest therapy options for periodontitis

A recently completed study by the ERGOPerio group (Tonetti et al., 2012) investigated the therapeutic effect of slow release of active ingredients in periodontitis during SPT, which has been shown to have a positive therapeutic effect on inflammatory response as well as in the case of deep pockets (≥5 mm). Local antibiosis also seems to be the most effective approach for treating peri-implantitis due to the high concentration of active ingredients. The microbial flora is for the most part comparable with periodontitis, although peri-implant lesions may also be affected by staphylococcus aureus (typical pyogenic organism). The discharge of pus when probing a pocket is a clinical indication of infection in the diagnosis of peri-implantitis. The greatest challenge here is the removal of biofilm, a procedure that is considerably more difficult in the case of implant surfaces than in the case of natural dentition. Currently there is no standard, evidence-based approach to therapy: local antibiotics may provide an answer for the future, however, this must first be borne out by a study. Nevertheless, Professor Lang summarises as follows: “Nothing excuses the patient from cleaning his teeth every day”.

Dr. Waleed S.W. Shalaby, Chief Science Officer at PolyMed Inc., USA, continued in the same vein as Professor Lang, and presented the latest biomaterials for oral and periodontal applications. He provided detailed information on the critical aspect of the slow release of active ingredients in local antibiosis.

According to Dr. Shalaby, “The development of Ligosan Slow Release for non-surgical therapy of periodontitis is a good example of functional technological innovation”. Its main feature is its bioadgradable carrier substance comprised of hydrophobic and hydrophilic parts, which ensure that the initially fluid consistency enables penetration into the deep areas of the periodontal pocket that are difficult to reach. Liquid environments increase the viscosity, creating a gel consistency that ensures that the carrier substance remains at the active site. This ef-
Atlantis™ crown abutment is an efficient, effective and aesthetic alternative to traditional cast abutments for single-tooth, screw-retained restorations. Like Atlantis™ patient-specific CAD/CAM abutments for cement-retained restorations, the Atlantis crown abutment is uniquely designed from the final tooth shape for more natural aesthetic results and available for all major implant systems. It is also precision-milled from a solid blank of biocompatible zirconia, which eliminates the need to cast with precious metals.

What’s more, because porcelain is applied directly to the Atlantis crown abutment, it can be easily retrieved, if needed, and the time and cost of preparing a separate coping is recaptured. Atlantis crown abutment is available in five shades, including a new translucent zirconia in white. It can be placed in all positions in the mouth and is covered by a comprehensive warranty.

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Risk-based follow-up ensures long-term therapy success

The second event on Friday evening focussed on current therapy options in periodontal treatment. In the first presentation, Professor Peter Ratka-Krüger from the University of Freiburg, Germany, looked at supportive periodontal therapy in daily practice, underlining the importance of SPT in long-term therapeutic success. She based her conclusions on a variety of studies, all of which provide scientific evidence of the positive impact when patients with periodontal disease are treated regularly and consistently using SPT techniques. Based on a risk assessment at various levels (Lang & Tonetti, 2005), an individual risk analysis is essential. This allows the clinician to identify patients at greater risk of disease progression and to provide them with more frequent and intensive therapy.
sis can be performed, helping to prevent insufficient or excessive treatment. Professor Batka-Krüger continued with a description of the timeframe for a follow-up check-up, providing detailed information on the individual steps and what they entail. She referred back to the positive effect discussed in the first Heraeus symposium, specifically that of additional topical administration of SRD gel in the case of previously untreated cases of periodontitis (Eickholz et al., 2002), and once again emphasised the advantages of local antibiotics: reliable, simple and fast application. The additional benefits of this approach combined with SRP during SPT are also scientifically proven (Tonetti et al., 2012). In this regard, she also referred to a study (Dannewitz et al., 2009) in which the effect of topical SRD administration in addition to SRP during SPT was investigated in teeth with furcation defects. Once again, improvement was observed at furcation sites compared with SRP alone. In her conclusion, Professor Batka-Krüger described supportive periodontal therapy as the key to long-term therapy success. Regular participation in risk-based follow-up allows recurrences to be recognised and treated at an early stage, thus preventing tooth loss. Local antibiotics can boost the effect of mechanical therapy, contributing to the success of treatment.

In the second presentation “Telomere Length, Oxidative Stress and Chronic Periodontal Inflammation: Implications for Supportive Therapy”, Juliette Reeves, Clinical Director at Perio-Nutrition, Great Britain, looked at previously little-known links with periodontitis. Telomeres are regions at each end of a chromosome that shorten each time cells divide. This process is accelerated by oxidative stress. The length of telomeres is related to aging, chronic infection, oxidative stress and systemic illness (Zglinicki et al., 2005). Over the last ten years, the effects of periodontitis on general health have been clearly established. Masi et al. (2011) found that shorter telomeres are linked to periodontitis and that their size correlates with oxidative stress and the gravity of the condition. Gilley et al. (2008) proved that telomere degradation, the extent of chronic infection and oxidative stress can be reduced through changes in lifestyle (smoking, nutrition, obesity, stress). In her presentation, Ms. Reeves once again demonstrated the evidence-based links between living a healthier life and periodontal and general health, and defined the control of inflammatory response as a primary goal of treatment.

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Gumsaver® unveils a brand new oral health system designed to treat and prevent gum disease

The gumsaver® team have just returned from presenting this data at the International Association for Dental Research (IADR) General Session in Brazil and received wide acclaim from their global colleagues.

Invented by Leamington-Spa based dentist Dr Hani Mostafa, Gumsaver® has been designed to tackle one of the UK’s most significant public health challenges today.

Inevitability

“As a practicing dentist for 14 years, I have always been frustrated by the inevitability of tooth loss amongst patients with periodontal disease. Since 2006, I have been advocating the use of a narrow headed inter-dental brush and sub-gingival oral hygiene techniques, as taught by Philip Ower and the late Graham Smart. I have designed Gumsaver® to enable the dentist, therapist and hygienist and more importantly the patient, to clean below the gum-line, thereby removing sub-gingival pathogenic bacteria from the root surface.”

The gumsaver® system includes a soft bristled tool specifically designed to remove the bacteria from beneath the gum line and between the teeth, and a simple three step cleaning technique.

We have designed Gumsaver® to make the task of looking after gums and teeth simple for dentists, therapists, hygienists and the patient:

• The ergonomic design of the brush along with the simple 3 step technique means patients can be taught how to treat and prevent gum disease at home.

• The bristle heads are angled towards each other and are spaced apart, providing a small clearance in which the inter-dental spaces are lined up during use.

• An up and down motion will guide a head under the gum-line and into the pocket to remove bacteria rooted deep inside the inter-dental space. Just repeat in between every tooth, inside and out.

• The unique angle of the heads make it easy for the patient to use and the soft bristles will reduce any discomfort, thereby improving patient compliance.

Audit

In an audit of 95 patients with pocket depths of 5.5 – 10mm (BPE 3 or 4), Warwick Dentistry found that 98 per cent of subjects using the Gumsaver® system experienced a significant improvement. After just six months of using the Gumsaver® system, a staggering 65 per cent of subjects presented BPE scores of 0. In other words, their gum disease had been completely eradicated. The Gumsaver team has just returned from presenting this data at the International Association for Dental Research (IADR) General Session in Brazil and received wide acclaim from their global colleagues.
A historical perspective of the development of the Laser-Assisted New Attachment Procedure is presented in this article. The simplicity of the protocol is discussed, as well as its nuances. The concept of the Laser-Assisted New Attachment Procedure (LANAP) was born back in 1989 with Drs Robert Gregg II and Del McCarthy. As with most general dentists battling with the day-to-day realities of periodontal disease, they were looking for an answer on how to better care for their patients. The reality at the time was that periodontal disease was difficult to treat and maintain. It was primarily based on older concepts of wound debridement and amputation. Once treated, relapse was common. The patients would recall their experiences to friends and family, making case acceptance for periodontal treatment often a challenge. During this same time, Drs Gregg and McCarthy were involved in the early use of Nd:YAG lasers in dentistry. Confronted with patients not wishing to lose teeth and declining traditional surgery or extraction, they developed the LANAP protocol, which eventually led to its USFDA clearance in 2004.

In concept, the LANAP protocol is rather simplistic. The ultimate goal is to set up the periodontal environment to promote self-regeneration of the lost attachment and osseous structure that result from LANAP—Laser-Assisted New Attachment Procedure. Reinforced when new attachment was found on all the LANAP-treated teeth in the initial histology studies done by Dr Ray Yukna. LANAP is also a very safe protocol. The use of the Nd:YAG laser has often been of concern by some owing to possible damage to root surfaces and the tissue attachment but, with a basic understanding of laser physics, laser-tissue interaction parameters were developed that enabled the use of an Nd:YAG in a very safe and effective manner. LANAP is also standardised. That is, before a doctor can obtain his laser he goes through three days of training: one day of laser physics and laser-tissue interaction and then two days of hands-on training with patients. This is then followed up by two more separate days of treating patients to refine techniques and add other treatment modalities utilising the Nd:YAG. Because of the simplicity, predictability and standardisation of LANAP, it has become a very safe and effective way to treat periodontal disease. The simplicity of the LANAP protocol can be seen in Table I.

LANAP protocol

Step A

Patients undergo a full dental examination and treatment plan—as with all dentistry. If they have an appropriate diagnosis of Type III or greater periodontal disease, all treatment options are presented to the patient. The initial step of the LANAP protocol, after anaesthesia has been administered, is bone sounding around each tooth. The objective is to determine areas of osseous defects that cannot be seen radiographically. Step B

This is the first time the laser is used. The objective of this step is to remove only diseased epithelium, to affect selectively bacte-

**Fig. 1.** Selective thermal ablation of epithelium.

**Fig. 2.** Formation of the stable fibrin clot.

**Fig. 3.** Periodontal charting.

'We know periodontal disease is a multifactorial disease process and patient behavioural routines can play a significant role'

---

Dr David Kimmel discusses the LANAP protocol

**Fig. 1.** Periodontal charting.
ria associated with periodontal disease, to affect the calculus present, and to affect thermo-labile toxins. The bacteria that are associated with periodontal diseases are pigmented and are found in the sulcus, within the root surface and within the epithelial cells. One of the reasons for the predictability of this step is in the selection of a free-running pulsed Nd:YAG laser with a wavelength of 1,064 nm and pulsed in a range of seven different microseconds. The shorter 1,064 nm wavelength was selected for its affinity for melanin or dark pigmentation, unlike the longer wavelengths that are highly absorbed in water and would have a shallow depth of penetration. This ability to increase the depth of penetration of the laser energy with minimal collateral damage is the reason that the diseased epithelium can be selectively removed without damage to the underlying tissue, leaving intact rete pegs. The diode lasers are also known for this selective absorption in pigmented tissues, but the free-running, pulsed Nd:YAG lasers differ in their ability to operate at very high peak powers in very short timeframes, which allows the Nd:YAG to have the greater depth of penetration and the lack of collateral damage.

Step C
This step in the LANAP protocol is straightforward; it is just a matter of using the piezo-scalers to remove the calculus present on the root surfaces. The removal of calculus is believed to be easier after the interaction of the laser energy with the calculus. The first interaction of the laser results in the initial formation of a mini-flap, thereby further assisting in the removal of calculus because of increased visibility and access to the calculus.

Step D
The next step again utilizes the laser. This time the parameters are varied to enhance the ability to form a fibrin clot to close the mini-flap and to disinfect the site again. The formation of the stable fibrin clot is significant, as it is stable for approximately 14 days. The role of the fibrin clot is to keep the...
sulcus sealed against bacterial infiltration and to prevent the growth of epithelium down into the sulcus. Of laser wavelengths not only lack the ability to form this stable fibrin clot, but also require repeated treatments to prevent epithelial growth down into the sulcus.

The ability to select the laser tissue interaction specifically is unique to the PerioLase MVP-7 (Millenium Dental Technologies). Through the use of specific fibre sizes, energy, repetition rates and standardisation of the energy at the fibre tip, this protocol can be followed in a predictable and reproducible manner. The high standard of training that each LANAP doctor receives also contributes to the predictability of this protocol and to its safety. Patients often present with different tissue types along with different degrees of disease. One of the purposes of the hands-on training is learning to recognise these differences and how to change the laser parameters accordingly so that the desired laser-tissue interactions are achieved.

Step E
The fifth step in LANAP is the compression of the fibrin clot to enhance the healing process. Because laser wounds heal by secondary intention, closer approximation enhances the healing time.

Step F
Following the compression and stabilisation of the clot, the last step of LANAP is refining the occlusion. Occlusion has been considered a greater cofactor in the progression of periodontal disease than smoking. In order to minimise this role, extensive adjunction of occlusal refinements. No sub-gingival restorations or periodontal probing is done during this time. Only during the final post-operative visit is a periodontal probing done. The results that are seen from LANAP treatment are very similar to the following cases, where new bone fill can be seen in vertical osseous defects. The bone fill ranges from simple proximal defects to the more complex furcation defects. The hallmark of LANAP is pocket reduction, new tissue attachment and a lack of tissue recession.

LANAP case 1
The patient in this case was a 40-year-old female patient with a history of lupus, rheumatoid arthritis and Sjögren’s syndrome. She was also a smoker. There was generalised deep pocketing as seen in her periodontal charting. The extent of the osseous defect is apparent. Minimal to no recession is shown in the preoperative clinical photograph in Figure 7 and the post-operative in Figure 8.

LANAP case 2
The patient in this case was a 59-year-old male patient, with Type 1 diabetes and a smoker. His periodontal pocketing was 7 mm on the mesial second premolar. The preoperative X-ray is shown in Figure 9 and the 56-month post-LANAP X-ray in Figure 10. The 7 mm pocket had been stable and maintained postoperatively is shown in Figure 6. The change in the osseous defects is apparent. Minimal to no recession is shown in the preoperative clinical photograph in Figure 7 and the post-operative in Figure 8.

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September 10-16, 2012

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This course provides the participant with a programmed approach to diagnosis and treatment planning, you will discover how to visualise optimum dentistry from an aesthetic, functional, biological and structural perspective.

Special emphasis will be placed on the four options of treatment (reshaping, repositioning, restoring and surgical correction), so that the correct option(s) are chosen for each patient. Additionally, each student will learn how to segment large treatment plans, so that patients with financial issues can receive optimum care over time. The focus of the programme is to integrate a comprehensive treatment planning process into their practice. Suggestions will also be made on creating time and a place for optimum treatment planning. Finally, a consultation process will be discussed in detail, ensuring each participant will enjoy a healthy case acceptance rate.

LEARNING OBJECTIVES

- Establish a step-by-step process for treatment planning any restorative case, from the simplest to the most complex.
- Special emphasis will be placed on the four options of treatment (reshaping, repositioning, restoring and surgical correction).
- Explore why 90% of mistakes occur not during the restorative phase, but rather during the treatment planning process.
- Plan and visualise ideal aesthetics and ideal function.
- Design programmed treatment planning processes and integrate into your practice.
- Discover the need for/value of quality records.
- Master the 16 functional and esthetic components of healthy, functionally correct dentition.
- Investigate how the teeth should be positioned in space for optimum aesthetics, phonetics and function.
- Identify specifically how to utilise the diagnostic photographs in conjunction with mounted diagnostic models to visualise an optimum course of treatment.
- Create a segmented treatment plan so that optimum care can be delivered over a longer period of time.
- Creating time and a place for treatment planning.
Dental patient bib holders source of bacteria

Hygiene in the dental office is a matter of course and a must for patient safety. Instruments are sterilized daily and work surfaces disinfected. Moreover, dentists and assistants wear gloves and face masks. Nonetheless, a seemingly harmless object is found wanting in terms of hygiene in many dental offices: the patient bib holder. These are often contaminated with bacteria, a recent study by Witten/Herdecke University (Germany) has shown. A total of 50 metal and plastic patient napkin holders were subjected to microbiological tests. The results are alarming. Bacteria were found on 70 per cent of the bib holders.

Bacteria were found on 70 per cent of the bib holders, despite the fact that some of the holders were regularly cleaned and even disinfected. The most frequently found microorganisms were staphylococci and streptococci. Also, different types of rods, pseudomonads - both types of bacteria - fungi as well as other types of cocci were found on individual chains. Although all were non-pathogenic bacteria, it is clear that, in principle, bacteria transfer can occur via bib chains. During a comparable study conducted by the University of North Carolina's the E.coli bacterium, which can cause serious diseases, was found on napkin holders.

Risk of cross-contamination

Previous studies published in 2010 and already noted the potential risk of cross-contamination. The staphylococci and streptococci mainly found in the current study occur all around us and are non-hazardous for healthy people when found in low concentrations. However, it should be noted that both types of cocci can also cause infection: staphylococci are responsible for wound infections, boils and food poisoning, while streptococci can lead to scarlet fever, endocardium inflammation and pneumonia. The detected fungal species can also trigger physical reactions such as allergies, fever or irritation of the respiratory tract if they occur in higher concentrations.

In view of the possible hazards posed by germs on patient napkin holders, the conventional practice of cleaning such utensils is unacceptable. Even if no known evidence for serious infections exists to date, a change of thinking is needed here so that no potentially contaminated napkin holders are used on patients during dental treatment.

Disposable napkin holders such as Bib-Eze™ from DUX Dental (www.duxdental.com) offer the solution: they are easy to handle and provide a safe alternative to traditional metal or plastic reusable holders while eliminating the contamination risk. Hygienic, disposable napkin holders are the right choice for you and your patient.

*Study Report Witten/Herdecke University, Faculty of Health, Germany: Microbial contamination of patient bib holders, February 2012.
2 UNC School of Dentistry, Chapel Hill, North Carolina. Bib Chain Contamination Study.

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In search of the confidence element
by Glenys Bridges

Many things have changed in the profession over recent years. One thing that has not changed is the most frequently given answer by students enrolling onto non-clinical skills programmes, when asked “What do you want from the course?” The majority of new learners say: “I want to feel more confident in my work.”

The good news is that when asked in end of course evaluations, “What did you gain from the course?” the response is always, “confidence.” From the trainers point of view this raises a few questions, beginning with: “What is the elusive ‘confidence element’ and how does training increase feelings of confidence and competence?”

The starting point to answer these questions is a dictionary definition for self-confidence - Macmillan Dictionary defines self-confidence as ‘a feeling that you can do things well and that people respect you’. Let’s look at these two elements individually.

Feeling you can do things well:
They say that “practice makes perfect”. There is no doubt that we feel much more comfortable when doing familiar work task, than we do when trying something new. But if the technique used is poor, or the task unfocused and not fit for purpose repetition will not improve results. To do things well we must be able to identify the required end results, so that we can plan ways to achieve those results using methods that recognise the needs of the patients, the dental team and the dental business. The skills for this are what the training must provide. Namely skills of audit and evaluation can be taught and applied to individual tasks, so that these are no longer empty tasks performed for compliance, but meaningful activities leading to tangible benefits, continuous improvement and increased self-confidence.

Feeling that people respect you:
Something very few dental teams have truly understood is the immense power for the good that can be accessed by offering support and positive regard to your team colleagues. We have got the idea that teamwork involves trust and cooperation, yet no idea of how to support each other’s skills and confidence by showing them respect. Too many of the dental teams I work with have not got a working knowledge about what respecting colleagues’ means, or how to do it.

In my opinion some of the main reason for the lack of respect and recognition extended to dental colleagues are due to:
• The tendency to be task-focused, rather than person-focused
• A failure to thank colleagues when thanks are due
• Problem-focused blame, rather than solution-focused cultures

Each of these lead to feelings that colleagues are secretly pleased to see you fail, rather knowing that your colleagues are watch , rather than getting ready to stab you in the back. It is much more complex to decide how training can help with this it aspect of self-confidence.

There are many formats training can take; each format has its part to play in developing quality dental services when woven into an overall training and development plan. Macro aspects of training look at on the job instructions, how to do... Without doubt the confidence of workers is higher when they know what is expected of them and how to deliver this.

Macro aspects of training are the route to lasting confidence. This is because it provides ‘tools to think with’. This provides a working knowledge of proven theories and techniques so that people can master their responsibilities, not only when things are going well, but they have the resources to put things right when things are not going to plan.

Training to secure this level of competence for clinical for dental professionals is generally available, whereas this sort of quality of training for the non-clinical dental team lags behind. As a result the self-confidence of non-clinical dental professionals is lower than that of their clinical colleagues.

In June a meeting of non-clinical dental professional, practice manager, trainer and dental media representatives met at Aston University Business School to form CASPEIR, Coordinators of Administrative Standards and Professional Education for Receptionist, practice managers and care coordinators. One of CASPEIR’s objective is to increase the profile and provision of quality non-clinical dental training and secure the confidence element in practices throughout the UK. Watch this space.

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About the author
Glenys Bridges is an independent dental team trainer. She can be contacted at glenys.bridges@gmail.com

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Dental Tribune United Kingdom Edition
Complications in the leasehold system

Ray Goodman discusses disagreements over property conditions

It is common in the UK for commercial premises to be held by tenants on a leasehold basis, and many dental practitioners will be familiar with some of the practical aspects of that through their own experience. Most leases contain provision that the tenant should keep the property in a good state of repair, maintaining the building to an acceptable standard and generally looking after it, on behalf of the landlord or owner of the freehold. Unless a schedule of condition is agreed with the landlord at the outset, the covenant to repair usually applies regardless of whether the property was in a poor state of repair when the leaseholder takes over. This means those who are unprepared could be faced with immediate repair bills for a property they have just taken over. It is no defence for a tenant to plead that “the property was like that when I took over, so why should I improve it”. This is why it is crucial to take proper advice before entering into a new lease so that such issues can be negotiated and, where possible, onerous repair obligations can be avoided.

Naturally, disagreements can occur when freeholders believe that their tenants are not keeping the property in the condition agreed upon. Leases often feature provision for the landlord to inspect the property on request to ensure they can keep an eye on the condition of their investment.

Timetable
Landlords who feel the repair covenant has been breached can, depending on the terms of the lease, be entitled to serve a schedule of dilapidations, which obliges tenants to rectify the breach of the covenant by carrying out the necessary repairs. A timetable for the repairs will be drawn up as part of this process, and if it is breached the landlord may carry out the repairs on the tenant’s behalf and charge them for it.

Depending on the lease in question the landlord would usually have a right to serve...
a schedule of dilapidations at any time. However, in practice the issues usually arise when the tenant is seeking to make alterations or sell the property on. At this point, a disagreement over the condition of the property can be time consuming and costly for the existing leaseholder.

It is not uncommon for a lease to contain provisions stating that it cannot be assigned to a new leaseholder if there are any existing breaches of the lease. Landlords sometimes choose to serve a schedule of dilapidations when there is the opportunity of an assignment, in a bid to force the existing leaseholder to carry out repairs before they are able to sell their interest in the property.

Impact
The impact can be dramatic, in a bid to force the existing leaseholder to carry out repairs before they are able to sell their interest in the property.

Recession can make landlords very keen to maintain their properties in a good condition, in case tenants go out of business and they end up with a vacant property that needs to appeal to a new user. As a result, a difficult economy can mean landlords are more likely to serve a schedule of dilapidations. More unscrupulous freeholders can also over-value repair works with the view to making a profit, thought whether this is possible will depend on the drafting of the lease.

Solution
The complexities of the UK leasehold system, and the differences in the drafting of leasehold documents mean there is no ‘one size fits all’ solution to these issues. The common terms involved are by no means universal. This makes it all the more important that your lease is well-drafted and that you are fully aware of any obligations and conditions it entails. As always, expert advice from a dental lawyer is an essential safeguard.

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**Local rules for local PCTs mean care is needed when designing Local Decontamination Units**

Regional differences in the implementation of HTM01-04 guidelines make it vital for dentists to seek expert advice when redesigning their practices, says Roger Gullidge of Roger Gullidge Design.

“At the heart of the issue is the way that HTM01-04 is written. Like many official and bureaucratic documents, it is complex and daunting. Dentists have interpreted passages of the document in different ways and even enforced it accordingly,” says Roger Gullidge Design. Factors such as ventilation within decontamination units can be especially essential when designing the layout of the units, he adds.

“All guidelines are put in place to protect patients,” says Roger Gullidge. “The process of achieving that protection can be far smoother if you have expert advice at the right time.” Roger Gullidge Design is a specialist design and practice management consultancy specialising in the dental sector. Call 01790 784442 for more details or visit www.rogergullidge.com

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**Drill-free dentistry introduced in Colchester**

National firm Dentist Direct has launched its first new style practice which aims to stomp out fear of drilling and infections among dental patients.

Dentist Direct’s first practice has now officially opened in Colchester, with Principal Dr Neil Sanghavi, allowing patients to be treated with revolutionary laser dental technology which can be used instead of drills and needles for almost any dental procedure and which—in most cases—is completely painless.

This technology, known as the Waterlase iPlus works by using laser energy with a gentle stream of water, reducing pain, anxiety and trauma for patients and instead creating a much more comfortable and memorable dental experience. Principal dentist Dr Neil Sanghavi said: “I think it’s a brilliant concept for dentists like myself who want to grow their clinical skills and concentrate on caring after their patients rather than spending time worrying about the business and compliance side of things.”

For more information please call Robin@shilty or Emily Parker at Harveys & Hugs on 01325 466666 or email info@shilty.com or emily@shilty.com

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**New recession-free Laser & Whitening products from Quicklase Quicksafe**

Wow, it’s here! Quicklase have launched their new recession-free laser & whitening. It is British-made, calibrated and serviced here in the UK and is designed to appeal and be ostensible by all Dental Practices without fear of overspending. It comes fully loaded with full features and all programmable pre-set treatments, including those for delicate toning on ivory teeth, enamel and teeth whitening. There is a colour coded screen for ease of use with an aid fibre tip to protect the lips. In addition there is a wall mount bracket option for those who prefer. The new dental.laser is half the price of its predecessor.

In addition, QuickiWhite have launched their new offers for their Carbamide and in surgery kits, the kits are now in a special cosmetic packaging box. The brand is known for effectiveness and excellent fast results.

**New award winning website**

All Dental Focus websites are compatible with mobile technology including iPhones, iPads, and other smart technology devices. The Dental Focus team can also help you set up your own practice blog, and can optimise your website to achieve Page 1 Google Rankings.

Krishan Jothi aka the Master is the Internet Marketing Director supported by his trusted group of experts. Don aka the Genius, Adrian aka the Wizard and Gauti aka the Surf. To learn more about how an exclusive website can benefit your practice, contact the Dental Focus superheroes today!

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There seems to not be much space left for normal floss. “

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shaping your investment and making sure all call will be in line with
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Schröder W1 brings a new level of freedom and flexibility to dental
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The journal of oral implantology • Issue 2/2012

Vol. 2

Dental Tribune UK

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COURSE ANNOUNCEMENT

MULTI-SYSTEM IMPLANTOLOGY CERTIFICATE COURSE AT
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Recognised by University of Salford

Applications are invited for a hospital based “certificate” year course (one day a month) starting on 16th November 2011.

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FOR FURTHER INFORMATION: Professor T.C. Ucer, BDS, MSc, PhD,
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