An App to make you beam

A new toothbrush has been designed to use your phone to tell you if you are brushing enough. The brush, designed by Beam Technologies, connects to a smartphone app to make sure you spend enough time brushing your teeth. With the average person spending just 46 seconds brushing their teeth, the Beam brush is designed to change that – it is connected to your phone via Bluetooth, and times how long you brush for. The app also monitors the number of strokes and can alert the user if they have forgotten to clean their teeth. The toothbrush is manual, and works by reacting to the body’s bioelectricity. This starts the timer, and the information is then automatically updated to measure progress through the user’s phone. www.beamtoothbrush.com/index.php

NICE tool counts cost

A new interactive tool developed by NICE and Brunel University will help local authorities count the cost of tobacco control interventions in their communities. The tool also models the longer-term cash savings that authorities can expect by putting tobacco control strategies in place. The Tobacco Return on Investment Tool is a Microsoft Excel-based program that evaluates a portfolio of tobacco control interventions and in different payback timescales. Packages of interventions can be mixed and matched to see which intervention portfolio or package provides the best ‘value for money’. The tool is accompanied by a package of support materials, including a user guide and technical report, which can also be downloaded from the NICE website.

www.dental-tribune.co.uk

Don’t be scared of Oct 31, celebrate!

In our exclusive interview with teeth whitening expert Dr Wyman Chan, we hear that it’s all white now that the law surrounding hydrogen peroxide use is changing...

This week marks the date that sees the long-lobbied for clarity in the protracted debate over the legality of tooth whitening.

According to the amendment carried last year by the European Commission, tooth whitening products containing up to six per cent hydrogen peroxide can now be supplied to patients for use as a take home product, providing certain conditions are met.

Dr Wyman Chan, a dedicated teeth whitening dentist, has been following the developments, and believes that dental professionals should be embracing the freedom that the law amendments have given, not be wary of them.

He said: “It’s exciting, it’s excellent news, and I think we all should celebrate. Dental professionals, dental practitioners who are practising teeth whitening should celebrate, should go and have a party. It’s the first time in so many years that we can do teeth whitening legally from October 31. Before then, even now, we’re doing it technically illegally. So that’s why I’m so happy because I am a dedicated teeth whitening dentist. It’s the only thing I do and now I can do it without fear.”

One thing that Dr Chan has noticed is that although the amendment is supposed to bring an end to the confusion over what can and cannot be done with regards to the supply of teeth whitening products to patients, it seems that for many it isn’t clear what the law is changing. “I’m bemused by the debate going on in forums and also the position taken by many reputable bodies - I won’t name any of them. I think they didn’t read the documents properly – I think they have got it wrong. That’s my opinion. Maybe I’m wrong, but I’m confident I’m correct. Let me explain why I think that. Because this is not new law, this is an amendment. They’re amending an
the products are used only as intended in terms of frequency and duration of application. These conditions should be fulfilled in order to avoid reasonably foreseeable misuse.

Those products should therefore be regulated in a way that ensures that they are not directly available to the consumer. For each cycle of use of those products, the first use should be limited to dental practitioners… or under their direct supervision if an equivalent level of safety is ensured. Dental practitioners should then provide access to those products for the rest of the cycle of use. (European Union Council Directive 2011/84/EU)

Dr Chan believes that the confusion is many think the use of tooth whitening or bleaching products containing more than 0.1 per cent and up to 6 per cent of hydrogen peroxide present or released from other compounds or mixtures in these products may be safe if the following conditions are satisfied: an appropriate clinical examination is carried out in order to ensure there are no other risk factors or any other oral pathology of concern and that exposure to these products is limited so as to ensure that

existing law. Actually it is limited so as to ensure that pathology of concern and that risk factors or any other oral examination is carried out so we can get excellent results. It doesn't matter what product you use, with six per cent you will get results. So the clarity we now have is nothing to do with the debate people are having at the moment – which is about chairside (whitening). This has nothing to do with chairside – they are amending the law about oral hygiene products.

"The original Directive came into force in 1976, regulating products directly available to the consumer as over the counter products. That’s why it was limited to 0.1 per cent hydrogen peroxide because of daily use and long term exposure. I agree with the cosmetic commission of the EU that it should be regulated, that the level should not be more than 0.1 per cent because you can swallow a lot of toothpaste and mouth rinse into the stomach every day. So it was correct at that time, 1976. In the early 1990s teeth whitening became popular, it became the norm. In 1976 there was no such thing as home whitening, it was brand new technology. Things seemed to be moving too fast for the EU – they needed to catch up with the new technology.

“They’ve (SCCS) been debating for years the safe amount for consumer self-dosing application, and there’s a lot of evidence from scientists, and they all agree that up to six per cent is safe for the consumer to take home. Of course this is after they’ve had a clinical examination - there are conditions attached which I think is fair, for example they need to be examined by a dentist so now take home whitening is officially a dental procedure. In addition the first use should be by a dental practitioner, or supervised by a dental practitioner, so now home whitening is very much the practice of dentistry."

Another big issue regarding whitening is the rise of people outside of dentistry providing tooth whitening services to the public. With the law amendment, Dr Chan says this can help put a stop to this, protecting patients further. "I think this amendment has plus and minuses. A plus is that there are a lot of non-dental professionals – I’ll not call them beauticians, as many are mechanics and bricklayers trying to make some fast money - giving customers hydrogen peroxide to take home with them so that will be stopped now. Trading Standards Agencies can stop anything which I think is fair, for example they need to be examined by a dentist so now take home whitening is officially a dental procedure. In addition the first use should be by a dental practitioner, or supervised by a dental practitioner, so now home whitening is very much the practice of dentistry."

In an attempt to help dental professionals understand tooth whitening and what can be done, Dr Chan has partnered with Healthcare Learning Smile-on to develop a new educational programme on the subject. "I’m really excited about it, because when it comes to legality a lot of dentists are still confused because a lot of companies are withdrawing chair side products and we need to review the literature. A lot of clarity has to be made in this field. We’ll be able to supply dental profession- als with the supporting docu- ments about whitening so you can cover the legality but it will also aim to teach them about the modern ways of doing teeth whitening effectively. There is a lot of talk that chair side whitening is all about dehydrating the teeth but that is just not true. I do a lot of chairside whitening - you need a lot of knowledge to make it work. We talk about chairside whitening, home whitening, how to deal with patients with sensitivity."

To review the amendment to the whitening Directive go to http://ec.europa.eu/con-sumers/sectors/cosmetics/documents/directive/92-con-solidated-version-of-cosmet-ics-directive-76/768/eecc

Dr Wyman Chan at work in his practice
This week is a landmark time for dental professionals who supply tooth whitening to their patients. Finally it will be possible to provide patients with take home whitening kits that will provide results that won’t make you look over your shoulder for the nice guys and gals from Trading Standards.

Til Qureshi, president of the BACD, has released this statement: After many years of uncertainty regarding the legality of tooth whitening in the UK, the BACD welcomes the amendment to the UK cosmetic regulations as a result of European Council Directive 2011/84/EU that finally legalises tooth whitening by dental professionals.

We commend the work the GDC does protecting patients and re-affirm our support for its work prosecuting non-dentists illegally providing whitening. We call on Trading Standards departments across the UK to embolden their approach in tackling non-dentists who illegally provide whitening treatments and continue to put the public at risk.

And we call on the beauty industry to ensure that its members, and those who train them, understand the new legal framework and leave whitening to those who can provide it legally, safely and in the best interests of patients; the dental profession.

The future’s bright, the future is six per cent hydrogen peroxide!

The GDC’s decision to freeze the Annual Retention Fee (ARF) at £120 for dental nurses in 2013 is “inadequate” says Nicola Docherty, President of the British Association of Dental Nurses.

The decision shows that the GDC is “out of touch with registrants” says Nicola. “We have supplied the GDC with detailed information on dental nurse salaries, showing that the £120 ARF causes considerable financial hardship to dental nurses. We have also requested that the GDC lower the ARF for dental nurses to a fee more in line with salaries - instead of charging dental nurses the same ARF as hygienists and therapists - and that they implement a special fee for those working part time.”

A recent salary survey conducted by BADN shows that the majority of Registered Dental Nurses are paid between £10,000 and £20,000 per year - in contrast with hygienists and therapists, whose recommended starting salary is £26,000. However, the GDC has decided to continue charging one ARF to all Dental Care Professionals, completely disregarding the fact that dental nurses earn less than half that of hygienists and therapists.

“BADN has always supported, and continues to support, registration in principle, as being in the best interests of the patient. However, the GDC’s heavy handed and insensitive implementation, including the imposing of an unreasonable ARF, has alienated many dental nurses and must be rectified as soon as possible” said Nicola.
Rise in confidence amongst dentists

Confidence in children improves dental health

A new study, published in the Journal of Dental Research has found that an intervention designed to bolster their “sense of coherence” had “the ability to see life as a challenge in which coping skills can be used to deal with stressors”, and showed significantly better oral health-related quality of life compared with children from schools randomly assigned to a control group. The children in the intervention group also exhibited improved beliefs about the importance of healthy dental behaviours and had better gingival health than those in the control group.

“This is a hugely important study in the dental literature. While there is some evidence in dentistry of the benefits of a sense of coherence, much of this work is cross-sectional so we don’t really know if sense of coherence really brought about any possible change,” said study co-author Sarah R. Baker, PhD, a health psychologist at the University of Sheffield in an interview with Medscape Medical News. “Our study is the first intervention study to show that improvement in coherence can have influence oral health,” she said.

In the study, 12 different primary schools were randomly assigned to the intervention group or the control group. Fifth graders, aged 10 to 12 years, participated. Students assigned to the intervention group received seven sessions over two months focused on child participation and empowerment. Each session lasted 50 to 40 minutes. The first four sessions were classroom-based activities, involving didactic learning, games, and discussions. The last three were health-related school projects that included all students and staff, and involved brainstorming, planning, evaluation, and implementation. The intervention was delivered by six teachers who went through specialised, intensive one-day training.

Results indicated that compared with the control group, the children who received lessons in sense of coherence had mean scores on the oral health-related quality-of-life questionnaire that indicated fewer functional limitations and other problems due to dental health three months after the intervention. Children in the intervention group also showed a greater sense of coherence than did those in the control group and were more likely to rate healthy dental behaviours as important. It also found that more children in the intervention group than in the control group had normal gingival health three months after the intervention.

The Healthcare Confidence Index was first published in August 2011 and is now in its third wave. It aims to provide an insight into the attitudes and opinions of primary healthcare providers; GPs, dentists and pharmacists, over the next one to five years.

To view the full Lloyds TSBC Commercial Healthcare events of any future please visit www.lloydystsb.co.uk/healthcare and to take part in the next Healthcare Confidence Index visit www.healthcare-confidenceindex.co.uk.
Dental Webinars
Be WHerever You Want

The UK’s leading online seminars

Smile-on webinars deliver a unique live experience using the world’s leading thinkers to bring you a ground breaking, interactive learning experience.

Engage with a leading expert, ask questions, get solutions.

Relax in the comfort of your own home and keep up to date through interacting with the world’s leading thinkers.

Webinar 1: Introduction to the MSc in Healthcare Strategy and Performance
Speaker: Sam Volk
Date: 30th October 2012

Webinar 2: CBCT for everyone
Speaker: Colin Campbell
Date: 7th November 2012

Webinar 3: Rubber-dam Techniques - Overview and New Matrix Systems
Speaker: Dr Ian Cline
Date: 14th November 2012

Webinar 4: Contemporary no-preparation veneers
Speaker: Dr James Russell
Date: 20th November 2012

Webinar 5: Dental Implantology - At the Cutting Edge of Dentistry
Speaker: Dr Nilesh R. Parmar
Date: 21st November 2012

Webinar 6: Sharpen Up Your Instrumentation!
Speaker: Alison Grant
Date: 28th November 2012

Smile-on webinars deliver a unique live experience using the world’s leading thinkers to bring you a ground breaking, interactive learning experience.

Engage with a leading expert, ask questions, get solutions.

Relax in the comfort of your own home and keep up to date through interacting with the world’s leading thinkers.

To book your Free place go to:
www.dentalwebinars.co.uk
or call us on 0207 400 8989

Sign up for FREE www.dentalwebinars.co.uk
Young dentists call for DFT guarantees

Dental practice has performed complete dental implants for free after winners were nominated on Facebook. Brighton Implant Clinic’s charity, The Smile Foundation, provides dental implant treatment has a direct impact upon use my dental skills to help those less fortunate than myself,” said Dr Bruno Silva, Head surgeon at Brighton Implant Clinic.

The launch of the petition follows a recent admission by the Department of Health (DH) that 55 UK graduates from the 2011 cohort have not been allocated DFT places. Each graduate, DH acknowledged, would have cost the public purse approximately £130,000 to train.

Dr Martin Nimmo, Chair of the BDA’s Young Dentists Committee, said: “It is perverse that students who have strived hard to pursue a career in NHS care are being denied the training places they need to fulfil that ambition. This is a significant waste of taxpayers’ money, and a tragedy for the graduates who have taken on large amounts of debt in pursuing their vocation. Given that there are some areas of the UK where patients who wish to access NHS care cannot do so, it is also nonsensical.

“I urge all current and potential members of the profession, and taxpayers, to join young dentists in calling for a guarantee that this farcical situation will never be allowed to happen again.”

YDC asks also expresses concerns that robust data should be used in workforce planning, that barriers to young dentists becoming practice owners are mounting and that careers in dental academia and specialist training must remain viable options for young dentists.

East Sussex practice offers free dental implants

Young dentists are calling for support for their demand for Government to guarantee all graduates from UK dental schools a Dental Foundation Training (DFT) place. The demand comes in the British Dental Association’s (BDA’s) newly-published YDC asks, a mini-manifesto for young dentists developed by the organisation’s Young Dentists Committee (YDC). The Committee is asking those who support it to sign a Government e-petition founded by YDC Chair Dr Martin Nimmo. The petition argues that the failure to allocate DFT places to UK graduates both wastes taxpayers’ money invested in dental academia and specialist training and that careers in dental academia and specialist training must remain viable options for young dentists.

Researchers in Australia have found that those with rheumatoid arthritis are likely to develop periodontal disease. According to doctoral candidate Melissa Cantley from the University of Adelaide, gum disease can affect joint tissue health, and arthritis influences and alters healthy tissue within the mouth.

The research found that mice who suffered from periodontal disease would suffer major bone loss within the joints, and that mice who had rheumatoid arthritis showed signs of major bone loss in the jaws.

The Smile Foundation is using Facebook as a voting platform, where social networkers can vote for those who deserve treatment. Using Facebook has allowed patients to interact with one another and write why their nominations deserve free treatment under the charity.

This year with the help of Facebook Dr Silva has begun offering regular opportunities to win a ‘smile makeover’ tending to the winner’s every need. So far we have seen hundreds of cases of people’s teeth simply need to be restored.

The prize is open to UK residents who are between 21 and 99 years of age. The contest closes on November 29th at 5.58pm.
IDH show they’re good sports

IDH support Dentist’s Sports Day to show human side of corporate dentistry

Integrated Dental Holdings (IDH) competed among 1000 dental students from University’s across the country in the annual BDSA (British Dental Student Association) Sports Day in Manchester.

As the largest dental employer in the UK, IDH sponsored the event, whilst providing water and fruit for the players from one of their mobile dental units. In a first for this typically student-only tournament, IDH teams* competed in both the football and netball leagues.

Health staff encouraged to get flu jab

Health staff are being reminded to get vaccinated against flu to cut the risk of it spreading to patients and colleagues this winter.

Frontline healthcare workers are more likely to be exposed to the influenza virus, particularly during winter months when some of the people in their care will be infected. It has been estimated that up to one in four health-care workers may become infected with influenza during a mild influenza season, a much higher incidence than expected in the general population.

Director of Nursing Viv Bennett says: “Flu can kill, so we are reminding everyone to get vaccinated against flu to protect patient care.

Being vaccinated is the only way to almost eliminate the risk of flu spreading to our workforce during times of increased sickness, so it will reduce the impact of flu to protect patient care. Being vaccinated is the only way to almost eliminate the risk of flu spreading to staff to colleagues, patients and families.”

Alex Handley, Graduate Recruitment Partner at IDH comments on the day, “Despite getting unceremoniously thrashed by the competition we had a great day! We got to spend time with the students on a social level and had the chance to tell them, in an informal setting, about the career opportunities at IDH. We have a year round presence in all UK Dental Schools where we are able to educate the students on the dental employment market, and we welcome every opportunity to support the next generation of clinicians.”

Sensodyne Repair & Protect

Harnessing bone regeneration technology for dentistry

Sensodyne Repair & Protect is different. It has a unique NovaMin® plus fluoride formulation which:

Delivers calcium and phosphate into the patient’s saliva

Provides favourable conditions for hydroxyapatite-like reparative layer formation

Repairing exposed dentine

In vitro studies have shown that the hydroxyapatite-like layer starts building from the first use* and is around 50% harder than dentine.

Protecting patients from the pain of sensitivity

The newly formed hydroxyapatite-like layer integrates with the patient’s dentine by firmly binding to the collagen within it. In vitro studies have shown that the reparative layer builds up over 5 days and remains resistant to the chemical and physical oral challenges that your patients may encounter in their everyday lives.

The reparative layer forms over exposed dentine and within the dentine tubules and, with twice-daily brushing, provides your patients with continual protection from dentine hypersensitivity.

References:
Four days in London: MSc Residential

Ken Harris tells all from the second Residential of the MSc in Restorative and Aesthetic Dentistry

Wow, what was I drinking last night? Ah, I remember now, it’s the second MSc residential course, and I’m not in Kansas anymore. I’m in London, and the upcoming four days constitute one of the highlights of this MSc course. The venue nestles close within the shadow of the Tower of London, and just a rinse and spit from the iconic Tower Bridge.

Answers on a postcard

First question, first day; “why are we filling white teeth with silver fillings?” answers on all three sides of a postcard please. As suspected, it’s not just me who spends anordinate amount of time carefully placing posterior composites.

Eye-opening!

After a few drinks it’s suddenly it’s bedtime. Funny how time races when you are enjoying yourself. “What art thou that usurp’st this time of night?”, a fire alarm had us all outside at 5.00 AM appreciating Tower Bridge by moonlight, as well as a few other eye-opening sights. An ecstasy of fumbling then back to bed.

However, Aurora in her saffron robe soon gave way to Apollo in his flaming chariot, and I made my way snail-like to school, complete with shining morning face, to begin the first of two days covering indirect restorations. Our guide into the porcelain underworld (and hopefully out the other side) was to be the effervescent Prof Nasser Barghi from San Antonio. Here is one (adopted) Texan who by teaching 44 weekends per year could definitely not be described as “all hat and no cattle”.

He is an encyclopaedia of all things ceramic; what this guy doesn’t know about bonding techniques could be etched upon the inside of a porcelain veneer. Following an absorbing two days of both theory and hands-on sessions we emerged tired but happy and with lots of state of the art clinical techniques easily applied in a busy practice environment. This residential course has such a significant hands-on element

“A fire alarm had us all outside at 3.00 AM appreciating Tower Bridge by moonlight, as well as a few other eye-opening sights. An ecstasy of fumbling then back to bed.”

The final day began with a hands-on root canal session in the company of the irrepressible Dr Daniel Flynn and some extracted teeth. Despite a wide range of nickel titanium to play with it still seems the 3 most important tools remain irrigation and irrigation. “Plus ça change”

Fataally flawed

The afternoon session introduced us to the wacky world of Research Methods. We listened first in bemused silence, progressing into unsettled mutterings and finally erupting hilariously into almost outright disbelief. It appears that almost all research is fatally flawed, especially the abstracts. I was mightily uplifted to see such dissent for once, a normally calm and placid profession rose up as one to express good-natured hoots of derision. We stood against them, as proud clinicians, and sent them (the academics) homework, to think again. Such a feeling of togetherness is rare in dentistry, altogether now … “I’m Spartacus!”, Inspirational, but we all know what happened to him don’t we.

A hugely enjoyable four days with top flight speakers and thought provoking discussions amongst colleagues, (with the occasional large sirloin thrown in!). However, I still wonder if we have learned enough yet to placate the savage beast that is the “once in a generation phenomenon” known as Dr Martin Kelleher. Check your screen for the latest odds!!

A horse, a horse! I suspect not, and with the news that yet another disillusioned dental colleague (name deleted to protect your ears from the harsh clang of a name being dropped) is selling his practice, I’m thinking; maybe we should all be choosing the primrose path of dalliance rather than studying (are you listening GDC?). Maybe right now is the winter of our discontent; “a horse, a horse my practice for a horse!”

About the author

Ken Harris graduated from the dental school of the University of Newcastle upon Tyne in 1982 and passed MFDSRCP(UK) in 1996. He maintains a fully private practice with branches in Sunderland and Newcastle upon Tyne specialising in complex dental reconstruction cases based upon sound treatment planning protocols. He is one of only two Accredited Fellows of BACD, holds full membership of BAAD and remains a sustaining member of AACD. He is currently UK Clinical Director for the California Center for Advanced Dental Studies and the only UK Graduate and Mentor of the Icon Center in Seattle.
Setting up on your own
Puja Patel discusses Unincorporated Business Structures

Setting up your own practice is an exciting career move for any practitioner. There will be a myriad of decisions that will need to be made. The first and most obvious is ‘Where do I start?’.

Before deciding to establish your own practice, make sure you understand what’s involved, the most critical steps, the timetable and costs. It will take thought, planning, management skills and appropriate advice.

First, you will need to decide if you are going alone or with a colleague and if the latter, in what type of entity. Here, we look at unincorporated business structures. A single-handed ownership where you are the only dentist in a new environment can be a daunting position. Therefore, many dentists (who are not buying an established practice) opt to start from scratch with a colleague.

There are various forms of joint venture and it is important to choose at an early stage the most suitable arrangement. The two forms of unincorporated joint ventures which may be familiar to dentists are expenses sharing arrangements and partnerships.

Expense sharing arrangements can be distinguished from partnerships by the degree of integration between the dentists. It is important that dental practitioners understand the differences between expense sharing and partnerships to ensure their business is protected and that there are no nasty surprises at a future date.

The expense sharing arrangement is most commonly used where dentists operate separate dental practices but in close proximity. Whilst they continue to trade as distinct businesses, the parties agree to share common expenses such as common areas, staffing costs, utilities or marketing.

A partnership is an integrated joint venture and the dental business is the business of the partnership rather than of the individual parties. A partnership business is a closer relationship than that envisaged by an expense sharing arrangement.

Whilst many dental practitioners in partnership set out with the express intention of being a partner, there are a number of dental practitioners who believe they operate under an expense sharing arrangement when in fact they are partners. This can lead to entirely unforeseen and undesirable consequences.

NHS dentists face particular problems with such a mix up as it has the potential of putting the NHS contract in jeopardy. GDS Contracts can be made with an individual dental practitioner, a partnership and a dental corporation. Accordingly, where multiple dentists are signing up to a single GDS Contract, they are almost certainly doing so as a partnership. PDS Agreements differ in that they cannot be made with partnerships and are instead entered into by a group of individuals (although they are likely to be in partnership by virtue of this arrangement).

Dental practitioners who sign an NHS contract as a partnership, are holding themselves out to be a partnership to the PCT and are jointly responsible under that NHS contract for the obligations under that contract.

If you are looking to operate your new dental practice under an unincorporated business structure, think very carefully how you wish the relationship with your colleague is to be governed.

About the author
Puja Patel is a member of the Commercial Team at Lockharts and works primarily in advising dentists, dental care professionals and dental corporate bodies on the commercial aspects of dentistry.
What’s in a name?
Alun Rees discusses the dental identity crisis

That by which we call a rose. By any other name would smell as sweet.”
Shakespeare - Romeo & Juliet.

I think it’s fair to say that a lot of dentists struggle for an identity of their own. Are you a dental surgeon, a dental practitioner or “just” a dentist? Many change descriptions as they progress through their careers; certainly I believed dental surgeon had a certain ring to it when I was doing my hospital resident posts. Pompousness usually precedes deflation as it was when I asked for patients to be referred to the department of oral and maxillofacial surgery and was asked by nurses and porters, did I mean the dental clinic?

To add to this where do you work? A quick look at Google would have you believe that what were once just “practices” are now anything from surgeries, smile centres, dental care, family dental health care centres, implant clinics and spas.

I have nothing against differentiation and during the first decade of practice ownership I changed the name of what I called the place where I went to work several times. Initially I implied ownership of an area by taking the suburb’s name and adding the word dental. Next I was influenced to promote health (nothing wrong with that) so I became the suburb “dental health care centre”.

Eventually I came from behind the names and realised that if I wanted to be successful on my own terms it was me that people wanted to see. The process wasn’t without wobbles, I had got so used to being part of a “thing” that I shied away from just being me but once I became comfortable with it I was happier and so were the patients.

They wanted a relationship with a real human being whose name they knew, someone who they trusted and to whom they could refer their friends when requested. So I became Alun, their dentist.

Then we made it harder to become a patient, whenever a potential new patient rang to make an appointment the first question asked was, “can I ask who referred you because Alun usually only sees new patients on referral from existing patients.” That was said even when I was desperate for patients - it implied exclusivity and invitation. The follow up was left to my reception team; if they felt that the person on the phone was someone who would fit with us then they were able “to make an exception” in their case. If they made a fuss or demanded to be seen then they wouldn’t have suited us anyway so there was little point in starting a relationship.

At this point I’d like to introduce the difference between a transaction patient and a relationship patient and why it’s important to attract the latter to your practice if you want long-term success. Very few people are entirely comfortable letting someone who they don’t know very well and may, therefore not fully trust, work in what is a very sensitive area. Don’t forget, no matter what you call yourself, your area of expertise is the mouth and most people don’t leap out of bed in the morning with the cry, “Fantastic, dentist today, hope it’s a long appointment!”

So what’s the difference?
Transaction patients.

- Interested in price alone
- They believe all dentists are the same
- They love Groupon or other discount offers
- They show no loyalty, you keep the practice open for them on Saturday and by Tuesday they have found someone else
- They want the best deal you can give them and are never afraid to ask
- Ask for referrals and they want to know what’s in it for them
- You make very little profit

On the other hand...

Relationship patients

- Seek trust and confidence
- They want to use friendly companies with familiar people and reliable products
- They are lifetime patients.
- They will pay more and they know it
- They find it emotionally tiring to shop around
- Ask for referrals and they are flattered and pleased to help
- They are profitable over the long term

Exclusivity does not mean unavailability, in fact quite the opposite. Your business depends upon you being able to give the support and service to your patients that you would expect to receive yourself.

Nor does it mean that you have to be the only visible name and face of the business. Your qualities as a leader will be tried and tested so you have to absolutely sure in what you are trying to achieve. Your team and their training becomes even more important so that everyone is aware of the standards that you set for yourself and expect from them.

Your systems must be able to cope with everything that is thrown at them. When those patients with whom you have worked so hard to build a relationship are ready to commit to the treatments that have been discussed, you and the team are ready.

Your marketing must reflect your desire to attract relationship patients. Your website should have testimonials either in video format or at some length, not just sound bites. Your Internet activity should exhibit the fact that you are in this for the long haul.

There is of course an exception to this. If you are the sort of person who shops around for the cheapest deal you can get, who objects to paying other professionals what they are worth and who haggles over payments then you are very unlikely to attract relationship patients.

Instead you’ll spend your time saying “What’s the matter with them? Why won’t they commit?” not to mention spending a fortune trying to attract more and more transaction patients who will leave you at the first marketing email for cut price whitening from the people down the road.

People aren’t stupid; they will know that you’re after the profit today and aren’t interested in their long term needs and wants. It’s unfortunate that the traditional NHS approach with its emphasis in making the patient “dentally fit”, what ever that really means, coupled with the removal of registration in 2006, does nothing to encourage a long term relationship.

So what’s the name for you and your business?
Apprenticeships

Jane Armitage looks at apprenticeships as a suitable staffing solution

Working in a busy dental practice can sometimes become hectic, how often do you have a rota that you have to redo it as suddenly you are short staffed due to illness etc.

It’s at these times when you wish you had an extra pair of hands.

Yes we have the support of agencies but this comes at a financial cost.

Induction
A good induction programme will benefit both parties. However with agency staff although you will give an overview of what is expected it is not in depth as there isn’t the time, that nurse is required in surgery to cover at short notice so if you haven’t the time to do a full induction and having just done an overview who’s at fault if something goes wrong?

During last winter the viruses struck and at one point we had several staff off sick at the same time which meant juggling clinics, finding replacement for those on the rota obviously are unsure where anything is which can add more pressure to the day. We worked through it but it did make us think of an alternative suitable back up.

There’s nothing worse than having to cancel a list especially due to staffing shortage, this should never happen. Normally patients will accept illness or circumstances happen, however I found myself in this position only a few weeks ago. The reason for cancelling was a parental bereavement to one of the dentists even in this sad circumstance but a couple of members of the public weren’t amused. So cancelling due to staffing problems is not a good idea.

In the past if we have a vacant post I would advertise and employ a qualified nurse suitable for the position. The advantage of this is the qualified part and also it delivers a service to the patients and it maintains the current staffing levels. Even though staffing levels are fine, an extra pair of hands is always wel-

‘There’s nothing worse than having to cancel a list especially due to staffing shortage, this should never happen’

come which is why I decided to look at employing an apprentice nurse. My reason for this was although at that point we were fully staffed, if we could train an apprentice from scratch they would work to our protocols and hopefully quickly adapt. I personally think that if a young person has already enrolled at College for the dental nurse course that shows they already have an interest; the requirement is they enrol but then need to find a placement.

At the time of writing the cost to the practice is £2.60 per hour for employees aged 16 – 18, there is a slight increase coming in October. This rate is not set in stone and can be increased at the discretion of the practice.
Extra money can always be paid as an incentive. The apprentice NMW applies to all 16-to-18 year olds and to those aged 19 and over in the first year of their apprenticeship.

If the apprentice is aged 19 and/or has completed their first year of the apprenticeship you must pay the national minimum wage appropriate for their age.

There is also the cost of supervision and training supplied by the college, the National Apprenticeship Service will match the employers commitment to hiring apprentices by covering in full the training costs or if over 19 a very small fee will be payable by the practice.

The college course is NVQ-based with day release once a fortnight.

At the moment there is an employers’ incentive grant scheme available until funding ceases early next year.

This is aimed at eligible employers offering employment through the apprenticeship programme. This scheme assists by providing wage grants to anyone recruiting an apprentice. The criterion is The National Apprenticeship Service will provide 40,000 Apprenticeship grants to employers recruiting 16 – 24 year olds with a value of £1,500.

The £1,500 is in addition to the training costs of the apprenticeship framework which are met in full for ages 16 – 18 and 50 per cent for those aged 19 – 24.

Eligible employers must have never employed an apprentice before or who have not been in a position to commit to employing an apprentice again within the last 12 months.

I believe this is worth knowing; it’s a small amount but it’s money that is available.

Looking back this has been one of the best decisions I have made. It’s a cost effective way of training with no strings attached. Downsides being after two years you are likely to have become attached to this apprentice who is aware from the outset there is no guarantee of a permanent job on qualification. This decision then lies with you do you employ them or start the process again.

Looking back this has been one of the best decisions I have made. It’s a cost effective way of training with no strings attached.
Workplace communication skills are quite possibly the most written about interpersonal skill. The reason for this being that peoples’ sense of wellbeing is directly linked to the quality of their communication with their colleagues. Many dental professionals recognise that top-down communication in dental teams frequently leaves a lot to be desired. In some cases this is due to the fact that implicit rules that have evolved over many years which set the tone of workplace communications.

Since the introduction of care quality standards, there is a requirement for practices to develop explicit communication protocols characterised by clearly defined policies, procedures and protocols. The objective of these protocols is to provide a communication framework that will ultimately equip dental teams to provide the highest possible standard of dental care to patients. An important part of patient care is ensuring that patients have positive experiences every time they contact the practice. These positive experiences in face-to-face interactions can stem from the warmth and friendliness shown by team and on a more formal basis the language and protocols used in written communications. Most practices have established guidelines in place for face-to-face interactions, however many still need to put into place protocols and procedures to govern the tone of the written word in the following formats; letters, notices and reports. Written communications can be effective communication channels, as long as they are constructed correctly and abide by the following guidelines:

Letters
Letters to patients should have a businesslike but amiable tone. They should be concise and factually accurate. All references and details in the content of the letter should be checked and correspondence proof read before being sent out, as errors can cause confusion. Attention must be paid to the correct use of grammar, punctuation and paragraphs, with avoidance of the use of abbreviations, jargon, or colloquial language. Letters must be signed by the appropriate person e.g a report will be signed by the dentist as verification of the information within. But a less formal letter to a patient can be signed by an administrator.

Presentation
Letters must be produced on practice stationery. The layout

---

**The Patient Experience**

Glenys Bridges focuses on patient communication

*“Cosmetic Interfaces: Bringing It All Together”*

**Featuring**

Dr Rafi Romano, Dr David Garber & Dr Maurice Salama

**The British Academy of Cosmetic Dentistry**

*Ninth Annual Conference 2012*

Thursday 22nd, Friday 23rd and Saturday 24th November 2012
Manchester Central, Petersfield, Manchester M2 3GX

e-mail suzy@bacd.com or visit www.bacd.com, Please quote 120 when booking
must be reader-friendly and attractive using the house style and font. Correspondence with patients will include new patient letters to introduce the practice; these letters provide important opportunities to set the tone of the relationship between the practice and the patients.

In most cases template letters will be made available ready to be personalised for use. Templates should be signed off by the practice management and in a format that prevents errors in adding personalised content. In some cases styles and formats could be used to appeal to patients based on their age or demographic.

Emails
Whereas the etiquette for letter writing is generally understood, this is not the case for email etiquette. In many cases these days email is the preferred method of communication. They are fast and effective, but to ensure they project the correct image of the practice, guidelines should be in place, since emails sent out from the practice reflect upon its friendliness and professionalism. Therefore measures should be put in place to ensure that the language used is polite, courteous, and appropriate. Stringent measures should be taken to ensure confidentiality is maintained and your computer equipment is virus guarded.

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

Some communication topics are covered in my new dental reception course Purely Practical Reception Skills Please email glenys@glenys-bridges.co.uk for details.

The patient experience is built up on many levels. Most dental teams understand the influence of face to face communications. If they can raise the standard of their written communication skills up to the level of their face to face communications, dental teams will make progress in building lasting respectful relationships with their patients.

Communication through letters can set the tone between patients and practice...
Need a new challenge?

Michael McCallion of FT&A Medical Recruitment offers jobseekers and candidates some useful advice...

D o you find yourself clock watching after lunch?!

Do you spend Sunday nights dreading the upcoming Monday morning?

Is the role not fulfilling your expectations?

A new challenge is required then. What should you be bearing in mind if you wish to get the job of your dreams? Let's start at the beginning:

• Your CV. This may seem an obvious thing to say but it needs to be said because so many professionals still get it wrong. Do your best to avoid any gaps in the employment history. If there are gaps, make sure that you can adequately explain them. Not everyone is fantastic at spelling but you can get it checked by someone who is! Don't embellish or lie – it will catch up with you. An on the ball recruitment agency will be able to review your CV and offer advice on how and where to improve it.

• How far will you travel? It is wise to be realistic – particularly if you will be beholden to public transport!

• Salary. Quite possibly number one on your list?! It is of course a vital part of the process and one of the most important reasons for choosing or not choosing a role. Your expectations need to be realistic however. It is tough out there and many dental professionals can have an overvalued opinion of what they are worth. Have in your mind the minimum that you will consider and be open and honest about the numbers with any potential employer. There is no point in accepting an offer that you feel is too low and then whingeing about it for months to come – a frank dialogue is in everyone’s best interests.

• Conditions and Benefits. These can be somewhat overlooked as many push for the salary above all else. A mistake – pension provision, holidays, flexible working hours can make a ‘maybe’ job become a ‘definitely’.

• Appropriate dress and appearance for interviews. This may come as somewhat of a surprise in a recruitment article for a professional magazine. In our experience though it is actually quite common for candidates of any education to get it spectacularly wrong when attending interviews! All we suggest is that you give this some consideration – what is the role? Who am I meeting? What level of seniority will I be looking to hold?

• Register with agencies that you can trust. It generally doesn’t cost anything to join an agency but choose with care you can be, the more posts will be open and available to you.

• CRB, GDC etc. As you would expect these all need to be in order and up-to-date.

• Do you have good, solid references? Are you sure? It is not uncommon for some candidates to find that what they thought were references expressing how wonderful they were and an ideal employee, are quite different.

• What type of role is it that you are looking for? Temporary, permanent – have you considered a locum appointment? The more flexible that you are looking for, the more opportunities you will consider and be open and honest about the minimum that you will accept.

Raising Finance?

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

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

DO ensure your CV is up to date with particular focus on any past managerial experience.

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

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

Search for Frank Taylor and Associates

Follow us @Franktaylorassoc

Tel: 08456 123 434
01707 653 260
www.ft-associates.com

Frankly Speaking

A new challenge is required then. What should you be bearing in mind if you wish to get the job of your dreams? Let’s start at the beginning

FT&A

Medical Recruitment
25 Clinical tips for general practice part II

Dr Ashish B Parmar discusses tips 15-25 his ways to improve your clinical dentistry for the benefits of patients

One of the best ways of becoming a better dentist is to learn from and be mentored by top dentists. I have been fortunate to be mentored by world-class dental educators.

I recently did a webinar for Smile On. This second part of my article is a follow up on this well attended webinar; I will finish discussing some tips and advice to allow you to offer a higher standard of dental care in your practice. I will be talking about a range of clinical techniques and dental materials.

DISCLAIMER: I am not paid for promoting or mentioning any dental materials. I will simply explain the preferred products that I use in daily practice, as well as on my training Courses.

TIP 15: Laser Gingival Contouring (Figs 1, 2, 3, 4)

I use a soft tissue diode laser to carry out artistic, minimal gingival contouring changes. By placing the zenith positions of the upper teeth in the correct positions allows more natural and attractive looking smiles. The theory and techniques to do this can easily be learnt, and the prices of lasers has come down a lot over the years.

I also use a “hard tissue laser” to correct gummy smiles by doing gingival contouring followed by the removal of bone subgingivally by up to 2mm to recreate the biologic width. This allows faster healing times, no need for incisions (ie a non-surgical osseous recontouring technique) and minimal or no post-operative discomfort. The key point is that laser energy has a sterilising effect and promotes faster and better healing.

For a look that’s hard to beat. The new Luxatemp Star.

Stunningly beautiful temporaries with proven durability:

The new Luxatemp Star offers outstanding results for break resistance and flexural strength! The newest generation of DMG’s top material Luxatemp scores even better: excellent stability, maximum fit and reliable long-term color stability. No wonder experts recommend it.

Find out more at www.dmg-dental.com
TIP 14: Fibre-Reinforced Composite Dentistry (Figs 5, 6, 7)

I strongly advocate dentists to learn about fibres in dentistry. I use the everStick range of fibres for numerous minimally invasive procedures including:

- Periodontal splinting
- Fixed retainers after orthodontic treatment
- Replacing a missing incisor, premolar or molar tooth (studies show success rates of over 10 years)
- Extraction of a tooth, resecting the apical portion of the root and splinting it to the adjacent teeth in the mouth
- Making a custom-fitting fibre post, which is then used to make a bonded composite core, before crown preparation
- Reinforcement of large composite direct restorations

Have a look at my practice website at www.smiledesignbyash.co.uk/general-dentistry/ffi reglass_dentistry and also the website www.sticktech.com.

TIP 15: Customised Composite Shade Tab (Fig 8)

It is a good idea to purchase a blank shade tab that GC make, which can then be used to make a customised shade tab with the different colours of composites you have in your composite kit. This will allow accurate shade matching ability when doing more demanding anterior composite build-ups using the layering technique. My preferred composite products I use in practice are G-aenial for the anterior teeth and Kalore for the posterior teeth. Have a look at www.gceurope.com to find out more about these composite products, as well the very good App that GC have developed to help dentists in complex anterior build-ups using the layering technique.

TIP 16: Use of Luxacore (DMG), Luxabond (DMG) and EverStick Posts (Sticktech) to do a bonded Post/Core build up (Figs 9, 10)

I use everStick Posts (0.9mm and 1.2mm fibres) to anatomically adapt the flexible fibres in the prepared root canal after the root filling. Root canals are never circular in cross section, which is why this technique is superior than using pre-fabricated fibre posts, which are circular in cross section. I use Luxabond as the bonding system, and Luxacore to cement the post and build up the core simultaneously. The tooth can then be prepared minutes later. The whole clinical technique can be viewed on a video (part of a series) on my Academy website at http://www.theacademybyash.co.uk/Clinical-Cases-Videos/porcelain-veneers-prep-videos.html.

TIP 17: Composite Veneers (Figs 11, 12, 13, 14, 15, 16)
I have done a lot of porcelain veneers over the years. However, increasingly I am using composite as a material of choice in a number of cases. Following simple orthodontic treatment using the Inman Aligner or 6 Month Smiles, teeth can be straightened quite well. Composite can then be used to make minor improvements (typically after teeth whitening has been done). This particular case shows the before and after of a patient that required five anterior composite veneers. The patient was a bruxist and I was not keen on providing porcelain restorations in this case. The teeth were roughened slightly on the labial surfaces without any local anaesthetic needed. The veneer build-ups were done under rubber dam using a putty index made from diagnostic wax ups (to give an accurate reference to the palatal aspects of the teeth so that a thin enamel palatal “wall” could first be built to help with the rest of the layering technique). The patient was delighted with the result, which only required one long appointment.

TIP 18: The “Spade” Instrument (Figs 17, 18)
The instrument shown here (which I call the “spade”) is a great instrument to help with easy and quick shaping of labial surfaces of teeth that require composite veneers, as well as during addition of flowable composite material when making trial smiles using Luxatemp (DMG). It is a Hu-Friedy instrument and the reference code is TNCCIB.

TIP 19: Learn to do the Inman Aligner and 6 Month Smiles (Figs 19, 20, 21, 22, 23, 24, 25, 26, 27)
I have found the UK courses to learn about the Inman Aligner and the 6 Month Smiles braces to be excellent. I now use both these braces in clinical practice for the benefit of my adult patients. Visit www.inmanaligner.com and www.6monthsmiles.com to find out more.

TIP 20: Luxatemp (DMG) and Luxaglaze (DMG) for Temporaries (Figs 28, 29, 30)
Luxatemp is a 5-star Reality rated product and rightly so! It is the number one choice for making trial smiles by the leading cosmetic dentists in USA and UK. I have been using it for many years, and B1 is my favourite colour. You can get Luxatemp Fluorescence or Luxatemp Star (stronger - if you require more durable transitional restorations to last longer in the mouth). The use of Luxaglaze light cured varnish will significantly improve the appearance and stain resistance of the temporaries.

TIP 21: Use of a Speed Increasing (Red Ring) Handpiece to perfect Preparations (Fig 31)
I highly recommend the use of a speed increasing handpiece in an electric motor. Friction grip burs under water spray can be used to get smooth, precisely prepared and finished tooth preparations. I have been using NSK handpieces for many years in my practices and recommend the Ti-Max X95L handpiece. You can contact Alex Breitenbach at NSK on 07900 245516 for more advice on NSK handpieces.

TIP 22: Natural Die Material Shade Guide (Ivoclar) (Fig 32)

Create æ-motion with G-ænial from GC
The all-round composite for aesthetically invisible single and multi shade restorations.
Introducing the age-specific shade selection system.

With G-ænial you can reinforce your aesthetic skills and ability to match every restoration with nature thanks to the straightforward shading system. The choice of the enamel shades is made according to the age of the patient:

• JE - Junior Enamel for youngsters
• AE - Adult Enamel for adults
• SE - Senior Enamel for your senior patients

Selecting the right shades has never been easier!

GC EUROPE N.V.
Head Office
Tel. +32.16.74.10.00
info@gceurope.com
http://www.gceurope.com

GC UNITED KINGDOM Ltd.
Tel. +44 1908 218 999
info@uk.gceurope.com
http://uk.gceurope.com
This is an essential shade guide to have for doing Smile Makeovers properly. The prepared teeth can be matched carefully with reference to this shade guide. The ceramist technician can then ultimately produce model dies of the matched colour. This will help with precise colour matching as the porcelain build-ups are done. You need to write down the “Stump Shade” colour eg ND37.

TIP 24: Cementation with Vitique (DMG) (Fig 35) Vitique is my number one choice of cement to work in a stress free manner. I also use Vitique to cement in porcelain inlays, onlays and all porcelain crowns.

TIP 25: The Celebration (Fig 36) One of the best rewards for me in private practice is seeing the emotional reaction when a patient sees their new smile for the first time. We celebrate this important moment in the patient’s life by presenting her with a nice bouquet of flowers, a signed card by the dental team with the before and after photographs. We also celebrate with non-alcoholic champagne served in crystal glasses on a silver tray. Our patients are genuinely touched by the special effort we go to during this “Celebration”. We also send the patient for a complimentary photo shoot with a professional photographer. The patients love the photos taken showing their increased confidence, because of their new smile. They get a complimentary photograph from the photographer, and we get the images that we want for our marketing use eg to go on the website as a case study. Please have a look at the Reveal for Dima, one of my patients who had a complex Smile Makeover, on my Academy website at http://www.theacademybyash.co.uk/Clinical-Cases/Videos/porcelain-veneers-the-reval.html.

Summary I have mentioned DMG a number of times as I genuinely believe they make world-class dental materials. You can visit their UK website if you want more information ie uk.dmz-dental.com/start.uk. You can also contact Paul Willmer from DMG on 07530 450598.

I hope you found these 25 Clinical Tips useful. However, clinical skills are only one of the important jigsaw pieces needed to create a successful and profitable dental practice. You can visit my informative teaching website www.theacademybyash.co.uk for a lot of useful articles, videos and other material free of charge. Also have a look at the practice website for patients www.smiledesignyash.co.uk.

If you would like to chat to me to find out more about the unique and inspiring 8-day Hands-On Smile Design & Occlusion Course I offer, then you can email me at training@theacademybyash.co.uk or phone me on 07971 291180. You can also have a chat with my Manager Cheryl on 020 85000544, in case I am not available.

This popular Course occurs only twice a year, and I limit the training to six dentists per course.
The aim of orthodontic diagnosis is to identify dento-alveolar, skeletal and functional alterations in the maxillo-facial complex. Diagnosis and treatment planning are based on a combination of study models, intra-oral and extra-oral images, and radiographs, traditionally consisting of panoramic and cephalometric radiographs. Cephalometric analysis (CA) plays an important role in diagnosis and treatment planning.

Traditional CA is based on three different X-ray projections: latero-lateral teleradiography, postero-anterior teleradiography and axial projection. However, conventional radiographs are limited because they provide a 2-D representation of 3-D structures. The traditional system, analysing the three dimensions separately, is insufficient because dento-facial alterations often take place in 3-D space.

Thus, the limits of traditional CA are:
- Errors in radiographic projection, resulting in enhancements and distortions
- Operator errors in the measurement systems
- Errors in the identification of the cephalometric landmarks owing to superimposition of anatomic structures
- Inability to evaluate the three dimensions of the craniofacial complex.

The recent introduction of CBCT in combination with computer software allows the application of this new methodology to different fields of dentistry, including its successful use in orthodontics.

At the Orthodontic Department at the University of Milan, CA is performed with a new 3-D methodology that allows for an easy, effective and repeatable way to decrease operator-driven errors. It is based on the identification of 18 points (10 median and 8 lateral), all of which are identified on a hard tissue CT section and verified on the two remaining CT sections. Further verification is then performed on the volume rendering generated by SimPlant OMS (Materialise). The 18 points determine 56 measurements on the sagittal, vertical and transversal dimensions (Fig. 2). At the Uni-
versity of Milan, 44 skeletal Class I normodivergent patients were selected from an archive of 500 CBCT scans. The cephalometric diagnosis of a skeletal Class I normodivergent relationship is based on the School of Milan. The same patients were then analysed with 3-D cephalometry. The results allowed the identification of a normal range of values for each measurement (Table II).

The 3-D technique goes beyond the limitations of 2-D analysis in many ways:

- effective representation of true 3-D morphology of the cranial structures without distortion, avoiding projection and identification errors
- reduced operator bias because the measurements are performed automatically
- simplicity and repeatability in the identification of landmarks,

The introduction of 3-D imaging techniques has revolutionised the planning phase of combined orthodontic and surgical treatment using true anatomic structures without superimposition or the problems of geometric construction:

- ability to obtain CA using the three dimension
- dento-skeletal alterations can be analysed in 3-D in order to determine appropriate treatment.

Combined orthodontic and surgical planning

The introduction of 3-D imaging techniques has revolutionised the planning phase of combined orthodontic and surgical treatment. The use of the computer, together with dedicated software, allows for a fast, precise and standardised procedure. 3-D virtual planning entails the following:

- CBCT scan
- high-definition impression
- reference aligner
- digital scan cast
- CBCT digital cast interface

Using virtual planning, it is possible to obtain the virtual visual surgical treatment objective and the virtual orthodontic model. High-definition impressions are obtained using polyvinyl siloxane, which guarantees well-defined details while allowing for the double-pour method. Double-poured casts are necessary to obtain an adequate scan and require the use of both a full cast and individual dental elements selected from a second cast. Single dental element scans allow for proper analysis of contact points. An optical cast scan is performed using structured-light scanners, which produce a 3-D image captured by a camera. In this manner, a group of points is determined by the software, which then determines the coordinates of the acquired points and finally creates the 3-D image (Fig. 5).

Moreover, the digital dental cast is then combined with the CBCT scan, which allows for a very detailed analysis of both the bone (through the CBCT scan) and the dental structure (through the cast scan). CBCT does not provide enough data regarding all the dental details necessary to produce the orthodontic model (Fig. 4).4

Table I_Effective radiation dose (background radiation 8 μSv/day).

<table>
<thead>
<tr>
<th>Method</th>
<th>Scan parameters in kV</th>
<th>Dose in μSv</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cephalometric analysis</td>
<td>65 (15 mSv)</td>
<td>1.5</td>
</tr>
<tr>
<td>Lateral-lateral radiography</td>
<td>90</td>
<td>3.0</td>
</tr>
<tr>
<td>Postero-anterior radiography</td>
<td>90</td>
<td>3.0</td>
</tr>
<tr>
<td>Multi-slice CT</td>
<td>120/400 (5 mSv)</td>
<td>0.05</td>
</tr>
<tr>
<td>CBCT</td>
<td>(120/400 mSv)</td>
<td>0.05</td>
</tr>
</tbody>
</table>

In order to superimpose the two records properly, a specific three-contact point bite registration wax, known as the reference aligner, has been introduced. The reference aligner needs to be applied to the teeth when the high-definition impressions are taken. It is made of Moyco (an extra-hard wax) and consists of a supporting...
arch and three spheres. These are made of calcium-based glass, which has cast-pouring radiopaque properties. The wax is applied during CBCT and is placed between the cast arches during the optical scan (Fig 5).

It is remarkable that the wax thickness does not significantly influence the accuracy of the radiographic scan and consequently the results of the CA. The software is able to recognise the presence and size of the spheres in the CBCT scan and matches them to those corresponding areas on the cast. This is currently the only method that allows for an overlap with an error margin of less than 0.1 mm. Once the data has been collected, it is possible to perform different kinds of analyses before the surgical treatment. The software presents powerful segmentation tools that allow the splitting of the maxillofacial complex from the mandible, providing two separate images.

This feature is relevant in orthodontic and surgical planning for calculating bone movement. The clinician can select the tissues to be moved following a procedure similar to the manual one. For example, it is possible to select the osteotomic lines in order to simulate a forwards or backwards mandible shift, finding the exact shift needed (in mm) to properly correct the malocclusion (Fig. 6). Once the bone correction has been finalised, it is possible to create a 5-D orthodontic model and display the resulting dental correction to be obtained by the end of the treatment.

Finally, shifting back the bone structure (and the dental arch with the final model) to the original maloccluded position, it is possible to obtain the target cast to be reached before the surgical treatment. On the cast, it is then possible to build successive images using CAD/CAM techniques to track progress towards orthodontic presurgical treatment.

Virtual surgery has a twofold objective: firstly, to verify that the planned shifts are in fact feasible; and secondly, to position the cast according to the ratios needed to build the surgical splint, which will be used during the surgical procedure. The digital cast superimposition reduces the treatment planning phase, as it is not necessary to reveal the facial arch or to use the articulator. In fact, all the data can be sourced from the combination of the CBCT and cast scans. Recent studies focus on the enhancement of the system through the development of an intra-oral scanner, which will allow direct 5-D impressions, skipping the conventional impressions, which-although precise-can be influenced by manual errors.16

Although complex, using software offers many advantages because it enhances both orthodontic and surgical techniques, while ensuring a very high quality result. In fact, a CAD/CAM tech-
nique allows for a standardised procedure and easy quality checking, in comparison to traditional operator-performed techniques, which are open to inaccuracies.

Creating customised multi-bracket appliances

In virtual orthodontic and surgical planning, it is possible to create a digital orthodontic model once the bone bases have been shifted towards their proper position. The latest dental shift software is able to perform single-element segmentation automatically. The operator can obtain a full 3-D visualisation of the dento-alveolar relationship and can consequently modify tip and torque, rotate and shift dental elements in the 3-D space in order to simulate the orthodontic treatment.

In order to display the results of the pre-surgical orthodontic treatment immediately, the software shows two overlapping images, differently coloured to distinguish the initial situation from the ideal one (Figs 7 & 8). As a result, a digital model is created, containing all the details to reach a functional occlusion.

The first step in the process of creating a customised bracket is possible thanks to CAD/CAM technology. The CAD/CAM technique entails two phases: the design phase (CAD) and the manufacture phase (CAM). The design phase is performed through computers that send instructions to milling machines in order to create the end-product. These machines work either through removal (such as a CNC cutter) or through addition—stereolithography (SLA), 3-D print or plastic materials/composites, laser sintering (SLS) or laser fusion (SLF) of metal materials.

The elements that allow the bracket customisation depend on its base. The base is designed through the CAD software and placed on the centre of the dental surface. The software will then allow us to customise the bracket (Figs. 9 & 10). In designing the bracket, it is possible to distinguish between a partial and a complete customisation. The first entails the customisation of the size and shape of the bracket portion facing the dental surface, but features a standard angle in the non-customisable portion of the twin bracket. Complete customisation entails the additional modification of the angle between the bracket base and the twin portion. This is the ideal, considering that the spatial parameter of the dental elements might vary according to the different malocclusions.

Once the design phase has been finalised, the brackets are ready for manufacture by a milling machine. These machines, which mill very small items, need to be run in a standardised environment with maintained conditions to guarantee high precision while minimising the possibility of errors. Consequently, the higher the precision required, the larger the milling machine will be. It is also necessary to place the machine in a dedicated environment with a special floor cover with amortising panels that stabilise the cutter and partially absorb the vibration produced.

Moreover, a very small cutter of approximately 0.001 mm needs to be used. For example, considering that the smallest cutters can remove up to 5 per cent of a millimetre each time, three to four passes will be required to create the mesh facing the tooth (Fig 11).

The technological progress represented by CAD/CAM as described is based on the digital design feature and the computer-automated manufacturing process. The main advantages are better control of the production process and a significant reduction in operator-driven errors, while enabling the use of sophisticated materials, such as Grade 5 titanium, which was not possible with traditional techniques.

Editorial note: A list of references is available from the publisher.
CEREC OMNICAM

THE EVOLUTION OF SIMPLICITY

The new CEREC Omnicam combines powder-free ease of handling and natural color reproduction to provide an inspiring treatment experience. Discover the new simplicity of digital dentistry – exemplified by Sirona’s premium camera portfolio: CEREC Omnicam and CEREC Bluecam. Enjoy every day. With Sirona.

UNRIVALLED HANDLING  ■  POWDER-FREE  ■  SCANNING IN NATURAL COLOR

sirona.com

T h e  D e n t a l  C o m p a n y  sirona.
Choosing the right people
Michael Sultan discusses the importance of staff

Staff are fundamental to any business. This is especially true in dentistry where nursing staff in particular work “on the front line”, speaking and interacting with patients, guiding them through their treatment, and putting them fully at ease.

As anyone who has ever set up their own business will appreciate, finding the right staff can be a very difficult task, and even when you think you’ve found the right person, sometimes it just doesn’t work out. In these cases, it can often be just as hard to get rid of team members as it can be to employ them in the first place!

So, finding the right staff can be a challenging process – one made even more testing by the time commitments we must make to the general day-to-day running of our practices. Of course the solution is to make sure we employ the right people in the first place, but very often this is not as easy as it may seem.

A part of the problem stems from the fact CVs just don’t tell us what we need to know. They depict a very two-dimensional view of a person, and are often filled with the same phrases (such as “team player”, “good timekeeping”, “excellent organisation” etc) that make it extremely tricky to distinguish between candidates. And things aren’t always made easier at the interview stage either. Often we will find we ask the wrong questions, or aren’t able to sufficiently judge potential employees based on a short, and very formal conversation.

How then, are we supposed to find out what people are really like?

Here at EndoCare, we’ve recently taken to asking candidates a set of questions they might not normally expect. Aside from all the regular sorts of questions you might field in an interview, we’ve devised a few extras that we think help us to learn a little more about the people who want to come and work for us.

Naturally, these questions are all “loaded” in a sense, but equally they’re not designed to bring about any kind of fixed response. Ultimately, they help us build a better picture of “who we’re really dealing with”, and hopefully, they give candidates a similar impression in turn.

One of the first questions we like to ask is: “What did your father do?” This isn’t a middle-class type of question designed to judge a person’s background. More it is a question designed to shed light on a candidate’s work ethic, and their general approach to working life. For example at EndoCare, we pride ourselves on going the extra...
mile for patients, and so we like to employ people who share our same ethic for work, whose parents may have imparted upon them some sense of going beyond the normal hum-drum of 9–5. That’s why we’re always interested to learn of candidates whose parents may have worked long hours—who may have demonstrated the need to go that little bit further to “get the job done”.

Another question we like to ask is, “What did you want to be when you were young?” and as a follow-up, “What did your parents say?” As an employer, naturally we look for a positive attitude in our employees. We are also looking for people who demonstrate some sort of aspiration. Though I doubt many people can honestly say they wanted to be a dentist, or a dental nurse growing up, the responses we tend to get are an interesting reflection on the people we’re interviewing. For example, those with parents who would crush their aspirations (even if they wanted to be an astronaut!), tend, in general, to be less aspirational as individuals and less motivated to push themselves to enhance their careers. Obviously there’s an element of generalisation here, but the conversation that emerges from the questions “What did you want to be when you were young?” really can shed some interesting light on a person!

Our third and final question we like to ask potential employees is, “Are you ‘touchy feely’” or the slightly more refined question, “Are you a warm, empathetic person?” From experience, empathy and compassion are two elements to a person’s nature that just can’t be taught. Either you’re a naturally warm person, or you aren’t. There really isn’t an in-between here. For someone working in the caring profession that is dentistry, empathy is absolutely critical. That’s why at EndoCare we rate empathy and warmth of feeling as two of the most important facets to any of our members of staff.

Of course there’s no right or wrong answer to any of our questions, and even with the last one the answer is never going to be as simple as yes or no. What these questions do is give us an opportunity to learn a little bit more about the people we may potentially employ. Obviously these questions won’t work for everyone as each business is different, and each dental practice will have its own way of doing things. At EndoCare for example, we want genuine hard working, aspirational people who are fundamentally caring at heart, and so we form our questions appropriately.

So, when the time comes around to find a new member of staff, ask yourself, what are your practice values? How do your staff members reflect these values? Though these might seem like simple points to consider, they really do require an awful lot of thought. After all, staff are important—they are at the heart of everything a dental practice does—and for this reason, it pays to choose your questions carefully!

---

**Honigum.**

**Overcoming opposites.**

Often times, compromises have to be made when developing impression materials. Because normally the rheological properties of stability and good flow characteristics would stand in each other’s way. DMG’s Honigum overcomes these contradictions. Thanks to its unique rheological active matrix, Honigum yields highest ratings in both disciplines.

*The Dental Advisor* values that fact: Among 50 VPS impression materials, Honigum received the best «clinical ratings» — see the table.

We are very pleased to see that even the noted test institute *The Dental Advisor* values that fact: Among 50 VPS impression materials, Honigum received the best «clinical ratings» — see the table.

www.dmgl-dental.com

---

**About the author**

Dr Michael Sullivan BDS MSc DFO FRCD is a Specialist in Endodontics and the Clinical Director of EndoCare. Michael qualified at Bristol University in 1986. He worked as a general dental practitioner for 5 years before commencing specialist studies at Guy's Hospital, London. He completed his MSc in Endodontics in 1993 and worked as an in-house Endodontist in various practices before setting up in Harley St, London in 2000. He was admitted onto the specialist register in Endodontics in 1999 and has lectured extensively in postgraduate dental groups as well as lecturing on Endodontic courses at Eastman CPOD University of London. He has been involved with numerous dental groups and has been chairman of the Alpha Omega dental fraternity. In 2008, he became clinical director of EndoCare, a group of specialist practices.

For further information please call EndoCare on 030 7224 0999. Or visit www.endocare.co.uk

---

**Dr Michael Sul-**

huan BDS MSc DFO

**FRCD** is a Specialist in Endodontics and the Clinical Direc-

**tor of EndoCare.**

Michael qualified at Bristol University in 1986. He worked as a gen-

eral dental practitioner for 5 years be-

fore commencing specialist studies at Guy’s Hospital, London. He completed his MSc in Endodontics in 1993 and worked as an in-house Endodontist in various practices before setting up in Harley St, London in 2000. He was admitted onto the specialist regis-

ter in Endodontics in 1999 and has lectured extensively in postgraduate dental groups as well as lecturing on Endodontic courses at Eastman CPOD University of London. He has been in-

volved with numerous dental groups and has been chairman of the Alpha Omega dental fraternity. In 2008, he became clinical director of EndoCare, a group of specialist practices.

For further information please call EndoCare on 030 7224 0999. Or visit www.endocare.co.uk

---
United Kingdom Edition

For further information please contact Aronie 4 Tea lid on 01428 652131, Or visit www.anyoneservices.com
For more information contact Dr. Howard White

No brainer offers QuickLase launched their new QuickLase Integra combined in 6.8 hour procedures and at home 16% carbamide peroxide syrups kits to conform to the new whitening regulation. It is an add on to their famous competitive in-expensive QuickLase carbamide to boost up your surgery income, the teeth whitening brand is well known for its effectiveness, fast whitening and as a manufacturer the client is in to do. The dental care professionals sold at regular market starting from 26 00 per person and supported by patients marketing.

In addition, QuickLase have their new Dental Lasers Desktop lasers. The 3x power increase on £395 and 2x power increase on £295. The QuickLase Powerprint cordless laser at special price of £199. It is half the price of its competitor, with 5x selectable competitive pre-set.

Celebrating our 20th year serving dentistry with special offers. Call us on 01272 780090 for further information or visit www.QuickLase.co.uk

Dental Sky held a fund raising day on 27th September for Dentaid UK project. With the assistance of our customers, the sales team are able to raise money by holding one of their annual Dentaid Day events. Customers were offered amongst other deals an introductory offer of half the normal retail price. The award winning innovative Procare dental system was also a popular exhibit which attracted a lot of interest throughout the exhibition. As always many matters have also been covered; the unit has a touchless sensor to turn the light on/off as well as allowing the user to switch to a composite mode setting so that you can work uninterupted with composite-cure materials.

As the 10 LED lights are encased in a one piece cover there’s no risk of dust or mist build-up and the unit is easily cleaned. The Belmont 900 Series is available as a complete system was also a popular exhibit which attracted a lot of interest. Environmental concerns still exist for all, and the new Belmont Series LED operating lights from Takara Belmont. They have a life expectancy of 40,000 hours, which translates, means around 25 years for the average surgery. Longevity is not it is only. It is designed to reduce eye fatigue, by virtue of its 5,000 Kelvin neutral white colour temperature, a feature which also makes it ideal for surgical colour. Flexibility of use is also ensured as dental care professionals can choose to use it in various medical treatment rooms. Environmental concerns still exist for all, and the new Belmont Series LED operating lights from Takara Belmont. They have a 10 LED light system with monthly fee allowed customers to see a range of different products. The system was also a popular exhibit which attracted a lot of interest. Environmental concerns still exist for all, and the new Belmont Series LED operating lights from Takara Belmont. They have a 10 LED light system with monthly fee allowed customers to see a range of different products. The system was also a popular exhibit which attracted a lot of interest. Environmental concerns still exist for all, and the new Belmont Series LED operating lights from Takara Belmont. They have a 10 LED light system with monthly fee allowed customers to see a range of different products. The system was also a popular exhibit which attracted a lot of interest. Environmental concerns still exist for all, and the new Belmont Series LED operating lights from Takara Belmont. They have a 10 LED light system with monthly fee allowed customers to see a range of different products. The system was also a popular exhibit which attracted a lot of interest. Environmental concerns still exist for all, and the new Belmont Series LED operating lights from Takara Belmont. They have a 10 LED light system with monthly fee allowed customers to see a range of different products. The system was also a popular exhibit which attracted a lot of interest. Environmental concerns still exist for all, and the new Belmont Series LED operating lights from Takara Belmont. They have a 10 LED light system with monthly fee allowed customers to see a range of different products. The system was also a popular exhibit which attracted a lot of interest. Environmental concerns still exist for all, and the new Belmont Series LED operating lights from Takara Belmont. They have a 10 LED light system with monthly fee allowed customers to see a range of different products. The system was also a popular exhibit which attracted a lot of interest. Environmental concerns still exist for all, and the new Belmont Series LED operating lights from Takara Belmont. They have a 10 LED light system with monthly fee allowed customers to see a range of different products. The system was also a popular exhibit which attracted a lot of interest. Environmental concerns still exist for all, and the new Belmont Series LED operating lights from Takara Belmont. They have a 10 LED light system with monthly fee allowed customers to see a range of different products. The system was also a popular exhibit which attracted a lot of interest. Environmental concerns still exist for all, and the new Belmont Series LED operating lights from Takara Belmont. They have a 10 LED light system with monthly fee allowed customers to see a range of different products. The system was also a popular exhibit which attracted a lot of interest. Environmental concerns still exist for all, and the new Belmont Series LED operating lights from Takara Belmont. They have a 10 LED light system with monthly fee allowed customers to see a range of different products. The system was also a popular exhibit which attracted a lot of interest.
**EndoCare**

At EndoCare we pride ourselves on our caring, customer-centred approach. For us, maintaining the health, and therefore the happiness of our patients is always our number one priority, of our patients is always our number one priority, and the comfort and wellbeing of our patients is always a top priority.

**EndoCare’s Core Values**

- **Customer-Centricity:** We strive to provide excellent care and service to our patients, ensuring they feel valued and respected.
- **Innovation:** We continuously seek to improve our practices and treatments to advance the care we provide.
- **Ethics:** We uphold the highest ethical standards in all aspects of our work.
- **Teamwork:** We collaborate effectively as a team to deliver the best care possible.
- **Responsibility:** We take responsibility for our actions and strive to do what is right.

EndoCare offers a wide range of treatments and services, including:

- Root Canal Therapy
- Endodontic Surgery
- Complex Case Management
- Root Canal Retreatment

**EndoCare’s Referral Program**

Diplomacy saves the day with Roger Gullidge Design

Tactful communication and persuasive diplomacy from Roger Gullidge, founder of Roger Gullidge Design, saved the day for Apar 5yed when he was needing to launch Pearl Dental in Strathmarn.

"It wasn't for him the whole thing would have been a complete disaster," says Apar. "He was absolutely brilliant to work with, he listened to everything I had to say and helped as far as possible with any ideas I had that I wanted to implement in the practice.

When disagreements with building contractors threatened to derail the development of the practice, Roger Gullidge stepped in to mediate, quickly finding a resolution that all parties could accept.

"It helped me feel that I had regained complete control of the project, but without Roger's intervention the builders would probably have left," says Apar.

EndoCare offers a number of referral schemes, for further information please call 011 251-5532 or take a look at www.grahamgedenrco.com.
The completed case includes:

- Customised Implant Abutments
- Implant Complete
- All The Elite Service Promises
- Location Jig
- Fitting Screw
- Laboratory Analogue
- Any Elite Restoration
- Hybrid Zirconia-Titanium Abutment
- Choose Any Elite Restoration from:
  - Full Metal Crown
  - ZirconArch
  - ZirconiaFC
  - ® e.max Press
  - PFM

All The Elite Service Promises

The All Inclusive Laboratory Implant

£250

All For Just

per unit

compare to Stock prices*

‘CosTech Complete’

How does

Comparison

Lab Crown and charges:  £185

Stock abutment + Screw:  £140

Total:   £350

Lab Analogue:  £25

Crown .  † T&C Apply

®

*Based Average Prices with ZirconArch

SAVING YOU UP TO £100 per unit

means no shocking bills at

the end of the month.

Our clear pricing promise

Saving you

£100

03/09/2012   16:03:06

28/06/2012   10:27

28/06/2012   10:32

Illustrations & images courtesy of Amman Girrbach ©

from:

CosTech Implant Centre

CosTech Implant Centre

Dental Tribune UK

Editorial Board

Dr Neel Kohlari
BDS Principal and General Dental Practitioner

Dr Stephen Hudson
BDS, MF GDP, MSc General Dental Practitioner

Mr Amit Patel
BDS MSc MClindent MFDS RCS Eng BDS
Specialist in Periodontics & Implant Dentist Associate Specialist Birmingham Dental Hospital

Professor Nick Grey
BDS, MDSc, Phd, DRD RCS Eng, MRD RCS Eng, FDSRCS Ed, FHEA
Professor of Dental Education, National Teaching Fellow, Faculty Associate Dean for Teaching and Learning School of Dentistry, Manchester

Professor Andrew Eder
BDS, MSc, MF GDP, MRD, FDS, FHEA
Director of Education and CPD, UCL Eastman Dental Institute

Mr Raj Rajadayan OBE
MA(Clin Ed), MSc, FDSRCS, FF GDP(UK), MRD, MGDs, DRD

Dr Trevor Bigg
BDS, MGDs RCS (Eng), FDS BCS (Ed), FF GDP(UK)
Practitioner in Private and Referral Practice

Baldeesh Chana
BDH, RDFT, FETC, Dip DHE
President, BADT and Deputy Principal Hygiene and Therapy Tutor, Barts and The London School of Medicine and Dentistry

Dr Stuart Jacobs
BDS MSD (U Ind)
Full-time Private Practitioner

Shaun Howe
RDH
Dental Hygienist

Dr Richard Kahan
DS MSc (Lond) LDS RCS (Eng)
Endodontic Specialist

Mrs Helen Falcon
Postgraduate Dental Dean, Dental School, Oxford & Wessex Deaneries

Professor Liz Kay
Foundation Dean and Professor of Dental Public Health
Plymouth University Peninsula Schools of Medicine and Dentistry Dean of the Peninsula Dental School, Plymouth

Pam Swain
MBA LGCI FIAM MCMI BADN®
Chief Executive, British Association of Dental Nurses

Mr Raj Rattan
Associate Dean, London Deanery

Dr Paroo Mistry
BDS MFDS MSc MO Surg FDS(Orth) Specialist Orthodontist

Dr Peter Galgut
PhD (LMU), MPhil (Lond), MSc (Lond), BDS (Bath), MRD RCS (Eng), LDS RCS (Eng), MF GDP(UK), DDF Hom, ILTM
Periodontal Consultant

Mr Amit Rai
BDS (Hons) MF GDP(UK) MJDF RCS Eng FHEA General Dental Practitioner

DPTI (VT) Programme Director, London Deanery

Sneha Gokhale– Gaikwad
BDS, MDS (INDIA)
Specialist in Periodontics and Implant Dentistry Diploma in laser dentistry (Vienna, Austria)
Whatever your management role.....
you can find a qualification to benefit you and your practice.
UMD Professional’s range of qualification courses are accredited by the Institute of Leadership and Management and provide a practical management training pathway for dentists, DCPs and practice managers.

ILM Level 3 Certificate in Management
designed for senior nurses and receptionists and new managers taking their first steps in management

ILM Level 5 Diploma in Management
for existing practice managers and dentists

ILM Level 7 Executive Diploma in Management
for dentists and practice business managers, and accredited by the Faculty of General Dental Practice as part of the FGDP Career Pathway

For full details, course dates and venues contact Penny Parry on:
020 8255 2070  penny@umdprofessional.co.uk
www.umdprofessional.co.uk

COURSE ANNOUNCEMENT
MULTI-SYSTEM IMPLANTOLOGY CERTIFICATE COURSE AT
TRAFFORD GENERAL HOSPITAL, MANCHESTER
Recognised by University of Salford
Applications are invited for a hospital based “certificate” year course (one day a month) starting on 7th November 2012.
This unbiased multi system clinical course in its 20th year is designed to teach practitioners how to incorporate implant treatment to their practices safely with the back up of three most documented implant systems according to the FGDP/GDC Training Guidelines. Astra, Nobel Biocare and ITI/Straumann, the market leaders in implantology for their unique indications, predictability, research and documentation, are taught step-by-step during the year course. Each participant will have the opportunity to place implants in their patients under supervision. The course has been granted approval by the FGDP(UK) for accreditation towards its Career Pathway.

COURSE CONTENTS AND BENEFIT
• Keynote consultant/specialist speakers from UK and abroad
• Certification for three major implant systems and GBR techniques
• Prepare for Diploma examinations or further academic study (e.g. MScs)
• Benefit from extensive network of accredited UK Mentors
• Clinical practice support and advisory service
• Implant team with highly proven 20 years’ clinical research and teaching experience
• Become an ITI member (with complimentary 1st year’s subscription) (worth £200)
• Receive complimentary editions of five ITI Treatment Guides (worth £350)

FOR FURTHER INFORMATION: Professor T.C. Ucer, BDS, MSc, PhD,
Oral Surgeon, Oaklands Hospital, 19 Lancaster Road, Manchester M6 8AQ.
Tel: 0161 237 1842  Fax: 0161 237 1844  Email: ucer@oral-implants.com
www.oral-implants.com
HELP PROTECT YOUR PATIENTS’ HEALTHY GUMS

TWICE DAILY BRUSHING WITH A FLUORIDE TOOTHPASTE
TWICE DAILY USE OF MOUTHWASH FOR PROLONGED DISRUPTIVE EFFECT ON PLAQUE
INTERDENTAL CLEANING FOR EFFECTIVE PLAQUE CONTROL

THE CORSODYL DAILY RANGE OF PRODUCTS NOW OFFERS EVEN MORE CHOICE FOR PATIENTS WHO WISH TO MAINTAIN THEIR GUM HEALTH

RECOMMEND THE CORSODYL DAILY RANGE

CORSODYL is a registered trade mark of the GlaxoSmithKline group of companies.