Avoid UK graduate foundation training fiasco, BDA warns

Association calls for action over DFT places

The British Dental Association (BDA) is calling on the Department of Health (DH) to ensure that this year's dental graduates are not left without a dental foundation training (DFT) place when they have graduated.

This is in response to the situation last year, which left 55 UK dental graduates without a DFT place, and comes after the announcement by COPDEND (The UK Committee of Postgraduate Dental Deans and Directors) that 1,139 applicants, of whom 1,026 are students or recent graduates of UK dental schools, have been invited to take part in the assessment centres to compete for an estimated 952 funded training posts in NHS practices.

Commenting on the situation, Dr Judith Husband, BDA Chair of Ethics, Education and the Dental Committee, said: “COPDEND’s announcement raises the spectre of another year of heartbreak for dental students and squandered public money. Denying UK graduates who want to undertake foundation training a place serves the interests of neither patients, taxpayers nor the graduates themselves. The Department of Health must consider this an early warning and act now to ensure that 2015 does not see a repeat of the senseless situation that has been witnessed this year.”

Dental Tribune spoke to CDO for England Dr Barry Cockcroft about the BDA’s concerns. He stated: “Last year over 87 per cent of UK graduates got a place on a foundation training scheme at the first time of asking and I suspect, although I don’t know, that the people who didn’t have now applied in this year as well.

“On top of that, the actual number of applications this year is lower than last year. We do know that some people who have applied to the scheme have applied in Scotland as well. We also know that last year the National Health Service came up with more training places later on in the year when the financial situation was clearer and we would fully expect that to happen again.

“I think there were lessons learnt last year and the communications to students will be better and also better timed this year; but for the vast majority of students they will get a greater degree of security from this process much earlier than they used to do under the old system.

“At the end of the day the fact is that legally this is employment. We know that last year a significant number of graduates, from the Irish Republic especially, were successful in getting places in open competition. However, as it is employment we cannot discriminate against applicants from the EU in applying for these places, but for the vast majority of students they will get a greater degree of security from this process much earlier than they used to do under the old system.

“Numerous communications to students will be approved or funded. We acknowledge that these figures may cause some anxiety for applicants to foundation training, and would like to reassure them that we are doing all we can to ensure a fair and equitable process and to recruit as many high quality training places as we can. Dental Foundation training is a period of employment and we are complying with UK employment law.”
Move over Movember, this month is all about action against oral cancer

The Mouth Cancer Action Month takes place in November once again, fighting the battle against oral cancer.

The campaign, co-organised by the Mouth Cancer Foundation, takes place from 1 - 30 November, with the aim to improve awareness of the symptoms, risk factors and early warning signs of the disease. Signs include ulcers that do not heal within three weeks, red and white patches in the mouth, lumps in the neck and unusual changes in the mouth.

More than 1,800 people die from mouth cancer in the UK each year, with almost 6,000 new cases being diagnosed annually. As it stands, people with mouth cancer are more likely to die than those with cervical cancer or melanoma skin cancer.

As part of Mouth Cancer Action Month, dental practices across the UK are offering free mouth cancer screenings. The East Yorkshire practice Perfect 52 is taking part, and will be holding screenings every morning from Monday 12th to Friday 16th November.

Practice Manager Nicki Rowland said: “Last year we screened 54 people completely free of charge and had zero referrals. This year we are offering free screening for a full week because we want to encourage people to come for the screening. We want to invite anyone over the age of sixteen to come in particularly if they smoke, drink, are sexually active and have a poor diet, or are exposed to any combination of these predisposing factors. Hopefully by raising awareness of this terrible disease we will encourage more people to self-check and visit their dentist for the regular examinations that could save their life.”

The British Dental Health Foundation is also holding a reception at the Houses of Parliament in aid of the campaign.

Photodynamic therapy under spotlight

Photodynamic therapy comes a class of drugs with light to selectively destroy cancer cells. The drug is injected into the patient and absorbed by the body’s cells. The drug tends to remain in cancer cells for a longer period of time. When exposed to a specific wavelength of light, often administered by a laser, the drugs produce a form of oxygen that kills nearby cells. This therapy is currently used to treat certain forms of oral cancer, in addition to other cancers. However, current oral cancer technologies have the potential to damage other healthy cells in the throat and mouth during treatment.

Photodynamic therapy combines a class of drugs with light to selectively destroy cancer cells. The drug is injected into the patient and absorbed by the body’s cells. The drug tends to remain in cancer cells for a longer period of time. When exposed to a specific wavelength of light, often administered by a laser, the drugs produce a form of oxygen that kills nearby cells. This therapy is currently used to treat certain forms of oral cancer, in addition to other cancers. However, current oral cancer technologies have the potential to damage other healthy cells in the throat and mouth during treatment.

Lucifics – founded in 2011 by University of Rochester graduate William Cottrell – is developing a new technology that more effectively focuses photodynamic treatment on cancer cells and shields other parts of the oral cavity from the reflected light that can cause the drug to activate and damage healthy tissue.

It takes just 90 seconds to save a life!

The Mouth Cancer Foundation is launch- ing its 2012 Mouth Cancer Awareness Week ini- tiative by calling for dentists across the UK and Ireland to take part in a pilot scheme for a brand new thorough screening accreditation initiative.

The Mouth Cancer Screening Accreditation Scheme recognises dental practices that demonstrate a visible commitment to increasing public awareness of mouth cancer screening to all patients and to establish a documented referral pathway with a local specialist department.

Awareness is integral to achieving early detection of head and neck cancers, thus saving lives. The Mouth Cancer Foundation will accredit dental practices that routine- ly participate in oral cancer screening. The programmes will include professional development and training programmes suitable for all members of the practice team to ensure regular screening benefits practice patients.

The Mouth Cancer Screening Accreditation Scheme is open to any dentist registered with the GDC or any dental practice whose clinicians are registered with the GDC. Dentists who take part in the pilot scheme will receive associate accreditation when the Mouth Cancer Screening Accreditation Scheme launches.

It is estimated that by 2050, there will be 790,000 cases of oral cancer worldwide. Our goal is develop a way to treat oral cancer effectively, but limit the traumatic side effects and after- math that come with the current treatment methods.

Chewing Betel Quid increases risk of cancer

Chewing betel quid - the fourth most popular psychoactive substance in the world after tobacco, alcohol and caffeine - exposes its 600 million users to substances that act as direct carcinogens in the mouth, according to a new study in ACS’ journal Chemical Research in Toxicology.

Betel (QD) consists of nuts from the areca tree, sometimes combined with spices, such as cardamom or saffron, and other ingredients. Available in commercial forms, QD is popular among people in China, India and other Asian countries, and people of Asian heritage living in other countries. Scientists have known for decades that chewing QD can lead to oral cancer, and showed recently that the substances in QD could change into carcinogens in the body.

The authors of this study explored whether there were any substances in the areca nut that can cause cancer directly, without any need for the body to change or “activate” them.

They discovered that compounds in the areca nut can “alkylate” the genetic material DNA, causing changes that increase the risk of cancer, and they are present in betel quid in amounts high enough to do so.

“Our study showed that these alkylating agents are present at levels sufficient to cause DNA damage and potentially have adverse implications to human health, particularly in the case of the development of oral cancer for QD chewers,” said study authors Mu-Rong Chao and Chiu- tung-Wen Hu.
Editorial comment

Is it me or has it gotten cold all of a sudden? It can only mean one thing – we are now well into the month of November. Soon we’ll be singing Christmas Carols and wondering where the year went!

Of course November has extra significance for dental professionals. As well as being the time for the menfolk to be sporting strange caterpillar-like growths under their nose for the men’s health campaign of ‘Movember’, it is also the time where we can raise awareness in the public’s consciousness about oral cancer.

Practices around the country have been offering free mouth cancer screening and awareness of the symptoms; and this week sees a reception at the House of Commons to support Mouth Cancer Action Month.

Please send me in pictures etc about what you and your practices are doing to promote Mouth Cancer Action Month; it is always great to hear what you are doing. And remember, if in doubt, check it out!

To help raise money for the homeless charity CRISIS, Dr Nilesh R Parmar is holding an exclusive ‘Ice White Xmas Party’ charity event on 1st December at London’s trendy Holborn House venue.

Nilesh said: “I’m very committed to working closely with charities, and, this year, my aim is to bring together family, friends and colleagues to raise lots of money for the worthwhile charity CRISIS, at a time of year when the homeless need it most.”

Sponsored by Astra Tech (Denstply Implants), Digimax, Enlighten and Manan Ltd, the fun-filled charity event will also host a raffle, which will see guests win some fantastic prizes. Prizes up for grabs include an iPhone5, spa day, luxury driving experience day, a personal training session, teeth whitening treatment and a week’s stay in an apartment in Puerto Banus, Spain. All proceeds from the raffle will go to CRISIS.

Guests will also enjoy a champagne reception accompanied by canapés and live entertainment. Tickets to this exclusive event are available by invitation only, so to receive your invitation, email icewhiteparty@gmail.com.

Donations are greatly appreciated, and can be made on the night, or via the Just Giving website http://www.justgiving.com/theice-whitechristmasparty

More effective caries prevention than a regular fluoride toothpaste

Dental Tribune United Kingdom Edition • November 12-18, 2012

News
Manchester practice a BDA winner

A dental practice in Manchester has been named British Dental Association (BDA) Good Practice Scheme Practice of the Year. Maple Dental Care Ltd, in the Brooklands area of Manchester, won the award following a rigorous selection process, which included a visit to the practice by judges for the Scheme.

The practice is one of roughly 1,800 members of the Good Practice Scheme, which has now been running for over ten years. The Practice of the Year award is judged on criteria covering many aspects of practice management and care delivery such as patient communications and the care pathway, health and safety and infection control, team training and team working, and corporate social responsibility.

Judges this year were particularly impressed with Maple Dental Care’s commitment to delivering ‘a caring pathway of evidence based dentistry for patients’. They also praised the range of treatment options and additional services the practice provided, and its commitment to lifelong learning amongst its staff.

Clinical Director of the practice, Ian Hunt, said: “We’re delighted to win this accolade, it reflects a real team effort and is a wonderful reward for the hard work and care the team provide each day.”

The practice will be presented with their award at the BDA’s Honours and Awards Dinner which takes place in London at the end of November.

Study to help identify potential cavity sites

The results of a four-year, $5.4m National Institutes of Health-funded study led by a researcher from the Indiana University (IU) School of Dentistry will help dental professionals identify which at-risk sites on teeth are likely to become cavities if no preventive action is taken.

The study, published in the Journal of Dental Research and led by Andrea Ferriera Zandona of the IU dental school, is believed to be the first extended examination of the natural history of dental caries since 1966.

A total of 565 children between the ages of five and 15 were recruited for the study in 2007. Of these, 558 children completed all examinations. The children were examined at regular intervals over 48 months.

According to Zandona, a lot is known about caries, but little is known about the process that leads from early caries lesions to cavities. Caries lesions are an early sign that a cavity might develop.

To date, the practice has been to wait and watch lesions until they reach the point where the dentists believe a filling is required, Zandona said.

The purpose of the study was to evaluate whether lesions could be evaluated using the International Caries Detection and Assessment System (ICDAS), a standardised visual examination that requires no special equipment, to identify with greater predictability which ones were more likely to become cavities.

“What we were trying to see was if we could identify when lesions reach the point that they will become cavities,” Zandona said. “Are there some signs we see on teeth that signal when it is progressing towards cavitation?”

IU researchers developed the ICDAS examination with a small group of international scientists. In the study, examiners used the ICDAS to give lesions a score, ranging from 1 to 6 - with one representing a lesion so small that it was difficult to see and scores greater than 5 indicating what is usually considered a cavity – and judged whether a lesion was active or not. The lesions were tracked during the 48 months, with some registering higher and higher scores until they progressed to cavities.

After analysing data collected in the study, the researchers concluded “characterisation of lesion severity with ICDAS can be a strong predictor of lesion progression to cavitation.”

Singing dentist raises thousands for charity

A singing dentist has raised more than £5,000 for diabetes after performing at a concert in East Sheen.

Andrew Bain, 59 (pictured), took to the stage at the All Saints’ Church on Saturday, October 15, to raise money for the Juvenile Diabetes Research Foundation.

Mr Bain, who has worked at the Park Dental Clinic in East Sheen for four years, was joined on stage by Ruth Wood, Middleton and Rochdale. And health chiefs are keen to roll-out the reversed fluoride treatment instead of waiting for lesions to become cavities.”

She said: “The response has been overwhelming. I can’t believe that people have been so kind and supportive. I am so thrilled they enjoyed the show and that we managed to raise so much money.

“Thank you so much to everyone who has supported this cause.”

Rochdale Youngsters get their teeth into new dental scheme

Good oral health is vital – and it’s important that youngsters never forget the importance of looking after their teeth, mouth and gums. I’d urge all parents involved to support the programme which will make a real difference to their children’s oral health.”

The initial pilot programme involves three schools – St Peter’s CE Primary School, Rochdale; Belfield Community Primary School, Rochdale and Bowlee Primary School, Langley, Middleton. And health chiefs are then keen to roll-out the scheme across the Rochdale Borough once the pilot has been evaluated.

Andrew Forrest, Oral Health Manager at Pennine Care, said: “With support and supplies from our oral health specialists, school teachers will supervise children aged 5 to 7 brushing their own teeth once during the school day. Teachers will be trained to ensure that only a pea-sized amount of toothpaste will be used for tooth brushing which is the recommended amount for primary school-aged children.

“Children in the Rochdale Borough have some of the highest rates of tooth decay in the country so we want to reverse this trend and ensure our children have happy, healthy smiles.”
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: Rubber-dam Techniques - Overview and New Matrix Systems
Speaker: Dr Ian Cline
Date: 14th November 2012

Webinar 2: Contemporary no-preparation veneers
Speaker: Dr James Russell
Date: 20th November 2012

Webinar 3: Dental Implantology - At the Cutting Edge of Dentistry
Speaker: Dr Nilesh R. Parmar
Date: 21st November 2012

Webinar 4: Peri-implantitis - a future timebomb
Speaker: Amit Patel
Date: 27th November 2012

Webinar 5: Sharpen Up Your Instrumentation!
Speaker: Alison Grant
Date: 28th November 2012

Webinar 6: Motivating patients to improve their oral health behaviour
Speaker: Dr Vesna Zivojinovic-Toumba
Date: 29th 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.

Free
www.dentalwebinars.co.uk
0207 400 8989

1.5 Hours CPD Points

Sign up for FREE www.dentalwebinars.co.uk
Business recognition for Brush-Baby

An infant dental-care company has reached the final of the Nectar Business Small Business Awards, a national competition to reward and recognise the importance of small businesses to the economy.

Brush-Baby was awarded Highly Commended in the Innovation of the Year category at an Awards Ceremony hosted by Karren Brady, UK businesswoman and star of BBC 1’s ‘The Apprentice’.

As a mum wanting the best dental care for her baby, Brush-Baby founder Dominique Tillen, struggled to find a suitable product for her baby daughter. Therefore, perceiving a gap in the market based on her own needs, she researched, manufactured and developed a Chewable Toothbrush. Ergonomically designed and endorsed by dentists, and loved by infants who literally “chew” on the toothbrush initially to soothe teething gums and then to clean emerging teeth, it has gone on to establish itself as an award-winning product in the Brush-Baby range of dental products.

Dominique said: “I am delighted that Brush-Baby was so highly respected and ultimately rewarded. However, I am even more pleased from the chemical antiseptic toothpaste, including some over-the-counter products. Examples include: antiseptic creams, wipes, cleansers and skin preparations, antiseptic mouthwashes, toothpastes and dental implants.

The General Dental Council is reminding all registrants that its ‘Standards for dental professionals’ says: 5.5 Find out about current best practice in the fields in which you work. Provide a good standard of care based on available and up-to-date evidence and reliable guidance.

Antidepressant eases pain of oral mucositis

A n oral rinse of the antidepressant doxepin significantly eased pain associated with oral mucositis and skin preparations, radiation therapy for cancers of the head and neck, a study led by Mayo Clinic found. The findings were presented at the American Society for Radiation Oncology annual meeting in Boston.

“Oral mucositis or mouth sores is a painful and debilitating side effect of radiation therapy,” says principal investigator Robert Miller, M.D., a radiation oncologist at Mayo Clinic. “Our findings represent a new standard of care for treating this condition.”

Dental nurse struck off

Shetland-based dental nurse Melanie Inkster has been struck off by the General Dental Council following a public hearing which she failed to attend.

Ms Inkster was employed as a dental nurse at 90 St Olaf Street, Lerwick, Shetland. The GDC’s Professional Conduct Committee found that on 12 December 2012, she overcharged patients for their treatment; falsely recorded lower payments as having been received; and took the sum overcharged for her own use.

The hearing was told that Ms Inkster admitted her actions during her employer’s disciplinary process, when it was recorded that she said “It was not something she would normally do but it started and got out of hand”.

The Committee said: “Ms Inkster’s actions fell far short of the standards of the profession, and her conduct was inappropriate and dishonest. Ms Inkster’s action was a serious breach of patient trust and disregard of basic tenets of the profession. Her actions in stealing from patients and the practice were dishonest, systematic and sustained conduct over a period of time.”

Whilst recognising that dishonesty does not inevitably lead to erasure from the GDC’s register, the case also involved breaches of patient trust. Ms Inkster’s behaviour has been deemed so unacceptable to the reputation of the profession that erasure is the only appropriate and proportionate sanction.

Ms Inkster has until 2 December 2012 to lodge an appeal to the Court of Session.

Fund for aspiring researchers

Looking to get into clinical research? A £4.5M start-up fund has been established for medical and dental professionals engaged in research to help kick start their scientific career by allowing them to pursue academic work alongside patient care.

The money will be distributed in grants of up to £50,000 to clinical lecturers (dentists/doctor who hold a PhD/MD and are working towards completion of specialty training) to help them gather preliminary data and strengthen their applications for longer term fellowships and funding. The grants will be awarded biannually from 2015 for four years through the Academy of Medical Sciences Starter Grants for Clinical Lecturers Scheme.

The Starter Grants for Clinical Lecturers scheme was launched in 2008 by the Academy of Medical Sciences in partnership with the Welcome Trust. Since then the scheme has awarded £4.5m in grants to more than 150 clinical lecturers who have gone on to secure substantive research funding, set up their own laboratories, authored articles in high-ranking peer-reviewed journals and secured senior research posts.

A review of the first three rounds of the Starter Grants for Clinical Lecturers scheme found that 96 per cent of award holders had generated preliminary data that formed the basis for substantial research funding, and despite the scheme being new, 48 per cent had already noted significant career developments or promotions since receiving their award, and 58 per cent had already authored a peer-reviewed article as first author in high impact journal publications including The New England Journal of Medicine, Nature Genetics and Lancet Neurology.

The deadline for the next round of applications is 4 March, 2015.

Patients reported pain associated with oral mucositis n a pain questionnaire with a scale of 0 to 10 administered at baseline and then at five, 15, 30, 60, 120 and 240 minutes after rinsing with doxepin. Patients could continue doxepin after the study, and the patient rated the doxepin was well tolerated, though stinging, burning, unpleasant taste and dryness were reported as side effects.
BDHF smokeless tobacco leaflet launched

O
ti cal health charity the British Dental Health Foundation has produced a new public information leaflet on the topic of smokeless tobacco.

Presented in a Q&A format, ‘Tell Me About: Smokeless Tobacco’ contains information about the effects of smokeless tobacco, particularly addressing its relationship with mouth cancer.

The leaflet also explains the health benefits of giving up smokeless tobacco, as well as offering advice on how to quit.

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter OBE, says more work needs to be done to improve education of smokeless tobacco, especially in South East Asian communities and believes dental professionals are in the ideal position to communicate the key messages.

Dr Carter said: ‘There is currently a lot of on-going confusion about the risks of smokeless tobacco, which is particularly worrying given the number of people, mainly those in ethnic minority groups, who use it.

“That is why we have produced an information leaflet specially focussing on smokeless tobacco – what it is, what it is made of, and why it is so dangerous. The leaflet can be displayed in waiting rooms, or handed out to patients who might be at risk. It is written using non-technical language and has been awarded the Plain English ‘approved’ logo, which is a guarantee that the language is straightforward and easy to understand by the general public.

“We encourage all dental practices, particularly those with high ethnic minority patients, to stock this leaflet and help eliminate one of mouth cancers growing risk factors.”

‘Tell Me About: Smokeless Tobacco’ is freely available to view online at www.dental-health.org/tell-me-about/topic/mouth-cancer/smokeless-tobacco while printed versions can be purchased in packs of 100 from the Foundation’s shop.

AOG 2015 tour announced

K-based dental organisation the AOG has announced that it is organising a research trip to New Zealand, with the option of extending the trip to include a visit to Australia, offering the experience of a lifetime.

The trip to New Zealand will take place January 21-1 February, travelling around the country from Auckland to the sulphur thermal pools and Maori culture of Rotorua and then Hawke’s Bay in the North, before heading south to Christchurch, the glacier of Franz Joseph and the breathing scenery in and around Queenstown.

The Australia extension then flies to Sydney, Cairns and Brisbane, visiting Sydney Harbour, the Blue Mountains, and the Great Barrier Reef.

Dentists’ fund calls for Christmas aid

In a time of global economic crisis, the Benevolent Fund has received the highest ever number of applications for assistance. When tragedy strikes, be it an accident or ill health, or there is another reason why a dentist cannot work, it may not be long before financial worries become serious problems.

Christmas adds an additional burden and, together with escalating winter fuel bills, leaves some dentists unable to cope and fearful for their family’s future. The BDA Benevolent Fund offers grants where appropriate to help UK dentists and their families during the hardes of times.

One grateful recipient of the Fund’s assistance said: “Thank you for informing me that the BDA Benevolent Fund are able to help support me and my family over the coming months, since my husband’s stroke. I cannot tell you the relief and gratitude I feel. Your letter made me cry. I am so touched by the generosity of the charity and of friends, neighbours and even complete strangers. The world is a kinder place than I ever gave it credit for.”

Please give a gift to the Fund’s Christmas Appeal and help your colleagues and their dependents when they need it most.

Visit www.bdabenevolentfund.org.uk or send a cheque to BDA Benevolent Fund, 64 Wimpole Street, London W1G 8YS.

Lecture programme announced

The Alpha Omega dental fraternity has announced its lecture programme for the 2012/2013 period. Lectures include:

• 29/1/2013: The therapeutic gradient, a medical concept for actual dentistry? - Dr Jean Pierre Attal
• 12/2/2013: Wearing away - Prof David Bartlett
• 50/4/15: Some psychogenic neuropathic aspects of restorative dentistry - 28 years of clinical experience - Dr Michael Wise
• 21/5/15: Biology and aesthetics - are all crowns equal? - Dr Ailbhe McDonald
• 28/0/15: Annenber Lecture featuring Dr Didier Dietschi

All evening lectures will be held at the BDA, 64 Wimpole Street, London, with registration at 6:30pm for a 7:15pm start. These evenings are all free to members, with guests welcome at no charge for one meeting.

The annual Annenberg Lecture will be held at the RAF Museum, Grahame Park Way, London. This special event will feature lectures from 9am-4:30pm and will include a trade show available during the lecture break periods.

This special event is available for £500 to AO members and £540 to non-members, with special rates available to those who book before 28th February 2013.

For more information visit www.aog.org.

Visit www.bdabenevolentfund.org.uk for more information.
Performing Dentistry

Neel Kothari discusses UDAs and Associates

It is my contention that dental associates have suffered the most following the 2006 overhaul of the NHS dental system. Far from being the beacon of the self-employed world in full control of what goes into the patient’s mouth at the point of delivery, dental associates are now more commonly finding themselves tenaciously close to the definition of an employee, being told how many points are needed to be collected every month, the value of each point irrespective of how hard it is to achieve it and increasingly what work they can and cannot carry out on the NHS.

The official term ‘performer’ clearly does not do justice to the complex and intricate relationship between a dentist (or any healthcare professional) and their patients. Whilst technically associates are ‘performing’ a service, this service is almost impossible to perform to best practice guidelines within the auspices of only three bands. Whilst a label is just a label, I am concerned that the respect of associates within the profession is slowly disintegrating. Labels have an emotional attachment for many people, so as a profession what do we want, dentists practising their profession or performing within a contract?

In a recent job advert placed online by an unnamed corporate group, the position was for an associate GDP to ‘perform’ 8,915 UDAs for a ‘competitive’ salary and a 50 per cent contribution for lab fees. Sounds pleasant, but how will this work? If we assume that one takes six weeks off work for holidays and one week for CPD, this works out 58.5 UDAs per day needing to be achieved for the target to be met. I’m sure some will think ‘fine’, whilst others may frown, however one thing that I really can’t figure out is how on earth this relates to clinical need. Can one really carry out 8,915 UDAs a year without knowing how much actual dentistry is needed to meet their allocation or does this simply place an unfair and perverse incentive on the dentist in order to ‘perform’ their associate agreement?

Let’s not forget that many of these UDAs will often include ‘new patients’, who could require a ridiculous amount of work in order to achieve three or 12 UDAs. What sort of incentive does this place on associates aiming to meet their UDA allocations: large fillings or gold onlays? Treat all cavities or watch some? Available on the NHS or Private only? Root canal therapy or extraction? Of course as a mere dentist, I dare not suggest that clinical decisions are being affected by financial incentives rather than the patient’s best interest. Thankfully the Health Select Committee did that for me (2nd July 2008).

Along with completely irrelevant UDA targets with little sensible link to treatment need, dental
associates all too frequently are placed in a very difficult position, whereby in order to get a job they have to accept UDA targets not really designed for them, levels of remuneration based on the realities of supply and demand rather than clinical need and the full liability of clinical decision making should something go wrong. This cocktail of ingredients may work for the architects of the nGDS contract, but surely there must be a trade off in front line services and the professional integrity of those dentists who are often placed in this position.

Whilst many within the industry may complain of how they have been affected, I personally feel that the worst affected are dental associates, especially those just entering into the profession. The complexity of providing quality NHS dental services seems to be traded off in a system designed to make professionals meet targets and score points based on formulas designed by a series of accountants rather than focusing on quality dental care.

Over the past few years I have had many conversations with colleagues on the basis of ‘what do you provide on the NHS?’ The availability of NHS provision is not really a postcode lottery but probably more a case of how the dentist interprets the 2006 contract and what funding they have in place. Whilst the vast majority of dentists are most likely in agreement over what constitutes standard treatment, we come back to the age old question of ‘what exactly should be available on the NHS.’ The standard DH answer to this question is whatever is clinically necessary. In some cases ‘clinically necessary’ ranges from a full acrylic denture to an all on four implant supported bridge!

Now corporate organisations may not like this next bit, but oh well.

The ability to use the youngest members of our profession in an attempt to meet a ridiculous number of points for a fee scale designed to encourage a swing away from best practice is unfair, untried and untested. It deliberately abuses the self employed nature of an associate and their ability to retain control, whilst at the same time heavily promoting business agendas which are not always in the patient's best interest. This dilutes professional integrity in a worse way than when Mercedes Benz released their A class (original design not the latest version which starts on the road from £18,945).
Snoring is a common problem. Loud and frequent snoring can be more than just a nuisance to sleep partners; it can disrupt whole households and has associated inherent health risks.

Snoring is also the primary symptom of Obstructive Sleep Apnoea (OSA), which is a serious medical condition; 50-60 percent of asymptomatic snorers will have some degree of sleep apnoea. When OSA is also associated with excessive daytime sleepiness it is referred to as Obstructive Sleep Apnoea Hypopnea Syndrome (OSAHS).

Dentists are ideally placed to provide Mandibular Repositioning Devices for the treatment of simple snoring and mild to moderate sleep apnoea, and many are becoming increasingly interested in treating snoring patients in general practice.

However, they may be deterred by concerns over screening patients for OSA and complying with medicolegal guidelines. Breaking into a new branch of dentistry, so closely allied to medical practice, can be quite daunting and many practitioners are dissuaded from providing such treatments.

In the UK, we lag behind the US and most of Europe in the treatment of snoring and OSA with oral devices. To help encourage more effective treatments, it was felt that an association of all interested parties was required. Anyone connected with the provision of treatment to OSA patients would be welcome to join; be they dental surgeons, dental technicians, medical practitioners, respiratory nurses, ENT consultants or consultant respiratory physicians.

To this end, a group of highly motivated dentists and technicians decided to act as a catalyst for the establishment of this British group and formed the British Society of Dental Sleep Medicine - BSDSM (www.dentalsleepmed.org.uk and @BSDSM).

The society encourages intercommunication and dissemination of knowledge between interested parties, with the ultimate aim of improving the treatment of patients with sleep disordered breathing (SDB), through the involvement of GDPs and the provision of oral appliances. The BSDSM also works toward facilitating a coordinated, synergistic approach with the medical community for research, treatment, education and professional development.

Patient selection
One of the first problems faced in the treatment of snoring patients is selecting those patients who are safe to treat.

Whilst the diagnosis of OSA lies firmly within the remit of the consultant respiratory physician, the dentist has a role in screening for and suspecting the presence of OSA. Dentists can provide MRDs to treat simple snoring without referring the patient for specialist diagnosis. However, the dental treatment of patients suffering from OSA with MRDs can only be undertaken if the GDP is working as part of a multidisciplinary team comprising a consultant respiratory physician. Safe patient selection therefore, was a major issue.

To address this issue, the BSDSM convened the Sleep Medicine Working Party, comprising experienced GDPs working in the field of SDB, eminent ENT and respiratory physicians. Our aim was to produce a robust, easy to use screening protocol. This tool would allow GDPs to select those snoring patients deemed unlikely to suffer from significant OSA (who can be treated in practice without prior referral for diagnosis) and those who would benefit from referral for specialist diagnosis.

This protocol (Ref 1) was presented to the British Thoracic Society Sleep Advisory Group in 2007 who “accepted the principles and value of such an approach”. It has been accepted by Dental Protection (UK) Ltd and the Dental Defence Union, and has also been incorporated into the Association of Respiratory and Sleep Apnoea Consortium (ARTP SAC) Standards of Care for Mandibular Repositioning Devices and Dental Sleep Medicine Services 2011.

Dentist training
The BSDSM provides regular basic hands-on training courses as well as advanced training. Such courses cover an introduction into sleep and SDB, how oral devices work, patient assessment and screening, follow up requirements, device selection, practical aspects of appliance provision, use of home sleep monitoring devices and tips on how to introduce a successful dental sleep medicine service into your practice.

A major advantage of our training courses is that the BSDSM is a non-profit making society which is totally independent of any commercial interests or bias. We are free to demonstrate many different devices and products from a range of providers. If our experience shows it works, we will share it with you.

I firmly believe that there is no one perfect device that can be universally prescribed for every patient, so it is essential that GDPs are famil-
be recognized by health care providers throughout Europe and would allow patients and sleep physicians to recognize those practitioners who had received training at the highest level.

What BSDSM members think

“The BSDSM has been invaluable in raising my awareness about the importance of the dentist’s role in the treatment of SDB and the important practice role we have in treatment of snoring and sleep apnoea” (J.Browker)

“Even as a dental professional I was a victim of serious snoring. The BSDSM raised my awareness of the problem and showed me the correct way to screen and treat patients. My practice is now pretty much limited to caring for patients with SDB” (A.Desai)

“If you’re a question about SDB, contact the BSDSM. Their knowledge has been invaluable to me as I’ve developed my practice in this field of dentistry” (L.Lumness-Barnes)

Sourcing a trained dentist

To help members of the public find trained GDPs we feature a ‘find a dentist’ page on our website. BSDSM members are listed geographically and can post their practice contact details. Prospective patients are reassured that these GDPs have been trained in line with current guidelines/best practice.

Membership benefits

BSDSM membership entitles you to receive the international journal “Sleep and Breathing”; an eminently ‘readable’ publication featuring case reports and original articles on a vast range of sleep disordered breathing problems.

The BSDSM board fully supports its members and is just an email away from helping out with difficult cases and problems encountered.

The BSDSM provides members with a whole range of standard documentation which saves a lot of surgery time and effort. GDP, GDP and sleep physician letters, patient information leaflets and sleep physician letters, patient information leaflets and detailed medical / snoring assessment questionnaires. The use of BSDSM patient assessment and recall assessment check sheets speed patient recall and ensure that no vital information is left unrecorded. We also provide our members with specimen valid consent to treatment forms and oral appliance care leaflets as well as detailed instruction on patient selection.

All BSDSM members receive substantial discounts on BSDSM and other international meetings. The BSDSM is affiliated to the European Academy of Dental Sleep Medicine (EADSM). The BSDSM also has links to several other professional Sleep Related societies such as the British Lung Foundation and the British Sleep Society to name but a few.

Through our affiliation with the EADSM, our aim for the future is to encourage our members to become EADSM accredited Dental Sleep Medicine practitioners. This qualification would

The Wolf light curing light is a high-performance light source for polymerization of dental materials. It consists of a charger and a cordless handpiece powered by a rechargeable battery. The unit is designed for use on a table and cannot be wall-mounted. The light source is a high-performance light-emitting diode (LED).

In contrast to halogen lights, the emitted light specifically covers the light wavelength between 430 and 480nm. The polymerization performance is so high that the exposure times can be reduced by 50% in comparison with a conventional halogen light (with light intensity typically ranging from 600 to 800mW/cm2).

Selected filling composites can be cured in as little as 5 seconds if the light guide can be placed in close proximity to increment. Settable exposure times:

• 5, 10, 15, 20 sec
• Continuous mode (120 sec)
• Tack-cure mode

**About the author**

Dr Ray Dookan BDS, MFDSRCS (Eng), MFGDP (UK), MFGDP (EADSM), FFDP (UK), DIP DENT SED is a GDP practising in Guernsey with a particular interest in the treatment of snoring and OSA patients. He is President and co-founder of the BSDSM, a Board member of the European Academy of Dental Sleep Medicine and a Board member of the Association for Respiratory Technology & Physiology Sleep Apnoea Consortium.
Am I doing social media right? This is a question I hear a lot these days. The reality of social media in any industry is that it continues to evolve. New strategies are being implemented on platforms such as Facebook everyday. Unfortunately, there are some practices who’ve got social media all wrong. In fact, I’m often tempted to stop calling social media marketing “marketing” at all. Why stop calling these platforms “marketing” tools? Consider the fact that social media like Facebook and Twitter have become fundamental forms of communication for millions of people. Unfortunately some practices still see platforms like Twitter and Facebook as marketing tools (where they’ll run short term campaigns), rather than considering the long term value these communication mediums can deliver. Social media platforms are now primary places people choose to spend their time not on television, not on email, and increasingly not even on Google.

The problem with the mindset of social media being a short term marketing campaign is that people then see the use of Facebook or Twitter as expendable, of little value, while at the same time expecting fast results from their campaign efforts. In some cases practices will do just about anything to get those fast results.

Examples of trying too hard or too fast on Facebook are:

- Resorting to posting things that don’t reflect your brand or core values. Example: a high end aesthetic practice posting silly photos which the doctor is unaware of.
- Posting too often with the belief that more posts will mean greater returns. Example: a practice posting every day, or multiple times per day, when a few times per week would suffice.
- Sacrificing quality for quantity. Example: a practice buying likes which are fake likes bought with the sole purpose of inflating their numbers.

So who’s succeeding in social media today? It is the practices, people, and businesses who expect that social communities will be around for the long term. For example, Harvard Business Review (HBR) recently published an article titled Marketing is Dead. In the article, one of the few suggested ways to survive in our new world of marketing is to use social media properly. The HBR author, Bill Lee said, “when you contemplate a major purchase, such as a new roof, a flat screen TV, or a good surgeon, you’re not likely to go looking for a salesperson to talk to, or read through a bunch of corporate website content. Instead, you’ll probably ask neighbours or friends — your peer network — what or whom they’re using.” Mr Lee goes on to say how smart businesses should already be positioning their social communities to replicate these buying experiences.

A specific example of what this looks like is having a Facebook page which reflects your values and displays robust positive patient comments or testimonials. This also means that you must put
more thought into your social media communication tools altogether. If you are paying a service to “handle everything for you” and you don’t even understand what any of this means, stop doing that. Take some time to become informed. As a business owner, you would never consider buying a new piece of equipment or investing hundreds or thousands of dollars on something you knew nothing about, so why do that with your social media budget?

In order to succeed in social media, the first thing you must adopt is a mindset that social media communication will be around for the long term—not short term marketing campaigns.

Here are a few guidelines you can follow to help make the most of your social media communities:

• Am I aware how my brand and our practice values are being represented on our Facebook or Twitter accounts?

• Do I understand, and can I appreciate, the difference between short term marketing campaigns vs. fostering relationships to grow quality social communities?

• Is my practice being mindful about the amount of posting that we do? Are we honoring the newsfeed space of valued patients who’ve liked our page, or are we throwing caution to the wind and posting as much as possible in order to force our name and face in front of people.

• Have we used a service to buy likes so our number of fans looks inflated? Or have we acknowledged it’s okay to grow slowly, with the intention of engaging patients or people in the community who genuinely have interest in our practice?

The good news is that social media communities can morph into different personalities. If you don’t like the community you’ve built to date, you can change your strategy and make over your page. Remove the contest you were never comfortable with, adjust the amount of posts you are making, or consistently invite patients to share their thoughts on your page. Practices can be largely disappointed with the results of their social media efforts when they don’t understand the purpose, goals, or objectives in the first place. Begin with the end in mind. More and more so, the end is farther away than you think.

Adopt a mindset that your social communities will be around for the long term. When done right, social media can help you shine in what’s often called a grim marketing landscape. In addition it can enhance your online reputation, and represent the high quality of patient experiences in your practice. The ultimate key to success in social media is to find a happy medium in sharing your personality, the human side of your practice, to make meaningful connections with other people, while never losing sight of your core values.

About the author

Rita Zamora is an international social media marketing consultant and speaker. She and her team actively co-manage dozens of dental practices and social media programs. Her clients are located across the United States and internationally. Rita has been published in many professional publications. Rita is also Honorary Vice President to the British Dental Practice Managers Association. Learn more at www.DentalRelationshipMarketing.com or email Rita: ritaz@ritazamora.com

“Am I aware how my brand and our practice values are being represented on our Facebook or Twitter accounts?”

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

The Dental Company
Dentistry can be a challenging environment at the best of times, but with competition for patients so rife it can be a challenge in itself to make your practice stand out. For specialist or referral practices in particular, this challenge can prove particularly tough, as you’re not only selling your services to patients, but you’re also selling yourself to fellow professionals as well.

Given the massive change the internet has brought about in our world, it’s fair to say if you want to market your practice successfully, you really do need to have a practice website. While some dental practices may be happy with a simple “nuts and bolts” website – one that contains just basic information and contact details – to really make a success of your referral business you should endeavour to create something that sets you apart; something that “sells” your practice and your practice team to fellow professionals and patients alike.

There are many ways you can achieve this, and with the services of a professional web design team, you will find this far easier to accomplish than without. In essence, for your referral practice to become an online success, your practice website needs to be unique, it needs to be exclusive – it needs to embody everything that is unique about your practice, but in digital form. For your website to be truly exclusive, it needs to be a number of things: it needs to look appealing, it needs to contain lots of interesting and engaging content, and it needs to be optimised for the web.

In order to fully realise your practice vision, the very best websites will consist of a strong blend of eye catching, intelligent design, and content that reflects who you are, and the core values your practice team hold dear. For referral practices this point is particularly important – both for attracting patients, and practices seeking to refer.

To meet the needs of these two different groups, many websites will now be split into two sections: one for patients, and one for professionals. In each section you will need to include content suitable for the target market you are seeking. This may include video, or written testimonials (from patients and/or den-
tists), treatment guides, and even a practice blog.

Though of course, creating an exclusive practice website is a significant task, this isn’t a task you need to achieve on your own. After all, you’re a dental professional, not a web designer, and you should rightly spend your time concentrating on that which matters most: your patients. To make the most of your online marketing efforts then, it pays to trust experts with experience in dentistry to help you achieve the best website to help your practice grow.

The first thing anyone sees when they open a new web page in their internet browser is the design. If your website looks cheap or poorly designed then chances are the user will choose to look elsewhere. Remember, your website is a 24/7 “shop window” for your business. How you present yourself through your shop window says an awful lot about you and your business. It’s therefore vitally important that what you display looks good!

Compatibility is also another important factor to consider for any practice website. Poorly designed, static web pages will not display very well on portable devices, and can prove particularly difficult to navigate if viewed through these mediums. An experienced web design team will know that good web design is much more than just what a website looks like – it also includes the technical elements that many people will just take for granted. If a potential referrer visits your website and either can’t see or can’t navigate their way around it easily, then you may well find your website turns away many more referring clinicians than it attracts!

The third “pillar” of good website design is content. Good content is absolutely key to all successful websites, as ultimately people visit websites in order to digest information. Content is also extremely important from a technical perspective as well, as high quality, regularly updated content can help boost your search engine results and can also influence your “conversion rate” – that is, the number of people who contact you as a result of visiting your website.

Indeed, many practices nowadays will run a practice blog as a good way of engaging patients in issues relating to oral health. As a referral practice, you might also like to consider posting case studies and examples of complex or particularly difficult cases you have treated. This can be a great way of demonstrating your commitment and skill, and will show colleagues the type of specialised service you can offer.

To help you make the most of your online marketing efforts, employing the services of an experienced web design team really can make all the difference. Companies such as Dental Focus ® Web Design for example can really help make your referral practice stand out with an exclusive website design that is search engine optimised, GDC compliant, and fully compatible with all internet browsing devices.

In this highly competitive age of dentistry, it’s absolutely essential that you market yourself effectively to the world. For referral practices, this is especially important, and it is crucial that you make use of all the tools at your disposal. To make your practice an online success, invest in an exclusive website, and see your referrals grow.
Why improving your practice is a mystery – part 12

Jacqui Goss highlights the importance of readability

H ave you got a couple of minutes? Well obviously you have as you’ve decided to read this. Anyway, have a go at this and then continue reading.

On your computer use a search engine to find a readability index. Alternatively, go straight to www.standards-schmandards.com/exhibits/rix/index.php

Now copy and paste some text (a few hundred words at least) from your website into the box and click the ‘Calculate score’ button. You will get a score for how readable the piece of text is. Note that the American grade system is like the British school year system, but our year 1 is their Kindergarten, our year 2 is their grade 1 and so on.

There are many different readability indices with interesting names such as the Flesch-Kincaid readability test, the Coleman-Liau Index, the Gunning Fog Index and the Fry Readability Formula (developed by Edward Fry not Stephen!). They each calculate readability in different ways using criteria such as the average number of sentences and/or syllables and/or characters per so many words.

Of particular interest to us is the SMOG (Simple Measure of Gobbledygook) grade as it is widely used for checking health messages – to estimate the years of education needed to understand a piece of writing. A study into the readability of online Parkinson’s disease information by PB Fitzsimmons et al published in the Journal of the Royal College of Physicians of Edinburgh (issue 40 pages 292-6) concluded: ‘Simple Measure Of Gobbledygook should be the preferred measure of webpage readability.’

The only UK study into patient information that I’ve been able to find was reported as a research abstract in the British Dental Journal (22 July 2006). It was undertaken to assess the quality of a range of patient information leaflets produced by the British Dental Association. Readability was assessed using Flesch-Kincaid and SMOG. Quality was assessed using DISCERN – a quality criteria instrument for consumer health information developed at the University of Oxford and funded by the NHS Executive Research and Development Programme.

One of the findings was that ‘All leaflets scored quite well for readability’. However, ‘...most leaflets scored poorly in setting out clear aims in the opening paragraph, in identifying sources and dates of information provided, and other sources of advice and support available.’

Okay, enough of the background. Let’s get down to practicalities and look at some of the ways you can ensure that the information you give patients is of high quality and suitability. Start with something easy – test the readability of your website. I suggest using the one run by the National Institute of Adult Continuing
Education (NIACE) which can be found here: www.niace.org.uk/mise/smog-calculator/smogcalc.php. From this site there's a link to a very useful document called Readability, which you can download for free. It will help you interpret the SMOG results and produce easily read print material too.

You can use an Internet search engine to find other readability test tools for your website. You should also consider how accessible your website is. Much information can be found on the Accessibility section of the World Wide Web Consortium (W3C) website: www.w3.org. Some of the suggested tools are probably best used by your website developer as they are quite ‘techy’.

Recognising this, British Standard 8878:2010 Web Accessibility: Code of Practice (BS 8878 for short) was developed and published in December 2010 to help non-technical people optimise the accessibility of their websites. The standard is available to purchase from the BSI shop (shop.bsigroup.com) for £100, although there’s lots of free information about it here: shop.bsigroup.com

The Scottish Accessible Information Forum (www.saiscotland.org.uk) is another source of useful information.

Now look at the patient information leaflets you’ve produced in-house – such as your patient welcome pack. As well as applying the readability tests, I suggest you download the free PIP Guide to Appraising Health Information from the Patient Information Forum website www.pifonline.org.uk.

Take a look also at the Plain English Campaign website (www.plainenglish.co.uk) which has a number of free guides, including one entitled How to write medical information in plain English. It also has grammar guides on various subjects such as punctuating sentences.

You may wish to apply for a Plain English Campaign Crystal Mark – a seal of approval for the clarity of a document. You could be one of the first dental practices to join a list of health organisations with Crystal Marks that includes the British Dental Association and the General Dental Council. There is also an Internet Crystal Mark for websites. An example of a website with a Crystal Mark is that of the Health & Care Professions Council (www.hpc-uk.org).

Next, examine the leaflets from commercial organisations that you make available to your patients. By now you should be getting a feel for good readability and accessibility but if you have any doubts, run them through one of the tests mentioned above.

I also wonder whether good readability and accessibility should influence the choice of magazines and newspapers you put in the patients’ lounge. Unfortunately, I’ve not been able to find any analyses of magazines and only limited information for newspapers. The National Institute of Adult Continuing Education (NIACE) did an analysis of editorials using SMOG and found average scores (in terms of years of education needed for comprehension) as follows:

- The Sun – under 14
- The Daily Express – under 16
- The Telegraph – over 17
- The Guardian – over 17

As a comparison, inputting the first three paragraphs of this article into the same SMOG calculator accessed via the NIACE website gave a result of 16.9.

Finally, when looking up information on HealthWatch – the new consumer ‘champion’ for health and social care in England – I was interested to discover (on www.cqc.org.uk) two versions of a document Preparing for HealthWatch: CQC’s plan to set up HealthWatch England. One was ‘normal’ and the other was ‘Easy to read’. Have a look at them and note the differences.

About the author

Jacqui Goss. A proven manager of change and driver of dramatic business growth, Jacqui Goss is the managing partner of Yes!RESULTS. By using Yes!RESULTS dental practices achieve an increase in treatment plan take-up, improved patient satisfaction and more appointments resulting from general enquiries. Yes!RESULTS turns good practices into great practices.

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!
I had the pleasure of attending a study day in Dorset with the Oral Health Promotion Unit of Special Care Dentistry at Dorset County Hospital NHS Foundation Trust recently. Philips were supporting the day, along with Henry Schein, Dentsply and Survival 52. The day was run by Debbie Chandler and Richard Valle-Jones.

The first speaker was Kerry Martin of Dorset People First, a charity group who support people with disability and who campaign for respect and quality treatment for their members. Kerry is herself disabled and gives a wonderful, eloquent insight into how we as healthcare professionals deal with them as patients. Embarrassingly, there tends to be common mistakes we make which make it very difficult for the patient. Kerry videoed other members of Dorset People First to help highlight the issues for the delegates. These same members offered solutions to the common problems also.

The three most common errors were:

- Talking to the patient like a child or idiot. Learning disability does not mean no brain whatsoever!
- Rushing the treatment and not explaining well what is going to happen. Not communicating effectively generally.
- Not explaining the choices well and allowing for informed choice.

“Embarrassingly, there tends to be common mistakes we make which make it very difficult for the patient”

I am so glad to report that Kerry had recently had a hygienist session where the hygienist had worked with Kerry to make sure she was comfortable and checked regularly that what she was saying was understood. She also spoke to Kerry on an equal level and that was well received also.

I then spoke on treating patients with Pervasive developmental disorders (PDD) and how to communicate and plan for successful treatment sessions. PDD is often referred to as the umbrella term Autistic Spectrum Disorders (ASD) by parents and professionals.

Here I was trying again to show the patients’ point of view and give an understanding into what can trigger a bad experience for the patient and result in no treatment being possible.

Again we looked at healthcare professionals’ assumptions of non verbal meaning not able. Non verbal patients can and do often have high understanding and should still be given the right to choose and give consent in these situations. I talked about Makaton, a simple signing, picture language to accompany speech which is used a lot for people with learning dis-
Healthcare Professionals

secure your career with a

MSc in Healthcare Strategy & Performance

The latest degree from Plymouth University Peninsula Schools of Medicine & Dentistry and Healthcare Learning Smile-on.

This course facilitates the best principles of Management, Entrepreneurship and Innovation and how this can be applied in the healthcare industry

- Part-time over two years
- Delivered using the latest technology
- Designed to fit around you

Give your future strategic DIRECTION

Learn while you work, in your own TIME

SOLIDIFY your career path

info@healthcare-learning.com
Call: 020 7400 8989
abilities. To learn more visit www.makaton.org.

I also discussed PECS – Picture exchange Communication System, and how using pictures and words to form a story book and order of treatment can reduce anxiety and increase compliance.

This topic led nicely into the third speaker of the day, Paul Greening who discussed the Mental Capacity Act. Here he discussed the learning difficulty and communication issues when it came to many patient groups, including those with dementia. With one in three over 65s going to die with some form of dementia, this is a real and relevant topic for discussion with all dental professionals, not just those in Special Needs Units. He explained the three criteria for consent very well and in an easy to understand form.

The criteria he discussed were:
• Can I understand what you are saying to me?
• Can I remember it for a period of time and weight the information?
• Can I come to a conclusion?
• Can I communicate this to you?

If the answer is no to any of these questions then you cannot assume patient consent. In this situation, you either need to seek consent from a party with authority, not always the parents, family or carers, or ask for someone to come and act as an independent on the patients behalf.

They would ask the questions and help you to come to the right choice for the patient. There are exceptions to this rule. When the patient's life is in immediate danger then the healthcare professional will be allowed to make the decision in their patient’s best interests. I would feel this would be a rare occurrence in dentistry. There are also the considerations required for when the patient was able to decide previously but is now no longer able.

That patient may have had very clear opinions on certain forms of treatment and if aware of their condition its rate of deterioration, made and Advanced Capacity for Treatments document with their attorney where they documented their wishes while still able.

All of the talks and problems they looked at were resolved with good understanding and communication with the patient. Communicating with someone with a disability and or learning difficulty cannot be achieved by speaking louder and more slowly!

The day was incredibly positive and showed a great respect and desire for good quality treatment for this ever expanding patient group. What it also highlighted to me was a need for good postgraduate lectures, workshops and training in this field to better serve us in the dental profession which in turn will better serve the patient and maintain a good level of oral health; our ultimate goal.

“‘If the answer is no to any of these questions then you cannot assume patient consent.”

About the author

Mhari Cox - Mhari has 20 years experience in dentistry, working as a nurse, receptionist, oral health advisor and ultimately hygienist in a variety of practice environments. She is passionate about her profession. At present, she works as Senior Professional Relations Manager for Philips Oral Healthcare and clinically as a hygienist in central London.

In 2006 she was the Dental Awards hygienist of the year, and was highly commended in 2010; 2011 saw her placed 15 in the Dentistry Top 50 most influential people in the U.K.
Why would you use the EndoVac?

This case report by Daniela Mancuso shows how efficient and successful the disinfection of the root canal system can be when using the EndoVac irrigation system.

I t is known that the clinician must have knowledge of not only the normal anatomy of the root canal but also its variations. Also known that the success of the root canal treatment is fully dependent on the understanding of the root canal anatomy and morphology and how the entire system is debrided, disinfected and filled. However, doubts still remain in how to be more efficient in the disinfection of the root canal system.

Various intracanal irrigant delivery devices and techniques have been described to increase the distribution of the irrigating solution within the root canal system. However, only the EndoVac combines safety, when measuring the apical extrusion of irrigants, with efficiency, when using the irrigation to debride root canals in the apical third.

This case report shows how efficient and successful the disinfection of the root canal system can be when using the EndoVac irrigation system.

**Case Report**

A 65-year-old female patient was referred for root canal treatment of 15 by her general dental practitioner. Her complaint was a “throbbing pain and a swelling” over 15 which started two months after the cementation of a new porcelain fused to metal crown (PFM).

The clinical findings, radiographic findings, and vitality tests led to a diagnosis of irreversible pulpitis, necessitating endodontic therapy. After thorough examination it was decided that the root canal treatment should be carried out through the PFM crown as it was in good conditions and the patient did not want to have the crown out. Her medical history was considered normal.

Radiographic evaluation of 15 revealed possible two narrow sclerotic canals (Fig 1). The tooth was anesthetised and isolated using the rubber dam. Access cavity was performed and the two narrow sclerotic canals were found. The pulp chamber was frequently flushed with five per cent sodium hypochlorite combined with Slick Gel ES (SybronEndo) to help the negotiation of the sclerotic canals removing debris and bacteria. Sodium hypochlorite was delivered into the pulp chamber with the EndoVac and the Master Delivery Tip (MDT) (SybronEndo). After the establishment of the patency, working length (WL) radiograph was taken (Fig 2).

A crown down technique was performed using ‘Twisted File’ (SybronEndo) and a thorough irrigation was performed with the EndoVac and the MacroCannula. The final irrigation was performed with the EndoVac and the MicroCannula according to the final sequence in each canal (Fig 3):

1. Place MicroCannula to full WL, and deliver NaOCl from MDT for 10 seconds. Stop delivery and watch for MicroCannula to suction (PURGE) all NaOCl from the canal.

Why would you use the EndoVac?

This case report by Daniela Mancuso shows how efficient and successful the disinfection of the root canal system can be when using the EndoVac irrigation system.

---

**Clinical**

November 12-18, 2012

---

**SybronEndo**

the UK’s Premium Endodontic Conference

Friday 1st February 2013

Experience some of the world’s greatest speakers in a breathtaking setting

Innovate with a brand new format of lectures

Network with your peers and speakers over a fantastic lunch and drinks reception

First 50 delegates to sign up enjoy the ultimate lunch and learn with our speakers

G. John Schoeffel  
Gary Glassman  
Simon Cunnitngton  
Gianluca Gambarrini

---

Book now to secure your place

The conference will be held in the exclusive Altitude 360° Altitude 360°, 29th Floor, Millbank Tower, 21-24 Millbank, London, SW1 4QP

Places are limited, book now with Smile-on on call 020 7400 8989 or email info@smile-on.com
Repeat previous step again.

Again deliver NaOCl for 10 seconds - BUT - instead of purging, quickly remove the MicroCannula while the MDT continues to deliver NaOCl. This is referred to as “charging” the canal.

Let the NaOCl work for at least 60 seconds (passive wait) before proceeding to the next step.

Place MicroCannula to full WL and deliver EDTA from MDT for 10 seconds, leaving the canal filled (charged) with EDTA for 60 seconds.

Place MicroCannula to full WL and deliver NaOCl from MDT for 10 seconds. Stop delivery and watch for MicroCannula to suction (purge) all NaOCl from the canal.

Repeat previous step for another 10 seconds.

Repeat again, but after delivery for 10 seconds remove the MicroCannula immediately before removing the irrigant from the canal, leaving the canal filled (charged) with NaOCl.

Let the NaOCl work for at least 60 seconds before proceeding to the next step. While waiting, fitting of a gutta-percha point is optional.

Place MicroCannula to full WL for at least three seconds.

Conform canal is dry or continue drying with paper points.

An alternative sequence can be followed to shorten the time if the canal irrigation is done at the same time in both canals (Fig 4).

Both canals were obturated in the same visit with gutta-percha and Sealapex (SybronEndo) using the Elements Obturation Units (SybronEndo) for continuous wave of condensation. The complexity of the root canal anatomy can be seen in the final X-ray (Fig 5).

Patient was seen after one week for a final composite filling and she reported she had not experienced any pain since the obturation.

Discussion

Indispensable procedures such as the correct location of the canals, thorough debridement, efficient cleaning, precise obturation and good restoration are paramount for the success of the root canal treatment. Vertucci reported that a considerable number of failures could be assigned to anatomical variations, such as the presence of canals not usually found.

Other authors, although they agree with Vertucci’s report, also consider most of the failures related to an inefficient cleaning. It is generally believed that the major cause of failure is the survival of microorganisms in the apical portion of the root- filled tooth.

Therefore, many studies have been done to see which system can clean better this apical portion. Recent studies have shown that the apical negative-pressure irrigation system EndoVac (SybronEndo) is more effective in removing smear layer from the apical third resulting in significantly less debris and consequently producing better disinfection at the apical third of root canals than current irrigation methods using positive pressure or conventional needle irrigation \(^{1,2}\).

Heilborn et al.\(^{3}\) also showed in their histology study that the apical negative-pressure irrigation system EndoVac has the potential to achieve significantly better root canal cleaning at the apical third of root canals and in less volume and exposure time than required with traditional positive-pressure irrigation. Saber and Hashem\(^{4}\) compared the smear layer removal after final irrigant activation with ANP and MDA resulted in better removal of the smear layer than with MDA or PI.

Another concern when cleaning the apical third is the extrusion of irrigation solution beyond the apical constriction resulting in post-operative pain. It is known that Sodium hypochlorite can cause severe tissue irritation and necrosis if extruded into the periodontal ligament space. Therefore, many studies were done and different delivery techniques were discussed to reduce this potential risk. Desai and Himel\(^{5}\) concluded in their study that the EndoVac did not extrude irrigant after deep intracanal delivery and suctioning the irrigant from the chamber to full WL and deliver NaOCl from MDT for 10 seconds. Stop delivery and watch for MicroCannula to suction the irrigant from the canal (Fig 4).

References

5. Mitchell RP, Yang SE, Baumgartner JC. Apical extrusion of irrigant from the chamber to full WL and deliver NaOCl from MDT for 10 seconds. Stop delivery and watch for MicroCannula to suction (purge) all NaOCl from the canal.
6. Let the NaOCl work for at least 60 seconds (passive wait) before proceeding to the next step.
7. Place MicroCannula to full WL and deliver EDTA from MDT for 10 seconds, leaving the canal filled (charged) with EDTA for 60 seconds.
8. Let the NaOCl work for at least 60 seconds before proceeding to the next step. While waiting, fitting of a gutta-percha point is optional.
9. Place MicroCannula to full WL for at least three seconds.
10. Confirm canal is dry or continue drying with paper points.

About the author

Dr. Daniela Mancuso BDS, MSc, PhD. Specialist in both Endodontics (in Brazil) and Prosthodontics (in Brazil) and in the UK is Clinical Lecturer at Queen Mary University of London (UK), at University of Warwick (UK) and other university lecturers at Sao Paulo State University (Brazil). She is also part of the multidisciplinary team at the Westminster Centre for Advanced Dentistry, UK and at CastleView Dental, UK.
High lip line treatment: a case study and recent developments

Dr Peter JM Fairbairn BDS (Rand) looks at the treatment of high lip lines

The move to less invasive treatment options in aesthetic Dentistry driven by GDP-provided orthodontic programs has been a step forward in patient care, supported by the British Academy of Cosmetic Dentistry (BACD). The straighten and whiten mantra (Figs 1 and 2) with associated composite bonding is the future but there are still complex issues and the extreme high lip line (more than 5mm of visible gingivae above the laterals on smiling hard, Fig 5) or “Gummy” smile is one of the most difficult to treat.

“Expectation is merely premeditated disappointment” this is the pervading fear in all aesthetic treatment plans, especially the more complex cases

“Expectation is merely premeditated disappointment” - this is the pervading fear in all aesthetic treatment plans, especially the more complex cases. Social media and an increase in appearance-driven trends has raised our patient expectations which can be difficult to sate in these, the most challenging of aesthetic cases.

Balance (Fig 4) is the key to achieving both our own, and our patients’ desires, especially in high lip line cases where even at rest all of the anterior teeth may be visible. Thus in these cases, achieving balance in the soft tissue can see a beneficial result.

There are many ways to achieve this balance; either orthodontically, by gingival contouring, or crown lengthening (hard and soft). Orthodontics is the least invasive method, and with the use of the Inman Aligner introduced five years ago by Dr Tif Qureshi, this option to improve the tissue balance is routinely utilised. This can be done in as little as four weeks (Fig 5) and as we see in this case where the patient did not want any surgery, the balance has been improved.

For more information or to place an order in the UK please call 0800 169 9692 or in Ireland please call +44 1438 245000

email sales.uk.csd@carestream.com

or visit www.carestreamdental.co.uk

© Carestream Dental Ltd., 2012.
The aetiology of the extreme high lip line is often multi-factorial, a combination of the four main causes. Skeletal deformity often leads to the most difficult cases and they are often associated with another of the main causes, muscular hyper-activity, which can result in an unsatisfactory outcome even after orthognathic surgery. The other factors are over-eruption which can with difficulty be treated with orthodontic intrusion and finally merely a short upper lip which is rare.

Treatment modalities for these cases can be divided into non-surgical and surgical. Non-surgical solutions are orthodontic intrusion mainly in younger patients but this can be difficult and needs specialist attention. The use of Botulinum Toxin is the other solution and here the use of 40 units, 15 at each corner (for levator labii superioris alaeque nasi) of the nose (Fig 6) and 10 units in the centre (for depressor septi). Whilst good results can be achieved in the muscular hyper-activity group, it appears to wear off in three months and it has been noticed that on further applications the effect may not be as satisfactory.

Surgical solutions are orthognathic surgery, surgical crown lengthening and finally lip repositioning surgery. The first requires a specialist team and is generally only suited for the most extreme cases as long-term side effects such as paraesthesia are a possibility. It has also been seen that even after hard tissue correction further soft tissue work (lip repositioning) may be needed for the desired aesthetics.

The last two surgical modalities only need GDP or Perio-odontist skills and are both low risk, low pain solutions although crown lengthening may require extensive dental restorative processes. They can be used together but the biology must be respected and a minimum of 5mm of attached gingiva must be retained (Figs 7 and 8).

Case
This 26-year-old patient fitted in with the type seen routinely; 95 per cent of the cases seen are young females who all show the same photographs of their smiles when at a social function (un-restrained and under the influence of alcohol) which they really dislike to the point of having developed a habit of covering their mouth with a hand when smiling hard. Seeing a case or two every week the same features and characteristics are repeated and there is an immense effect on these patients psychologically, with some even having discussed events of bullying.

In these cases there is often...
described a solution for a problem and time is needed at consultation to clearly discuss all the issues as expectations are naturally very high. This is why the most important phase is the consultation and consent phase as all cases are different and some will (as it is a soft tissue procedure) have more relapse than others. This is an important point to remember as post-surgery the patient will have the smile they dreamt of but some may relapse, which may in turn lead to disappointment even if it is still much better than the original situation. For this reason it is highly advised to keep photographic records. Colleagues should also be aware that the desire to help desperate patients can cloud case judgment, and it is felt that the vast majority of patients have fulfilled the patients expectation but follow-up is complicated by the distance most patients have to travel.

Case assessment and selection as well as careful consent procedure is critical in under-

Even at rest the patient exhibited 5mm of gingivae (Fig 9) and when smiling hard (Fig 10) she showed why this is often more reconstructive than aesthetic surgery. This also shows why it is important that we straighten and whiten these cases as patient’s teeth are always on show and thus need to be an asset.

After consent we can then proceed with the surgery and always begin with a chlorhexidine mouthwash. The distal buccal corridors are packed with gauze to prevent blood seeping back and with a scalpel (number 15 blade) start with the incision on the mucosa of the inner surface of the lip first using a brushing stroke so as to merely cut the surface. Starting at the frenum and making an ovoid shape to the canine area (we used to go back further but now see benefits of making a shorter deeper ovoid) then make the second incision at mucro-gingival margin back to the frenum. The surface mucosa then may be peeled off (Fig 11, another case) and then repeated on the other side until you have the full ovoid removed (Fig 12). This is then sutured together finely yet tightly using 5.0 silk interrupted sutures, remembering to always start at the centre to assure correct assimilation of the borders.

The patient must not use any excessive lower facial expressions in the two weeks curing period following the treatment. After this point the remaining sutures are then removed (some fall out after 10 days). The patient is then shown the result and it is recorded and again asked to refrain from smiling for another week.

After six months the patient returned and whilst the rest position (Fig 15) and a small amount of bone removed with a round bur with the lips on hard smiling due to the shape of the teeth and position of the enamel cementum junction. A flap was then raised from 3 to 5 (Fig 13) as it always is the hard smiling expression was the same (Fig 13) as no excessive lower facial expressions were used.

Prior to the flap being re-sutured with Prolene, Electrosurgery was then used to remove the excess gingival tissue to the correct level (Fig 16) and the scar from the lip surgery can be seen. After a further three months the patient came in for a follow-up (she lived 200 miles away) and further photographic records were taken to show the case at nine months post the initial surgery. The rest position now had balance (Fig 17) and on hard smiling (Fig 18) the patient was very contented with the outcome and even consented to a full-face photograph (Fig 19) which she had declined prior to the surgery. She felt her expectation had been met, and the case was a satisfying result with very low trauma and no long-term side effects to the patient. Her new, more confident approach to life was also particularly pleasing.

Conclusion: Being a soft tissue procedure, relapse can always be an issue especially in cases with very hyper-active musculature. More than 560 cases in the last eight years it is felt that the vast majority of them have fulfilled the patients expectation but follow-up is complicated by the distance most patients have to travel.
standing our patients and their desires. More recent changes to procedure to minimise relapse in the more complex cases include using shorter but wider ovoid incisions (3 to 3 inch width), deeper connective tissue suturing (Fig 20) and Myectomies done by a plastic surgeon.

A multi-disciplinary approach to the solution of this complex emotional problem with a variable aetiology may require specialist referral as this type of solution is often the best option. We are currently working with a US Dental School, carrying out long-term research into the situation of this surgical procedure.

For further enquiries about the British Academy of Cosmetic Dentistry (BACD) and to register for the BACD 2012 Annual Conference in November:

visit: www.bacd.com, call: 0207 612 4166 or email: suzy@bacd.com

REFERENCES


About the author

Dr Peter JM Fairbairn is the principal dentist at the referral based Scarsdale Dental Aesthetic and Implant Clinic based in West London and has a special interest in surgical dentistry. He has lectured globally on surgical procedures in over 30 countries as well as written numerous articles and chapters in two published books.

He is an active member of the BACD, AAD and LDF.
Supporting diabetic patients with their oral health

A look at the Waterpik®

Dental professionals all understand the importance of good oral health. In order to maintain the best possible oral hygiene, we recommend our patients brush for at least two minutes twice a day with a fluoride toothpaste, changed every three months, and of course, visit the dentist every six months for a check-up.

But while these guidelines may be adequate for the average patient in good bodily health, for certain groups a more rigorous oral hygiene regime is required. Diabetics are one such group. According to sources, since 1996 the number of people with diabetes in the UK has risen from 1.4 to 2.9 million. This figure is expected to rise to 4 million by 2025. Not only is diabetes a serious condition affecting patients’ general bodily health, it can greatly impact upon their oral health as well.

Research would suggest that people with diabetes (either type 1 or type 2) are at a higher risk of developing oral health problems such as gingivitis and periodontitis. This is because diabetics are generally more susceptible to bacterial infection, especially if they are uncontrolled, and oral infection can start at a younger age and be more severe. As such it is vital that patients in this highly susceptible group give extra attention to their oral health.

For diabetic patients, visiting the dentist regularly becomes even more of an essential activity and regular sessions with the hygienist are highly recommended. For the best oral health outcomes, diabetic patients should include periodontal care as part of their daily oral hygiene routine.

Traditionally, dental practitioners will often recommend flossing as a useful adjunct to regular brushing. If carried out correctly, floss can still be a useful tool for some patients, however the number of cases in which floss is actually used varies. Flossing by patients is surprisingly limited. For a start, dental floss is notoriously difficult to use correctly, and for patients with dexterity problems in particular, it just isn’t suitable at all. This has led to many questions being raised regarding floss, its efficacy and its effectiveness in supporting good periodontal health.

Indeed, in a study on the benefits of floss in reducing interproximal caries, Injuoel and colleagues identified 144 different studies, of which only 10 were thought appropriate for inclusion in the final report. With the report suggesting a significant lack of evidence actually supporting the use of floss it would seem prudent then for clinicians to change the oral health message from “interdental cleaning” to “interproximal caries” and so focus chair-side education on patient preference and clinically proven outcomes. Similarly, Berkner and colleagues reported a lack of evidence for adding flossing to tooth brushing in reducing gingival inflammation and bleeding.

With this in mind, clinicians should consider the alternative products available to support patients’ oral health. Of the many different products available, one of the most effective is the Water Flosser. Although, as with most oral healthcare products, there are a number of brands available on the market, however, they don’t all provide the same scientifically verified outcomes. Furthermore it should be remembered that studies conducted on one brand are not transferable to other brands.

First developed by Water Pik in the middle part of the 20th century, Water Flossers (also known as oral irrigators or dental water jets) are a highly effective, clinically proven alternative to dental floss. Scientific evidence suggests, for example, that Water Flossers significantly reduce plaque biofilm from tooth surfaces, and the Waterpik® Water Flosser in particular has been proven to remove 99.9 per cent of plaque biofilm after only a three-second treatment. Indeed, Waterpik® Water Flossers have also been shown to reduce gingivitis, bleeding, probing pocket depth, host inflammatory mediators and calculus. This means Water Flossers are particularly suited for diabetic patients who must take particular care with their oral health.

When compared with traditional string floss, the benefits of a high quality Water Flosser are quite remarkable. In 2005 for example, Barnes et al. compared manual or power brushing alongside use of a market-leading Water Flosser with a classic jet tip to manual brushing and flossing. Results demonstrated that regardless of toothbrush used, the addition of a Water Flosser was better at reducing gingivitis and gingival bleeding compared to brushing and flossing.

In 2008, a study by Sharma et al. evaluated the efficacy of Waterpik® Water Flossers using a specialised orthodontic tip with adolescents in fixed appliances compared to flossing. Results in this study showed that the Waterpik® Water Flosser was significantly better than brushing and flossing or brushing alone for reducing plaque biofilm and gingival bleeding.

Most recently, Rosema et al. compared manual brush plus a top-selling Water Flosser with either a standard jet tip or a new prototype tip to manual brush and flossing. At four weeks, it was evident that either type of tip used alongside manual tooth brushing was significantly better at reducing bleeding than flossing. Notably, the flossing group showed no difference statistically or numerically from baseline to four weeks. The 15 per cent reduction seen at two weeks reverted back to baseline (0 per cent) at four weeks.

Given the significant weight of evidence supporting the use of Waterpik® Water Flossers, it is clear that patients from high risk groups can benefit greatly from adopting a Water Flosser into their regular oral hygiene regime. For best results, and to ensure diabetic patients receive the best possible care, clinicians should recommend brands and products that are supported by scientific evidence-based reports.

In addition to the above, Waterpik® products are widely available in Boots stores and selected Lloyds Pharmacies.

For more information on Waterpik® Water Flossers please speak to your wholesaler or visit www.waterpik.co.uk. Waterpik® products are widely available in Boots stores and selected Lloyds Pharmacies.

Luxator®

Less traumatic extractions

Specially designed periodontal ligament knives with fine tapering blades that compress the alveolar bone, cut the membrane and gently ease the tooth from the socket with a minimum of tissue damage. Available in 9 standard sizes and 5 short sizes, enabling an easier working position for smaller hands.

Luxator Kit LK4 (4 instruments) Plus FREE: Forte 3.2 worth € 62.00

Luxator Kit LK7 (7 instruments) Plus FREE: Forte 3.2 & RootPicker worth € 108.50

Contact Info

For more information on Waterpik® Water Flossers please speak to your wholesaler or visit www.waterpik.co.uk. Waterpik® products are widely available in Boots stores and selected Lloyds Pharmacies.
centreforthedentistry.com

For more information, visit www.centrefordentistry.com or email partners@centrefordentistry.com

For further information contact Clark Dental on 01268 733 146, or visit www.clarkdental.co.uk or www.clarkdentalltd.co.uk

Endodontic referrals – believe in something better

At EndoCare, we believe in something better. Our team of Specialist Endodontists all have highly qualified and passional reputations. All our referrals meet the highest standards of treatment to all our patients. Because we focus exclusively on Endodontics, all our practices are equipped to the highest standard to deal with even the most complex of cases.

By its very nature, Endodontic treatment can be a stressful, yet do and endurance to maintain high levels of standards in Endodontics.

To EndoCare you can ensure that your time is that”的 recommendation. We assure that your patient will receive immediate care and can expect the best results. The value our referring practice high and always ensure you are kept up to date through every stage of the treatment process. We will also recommend any and all follow-ups and together discuss cases, offer help and give advice on all aspects of Endodontoics and patient care.

Refer your patients to EndoCare today to find out for yourself why we are one of the most trusted names in Endodontoics.

For further information please call EndoCare on 020 724 0999 or visit www.endocare.co.uk

The All New CPRD Pro App. Verifiable CPRD at Home or on the Go.

Keeping track of your CPRD is almost a full time job in itself. Free up time and make your download today! CPRD Pro is a free app that allows you to earn verifiable CPRD using any smartphone, tablet or computer.

Designed specifically for dental professionals in the UK, the app gives you instant access to a library of quality content from some of the most highly respected names in dentistry. You can download these at your convenience or, if you get tired of everything, can contribute to our ever-expanding database and earn rewards for your efforts.

For more information visit CPRD Pro at cprd.co.uk/CPRDPro

The All New CPRD Pro App, Verifiable CPRD at Home or on the Go.

CPRD Pro is a free app that allows you to earn verifiable CPRD using any smartphone, tablet or computer.

Designated specifically for dental professionals in the UK, the app gives you instant access to a library of quality content from some of the most highly respected names in dentistry. You can download these at your convenience or, if you get tired of everything, can contribute to our ever-expanding database and earn rewards for your efforts.

For more information visit CPRD Pro at cprd.co.uk/CPRDPro

The revolutionary Powder-Free CEREC® Omnimate

The launch of the revolutionary powder-free CEREC® Omnimate from Ceramic Systems, the UK’s CEREC® Specialists, enables continuous full colour image streamlining and unique benefits of the CEREC® System even greater.

CEREC® enables practitioners to fabricate restorations exclusively using a full colour CEREC® 3D visual model, which can be used to counsel patients to create the ideal model for additional filtration or treatment of CEREC® restorations via a milling unit.

In addition, the CEREC® Omnimate and CEREC® System enable dentists to cut down their Lab Bills by up to 90%.

CEREC® enables Dentists to create high quality and durable channel all-ceramic restorations in the most effective and efficient way.

quick, efficient and easy to use, CEREC® is a computer-aided method for creating precision-fitting all-ceramic restorations. Virtually every dental laboratory it enables Dentists to design and create all-ceramic inlays, onlays, partial crowns, inlays and crowns for the anterior, premolar and molar regions in one visit.

For further information contact Ian Pinner on 01122 592405, e-mail i.pinner@ceramic-systems.co.uk or visit www.ceramic-systems.co.uk

Dental Tribute

United Kingdom Edition

November 12 - 18, 2012

28 Industry News

Dr Helen Harrison of Granta Dental, Cambridge, says: “For my new practice I decided very early on that I wanted to work with Clark Dental. From my experience working with them on my previous practice refurbishment, I knew that Dr Chris Barrow and his team would do an excellent job.

“Since February 2012, when they sorted out all the engineering issues. "I have been very impressed with the high level of service and expertise I have experienced working with Clark Dental. From the very first phone call, Chris Barrow and his team were prompt and professional.

“Given the agreed price, I was able to look at the cost of the project and immediately knew that Clark Dental would deliver the highest quality of service. The team understood my needs, worked to my building and.I was even able to discuss the project on a daily basis.

“We were really glad that we brought Clark Dental in at an early stage in the project as they became an integral part of our team. They liaised with David our architect and we worked through many problems we had to get involved. They then did all the shuffling of the equipment from the old practice as well as the installation of the new equipment. It was all immensely well planned and executed, they delivered what they promised, when they promised - invaluable!”

For more information call Clark Dental on 01268 733 146, email info@clarkdental.co.uk or visit www.clarkdental.co.uk

Centre for Dentistry

For further information, visit www.centreforthedentistry.com or email partners@centrefordentistry.com

Making your website a Google success with Dental Focus® Web Design!

Google is the world’s most popular search engine. As such, where you rank on Google search results can be a critical factor in deciding whether patients visit your website, or that of your competitors.

To help you achieve page 1 Google rankings, the experienced team at Dental Focus® Web Design can guide you in all aspects of SEO, and can advise you on best strategy for making your website a success. This includes support with keywording, blogging, linkbuilding, and social media. We can also include advice on use of analytics and other strategies to put your practice well and be found on Google Map.

With over 10 years experience working in dentistry, Dental Focus has a proven track record of success. The dedicated team are renowned for their excellent level of service, and the quality of their work with over 3200 page 1 Google rankings for 300 dentists on the free national/nongovernmental listings.

For more information on how Dental Focus can help make your practice a Google success, contact Dental Focus Web Design today!

For more information please call 020 7183 8388, or visit www.dentalfocus.com

Classic Dental can supply ‘off-the-shelf’ solutions for worktops, sinks and taps tackling the major areas of compliance, leaving Practitioners free to concentrate on Dentistry. Many Classic Dental products are suitable for the smallest spaces to complete new builds. These Classic Dental ranges feature quality post-formed worktops, PVC-edged doors and carcass fronts, quality sinks and mixer taps; all designed on a bespoke basis. CDC can include split height designs for saprophyte argonics, custom instrument drawers which lock in the open position, custom suction-motor housings, CVT tip support modules, twin storage and single gangway runners for smaller surgeries.

CDC Classic Dental is extremely competitively priced and available either ‘supply only’ or with full installation support. Like the remainder of the Classic Dental range it is designed to suit every budget without compromising on form or function.

For further information email Classic Dental Clay Ltd on info@classicdentall.co.uk or visit www.classicdentall.co.uk

“Less than £1.39 per 100 wipes”

This is an excellent time to try ChariSafe® Alcohol-Free Economy Wipes. Buy 600 wipes before the end of October for £38.00 + VAT. These mean these wipes are available at less than £1.39 per 100 wipes. ChariSafe® Alcohol-Free Economy Wipes are alcohol free, yet highly effective on the newly reclassified EC regulations regarding the disinfection of medical devices, and carry the CE mark with pride!

The Alcohol free disinfectant used with ChariSafe® Economy wipers adorbs and penetrates into the cell wall of bacteria, fungi and the envelope of viruses. It attacks the phospholipid membrane, altering its structure-causing disorganisation and death. These wipes have a sheet size of 24cm x 14.5cm providing a highly effective 99.9% reduction in HIV, HBV and HCV viruses. It is attacks the phospholipid membrane, altering its structure-causing disorganisation and death. These wipes have a sheet size of 24cm x 14.5cm providing a highly effective 99.9% reduction in HIV, HBV and HCV viruses. It attacks the phospholipid membrane, altering its structure-causing disorganisation and death.

For further information on the full range of Kentend disinfectants, CharlSafe®, PractiSafe®, PractiSafe® Soak and InstrumentSafe® visit the Kentend website www.kentend.co.uk. For further information on special offers or to place orders call Helen on 01795 770256 or visit our website www.kentend.co.uk

Classic Dental has a proven track record of success. The dedicated team are renowned for their excellent level of service, and the quality of their work with over 3200 page 1 Google rankings for 300 dentists on the free national/nongovernmental listings.
Spry Toothgel with xylitol – the perfect way to keep children's teeth clean from an early age.

We all know it's important parents introduce their children to good oral hygiene habits from an early age.

Spry Toothgel is effective against dental caries by helping the body’s natural ability to proliferate and adhere. This makes xylitol an excellent tool in the fight against dental caries.

Based on all-natural ingredients, Spry Toothgel is completely safe for infants and young children. It is non-toxic and gentle enough to be used by children as young as 2 years of age.

Available in a handy 60ml tube, Spry Toothgel is a great way to introduce your children to the joy of regular brushing.

For further information contact Anyone 4 kids Ltd on 01428 652131, or visit www.anyone4kids.com
The completed case includes: technical side. You will pay one single price for any restoration, which includes everything you require on the inner/outer template. Customised Implant Abutments provide an accurate fit and a perfect anatomical match, ensuring the best possible aesthetic and functional outcome.

All The Elite Service Promises
- Fitting Screw
- Laboratory Analogue
- Soft Tissue Model
- Any Elite Restoration
- Hybrid Zirconia-Titanium Abutment

Choose Any Elite Restoration from:
- Full Metal Crown
- ZirconArch
- ZirconiaFC®
- e.max PFM
- Ceramic Veneer
- Copings
- Fitting Screw

With customised zirconia abutments, we can tailor the full implant restoration to your patient. We also offer a wide range of other options to enhance the overall result. Contact Costech Implant Centre Today for further information and to discuss your specific needs.

£250 All For Just per unit 'CosTech Complete'

March 2012, CosTech is proud to launch the Complete Restoration Solution. This comprehensive package includes all the necessary components for a successful implant restoration, ensuring that you can focus on delivering the best care to your patients without the hassle of managing multiple suppliers.

No Hidden Charges!

Savings you up to £100 per unit with the 'CosTech Complete' package, compared to stock prices. Lab Crown and charges: £185 Stock abutment + Screw: £140 Total: £350 Lab Analogue: £25

*Based Average Prices with ZirconArch

Dental Tribune UK Ltd

Follow us on Twitter
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

---

**SmileGuard**

SOMETHING TO SMILE ABOUT

CUSTOM-FITTING MOUTHGUARDS
The best protection for teeth against sporting oro-facial injuries and concussion.

NIGHTGUARDS
The most comfortable and effective way to protect teeth from bruxism.

BLEACHING TRAYS
The simplest and best method for whitening teeth.

SNOREGUARDS
Snugly fitting appliances to reduce or eradicate snoring.

OPROREFRESH
Mouthguard and tray cleaning tablets.

FOR MORE INFORMATION VISIT WWW.SMILEGUARD.CO.UK

EMAIL INFO@SMILEGUARD.CO.UK OR CALL 01442 430694

---

**PFM Dental**

Selling Your Practice?

- Professional Sales Agency
- Practice Valuations
- Nationwide Service
- Register of Buyers

Telephone: 01904-670820
Email: martyn.bradshaw@pfmdental.co.uk
Web: www.pfmdental.co.uk

---

**Mizrahi Dental Teaching**

Dr Basil Mizrahi

S.S.B.D., D.M.D., M.S., Clinical Periodontics (M.D.)
Clinical Lecturer, Esthetic Dentistry
Diplomate, American Board of Periodontics
Diplomate, American Board of Oro-Facial
Diplomate, International Board of Periodontology & Implant Dentistry

Unique opportunity for practical learning in small groups by Dr Mizrahi, one of the leading practitioners in the field

Variety of advanced teaching options available

1. Advanced Aesthetic and Restorative Dentistry
   - Hands-on course
     - 10 Fridays, 9.30 – 4.30, Jan-July, CPD=50 hours
     - Limited to 16 delegates
     - Practical, clinically relevant teaching
     - High quality video of live procedures
     - Cost £5000 for complete
     - £200/day for modules

2. Master Classes with Live Patient Treatment
   - Level 1 – Crown and bridge patient treatment
   - Level 2 – Treatment of your own patient under supervision
   - New State-of-the-Art Facility

3. Treatment Planning Study Club
   - Meet 3 times/year, Friday, 9.30-1, 3, 6pm/year

www.mizrahi-dental-teaching.co.uk

---

**SmileGuard**

SmileGuard is part of the OPRO Group, internationally renowned for revolutionising the world of custom-fitting mouthguards. Our task is to support the dental profession with the very latest and best oral protection and thermoformed products available today.

---

**PFM Dental**

Selling Your Practice?

- Professional Sales Agency
- Practice Valuations
- Nationwide Service
- Register of Buyers

Telephone: 01904-670820
Email: martyn.bradshaw@pfmdental.co.uk
Web: www.pfmdental.co.uk

---

**Mizrahi Dental Teaching**

Dr Basil Mizrahi

S.S.B.D., D.M.D., M.S., Clinical Periodontics (M.D.)
Clinical Lecturer, Esthetic Dentistry
Diplomate, American Board of Periodontics
Diplomate, American Board of Oro-Facial
Diplomate, International Board of Periodontology & Implant Dentistry

Unique opportunity for practical learning in small groups by Dr Mizrahi, one of the leading practitioners in the field

Variety of advanced teaching options available

1. Advanced Aesthetic and Restorative Dentistry
   - Hands-on course
     - 10 Fridays, 9.30 – 4.30, Jan-July, CPD=50 hours
     - Limited to 16 delegates
     - Practical, clinically relevant teaching
     - High quality video of live procedures
     - Cost £5000 for complete
     - £200/day for modules

2. Master Classes with Live Patient Treatment
   - Level 1 – Crown and bridge patient treatment
   - Level 2 – Treatment of your own patient under supervision
   - New State-of-the-Art Facility

3. Treatment Planning Study Club
   - Meet 3 times/year, Friday, 9.30-1, 3, 6pm/year

www.mizrahi-dental-teaching.co.uk

---

**SmileGuard**

SOMETHING TO SMILE ABOUT

CUSTOM-FITTING MOUTHGUARDS
The best protection for teeth against sporting oro-facial injuries and concussion.

NIGHTGUARDS
The most comfortable and effective way to protect teeth from bruxism.

BLEACHING TRAYS
The simplest and best method for whitening teeth.

SNOREGUARDS
Snugly fitting appliances to reduce or eradicate snoring.

OPROREFRESH
Mouthguard and tray cleaning tablets.

FOR MORE INFORMATION VISIT WWW.SMILEGUARD.CO.UK

EMAIL INFO@SMILEGUARD.CO.UK OR CALL 01442 430694

---

**PFM Dental**

Selling Your Practice?

- Professional Sales Agency
- Practice Valuations
- Nationwide Service
- Register of Buyers

Telephone: 01904-670820
Email: martyn.bradshaw@pfmdental.co.uk
Web: www.pfmdental.co.uk

---

**Mizrahi Dental Teaching**

Dr Basil Mizrahi

S.S.B.D., D.M.D., M.S., Clinical Periodontics (M.D.)
Clinical Lecturer, Esthetic Dentistry
Diplomate, American Board of Periodontics
Diplomate, American Board of Oro-Facial
Diplomate, International Board of Periodontology & Implant Dentistry

Unique opportunity for practical learning in small groups by Dr Mizrahi, one of the leading practitioners in the field

Variety of advanced teaching options available

1. Advanced Aesthetic and Restorative Dentistry
   - Hands-on course
     - 10 Fridays, 9.30 – 4.30, Jan-July, CPD=50 hours
     - Limited to 16 delegates
     - Practical, clinically relevant teaching
     - High quality video of live procedures
     - Cost £5000 for complete
     - £200/day for modules

2. Master Classes with Live Patient Treatment
   - Level 1 – Crown and bridge patient treatment
   - Level 2 – Treatment of your own patient under supervision
   - New State-of-the-Art Facility

3. Treatment Planning Study Club
   - Meet 3 times/year, Friday, 9.30-1, 3, 6pm/year

www.mizrahi-dental-teaching.co.uk
Love Handpieces?
Love Synea Fusion

Special Offer valid from 1st October to 31st December 2012

Life is full of surprises!

NEW Synea Fusion

A synthesis of design, technology and value

Great performance at a great price, with proven quality and reliability!
The new range of Synea Fusion builds on the already established and respected reputation of the W&H Synea brand. New for 2012, Synea Fusion offers a full range of quality handpieces at an exceptionally attractive price.

Special Launch Offer
Buy any 3 Synea Fusion Handpieces get a 4th FREE

All with 2 Year Warranty

From Only £490 RRP

W&H (UK) Ltd, 6 Stroud Wood Business Centre, Park Street, St Albans, AL2 2NJ
Tel: +44 (0) 1727 874990 Fax: +44 (0) 1727 874528 Email: office.uk@wh.com
www.wh.com

Information is correct at time of publication and relates to W&H products and services available in the UK and Ireland. Prices are quoted in £ sterling and are subject to VAT at the prevailing rate. Offers valid from 1st October to 31st December 2012, excluding BDIA Dental Showcase. These offers cannot be used in conjunction with any other offers.

E & O E.