Regulator flexes inspection muscles
Practice in Cheshire set to come under CQC spotlight

The sudden closure of the West Street Dental Practice in Congleton, Cheshire follows a series of events, one being a CQC inspection that identified major concerns in six come areas and another concerning the termination of its contract with the Central and Eastern Cheshire Primary Care Trust.

The major areas of concern ranged from the care and welfare of people who use the services; cleanliness and infection control; safety, availability and suitability of equipment and requirements relating to workers and staffing and supporting staff. The inspectors informed the practice that it was not meeting essential standards and must improve.

During the CQC inspection no evidence was discovered to show false teeth were disinfected before fitting or that impressions taken of people’s mouths were disinfected before sending to the laboratory. Bags of clinical waste were overfilled and split and stored near clean items, there was an X-ray machine in poor condition and inspectors also discovered that there was no device installed to prevent mercury getting into the waste water system.

The Central and Eastern Cheshire Primary Care Trust had been working closely with the staff at the dental practice for three years, however despite their best efforts and the offer of a Capital Grant, the PCT stated that Mr Setumo Madiehe, the principal dentist at the practice, was unwilling and unable to make the necessary changes; the decision was therefore made to terminate his NHS dental contract.

CQC regional director Sue McMillan said: “What we found at this practice is extremely concerning and we’re confident any patients using this service would share our concerns.

“This is the first time we’ve had major concerns about a dental provider, with this group only recently having come under regulation by the CQC. It is cases such as these that show the value of regulation.”

In the Congleton Chronicle, it was stated that the notification of the practice’s closure to patients was a sign on the West Street Dental Practice door explaining that the practice had been closed on a “permanent basis” and that the PCT had terminated its contract with them.

However, the Dental Commissioning Manager at the PCT has confirmed that other NHS dentists in Congleton, Crewe, Sandbach and Macclesfield had been found to see the patients that had been under treatment with Mr Madiehe. Patients would not be disadvantaged by having to pay for a new course of treatment with another dentist, as the PCT covered this cost.

A spokesperson from the PCT said: “The PCT is committed to ensuring that all patients who are currently under treatment with this practice are provided with an alternative NHS dental service to enable them to complete their course of treatment.

“The PCT will also ensure that this current loss of NHS dental service provision in Congleton will be provided again in the near future.”

Medical miracle
Mother gives birth after cancer treatment

Crisis campaign
Laura Hatton speaks with a Grissi volunteer

Holistic treatment
Mhurti Coxon discusses periodontal diseases

Dental retirement
Leo Briggs discusses retirement issues
Dental Tribune: United Kingdom Edition • November 28–December 4, 2011

2 News

Confusion continues over risks of chewing and smokeless tobacco

Despite high levels of public awareness of the risks of smoking tobacco, confusion continues about the dangers of using smokeless or chewing tobacco.

New research undertaken with a large sample of British South Asian origin indicates that nearly 80 per cent are unsure or underestimating the harmful effects of using smokeless or chewing tobacco. Smokeless tobacco is used widely in South East Asian communities, especially by women.

The research found that more than one in six (17 per cent) people of Asian ethnic origin used smokeless tobacco. Smoking of normal tobacco was only slightly higher at 22 per cent. Approaching a third of respondents (29 per cent) considered smokeless tobacco to be less harmful than normal tobacco and just under a quarter (24 per cent) did not know. In reality, smokeless tobacco is more dangerous and the incidence of mouth cancer is significantly greater among South Asian women.

The types of smokeless tobacco products most used in the UK often contain a mix of ingredients including slaked lime, spices, flavourings and sweeteners. Arvica nut — a known carcinogen — is also sometimes added. Unlike normal tobacco they are not burnt, but can be used in a variety of ways including sucking, chewing, inhaling through the nose or rubbed onto gums. Gutka, Khaini, Pan Masala, are just some of the many varieties of smokeless tobacco used in the UK.

Despite the higher risk of mouth cancer in South Asian communities, less than ten per cent of respondents said they had ever asked their dentist to check for mouth cancer.

The British Dental Health Foundation conducted the survey in the run up to Mouth Cancer Action Month, which began on 1st November. Smokeless tobacco, along with smoking, drinking alcohol to excess, poor diet and some sexually transmitted infections (Human Papilloma Virus) are some of the many factors for mouth cancer which is likely to affect 60,000 people in the UK over the next decade.

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, said: “More work needs to be done to improve our knowledge about the usage of smokeless tobacco and the best ways of communicating clear messages to remove the ongoing confusion about the risk of smokeless tobacco. Education is key and we hope Mouth Cancer Action Month will provide an opportunity for everyone living and working in South East Asian communities to raise awareness.”

“It is really important that everyone knows the warning signs for mouth cancer. They include ulcers which do not heal within three weeks, red and white patches in the mouth and unusual lumps or swellings in the mouth. Our message to everyone is ‘If in doubt, get checked out’.”

Recognition of peers

Orthodontist takes on the Chairmanship of Health Watch

At a recent meeting of the charity Health Watch, consultant Orthodontist and long term BOS member Keith Isaacson, who has been a member of Health Watch virtually since its inception in 1992, was elected as Chair.

However even though when he joined almost a decade ago it was called ‘Quack Busters’ (the name was changed to a more formal title when it became a charity) its aim is still to ensure that media coverage of evidence-based medical treatment is accurate.

Health Watch awards an annual prize to a clinician, researcher worker or journalist who is considered to have made a significant contribution to the public awareness of untreated and untreated conditions, whether mainstream or complementary. At the presentation of the 2011 Annual Health Watch Award, Dr Fiona Godlee, the President of Health Watch handed a silver salver to this year’s winner - Brian Deer.

In his acceptance speech Brian Deer explained very clearly how Dr Deer had gathered together parents of children with Autism and presented them with the idea for the MMR scandal and the part played by Dr Andrew Wakefield.

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Editorial comment

Is it me or is it silly season for conferences and meetings? Looking back at my calendar and I can see that I haven’t spent more than three days a week in the office due to a conference or meeting in the last month. To many people they would say excellent, but my inbox is saying ‘give me a break!’.

Despite this it has been an interesting time visiting meetings such as the BACD annual conference and the BSDHT annual meeting. Not only do I get to network with many of the companies who support these events with their time and their products, but I get the rare chance to speak to delegates, many of whom read Dental Tribune and the specialist titles we produce in the areas of implants, aesthetic dentistry and endodontics. It is great to get feedback from readers, both the good and the not so good, this allows me to see the bigger picture in what we are producing as it is very easy to hide in a little publishing bubble and pretend you know what your readers want!

So if you get a minute, I’d love to hear what you think about Dental Tribune – drop me an email and let me know! Lisa@dentaltribuneuk.com...

Apprentice scheme launched

A major initiative to recruit more than 100 apprentices throughout England in the next 18 months has been launched by national dental organisation Genix Healthcare Limited. The programme aims to promote the dental profession and support the need for qualified and highly skilled dental nurses.

The programme will provide comprehensive training support for candidates for as long as three years, taking them through to achieve a level three qualification. The first stage will work towards an Intermediate Level Apprenticeship in Customer Service. After an induction candidates will work in a practice and have the opportunity to progress to an Advanced Apprenticeship in Dental Nursing (level three). This will involve spending up to 18 months ‘chair side’ in a dental surgery.

Well known life coach and trainer to the dental profession for over 16 years, Chris Barrow, will be supporting the apprentices with customer service training. He said, “People must learn at an early stage how to converse with the world effectively. As a passionate advocate of communication skills and customer service training I am delighted to be supporting this remarkable initiative.”

Sian Nelson-Jones, clinical director of Genix Healthcare said: “This is a rare opportunity for individuals to get a great start in dentistry. Genix Healthcare has built a strong reputation in the industry and spending three years with us will heavily support their career credentials with the prospect of a permanent position with us. They will be working in stylish, modern practices, equipped with all of the latest technology, and learning from talented professionals who really care about their work and about passing on their skills to others.”
Mouth cancer campaigners believe that many sufferers are being treated unequally and face years of having to fund their own restorative dental treatment.

People with mouth cancer have no guarantee to receive restorative treatment paid for by the NHS. Mouth cancer sufferers are exempt from inequality to be put right in the campaigners are calling for the NHS dentists is hindering improvements in mouth cancer survival rates. Many NHS patients have no guarantee to receive the same level of treatment and support as any other cancer patient.”

Mouth cancer campaigners are also concerned about the lack of free examination for mouth cancer from NHS dentists is hindering improvements in mouth cancer survival rates. Many NHS patients have to pay to have a mouth cancer check – a condition which kills more than cervical cancer and testicular cancer combined each year.

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, said: “Early detection is particularly important to survive mouth cancer. Compared to other cancers, the survival rates for mouth cancer have only marginally improved over the past decade. We hope Government will take a closer look at the current policy and develop new NHS dental commissioning arrangements which actively support early detection of mouth cancer. This commitment would be a major step to save the lives of 30,000 mouth cancer sufferers over the next decade.”

A recent YouGov survey of 1,495 cancer patients for Macmillan Cancer Support has already highlighted the financial hardships of many cancer sufferers. The survey found that two thirds (66 per cent) reported an increase in costs as a result of travelling to hospital and/or an increase in household expenses. The survey also found that nearly a third (29 per cent) of those financially affected have spent all or some of their savings, and nearly one in ten (9 per cent) have borrowed money to cover the additional costs of cancer. For some mouth cancer patients, this is just the tip of the iceberg.

Orthodontist receives MBE

On 3 November 2011 Chris Kettler, (pic
tured), Specialist Orthodontist and Past Honorary Secretary of the British Orthodontic Society was invited to receive his MBE from Her Royal Highness Princess Anne. Following the investiture Chris offered his thoughts about the honour and about the experiences which led to this event.

“I was really proud and delighted to attend the Investiture at Windsor Castle on 3rd November 2011, with two of my sons, to be presented with the MBE by Princess Anne. The citation was “for services to orthodontics”. I am also especially proud for our specialty of orthodontics and the BOS, I believe this is recognition of all we have achieved together in the BOS during the past thirty five years.

“When I started in orthodontic practice, the arrangements for providing orthodontics in the GDS were unbelievably ludicrous... Over the years, there was some relaxation of the rules but the fundamental situation remained unchanged. When the opportunity arose to design a PDS Pilot for orthodontic provision through the initiative of the Consultant in Dental Public Health in Bedfordshire, I could not resist.

“Prior to Unification, the BDA, the DH, the GDC and other bodies would pick off the separate Orthodontic Societies one by one. The founding of the BOS in 1994 brought immediate political benefits and other bodies were suddenly keen to talk to us. It is a fact that the inclusion in our membership of 490 GDPs was very helpful in the political acceptance of the BOS.

“Has it been hard work? Yes, but it has been immense fun. I have had great fellowship working with fellow orthodontists towards the same goals. It has been immensely frustrating at times but wonderfully rewarding when we achieve our aims. I have met so many people in orthodontics and other areas of dentistry, both in the UK and abroad. It has been so much better to be involved, and at least to understand why we are making slow progress, than to stay at home, being frustrated by the system and doing nothing about it.

“I hope my narrative will encourage other members of the BOS to come forward to work for the Society. We must continue to work to preserve what we have achieved and there is still much to do to improve the provision of orthodontics in our country both for patients and for orthodontists. Don’t wait to be asked. If you know someone talented but reticent, nominate them.

“I thank everyone in the Society for their fellowship over these many years and I thank all those in the Society who sponsored me for the award. We can all take pride together.”

Watchdog faces DH investigation

The CQC has once again come under fire after a series of allegations which could have risked patient health. Concerns are continuing to mount over patient care and recent reports have stated that to address the issue state health secretary, Andrew Lansley, is considering reforming NHS regulation and the Department of Health have launched an investigation into the running of the watchdog.

This course of isn’t the first time the issue of neglect has been raised. As the attention of officials; in September the CQC was accused of neglecting its core duty of patient care in favour of its duty around registration of care providers. Such incidents have led to a level of mistrust between the governing body and the healthcare professions and many are questioning the CQC’s purpose.

Even still, in response to past claims that the CQC have failed to investigate concerns, the regulator has argued that they are not inadequately funded and have asked the government for a reported £1.5m for a new regime and to boost its inspection workforce.
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Small things. Big difference.
A British mum has made medical history after successfully giving birth having had chemotherapy cancer treatment during her pregnancy.

Mum-to-be Sarah Best, 30, was diagnosed with mouth cancer when she was four months pregnant and was told that if she didn’t opt to have radiotherapy the cancer was sure to spread.

As Sarah underwent radiotherapy and chemotherapy treatment to treat the mouth cancer two five-cm thick lead shields were used to protect baby Jake from the radio waves.

But what is most incredible about this story is that Sarah unexpectedly gave birth to a healthy baby boy just hours after receiving her last course of radiotherapy.

“I was devastated when I was told I had cancer,” said Ms Best, who had an operation to remove a tumour from her tongue, was quoted saying in The Telegraph.

“The surgeons managed to remove most of it but they said they saw specks of cancer cells on my lymph nodes.

“I thought pregnancy was supposed to be the happiest time. You’re supposed to feel wonderful.

“I was really worried about the effect the radiotherapy could have on the baby but the doctors said the lead shield would protect him.”

“I was expecting to have Jake at least a month after my treatment ended but I suddenly went into labour on the last day of my treatment.

“He is so special to us and thankfully is perfectly healthy. He is healthy, smiley and smart – I couldn’t be luckier.”

Sarah, who has described her new-born son as a “mini-miracle” has been given the all clear from cancer.

Consultant oncologist Lydia Fresco, who helped design and build the lead guard for Sarah, said in The Telegraph: “Sarah’s case was extremely rare. As far as published cases go she was the only woman with mouth cancer in the world to have this combination of chemotherapy and radiotherapy while pregnant.”

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Convenience
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Students will be able to communicate with a diverse multi-ethnic and global community of peers, with whom they will also share residential get-togethers in fantastic settings around the world.

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Colour changing toothpaste? Now you’ve seen it all...

A retired dentist from St Louis in the US has invented a toothpaste that changes colour.

Dr Howard Wright, the dentist behind the invention, says that the process, which has taken an incredible 10 years to achieve, will make children actually want to brush their teeth for longer so they can see the colour changing process happen.

“Ten years is a long time to spend fighting for your product. But if you truly believe in your invention, the fight is exhilarating,” Dr Wright, a graduate of the Washington University School of Dental Medicine, was quoted.

The magic behind the colour changing toothpaste, Vortex, is refreshingly simple, and works on the basis of simple colour mixing to make new colours. According to a report, Vortex is dispensed as two streams of blue and red toothpaste and when mixed together during the brushing process, it turns to purple.

“By brushing vigorously, kids delight in watching the toothpaste change colour,” says Dr Wright. “The colour change is accomplished not through a chemical reaction, but by simple optics.”

Vortex Toothpaste also has an emphasis on natural ingredients, and contains no sodium-lauryl-sulfate, or SLS, a common foaming agent.

“When brushing with conventional toothpaste,” says Dr Wright, “children find that the heavy foaming makes breathing through the mouth difficult, making the experience frightening. Remove the SLS, make it change colour, and you have kids wanting to brush their teeth.”

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Aquafresh has developed a range of toothbrushes and toothpastes that are specifically designed for each stage of a child’s oral development.

Aquafresh also offers a range of FREE motivational materials to reward children’s good brushing efforts, helping support your practice to deliver a positive dental experience.

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The nitty gritty truth

Laura Hatton interviews Jane Lelean, dentist, business coach and volunteer at the annual Crisis at Christmas campaign, on re-evaluating what dentistry really means

Give me a smile

I recently interviewed Jane Lelean, a dentist and international business coach and trainer, who had for the first time taken part as a volunteer dentist during Crisis at Christmas 2010.

Jane explained that for many years dentistry has been one of the services that the charity provides and although only basic treatment is available, the different it makes is priceless.

“Dentists have the unique opportunity to change someone’s life by simply changing their smile,” Jane said, “and for me this was about giving people an opportunity.”

So Jane took the leap and volunteered: “It was the best four days and a very humbling experience. The people that arrive at the centres are just normal people. One person in particular on Christmas day didn’t eat and when I found out why it turned out that he was fasting so he could understand how much he actually had. Everyone there is so conscious and appreciative of what’s being given to them.”

Understandably, not every homeless case is the same: “There was a person in a wheelchair who was just really angry,” Jane explained. “He’d previously broken his back in an accident and could no longer work, meaning he was unable to afford to pay his rent. He was made homeless the day before Christmas Eve.

“He really had a problem with being homeless and he kept saying that he didn’t want to be here next year. There was so much anger behind those words, so I kept asking him: What do you want to do then? And he just kept repeating that he didn’t want to be here again and again.

“I don’t know what happened but suddenly he changed his way of thinking and announced that next year he was going to come back as a volunteer and lead a carol service; he then broke out in song and it was simply incredible.”

Smiling as she let her mind drift back to that moment, Jane enlightened me on how charitable dentistry is different compared to dentistry in a dental practice. “Putting aside the fact that you don’t have all the equipment or a typical surgical environment around you, the people you treat are incredibly grateful, much more than your usual patients. It really feels like you’re treating people and not just patients. They’re so grateful.”

“We even got referrals. People were seeking me out to say thank you, and others were telling their friends about their experience and coming to see us.

Hygienist’s dream

“Usually the work we carried out was a simple case of cleaning people’s teeth, but what I found most amazing was that they actually asked for floss! How many patients normally ask for interdental brushes?! It really is a hygienist’s dream!”

Even Mary Farnell, a long-time volunteer, had said in a Crisis press release how “watching a group of chemically dependent guests in rapt attention while being told about interdental cleaning was a revelation.”

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Approximately 6,000 people in the UK annually are diagnosed with oral cancer - with an estimated 2,000 deaths every year
(Source: British Dental Health Foundation, www.mouthcancer.org)

Oral Cancer – prevention, examination, referral has been designed to support all health professionals by updating their knowledge, highlighting the importance of oral cancer screening, and providing practical tools for communicating with patients and colleagues.

The programme comprises four topics:
1: The facts - Providing a background into the incidence, causes and development of oral cancer
2: Team Approach - Looking at all aspects of communication both within the team and with patients
3: Screening Examination - Practical advice on improving the opportunistic screening procedure in practice
4: Case Studies - Providing first hand experiences of examining, making referrals and living with oral cancer

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Check up

“I’ve always been grateful,” Jane said, “but during my time at Crisis I was struck by the saying but there for the grace of God.

“Many of the people that were there just slept; I learnt that when living on the streets homeless people have to sleep with their heads behind bins so they don’t get attacked. It really is a harsh world they live in. They’re so vulnerable and their life expectancy drops drastically.”

“It makes you realise how fortunate you really are.”

The Crisis experience is an opportunity to think outside the box and re-evaluate what dentistry really means. This year Crisis at Christmas runs from 24th-28th December.

“The Crisis website, www.crisis.org.uk has lots of information about the charity and how to volunteer. Companies wishing to donate materials, loan equipment or provide free samples are very much appreciated.

Crisis also organises other charity work and spends a lot of time and energy helping people both young and old get off the streets and back into work. Crisis Skylight is involved in providing learning and skills in London and Newcastle by running education, training and employment centres. Crisis Skylight also runs cafés and social enterprises that provide real job training.

Working conditions
Crisis runs on donations; everything from the stock that the charity uses to the premises that the meetings take place in. Last year volunteer dentists accommodated two donated mobile units and although they were small, they were nonetheless functional and stocked with equipment.

“Last year Henry Schein donated a lot of materials,” Jane stated. “And if anyone wishes to donate dental supplies, what we really need are ultra-sonic cleaners and scalers; for us these are incredibly valuable items because although cleaning is a basic task, cleaning the homeless people’s teeth is what the dentists spend most of their time doing.”

“Aside from the cleaning, we do talk to them as well, but we’re not allowed to ask them about their past; the aspect is to focus on the future. We even help them by having a no drink or drugs rule, which is consistent throughout all of the sites; even mouthwash with alcohol is banned.”

There for the grace of God
When it came down to question of how the experience changed her, it became obvious to me that until I had seen the situation for myself, there would be no words that Jane could use to describe the way it had changed her.

“However, the charity needs more dental nurses to help out,” Jane explained. Even though every member of the dental team is welcome, volunteer dental nurses are worth their weight in gold.

Source: British Dental Health Foundation, www.mouthcancer.org
Moroccan mercy trip
Richard Howarth tells of his successful mission with the Dental Mavericks

The problem I have had since I returned from Morocco is answering the question “how was your trip?” in just a few sentences. Words that spring to mind are adventure, challenge, emotional, joy and sadness. I could add many more but can sum up with one word: successful.

The aim with the charity Dental Mavericks was to bring a small group of dental professionals together, transport them to the remote North East coastal town of El Jabeh in Morocco and see 160 children, screen them for dental pain and provide urgently needed relief. Our equipment was simple; three field dental chairs (which we had raised funds to purchase from Dentaid) and equipment that was required to remove teeth and place simple glass ionomer restorations. Thanks to Henry Schein for the kind donation of the equipment and materials, this was all possible. Dentaid also prepared sacks posters giving oral health advice, story books and dental educational material all in French, the second language for some of the children, the first being Arabic.

Licence to travel
The team of four dentists, two dental nurses a general nurse, plus Cally Tony and Jess from MPDO and translator and guide Domien, gathered in Southern Spain to travel with all the kit in a trailer behind a mini bus via ferry to Morocco. We had been given a special licence to travel to El Jabeh to provide dental treatment to the children of the local school which was the focal point, with many more children travelling in from remote villages. The first couple of days gave us time to acclimatise and settle the team as well as a delegation from Dental Mavericks meeting with the Health Minister for the District (large county). We were unable to bring anaesthetics due to the strict (large county). We were introduced to the Chief of the medical centre, where we were to use a couple of offices and convert them into dental suites in the loosest terms. We had permission to use these rooms in the clinic for two days.

Keeping in action
The next morning was an early start unloading the dental equipment setting up the field chairs and arranging systems. We eagerly waited for the arrival of a delegation from Chefchaouen with our anaesthetic and also a Moroccan dentist to help translate. At 10am the first group of children was brought over from the school; one of us screened the children as they came in with the help of our translator Domien and the Moroccan dentist. We identified the children who had dental pain and then decided what treatment we could provide. We worked in rotation keeping the three field chairs in action right up to 5pm.

I only remember seeing one child with a filled tooth the rest had never seen a dentist. Their oral health and hygiene was very poor with significant numbers having first permanent molars diseased beyond repair. A diet rich in sugar and honey and no dental health routine or health care would have made most UK dentists shocked at the levels of decay. The day was made as much fun as possible with the regular appearance of Roger the Rabbit and supply of pencils and pictures to colour. Each group received oral health advice and supplies of brushes and toothpaste.

I said at the start the trip was successful - we achieved our goal. We screened 160 children. We found more than 50 per cent of them in dental pain and we treated all of them. Sadly the majority of care we provided was extractions. This was emotionally difficult but made up by the smiles and hugs the children gave us the next day.

Dental Mavericks cannot leave this community with the job only partly done. We have big plans to get dentists there more regularly both local professionals from Chefchaouen three hours away and also from the UK. We raised £10,000 for the trip this year and next year we raised £20,000. We left this community with the three field chairs in action. Two of the chairs we donated, one to the clinic in El Jabeh and one to the district to be used in the surrounding area. Hopefully in the future we can provide dental care that would be more familiar to the children we care for in the UK.

If you would like further information or would like to donate to this worthwhile cause the visit www.dental-mavericks.org.

About the author
Richard Howarth is usually found in his practice in Stafford where he has the luxury of safe running water and all the equipment and trained staff required to provide modern dentistry.
Canary System is approved

The Canary System™ is now approved to be marketed and sold in the European Union.

“We are now open for business in the EU to support the demand that we’ve experienced from dental professionals across Europe who are interested in adopting our innovative early caries detection system,” announced Dr. Stephen Abrams, CEO of The Canary System’s manufacturer, Quantum Dental Technologies (QDT) in Toronto, Canada.

“We’ve been contacted by many dental professionals wanting to know when The Canary System would be available for sale in Europe, and now that we have our CE mark, we are looking forward to getting The Canary System into dental offices across Europe,” said Dave Kelton, Vice President of Sales. “We invite dentists and other oral health professionals to contact us to see The Canary System in action and learn how this powerful tool can change the way caries are detected and treated.”

Quantum Dental Technologies is currently finalising distribution agreements in Europe to ensure that The Canary System becomes widely available.

“The expansion of sales to Europe builds upon QDT’s marketing and sales efforts in Canada, where QDT is engaged in a cooperative marketing relationship with 5M ISPEL, whereby 5M’s innovative remineralization products are provided with the sale of The Canary System,” explained Josh Silvertown, Vice President, Corporate Development.

THE CANARY SYSTEM is powered by PTH-LUM – a revolutionary new tool that can detect, map and monitor carious lesions on any tooth surface -- earlier and more accurately than ever before.

The Canary System is a low-powered laser-based device that uses a novel combination of heat and light to directly examine the crystal structure of teeth and map areas of tooth decay. The Canary System’s interactive software and printed patient reports engage patients in their own oral health-care like never before. For more information, please visit www.thecanarysystem.com or email info@thecanarysystem.com to request additional information.

Fruit and vegetable supplement helps fight periodontitis

According to a new study which appeared in the Journal of Clinical Periodontology, a diet supplemented with fruit and vegetable juice powder concentrates help fight periodontal disease.

The study, which was conducted at the University of Birmingham, showed that a daily dosage of capsules containing concentrated phytonutrients actually improved the clinical outcomes for patients with chronic periodontitis.

The authors have stated that the study is the first of its kind, because the patients were given supplements during standard mechanical therapy.

For the study the volunteers were randomly assigned to groups, where they either took fruit and vegetable powder concentrate capsules, vegetable, and berry powder concentrate capsules, or took a placebo. Out of the volunteers 60 took part in a six month review, whilst only 54 completed the eight month review.

The researchers found that for the groups that took supplements in just two months there was a significant improvement in gum pocketing; furthermore, notable improvements in gum bleeding were recorded, as was dental plaque, which was lowered.

Could tooth gum disease predict the risk of heart disease?

Researchers in Taiwan and Sweden have completed two new studies that have given further insights into the links between oral hygiene, gum disease and cardiovascular events. Although it is becoming commonly known that oral health is directly linked to the overall health of the body, researchers in Taiwan have found that dental patients who underwent professional cleaning and scaling had reduced risks of strokes and heart attacks. However, what is increasingly interesting is that the researchers from Sweden have discovered that periodontal or gum disease may in fact predict a person’s risk of heart failure, stroke and heart attack.

For the Swedish study, the researchers examined almost 8,000 participants with periodontal disease; the results of their research showed that certain types of gum disease can in fact predict the risk of cardiovascular problems, such as heart attacks, heart failure and strokes to different degrees.

The studies were presented at the American Heart Association’s (AHA) Scientific Sessions 2011, and are abstracts are available in the AHA journal Circulation. http://circ.ahajournals.org/
Charity launched to raise obesity awareness

The major issue of obesity in today’s society is costing the nation an extensive amount of costs climbing to an estimated £2 billion. However, a new charity Obesity Action Campaign, which was launched on Monday 14th November in the House of Lords, aims to address this issue.

The main aim of the charity is to raise awareness of obesity and its adverse health consequences, with particularly emphasis on the lesser-known consequences of liver and pancreas disease. The campaign also hopes to educate mothers about healthy eating prior to pregnancy and parents about the healthy feeding of children.

The address comes in good time however as it has just been found out that the health of guns improves with weight loss. Researchers from Case Western Reserve University School of Dental Medicine discovered that the human body is better at fighting gun when fat cells disappear.

Dr Jude A Oben, a Trustee of the charity, Consultant Physician Gastroenterologist specialising in obesity and liver disease at Guy’s and St Thomas’ Hospital and the Royal Free Hospital Hampstead, London and a Senior Lecturer at University College London, said: “50,000 people die every year because of obesity related illnesses.

Adult obesity rates in the UK are about 50 per cent of the population and rising.

“I’ve been working in medicine and science for 22 years and continually see patients who don’t know how to tackle their obesity or how they should look after their children. We take it for granted that people know how to look after themselves. We are continuously being informed about what we should eat and how much we should exercise. The message is not getting through! We have to change tack. We have to address this obesity epidemic head on!”

 BSDHT Poster

Attendees at the British Society of Dental Hygiene and Therapy Oral Health Conference & Exhibition in Bournemouth this year were privy to the latest initiative by the BSDHT.

Sally Simpson, President of the BSDHT, said: “Following the success of last year’s poster exhibition and competition at the BSDHT-hosted International Symposium of Dental Hygiene in Glasgow last July, we felt it important that we continue to promote and provide opportunity for dental hygienists and dental hygienist-therapists in the UK to showcase research projects and studies they are involved in.

It is one of the Society’s goals to further support its members with an interest in research, and to provide prospects for its members to pursue these interests and educational opportunities for increased development in the research field.”

Deborah Lyle, Water Pik, Inc.’s Director of Clinical Research said: “Water Pik is renowned, not only for its range of interdental cleaning products, but also for the meticulous clinical research behind them that has kept the company at the forefront of dental technology for over fifty years. This is a great initiative from the BSDHT that enforces the clinical message that enables dental hygienists and dental hygienist-therapists to make effective clinical judgments when in practice, and is something that we are proud to support.”

Water Pik, Inc. is committed to sponsoring high quality research studies that are conducted at universities and independent research facilities, and are published in peer-reviewed journals.
It is our choices that show what we truly are...

Dental Tribune reviews the latest series of Up-To-Date seminars hosted by Oral-B...

November 2011 saw the latest series of Up-To-Date events kick off in London.

The event was held at the Novotel St Pancras, home of the Shaw Theatre. The theatre itself holds almost 450 people, and true to form the venue was packed with a variety of dental professionals looking forward to two excellent speakers.

The evening began with host Stephen Hancocks setting the scene for the event. He looked back to when the lecture series was first launched at the Royal College of Surgeons in 2002. It was even in the early days more popular than Oral-B could have imagined and now each event is over-subscribed by delegates.

First to speak was Prof Iain Chapple, Professor/Head of Periodontology and Consultant in Restorative Dentistry at Birmingham Dental School/Hospital. His presentation, Floss or Die? Eat Well or Die Young? Work out or Burn Out? looked at the importance of periodontal health to general health and wellbeing.

A lively and engaging speaker, Prof Chapple discussed how lifestyle choices impact upon longevity and how our day to day behaviour drive inflammation in our bodies. He highlighted the major causes of mortality and the impact that periodontal health can have on the body; as well as the effect that factors such as diet, sleep and exercise can have on ageing, inflammation and longevity.

Highlighting his point by using the quote ‘We are not defined in life by our abilities, more by the choices we make’ (any guesses who said it?), he explained that the majority of chronic disease (which causes 60 per cent of all deaths) can be explained by major modifiable risk factors, including unhealthy diets, physical inactivity, tobacco use and stress. Posing the question is periodontitis a modifiable risk factor for mortality?, Prof Chapple went on to look at some of the causal associations between periodontitis and chronic diseases such as cardio-vascular disease.

Looking at some of the potential treatment solutions to periodontitis (extreme as they may be!) such as full mouth cleans or implants, Prof Chapple showed that these are not helpful when looking at the inflammatory response of the body. This led on to a discussion of anti-inflammatory agents and the impact of nutrition and glucose levels, tying it in with Type 2 diabetes.

Prof Chapple concluded by wrapping up his presentation into one main take home message – that managing lifestyle and behaviour is an important but under recognised part of oral care. And in case you are still wondering, the quote he began with was Albus Dumbledore’s ‘Hogwarts’ greatest Headmaster’.

The second lecturer was Prof Philipreshaw, Professor of Periodontology and Consultant in Restorative Dentistry at Newcastle University. His presentation, Inflammation, Obesity and Periodontal Disease looked further into the link between obesity and periodontal disease. With global obesity rates reaching epidemic proportions, and the increased risk of conditions such as diabetes and cardiovascular disease connected with it; the issue is at the forefront of many healthcare concerns. Coupled with the emerging evidence that obesity may increase the risk for periodontitis, and the lifestyle choices discussed by Prof Chapple become even more relevant.

Reviewing the current evidence supporting the link between perio and obesity, Prof Preshaw discussed the inflammatory link that seems to exist between the two.

He began by looking at the statistics of obesity level both nationally and globally. In England, 22 per cent of men and 24 per cent of women are obese, with 50 per cent of children considered overweight or obese (15 per cent are classified as obese, an increase of four per cent since 1995). This is despite the fact that less saturated fat and added sugar is consumed than 10 years ago.

 Globally, this situation doesn’t look much better. According to the World Health Organisation, worldwide obesity has doubled since 1980, with figures standing in 2008 as 1.3bn overweight and 500m obese. In 2010, 45m under fives were classified as being overweight.

Moving into more dental-related related themes, Prof Preshaw looked at the history of perio and the theories of inflammation and infection, starting with the germ theory of disease developed by Robert Koch in 1876; and finishing in 2010 when the American Academy of Periodontology stated that yesterday, scientists believed that periodontal disease resulted from the actions of plaque. Today, scientists have determined that periodontal disease results from the inflammatory response to bacteria in plaque.

Looking at some of the studies that have been published over the years which have hinted at an association between obesity and perio, he then illustrated the inflammatory host response at a molecular level. Summarising, he proposed that periodontal clinicians should advise obese patients of the possible oral complications of obesity – not an easy task, but one that could help patients make their lifestyle choices more informed.

This year’s Up-to-date series looks to not only match but exceed the standards set by earlier series and if you can make one of the remaining dates I would definitely recommend going!

For more information contact Julia Fish at julia@ab-communica-
tions.com . Alternatively, you can call Julia on 07585 508550.

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formation Centre for health and social care.
Bacteria are no slouches at adapting

Dentistry is evolving as a beast and not least of all the preventative and periodontal limb of it. All the best things evolve. Darwin said it well - “It is not the strongest of the species that survives, nor the most intelligent that survives. It is the one that is the most adaptable to change.”

Bacteria have been no slouches when it comes to adapting. We are seeing the incidence of antibiotic resistant superbugs rise. These superbugs release superantigens which can invoke an exaggerated immune response. But fear not, research is underway to find a specific target for these antigens to render them impotent. Let’s hope it takes them a while to adapt to that. And let us not forget the viruses which have been quietly thriving in our overly antibacterial environment for the last decade or so. This is an area which will become more relevant in time.

Bacteria in the mouth have also adapted to our modern host environment. They are finding the increase in obesity, poor diet and poor oral hygiene a favorable one for them.

Research carried out at Queen Mary’s Blizard Institute showed that normal bacteria that live in our mouths provide the catalyst for the development of periodontal disease. P. gingivalis was introduced at very low levels, yet it had a major affect on both the immune system and the inflammatory system. This research shows our regular bacteria being antagonised by a few aggressors and acting and reacting accordingly. The research is leading them to look at probiotics as a possible solution. This has been looked at before in the form of probiotics but the long term research is not there to support it as of yet.

The 7th European workshop on periodontology’s consensus was this:

All microbial communities are shaped by both physical and biological factors. For example, a change in the availing ability of nutrients, pH and redox potential of the site can alter the overall composition of the biofilm. In addition, lifestyle factors, such as diet, smoking, general health and oral hygiene practice, can act as modifiers of the characteristics of the biofilms.

“This being said it seems to me that our methods of controlling, stabilising and preventing dental disease must become multifaceted if we want to get the best result. And so, we as dental professionals must evolve our approach to healthcare of our patients to provide them with the best chance for a favorable outcome. And that means adapting and changing what we practice and how we practice it."

Risk assessment

Risk assessment is now an essential part of treatment of any patient and it is each practitioners duty to find a comprehensive way of taking a risk assessment from each patient and revisiting it at each visit. QOC are adamant that this is best practice, and the NHS pilots all have it at their core. GSK have built a gum care pack for each team member with good support and training can become in charge of the patient’s risk assessment.

Diet analysis

Gone are the days of merely looking for sugar spikes in a three day diet sheet. We need to think about sugar frequency definitely but we also have to look at alcohol intake, fat intake and balance of diet for optimum health. We need to encourage consumption of the known ‘superfoods’ to reduce the free radicals circulating in the body. We also need to understand that sugar spikes not only increase the risk of dental caries but affect the cells, their life span and quality too. You are what you eat has never been more true.

Obesity

The NHS Information Centre www.nhs.uk published these findings on obesity levels in 2010.

• In 2008, almost a quarter of adults (24 per cent of men and 25 per cent of women aged 16 or over) in England were classified as obese (BMI 30kg/m2 or over).

• A greater proportion of men than women (42 per cent compared with 32 per cent) in England were classified as overweight (BMI 25 to less than 30kg/m2).

• Thirty-nine per cent of adults had a raised waist circumference in 2008 compared to 25 per cent in 1995. Women were more likely than men (44 per cent and 34 per cent respectively) to have a raised waist circumference (over 88cm for women and over 102 cm for men).

• Using both BMI and waist circumference to assess risk of health problems, for men: 20 per cent were estimated to be at increased risk; 14 per cent at high risk and 21 per cent at very high risk in 2008. Equivalent figures for women were: 15 per cent at increased risk; 17 per cent at high risk and 24 per cent at very high risk.

• In 2008, 16.8 per cent of boys aged 2 to 15, and 15.2 per cent of girls were classed as obese, an increase from 11.1 per cent and 12.2 per cent respectively in 1995. Whilst there have been marked increases in the prevalence of obesity since 1995, the prevalence of overweight children aged 2 to 15 has remained largely unchanged (values were 14.6 per cent in boys and 14.0 per cent in girls in 2008).

For boys, on weekdays, the proportion who spent 4 or more hours doing sedentary activities was 35 per cent of those who were not overweight or obese, 44 per cent of those classed as overweight and 47 per cent of those classed as obese in 2008. For girls, a comparable pattern was found; 37 per cent, 45 per cent and 51 per cent respectively.

So, without a doubt, difficult territory but we have a duty as healthcare professionals to discuss the correlation with being seriously overweight with ill health and the long term repercussions for the patients’ oral health. We also need to encourage an active lifestyle, selling exercise as a way to support the stabilising of periodontal disease and reducing the risk of future disease. Many clinicians feel they are not the right person to be discussing these things. If you remember back a bit in our development as a profession, smoking cessation was not seen as our area for discussion, or diabetes control, nor STIs in particular.
the HPV. Now, you would be a poor clinician to not be factoring these things into your care for your patients and reinforcing the health messages.

And so it comes down to change. We have to adapt our practice to best suit our patients and create the best out-

come and long term health plan for them. And that means looking at the issue of dental disease from all angles and treating it with any solution available. Ian Chapman said it best recently. You work hard and come home stressed. You recognise your stress and go to sleep. Get seven hours sleep and then get up and do it all again. It doesn’t sound too bad at all when you say it like that. We need to encourage our patients to want to live a healthy life and not just focus on the oral hygiene routine as a solution.

Time is a factor
I appreciate that we have to factor cost and time manage-
ment into our care for our pa-
tients, but, if we are all willing to change, and look at solu-
tions to facilitate that change, then there is no reason why we can’t treat our patient as a whole and get good results from doing so. This is where the team method of working, with everyone having a clear area to work on, will come into its own. More about that another time.

About the author
Mhari Coxon has 20 years’ experience in dentistry, working as a nurse, receptionist, oral health adviser and latterly hygienist in a va-

riety 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. From Chairing the London BSDHT for 5 years, and working as an MSc, Mhari excels at motivating and re-ordin-
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cialist group, the BSDHT, the RDA, the International Symposium of Dental Hygiene, the dentistry shows and many others. In 2006 she was the Probe Awards hygiene of the year, and was highly commended in 2010. 2011 saw her placed 15 in the Dentistry Top 50 most influential people in the UK.

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Image courtesy of Michael Reddy, DDS Image courtesy of Cary Shapoff, DDS
Advances in medical technology and better standards of public health have meant a significant increase in average life expectancy in the West in recent years. Whilst increasing life expectancy is a predominantly positive step forward, it can throw up unexpected issues for the ageing inhabitants of the world’s most advanced societies. One problem faced by the ageing population is the maintenance of one’s natural dentition.

Traditionally, people suffering from a loss of dentition have utilised various types of prosthodontics. Dentures, the most common and least expensive prosthetic device, have been improving the lives of edentulous people for several centuries. However, despite rapid advances in denture technology, even the most skilled and experienced professionals find it difficult to prevent the occurrence of at least some on-going soreness or slipping. Furthermore, dentures are greatly enhanced by the added stability that even one natural tooth provides and their efficacy is therefore significantly improved by the addition of four or more implants.

Titanium dental implants are the best way to restore the form and function of natural teeth, being biocompatible with bone and potentially capable of lasting for the rest of a patient’s life. Unfortunately, these require an invasive surgical procedure and can take upwards of six months to heal. The cost of a single implant – anywhere from £800 to £3,000 – also makes this treatment option unaffordable for many, a trend that is only likely to continue in the future in light of the country’s economic situation.

It is therefore extremely important that patients develop a daily routine of thorough oral care from childhood and continue to maintain these good habits throughout their adult lives. The pioneering “preventative dentistry” approach of the British Dental Health Foundation from the 1970s onwards encouraged patients of all ages to take a more pro-active approach to their oral health. Through this approach patients are encouraged to think of their trips to the dentist as a regular source of education and guidance, which can in turn ease dental phobia, as healthy teeth are less likely to require invasive or painful treatments. This method has led to a significant improvement in the Nation’s oral health, with the percent-
The emphasis placed on the importance of preventative care in the recent Steele report is further testimony to the success of this initial ‘health drive’. The need to clean one’s teeth twice a day for the generally accepted minimum level of dental care. Interproximal care however, is often overlooked as many patients are unwilling to devote time and effort to flossing, and few are aware of the alternatives. Brushing alone, even very thoroughly, can only remove a limited amount of plaque (very vigorous brushing can also be counter-productive, due to its propensity to cause enamel abrasion). For more ‘comprehensive’ plaque removal, a whole body of research points to the effective use of floss or interdental brushes in supplement to brushing.

Interproximal cleaning with an appliance designed specifically for the purpose is therefore essential for anyone wishing to ‘future proof’ his or her smile; as much plaque as possible should be removed daily to minimise the risk of caries or periodontal disease developing.

Compliance is a tricky thing however, and the message that conventional brushing should be just one part of a comprehensive tooth-cleaning regimen will need to be promoted by dental health professionals at every opportunity. Advice and guidance on the use of floss and interdental brushes should also be an important part of this process as patients may be unaware of the different methods of interproximal cleaning available to them.

Manual dexterity problems can also be an obstacle to interdental care, particularly during the vital habit-forming years of childhood or when people encounter unrelated health problems in later years. These patients, however, need not give up on interproximal care. Companies produce dental aids suitable for every situation such as dental tape, which is easier to use than conventional floss, or interdental brushes that are ergonomically designed to allow successful usage even by those with reduced manual dexterity or wearing fixed orthodontic appliances.

Making interproximal care a standard component of most people’s dental routine has the potential to bring about the most positive impact on British oral health since the practice of preventive dentistry gained acceptance around 40 years ago. By encouraging good oral health care at home, dentists and dental care professionals can ensure patients retain their natural dentition for as long as possible, making invasive treatments a rarity.

The message that conventional brushing should be just one part of a comprehensive tooth-cleaning regimen will need to be promoted by dental health professionals at every opportunity.

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The use of lasers in periodontal treatment

Howard Golan discusses technology in dentistry

There are some dentists that embrace technology. Technology can improve the delivery of dentistry and also help traditional dental philosophies evolve. For example, a patient presents with an emergency; a broken cusp on an upper bicuspid, bellow the free gingival margin. Technology, lasers and CAD/CAM specifically, allows the clinician to provide endodontics, osseous crown lengthening, an adhesive core build up and a definitive porcelain restoration all in a single appointment.

The advantages to this type of treatment are obvious. However, the dentist must be willing to alter his/her current dental philosophy and many times make an initial financial investment that is larger than what the clinician is used to. The traditional way to provide treatment such as endodontics in one-two visits, a post and core, an elasticomer impression, provisional restoration, referral to a specialist, surgical healing time and then definitive cementation of the restoration currently is a valid and overwhelmingly used treatment sequence. Sometimes, however, newer technology can perform these tasks just as well if not better than traditional methods all the while improving the dental experience for the patient.

Lasers have been used in dentistry for the removal of soft tissue for more than two decades. Carbon dioxide, Nd:YAG, and Diode lasers have been very predictable and successful for the removal of oral soft tissue in the last decade, the erbium lasers have been used for soft tissue and for restorative, endodontic, and surgical procedures. Erbium lasers are efficient in removing enamel, dentin and bone. However, the last five years have seen a tremendous push by the laser manufacturers for the lowest cost and most portable diode lasers. Due to their more approachable price point, and an increasing number of US jurisdictions allowing hygienists to use these tools, the diode lasers have had sort of a renaissance.

One of the most impacted areas of laser use in a general practice has been in the area of periodontal treatment. The treatment of periodontal disease is often a difficult arena for the general dentist to enter. As a chronic disease that so often relies on the host response for success, true treatment success is often never seen. Often times the general dentist chooses not to treat periodontal disease, referring patients to a specialist. As will be shown in subsequent paragraphs, this modality many times results in the patients never getting treated at all. Lasers have allowed me to treat many different periodontal cases. It has introduced patients to periodontal treatment in a minimally invasive way ensuring that almost all patients diagnosed with periodontal disease get treatment. Lasers have allowed me to increase the services that I provide in my practice by adding periodontal procedures that would have not been done before the integration of laser technology.

Finally, introducing more and more patients to periodontal treatment has increased my referrals to periodontal specialists.

The controversy: Science vs Clinical results

I have always been an advocate of evidenced based dentistry. I rely on the results of evidence more than ever before. From endodontics to adhesive dentistry scientific evidence is important in formulating my treatment decisions and protocols. Periodontal disease has and continues to be researched heavily. Each year the systemic impact of periodontal disease is being uncovered and understood each day. The periodontal community aims to base its treatment decisions on science. However, there is no absolute cure for periodontal disease. It is a complicated often chronic multifactorial disease process. Bacteria are just one factor. However, one must also look at patient compliance, environmental factors including the patient’s restorative history, and systemic issues. Thus, it is essential that clinicians in evaluating and treatment planning a patient for periodontal disease look at a wide spectrum of factors, many of which might conflict with the scientific literature.

Lasers have been controversial because of the claims of the manufacturers that are not solidly backed up by science. There is no question that the lack of multi-centre, double blind, and randomised trials inhibits the ability of lasers to gain widespread acceptance in the periodontal community. However, each and every day practitioners, general and specialists alike practice dentistry based on anecdotal evidence relying on their own successes and failures to treat their patients.

If we as clinicians only practice what and how science tells us to practice then we are many times doing a disservice to the patient. Dentistry is both a science and an art and the individual judgment of the clinician is often as important as a published research article. Thus, we can use lasers and the science that it available as just one battalion in a large army against the fight against periodontal disease. Lasers provide advantages that traditional therapies do not. When used properly, laser therapy is a big weapon in this fight.

What do lasers have to offer?

Lasers (Light Amplification by Stimulated Emission of Radiation) have a clinical effect of oral tissue. This light energy can be converted to heat and that heat is used to remove tissue and destroy bacteria. However heat can have negative effects on tissue. Hard tissue burning or melting and possible soft tissue necrosis must be avoided or at least minimised. Other lasers use the potential energy of light and convert it to kinetic energy with another substance (eg water) to remove or ablate tissue. This allows the effective and efficient removal of infected epithelium and granulation tissue without the necrotic effects of heat. This provides less post-operative issues such as swelling and pain.

Lasers are also effective in removing hard tissue including bone and calculus. In fact the US Food and Drug Administration has approved a laser for calculus removal.

Furthermore, because of the ability to collimate and bend light, lasers can access areas such as furcation and root anatomy that even surgical access with curettes and ultrasonics could not. Thus many procedures that were once absolute surgical cases can be treated non-surgically.

The treatment of periodontal disease requires the proliferation of some cells while excluding other cells. To get re-attachment and regenerate epithelium cells need to stay away from the healing site while fibroblasts and odontoblasts should be encouraged to enter. Lasers have the ability to assist in both areas. For exclusion, lasers can de-epithelialise the area, by removing the epithelium to the connective tissue,
both on the internal pocket wall and the external pocket wall. The fast growing epithelium is retarded to allow the slower moving fibroblasts and osteoblasts to do their work. For proliferation and migration, lasers when introduced to the oral tissue at power levels too low to cut, have actually been shown to increase the proliferation and migration of the osteoblasts and fibroblasts.

This is called photobiomodulation or low-level laser therapy (LLLT). The use of LLLT is ever expanding in medicine and dentistry. In dentistry, LLLT is used for pain relief, such as TMD and wound healing and to control inflammation, which is essential for the successful treatment of periodontal disease. Finally, the LLLT allows patients to heal from laser procedures faster and with fewer incidents by supporting the wound healing response and suppressing the inflammatory response.

Laser assisted periodontal therapy: Clinical situations
Treat General/Refer Specific

One of the biggest challenges in a general practice is getting patients to actually go to a periodontist once referred. Patients are consistently referred but many times but never follow through. If their condition goes untreated it affects their health, their mouth and does not allow me to go forward with other treatment such as prosthetics. Patients are more likely to follow through with treatment when it can be accomplished within the general office. Often periodontal disease is not acute/slowly painless and thus patients will prolong the treatment until there is an acute problem. A less expressed but as significant of a reason for patients not to the specialist is fear. Periodontal surgery does not have a great reputation, irrespective of the ability of the clinician. Patients hear stories of pain, swelling, bleeding and sensitivity. The last thing clinicians want are patients not going to have treatment because of fear. However, when sent to specialists for specific procedures on a finite number of periodontal sites, the patient is more likely to seek treatment. Specifically, we have seen that a patient that is referred for the treatment of tooth #14 (maxillary left first molar) does not hesitate to go for treatment compared to a patient that is sent to that very same referral for the upper left quadrant.

Therefore, our philosophy is to treat as much of the disease process in the general practice non-surgically, then upon re-evaluation send only the nonresponsive areas to the periodontal specialist for surgical intervention. Introducing a laser into the non-surgical equation provides the patient with a minimally invasive non-surgical option. The laser provides something different, something new that most patients are not familiar with. Scaling therefore is not the primary therapy but an adjunct to laser therapy. Thus, the patient realises that surgery will only be done after all non-surgical options are exhausted and that those treatments will not be painful and there is no reason to fear “gum” treatment. When surgical intervention is recommended, the patient understands the efforts made and that surgery must be accomplished in a localised area, minimising the potential uncomfortable post-operative consequences.

With this philosophy, we have seen a threefold increase in the number of patients referred to the periodontist that actually have the treatment completed within a reasonable time of referral. This is...
compared to referrals before lasers were introduced into the practice.

**Site Specific Treatment — the recall patient**

When a minimally invasive procedure is available to patients, it takes much less effort to educate a patient and get the patient to accept treatment. When a laser is placed inside the hygiene treatment room, a recall patient with an isolated periodontal pocket can be treated at the time of recall.

In many jurisdictions in the US, hygienists can use lasers for periodontal treatment. This allows the dentist to diagnose the condition on examination, instruct the hygienist what to do and leave the room and return to treating his own patients. Thus, a patient can not only have their cleaning and check-up but also take care of a dental issue without having to return until the next recall.

Even in those States that do not allow a hygienist to use a laser (such as the author’s) the laser in the hygiene room still allows for this but the dentist does the treatment with the laser. Moreover, site-specific treatment adds a new dimension to the treatment spectrum. Instead of just a scaling and root planning procedure, the dentist can perform, and thus bill a profitable and more definitive treatment with a laser. Figs 1 & 2 illustrate a patient on a recall visit that exhibited a 5mm pocket on the mesial of maxillary left first molar. Laser assisted site specific treatment was performed in the hygiene room with a Er:Cr:YSGG laser (Waterlase MD, Biolase Technology, Irvine, CA) and a 940 diode laser (EZlase, Biolase Technology). The perio charting shows initial and three and six months recall probing depths.

**Management of the hopeless periodontal patient**

Many times a patient presents to the office with the following history: Patient has a history of periodontal disease with significant bone loss and periodontal pocketing. The...
patient had four quadrants of periodontal surgery to treat this condition many years ago. Upon examination, the periodontal pocketing is still present or has returned and the clinician recommends periodontal surgery again. However, the patient tells you that he/she will “never go through that again.” The patient had a bad experience with surgical intervention will not entertain the idea of referral to a periodontist. Thus, the patient never has the treatment recommended. Furthermore, there are patients where through everyone’s best efforts the treatment is never successful. These patients are referred to as “refractory” cases.

These patients are particularly difficult since they have spent much money and time and do not see results. Many times they need significant extractions and implants, but at the present time refuse this treatment due to financial or emotional obstacles. Every dental practice has these patients. Laser therapy provides an opportunity to manage, stabilise or treat these patients at reasonable cost compared to surgical therapy or extractions. Refractory cases will not be “cured” with laser therapy but if we can stabilise the disease process then we provide an invaluable service to the patient. Laser treatment might occur every recall visit or with increased frequency depending on the extent of the disease process.

Often we can maintain a patient with his or her own teeth longer than originally thought. This is an area of laser dentistry that was unexpected but has become one of the most rewarding. The figures in fig 2b illustrate a typical hopeless case. Patient is 48 with a long history of periodontal treatment including numerous SC/RP visits and surgery. Patient’s hopeless maxillary anterior was

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restored with implants. The lower arch was treated with laser therapy and scaling. Though there is no evidence of regeneration, the change in the marginal bone is evident three years later. This patient is now five years post treatment with stable periodontal tissues (Figs. 5 & 4). Patient is compliant with three months recall.

Prosthetic replacement: Marriage of technologies

Patients with crown and bridge often present with periodontal pocketing and inflammation. Often, the prosthetics either invade biologic width or the crowns are under-contoured below the gingival margin. Treatment of this situation would include replacement of the crowns and treatment of the soft tissue. If there is biologic width invasion then a crown lengthening procedure is needed to adjust the height of the alveolar bone. This condition is often caused by the fundamental need of mechanical retention of the crowns.

Due to caries, fracture and short clinical crown heights, the crown preparation needs to be placed significantly under the free gingival margin in order for the crown to stay on. Technological advances in ceramics and adhesion allow for posterior restorations to be adhesively bonded to the tooth allowing for equi and supra-gingival restorations. These restorations coupled with laser therapy can resolve a periodontal pocket within weeks without surgery and more trauma to the root surfaces.

If biological correction is needed, then the use of a laser to incise the attachment and remove the bone can often be accomplished without flap reflection. This minimises post-operative pain, swelling and leads to more patient acceptance and profitable treatment for the dental practice. Figs 4-9 illustrate pocketing and inflammation associated with crowns on the maxillary left first and second molars. The crowns were removed and laser assisted periodontal debridement and curettage was performed. Fig. 7 shows 14-day healing prior to cementation. Fig. 8 are the adhesively bonded ceramic crowns (eMAX, Ivoclar Vivadent, Amherst, NY). Fig. 9 shows the initial and three months recall periodontal charting.

This article is designed to introduce the dental community to lasers and their use in periodontal treatment in a general dental practice. The use of lasers does not eliminate the need for surgery, and especially the wonderful work of periodontal specialists. However, when a philosophy of minimally invasive treatment is employed, then patient and dentist work together to help the patient accomplish their periodontal treatment goals. There will be an increase in periodontal treatment plan acceptance and an increase in periodontal referrals that actually result in treatment.

Editorial note: The literature list can be requested from the editorial office.

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Dental retirement: what should be considered?

Leo Briggs discusses the issues that dental professionals must consider as they plan for their retirement.

It is important that even after retirement and closing down a practice, a dental professional continues to store patient records in a secure manner which will protect patient confidentiality. The Data Protection Act (DPA) states that appropriate technical and organisational measures should be taken against accidental loss or damage of or to personal data (DPA, Principle 7). Some dental professionals may opt to employ a commercial archiving facility to store records, while others may choose to store them in a locked cabinet at home. Whatever method a dental professional opts for, it is important that it is secure and accessible, so that if necessary, records can be accessed in order to respond to a patient claim or complaint.

If a practice has not been closed down but instead ownership has passed to another dental professional, solicitors acting for the vendor should incorporate into the sales agreement a clause for records to be retained by the vendor to be given reasonable access to them so that if a claim or complaint is made, patient records can be obtained.

A time will of course come when the minimum time frames for storing patient records ends and a dental professional may wish to dispose of their records. It is important that when this happens, they are disposed of in a secure manner and one that continues to take into account patient confidentiality, as well as in accordance with national and local waste disposal requirements.

Removal from the dentists' register

If a dentist is permanently retiring, they do not need to remain on the dentist's register. Once removed from the register, dentists who would like their name restored must and that they do not wish to return to the profession in another role, for example, carrying out occasional locum work or acting as an expert witness.

Membership to a dental defence organisation

Another consideration is how retirement affects the status of membership of a dental defence organisation. For DDU members, it is not necessary to continue to pay DDU subscriptions and membership can be transferred to free-of-charge retired status. Retired members of the DDU have access to discretionary assistance for clinical procedures carried out up until the date of retirement, as well as continuing to receive copies of DDU publications. In addition, cover for clinical negligence claims will continue to be provided for a 10 year period after retirement.

Not all medical defence bodies provide the same benefits to retired members so it is important that before retirement, dental professionals contact their individual defence body to enquire into the services they will provide once the dental professional's career is complete.

Leo Briggs has been a senior legal adviser at the Dental Defence Union since 2005. His role involves helping DDU members to resolve the dento-legal dilemmas that arise in everyday practice and supporting dental professionals with patient complaints, disciplinary proceedings or DDU investigations. Leo qualified from University College Hospital, London in 1989 and has worked extensively in the Community Dental Service as well as in general dental practice. He has a particular interest in Clinical Periodontology and has a masters degree in Periodontology from the Eastman Dental Institute, London.

The thought of retirement can be an exciting prospect. For many people it will be the first extended period of free time they have had since their late teens or early 20s and planning what to do next can be a pleasurable and interesting task. But for dental professionals retirement comes with added responsibilities – continuing care, for example, if another dental professional at the practice will be taking over their treatment or if arrangements have been made with another practice.

Protecting patient records post-retirement

Most dental professionals will have taken great care to keep accurate patient records and to store them securely throughout the course of their career. A question that often arises on retirement is what should be done with records now? This answer will depend on what is happening to the practice next.

Adult dental records are expected to be retained for a minimum of 11 years after the date of the last entry. In the case of minors under the age of 18 years, records should be kept for 11 years after the date of the last entry or until the patient is aged 25 years – whichever is the longer period. If there is a record belonging to a patient where there has been an adverse incident, it may be wise to retain the record indefinitely. Although a matter may seem to have been resolved satisfactorily, keeping the record will protect the dental professionals involved if any further issues arise at a later date – and this can sometimes be several years after the incident.

The thought of retirement can be an exciting prospect. For many people it will be the first extended period of free time they have had since their late teens or early 20s.

It is important that both private and NHS patients are informed of your forthcoming retirement.
Monday morning blues

Jane Armitage talks about sickness issues

Sometimes I hate Mondays. It’s a nice weekend, the sun was shining but Monday is lurking and it’s back to routine.

I set off for the practice, thinking about what I have to do in the coming week and how can I juggle my workload around. I’m thinking how it will be ok as I have someone spare this week, when suddenly it comes - the phone call: “I’m not going to be in today I’ve been sick all weekend!”

I log all sickness dates with the reason of absence. I must admit there is a certain pattern to that. I would imagine at some point in your working life most managers have had a conversation similar to that.

What can you do? At the time not a lot, unless you can prove the reason for absence was not genuine, in which case it could be treated in accordance with the practices disciplinary procedure. But for the time being your workload has just increased and someone’s weekend has just lengthened.

Thankfully there are protocols in place for frequent short absences. We are all aware of the knock on effect absence has on others. Sickness cannot be helped, it happens, but how annoying when it happens and in your own mind you doubt it. It boils down to trust and how effective your infection control and procedures are in monitoring short and frequent absences; in your own mind you have to know that what you have in place is good enough to control this problem and that staff understand they have these things in place.

It’s usually pre or post Bank holidays, during the first two weeks of August or a Monday/Friday. Years ago when I first started logging the complaint and the day etc. I would never have imagined a sequence would slowly start to appear. May I add not on everyone’s profile but when it happens it’s usually certain members?

On the return to work I carry out a back to work interview. Short questions are asked, did you need any medication, was a GP visit necessary and end by saying “Glad to have you back hope you’re feeling better”. If there have been four or more self-certified absences within a short time I would arrange a meeting to discuss the cause, basically to ensure there was nothing in the day to day work of the employee that was causing illness. Following this if another bout of sickness came I would request a medical report to ensure there was no underlying cause. I also use this sickness record as a conversation tool for appraisals.

Monitoring of the sickness procedure is simple. People are human and if some can get away with things they will, but for the rest of the team it comes at a price.

So the next time the weatherman predicts a scorching week ahead think of your colleagues working at double speed; there’s always next weekend.

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Jane Armitage, is an award-winning practice manager and has almost 40 years industry experience. She is currently a practice manager for Thompson & Thomas, and holds a Vocational Assessor award. She is also a BDA Good Practice Assessor, BDA Good Practice Regional Consultant, and has a BDA Certificate of Merit for services to the profession. She has her own company, IA Team Training, offering a practice management consultancy service, which includes on-site assistance covering all aspects of practice management.
A Scottish perspective
Nicola Docherty discusses the future of dental nursing

Scotland is for many a land synonymous with picture postcard views, whiskies, T in the Park and lots of rainy weather. However it has pushed its way forward through the clouds and become home for elemental developments in dentistry, and especially in dental nursing.

Varying from remote and rural areas with single man dental practices, to densely populated cities boasting large dental boutiques and corporate dental businesses, Scotland is at last overcoming its access challenges of the early noughties.

We have over 4,000 dental nurses with nearly 1,000 more undertaking their primary qualification through FE Colleges, private providers and NHS Education for Scotland. Currently the two main qualifications available to our Scottish trainee dental nurses are the National Examining Board for Dental Nurses (NEBDN) Diploma in Dental Nursing and the SVQ in Oral Healthcare level 3. Recent developments have also given us a HNC/HND in Dental Nursing which will be available in the near future. The qualification can be taken over one or two years depending on the level required.

Across the country dental nurses can also gain access to a wide variety of post qualifications and CPD opportunities. As well as the NEBDN post qualifications, we offer Professional Development Awards (PDA) in Dental Practice Management, Facilitating Learning, Training & Assessment in the Workplace and various certificates in oral health promotion and nutrition. In each region throughout Scotland, we have teams of dedicated professionals available to give out career information, educational support and CPD guidance to all dental nurses wishing to further their career or looking for a change in vocational direction.

Some of these dental nurses who were looking for a change have ended up being part of the driving force in two of Scotland’s largest dental directives. Dental nurses make up the Oral Health Improvement team which supports the Childsmile Programme across the country by delivering the training needed to support Extended Duty Dental Nurses and Dental Health Support Workers involved in delivering the Childsmile Programme throughout Scotland. Childsmile is a national programme designed to improve the oral health of children in Scotland and reduce inequalities both in dental health and access to dental services.

Decontamination and infection control is the other important area that many dental nurses are involved in taking forward to aid the improvement of the service. We have a committed team of dental nurses employed to go throughout the country to give in practice training to general dental practitioners to enable practices to look at their existing processes and to consider any changes required to improve the practice closer to the requirements of current guidance. Formulating an agreed action plan detailing timescales and responsibilities is an essential component of the training. This training will be available free of charge to Scottish NHS practices until December 2012.

Dental nursing is evolving and becoming a vocation that is sought after and recognised. Scottish dentistry is striving to support these changes and promote the dental team in a professional manner and looks forward to a bright future.

About the author
Nicola Docherty has been working as a dental nurse for 25 years and has experience in the salaried and hospital service, and general dental practice. She currently works for NHS Education for Scotland as Senior Dental Nurse/CPD Tutor for the West of Scotland. She participates on many DCP and educational committees and is an examiner for the National Examining Board for Dental Nurses. Currently she is also the BADN President.
Fast 50 List: Syneron reaches ninth

Syneron Dental Lasers (www.synerondental.com), the world’s leading provider of innovative dental laser technologies and the inventor of the LiteTouch™ and Laser-in-Handpiece™ technology announced today that it has been ranked 9th on the prestigious 2011 Deloitte Technology Fast 50 competition in Israel. Deloitte’s Technology Fast 50 is a global program that recognizes the 50 fastest growing public or private technology companies in each region. To determine the fastest growing companies, Deloitte reviewed fiscal year revenues over five years (2006-2010), calculated the revenue growth percentage over five years, and compared the growth of technology companies.

“We commend Syneron Dental Lasers for being ranked 9th amongst Deloitte Technology Fast 50, with a phenomenal 1,244 per cent growth rate over five years. It is a tremendous accomplishment to be ranked amongst the top 10 fastest growing technology companies within its first entry into the Fast 50 ranking in Israel”, said Tal Chen, Partner in charge of the Deloitte Brightman Almagor Zohar Technology Fast 50 Program.

“It is an honour to be recognised as one of the top 10 fastest growing technology companies in Israel by a respected organisation such as Deloitte,” said Ira Prigat, President & General Manager, Syneron Dental Lasers. “Our company’s Laser-in-the-handpiece™ innovation has played a pivotal role in transforming the way practitioners perform dental treatments today. Just as the mobile phone freed our world from wires, so has the LiteTouch freed dentists from the use of traditional tool as well as bulky optic fibres, making laser dentistry completely portable,” Syneron Medical’s CEO Louis P Scafuri commented: “This award is a tremendous achievement for Syneron Dental Lasers. It is a testament to the company’s strength and commitment to developing the most innovative technologies in the laser dentistry space.

“Looking forward, I’m confident the company will continue its market leadership and strive for excellence.”

Dr Shimon Eckhouse, Chairman of the Board of Syneron Medical commented: “The Deloitte award and recognition is an excellent affirmation of Syneron Dental’s focused vision, product and technology strategy and steady business growth. The outlook for Syneron Dental Lasers is promising; the company has raised the bar for laser dentistry with its next generation LiteTouch™ innovative technology.” LiteTouch™ is the world’s smallest versatile Erbium YAG dental laser for both hard and soft tissue dental treatments. The unique “Laser-in-Handpiece™” incorporated in the LiteTouch™ - a fiber-free laser delivery mechanism, which mimics the feel of the turbine drill, but has all the benefits of the laser. The laser energy is swiftly delivered to the tissue, providing supreme cutting power and precise incisions for hard tissue and bone.

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Decontamination in practice

There has been a bewildering amount written about decontamination recently, and sometimes it’s hard to make sense of it all. Which is why professional equipment advice from a trusted supplier or manufacturer is so important.

W&H offers the full equipment package for compliance with the latest decontamination guidelines, from top quality handpieces designed with hygiene in mind, through washer disinfectors, lubrication systems, and vacuum sterilizers.

Contact W&H (UK) on 01727 874990 or office.uk@wh.com for further details and/or to arrange a visit from your W&H representative.