Could potatoes fight disease? 
A new project will investigate the potential of naturally occurring chemicals in potatoes, tomatoes and safari foods to combat human diseases such as cancer and arteriosclerosis and ease the pain caused by various ailments. The DISCO project also hopes to find sustainable ways of producing these chemicals, known as bioactive compounds. The DISCO partners, which include 15 organisations from seven countries, aim to capitalise on their experience in metabolic engineering, hyper-production of high-value plant substances, and in bringing technology to the market.

Only 20 per cent of children eat vegetables
Only one in five children eats vegetables every day, and one in ten totally refuses to eat vegetables, according to a survey commissioned by Vouchercloud. The Infant & Toddler Forum (ITF) says that children need healthy eating habits early. The ITF says that children need to be encouraged to try new foods and it is best to begin healthy eating habits early.

1,000-year-old plaque reveals diet and disease
Researchers have discovered disease-causing bacteria in 1,000-year-old teeth similar to disease-causing bacteria in humans today. The research team extracted DNA from samples of the dental calculus - which preserves bacteria and microscopic particles of food on the surfaces of teeth - of a German Medieval population. They discovered the ancient human oral cavity carries numerous opportunistic pathogens and that periodontal disease is caused by the same bacteria today as in the past, despite major changes in human diet and hygiene.

Brain tumour
Teeth found in baby’s brain

Killing Kennedy
A look back at the assassination of JFK by witness Dr Don Curtis

Plaque related perio
A clinical audit

Perio meets implants
By Rainer Buchmann

New leader for the PEC to take the reins at the BDA

The British Dental Association chooses new chair for Principal Executive Committee after dramatic few months of upheaval

Dr Mick Armstrong has been elected as the new Chair of the British Dental Association’s (BDA’s) Principal Executive Committee (PEC) following the departure of previous incumbent, Martin Fallowfield.

Dr Armstrong (pictured) is a general dental practitioner in a mostly-NHS practice in Castleford, West Yorkshire. He has been a member of the PEC since its inception in July 2012, having been elected to its membership by BDA members across Yorkshire and the Humber. He graduated from Newcastle Dental School in 1985. He has served on the BDA’s Representative Body and General Dental Practice Committee, and was Chair of the Conference of Local Dental Committees in 2011.

Commenting on his appointment, Dr Armstrong said: “I am honoured to be elected to serve the profession as Chair of the BDA’s Principal Executive Committee and look forward to leading the profession as it attempts to navigate the minefield of complexity it is confronting.

“Dentistry in the UK is facing a complicated and evolving set of challenges. We are increasingly underfunded, but over-regulated. High standards are expected of the care we provide to our patients, but often the treatment we receive from those that fund and oversee us leaves a great deal to be desired. All too often the professionalism of dentists and their ability to put patients first is challenged, rather than supported. We must assert our professionalism as the guiding force by which decisions about dentistry should be made and I will lead practitioners in doing exactly that.”

Dr Armstrong will give his first address as the leader of the professional association at the 2014 British Dental Conference and Exhibition, which takes place in Manchester from 10-12 April.

www.dental-tribune.co.uk

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News in Brief

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First lay GDC chair to speak at BDA conference

The GDC’s first lay Chair, William Moyes, will address the issue of patient protection at this year’s BDA Conference. The event takes place at Manchester Central Convention Complex 10-12 April 2014. Mr Moyes will be speaking 11 April - Charter Room 2 at 11:45am. For more information visit the GDC website.

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Water fluoridation could save NHS millions

The NHS could save at least £4 million every year on hospital admissions for the removal of rotten teeth if water fluoridation were extended to areas with high levels of tooth decay, according to research published in the British Dental Journal.

Analysis by the researchers of hospital statistics over a three-year period suggests that on average, 6,900 young people were admitted annually for dental extractions in the largely non-fluoridated North West. In the same period, that figure was just 1,100 in the West Midlands which is largely fluoridated.

Using data from 2008-9, the cost of carrying out a dental extraction under general anaesthesia was £558 or £789 depending on the complexity of the procedure, bringing the total cost of the operations to around £4 million in the North West.

Professor Damien Walmsley, the British Dental Association’s Scientific Adviser, said: “This study is a powerful reminder of how water fluoridation saves the NHS money, and how whole populations can benefit from a huge improvement in their dental health.

“It’s a shocking fact that over 25,000 young people in England last year suffered such poor dental health that they had to have teeth removed under general anaesthetic in hospital.”

Teeth found in baby’s brain tumour

Multiple fully formed teeth have been found inside a tumour mass that was growing in the brain of a four-month-old child.

The boy was initially admitted to a clinic in Baltimore after a routine paediatric visit due to an increasing head circumference. The doctors also found structures near the mass similar to those of teeth in the mandible.

Upon surgical removal of the tumour, the surgeons found a number of teeth inside the mass, which was identified as an adamantinomatous craniopharyngioma. Such tumours arise from Rathke’s pouch, an embryonic precursor to the anterior pituitary, and consist of stratified squamous epithelium and wet keratin, and may be cystic.

Teeth were found in the tumour mass

Gingival implant helps reduce cluster headache

A new mini-implant has been developed to help those affected by cluster headaches.

Cluster headache is one of the most severe forms of headache. It is usually unilateral and occurs mostly around the eye or in the temple, and attacks can last up to several hours.

A remote control is used to begin the therapy

The ATI Neurostimulation System includes a novel, miniaturised device that is implanted using oral surgery, leaving no externally visible scars. When the patient feels a cluster attack beginning, they hold a remote controller up to their cheek to begin the neurostimulation therapy.

A new clinical study published online in Cephalalgia shows that the device demonstrated clinical effectiveness in treating cluster headache, and provided significant improvement in patient quality of life and headache disability.

“Cluster headaches cause so much disability that patients are often unable to function normally,” said Professor Dr Jean Schoenen from the University of Leige in Belgium.

“Current preventive treatments are often ineffective, and in many patients acute and preventative treatments may not be tolerated or are contraindicated. This new and innovative therapy offers a way for a significant number of patients to control the debilitating pain of cluster headache.”

Call for smoking in films to be banned

More than two thirds (67 per cent) of those surveyed thought films which involved smoking should receive the highest classification rating, suitable only for adults. According to the British Board of Film Classification, rated-18 films currently allow scenes of drug-taking, provided ‘the work as a whole must not promote or encourage drug misuse’.

The film board makes no reference to smoking or alcohol misuse, two of the leading risk factors for mouth cancer.

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter OBE, said: “The risks of smoking to the whole must not promote or encourage drug misuse’.

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Chief Executive of the British Dental Health Foundation, Dr Nigel Carter OBE, said: “The risks of smoking have been well documented for many years, yet for many young people the message still isn’t getting through. Children see movie stars as role models. If they are smoking, children are more likely to take up the habit. The same applies to sports stars, people we see on every day TV and even parents. By re-classifying films containing smoking scenes, it could lead to a drop in the number of young children taking up the habit.”
Study queries sense of extracting teeth before heart surgery

Removing an infected tooth prior to cardiac surgery may increase the risk of major adverse outcomes, including risk of death prior to surgery, according to a study in the March 2014 issue of The Annals of Thoracic Surgery.

Dental extraction of abscessed or infected teeth is often performed to decrease the risk of infection during surgery and endocarditis (an inflammation of the inner layer of the heart) following surgery.

Cardiac surgeon Joseph A. Dearani, MD, along with anaesthesiologists Mark M. Smith, MD and Kendra J. Grim, MD, and colleagues from the Mayo Clinic in Rochester, Minn., evaluated the occurrence of major adverse outcomes in 205 patients who underwent at least one dental extraction prior to planned cardiac surgery from 2003 to 2013. The median time from dental extraction to cardiac surgery was seven days (average 35 days).

“Guidelines from the American College of Cardiology and American Heart Association label dental extraction as a minor procedure, with the risk of death or non-fatal heart attack estimated to be less than one per cent,” explained Dr. Smith. “Our results, however, documented a higher rate of major adverse outcomes, suggesting physicians should evaluate individualized risk of anaesthesia and surgery in this patient population.”

In this study, patients who underwent dental extraction prior to cardiac surgery experienced an eight per cent incidence of major adverse outcomes, including new heart attack, stroke, kidney failure and death. Overall, three per cent of patients died after dental extraction and before the planned cardiac surgery could be performed.

Noting the limitations of their retrospective review, Dr Dearani said: “With the information from our study we cannot make a definitive recommendation for or against dental extraction prior to cardiac surgery. We recommend an individualised analysis of the expected benefit of dental extraction prior to surgery weighed against the risk of morbidity and mortality as observed in our study.”

Editorial comment

Welcome to this month’s Dental Tribune UK edition.

As you will have seen from the front cover story, the British Dental Association has appointed a new leader of the Principal Executive Committee.

Dr Mick Armstrong, a GDP from Yorkshire, has been a member of the PEC since July 2012 and is seen by many to be the man who can steady the ship of the BDA and make the changes necessary to see the Association back on track to represent their members.

Congratulations and good luck Dr Armstrong!

On the subject of the BDA, next month sees the first BDA Annual Conference and Exhibition since the membership structure changes and the ensuing damage to finances etc. it will be interesting to feel the mood of both management and members at the event. It is being held in Manchester 10-12 April, I may see you there.

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Aggression towards NHS staff on the rise

The NHS has reported a rise of verbal and physical aggression towards health and social care staff – up 5.8 per cent to 65,199 reported assaults in 2012/13. Now a University of Huddersfield lecturer has called for a programme of research to establish the best methods for dealing with the problem.

Various techniques known as ‘de-escalation’ have evolved in different NHS settings, but Dr Andrew Clifton says there is a lack of solid evidence to identify the most successful approaches.

In a new article entitled De-escalation: the evidence, policy and practice, Dr Clifton and his co-author Dr Pamela Hughes call for a ‘randomised controlled trial’ to be conducted. This would involve the comparison of different de-escalation techniques employed at a sample of different hospitals and settings, such as A&E departments or acute psychiatric hospitals. Evidence could then be compiled to show which the most effective methods were.

De-escalation techniques can be purely verbal, says Dr Clifton, or they can involve a physical intervention. “It could be the physical environment or the human environment of the staff,” he says. “It could be a case of having members of staff who are highly skilled and trained in the latest de-escalation techniques which are supported by evidence,” he says.

Dr Clifton points out that failure in dealing effectively with aggression is highly costly for the NHS, in terms of time and resources.

Acupuncture holds promise for treating inflammatory disease

When acupuncture first became popular in the Western Hemisphere it had its doubters. It still does. But over time, through detailed observation, scientists have produced real evidence that ancient Chinese practitioners of the medical arts were onto something.

Now, new research documents a direct connection between the use of acupuncture and physical processes that could alleviate sepsis, a condition that often develops in hospital intensive care units, springs from infection and inflammation, and takes an estimated 250,000 lives in the United States every year.

"Sepsis is the major cause of death in the hospital," says Luis Ulloa, an immunologist at Rutgers New Jersey Medical School who led the study, which has been published in the journal Nature Medicine. "But in many cases patients don’t die because of the infection. They die because of the inflammatory disorder they develop after the infection. So we hoped to study how to counter the inflammatory disorder."

The researchers already knew that stimulation of one of the body's major nerves, the vagus nerve, triggers processes in the body that reduce inflammation, so they set out to see whether a form of acupuncture that sends a small electric current through that and other nerves could reduce inflammation and organ injury in septic mice. Ulloa explains that increasing the current magnifies the effect of needle placement, and notes that electroacupuncture is already FDA-approved for treating pain in human patients.

When electroacupuncture was applied to mice with sepsis, molecules called cytokines that help limit inflammation were stimulated as predicted, and half of those mice survived for at least a week. There was zero survival among mice that did not receive acupuncture.

Ulloa and his team then probed further, to figure out exactly why the acupuncture treatments had succeeded. And they made a discovery that, on its face, was very disappointing. They found that when they removed adrenal glands — which produce hormones in the body — the electroacupuncture stopped working.

That discovery presented a big roadblock to use of acupuncture for sepsis in humans, because most human cases of sepsis include sharply reduced adrenal function. In theory, electroacupuncture might still help a minority of patients whose adrenals glands work well, but not many others.

So the researchers dug even deeper — to find the specific anatomic and functional changes that occurred when electroacupuncture was performed with functioning adrenal glands. Those changes included increased levels of dopamine, a substance that has important functions within the immune system. But they found that adding dopamine by itself did not curb the inflammation. They then substituted a drug called fenoldopam that mimics some of dopamine’s most positive effects, and even without acupuncture they succeeded in reducing sepsis-related deaths by 40 percent.

Ulloa considers the results a double triumph.

On the one hand, he says, this research shows physical evidence of acupuncture’s value beyond any that has been demonstrated before. His results show potential benefits, he adds, not just for sepsis, but treating other inflammatory diseases such as rheumatoid arthritis, osteoarthritis and Crohn’s disease.

On the other hand, by also establishing that a drug reduced sepsis deaths in mice, he has provided an innovative road map to forward developing potential drugs for people. That road map may be crucial, because no FDA-approved drug to treat sepsis now exists.

"I don’t even know whether in the future the best solution for sepsis will be electroacupuncture or some medicine that will mimic electroacupuncture," Ulloa concludes. "I’m a little bit skeptical," he says, "that this research has opened the door to both."

Epigenetics could play role in dental care

A visit to the dentist could one day require a detailed look at how genes in a patient’s body are being switched on or off, as well as examining their teeth, according to researchers at the University of Adelaide.

“Our genetic code, or DNA, is like an orchestra – it contains all of the elements we need to function – but the epigenetic code is essentially the conductor, telling which instruments to play or stay silent, or how to respond at any given moment,” says Associate Professor Toby Hughes.

“Such a discovery is a crucial step in our understanding of the role that epigenetics play in oral health targets for the study of epigenetics include the inflammation and immune responses that lead to periodontitis, which can cause tooth loss; and the development and progression of oral cancers.”

The paper has been published in the Australasian Dental Journal.
Sugar tax may be introduced, says chief medical officer

A sugar tax may need to be introduced to cut down on obesity rates, chief medical officer Dame Sally Davies has said.

According to the BBC, she told a committee of MPs that the government needs to be firm with food and drink manufacturers in order for them to reformulate their products.

Dame Sally said: “We have a generation of children who, because they’re overweight and their lack of activity, may well not live as long as my generation. They will be the first generation that live less, and that is of great concern.”

She added that she believed researchers will find that sugars are addictive, and the public needed to have “a big education” over how “calorie packed” some smoothies, fruit juices and carbonated drinks were.

“People need to know one’s fine, but not lots of them,” she said. “We may need to move towards some form of sugar tax, but I hope we don’t have to.”

Terry Jones of the Food and Drink Federation said any extra tax on sugar would “hit the poorest families hardest at a time when they can least afford it,” adding that sugar content was already clearly labelled among products’ ingredients.

Dentist saves patient’s life

A woman was saved by her dentist when she suffered a heart attack on her way to work.

According to the Ilford Recorder, Catherine Forman from Barkingside got a lift from a stranger during the London Tube strike. Once in the car, Catherine experienced a pain in her chest, breathlessness and loss of vision.

The driver stopped at The Valentine Dental Health Centre in Ilford where Dr Hitesh Mody (Catherine’s dentist) used his medical kit and knowledge from a DVD on emergencies in the surgery to provide first aid. Dr Mody administered aspirin and a spray containing glyceryl trinitrate which helps the heart to pump more easily while they waited for an ambulance to arrive.

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Buying a dental practice – everything you need to know

In the second of his series on buying a practice, Jon Drysdale considers the critical issues of where to look and how to assess its value.

Much like purchasing a house, often the hardest part of buying a practice is finding one that is suitable. The mantra ‘location, location, location’ isn’t necessarily as important as with house buying because you’re not going to live there and don’t need to consider such things as where your children will go to school. I find most dentists know the broad geographical area they’re considering. Not all regions offer the same availability of practices so the larger the area you’ll consider, the greater your likely choice.

Town or country? Our experience of selling dental practices tells us that city centre practices and those close to large centres of population are in high demand. There are a variety of reasons for this not least because highly populated areas attract large numbers of dentists and competition for practices can be fierce. Also, corporate bodies tend to favour having practices in close proximity for the sake of efficiency (transfer of staff, ease of visiting etc) and this is usually only possible in large conurbations.

It doesn’t necessarily follow that city centre practices are more profitable than rural ones. Dentists prepared to look slightly further afield than cities and large towns may be rewarded by finding a practice which is great value for money and turns a good profit. Where you live in relation to the practice is a consideration. A commute of up to an hour each way is probably the limit for most dentists – after all dentistry is a demanding job, physically and mentally.

How to search? Wherever your desired practice location, it is worth registering with all the main dental practice agents to receive details of practices coming to market. Establishing your financial position with these agents is worthwhile in order that any offer you make is taken seriously. Preparing the groundwork for this is vital and part one of this series provided details on this.

Dental practice sales agents will usually provide a prospectus outlining the main financial aspects of the practice as well as details of turnover, equipment and location. An asking price for goodwill (usually including equipment) should be stated as should the price of purchasing any freehold property, if applicable. An asking price isn’t necessarily an accurate valuation, although it should be a realistic estimate of the eventual sale price. NHS practices in built...
up areas often sell for more than the asking price due to competing buyers. In this situation the agent should set a closing date for offers.

Many practices are sold by word of mouth, so keep your ear to the ground with colleagues and friends. Often associates get first refusal on buying the practice they work at. This can be a good way to buy, although negotiations on price can be difficult between a principal and an associate or associates trying to maintain a working relationship.

How to value?
As mentioned, the asking price may be determined by the selling agent. Making your own assessment of the value of a practice can be difficult. The key element to this is profitability and not, as is often thought, the turnover. While asking prices are commonly expressed relative to the turnover (e.g. 100 per cent of turnover) this is not necessarily a meaningful way to arrive at a valuation. For example, two practices in similar locations with similar turnover but different levels of profit are probably not worth the same.

A professional valuer (see www.aspd.co.uk) will be able to offer their assessment of the value having reviewed the financial information and equipment. For associates buying a practice where they already work, a jointly instructed valuation with the principal can be a good idea. However, the value here may be hard to dispute for either party, so this can work against you in some situations. Factors that increase or decrease the value of a practice tend not to be counted and are usually financial. For example a practice with private fee income from a capititation scheme is likely to be valued higher than one with fee per item private income. Practices that are deemed to be overstaffed or those with a relatively high cost lease will find it harder to command the highest price.

What to offer?
You must view the practice before making an offer. This can be an important element in the vendor’s decision making process. Turn up on time, ask relevant questions and try to build a rapport in a professional manner.

Practice owners are unlikely to be impressed with an offer significantly (probably 10 per cent or more) lower than their stated asking price. For practices in popular locations this approach just won’t work. If the practice is being sold through an agent, remember the agent is acting for the vendor and not you the purchaser. Agents will take note of your credentials as a buyer including your financial position and discuss this with the practice owner.

If ‘best and final offers’ are requested this usually means there are multiple offers on the table and the practice is popular. Without stating the obvious, put your best offer forward, having first checked this is financially viable. Don’t be too disheartened if you aren’t successful. The experience will be valuable and most dentists don’t buy the first practice they look at.

In part three of this series we will look at the different ownership options including partnerships and limited companies and the financial implications of each.
“Kennedy’s wound was clearly incompatible with life”

Few people are granted the opportunity to become an active part of historical events. Seventy-six-year-old Dr Don T. Curtis, a former dentist and oral surgeon from Amarillo in Texas, is one of them. As a resident in oral and maxillofacial surgery at Parkland Memorial Hospital in Dallas, he was one of the first doctors to have performed emergency treatment on US President John F. Kennedy after he was shot on 22 November 1963. DTI Group Editor Daniel Zimmermann had the opportunity to speak with him about that day and the reason he thinks that there was more to the assassination than a lone gunman.

DTI: A feature film about the events at Parkland Memorial Hospital, produced by Tom Hanks and starring Billy Bob Thornton, has just been released on the 50th anniversary of the Kennedy assassination. Have you seen it, and does it stay true to the events, in your opinion?

Dr Don T. Curtis: I have not seen it but I have heard criticism that it paints rather a sensationalised picture of the events. I guess I would go see it if it were shown here in Amarillo.

You began working at Parkland Memorial Hospital in 1963. What was your position back then?

At that time, I was halfway through my first year of residency in oral and maxillofacial surgery. Before I took a residency there, I also completed an internship. I became interested in the field while working as a surgical technician in a general hospital during my time in dental school at the Texas A&M University Baylor College of Dentistry in Waco.

Were you aware of the president being in Dallas on 22 November 1963?

I was not aware of that and was surprised when they brought him to the hospital. I had a surgery scheduled for later that day and was on my way to have lunch. The way to the lunch-room however required me to leave the building and walk across the receiving area of the emergency room.

‘When I got there, it was obvious that the president was in extremis. He tried to breathe but was unable to do so’
where I noticed police cars and the presidential limousine, which had blood on it and roses that were given to the First Lady, Jacqueline Kennedy, when she arrived at the airport. When a policeman asked me whether I was a doctor, I said yes. He then replied that the president was hurt and escorted me to the trauma room where President Kennedy was.

In what condition was Kennedy when you arrived?

When I got there, it was obvious that the president was in extremis. He was conscious but unable to do so. Dr. Charles James Carrico, a Parkland resident surgeon, had placed an endotracheal tube in an attempt at ventilation. However, that did not work because there was a blockage of the president's airway, so he decided to do a tracheostomy.

I helped the nurse to undo the president's tie and remove his shirt to prepare him for the procedure. Then Dr. Malcolm Perry, a senior surgeon, came into the room and it was decided that he should do the tracheostomy. Dr. Carrico assisted Dr. Perry, and I performed a cut-down on the left leg to provide for intravenous replacement of blood. When I looked up later, the room was filled with the senior chiefs of all surgical departments at Parkland. There were also some people I did not know.

‘Nothing that we did made a difference. Kennedy’s wound was clearly incompatible with life’

Were you aware that the president had been the subject of an assassination attempt?

I was unaware of the nature of the injury to the president because his head was on a pillow and I could not see a wound. I remember the chief of neurosurgery, Dr. Kemp Clark, rotating Kennedy’s head to the left, revealing that the posterior part of his skull had been radically fractured. He then said, “Stop; this injury is incompatible with life.”

What was the atmosphere in the room?

It became very quiet. Nobody said anything.

In your opinion, was there any chance that the president’s life could have been saved?

Nothing that we did made a difference. Kennedy’s wound was clearly incompatible with life.

According to eyewitnesses, discussions broke out about who was authorised to do the autopsy. Did you notice any of that?

I did not because I left the trauma room soon after the president had been pronounced dead and went back to the clinic to see my patient in the operating room. However, I found that all scheduled surgeries for that day had been cancelled and all patients had been sent back to the ward. Only a few surgeries were underway at that time, including that of Governor John Bowden Connally, who had also been injured during the shooting.

I told my patient that her surgery had been postponed. She understood that. Since there was nothing else for me to do, I then cleared my business in the clinic and went home. There, we spent the weekend watching television and listening to the news on the radio. We were relieved that President Lyndon B. Johnson had made it safely back to Washington and that the government was uninterrupted. Finally on Sunday, we learned that the suspect, Lee Harvey Oswald, had been shot, which indicated that there was something going on in addition to just a lone shooter.

The majority of Americans do not believe that Oswald acted alone, as concluded by the report of the Warren Commission appointed by the government to investigate the circumstances of the assassination. Did you observe any irregularities between this official version and the events you witnessed?

The Warren Commission’s report reflected what the people wanted to hear, which was that Oswald acted alone and that there was no conspiracy. The...
doctors of Parkland however when wiping the blood from Kennedy's neck for the tracheostomy found a single bullet hole that was apparently an entrance wound, which meant that must have been a projectile that entered the president from the front. Because of its nature, the wound on the back of Kennedy's head was an exit wound, so there must have been at least two bullets that came through the front.

While all the doctors' testimonies, including mine, were included in the report, their knowledge of the wounds did not have much influence on the Commission's overall conclusion. Why it was interpreted that way has remained a mystery for the past 50 years.

What do you believe actually happened that day? My personal belief is that there were of course multiple shooters and that Oswald did not do it alone. This would indicate however that there was in fact a conspiracy.

After the events, you stayed at Parkland Memorial Hospital for another two years. Were the events discussed by the staff in the aftermath? We actually never talked about it. This was something we just did not want to discuss. However, I left Parkland in 1965 for an exchange residency in London and Zurich, where I often discussed the events with my colleagues abroad. Particularly in England, there was much interest in US politics and the assassination.

You recently went public with your knowledge after

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You recently went public with your knowledge after
Management of plaque related periodontal conditions

A clinical studying the assessment and management of plaque-related periodontal conditions of patients by the practitioners at a general dental practice in Hertfoldshire in 2013

Abstract:
Undiagnosed and unmanaged periodontal conditions are fast becoming one of the biggest areas of litigation and complaints within the dental field. Thorough periodontal assessment is vital for diagnosis, treatment planning and monitoring the progression of periodontal disease. This is a report of a clinical audit that studied the periodontal assessment carried out at a general dental practice in Stevenage, Herts. This audit was conducted over a seven month period, analysing 50 patients for each audit cycle. A new protocol for periodontal assessment using the guidelines of the British Society of Periodontology was introduced. The results demonstrate a marked improvement in assessing the periodontal condition of patients in this general dental practice.

Clinical relevance:
Regular periodontal assessment is required to aid diagnosis, treatment planning and monitoring of disease. Without such assessment, it is possible to misdiagnose, develop incorrect treatment plans and prevent objective assessment of disease progression. With the periodontium being the scaffolding for all other restorative techniques performed by dentists, this is an essential area which must not be overlooked or under managed.

Null Hypotheses:
The five dental practitioners being audited would not exceed the expected percentage of 50 per cent of patients being provided with Gold Standard treatment with regards to periodontal monitoring and management.

A primary objective is that, as long as the first objective is achieved, the majority of the patients receive the ‘Gold Standard’ of screening and treatment with regard to surgical periodontal therapy. Specific risk factors for patients were not included, such as smoking status and medical conditions. Ten patients were chosen at random from each of the GDP’s day lists. These patients had been seen within four weeks of 17th December 2012; the start date for the audit. Null Hypotheses:

- The patient must have been seen for an exam within the four weeks prior to the audit start date. This ruled out the possibility that the patient had attended for an emergency appointment in the last four weeks, where a full exam including a periodontal screening may not have been carried out.
- The patients must have been over 18 at the time of their most recent exam and any edentulous patients were excluded. This meant that an exam must be carried out.

‘The aim of this audit is to assess periodontal screening and subsequent non-surgical periodontal treatment for patients with plaque-related periodontal conditions at the practice compared to that suggested in guidance documents’

The main objective for the audit is to investigate the standard of screening and treatment patients are receiving with regards to their periodontal condition. This will be achieved by ensuring that the number of ‘Unacceptable’ treatments provided is minimal, meaning the majority of patients seen at the practice receive at least an ‘Acceptable’ level of treatment, if not the ‘Gold Standard’ level. In this way, the audit aims to disprove the first null hypothesis.

A secondary objective is that, as long as the first objective is achieved, the majority of the patients receive the ‘Gold Standard’ of screening and treatment with regard to their periodontal condition. In this way, the audit aims to disprove the second null hypothesis.

Description:
This audit examined sets of patient’s notes kept by the five dental practitioners (GDP’s) working at the practice with regards to their periodontal screening process and any follow up treatment based on this. The type of treatment investigated was the initial treatment phase of plaque-related periodontal conditions which concerned patient’s oral hygiene habits, and any professional and patient-based cleaning of their teeth i.e. non-dit. This gave an overall sample size of 50 patients, which was deemed a decent sample size for the audit. A four week period prior to the date of the audit was chosen meaning that any periodontal treatment suggested for the patient at the time of their exam was likely to have been carried out or at least started by the start date of the audit. Notes before this were not investigated as this may not represent the most current practice of the practitioners being audited.

Inclusion criteria for the patients were as follows:
- The patient must have been seen for an exam within the four weeks prior to the audit start date. This ruled out the possibility that the patient had attended for an emergency appointment in the last four weeks, where a full exam including a periodontal screening may not have been carried out.
- The patients must have been over 18 at the time of their most recent exam and any edentulous patients were excluded. This meant that an exam must be carried out.

Ref 1.0 Flowchart constructed in order to grade patients notes with regards to their periodontal screening and management.
include a full periodontal screening, which may not have been done for children and adolescents, or patients without their natural teeth remaining.

A flow-chart was constructed which was followed during the auditing process in order to score each set of notes based on whether sufficient periodontal screening had been carried out and whether the correct subsequent non-surgical management was recommended or carried out based on the results of the screening.

Each of the sets of notes were studied and the flowchart followed in order to grade the overall process of the monitoring and managing plaque-related periodontal disease. The flowchart is shown in Ref 1.0.

By following the flowchart, each patient’s screening and management was given a score according to the number of correct steps completed. If any step had not been correctly completed this was reflected in the scoring system and lead to a lower overall score for the patient’s treatment.

A standard BPE was accepted as an appropriate screening of periodontal health during a patient’s exam.

If a patient had been offered the correct treatment (i.e. it was recommended) according to the findings of their screening, but had refused to accept or failed to attend for treatment suggested by the GDP, the practitioner was scored according to the flowchart and any patients with a BPE of 3, 4, * or with pockets ≥4mm, who had undergone plaque-related periodontal treatment for this, in order to monitor healing and observe where further treatment may be necessary. Therefore if, for these patients, a recall period was not stated in their notes or modified on the computer system following treatment, this was seen as inappropriate follow-up.

The type of follow-up treatment was not included as part of this audit. This was due to the fact that not enough time would have passed between the start of the audit and the allocated four week period prior to this, from which patients were chosen, in order for the follow-up treatments to have been carried out.

‘Appropriate’ management of the periodontal condition included further investigations and treatment based on the BPE and was decided upon by amalgamating information from three different sources. A chart was drawn up which indicates the correct management for each particular finding of the BPE screening. This is shown in Table 1.0; the sources are also quoted below the table.

This audit included whether a diagnosis was made relating to the periodontal condition. The accuracy of diagnosis in relation to the BPE findings was not investigated as this is outside the scope of the audit.

Each grading which was given to a patient’s periodontal treatment according to the flowchart was then put into one of three categories: Gold Standard, Acceptable and Unacceptable. This reflected the standard of treatment delivered to each patient. The scores included in each category and explanations are as follows:

Gold Standard= 5
Unacceptable= 0-2
Acceptable= 3-4

Table 1.0

- Function involvement, recession and probing depth of 7mm or more.
- Treatment suggested by the GDP, this was seen as inappropriate follow-up.

Table 1.1

<table>
<thead>
<tr>
<th>Category</th>
<th>Expected Percentage</th>
<th>Actual Percentage Audit Cycle 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gold Standard</td>
<td>&gt; 50</td>
<td>32</td>
</tr>
<tr>
<td>Acceptable</td>
<td>≤ 50*</td>
<td>56</td>
</tr>
<tr>
<td>Unacceptable</td>
<td>&lt; 10</td>
<td>12</td>
</tr>
</tbody>
</table>

Table 1.2

<table>
<thead>
<tr>
<th>Category</th>
<th>Expected Percentage</th>
<th>Actual Percentage Audit Cycle 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gold Standard</td>
<td>&gt; 50</td>
<td>74</td>
</tr>
<tr>
<td>Acceptable</td>
<td>≤ 50*</td>
<td>24</td>
</tr>
<tr>
<td>Unacceptable</td>
<td>&lt; 10</td>
<td>2</td>
</tr>
</tbody>
</table>

*Where Gold Standard and Unacceptable treatments are within the stated expected values

Ref 1.1

Graph showing expected ranges of each category and actual percentages for first cycle

Sources:
**Are you prepared for a medical emergency in your dental practice?**

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- Aspirin (300 mg)
- Glucagon injection (1 mg)
- Oral glucose gel
- Midazolam 10 mg (buccal)

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² Bag is an optional extra and will incur a charge
³ Only applies to certain products

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Periodontal disease is becoming increasingly prevalent amongst today’s population due to, amongst other factors, people living for longer and maintaining their natural teeth later into life.

The next step to improve the results further would be to ensure that all dentists are using the stickers during every adult patient exam, as where this wasn’t being done, some elements were still being omitted resulting in a judgment which was less than Gold Standard. In the future the monitoring and management of periodontal condition will need to be re- audited to ensure these standards are maintained and improved on where possible. The results from both cycles can be seen represented in the pie charts in Ref 1.4.

Limitations and Improvements to the Audit:
There are many limitations to this audit and possible improvements which could be made to refine the results and give a much broader and more accurate representative of peri- odontal screening and treat- ment at the practice. Firstly, a very small sample size was considered. According to the number of patients recorded on the practice system, 50 patients make up about 0.56% of the total patient population of the practice. A much larger sample size would be needed to make the results of the audit more reliable.

The presence, or otherwise, of risk factors for periodontal disease was not accounted for in this audit. The aim of the audit was to determine whether the correct non-surgical plaque-related treatment was being carried out for each patient according to the screening results, regardless of the risk factors, e.g. medical conditions, medications and smoking status. It was assumed that these risk factors were observed by the GDP and discussed in investigated accordingly. Also, the precise diagnosis arrived at for each patient was not investigated. The audit only looked at the basic principles of man- 
gerating a patient’s periodontal condition at the exam, and would be less likely to forget to include aspects such as a diag- nosis and suggested follow-up period. The sticker is designed to give the practitioner a ‘tick system’ for the management of the patient’s periodontal condition. The treatment recommended for the BPE score found may be shown in the brackets next to the treatment options, making it easy for the GDP to tick which treatment they recom- mend the patient should re- ceive according to the BPE score and diagnosis recorded above. There is also an option to circle whether the GDP will carry out the treatment or whether it is to be carried out by the hygienist working at the practice.

These stickers were distrib- uted between the four surger- ies and one was also given to the receptionists. Staff, in- cluding the GDP’s, nurses and receptionists, were instructed to put a sticker in each patient’s notes if they were attending for a check-up only so that this could be completed at their appointment.

Following implementa- tion of these stickers into the patient’s notes, 50 patients were reviewed and audited four weeks later by again choosing and ex- amining 10 patient’s notes from each GDP’s list at random who had attended for an exam and recording the score. As shown by the table (1.2) and the graph below (Ref 1.5), the results from the second cycle of the audit were found to be within the expected val- ues set out at the beginning of the audit, therefore disproving both the null hypotheses. The audit has therefore achieved its aim by improving the over- all standard of monitoring and management of patient’s periodontal conditions at the practice. It was found during the second cycle of audit that where the stickers were used in the patient’s notes, Gold Stand- ard treatment was delivered or planned, resulting in the signif- icant improvement in the find- ings during the second cycle.

Changes implemented to im- prove overall standard of treat- ment provided:
As shown in the specific pattern shown from the scores for the different practitioners, it was not deemed appropriate to speak to each individually to improve the results, but to implement a method which would improve the practice’s score as a whole for the periodontal diagnoses, management and follow up.

With this in mind, a sticker was produced and provided, which was to be stuck to each patient’s notes who was attend- ing for a regular check-up, and which outlined the key parts of diagnosis, treatment and follow-up for periodontal condi- tions. The sticker designed is shown in Ref 1.2.

Using this, each practitioner would be able to easily record and quickly understand and act on the results regard- ing a patient’s periodontal condition at their exam, and would be less likely to forget to include aspects such as a diag- nosis and suggested follow-up period. The sticker is designed to give the practitioner a ‘tick system’ for the management of the patient’s periodontal condition. The treatment recom- mended for the BPE score found may be shown in the brackets next to the treatment options, making it easy for the GDP to tick which treatment they recom- mend the patient should re- ceive according to the BPE score and diagnosis recorded above. There is also an option to circle whether the GDP will carry out the treatment or whether it is to be carried out by the hygienist working at the practice.

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Perio meets implant dentistry

Author Rainer Buchmann

The preservation of the natural dentition is the prerequisite in daily patient care. In advanced periodontal disease, the successful realisation of implant therapy requires knowledge in patient expectations, clinical diagnostics, proper surgical skills and delegation of basic services to dental hygienists. Implant treatment in severe periodontitis demands a two-step, time-tested approach, evaluating the outcomes of basic periodontal therapy before implant placement.

Integrated dentistry: Success

The successful positioning of dental partnerships in the fast-growing health market implicates predictable treatment strategies to save permanent teeth. According to orthopaedic, cardiac or vascular medicine, an on-time decision-making protocol for implant therapy is recommended to counterbalance functional and aesthetic discomfort in advanced endodontic and periodontal breakdown settings. Patient’s current and future expectations drive our practices into the necessity to provide synergistic periodontal and implant treatment solutions. The advantages are:

- Optimising implant success by proceeding with periodontal therapy
- Enhanced economic profit due to by-effects from delegated scaling and root planing
- Promotion of oral and body health of both dental patients and staff members

The need to preserve healthy teeth and gums, the ever-expanding influences of web, TV and magazines and an increase in low-cost implant treatment render implant dentistry internationally attractive. The transition of dental practices into the implant market is reasonable, especially for growing dental partnerships. The capital investment and running costs for a surgical implant setting are redeemed by more than 50 implants a year. Because of the economic commitment, a careful financial strategy is needed not to neglect challenges and developing concepts preserving and salvaging compromised teeth from conservative and periodontal dentistry.

Decision-making

Classical implant therapy protocols comprise must-indications resulting in an immediate treatment plan. According to patient preferences, clinical settings and insurance plans, these must-indications with an ad-hoc implant placement recommendation are, in order of precedence:

- Long-term missing bridgeworks or prosthesis, edentulous mandible
- Advanced endodontic damage
- Trauma (tooth fracture)
- Oral cancer surgery

Periodontal diseases represent can-indications. Treatment planning is running more complex. The decision-making comprises a time-tested therapeutic approach. In advanced periodontal settings of more than 50 per cent bone loss with furcation involvement level III, patients suffer from oral discomfort. The tooth prognosis becomes less positive, the frequencies of follow-up visits increase (Fig 1). Periodontal therapy ‘before’ implant planning is aimed at saving doubtful (not hopeless) teeth with a grace period of at least three to six months to evaluate for periodontal treatment outcomes. Thorough scaling and root planing frequently results in a mid-term improvement (two years) up to a long-term stabilisation (five years) of preliminary affected teeth.

The decision to maintain the periodontally compromised dentition undergoes the following criteria (Fig 2):

- Patients with no preferences to comfort, aesthetics and costs
- Patients willing to accept enhanced tooth mobility, occasional...
food impaction and frequent professional tooth cleaning.
• Individuals with chronic diseases and autoimmune disorders

The recommendation to replace affected teeth with implants is indicated in the following clinical situations and should be planned on-time after completion of periodontal therapy (three to six months):
• Patients running a demanding business striving for fixed teeth
• Enhanced masticatory and clearance
• Long-term rehabilitation with input in time, effort and expenses

Currently, the items above are effective at implant placements within the local bone, minor lateral hard and soft tissue deficiencies, following sinus floor elevation, in settings with sufficient implant abutment distances of 3mm and after periodontal therapy. Extended surgical protocols enhance treatment time (Fig 5), render the case prognosis uncertain and may aggravate long-term success.

Implant therapy in advanced periodontal disease

The survival rates of teeth with severe periodontal damage published in evidence-based studies are rarely valid for patients inpainting treatment in dental offices (Fig 4). Shortcomings in oral hygiene, lack in supportive care, oral dysfunctions, stress, smoking and general disorders abbreviate the function times of periodontally compromised teeth sustainably.

The advice to replace affected teeth with implants in advanced periodontal settings within the maxilla implicates on-time patient information of the second and third molar removal: implant placement and prosthetic bridges are scheduled in the functional masticatory area until to the first molar. In the mandible, the second molars can be preserved due to their beneficial root anatomy. They should be restored, but not included in implant planning. Following the removal of the first molar in the maxilla, implant therapy is often preceded (if the supporting bone is less than 4mm) or accompanied by a simultaneous sinus lift. The dentition treatment plan in periodontally compromised patients results in a reduced dentition (Fig 5):
• Fixed bridgeworks in the maxilla and mandible up to the first molar
• Maxilla: preservation of premolars, and first molars, tooth removal and implant therapy with sinus floor elevation at furcation involvement level III (Fig 6)
• Mandible: preservation of second molars, restoration, no inclusion into bridgeworks
• Volume thickening with free autogenous gingival graft in initial thin biotype settings (Fig 7)

• Short implants in both esthetically and functionally less demanding situations as an alternative to surgical augmentation (Fig 8).

Low bone quality (DS/D4), lateral hard-tissue deficiencies and increased mechanical loading are contraindications for short implants. According to conventional implant rehabilitation, the horizontal width of the alveolar bone crest is the fundament for functional stabilisation, vascularisation and nutrition, thus for implant survival and clinical success (Fig 9).

Inflammation and hygiene

Clinical healthy and stable implants are completely covered within the alveolar bone by osseointegration. They also are attached to the peri-implant gingiva and thereby become functionally included into the body’s metabolism. This explains the high overall survival rates of oral implants between eight and more than 15 years. The combination of
• A thin biotype gingiva with lack of soft tissue protection
• Functional overload due to three molars in a missing front-canine equilibration
• Loss of biofilm protection by periodontal diseases often causes mid-term damages (two years after functional loading) of the implant-to-bone interface. Like periodontally affected teeth with lack of hygiene access and enhanced biofilm accumulation, implants develop a potential risk of inflammation when bacteria enter the implant-to-bone interface (Fig 10). If the close hard and soft tissue sealing disappears irreversibly, foreign-body infections occur within the oral cavity, which are more harmful for the implant-supporting bone and the body health than periodontal diseases. The best protection against peri-implant inflammation is not avoiding implants: a careful implant placement strategy with concomitant thickening of the surrounding tissues and relief from functional overload precede by comprehensive periodontal therapy (hygiene) are the best therapeutic helpers for implant survival and oral health (Fig 11).

Summary

In advanced periodontal diseases, the network between medi- cal progress and ever-expanding patient’s expectations requires a time-tested schedule with a grace period of three to six months to evaluate the affected dentition for periodontal treatment outcomes. If patients anticipate immediately fixed and aesthetic restorations, on-time implant therapy with minimal augmentative solutions is recommended. Preservation of periodontally compromised natural teeth is advised when patients display no preference for further comfort and aesthetics. Periodontal therapy is continued, supplemented with surgery in advanced intra-bony settings where oral hygiene is impaired. The long-term success for the natural dentition and implants similarly depends on patient’s medical and local risk factors that cannot be forecasted with any genetic or susceptibility test for sale.
Advancements in dental technology offer better solutions for traditional oral health problems than ever before. Technology makes dentistry as comfortable, durable, efficient and natural-looking for the patient as possible. Patient and dentist benefit from newer techniques that are less invasive and more dependable than ever before. Procedures that formerly took multiple trips to the dentist or required multiple health care providers can now often be performed in the comfort of one surgery by one qualified provider.

Technology increases efficiency significantly. With the latest generation of dental equipment, patients see exactly what you see. This creates trust and empowers them to make decisions about their own care, and not rely purely on the first advice they’re given.

Technology also helps with patient education and case acceptance. If someone is missing a tooth, the team can virtually place an implant and crown with 3D scans and show them exactly where the tooth will go. Patients can see digital X-rays and photos of their teeth blown up on flat screen monitors right in front of or above their dental chair.

Showing patients what’s going on in their mouth, versus just trying to explain it, leads to quicker understanding and fewer questions, making both dental practitioner and hygienist’s job easier.

A system that’s going to particularly appeal to hygienists is Acteon’s Air-n-Go.

This is the first dual purpose – supra and perio – air polisher. No other polisher better exemplifies the possibilities of combining the beauty and health of your patients’ teeth. It speeds up treatment, maximising your time, while giving your patients the most gentle, yet powerful cleaning experience they’ve ever encountered.
Air-n-Go is extremely versatile. The device is made up of a convertible handpiece, available in supra and perio versions, that are compatible with high performance powders, unique in that they are made from all natural components and taste great. Treatments are very gentle, which results in a significant reduction in bleeding and pain. A winning combination for patient choice.

The reason for Air-n-Go’s versatility is its convertible handpiece. This increases options for supra-gingival and sub-gingival treatments. In Supra mode, it helps you achieve perfect cosmetic results with fast, effective, painless polishing that is gentle to both the gingiva and teeth. In Perio mode, it transforms into a simple and efficient device to treat periodontal disease and peri-implantitis sub-gingivally. Just 20 seconds of maintenance is enough to treat periodontitis or peri-implantitis effectively.

The ergonomic handpiece
The handpiece has been designed to create better working conditions for whoever handles it. It is fine, lightweight, well balanced, easy to manipulate and has 360° rotation, resulting in less stress and less manual fatigue. It enables smooth, fast movement, improved visibility and excellent accessibility, even in the difficult to reach posterior areas. A non-slip silicone ring on the front gives you a better grip during treatment – even with wet gloves. Manipulation is precise to enable the practitioner to focus on the treatment area. Two exchangeable heads – short and long to suit all hands and needs and wants of your patient during sub-gingival treatments. The use of this device eliminates bacteria in the pocket and prevents recurrence of the disease.

And it’s worth noting here that ‘Perio’ powder can also be used in supra mode for the prevention and control of periodontitis and peri-implantitis.

Powders
The well-being approach to prophylaxis is a concept that is perfectly matched to the needs and wants of your patients. The Classic range of Air-n-Go powders are indicated for maintenance, prevention of tooth decay and improving the oral hygiene of the patient. Their abrasive properties cause no damage to the enamel, the gingiva or the root surface.

This range comes in a variety of flavours that each patient chooses, according to individual taste. There is a choice of cola, raspberry, neutral, peppermint or lemon. The fine balance between flavour and sodium saccharin concentration removes any unpleasant taste and offers a feeling of freshness.

In addition to Classic, there is Pearl, a powder specifically designed for supra mode and Perio, exclusively for sub-gingival treatment.

Many patients think of a polishing session as an unpleasant experience, so the motivation to establish a maintenance plan fades quickly. Most sodium bicarbonate-based powders are already been prepared. I like mine!” Carlos, 31.

“Like many people, I’m afraid of going to the dentist and I hate having my teeth polished. You have to admit that it hurts and isn’t pleasant at all. But this time, it was quite the opposite – completely different! During this session, I forgot my fear and felt no pain at all, although I’m very sensitive where my teeth are involved. It made me want to come back to my dentist.” Stephanie, 23.

“Since I was offered the flavour I want. For once, I can have my say at the dentist! I really liked the raspberry – it was almost as if I was actually eating some.” Maya, 11.

“Some of the patients I have treated over the years have been very specific in their requirements. They have different expectations in terms of taste and appearance. Some prefer a glossy finish, while others prefer a matte look. With Air-n-Go, I can offer both options, and patients are very happy with the results.” Carlos, 31.

“Now I can offer my patients a choice of different flavours that suit their individual preferences. It’s like having a personalized treatment.” Stephanie, 23.
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References:
1. Bleeding Index Reduction DOF 1 – 2013 (LER/A0001).
2. DOF 2 – 2013 (LKP/L00005).
3. NEC/L/13/024/0b

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“Therapy has been innovate for mc/says Paul. “After 28 years in implantology I chose Nobel Biocare for its biocompatibility, ease of use, success rate, and innovation.”

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The Carl Zeiss OPM I View Microscope – ‘I remain as impressed now as I was when I purchased it’

‘I’ve been using the OPM I View microscope for over 18 months now and I remain as impressed now as I was when purchased!’ says Dr Devon Sangha of The Mercer Clinic in Maidenhead. ‘The unit is very well designed, its arms and most interfaces allow it to be positioned at a wide angle of image over a two-metre span. Its locking screws hold very well and it allows for very gentle tightening of minor degrees of movement, especially important when under high magnification. A DSLR or Camcorder specialist scope adaptor can be mounted on the unit. It’s great for presentations to colleagues and beyond.’

The Carl Zeiss OPM I View microscope is available exclusively from Nuview in the UK. ‘Jordan and his team at Nuview recognise this purchase as a large investment’, continues Dr Sangha. ‘I have dealt with the team for a few years now and have no hesitation in recommending them. They offer good technical support, advice and a prompt service.’

For more information please contact Nuview on 01453 872266, email info@nuview.ltd.co.uk or visit www.nuview.co.uk

BPF guidance at your fingertips – new gum health app available

GlaxoSmithKline Consumer Healthcare, manufacturer of Corsodyl mouthwash, has launched a new mobile app to help support dental professionals with the use of the Basic Periodontal Examination (BPE) app provides information on:

• Description and clinical image of each BPE code
• Background to the BPE code
• Summary of recommended treatment

Developed by the British Society of Periodontology, the BPF allows dental professionals to consistently and accurately assess patients’ gum health.1 The assessment of gum health, together with the provision of support for patients to help prevent periodontal disease, will be of even greater importance once the Dental Quality & Outcomes Framework comes into force in the revised dental contract.2 The Corsodyl brand is committed to supporting dental professionals when educating patients on the importance of gum health and the prevention of gum disease. This app forms part of a range of material that also includes the Corsodyl/Gum Care Guidance Pack which can be requested for dental practices.

For more information, please call 0845 602 5094 or visit www.gsk-dentalprofessionals.co.uk

Philips extends support programme for young dentists

Young dentists are the focus of the Philips exhibition presence at the DKA Conference and Exhibition in Manchester this April, and trainee and TD dentists are particularly encouraged to visit stand number B05.

To further their on-going thirst for knowledge both novice and experienced dental professionals are being offered free access to the expanded Philips website, giving them access to free CDP material, mentoring tutorials and other information to smooth their path towards success.

A click on a QR code on the show stand which will direct visitors a direct to the new website – www.philips.co.uk

For those hungry to learn about the latest innovations in tooth whitening, members of the Philips team will be at the show to take them through the intricacies of the Zoom range.

Also on show will be the upgraded Philips Airfloss – an award winning interdental cleaning device within reaching ambitions. The hand-held device fees micro-droplets of air and water (mouthwash) between the tooth giving the whole mouth a thorough clean in 30 seconds.

Show visitors will also be able to get a handle on the newest Sirona – its Philips Sonicare for Kids which targets young patients aged 4-10.

For more information please visit the new website www.philips.com or email philipssoralhealthcare@philips.com or telephone 0800 657 222.

The University of Buckingham and LDSA agreement

The University of Buckingham and the London Dental Students’ Association (LDSA) signed a joint venture agreement on April 27th 2012 to establish a Dental School in Leicester which would initially provide a five year BDS degree course. This was to complement a new Medical School which the University was also pursuing at the time.

In October 2012 the University and the LDSA hosted a launch in Leicester to an invited audience of 200 delegate drop-in session. As required by the project alone has left the University with no choice but to delay to the Dental School and the LDSA agreement. As the University is unable to commit to a start date this has made it impossible for the LDSA to complete contracts for the provision and construction of facilities as required in the joint venture. Both parties therefore reached an amicable agreement to end the joint venture in June 2014.

The University of Buckingham will support, as far as it is able, the efforts by the LDSA to attract an alternative venture partner.

Orthodontic treatment has the Orthodontist Dr Preet Bhogal, two highly experienced and qualified professionals to offer orthodontic treatment, implant work and complex multi-disciplinary cases.

Regardless of your dedication to training and education, at some point you will come across a patient that requires treatment outside of the usual scope of practice. In those cases, patients offer the widest range of treatment options by referring the award-winning London Smile Clinic. The practice is open for referrals for orthodontic treatment, implant work and complex multi-disciplinary cases.

The expert team includes implantologist Dr Zak Kanaan and Specialist Orthodontist Dr Pravej Bhogal, two highly experienced and qualified professionals dedicated to ensuring the success of your patient’s treatment.

As the referring dentist, you will be involved in the treatment planning, regular progress updates, and to receive an update on each stage of the treatment. Every case is documented with before and after photographs, while orthodontic referrals receive treatment planning models to send to their consultant.

Offer your patients more – contact the London Smile Clinic and see how they can undertake procedures that are outside of your capabilities.

For more information, please contact 020 7235 2259 or visit www.londonsmile.co.uk/ABOUT – your patients will be glad you did.

The London Smile Clinic

Enhance Your Patient Service With The
Experts All The London Smile Clinic

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Whatever questions you may have about selling a practice, Christie + Co can help provide you with the right advice and help in gaining a better result – your business or retirement goal, meet with ease.

To discuss how Christie + Co might help you achieve your future plans please contact Simon Hughes on 0207 227 0149

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What you can look forward to: a first class program, lectures from renowned speakers, exciting workshops, a stylish party with a Spanish twist at a wonderful location. Do not hesitate to register now.

See you in Valencia!