Don’t let drink sneak up on you

People will be warned that they are at risk from serious illness including heart disease, stroke and cancer if they drink just a little bit more than they should, says Health Secretary Andrew Lansley.

A brand new nationwide Change4Life campaign launched last week, will expose that drinking slightly over the lower-risk alcohol guidelines can seriously impact long term health.

While people recovered from their weekend excesses or wound down with a glass of wine at home, the new TV adverts went out for the first time.

The adverts highlights that regularly drinking around two large glasses of wine or two strong pints of beer a day triple the risk of developing mouth can-cer and double the risk of devel-oping high blood pressure.

A shocking new survey has revealed that most people are unaware of the serious illnesses caused by drinking more than the guidelines. For example:

- 57 per cent did not realise it reduces fertility
- A new online calculator will be available on the Change4Life website to help people check how much they are drinking and work out whether they need to cut down. Two million leaflets will also be available for Change4Life supporters and health professionals around the country.

The campaign also offers handy hints and tips on how people can cut down – such as having booze free days, not drinking at home before people go out, swapping low-alcohol or alcohol free drinks and simply using smaller glasses.

Secretary of State, Andrew Lansley said: “It’s crucial we support people to know about how drinking too much poses risks to their health and how they can take control of their drinking.

“It can be easy to slip into the habit of having a few extra drinks each day, especially when drinking at home. But there can be serious health risks. Don’t let drink-ing sneak up on you. That is why I am launching this campaign, to alert people that it is not just binge drinkers that damage their health. There are simple ways we can all cut down how much alco-hol we drink if we need to.”

“Change4Life is a fantastic, well known campaign, which has already helped a million families around the country. I want to expand it beyond eating well and moving more, so people look af-ter themselves and really do live longer.”

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www.dental-tribune.co.uk
Andrew Lansley has announced extra cash for dentistry in a major Government drive to increase the number of people able to access an NHS dentist.

820,000 more people have already been given access to an NHS dentist since May 2010. Today £28 million of funding has been announced, which will bring the number of extra people now able to access an NHS dentist to one million.

The funding will be given to PCTs, who have bid for the cash to spend on expanding local services in ways that best meet their patients’ needs. This will include things like increasing the number of appointments with NHS dentists and providing care in people’s homes for people who can’t travel to see an NHS dentist.

Health Secretary Andrew Lansley said: “Too many people are unable to access an NHS dentist since May 2010. To reverse this trend the Government’s drive to increase access to NHS dentists will include things like increasing oral health and increase access to services.

“Alison Simpson, a dentist who runs a dental practice in Northampton said: “This is fantastic news for people who couldn’t get to see an NHS dentist before.

“We will use the money to make sure that an extra thousand people in the Northampton area will get access to NHS dental care. This means local people will have healthier teeth, and will be less likely to suffer from long-term dental problems.”

Save water, save money!

Water consumption in the UK is up 50 per cent per person since 1970 and it is feared that if the trend isn’t reversed there will come a time when the demand just won’t be able to be met. This will have a devastating effect on the UK’s rivers, lakes and stream levels, animal and plant life so this year, for the first time, the National Smile Month Campaign is promoting responsible water use.

The campaign aims to encourage adults and children to turn off the tap when brushing their teeth and save up to 12 litres of water, every time. So far Save Water Save Money and 19 of the UK’s Water Companies have joined forces to encourage water efficiency, by raising awareness of the high levels of water wasted in the bathroom.

Currently, 25 per cent of household energy is spent heating up water and according to Waterwise, if every adult in England and Wales turned off the tap when brushing their teeth, it could save enough water to supply nearly 500,000 homes or fill 180 Olympic swimming pools – every day!

A list of key facts, water saving products and advice on why we should save water can be found on the National Smile Month website, www.nationalsmilemonth.org/page/turn-off-the-tap

Are clinical decisions affected by fear?

Former Dentist of the Year Dr Helen Chapman, Dr Susan Chipchase and Dr Roger Bretherton from the School of Psychology at the University of Lincoln have been awarded £77,557 from The Shirley Glasson Trust Fund to investigate ’Dentists’ emotions and clinical decision making: individual differences in susceptibility and the development of a coping package’.

During this 15 month project, the researchers will explore the emotions experienced by dentists in their clinical work and identify possible implications of these emotions.

An early information gathering stage will inform the development of a coping skills package, based on cognitive-behavioural principles, which will be evaluated in the last stage of the research.

The ultimate aim of this research is that this coping skills package will be included as part of dentists’ continuing profession al development to increase their awareness of how their emotions may impact on their clinical work and equip them with the skills to cope with these emotions in their dentistry work.

The research question was originally posed on the Primary Dental Research Forum. A survey via the discussion forum of GDPUK found that 60 per cent of participants felt that their clinical decision making was affected by fear on a daily basis. Contributors also felt that training to help cope with the issue is needed.

The research team is currently seeking to recruit a pool of volunteers from the Lincolnshire area who might be interested in participating in an hour-long face-to-face interview to discuss this issue which will be conducted at their practice. From this pool, the team hopes to draw a sample of dentists who represent a complete cross-section of primary care dentists.

If you think you might be interested in participating, please contact Helen Chapman at hchapman@lincoln.ac.uk or 0796 455 6516. You will then be sent a full description of the study so that you can make an informed choice about possible participation.

3D printer designs jaw

A jaw that was designed and created by a 3D printer has been fitted to an 83-year-old woman in what doctors say is the ‘first operation of its kind.’

The jaw is far from a simple design, with articulated joints and cavities to help encourage muscle attachment and grooves to direct the re-growth of nerves and veins; according to a BBC report, it was made out of layers and layers of titanium powder that was heated and fused together by a laser.

“Once we received the 3D digital design, the part was split up automatically into 2D layers and then we sent those cross sections to the printing machine,” Ruben Waathme, LayerWise’s medical applications engineer, said in the BBC report.

“This was repeated with each cross section melted to the previous layer. It took 55 layers to build 1mm of height, so you can imagine there were many thousands layers necessary to build this jawbone.”

Once completed, the new jaw was then given a bioceramic coating.

The team said the operation, which was carried out in June in the Netherlands, took four hours and incredibly the woman was able to go home after four days.

“Shortly after waking up from the anaesthetics the patient spoke a few words, and the day after the patient was able to swallow again,” said Dr Jules Poukens from Hasselt University, who led the surgical team.

Technicians are hoping that after the operations success, similar techniques will become more common in the future.

The jaw itself has been described as ‘patient-specific’ and although it weighs a third heavier than the woman’s previous jaw, doctors have said that it won’t be long before she gets used to the extra weight.

The surgery follows research carried out at the Bio-medical Research Institute at Hasselt University in Belgium, and the implant was built by LayerWise - a specialist metal-parts manufacturer based in the same country.

However, the work doesn’t stop there. Later this month the team will remove healing implants that were inserted into the implant’s surface; this will be followed by the attachment of a specially made dental bridge and false teeth, which will be screwed into place.

The research follows a separate project at Washington State University where engineers demonstrated how 3D printer created ceramic scaffolds could be used to promote the growth of new bone tissue.
Smile centre launches

Two of the North West’s leading dental clinicians have teamed up for a joint venture in Manchester.

Clinical Dental Technician Barrie Semp, owner of The Smile Centre in Whitefield, has joined forces top dentist Phil Broughton, owner of The Mall in Manchester. Situated in Pall Mall, The Smile Centre at The Mall will provide a complete service for patients covering dentures, dental implants and cosmetic dentistry. Broughton, who leads a team of six dentists, will also provide dental services to Semp at The Smile Centre’s other new clinic in Lichfield, Staffordshire.

Semp, who sits on the board of the British Association of Clinical Dental Technology, said: “I am delighted to be joining forces with Phil Broughton and The Mall team. Phil is widely recognised as one of the leading implant dentists in the UK.

“Implants are an increasingly popular option for replacing missing teeth and can be inserted directly into the jawbone like the roots of natural teeth. The dentures are then securely fixed to the implant.

“The new venture will also offer patients the complete range of cosmetic dentistry including teeth whitening, orthodontics and veneers.

“By joining forces, we are combining two of the most advanced dentistry businesses in the North West, providing patients with a customer experience second to none.”

Phil Broughton, who includes footballers, actresses and other celebrities among his patients, said: “The opening of The Smile Centre at The Mall is a superb development not just for our two businesses but, more important ly, patients across the UK. This joint venture brings together the country’s leading dentist with our own, technically advanced, mercury-free, independent dental practice. We are delighted to be joining forces to offer The Mall’s patients with a customer experience that is second to none.”

m Health.

Editorial comment

In these days of focusing on the patient journey it is easy to forget that the practitioner takes a journey too.

It seems that the practitioners’ journey is coming more into focus as research looking at the clinical implications of the emotional state of the clinician is about to begin.

As you can see from our article on page two, a research project ‘Dentists’ emotions and clinical decision making: Individual differences in susceptibility and the development of a coping package’ is looking for Lincolnshire-based volunteers to take part in the research. The aim is to develop strategies to help clinicians cope with emotions to minimise the impact on clinical decision-making.

Recently, a report into the three years of the existence of the Practitioner Health Programme (PHP) has been published. PHP provides healthcare services to medical and dental practitioners primarily in the London area; over the last three years more than five per cent of those who used PHP’s services were dentists. Many of the cases that PHP has seen include addiction or mental health diagnoses.

Given that those in the healthcare profession are often the ones most reluctant to seek treatment (physician, heal thyself’ springs to mind) this rising awareness of practitioners’ needs is a vital time.

Take care of yourselves.

Do you have an opinion or something to say on any Dental Tribune UK article? Or would you like to write your own opinion for our guest comment page?

If so don’t hesitate to write to:

The Editor

Dental Tribune UK Ltd.

4th Floor, Treasure House,

19-21 Hatton Garden,

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Or email:

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Applying fluoride varnish containing 22,600ppm F is a recommended intervention in ‘Delivering Better Oral Health – An evidence-based toolkit for prevention’.

Duraphat 50 mg/ml Dental Suspension. Active ingredients: each of suspension contains 50mg Sodium Fluoride equivalent to 22.6mg of Fluoride (22,600ppm F).

Indications: Prevention of caries; de-eruption of hyper-mineralized teeth. Dosage and administration: Recommended dosage for single application for mol e teeth: up to 0.25ml (15.63mg Fluoride) for primary teeth; up to 0.4ml (19.94mg Fluoride) for permanent teeth; up to 0.75ml (15.63mg Fluoride). For caries prophylaxis the application is usually repeated every 6 months but more frequent applications (every 3 months) may be made. For hypermineralization 2 or 3 applications should be made within a few days.

Contraindications: Hypermineralization to coronaries and/or any other conditions. Ulcerative gingivitis. Stomatitis. Bronchial asthma. Special warnings and special precautions for use: if the whole dentition is being treated the application should not be carried out on an empty stomach. On the day of application other high fluoride precautions for use a fluoride gel should be avoided. Fluoride supplements should be suspended for several days after applying Duraphat. Interactions with other medicines: The presence of alcohol in the Duraphat formula should be considered. Undesirable effects: Colorectal variant has been observed in subjects with tendency to allergic reactions. The dental suspension layer can easily be removed from the mouth by brushing and rinsing. In rare cases, asthma attacks may occur in patients who have bronchial asthma.

**Cigarette machine ban begins in Wales**

The ban on cigarette vending machines came into force in Wales on 1st February and is soon to be issued in Northern Island on 1st March.

The ban came about after it emerged that a shocking 10 per cent of smokers between 11-15 years-old bought cigarettes from vending machines: with the new law in place young people will now find it much harder to buy cigarettes.

The ban was originally imposed in England in October 2011; however, due to legal reasons, it has taken time to be imposed in other areas of the UK.

“Banning sales of tobacco from vending machines is a step in the right direction to reducing smoking addiction in childhood and improving the public health of our communities,” said Steve Whitehouse, chair of Wales’ heads of trading standards (WiTOs) officials in a BBC report.

There were an estimated 5,000 vending machines in Wales before the ban was imposed and research published by Welsh trading standards officials in 2009 young people could successfully purchase cigarettes from vending machines. Health Minister Lesley Griffiths said: “Making cigarettes less accessible is one way of discouraging children from taking up smoking in the first place.

“It will also support the efforts of the many adults in Wales who try to quit smoking each year.”

From 1 February, a business found to be too close to public from a vending machine could be fined up to £2,500 and if vending machines display tobacco advertising the business could face a fine of up to £5,000 and a two year prison sentence.

www.bbc.co.uk/news/uk-wales-politics-10815794

**Suffolk dentists miss out on funding**

According to a recent report, NHS Suffolk has not applied for a portion of the £2m set aside by the Government to help increase the amount of people to have an NHS dentist.

The funding was available for Primary Care Trusts (PCT) throughout the region as part of a £28m project announced by Health Secretary Andrew Lansley. The cash had been set aside for PCTs to expand local services to best suit patient needs, however, according to an NHS Suffolk spokeswoman, the PCT did not bid for the additional funding due to a concern that dentists would not be able to meet the requirements for the funding to be used this year.

According to the report, NHS Suffolk has invested more than £5m in the dental community over the past four years; in total, seven new practices have been established and existing practices have been expanded. Overall, the investment has helped more than 60 per cent of NHS practices accept new patients.

The spokesperson said in a report: “Providing NHS dental services within a rural area does present more of a challenge. In response to this challenge in 2008, NHS Suffolk’s Board established standards for access to NHS dental care; individuals living in an urban area should be within six miles and those living in a rural area within 12 miles of an NHS practice and we continue to aim for our dental provision to meet these standards.

“For instance a routine appointment would be available within six weeks and an urgent appointment for anyone in pain within 16 hours. These standards are being met across Suffolk.”

**Sussex dentists ‘struggle to fill NHS holes’**

According to report, dentists throughout Sussex are struggling to fill gaps caused by a shortage of NHS patients. Although health bosses are urging the public to take advantage of the NHS dental places, some practices are not registering as many new patients as they had planned.

For example, a practice that opened in Worthing six months ago in response to calls from local residents for more NHS dentists, has failed to fill the number of patients originally expected. The practice currently cares for 1,000 patients and yet has the potential to care for up to 6,000 people.

Practice manager Shane Smith, of The Tooth Booth said they had until the end of this financial year to boost numbers or they could lose vital funding.

He said: “We have been surprised at the lower-than-expected numbers because a lot of people have been talking about unavailability of NHS dentists. “Yet we are here and we are finding it difficult to get people to come along.”

The practice opened on August 1, having been commissioned as part of a £1.8 million investment in dentistry across the county by NHS Sussex.

NHS Sussex dental contracts manager Tim Price said: “Often people don’t realise that there are NHS dental practices across the county taking on new patients, just like Tooth Booth in Worthing, and we would encourage people looking for a NHS dentist in the Worthing area to call the practice and book an appointment.

“We can assure people that dental practices across Sussex continue to take on new NHS patients.”

**Dentist gets paper clip prison sentence**

Boston dentist, Mr Clair, who had been using paper clips as a cheap alternative in root canal treatments, was sentenced at the Bristol County House of Correction, U.S. Reports claimed that he had not only faced charges of assault and battery, but also faced charges with regard to defrauding Medicaid of $150,000.

The court heard that Mr Clair’s substandard dental treatment left many patients in terrible pain and a number of patients developed a range of problems, including loss of teeth and infections.

Originally the prosecutors had requested a five-seven year sentence; however, much to the annoyance of Mr Clair’s victims and former colleagues, the dentist only received a one-year sentence.

According to reports, the final sentence was decided after ‘mitigating factors’ were taken into account; these included a lack of criminal record, mental health issues and the fact that Mr Clair accepted responsibility for his actions. However, after it was revealed that Mr Clair’s former staff members were concerned for their own safety, a further request from the prosecutors that Mr Clair stay away from his victims and ex-colleagues was granted by the Judge.

Reports further stated that Mr Clair is now banned from practicing dentistry anywhere in the USA and upon his release prison he will have to complete five years of probation.
Switch on to new ideas

Speakers:
Prof Nasser Barghi
Dr Richard Kahan
Prof Gianluca Gambarini
Dr Wyman Chan
Dr John Moore
Dr Ajay Kakar
Ms Jackie Coventry
Dr Mona Kakar
Basil Mizrahi
Fraser McCord
Mhari Coxon
Amit Patel
Anthony Roberts

EARLY BOOKING DISCOUNT
‘Give dental kits to every child’

A £15m project aiming at improving the dental health of children has been introduced in Scotland.

Although the scheme, which is called Childsmile, has been described as ‘ambitious’ by Public Health Minister Michael Matheson, it’s focus is to stress to children the importance of brushing their teeth.

The scheme will mean that by the age of five, all children will be given a pack containing a toothbrush, toothpaste and an information leaflet at least six times.

In the more deprived areas of Scotland, fluoride will be applied to children’s teeth to help prevent them getting tooth decay.

So far children have been taught how to brush their teeth properly in more than 90 per cent of nurseries and primary schools in the most deprived areas.

Mr Matheson said in a report: “Thanks to work to ensure that children know the importance of dental care at the earliest age, Scotland’s children are now primed to have a lifetime of good oral health.

“Through Childsmile nursery we have seen specially trained dental nurses going into schools and providing clinical preventive care to children. Targeting children in the most deprived areas, Childsmile School is also delivering a range of preventative care interventions for children in primary one and two to reduce the risk of dental decay.”

Ray McAndrew, associate medical director in oral health at NHS Greater Glasgow and Clyde, said in the report: ‘This exciting programme encourages dentists and their staff to give advice to parents on the care of their children’s teeth. It places a strong emphasis on preventing dental decay through daily tooth brushing using fluoride toothpaste and advice on diet.

‘Childsmile Practice also encourages dentists to apply fluoride varnish to young children’s teeth, which has been shown to reduce tooth decay.”

So far around 900 dental practices across the country are involved in the scheme.

Sugar taxes have been suggested to curb and control the consumption of sugar

In the past 50 years sugar consumption throughout the world has more than tripled and according to US experts, the sweet granule is just as damag- ing and addictive as alcohol and tobacco and should be regulated.

To curb and control the soaring consumption of sugar new policies, such as sugar taxes, have been suggested by a University of California team. Other suggestions have been made in the jour-

nal Nature, where Prof Robert Lustig argued for a ‘major shift’ in public policy, suggesting that taxes, age restrictions and limiting the sales of sweet food and drinks during school hours would be a change in the right direction.

However, the Food and Drink Federation have reportedly said that ‘demonising’ sugar would not solve the problem, as the key to good health is a balanced diet.

Even still, several countries have already started imposing taxes on what are considered as unhealthy foods, such as soft drinks and saturated fat, and now US researchers are proposing similar policies on sugar.

Dr Peter Scarbrough of the British Heart Foundation Health Promotion Research Group at the University of Oxford, said in a report that although imposing taxes on certain foods was something policymakers should consider, doing so could have ‘unintended consequences’ in the form of people cutting out fruit and vegetables so they can afford the sweeter things in life.

He told the BBC: ‘If you only tax one aspect of food like sugar you can have unintended conse- quences... [But] if you tax fat, salt and sugar, combined with subsidies for fruit and vegetables, you’ll get healthier diets.’

Chief Executive of the British Dental Health Foundation, Dr Ni- gel Carter, said: “A proposed tax on sugar certainly could have a positive impact on oral health, particularly for children. Tooth decay remains a large problem, with one in three children starting school with the disease.

“However, it remains to be seen how such a tax would be implemented successfully. It is not as simple as merely taxing sugar, as all fermented carbo- hydrates would also need to be taxed, so we should approach the idea with caution.

“It is clear from the ris- ing number of health prob- lems resulting from high suga- ar consumption that people need more education on what sugar-free alternatives are avail- able. People also need clear in- formation and advice on how they can regulate their diet. The frequency of sugar intake can cause damage to teeth, so cutting down on sugary foods and drinks will satisfy not just oral health, but overall health too.”

Barbara Gallani, director of food safety and science at the UK Food and Drink Federation, said in a BBC report that: “The key to good health is a balanced and var- ied diet, in the context of a healthy lifestyle that includes plenty of physical activity.”

Sugar Nutrition UK said: “Over many years, a number of expert committees have examined the scientific evi- dence relating to the con- sumption of sugar and other carbohydrates. These committees have included The European Food Safety Authority (2010), World Health Organization and Food and Agriculture Organization (2003), Institute of Medicine of the American Academies (2002), Food & Agriculture Organization of the United Nations (1998) and UK Department of Health (1990).

“All have concluded that the balance of available evidence does not implicate sugar at the level currently consumed in any of the ‘lifestyle diseases’ such as obesity, diabetes, coronary heart disease, or cancer at any site.”

BDA calls for retirement age pensions proposal to be rethought

The British Dental Association (BDA) is calling for a proposal to extend den- tists’ working lives to the age of 68 to be abandoned by Govern- ment. The proposal is part of a raft of fundamental reforms Government wishes to make to the NHS pension scheme. Health trade unions, includ- ing the BDA, are consulting members on the acceptability of those proposals, the current iteration of which was arrived at before Christmas 2011 as the best achievable by negotiation.

The BDA call follows a sur- vey of more than 4,000 den- tists, which found that a signifi- cant majority of practitioners (68 per cent) did not think it was safe for practitioners up to the age of 68 to continue treating patients. A further 14 per cent of respondents said they were unsure whether doing so was safe or not.

Practitioners’ concerns have been communicated to the Department of Health (DH) in a letter from Dr Su- ste Sanderson, the Chair of the BDA’s Professional Affairs Committee. The warning echoes that ex- pressed by other bodies repre- senting health professionals, including the British Medical Association.

The BDA survey also asked dentists whether they might, in principle, consider taking in- dustrial action if they consider the proposals unacceptable. The response to that question is being analysed and will inform a BDA Representative Body de- cision of whether the govern- ment of dentists participating in such action when the pensions proposals are finalised follow- ing further talks.

Dr Sanderson said: “A great deal of concern has been expressed about clini- cians being asked to extend their working lives as a result of these pensions proposals. Dentistry, like other careers in healthcare, can be very physi- cally demanding. The wisdom of asking dentists to extend their working lives is ques- tionable and, as this survey shows, a cause of significant anxiety to those best-placed to judge their own ability to carry on providing care to patients. We are asking Gov- ernment to listen to these concerns and re-think this proposal.”

Is it time to call for a sugar tax?

New research published in The Journal of Clinical Dentistry (Volume XXII 2011 Number 5) has found that baking soda toothpastes are more effective in enhancing plaque re- moval from harder-to-reach areas of the dentition than non-baking soda variants.

In addition to offering imme- diate plaque removal benefits, baking soda toothpastes were also found to remove twice as much plaque after repeated regular brushings than non-baking soda toothpastes.

Dental consultant for Church & Dwight Co., Inc, the maker of Arm & Hammer toothpastes, Dr Graham Bannby says: “The clinical credentials and potential health benefits of baking soda have been long in investi- gation for many years. This new study provides evidence that the use of baking soda in toothpastes can result in greater plaque re- moval than in non-baking soda toothpastes.”

To date, there have been numerous studies to support the efficacy of baking soda as a mechanism for plaque removal. This new study states that baking soda is a unique ingredient, clini- cally demonstrated to remove plaque biofilm present on tooth surfaces.

In all but one of the 24 com- parisons carried out, baking soda toothpastes were relatively more effective in areas with less access by the interdental. This indicates that plaque removal is achieved by the action of baking soda in its disodium hydrogen carbonate form rather than due to physical displacement caused by the baking soda crystal.

Studies analysis supports baking soda plaque removal

N

Dental叫法 for retirement age pensions proposal to be rethought
MDDUS welcomes clarification of treatment during pregnancy

Dentists in Scotland are urged to get up to speed with the latest advice issued on the contentious subject of the use of amalgam fillings during pregnancy.

NHS practitioners in Scotland will have received a document entitled ‘White fillings in those who are pregnant or are nursing mothers’ with their January schedules.

Over the past few months, UK-wide dental defence organisation MDDUS has received a number of enquiries in relation to this increasingly controversial issue.

While the advice in this circular represents a complete departure from previous policy, MDDUS dental adviser Doug Hamilton welcomes the publication of definitive guidance for posterior restorations in pregnant patients.

He says: “Provision of amalgam during pregnancy has always been attended by more general concerns in relation to its possible teratogenic effects.

“Current advice from MDDUS continues to mirror that provided by the Department of Health - while foetal risk from amalgam is largely theoretical, placement and removal of this material during pregnancy should be delayed unless there is an over-riding clinical need.”

Clearly, such clinical concerns do not apply where a pregnant patient will not consent to the placement of amalgam. However, in these circumstances, problems have arisen where practitioners have offered these patients an alternative in the form of posterior resin, but on a non-NHS basis.

“To do so would seem quite reasonable since there has never been any section in the Statement of Dental Remuneration which expressly provides for non-amalgam posterior occlusal fillings in pregnant patients,” says Hamilton.

“Yet, in adopting this approach, NHS practitioners were potentially in breach of their terms of service.

“Finally, these patients could have been offered a temporary dressing followed by a permanent amalgam post-partum, both of which are available on the NHS. Secondly, it was the established custom and practice at Practitioner Services to award a code and discretionary fee which allowed posterior resin to be provided free of charge for pregnant patients.

“Therefore, in instances where complaints were made by patients who had paid privately for this treatment, it was the advice of MDDUS that a refund should be offered.”

In response to the growing confusion, a circular was released by Practitioner Services in September confirming their ongoing policy of approving and funding of resin fillings in posterior occlusal surfaces during pregnancy, but indicating that each case would be scrutinised by a dental adviser to prevent the replacement of existing amalgams unnecessarily or for non-therapeutic purposes.

However, the latest advisory note reverses this position, stating that, for the first time, no fee will be payable under GDS arrangements for the placement of posterior resin in a pregnant patient unless they also have an exceptional medical condition.

“It might be assumed that this change in policy automatically validates the provision of this treatment on a private basis,” adds Hamilton. “Dentists should read the details of the January 2012 directive before deciding which treatment options a pregnant patient is entitled to consider.

“Every case must be individually assessed and discussed,” advises Hamilton. “If the patient in question consents to amalgam and the dentist agrees then this material should be used.

“Alternatively, if the proposed treatment does not require removal or placement of amalgam, then an application may be made to PSD for a temporary dressing fee, so that the tooth can be restored with amalgam after the birth.

“NHS patients should be offered these options to avoid infringement of the practitioners’ terms of service.”

While the flow chart which accompanies this circular is very informative, some practitioners may feel that it fails to address every clinical scenario.

In response to these possible concerns, Hamilton concludes: “These guidelines may be subject to further clarification. However, at this stage, we anticipate that, where retention of a temporary dressing requires amalgam removal, an NHS fee may not be payable. In such circumstances, the practitioner should make scrupulous clinical notes (ideally accompanied by pre-operative photographs), together with a very careful record of the consenting process.

“As always, practitioners must be prepared to justify the recommendation of private treatment to NHS patients.”

Members of MDDUS who have concerns in relation to this matter should not hesitate to contact a dental adviser for further information.

Cocktail of uncertainty for dental students

A cocktail of spiralling levels of debt for dental students, uncertainty about the financial support available to them, and concerns about changing career pathways, could conspire to dissuade capable young candidates from applying for careers in dentistry, a new British Dental Association (BDA) report warns.

Student Futures warns that significant levels of debt, potentially as much as £90,000, could have a psychological effect on potential candidates, deterring those who feel unable to take on such a financial burden from applying for places at dental schools.

These concerns could be exacerbated, the report warns, by other changes that make the cost of studying a dental degree difficult to assess, including likely increases to tuition fees to £9,000 as a result of 2011 Government reforms and continued uncertainty about the student bursary system.

The difficulty of judge-ments about whether to take on uncertain levels of debt is further complicated, the report warns, because the shifting labour market into which dentists will graduate makes careers and future earnings more unpredictable than ever.

Dr Martin Nunn, the Chair of the BDA’s Young Dentists and Student committees, said: “Many dental students already incur significant debts completing their studies. The size of these debts alone may be prohibitive to some potential candidates, whose concerns about their personal finances may be deterring them from applying for dental courses. Uncertainty about funding arrangements and career prospects make decisions about whether to apply for dental courses even harder.

“If the Government is serious about its very laudable Fair Access to the Professions agenda, then it must think seriously about these issues and seek to provide certainty by finalising arrangements for NHS bursaries to ease concerns about how studies can be funded.

“It must also continue its pursuit of the reform of dental services in England that could help provide greater certainty about career prospects.”

Student Futures also calls for better links between schools and dental schools and more exposure to business and management training for dental students, as well as the maintenance of dental academic staffing levels to protect teaching standards. The report is available on the BDA website.
What are you going to do?

Stephen Hudson provides part II of his conspiracy trilogy

What are you going to do? In my recent article Are they all out to get you? I put forward the concept of dealing with the irritations and annoyances in life by either accepting them completely, or taking massive action to change them. Both concepts are designed to empower you and give you back your piece of mind. Both actions are designed to change your focus, and I want to talk about these concepts in more depth.

Acceptance

Of course as we both know, it was never going to be as easy to accept such things. It is amazingly hard to accept that your council’s traffic planning office is run by complete nannies who should have been sacked years ago, especially if you drive to work every day. Imagine then how hard it can be to accept blatant corruption and injustice in your own supposedly civilised country. Can you look at the crimes the banks have been allowed to get away with and not feel a tad irritated? Can you see the growing underclass of people in this country that have been beaten down psychologically (and sometimes physically) by the system, who see themselves as having no future within that system and not feel just a smidge annoyed? Can you stand by as our politicians order our military to act as judge, jury and executioner in countries that many in this country couldn’t find on a map, without raising an eyebrow?

It’s difficult isn’t it? But here come those questions again:

Can you actually do anything about what is troubling you?

And if so, are you actually prepared to do anything about it?

Are you prepared to take the massive action required, to put your head above the parapet and to make yourself a target to the establishment?

‘Are you prepared to take the massive action required, to put your head above the parapet and to make yourself a target to the establishment?’

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It is perhaps time to focus your life somewhere else, and stop reading the damned newspaper. Switch off the TV, and go outside, breathe deeply and revel in the miracle of life.

This world is amazing, so if you either can’t or won’t do anything about the problems of the world, then I would say it is time to focus on what is right, and how your life can be improved.

Right to judge
And another thing, don’t think anyone has a right to judge you if you said no. There are a million and one scandals, famines, wars, corrupt politicians, crimes and injustices in the world to keep you busy ever second of every day. Whilst I would argue that one person CAN change the world, you are not necessarily that person. I’m certainly not, I realised that months ago. For years I’d been raging about this and ranting about that and it didn’t achieve a damn thing except a deep feeling of dissatisfaction and indignation. Here are a few, just as a taster:

- The fact that the Blair government went into an illegal war in Iraq
- The fact that we are one of the largest exporters of weapons in the world
- The fact that the electric car has been a viable technology for over 50 years and yet has been allegedly suppressed… and if that’s not enough, put the following into Google “Japanese cars that run on water”
- The blatant incompetence of all western governments in dealing with this financial crisis
- The fact that big pharmaceutical companies are not researching new antibiotics because there’s not enough profit there… whilst our battle against bacteria slowly slips towards the dark ages
- The fact that there are poisons in our food...

Rant, rant, rant… repeat until sectioned under the mental health act.

Well, enough of this. I can’t change any of that. And even if I could, I’m not sure I have the courage or the fortitude to make that change.

Life impacts
I can still take massive action though, for my health (mental and physical) and my wealth. I can take massive action to remove the impacts on MY LIFE by voting with my wallet and by taking control of what I think and what enters my body. I can take massive action for my business and in my relationships, and I can choose to do that RIGHT NOW, and so can you. One of Ghandi’s most famous sayings was:

*Be the change you want to see in the world*.

You can make your life a shining beacon of wealth, health, honesty, compassion and love. You can’t change the plight of the Palestinians or the fate of the rainforest, but you can change yourself. You control

- What you eat
- Where you shop
- What you focus your attention on
- Who you spend your time with
- What you read
- What you wear
- What you drink
- How you spend your time

And of course, some of you will have answered YES to both of those questions. Some of you will see some a problem, some injustice, and just be able to sleep at night if you didn’t at least try and make a change.

Again, I have no problem with that, but when it comes to this, there is no ‘try’, there is only ‘do’ (thank you Yoda). To make change you need guts, commitment and perserverance. It requires focus and conviction. It requires your life’s energies. And you may well be the next Ghandi, the next JFK, the next Martin Luther King or the next Brian Haw. But all of those people made great sacrifices for what they believed in, and all of them paid the ultimate price. If you are going to do this, you need to leave your naivété behind.

So what are you going to do?
Are you going to BE the change you want to see in the world?
Or are you going to try and MAKE the change?

That decision I leave up to you. But to do nothing just makes you part of the problem.

About the author

Stephen Hudson is a Dental Practice owner working in Chesterfield. When he qualified in 1995, he soon realised that the way most dentists treat their dentistry was slowly killing them, and decided he needed to try and do something to reverse this trend. This was why he set up the website www.gdpresources.co.uk. He can be contacted through his website.
Routine housekeeping
Sharon Holmes on checklists, templates and task tracker's

Running a dental practice has become a pressured role. There are many daily routine tasks that need to be carried out to ensure that you are managing the practice effectively. To enable me and my teams to work in an organised fashion we have created a variety of check lists or templates if you prefer. There are three areas that we cover; they are daily, weekly and monthly. They are for the receptionists, procedures for the nurses and for the practice manager.

Relevant tasks
They are carefully thought out lists of each task that needs to be carried out. It also forms part of CQC protocol whereby everything needs to be documented and evidenced based. I have created a ‘site visit checklist’ for senior management. On this check list is recorded all the relevant tasks that need to be checked and signed off. I have broken the duties down into categories to make sure I cover all tasks. For example when it comes to routine computer work I have a category named as IT and on the list is, EDI transmissions sent, responses checked and backups done and so forth. The categories that I have are as follows:

1. Administration - financial reports
2. IT – submissions and claims
3. Patient complaints
4. Staff management HR – leave forms, sick leave etc
5. Clinical Governance - infection control
6. Health and Safety – fire, safety, emergency drug kits and 02 cylinders
7. COSHH – control of substances
8. Maintenance of equipment – chairs, suction and compressors
9. Record of stock purchased – using budget report
10. Practice stationery – private or NHS
11. Reception and patients’ toilet – for tidiness and sundries

Each week the practice manager has the responsibility of carrying out the initial site check prior to my site visit. I then email this report back to the practice. This report is printed and signed off by the practice manager acknowledging that the tasks have been completed. I find this to be one of my helpful ‘tools’ in keeping up to speed with all the necessary procedures that we now have to carry out routinely. If there are any tasks that need to be carried out (for example the fire extinguishers may require their yearly service) this gets added onto our ‘Task Tracker’.

Each week when the practice manager and I meet we use the site visit check list as well as the task tracker to keep abreast of what needs to be done.

Briefing
Each Monday afternoon I receive a ‘weekly briefing’ folder which contains the site visit check list, weekly financial summations as well as any agendas for staff meetings or training sessions that have been carried out. Each Tuesday morning my assistant and I sort through all pending issues. During these site visits Dr Solanki also meets with each associate making use of the weekly financial summations, which has an overview of the KPIs. Based on the information at hand we can monitor each associates performance from monitoring their UDA performance. In this way we can spot any over or under performance which could be a risk to the practice.

As Winston Churchill once said: “You have enemies? Good. That means you’ve stood up for something, sometime in your life.”

Making a checklist is a great way to keep organised

It is impossible in today’s times for one person to be solely responsible for carrying out all tasks as well as taking care of the welfare of the staff and the patients alike

Great effort
It takes great effort to take care of a dental practice to the degree that each member of the team is carrying out its tasks. It is impossible in today’s times for one person to be solely responsible for carrying out all tasks as well as taking care of the welfare of the staff and the patients alike.

There is no truer meaning to the term ‘teamwork’. With great effort and attitude we could all work in a calmer and happier work environment without constantly worrying about the threat of the Care Quality Commission. Unfortunately the job is never done until the paperwork is completely finished and that just never ends!

‘It is impossible in today’s times for one person to be solely responsible for carrying out all tasks as well as taking care of the welfare of the staff and the patients alike’
High fibre diet dramatically lowers inflammatory disease risk

A study by researchers from the Fred Hutchinson Cancer Research Center has shown that a diet rich in high-fibre foods significantly reduces markers of inflammation associated with the onset of chronic disease.

The study, which was published in *The Journal of Nutrition*, explained that a diet rich in slowly digested carbohydrates, such as leafy green vegetables, significantly improves insulin signalling and resistance that promote life-shortening diseases including cancer, cardiovascular, stroke and dementia.

The study was conducted on 80 men and women from Seattle, WA; using a standard BMI scale, half of the participants were overweight, whilst the other half were healthy and of normal weight.

According to a report, the researchers discovered that among those that were overweight and obese, a low-glycemic-load diet reduced a biomarker of inflammation called C-reactive protein by about 22 per cent.

Previous studies have suggested a correlation between dietary carbohydrate and sugar consumption; however, this specific research is important, as one report suggested, because the C-reactive protein is associated with an increased risk for many cancers as well as cardiovascular disease.

It has been suggested that eating between 50 and 50 grams of fibre a day from a variety of different foods can help control systemic inflammation and lower disease risk.

The study provides another chapter to the growing body of research that demonstrates the importance of dietary choices to prevent heart disease, cancer, diabetes and most chronic illnesses.
Practical periodontics in daily practice

Amit Patel discusses the ways to help diagnose periodontal disease

Cosmetic and implant dentistry has become increasing popular amongst dentists who provide the treatment and patients who seek it, but as this type of dentistry increases so does litigation. Defense organisations have noted that their highest litigation costs are due to an increase in undiagnosed periodontal disease, poorly planned cosmetic and implant dentistry. A failure to diagnose periodontal disease, inadequate records, poor quality treatment and treatment planning, supervised neglect and failure to refer, all lead to increased litigation within the profession.

The guidance for standards set by the general dental council states that a clinician should work within their knowledge, professional competence and physical abilities, and to refer patients for a second opinion, further advice when necessary and to refer patients for further treatment when necessary.

As the clinician it is important to assess the periodontal condition before starting any simple or complex restorative dentistry. There is very good long term evidence to show that once the foundation of the periodontum is stable and good plaque control is achieved, the restorative treatment will have a better long term prognosis. This article will briefly discuss the simple tools we have within our surgeries to help diagnose periodontal disease and when to treat and when to refer using the British Periodontal Societies referral policy.

The clinical signs of chronic periodontal disease are gingival inflammation and bleeding, pocketing, gingival recession, tooth mobility and migration, alveolar bone loss and halitosis. Figure 1 shows a patient with gingival inflammation and bleeding on probing with pocketing greater than 5mm. A good predictor of gingival health is no bleeding.

A furcation probe or Nabet’s probe is also an essential tool when assessing the degree of furcation involvement of a molar tooth. We can measure the amount of horizontal bone loss that has occurred within the furcation this is classified as class 1, 2 and 5 furcations. The dark bands represent 5mm markings (Fig 5). Class 1 furcation is noted when the furcation probe penetrates less than 3mm into the furcation (Fig 7). A class 2 furcation is when the probe penetrates greater than 3mm but does not go all the way through the furcation (Figs 8, 9). A class 5 furcation is when the probe passes through the furcation unimpeded (Figs 10, 11).

Radiographs are another important tool used to assess the bone levels around each tooth, root morphology and furcation involvement and therefore the support present and long term prognosis of the teeth (Fig 9). Long cone parallel radiographs or vertical bitewings are taken of sextants when the score is 5 or more (Fig 6).

Risk factors

The clinician should also be aware of risk factors which
can exacerbate the existing periodontal disease; diabetes, smoking and genetics. A combination of these factors makes certain patients susceptible to higher risks of periodontal disease. These cases may be treated in practice but referral to a specialist would be required if the disease is not stabilised.

Recognition of risk factors include:

- BPE scores of 3, 4 or * in patients under 55 years old
- A high bleeding percentage with a low plaque score
- A family history of early tooth loss due to periodontal disease

**Oral hygiene**

A high standard of oral hygiene is critical for successful periodontal therapy. There is lots of evidence to show that regular plaque removal around periodontally involved teeth at a level that prevents bleeding on probing leads to a reduction in disease progression. It is essential that the patient is taught ways that are simple and yet effective to improve their plaque control at home with daily use of a rotating oscillating electric toothbrush and interdental brushes (Fig 12). A systematic review by the Cochrane Library has shown that a rotating oscillating electric toothbrush is far more effective at removing plaque.

A study has shown that using the correct sized interdental brushes can improve the periodontal condition significantly. A recent systematic review has also shown that flossing by patients has no effect on the plaque index or gingival index and flossing is not

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**Effective in periodontally compromised patients.** Interden- tal brushes have been shown to remove more plaque than flossing.

It is important to motivate your patients to use the largest interdental brushes (Figs 11, 15) but this can be a little difficult as they may not be able to see the short term benefits as their gums may bleed more and the interproximal spaces will become larger. It is essential to continually reinforce the same message this will reassure the patient and after a short time they will see visible benefits ie less bleeding on cleaning and healthier looking gingiva.

A case study
A 52-year-old gentleman was referred to me complaining of loose teeth and bleeding gums for more than 12 months. He is fit and well and is a non-smoker. A diagnosis of generalised aggressive periodontitis was made from the clinical examination (Figs 14-17). At the consultation appointment oral hygiene instructions was given and the largest interdental brushes demonstrated. At the following appointment the full mouth non-surgical phase was carried out with systemic antibiotics. From Figures 18-21 it can be noted that using the correct size interdental brushes can lead to a reduction in inflammation and therefore a reduction in pocket depth.

Eight weeks after the nonsurgical phase the patient was reviewed for a periodontal reassessment. It was noted that the periodontal tissue had responded extremely well to the initial therapy with pocketing of 5-4mm throughout the mouth (Figs 22, 23).

The patient will now be placed on a three-monthly maintenance regime where there will be reinforcement of oral hygiene instructions and subgingival plaque removal of any deep sites. This will be carried out by his general dentist or hygienist. My plan would be to review the patient in six months’ time to review his periodontal condition.

It is important to know that periodontal therapy works and a healthy periodontium is the backbone of good restorative dentistry. Treating periodontal disease can be challenging but can also be very rewarding. It is important that careful assessment, treatment, referral to a specialist if necessary and monitoring of your patients is essential to avoid any future problems.

For further information regarding the BPE and referral policy, contact the British Society of Periodontology or refer to the BSP website www.bsperio.org.uk.

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**About the author**

Amit Patel BDS MSc MCBd Dent MFDS RCS Eng. Specialist in Periodontology & Implant Dentist. Amit is a Specialist in Periodontology practising at Grace House Specialist Dental Centre in Birmingham. His special interests are dental implants, regenerative and aesthetic Periodontics. Amit graduated from the University of Liverpool and completed a 4 year specialist training programme in Periodontics at Guy’s, King’s & St Thomas’ Dental Institute. Amit is also an Associate Specialist in Periodontics at the Birmingham Dental School. He has taught at undergraduate and postgraduate level, including lecturing to dental practitioners both in the U.K. and internationally.

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References:
Dental school is an odd place. We cram all this academic information into our brains while trying to perfect several manual skills and to add some interest you need to perfect your people and communication skills pretty quickly, or you will hear about it.

It is no surprise then, that some skills can be forgotten, or remembered falsely and not revisited for quite some time. Often it is the less interesting ones that go from our memory, and for many, periodontal instrumentation is one of those.

And so I have compiled this article to provide a base knowledge of instruments options available, giving an understanding of hand instruments and blade shapes.

Using instruments designed for the area saves time, reduces operator fatigue, improves calculus removal and reduces tissue trauma.

Do we need hand instruments? Ultrasonic scalers have evolved to be very effective when used correctly. They are seen (incorrectly) to be faster. The angled, narrow and curved tips allow better contact and they are seen to reduce operator fatigue. There is research out there that says “Under our experimental conditions, this clinical study demonstrates that mechanical root planning with power-driven instruments, as effective as the usual procedures (hand and sonic instruments), represents a satisfactory and alternative means of nonsurgical root therapy.”

Others say no to ultrasonics alone stating “In conclusion, ultrasonic instrumentation at high power settings produces rougher root surfaces than ultrasonic instrumentation at lower power. An addition, manual instrument with currettes produces lower roughness than ultrasonic instrumentation independently of power setting.”

And it seems neither is superior when it comes to biofilm disruption. Research concluded that “The analysis of microscopical and cultural data did not show any differences between hand and ultrasonic debridement. Both treatments reduced the microscopical counts of rods, spirochetes and motiles and reduced the total volume forming units and number of black-pigmented Bacteroides and Capnocytophaga, resulting in a subgingival microbiota consistent with periodontal health.”

And so, one conclusion to come to, and the therapy blend that works best for me, is to use both. If there are heavy deposits supragingival then the ultrasonic is your friend to remove these. Then I tend to hand scale with an overlapping technique and follow that with an ultrasonic debridement using a cross hatch technique, paying particular attention to furcations and deeper pocketed sites.

What is a universal instrument? Its working end is perpendicular to the terminal shank, it has two cutting edges and the toe is rounded. Universals include: Columbia; Langer; Goldman – Fox; All-purpose Curettes; McCall.

The technique for using a universal blade is placing the terminal shank parallel to the tooth.

To remove deposits, the cutting edge is applied to the tooth surface and the facial surface of the blade is tilted toward the tooth to achieve an approximate 89º angle between the tooth and blade. You then apply lateral pressure.
against the tooth and pull upward while maintaining contact with the tooth.

Langers
Langers combine a universal, two cutting edge working end with the shank angulation found in Gracey instruments. This gives some site specific benefits when instrumenting while retaining the flexibility of a universal instrument.

All-purpose Curettes
There is an instrument called the Syntette made by LM instruments and if we were to only be allowed one instrument in my kit, this would be it. It is a universal but has the blades angled like a Gracey and angulations in its shank which allow for use pretty much anywhere in the mouth.

What is a Gracey?
The Gracey curettes combine a unique offset blade with nine different shank designs to be used on specific tooth surfaces. This improves the ergonomic fit to the tooth surface. The blade is offset from the shank at 70º. This creates one cutting edge which is referred to as the lower edge. The higher edge has no blade so the instrument is single bladed. Gracey curettes are used in a set to completely scale the dentition and are seen as finishing instruments by some periodontists.

Gracey Technique
The blade of a Gracey curette is correctly adapted when the lower cutting edge is against the tooth, and the terminal Shank is parallel to the tooth surface being scaled. Apply lateral pressure against the tooth (root) and pull upward, maintaining the parallel shank.

• Gracey 1/2, 5/6 are all anterior instruments. They can also be used on the premolars.
• Gracey 7/8, 9/10 are for molars and are used on lingual and buccal surfaces on molars also. They could be used on anterior also.
• Gracey 11/12 is for mesial of molars and can be used lingual and buccal surfaces.
• Gracey 13/14 is for the distal of molars.
• Gracey 15/16 is for the mesial of premolars and has a longer shank and therefore a longer reach.
• Gracey 17/18 is for the distal of premolars and is particularly useful on 7s and 8s.

Blade length
It is important to take into consideration patients comfort when using periodontal instruments. Using larger blades with tight and firm tissue can be very painful for the patient and restricting for the clinician in terms of access. So it is useful to use the smaller mini or micro heads on instruments as they allow better access.

Furcation scaling
This is one of the most challenging areas of scaling and understanding the morphology of the molar tooth is key. You must treat each root as a single tooth. There are diamond coated instruments which can be used as a finishing tool but not for heavy deposit removal.

Risk factors
No matter how well you use a range of instruments to debride, the non-surgical approach will almost always fail without modifying risk factors, in particular smoking, and maintaining a high level of commitment from the patient in terms of oral hygiene and plaque control. Maintenance is key to success.

References

About the author
Mhari Coxon has 20 years experience in dentistry, working as a nurse, receptionist, oral health adviser and ultimately hygienist in a variety of practices, 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. A keen writer, Mhari is on the Publications Committee of Dental Health, the British Society of Hygienists and Therapists (BSHT). Dent Tribune, has a column in Dental Tribune and writes articles for many other publications and online sites.
Hyaluronan was introduced to the UK ten years ago. However, many dentists across Europe may well have heard of it but are not amenable to its potential and have simply ignored it, while many more have actually never heard of it. Dental Tribune International spoke with Dr Peter Galgut, practising periodontist from London and world-renowned lecturer, who has been instrumental in initiating and monitoring several research projects and innovative new applications of hyaluronan in dentistry since it was first launched in the UK. Galgut is one of the authors of a key research paper published on the use of hyaluronan in general dental practice, as well as several other papers published in a number of different publications describing its role and use in clinical practice.

Dental Tribune International (DTI): Dr Galgut, what is hyaluronan, and what makes it so special?

Dr Peter Galgut (PG): Hyaluronan is the commercial name for hyaluronic acid. Hyaluronic acid is the key constituent of “ground substance”, which is the natural substance in which all of the cells of our bodies grow and live. It is part of a widely occurring group of natural substances called glycosaminoglycans, also called mucopolysaccharides. It is made up of two well-known naturally occurring molecules, glucuronic acid and glucosamine, and has been given the name ground substance because it is the major constituent of the basic matrix for cell growth and development of all animal tissues. Ground substance varies depending on where it is in the body. It may be more dense and viscous due to larger molecular sizes and less water content, or more fluid, containing more water and smaller molecules.

DTI: In which medical areas is hyaluronan already being used?

PG: It is commonly used in the cosmetic industry as a dermal filler. As it has been used extensively for this purpose with no side-effects or other harmful results, it is known to be completely safe. Hyaluronic acid, like most organic molecules, may have different sizes and structures. The version of hyaluronan used in dentistry differs from the type used in cosmetic medicine, because in cosmetic medicine a large molecule that does not resorb is needed, whereas in dentistry a much smaller molecule is used so that it can seep through the mucosa and become an integral part of the wound-healing process. It is therefore used as a perfectly natural and harmless anti-inflammatory substance and wound-healing promoter in numerous situations in the oral cavity.

DTI: What is the scope of application of hyaluronan in dentistry?

PG: Hyaluronic acid is a natural gentle healing promoter and inflammation reducer. Although its primary use is in promoting healing of gingival inflammation, it has many other uses in soothing and
promoting healing in mouth ulcers, burning mouth and dry mouth conditions, traumatic injury such as food burns, and even medical conditions such as sore throats and other inflammatory conditions in the mouth and throat.

DTI: Does hyaluronan have any properties that could bring its medical use into question?

PG: No, hyaluronan has been used in the cosmetic industry and in dentistry for more than ten years without a single undesirable medical or dental effect. Because it is a naturally produced substance that is normally produced by our bodies to promote healing and reduce inflammation, it is tolerated extremely well without side-effects. There are no medical or dental contra-indications to its use. In fact, it is so safe to use that it is available over the counter as an ingredient in many over-the-counter products.

DTI: Can any dentist use hyaluronan for dental treatments?

PG: Yes, any dentist can use hyaluronan to promote healing and ease post-operative pain after surgery, extraction, and other minor surgical procedures. It is also very helpful to soothe the pain and aid healing of mouth ulcers, aphthous gingivitis, leishman plaques, and other conditions. It is particularly good for promoting healing for periodontal conditions, provided the dentist or hygienist first ensures that all of the sub-gingival plaque and calculus have been completely removed and high levels of oral hygiene are established. Characteristically, the dental professional will apply the more concentrated professional formulation to areas of inflammation, which is then topped up daily using the home care formulation available from many dental suppliers and at many supermarkets and chemists.

DTI: Where can dentists obtain detailed information about hyaluronan and how to include it in their treatment plans?

PG: Detailed information is available from the suppliers of the product in the UK, and by going directly to the company website by searching for its trade name, Gengigel. I also give seminars and lectures on modern management of periodontal diseases and the use of pharmacological adjunctive agents such as hyaluronan throughout the UK and internationally, and if a local group of dentists or hygienists wants to arrange a lecture by me in their area, they are welcome to contact me to arrange one. The best way to contact me is by going to my website www.periodontal.co.uk and filling out the enquiry form, or e-mailing me at admin@periodontal.co.uk.

DTI: Where can dental professionals purchase hyaluronan?

PG: Dental professionals can purchase hyaluronan, trade name Gengigel, from most dental suppliers who supply other items of preventive care such as toothbrushes and interproximal cleaning aids. If they experience difficulties in obtaining hyaluronan in their own countries, dental professionals can visit the manufacturer company’s website http://ricerfarma.weblight.it and download a distributors list. Members of the public can purchase the home care formulation from several supermarket groups and most pharmacies in the UK and some European countries.

DTI: Is there any current research on hyaluronan and its use in dentistry?

PG: There is a substantial amount of research available in hyaluronan regarding its medical applications. In dentistry, a considerable amount of research has been published and presented at various dental meetings and conventions. The current bibliography lists over 20 published papers on research carried out throughout Europe. On 5 September 2011, the First International Symposium on Hyaluronan was held in Frankfurt, attracting 11 international lecturers and over 200 delegates.
The Benefits of Xylitol
Martin Last discusses Xylitol and what makes it such a popular choice

There is a growing trend in confectionary manufacturers to adopt the use of Xylitol as a primary sweetener in the likes of gum, mints and candies. Xylitol is a white crystalline sugar alcohol that looks and tastes just like sugar, but with 40 per cent less calories. It was first discovered in the late 1800’s by German and French chemists, and was adopted for widespread use in Finland with the sugar shortages of the Second World War. As uptake increased researchers soon discovered Xylitol’s ability to metabolise in the body without using insulin, and later began to fully appreciate Xylitol’s unique impact upon oral health.

Chemical Composition
Most carbohydrates that we consume (sugars and polyols) are based on a 6-carbon monosaccharide structure, such as fructose (fruit sugar), and glucose. These sugars can form bonds with other sugars to form saccharide units. Unlike most sweeteners, Xylitol has a unique 5-carbon sugar alcohol structure, and as such is both very stable, and does not link together with other sugars.

One of the most notable benefits of Xylitol’s unique structure is that it appears to be unfavourable in the metabolism of a number of pathogenic bacteria, weakening their ability to proliferate and adhere. This in turn reduces bacteria acid fermentation, and so goes a long way to explaining some of Xylitol’s key anti-plaque benefits.

The Benefits of Xylitol in Oral Health
As a consequence of its unique 5-carbon structure, Xylitol exerts a specific inhibitory effect on S.mutans – the bacteria most closely associated with tooth decay. Xylitol also helps prevent plaque from adhering to teeth, which helps to stop demineralisation before it begins. Studies further support claims that Xylitol dentifrices, gum and candy significantly reduce the incidence of caries and periodontal disease in both children and adults.

One of the most notable benefits of Xylitol’s unique structure is that it appears to be unfavourable in the metabolism of a number of pathogenic bacteria, weakening their ability to proliferate and adhere.
Slowly but surely there is a growing body of evidence to support the use of Xylitol to the benefit of oral health; according to a recent report published by the ADA Council on Scientific Affairs, sugar-free chewing gum, lozenges and hard candy including Xylitol or polyol combinations “could be beneficial in preventing cavities when used as adjuncts to a comprehensive cavity prevention program”. While the report admits that there is still plenty more research to be done, the report is in itself a major landmark in the recognition of Xylitol as an important tool in the war against dental plaque. With one of the world’s largest dental associations starting to take note, it will not be long before word spreads further still.

Xylitol is as sweet as table sugar, yet its metabolism in the body requires only a very minimal insulin response. It rates at only 7 on the glycemic index compared to sucrose, which has a GI rating of 83. Compared with traditional table sugar, Xylitol causes a much smaller increase in both insulin and blood glucose levels with no hypoglycaemic “rebound”. This is naturally of major benefit to diabetics who may well consider Xylitol a suitable sugar alternative after consultation with their GP.

There is also an increasing weight of evidence to support the use of Xylitol for its inhibiting effect on certain forms of bacteria. In a series of studies undertaken in Finland, researchers found that 8.4 grams of Xylitol taken orally on a daily basis reduced ear infections by 42 per cent, and 10 grams of Xylitol syrup taken daily reduced ear infections by 50 per cent. Evidence would seem to support then a general assertion that Xylitol can contribute to creating an environment not conducive to bacterial growth. Indeed the benefits of Xylitol are even extending to those with cystic fibrosis, who benefit from the effect Xylitol has on the reduction in the salinity of airway surface liquids, in addition to Xylitol’s other antibacterial properties.

Looking to the Future

Xylitol has long been enjoyed in several counties in Europe and Asia, and is slowly finding its way into homes in the UK. With a growing weight of evidence to support its use, it’s easy to see why the demand for Xylitol is increasing so rapidly. As science discovers more ways that Xylitol can benefit our health we will certainly find Xylitol being put to use in an increasing number of different products.

About the author

Martin Last, the founder of MPL Marketing Services, is a leading marketing consultant in the healthcare industry, focusing on food supplements and health related products. With over 20 year experience, Martin is an established and high profile consultant in the industry, attending many of the national and international events worldwide. Speaking at regular events in the UK, EU and USA he has expertise on how the changing EU regulatory environment is influencing changes in marketing strategies in the healthcare industry. He also writes for a number of the influential trade journals on related topics. By keeping at the forefront of industry developments around the globe, with a network of international contacts, he can provide its clients the eyes and ears on the latest business developments.

Martin is the Chairman of the major UK trade association, the Health Food Manufacturers Association (HFMA) and in this role represents the HFMA at UK and International meetings with politicians, regulators, related associations and interest groups to help maintain communication and coordination on the position with EU regulation to help safeguard the UK Natural Products Industry. For further information contact Anyone 4 Tea Ltd on 01730 890290, or visit www.anyone4tea.com. As a specialist distributor of selected natural products, Anyone 4 Tea stocks a comprehensive range of Xylitol-based products. These include the Spry Dental Defence System®, Spry Xylitol Chewing Gum and Spry Xylitol Mints.
Easing anxiety with daily prevention

With dental anxiety a common problem, Johnson & Johnson Ltd look at how encouraging daily prevention can help soothe patients’ fears

Talking through treatments with patients can help ease their concerns

It will not be news to you that many of your patients suffer from some level of anxiety when visiting the dental practice, ranging from slight nervousness to phobia. Offering a service based upon wellbeing and care as you do, it may initially be difficult for you to fathom why some patients are affected in this way. Why don’t patients simply understand that you mean well and there is nothing to be scared of? Anxiety, of course, has little to do with rationality so it falls upon the dental team to come up with innovative ways to smooth the way for worried patients.

The root of anxiety

To address the issue of nervousness among patients, first we must understand the reasons why they feel this way. For example, for some, the fear they now experience may stem from a previous bad experience, while others will have picked up on a parent’s anxiety during their childhood. Whatever the reason for their nervousness, patients may compound their worry by putting off attending a routine appointment, which may lead to further concern that treatment will be needed, even if they are employing an effective daily prevention regime. And, of course, there are those patients who will be aware that they have neglected their oral health and are nervous that this inattention will result in being told at the next check-up that they need extensive dental treatment.

Managing fear

One way in which you can manage your patients’ fears is by taking on the responsibility of helping to improve their daily prevention regime, so that their oral health takes a turn for the better. When a patient knows that they have done everything in their power to achieve a healthy mouth, it can help to reduce any apprehension they feel about attending a check-up or hygiene appointment.

Thus, the first step in this plan is to communicate effectively with patients. Think creatively to make the most of what is available to you. Build a good rapport, gently question the patient about their fears and listen carefully to their answers to help create an environment that the patient will perceive as safe and sympathetic. You may want to do all of this before the patient even sits in the dental chair, as it may help to reduce their initial worry.

When the patient is in the chair, try to work at a pace with which they are comfortable and keep up a commentary of what you are doing and why, so their imagination doesn’t run away with them.

Creating a social networking page that you update regularly that encourages oral healthcare and, perhaps, offers daily hints and tips will also help in the fight against dental fear, as it will encourage patients to keep brushing, flossing and rinsing between appointments.

Complementary approaches

Sometimes more is needed than your best communication skills. The benefits of holistic approaches have become much more widely accepted over the last few years, and it is worth finding out about some of the ‘alternative’ ways in which anxious patients may be helped, including:

- Acupuncture
- Hypnotherapy
- Homeopathy
- Neuro-linguistic programming (NLP)
- Cognitive behavioural therapy (CBT).

Communication & collaboration

When it comes to helping patients suffering from dental anxiety, the essential point is that the situation can be improved. Through caring and effective communication, as well as being creative in conveying the importance and benefits of daily prevention, you and your patients can form an enduring partnership that will both improve their oral health and soothe their anxiety.

For some, the fear they now experience may stem from a previous bad experience, while others will have picked up on a parent’s anxiety during their childhood.

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Reasons to be cheerful - the banks ARE lending

Lis Hughes discusses the difference between market perception and market reality

Banks’ and ‘good news’ are words that are rarely nowadays used in the same sentence – but it is true, contrary to popular belief the banks ARE actively lending to the dental profession.

There is though a big difference between market perception and market reality. The doommongers out there would have us all believe the banks have simply shut up shop and indeed any flick through the pages of the Daily Mail or Express would back up this view.

Market reality however is very different. There are now more high street banks than ever before who will lend to dentists who wish to purchase a practice.

At last count there are nine banks who understand dental practice goodwill and will lend for a new practice purchase – be it leasehold or freehold. Can you name all nine???

Coupled with this there are at least 10 specialist asset purchase lenders who will be able to assist with equipment and potential refurbishment costs.

The UK banks actually have an edict from the Government to lend and with the dental industry being one of very few so called ‘Green Light’ sectors they are being actively encouraged to lend.

All banks though are different – each has its own preference as to the type of practice they will lend on and have differing credit and lending policies and it is difficult for the individual dentist to know the best bank to approach for the best chance of securing a positive response.

Even with individual banks it can still be down to chance - whilst it may be the right bank you may be approaching the wrong manager who simply does not understand the dental profession.

You may strike lucky and find both the right bank and the right manager - but how do you know they are offering you the best possible proposal? Remember the banks are tasked with maximising the returns on any borrowing

(At last count there are nine banks who understand dental practice goodwill and will lend for a new practice purchase – be it leasehold or freehold. Can you name all nine?)

For the best possible chance of a positive lending decision and to secure the most competitive terms from the banks it is wise to engage the services of a specialist independent dental business advisor. From their knowledge of the WHOLE banking market they could firstly ‘shape’ your proposal in to a format which would appeal to the banks and then submit your proposal to a number of these lenders to ensure maximum chance of a positive and in turn secure the best lending terms available.

David Brewer – specialist Business Advisor at FTA Finance said: “The most common question asked of me is ‘are the banks still lending?’ My answer is always a resounding YES. In 2011 we submitted over 210 individual dental lending proposals to the banks with overall borrowing of £101M. Of these just over 95 per cent were approved by at least one of the banks. The clients proposal quite often needs an element of ‘tweaking’ to ensure it is presented in a way which will appeal to the banks however once submitted I am confident of securing a positive outcome.”

So whether you are an Associate looking to buy your first practice or indeed and existing practice owner looking to acquire your 2nd or 3rd this is a good time to raise finance.

Even if your Bank says NO - this quite often means there is nothing wrong with your proposal - you simply do not fit that bank’s credit criteria. And remember there are potentially eight other banks out there looking to lend.

About the author

Lis Hughes is a Director of Frank Taylor and Associates and works specifically with the clients as the transaction proceeds through the sale and purchase process. A recognised voice of authority on what is happening in the dental sector, Lis will be provide an update on CQC and the impact of good compliance on the valuation of a practice.

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

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

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Money Matters 23
Managing expectations
Michael Sultan on complex attitudes, hopes and fears

As ever, the media and advertising especially have much to answer for by bombarding us with images of physical perfection in order to sell anything from cars to cosmetic dentistry.

Understanding and managing expectations is paramount, underlined by the 2003 OFT report that stressed the importance of good communication in achieving patient satisfaction, and subsequently reinforced by CQC regulations that require documentary proof of informed patient consent.

Expectations are bound up in rationality and emotion, complex attitudes, hope and fear. At a very simple level, rational expectation is determined by what is likely to happen – if you drive at 100mph towards a brick wall, it is very likely that you’ll hit it. In other words, by removing the uncertainty that would otherwise mean the car colliding with the brick wall would be a complete surprise, we are effectively managing expectations. However, when emotional expectation becomes belief about what may happen in the future, disappointment is a frequent outcome.

As ever, the media and advertising especially have much to answer for by bombarding us with images of physical perfection in order to sell anything from cars to cosmetic dentistry. Because most of us have realistic expectations, we know perfectly well that buying a particular vehicle is not going to put us on a par with George Clooney as soon as we turn the ignition. But, when an idyllic beach front hotel turns out to be a building site, we will complain not just because it didn’t meet our expectations but it is not what we were sold. Therein lies the conundrum - the ‘contract’ between dentist and patient that is so much more than the simple exchange of money for treatment or services.

The term ‘psychological contract’ was adopted in the 1960s to describe the relationship between employers and employees but in some ways it could equally well apply to the relationship between dentists and patients because the expectations of both parties will include be-
haviour; does the patient take advice, carry out actions to improve their oral health or aid recovery? Does the dentist pay attention to the patient’s expectations, their anxiety about pain and fear?

When a patient is referred for specialist endodontic treatment, there are several layers of expectation; the patient’s obviously, their referring dentist and the endodontist. One of which sounds eminently straightforward except that it is at this point that the information one gives can alter a patient’s expectations which may well be necessary if they appear unrealistic.

With all pain there is the emotional component of anxiety that always needs to be addressed sympathetically. The patient needs to understand how anaesthetics differ, that with infected teeth and swelling, unless there has been good drainage, pain is likely to persist until the treatment or antibiotics begin to work; that low grade pain from bruising is likely, and that there is never a 100 per cent guarantee of success.

Because they are invariably referred while in pain, patients are more concerned with immediate relief than the longevity of the treatment but it is our duty to explain that while endodontists can root fill most teeth there may be little long term benefit if the tooth cannot be restored. If that is the case or there is further coronal leakage, the tooth will fail and the patient has to be made aware that for treatment to last the restoration on top is as important as the root filling.

Endodontics is difficult, time consuming and expensive but patients are fully entitled to expect that they will be treated well, comfortably and efficiently.

It is a natural human response to want to reassure that ‘all will be well and the pain will go away’ but we serve our patients and our profession far better by honestly managing expectations.

‘Endodontics is difficult, time consuming and expensive but patients are fully entitled to expect that they will be treated well, comfortably and efficiently’

About the author

Dr Michael Sulstan BDS 1986, FDS 1995, FICD is a specialist in Endodontics and the Clinical Director of EndoCare - a London based specialist practice. Michael qualified at Bristol University in 1986. He worked as a general dental practitioner for five years before commencing specialist studies at Guy’s Hospital, London. He completed his MSc and in Endodontics in 1993 and worked as an in-house endodontist in various practices before setting up in Harley St, London in 2000. He was admitted onto the specialist register in Endodontics in 1999 and has lectured extensively to postgraduate dental groups as well as lecturing on Endodontic courses at Eastman CPO, University of London.

For more information about EndoCare please call 020 7224 0999 or visit www.endocare.co.uk

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The essence of simplicity

Amanda Hastie, Marketing Manager of dbg, discusses the new dbg patient plan

For practices seeking to attract new patients and increase the general value of their business, the new dbg patient plan provides practices with the ideal means through which to expand and enhance their current income streams. One of the most significant benefits of dbg patient plan is that it provides an excellent foundation for growth. By providing a stable, regular monthly income at a low cost, dbg patient plan allows practices to plan for the future with far greater certainty that isn’t impacted upon by the likes of seasonal variations and major changes in the local economy.

Patient Perspective

From a patient’s perspective, dbg patient plan is a great way of spreading the cost of dental treatment over the year. This can be a powerful selling point to patients looking for a new dentist. Furthermore, because you are able to spend more time with your patients, they will feel they are receiving a better service and so in turn will be more inclined to recommend you to others.

As a consequence of adopting dbg patient plan, attendance rates are also likely to improve. By investing their earnings into a monthly scheme, patients will be more likely to attend for routine appointments as they have already paid for your services. This will have a positive effect on the overall oral health of your patients, and because you are seeing your patients more regularly, there will be an increased opportunity to discuss non-routine procedures and so improve your income streams in other ways as well.

Clinical Perspective

From a clinical perspective, dbg patient plan avoids any economic disincentive there might be to delivering exactly the treatment that each patient requires. Under the current NHS contract, many practices have felt committed in terms of the quality and level of treatment they can provide, and also in terms of the independence they can exert. For this reason, many practices have left the NHS system to move over to private practice, with numerous practices adopting patient plans to significant positive effect. dbg patient plan can help practices greatly with the transition to private practice, and can also provide substantial benefits to mixed practices seeking to offer an enhanced service for their private practice patients.

Another important aspect of any patient plan is branding. One of the major benefits of dbg patient plan is the simplicity and flexibility that the plan offers. Many plans will feature an abundance of unnecessary options and features which you may well feel are inappropriate for your practice and add on an additional cost. A simple, straightforward package such as dbg patient plan however will offer you only the services you need, at a far lower cost than many plans operated by its competitors.

Insurance

An important aspect of any patient plan is insurance. Many schemes, including the dbg patient plan, offer include supplementary insurance packages as an optional extra. These will often be available in a number of different levels of cover that can be tailored to your practice’s specific needs. From a patient’s perspective, insurance can be a major selling point of any patient plan package. The unexpected cost (and pain!) of emergency treatment can have a major impact upon a patient’s life, and potentially their livelihood. By offering a patient plan with added dental insurance cover not only will your practice be covered for the likes of out-of-hours fees, but you will also be offering your patients an extremely cost-effective means of guarding themselves against unexpected financial outlays.

With an experienced team to guide you through every stage of the implementation process, dbg will provide you with full on-going support and can offer expert advice to help you decide upon the range of plans you wish to offer, and at what monthly charges. The next stage of the process is the design and production of your personalised practice-branded marketing material, which dbg can mail to your patients directly on your behalf.

If you already have a patient plan in place, but are seeking to transfer, dbg is able to offer practices complete seamless transfer, coupled with exceptional customer service to help support you through the move.

dbg also offers a range of additional support services that can be linked with your practice’s wider needs. These include the ability to combine the plan with dbg560 that allows practices to take full advantage of dbg’s wealth of experience in the field of training and compliance. dbg360 includes use of the dbg’s unique Virtual Compliance Office (VCO) system for additional support and added value.

Excellent Foundation

By providing a stable, regular monthly income, the flexible dbg patient plan provides an excellent foundation for growth, giving practices the ability to far better plan for the future, while at the same time attracting new patients, and enhancing the level of care they can provide.

Given just how many advantages are to be found in adopting a patient plan it is easy to see why so many practices are making the switch. In this age of increasing regulation, dbg patient plan offers practices the freedom to seize control of their operations and work in conditions that allow for far greater flexibility with far more time available for practitioners to spend doing what they do best: treating patients.

dbg – practice made perfect!

For more information on the new dbg patient plan please call 0845 00 66 112 or visit www.the dbg.co.uk.
Why PPC (pay per click)?

If you're looking for highly targeted marketing with instant results and a high return on investment, look no further than PPC...

1. Immediate results
Setting up a PPC campaign and getting your Ads to show at the top of Google in the sponsored listings can take as little as 24 hours, this means you could start seeing new patient enquiries in a matter of days - substantially quicker than organic search engine optimisation (SEO). That's not to devalue the importance of SEO, it is a fantastic long term strategy for driving traffic to your website and the two strategies are in no way mutually exclusive. A strong campaign will see the two strategies working together hand in hand.

2. Pay as you go
In PPC, advertising costs are only accrued when a potential patient clicks on your Ad and is taken through to your website/landing page. The cost per click model is so effective and popular with advertisers because users actually have to perform a desired action before any money changes hands. Because you can actively target customers who are searching for a dentist/dental treatment you can expect much higher conversion rates than more traditional forms of advertising.

3. Budget flexibility
With PPC you have a tremendous level of control over your advertising costs. You can set a maximum daily budget to help manage costs over the month and specify an amount that you are willing to pay per click which will never be exceeded. Using the analytics and reports you can monitor the performance of your keywords and adjust your budgets accordingly. Any budget changes are instantly reflected.

4. Highly targeted campaigns
PPC campaigns are the most highly targeted in online advertising. You have complete control over what keywords trigger your Ads and you even have the option to add negative keywords which will prevent your Ads displaying for a certain keyphrase. To illustrate this, a cosmetic dental practice could add 'NHS' as a negative keyphrase if they don't offer any treatments on the NHS. PPC campaigns also allow users to target particular areas and locations and even have options to display Ads at specified times in the day – clever stuff!

5. Performance tracking
PPC programs have powerful analytics tools and reports which allow your campaign to be monitored, refined and optimised to ensure a better ROI. Ad and keyword performance can easily be measured so you know which of your Ads is performing best, which keywords are driving the most traffic to your site and for what cost. Advances in analytics software mean that you can track every email and call generated from a campaign making measuring the accurate ROI a very simple task. Going one step further, the software will record all calls made to a specific number allowing you to listen to your team respond to your new patient enquiries.

About the author
Amy Rose-Jones is the Marketing Manager at Dental Design Ltd, the leading design and marketing agency for the dental profession. With more than nine years of dental marketing experience, Amy has a passion for driving your business forward through a unique blend of creative and marketing skills. Dental Design is leading the way in PPC marketing within the dental profession; start your campaign today, call us on 01202 238487.

Dental Design is a leading design and marketing agency for the dental profession. With more than nine years of dental marketing experience, Amy has a passion for driving your business forward through a unique blend of creative and marketing skills. Dental Design is leading the way in PPC marketing within the dental profession; start your campaign today, call us on 01202 238487.
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Awards, which recognises the achievements of dentistry's crème de la crème.

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The LR appliance from Oralign is a fixed orthodontic appliance that offers

Waterpik® Water Flosser Studies show that it is up to two times more effective than string floss at improving gingival health. Dental professionals have a responsibility to ensure that patients understand the importance of daily oral healthcare, and are aware of all options available to assist them in maintaining sound dentition and gums, as well as overall systemic health. In a recent survey, dentists were asked the main reason for recommending the Waterpik® Water Flosser. The top responses were:

- Reduces gingivitis - Removes plaque biofilm - Extensive scientific evidence

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The NobelActiveTM 3.0 implant has excellent primary stability, which is one of the main innovations in dental care.

Studies have shown that Waterpik® Water Flosser is up to 2 times more effective than string floss.

The LR appliance from Oralign is a fixed orthodontic appliance that offers

In aesthetic and restorative dentistry. Dentists are often asked by patients

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In aesthetic and restorative dentistry. Dentists are often asked by patients
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