A new toothbrush packaging wins award

Biodegradable toothbrush packaging wins award. A new toothbrush packaging has won an award for its biodegradable properties. The packaging 'Dis-solve' has won third place in Remarkable Packaging & Alternative 2012. The paper packaging, designed by Simon Laliberte, is made with a cellulose-based compound of tree pulp which can be dissolved completely in water in less than ten seconds. To open the packaging, it can be simply washed away, never to be seen again.

Teeth are biggest attraction

A study carried out by Match.com has revealed that we judge the opposite sex mostly on their teeth. The study was carried out over three years and the results have produced a top ten list of things that men judge women on, and vice versa. Over half of the list focused on appearance, with 58 per cent of men judging women on their teeth, and 72 per cent of women judging men on their teeth. Grammar took second place, followed by hair and clothes.

Wal-Mart 'steals' dentist's idea

According to Drilucspid.com, dentist Kianor Shah has filed a lawsuit against Wal-Mart, claiming the retail chain stole his idea for putting dental clinics into its stores. Dr. Shah claims he pitched the idea of opening low-cost, full-service dental offices in big-box retailers to Wal-Mart. After the chain committed to Dr. Shah’s idea, store officials suggested the idea be put forward to Wal-Mart. After the chain committed to Dr. Shah’s idea, store officials subsequently rejected the proposal, according to his complaint. Dr. Shah claims he pitched the idea of opening low-cost, full-service dental offices to Wal-Mart retailers to Wal-Mart. After the chain committed to Dr. Shah’s idea, store officials subsequently rejected the proposal, according to his complaint. Dr. Shah claims he pitched the idea of opening low-cost, full-service dental offices in big-box retailers to Wal-Mart. After the chain committed to Dr. Shah’s idea, store officials suggested the idea be put forward to Wal-Mart. After the chain committed to Dr. Shah’s idea, store officials subsequently rejected the proposal, according to his complaint. Dr. Shah claims he pitched the idea of opening low-cost, full-service dental offices to Wal-Mart.

Wal-Mart, Moreno Valley, CA, store, inspired by Dr. Shah in its development, and Ken An-

vise president of business operations, chair Kevin O’Brien said: “We are pleased that a light has been shone on some of the problems to which I was seeking to draw attention and if, as a result of this, the task of my successors is easier, I can take considerable comfort from that.

11 years of service to my profession...”

“Clearly, the GDC is in a better place now than it was during the turbulent period which may have contributed in part to the events that are chronicled by this report. In particular, the early stages of the FIP procedures have been overhauled and this process of improvement is continuing. We welcome that, and also the spirit in which the GDC has acknowledged that all was not well when we first voiced our own concerns.

Peter Ward, the Chief Executive of the BDA, commented: ‘This report identifies deeply concerning failings around the departure of Dr Lockyer from her role at the GDC. The mishandling of proceedings that is spelt out in this report is astonishing. For a professional regulator, to have made such errors in the handling of proceedings is deeply troubling.

“Dentistry needs a strong regulator in which practitioners and patients alike can have confidence. The GDC will have a great deal of work to do to assuage the doubts about it that will have been engendered by its handling of Dr Lockyer and convince the profession that it really has achieved the improvements in its regulatory performance that the PSA identifies.”

Alison Lockyer said: “I am pleased that a light has been shone on some of the problems to which I was seeking to draw attention and if, as a result of this, the task of my successors is easier, I can take considerable comfort from that.

“It is nevertheless disappointing that the opportunity for a full investigation has been missed and the report from the Professional Standards Authority confines itself to the issues specified by the Department of Health.

“I am proud to have given over 11 years of service to my professional regulatory body and am very grateful for all the support, both personal and professional.”
Mobile phones detect mercury contamination

Chemists at the University of Burgos (Spain) have manufactured a sheet that changes colour in the presence of water contaminated with mercury.

A team at the University of Burgos have now developed a technique for detecting the presence of mercury in water “in a cheap, quick and in situ way,” as explained to SINC by José Miguel García, one of the authors of the study. Details have been published in the Analytical Methods journal.

The method consists of placing the fine sheet created by the researchers in the water for five minutes. If it turns red, this signals the presence of mercury. “Changes can be seen by the naked eye and anyone, even if they have no previous knowledge, can find out whether a water source is contaminated with mercury above determined limits,” outlines the lecturer García.

The membrane contains a florescent organic compound called rhodamine, which acts as a mercury sensor. “Rhodamine is insoluble in water,” says the researcher. “But we chemically fix it to a hydrophilic polymer structure in such a way that when put into water it swells and the sensory molecules are forced to remain in the aqueous medium and interact with mercury.”

The technique could be used for detecting mercury in certain spills and for studying its presence in fish.

Scotland bans cigarette displays force for smaller retailers on April 6, 2015.

Announcing the dates, Scottish public health Minister Michael Matheson said: “Evidence shows that these bans will help prevent young people from taking up smoking.

“That is why we believe this is the right approach for Scotland and I am delighted we are now in a position to implement these bans, which is a key step in maintaining Scotland’s position as a world leader in tobacco control.”

A similar ban on display of tobacco at point of sale in larger shops is already in force elsewhere in the UK.

UK medical schools receive £300,000

All 32 medical schools across the UK have been awarded funds for innovative activities that aim to foster a research culture in all clinicians entering the NHS.

The awards are made by the Academy of Medical Sciences as part of a £1m, five year scheme called INSPIRE which is supported by the Wellcome Trust and aims to stimulate medical and dental undergraduates to pursue scientific research. The awards are the first of two rounds, with an additional special project fund of £100,000 available to enable any high impact activities to be rolled out across the UK.

On the awarding of the grants, Professor Sir John Tooke PMedSci, President of the Academy of Medical Sciences said: “Inspiring students to pursue research is crucial for the future of medicine in the UK. By nurturing talent from an early stage, we can ensure that future patients in its will benefit from the latest breakthroughs in medical science.”

INSPIRE, a project run by the University of Edinburgh, will harness two currently unconnected in-house electronic portals to establish a dynamic, online, searchable database of project opportunities, which could later be rolled out nationally.

The Academy will also run a series of sharing conferences to enable medical schools to showcase activities and share learning.

The second round of INSPIRE small grants will be awarded in 2014.

GDC seek Chair and Council Members

The UK’s dental regulator, the General Dental Council (GDC), is seeking to appoint a Chair and eleven Council members to take office in October 2013.

Applicants need a strong commitment to patient protection and the promotion of confidence in the regulation of dental professionals to ensure the GDC continues on its path of continuous improvement.

There will be an equal number of registrant and lay members and the GDC is required to have at least one member who lives or works wholly or mainly in each of England, Scotland, Wales and Northern Ireland.

Heavy penalties for breaching tooth whitening regulations

Dentists are now legally able to provide higher strength tooth-whitening to patients. However, the new regime brings with it heavy penalties for those who breach the conditions which accompany the regulations, warns Andrea James, Head of Healthcare Regulatory with George Davies Solicitors.

She points out that if you breach the law, the maximum penalty is six months imprisonment and/or a fine of up to £5,000. Trading Standards Officers can legally enter and inspect a dental practice at any time to see if a breach has occurred.

Andrea’s comments follow last year’s changes in UK law relating to whitening which were, in turn, a response to an EU directive on consumer safety. Dentists are now legally able to provide tooth whitening with hydrogen peroxide and other compounds or mixtures that release hydrogen peroxide up to six per cent strength instead of the previous 0.1 per cent maximum.

This is subject to compliance with certain conditions. Those conditions are that the products:

• May be provided to consumers to complete the cycle of use.

• Must not be used on any person under the age of 18.

In the circumstances, she continued, it is wise to avoid treating patients under the age of 18. However, the BDA and Dental Protection Ltd are working to obtain clarification of the position on treating Under 18s when this would be in the patient’s best interests. Additional clarification is being sought for those occasional situations when the use of a higher concentration of hydrogen peroxide, during an in-surgery treatment, would be in the patient’s best interests.

-
Thackeray Dental Care, based in Mansfield, Nottinghamshire, are pleased to announce they have been awarded the prestigious Investors in People Gold accreditation. This follows their success 3 years ago at being awarded the Bronze level at their first attempt.

This is a rare achievement in any sector, and especially so in dentistry, there only being a handful of practices in the UK to have reached this level. Only three per cent of organisations who achieve Investors in People are able to reach the Gold Standard. To reach this level, the practice was assessed against 196 different aspects of externally set criteria, and had to achieve at least 126 additional requirements over and above the 39 required for the standard IiP award.

Simon Thackeray, practice owner says: “Being awarded Investors in People Gold is an enormous achievement, especially as it is not an industry specific award, and shows that a dental practice can be externally measured for its business abilities and team success rather than just use its own industry as a benchmark. Knowing that only an elite group of UK businesses have reached this level of recognition and that we are part of that small group is quite exciting. In an era of tickbox dominated assessments by organisations such as PCT’s and the CQC who don’t understand dentistry, a rigorous and tested accreditation that actually means something in the wider community, that isn’t just a series of tickboxes, but recognises the culture and environment of a practice is far more valuable to me as a practice owner and leader. It shows us that we are doing the right thing.”

Introducing the first in a new expert range from Listerine® – a twice-daily mouthwash built on potassium oxalate crystal technology that blocks dentine tubules deeply for lasting protection from sensitivity.2,3

In just six rinses Advanced Defence Sensitive blocks 92% of dentine tubules; twice as many as the leading recommended pastes.1,4

It can be used alone for lasting protection,3 or in combination with the most recommended paste from the leading sensitivity brand, to significantly increase the number of tubules the paste blocks in vitro.4,5

* Based on % hydraulic conductance reduction

Advanced Defence Sensitive blocks 92% of dentine tubules in just 6 rinses in vitro4

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, London, EC1 8BA
Or email: lisa@healthcare-learning.com

The team at Thackeray Dental Care

Recommend Advanced Defence Sensitive for expert care when you’re not there
Calls for HPV vaccine for boys

Throat cancer can be caused by HPV (Human Papilloma-virus). With rates of throat cancer on the rise, the Foundation is advocating for boys to be vaccinated against HPV, a vaccine which is currently given to girls in the UK in an attempt to cut cervical cancer rates.

The Throat Cancer Foundation says such a vaccine could cost as little as £45 per person, and save hundreds of lives.

Professor Christopher Nutting, lead clinician of the Head and Neck unit at The Royal Marsden Hospital in London, said: “We are seeing a rising number of cases of throat cancer in our clinics in the UK. We need to do all we can to raise awareness of this issue, so the launch of the Throat Cancer Foundation is timely.

“At the moment girls are routinely vaccinated against HPV but boys are not, meaning they are routinely being exposed to a virus that can cause life threatening cancers.

“Evidence from Australia proves that HPV vaccination is effective; where a national programme led to a 90 per cent drop in cases of genital warts in men and women.”

Are tooth development and weaning closely related?

For more than two decades, scientists have relied on studies linking tooth development in juvenile primates with their weaning as a rough proxy for under-

standing similar landmarks in the evolution of early hu-

mans. New research from Harvard, however, challenges that thinking by showing that tooth development and wean-

ing aren’t as closely related as previously thought.

A team of researchers led by three members of Har-

vard’s Department of Human Evolutionary Biology — pro-

fessors Tanya Smith and Richard Wrangham and postdoc-
tor fellow Zarín Machanda — used high-resolution digi-
tal photographs of chimps in the wild to show that after the eruption of their first molar, many juvenile chimps con-
tinue to nurse as much as, if not more than, they had in the past.

Understanding how those early human species devel-

oped, Machanda said, can help shed light on one of the most unusual aspects of hu-

manity — childhood.

“One of the most important changes that occurred over hu-

man evolution is our extended period of juvenile de-

velopment,” she said. “Compared to other primates, the apes have a very long child-

hood, and compared to other apes we have a very long childhood. By examining how chimps develop through their childhood, the hope is we can understand how and when that extended childhood be-

gan, and that will give us a greater understanding of the evolution of the human spe-

cies.”

The researchers, studying the Kanyawara chimpanzee community in Kibale National Park in Uganda, teamed with wildlife photographers who snapped photos of the teeth of juvenile chimps whenever they opened their mouths.

What the images revealed, Smith and Machanda said, came as a surprise.

Where earlier studies sug-

gested that juvenile primates were weaned shortly after the first molar eruption, this study showed that, in addi-
tion to eating more solid food, chimps continued to “suckle as much, if not more, than they had before,” Smith said.

“They were showing adult like feeding patterns while contin-

uing to suckle, which was un-

expected.”

IDH launch regional dentist role

Integrated Dental Holdings (IDH) has announced the creation of a new type of dentistry role aimed at grad-

uate dentists, offering free continued professional devel-

opment training (CPD) and realistic UDA targets to ease them into the workplace post study.

The Regional Dentist at IDH will put graduates into roaming positions across the country, gaining experience with the largest dental em-

ployer in the UK. This allows them to work in a variety of practices, with different cli-

icians during a year-long contract before they have the opportunity to move into self-

employed Associate positions within the business.

Matt Reeves, Head of Re-

sourcing at IDH says, “We’re aware of how tough the first year of work can be for a new dentist and this gives them an opportunity to secure a role that is tailored to their level of experience and desire for variety. We ran this scheme on a smaller scale last year with 10 graduates and were encouraged by their feedback, therefore have created a fur-

ther 50 roles for this year’s graduates.”

The successful applicants will be given a driving allow-

ance to cover their travel costs as well as mentoring from clinicians and resourcing ex-

perts at IDH to help them with the practicalities of the role.

Neil Haldar, a current IDH Regional Dentist in the Mid-

lands commented, “The secu-

rity, variety and financial re-

wards far outweigh being an associate. It’s a perfect move if you’re finishing your vocational training or if you’re cur-

rently an Associate. I’ve learnt a lot more than my friends (in Associate roles elsewhere) by working with a variety of den-

tists and specialists across my region.”

The IDH Regional Dentist offer for 2013 is a competitive total earnings package which includes basic salary, car al-

lowance, lab fees paid, free online CPD and access to off-

site networking/development days.

Anyone interested in ap-

plying for the Regional Dentist Programme can contact the IDH resourcing team online or on 0845 647 7364.
Aspire Academy - for tomorrow’s leaders
Friday 1st March at the Dentistry Show

Free to attend
www.thedentistryshow.co.uk/leaders

Offering newly qualified dentists a clinical and professional insight into being a modern dentist and a future practice owner. If you qualified between 2007 and 2011 then this is for you - it’s what you don’t get taught at dental school.

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• Networking drinks after the Show
• Discounted party ticket for the Heart Your Smile Ball

Hosted by Raj Rattan with presentations from Nilesh Parmar & Prem-Pal Sehmi, Kevin Lewis, Elaine Halley and Daz Singh
Drinkers underestimate alcohol intake

Do you know your intake?

Some people could be underestimating their alcohol intake by as much as 40 per cent, according to new figures the Department of Health have published.

The recent Health Survey for England highlighted underestimations in both the amount and frequency that people drink, raising major concerns about the nation’s knowledge of alcohol.

Research shows across the country 80 per cent of those that drink too much acknowledge the health risks but think of themselves as modest drinkers. More than 60 per cent of these drinkers have no intention of cutting down.

To get a picture of drinking habits, the Change4Life team asked 19 individuals to keep a detailed drinks diary for two weeks. The findings show those that took part were drinking on average the equivalent of an extra large glass of wine each day, or 40 per cent more that they thought.

After keeping a drinks diary for a week, people were offered simple tips on cutting down and as a result, they:

- cut their alcohol consumption by over a third;
- saved around £33.55 a week – or more than £1,750 a year; and
- consumed 1,658 fewer calories a week an average of 236 calories a day – around 10 per cent of the average person’s daily intake and the equivalent to 125ml (a small wine glass) of cream per day.

Participants also said that cutting down improved their physical and emotional well-being. And those involved also reported that adding more mixer to drinks and substituting alcoholic drinks with soft drinks were the most popular tips to include in their lifestyle.

Other tips for cutting down included having booze-free days if they drink every day, not drinking at home before going out, swapping to low-alcohol or alcohol-free drinks and simply using smaller glasses.

Dentist joins mouth cancer screening scheme

The Mouth Cancer Foundation has announced that Dr Philip Lewis, as an Ambassador to the charity, Dr Lewis will become the lead consultant on the charity’s brand new life-saving initiative, the Mouth Cancer Screening Accreditation Scheme which launches in April.

The scheme aims to encourage all dental practices across the UK and Ireland to carry out a thorough head and neck cancer screening which can be done in under two minutes. The Mouth Cancer Foundation will recognise dental practices that demonstrate a visible commitment to increasing public awareness of mouth cancer screening to all patients and to establish a documented referral pathway with a local specialist department.

Mouth Cancer Foundation Ambassador Dr Philip Lewis says “I am delighted to work with the Mouth Cancer Foundation and honoured they have elected me to join their distinguished group of Ambassadors. I can think of no activity more important for dental professionals than the early detection of mouth cancer and look forward to helping in any way I can to promote the aims of the Foundation.”

Founder of the Mouth Cancer Foundation, Dr Vinod Joshi says “We are privileged such a well-respected dentist has agreed to work with us on the Mouth Cancer Screening Accreditation Scheme. We look forward to working together to save as many lives as possible through earlier detection of head and neck cancers.”

For more information or to take part in the pilot scheme please contact the Mouth Cancer Foundation via info@mouthcancerfoundation.org or call +44 (0) 1924 950 950.

Call for dental plastics research bids

The Shirley Glassstone Hughes (SGH) Trust Fund has launched its annual call for research proposals. The Trust Fund was established in 2002 by Shirley Hughes (SGH) who, along with her family, was a long-time supporter of research in restorative dentistry.

The SGH Trust Fund invites interested UK dental practitioners to win up to £200K of funding for research. Bids for the funding must come from teams led by a primary care dentist. Applicants have until Monday 29th April to submit their research proposals. Applications will be assessed by a panel of international experts, with the winning bid expected to be announced in September.

The Trust Fund has also launched its annual research bursary scheme. The award of £5,000 is open to all primary care dentists to join the debate on the phasing out of dental amalgam, occupational risks associated with clinical den- tistry, the effects of cognitive behav- ioural therapy on phobic or fearful patients, and the relationship between dental and systemic disease – and contribute further suggestions of areas for investi- gation. Evidence summaries will be produced in response to sug- gestions, and areas for which an evidence base is lacking will be considered for the research grant competition in 2014.

Professor Elizabeth Kay, the Chair of the SGH Management Committee, said: “We are com- mitted to supporting research in primary dental care. We believe that dentists being involved in, and aware of, research evidence creates a questioning culture which drives up standards and benefits oral health. I encourage all primary care dentists to join the debate at Curious About.”

Rebecca faces Marathon Challenge

Rebecca Beard, Marketing and Events Executive at Software of Excellence has more reasons than most to want to succeed in this year’s London Marathon. Having applied to run in aid of numerous charities and the Breast Cancer Care, she has been offered a place, just 88 days to train and raise the £8,800 left to train and raise the £8,800 she has set as her fundraising goal, but with donations being pledged at a rate of £100 per day she is confident of making the target.

“Breast cancer affects so many people and I hope that when I cross the finishing line my efforts will help take a small step closer to finding a cure for this life changing and devastating illness. Together with the support of my family, friends and colleagues I am confident that we can achieve this goal.”

You can help Becky by making any donation, however small, simply visit http://uk.virginmoneygiving.com/BexxLondonMarathon or to donate £1 just text BEXX47 to 70070.

Becky will run for Breast Cancer Care
A quarter of cancer patients face isolation

One in four (25 per cent) of the 25,000 newly diagnosed cancer patients in the UK - an estimated 76,000 patients each year - lack support from family and friends during their treatment and recovery, according to new research published by Macmillan Cancer Support. A third of those (seven per cent) – an estimated 20,000 people each year - will receive no help whatsoever, facing cancer alone.

The Facing the Fight Alone report – which looks at the number, profile and experiences of isolated people living with cancer - found more than half (55 per cent) of health professionals have had patients opt not to have treatment at all due to a lack of support at home from family and friends. Nine in ten (90 per cent) health professionals felt that a lack of support at home leads to a poorer quality of life for patients, whilst over half felt that it can lead to poorer treatment decisions (54 per cent) and a shorter life expectancy (56 per cent).

Ciarán Devane, Chief Executive of Macmillan Cancer Support, says: “This research shows that isolation can have a truly shattering impact on people living with cancer. Patients are going hungry, missing medical appointments and even deciding to reject treatment altogether which could be putting their lives at risk – all because of a lack of support.

“But these figures are just the tip of the iceberg. As the number of people living with cancer is set to double from two to four million by 2050, isolation will become an increasing problem and we need to address this now. That’s why we are launching a new campaign to help tackle this crisis and to ensure that in future, no-one faces cancer alone.”

ADI holds 25th anniversary team congress

How long do implants last? will be the focus of the Association of Dental Implantology’s (ADI) 2013 Congress. The UK’s largest implant association is hosting their biennial Congress from 1 – 5 May 2013 in Manchester, focusing on the complications, risk management and prognosis of implant treatment.

Delegates will be able to participate in lectures from internationally acclaimed speakers, visit the specialist implant exhibition and network with colleagues from the global implant industry.

Attendees will benefit from the many networking opportunities on offer, including the ADI Oscars Bash, which takes place in the Midland Hotel on the Thursday night.

ADI President Professor Gemal Ueer says “Following decades of research and development, when patient demand and expectations are rising, we should address: what are the real challenges and problems facing us today that affect the success and longevity of implant treatment? I am confident that the ADI 2013 Team Congress will answer this important question.”

The presentations will cover the full spectrum of topics relevant to anybody who is involved with dental implantology or is planning to enter the field. The Congress will feature lectures on the complete dental implant process, from diagnosis, placement and after-care to associated risks and complications. It will also include sessions on many specific aspects involved in the running of a dental implant service, such as legal considerations and managing patient expectations.

The Congress exhibition, open over the two days, will give delegates the chance to see the latest products, learn up-to-date techniques and meet industry leaders. Exhibitors to date include, BioHorizons, Biomet 3i, DENTSPLY Implants, Gestlich Biomaterials, Implantium, Megagen Implants, Nobel Biocare, Straumann and many more.

The ADI 2013 Team Congress takes place 1 – 5 May at the Manchester Central Convention Complex. Visit www.adi.org.uk/congress2013 for the full programme and to confirm your registration.

HEA and ASPiH join forces on two-year simulation initiative

A two-year joint project is underway between the Higher Education Academy (HEA) and the Association for Simulated Practice in Healthcare (ASPiH) to promote simulation-based education (SBE) in health and social care.

Launched with the support of the Department of Health (DH), the initiative will investigate how simulation is being integrated into health-care education curricula, develop and strengthen relevant communities of practice, inform the existing and future commissioning and quality assurance processes for the education and training of healthcare professionals, and influence policy in the field.

Professor Bryn Baxendale, President of ASPiH and Chair of the Project Strategy Group said: “Simulation can help learners prepare for the realities of clinical practice and enhance their level of readiness as a new graduate.

High quality SBE may also help relieve the pressures faced by courses heavily reliant on placement-based training as well as contributing towards improving quality and safety of patient care.”

The project has appointed a team of part-time regional Simulation Development Officers (SDOs). SDOs are establishing a stakeholder database, developing an evidence bank of current good practice which will inform and help define a future professional standards framework and building links with government bodies. They are also organising workshops, meetings and events. Their work is being coordinated by an operational group, chaired by the Project Lead.

Geoff Glover, Head of Health and Social Care and Assistant Director, HEA said: “This collaborative project is expected to create opportunities for ASPiH and the HEA to contribute to the recommendations within the overarching Department of Health Technology Enhanced Learning Framework in relation to SBE. It will support the development of strategic relationships within the new workforce development structures for health and social care at a national level.”

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High quality products with lowest prices guaranteed in the UK with this special offer

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www.scrub-up.com
Traditionally, all surgeons in the UK and Ireland are designated the title “Mr” or one of the appropriate female equivalents. Our medical colleagues graduate with the title “Dr” until those that want to follow the surgical pathway are elected to one of the Royal colleges and become “Mr”, “Mrs” or “Miss” again. This all harks back to the days where surgery was carried out by barber-surgeons who did not have formal medical training, usually on the basis of apprenticeships. When the fields of medicine and surgery became more integrated, surgeons kept their titles as “Mr”. This is a reference back to these origins.

As dentists, we do not have a choice of career pathway between dental medicine and dental surgery in the same way; we all graduate as dental surgeons so by default our title is “Mr”. However, perhaps as a result of modern globalisation, many dentists now refer to themselves as “Dr”. Upon graduating, I did exactly that; I was given a badge with “Dr Alexander Holden” written on it and shortly afterwards my bank cards said the same thing.

Personal choice

Although my bank cards today still say “Dr”, I do not introduce or advertise myself as this professionally; my patients know me as Alex and my referral letters are sent from Mr Holden. This is simply a matter of personal choice; I am a dental surgeon, not a dental doctor. I would be quite happy to be in a practice where other dentists chose to call themselves “Dr” but as I am devoid of a doctorate, I will stick to “Mr”.

Although I do not use it, I feel that it is important for dentists to be able to use the courtesy title if they wish; medical doctors in this country do not graduate with a doctorate in medicine so it is purely a courtesy title for them too. My views go beyond this non-objection in that I feel that perhaps dentistry is currently lacking a coherent career pathway for young dentists and this should be considered as a further possible change to dentistry in the UK. The pathway has suffered somewhat of recent times; typically dentists would graduate, complete VT and then after a period as an associate, buy into a practice. Now that being a practice owner does not necessarily pay more than being an associate and the prices corporates are willing to pay for practices is greater than that which new buyers can afford; the traditional career pathway is somewhat scuppered. Combining this with the possibility of a new contract in the NHS and direct access which will potentially favour the use of DCPs over associates for some roles and the old career pathway might be considered well and truly closed.

Change for better

DF1 and DP2 (Dental Foundation) were credible and valid steps in attempting to make dentistry similar to medicine in its initial stages after graduation. I strongly believe that the new change has been for the better as now DF1 is more holistic in its view of dentistry; VT could perhaps be accused of being prescriptive of a career in practice whereas DF1 is more exploratory of dentistry as a whole.

Holistic is an interesting word to choose as it could equally apply to the new direction dentistry is following. As a profession we are waking up to the idea that dentistry is more than just what we can do in the dental surgery; our reach and arguably our responsibility stretches beyond, now looking at patients as more than just a mouth and re-evaluating our place in healthcare in general especially us in many cases we will see patients more often than their medical GP will.

To this end, is it possible to consider a similar dichotomy in dentistry as there is in medicine? This is especially pertinent as new restorative dentistry is moving towards more minimally invasive techniques and a chemotherapeutic approach with fluoride application than the more traditional ‘drill and fill’ approach.

The research into periodontal disease is highlighting ever more that periodontitis is more of a multi-factorial, systemic condition than we once considered it to be; no longer is it simply because patients don’t brush their teeth (although oral hygiene is by far the most important factor in chronic periodontitis.) The links between coronary heart disease, diabetes and other systemic, inflammatory and immunological conditions is not simply one way. This surely calls for us as dentists to be more holistic in our approach.

Dichotomy

To recognise this new dichotomy of practice, will we see a change in dental education, so that dentists graduate with more of a general orientation like medics, to then become either more like dental physicians or alternatively dental surgeons? The days of the generalist seem to be numbered; the new contract may well favour the specialisation of dentists to new degrees, with DCPs becoming more responsible for generalist work.

With the increasing emphasis upon skill-mix and an increasing political pressure to save money, just how long will it make sense for us to be as generalist as we are now?

We are not currently in a situation where the technological and materials are suitably tested and developed along with teaching and research, for this dichotomy to be fully realised. It does however seem to be inevitable that the more research takes us towards regenerative and preventative dentistry, the more the role of the dentist will change from surgeon to physician.

It is already the case that dental public health (very much non-surgical in approach) is a specialty examined and gained from the Royal Colleges of Surgeons, not from the Faculty of Public Health which is part of the Royal College of Physicians. This is simply due to an anomaly created by how the dental specialties are organised. This raises a question of how it can be justified having separate dental public health specialists when the determinants for oral diseases and most chronic diseases are common to one and other? It would actually be much better to have one overarching specialty of public health that covered the health needs of the oral cavity as well as the rest of the body.

Refocus

This need for a holistic approach is possibly more obvious in the specialty of dental public health, but I do believe that as we move further into the future and the surgical management of caries and other oral disease becomes less and less invasive, perhaps we need a similar re-focus of how dental training is organised, our affiliations to which faculties are appropriate and perhaps even a serious discussion about how we define ourselves as professionals.

About the author

Alexander Holden is dentist in NHS general practice who is also undertaking further training in law and dental public health.
In the uproar following the 2006 dental contract, one of the main criticisms coming from all quarters was that no pilot studies had been carried out before it was rolled out - and that if it had been, surely it wouldn’t have been implemented in its current form.

By definition a ‘pilot’ is a small scale study designed to test a system for flaws before a full scale launch, in order to avoid costly mistakes.

As we all know, trials are currently taking place in preparation for the ‘New New Contract’; however, as these trials do not test the final version of the contract, is it correct to describe them as ‘pilots’? One might argue that by not field testing the final version of the new contract the current trials are dragged a long way away from the definition of a ‘pilot’ and simply do not test the most unpredictable variables of the lot: the human responses towards the incentives contained within the new contract and how this might skew clinical decision making.

The current trials aim to explore a range of facets such as a patient pathway, a quality and outcome framework, and methods of remuneration. As I simply don’t understand the first two, I will stick to examining the third aspect, remuneration, in this article; however, I promise to come back to you if I can manage to get my head around these in the future. The three remuneration models being tested are Type one - guaranteed income, Type two - a simulation of capitation and Type three - a simulation of capitation for routine treatment and guaranteed income identified for complex treatment.

At present the DoH has not confirmed whether it will or will not ‘pilot’ the final version of the contract prior to implementation but surely there is a good case for this to be piloted for a reasonable amount of time before we can judge its merits. Recently the DoH announced that it is to introduce another 25 pilot sites to the existing 70. The DoH claim that the extra sites will help fine-tune different parts of the new contract that will see dentists paid for the number of patients they care for, and the health results they produce, rather than the number of courses of treatment they perform.

I strongly support piloting the new dental contract, in

New Dental Pilots: Practical or Pointless? Will the pilots tell us anything useful? asks Neel Kothari

‘By definition a ‘pilot’ is a small scale study designed to test a system for flaws before a full scale launch, in order to avoid costly mistakes.'

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fact, this is exactly what I think we should do – so let’s pilot the new dental contract and not a range of independent parts which may work completely differently when put together. If a decision has already been made to go for a blend of part capitation and part payment or alternative, let’s focus on testing this blend extensively and figure out where to go from there. Let us not forget that there were rumblings of having ‘evidence’ to support the 2006 contract, however on critical review by the HSC this position was not supported.

One of the most important things we need to decide upon before we can trial any form of change is the basis of what we are changing to. This is something we can only really do effectively if the government and the profession have a frank and open discussion about what is going to be provided in the new dental contract system.

Unfortunately, dentistry is expensive, has always been expensive and probably always will be expensive, but in light of this expense if the government funds a ‘core’ system then, no matter how we polish it, a core system is what we will get.

In my opinion what we really need to be discussing is how, in the face of a very limited budget, we can get dentists (myself included) to do more dentistry for less money in a way that is perceived to be fairer by all and incentivises the profession to want to do what is in patients’ best interests. Frankly it’s not in anyone’s interest if dentists get paid ridiculously high sums of money for carrying out a small filling and then a comparatively low sum of money for root treating a multi-rooted tooth. The skew in remuneration between ‘reward’ and ‘effort’ has effectively degraded the profession leading many to consider NHS dentistry as a core service in all but name.

In 2008 the Health Select Committee (HSC) reported on the state of the dental sec-

‘One of the most important things we need to decide upon before we can trial any form of change is the basis of what we are changing to’

Whatever alternative is eventually introduced quite clearly it is going to be as new to the NHS as UDAs were back in 2006. In light of the furore over the 2006 contract and the lessons supposedly learned, I find it amazing that the DoH has not confirmed whether or not it is planning to carry out a full pilot of the final version of the new contract before it decides to roll it out to the profession. Until it does, I ask the simple question: are these current ‘pilots’ practical or pointless?

One of the most important things we need to decide upon before we can trial any form of change is the basis of what we are changing to.
A new mobile diagnostic platform is designed to speed up identification of the eleven most relevant periodontitis pathogens considerably. Scientists at the Fraunhofer Institute for Cell Therapy and Immunology IZI in Leipzig have collaborated with two companies, BECIT GmbH and ERT-Optik, to develop a lab-on-a-chip module called ParoChip. In future this will allow dentists and medical labs to prepare samples quickly and then analyse the bacteria. All the steps in the process - the duplication of DNA sequences and their detection - take place directly on the platform, which consists of a disk-shaped microfluidic card that is around six centimetres in diameter. “Until now, analysis took around four to six hours. With ParoChip it takes less than 30 minutes. This means it’s possible to analyse a large number of samples in a short amount of time,” says Dr. Dirk Kuhlmeier, a scientist at the IZI.

Samples are taken using sterile, toothpick-shaped paper points, after which the bacteria are removed from the point and their isolated DNA injected into reaction chambers containing dried reagents. There are eleven such chambers on each card, each featuring the reagent for one of the eleven periodontal pathogens. The total number of bacteria is determined in an additional chamber, via polymerase chain reaction (PCR). This method allows millions of copies of even tiny numbers of pathogen DNA sequences to be made.

In order to generate the extremely quick changes in temperature that are required for PCR, the disk-shaped plastic chip is attached to a metal heating block with three temperature zones and mechanically turned so it passes over these zones. This causes a fluorescent signal to be generated that is measured by a connected optical measuring device featuring a fluorescence probe, a photo detector and a laser diode. The signal makes it possible not only to quantify each type of bacterium and thus determine the severity of the inflammation, but also to establish the total number of all the bacteria combined.

Obesity can lead to gum disease

According to an article published in the January/February 2013 issue of General Dentistry, the peer-reviewed clinical journal of the Academy of General Dentistry (AGD), obesity may be a risk factor for gum disease.

“We know that being overweight can affect many aspects of a person’s health,” says Charlene Krejci, DDS, MSD, lead author of the article. “Now researchers suspect a link exists between obesity and gum disease. Obese individuals’ bodies relentlessly produce cytokines, proteins with inflammatory properties. These cytokines may directly injure the gum tissues or reduce blood flow to the gum tissues, thus promoting the development of gum disease.”

Research on the relationship between obesity and gum disease is still on-going.

“What we do know is that it’s important to visit a dentist at least twice a year so he or she can evaluate your risks for developing gum disease and offer preventive strategies.”

The best way to minimise the risk of developing gum disease is to remove plaque through daily brushing, flossing, rinsing, and professional cleanings.

“A dentist can design a personalised program of home oral care to meet each patient’s specific needs,” says Dr. Shamoon.
Blackberries could prevent and treat gum disease

According to new research published in the Journal of Periodontal Research, the antibacterial properties of blackberry extract could help to prevent or aid in the treatment of gum disease, which, if left untreated, may result in tooth loss.

Natural extract from blackberries have previously been linked with blocking the spread of cancer cells, and showed the greatest total antioxidant capacity when measured against blueberry, raspberry, red currant, and both cultivated and wild strawberries.

Blackberries join a growing list of foods that could help prevent oral health problems. Strawberries and green vegetables have been linked to reducing the chance of developing oral cancer, while other studies have discovered fish and fish oil can fight gum disease.

“Although the study is promising, it is important to remember that any use of blackberries in preventing and treating gum disease should be as well as maintaining a good oral hygiene routine. Prevention is a really important word when it comes to oral health and it is fairly easy to keep on top of. It does not take up too much time or a lot of money, yet it is surprising how many people actually forego basic oral hygiene principles, including brushing for two minutes twice a day.”

Gingivitis bacteria manipulates immune system

A new research report published in the Journal of Periodontal Research, shows how the bacteria known for causing gum disease, Porphyromonas gingivalis, manipulates the body’s immune system to disable normal processes that would otherwise destroy it.

Specifically, the report shows that this pathogen prompts the production of the anti-inflammatory molecule Interleukin-10 (IL-10). This, in turn, inhibits the function of T-cells, which would otherwise help to protect the host from this particular microbial infection.

To make this discovery, scientists used cells from mice that were exposed to P. gingivalis. One portion of the cells was treated with an inhibiting antibody against IL-10 and the other portion of cells was not treated. All of the cells were then tested for interferon gamma production. An increase of interferon gamma production was seen in the treated cells, but no increase was found in the untreated cells.

These findings suggest that the damage done by P. gingivalis happens when the immune cells of the host are first exposed to this pathogen, and further implies that for treatment to be successful, it must be started as early as possible.

This study highlights the mechanism by which P. gingivalis can establish a chronic infection in the form of periodontal disease and provides insight into how the disease develops.

“Gum diseases and the infections that cause them can be incredibly stubborn and difficult to treat,” said John Wherry, Ph.D., Deputy Editor of the Journal of Leukocyte Biology. “What isn’t as well known is why these infections are so difficult to eradicate. These new studies now demonstrate that these bacteria go beyond merely evading our body’s defenses and actually manipulate our immune systems for their own survival.”

Gum disease may worsen AIDS

Scientists at the Texas Biomedical Research Institute have found that moderate gum disease in an animal model exposed to an AIDS-like virus had more viral variants causing infection and greater inflammation. Both of these features have potential negative implications in long term disease progression, including other kinds of infections, says the report published in the Journal of Virology.

The public health message from the study is that even mild inflammation in the mouth needs to be controlled because it can lead to more serious consequences, said Luis Giavedoni, first author of the study.

“After infection with the simian AIDS virus, the generalised acute inflammation induced by the virus was exacerbated in the animals with gingivitis, indicating that even mild localised inflammation can lead to a more severe systemic inflammation,” he said.

Giavedoni and his colleagues studied whether inflammation of the mouth would increase the susceptibility of the monkeys becoming infected with the monkey AIDS virus. This was based on epidemiological evidence that shows that infection and inflammation of the genital mucosa increases the chances of becoming infected with HIV by the sexual route.

The scientists induced moderate gum inflammation in a group of monkeys, while a second group without gum inflammation served as a control. After exposing both groups of macaques to infectious SIV, a monkey virus similar to AIDS, they did not observe differences in the rate of infection in the mouth, indicating that moderate gum disease did not increase the chances of getting infected with the AIDS virus.

“However, we did observe that the animals that had gum inflammation and got infected had more viral variants causing infection and they also showed augmented systemic inflammation after infection; both of these findings may negatively affect the progression of the viral infection.” Giavedoni said.

Study links periodontitis with diabetes

Long-term data published in Diabetes Research and Clinical Practice has provided further scientific evidence that people with Type 2 diabetes mellitus (T2DM) have a great risk of periodontitis.

The researchers have sent over 50,000 males biennial questionnaires, since 1988, and from their data found that “at baseline, men with T2DM were more likely to report hypertension, were missing more teeth, consumed less alcohol, and were less likely to be dentists than those without.”

Risk of periodontitis was found to be 50 per cent higher in men with T2DM than in men without. T2DM was also associated with a 22 per cent increased risk of tooth loss compared with those without.

“This study with 20 years follow-up, T2DM was significantly associated with greater risk of self-reported periodontitis”, the study authors wrote.

“These results hold important public health implications due to the associations between periodontitis and cardiovascular disease and nutritional alterations associated with tooth loss. Greater collaboration between dentists and cardiologists could be used to identify at-risk patients in both clinical settings.”
EuroPerio7 - A Sparkling Success!
Report by Peter Galgut

EuroPerio is a tri-annual conference in which everyone involved in periodontics in Europe and farther afield gathers together to learn and see what’s new and what is up and coming in periodontics. This year the 7th conference was held in the beautiful old city of Vienna, with all its lovely restaurants and coffee houses, beautiful buildings, galleries, palaces and lovely congenial atmosphere.

Dentists, hygienists, periodontists in clinical practice, teachers, professors, and research workers in periodontics gather together to share their knowledge and experience and learn from each other. The social programme brings people together in a formal way so that old friends can catch up with each other and renew old friendships. However most of the socialising goes on in the many cafes and corridors in and around the conference centre.

The programme is so extensive that many lectures go on concurrently and it is often difficult to choose which one to go to as there is always something of interest to the clinician as well as researchers’ students, hygienists and general dental practitioners.

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The trade show usually has over 100 participants showcasing the newest and the best products in preventive and periodontal care available in Europe with some companies also from the United States and elsewhere.

The 2012 conference featured lectures on implantology, highlighting new implants, and new techniques for not only placing implants, but maintaining them as well. Several companies had innovative systems for sinus lift procedures and placing graft material into the sinus cavity utilizing minimal surgical intervention techniques.

Other lectures covered new concepts in periodontal disease management, preventive care. So, this is not just a conference for periodontists but there is something for everyone who is interested in preventive and periodontal care.

What is really exciting is that the next EuroPerio (8) conference is going to be held right here in London. The organising committee of the British Society of Perio is working hard at putting this major international conference together, and it is a great opportunity to showcase the best in British dentistry to Europe. The conference is scheduled to take place in the Excel Centre on 3-6 June 2015, so please put the date in your diary, and register for the conference as soon as the bookings open. Even better, why not join the British Society of Periodontics in advance (Phone Helen Clough: 0844 3551915, or visit the website www.bsperio.org.uk) and make sure that not only do you keep your preventive care programme and your periodontal treatment strategies up-to-date, but also that you are first in the queue when bookings open in 2015.

About the author
Dr Peter Galgut qualified as a dentist in 1971, and gained a MSc with distinction in Periodontology in 1983. Subsequently he obtained the MRD (Membership in Restorative Dentistry) and also the MFGDP from the Royal College of Surgeons of England. He was awarded a MPhil in acknowledgement of his research in biomaterials and wound healing. In addition, he has a Diploma of Dental Homoeopathy awarded by the Faculty of Homoeopathy at the Royal National Homeopathic Hospital, London. He is well published and he has worked as a Senior Research Fellow at the Eastman Dental Institute, researching dental calculus and subjects related to preventive dental care. He has published over 120 papers arising from his work.
Perio-endo lesion: Dilemma unfolded

Dr Naylah Fajandar, MOs, Dr. Sneha R. Gokhale-Gaikwad, MDS, Dr. Sameer Jadhav, MDS, Dr. Vivek Hegde, MDS

Scientific advances have segmented the field of dentistry into a vast number of specialisations. Each specialised clinician performs a specific task. However, there are instances where treatment from single specialist will not eradicate the disease, the reason being the intricate nature of tooth, with its surrounding environment. In such cases it then becomes mandatory to adopt an interdisciplinary approach among professionals for complete rehabilitation. An interdisciplinary approach is most commonly required in cases of an Endodontic-Periodontic lesion.

The relationship between periodontal and pulpal disease was first described by Simring and Goldberg in 1964. Since then the term ‘Perio-Endo’ lesion has been used to describe these lesions. Perio-endo lesions arise from inflammation or degeneration of both pulp and periodontal tissues as a result of an intimate embryonic, anaatomic and functional inter-relationship between them.

The various pathways of communication between the pulp and the periodontium may be classified as follows:

I) Developmental pathways include the apical foramen, lateral or accessory canals, dentinal tubules, developmental or lingual grooves
II) Pathological pathways include empty spaces created by destroyed sharpay’s fillers, root fractures following trauma, idiopathic resorption (internal or external) and cemental agenesis or hypoplasia.
III) Iatrogenic pathways include exposure of dentinal tubules following root planning and accidental lateral perforations during endodontic treatment.

Endodontic-periodontic diseases can be classified into:

A. Primary endodontic disease: A chronic apical abscess may drain coronally through the periodontal ligament into the gingival sulcus. This condition may mimic clinically the presence of a periodontal abscess. Primary endodontic lesions usually heal following root canal treatment.

B. Primary periodontal disease: These lesions are caused primarily by periodontal pathogens. In this process, chronic periodontitis progresses apically along the root surface. In most cases, pulp tests indicate a clinically normal pulp reaction.

C. Combined lesions: Primary endodontic disease with secondary periodontal involvement:

If after a period of time a supervening primary endodontic disease remains untreated, it may become secondarily involved with periodontal breakdown. The tooth now requires both endodontic and periodontal treatments. If the endodontic treatment is adequate, the prognosis depends on the severity of the periodontitis and the efficacy of periodontal treatment. With endodontic treatment alone, only part of the lesion will heal to the level of the secondary periodontal lesion.

Primary periodontal disease with secondary endodontic involvement:

The apical progression of a periodontal pocket may continue until the apical tissues are involved. In this case the pulp may become necrotic as a result of infection entering via lateral canals or the apical foramen.

True combined disease: True combined endodontic-periodontal disease occurs less frequently than other endodontic-periodontal problems. It is formed when an endodontic disease progressing coronally joins with an infected periodontal pocket progressing apically. In most cases periapical healing may be anticipated following successful endodontic treatment.

This case report describes a case with most common symptoms of pain and swelling.

Case Report:
A 35-year-old male patient reported to the Department of Periodontics, M.A.Rangoonwala Dental College and Research Center, Pune with the complaint of pain, swelling and pus discharge from the mandibular right posterior region for four to five days. The tooth pain was moderately throbbing in nature and aggravated on mastication. The patient first noticed a small swelling in the gingiva which increased in size over three to four days. The tooth showed evidence of vertical or horizontal
Phase I therapy: The patient was recalled for scaling and root planning after four days. Patient continued to complain of mild pain though the swelling had reduced. After evaluation of the Phase I therapy, endodontic therapy was initiated.

Definitive treatment: An access cavity was prepared and the root canal system was cleaned and shaped during the first session using Protaper (Dentsply) along with copius irrigation with 5.25 per cent sodium hypochlorite and saline. The patient returned after one week and the endodontic treatment was completed using six per cent gutta percha and AH Plus sealer (Dentsply Maillefer). Endodontic restoration was done with silver amalgam, (Fig 3).

After the endodontic treatment, the patient was asymptomatic and the gingiva appeared healthy. However, the pocket probing depths were still nine and 5 mm mesially and basally respectively. Access flap surgery was performed to eliminate the pocket. After flap reflection, debridement of the defect and furcation was performed using hand curettes (Hu Freidy®) and ultrasonic instrumentation (Figure 4). The intra-bony defect was a combination of two and three wall defect. Two wall defect in the coronal portion of the mesial root and three wall defect apically (Fig 5). Freezed dried bone allograft (FDBA) was placed in the furcation as well as in the intrabony defect (Fig 6). The flaps were approximated with the help of 5.0 black braided silk suture (Sterisil®). The graft material was completely covered and the flap was closely adapted to the tooth. Periodontal dressing was placed. Amoxicillin 500mg tid was prescribed for five days to assure minimal infection during healing phase. Immediate post operative radiograph was taken which shows evidence of graft placement in the defect and the furcation area (Fig 7). Patient was recalled after a week for removal of sutures.

Patient was recalled at regular intervals for maintenance program and oral hygiene instructions were reinforced. There was no evidence of antigenic response to the graft. Radiographs were taken at the intervals of six months and one year. The radiographic picture clearly shows bone fill in the furcation and intrabony defect after one year (Fig 8). Thus the tooth was successfully treated by endodontic and periodontal interventions with satisfactory results.

Discussion:

In periodontitis, a periodontal abscess represents a period of active bone destruction (exacerbation), although such events also occur without abscess formation. The existence of tortuous pocket may favour the formation of abscesses (Carranza 1990). The marginal closure of the periodontal pocket, may lead to an extension of the infection into the surrounding periodontal tissues due to the pressure of the suppuration inside the closed pocket (Kareha et al 1981, Newman and Sims 1979). Changes in the composition of the microflora, bacterial virulence, or in host defences could also make the pocket lumen inefficient to drain the increased suppuraton.

In the absence of periodontitis, periodontal abscess can occur due to impaction of foreign bodies, lateral perforation of the root during Root canal therapy or hairline longitudinal fracture of teeth (Carranza 1990, Abrams et al 1992), infection of lateral cysts (Kareha et al 1981), local factors affecting the morphology of the root. The presence of external root resorption (Yusof and Ghazali 1989), an invaginated tooth (Chen et al 1990), or a cracked tooth (Gousse 1981) have also been suggested as predisposing factors for periodontal abscess formation.

In this case, periodontal abscess was a result of Chronic Periodontitis with secondary endodontic involvement. It has been suggested that intrapulpal infection tends to promote marginal epithelial down growth (Chen et al 1990), or a cracked tooth that allow bacteria to enter the coronal portion of the root. Therefore, definitive periodontal therapy is required to prevent further progress of the disease.

Periodontal surgical procedures result in a harmonious anatomical relationship between the tooth and gingiva as well as correction of any underlying osseous defects which leads to positive correlation between the contour of the gingiva and the topography of the underlying alveolar bone. Persisting osseous irregularities may result in residual deep sulci or pockets making a sustainable level of acceptable plaque control more difficult, thus increasing the chances of further periodontal breakdown.

Periodontitis is a chronic immune-inflammatory disease caused due to infection by specific micro-organisms. A chronic lesion consists of macrophages, plasma cells, granulation tissue and destructed collagen fibres. An acute inflammatory response results in dynamic healing response to appropriate therapy.
and is more favourable for achieving new attachment.

Therefore periodontal flap surgery along with bone graft placement lead to a more favourable response in this case. Trombelli et al. (2002), in his systematic review stated that use of biomaterials/ biologicals along with open flap debridement was more effective in improving attachment levels in intra-osseous defects. The morphology of the defect is an important factor that determines the outcome of the regenerative therapy. In this case, there was a combined two to three wall defect and a grade II furcation involvement which provides most predictive outcome of grafting procedures. The management of grade II furcation involvement presents a unique clinical problem. Reasons for compromised results in furcation areas include the lack of proper access for instrumentation as well as for proper maintenance care due to the complex furcation anatomy and consequently a persistence of pathogenic microflora.

The recent systematic review by Scalean et al. (2008) provides histological evidence of periodontal regeneration with the use of grafts and barrier membranes in combination. However, the combination of grafts and barrier membrane did not provide additional advantage in grade II furcation and three wall defects. The space providing properties of the graft material proved to be useful in periodontal regeneration. In this case, barrier membrane was not used as the tissues were fragile and there was a risk of membrane exposure. However, satisfactory results have been obtained with FDBA as a bone graft material.

Mineralised freeze dried bone allograft (FDBA) has osteo-conductive properties thus acts as a scaffold for bone formation. Extensive research has been done on FDBA as a graft material. Mellonig in 1991 found that at least 50 per cent bone fill in 67 per cent of periodontal defects and the percentage increased to 78 per cent if it was combined with autograft.

In the present case, the lesion was primarily of periodontal origin with secondary endodontic involvement. Therefore, the success of the treatment depended on the periodontal treatment. Satisfactory results were obtained after access flap surgery along with the use of FDBA.

Conclusion: The endo-perio lesions have always been a diagnostic and prognostic dilemma. The treatment plan also varies depending upon the type of lesion. Primary endodontic and periodontal lesions heal completely by endodontic and periodontal therapy respectively. However, combined lesion often requires both endodontic and periodontal therapy. Proper diagnosis, decision making and treatment plan can change the prognosis of such cases from hopeless to hopeful.

References:

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Oral health in old age: Mouthwash as an adjunct for the elderly

Howard Thomas discusses the importance of oral hygiene in the elderly

According to Government statistics, there are 10 million people in the UK who are over 65 years old and this figure is anticipated to almost double by 2050. Added to this, life expectancy continues to increase; a baby born nowadays might expect to live to 91 or 92 years of age. However, healthy life expectancy is not keeping up with our ageing population, the Government claims, because of older residents’ proportionally greater demands on public services.

These demographic trends highlight the need for dental professionals to focus their attention on the maintenance or improvement of our older generations’ oral health. For elderly patients, ageing itself is an additional factor contributing towards poor oral health, as is systemic disease, weakened immunity and infirmity; the latter of which may contribute towards an inadequate oral hygiene routine.

Oral and dental disorders have a particularly significant impact on patients who are more advanced in years. Whether they are denture wearers, have partial tooth loss or still retain all of their own teeth, for the elderly, a healthy mouth is crucial to their quality of life. With few other distractions, the ability to communicate for social acceptance and interaction, along with enjoyment of food are essential to achieving psychological wellbeing. And of course being able to eat a variety of meals and ingredients increases the likelihood of taking in the right nutrients for optimum overall health.

A lack of oral hygiene, leading to infection, disease and/or pain, has severe repercussions in terms of an older individual’s confidence, dignity and nutritional needs. Unsightly inflammation, bleeding, missing teeth, or sores leading to ill-fitting dentures will knock self-esteem and encourage avoidance of others to prevent risk of embarrassment. But this self-imposed isolation brings a great deal of unhappiness in itself. Evidence also suggests a connection between substandard oral health and serious disorders such as pneumonia in older patients, with those who are hospitalised or in care homes made especially vulnerable.

In addition, older patients are at high risk of suffering from xerostomia, or dry mouth, which seriously enhances the risk of dental disease. As the population ages, they are increasingly likely to be receiving prescription drugs for age-related conditions and, unfortunately, dry
The link between alcohol and remaining concern regardingative mouths. In addition there patients and those with sensi-
oral tissues and cause a dry ingredient, which can irritate still contain alcohol as a keyingredient. Manywashes are the same. Many
forms of gum disease and caries.

However not all mouthwashes are the same. Many still contain alcohol as a key ingredient, which can irritate oral tissues and cause a dry mouth – clearly an unsuitable form of gum disease and suffer fromover 90% of the population has some
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About the author
Following his degree in biochemistry, Howard’s early career was in the pharmaceutical industry, where he worked for a host of the world’s leading multinationals before becoming CEO of Merck for 11 years. After leaving Merck, Howard set up his own company Britannia Health Products, Britannia Health Products developed and launched the world’s first Evening Primrose Oil product (Efamol), which became market leader and remains the world leader in Evening Primrose Oil products. Since 1980, Howard has worked with many research groups developing “natural remedies” and has been involved with many health-related organizations. He set up his own nutritional supplement company for the human and veterinary markets and also has been director of a number of biocontrol start-up companies in the Cambridge area.

Until recently, his principal activity was as Chairman of Life Plus Europe, a successful multi-level marketing company supplying nutritional products on a personal support basis throughout Europe. In January 2001, he sold that business to the US affiliate and is now taking a much more active role in the management and development of Oralx Ltd. Howard is focusing on developing a range of natural products for the dental market. The dental market in terms of product development has been neglected by companies, yet over 90% of the population has some form of gum disease and suffer from minor to severe discomfort.
Probiotics: Bactiotherapy for oral health

Dr. Rahul Kale, MDS, Dr. Sonal Tambwekar, MDS, Dr. Sumanth, MDS, Dr. A. Sanjay Jain, MDS, Dr. Sharmila Baliga, BDS

Probiotics literally means “for life”. They are microorganisms proven to exert health-promoting influences in humans and animals. Probiotics are defined by the World Health Organisation as “live microorganisms which when administered in adequate amounts confer a health benefit on the host”. A recent defined description of probiotics is “a preparation of a product containing viable, defined microorganisms in sufficient numbers to alter the existing microorganisms in the intestine of the host and thereby exert beneficial health effects.”

These bacteria have to be the natural flora so as to be able to resist acid and bile, to survive during intestinal transit, to adhere to the intestinal mucosa, and to produce antimicrobial substances in order to retain the characteristics that contribute to their beneficial health effects.

Probiotics must have the ability to inhibit gut pathogens, and they have to be stable during manufacture and storage which can influence both viability and functional properties. A number of bacterial strains have been isolated. However, all do not have the same efficacy. It is important that the potential probiotic strains are well selected prior to use. A combination of strains can enhance adherence in a synergistic manner.

Increase in antibiotic resistant infections due to overuse of antibiotics by physicians has prompted the need to seek safer ways to treat infections.

Recent scientific investigations have supported the important role of probiotics as a part of a healthy diet for human as well as for animals and may be an avenue to provide a safe cost effective and natural approach that adds a barrier against microbial infection. The use of probiotics in antibiotic resistance is termed as a microbial interference therapy. This concept of microbial ecological change as a mechanism for preventing dental change is an important one since oral infections constitute most common forms of infections in humans. Evidence is now accumulating that probiotics may also play a role in oral ecology. Researchers believe that the probiotics are beneficial for oral health in prevention and treatment of various dental diseases.

In 1907, Elie Metchnikoff, a Nobel prize winning Russian microbiologist, first proposed a hypothesis where he suggested that the long, healthy life of Bulgarian peasants resulted from their consumption of fermented milk products. He believed that when yeasts from fermented milk products positively influenced the microflora of the colon, decreasing toxic microbial activities within.

In the 1950s, a probiotic product was licensed by the United States Department of Agriculture as a drug for the treatment of scour among pigs.

The term probiotics which is an antonym to the term antibiotics, was introduced in 1965 by Hallen and Stilling as substances produced by microorganisms which promote the growth of other microorganisms.

Mann and Spoerig (1974) found that people who drank yogurt fermented with strains of Lactococcus sp. had very low values of blood serum cholesterol.

The first probiotic species introduced into research were Lactobacillus acidophilus by Hull et al in 1984 and Bifidobacterium bifidum by Holcomb et al in 1991 (Tanboga et al 2005).

In 1994, the WHO deemed probiotics to be the next most important immune defence system when commonly prescribed antibiotics are rendered useless by antibiotic resistance. (Kaalasapathy and Chin 2000; Levy 2000).

Over the last century, various microorganisms have been used to prevent and cure diseases leading to the coined of the term probiotics.

Several mechanisms have been suggested to contribute to the action due to probiotics. Probiotics improve colonisation resistance to gut pathogens by reinforcing the mucosal barrier and restoring normal gut micro ecology after diarrhoea. If the intestinal microflora is deficient, antigen transport is increased. Probiotics have been shown to normalise an increased permeability. Binding is considered to be the first step in pathogenesis, and binding the bacteria to intestinal mucosa or mucus may allow the colonisation. Probiotics compete with pathogens for binding sites and available substrates. The rate of progression from inflammation through dysplasia to colon cancer has been seen to be reduced in experimental animals.

Researchers have shown that the probiotics have bio-therapeutic potential for prophylaxis against the candidiasis. The probiotic bacteria can protect individuals from candidiasis by immunological and non immunological mechanisms.

Probiotics can activate and modulate the immune system. They reinforce the gut defence by immune exclusion, immune elimination and immune regulation.

Effects of probiotics on oral health:

Since the mouth represents the first part of the gastrointestinal tract, there is every reason to believe that at least some probiotic mechanisms may also play a role in that part of the system. Mechanisms of probiotics are drawn entirely from GIT studies; their applicability to oral health needs further studies. It may also anticipate that resident probiotics could exist in the oral microflora. They may function in the complex ecosystem of dental plaque and in formation and development of oral biofilm in general.

Some hypothetical mechanisms of action of probiotics in the oral cavity are discussed here. Probiotics may act by direct or indirect interaction on oral biofilm and microflora and vice versa.

Direct interactions may include:

1. Involvement in binding of oral microorganisms to proteins (biofilm formation).
2. Action on plaque formation and on its complex ecosystem by compromising and intervening with bacteria to bacteria attachments.
3. Involvement in metabolism of substrate (competing with oral microorganisms of substrates available).
4. Production of chemicals that inhibit oral bacteria (antimicrobial.
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3. Regulation of mucosal permeability
4. Selection pressure on developing oral microflora towards colonisation by less pathogenic species.

There is scientific evidence that certain strains of probiotic microorganisms confer benefits to the health of the host and are safe for human use. However further research is required to affirm benefits of probiotics.

There exists a connection between dental health, including oral health. The mechanisms of action of probiotics in the complex interplay in developing and developed microbial colonies and oral biofilms are also not known. Randomised controlled trials are needed to assess the best means of administering probiotics and the dosages needed for different preventive or therapeutic purposes.

We also know little about the possible naturally occurring resident probiotics of the mouth. Further research is needed to determine how various probiotic strains are able to prevent the growth of oral microorganisms other than those that carry pathogens and Candida investigated to date.

Bacteriotherapy in the form of probiotics seems to be a new alternative for oral health giving a new research field for dental science to proceed.

References:
resident probiotics of the mouth. Curr Opin Gastroenterol 2008; 24: 77-83.
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<th>Type of Practice</th>
<th>Cost per month</th>
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<tr>
<td>5 or more Surgery Practice</td>
<td>£111</td>
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Implantology - The Camlog Way

Author: Sunny Kaushal BDS (U. Birm) Dip Imp Dent RCS (Eng) MSc (U. Lond)

With well over a thousand implant systems currently on the market there is a lot of choice when it comes to picking the right one to put in your practice. After extensive experience with a variety of systems dating back to the mid 1990’s, I recently began placing Camlog implants, developed by Dr. Axel Kirsch. The design of this system eliminates the risk of abutment rotation and screw loosening, while at the same time offering extraordinary ease of use.

One of the things that is attractive about the Camlog system is that its surgical kits are organised with a number of fail-safe applications, such as depth guides for all of their drills for osteotomies.

This is particularly useful for those clinicians at an early stage in their implant careers as it assures safety and precision for its users, and something I find builds a great deal of confidence when I am mentoring.

Another interesting feature is that the implant profiling drills are not end-cutting, so they will only go where you drill the initial osteotomy site and only to the depth of the osteotomy.

Surgery - Benefits at a glance
• One surgical set for both implant systems
• Colour-coded instruments arranged in the surgery set in logical order of use
• Depth stops and laser markings for safe and individual implant bed preparation
• Special design of multiple-use drills foratraumatic, efficient and accurate preparation
• Implant packaging includes cover screw for submerged healing

The prosthetic system is comprehensive and user-friendly: They have a trilobe platform, which is beneficial because it keeps the prosthetic phase simple.

Additionally, the abutments engage the implant internal connection for longer length than most systems, which I feel gives a better connection in the long term and leads to less of a chance of screw loosening.

CAMLOG® Implants
The heart of the CAMLOG® Implant Systems is the innovative implant-to-abutment connection, known as the Tube-in-Tube®. The positive press fit of the highest precision and anti-rotation stability allows the simple and durable prosthetic rehabilitation of single crowns and bridges as well as a secure and lasting screw connection.

As a result of the positive press fit and the specially designed cams of the Tube-in-Tube® connection, all forces acting on the connection are distributed in an ideal manner. The abutment screws are minimally loaded and only have a holding function. Therefore, screw loosening or screw fractures are practically eliminated. Clinical results confirm these outstanding properties.

Tube-in-Tube® connection - Benefits at a glance
• Precise, anti-rotational positive locking allows simple and durable prosthetic connections
• 5 grooves (implant) and 5 cams (abutment) enable clear, secure and fast positioning of abutments
• Comparative studies with other well-known implant systems have demonstrated that the CAMLOG® connection yields excellent results for fit and accuracy

CONELOG® Implants
The new CONELOG® implants are equipped with a cone (1.5°) and three grooves in the inner configuration for positioning CONELOG® abutments.

The CONELOG® abutments are apical with a cone and three cams, and lock into the conical connection and the three grooves of the implant. The CONELOG® abutment does not cover the implant shoulder, thereby, offering integrated platform switching. A CONELOG® abutment screw is used to fix CONELOG® abutments in the CONELOG® implant with a defined torque.

Conical Connection - Benefits at a glance
• Precise, self-locking anti-rotational conical implant/abutment connection
• Integrated platform switching
• Proven CAMLOG indexing makes abutment positioning simple, fast and accurate

Implant Surface - Benefits at a glance
• Sand-blasted, acid etched Promotec® surface for fast osseointegration
• Six weeks healing time in good bone quality
• Scientifically documented, clinically proven

I am now almost exclusively using Camlog implants in my practice and to date have not encountered a clinical situation in which the implant was unable to fulfill the role necessary.

The following case studies demonstrate the surgical and prosthetic flexibility of the Camlog system, from clinicians who understand the need for a reliable and user-friendly system, and who have adopted the system into their practices.

Case Study 1
This 67-year old lady was referred to me with a view to replacing her failing upper incisors with dental implants. This was to include replacement of her upper right canine that was lost some time ago and being replaced with a badly designed cantilever bridge.

Her medical history was clear and she had a heavily restored dentition that was otherwise well maintained. Her oral hygiene was excellent.

Following a full clinical and radiographic examination I opted to extract all four incisors with immediate implant placement. In this case, I chose to replace each tooth with a dental implant. Not something I would routinely do, however, I was concerned about the long-term prognosis of some of her upper posterior teeth and this would give me the option of creating a reduced dental arch, with minimal future intervention should the need arise.

The sockets were thoroughly debrided and implant osteotomies were prepared to engage the palatal shelf and ensure good primary stability. All four sites were prepared to receive 3.8mm x 11mm ConeLog® Implants. The implants were placed and covered with the Bio-Guide membrane was used to stabilise the graft material.

The healing was uneventful and the implants were uncovered after approximately 12 weeks. Large wide body healing caps were inserted to commence site
Following a healing period of approximately three months the patients existing dentures were relined and duplicated to form radiographic stents. This was done using a mixture of 10 per cent-15 per cent Barium Sulphate in the base acrylic and radiopaque teeth (SR Vivo TAC and SR Ortho TAC by Ivoclar Vivadent). The patient was then referred to have CT scans of both jaws.

The digital data obtained from the scans was then used to plan the positions of the Camlog implants and sent to a specialist laboratory for surgical drilling guides (Camlog Guide) to be produced. There was sufficient bone for 6 implants in the upper jaw and 4 interforaminal implants in the lower (Camlog Guide Screw Line Implants, Promote Plus). The laboratory also provided the

"I have been placing and restoring CAMLOG implants for several years with great success, due to its precision and simplicity in both the surgical and restorative aspects. The system also offers complete versatility with terrific affordability, without compromise. CAMLOG has well over 10 years history of use and clinical studies to back it up. For my patients, I want to provide the best treatment and materials I can."

Case Study 2
This lady was presented with advanced periodontal disease affecting all her remaining teeth and was looking for a "fixed solution". The first stage in the treatment process was to remove all the remaining teeth and provide conventional upper and lower full dentures.
provisional acrylic bridges to immediately load the implants after placement.

With the planning complete, the patient returned for surgery. This was carried out under local anaesthetic, and involved securing the surgical guide with small pre-determined screws followed by preparation of the implant beds with the corresponding guided drills. The upper jaw was completed first, followed by the lower. The provisional acrylic bridges were then secured to the implants.

The provisional bridges were left in situ for approximately six months before being removed and impressions taken for the definitive bridgework. Duralay verification jigs were used to ensure the accuracy of the impressions.

The definitive, screw retained, bridges were constructed from a milled bar overlayed with acrylic. The patient was delighted with the result.

“The CAMLOG system was introduced to me around three-four years ago when I found more and more indications for finding a more economical solution to restoring edentulous arches. After looking into CAMLOG implants and their restorative versatility together with the simple system of placement I trained up on CT guided implant placement and found the guided CAMLOG implants to be of perfect application to my needs. I now use CAMLOG implants for most of my surgical and restorative cases. My laboratory technician based in California is also very comfortable with the system resulting in superior technical results as well as the simplicity and versatility of placement. It appears to be a well researched and documented system to which I have found the product support to also be very good.”

Case Study 5

This delightful 56-year-old lady presented to me complaining that she wasn’t happy with the appearance of her teeth and she couldn’t tolerate wearing dentures. She had had some teeth extracted a short time before and was given a set of immediate partial dentures and was referred to a college dentist for a full examination. It was clear that all the remaining teeth needed to be extracted. This was duly carried out and the patient was constructed a set of transitional full upper and lower dentures whilst her mouth was opened a lot of discomfort.

The patient was delighted with the result.

Andrew Chandraprakash RGS (U. Birm), DFGDP(U.K), DPD(Bris), MClinDent(Pros) Andrew qualified from Birmingham University and rapidly progressed to achieve further qualifications and training which form the basis of his special interests; dental cosmetics, treatment planning and management of wear. Andrew works with eminent colleagues in various disciplines of dentistry to create smiles that not only look naturally outstanding but also function efficiently and comprehensively. Andrew has gained knowledge in all aspects of restorative disciplines and continues to update his knowledge with international studies on a regular basis. His interests and skills have led to a focus on prosthetic interfaces and composite bonding. He is Chair of communications on the Board of Directors for the British Academy of Cosmetic Dentistry and a long-standing member of the AACD, the International Team for Implantology and the British Society of Occlusal Studies. He is also an educator to other dentists and key opinion leader in the industry within the disciplines of aesthetic dentistry, treatment planning and composite artistry.

Sunny Kanshal BDS (L. Birm), Dip Imp Dent RCS (Eng) MSc (L. Lond) Sunny is the Principal Dentist at Chic Teeth in Cheadle Hulme and has over 16 years experience in Dental Implant Surgery and restoration. He is also an Implant Surgeon at the respected Harley Street Oral Reconstruction Centre. He was an elected Committee Member of the Association of Dental Implantology (ADI) and member of the British Academy of Cosmetic Dentistry. He is a graduate of the Royal College of Surgeons and gained a Diploma in Implant Dentistry with an advanced certificate followed by an MSc (Implant) with distinction from the University of London. Sunny has a special interest in implant retained overdentures and is a lead implant surgeon for changing faces denture clinics. He also has a passion for teaching and is an ADI mentor as well as a tutor for the highly respected Royal College of Surgeons of England. To compliment this, he actively encourages referring dentists to get involved in the restorative process and provides one to one training in all aspects of restoring implants.

Dr Marcus Gambrimbe RDH (L. Birm). Marcus is a Principal Dentist at Cape Road Dental Practice & Implant Centre in Warwick and Director of The Warwickshire Oral Surgery Clinic, where he receives referrals for both simple and complex implant cases. His main area of interest is in the area of guided surgery and immediate load. He also works alongside Consultant Oral and Maxillofacial Surgeon Mr. Nat Parmar offering treatment under general anaesthetic.

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healed. This was a very positive step forward for the patient however she was still experiencing some difficulty retaining her new teeth, especially the lower set.

After a lengthy discussion about her options, she opted to proceed with implant supported overdentures. This traditionally constitutes a minimum of four implants in the maxilla and two in the mandible. This option would also allow me to uncover the patient’s palate and increase her taste and temperature perception.

Four Conelog® Implants were placed in the maxilla and two in the mandible. Even distribution of the maxillary implants is essential to ensure adequate retention and the distribution of occlusal forces.

After a healing period of three months the implants were uncovered and Locator Attachments (Zest Anchors) were torqued on.

This was followed by construction of a new set of implant retained overdentures.

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About the author
Marc Northover is considered to be one of the UK’s leading Clinical Dental Technicians, where for the last decade he has worked as an opinion leader on behalf of an international dental organisation, offering master classes and one-to-one mentoring to up and coming Clinical Dental Technicians. Marc regularly teaches on courses for dental professionals in the UK and abroad on his chosen topic of complete dentures and continues to work very closely with the UK’s leading Dentists, Dental Technicians and Clinical Dental Technicians as part of the network of Changing Faces® Denture Clinics. Marc graduated from the Royal College of Surgeons, England in 2007 with a Diploma in Clinical Dental Technology and was a founding advisory board member of British Association of Clinical Dental Technology and remains an active member today. Marc’s professionalism, patient care and expertise were recognised at the annual Dental Awards 2009 and 2010 where he was awarded Clinical Dental Technician of the year for two consecutive years. He practices as a CDT at Changing Faces® Denture Clinic, Birmingham, where working with Dental Practices that share his vision, he offers the highest standards of care possible as part of a multi disciplinary team. Marc is a regular delegate at international conferences and has a particular interest in the role of dental implants to assist denture stabilisation.
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