Fluoride scheme gets green light

Judicial Review of fluoridation decision in Hampshire says process was not illegal

The High Court has ruled that a health authority was not acting unlawfully in seeking to add fluoride to Southampton's tap water.

The proposal by South Central Strategic Health Authority (SCSHA) to increase the level of fluoride in water to one part per million, was given the go-ahead in February 2009 after research showed the move would significantly improve dental health. However, resident Ms Milner, who was backed by local anti-fluoride campaign groups, took legal action to challenge the decision, claiming that the SCSHA tried to illegally force the fluoridation of Southampton's water.

At a judicial review, Mr Justice Holman dismissed the legal challenge against the process. The judge expressed sympathy for people who disagreed with fluoridation but said there was no illegality in the decision-making process.

“It is not the law that fluoridation can only occur when a majority of the local population agrees. Parliament has firmly entrusted this area-specific decision making to the relevant SHA. This SHA have not acted unlawfully and no court can interfere with their decision.”

During the hearing, Ms Milner's counsel David Wolfe had argued that residents would have “no choice” but to drink fluoridated water. Campaign groups, which backed the mother-of-three's case, said potential side effects range from bone cancer to thyroid problems and brown spots on the teeth.

The British Dental Association (BDA) also welcomed the decision. BDA Scientific Adviser Professor Damien Walmsley said: “The BDA is pleased with the result because it is likely to encourage consultation on similar schemes in other parts of the country where fluoride could help address the poor dental health of the population.

“A recent European summary of the latest scientific evidence reiterated the view that water fluoridation is a safe and effective method of reducing oral health inequalities.”

www.dental-tribune.co.uk
Understanding the impact of alcohol use

A new report launched today by the World Health Organisation (WHO) has stated that wider implementation of policies is needed to save lives and reduce the health impact of harmful alcohol drinking. Harmful use of alcohol results in the death of 2.5 million people annually, causes illness and injury to many more, and is increasingly affecting younger generations.

The Global status report on alcohol and health analyses available evidence on alcohol consumption, consequences and policy interventions at global, regional and national levels. It stated that:

- Nearly 4 per cent of all deaths are related to alcohol. Most alcohol-related deaths are caused by alcohol result from injuries, cancer, cardiovascular diseases and liver cirrhosis.
- Globally, 6.2 per cent of all male deaths are related to alcohol, compared to 1.1 per cent of female deaths. One-in-five men in the Russian Federation and neighbouring countries die due to alcohol-related causes.
- Globally, 520,000 young people aged 15-29 years die annually, from alcohol-related causes, resulting in 8 per cent of all deaths in that age group.

Endorsed by WHO’s Member States in May 2010, the Global Strategy to reduce the harmful use of alcohol was to promote a range of proven effective measures for reducing alcohol-related harm. The measures include taxation on alcohol, reducing availability through allowing fewer outlets selling alcohol, raising age limits for those buying and using effective drink-driving measures.

Pioneering partnership between Smile-on, Free State

In a groundbreaking agreement, the Central University of Technology, Free State, South Africa (CUT) has joined forces with UK-based leading provider of blended learning resources Smile-on Ltd for the provision of a range of the company’s resources to support CUT’s educational vision.

The contract was signed by Noam Tamir, CEO of Smile-on and Jeanné Oosthuysen, lecturer and programme manager at CUT, at the recent Clinical Innovations Conference South Africa. This will see five of Smile-on’s leading educational resources being integrated into CUT’s dental programme: The Bleaching Business, Communication in Dentistry: Stories from the Practice, Key Skills in Primary Dental Care, Clinical Photography, and Dental Nursing Education for Tomorrow (DNNET).

Commenting on the news, Ms Oosthuysen said: “The vision of CUT is to be a globally connected African university that focuses on the needs of Southern Africa and supports graduates with citizenship skills and competencies in appropriate technologies.

“For me, learning is a way to interact with the world – it is a lifelong process. As modern-day educators, we are constantly faced with this challenge to adapt and change in order to broaden our horizons and expertise. CUT and the University of the Free State are the only higher educational institutions in the central region of our country. The lack of a School of Dentistry in the Free State presents a big challenge, as CUT is offering only the training in dentistry from the central region of South Africa. This problem has been addressed by cooperative links and support systems that has been established with international experts in this field of research and education in dentistry.

“Resources in dentistry, dental education colleagues and other support systems are often only available at dental faculties in Johannesburg, Pretoria, Cape Town and Durban. This challenge is the reason for wanting to be involved with Smile-on and being a pioneer of blended learning for dental assisting in South Africa.”

Noam Tamir, CEO of Smile-on commented “At Smile-on we share the vision of connecting our clients to a global network and we are delighted that by working together with CUT we can help bring much needed resource to this region.”

Mercury negotiations

The FDI Mercury Task Team, led by the FDI President Elect, Dr Orlando da Silva, participated in the second session of the United Nations Environment Programme Intergovernmental Negotiating Committee on mercury (INC 2) to prepare a global legally binding instrument on mercury that took place in Chiba, Japan from 24-28th January.

The FDI’s team is working in close co-operation with members of the International Association for Dental Research to articulate to the INC that dental amalgam currently constitutes an important element in maintaining and protecting global public health, as reflected in FDI General Assembly Resolution on Dental Amalgam (GA 2009) and Dental Amalgam Motion (GA 2010).

Importantly, FDI made an intervention at the INC 2 plenary session highlighting strategies that phase up effective prevention for dental caries and associated health programmes that we believe will result in the phase down of restorative materials, including dental amalgam. This will lead to the reduction in the use of dental restorative materials and ensure optimal oral health, particularly for those most disadvantaged, and in need of treatment.
Editorial comment

As I write, there is considerable turmoil in the profession over the upcoming GDC meeting where the Council will decide whether or not to rescind the use of Dr as a courtesy title by dentists. This is quite an emotive subject for dental profession- als, with conversations flowing from all channels about the move either demeaning the status of dentists, or being against the use of Dr to be at the level of surgeon, and every degree in between!

For me, I find the inconsistent use of ‘Dr’ to be the confusing issue. When speaking to dentists (I do that sometimes you know!) I never know whether to use Dr’, ‘Mr’ or ‘Ol’ – thought I do find that ‘Ol’ works best.

Before I go, I can’t let this week go by without mentioning the YouTube video by NHS Northamptonshire. For those not in the know, this is a two-minute viral video spoofing the classic ‘vampire in the bedroom’ scene with the twist of bad oral hygiene.

Although it was released in November 2010, it seems to have captured recently the imagination of the tech-savvy dental fraternity. ‘True Blood’ it isn’t, but it is an appropriate approach to get young people interested in visiting the dentist! Go to http://www.youtube.com/watch?v=xxI1HzNjwZU&feature=youtube_gdata_player and see what you think.

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, Treasury House, 19-21 Hatton Garden, London, EC1N 8BA

Or email: lisa@dentaltribuneuk.com

ARF x 36k

The General Dental Council has successfully processed 90,962 annual retention fee (ARF) payments from its dentist registrants.

The deadline to pay the fee for 2011 was 51 December 2010. Nearly 5,000 of those who paid used the regulators’ eGDC website www.eGDC-uk.org.

This allows users to:
• Log their Continuing Professional Development (CPD) hours;
• Update their registered address or complete a Direct Debit instruction online;
• Access their Annual Practising Certificate information;
• Have control over many of their registration responsibilities 24/7.

886 dentists were removed from the register for not paying their ARF – so far 171 applications for restoration to the register have been received. 514 dentists voluntarily requested that their names be removed.

If a dentist missed the deadline to pay their ARF they will need to apply to be restored to the register. Practising while not registered is considered illegal practice and the GDC will take action through the criminal courts. Dentists who want to return to the register must:

• Complete a form to apply for restoration;
• Have a medical examination and provide a character reference;
• Pay a fee of £696 – which includes the ARF;
• If they were practising overseas while off the register, they must provide a letter of good standing from the relevant authority of the country/state in which they last worked;
• If they were working in the UK when their name was removed from the register, they and their employer will need to explain the circumstances in a letter.

If this has occurred they are advised to contact their solicitor or defence organisation before submitting their application.

Further information can be found at www.gdc-uk.org or by calling 0845 222 4141.

NEW

40% of denture patients are concerned about denture odour

Yet many denture wearers fail to keep their dentures clean.

That’s because brushing dentures with ordinary toothpaste can scratch denture surfaces. And scratched surfaces can lead to bacterial growth leading to denture odour.

Scanning electron microscope (SEM) images at 240 minutes confirm a significantly higher build up of Streptococcus oralis on denture materials previously cleaned with ordinary toothpaste vs. a non abrasive solution.

Poligrip denture cleansing tablets effectively remove plaque and tough stains without scratching, to leave dentures clean and fresh. Poligrip Total Care denture cleansing tablets also kill 99.9% of odour causing bacteria.

Recommend Poligrip denture cleansing tablets to help your patients control denture odour

References:

POLIGRIP is a registered trade mark of the GlaxoSmithKline group of companies.
A new study suggests that women may be more than 11 times more likely to suffer from breast cancer if they have missing teeth and gum disease.

The study carried out by the Karolinska Institute in Sweden on over three thousand patients, showed that out of the 41 people who developed breast cancer those who had gum disease and loss of teeth were 11 times more likely to develop cancer.

As this appears to be the first study presenting such findings, Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, believes there is more needs to be done in order to confirm the results.

Dr Carter said: “If future studies can also testify to the link between missing teeth and breast cancer, more has to be done to raise public awareness on the issue. The British Dental Health Foundation has a history of campaigning for better oral health, and the findings presented in the study indicate another clear link between your general and oral health.”

The study was carried out in Sweden.

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The idea for CROOKED occurred when a man who had experienced serious health problems approached Florida filmmaker Todd Thompson and his Orlando-based production company, Stars North. The man’s hope was that Thompson could create an animated film that was entertaining and would teach the importance of dental health to young audiences.

The result was CROOKED, a 17-minute film that stars Kendall Ganey (The Little Princess, Ace Ventura Pet Detective), Bob Mitchell (October Road, Eastbound and Down) and introduces Sarah Grace Ackerman and Justin Garcia.

Featured in the 2011 American Dental Association® Catalogue, CROOKED is available online at www.dentalmovie.org or www.amazon.com.

Reports have stated that a percentage of sales from the film will be donated to National Children’s Oral Health Foundation: America’s Toothfairy®, a nonprofit organisation dedicated to delivering oral healthcare to underserved children. For more information, please visit www.ncohf.org.

Films on teeth are fast becoming a popular choice for educating children © Stars North

Tooth loss linked to breast cancer

The vast majority of those who work in health and social care are committed individuals with a strong sense of professionalism who aspire to deliver the highest standards. However, where there is poor practice or behaviour that presents a risk to the public, it is vital that swift action is taken, whether by employers, or by national regulatory bodies.

The regulatory system is becoming increasingly complex and expensive and requires continual Government intervention to keep it up to date. The Government must move to a proportionate and effective system that imposes the least possible costs and complexity, while maintaining safety and confidence for patients, service users, carers and the wider public.

Recently, Health Secretary Andrew Lansley presented ‘Enabling Excellence’ to Parliament regarding this debate. He said: “Regulation of healthcare workers and social workers makes an important contribution to safeguarding the public, including vulnerable adults and children. But we need an approach to professional regulation that is proportionate and effective.

At the moment, most processes – such as registration, investigation and complaints – that regulators need to have are set out in rules. Devolving powers to the regulators will give them greater freedom to define their own processes without approval from the Privy Council or Department of Health. Voluntary assured registration is intended to improve standards and drive up the quality of care without imposing the costs of mandatory regulation.

The Council for Healthcare Regulatory Excellence (CHRE) will set the standards for registrants and accredited organisations meeting its standards, meaning the public and employers would be able to easily identify what register a worker belongs to.

The abolition of the General Social Care Council forms part of our wider programme of social care reforms which will deliver a more independent model of regulation and strengthen the social work profession. The Council for Healthcare Regulatory Excellence will also become more independent and self-funding. They will review the efficiency of all regulators, with a view to reducing the overall costs of regulation.

The Health Secretary also announced to Parliament today that herbal medicine practitioners will be regulated from April 2012. The four U.K. health departments have agreed that the Health Professions Council (HPC) should hold a statutory register of practitioners who supply unlicensed herbal medicines to people to enable the supply of herbal medicines to continue after 50 April 2011.

Andrea Lansley

Young and CROOKED

A n engaging short film geared towards the younger generation is making headlines. CROOKED, now available on DVD, is a light-hearted tale of Samantha, a 12-year-old girl who is obsessed with losing her last baby tooth, (which happens to be crooked). Her fascination lies with her determination to get the perfect smile...and, of course, win the heart of the new boy at school.

Throughout the film, Samantha provides subtle but constant encouragement to turn brushing and flossing into a daily habit; throughout her time at school she brushes her teeth after lunch, and happily visits the dentist. And although the films goal is dental hygiene education, CROOKED becomes a balance of information and teen entertainment.

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The study was carried out in Sweden.
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GPS to map bat teeth

Biologists at the University of Massachusetts Amherst have “mapped” the topography of bat teeth. The clever use of GPS technology has been designed in order to better understand how toothy ridges, peaks and valleys have evolved to allow different species to eat everything from hard-shelled insects to blood and nectar.

Using a method based on geographic positioning systems, the researchers could characterise the topography of the bats’ molars in a way similar to how geographers characterise mountain surfaces. The researchers calculated a measure of dental complexity that reflects how “rugged” the surface of the tooth is and were able to illustrate a trend from relative simplicity of the shearing molars in insect eaters and omnivores to high complexity of the crushing molars in fruit eaters.

Working with field-collected bat skulls, researchers Sharlene Santana and Betsy Dumont of UMass Amherst, with Suzanne Strait of Marshall University, W. Va., compared the structure of molars across 17 species of the New World leaf-nosed bats that specialise in a variety of different diets (insects, fruits, and a combination).

They found that the molars of fruit-eating species had sharp outer edges that likely allow them to pierce tough fruit skin and pulp. By contrast, the molars of insect-eating species were less complex, possibly because of their smoother shearing surfaces. The study is published in the Feb. 16 online issue of the journal Functional Ecology.

Sweet taste of HPV cure?

New scientific research from New York based Cacao Biotechnologies is uncovering potential new applications for the antioxidant-rich cacao beans, which could spur an innovative approach to treating human papillomavirus (HPV), a precursor to oral and cervical cancer.

There are existing vaccinations for the HPV virus, however, they only effective against a small number of high-risk, cancer-causing HPV strains and are not free of serious side effects including convulsions and paralysis. As stated in the research article, “Vaccination will not cure someone who is already infected with the virus, so even with massive public health education campaigns, HPV will not soon be eradicated because it is so widely spread in the adult population.”

According to Penny Hitchcock, Chief of the Sexually Transmitted Diseases Branch of the US government’s National Division of Microbiology and Infectious Diseases, further research on topical microbicides and effective vaccines is critical.

Building on the work of Cacao Biotechnologies’ co-founders Drs Mark Guiltinan and Siela Maximova of Penn State University, scientists Dr Randall Murphy and Daniel Preston of Cacao Biotechnologies developed a suite of epicatechin-based super antioxidant compounds from cacao. The research article stated that based on the shape and an analysis of cacao molecules some epicatechin oligomers should have strong antiviral properties. Testing proved their theory correct and they had developed an antiviral compound specifically powerful against HPV.

B2A 2011 golf tournament

The Bridge2Aid (B2A) 2011 golf tournament is on and the team are delighted to announce that the hugely popular and now annual event will be held at Hankley Common Golf Course, in Farnham Surrey on August 50th, 2011.

Voted the 50th best golf courses in the UK by Golf World Magazine, and soon to host the Open Championship pre-qualifying competition in June, Hankley Common provides the perfect setting for B2A’s tournament this summer.

Starting the day with a light breakfast, followed by 18 holes and topped off with a delicious three course lunch, prize giving and a special auction with a round of Golf at the prestigious Loch Lomond up for grabs – this year’s tournament is set to be the best yet! If you’re a budding golfer, keen to host a day out for your team or simply looking to support the charity, there are now 25 teams available to book in one of Surrey’s finest golf courses.

A team of four can be booked now for just £488. For more information on the day or to book your team contact Stuart Thompson now on 01483 504944.
Walking in a webinar wonderland
Elaine Halley on deadlines, daughters and the bread-and-butter of dentistry

The time has flown past since my last blog – but I am happy to report that I did manage to get my final six cases for Unit 3 Anterior Aesthetics in and complete on time. This sounds so straightforward when I write it now – and does not reveal the reality which was that despite my best intentions, I was still texting my treatment co-ordinator last Saturday to ask her ‘how do I export the patient chart again?’ and snapping at my family on a Sunday afternoon to the tune of ‘I just need peace to get this DONE… and then I can play with Barbie, test you on your geography and paint your nails (not all the same child I hasten to add!’ Thank goodness the Six Nations started the following week or I would have had no hope of playing the ‘Go and ask Daddy’ card…

We also had a January deadline for the end of Unit 6, which was a final assignment based around designing a clinical research project. I must admit, that as a general practitioner, I have found the research unit the most interesting but also the most challenging. I particularly found this final assessment to be a challenge – I guess with years of experience and because restorative dentistry is my bread-and-butter, I have plenty to say in the case reports under the ‘discuss your use of materials and justification’, and ‘discuss what could have gone better or you would have done differently’ always leaves me with a torrent of justifications for the end result I see before me.

‘Define your structured search making use of MESH terms and Boolean Operators’ leaves me a little less than verbose. I did try – I went back through my notes, re-listened to webinars but still I found my writing in this area felt a little like my 10-year old daughter’s sentence construction. Something along the lines of ‘And then I would...’ Being as this counts for 60 per cent of my Unit 6 mark – we’ll have to wait and see!

The web platform now lets us keep track of our marks across all the completed units. We had our introductory webinar for Unit 4 where the rest of the year was mapped out. Part of the webinar was carried out by Wolfgang Richter who outlined some of the subjects that will be covered under Posterior Aesthetics.

Fiona Clarke let us know about some changes to the course – we have four case reports to do in this unit which are not due until September, but need a 500-word ‘defence’ in addition to our case reports. There was something about a complex case with 1,000 words to write but all will be revealed at the next residential in June. Eddie Scher is heading that up so should be good – but a few webinars to get through first. Posterior aesthetics – both direct and indirect. Luckily, I have just taken bitewings for a team member who shall remain nameless – and I may be able to get two or even three posterior quadrants of restorative work from her!!

We haven’t had a webinar for several months – I knew I was missing something in my life...!
Do’s and Don’ts
David Brewer discusses raising finance for practice purchase

It is a tough time at present for many associate dentists with a double whammy of the poor economic climate and increased practice costs putting the practice profits under increased pressure – and one area the practice owner can make savings is on the percentage share paid to associates.

The days of standard 50 per cent paid to associates are no more with 40 per cent and lower becoming increasingly common place.

ARE YOU CQC READY?
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All our NEW CQC Systems can be bought online at our website or we can send you an invoice if you prefer.

See our demo videos of the above at www.requireddentalsystems.com

DO ensure you approach your bank well in advance of any proposed purchase.

DO NOT leave it to the last moment. It can take up to three weeks just for a basic lending decision due to the banks ever more in depth assessment process. If a property valuation is needed you could potentially double this time.

DO ensure you have up to date financial information to present to the bank (associate

over future UDA values and further NHS cut-backs life is only going to become even more challenging for the associate and it is little wonder that more associates than ever before are looking to become masters of their own destiny by considering practice purchase.

However...the days of obtaining easy money from the banks simply because you are a dentist are long gone.

The banks are taking a much more critical approach to any funding requests and it is therefore essential that when approaching them for funding that you get it right first time – if you are ill prepared and the bank initially declines your proposal it is then very difficult to overcome that initial decision - all the more important therefore to engage the services of an expert BEFORE you speak with your bank.

Here are a few do’s and don’ts to ensure your proposal has maximum chance of a positive outcome:-

‘The banks are taking a much more critical approach to any funding requests and it is therefore essential that when approaching them for funding that you get it right first time’

F R O M 2 8 F E B R U A R Y T O 6 M A R C H 2 0 1 1
DO NOT present your bank with accounts which are two years old and a big pile of monthly schedules and expect them to add them up (that is one guaranteed way to annoy them).

DO have an up to date CV detailing all relevant professional and clinical experience (the banks will be looking for a good spread of experience ideally covering a number of practices).

DO NOT forget to include details of managerial experience on your CV (the banks will be looking critically at your CV to provide them with confidence that you can both manage the practice/staff).

DO ensure you detail all relevant information on the application forms – especially if you have savings (it does not mean you need to put all available savings towards the purchase; however banks are more inclined to lend to people who already have savings and have demonstrated ability to save).

DO NOT try to hide any existing borrowing you have. Ensure everything is detailed as the bank will only find out later when it undertakes its in-depth credit searches.

DO undertake your research of the local area and find out why the current owner is selling.

DO NOT go to the trouble and cost of preparing a detailed 50-page business plan. Most banks will simply not read it and most of the time it is not needed. A brief summary of your purchase proposals and proposed working arrangements post purchase should suffice – together with an outline profit/loss forecasts which you/your advisor can normally prepare by the vendor’s accounts as the bank can normally prepare by the vendor’s accounts. An accountant will be best placed to provide advice.

DO NOT leave the legal process to chance. Especially if there is an NHS contract involved ensure you use a solicitor who fully understands the process.

DO expect the bank to want you to put down a contribution towards the purchase. Obtaining 100 per cent funding is rare nowadays so expect to put down between 10 to 20 per cent of the purchase price.

DO NOT accept the first offer from your bank - make sure you shop around to obtain comparisons (If your bank knows you have only approached them they WILL offer less attractive rates/fees).

DO engage the services of an independent firm to liaise with the banks on your behalf – both to package your proposal to maximise chance of a positive result but also to negotiate terms.

REMEMBER the bank staff are tasked to maximise income for the bank – most dentists are very good at their day job but not when it comes to negotiating. Let the experts negotiate with the banks on your behalf – ultimately you will be the beneficiary securing more attractive terms which may not have been available if you approached the bank direct.

Finally... DO remember to take a short holiday before you purchase (you will need it...) and DO enjoy becoming a practice owner - it is certainly not an easy ride however ultimately much more rewarding and you are in control of your future.

Raising Finance?

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

DO ensure you provide an accurate summary of your current position including all savings and existing borrowing.

DO ensure your CV is up to date with particular focus on any past managerial experience.

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

DO undertake your own research of the local area and find out why the current owner is selling.

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About the author

David Brewer joined Frank Taylor and Associates in the role of healthcare business development manager in 2010. He has worked with the dental profession for more than 15 years accumulating extensive and banking experience. He can be contacted on 07817 756046 or david.brewer@ft-associates.com. Frank Taylor and Associates has a specialist finance division, Loan Hunter that arranges loans for practices. For more information, call 08458 125424.
As we all know, medical emergencies within dental practices are rare; the most common problems being fainting, hypoglycaemia, choking, seizures, asthma and anaphylaxis, even rarer are cardiac problems such as angina, heart attacks and cardiac arrest.

However, despite the rarity of these problems, medical emergencies can happen at any time in a dental practice, so we all need to be prepared to deal with them should they occur and the GDC is very clear in its expectations.

• All members of staff need to know their role in the event of a medical emergency
• At least two people are available to deal with medical emergencies when treatment is planned to take place
• Members of staff need to be trained in dealing with such an action

There is also an expectation from our customers and members of the public that dental practitioners and dental care professionals are competent in dealing with medical emergencies.

Back in July 2006, the UK Resuscitation Council released recommendations regarding standards for managing resuscitation and medical emergencies for dental practitioners and dental care professionals in general dental practice.

The recommendations include the following regarding AED availability and training:
• All clinical areas should have immediate access to an AED
• dental practitioners and dental care professionals should all undergo training in Cardio Pulmonary Resuscitation (CPR), basic airway management and use of an AED.

Hew Mathewson, now past President of the GDC “Welcomes these guidelines and congratulates the authors on their considerable work that has led to the publication” (March 2006).

Dealing with medical emergencies is just one of the recommended core subjects per CPD cycle with a suggested minimum number of 10 hours (defibshop.co.uk offer CPD accredited training in the use of an AED including CPR which takes four hours every 12 months and is worth four verifiable CPD points)

Sudden Cardiac Arrest can happen to anyone at anytime and the only effective treatment is an electric shock delivered by an AED.

The time from arrest to delivery of the first shock is the single most important determinant in survival. For every minute that goes by the patient’s chance of survival reduces between seven – 10 per cent.

“When the shock is delivered within five minutes of the sudden cardiac arrest, 50 percent of individuals survive,” said Deborah DiSanzo, vice president and general manager of cardiac resuscitation at Philips Medical Systems, manufacturer of the popular HS1 & FRx defibrillators.

So the question that needs addressing is “Why wouldn’t your practice purchase an AED?”

They are very simple to use, with only one or two buttons to operate.

Once activated the AED will provide clear voice prompts, reminding the user to call for the emergency services and where the electrode pads should be placed.

As soon as the pads are attached to the patient the AED will monitor the patient’s heart rhythm and decide whether to deliver a shock or not.

Some machines (semi automatic) will instruct the user to push a button whilst others will deliver the shock automatically (fully automatic).

Most defibrillators also provide clear verbal instructions on how to perform CPR during that part of the rescue protocol, the Lifeline View from Defibtech even has a small LCD screen with a colour video to prompt the rescuer. How amazing is that!

Not having an AED available to use on a collapsed patient may result in a member of the dental team being challenged if it can be shown that it could have favourably influenced the outcome, especially if the action of a dental care professional differs from the recommendation / guidelines from...
such an authoritative body as the Resuscitation Council.

We can’t think of a reason to lease that could be as little as £1.48 a day so again the question that needs addressing is “Why wouldn’t you purchase an AED?”

Lots of defibrillators to choose from and here are six of the most popular.

**Cardiac Science Powerheart G3 Plus**
The Powerheart AED G3 Plus is the newest defibrillator offered by Cardiac Science and is available in semi automatic or fully automatic versions. “Rescue Coach” intuitive prompts are designed to guide the rescuer through the rescue process and provide instructions. Prices start from £1,000 + vat.

**Defibtech Lifeline (Standard five year battery option)**
Defibtech Lifeline AED is a robust one piece unit built for real life situations. Built to US military standards for ruggedness and exceeds standards for splash and dust resistance.

The Lifeline AED is lightweight at only two kg, pads are pre-connected (adult or paediatric) and is also available in semi automatic or fully automatic versions.

**Medtronic Lifepak CR Plus**
Medtronic Lifepak CR Plus is available in either semi automatic or fully automatic versions.

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**About the author**
David Howarth is the Managing Director of defibshop.co.uk the UK’s number one online distributor of defibrillators, consumables and CPD verifiable training. Established in 2005 defibshop offers impartial advice on which defibrillator best meets your company’s needs and budget, and remains the only distributor of every manufacturer’s defibrillators in the UK. The defibshop website is the most comprehensive resource for defibrillators on the web and it includes, 360 degree images, full technical specifications, comparison tables, videos, cost of ownership over five years graphs and latest news articles.

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**Dental Tribune United Kingdom Edition · February 28-March 6, 2011**

**Feature 11**
Being more in dentistry

Dental Tribune speaks to the CEOs of IDH and ADP about the recently announced merger of the businesses, and finds out what the future holds.

The news regarding the merger of Integrated Dental Holdings (IDH) and Associated Dental Practices (ADP), caused a stir when it was first announced at the end of January, with its potential (subject to regulatory approval) to create the largest dental group in the UK.

And it’s pretty large! When completed, the merger will have more than 450 practices, with approximately 2,000 dental team members treating more than 3.5 million patients per year. But what does this mean for the future of the groups?

To find out, I asked Richard Smith (CEO of IDH) and David Hillier (CEO of ADP) to give me further insight into the reasons behind the merger. Both Richard and David are new to the area of dentistry, but each has a solid background in healthcare. Following a career in the retail sector, Richard spent the last five years as managing director of Lloyds Pharmacy, guiding the business through a period of major change in the pharmacy sector to maintain its position as one of the leading community pharmacy chains in the UK. David’s healthcare credentials span a longer time period, having entered the NHS and with PCTs and the Department of Health from working in the hospital sector, David brings valued experience to the new business.

Richard believes that the current situation in dentistry is very similar to the one which faced pharmacists a few years ago. With a change in regulations and a fundamental need to look at the way the sector worked, pharmacies needed to develop new working practices to survive and be successful. With the shake-up of the NHS system and a return to a more centralised commissioning structure, dental practices have to do much the same. Another similarity he has seen is the fractious nature of dentistry, where working together for a common goal is rarely seen. Richard said: “I feel that by working together we can bring real benefits to patients but also to the careers and professional lives of dentists and the dental teams.”

Having joined IDH in July 2010, Richard was very much thrown in the deep end of both dentistry and the proposed merger. “Yes it has been a whirlwind introduction to dentistry! No sooner had I started at IDH when we began exploring the possibility of merging with ADP so I had that happening whilst getting familiar with the business at IDH. It has been a challenging time but an enjoyable one.”

Richard is very excited by the future opportunities that’s the merger will provide. For him, it is all about being able to invest in the business and develop it and the dental professionals under its umbrella for the benefit of patients. One of the positives about the merger is that we will be able to invest in our practices and help our teams to continue improving patient care.

“One way we intend to do that is the establishment of a clinical academy, where we can provide opportunities for developing specialist skills in dentistry and all members of the practice. We want to support our staff to develop their skill sets, allowing their ability to offer a wider range of treatments to grow.”

David’s time with ADP only started in September 2010 so his experience is very similar to Richard’s. He commented: “I’ve only had a short period to get to know the business. We became aware that there was this opportunity for merging with IDH very shortly after I joined so I had to do two things; I first had to know where the business was and where we could take it, and would it [the merger] be a good move for the company and for the shareholders.”

He is very positive that the merger will create a grand future for both the companies and the patients they provide treatment for. “I think it gives a great opportunity to create a company with real scale which is able to actually bring up a new level of professional, to provide better resources, better investment, and better support to the dentists in the field.”

“I think the bigger you are you are able to have more resources to use in areas such as training and development – I think it’s one of the big advantages of being a large organisation. I think there are bigger opportunities for people to develop specialist skills in their professional development, both for dentists and nursing staff. A larger organisation would be able to offer better career opportunities and to actually put those skills to good use.”
Are we deluding ourselves?

Michael Sultan discusses the point of perfection in treating root canals

Over the years dentists have been preparing root canals with the intention of removing infected and inflamed material and ultimately making them easy to seal. The result of all their efforts would reveal itself in a post-treatment X-ray as a pretty, neatly shaped root filling fully sealing the mythical region known as the “apical third”. When we saw those satisfyingly smooth, regular shapes we deluded ourselves into thinking that we had done the perfect job.

However, if we were to clear that tooth, we would uncover an irregularly shaped canal system with an intricate network of interconnections. Years back the only reason the radiographic result looked so wonderful was because the material we used to create these root fillings - the silver point - was so radio-opaque. The reality, as we all know, is that the tool we rely on most - the radiographic film - is a two-dimensional image of a three-dimensional space and is woefully inadequate.

Gutta Percha
And so we moved on to gutta percha; after all, how can a rigid piece of metal possibly seal an irregular canal? However, this material wasn’t rigid and the canal needed to be well prepared so that we could adapt our filling material. Yet again we were under the illusion that we were doing a good job. Yes, our radiographs would reveal impressively filled canals, but what they did not show us was actually how clean the canal was, whether a rubber dam had been used during treatment, whether our irrigant had been saliva (no dam) or the industry-gold standard of bleach.

In the old days clinicians would use stiff, rigid, stainless steel files to try and shape these canals, the results often had little bearing on the canal’s original anatomy but just enlarged in the direction the file wanted to go in. We then moved onto the next instrument that, again, gives us a false sense of security: NiTi. These are actually wonderfully efficient cutting instruments that prepare a canal much faster than was previously possible. In reality, all these instruments do is create pretty shapes that bear no relation to the canal’s natural anatomy. This nicely shaped canal, narrow at the tip and gently flaring out to the orifice, hopefully encompassing the whole canal system somewhere in between, is really being shaped to receive our filling materials.

Basic Flaw
The problem is that the instruments are so conducive to efficiently cutting the canals, that tooth, we would uncover an irregularly shaped canal system with an intricate network of interconnections. Years back the only reason the radiographic result looked so wonderful was because the material we used to create these root fillings - the silver point - was so radio-opaque. The reality, as we all know, is that the tool we rely on most - the radiographic film - is a two-dimensional image of a three-dimensional space and is woefully inadequate.

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removing fairly central throughout the procedure. Much of the time the canal walls are not even being touched and, worse still, there is debris being produced which is pushed laterally into the canals’ irregularities. In fact, it doesn’t really matter which NiTi file system we use as they all have this same basic flaw.

To completely remove any debris and bacteria, of course irrigation is vital. However, for irrigation to work successfully the solution has to get to the right area. It has to be activated properly, it must be able to access the canals, and be replenished regularly. Simply syringing it in and leaving it to sit passively in the canal simply does not work.

Complex Biofilms
Bacteria do not just float about in the tooth’s canal. They are made of highly complex biofilms that are firmly attached to the walls of the canals and unless we physically remove them, the canals will never be clean. To this end we need to aggressively move the irrigant in and out of the canal walls to remove the bacteria within them.

As an inter-appointment dressing we generally use calcium hydroxide, which is often regarded as the most important dressing we can put in a tooth. It is given an almost mystical status with the ability to cap pulps, cause roots to grow, apexes to close and to kill all bacteria in sight. It may well be highly alkaline (if it hasn’t degraded to calcium carbonate in the jar) and kills bacteria well, but if bacteria are trapped in a muddy pool of debris the calcium hydroxide will be unable to reach it. One of the prime causative agents of endodontic failure is E. faecalis, which is resistant to alkaline solutions anyway. To compound problems further, the purpose of a root canal filling is to entomb any residual bacteria so that they are no longer viable.

This fluid tight root filling will deprive the bacteria of their food supply and cause them to wither and die. The problem is that all root filling materials leak (it is just a question of extent) and the bacteria themselves lay dormant, waiting patiently for leakage and their next supply of food.

Despite all our best efforts, even when we think we have a technically beautiful root filling and an excellent 3D seal of the canals, we still heavily rely on the final coronal seal of the tooth. Many studies have shown that a great root filling coupled with a poor coronal seal will unfortunately lead to failure.

With all these weak spots in our procedures it is perhaps surprising that we have any success rate at all and yet despite all we do, success rates remain high (95 per cent in uninfected teeth and about 80 per cent in re-treatment). So I will not be abandoning endodontics just yet to be seduced by larger pieces of titanium but I acknowledge the gaps in our knowledge and procedures, and am thankful that our patients have innate abilities to heal.

In order to progress and move forward, we will have to rethink how we overcome the aforementioned problems. In this respect I think the most exciting product on the market at the moment is the Self Adjusting File (pictured). This ingenious device expands to touch all canal walls and their irregularities whilst continuously vibrating and pumping irrigant through its hollow central lattice. In the future we will be using systems that actively kill bacteria rather than one that just relies on the constant flow of irrigants. In this field, photo-activated disinfection systems may show great promise for the future.

Insane
Those who repeat the same task over and over again, expecting a different outcome each time, are accused of being insane. I think that we are all guilty of trying to refine an already flawed approach and what we really need is a complete paradigm shift in our methodology and to stop really deluding ourselves about what is going on when we treat root canals.

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Dr Michael Sul-
tan BDS MSc FDS RCSD FICD is a specialist in Endodontics and the Clinical Direc-
tor of EndoCare. Michael qualified at Roehampton University in 1986. He worked as a general dental practitioner for 5 years before commencing specialist studies at Guy’s hospital, London. He completed his MSc and in Endodontics in 1993 and worked as an in-house endodontist in various practices before setting up in Harley St, London in 2000. He was admitted onto the specialist register in Endodontics in 1998 and has lectured extensively to postgraduate dental groups as well as lecturing on Endodontic courses at Eastern CPO, University of London. In 2006 he became clinical director of EndoCare - a group of specialist practitioners. For further information please call EndoCare on 0844 999 2020 or visit www.endocare.co.uk

Dentists strive for the 'picture perfect' root canal.
Computerised imaging

Joe Oliver discusses the importance of computerised cosmetic imaging in treatment planning of the aesthetic case

S
o what is computerised cosmetic imaging? Putting it simply, it is the digital manipulation of a photograph to simulate changes in form and colour of the teeth. Imaging allows you to visualise the proposed treatment. It is an excellent way to co-diagnose with the patient the proposed smile design. Remember that many of our patients are selfconscious about their smiles and find it difficult to discuss them. Using imaging, the patient is able to visualise various treatment options.

To the dentist, imaging is an invaluable tool to visualise slight changes within the parameters of smile design to see if such changes “suit” the overall look of the patient and fit their personality. This could relate to changes in incisal length and width or comparing changes in embrasure spaces. Providing a printed picture at consultation allows the patient to discuss the proposed smile design with their partners and members of their family.

Once the design has been decided upon diagnostics need to be made. Again the imaging picture is a very useful communication tool with the technician to visualise the end result one is aiming to achieve.

Case Example

The replacement of two units in the upper labial segment is probably one of the most difficult challenges in cosmetic dentistry today. It poses both difficulties for the ceramist as well as the clinician. Communication of shade has in the past been a major problem but fortunately nowadays laboratories are able to see patient digitally to alleviate this communication problem. Obviously shade is not the only consideration. Shape, contour and surface texture also play important roles. This is where the cosmetic imagery is so important. In many instances multiple visits are required to achieve a successful outcome.

Providing a printed picture at consultation allows the patient to discuss the proposed smile design with their partners and members of their family.

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Consultation

A young 21-year-old lady attended the clinic requesting the replacement of existing bonding on UR1 and UL1. The bonding had been originally placed several years before, and has had to be replaced a number of times due to breakage. The bonding in place was two years old. The patient was unhappy with its poor colour match, it being chipped and general texture. She was also worried as regards the thinning of her incisal edges.

Clinical Stages

Computer imaging: At the consultation, patients are encouraged to discuss their cosmetic dental problems as well as their general dental health. The appointment is one hour long and a good half of this time is taken by the patient talking and myself listening.

Once I have determined the overall aims of the patient, the imaging is carried out in all about 20 minutes. This is undertaken with the patient by my side, so they can give their design input, under my guidance.

A realistic image must be produced which can be achieved clinically. The patient must also realise that the picture is a simulation and the end result would not be an exact match. The image is then printed as part of the treatment plan and also sent to the lab as a guide for the fabrication of the diagnostics.

Preparation:

At the preparation appointment the patient was shown the diagnostic wax-up which met with her approval and matches the imaging. The preparation stent was at this stage placed over the teeth to be prepared, to see if any pre-contouring was needed along the lines of the APR/APT technique described by Gurel. Aesthetic pre-evaluative temporaries were then placed.

Once depth grooves were...
placed and the incisal edge reduction achieved the temporarily were removed and the grooves joined to produce a uniformly prepared surface.

The gingivae was retracted using cord followed by Expasyl. After two minutes the Expasyl was thoroughly washed off and a full arch impression was taken.

After such records were taken, an antiseptic agent was liberally applied to the preparations as well as a primer to seal the dentinal tubules. This acts as a desensitiser and prevents micro leakage.

Provisionals were then placed. These prototypes allow the patient to assess the shape of the final restorations and if any adjustments need to be made they can be implemented prior to the fitting of the final restorations. Final photographs and alginate impressions were taken of the prototypes.

The Fit Appointment
After the patient has been anaesthetised the provisionals are removed using a Mitchell’s Trimmer. At this stage the veneers were tried in to check the fit and also to ensure the design of the provisionals had been duplicated and everything matches the original imaging picture.

The patient at this stage is asked to comment. I seat the veneers altogether as this tends to be less complicated.

I tend to review my patients several days later to ensure gingival settling and to see if adjustments need to be made.

Conclusion
Cosmetic imaging is something that can be easily integrated into many practice environments. It is a tool that is not a substitute to other diagnostic methods but an invaluable adjunct to them. It has been shown to increase patient acceptance of treatment plans. In this case example, you can see it accurately depicts the final end result.

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Dawson P. Functional Occlusion from TMJ to smile design. Mosby 2007
Gurel – The science and art of porcelain laminate veneers. Quintessence 2003

About the author
Joe Oliver is the founder of The Welbeck Clinic; a highly acclaimed dedicated centre for cosmetic dental excellence in the London Harley St district. With more than 15000 veneers fitted, he is a pioneer in cosmetic dentistry, performing in the region of 200 complete smile makeovers a year. He is one of the founders of Cosmetic Dental Seminars, which runs state of the art courses in aesthetic dentistry, www.cosmeticdentalseminars.org

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Digital Imaging is an extremely fast growing area within today’s dentistry field, and one that may require a dentist to make a substantial investment in terms of equipment. Due to the complex nature of Digital Imaging, the necessary equipment currently available is often highly advanced and relatively new to the imaging market. With this in mind, it is vital that suppliers keep up to speed with industry developments; and one that has is The Dental Directory.

Dr Boota S Ubhi is the Specialist Periodontist and Implant Surgeon at the Birmingham Periodontal and Implant Centre. He works alongside Dr Tuss Tambra who is an American trained Specialist Prosthodontist. The practice is a large specialist centre based in Harborne, Birmingham and has a wide referral base covering most of the Midlands. He has been a client of The Dental Directory for the last thirteen years.

‘I have been using the services of The Dental Directory since 1997 and have had only positive experiences in all of my dealings with them. Initially The Dental Directory offered me a very good deal on a particular product, the Digital Imaging equipment I needed very little input from me. The engineers arrived at 8am to set up the scanner, were extremely pleased with how this worked out and investigated the CT scanner options.’ Having read research produced by the University of Manchester, Dr Ubhi learned that the i-CAT scanner provided the best quality images, and most importantly, the lowest dose of radiation available on the current market. After intensive consultation, The Dental Directory supplied Dr Ubhi with a Gendex GXCB-500 CBCT System.

‘The equipment arrived promptly and was exactly to spec; I was delighted. The whole experience was thoroughly well-planned, low stress and professional; qualities that I’ve come to expect from The Dental Directory.’

The Dental Directory: Experts on Digital Imaging Equipment

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In addition to this, the practice facilities which include a large lecture room and dedicated surgical suite allow them to provide training to referring dentists and their staff to enable them to gain the understanding and confidence to deal with advanced dental care. The Surgical and Prosthodontic 10 day modular implant course is now in its 5th year. This course covers surgical implant therapy, sinus and bone grafting, bone augmentation and the Prosthodontic aspect of Implant therapy. Nurse’s courses are also run and cover a range of topics including basic implant techniques, care of instruments, sterile techniques, implant kits and care of patients before and after treatment.

Five years ago, Dr Ubhi changed to using both the intra-oral and extra-oral digital imaging supplied by The Dental Directory. He was extremely pleased with how this worked out and investigated the CT scanner options.

Dental Directory, and Dr Ubhi is extremely happy with his purchase. He feels that the addition of 3D imaging to his practice means that he is providing a much higher standard of care for his Implant cases. The planning and execution of his treatment is much quicker and safer due to the on site CT scanner. He explains,

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After-sales and backup support is a key area for consideration after having purchased a new piece of equipment. Should something go wrong, it is always vital that the appropriate expert be on hand to support the customer and resolve the issue quickly and effectively. The Dental Directory boasts highly skilled and knowledgeable staff members, who are able to offer the right levels of support should it be needed. As Dr Ubhi says,

‘The support provided by The Dental Directory is second to none. They offer a consistent level of customer care, and will always do over and above what is necessary in order to resolve an issue. This is very reassuring and certainly encourages customer loyalty. After the i-CAT scanner was set up, a member of The Dental Directory team came down to provide us with two days of training. All of his instructions were extremely clear and any questions or queries that were raised were answered precisely and confidently. We were also offered further software training after the initial training session, which we took up. This we found invaluable as it cleared any queries we had after the installation.’

Priding itself on not being tied to any particular manufacturer, The Dental Directory has Technical Sales staff that can give you comprehensive advice on the best Digital Imaging equipment to meet your unique requirements.

If you are a dental professional needing astute, unbiased and impartial advice on which Digital Imaging solution is best for your practice, The Dental Directory should be your first port of call.

For more information on how digital imaging systems can improve your practice, call Mohammed Latif on 07808 943647 or The Dental Directory Equipment Department on 0800 585 585.
The Inman Aligner Part II - A progressive approach to smile design
Dr Tif Qureshi discusses alignment, bleaching and bonding

The following article is Part II in a series discussing the use of the Inman Aligner as a tool for MICD. The first article demonstrated that standalone treatments offer patients an alternative to fixed braces, which are uncomfortable and have long treatment times, and to expensive clear aligner treatments in suitable cases.

This article will demonstrate that patients who desire a more traditional smile makeover can achieve beautiful results in a more progressive manner that allows them to make their choices along the way.

This often results in virtually no removal of tooth structure and a treatment result with the responsibility of decision-making shared between dentist and patient.

Moreover, the subject matter of this article could potentially start one of the most controversial debates in cosmetic dentistry for years. We are not only discussing a radically different approach to smile makeovers, but critically a sharply different approach to the traditional methods of planning smile design.

What would you choose?
Patients entering cosmetic practices are often assessed at the initial consultation. They have digital photographs taken and perhaps study models are made. Normally, dental imaging software is used to show patients what can be achieved. These ingenious programmes can help patients realise what is possible. Naturally, care must always be taken when promising treatment results that are viewed digitally.

While computer imaging can be a very powerful tool to help the patient see the potential in his/her smile, I believe it also can make a patient focus on a certain prescribed goal that may not be the only way of satisfying his/her wishes. Dentists using imaging would ideally create a set of five to ten different outcomes of varying degrees of improvement to allow the patient to make a more informed decision. While ideal, it is not certain that dentists actually present different levels of treatment to their patients digitally.

Even if they were able to see various images of their teeth, it can still be difficult for a patient to really see and feel the suggested changes in their mouth. One can question the ethics of allowing patients to commit to a potentially irreversible procedure based on 2-D photographs.

Three-dimensional wax-ups can also be very useful at this stage. If a patient is keen on the image, going to an additive wax-up can sometimes allow for a direct preview try-in using a silicone stent taken from set-up. Temporary material of variable shades can be tried in directly, without any bonding to allow the patient to see the proposed outline, form and overall aesthetics.

Despite this, veneers are often used to treat alignment issues and it is very difficult for patients to appreciate the alignment of their own teeth with wax-up or imaging. By approaching these cases with a different protocol in mind, a dramatically less invasive treatment plan becomes evident.

Alignment
The first step is to look at the patient’s tooth alignment. Misaligned teeth often cause issues in gum heights, line angles, light reflections, shades and tooth length. Correcting the misalignment first can create a completely different perception of the apparent problems. Next, the teeth should be bleached. This can be done either immediately after the teeth have been aligned or preferably simultaneously.

After alignment and bleaching, edge bonding (we term this the ABB concept) should be offered to improve the incisal edge outline. This combination of treatments also works well because the Inman Aligner is a removable appliance and only needs to be worn 16 to 18 hours a day. This means simultaneous bleaching is very possible and straightforward.

A recent study from Sweden indicates a cost-benefit advantage of treating patients with removable appliances in general dental clinics, rather than with fixed appliances at specialist orthodontists. The conclusion of this study is significant, since a popular choice amongst aesthetic dentists in the UK is removable orthodontics.

The cases outlined below highlight patients who either, at the start of treatment, or for years, had originally wanted veneers and had a specific result in mind that only veneers could have offered quickly. They were all concerned about the degree of preparation required, so undertook alignment first. Then, part of the way through, started bleaching and very quickly changed their minds about what they wanted once they saw their own teeth improve.

Case I (Figs 1–8)
Laura was concerned about her very prominent central incisors. She wanted to have them straightened and had considered veneers. She had ruled out conventional orthodontics and invisible braces because she wanted a quick treatment and did not want anything stuck to her teeth, which is the reason that she had refrained from orthodontic treatment. Several years ago, she may well have had veneers placed.

On viewing her teeth before the occlusal photograph, it was quite clear that this would have involved massive preparation of the upper central teeth. Preparation would have been well into dentine and may have even involved elective endodontics.

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On viewing her teeth before the occlusal photograph, it was quite clear that this would have involved massive preparation of the upper central teeth. Preparation would have been well into dentine and may have even involved elective endodontics.
Her lateral teeth would have needed little preparation, but the emergence profiles would have been poor, creating unesthetic aesthetics and a possible periodontal risk later on. Instead, the alignment was completed with an Inman Aligner in ten weeks. Her treatment sequence is detailed below. BACD-style digital photographs were taken and the amount of crowding was calculated using an electronic crowding calculator, which can also be done by arch evaluation of the patient’s study models.

We measured the ideal curve and subtracted this measurement from the total mesio-distal widths of the teeth being moved. The results showed that there was only 1.6mm crowding. This seemed less than one would have expected; the reason for this was that because the laterals were being pushed out, the arch was being expanded, thus creating space.

It was clear from the photographs that despite the obvious crowding, there was some less obvious irregular tooth wear. It was important to indicate this to the patient, as this would become more evident once the misalignment had been corrected. The patient was quoted for three incisal composite tips.

She opted for an Inman Aligner with an incorporated expander. These expanders are a very handy way of creating extra space either to treat cases that are more complex or to use instead of performing interproximal reduction (IPR).

In this case, no IPR was performed. We planned to get nearly all space by using the midline expander. The patient was instructed to turn the midline screw once a week after one week of wear. Each turn is 1/4 of a revolution and equates to 0.25mm. At week six, bleaching was started with soft rubber sealed trays. After nine weeks, the patient had expanded 1.8mm and her teeth were in alignment. (As a rule, less than 2.5mm expansion with an incorporated expander is easily tolerated.)

Looking at her post-align ment result, the golden proportion, gingival heights and axial inclinations had improved dramatically, all without a hand piece being picked up and in the space of nine weeks. What was very clear to the patient at this point was that she only needed some simple bonding to improve the incisal edge outlines. Without the use of an anesthetic, the edge outlines were prepared with very slight roughening of the edge, bonding of hybrid composite on the load bearing edge and a micro-fill on the facial surface. The edges were then polished.

The patient was thrilled with the result we achieved using an Inman Aligner and some simple bonding. She described that when she had once considered having veneers, she had hoped for a similar result. There are still minor imperfections, but, in my opinion, these contribute to her natural beauty.

There is a stark contrast between the treatment selected and the potential treatment approaches in this case. Where once a patient, who refused orthodontics, would have consented and received highly aggressive tooth preparations to achieve correct alignment with veneers, now a removable aligner and some simple bonding were able to achieve a similar and arguably better result in less than three months with not a micrometer of tooth reduction needed.

Case II (Figs 9–17)

This young lady had been attending my practice for some time and was aware of porcelain veneers, having seen our previously advertised cases. We had spoken about the aesthetic benefits of veneers years before. However, on reviewing her case, it was clear that we could improve her alignment dramatically with an Inman Aligner in a short period.

We took an occlusal image of her anterior teeth and outlined the amount of tooth structure that would have to be removed to produce veneers that would look aesthetic. It was immediately apparent to the patient that alignment of her teeth would offer a possibly better treatment outcome. Her case was suitable for an Inman Aligner and as only 2.5mm crowding was present, this meant it could be treated quickly and simply.

Her Inman Aligner was fitted and IPR performed progressively over three visits. At week eight, upper and lower bleaching trays were constructed even though her alignment was not yet complete. Home whitening was begun with clear and concise instructions.

We used rubber trays with a deep seal cut into the model to create a tight dam effect. Over two weeks, her teeth whitened nicely and at week ten, she returned for a review. Interestingly, the patient’s perception of her smile had changed dramatically. Owing to the improved line angles, whiter teeth and balanced gum heights, her eyes were now only drawn to the irregular outline caused by chipping and differential wear.

The patient then enquired about fixing the edges. We offered to bond the incisal edge with virtually no preparation. A hybrid composite (Tetric Flow, Ivoclar Vivadent) was placed palatally and incisally with a micro-fill on the facial surface. This was done in 10 and 11 shades to match the bleaching. The patient was delighted with the result and a wire retainer was bonded immediately.

Despite some clear deviations from her ideal simulated smile, the patient explained that she felt her smile after alignment was better than she had imagined her veneers would have been. Had veneers been placed, we could perhaps have corrected the golden proportion more fully, balanced the zeniths, improved the canine outlines, widened the buccal corridors, etc. However, that was clearly not what the patient desired. Should she later decide that she does need further improvements, we can proceed with already straightened teeth. The ABB smile design is progressive and not sudden or rushed. In this manner, the patient is given the opportunity for decision-making in his/her treatment and the responsibility in choice is shared.

There is a stark contrast between the treatment selected and the potential treatment approaches in this case.
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**Case III (Figs 18–26)**

This patient presented with what she described as a “wonky smile”. She had previously looked into the possibility of having porcelain veneers placed so understood some of the aims of smile design. However, on studying her teeth, it became clear that there was potential to pre-align first. Her upper right central was mesially rotated by approximately 50° and her laterals were slightly in-standing and mesially inclined.

Furthermore, she had fairly stained teeth, with the canines two shades darker than the centrals.

On examining the acclusal view, the patient became aware of the extent of aggressive tooth pre-paration that would be required to place a veneer. She understood that her teeth needed to be aligned first before we decided on the next step in design. An Inman Aligner was used over the period of eleven weeks to de-rotate the front tooth and to tip out the laterals. At week eight, bleaching was begun using 5% to 45-minute a day H2O2 gels. Simultaneous whitening is a very attractive part of aligner treatment, as it helps with patient motivation. After alignment, the case was re-examined. Once her teeth had been straightened, it became evident to the patient that her problem concerned edge shape, which had actually worsened with alignment owing to differential wear. In fact, the left central was 2.5 mm shorter than the right. It was very clear to the patient that only these incisal edges needed building in order to achieve the smile she desired.

For placement of the incisal edges at week 12, no local anaesthesia was administered. Other than slight roughening of the worn incisal edges of the upper left 1 and 2, no other preparations were needed. A tetric hybrid composite (Tetric Flow, Ivoclar Vivadent) was built up free-hand on the incisal edge and palatal surface to match the outline of the other central.

A small amount of white opaquer was dotted in to match the facial surface and was simply filled with a nano-hybrid composite (Venus Diamond, Heraeus) for high polish. The composite was polished vertically using rubber sticks (Polifon, DENTSPLY DeTrey) to try to blend in with surface anatomy to mask the join. The process was repeated on the lateral.

The patient was held in retention using her aligner and an impression was taken for a wire retainer to be fitted two weeks later. It was especially nice to retain the natural aesthetic characterisation of this patient.

Ceramic work, as beautiful as it can be, would certainly have changed her appearance more; some may say for the better, but that was not what the patient actually wanted. She wanted her own teeth to have correct length and look straighter and whiter.

**Shared responsibility**

The ABB concept can truly be described as minimally invasive. At the same time, it actively involves the patient in the treatment, giving him/her a feeling of being in control and taking responsibility for his/her treatment. This has been proven to be of great significance when measuring patient satisfaction of treatment results.4

There are many anecdotal stories about patients who had technically beautiful veneers placed but found that these simply did not meet their desires.

**There are many anecdotal stories about patients who had technically beautiful veneers placed but found that these simply did not meet their desires.**
The problem is that even with no-preparation veneers, an irreversible procedure has been undertaken and this has been done mainly based upon the treating dentist’s opinion, with the patient having very little input.

In my experience, every patient that I have treated according to the ABB concept has accepted the result happily, even though technically it might not be perfect from a smile design point of view. Nowadays, with rising levels of litigation, one would have to question the wisdom of selecting a treatment path that could result in conflict over one in which the patient participates in key decisions and sees his/her own teeth improve.

I believe this approach firmly sits alongside MICD core principles, which recommend a more minimally invasive and patient-led approach.

**Conclusion**

I understand the controversy in challenging the traditional approach to smile design, but the new mantra of progressive smile design is vital when we are looking to give our patients what they actually want. Previously, pre-whitening was always a way of giving our patients an alternative view of their teeth. Now, and more significantly with alignment techniques, patients can make their own decisions and massively reduce the risks by breaking down the process of a smile makeover into stages and reassessing at each point.

With ABB, it is possible to align, whiten and bond a case in less than 12 weeks, which previously might have required eight to 10 veneers, four times the cost and significant tooth preparation. Thus, a dramatic contrast in pathways has been created. If a patient is happy after alignment, whitening and minimal bonding, then this has to be viewed as a success.

This UK technique is now a significant new treatment discipline in itself and cosmetic dentistry will be better for it. After all, what would you choose to have?

Editorial note: A complete list of references is available from the publisher.

**About the author**

Dr Tif Qureshi is Vice-President of the British Academy of Cosmetic Dentistry. He presents hands-on courses and lectures on the Inman Aligner worldwide. For information on course dates and training, please go to www.straight-talks.com or www.inmanaligner.com. Alternatively, contact Caroline Caven on +44 207 255 2559 or at info@straight-talks.com.
In at the deep end

Orthodontist David Gale converts a domestic property into a specialist centre

Finding the ideal premises to convert into a dental practice can involve months of targeted searching. It’s fair to say that most would probably consider a domestic property with an indoor swimming pool as an unlikely and somewhat unusual candidate for refurbishment.

However, orthodontist David Gale, not put off by the building’s atypical feature, has converted its interior into a fabulous Specialist Orthodontic Referral Centre in a prime Hampshire location.

David’s search for a new location began in 2006 after five successful years’ operating out of rented premises in Fareham. It was clear the practice was outgrowing its premises and as the building could not be altered to meet new regulations, he began to look for an alternative location in which to create a specialist orthodontic centre.

Proportions
The property David settled on was a large private house with an indoor swimming pool just five hundred metres down the road. Chosen because of its ideal proportions to convert into a purpose designed specialist practice it also benefited from two hundred and fifty metres down the road. The swimming pool is now underneath the therapists suite without water.

Decon work
The work required was extensive: “The refurbishment was fairly complex and involved removing the back of the property, building an extension, stripping out all theatre. All the requirements of the Disability Discrimination Act and new proposed cross-infection legislation had to be met and the layout needed to ensure efficient workflows could be put in place to enable a NHS and private specialist dentistry business to be viable.”

The wondrous electrics, plumbing and waste services and removing all floors, ceilings and some walls before being rebuilt. The lecture theatre was installed over the top of the swimming pool. The project took eight months to complete and we opened the new practice in February 2008.”

David turned to DESS Ltd to procure all the practice equipment and dental chairs and Planmeca for the radiographic equipment. David had worked with DESS since 2001 and used their services in his previous premises. He explains why he chose to use them for this project.

“I gave my architect a challenging brief, to transform the current building and pool into three surgeries and a lecture theatre’

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David explains: “I chose Bel- mond equipment for my previous practice as it was highly recommended by my dental dealer. Despite intensive use over five years the chairs proved to be extremely reliable so they were my first choice for the new practice. I chose the Cleo I model for all the surgeries as I wanted a ‘knee break’ chair so patients could get in and out quickly and easily and so we could talk with them sitting up. A lot of orthodontics is communication. The small footprint of the Cleo I means that the team can move around the chair more easily’.

A show of success
In 2010 on the back of the success of the new practice, David decided to carry out further enhancements, converting the existing lecture theatre into a three chair orthodontic therapist treatment suite. This time the six-week project was ‘self-contained’ and with the builders working over the weekend to join the new suite to the main practice, there was no disruption to patients.

Reflecting on the refurbishment and the practice he has created David feels that although it
took nearly two years from purchase to completion, this kind of project can’t be hurried. He has the utmost praise for the project team.

“I have to say that we all really enjoyed working together and have stayed in touch. I’ve treated many of their children since so it’s been nice for them to benefit from the new practice they helped to build.”

When asked what advice he would give anyone undertaking a similar project David is clear: “You really need to choose people with a good reputation. They almost certainly won’t be the cheapest but in the long run it is cost effective as it saves mistakes, chasing up and your stress. I’d also really recommend employing a building contract manager so you don’t need to micro manage the project and can keep the day job going. Mine was planned and managed by an architect and an independent quantity surveyor so my main role during the building was to make quick decisions when required, so I didn’t hold up progress.”

The move to the new building has enabled David and his team of 17 staff to provide a much improved service to more than 10,000 patients.

“But not only is the practice a bright and welcoming environment in which to be treated, it is also laid out to maximise the efficiency of workflows for the staff and to ensure we can stay ahead of regulatory requirements. I am hopeful we have thought of everything and the building is future proof.” Of course, time will tell.

For more information about the David Gale Specialist Orthodontic Referral Centre please visit www.david-gale.co.uk.

**About the author**

David Gale is a registered specialist orthodontist with The General Dental Council, and is a member of the British Orthodontic Society and British Dental Association. His main objective is to help every patient achieve his or her ideal smile, in a relaxed and friendly environment. David qualified from university as a dentist in 1989 after which he worked within the I & R hospital service. He became a Fellow of the Royal College of Surgeons of England in 1993 having gained the Fellowship in Dental Surgery (oral surgery). Following a postgraduate education in most of the dental specialties David was selected for a three-year orthodontic specialist training in 1994. In 1997 David was awarded the Membership in Orthodontics from the Royal College of Surgeons of England and also gained a university Masters in Science Degree in orthodontics. Following further higher specialist hospital training David was awarded the Fellowship in Orthodontics from the Royal College of Surgeons in 1999, which led to consultant accreditation in 2000. David worked as the consultant orthodontist at the Royal Hospital Haslar, Hampshire for two years. David has authored scientific papers and has presented lectures at National and International specialist conferences. He is also a National Dental Nurse examiner. In 2002 David set up the Specialist Orthodontic Referral Centre in Fareham which is now his professional home.
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Bridge2Aid celebrate six years of Hope Dental Centre in Mwanza

Bridge2Aid (B2A) are delighted to celebrate six wonderful years of the Hope Dental Centre in Mwanza, Tanzania and share this success with the UK Dental community, without the support of whom, improving oral health in this area would not have been possible.

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With all profits from Hope Dental Centre donated to the work of B2A, the Centre and B2A clearly would not be where it is today without the help and support of the UK dental community. Thank you to the dental professionals who have tirelessly fundraised to support the Centre and our teams, the support of the UK dental trade who continue to donate material and equipment, and an extra special thank you to A-dec who have donated, shipped, installed and now service, two chairs.

For further information on Hope Dental Centre visit www.hopedentalcentre.com or to find out about how you can help us to continue to improve oral health in Tanzania over the next six years visit Bridge2Aid now at www.bridge2aid.org or contact us directly on info@bridge2aid.org or 0845 0047559.
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‣ Excellence in Posterior Composites
‣ Restorative aspects of Cosmetic treatment
‣ Restoration of the root filled tooth
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Today you can go further than treating the pain of dentine hypersensitivity with Sensodyne. Today you have new Sensodyne® Repair & Protect containing NovaMin® calcium phosphate technology. NovaMin® builds a reparative hydroxyapatite-like layer over exposed dentine and within the tubules.1-5

Starting to form from the first use5, this reparative layer creates an effective and lasting barrier to the pain of dentine hypersensitivity6-8, with twice-daily brushing.

Explore a new layer of opportunity with Sensodyne Repair & Protect


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