Dentist fakes death
A dentist who was £395,000 in debt and faked his own death in a £1.8m life insurance scam has been sentenced last March for five years. The dentist, who reportedly started a new life in Scotland after his insurance scam, has also been accused of falsifying documents to obtain work in Britain. According to reports, Plymouth Crown Court was informed that Parisis faked his own death because he was £395,000 in debt. It was also revealed that because of a string of complaints against his name, he was about to be barred from working as a dentist. At the time of writing, Parisis was due to appear under the name of Neil McLaren at a hearing of the Professional Conduct Committee of the GDC in London on 24 February, accused of procuring entry on to the General Dental Council’s register in the name of Neil Edward McLaren with the use of fake documents.

Tackling tooth decay
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Illegal handheld dental x-rays flood online market

Dental professionals have been warned by the US Food and Drug Administration (FDA) of a batch of potentially unsafe handheld dental x-ray units that are being sold online.

The warning comes after growing concerns that the devices are both unsafe and ineffective; according to one report it is believed that the devices could expose users and patients to unnecessary and potentially harmful x-rays.

The safety of the devices was also alerted by The Washington Dental Society in a report. "CTLP gives Treponema access to dental plaque, causing bleeding gums and gum disease. Inhibiting CTLP would deny Treponema access to the bacterial communities responsible for dental plaque, which in turn would reduce bleeding gums and slow down the onset of periodontal disease and tooth loss."

"If a drug could be developed to target this factor, it could be used in people who are at higher risk from developing gum disease."

The study explains how oral bacteria, such as Treponema denticola, frequently ‘gang up’ with other pathogenic oral bacteria to produce destructive dental plaque, causing bleeding gums and gum disease. It is believed that this interaction between the bacteria is crucial to the development of periodontal disease.

Researchers from the University of Bristol discovered that during this interaction the molecule CTLP acts as the access key, allowing bacteria to latch onto oral bacteria, leading to blood clotting and tissue destruction. Professor Howard Jenkinson, who led the study, said in a report: "Devising new means to control these infections requires deeper understanding of the microbes involved, their interactions, and how they are able to become incorporated into dental plaque."

"CTLP gives Treponema access to other periodontal communities, allowing the bacteria to grow and survive. Inhibiting CTLP would deny Treponema access to the bacterial communities responsible for dental plaque, which in turn would reduce bleeding gums and slow down the onset of periodontal disease and tooth loss."

"If a drug could be developed to target this factor, it could be used in people who are at higher risk from developing gum disease," explained Professor Jenkinson.

Contraceptive injection linked to poor periodontal health

According to research in the Journal of Periodontology, injectable progestosterone contraceptives may be associated with poor periodontal health.

The study found that women who are taking depotmedroxyprogesterone acetate (DMPA) injectable contraception are more likely to have indicators of poor periodontal health. "Healthcare professionals using these devices should verify they are purchasing and using those that have been cleared by the FDA bear a permanent certification label/tag and an identification (ID) label/tag on the unit. It should also display a warning label, the full name and address of the manufacturer of the unit, the month and year of manufacture, and finally the place of manufacture."

"If a drug could be developed to target this factor, it could be used in people who are at higher risk from developing gum disease," explained Professor Jenkinson.

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King’s crown up for auction

Buying teeth once belonging to famous icons has been a popular choice of purchase at auction houses recently, and it doesn’t seem to be stopping anytime soon, with the latest famous tooth going up for grabs once belonging to Elvis Presley!

What has been jokingly called the King’s Crown, the item is actually a mould of Elvis’ mouth with a spare crown in place.

The crown was created by the former King of Rock n’ Roll’s dentist in case he chipped his front tooth whilst on tour.

The dentist in question was former Memphis dentist Henry Weiss, who was Elvis’s dentist up until 1971. According to a report, he used to do all his dental work and was even called away on tour when Elvis crashed his crown on a microphone while performing at the International Hotel, now known as the Hilton Hotel, in Las Vegas.

Paul Fairweather from Omega Auctions, Manchester, said in a report: “Following on from Lennon’s tooth back in November which sold for £19,500, we were extremely excited on the consignment of this truly unique item from the King of Rock & Roll.”

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Colgate Fluoride Daily Dental Rinse

**PRODUCT INFORMATION**

**Name of the medicinal product:** FluoriGard Daily Dental Rinse. **Active ingredient:** Sodium Fluoride 0.05% w/w (225 ppm F). **Indication:** To aid in protection against dental caries. **Dosage and administration:** Use once per day, preferably after brushing teeth. Rinse 5-10ml around and between teeth for one minute and then spit out. Do not eat, drink or rinse mouth for at least fifteen minutes afterwards. **Contraindications:** Do not use under six years of age. **Special warnings and precautions for use:** Do not swallow. Excess dosage may cause nausea, and in children under seven, dental fluorosis. **Undesirable effects:** When used as recommended there are no side effects. **Legal classification:** CSI. **Product licence number:** PL0049/0012. **Product licence holder:** Colgate-Palmolive (U.K.) Ltd. Guildford Business Park, Middleton Road, Guildford, Surrey, GU2 8JZ. **Recommended retail price:** £4.75 (500ml bottle) **Date of revision of text:** September 2003.

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Severe dental erosion link to eating disorders

Eating disorders can be physically and emotionally destructive, but the results of a new clinical study indicate oral health is also destroyed by the condition.

The study by the University of Bergen in Norway revealed patients with an eating disorder — such as Anorexia and Bulimia — had significantly more dental health problems than those without, including tooth sensitivity, facial pain and severe dental erosion.

The report highlighted that more than one in three of those with an eating disorder (56 per cent) had ‘severe dental erosion’ compared to just 11 per cent of the control group. Those with an eating disorder also self-reported higher daily tooth sensitivity, higher occurrence of facial pains and of dry mouth.

It is estimated eating disorders affect 1.1 million women and men in the UK, although many more do not come forward with their problems. While vomiting is often associated with eating disorders, the results of the research reveal oral health is likely to suffer too.

Chief Executive of the British Dental Health Foundation Dr Nigel Carter discussed the reasons behind the apparent poor oral health and offered some advice for sufferers.

Dr Carter said: “When you vomit repeatedly, as with certain eating disorders, it can severely affect oral health.

“The high levels of acid in the vomit can cause damage to tooth enamel. Acid attacks of this sort on a frequent basis means the saliva in your mouth won’t have the opportunity to naturally repair the damage done to your teeth by the contact with the acidic vomit, hence the increased severity of dental erosion witnessed in the study.

“People suffering with an eating disorder should look to, wherever possible, rinse their mouth as soon as possible after vomiting to help reduce acid effects. Do not brush immediately after vomiting as this may brush away softened enamel. The use of a fluoride toothpaste will help to protect teeth over time, and by chewing on sugar free gum it will help to increase saliva flow and neutralise acids in the mouth. It can also prescribe high strength fluoride toothpaste which will help to protect your teeth.

“We would highly recommend more frequent visits to the dentist to ensure the problem does not deteriorate further and to identify whether any treatment would be required. If the problem persists, don’t be afraid to discuss your problems.”

Support groups such as Anorexia and Bulimia Care www.anorexiabullimi.acare.org.uk/ are on hand to provide advice and support. The Foundation’s own ‘Tell Me About’ www.dentalhealth.org/tell-me-about/topic/mouth-conditions/dental-erosion leaflet on dental erosion also gives some advice on how you can continue to look after your oral health.

Research points to possible association between oral bacteria and bowel cancer

The bacteria associated with the most common cause of tooth loss in adults could be a pre-cursor for the development of bowel cancer, according to a team of scientists.

The link comes as scientists at the Dana-Farber Cancer Institute and the Broad Institute in America found an abnormally large number of Fusobacterium, a bacterium associated with the development of periodontal (gum) disease, in nine colorectal tumour samples, pointing to the possibility the two could be associated.

Bowel cancer, also known as colon cancer, is one of the top three deadly cancers in the UK. Around 55,000 people get diagnosed with bowel cancer every year and around half of them die.

Although lead author Matthew Meyerson, MD, PhD, co-director of the Center for Cancer Genome Discovery at Dana-Farber and a professor of pathology at Harvard Medical School believes further research is needed to discover the extent of the link, the research suggests the bacterium could be a factor in the development of cancer.

Dr Meyerson stated: “At this point, we don’t know what the connection between Fusobacterium and colon cancer might be. It may be that the bacterium is essential for cancer growth, or that cancer simply provides a hospitable environment for the bacterium. Further research is needed to see what the link is.”

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, believes the research further highlights the importance of good oral health.

Dr Carter said: “This research, although at an early stage, is more evidence of the systemic links between oral and overall health. Everyone sufferers from gum disease at some point in their lives, which could potentially endanger thousands of people if they persist in neglecting their oral health.

“If you have swollen gums that bleed regularly when brushing, bad breath, loose teeth or regular mouth infections appear, it is likely you have gum disease. To avoid further deterioration in your oral health, visit your dentist for a thorough check-up and clean.”

The research, presented in Genome Research (October 18 2011) made the discovery by sequencing the DNA within nine samples of normal colon tissue and nine of colorectal cancer tissue, and validated by sequencing 95 paired DNA samples from normal colon tissue and colon cancer tissue. Analysis of the data turned up unusually large amounts of Fusobacterium’s signature DNA in the tumour tissue.

UMD Professional celebrates a record number of qualified practice managers

A record number of dentists and dental practice managers from all over the UK celebrated achieving a nationally recognised management qualification with UMD Professional at an awards ceremony in London last month.

72 managers and dentists achieved an Institute of Leadership and Management qualification with UMD Professional in the last year, the highest number to date, and 25 of them came together in London to celebrate their success at an awards reception.

The successful candidates were presented with their certificates by John Tiernan, Director of Educational Services for MPS and Dental Protection Limited.

Fiona Stuart-Wilson, Director of UMD Professional said: “We are delighted not only to celebrate everyone’s success but also to mark a record number of passes in the last year. We are very pleased to see in so many cases that practices are willing to continue investing in their managers’ development by supporting them through the course, and to reap the benefits of the training they have undertaken.”

UMD Professional is currently taking applications for their regional workshop courses and distance learning programmes, and grants are still available in some areas.
Switch on to new ideas

Speakers:

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

18th and 19th May 2012
Millennium Gloucester Hotel & Conference Centre, London Kensington

info@smile-on.com | www.clinicalinnovations.co.uk | 020 7400 8989

EARLY BOOKING DISCOUNT
Elderly woman dies due to contaminated dental equipment

An article recently published in The Lancet describes a case report of an 82-year-old woman in Italy who died of Legionnaires disease due to contaminated dental equipment.

The report describes how the elderly lady had no underlying disease, after a chest radiography and a Legionella pneumophila urinary antigen test, the woman was promptly diagnosed with Legionnaires’ disease. Although she was immediately given oral antibiotics the patient developed fulminant and irreversible septic shock and unfortunately died two days later.

The case report prompted an investigation into finding the source of L pneumophila, and after enquiring about the patient’s whereabouts during the incubation period, it was revealed that she had attended two dental appointments.

As a result, samples were taken from both the woman’s home and the dental surgery that she visited in order to investigate possible L pneumophila contamination. According to the report, samples from her home tested negative for L pneumophila, however, samples from the dental practice tested positive and showed genomic matching between L pneumophila in the dental unit waterline and in the women’s respiratory secretion.

The authors have called for various control measures at dental surgeries to prevent similar incidents.

Could oral blood be used to screen for diabetes?

A recent study has suggested that oral blood samples taken from pockets of periodontal inflammation can be used to measure a patient’s diabetic status.

The NYU nursing-dental research team found that the technique, which works by using oral blood samples to measure hemoglobin A1c (which is widely used to test for diabetes), compares well to blood samples taken from the patients’ finger.

Samples of oral and finger-stick blood were taken from 75 patients with periodontal disease; the NYU researchers then compared the hemoglobin A1c levels from the oral and finger-stick blood. The results that produced a reading of 6.5 or greater in the oral sample corresponded to a finger stick reading of 6.5 in identifying the diabetes range.

“In light of these findings, the dental visit could be a useful opportunity to conduct an initial diabetes screening - an important first step in identifying those patients who need further testing to determine their diabetes status,” said the study’s principal investigator, Dr Shiela Strauss, associate professor of nursing and co-director of the Statistics and Data Management Core for NYU’s Colleges of Nursing and Dentistry, in an online report.

Throughout the year-long study, dentists and dental hygienists were able to collect finger stick blood samples and send them to a laboratory for analysis thanks to a hemoglobin A1c testing kit that was designed specifically for the study.

“There is an urgent need to increase opportunities for diabetes screening and early diabetes detection,” Dr Strauss added in the report. “The issue of undiagnosed diabetes is especially critical because early treatment and secondary prevention efforts may help to prevent or delay the long-term complications of diabetes that are responsible for reduced quality of life and increased levels of mortality risk.”

The study was funded by an NYU CTSI (Clinical and Translational Science Institute) grant, which was awarded to the research team last year. The findings were then published in the Journal of Periodontology.

According to the report, the research is part of a series of NYU nursing-dental studies examining the feasibility of screening for diabetes and other physical illnesses in the dental setting.

NEBDN calls for examiners

The National Examining Board for Dental Nurses (NEBDN) is seeking to recruit new members to its Panel of Examiners in order to deliver the new NEBDN National Diploma in Dental Nursing examination.

Featuring Objective Structured Clinical Examinations (OSCEs), NEBDN has completely revised the format of the qualification in order to provide a more modern approach to the assessment of Dental Nurses.

To become an Examiner with NEBDN you must:

• Have previous experience of assessing OSCEs within dental training
• Be registered with the General Dental Council
• Be currently practicing as a Dental Surgeon or Dental Care Professional
• Have two years’ experience since qualification
• Be well organised and able to maintain high quality standards
• Be passionate about Dental Nurse Education and helping people reach their full potential

Becoming an Examiner will help you to:

• Improve your personal development and professional status
• Develop your skills and understanding of Dental Nurse Education and training
• Gain verifiable CPD through on-going support and training
• Network with other professionals with a commitment to improving Dental Nurse Education

Further information please contact sarah@nebdn.org.

Full training and support will be provided. Successful applicants will be invited to an assessment day in April / May 2012.

‘VSS Mentor’ launched

Visiting Specialist Services (VSS) has announced the launch this month of ‘VSS Mentor’, a new UK wide mentor programme in implant dentistry for GDPs. This new programme provides clinicians undertaking implant training with support in their own practices from an experienced mentor. Practitioners can choose from a range of levels of support to best suit their needs, from a single mentoring session to a full mentoring programme which supports dentists from their first implant placement through to becoming an independent implant surgeon.

“There are several excellent courses in implant dentistry in the UK, and our aim is to provide additional support to help the practitioner gain experience and confidence in their own practice environment with the supervision and guidance of a clinician experienced in the field,” said Fadi Barrak, Director of VSS and one of the VSS Mentors.

“By providing support in this way we can help dentists to develop their implant service more quickly and effectively, and build their practice’s profile and goodwill which is especially important in the current economic climate.”

To find out more please contact 0845 6585757.
20 years of service for BADN’s Pam

A prescription for prescribing

Trial programme carried out by Cardiff University could help significantly reduce the number of antibiotic prescriptions handed out by GPs.

The programme meant that the 69 Welsh GP practices that took part in the two-year trial received antibiotic prescribing and resistance data obtained from their own practices. It also meant that GPs had access to online learning materials and ‘consulting skills’ tools, enabling and encouraging doctors to effectively discuss treatment options with their patients.

According to a report, the researchers found that participating practices greatly reduced their numbers of antibiotic prescriptions. They also calculated that if the initiative was to be introduced throughout the UK, prescriptions could be cut by a staggering 1.5 million per year, saving the NHS money. It would also help tackle antibiotic resistance.

OnDEC, a joint enterprise between King’s College London Dental Institute and the NHS London Deanery, is celebrating after winning a prestigious award at the 2011 Elisabeth Paice Awards for Educational Excellence in Medical and Dental Education. The team behind running the education and training centre was nominated as winner in the category of Best Postgraduate Education Centre Team.

The annaul Elisabeth Paice Awards identify and reward those making outstanding commitment and contributions to postgraduate medical and dental education and are judged by a panel from the NHS London Deanery.

The LonDEC team was honoured with the title Best Postgraduate Education Centre Team 2011 at the awards presentation evening held at the De Vere Holborn Bars Hotel.

After receiving the award Bill Sharpling, Director of LonDEC and Senior Clinical Teacher at the Dental Institute and Dental Tutor for the London Deanery, said: “I am extremely proud of the LonDEC staff and vast team of teachers that contribute to the success of the Centre. The contribution from Perry Tatman, Tara Owen, Victoria Hegarty and Tora Laine has been a significant factor in receiving this team award, as has the committed weekly teaching by Raja Majithia and Sandra Smith.”

“The courses we arrange include events for 10 to more than 300 delegates. In the last two years, we have offered 142 programmes from two-hour evening seminars, half day and one day courses and three day master classes. Additionally, we host the nine-day residential programmes, which form part of King’s College London Dental Institute’s blended learning master’s degree programme training. Our high quality London Dental Deanship CPO programmes continue to receive excellent feedback and during the last year the team have overseen 471 courses, of which 516 were dedicated Deaney courses.”

Prof Nairn Wilson, Dean and Head of the Dental Institute, said: “The Elisabeth Paice Award is a very deserved honour for LonDEC. Building on such success, it is hoped that LonDEC will continue to grow and develop as a ground-breaking centre of excellence.”

LonDEC was shortlisted for an Elisabeth Paice Award in November 2010 for the outstanding quality of its programmes and for the value they bring to the dental profession. The team is particularly proud of its strong reputation for high quality education and training on a range of topics.

“The courses we arrange include events for 10 to more than 300 delegates. In the last two years, we have offered 142 programmes from two-hour evening seminars, half day and one day courses and three day master classes. Additionally, we host the nine-day residential programmes, which form part of King’s College London Dental Institute’s blended learning master’s degree programme training. Our high quality London Dental Deanship CPO programmes continue to receive excellent feedback and during the last year the team have overseen 471 courses, of which 516 were dedicated Deaney courses.”

Prof Nairn Wilson, Dean and Head of the Dental Institute, said: “The Elisabeth Paice Award is a very deserved honour for LonDEC. Building on such success, it is hoped that LonDEC will continue to grow and develop as a ground-breaking centre of excellence.”

LonDEC was shortlisted for an Elisabeth Paice Award in November 2010 for the outstanding quality of its programmes and for the value they bring to the dental profession. The team is particularly proud of its strong reputation for high quality education and training on a range of topics.
Managing CQC the Genghis Khan way
Michael Young on registration, regulation and regulators

When I graduated in the late 70s I could only have literally walked out of dental school and set up a new National Health Service (NHS) practice in the back room of my house, if I had one. All I needed was a Family Practitioner Committee (FPC) number, a quick chat with the local Planning Department (or I could have kept quiet, as the chap who owned the practice I bought in the early 1980s had done in the 1960s), some professional indemnity insurance, oh, and a nurse and a receptionist. Maybe the privately educated but not too bright daughter of the local farmer chances trying her hand at nursing. Finding a receptionist shouldn’t be too much of a problem, after all what can he so hard about answering the telephone, making appointments and taking a bit of money from the patients? The Dental Practice Board (DPB) will send one of their Dental Officers around to give the place the once over, make sure I’ve got enough of everything, and that the surgery and waiting room (the hallway at the back of the house) are nicely decorated. Hopefully the NHS, the FPC and the DPB wouldn’t bother me again. As long as I kept out of trouble and stayed in the General Dental Council (GDC) dental register, I would never have to open another dental book or journal ever again. My nicely spoken nurse would never have to trouble herself with keeping up-to-date or passing exams. Yes, the next 55-40 years until I retired were going to be just dandy, or so I thought.

That’s how it was for dentists a generation ago, but oh my, how things have changed: bit-by-bit, dentistry has slowly been coming under the ‘control’ of various regulatory bodies. Health and safety legislation, disability discrimination, clinical governance, and the annual complaints audit all crept in. Initially, only dentists, hygienists and therapists had to be on the GDC register; but now dental nurses and technicians (DCPs) also have to be registered. Everyone now has to undertake continuing professional development (CPD). And so it went on; more regulations, more accountability, more paperwork, and inevitably, more cost.

Now it seems that dentists and their practices have the daddy of all regulations and think we would have been well placed to comply with CQC. As the BDA itself states: The Care Quality Commission (CQC) has accepted that membership of the Scheme is a reliable indication that the practice is using a QA framework. Practices meeting the Scheme standard should be well positioned for meeting CQC compliance.

If we were not a BDA Good Practice or a member of any other compliance scheme, then I think that my practice manager and myself, and the team would have our work cut out.

CQC compliance involves the whole team, and so everyone at my practice would be made aware of CQC from the outset, and would then be expected to help the practice comply. There has been a great deal of negativity from dentists about CQC, but when either my practice manager or myself talked to the rest of the team about CQC, we would always be very positive about it.

‘That’s how it was for dentists a generation ago, but oh my, how things have changed: bit-by-bit, dentistry has slowly been coming under the control of various regulatory bodies’

There is no point undermining people’s confidence in something if you then expect them to help you.

Assuming that your practice is compliant then the next stage of the CQC process should hold no fears for you or your team. A CQC inspection, or a ‘Review of Compliance’ as they are correctly termed, is the next thing that will happen. I have heard of practices that have only been given a couple of days’ notice by the CQC prior to one of these reviews. If your practice is compliant then this should not be a problem, because apart from a quick check to make sure that you have everything you should have to hand, you will have prepared. I would have prepared my team well in advance, well ahead of receiving notice of a review, talking through the purpose of the review, how it is going to be conducted, and what should be said if anyone asked a question by the inspector. This is not cheating.
this is planning.

It does not matter how well you prepare, an inspection is going to be a stressful event. You imagine that the practice manager won’t be able to find that one bit of paper that you both saw yesterday: yet somehow, they will ask the youngest and newest member of the team a question to which they give totally the wrong reply. You might think that the one patient they ask about the practice is the one you didn’t want them to ask! There is always the thought that you have overlooked something or other was inspecting. I’d very happy if we had, but not too disappointed if we hadn’t, unless it was something really serious. I’d then go through the report line-by-line and work out exactly what had to be done by the practice to fully comply. I would then hold a special team meeting in which all the concerns arising from the report would be discussed and an action plan for each one discussed and agreed. Written objectives would be given to each team member so that I know that what must be done is done and that it is done on time. The safety of patients, you and your team through stringent cross infection control measures is a good thing. Criminal record checks on employees are sadly a reflection of our modern risk aversion psyche. Improving the overall quality of dental care and treatment must surely make sense to everyone working in dentistry. Isn’t it about time that private practices were brought into line and that they too were inspected alongside NHS practices? Some dentists might resent outside interference, but the fact is that CQC is here, and it is better to work with it than against it. Practices that are professionally and progressively managed, and who take a very positive attitude towards managing change, should have no or very little problem with CQC. I don’t think Genghis Khan would have shied away from the challenge, nor do I think he would have thought of CQC as a bad thing.

‘Improving the overall quality of dental care and treatment must surely make sense to everyone working in dentistry’

that unknown to you, the nurse has been doing her own thing regarding the decontamination and sterilisation of instruments. I think it is fair to say that the inspector is not there to catch you out, but an opportunity for me to find out from someone who should know, how my practice could improve.

The ‘Review of Compliance’ report arrives. I would not expect the practice to have satisfied everything that the inspector was inspecting. I’d very happy if we had, but not too disappointed if we hadn’t, unless it was something really serious. I’d then go through the report line-by-line and work out exactly what had to be done by the practice to fully comply. I would then hold a special team meeting in which all the concerns arising from the report would be discussed and an action plan for each one discussed and agreed. Written objectives would be given to each team member so that I know that what must be done is done and that it is done on time. The safety of patients, you and your team through stringent cross infection control measures is a good thing. Criminal record checks on employees are sadly a reflection of our modern risk aversion psyche. Improving the overall quality of dental care and treatment must surely make sense to everyone working in dentistry. Isn’t it about time that private practices were brought into line and that they too were inspected alongside NHS practices? Some dentists might resent outside interference, but the fact is that CQC is here, and it is better to work with it than against it. Practices that are professionally and progressively managed, and who take a very positive attitude towards managing change, should have no or very little problem with CQC. I don’t think Genghis Khan would have shied away from the challenge, nor do I think he would have thought of CQC as a bad thing.

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minocycline in each 0.5g of gel.

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The movement of social metrics

Rita Zamora talks about how to thrive in social media

What was your most pressing social media challenge in 2011? Chances are you might say it was one of the following:

1. We weren’t really sure what we were supposed to be doing
2. We didn’t have the time to manage it
3. We didn’t know if our efforts were working

Let’s look at each challenge, as well as solutions.

Problem number one: We weren’t really sure what to do if you aren’t sure what you are doing on Facebook or Twitter, know that you are not alone. Everyday new practices join these social media platforms and find their own way... or not. Because social media is a “free” tool to use, often practices struggle with the idea of spending money for help with social marketing. However, remember that time is money. Investing in a course or some coaching can not only help you get ahead, but it can also help save hours of time and frustration.

Solution
First and foremost, consider your goals. What results would you like to see from your social marketing efforts? By answering this question, you can determine which social marketing platforms you should be working with. Note, not all practices are cut out for every social media platform. For example, if you said your primary social marketing goal is to network and connect with other businesses in your community, I’d recommend you utilise Twitter.

On the other hand, if you wanted to increase word of mouth referrals and grow relationships with patients, then Facebook would be an ideal tool to use. It can be frustrating not knowing if you are doing the right thing on social media, and even more nerve wracking to learn you aren’t even using the proper platform. So, begin with the end in mind. What are your goals? Once you know your goals, you will discover which social media tool is best for you. You can then start or focus on that one platform and master it.

Problem number two: We didn’t have time to manage it
Now that you know what your goals are, and which social tools are best for you, we can address challenge number two: finding the time to manage social marketing.

Many practices are struggling to keep up with creating content for their Facebook page, finding time to tweet on Twitter, or make video for their YouTube channel. Not to mention we now have Google+ pages as well. The best way to survive (and thrive) in social media management is to have a plan. Your plan may involve partial delegation of your activities or hiring someone to manage your activities internally. Either way, without a plan you are planning to fail.

Solution
Put a basic strategic plan in place. You wouldn’t get into a car or hop a train without knowing where you are headed. If you don’t have a plan for your social
efforts you could end up driving around in circles. No wonder so many practices find themselves lost! To help you get clear direction and most importantly make your efforts both manageable and effective, take time to create a basic strategic plan.

Consider the following:

1. **Who will be responsible for your marketing efforts?** Decide if you will manage these efforts internally or partially out-source the responsibilities. Notice I don’t recommend total outsourcing of your efforts. If you are considering totally outsourcing your social marketing so you “don’t have to see or touch it”, then social media marketing may not be a good fit for you.

2. **What is your promotional strategy?** Although social media is a digital tool, much of the success of your efforts will rely on your offline marketing. Think about signage, scripting for verbal invitations, and other tangible support materials.

3. **What is your content strategy?** Determine how you will come up with content for your Facebook Page. Consider what you will tweet about and how you will interact... Note also how often and when you will participate, such as Tuesday and Thursday mornings or when the practice is typically slower.

**Problem number three: We weren't sure if it was working**

Once you have a plan and systems in place to leverage your social marketing, you are ready to address challenge number three. Do you know if your social marketing efforts are really working? Much like getting into a car without knowing where you are going, if you aren’t sure how you are going to measure social media successes, how will you ever know how you are doing? To use an analogy, how do you know when you are successful at driving your car to your practice? The answer of course is that you actually got to your practice. To know if you were successful at your social marketing efforts, you must have some specific measurable outcomes that match your overall goal in mind.

**Solution: Decide which metrics you will measure**

As with any marketing activity, social media efforts should be measured. While there are several metrics you can use to determine how you are doing, the most important metric of all is tracking specifically where new patients have seen you.

Often practices say they are seeing the number of new patients “from the internet” grow. The best way to learn exactly where you were found is to ask. Wait until new patients visit your practice for their first visit—and you’ve wowed them with excellent service. Then simply say: “We are working hard to ensure we can be found easily in our community. Would you mind telling us if you happened to see our, ie: Facebook, Twitter, Google+ or YouTube?”

Keep in mind the movement of social metrics may move slowly. However the quality of new patient referrals via social media (conversational, relationship-focused) will, for most practices, be far greater than those acquired via traditional media (one-to-many, sales-oriented). If you haven’t already, make the most of the unique opportunities social marketing has to offer. Thrive in 2012 by considering your goals, putting a basic plan into place, and tracking exactly where people have seen you. Following these recommendations will put your practice on the right track for a socially successful future.

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**About the author**

Rita Zamora is an international social media marketing consultant and speaker. She and her team actively co-manage dozens of dental practices’ social media programs. Her clients are located across the United States and internationally. She has been published in many professional publications. Rita is also Honorary Vice President to the British Dental Practice Managers Association. Learn more at www.DentalRelationshipsMarketing.com or email rita@ritazamora.com.
Are you buying what you think you’re buying?

Ray Goodman discusses the small things that can all too often trip you up when buying a practice

There is no denying that the process of buying a practice involves a significant amount of paperwork from associate agreements to X-ray testing certificates. This avalanche of paper can often seem overwhelming and it is then easy to miss the small things that can all too often trip you up, and have a huge impact on what you are buying as opposed to what you think you’re buying.

Having a specialist dental solicitor to help guide you through the process, and check the paperwork for discrepancies can prove invaluable as this recent case history illustrates.

The practice in question was spread over two floors, with the upper floor including a room above a public passageway leading to a rear courtyard. During the routine process of checking that the plans at the Land Registry matched what the buying dentist believed was included in the purchase we discovered that the documents at the Land Registry missed off the room above the passageway. This meant that the selling dentist simply didn’t have legal ownership of this room.

The dentist buying the practice understandably believed he was buying the room in question, which was being used by the practice as a surgery. However, technically speaking this was not part of the property being sold.

The situation was resolved using the rules of adverse possession (commonly known as squatters’ rights) and assigning these rights to the buyer. This allowed the buyer to acquire a right to use this room and a right to register a title to that room at the Land Registry. Any unknown rights of third parties against the room were insured against with a one-off payment insurance policy.

However, the claim was further complicated due to the fact that there was a passageway running beneath the room which was used by members of the public. Clearly the selling dentist didn’t own the passageway beneath the room but consideration had to be made as to what was and what was not owned - for example what about the beams on the underside of the room that offered it support and what rights were available to carry out repairs?

A specialist dental solicitor will be able to guide you through the process and find solutions to your problems. However, in this instance the plans at the Land Registry didn’t match what the buying dentist believed was included in the purchase we discovered this irregularity if and when the dentists decided to sell on the practice?

The lesson is clearly to never assume anything and always check the detail, even on what at first glance, seems a straightforward property conveyance. Because dentistry has many specific relating to legal matters including contracts, regulatory responsibilities, partnership agreements, patient complaints and property ownership, it is really important to employ legal advisors who know and understand the dental profession.

Everyone in business is facing the financial challenges of the recession, and it can be tempting to think it is not worth spending money on specialist lawyers for what appears to be a straightforward transaction or arrangement. Sadly, examples of false economy in business are legion, and choosing to dispense with legal help on the grounds of cost is well proven to be one of them.

When it comes to matters of the law, especially when trying to avoid or resolve claims or disputes, attention to the smallest detail is crucial. What may seem inconsequential or irrelevant to a layman may prove to be the linchpin of a complex compensation claim further down the line. That is why contracts need to be planned with all eventualities in mind, and property details and accounts need to be meticulously examined. It is surprising how business and healthcare by resolving issues before they become problems.

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Ray Goodman is a Member of the Association of Specialist Providers for Dentists (ASPD), a legal member of NASDA (National Association of Dental Accountants) and included on the BDA list of recommended dental solicitors. He has a comprehensive understanding of the commercial and professional objectives of Dental Practices, along with all the relevant legal requirements. In his spare time, Ray has ambitions to be the next Eric Clapton.

For more information call Ray Goodman on: 0151 707 0090, or email r@goodmanlegal.co.uk
The right to be pain free
Michael Sultan discusses pain

Pain is defined by The World Health Organisation as "an unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage".

While recognising its existence, what the WHO doesn’t mention is that pain is, of course, entirely subjective which is one of the reasons why it is such a challenge and a major global public health issue. We probably know far more about pain and its treatment than ever before, yet there is a disconnection between having that knowledge and using it to treat and manage pain.

I believe passionately that dental professionals in general, and endodontists in particular, should commit to the right of every patient to be free of pain and through our work as compassionate professionals, to understand acute pain management if we are to provide real health and emotional benefits for our patients.

We are approaching the end of the global year against acute pain", during which time the International Association for the Study of Pain (IASP) published a paper that points to inadequate education of healthcare practitioners as one of the main reasons for underestimating the seriousness of, and failing to recognise treatment options for, acute pain.

By increasing our own awareness and understanding of the issues surrounding the assessment and treatment of acute pain, we can in turn, help educate our colleagues in the use of anaesthetics and analgesics so they are better placed to offer information and help to their patients, many of whom are reluctant to use painkillers for fear of unpleasant side effects or even, addiction.

Acute pain is the awareness of noxious signals from damaged tissue and is complicated not only by sensitisation in the peripheral but also by changes in the central nervous system. Someone’s emotional state can often have a significant influence on pain and increase the level of distress and impact on quality of life. Pain is hugely debilitating and makes life extremely miserable for millions of people every day and there are many underlying cultural, economic and social reasons that should also be taken into consideration.

I firmly believe that the dental profession must work with the government, policy makers and campaigners to ensure that every patient has access to pain free dentistry.

In some cases this will mean NHS patients will receive treatment from private dental specialists, as was raised by the Steele report, which suggested that poorer patients are forced to settle for extractions and dentures rather than tooth preservation, with root canal treatments a preserve of the rich.

While there is no legally enshrined right to be pain free, there are those who believe that the internationally established and recognised rights to health include that by implication and inference. We should at least encourage greater awareness, better education and knowledge sharing as well as raising patient expectations to be pain free.

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At last!... independent proof that The Dental Directory gives High Street Dental Practices the very best prices!
Dental Associates: SOS
Neel Kothari discusses the problems surrounding UDAs

BDA chair Susie Sanderdon OBE, recently said it was the worst time in history to be a dental associate — and I think many of us would absolutely agree. The implementation of the UDA payment system messily dissected the profession seeing a large proportion of power swing towards government. Front line staff such as dental associates no longer claimed a fee from the NHS but rather through a middle-man, the practice owners. The 2006 dental contract was made between PCTs and practice owners (not necessarily dentists) who in turn engaged in contracts with dental associates - and with it all hell broke loose.

What a crazy situation we are now in where a dental professional can accept an associate position for a ridiculous sum of money (£7.50/UDA lowest rate found online) without having a clue as to the need in the local area or the full rate received by the practice owner. £7.50/UDA could really be pretty fair for a well maintained stable list of patients who require little or no work, but without knowing the full rate, how on earth is an associate meant to know exactly how much work is needed per UDA? For example if an associate received £7.50/UDA on a high risk list of patients there are strong perverse incentives to either undertreat or restrict treatment options, which in my opinion really is not fair for associates or for patients.

Dental associates and those newly qualified entering into our profession have probably been affected most by the 2006 contract. All too frequently they are placed in a very difficult position, whereby in order to get a job they have to accept UDA targets not really designed for them, levels of remuneration based on the realities of supply and demand rather than clinical need and the full liability of clinical decision making. At the same time this subgroup is being held to an exceptionally high standard, constantly worrying about the threat of litigation and practising defensive dentistry. Dental associates do have a range of options to support them in providing a first class service to their patients, but without the financial support structured into the UDA...
system, on a practical level many of these options are about as useful as a chocolate teapot.

Unfortunately dentistry costs money; it is expensive and always has been. I think it is very unfair to place the newest members of our profession into the untenable position of having to choose between 1) earning a living by playing the UDA game and 2) treating patients as they were taught to do in dental school. Whatever happened to the concept of a fair day’s wage for a fair day’s work?

I have mentioned the concerns surrounding litigation and clinical decision making for associates (as well as the profession as a whole). But why has this become such a concern? Well historically the legal standard by which healthcare professionals were judged was based on that of the ‘Bolam test’ (Bolam vs Friern Hospital Management Committee, 1957) which stated that “if a doctor reaches the standard of a responsible body of medical opinion, he is not negligent”. In this regard, one could argue that a responsible body of dental opinion could be used to defend the standard of clinical care within NHS dentistry. Except that the Bolam case is now largely outdated following the ruling made by the House of Lords in the Bolitho v. City and Hackney Health Authority (1997), which has been seen as a departure from the Bolam test, whereby the standard of care was judged based on a sound body of expert opinion. This effectively means that, just because others in the profession would have made the same decision, that alone is not enough to justify the standard of clinical care. Associates are therefore being judged by the very highest of standards, but it is clear to most of us working within the NHS that the capped funding system is often unable to deliver what experts might consider best practice, no matter how much we want to believe in the principle of ‘swings and roundabouts’ – sometimes associates can feel like they are faced with a terrible vicious circle where they are confronted with endless roundabouts and, despite their dental school education and training, be pushed to make a living. This is surely not a fair way for associates to have to work.

So what about the future for associates? Well hopefully many of these issues will be addressed by the new contract; through the current pilots we have a unique opportunity to test this in practice. Whether or not things will improve for the profession will depend on a number of factors, key questions being: is fair for dentists, fair for patients and is it financially sustainable by the NHS? Furthermore, will it provide a fair day’s wage for a fair day’s work for all members of our profession? Associates have suffered a great deal since 2006. They have been manoeuvred into a very vulnerable position, where practice owners have the dominant role, setting targets and UDA rates to achieve their business goals, where associates have to aspire to the very highest standards on only limited funding and where at the same time the culture of litigation is growing exponentially. We need to see far more support for associates, far more fairness and far more clear and realistic expectations. Let’s see what the new contract will offer. I’m on tenterhooks.

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Selling without the “S” word
Alun Rees discusses how to get the most out dental “sales”

There’s more to success in dentistry than a flat screen TV, a leather sofa and a treatment co-ordinator - as good and desirable as those things are.

Of the Seven Pillars of Dental Practice Management(c) it’s a sale that has most of the Dementia about it. During seminars, delegates will happily spend an hour talking about marketing or the problems with their team but then skirt around the “selling” bit. Perhaps it’s because they feel that if they aren’t selling loads of treatment they are somehow “not good enough”. Perhaps there is still a feeling that “selling” is somehow not a professional activity. Without doubt there is still a reluctance to embrace a “sales” process. I once had a conversation with a client who threatened to throw me out if his practice if I even mentioned sales during a team training session.

So I set myself a challenge. How to do a half-day presentation on “sales” without once using the “s” word itself?

Why do it? Well as with everything else - in response to my clients and audiences. I sense boredom and even alienation with the overwhelm of clever, “sophisticated” marketing techniques that mean you will soon have a guaranteed 10/100/1000 patients beating a path to your door by doing x or y with Google ad-words, and whatever social media is top of the pops this week. Not that I’m knocking 21st century marketing techniques.

All these patients are, of course, going to demand “sexy, funky” dentistry for which they will pay tens of thousands of pounds. And if they have problems affording it, we’ll send you on a course so that you can sell finance.

Now I’m not sure from which particular planet some of the people who suggest these techniques come from, but it’s not the same one that I and the majority of people who are privileged to have BDS after their names hail. The constant pursuit of new patients on which to inflict someone else’s misplaced ideas of what is good dentistry can only lead to the effect described by Colin Dexter who related an overheard conversation between two dentists complaining that their district was “worked out” as if it were some sort of mine and they were having to move on.

A recent exchange of emails with a young friend saddened me; this dentist had been in a position of an intern in a private practice. It was made clear to him that he should be looking to gross over £2,000 on each and every new patient. Eventually he opted to return to the NHS because as he said “I know what my targets are there and I understand the limitations of the system”.

What individuals who would have you believe that dentistry is the same as every other business overlook is that teeth aren’t widgets, teeth were not put into mouths for the benefit of the dental profession and that people are not mouths on legs.

Of course you must count the “sales” made and the influence of new marketing.
campaigns. I will never argue against the philosophy of “no management without measurement.” If you aren’t counting you can never know when things are getting better or worse.

So back to my experience. Did the audience benefit? Well, as usual the proof will be in the pudding. Certainly “Selling without the S-word” was well received and I hope gave them confidence in their abilities to:

- Put their patients at their ease
- Take a full history of the patient’s needs and wants
- Present all the options
- Explore objections
- Gain permission to discuss the subject again in a certain time frame
- Not taking it personally if a patient rejects what you think is the right treatment plan for them
- Ask for new referrals from their existing patients

The one fundamental point that I made is that you are not selling a composite restoration, a veneer or even a course of orthodontic treatment; you’re not even selling the benefits of the associated outcomes. You are creating a professional relationship that you want to endure for years; a relationship that puts the health and wellbeing of the patient at the very centre of everything that you do. It’s not about the money or the UDA’s; it’s about the people who choose you and who you choose. The rest will follow as long as the remainder of the pillars are in place.

As Seth Godin put it: “One basket, cared for and watched carefully. When no one else can focus on and serve that customer as well as you (because you have no choice, it’s your only basket) you have a huge obligation but you also have a platform to do great work.”

If I may borrow some more words, this time from my friend Jane Ainsworth who summed this up in a recent posting on GIPUK: “Perhaps it doesn’t matter how much practice owners spend on decor, marketing and presentation. If patients don’t perceive knowledge, skills, and empathy, or perhaps what the King James Bible means by charity, it won’t be enough to keep them in the practice.”

We risk losing sight of what we are here for if we’re not careful. Dentistry is under attack from politicians, bureaucrats and “modernisers”. One way to fly the professionalism flag is to ensure that all our relationships, especially those with patients are of the highest quality. Mike Wise taught me that: “Character is doing the right thing when nobody’s looking.”

Character comes from an individual expressing their authenticity. This means telling each and every patient the truth about his or her mouth, oral health and the advantages of good dentistry, as you see it. Sometimes that means that they may not like what you have to say and initially you may feel you do not have the right words to use. Well it’s time to practice, in the same ways that your practical skills need to be honed and perfected so does your verbal expertise. I don’t mean by learning platitudes by rote but by fully understanding and meaning what you say, so that you say what you mean in words that your patients understand. That may well mean using different words for different patients. Obvious? Try recording your conversations and see whether the patient hears what you think you’re saying.

Selling is ultimately the highest form of communication, it’s about making the perfect match between the skills that you have to offer and helping your patient realise their needs and wants. Be prepared though, sometimes the process will take years and that’s what being a professional is all about.

If you’d like more details of “Selling without the S word” get in touch.
Why improving your practice is a mystery - part five

Jacqui Goss explains how to develop a patient-centred practice

So far in this series I’ve written about how potential new patient enquiries should be handled, creating a good impression and, in the last article, some ways of finding out what patients really think of you and your practice.

Here, I’m continuing with the last theme by discussing patient consultation groups (PCGs) and why they can help you achieve a patient-centred practice.

In the health service and general medical practices, PCGs have been around for a while. Indeed, from April 2010 all PCTs and SHAs were legally required to explain how they have acted upon feedback from patients and the public – the buzz phrase being “Real Accountability.”

CQC Outcome 1 (respecting and involving people who use services...) means it is now a regulatory requirement for dental practices to gather feedback from patients (but not the public).

PCGs are a mechanism for collecting face-to-face verbal feedback from patients in a cost-effective, minimally demanding (for the patients) way which, if done properly, should generate accurate and honest feedback. Don’t think of PCGs as merely ticking another CQC box – they can prove vital in helping you develop your practice.

Okay, so what is a PCG? Essentially, it’s a number of your patients meeting to discuss you, your team and your practice. They are encouraged to consider different aspects of your service and make positive or negative comments.

Clearly, you will need to initiate such a meeting and encourage them to continue. Here are some things to consider.

• How many patients should be in a PCG?
  I suggest ten attendees (see below) as a manageable number for a meeting

• How do you arrange the first meeting?
  Decide on a date, a time and a location and invite patients with a personal letter, by telephone or when they visit your practice. Outline the reason for arranging the meeting and explain that you value their involvement and feedback

• Who should you invite?
  You want a cross-section of patients – different ages, gender, ethnicity and social class. You want long-term patients and new patients, patients who’ve had lots of treatment and patients who’ve had little. They should be patients seen by each member of your clinical team. Some will be working, some won’t. Some will have families, some won’t. Of course, to achieve such a broad cross-section you’d need to invite hundreds of patients. In practice try for the best cross-section you can by inviting 12 to 15 people – some
will fail to turn up on the night and you’ll probably have about the right number of actual attendees.

• Which days and times are best? Avoid Fridays and weekends that are dates when there is a vital football match or the final of Strictly Come Dancing on television. Early evening, say 7.00 or 7.30pm, is probably as good a time as any. State a finish time (and stick to it) – about one and a half hours is the maximum time the meeting should last.

• Where should you hold it? In your practice is both the best and cheapest option. It’s good for patients to visit your practice for other than treatment as it helps lower any barriers to communication. Second choice would be to hire a private room in a smart local hotel.

• Who should run it? Not you! Patients will be most unlikely to express honest opinions if the dental principal hosts the meeting. The same applies to members of staff. Use a facilitator – somebody good at controlling meetings while involving everybody and with some knowledge of dentistry and your practice. Importantly, even though they will be receiving a fee and/or expenses, the facilitator can declare themselves independent and assure the group members of confidentiality.

• Should staff attend? This is a tricky one. On the one hand you want there to be dialogue and interaction during the meeting so that issues raised by patients can be addressed. On the other hand, you don’t want patients to feel uneasy at the presence of people they may be indirectly (or even directly) criticizing. Given that clinical matters are not to be discussed, I suggest your practice manager and/or patient coordinator and maybe a member of your front of house team should sit in – with the proviso that they leave the room if doing so will aid openness.

• What about refreshments? Offering light refreshments such as tea, coffee, soft drinks and biscuits is a good idea and would certainly be deemed courteous. Of course, you’ll wish to make sure what you offer is both nutritious and good for their teeth!

• Should they be paid? Advertising any form of payment or gift could be construed as an induce-
ment to attend and might well land you in trouble with the GDC. However, it would be polite to give par-
ticipants some form of ‘thank you’ at the end of the meeting.

As preparation for the first meeting, you’ll need to liaise with your facilitator. Discussion within the PCG needs to be both directed and free ranging – an obvious contradiction. The facilitator needs an idea of the sort of things you want feedback on. Maybe it’s your new appointment booking system, the practice website or the range of services you offer. You may also wish the facilitator to preview things you are considering introducing – a practice plan, finance terms, later opening hours and so on.

The facilitator can usefully ask very open questions of the group such as “How could we improve your visits to this practice?” In my experience the answers are often quite small things that are easy overlooked. In one practice the first afternoon appointments are at 2pm but the door is kept closed from 1pm to 2pm for lunch – so patients arriving early (as must do) have to wait outside in the cold and rain. Opening the door at 1.55pm solved this problem.

You’ll also be pleased to learn that some people in PCGs declare themselves very happy with a dental practice. Patient feedback is not always negative and is certainly not to be feared. The old retail adage of “the customer is al-
ways right” (thought to have been coined by Harry Gordon Selfridge in the early 1900s) applies equally to dental practices. Initiate regular PCG meetings (perhaps with the membership changing a little each time), act on the feedback and you’ll soon fulfill the ideal of a patient-centred practice.
Impacted canines - a case study
Dr Nilesh R. Parmar discusses Maxillary canines

The impaction of maxillary canines is a common problem. Research by Thilander and Myrberg estimated the prevalence of impaction at 2.2 per cent. Impactions are twice as common in females as in males, with up to 8 per cent of cases presenting with bi-lateral impactions (Dachi et al.) In this case report I shall be describing the management of an impacted canine which was removed and replaced with an implant supported restoration.

This lovely lady presented with a retained URC and an impacted UR3. She was aware of the impaction and wanted a cosmetic solution for the URC. Clinically, the URC was gr 2 mobile with no associated pathology. The canine could not be palpable labially and a midline/palatal impaction was suspected.

Clinical examination revealed a minimally restored dentition with good oral hygiene. She was medically fit and well and wasn’t taking any medication. To further assess the position of the UR3 a Sirona Galileos collimated CBCT was taken. This showed the UR3 to be almost horizontally impacted, with the crown tip in close proximity to the root apex of the UR2.

The treatment options available were:

1. Extraction of the URC and orthodontic alignment of the UR3. Due to the position of the UR3 orthodontic extrusion would be difficult and may take up to two years to complete. There is also a risk of resorption around the UR2.

2. Extraction of the URC with provision of a restorative replacement. This could be:
   - A single tooth denture
   - A resin retained bridge
   - An implant retained crown

After careful consultation the patient opted for extractions of the UR3 under GA with an implant retained crown.

Once the UR3/URC were extracted the patient was provided with a temporary partial denture. Two months after the extractions an Astra Tech 5.0 x 15mm implant was placed. Due to the canine impaction, there was a very thin ridge of bone present with a pronounced concavity. An Astra Tech osteotome was used to widen the alveolar ridge in order to place the implant. The buccal aspect of the implant was grafted with a bovine bone graft material (Gen-Oss) and covered with a porcine membrane. A 2 stage surgical approach was adopted and the implant buried. Despite the buccal fenestration of the implant, a primary stability of 35Ncm was obtained.

A fixture level impression in impregum was taken and an Astra Tech shaded Atlantis Zirconia Abutment ordered. The Virtual Abutment design system supplied by the Atlantis system allows for the technician to liaise directly with the dentist to ensure that the soft tissue emergence of the abutment is correct.

A shaded A2 Zirconia abutment was used to ensure the E-max crown didn’t appear to bright when fitted.

The abutment was torqued to 25Ncm and the crown cemented with temp bond. The excess cement was removed and a baseline LCPA was taken. The patient was very happy with the final result and the work has a very good long-term prognosis.

Figs 6-8 - Buccal fenestration covered with bovine bone graft and membrane
Fig 9 - Closure with 5,0 PGA

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United Kingdom Edition
References

About the author
Dr Nilesh R. Parmar BDS (Lond) MSc (Prosth Dent) MSc (Imp Dent) Was voted Best Young Dentist in the East of England in 2009 and runner up in 2010. Nilesh is one of the few dentists in the UK to have a degree from all three London Dental Schools and is currently studying for his 3rd MSc in Orthodontics. Nilesh is an Astra Tech Clinical Coach and has his own practice in Southend on Sea, Essex. He also works as a Visiting Implantologist at Sparkly Smiles in Blackheath. www.drnileshparmar.com

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Fig 13 - The pontic on the denture was adjusted to further support the tissues
Fig 14 - Appearance after second stage surgery
Fig 15 - Atlantis Virtual Abutment Design proposals
Fig 16 - Shade taking using multiple tabs for comparison
Fig 17 - Atlantis Virtual Abutment Designs
Fig 18 - Atlantis Virtual Abutment Designs
Fig 19 - Atlantis Virtual Abutment Designs
Fig 20 - Atlantis Shaded Zirconia abutment in situ
Fig 21 - E-max try-in
Fig 22 - Final appearance

Figs 13-12 - Second stage: Note the healing abutment supporting the excess tissue pushed over from the palatal to the buccal side
Figs 14-15 - Appearance after second stage surgery
Fig 22 - E-max try-in
An evolving vocation

Leigh Morrison discusses dental nursing in Northern Ireland

Many things have changed over the years for dental nurses - we were once known as Dental Surgery Assistants (or DSAs) but changed our title to “dental nurse” in 1994. Since 2006, together with dental therapists, hygienists and technicians, dental nurses are required to register with the General Dental Council on the GDC’s Dental Care Professionals’ Register. With this progression in professionalism the level of education provided has changed to reflect this.

As dental nurses we can find ourselves in a variety of different roles ranging from dental nurse, decontamination nurse, practice manager to practice owner. We may find ourselves undertaking any number of these roles in our normal working day. This is why dental nurse training has evolved to cover these additional duties and responsibilities such that we are now an all-round dental professional, ie more than a typical dental nurse of old. Dental nurse training has been provided in Northern Ireland now for more than three decades. There are currently 1512 dental nurses from Northern Ireland registered with the General Dental Council, with many more dental nurses undergoing training in various providers.

The new National Examining Board for Dental Nurses (NEDBN) in Dental Nursing is the qualification that is delivered throughout Northern Ireland by many training colleges and educational providers.

Courses provided can vary from:
• Full time – college attendance three days per week and a two day placement in various GPDs, community, hospital and specialist clinic
• Part time day release attending college one day per week and four days in general practice
• Part time evening classes while working in practice

On successfully passing the exam and GDC registration the dental nurse can then progress to a course where they can complete additional qualifications/additional skills.

Following on from the underpinning knowledge being provided for dental nurses in Northern Ireland, the Northern Ireland Medical and Dental Training Agency (NIMDTA) provides many courses for dental nurses to update their core knowledge. Some of these courses include Medical Emergencies, Radiography, IPC, Complaints and Legal & Ethics further to this dental nurses can add additional skills to their portfolio: Intra Oral Photography or Cannulation for Sedation Qualified Nurses to name but a few.

Decontamination workshops have also been developed by NIMDTA to enhance the knowledge of the members of the dental team when it comes to the handling and usage of decontamination equipment used within the dental surgery. This is also supported by “in practice” training sessions which are currently up and running. This means that the entire dental team can undertake this training simultaneously in their own environment. This has real and obvious benefits for the personnel involved and individual.

For full contact information for all training providers in Northern Ireland please contact NEDBN or visit their website www.nedbn.org

To place an order or for further information, please contact us on 020 8668 1500 or visit our website www.periproducts.co.uk

About the author
Leigh Morrison qualified as a dental nurse after passing her exam at Newcastle Dental Hospital in 1995 and has worked in general practice, orthodontics, private dentistry as well as for the Ministry of Defence. She gained her Radiography Certificate in 1995. Leigh went on to gain her C&G 7302 in February 2006. In 2006 Leigh started work with NHS Education for Scotland as a Regional Dental Nurse Tuteur where she went on to gain her C&G 7305 & 7306 and is aiming to complete the C&G 7305 later this year. Leigh is also an examiner for NEDBN National Certificate.
The Dawson Academy

The Dawson Academy is a postgraduate educational facility dedicated to the advancement of dentistry. All our instructors are practicing dental professionals who have implemented the Dawson teachings into their own practices and bring that real-world experience back into the classroom.

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The Core Curriculum at The Dawson Academy UK has been developed as a complete plan for general dentists, specialists and dental practice team members striving to develop a highly effective practice. The continuing education courses have been designed to clarify the concepts and provide hands-on training in the skills that are needed to practice master quality, complete dentistry.

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“I would recommend this course to everyone that wants to move away from single tooth dentistry and more into the realms of full mouth dentistry. The great thing is it also improves your decision making for the simpler cases.”
Harvinder Singh Thiaro, Nottingham

“My clinical confidence has grown immensely and my case assessment feels stress free now. The uptake for work, and therefore my income, has increased massively. I had easily recouped my investment in the course fees plus a lot more in just six weeks.”
Tim Earl, East Sussex

“Great atmosphere, a lot of fun!”
Theresa Milton, Sweden

“Ian Buckle is incredibly knowledgeable, approachable and realistic.”
Jacqueline Fergus, Aberdeen

“I felt the pace of theory and hands on was spot on, clearly understandable processes to take back to my own practice.”
Steven Rees, Buckinghamshire

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Neeta Shah, Middlesex

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I have to say, saying to someone “I am going to be a part of making dental history this year” is not something I had put on my goal list for 2012. But, with a little blue sky thinking and the enthusiasm of Dr Matthew Perkins, I find myself in just that position.

Modern concepts
On Saturday the 3rd March 2012, Mathew Perkins and I are privileged enough to be presenting ‘Modern Concepts of Periodontal Instrumentation’ at the Dentistry Show 2012 at the NEC. This is set to be a unique experience, the first of its kind in the UK and it aims to simultaneously broadcast a lecture at the same time as a patient is being treated in the live theatre space at the event. This will enable you to be in the lecture theatre and see the treatment live on screen as Mathew discusses the concepts or for you to take a seat at the live theatre and watch the lecture on the screens while the patient is being treated. The patient will be treated in real time and therefore I will be working with them for around an hour.

Back to basics
Periodontal instrumentation should be back to basics stuff, but the number of dentists and DCPs that ask for assistance in this matter is huge. When I get feedback from course, there are always a number of requests for hands on instrumentation. And if it is not an everyday used skill, as it is for many dentists, then we could all do with a refresher.

The aim of the presentation is to revise the aetiology of periodontitis, and the rationale for non-surgical treatment of the disease. In practice, good non-surgical periodontal treatment can treat the majority of patients. The concept that we no longer need to scrape the root until glassy smooth is something that has passed many by, and the presentation will show us why it is no longer necessary and what we should be aiming to achieve when we debride our patients with periodontitis. Mathew’s engaging realistic lecture style makes this subject accessible, absorbable and achievable.

Know your Langer
Many in the profession will have trained with the use of universal curettes and the concept of site-specific curettes is intimidating. Knowing your Langer from your
Gracey is important when you start to build a periodontal debridging kit. Again, we will run through these and their uses in detail, with the live link up meaning that while we talk about the instrument, you can watch its correct use direct from the live theatre.

The use of more efficient Gracey curettes means the job is done better and also saves your posture for the years ahead. I will be using loupes throughout and show some techniques to reduce operator fatigue to make debriding a full mouth an easier task and not tiring. I will also be using the smallest blades possible to ensure patient comfort and better access.

We will then be talking about ultrasonic and sonic instrumentation and their role on non-surgical treatments. Again, the rationale and correct techniques will be revised and their use demonstrated live on a patient.

**Adjunctive therapists**

In the final section, adjunctive therapies such as SyLc (an air polishing system which repairs and builds the root surface as you use it, rather than removing tooth surface), laser therapy and the role of topical antimicrobials will be discussed and Mathew will give his own opinions on their efficacy and indications.

**Mathew will also be guiding us on when to refer on a case to a specialist. It is better for the patient to recognise and refer quickly to allow for more treatment options.**

The conclusion will neatly wrap up the tips, techniques and instruments discussed throughout the session, and allow delegates to ask clinical questions to both Mathew and myself. At the end of the presentation, delegates should have a clear understanding of the rationale for periodontal debridment in the 21st century and have been introduced to some ways of achieving gold standard outcomes safely and effectively for the patient and indeed, for themselves.

**At the end of the presentation, delegates should have a clear understanding of the rationale for periodontal debridment in the 21st century**

The presentation takes place at Dentistry Show 2012 at the NEC on Saturday 3rd March at 11.15am in the Hygiene and Therapy Lecture Hall and simultaneously in the Live Theatre.

We look forward to seeing you there.
Resolving severe upper anterior crowding with ‘invisible’ orthodontic splint therapy

Dr Gary Dorman leads us through the treatment of maxillary crowding using In-Line orthodontic splints

People of all ages want a beautiful, natural smile as well as healthy teeth and gums. An increasing number of adult patients with anterior spacing or crowding adults are willing to undergo orthodontic treatment in order to achieve this.

In many cases, invisible splint/brace therapy can be applied successfully. However, they usually want the appliance to be as inconspicuous and comfortable to wear as possible. In many cases, invisible splint/brace therapy can be applied successfully. In this case the anterior crowding was treated with In-Line splints, produced in Germany by Rasteder Orthodontics Laboratory (www.in-line.ee).

Initial situation
The patient wanted to resolve her severe maxillary crowding in order to improve both the appearance of her smile and her dental hygiene. She expressed a desire to have the mal-alignment corrected with a therapy which should be as invisible as possible. The robustness and the thickness of the splint. This solution met her need for comfort; the splints affect the patient's speech only initially and are visually barely noticeable. In-Line's laboratory charges are also significantly lower than some competitive brands, which brings the treatment within the reach of a wider range of patients.

An In-Line splint
Treatment planning
A quotation with treatment recommendations and a 3D digital set-up was requested from In-Line. The 3D set-up includes seven images of the final situation, allowing the patient to see how her teeth will appear after treatment from all angles. (Figs 5, 6, 7). An overlay image showing the movements made by each tooth is also provided. (Fig 8) In addition to the 3D set-up photographs, study models of the anticipated final situation were also requested.

The treatment plan prescribed seven splints for the upper arch and four splits for the lower. In-Line splints must be worn for five-six weeks; each splint can effect a movement of up to 0.6mm. The treatment recommendations proposed slight interproximal reduction of 0.15mm between five designated contact points in the upper arch. IPR was not required on the lower arch. In-Line's state of the art software is able to accurately calculate the amount of IPR required in advance of treatment.

Treatment progress
The patient was given new splints successively at individual check-up appointments, at intervals of approximately six weeks. Interproximal enamel reduction was carried out incrementally over the first three to four splint fittings, until the enamel had been reduced by the specified amount.

The patient’s compliance was excellent and made a significant contribution to the success of the treatment. She wore the splints for the recommended time of at least 18 hours a day and the treatment goal was reached ahead of the scheduled eight months (Fig 9, 10, 11, 12, 13).

A comparison of before and after study models shows the impressive results achieved with around nine months of invisible splint/brace therapy (Fig 14, 15).

A comparison of the study models showing the anticipated final situation (sent by In-Line pre-treatment) and the post treatment study models shows that the treatment goal had been achieved almost perfectly (Fig 16, 17).

Retention
Long term retention is crucial following adult orthodontic treatment in order to avoid the risk of potential relapse. In-Line initially supplies a retention splint with each splint set, however this splint is only intended to be a short term solution. The Laboratory also supplies two products for long term retention; an unbreakable retention splint to be worn for three-four nights per week and a 3–3 bonded wire retainer. The patient opted for a 3–3 bonded wire retainer as her chosen method of long term retention.

In In-Line's state of the art software is able to accurately calculate the amount of IPR required in advance of treatment.

Fig 1 Initial situation frontal view
Fig 2a and b Initial situation lateral views
Fig 26
Fig 3 Occlusal view of severe maxillary anterior crowding
Fig 4 Occlusal view of mild mandibular anterior crowding
Fig 5
Fig 6
Fig 7
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About the author

Gary Dorman
BDentSc
Gary Dorman trained in Dublin and qualified in 1990. He joined the Hartley Dental Practice in Kent as an associate in 1991 and became Principal in 1998. He first discovered In-Line in 2007 having treated himself with the system. He has since successfully treated many of his patients with the system as part of his General Dentistry. If you would like more information please email Gary at garydorman@hotmail.com, call the Hartley Dental Practice on 01474 705484, or visit the website www.hartleydentalpractice.co.uk

In-Line®, the favourably priced alternative from Germany!

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The device consists of an ergonomic container with both an inner and outer chamber, and integrated brush. To use the device simply fill the inner chamber with a recommended instrument cleaner such as Uninet (Cleaner/Destainer GEY 010, GEK 050 or GEK 250), and push the hand instrument through the brush with a "lo and from" movement; repeat as necessary to clean off excess materials.

Instruments can be left in the outer ring to drain. For more information, contact The Dental Directory on 0800 585 5850, or visit www.dentaldirectory.co.uk.

BioHorizons – dedicated to dental implants

BioHorizons is proud to be exhibiting its dental implant products on stand 8D1 at the first ever Scottish Dental Show, to be held on 24 and 25 May at Hampton Park in Glasgow.

On show will be BioHorizons’ four comprehensive implant lines, including Laser-Lok, and three small diameter systems, covering virtually every surgical and prosthetic indication or clinician preference.

Also available to view will be bio-resorbable products scientifically proven for a wide range of soft and hard tissue applications, prostheses not only by range of indications and patient conditions, but also manufactured to some of the tightest machine tolerances in the dental industry, as well as a broad range of instruments and motors to meet your needs.

For more information, please call 01344 752750, email info@biohorizons.com or visit www.biohorizons.com.

Composi-Tight GD™ best for Class II’s

The Composi-Tight GD™ 3D Matrix System from Gannon Dental Solutions has been named the 2012 Top Surgical Matrix and Preferred Suturing System by The Dental Advisor. Composi-Tight GD™ produces tightly anatomically accurate contacts at the height of contour with virtually zero flash, accomplished with three dimensionally contoured flat tips that conform to the surface of the tooth, sealing the edges of the composite band. Composi-Tight is the only system to employ this technology. Separation of the teeth, by compression of the interdental septum, is carried out by stainless steel wire reinforced by advanced polymers. This combination produces a ring that is fully steam autoclavable and retains its tension and shape for hundreds of hours.

The advanced 3D separator rings are provided with Gannon’s new Slick Bands non-stick surgical matrix bands. These soft, pre-contoured, ultra-thin matrix bands are available in 5 sizes covering a wide range of cases. Bonding agent adhesion to the matrix band is virtually eliminated allowing for easy band removal while producing extremely tight contacts. This award winning matrix bands are available in 5 sizes covering a wide range of cases. Bonding produces a ring that is fully steam autoclavable and retains its tension and shape for hundreds of hours.

For further information on special offers or to place orders call Jackie or Helen on 0800 242 1850.

The LR appliance from Oralign

Oralign – dedicated to dental restorations

Oralign is looking forward to using the LR appliance. It will fit in nicely at our practice. It’s very easy to use and the patients love that they can wear it at night. It’s very comfortable and so much easier than our previous retainer. "UAPM stops your teeth from coming completely together, so the muscles are ‘at rest’. This prevents the production of lactic acid, which causes fatigue, aches and pains. If muscles are more relaxed, athletes are freed up to perform better. “To start with, I’m targeting my existing patient list, making use of the bi-annual practice newsletter and placing other literature in the waiting room. “Once the service has bedded in, I’ll look further afield to spread the word.” For more information on how your patients can benefit from Under Armour Performance Mouth件TM go to www.bitecare.com, or call Navine on 01453 872266 or email armortime@mouthcare-ltd.com.

The Lift appliance from Oralign – a revolution in anterior teeth alignment

The Lift appliance from Oralign Ltd is a fast and effective way to straighten anterior teeth, and only requires 14-16 hours of wear per day. Dr Lisa Godfrey of Smedley’s Signature can’t wait to bring the Lift appliance to her patients to help them achieve better results faster.

"One of the main benefits of the lift is invisibility – it’s a lot less bulky that other similar products on the market, and one of its main selling points that patients don’t have to wear it for 24 hours a day. "Patient interest for this has been great – in fact I’m even considering using the Lift appliance myself!"

For clinical information please contact Dr Ross Hudson on 07700 243909 or email ross@oralign.co.uk.

For information on administration please contact Dr Lister Ebban on 07731 875 533 or email leister@oralign.co.uk or www.oralign.co.uk.

Cheekie newsflash

Reports just in have confirmed that Dental Sky have taken leave of their senses! They’re selling Cheekie newsscrap on a BUS1 & GAT1 1980’s refreshment trolley. That’s right - if you order any 4 items, you’ll receive the cheekie newsscrap for free.

Cheekie is USA’s most popular choice of scrubs by healthcare professionals. So don’t miss out, and call 0800 294 4500 or visit www.dentalsky.com to see the full range of styles and colours.


Does your demo unit need an MOT?

If your demo unit is older than 8 years old you may need to book it in for a service. It’s not legal to use an old instrument if it’s not certified. It is a legal requirement to have a demo unit serviced on a regular basis.

That’s why Oralign is meeting practices to discuss this issue with the Oralign team.

"Oralign will be visiting all practices in the next few weeks to discuss the issues. This is an excellent time to consider a new demo unit as special offers are being announced for those who upgrade their Oralign units to a new demo unit.

"Our current deal is that we will upgrade your practice’s current Oralign unit to a new demo unit at a discount of 50%. This means a brand new Oralign demo unit will only cost your practice £650*

FenderWedge protects and separates during tooth preparation.

FenderWedge protects the tissue and separates the teeth, simplifying the following application of a matrix. It can be applied buccally or lingually for optimal access and vision. Available in four color coded sizes.

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Pensions legislation has undergone major changes again and some dentists may fall foul of the new rules without even being aware, resulting in an unwanted additional tax bill.

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