The General Dental Council (GDC) has caused outrage among dental professionals this July with a proposed 64 per cent hike in Annual Retention Fees (ARF), followed by an advert placed in the Telegraph days later, advertising the Dental Complaints Service (DCS). The advert reportedly cost £60,000.

The GDC has said that the increase to the ARF is needed to cover the rising number of complaints against registrants. The proposal would see the ARF for dentists increase to £945 a year and for DCPs to £128, a 64 per cent and 6.7 per cent increase respectively.

The announcement has since had a lot of backlash on social media, with one Twitter user tweeting “Fewer job prospects, less earning potential, increased retirement age and now higher ARFs” while another said “£945 #GDC ARF is prohibitive. Twisting the knife, with one Twitter user saying: “GDC ‘forced’ to raise dentists’ fee to manage complaints but found encouraging dental complaints”, and another saying: “They’re honestly made me feel like chucking the towel in. Even our professional body is against us.”

Approximately a week later, dental professionals were outraged yet again by the regulator when a full-page colour advert appeared in the Telegraph.

The GDC has denied that the advert cost £60,000, stating in a press release that it cost £5,500.

The BDA has even called on Health Secretary Jeremy Hunt to initiate an urgent investigation into the competence of the GDC.

Mick Armstrong, chair of the British Dental Association’s Principal Executive Committee, said the increase in fees is ‘unacceptable’, especially as the latest Professional Standards Authority (PSA) report on the GDC was highly critical of the regulator.

He said: “The suggestion that the profession pay more to fund a Council that has been shown unable to do its job properly is unpalatable at the best of times but now it appears that the profession is being asked to feel the boot for failure.”

Dr Armstrong added: “It’s not just huge rise in fees that has left the dental profession aghast, but, when dentists are expected to tolerate poor performance by the very body that is charged with the duty to assess their fitness to practise, we are justifiably outraged.”

An e-petition has also been released, asking the government to review the fee increase. At the time of writing, the petition has gained 15,583 signatures.

The Telegraph reportedly cost £60,000.

This advert is seen by the profession as the regulator twisting the knife, with one Twitter user saying: “GDC ‘forced’ to raise dentists’ fee to manage complaints but found encouraging dental complaints”, and another saying: “They’re honestly made me feel like chucking the towel in. Even our professional body is against us.”

The General Dental Council’s actions this month have caused outrage among the profession.
The Care Quality Commission (CQC) has hired 154 inspectors who failed basic competency tests, official reports reveal.

Internal documents show inspectors the CQC recruited in 2012 failed “some or all of its recruitment activities” during its “significantly flawed” hiring process. This was at a time when the regulator was under fire following a series of scandals in the NHS and care sector.

The document, which was obtained by the Health Service Journal, says that the CQC may face legal action if they try to get rid of the staff as those employed were unaware of the flawed process. The report reveals that pass marks for tests to get a job as an inspector were dropped from 60 per cent in order to fill the posts. It further reveals that 126 of the staff who failed the tests remain in post more than one in ten of its 1,051 inspectors. However, those 126 are not aware of the issue.

The regulator says records, which provide any evidence about why the recruits were given jobs, have been destroyed, as they were automatically deleted from the NHS Jobs system after 12 months.

David Behan, CQC Executive, said: “This issue is not about individual inspectors but about the systems and processes we put in place, which we have changed. All of our inspection staff, regardless of when they were appointed and recruited, are subject to a probationary period, regular performance management reviews, one-to-ones, and their work is quality assured.”

Almost 70 per cent of Navajo children have tooth decay

Your oral health remains a major problem in the Navajo Nation and among American Indians overall, a new study from the Colorado School of Public Health has found.

Terrence Batliner from the School said: “The oral health among Native Americans is abysmal with more than three times the disease of the rest of the country. The number one problem is access to care.”

The study, published in the Journal of Public Health Dentistry, showed that 69.5 per cent of Navajo children had untreated tooth decay. That compares with 20.48 per cent among all other race and ethnic groups.

Much of the Navajo Nation is remote with 22 dental clinics serving 225,659 residents. The dentist-to-patient ratio is 2.5 dentists per 100,000 residents; among the lowest in the country.

Batliner says the creation of dental therapists for the reservation will increase access to care. “They learn how to do fillings and extractions along with providing preventative services. This program has proved to be a raging success among tribes in Alaska. The quality of care is good.”

However, the American Dental Association has filed suit to try and block the use of dental therapists on tribal lands.

Unregistered dental hygienist prosecuted

A woman has been prosecuted by the General Dental Council (GDC) for continuing to practise from the GDC register on 3 occasions.

Ms Loftus was removed and ordered to pay £250 towards the GDC’s legal fees and a £20 victim surcharge.

The GDC’s legal fees and a £20 victim surcharge.

Research predicts oral cancer aggressiveness

Researchers at Washington University School of Medicine have found a way to predict the aggressiveness of mouth cancer in patients.

Published in Clinical Cancer Research, the investigators found a consistent pattern of gene expression associated with tumour spreading in mice. Analysing genetic data from human oral cancer samples, they also found this gene signature in people with aggressive metastatic tumours.

This exposure sometimes produced tumours in the mice that did not spread, but other times resulted in aggressive metastatic tumours, similar to the variety of tumours seen in people.

Tooth development from adult stem cells

Scientists are developing an innovative procedure that would use cells from adult patients to grow full, functioning teeth in situ.

Teeth can be grown from embryonic cells but Professor Paul Sharpe at King’s College London Dental Institute, says a treatment using only adult cells and growth-stimulating chemicals has a much better chance of ever making it to market.

Embryonic cells are surrounded by ethical controversy and could not be collected in the numbers necessary for approved large scale treatment in patients. Adult cells are a more accessible option and, if the patient’s own cells are used, they could also negate the need for a lifetime of immunosuppressant drugs to avoid rejection.

To grow a new tooth requires two types of cell, epithelial cells and mesenchymal stem cells. One of these types of cells must send instructions to the other cell population to begin creating the different cell types and tissues needed in teeth.

The team has already shown that epithelial cells collected from adult patients’ gums tissues during routine dental surgery can respond to instructions from embryonic mesenchymal cells to growth of teeth. The team is now searching for a source of mesenchymal cells from adults that will trigger the same responses.

Wales bans smoking in cars with children

First Minister Carwyn Jones and Health Minister Mark Drakeford have announced that a ban on people smoking in private vehicles when children are present will be introduced in Wales.

In 2011, the First Minister announced the Welsh Government’s intention to mount a campaign to tackle children’s exposure to second-hand smoke in cars. New research shows that although the number of children being exposed to smoking in cars has declined, there is still a ‘sizeable minority’ of young people who are exposed to smoke in private vehicles.

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Dentist tries to perform treatment in McDonald’s, struck off

A dentist who attempted to provide dental treatment in McDonald’s has been struck off by the General Dental Council (GDC).

Anca Claudia Macavei, who worked at the Cannon Street Practice, was charged with not carrying out sufficient diagnostic assessments during initial appointments; performing root canal treatment without gloves; and not undertaking sufficient treatment planning for patients; among other charges.

Ms Macavei also attempted to provide dental treatment for a patient in a McDonald’s restaurant and in the hallway outside of a dental practice, and requested that another patient attend a dental appointment in McDonald’s.

The GDC’s Professional Conduct Committee said: “In view of the outstanding concerns that remain, the Committee concluded that you would be unable to practise safely as a dentist without restriction on your practice or at all. It also concluded that public confidence in the dental profession would be undermined if a finding of impairment were not made in the circumstances of this case.”

Ms Macavei is currently lodging a High Court appeal.

NHS could face funding crisis before General Election

The NHS is ‘poorly placed’ to deal with continuing austerity and could experience a funding crisis before the 2015 General Election, new research from Nuffield Trust reveals.

The report, Into the Red?, reveals that until 2013, the NHS was coping well with a squeeze on funding due to increasing demand on the health service and the consequences of public sector austerity since 2010. However, provisional data from the 2013/14 financial year shows that cracks are starting to show due to severe financial pressure.

NHS and Foundation Trusts as a whole were at least £100m in the red in the last financial year, with 66 trusts in deficit in 2013/14. It also found that 19 Clinical Commissioning Groups ended the last financial year in deficit and NHS England projected a £377m overspend on specialised services.

The analysis concludes that reforms to NHS services by adopting new technologies and promoting out-of-hospital care could help put it on a more sustainable financial footing in the future, but expecting this to happen in the next few years and without additional funding is unrealistic.

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Dentist gives accident patient new set of teeth

A girl who lost six teeth after a cycling accident has received a brand new set of teeth from a dentist – for free.

Alex Kerr, 20, was hit by a car as she cycled home from work in November 2013. Doctors saved her life but said she would have to go on an NHS waiting list to have her teeth repaired. However, after reading about the accident, Dr Wynand de Jeger from the Brooklands Dental Practice offered to perform the £12,000 worth of dental work for free.

Alex told the Metro: “I was just so self-conscious all the time and sometimes didn’t want to leave the house. I can’t even imagine what it would be like if I couldn’t have these implants done. Me and my boyfriend had just moved into a new flat when I had my accident and now I can finally begin to enjoy it.

“My family just can’t believe how confident I am again. My smile is nothing like it was after the accident. I’m really happy. I am so grateful to everyone at Brooklands, especially my dentist. He was the one who contacted me and he has been there all the way through my recovery.”

BDA to challenge FD pay cut

Dental graduates are leaving universities with an average debt of £25,000, and the BDA believes an eight per cent pay cut at the start of their careers ‘exploits the most vulnerable members of the profession’.

The Department of Health says that the pay cut brings dental salaries in line with their medical equivalents. However the BDA argues that medical trainees have the opportunity to earn additional NHS income, meaning they earn on average £40,000.

Chair of the BDA’s Principal Executive Committee, Mick Armstrong, said: “We are both angry and disappointed over the failure to grasp the strength of feeling against these cuts, which frankly many see as an attempt to prey on the most vulnerable members of the profession.”

The BDA’s campaign to oppose the cuts has won support on Twitter, where the BDA is encouraging tweets using the hashtag #DFTPay, and on the BDA’s Facebook page. To sign the e-petition, visit http://petitions.direct.gov.uk/petitions/64208.

Almost 26,000 children hospitalised for tooth decay

Tooth decay is the most common reason children are admitted to hospital, research shows.

The latest figures from the Health and Social Care Information Centre found that the number of hospital admissions for five to nine-year-olds with dental problems was 25,812 in 2015-14. This is up by more than 5,000 from 2010-11, when the figure was 22,574.

The figures also showed that in 2015-14, almost 500 children aged five to nine were hospitalised each week due to tooth decay.

Kathryn Harley, former dean of the faculty of dental surgery at the Royal College of Surgeons, told the Sunday Times: “We have children who require all 20 of their baby teeth to be extracted. It begs the belief that their diets could produce such a drastic effect.”

These figures follow last month’s (June 2014) ITV documentary The Dentists, which highlighted the prevalence of tooth decay in children. The programme focused on children with high levels of decay being admitted to the University Dental Hospital of Manchester for multiple extractions, with one four-year-old’s baby teeth being almost all rotten.

Claire Stevens, Consultant in Paediatric Dentistry at the University Dental Hospital of Manchester, and spokeswoman for the British Society of Paediatric Dentists, said at the time: “If these children had seen a paediatric dentist earlier, it might have been possible to save their teeth, instead of removing them and potentially triggering dental anxieties for life.

“In the 21st century, it’s entirely unacceptable that children in the UK are having to undergo a general anaesthetic, losing their teeth at a young age due to a disease which is entirely preventable.”

‘Fake’ ecstasy pills made from dental anaesthetic

Illegal drug suppliers are bulking out ecstasy pills with a dental anaesthetic, with experts warning that users are risking their lives by taking these ‘fake’ pills.

According to the Evening Times, the pills contain only a fraction of ecstasy. They are bulked out with benzocaine, a legal dental anaesthetic which is easily available for sale on the internet.

A source told the paper: “Dealers use benzocaine to make money. They don’t care what mixing agents they use, or how dangerous they are, as long as they look like drugs and can create a similar effect. You could be putting anything into your body. Although benzocaine is legal, it is an extremely dangerous drug, if not used properly.”

A spokeswoman from the British Dental Association added: “As a local anaesthetic, benzocaine will make parts of the body numb which could result in accidental injury.

“An overdose of benzocaine can cause life-threatening side effects such as uneven heartbeats, seizures, coma, slowed breathing, or respiratory failure, where breathing stops.”
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Snoring isn’t just an embarrassing, annoying noise it’s documented to be a sign of obstructive sleep apnoea (OSA) or airway blockage and a potential killer. It’s linked to long-term chronic disorders such as raised blood pressure, adult onset diabetes, carotid artery and increased risk of stroke.

OSA, resulting in serious sleep disruption, can produce greatly impaired performance at work, at home, and on the road. Car accidents are statistically much more common in this group.

Snoring is caused by partial airway obstruction. The severity of the health effect varies widely. Dentists are perfectly positioned to screen for the signs and symptoms which may predict the presence of OSA and refer such patients to a respiratory physician for further diagnosis. If OSA is not suspected then the trained GDP is ideally placed to treat the snoring patient with a mandibular repositioning device (MRD).

In addition, dental sleep medicine is an interesting and rewarding skill to introduce into your practice.

Kirsten Rogers introduced a dental sleep medicine (DSM) service into her practice at 53 Wimpole Street, London.

She says: “Starting a dental sleep medicine service in your practice is easy. Being a relatively new field in dentistry, it would be prudent to seek out non-commercial post-graduate courses. By attending a short course with the BSDSM you will gain a solid foundation of knowledge and be well on your way to successfully managing patients with snoring and sleep related disorders.

“Joining the Society gives you access to a complete clinical guide so that you are ethically covered and standardised for every case. It’s a non-profit organisation run by genuinely caring dentists with years of experience in dental sleep medicine.”

Granta Dental is a private practice in a residential area close to the centre of Cambridge and was established by Dr Helen Harrison in 1990. With her special interest in TMD and occlusal problems, Helen has always sought to give patients a much clearer understanding of the links between their dental experience and the function of their whole oral and cranial systems (including their breathing).

When Dr Thomas O’Connor joined the team in 2013 he brought his knowledge and training which he gained from the BSDSM with regard to sleep apnoea and provision of mandibular repositioning devices and Granta Dental began to provide home sleep studies with the ResMed ApneaLink monitoring system.

Helen Harrison says: “Together with some further training with the BSDSM for all three dentists on the team and the implementation of its clear protocols and pathways for assessing and managing the presentation of sleep disorder in our patients we can now offer a much more comprehensive and clearly understood approach to patient care.

“Many patients are totally unaware, or in denial of, the
Ten tips for introducing dental sleep medicine (DSM) to your practice:

1. Go to www.dentalsleepmed.org.uk for more information and details of BSDSM courses.
2. Educate yourself with non-commercial courses in DSM.
3. Explore a variety of custom-made mandibular repositioning devices (MRDs).
4. Introduce yourself to local medical practitioners and specialists in respiratory medicine and ENT.
5. Add a simple screening question to your patient medical history form: ‘Do you snore?’
6. Decide on your fee scale – a standard initial assessment fee then an overall fee for providing an MRD (each device will have a different cost) and initial follow-up visits for adjustment.
7. Obtain a selection of tools such as a George Gauge™.
8. Educate your reception staff and nurses in the practice’s new dental sleep medicine service.
9. Be primed with questions when speaking with patients and know the Epworth Sleepiness Score (ESS) inside out.
10. Allow at least an hour for a new patient’s first visit for a snoring and OSA assessment and possibly impressions for an MRD.

In keeping with our ethos of evidence-based treatments and measurable outcomes, all the mandibular repositioning devices we use are adjustable and titratable. We provide follow-up with further home sleep studies and are delighted to find that the anecdotal improvements reported by patients and their partners are backed up with genuine improvements in measurable sleep function and a reduction in the Apnoea Hypopnoea Index.

“The ability to offer a worthwhile service to patients with a home sleep study has introduced a new income stream to the practice, improved our communication with GPs, medical specialists and the hospital services, and is a welcome demonstration to our patients that our role as dentists in the health and wellbeing mix stretches well beyond the maintenance of good looking smiles.”

One of the objectives of the BSDSM is to ‘educate and support practitioner dentists’ and in pursuit of this it runs regular one-day workshops which are virtually essential for dentists wishing to introduce DSM to their practice. Each workshop provides an overview of sleep-disordered breathing, shows how mandibular appliances work (with examples and the advantages and disadvantages of each) and how participants should assess and monitor their patients. Custom and non-custom devices are described as well as pre-treatment screening and medicolegal issues. Hands on George Gauge™ sessions provide a quick, easy and reliable method of recording a protrusive registration.

The workshops include tips on how to introduce a dental sleep medicine service into a practice and delegates receive a comprehensive course manual, as well as the BSDSM screening protocol – accepted by Dental Protection (UK) Ltd, the Dental Defence Union and the Association of Respiratory Physiology and Technology (Standards of Care document relating to MRD therapy).

The next BSDSM course is on 18 October in central London and information about this and membership of the society is on: www.dentalsleepmed.org.uk.

The British Society of Dental Sleep Medicine is affiliated to the European Academy of Dental Sleep Medicine. Web: www.dentalsleepmed.org.uk
Top tips for aesthetic brilliance part 3

The final part of Lloyd Pope BDS’s description of Galip Gurel’s thoughts on digital imaging, one of the cornerstones of Galip Gurel’s presentation at the 10th Annual BACD Conference

How to connect the links – the digital world

Most cases are quite complex and involve many aspects. Therefore you need digital photographs. Galip Gurel (GG) believes that if you don’t do digital photography then you can’t possibly deliver top-end Aesthetic Dentistry. Therefore you need a proper camera with suitable flash – not just a ring-flash.

You need to document the case step-by-step, otherwise you run the risk of forgetting critical bits of information. The brain can’t concentrate and store all the information it is exposed to. If you look at a smile you might recall the basics, but will fail to retain nuances regarding individual tooth positioning etc.

GG uses these pictures as part of the weekly Practice Group Discussion Meeting. This is a two hour meeting during which all Practice Members will discuss any positive and negative things that have occurred during the week. The second part of the meeting is when they discuss the new patients who have joined the practice that week. They document the cases with pictures leading to a keynote (Apple equivalent to PowerPoint) presentation for discussion regarding potential treatment options for each case. This helps them come up with different ideas. Regarding aetiology and diagnosis there is only one of these, but regarding treatment there can be many.

Pre-operative interviews are always recorded on a camcorder so that they have a record of what was said by the patient and Dentist. However, not all patients are camera-friendly so the interview is good for medicolegal use, if necessary, and also generates hundreds of intraoral pictures which can be used for treatment planning.

Then they create the mock-up which is used for the discussion between the Dentist and patient.

Always sit the patient up and don’t let the patient see what they have done until the mock-up has been completed fully. Then let the patient see the final suggestion.

If you give a patient a mirror they will start to titivate their hair, pull ridiculous smiles etc before they even start to look at the proposed smile design. The whole effect will have been ruined. Therefore take digital pictures first and show these to the patient; document with photos including a 12 o’clock view to check the proper profile etc.

Important tip - ban mirrors.

Use the mock-up for the patient discussion. This is a videorecorded mock-up analysis, during which GG gets the patient to talk generally about the set up in order to identify if there is anything wrong as far as they are concerned. This normally takes about 50 minutes from start to finish.

At this stage GG is only concerned with the labial and incisal appearance. He is not bothered about any lingual erosion etc. He wants to make sure that the patient is...
100 per cent happy with the proposed design and resultant appearance before he proceeds to do any tooth reduction etc.

When it comes to final decision making it is important to consider who will be involved, what treatment will be performed and by whom. However, it is very difficult to get all the interested parties together at the same time. Consequently GG uses different tools in order to facilitate this. These tools include Keynote, Dropbox and Skype so that video conferencing sessions can be conducted between all the concerned parties at a mutually convenient time, wherever they happen to be located in the world at any specific time or day. Incidentally, Skype can be downloaded free of charge and the video conferencing facilities are also free.

GG also uses offline treatment planning sessions to create presentations which can be downloaded by the other parties at any time convenient to them. They can be sent via dropboxes to whoever needs them.

**Actual treatment**

The Dentist needs to transfer the aesthetic occlusal plane to an articulator. Previously this was only possible via a facebow, which was prone to errors due to the position of the ears etc.

Now GG uses a digital facebow transfer concept, which is very simple and very accurate.

For the procedure, take a simple full-face photograph. Then zoom in and take an introral close-up with lip retraction. Alter the opacity of the picture and drag it over the full face image. At this stage it won’t be to the correct scale, but you can resize and rotate it to get the correct orientation etc. You can then zoom out and send this image to the laboratory.

The Guided Diagnostic Aesthetic Wax-up is the most important and critical step. To create his Aesthetic Pre-Evaluation Temporaries GG uses Luxatemp, which he has used for many years. He then prepares the teeth through the APT.

For the final restorations he uses Emax all-ceramic restorations with a ceramic build-up incisally.

He does a try-in using the try-in pastes. At this stage he doesn’t let the patient have a mirror to look at the results, because they simply start pulling silly and unnatural faces and this totally destroys the impact of seeing the new restorations for the first time. Instead he takes digital images and then discusses these with the patient showing them the new teeth in natural expressions. These pictures are taken against a flat white background, so there are no visual distractions, and then sent to a large screen LED television for the patient to see. If the patient is 100 per cent happy then they go ahead and bond the restorations, normally two-by-two i.e. two centrals, lateral and canine, other lateral and canine etc.

Finally he shows the patient before and after pictures so that they can see the changes he has created. Patients cannot necessarily recall the original appearance after the new smile design has been created.

Finally GG described a very complex case which had been performed in one working day with the patient in Istanbul and the Technician in Brazil. This had involved all the conventional stages described previously with the working models etc produced by 3D printers in Brazil and Istanbul. 

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www.dmg-dental.com
For more than 150 years, the Westminster Hospital in London took care of the sick and disabled until making way for the Queen Elizabeth II Convention Centre in 1994. One of the most high-profile convention venues in the British capital today, this modern flat-roofed building opposite Westminster Abbey now stages over 350 events each year.

Recently, dental manufacturer Ivoclar Vivadent from Liechtenstein hosted hundreds of professionals from all over the globe at the prestigious venue to discuss the latest in monolithic restorations.

Following the principle that dental restorations should always mimic the natural dentition, prominent clinicians from Europe and the Americas presented a number of clinical cases that demonstrated what can be achieved with dental ceramics. Impressive restorative work was shown by German dental technician Oliver Brix and the UK’s own Dr James Russell, among others, who discussed clinical cases treated using Ivoclar Vivadent’s IPS e-max. While it is still not able to reproduce nature entirely, the restorative system, along with other modern dental materials, has not only changed how cosmetic dentistry is performed, but also allowed it to be increasingly less invasive, Russell said.

The use of CAD/CAM technology was further shown by Italian technician Michele Temperani to achieve higher aesthetic outcomes when combined with all-ceramic materials. Issues in the field were also addressed, including the correct bonding technique, which, according to Belgian presenter Bart van Meerbeek, depends on functional monomers. While research has shown that self-etching is often the most effective approach, the etch and rinse technique is still required in many cases, he explained.

During a round-table discussion held on the first day, all experts agreed that a thorough diagnosis and a good working relationship between the clinician and dental technician are still among the most important criteria for achieving the best results.

Overall, Ivoclar’s latest expert event drew over 750 delegates to London. Organised in collaboration with King’s College London Dental Institute, one of the most prestigious dental institutions in the UK, it was the second edition of a series that started in Berlin in Germany two years ago. A follow-up event has already been scheduled for 2016 and will be held in Madrid in Spain, Chief Sales Officer at Ivoclar Vivadent Josef Richter said.

Delegates can look forward to a number of new products to be launched by Ivoclar Vivadent during the year, including the much-anticipated IPS e.max Press multi, which will allow horizontal pressing for long-lasting clinical success. Also announced were new furnaces in Ivoclar Vivadent’s Programat line with a new design that will offer guided pressing, among other features, to make restorations easier and faster.

In response to increasing demand, Wieland Dental, part of Ivoclar Vivadent since 2012, will be launching a new version of its compact CNC milling system Zenotec that will allow wet pressing. The company’s offering of Zenostar zirconia, as well as abutment solutions, will also be extended.

Ivoclar Vivadent discusses monolithic restorations in London

DTI’s Daniel Zimmermann reviews the expert event in London
Rehabilitation of an atrophic mandible with 3D planning

Authors: Rainer Fangmann & Lars Steinke

Introduction
Patients with fixed restorations in the form of large-span bridges often wish to retain a fixed solution, even if the distal bridge abutments have been lost. Yet prosthodontists advise a shift in treatment to a removable prosthesis. This is due to a lack of knowledge of current possibilities regarding bone augmentation and implantation. The argument that implant-borne (fixed) restorations promise quality of life, appeal and youthfulness is ignored. As a consequence, removable restorations are only partially accepted and result in patient dissatisfaction in the long term. The desire for permanent rehabilitation remains. The opportunity for immediate placement of an implant and, if necessary, augmentation of the posterior section of the mandible to address resorption is missed.

Initial situation
A 71-year-old female non-smoker in a good general and nutritional state presented with multiple prosthetic restorations in the maxillae, consisting of bridges and single crowns placed at different times. The mandible revealed an insufficient denture. Tooth 43 had been destroyed by caries under the crown and had a treated root canal (Fig. 1). The patient requested rehabilitation with a fixed prosthesis. As a result of years of wearing removable prostheses, the mandible revealed an atrophy pattern of resorption Class V–VI on the right and Cawood Class IV on the left.

Procedure

Treatment planning
Bone augmentation with autologous material from the retromolar region/corpus of the respective sides and delayed implantation was discussed with the patient. She requested a preoperative 3D image (Fig. 2) to clarify the necessity of augmentation. Three-dimensional planning with coDiagnostiX (Dental Wings) for implant placement and immediate restoration via Multi-Base Abutments (Straumann) was recommended after augmentation.

Surgical procedure
The patient requested general anaesthetic during bone augmentation. This was followed by the typical incision of the gingival margin and appropriate relieving incisions. Once the dimensions of the receiving site had been determined, the corresponding mandibular lamina and/or corpus site was selected. After determining the dimensions and the morphology of the bone graft, a mono-cortical bone block was harvested from the donor site by piezo-surgery (Fig. 3). Using a Safescraper (Meta Advanced Medical Technology), this was thinned down extraorally to a final thickness of 1 mm. The thinned block served as a biological membrane to stabilise the particulate bone material vestibularly and orally. First, a cortical lamella was fixed occlusally over the osteosynthesis retaining screws in gliding holes (Fig. 4). This lamella was lined with cortical chips soaked in autologous venous blood. In order to secure the graft, it was covered with a further lamella vestibularly, which was fixed with osteosynthesis retaining screws (Fig. 5).

This was followed by fully tightening the screws inserted into the gliding holes of the occlusal lamella to compress the particulate graft. This was followed by wound closure with sutures. On the left side, augmentation was performed by applying the tongue-in-groove technique (Figs. 6–8). Clindamycin 600mg was administered as a short intravenous infusion and continued orally over six days.
days. After coDiagnostiX planning (Figs. 9&10), the osteosynthesis retaining screws were removed after four months and the implants placed. Tooth 45, which had been destroyed by caries, was removed on the right. Immediate implantation was performed using a Straumann Bone Level implant (Ø 4.8 mm, L 12 mm).

Straumann Bone Level implants (Ø 4.1mm, L 10mm) were inserted in positions 44 and 46 (Fig. 11). On the left, three Straumann Bone Level implants were placed (in position 55, a Straumann Bone Level implant made of Roxolid; Ø 5.5 mm, L 14mm; in positions 54 and 55, Straumann Bone Level implants; Ø 4.1mm, L 10mm; Figs. 12-15). All implants had the SLActive surface specification.

Temporary immediate restoration
All implants were fitted with 0 degree Multi-Base Abutments with a gingiva height of 4mm (Figs. 16&17). A Narrow CrossFit Connection Multi-Base Abutment (Ø 4.5mm) was used for the Narrow CrossFit Connection Roxolid implant. The terminal implants were fitted with Regular CrossFit Connection Multi-Base Abutments (Ø 6.5mm). Impression taking was performed with a foil technique tray (Fig. 18) with colour-coded impression components (Fig. 19).

The laboratory-made temporary prosthesis (Fig. 20) was screw retained occlusally via integrated temporary copings (Fig. 21). The screw channel was sealed with a foam pellet soaked in 0.1 per cent chlorhexidine gel and a light-curing temporary resorption (Fig. 21). The screw channel was sealed with a foam pellet soaked in 0.1 per cent chlorhexidine gel and a light-curing resorption (Fig. 21). The temporary restoration remained in place for six months (Fig. 22).

Final restoration
The existing metal-ceramic veneer crowns in positions 52 to 42 were removed and the teeth prepared again. For impression taking, the impression posts were laboratory customised to correspond with the gingival emergence profile created by the Multi-Base Abutments. This was followed by a single-session, two-phase impression using the double-mix technique with a polyester impression material (Fig. 23) and corresponding colour and shade selection.

In order to continue support of the ideally shaped soft tissue (Figs. 24 & 25), a decision was made in favour of CAD/CAM customised abutments made of zirconium dioxide. The basal component of the future mesostructures was designed such that the gingiva would be supported optimally and create an ideal transition from the implant connection to the bridge contour. After a pronounced temporary break, one no longer needs to expect changes to the gingival margin. In order to ensure the required fit and the stability needed for the molar region, one-piece zirconium dioxide abutments (Figs. 27 & 28) were fabricated.

Thus, the future crown margin was placed only 0.5 mm sub- and epigingivally. The wax model (Fig. 26) on auxiliary parts, which corresponded to the implant connection, was digitalised using the Straumann CARES Scan CS2 scanner. After data transmission, the fabrication of the individual abutments was performed in the Straumann milling centre. In order to ensure the required fit and the stability needed for the molar region, onepiece zirconium dioxide abutments (Figs. 27 & 28) were fabricated.

The dental panoramic tomogram shows the situation 18 months after implantation (Fig. 55). The screw channels were filled with non-irritating PEMAX in a trough-shaped final design. Then the final restorations were inserted (Fig. 34).

Conclusion
The safety of the surgical methods and the augmentation materials used was of the highest priority in the patient information and treatment. The decision was therefore in favour of the patient’s own materials. This ruled out the risk of infection for the patient, as well as immunological rejection of the transplant. “In its cancellous form, autologous bone [...] is superior to all other bone substitutes with regard to its biological value, and is still considered [...] today to be the ‘gold standard’ among augmentation materials.” In addition, autologous bone is partially osseogenic and osteoconductive.

When choosing the implant system, the focus was on the greater safety and better predictability in the early treatment phase with immediate loading. As a result, only an implant system with the SLActive surface was an option. Studies have proved 60 per cent more bone-implant contact with the SLActive surface after two weeks compared with the SLA surface. Immediate loading of Straumann SLActive implants achieves a survival rate in excess of 97 per cent after one year.

Computer-aided, template-guided surgery via coDiagnostiX was used to place the implants. The procedure shows average horizontal deviations between the final and the planned position to 1 mm.
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Acknowledgement: The authors wish to express thanks to Was- sermann Zahntechnik for the drill templates and interim abrivation, to PKC Dental-Labor for fabricating the prostheses, and to Martin Holz (dental techni- cian/system expert at Strau- mann) for co-ordination, com- munication and step-by-step support.

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

About the authors

Dr Rainer Fangmann ob- tained a Doctor of Medi- cine degree in 1991 and a Doctor of Dental Medicine degree in 1995 from the Hannover Medical School in Germany. Since 2003, he has operated a joint dental practice specialising in oral and maxillofacial surgery and implantology with Dr He- lena Fangmann in the Gesundheitsze- ntrum St. Willehad in Wilhelmshaven, Germany.

Dr Lars Steinke has run his own practice with a focus on aesthetic den- tistry in Schortens, Ger- many since 2004. www. dr-steinke.de

Dr Fangmann and Dr Steinke have been collaborating with Sirona to develop a guideline for minimally invasive surgery.

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Fig. 26
Fig. 27
Fig. 28
Fig. 29
Fig. 30
Fig. 31
Fig. 32
Fig. 33
Fig. 34
Fig. 26
Fig. 27
Fig. 28
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Fig. 32
Fig. 33
Maestro Scanner system

Author: Terence Whitty

The concept of digital study models has often been talked about, particularly in orthodontic circles, as a solution to the considerable physical space required to store plaster models. If a model could be scanned in three dimensions to a high degree of accuracy, stored electronically and then reconstituted should the need arise sometime in the future, then the need for physical storage of models could potentially be eliminated.

While there has been talk of this, little in the way of real solutions have been available. Study model scanning services exist but often if you look at the fine print in their terms and conditions, you may not even own the scans of your own models! A recent discovery is a digital study model system with a host of very “useable” features and advantages. They are easy to make, inexpensive, very accurate, cost very little to store and transportation is a breeze.

Amazingly, you can store more than 800 sets of models on one DVD-R disc or an average 500GB hard drive could hold a staggering 100,000 sets of models! Much better than rooms and rooms full of study models. Digital models have many advantages. They can be moved, manipulated, measured and stored electronically and then reconstructed should the need arise sometime in the future. Digital models can be emailed to clients.

New digital study model
I have been working with digital models for some time and have examined several systems on the market today. I have recently found a great new digital study model system with a host of very “useable” features and the best news of all is that it is very affordable.

The Maestro Scanner system is a smartly designed state-of-the-art structured light 3D scanner. It uses patterns of light and two digital cameras to measure the surface of the model in three dimensions. Projecting a narrow band of light onto a threedimensionally shaped surface produces a line of illumination that appears distorted from other perspectives than that of the projector, and can be used for an exact geometric reconstruction of the surface shape. This is the basis of structured light scanning and in this case, uses no lasers so it’s completely safe for anyone to use. It also has great accuracy and is quite speedy in operation. This type of scanning is used by many digital CAD/CAM manufacturers so the technology is well proven for our market.

Digital models are processed. Once you scan the upper and lower models and acquire multiple dies (up to eight) in one scan. Some of the more advanced C&B scanners are not able to do this. Remember, digital study models are not just for orthodontic purposes but can be used for all dental models. It’s a great way to diagnose, discuss and store models.

Quality
The quality of the scans is more than impressive with a great amount of detail once the scans are processed. Once you scan the upper and lower models and do a quick occlusal scan, the registering of the scanned models into the correct bite relationship is completely automatic. This is a feature I really like. You can also register the models in various relationships—centric relation; centric occlusion; protrusive or construction bite to name a few. There are also various editing and measuring tools provided and you can do adjustments to the scans if need be. You can save the finished files in industry standard STL or a proprietary ORTHO and ORTHO iPad file format. File sizes are quite small and easily emailed to clients.

One of the additional notable features of Easy Dental Scan is the option to batch scan. In many systems, immediately after the scan is completed, it is processed which can take quite a bit of time. With the batch scan, you can quickly scan several models and then complete the processing of the scans at a later time. You simply walk away and the computer does all
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Non-extraction treatment of a Class II case with a missing mandibular central incisor using a CAD/CAM lingual orthodontic system

Author: Khaled Abouseada

A
dult orthodontic patients insist on aesthetic treatment options that have the least possible impact on their work and life. Clear aligners are an excellent treatment option that is well suited to many comprehensive orthodontic treatment plans. You may have already figured out that case selection is essential, and some movements are more difficult to perform well with removable aligners.

Inognito lingual braces (3M ESPE) are an ideal treatment option for adult patients who are best treated with a fixed system and who are looking for invisible orthodontics. They are also perfect for patients who are not committed to dealing with removable aligners. Lingual braces are an exciting advancement in orthodontic care, and many patients are thrilled. I would like to present a brief background on the Inognito lingual braces system, followed by a discussion of a case I treated with lingual braces and why I chose this system.1

The Inognito appliance is manufactured using state-of-the-art CAD/CAM technology. The first step in the fabrication process is taking accurate polyvinyl siloxane impressions and bite registration using polyvinyl siloxane, and then creating a model in plaster and a diagnostic wax-up thereafter (according to my direct instructions). The final model is then sent to me digitally for feedback, and I can make a series of changes until I am satisfied with the final result. The final model is then scanned with a 3D scanner and the brackets are designed on the computer. The bracket and archwire system consists entirely of individualised components. The bracket bases and bodies, the position of the bracket body on the bases, the bracket-slot orientation (ribbonwise), the direction of the archwire insertion (vertical or horizontal) and the archwire geometry are all individually adjusted to each tooth, according to malocclusion and the orthodontist’s instructions. Rapid prototyping technology is used for the manufacturing of the lingual brackets.

The braces are then cast from gold alloy, mounted in a flexible indirect bonding tray, and shipped out ready to be bonded. Direct bonding is feasible too, owing to the extended individual bases.

Bending archwires is one of the most difficult tasks in orthodontics. In this system, computer-operated bending of archwires using robots is used to manufacture precisely shaped archwires. Even superelastic archwires can be precisely shaped. This helps solve three major problems in lingual orthodontics:

1. Patient discomfort during the adaptation phase: The appliance is designed to be as flat as possible, not much higher than a bonded retainer; this significantly improves patient comfort.
2. Difficulties in re-bonding: The customised bracket base covers the major part of the lingual tooth surface and therefore allows direct re-bonding without the need for any other positioning aids.
3. Inaccuracies of the slots due to production and resulting variation in torque play are now part of the past, owing to Inognito. Measuring rates show divergences of not more than 0.008mm between the slots. The precisely shaped archwires also make high-standard finishing easily achievable.2, 3

Figure 1 shows the different steps in manufacturing braces with the Inognito system. The final model is then sent to the manufacturer (Incognito). The Class II malocclusion was corrected by non-extraction orthodontic treatment with a CAD/CAM fixed lingual appliance (Incognito). The Class III molar relationship had not changed at the end of treatment, but a Class I canine relationship was achieved and the facial profile improved owing to improvement of the position of the mandibular incisor in relation to the mandibular plane, which affects the position of the lower lip.

Diagnosis and aetiology
The patient was male, aged 25 years and nine months, and had the chief complaint of crowding of the maxillary and mandibular anterior teeth. He had Class III canine and molar relationships on both sides, a 2mm overjet, a 4mm overbite, a missing mandibular left central incisor, the maxillary midline was coincident with the mid sagittal plane, the mandibular midline was shifted to the left, the maxillary dental arch had about 7mm of crowding and lower dental arch had 8mm of crowding, excluding the width of the missing mandibular incisor, and the maxillary lateral incisors were in crossbite (Fig 2).

According to cephalometric analysis, there was a Class II jaw relationship and normal vertical facial height. The patient was in good health and his medical history showed no contra-indications to orthodontic therapy (Fig 5).

Treatment objectives
The treatment objectives included correction of the maxillary and mandibular crowding, improvement of the dento-alveolar and maxilla-mandibular relationships, improvement of facial aesthetics, and establishment of a stable occlusion and better smile.

Treatment alternatives
Three treatment options were suggested to the patient. The first alternative entailed labial orthodontics using either metal or clear brackets. The second option entailed lingual orthodontics, as the aesthetic demand was very high for the patient and clear aligners would not have been able to achieve the needed results. Both Options one and two were non-extraction.

The third option was to extract all four first premolars but this would have affected the facial profile negatively. After detailed discussion with the patient, we chose Option two, non-extraction using a lingual appliance.

Treatment progress
Treatment began with customised, pre-adjusted, CAD/CAM fixed lingual appliances (0.550mm slots) placed on both the maxillary and man-
Performing lingual orthodontic treatment for each patient in the average orthodontic office is now a reality. The treatment results are of a high level, and all our patients may benefit from an invisible appliance. Former problems, such as discomfort, speech alteration, finishing inaccuracies, and particular tooth anatomy, can be overcome in this manner.

The extraction of the mandibular incisors constitutes a therapeutic alternative in treating certain anomalies. It is not a standard approach to symmetrically treating most malocclusions, but the therapeutic aims must be adjusted in certain clinical situations to individual patient needs, even when this means that the final occlusion achieved is not ideal. The deliberate extraction of a mandibular incisor in certain cases allows the orthodontist to improve occlusion and dental aesthetics with minimal orthodontic treatment. In all cases, however, a diagnostic cast is required to predetermine the occlusal possibilities precisely.

Conclusion
The key to success in lingual orthodontics is in terms of both professional and patient satisfaction is practice and training. The Incognito system can be used for all types of malocclusions with the same precision as labial braces. The possibility of incisor extraction should be a part of every clinician’s portfolio of treatment techniques. If it is planned carefully and executed properly, incisor extraction can be an effective way of satisfying a particular set of treatment objectives.
Dr Khaled Abouseada is a consulting orthodontist involved in private practice in Saudi Arabia, Bahrain and Egypt. He lectures orthodontics at the Batterjee Medical College and Specialized Academy for Medical Training. He has lectured at many international dental and orthodontic forums. He is a certified trainer for CAD/CAM orthodontics and serves on the editorial board of Dental Tribune Middle East. He won the I Love My Dentist Award in 2010–2012 and the MENA Award for Orthodontic Best Case in 2010–2012.

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Editorial note: A complete list of references is available from the publisher.
Change of control clause? Don’t panic!

I’m often contacted by NHS dentists who have queries about the terms of their NHS contract. Very often the contract was signed a number of years ago and only now that the contract holder wants to sell their practice or incorporate do they have cause to examine the terms of the contract.

One of the most common examples we see is where a practice owner has previously incorporated their NHS contract into a limited company with the consent of the NHS. Whilst the approach taken by the NHS Area Teams to incorporation requests is nowadays uniformly uncooperative, this was not always the case and back in the days of the PCTs, there were many examples of certain PCTs being happy to permit incorporation without opposition. Those days sadly are now behind us.

If you did manage to incorporate your practice or if for any other reason you trade through a limited company, you will at that time have been issued with an NHS contract in the name of your limited company. Was that proposed new contract ever reviewed by a solicitor at the time you entered into it? If not then you may find that your NHS contract had a clause inserted called a “change of control” clause. The effect of a change of control clause is to restrict your ability to transfer the shares in your company to a third party on a sale.

These clauses were often slipped into the contracts without being brought to the attention of the contract holder and unless specialist advice was sought at the time, they can be a nasty surprise once discovered.

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change of control clause, don’t panic.

The main thing to remember is that the NHS Area Teams are under a duty to act reasonably in granting consent to a change of control. Sometimes this duty is explicitly stated in the contract with the words “such consent not to be unreasonably withheld”. Where those words are not present, in our opinion there is a strong argument that the duty is implicit anyway.

This view is reinforced by the recently issued (April 2014) NHS guidance document “Policy for Incorporation of Primary Dental Contracts” which gives area teams the exact wording for a change of control clause to be inserted to an NHS contract on an incorporation and states that consent to change of control should not be “unreasonably withheld, delayed or conditioned”.

On behalf of our clients, we have successfully obtained consent to change of control from a number of NHS Area Teams and in our experience, provided the proposed buyer of the shares is a registered dentist of good standing without previous disciplinary or conduct issues, capable of maintaining the existing standard of service provided at the practice, it would be unreasonable for the Area Team to withhold consent.

One further point to remember is that there is no express right in any of the regulations or guidance for an Area Team to impose alterations to the contract value when asked to provide consent to change of control under the NHS contract.

Whilst these are strong arguments we’ve used before to successfully procure consent to change of control, they are not always immediately accepted without the need for negotiation with Area Teams causing delays to a proposed practice sale.

Our advice is that if you have an NHS contract in the name of a limited company and you intend to sell your practice at some point in the future, have it reviewed by a firm of solicitors who are used to successfully dealing with these issues and obtaining consent. That way any change of control clause can be considered from the very outset.

In addition, instruct your Solicitor to open the dialogue with the Area Team as soon as you have found a buyer so that the issue does not cause delays further down the line.

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**About the author**

Thomas Coates is a Partner and Head of the Dental Team at LCF Law. Thomas has years of experience in acting exclusively for dentists and dental practice owners throughout England and Wales particularly in respect of practice sales and purchases, practice business structures, incorporation and general commercial advice. Within the Dental Team he can also call on Solicitor led expertise in Dental Employment and HR, CQC issues, GDC regulatory matters, NHS disputes and Property. Call Thomas on 0113 2440876 or email tcoates@lcf-co.uk for a no cost/obligation consultation.
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