Dentists are being reminded of their duty to adhere to the National Institute for Health Clinical Excellence guidelines for dental appointment recalls. One point that has caused debate is that dentists in England are reportedly seeing patients more than they need to. According to the briefing, this is in breach of their government contracts.

NICE guidelines state that adult patients should be recalled less than three months and two years, “based on a risk assessment, taking into account a checklist of risk factors, such as alcohol and tobacco use” whilst the recommended interval for children is between three and 12 months.

The guidelines also state that “the new dental contract, which will be based on registration, capitvation and quality, and remove the need to meet a UDA allocation, is likely to make the implementation of the NICE guidelines easier.”

According to reports, England’s CDO, Barry Cockerott, has sent copies of the new briefing to all dentists, stating that the figures from April to September last year show that 15 per cent of patients are being recalled for checks less than three months apart, and that 8 per cent of patients are seen at three-to-nine month intervals – “which means that 71 per cent of people are re-attending within a nine-month period”.

It added that: “Ensuring patients are given an appropriate recall interval is a professional and ethical requirement and helps patients to maintain good oral health.”

A spokesperson for the BDA said: “The NICE guidance on recall intervals represented a significant change for dentists and patients alike. Six-monthly check-ups have been the backbone of NHS dentistry since its formation.

“The opportunity to see healthy patients to detect disease before it was serious enough to produce symptoms and to institute a regular preventive advice was the norm; therefore it has taken time for patients and the profession to adjust to this change.

“Some patients still have an expectation to be seen six-monthly.

“As you know, the guidance states that the appropriate interval will depend on an individual’s clinical and risk factors – and according to CDO’s letter, the dentist will take a patient’s views on board before making a final decision, so there is an element of agreeing this between patient and dentist.

“Many patients want to see a dentist more frequently (either to pick up problems early, such as gum disease, or for reassurance about their oral health) and dentists have to change patient habits as well.

“The BDA agrees that recall intervals need to be tailored to the individual and based on the risk status of the patient. There are a wide range of risk factors to decide upon the recall interval, including the following major ones:

Smoking or tobacco use, excessive alcohol use, cardiovascular disease, bleeding disorders, anti-coagulants, immuno-suppression, diabetes, glucose medications, phenytoin, acid reflux, lack of fluoride, high sugar intake, high acid intake, new decay, anterior fillings, root caries, heavily restored dentition, mucosal lesions, poor oral health, plaque retention factors, low saliva flow, tooth wear, no fluoride, poor attendance pattern, and people with special needs.

“The guidance doesn’t necessarily clarify how many of the risk factors or ‘how bad,’ these need to be to achieve an ‘at risk’ status, so interpreting what is an appropriate recall period for a given patient may not always be clear cut.”
New stem cell research

Scientists from King’s College London have uncovered the first genetic evidence that shows cells found on the surface of blood vessels can act as stem cells to assist in both organ growth and tissue repair.

The study, funded by the Medical Research Council, is published today in the journal, Proceedings of the National Academy of Sciences (PNAS).

Up until now it has not been possible to show that a blood vessel (perivascular) cell can transform into a different cell in vivo (animals), but this study shows for the first time that they can in fact act as stem cells in this way.

Perivascular cells are scattered throughout the blood vessel walls and are involved in the first response to tissue damage, as an increase in blood supply travels to the site of the damage. Therefore the number of these cells is naturally increased at the site. As these cells are present in most human tissue, they could be utilised to provide an effective natural mechanism for organ and tissue repair.

The researchers carried out experiments in rodent incisor teeth, which continuously sharpen themselves by the shearing action of their tips. As tissue is lost during sharpening, this must be continuously replaced. The experiment showed that perivascular cells act as stem cells and differentiate into specialised cells when needed.

Secretary of State for Health to address British Dental Conference and Exhibition

Secretary of State for Health, Rt Hon Andrew Lansley CBE, (pictured), will address the 2011 British Dental Conference and Exhibition on Thursday 19 May, it has been confirmed this week. Mr Lansley will speak at 11am on the first day of the event, which takes place at Manchester’s Central Convention Complex.

Delegates at the event will have the opportunity to hear first-hand from Mr Lansley about major reforms to dentistry in England. His appearance will come at a pivotal time for dentistry as pilots intended to develop a new dental contract begin. Commissioning arrangements, too, will be in the spotlight, as discussions about the establishment of a new national commissioning board that would be responsible for dental care continue. Mr Lansley is expected to participate in a question and answer session following his address, which replaces the previously-advertised appearance by Parliamentary Under-Secretary of State Lord Howe.

Dr Susie Sanderson, Chair of the British Dental Association's Executive Board, said: “We are delighted to be welcoming the Secretary of State to Manchester for the 2011 British Dental Conference and Exhibition. Dentistry in England is in a period of transition that we hope will witness the replacement of the flawed 2000 dental contract with a system that works better for patients and dentists alike. Significant changes to commissioning arrangements that will see dentistry commissioned by a national board, rather than primary care trusts, proposed in the Health and Social Care Bill, are also being debated.

"Dentists from across England attending the event will be keen to learn more about the Government’s proposals."

Special service award to civil servant

Jerry Read, Head of Oral Health and Dental Education at the Department of Health (DH), was honoured by the Faculty of Dental Surgery and the Faculty of General Dental Practice at their joint Diploma Ceremony held on 1 April 2011, receiving a Special Service Award to recognise his outstanding contribution to the faculties and to dentistry as a whole.

In the citation given by Professor Derrick Willmot, the Dean of FDS, it was noted that Jerry has risen rapidly through the ranks at the DH, taking responsibility for many aspects of dental and oral health including the development of mandatory continuing professional development for dentists and dental care professionals. He was appointed Senior Principal Civil Servant in 1999 and is currently leading on oral health promotion and dental education.

Professor Willmot added that: “one of Jerry’s most notable achievements was his tireless and successful work over many years to promote water fluoridation in the UK.”

Russ Ladwa, Dean of the FDS(UK), said: “Jerry Read has played a key role in improving the oral health of the nation during his career at the DH. His help and advice to dental professionals and DH officials over the years has been invaluable and highly regarded.”

The Special Service Award, an inscribed medal bearing the arms of The Royal College of Surgeons of England, is presented only to individuals irreplaceable in their outstanding service to dentistry and the dental faculties.

Dentist jailed in UK

Vinisha Sharma, 37, who worked as a dentist for the NHS in Britain, has been jailed for three years after falsely claiming to possess dentistry degree from an institute in Amritsar.

Following a complex investigation by the NHS Counter Fraud Service Sharma was sentenced at the Westminster Crown Court after pleading guilty to seven counts of forgery.

Over a nine year period Sharma earned almost 250,000 pounds while working on the basis of the false Bachelor of Dental Surgery degree, which she claimed to have completed at the Sri Guru Ram Das Institute for Dental Sciences and Research in Amritsar.

Her deception was eventually uncovered following claims that she had removed the wrong teeth from a patient.

Judge Amjad Nawaz described Sharma’s offences as ‘pre-determined and dehter’ breaches of the public’s trust.

Reports quoted him saying: “It does seem to me that the level at which this offending took place and the organisation which must have gone behind it in order to obtain the documents, was very pre-determined and, in those circumstances, highly criminal. Much of what, sadly, she was telling people was a lie - that is the sad truth behind the offending in this particular case.”

The team found that when a tooth is damaged, specific new tooth cells (odontoblasts) are made by these perivascular cells to regenerate the tooth.

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Dental Tribune UK Ltd
Editorial comment

There is a new scheme - concocted by the Government to help them cut red tape and bureaucracy for us poor little folk in the real world. The Red Tape Challenge, launched at the beginning of this month and due to run for two years, is the Government's proposal for short-circuiting its own red tape and regulation across all aims to look at the 21,000 bits of bureaucracy for us poor little folk in the real world. The Red Tape Challenge, launched at the beginning of this month and due to run for two years, is the Government’s proposal for short-circuiting its own red tape and regulation across all aims to look at the 21,000 bits of bureaucracy.

Proposals should go further - BDA

Government plans for dental public health are targeted in the right direction, but do not go far enough, the British Dental Association (BDA) has warned. While supporting the broad approach of the plans and some of the specific proposals in the Government's Healthy Lives, Healthy People white papers, the BDA would like to see a more ambitious approach to dental public health.

The creation of a target for improving the oral health of five-year-olds, which reflects the Government's stated intention to reduce the level of dental decay in children, is a very positive step, the BDA believes. With a generation of British adults with heavily restored dentitions and complex needs now entering later life, the BDA believes that a target for improving the oral health of older patients should also be set.

The targeting of a reduction in the consumption of specific food products is also supported by the BDA but they believe that a stronger approach to reducing sugar intake would be appropriate.

An issue with the size of the dental public health workforce is also raised by the responses, which warn that more Consultants in Dental Public Health are needed. The BDA believes the expertise of these individuals must be fully integrated into wider public health structures and utilised in the formulation of the proposed Joint Strategic Needs Assessments and Health and Wellbeing Strategies.

A major concern for the BDA is the Government’s proposal for a health premium, a proposal it believes would see money pour into areas that are able to demonstrate improvements, rather than those that really need funding to meet the challenge of changing behaviour. Furthermore, the BDA’s response challenges Government to ring fence a dental element of the public health budget in order to protect spending on this vital area.

Colgate Total provides 72% reduction in plaque bacteria regrowth

...and protects your patients from the most common dental problems:

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- Cavities
- Gum Problems
- Sensitive Teeth
- Enamel Erosion
- Bad Breath
- Staining

For a healthy mouth recommend NEW Colgate Total.

*Illustration: Dramatisation illustrating reduction of plaque bacteria 12 hours after toothbrushing with Colgate Total vs stannous fluoride toothpaste.

Gum disease ‘more harmful than diabetes’

New research suggests that gum disease carries a higher risk of causing a stroke than diabetes, and its impact is nearly the equivalent of high blood pressure as a major cause of strokes.

High blood pressure (hypertension) and diabetes (diabetes mellitus) are widely recognised as major risks which contribute to non-fatal strokes (ischemic strokes). In recent years there has been growing evidence of the link between gum disease (periodontitis) and strokes. The latest research indicates that people are twice as likely to suffer a non-fatal stroke as a result of gum disease, compared to diabetes. The data also suggests its impact is equivalent to people with high blood pressure.

The research (see below), was presented at the 89th International Association for Dental Research (IADR) General Session and Exhibition in San Diego last month, is another reminder of the serious impact that poor oral health poses to general health and wellbeing.

Although hypertension and diabetes mellitus (DM) have been two major causes of ischemic stroke, the association between periodontitis and ischemic strokes is still equivocal. Hence, the authors evaluated the association between periodontitis and nonfatal ischemic stroke and compared its impacts with those of hypertension and DM.

A case-control study was performed with 145 hospitalised nonfatal ischemic stroke cases and 214 non-stroke population controls. After controlling for potential confounders, periodontitis was strongly associated with ischemic stroke. In conclusion it was stated that periodontitis is an evident independent risk factor for nonfatal ischemic stroke and its impact is almost same as that of hypertension and DM.

Devon dentist cycles for children’s charity

Devon Dentist Andrew Pickering, (pictured), is cycling from Lands End to John O’Groats to raise money for the Butterfly Hospice.

The 100 mile journey, which will begin 14th May 2011, is being organised by Team 900, a team from Devon who hope to raise money and awareness for the Butterfly Hospice in China.

The Butterfly Hospice opens its doors to abandoned children who have less than six months to live, giving loving end of life care to 18 abandoned babies. The aid of sur-

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gery they have good news for four children who are now well and six who are awaiting adoption.

Andrew has had kind donations and support and wishes to thank all those that have supported him so far. Andrew would like to extend his thanks to Ivoclar Vivadent, Chris Fleet from Fleet Hypnosis and Derek Brunt for Juice Plus, Torquay for their support for this worthy cause.

“We need a lot of support, we need sponsorship for the charity and also we are looking for corporate support for our team while on their journey so that all the money we raise can be sent to Butterfly Hospice.”

Andrew can be contacted at Rievewview Dental or on his email andweygdp@hotmail.co.uk

The winners all received financial support for research projects, electives and intercalated studies.

The awards were open to all third-year students as well as those looking to undertake an intercalated degree in UK and Irish dental schools, through a new dedicated and interactive website, www.3mespe.co.uk/dentalstudents.

Celebrating the future of dentistry

On Saturday 2nd April at the 2011 3M ESPE Dental Student Awards the achievements of the country’s brightest young dental rising stars were celebrated.

Guest were welcomed at a drinks reception where the finalists had a chance to network with leading dental professionals as well as the esteemed judging panel.

The awards were preceded by a morning on Innovative Solutions for the General Dentist - 2011 and Beyond with speakers including Dr Hein de Kloet, Professor Trevor Burke and Dr Avijit Banarjee and followed by an insightful debate on the future of dentistry from some of the industry’s most influential figures. This inspiring and eye-opening debate embodied the theme of the event.

The three categories in the 3M ESPE Student Dentistry Awards 2010-11 were the Award for Innovation, the National Award for Innovation, which went to Laura Cove, from Bristol Dental School, and the Award for Intercalated Studies, which went to Charlotte Currie from Newcastle Dental School.

Both the National Award for Innovation and the Award for Intercalated Studies were judged by an independent panel of leading dentistry experts, including Dr Amarjit Gill, President of the British Dental Association, Professor Nairn Wilson, Dean and Head of King’s College London Dental Institute, Professor Trevor Burke and Edward Attenborough, President of the British Dental Trade Association. The judges were highly impressed by the number of entries submitted and the calibre of the students entering across the three categories, which made the judging process both challenging and rewarding.

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The Awards for Innovation, Laura Cove, the winner of the National Award for Innovation and Charlotte Currie, winner of the Award for Intercalated Studies together with the 3M ESPE Educational awards judge, Professor Trevor Burke, Professor Nairn Wilson, President of the BDA, Amrit Gill, John Ralph from 3M ESPE and Edward Attenborough, President of the BDEA.

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Widening access to dentistry

How many 16-year-old students have set their sights on becoming a dentist? Some youngsters with that ambition face particular difficulties. These include students from low socioeconomic groups and those studying at institutions with below average results in national exams. Yet many such students have the talent and dedication to make excellent dentists.

On Tuesday March 15th the Dental Institute at the University of Leeds delivered a new ‘Becoming a Dentist’ information session to provide some help to 92 West Yorkshire students from groups under-represented in the profession. For example 50 per cent of them had home postcodes within the most deprived areas of the UK according to the index of multiple deprivations. A similar proportion came from families where neither parent had attended university.

The programme the students received included talks designed to increase their insight into dentistry, as well as information about the admissions process, and advice about meeting selection criteria. Four staff members and six dental students delivered the talks.

The feedback from those who attended was overwhelmingly enthusiastic. Everyone rated the event good, very good or excellent. Comments included “it made me more confident and motivated”; “it was all useful”; and “brilliant and insightful”.

Following the success of this new venture the Dental Institute at Leeds hopes to develop and extend this form of targeted support. The goal is to ensure that the dental student body is representative of the communities it serves whilst at the same time maintaining or improving academic and professional standards.

Robot ate my molars

Student Daniel Raabe, a former PhD student in the Queen’s School of Engineering at the University of Bristol, has been awarded a prestigious science prize after he designed a ‘chewing robot’ to mimic the action of a human jaw.

Bristol, has been awarded a prestigious 2010 Zwick Science ed the Paul Roell Medal in the engineering at the University of

Daniel has also been award-ed the Paul Roell Medal for his PhD work in the area of dental materials testing.

There were 55 entries from 16 countries competing for the prize.

Working in collaboration with the Department of Oral and Dental Science, researchers at the University of Bristol’s Department of Mechanical Engineering created the robot, which mimics the action of a human jaw. Currently, clinical tests of new types of crowns and other dental fittings, are usually tested in human mouths and they are often time consuming and by the time a new material has been evaluated the market has often moved on.

The UK currently spends approximately £2.5b each year on dental materials, which either replace or strengthen teeth; however a lack of an adequate method of field testing is hindering dental development.

Reports have stated that Dr Kazem Alemzadeh, senior lecturer in the Department of Mechanical Engineering at the university, came up with the concept after seeing aircraft simulators using similar movements.

The design and development of the chewing robot was carried out by Daniel alongside Dr An-drew Horstom, senior lecturer in the Department of Mechanical Engineering.

Dr Tony Ireland, a tutor at the Dental School, has also been involved in the development and testing of the robot.

Mr Raabe said to reporters: “By reproducing natural bite forces and movements, the chewing robot can help improve and accelerate the process of developing new dental restorative materials that may someday be found in a person’s mouth.”

‘Looks like a Candle’

ECH-Naisance introduces denturevault™, have produced what has been described as a “revolutionary dental storage and cleaning container that ‘Looks like a Candle’”.

After recognising an increasing demand for new hygiene solutions for retainers, TMD night guards, snore guards, dentures, and even partial dentures the device, which was revealed at the 2011 International Dental Show in Cologne, Germany, has been designed so people can discretely clean and store their removable dental appliances.

Until now, there has been little choice for storing and cleaning dental appliances and traditional methods of storage and cleaning have included the typical horseshoe shaped plastic case, conspicuous sonic cleaners, and the unsightly “teeth in a glass” method. However, denturevault™ uses an elegant design to create a faux-candle and this discreet method of concealment gives the user complete autonomy in having their appliance always within reach, overcoming the embarrassment and inconvenience of traditional methods.

Patient software launched

During a seminar at the Royal College of Physicians in London, Dr Tim Donley helped launch myDentalScore, the new interactive software tool.

Dr Donley told Liz Chapple, Director of Oral Health Innovation Ltd, that he believed myDentalScore would help motivate and inform patients and make them more likely to consult a dentist.

He said: “I have been waiting for something like myDentalScore for some time now. How great it is that the general public has an opportunity to gauge their risk for oral disease. This can only help motivate the thongs of people with unmet dental needs to seek care.”

MyDentalScore consists of an online questionnaire which asks about dental hygiene and history as well as lifestyle and delivers a score along with encouragement to discuss the findings with a dentist. It is now available for dentists to brand to their practice and add it as a link to their website.

For more information, or to invest in myDentalScore for your website, go to www.previser.co.uk/products/mydentalscore.html

Dentist celebrates milestone on top of the world

After visiting a charity’s table at a conference, Dr Joseph Pawlik, a Man- tua (USA) dentist, decided that for his 60th birthday he would travel to the other side of the world and provide care to children in Katmandu, Nepal.

“I picked the farthest place I could go, the most extraordinary place,” says Dr Pawlik. “I went to the other side of the world, 15 years ago. It was really rewarding and interesting.”

Heading out with Global Dental Relief, Pawlik ventured for the first time outside of North America to the bustling city of Katmandu.

Staying in a Buddhist monastery, the team of dentists treated children from the monastery’s school and orphanage, and also children from the community.

“Most of these kids have never seen a dentist,” he was quoted as saying. “A lot of them are in good dental health. It’s surprising because they don’t have toothbrushes, but then, that’s probably because they don’t eat all that junk food.”

In cases where there were cavities present, Pawlik described how the treatment was to fill them or extract the tooth if it was bad.

“It just breaks your heart when you have to take out their front teeth,” he was quoted as saying. “Over here, you can fix them. There’s crowns. There’s implants.”

The team of dentists spent a week in the city, where Colgate provided free toothbrushes for the children. They then trekked to the mountains for two weeks, intending to treat children in the villages there.

Having been invited to return to Nepal again, Pawlik said he is determined to go back as soon as he has the funds.

“The kids are unlike any other kids in the world,” he was quoted. “This is the first time anyone has poked around in their mouth, and they don’t make a move. They’re very dis-ci-plined... they’re the sweetest kids in the world.”
Around the world in 80 webinars
Elaine Halley on research, reading and falling by the wayside

Well – lo and behold I managed to pass the Unit 6 module! This was the module all about research which the University of Manchester decided we needed to learn sooner rather than later so that we have some insight into research before commencing our dissertations. (I am not entirely sure I know the difference between a thesis and a dissertation...probably shouldn't admit that at this point.)

Great intentions

So – after the trauma of getting all the cases for Unit 3 in plus the end of Unit 6 assignment in, the pressure has eased off and we are back to webinars and electronic feedback forms. I did start off with great intentions of getting my posterior composites and I fooled myself into the belief that I was going along – but that has fallen by the wayside already.

In fact, it was the very presence of a deadline for this blog which spurred me on to catch up with the webinars. In my defence, this illustrates the flexibility of this course which does adapt to your life – as long as you remember there are deadlines which creep up silently but surely!

The first webinar in Unit 4 was Trevor Burke on Posterior composites and I fooled myself into the belief that I had watched this live – until my children asked me ‘what had I watched this live – until myself into the belief that I had watched this live – until my children asked me ‘what was that man saying?’ and I realised I had been distracted into family life and had to re-watch most of it when I was alone. And worse than that – apologises Wolfgang – as I was listening to your webinar, my husband has banned me from listening to any more webinars without headphones as he complained that he bonding would be fascinating to a farmer!

Latest controversies

So – Dr Wolfgang Richter’s presentation on advanced composite techniques, introduced some of the latest controversies in the science which can influence us in clinical practice – including whether we should disinfect our cavities with chlorhexidine to prevent the reactivation of matrix metalloproteinases. These MMP’s degrade over time.

After presenting three or four papers telling us that we should do this, he then presented a paper which found that there was no benefit and that with a self-etch system, the bond strengths could be drastically weakened – the overriding message being that we must remember to be cautious and critical of research before jumping to change our clinical practice. An excellent illustration of how important it is for us to research claims independently before changing our clinical routines.

University of Jena

This was followed by an inlay/onlay lecture from a very cheerful Dr Harald Kuepper from the University of Jena in Germany. My postgraduate education to date has been mostly US based and so I must confess to never having heard of the University of Dental Medicine in Jena – and as it has recently been voted the number one of 31 Universities in Germany, I stand shame-faced as to my ignorance.

I must confess to never having heard of the University of Dental Medicine in Jena – and as it has recently been voted the number one of 31 Universities in Germany, I stand shame-faced as to my ignorance.

Dr Wolfgang Richter

I could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in could hear the ‘voices’ throughout the whole house! And I thought current concepts in...
Feelings have been riding high regarding the methods and conduct of the regulators of the dental profession, something that was just not the case a few years ago. To me it is not the fact the levels of respect to institutions have changed, it is that so many methods and operations of our regulators have become illogical these days, against the morals and values of so many of the profession.

I feel the GDC have done some things to address dentists’ feelings, the ARF has risen, but there seem to be steps being taken to prevent the New Year’s administrative removal from the register if bank account or cheque payment goes astray. On a much more important level, an august and respected body such as Dental Protection has gone on record to criticise the methods of the Professional Conduct Committee of the GDC. This article, in a DPL publication, was read widely, discussed and dissected and colleagues on GDPUK definitely made their feelings known about the GDC’s conduct committees and the way cases are taken forward and tried.

Talking of regulators, this part of my GDPUK column does not even start to capture the professions’ feelings of dismay and fear of the lack of both credibility and trust in the CQC. In the week the CQC sent out 4,000 emails to the wrong people, it became more and more clear that no one can believe a single word communicated by the CQC, either by email, on paper or on the telephone. Their goalposts and not just moving, they are on a perpetual roundabout! The words “not fit for purpose” must be the most common phrase when CQC is mentioned.

At least GDPUK has a role in allowing colleagues to share news as it develops, to reassure one another the nightmare may soon be over, and to share the responses framed by the various representative organisations. Those organisations themselves may base some of their response on the outcry on GDPUK, but they will never tell us that. It must be reassuring for the leaders of those organisations to review the vox pop as shown on the site, and to develop policy which echoes this.

There has been so much else to follow this month; here is a small sample.

A variety of surgery key boards have been discussed, some are more clinical appearance, and there is a wide variety of prices, for a few pounds [almost disposable] to the higher quality shiny white ones. One was recommended which is not just washable, it’s dishwasher proof.

A puzzling topic, which did not get a full answer, but it seems a worldwide regulation that pilots cannot fly for 24 hours after having an LA. Have you heard of this? No one seems to know why.

We have discussed the change in the pattern of the genders of students admitted to dental schools. We wonder how this will affect the profession in the coming years, and this lead a number of colleagues to reminisce about their days as students. One GDPUK colleague was awarded a chair as Associate Professor, and a friend of his from student days remembered an answer given by the now professor as to treatment of a snail track ulcer in the palate – “cut it out with an air rotor” said the star pupil!
There seems to be some confusion in the profession regarding the story of how the use of the title ‘doctor’ by the medical profession came about, and around the historical reasons for and against its use by dentists. I’d like to try to make the historical context of this now-contentious title a little clearer.

Throughout the seventeenth, eighteenth and into the nineteenth centuries, three distinct types of practitioner offered ‘orthodox’ (whatever that may mean - the subject of a different debate) cures: the physician, the apothecary and the surgeon. For the purposes of this title debate, it is the physician and the surgeon that concern us.

The physician’s services were generally offered to those with the means to pay well. He had attended a school of medicine, which in England meant Oxford or Cambridge until relatively recently. In order to gain entry to this medical school, he (and, for this period, it was only ‘he’) first needed to hold a higher degree, the granting of which would require him to defend an original thesis. This degree had been in existence for many centuries as the doctorate, a word taken from the Latin docere, to teach. Thus, the physician was a doctor before he even entered medical school. As a theoretical man, working on an intellectual level, actual physical contact with the patient was rarely required.

The surgeon’s services were employed by a wider population. The surgeon was a practical man - he had served a long apprenticeship, usually seven years, to a master and performed a masterpiece (with no written examination) to gain his right to join the Barber-Surgeons Company. This was a guild, which took its place alongside other liveried companies, such as those of the Goldsmiths, Coopers and Drapers. On 2 May 1745, royal assent was granted to the formation of the new, independent Company of Surgeons.

Physicians, then, took the title of doctor because they already held a doctorate. Surgeons, on the other hand, held no degree and retained the title of ‘Mr’. It can still be noted that medical surgeons revert to the ‘company’ title with some degree of pride, setting them apart from their physician colleagues.

Dentistry’s origins lie within surgery. Around the start of the eighteenth century, a small number of French surgeons, centered around Paris and epitomised by Pierre Fauchard, began to specialise: teeth, eyes and childbirth were prominent areas of surgical practice to which they turned their attentions.

Physicians, or ‘doctors’, have retained their original title out of courtesy. Dentists never held this title historically - the university-conferred dental degree post-dates that time when ‘doctors’ ceased to hold bona-fide doctorates by some margin.

So the debate will continue. Me? I hold a doctorate - in history - but my patients still call me ‘Mr’.

Once upon a time...a title story

Roger King Cambridge GDP and Ex-Wellcome Research Associate in the History of Medicine at Cambridge University, sheds some light on the Dr title debate
Having a tooth drilled can be the most nerve wracking idea for patients, and can ultimately put them off having any kind of restorative tooth treatment. The thing is, according to experts, root canal treatment should in fact be the first choice where possible for anyone with an infected tooth; however, every year thousands of teeth are still being pulled out as a result of infection.

Aesthetically, you would think that patients would rather save their tooth instead of living with a gap or flossing out for costly dental implants, but this is simply not the case. Referring to the latest figures from the NHS, more than two million teeth were extracted last year, whilst only half a million root canal treatments were carried out. These figures suggest that patients are not receiving all the information.

Treatments

Anxieties

The recent Adult Dental Health Survey showed that 50 per cent of adults are extremely anxious when someone feels anxious it’s about having a tooth drilled, and of adults are extremely anxious of adults are extremely anxious about having a tooth drilled, and when someone feels anxious it’s not easy to make decisions. So how many of these patients made their choice with all the information in mind? Were they fully aware that modern techniques root canal therapy can be painless?

Patients should be informed that if an infected tooth is left untreated it will result in bone loss, but they should also be informed that root canal treatment can save the tooth. In this day and age a variety of cosmetic dental surgery is available and patients could easily assume that saving teeth isn’t a top priority for dentists, or even the best choice for the patient. Of course, if a tooth can be saved, it should.

Fortunately for patients the Saving Teeth Campaign has been launched by the Harley Street Centre for Endodontics, meaning that for the first time in Britain there will be a campaign that will provide this much needed information for patients who are faced with a tooth infection. The Saving Teeth Campaign aims to raise awareness of the benefits of root canal treatment and the choices patients have.

The campaign’s key messages include:

• Saving a tooth is, where possible, better for the health of your mouth
• A well root-treated tooth covered with a crown can survive for many years if not for the rest of your life
• If a tooth becomes infected and left untreated bone loss can occur

There is a similar campaign in America fronted by the American Association of Endodontists (AAE). The aim is to let patients know that if they are faced with tooth loss they can consider Endodontics and they achieve this with photo competitions, articles in newspapers and posters all over dental practices. Compared to the UK, there are more than 15 million root canals performed annually in the USA.

In support of their Root Canal Awareness Week, the AAE carried out a survey which revealed that 70 per cent of Americans feared losing a natural tooth whereas the same percentage feared root canal treatment. What they didn’t realise was that root canal treatment is the exact procedure that can save their teeth.

Economic Endodontics

The UK’s Saving Teeth Campaign is run by endodontist Julian Webber, a world leader in the field of endodontics and his colleague and fellow specialist, Trevor Lamb. Supporters include recognised authorities in areas such as restorative dentistry, oral surgery, and the psychology of dentistry along with patients and high profile supporters Michael Winner and Peter Snow.

Talking about the campaign Julian Webber said: “Endodontics works when done properly and it saves teeth. It’s an economical way to preserve a tooth in function and avoid tooth loss.

“Last year’s figures from the Information Centre showed that four times as many teeth were taken out as there were root treatments and I believe there is scope for improving that ratio. If there’s a chance of saving a patient’s tooth we as a profession should always do so. Sometimes patients want infected tooth taken out but we need to make sure they understand all the implications of their decision and know what their choices are.

The literature clearly shows that teeth treated with root canal treatment with adequate coronal restoration are just as likely to survive as implant-retained restorations.”

Looking ahead to the future, the campaign ultimately wants to see figures showing that the number of extractions in the UK has gone down and to see the NHS recognising and remunerating the additional skills and equipment used by specialists and dentists with additional training.

Most importantly, Saving Teeth wants to ensure that patients are being encouraged to seek endodontics, either from their dentist or from a specialist.

As Dr Webber explained, in the end the campaign is about getting dentists to appreciate that their patients’ interests are really paramount importance: “Where possible if dentists think that they can’t do a difficult case then referring to a specialist should be the preferred option.”

“At the end of the day, endodontics is usually the best option for patients and should always be their first choice.”
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DENTAL TRIBUNE United Kingdom Edition - April 18-24, 2011

Getting Up to Date

Dental Tribune looks back at an informative and entertaining evening at the National Motorcycle Museum in Birmingham...

O
cal-B has a great reputation for delivering high quality seminars, so I was really looking forward to the 2011 lecture series called Up To Date: Oral-B Scientific: Exchange Seminars. Aimed primarily at dentists, dental hygienists and dental therapists, the 10-date series of seminars features a selection of three well-respected speakers: Nicola West, Trevor Burke and Iain Chapple.

Each of the speakers' presentations was based on the following:

Iain Chapple: Periodontal Medicine - a window on the internal medicine of the body. The biological base of Periodontology as a discipline is vast, as illustrated by the diverse nature of periodontal research and its intimate relationship with general health and well-being. Medical approaches to care employ a forensic and systematic approach to history-taking, physical examination and clinical investigations, focussed upon achieving a differential and ultimately definitive diagnosis. Once this is made, medical management involves treating the cause of the disorder by pharmacological or behavioural approaches and/or preventing disease onset or progression. This presentation will attempt to illustrate the enormous scope of practice of periodontal medicine, by guiding delegates through a heavily illustrated and systematic approach to investigating periodontal manifestations of systemic conditions. It will illustrate the "tip of the iceberg" of this far reaching and oft neglected aspect of periodontal care.

Trevor Burke: A pragmatic approach to the treatment of tooth wear. In the past, treatment of tooth wear was often by the crowning of affected teeth, or by a full oral rehabilitation, with many teeth being crowned, with the aim of protecting their surfaces from further tooth wear. The irony, of course, being that the treatment resulted in much more massive destruction of the affected teeth than the causative factors themselves. A strange way to treat teeth which were already compromised! However, advances in bonding techniques have enabled the use of minimally invasive treatment using resin composite restorations bonded to the worn surfaces. This presentation will discuss the optimum bonding agents for the procedure, the principles of dental aesthetics and how to achieve aesthetic improvement - the concept of pragmatic aesthetics - and will indicate the rates of success which may be expected.

Nicola West: New Concepts in Tooth Wear and Dentine Hypersensitivity. Tooth wear is a multifactorial condition of growing concern and is becoming increasingly significant in the management of our patients. People are now re-taing their teeth for longer, becoming more aware of their teeth and treatment possibilities, and expecting their teeth to last them a lifetime. Although there is usually one predominant cause of wear for an individual, a number of wear processes often occur together, the most common form, especially in the younger age groups, being erosive tooth wear. One of the effects of tooth wear, erosive tooth wear combined with abrasive wear, can lead to the condition which we are all familiar with, dentine hypersensitivity. Tooth wear is the most common dental problem after caries, periodontal disease and trauma, is likely to increase in the future. We need to know how to manage these cases with preventive measures, and most importantly, when to intervene restoratively, often committing that individual to a lifetime of dentistry.

Attending the event held at the National Motorcycle Museum in Birmingham, it was the turn of Iain Chapple and Trevor Burke to speak. With the room packed to the rafters as more than 300 people attended the event, both speakers had plenty to say.

Chairing the event was Dr Stephen Hancocks, himself not a stranger to the dental stage. Prof Chapple was the first to speak, discussing the ability that dentists have to save lives by their knowledge of the oral cavity and periodontal conditions in particular relating to more serious conditions manifesting within the body. Using a series of pictorial case studies, he illustrated the need for knowledge and limitations in examination when looking for signs of underlying disease.

He discussed the importance of the medical history as this can give clues as to what could be going on. Couple this with the examination process, which starts as soon as the patient enters the surgery, and it becomes clear that it is possible to help a medical diagnosis using oral diagnostic tools.

Prof Chapple concluded his presentation with five main tips:

- Periodontal disease is a large subject, but we don't see what we don't look for
- Several great medical problems surgically
- Avoid gingival biopsies
- Consider potential for multiple dental treatments
- Interpret clinical investigations with care

Next it was the turn of Philip Bellamy, a principal researcher at Oral-B, to showcase the company's latest innovation in its research - Dental Plaque Imaging Analysis (DPIA). This diagnostic tool allows researchers to score plaque levels during research in an objective and reproducible way, standardising their research for future analysis.

After coffee it was time to hear Trevor Burke discuss a pragmatic approach to tooth wear. Prof Burke began by discussing the 'golden proportion' and how it relates to the aesthetic preferences for dentition. After discussing some of the literature on the subject, he concluded that there is no real consensus among dentists with regard to smile design.

He then began to discuss the causes of tooth wear in relation to non-caries means: abrasion, attrition, erosion, abfraction, re-sorption. Particular attention was placed on erosion, which has been an emerging topic over the last few years and now is at the forefront of oral care methodology. Many of the causes of erosion are lifestyle related ie acidic drinks, gastric reflux, medication side effects. Prof Burke then moved onto the treatment of tooth wear: the use of bonding to dentine techniques, the ‘Dahl’ principle, composites.

This was an interesting event, for me personally I found Prof Chapple's presentation fascinating because of the potential dentists have to save lives (in fact Prof Chapple told us that 1 case study saves around ten lives a year because of their diagnoses).

There are still events scheduled for the coming weeks:

- May Newcastle Life Centre; 12 May London The Royal College of Physicians; 25 June Glasgow The Hilton Hotel, Strathclyde; 30 June Milton Keynes Horwood House

For more information or to book a place, contact Event Organiser, Julia Fish - email julia@communications.co.uk or call 07585 508550.
A new study has revealed that old-fashioned, manual faucets work better than new hands-free faucets.

The latest electronic-eye sensors to automatically detect hands and dispense pre-set amounts of water have been installed in the USA based Johns Hopkins Hospital, however a study has shown that they were more likely to be contaminated with one of the most common and hazardous bacteria in hospitals compared to old-style fixtures with separate handles for hot and cold water.

“Newer is not necessarily better when it comes to infection control in hospitals, especially when it comes to warding off potential hazards from water-borne bacteria, such as Legionella species,” Lisa Maragakis, MD, M.P.H. senior study investigator and infectious disease specialist, was quoted. “New devices, even faucets, however well-intentioned in their make-up and purpose, have the potential for unintended consequences, which is why constant surveillance is needed,” says Maragakis, director of hospital epidemiology and infection control at Hopkins Hospital and an assistant professor at the Johns Hopkins University School of Medicine.

Although the new style high-tech faucets cut daily water consumption by well over half, Johns Hopkins researchers identified Legionella growing in 50 per cent of cultured water samples, which were collected from 20 electronic-eye faucets. In comparison, the bacteria were found in only 15 per cent of water cultures from 20 traditional, manual faucets. Reports even stated that weekly water culture results also showed half the amount of bacterial growth of any kind in the manual faucets than in the electronic models.

The precise reason as to why there is a higher percentage in bacterial growth on the hands-free taps is still unknown; however, researchers have suggested that the valves offer additional surfaces for bacteria to become trapped and grow.

The Johns Hopkins researchers presented their findings at the annual meeting of the Society for Health Care Epidemiology (SHEA) in Dallas in April.

Infection control experts behind the latest study say that the electronic devices were widely introduced in patient care and public areas of hospitals across the United States, where the idea was to prevent bacterial spread from people touching the faucet’s water handles with their dirty hands.

Reports have stated that as a result of the study, which was conducted over a seven-week period from December 2008 to January 2009, Johns Hopkins facilities engineers removed all 20 newer faucets from patient care areas and replaced them with manual types. A hundred similar electronic faucets are also being replaced throughout the hospital, and hospital leadership elected to use traditional fixtures – some 1,080 of them – in all patient care areas in the new clinical buildings currently under construction at Johns Hopkins’ East Baltimore campus. The new buildings are set to open in 2012.

Lead study investigator Emily Sydnor, MD, a fellow in infectious diseases at Johns Hopkins, says Legionella bacteria, commonly found in water supplied from public utilities, rarely cause illness in people with healthy immune systems, but pose a real risk of infection in hospital patients whose immune systems are weakened from cancer chemotherapy, anti-rejection drugs after organ transplant, or from diseases such as HIV/AIDS.
Infection prevention
Richard Mugrave discusses cleaning and disinfection

Substandard hygiene procedures used in the medical profession should never be tolerated. It not only puts your patients in danger, it can also put you and your team at risk. It is necessary, therefore, to enlist the use of the most efficient methods of infection prevention in your surgery. To this end, it is essential that your dental team are fully trained in all methods of decontamination and informed as to the different types of harmful bacteria that can lead to diseases, such as MRSA and C.diff. Furthermore, relevant inoculations should be taken by all staff and recorded.

Before any decontamination regimes can proceed, it is important to remove and replace all disposable equipment in the surgery after each patient. Then, all areas and instruments should be ‘zoned’ into ‘clean’ and ‘dirty’ sections. It is worth noting that you should always clean from the cleanest to the dirtiest areas when decontaminating any surface.

Decontamination can be used as an umbrella term to incorporate cleaning, disinfection and sterilisation procedures. In the dental profession, this is necessary for maintaining the hygiene of surfaces and the reprocessing of instruments.

Cleaning
This removes foreign particles, such as dust, from surfaces. It is also the preliminary step in reprocessing instruments, and should be done as soon as possible after their use. It is vital for the successful sterilisation of equipment as debris can shield microbes from the steam of the autoclave.

Disinfection
This process aims to kill pathogens or render them inert. It is most often achieved using bactericidal cleaning agents that are effective against a wide range of microorganisms.

Sterilisation
The ultimate stage in instrument reprocessing, sterilisation destroys all forms of microbial life, including bacterial spores. It is a process crucial for those ‘critical risk’...
Cleaning removes foreign particles such as dirt from surfaces with the surface. This is enough only be in contact for a maximum using such a disinfectant will at least fifteen minutes. However, the appliance is in contact with an here as this only occurs if the biofilm. Clarification is needed binding blood and fix protein and especially on stainless steel, recommending caution when use alcohol based products; however it would be prudent to use aldehyde-free solutions.

The largest area in the surgery is the floor and, as such, it is a potential field for pathogens to thrive. Look into using a powerful disinfectant with strong particle loosening properties. In addition, floors vary greatly in material, so when purchasing a cleaner and disinfectant, it is worth making sure it has high material compatibility.

Successful cleaning and disinfection products frequently contain alcohol and yet, section 6.57 of the Department of Health’s HTM 01-05 regulations recommend caution when using alcohol based products, especially on stainless steel, as alcohol has been shown to bind blood and fix protein and biofilm. Clarification is needed here as this only occurs if the appliance is in contact with an alcohol-based solution for at least fifteen minutes. However, using such a disinfectant will only be in contact for a maximum of one or two minutes with the surface. This is enough time for harmful bacteria and viruses to be destroyed, but nowhere near enough to fix any proteins.

For more information call 0114 2545500 or visit www.schülke.co.uk
Also view their surface decontamination website at www.comparemikrozid.com
For infection control training visit www.s4dental.com

Cleaning is the primary step in reprocessing instruments and implants that penetrate human tissue, as this is where the highest chance of infection lies. The autoclave has proved to be one of the most effective methods of sterilisation. It involves the use of a machine that subjects instruments to high pressure saturated steam created using RO (reverse osmosis) water or distilled water in the reservoir.

When you look for products to aid you in your cleaning regime, it is important to remember the type of materials you are cleaning and disinfecting. Sensitive materials in the surgery, such as leather and soft PVC are vulnerable to strong alcoholic chemicals, so gentle, alcohol-free solutions would be advisable. Tougher materials, such as glass, ceramics and laminate work surfaces can be cleaned and disinfected with alcohol-based products; however it would be prudent to use aldehyde-free solutions.

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- Training, documentation and certificates.
- Radiography including IRR99 and IR(ME)R2000 compliance.
- Cross infection and decontamination including HTM 01-05 compliance and surgery audits.
- Medical emergencies including resuscitation, drugs, equipments and protocols.
- Training, documentation and certificates.
- Practice policies and written procedures.
- Clinical audit and patient outcomes including quality measures.

Your compliance with Clinical Governance and Patient Quality Measures will be questioned with the introduction of the Care Quality Commission*, HTM 01-05 and the increase in PCT practice inspections.

Would you like to know how you would fare when your practice is inspected and have the opportunity to take corrective action? The DBG Clinical Governance Assessment is the all important experience of a practice audit visit rather than the reliance on a self audit which can lead to a false sense of compliance. The assessment is designed to give you reassurance that you have fulfilled your obligations and highlight any potential problems. We will provide help and advice on the latest guidance throughout the visit.

For more information and a quote contact the DBG on 0845 00 66 112

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- Medical emergencies including resuscitation, drugs, equipments and protocols.
- Training, documentation and certificates.
- Practice policies and written procedures.
- Clinical audit and patient outcomes including quality measures.

The assessment will take approximately four hours of your Practice Manager’s time depending on the number of surgeries and we will require access to all areas of your practice. A report will be dispatched to you confirming the results of our assessment. If you have an inspection imminent then we suggest that you arrange your DBG assessment at least one month before the inspection to allow you time to carry out any recommendations if required. Following the assessment you may wish to have access to the DBG Clinical Governance Package with on-line compliance manuals.

For more information and a quote contact the DBG on 0845 00 66 112
The increased awareness of decontamination and cross infection control procedures within dentistry and legislative demands for compliance with HTM 01-05 have made practices consider their obligations in regard to infection control more seriously. Of all the aspects of decontamination mentioned in the guidelines one area that practices may be unaware of is their need to comply with a minimum standard of water quality, both in terms of the water going into their treatment centre and certainly in regard to the output quality of that water ie the water that goes into the patient’s mouth.

The problem of biofilm contamination of DUWLs has long been an issue in dentistry, research as early as 1963 first raised concerns and since then numerous studies have concluded that biofilm is prevalent in dental unit water lines (DUWLs). This is mainly due to the fact that in the majority of today’s most commonly used treatment centres, water is delivered via small bore tubing, providing an ideal environment for the development of bacterial biofilms. The biofilm itself gives rise to problems in two key areas: one; the physical restriction of the flow in narrow lumens and two; in significant numbers of planktonic bacteria in the output water.

Biofilm

The term biofilm refers to a collection of microorganisms that adhere to a surface and are surrounded by a protective and adherent slime (known as the extracellular matrix) which is secreted by the bacteria. Biofilms are particularly prevalent in water containing low concentrations of solids and low levels of nutrients. As well as DUWLs, biofilm can be found in streams and rivers, cooling towers and piped water systems etc.

Biofilms form when a few individual bacteria in the free floating (planktonic) state in water adhere to a solid surface such as the wall of a pipe or tube. The initial attraction to the surface is weak, but subsequent bacteria continue to adhere directly to those already attached and the behaviour of the aggregated organisms changes and starts to produce an extra-cellular matrix. This in turn increases adhesion and enables more planktonic bacteria to adhere easily to the film, and so the process continues, increasing levels of biofilm and causing water quality levels to fall below those required by the guidelines.

Significance of biofilms in the dental practice

Biofilm is difficult to identify, remove or control because the susceptibility of biofilms to external agents such as detergents and disinfectants is quite small when compared with that of individual planktonic organisms and each biofilm bacterium requires only small amounts of nutrients in order to survive and flourish. Furthermore, the design of today’s most commonly used treatment centres makes the dental unit water line the ideal substrate for biofilm growth.

DUWLs provide an ideal environment for the growth of bacterial biofilms for the following reasons:

- They are non-toxic; the materials used for tubing are selected for their non toxic properties and flexibility to suit the mechanical operation of dental units. Low toxicity to humans also means...
Dental unit water lines are a haven for pathogenic bacteria

Biofilms form when a few individual bacteria in the free floating (planktonic) state in water adhere to a solid surface such as the wall of a pipe or tube

low toxicity to bacteria.

- Water has a low flow rate: the small bore tubes used in dental units provide water at a typical flow rate of 30ml/min. The behaviour of water flowing through a tube means that the linear flow rate decreases from the centre of the tube to its wall. Low linearflow rates favour bacterial adhesion.

- Water flows intermittently: water only flows through the tube when instruments are in use, causing minimal disruption of the growing biofilm.

- Regular replacement of super-natant liquid: when instruments are used or the system is flushed, fresh liquid is brought into contact with the film, bringing with it nutrients and new recruits to join the film. The liquid moving downstream towards the distal end of the system carries bacteria released by the maturing film along with excreted matter.

- The surgery provides an ideal temperature range: dental surgeries are normally maintained at “room temperature” for the comfort of patients and staff. This is good news for the film-forming bacteria as they can thrive in this temperature range.

Why is biofilm bad for the practice?

The presence of biofilm is bad news for the dental practice on a number of practical levels not least because the quality of output water is covered by HTM 01-05 guidance and the presence of biofilm makes compliance with this standard very difficult. The existence of biofilm can lead to a reduction in water flow and even tube blockage leading to unit downtime and repair costs. In addition, biofilm can potentially accommodate large numbers of bacteria without any noticeable change in colour or smell and these symptoms are not an accurate indication of whether water lines are contamination free.

The guidelines do clearly state the acceptable maximum level of microbiological contamination in section 6.79. Where monitoring is carried out the microbiological contamination expressed as TVC (total viable count), the number of viable bacteria per millilitre of water (cfu/ml) should be expected to lie in the range 100 to 200 cfu/ml. This is similar to the quality that would be expected for mains supplies or bottled water.

The guidelines then go on to indicate a range of measures that can be used to reduce contamination and include the emptying and storage of water bottles at the end of each working day, the use of disinfectants “periodically” as a prevention measure, although no definition of “periodically” is provided and the flushing of water lines; “for two minutes at the beginning and end of the working day and after breaks. They should also be flushed for 20-30 seconds between patients.” Despite this recommendation however, the guidance acknowledges that flushing has little effect on biofilm build-up.

How clean is your water?

For many years the problem of biofilm in DUWLs has been studied and data collected that clearly demonstrates the presence of biofilm reduces water quality, making it unlikely to meet the minimum standards required by HTM01-05. In a study by Walker et al 2009, 95 per cent of samples taken from DUWLs had contamination levels above the current standard for EU drinking water. So in order to establish the quality of output water a practice needs to be aware of the quality of its input water and then regularly monitor levels of contamination.

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Effective solution

For over two years now, a manufacturing company based in Derby has been studying biofilms in DUWLs and the associated water quality in these systems. Extensive laboratory evidence has been collected and has clearly shown the challenge of managing DUWLs within the DH guidelines. The presence of biofilm in a DUWL system will add bacteria to the TVC of the input water, so to have any chance of compliance, the input water TVC must be well below the 200 cfu/ml limit.

The development by Dentisan of Bioclear as a solution to the problem of biofilm was a direct response to the research findings. The challenge was to develop a material that meets all the needs of the dental practice in terms of ease of use, reliability and safety and yet is effective in controlling and preventing biofilm and at the same time not harmful to the dental equipment itself.

Practical development work was undertaken at Nottingham University School of Biosciences using an initial grant provided by Medilink, and in lab trials Dentisan was able to clearly demonstrate that Bioclear has proven efficacy against the bacteria that make up biofilm, inhibiting re-growth of the film and enabling a system to maintain water quality of <200 cfu/ml, in line with HTM 01-05 section 6.79, subject to input water quality.

Biofilm was grown in a flow cell using bacteria obtained from a dental unit water line sample and allowed to develop for 10 weeks, the images show that the Pseudomonas aeruginosa biofilm was effectively removed by the product flowing through the cell.

References
The hands are a dental practitioner’s most important tool and as such need to adhere to the same stringent methods of cleaning as all other equipment used in the surgery. Both patients and staff can be put at serious risk of infection from pathogenic invaders as a result of lethal bacteria being spread around the practice environment by touch. This makes good hygiene protocols a must to prevent infection transmission within a clinical environment.

For instance, it is essential that before any surgery begins, any cuts or lesions on the clinician’s hands must be securely covered with a waterproof dressing before touching a patient’s mouth, as blood or saliva born viruses can enter or leave the body via open wounds.

The simplest method to ensure the removal of germs is the thorough washing of hands, and if you use the correct hand washing procedure with just hot water and soap, you should be able to destroy the majority of bacteria.

All jewellery should be removed before washing as pathogens also collect on them. The best washing procedure for your hands using soap and water should involve:

- Rubbing palms together, including wrists
- Rub the right palm over the back of the left hand, and left palm over the back of the right hand
- Rub palms together, with fingers interlaced
- Rub the backs of the fingers to opposing palms with fingers interlaced
- Rotational rubbing of thumbs clasped in opposite palms
- Rotational rubbing of fingertips in palms

This should take around 50 seconds and is more effective with a liquid wash solution. You should then rinse your hands thoroughly under running water. It is essential that this procedure is performed meticulously not only after visiting the toilet and before handling food or drink but also upon entering the surgery, before putting on gloves, after removing gloves, before leaving the surgery and after clearing a working area or handling any instruments.

Washing is made more effective when combined with the use of gloves and disinfecting alcohol rubs. The latter is very effective in reducing the spread of lethal bacteria such as MRSA on the hands of dental staff.

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However, there may be some side effects in the regular use of skin-cleansing products, as it can be detrimental to the condition of the skin. Indeed, weaker skin is more prone to skin complaints and cracking and this can deter some practitioners from being quite so main hygienic, but also that hands not only remain hygienic, but also that the professional does not suffer any ill effects.

To help this, use soap-free hand washes and find a rub that can minimise dryness and irritation. In addition, at the end of each clinical session after washing and drying your hands, enlist the use of a water-based moisturising cream or lotion to maintain healthy skin on hands and arms.

Allergies are also a severe issue for many people, and these can be linked to perfumes, colours and materials, such as latex. Those with such allergies can struggle to deal with them in a clinical environment, as the materials that trigger them are so crucial to the infection control procedures used in many surgeries.

For example, the natural rubber latex (NRL) is the material used in the manufacture of medical gloves and yet the number of people with allergic reactions to it is on the increase, especially among those in the medical field.

These reactions are due to the naturally occurring proteins within the material or additives used within poorer quality gloves and can result in a red itchy scaly rash, which may spread to other areas.

Direct contact is not the only thing that can trigger these reactions either. Inhaling latex powder from powdered gloves can also lead to these severe issues and in the worse cases, anaphylactic shock.

When wearing gloves is a necessity for your work in the dental industry, such allergies present a real obstacle in maintaining hygiene regimes. However, this problem is recognised by many supplies of gloves and as such, latex-free surgical gloves are now available. These can be worn without discomfort whilst still upholding rigorous infection control policies.

With the heightened awareness of infections and viruses in the healthcare environment, complying with the new HTM 01-05 requirements regarding hand hygiene should be essential to every practitioner.

The best products should be used in the washing, disinfecting and moisturising of their hands. However, practitioners need not put themselves at risk in order to have the most effective solutions.

With this in mind, suppliers, have produced hand disinfectants, along with soap free hand washes and protective emulsion with the aim of getting the perfect balance between infection control and your comfort.

All staff members should be advised to use hand-cleansing products, such as these, to give themselves and their patients the best protection possible from detrimental pathogens.
How we did it

Dental Tribune talks to practice manager Janet Edwards on infection control

With all the changes to dentistry with HTM 01-05 and CQC, one practice has adopted the guidelines to suit them and work with their practice and not against it.

The changes that have been made at Hoghton Street Dental Practice has generated masses of attention; practice manager Janet Edwards has been invited to speak at this year’s BDA conference and Schülke UK used Hoghton Street Dental Practice for the re-filming of their training packages in infection control.

Janet talked to Dental Tribune about their experience and how they achieved and managed to comply in the best way that they could...

“In the beginning we went in to it blind with just the BDA guidance on infection control. To enable us to create a sterilisation room we took over another part of the building that our practice was in. We relied a lot on our equipment supplier, Eschmann, and Martin Loftus, Business Development Manager at Eschmann, was a great help. Martin helped us with the design, setting up the flow-through and the completion of the room. Initially we had looked at dividing the room into two rooms but due to practicalities, it was decided that it was best to leave it as it was. In the room itself we’ve got four underbench washers and four autoclaves and at my other branch site I’ve got three underbench washers and four autoclaves. We basically compiled with best standards.”

However, complying with best standards wasn’t the only thing that Janet’s practice did. After the draft of HTM 01-05 came out in 2008, and Martin Fulford, BDS MPhil DGDP FIRMS, had audited for the practice, advising on training issues and even magnifying lights, Janet started making additional advances towards infection control that have since made her practices stand out.

“When the room was up and running we developed our own system that enabled us to trace instruments: This way if there is ever a query about a patient over a blood born virus we can prove that the tray of instruments that the patient had been treated with had gone through that particular washer, on that particular cycle, in that particular autoclave and we would know that the daily tests had been carried out on all the equipment. Basically, we validate the disinfection and sterilisation for patient instruments. "I believe no one else does this and we’ve had quite a few practices coming in to see how we work it and how we’ve developed it and they’ve taken some ideas away with them.”

Issues

However, as with any form of change, there were issues along the way, as Janet explained:

“One of the issues that was noticed when the washers were in use was that the number of handpiece repairs were in...
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creasing rapidly; we have since put in a handpiece cleaner in the machine which has drastically reduced repairs.”

Another point to remember is cost. With changes to your practice comes a price, such as setting up the room, the costs of running machines and changing your electricity supply.

“Many machines that are used could overload the current supply that a practice has and this is a cost that people need to be aware of,” Janet said.

Going back to validation, Janet explained the process of having the machines validated and serviced, the daily and weekly tests for protein residue and how the washer disinfectors and the autoclaves need to have printers or data capture loggers. Janet described how they’ve not only got printers on the autoclaves but how they’ve also got data capture on the washer disinfectors: “The data is downloaded on a monthly basis and saved on two different computers so we’ve got it backed up.”

The traceability side of things is something extra that the practice offers, but ultimately it’s a backup for the practice.

Rotation system
Janet’s practice also has a heat seal machine for the bagging and storage of instruments, and looking into finer details they have a tray rotation system to ensure that no trays are forgotten about. Janet also explained that if a practice has just been using autoclaves in the past they would be used to a 12-15 minute cycle: however, with a washer disinfecter the cycle time can be up to an hour.

are the sorts of things that people need to be aware of!”

“You have to look at the number of instruments that you’ve got and the turnaround time of getting those instruments back; we had to increase on the number of instruments that we had in the practice and that added to the costs. These did notice with the patients was that when we moved to the instruments being bagged in the heat machine and breaking the seal in front of them, we had comments from patients saying “that’s new isn’t it?”. When they do notice we explain to them that once the instruments have been sterilised this is how they’re stored so they don’t get dirty before they enter the patients’ mouth.”

“In the end I think it’s important that you do as much as you possibly can with the premises and circumstances that you’ve got; at the end of the day it’s one of those things that we can’t avoid.”

Janet will be speaking on Thursday 19th May 2011 at the British Dental Conference and Exhibition at the Manchester Central Convention Complex (MCCG), Manchester, (Thursday 19, Friday 20 and Saturday 21 May 2011).
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Looking after the face of your practice

Jane Armitage discusses bad receptionists

With all the talk of changes to dentistry, the CQC and new contracts, it is very easy to drop the baton and quickly become absorbed in other areas. It made me think...

In December I was admitted to Hospital and diagnosed with confirmed H1N1; on my discharge I was asked to contact my GP to be checked. So pumped with enough steroids to make me look like a beached whale, a non-existent voice and a peak flow of 310 I tried to do this simple request.

Have you ever tried to get a necessary appointment and fail to get past the receptionist?

Here I was struggling to breathe and all I got was “sorry no appointments today, you will have to ring again tomorrow”. I explained that the hospital had asked for someone to check me, but this made not the slightest bit of difference. I also needed a letter signed for the cancellation of my holiday and it required returning within a set amount of days or my claim would be void; the reply I got was “It will be at least three weeks - there other people before you.” I didn’t question her and I walked away - all I wanted was to be able to breathe, I do find it helps.

What an impression this young lady set for that practice. I left feeling worse than when I went in.

Rang the practice later, spoke to a different receptionist and the outcome was totally different. So how does this behaviour fit in to the CQC requirements? I am sure there are certain CQC outcomes where this action did not meet the standards.

As a practitioner working in surgery you can’t see what happens in the reception area; you rely on the professional behaviour of your staff to represent the standards you set. Speaking as a manager, although you try, you can’t see everything that is going on. I believe the face of the practice is the receptionist. She is the first contact point and her attitude can determine if a patient stays or leaves the practice. At the present time as an NHS practice UDAs are vital we need to achieve. As a private practice you can’t afford to lose patients at the first hurdle.

This has led me to question my own reception staff. Are they all singing from the same hymn sheet, do they go that extra mile? Sometimes you take things for granted everything’s ticking over nicely, nobody’s complained so why question. Well, how many have felt uneasy with a receptionist’s attitude or comment, not complained and instead gone to a different practice?

How many lost UDAs, how much lost income? You just wouldn’t know.

With this thought I decided to ask someone to contact the practice as a mystery shopper and ask various questions, some problematic to the reception staff. As a busy practice we quite often have more than two receptionists so I praved that their training had worked. The one area that we failed was a trainee nurse answering the telephone. No disrespect, but with this made not the slightest difference her and I walked away - all I got was “sorry no appointment and fail to get past the receptionist.

Our trainee dental nurse has had limited access to the reception, I understand she was only trying to help during a busy time but sometimes it is a better idea to answer the phone and collect the patient details and allow a trained receptionist to ring them back, rather than trying to accommodate and answer non-clinical questions when some of the answers you are uncertain of. This isn’t helping but could create trouble for the practice.

Before tackling any question you have to be certain of your answer, ensuring that any clinical question is referred to the appropriate clinical person.

This exercise taught me to ensure anyone answering the telephone or face to face conversations with patients had the appropriate training before entering the world of patient contact.

I have learnt from this experience, what I did to our staff may not be nice way of checking but it certainly is a worthwhile exercise where everybody can learn from the outcome.

Remember that the face of the practice is the receptionist.

About the author

Jane Armitage is an award-winning practice manager and has almost 40 years industry experience. She is currently a practice manager for Thompson & Thomas, and holds a Vocational Trainer award. She is also a BDA Good Practice Assessor, BDA Good Practice Regional Consultant, and has a BDA Certificate of Merit for services to the profession. She has her own company, JA Team Training, offering a practice management consultancy service, which includes on-site assistance covering all aspects of practice management with a pathway if required for managers to take these qualifications in dental practice management. If you’ve any memories of the early 1970s or any specific choices of topics you’d like addressed, call Jane on 0114 234 3346 or email janearm@tiscali.co.uk.
More and more adults are willing to undergo orthodontic therapy for cosmetic reasons. However, they usually want the appliance to be as inconspicuous and comfortable to wear as possible.

In many cases, splint therapy can be applied successfully, e.g. in case of anterior crowding in the upper and lower jaw. In this case the anterior crowding was treated with In-Line splints from Rasteder Orthodontic Laboratory, (www.in-line.eu).

Initial Situation
The 29-year-old patient was not content with the position of the upper lateral incisors and expressed a desire to have them corrected with a therapy which should be as invisible as possible.

In addition to treatment with the near-invisible In-Line splint therapy the possibility of a lingual treatment was also explained to the patient.

A combination of mandibular lingual and maxillary plate apparatus would also have been possible, but this option was not acceptable to the patient because of the coverage of the palate and the resulting impairment of speech.

The proposal of a lingual treatment took into account the patient's desire for an invisible treatment, which could also have rectified the deep overbite. Braces made of tooth coloured ceramics were rejected by the patient on aesthetic grounds.

The patient was comprehensively informed about the various treatment options. Among other things, he was shown a sample of an In-Line splint so he could get an impression of the material, the robustness and the thickness of the splint. This solution met his need for comfort. Wearing is comfortable, as the upper arch splints rest on the teeth only. The splints affect the patient's speech only slightly and are visually barely noticeable.

Course of therapy
In this case, both the upper and the lower jaws were treated with five splints each. The patient was given new splints successively at individual check-up appointments, at intervals of approximately six weeks.

To create additional space, inter-proximal enamel was slightly reduced in the mandibular front area. Care was taken to ensure that the splints worn had done their complete work and were now seated precisely and without tension.

In this particular case, in the preparation of the splints a tooth movement of about 0.5 mm was performed. The patient was given new splints at individual check-up appointments, at intervals of approximately six weeks.

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mm in the maxillary arch and of about 0.4 mm in the mandible per splint was programmed and implemented accordingly.

After six months, the treatment goal was essentially reached after the wearing of the fourth splint (Fig. 4 and 5).

By his compliance, the patient made a significant contribution to the excellent course of the treatment, since he had worn the splints for the recommended time of at least 18 hours a day.

Subsequently, the patient received the fifth pair of splints for fine adjustment and retention. For long-term stabilization, after initial hesitation on the part of the patient, a 0.019 x 0.025 wire retainer was bonded to the rear of the anterior segment of both arches.

Thanks to the patient’s very good compliance, with In-Line splints the planned result was achieved in about the same time period and with comparable results as with fixed appliances.

Despite the difficulty of vertical tooth movements with removable splints, a slight bite elevation resulted in the anterior region (Fig. 6). The de-rotation and alignment of the mandibular canines also succeeded well, and the patient is very satisfied with the results achieved.
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Disputes are not uncommon occurrences in the dental practice. Therefore, it is worth learning preventative measures that can be taken to avoid such disagreements, and effective methods of dealing with them if and when they take place.

To help professionals run a smoother surgery, Smile-On has provided a series of modules concerning communication and teamwork. Due to popular demand, a new module has been added to these topics in this series.

Communication and Conflict

Do you consider the word ‘conflict’ and ‘teaches professionals the most effective methods of gaining this from patients. Practice staff will learn ways of concisely explaining treatment options to patients as well as methods of promoting patient autonomy.

Communication and Conflict: Demonstrations to better understand the causes of complaints and how to avoid them. This module will also teach professionals how to manage and resolve conflicts efficiently and demonstrate how they can be beneficial to your business.

Recording Communication: This module discusses the value of recording conversations and emphasises the need for sensitivity and confidentiality. Practitioners will learn the types of conversation in the surgery that should be recorded.

For more information please call 020 7400 8989 or email info@smile-on.com

The OPRI Pico Microscope from Nuview

The OPRI Pico Microscope, designed by Carl Zeiss and created especially for the dental profession, represents a significant advancement in dental magnification and illumination. Already established as a specialist area like endodontics, the Zeiss Dental Microscope also carries an added bonus that generally new to the practice, it has been on sale for less than 2 years. The OPRI Pico Microscope comes in a range of different magnification - from 5x to 15x - and is substantially easy to use. A calming mixture of a smooth and pinpoint-precise Eyepiece Pro prismatic loupe comes in a range of 10 models. The Zeiss ProView Eyepiece loupe is as recommended to be used to overcome the outcome and simply even the most complicated of dental procedures.

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Are you interested in how to deal with your patients with regards to the effects of registration in respect of the transfer process, which is a concern for those who are currently in the process of a purchase of a dental practice. This is in guidelines for dental practitioners.
The recent Dentistry Show held in Birmingham featured a number of symposia presenting the latest thoughts in patient management and treatment modalities.

A session reviewing the latest trends in evidence-based prevention and management of periodontal disease was presented by Dr Anousheh Alavi, Colgate Scientific Affairs. This session provided an overall perspective for an integrated team-based approach, with particular reference to dental hygienists and therapists, discussed the evidence base and highlighted gaps in our clinical practice which could impact on the delivery of optimised prevention and care.

Dr Alavi began by revisiting subgingival plaque and the characteristics of biofilms, highlighting it is the particular composition of subgingival plaque biofilm in a susceptible patient which determines whether gingivitis progresses to periodontitis. Dr Alavi went on to briefly discuss a patient based approach to the management of periodontitis, and reviewed the skills and abilities each registra
t group would bring to benefit the patient. In addition, the GDC ‘Principles of Dental Team Working’ document includes a section on working effectively as a team.

She then summarised the evidence for what we advise patients to do. Evidence based dentistry includes the integration of best evidence, clinical judgement and patient values and circumstance. There are varying levels of filtered and unfiltered information which determine the quality and strength of evidence. Dr Alavi outlined the different degrees of strength of evidence as stated in the Department of Health guidance document ‘Delivering Better Oral Health—An evidence-based toolkit for prevention’.

Delivering Better Oral Health provides advice and support that should be given to patients presenting with or at risk of periodontal disease, and includes a list of conditions that predispose patients to periodontal disease. We need to ensure we provide patients with evidence-based advice, which requires us to be up to date on latest evidence in effective mechanical plaque removal, effectiveness of chemotherapeutic agents in toothpastes and mouthrinses, and evidence for therapeutic dosage of active ingredients.

It is also important to remember, in light of recent emerging evidence, patients with periodontal disease may be at risk of diabetes, cardiovascular diseases, adverse pregnancy outcomes and pulmonary diseases.

Dr Alavi concluded that as clinicians, we are as responsible for the periodontal health of our patients and its maintenance, as we are in diagnosing and managing periodontal diseases. The prevention and management of periodontitis requires consideration of the patient as a whole, and should be seen as a life-long process, shared between us and the patient. It is our responsibility and duty of care to assess the evidence for the advice we give and the efficacy of the products we recommend on behalf of, and for patients. There are key areas on mechanical plaque removal which need more robust research into patient home care regimes to optimise periodontal health, and this is a genuine opportunity for our current generation of clinicians.

References

Update on prevention & management of periodontal diseases

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The Clinical Innovations CONFERENCE 2011

Friday 6th and Saturday 7th May 2011
The Royal College of Physicians, Regent’s Park, London

Confirmed Speakers are:
Nasser Barghi, Eddie Lynch, Julian Webber, Wyman Chan, Tif Gureshi, Julian Satterthwaite, Trevor Burke, Bob McLelland, Peet Van Der Vyver, Wolfgang Richter, Liviu Steier, James Russell, Jason Smithson, Eddie Scher

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management of periodontitis, and reviewed the merits of engaging the whole dental team. The General Dental Council (GDC) publication ‘Scope of Practice’ sets out the skills and abilities each registrant group would bring to benefit the patient. In addition, the GDC ‘Principles of Dental Team Working’ document includes a section on working effectively as a team.

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