Massive patient recall after breach by dentist in Nottinghamshire

Thousands of patients treated by a dentist at Daybrook Dental Surgery in Gedling near Nottingham have been recalled by NHS England in Nottinghamshire to be tested for blood-borne viruses. Dr Desmond Jude D’Mello was recently suspended for 18 months by the General Dental Council for violation of cross-infection control standards in multiple cases. Police are also investigating the death of a woman believed to have been treated by the dentist and who died of viral acute myocarditis last year.

By Dental Tribune International

Over 20,000 patients have been placed at low risk of being exposed to hepatitis B or C and HIV. (Photograph Minerva Studio)

Millions lost to front-line health care abuse in Northern Ireland

Health and dental care worth £44 million were lost to cross-country fraud last year. Health and Social Care in Northern Ireland has reported. It said that, of over 30,000 dental and ophthalmic treatments claimed for exemption in the region in 2013, over 8,000 have been under investigation owing to charges of abuse.

More than 400 people have been removed from general practitioner lists in the last 18 months owing to fraudulent activities and more than 200 are facing legal action.

In most of these cases, exemption from health care charges was claimed under false pretences or fraud was committed by staff submitting false time or travel sheets. In one case, for example, £25,000 was claimed by a nurse forging her manager’s signature. The total loss is estimated at 3-5% of the region’s health care budget, which is £4 billion.

By Dental Tribune International

Fraud affects us all. All organisations suffer as a result and the health service is no exception. Every penny lost to fraud means less to spend on front line services, meaning that the range of treatment and care we may receive is severely reduced,” commented Northern Ireland’s Health Minister Jim Wells on the figures.

He said that the government is doing everything possible to investigate fraud and recover money lost, but support is also needed from the public to tackle the problem.

“No one is above the law. I would encourage everyone within the Health and Social Care system to familiarise themselves with how to report it and ask the public to ensure that they are aware of what they are entitled,” Wells said.

Since 2013, the service has been working with Counter Fraud Services to detect and prevent cases of fraud. This collaboration has resulted in a conviction rate of 96 percent, according to Health and Social Care.
GDC suspends dentist in rare case of malpractice

By Dental Tribune International

The General Dental Council (GDC) has reported that it is suspending the registration of a dentist from Northern Ireland, after a public hearing held by the disciplinary panel in London found him guilty of over 100 charges of malpractice. According to the council, he will be banned from practising dentistry for five years unless he exercises his right of appeal against being struck off the register within 28 days.

The suspension is a rare case of a member of the dental profession in the UK facing such a high number of malpractice charges. In addition to allegations of having misdiagnosed oral lesions and other conditions that led to the development of oral cancer, the council said that he had failed to carry out biopsies when necessary and misinformed patients about their condition.

Other charges against him involved poor patient management and record keeping. The council said that he had mistreated 27 of the patients he saw while working as consultant at the Royal Victoria Hospital’s School of Dentistry in Belfast between 2006 and 2010. He was removed from the post when patients he had treated presented with symptoms of oral cancer.

Until August, he had worked as a dental educator at Queen’s University Belfast, but lost in an unfair dismissal case.

Rise in endocarditis despite antibiotics guidelines for dentists

By Dental Tribune International

Scientists at the University of Sheffield have identified a significant rise in the number of people diagnosed with infective heart infection alongside a large fall in the prescription of antibiotic prophylaxis to dental patients owing to respective guidelines introduced several years ago. The researchers suggest that their results will provide the information the guideline committees need to reevaluate the benefits of administering antibiotics as a preventative measure.

The pioneering study is the largest and most comprehensive to be conducted with regard to the National Institute for Health and Care Excellence (NICE) guidelines, which recommend that dentists no longer give antibiotics before invasive treatments to patients considered at risk of the life-threatening heart infection infective endocarditis, which in 40 percent of cases is caused by bacteria from the mouth.

One of the largest assessment ever conducted on the disease, the review was looking at epidemiological data from more than 70 studies involving 500,000 patients from 37 countries. While it provides insight into the realities of the disease, according to the researchers, the results will have to be treated with caution owing to the problem on how to actually measure periodontal disease. A new standard introduced by the American Academy of Periodontology and the US Centers for Disease Control and Prevention in 2007, for example, makes it difficult to compare any data collected prior.

In the report, the researchers indicated any site with Community Periodontal Index of Treatment Needs – 4, clinical attachment of larger than 6 mm and pocket depth of 4.5 mm periodontitis.

Barts study on severe periodontitis reveals looming crisis

By Dental Tribune International

The research was funded by a grant from the National Institute of Dental and Craniofacial Research.
Dental materials: Are we all deviants?

Dr Thomas O’Connor, London

When I was training at university, every stage of a procedure was supervised, step by tedious step. The “idiot sheets” (as our restorative dentistry professor called them) for each material were available to be referred to and followed religiously. Deviating from those instructions was not an option.

A few years into practice, it begins to be difficult recalling what was said about which particular materials. You know that you were told what was compatible with what, and what was not. When a sales representative turns up with something wonderful and new and better, a little alarm rings in your head, cautioning you that what the representative is telling you is contrary to what you were taught. But no, the representative quite confidently assures you that the research says, the studies show and the in vitro trials prove. And most importantly, the new product is faster. Yes, faster, much faster. You can save a whole 30 seconds per procedure. You do not have to wait for the next step: this does two steps in one or even three, if you want to be really good. And faster is better.

At this point, you begin to regret your failing recall of material science. How am I supposed to evaluate which material is best, when each of the glossy brochures shows that they are all better than each other?

“Maybe we all have a bit of that in us.”

The truth of the matter is, of course, that virtually all of the mainstream products out there are fit for purpose. What makes any material good, bad or indifferent is how the clinician uses it, including skill, time, effort and the amount of care. Even the best of products is going to be rubbish in the hands of someone who uses it badly.

“Lithium disilicate crowns are useless,” I was told by a dentist recently. “Every one I have placed has fractured.” With twice as many years of clinical experience as me, this dentist was preparing for this material exactly as he would for a porcelain-fused-to-metal (PFM) crown, using a coarse diamond fissure bur. The same internal angles, same margins, same lack of surface finish, same flat occlusal surface on the preparation that he had always had, and cementing the final product with glass ionomer. This had served him well for PFM crowns, but this new material was letting him down.

What was his conclusion? The material was to blame. Progress was a bad thing. He was going to stick with what he knew worked, full coverage PFM crowns for everyone, and disregard progress.

Maybe we all have a bit of that in us. All of the exact details of every process can be lost in the day-to-day stresses of the workload. That little step being skipped just this once, then once again, and then another step gone the next time. It is the normalisation of deviance: people becoming so accustomed to deviating a little from procedure that “they don’t consider it as deviant, despite the fact that they far exceed their own rules for elementary safety”. Just skipping that little step this time, not performing the process exactly to the manufacturer’s instructions, finding a way that is convenient, and assuming no responsibility for the results of the deviance. When something goes wrong, when a restoration fails, when a patient is in pain, it is the fault of the material, or the patient, or the laboratory or the nurse.

The next time you are placing or cementing or layering, stop and ask yourself: am I being a deviant? Refer to your idiot sheet and take the time to recall the correct process step by step. And deviate back to normality.
The recent news that 22,000 patients of a Nottinghamshire dentist are being contacted and offered testing for blood-borne diseases, such as HIV and Hepatitis B and C, is truly shocking.

Every patient treated by Mr Desmond D’Mello over the last 3 decades is being urged to contact NHS England for testing, because of concerns about the standards of clinical care at his Nottingham surgery, primarily in relation to infection-control procedures. It is reported that NHS England were contacted by a whistle-blower in June 2014 and as a result Mr D’Mello has been suspended. Covert filming at his surgery apparently shows, among other things, failure to properly sanitise equipment and the re-use of dirty gloves. NHS England has assessed the risk of infection as low, but the concern that his patients are experiencing is completely understandable.

Dentists are subject to regulations that cover all aspects of clinical practice, including cleanliness and infection control. It is the responsibility of the Care Quality Commission (CQC) to inspect dentists, such as Mr D’Mello, and to ensure that fundamental standards are being met. According to the CQC, an inspection of his practice last year raised no cause for concern. However, in light of the information received by NHS England, a re-inspection identified failings in cleanliness and infection control standards, safety and suitability of equipment and monitoring of the quality of service.

No doubt questions will be asked in due course as to whether these failings could or should have been identified sooner. It is however, worth placing this undoubtedly troubling case into context.

Earlier this year, my law firm Sintons made a Freedom of Information Act request to the CQC in order to determine the level of enforcement action undertaken by the CQC in the dental sector. The response clearly demonstrated that the overwhelming majority of dental practices are compliant with the regulations and that the breaches that have come to light in this case are an exception to the rule.

By April 2014, there were over 10,000 locations where dental services were provided in England. The CQC undertook 5,720 inspections, which resulted in 34 warning notices being issued based on breaches of regulations. The warning notices stipulated a time period for the provider to take the necessary steps to remedy the breach.

The most common breach that was identified during the inspections were eight instances relating to cleanliness and infection control (down from 20 cases in the previous year). A failure to assess and monitor the quality of service provision accounted for a further seven warning notices.

In every case where a warning notice was issued, the provider responded appropriately and addressed the breaches to ensure future compliance. Consequently, the CQC took no further action.

The CQC have recently published their planning for the way primary care dental services should be regulated and inspected in the future. One of their priorities is to develop an approach to inspection that protects the public from unsafe care. While such an approach is welcomed, hopefully this troubling case in Nottinghamshire will not detract from the fact that the majority of dental services are safe and that the quality of care is good.

Amanda Maskery

Amanda Maskery is one of the UK’s leading dental lawyers. She is Chair of the Association of Specialist Providers to Dentists (ASPD) in the UK and a Partner at Sintons law firm in Newcastle. Amanda can be contacted at amanda.maskery@sintons.co.uk.
New US government regulation eyes mercury disposal by dental offices

By Dental Tribune International

WASHINGTON, DC, USA: Despite its known negative effects on the environment, tons of mercury derived from removed amalgam dental fillings end up in public wastewater systems in the US each year. New rules proposed by the Environmental Protection Agency (EPA) last week aim to reduce the threats posed by improper waste disposal by making it mandatory for dentists nationwide to employ amalgam separators, among other measures.

With the new regulations, which are part of the Clean Water Act, the agency hopes to decrease toxic metal discharges, including mercury, by at least 8.8 tons a year. In order to reduce the financial burden for states and localities, which would have to implement and oversee the new rules, EPA also announced initiatives to streamline oversight requirements of the dental industry. After submission to a public comment period and hearing in November, the rule is expected to become effective in September next year.

EPA estimates that up to 3.7 tons of mercury are released annually from dental offices in the US, which equals 50 per cent of the total mercury released by dentistry and other industries into the public wastewater system, according to the Zero Mercury Working Group in Vermont. While amalgam separators have been shown to be effective in the collection of the toxic metal before it is released, so far only 12 states, including New York and Massachusetts, have mandated their use in dental clinics. Under the new rules, dentists nationwide would be required to install and use these systems permanently for the very first time.

“This is a common sense rule that calls for capturing mercury at a relatively low cost before it is dispersed into the publicly owned treatment works. It would strengthen human health protection by requiring removals based on the technology and practices that approximately 40 per cent of dentists across the country already employ thanks to the American Dental Association [ADA] and our state and local partners,” commented Kenneth J. Kopocis, deputy assistant administrator for EPA’s Office of Water, in a press release.

The ADA has been recommending the use of separators for disposing dental amalgam through its best management practices guidelines since 2007. Reports show, however, that in states without mandatory use of the devices proper disposal of amalgam waste is still seriously lacking. Asked by Dental Tribune International to comment on the proposal, ADA officials would only say that it is currently being reviewed by their organisation to ensure that it will not place undue burden on the dental profession. Dental clinics that fully comply with the regulations will incur a cost of US$700 a year, according to EPA.

While relatively harmless when used in dental fillings, mercury can become highly toxic when it reacts with specific aquatic microorganisms. This variant, known as methylmercury, accumulates in fish and fish-eating animals, posing serious health risks to humans when consumed. Among other conditions, research has linked it to cardiovascular disease and developmental deficits in children.
Henry Schein opens new UK headquarters

By Dental Tribune International

Almost a year after construction started, Henry Schein opened its new UK headquarters in the Gillingham Business Park in October.

The new state-of-the-art and energy-efficient space and warehouse, will serve as the main office and distribution centre for the company’s dental and medical customers in the UK.

The new facility was built adjacent to the existing Henry Schein UK facility at the site, which was established in 1993. Its new warehouse includes an education centre with a showroom for product demonstrations featuring a wide range of innovative high-tech digital technology. The company is also planning to develop additional warehouse space if more storage capacity is needed.

“This new, outstanding facility is a source of great pride for our company, underscoring our commitment to environmental sustainability, as the project’s planning and construction has taken into account the impact on the surrounding environment,” said Stanley M. Bergman, Chairman of the Board and CEO of Henry Schein, at the opening on 8 October, which was attended by over 500 people.

The company stated that its new facility was built with sensitivity to the surrounding natural habitat and local animal species. Over the course of the project, measures were taken to clear vegetation in an environmentally sensitive manner and to protect and relocate protected wildlife inhabiting the development site, and a trained ecologist made periodic visits to the site. Henry Schein also worked with Medway Council, the government authority charged with providing local services to Gillingham and other nearby towns, to create an acoustic and visual barrier between the new facility and nearby homes by planting trees.

Influx of fake products targeted

By Dental Tribune International

According to figures from the Medicines and Healthcare Products Regulatory Agency (MHRA) in London, over 12,000 individual pieces of counterfeit and unapproved dental products were seized in the UK up to April this year. At the recent BDIA Dental Showcase, the British Dental Industry Association (BDIA) announced that it will partner with major dental and general media outlets, including the BBC, to heighten awareness among dental professionals and the general public of the dangers these products can potentially pose.

In addition to a widespread advertising campaign to be run in the British dental press in 2015, an upcoming episode of Fake Britain, a consumer rights show airing on BBC One, is going to address the situation, which, according to the BDIA, increasingly poses health risks to both patients and users of the products.

While they still represent a small market share, the number of substandard devices purchased by dental professionals has steadily grown in recent years across all segments.

“We are now seeing copies and substandard versions of more complex devices, such as dental X-ray machines and handpieces, being increasingly purchased through the Internet and other sources,” Bruce Petrie from the MHRA told Dental Tribune.

In order to address the situation, the agency in partnership with the BDIA launched the Counterfeit and substandard Instruments and Devices Initiative earlier this year, which aims to make more dentists aware of the problem and to report questionable products to the relevant authorities.

BDIA Executive Director Tony Reed commented. “We are pleased with the very positive reception that our initiative has received and the next step in growing awareness amongst the dental team is the launch of our advertising campaign.”

According to the BDIA, dentists and members of the dental team should be vigilant regarding products of unknown origin and report suspect devices immediately through its website. Products manufactured by reputable suppliers such as BDIA members generally pose no concerns, the association said.
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In a report, researchers of the Global Burden of Diseases, Injuries, and Risk Factors Study have recently shed light on the global dimensions of severe periodontitis, which now affects over 700 million people worldwide. This study is a major effort involving more than 1,000 scientists to systematically produce comparable estimates of the burden of 291 diseases and injuries and their associated 1,160 sequelae in 1990, 1995, 2005, and 2010.

Dental Tribune: How do the results compare to the situation prior to the surveyed period?

We have updated the data from the first Global Burden of Disease (GBD) study and generated comparable figures in 1990 and 2010. Therefore, we were able to compare the current and the previous situation to our survey in 2010. Since the study is unique, we do not have global data before the first GBD study. However, we know that oral diseases have decreased significantly in most industrialized countries, such as the UK and the US, in the last five decades.

Dental Tribune: Prof. Marcenes, the prevalence of severe periodontitis on a global scale has not increased significantly in the last two decades, according to your report. Why are the numbers worrying nevertheless?

Prof. Wagner Marcenes: Having more than 700 million people suffering from severe periodontitis is really worrying. Although the proportion remained the same in 1990 and 2010, the number of people needing periodontal treatment has increased dramatically. This is because worldwide more than one in ten people suffer from severe periodontitis and the world population grew from 5.3 billion in 1990 to 6.9 billion in 2010. Moreover, severe periodontitis tends to develop during adulthood, showing a steep increase between the third and fourth decades of life. With more people living longer and retaining their teeth for life, the risk of developing severe oral health-related problems, particularly periodontitis, will be high. The world’s population is expected to almost double by end of this century, implying that the number of people with severe periodontitis may at least double.

Prof. Marcenes: With more people living longer and retaining their teeth for life, the risk of developing severe oral health-related problems, particularly periodontitis, will be high.

Dental Tribune: In your report, you mention how difficult it is to determine disease prevalence owing to different classification systems. Is your presentation of the situation therefore a realistic one?

I am confident our report provides a realistic, comprehensive assessment of the global burden of severe periodontitis. After much consideration, we used a Community Periodontal Index of Treatment Needs score of 3.4, a clinical attachment loss of greater than 6 millimetres or a pocket depth of more than 5 millimetres as indicators of periodontitis. We used the measurements adopted by the World Health Organization, which are considered by most as the most reliable indicators of severe periodontitis. We endeavoured to reflect the measures adopted by the larger community of public health dentistry.

Dental Tribune: Thank you very much for the interview.
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Online reviews: Does Google really forget?

Naz Haque, Dental Focus

How is your relationship with Google, do you love or hate it? Does it display negative information about your dental practice? With right to be forgotten legislation, relief from career-damaging reviews now seems to be at hand, but does Google really forget?

In May, the EU Court of Justice found in favour of a Spanish citizen who sued Google for listing negative information about him, alleging that this information was prejudicial to his selling approved his appeal, contributing substantially to the right to be forgotten being drafted into European law.

For Google, this ruling opened the floodgate for requests for thousands of links to be removed from its search engine results page from residents in the EU. By July, it was estimated that the company had already received at least 50,000 such requests. Many applicants have made use of lawyers or search engine optimisation professionals, creating a niche for companies, which are charging the price of an implant per month to manage their clients’ online reputation on Google. The company’s hands are tied in this matter. Regardless of its algorithms’ preference in ranking news and media sites, they have to follow this ruling. Recent threats of financial penalties in various European countries have softened Google’s resolve further, and there is a similar ongoing case in Japan. Is it possibly the end of the line?

For some dentists, this could be the long-awaited answer to their prayers. In an era in which online competition is omnipresent, to the patient’s critical eyes, negative reviews can be very damaging to a business. In the past, a lifelong career could be destroyed by unsubstantiated hearsay online. A seasoned professional’s one error would previously always have been visible on Google, possibly damaging that person’s confidence, career and standing. I have numerous conversations about negative Facebook/Well/Google reviews on a weekly basis here at Dental Focus and receive a large volume of phone calls about how to be removed from Google for bad press.

What about data on dentists who have been investigated by the General Dental Council and cleared? Is not making this data available fair to them or do patients deserve to know the full story regardless of how much the dentist has invested in developing or redeeming himself or herself? If you were a prospective patient, would you perform a search and be put off by any negative findings?

No doubt, there is a minority who deserve to be highlighted on Google for all their wrong-doings. What is the position regarding having their names omitted?

In the first week of Google making available a means for search removal requests, 32 per cent (the greatest number by nation) of all applications came from the UK. When requesting removal from Google’s search engine results page, the user must not only list all links he or she wants to be removed, but also provide the reason that he or she wants to have such links removed. Invasion of privacy appears to be a popular reason.

Unfortunately, the company has also had numerous cases of fraudulent removal requests from impersonators trying to harm the competition. It seems that there is always good and bad practice, whatever the medium.

In order to manage this, Google states: “We will assess each individual request and attempt to balance the privacy rights of the individual with the public’s right to know and distribute information. When evaluating your request, we will look at whether the results include outdated information about you, as well as whether there is a public interest in the information—for example, information about financial scams, professional malpractice, criminal convictions, or public controversy on government officials.”

Will you be safe once a link has been removed from Google? There are sites such as hiddenfromgoogle.com that openly display all hidden results. Even if a result has been hidden, the bottom of the results page on Google states that some results have been removed. At times, it even provides a link to hiddenfromgoogle.com. It appears that, even if something has been deleted, Google still knows everything about you. Everything on the Internet is recorded forever.
Advantages of HEMOSTASYL for thixotropic wound dressing confirmed

Results from an empirical comparative study

Dr Sven Schomaker, Germany

Haemostasis has proved fundamental for the prevention of excessive blood loss and for wound healing after injury, or wound setting. It is a basic prerequisite for flawless work in restorative dentistry. There are numerous tissue management systems for haemostasis and retraction on the dental market, including mechanical techniques and locally acting chemical agents, which can be applied alone or in combination with retraction sutures.

In a survey in which German dentists tested the practicality of various haemostatic agents and compared them, the thixotropic HEMOSTASYL (Pierre Rolland, Acteon Group) achieved the best results. Among other things, the gel was found superior in terms of astringent and haemostatic effects, as well as handling properties.

The best means of avoiding possible bleeding complications is a conservative procedure that causes little trauma to the tissues and vessels. In many cases, a sufficient local therapy can also help prevent bleeding complications during and after surgical procedures or reconstruction. In addition to the body’s own haemostatic mechanisms, there are a number of measures and substances in dentistry that support haemostasis. They can be mechanical, chemical, thermal or surgical, or any combination of these. The choice of product or technique depends on the clinical situation (localisation, and the extent or risk of bleeding), as well as on the clinician’s preferences.

Adopting a different approach to the products available on the market, Pierre Rolland introduced a new type of gel in Germany in 2007. HEMOSTASYL is a thixotropic product for light to moderately heavy bleeding and contains aluminium chloride. Its angled syringe applicator facilitates direct and precise application. The gel achieves its haemostatic effect through a combination of aluminium chloride and kaolin. This is mechanically augmented by the thixotropic properties of the material.

Haemostasis should begin to take effect in less than 2 minutes, after which the treated area should be free of bleeding. The gel is applied with the application cannula, with no pressure exerted on the gingiva. After haemostasis has been achieved, the turquoise-blue substance is removed with a light air and water spray and simultaneously a suction (Figs. 1–4).

In order to determine whether this product offers advantages over other products used for haemostasis, some 1,000 sample packs were distributed to dentists, orthodontists and oral surgeons throughout Germany, along with instructions for use and a questionnaire. Over 900 participants agreed to take part in the test. The questionnaire was developed in collaboration with the Department of Medical Biometry and Epidemiology at the University Medical Center Hamburg-Eppendorf. It consisted of two sections: the first part dealt with general information about other products used for haemostasis and their indications, and the second part asked participants to evaluate HEMOSTASYL and compare it with the other products with respect to haemostatic properties, handling and time to haemostasis, as well as treatment properties.

Over the course of the study, HEMOSTASYL was tested 2,342 times. The majority (69.4%) of the participants applied it four to ten times. The properties of the product were compared with those of more than 13 other haemostatic products, including Viscotstat, Ultrastat, Ultrastringed, Ultra- dent, and Racepstatine, Septodont, which were used by over 50 per cent of the participants just under half of the participants said impression taking was the most frequent indication, followed by composite fillings. Only one in ten reported using it in tooth preparation. Other indications included cementation, temporary crowns, bracket bonding, retainer bonding, and amalgam and CERECK restorations.

Using the Mann–Whitney test, it was determined that the participants rated haemostasis with HEMOSTASYL statistically significantly better than with the other products for the listed indications. Almost 87% (443) of the participants gave haemostasis with the thixotropic gel a score of 1 or 2. Only 69.4% (354) of the participants gave any of the reference products such a high rating.

A result of no bleeding after application of one of the reference products, only 20% achieved this effect. Moderate bleeding with HEMOSTASYL was reported by 32.2% (164) of the participants. With the reference products, only 20% achieved this effect. The aluminim chloride in the gel appears to offer additional enhancement of haemostasis. As it can be applied directly and precisely in the mouth with the angled syringe applicator, it also fared better with the testers with regard to its handling and application. Other advantages are that it can be removed easily with an air and water spray and is easy to detect owing to its high-contrast turquoise colour. In addition, HEMOSTASYL was given a higher rating by most of the participants with respect to the time factor, as treatment (for example, taking an impression or bonding inlays) can be continued immediately after haemostasis with the haemostatic wound dressing under optimal conditions.

Participants also reported other benefits of the product, including painless treatment, particularly when the wound dressing is applied to a healthy periodontium, and high tolerability without undesirable systemic side-effects, as can be the case with haemostatic agents containing epinephrine for example.

Overall, HEMOSTASYL distinguishes itself with its thixotropic properties and consequent ease of application and very good adhesion to the tissue without exerting pressure, as well as the associated mechanical effect. The results proved that HEMOSTASYL is indicated for efficient haemostasis in cases of light to moderate bleeding. With clear indications for use and easy application with reduced risk to the patient, it can be considered another step forward in quality assurance in the dental practice.

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

Editorial note: A list of references is available from the publisher.
“Patients must be at the top of our agenda”

An interview with the Chair of the BDA Health and Science Committee Dr Graham Stokes, London.

In November, experts and researchers from around the UK met in London for a summit organised by the British Dental Association (BDA) to discuss what dentistry can do to address the problem of antimicrobial resistance. Dental Tribune UK had the opportunity to speak with Dr Graham Stokes, Chair of the BDA Health and Science Committee and one of the initiators of the summit, about its outcomes and implications for the profession.

Dental Tribune UK: Dr Stokes, antimicrobial resistance has been identified as a serious threat to public health worldwide in a report issued by the World Health Organization this year. Deputy Chief Medical Officer for England Prof. John Watson recently said that the rise of multidrug-resistant bacteria is creating the perfect storm. Is the summit to be understood as a response to these warnings?

Dr Graham Stokes: The summit was actually held in conjunction with the upcoming European Antibiotic Awareness Day on 18 November. We at the BDA felt the need to convene experts and researchers working in the field of antimicrobial resistance in order to consider the role of dentistry in addressing this difficult problem, in particular working towards improving awareness in the profession and among the general public.

Dentists are responsible for approximately ten per cent of all antibiotic prescriptions in the UK. How much do we know about how many of these are prescribed inappropriately?

Evidence suggests that of all antibiotics prescribed through dentistry, some are indeed inappropriately given. In many of these cases, patients could be treated in alternative ways that may be better suited to their pain. What we need to do is to determine how we can improve that situation by looking at the factors that influence the reason that antibiotics are given in dentistry, both in primary and secondary care. It is also important to work together to ensure that the appropriate treatment is given at the appropriate time to patients. They must be at the top of our agenda.

In a letter published in the recent edition of the British Dental Journal, your colleague Dr Susie Sanderson wrote that the encouragement for antibiotic stewardship in dentistry in the UK is lacking. Would you agree with this statement, and who is to blame for the situation in your opinion?

What we learnt at the summit was that dentists overall feel that they prescribe antibiotics to a minimal extent compared with other fields. They also perceive that pressure from patients sometimes influences whether and how antibiotics are provided, even when other treatments seem to be more appropriate. That is why we need a co-ordinated approach to ensure that there is enough time for dentists to treat patients properly, particularly those who come in unscheduled with an emergency. Such care needs to be appropriately funded as well. There needs to be greater awareness among dentists in general of the problem of antimicrobial resistance, however.

One of the aims of the summit was to compile a consensus report to present at the BDA’s next annual congress in Manchester. How far have you come with this endeavour, and what were the main points agreed on by most participants?

Obviously, there was a wide-ranging discussion on all of the topics and information presented to us. One of the recommendations was that dentists should have properly funded protected emergency slots in their daily work. We also need systems in place to protect dentists when complaints arise after they have performed a treatment that they believed was the appropriate one. Furthermore, it would be beneficial for dentists to monitor their own prescribing patterns so they can ensure the best care for their patients.

It is also important that we inform the public and our patients about antimicrobial resistance and encourage dentists to discuss their antibiotic-prescribing policy with their patients as early as possible. In order to do this, we need to ensure that graduates receive good knowledge of antibiotic prescription through their training and that they know how to translate this knowledge into practice. Leadership from the Department of Health is needed in co-ordinating all of these efforts to avoid repetition in different areas.

What will be the next steps to translate these recommendations into practice?

The overriding approach should one of education for the profession, our patients and the public with regard to antimicrobial resistance and working together with the commissioning bodies to ensure that patient care is put first.

What is the role of the dental profession in the fight against antimicrobial resistance in the future?

In dentistry, we need to ensure that we always provide our patients with the appropriate treatment. As we have regular contact with the public, we also have to educate them about the wider issues of antimicrobial resistance. By working together with our colleagues in medicine, dentists could play a key role in combating this significant problem, which we must all be aware of and take responsibility for.

Thank you very much for the interview.
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Roughening, cleaning and preparing

Sandblasters in dental practice are 'blast' for patients

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Put in the hands of a knowledgeable expert, sandblasting is the method of choice for cleaning and roughening dental surfaces. Long known by dental technicians, there is probably no laboratory in the world right now without a sandblaster—which is used for the removal of investment material residues or the upper, porous, inhomogeneous layer.

However, dentists used to work with subtler methods and on finer objects. Although sandblasting has no effect on soft tissue, there are harder substances which we as clinicians have to work on. For those, mini sandblasters offer a suitable treatment option in dental practice.

I have been looking for means and methods to make the cementing process of reconstructions much safer. In other words, I simply wanted to avoid de-cementing. Every dentist is aware of the complicated situation in which a crown or a post becomes loose. Replacing it can be a nuisance not only due to the treatment fee but also patient dissatisfaction. For those, mini sandblasters offer a suitable treatment option in dental practice. I became aware of the Airsonic Mini Sandblaster through a handout by Hager & Werken, a dental company from Duisburg, Germany. Although similar devices are available from other manufacturers, the favourable price of the Airsonic was unbeatable.

The question remains why sandblasting with the Airsonic by Hager & Werken enhances the adhesion of dental cements. Well, the roughening of the surface during sandblasting results in an overall surface enlargement. These ‘mountains and valleys’ are what we need for the mechanical interlocking which is basically what happens during cementation. There is no chemical process here.

By now, I have optimally prepared numerous crowns, bridges and dental posts for cementation with help of the Airsonic. Moreover, we found another type of application during the treatment of a child patient named David who needed to have his primary molars, that were slightly carious, restored. In the pictures you can clearly see that with the use of the Airsonic, and within a short amount of time, we were able to condition them optimally for the placement of occlusal composite fillings. No disruptive bleeding was observed at the surrounding gingiva tissue occurred, which is a common phenomenon during treatment with a powder jet. Of course, the sand has to go somewhere at the end which is why a good suction technique is required. But this is something we already need when working with a turbine. The Airsonic Mini Sandblaster is delivered with an optional adapter for coupling it quickly to the compressed air supply in dental practices and laboratories. There, it has its uses as well. Hager & Werken also offers the mobile Airsonic Absorbo Box which ensures a clean and fast working environment with abraded material remains and no extra suction system needed. The changeable filter absorbs the abraded material reliably.

Meanwhile, the sand blaster has shown to be an almost indispensable tool for our practice. It is not only cost-effective but is also very reliable. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is very reliable. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differentiates the Airsonic from all its competitors that need the pressure to be controlled via a valve. The integrated valve is what differ
A working opportunity for dental professionals in Europe

One of Europe’s largest and most modern private centres for general dentistry and implantology is looking for talented professionals interested to join its team of leading dentistry professionals that provide domestic and international patients with the highest standards of care by offering a wide range of treatment options. They have created the 21st century dental clinic in order to offer patients a welcoming environment and the very best experience in high-end dental treatments.

The Lausanne Dental & Implant Clinic provides high end implantology (including immediate loading procedures), as well as aesthetic and cosmetic dentistry, dental crowns, dental veneers, CEREC, teeth whitening, root canal treatment, gum treatment, hygienist services and wisdom tooth removal. Every member of the team has many years of focused training and ongoing personal development in the area of dentistry and implantology, in particular.

Located in the Olympic city of Lausanne in Switzerland, the centre consists of 18 large dental private practices and four high-tech surgery rooms dedicated to implantology and oral graft procedures. Inside the complex, a conference theatre hosts a state-of-the-art dental laboratory as well as continuing education courses on a regular basis.

In addition to the Lausanne facility, the group runs two other clinics in the region of Montreux. A new clinic is planned to open in early 2015 in Sion, the capital city of canton Valais. This will be the second largest in Switzerland after their clinic in Lausanne. For more information and how to apply visit www.swiss-dentalclinic.com.