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October-November 2013

Scottish Dental magazine

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ISSUE 5 VOL. 4

Editor's desk

with Bruce Oxley

Whose business is it?

The recent announcement that the ban on HIV positive dental professionals undertaking 'exposure prone procedures' was to be lifted was, as expected, received favourably by the profession.

Dentists, like their medical colleagues, recognise that the advances in anti-retroviral therapy, allied to the strict infection control and decontamination protocols employed within every dental practice, means that any risk to patients is negligable and has been for some time.

However, a matter of days after the Department of Health announcement, a story broke in Scotland that thousands of dental patients in Dumfries and Paisley had been contacted after a dentist had been 'outed' as being HIV positive.

If the individual was working outside the rules, then he/she will probably face some sort of sanction, regardless of the outdated nature of the legislation.

However, the subsequent coverage in the newspapers – with the *Daily Mail* running with the headline 'More than 3,000 patients may have been exposed to HIV after Scottish dentist contracted infection' – raises an interesting, and worrying, question.

I appreciate that the health boards involved in this latest 'scare' have a duty of care and saw it as their responsibility to contact all patients involved. However, if the dentist in question – and this is me hypothesising, I have no insider knowledge of the case – was on medication and his viral load was at a manageable level (i.e negligable) then the patients involved were no more at risk than they would be at any other dental practice.

The question is this: with the new rules allowing dentists with HIV to practise again, do patients have a right to know that their dentist is HIV positive, or is it none of their business?

My personal feeling is that, as long as all the precautions are being taken, there should be no need for these public panics to be issued through the press in future.

I suppose only time will tell if public perception will come round to the same way of thinking. ■

Bruce Oxley is the editor of Scottish Dental magazine. To contact Bruce, email bruce@connectcommunications.co.uk

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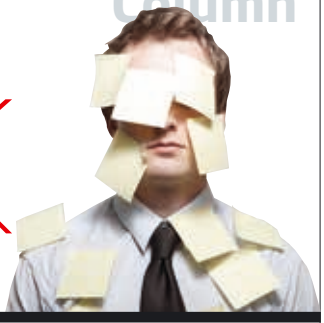

Bullied and blackmailed

In my previous column I discussed the paltry 2.51 per cent uplift in NHS fees which Scottish Government (SG) was proposing – the first fee uplift in over three years and one which will not remotely address the spiralling increases in dental practice expenses.

I have also previously discussed SG's proposal to reclaim alleged 'overpayments' to GDPs resulting from duplicate registrations, i.e. two dentists being simultaneously paid capitation or continuing care payments for the same patient. When a patient registers with a new GDP the computer system at Practitioner Services Division (PSD) should remove that patient from the list of the previous dentist and stop registration payments.

However, it appears that the system was inefficient in doing this and that, for a number of years, some duplicate payments were made outwith the knowledge of the dentists.

The BDA's Scottish Dental Practice Committee (SDPC), which represents the interests of GDPs in Scotland, has vigorously challenged SG's attempts to reclaim these monies from dentists. SDPC argues that it was PSD's inefficiencies that created the problem and this has been exacerbated by SG's policy of continuous registration of patients, dating back to 2006.

BDA Scotland sought legal opinion on the matter and was advised that there was a strong case to challenge at least part of the recovery – that relating to the period 2006-08. This accounted for around £2 million of the total £3.5m proposed clawback so would be a significant win on behalf of Scottish GDPs.

In the light of this opinion, the BDA duly notified SG that it was considering taking the matter to judicial review in order to prevent the recovery of the £2m from the period 2006-08. SG responded with the threat that if the BDA took such legal action then the offer of a 2.51 per cent fee uplift would be completely withdrawn and there would again be NO FEE INCREASE. SG's position was that it needed the money from the recovery in order to finance the fee uplift, effectively giving with one hand and taking with the other!

SDPC held an emergency meeting to discuss the SG ultimatum. The committee found itself with a serious dilemma. It did not wish to yield to threats and bullying from Scottish Government, especially when BDA/SDPC had a sound legal case. However, it also had an obligation to act in the best interests of GDPs in Scotland. I have learned that the meeting lasted several hours while the SDPC agonised over this difficult decision.

"The whole episode leaves a bitter taste and has further soured relations"

In the end, pragmatism prevailed and SDPC decided to withdraw the legal challenge; it reasoned that the majority of GDPs would benefit more from receiving the fee uplift than they would lose from the clawback.

However, the whole episode leaves a bitter taste and has further soured relations between Scottish Government and the dental profession. For SG to threaten to renege on a previous agreement does it no credit and will further deepen the mistrust.

The dental profession in Scotland deserves better than bullying and blackmail.■

DETAILS AND CONTRIBUTORS

Editor
Bruce Oxley
Tel: 0141 560 3050
bruce@connect communications.co.uk

Senior sub-editor
Wendy Fenemore

Sub-editors:
Gary Atkinson
Chris Fitzgerald

Design and production
Lindsay Neill

Advertising sales manager
Ann Craib
Tel: 0141 560 3021
ann@connect communications.co.uk

Subscriptions
Ann Craib
Tel: 0141 560 3021
ann@connect communications.co.uk

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Scotland's biggest dental show is back

Braehead Arena is to play host to the 2014 Scottish Dental Show

Following the success of the 2013 event, plans for the 2014 Scottish Dental Show are already at an advanced stage.

The show will be moving from its home for the last two years, Hampden Park, to a brand new venue, Braehead Arena on Friday 9 and Saturday 10 May 2014.

The new venue provides the scope for more than 130 exhibition stands in one hall, with the speaker sessions entering and exiting directly onto the trade show floor. At the time of writing, more than 40 per cent of exhibition stands have been sold, having been on sale only since the beginning of September.

The lecture programme will again offer up to eight hours of verifiable CPD and, for 2014, we have expanded our scientific committee to include Blackhills Clinic's clinical director Paul Stone and GDP Stuart Campbell who is a partner at Loanhead Dental Practice in Midlothian. They will join our scientific chairman Kevin Lochhead, clinical director at Edinburgh Dental Specialists, who has agreed to help shape the programme for a second year.

The talks will focus on four main streams: Dentists, Dental Team, DCPs and Business/Financial. The final programme of speakers will be announced in the near future but we can guarantee there will be something of interest for every member of the dental team to take back to their practice.

"There will be something of interest for every member of the team to take back to their practice"

We are also hoping to include a series of parallel workshops to run alongside the main speaker programme. Details are yet to be confirmed but are likely to include hands-on sessions, product demonstrations and small group seminars.

The website for the 2014 Scottish Dental Show is currently in development and will be ready to launch within the next few weeks. We are also planning on opening registration before Christmas with details of an exciting prize draw to be included.

THE VENUE

BRAEHEAD: Featuring more than one million square feet of retail, catering and leisure space, Braehead is one of Scotland's largest shopping centres and retail parks. Situated on the south bank of the River Clyde in Renfrewshire it is home to more than 150 retailers and has an annual footfall of 17 million.

Braehead Arena was built in 1999 and is located within the Braehead complex. It was a venue for the 2000 World Curling Championships and is the home rink of the Braehead Clan UK Elite Ice Hockey League team and regularly plays host to concerts, events and ice shows.

Awards. Ceremony relocates to the Glasgow Science Centre and promises a host of new categories

The science of dental awards

The 2014 Scottish Dental Show is not the only event moving to a new venue as the Scottish Dental Awards finds a new home. The Glasgow Science Centre will play host to the 2014 awards dinner allowing up to 450 guests to attend the ceremony.

Opened to the public in 2001, the Science Centre is situated at Pacific Quay opposite the SECC on the River Clyde. It is an independent Scottish charity that was set up to present concepts of science and technology in unique and inspiring ways.

One of the most fascinating attractions in the country, it offers interactive displays, games and activities as well as a state-of-the-art planetarium and IMAX cinema.

The judging panel from the 2013 Scottish Dental Awards is meeting up in the near future to discuss the new award categories, entry requirements and judging criteria. Unlike other awards, we have no plans to start charging for nominations and we hope to be able to offer an awards that is a true celebration – and reflection – of the dental industry in Scotland.

Further details will be published in due course online and in the next issue of the magazine.

NHS funding. Association warns of a decline in patient care if a cash-limited budget is introduced in Scotland

BDA issues budget warning

The BDA has warned that the introduction of a cash-limited budget for NHS dental care in Scotland could restrict the number of patients that can be cared for and prevent dentists providing treatment to those who want it.

The warning, delivered in the BDA's 2013 submission of evidence to the Doctors' and Dentists' Review Body (DDRB), follows notification that such an arrangement is being imposed for the 2013–14 financial year and that it has not been ruled out for 2014–15. The BDA is concerned that its imposition could result in patients going without the care they need.

News of the change has come after a challenging period for general dental practice in Scotland in which the burden of bureaucracy has been increased by changes to the way practices

Above: Dr Robert Donald

are inspected, and funding streams that have helped to solve problems accessing care have been scaled back or withdrawn completely. A 2.51 per cent funding uplift secured this year, while a step in the right direction, fell short of the DDRB's recommendation and does not address the gap opened up by several years of funding neglect, according to the association.

Dr Robert Donald, chair of the BDA's Scottish Dental Practice Committee, said: "We are battling through a challenging period for NHS dentistry in Scotland in which practitioners are striving to provide high-quality care to patients. The imposition of a cap on funding, which effectively tells some patients that they won't be cared for while others are, exacerbates the problems dentistry faces.

"For many years the Scottish Government has worked cooperatively with the profession and, as a result, access to care has been improved and a targeted attack on oral health inequalities has been launched with the widely-heralded Childsmile project. That progress must not be thrown away; it must be consolidated and built on. We're asking for a fair deal for dentistry in 2014 that starts to address funding issues and recognises that patients' needs, rather than cash limitations, must come first."

BADN criticises council

GDC

The British Association of Dental Nurses (BADN) has claimed that the absence of a dental nurse on the new GDC council presents a "void of knowledge on matters pertaining to dental nurses".

In a letter to the GDC's chair-elect William Moyes, the BADN welcomes the appointment of a lay member as chair, saying that it hopes this will lead the council away from its current "dentist focused culture towards one which more equably reflects the diversity of GDC registrants". However, it expressed concerns that of six dental appointees, only one is a DCP – technician David Smith.

The letter continues by saying: "The appointment of just one non-dental nurse DCP to the GDC fails to reflect the importance of DCPs in general and dental nurses in particular."

First prosecution in Scotland for illegal dentistry

CONVICTION

An unregistered dentist from Aberdeen has become the first in Scotland to be prosecuted for practising illegally.

Ronnie Barogiannis, of Lochside Terrace, Bridge of Don, pled guilty at Aberdeen Sheriff Court to a breach of Section 38(1) of the Dentists Act 1984. He was fined £500 – £76 less than the Annual Retention Fee.

He admitted practising illegally at the Bridge of Don Dental Clinic and Research Centre between 3 January and 5 March 2012. He claimed that he had applied to the General Dental Council (GDC) for registration in advance of his relocation from Greece to Scotland, and he only stepped in to help out when the surgery had just opened, despite not having received his papers.

The GDC confirmed that Mr Barogiannis had made "two or three" applications since June 2011 but that they had been incomplete. NHS Grampian stated that he has never applied to be included on their dental list.

Speaking to *The Herald*, Mr Barogiannis said: "This whole thing has been terrible. I made a stupid mistake and it has been a very difficult experience for me. I will have to start my career all over again.

"I am sorry about what has happened. I haven't worked as a dentist in more than two years but I made a mistake and it was wrong."

The case marks the first time a prosecution for the illegal practice of dentistry has been launched in Scotland. It was brought about by Police Scotland and the Procurator Fiscal, helped by the GDC.

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A 'victory for human rights'

The ban on HIV positive dental professionals treating patients has been lifted under new plans revealed by the UK Government.

Following years of campaigning, outdated rules stopping dental professionals with the virus performing 'exposure prone' procedures have been scrapped, bringing the UK into line with countries such as Sweden, France, New Zealand and Canada.

Dental Protection's dental director Kevin Lewis (pictured), whose organisation have led the fight to lift the ban on HIV positive workers, said: "This is a huge victory for human rights. After decades of living in fear and dealing with prejudice, dentists can finally return to their professional calling, although regrettably it is too late for some to do so. Patient safety should be at the forefront of healthcare, but the original rules were introduced as a reaction to a mysterious and exceptional case, the likes of which we have not seen before or since.

"We have long pushed for the scientific basis for limiting healthcare workers in their clinical practise to be reassessed. Although we welcome the new rules, we must know how they will work in practice, as well as ensuring that healthcare workers are given support and any additional training to re-enter the profession in order to deliver the safest possible patient care."

The regulations were brought in after the publicity associated with the death of an American dental patient in 1990, one of six patients believed to have been infected with HIV in an unresolved Florida case. Regulatory bodies in most countries responded to the case differently – the UK banned all HIV-infected healthcare professionals from undertaking exposure-prone procedures. Since most dental procedures are classified as exposure prone, the ban had a devastating significance for dentists diagnosed with the disease.

There have been two major developments since the rules were put in; anti-retroviral therapy, which is effective in lowering the viral level for patients with HIV, and improved infection control standards. Together these mean that it is safe for a dentist with the disease to return to work provided they comply with the conditions of the new regulations.

Patients contacted after HIV scare

Public health. NHS boards write to dental patients in Paisley and Dumfries

Thousands of dental patients in Dumfries and Paisley have been contacted after it was discovered the dentist who treated them has been diagnosed with HIV.

NHS Greater Glasgow and Clyde has contacted approximately 3,000 NHS and private patients registered with Kelburne Dental Surgery on Glasgow Road in Paisley, who were treated by the dentist at some point between January 2004 and March 2013. The health board revealed that it had written to the vast majority but they have been unable to trace about 250 NHS patients and 230 private patients.

The former dentist also provided Sunday emergency cover at Nithbank Hospital in Dumfries between April 2004 and 2007 and is thought to have treated nearly 250 patients. NHS Dumfries and Galloway said that it had contacted all but 14 patients thought to be affected.

The news came less than a week after the Scottish and UK governments announced they were to relax rules governing healthcare workers, including dentists, with HIV performing 'exposure prone' procedures.

Dr Syed Ahmed, NHSGGC consultant in public health medicine, said: "It is very rare for HIV to be passed from a health care practitioner to a patient because all work follows strict 'infection control' measures.

"These measures are designed to prevent infections like HIV being passed between people and through our investigations into this case we are confident that all appropriate infection control measures were followed by the dentist."

Edinburgh college launches clinical skills competition

The Royal College of Surgeons of Edinburgh (RCSEd)'s Faculty of Dental Surgery has launched a Dental Clinical Skills competition, to take place in the UK's 14 dental schools this autumn/winter.

The heats, which will take place from October to December, will see final year dental students showcase their clinical skills, with the best student from each heat winning a travel and accommodation package to compete in the Grand Final at RCSEd on 6 March 2014.

The overall winning prize is an all-expenses-paid trip to the Chicago Dental Society's Midwinter Meeting in February 2015.

The Grand Final of the competition will be followed by a dinner in the 500-year-old Edinburgh College at which presentations will be made to the winner and two runners-up. All participants in the competition will receive a certificate of participation and a year's Affiliation with the RCSEd.

For further information about the Dental Clinical Skills Competition please visit www.rcsed.ac.uk/dental-skills-comp or contact outreach@rcsed.ac.uk

SDPC decision gives uplift green light

Legal challenge. BDA committee decides against pursuing judicial review

An agreed funding uplift for general dental practice across Scotland is to be implemented following a decision not to pursue a judicial review process that would have prevented the award being made.

In light of the potential consequences of pursuing a legal case instead of accepting the award uplift, the BDA's Scottish Dental Practice Committee (SDPC) has decided not to pursue a judicial review of Scottish Government's decision to recover alleged overpayments of patient registration fees.

It was made clear to SDPC by the Scottish Government that if such a challenge were made, the uplift agreed by SDPC in good faith earlier this year would not be honoured. This would have led to practices across Scotland being deprived of the funding indefinitely.

It would also have caused significant pension detriment in the long term. The uplift will now be implemented from 1 November 2013 and backdated to 1 April.

A challenge could also have created further financial jeopardy, because in the event of an unsuccessful review the BDA would have been liable for both the Scottish Government's costs and its own.

The BDA's legal challenge to the proposal had already forced the Government to re-examine and delay implementation, allowing practitioners more time to understand the potential impact on their own practices and prepare for appeals where appropriate. It has also seen the timescale for the process extended and an appeals process for those who believe they are incorrectly being subjected to it established, following representations from SDPC.

Dr Robert Donald, the chair of SDPC, said: "This has been a contentious issue which has its genesis in the forced implementation of continuous registration arrangements to which the BDA objected strongly even before they were imposed.

"We have been presented with a very stark choice that has profound repercussions for dental care across Scotland and this is not a time to allow dogma to cloud our judgement.

"Practices and their patients come first and we are making the choice that best serves their interests by providing a much-needed and overdue injection of funding into NHS dentistry."

New salaried contract is finally agreed...

NEGOTIATIONS

Scotland's salaried dentists have voted overwhelmingly to accept the new terms and conditions and pay scales that have been negotiated by the Scottish Salaried Dentists Committee.

The changes, which will also support the creation of a new Scottish Dental Public Service, came after years of negotiation by the Britis Dental Association (BDA).

Robert Hamilton (pictured), the Chair of the BDA's Scottish Salaried Dental Committee, said: "We are delighted by the overwhelming support for these proposals. We believe this will finally see salaried

dentists in Scotland recognised for the important work we do, and will help secure the services we provide for our most vulnerable patients."

Further information about the implementation of the arrangements will be published on the BDA website following further discussion with Scottish Government.

New surgery kitted out

Corstorphine-based private referral clinic Vermilion has recently added a fourth dental chair to the practice.

The new chair will be used by Dr David Jones, practice limited to endodontics, and Dr Zannar Ossi, practice limited to prosthodontics.

Practice principal Dr David Offord said: "It's an exciting moment for us. We have been delighted with the Stern Weber S220TR chairs that we installed when we opened two years ago, and have gone with the same again.

"Thanks to Martin Moor and team at Clark Dental, Farahbod Nakhaei at NVDC and our indispensable IT contractor Ian Wilson."

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Seminar. Former Glasgow City Council leader Steven Purcell and Dr Bobby Broadfoot explored the stress journey at a recent seminar held at a Glasgow practice

How to avoid burnout

An evening seminar exploring stress, anxiety and professional burnout was held at Clyde Dental Centre in Glasgow recently.

Hosted by Clive Schmulian and featuring former Glasgow City Council leader Steven Purcell and Dr Bobby Broadfoot, the evening saw more than 20 dentists in attendance.

A self-deprecating and engaging speaker, Steven opened by saying: "I stand before you as a recovering politician," and went on to describe the circumstances of his "very public episode of stress, anxiety and depression".

He said that as high achievers, dentists were more likely to suffer from stress, anxiety and depression, however he countered that by saying: "As a high achiever, you have the powerful mind to cope with this."

He spoke about the tools that we all have to manage depression and how he managed to find emotional balance through things like meditation and the importance of talking to people in the same situation. He also mentioned the stigma attached to metal illness, stating: "I found that it was easier for me to come out just before a by-election than it was to come out as having a mental illness."

Steven was followed on to the podium by Dr Bobby Broadfoot who talked about the stress journey: from stress, through anxiety and onto burnout.

(l-r) Dr Bobby Broadfoot, Clive Schmulian and Steven Purcell

He also described the American definition of stress – cumulative trauma disorder – and remarked how it is a particularly apt description, as stress is cumulative and builds up over time. As well as the science of the sympathetic nervous system, he also discussed the lack of research into stress in dentistry, claiming that it "isn't a sexy subject. Relevant, but not sexy".

BDA. Recent change to membership structure has hit association's bottom line

Budget shortfall could lead to redundancies

Staff at the British Dental Association (BDA) are facing widespread redundancies as a result of the change in membership structure introduced in the summer.

The introduction of a three-tier system appears to have seen the vast majority of members choose the cheapest option, which has led to a budget shortfall in the region of £3 million.

BDA staff have been sent a letter of consultation as the first stage in making a round of redundancies.

Dr Martin Fallowfield (pictured), the chair of the BDA's Principal Executive Committee, said: "The dental profession has changed and our structure needed to change with it. We have asked dentists what they need from their professional association and shaped the BDA accordingly. Listening to feedback from the profession we have created a range of membership packages which allows members to choose, and pay for, the services they wish to receive.

"We have analysed the financial and resource impacts of their decisions and are now in the process of re-shaping the association to deliver the services they have asked for. This is the same business planning process any dental practice would go through when changing its practice balance.

"Unfortunately, this may mean some BDA staff leaving the organisation and we are consulting on proposed changes. We have already put in place a new financial model that supports the changed business model to ensure a sustainable future.

"Members can be assured that services will be sustained and that the future of the BDA is secure. This is a new era for the BDA and we can face the future confidently."

Comply with inspection checklists

ADVICE

Failure to comply with new practice inspection checklists could jeopardise access to NHS grants and allowances, dental defence organisation MDDUS has warned.

"There are some important changes practice owners should be aware of in both these documents and dentists should start to prepare now for inspections rather than waiting until closer to any potential inspection date," says MDDUS dental adviser Rachael Bell.

"NHS Boards and NES previously had their own practice inspection checklists. These have now been brought together into a single Combined Practice Inspection process to be carried out over a three-year rolling programme.

"Practitioners must meet all essential criteria, with all relevant documentation prepared for inspector review in the order set out in the checklist. Failure to comply with the standards in the practice inspection checklists could affect their access to NHS grants and allowances.

"Since the turn of the year, MDDUS has had queries from members regarding the new inspection checklists, from concerns about confidentiality issues to who will carry out the inspection."

Practices undertaking IV sedation must also ensure they comply with the guidelines on sedation.

"While an Automated External Defibrillator (AED) is recommended for non-sedation practices, it is mandatory for any practice using sedation," continued Bell.

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Graham Gilmour speaking at the conference

Event. Glasgow welcomes the scientific conference featuring an expanded speaker line-up and exhibition

New venue for Scottish BDA event

Nearly 400 delegates descended on Glasgow recently for the BDA's Scottish Scientific Conference and Exhibition 2013.

After outgrowing its previous venue at the Dunblane Hydro, the expanded event saw four lecture streams and a larger exhibition area at the Crowne Plaza Hotel. The event was officially opened by Chief Dental Officer Margie Taylor, who praised the event's organisation and said that the conference showed "the BDA at its best".

The clinical focus room featured Glasgow graduates Graham Gilmour – who spoke on 'Treatment planning and avoiding failure in fixed restorations' – and Mike Cassidy, who gave an 'Update in ceramic materials for use in crown and bridgework'.

The pain management room saw Samuel Caddens present on 'Facing down pains in the mouth and face – mechanisms, presentations and complications'. John Meechan then talked about 'Bespoke dental anaesthesia' before Tara Renton took to the stage to present on 'Minimising and managing trigeminal nerve injuries'. The final speaker was John Gibson, who spoke on 'The mouth – part of the face and part of the body'.

The core CPD room featured Graeme Ramage, who presented an overview of medical emergencies and David Conway and John Gibson, who covered oral cancer prevention and detection.

The final speaker room held a variety of talks aimed at the dental team including Margaret Ross's talk on 'Sharing the load: roles and responsibilities' and Richard Welbury and Christine Harris on safeguarding vulnerable children.

New oral health guidance for care homes

NEW RESOURCE

New oral care guidance for older people in care homes has been launched by NHS Education for Scotland, in conjunction with NHS Health Scotland.

The new resource, Caring for Smiles – A Guide for Care Homes, will serve as Scotland's national oral health improvement programme for dependent older people and has been endorsed by the Care Inspectorate.

The guidance emphasises the importance of providing person-centred, safe and effective care by detailing the importance of individual oral health risk assessments, providing daily oral care specific to residents' needs and describing the associated links between poor oral health and systemic disease.

It will support the training delivered by NHS teams and serve as a reference for oral health information and best practice relevant to older people.

Wesleyan buys up Practice Plan and Medenta

ACQUISITION

Wesleyan Assurance Society has announced the acquisition of the Practice Plan Group, comprising Practice Plan, a leading provider of practice-branded dental membership plans, and Medenta, one of the leading providers of patient finance to UK dental practices.

Craig Errington, Wesleyan's chief executive, said: "The acquisition of Practice Plan is part of a larger strategic growth programme that we are embarking upon over the coming years. Until now we have largely focused on providing personal financial services to dentists. Practice Plan is a strong and successful business and will play an integral role in helping us to grow our commercial offering to dental practices.

"Practice Plan offers a great synergy with the Wesleyan brand; it has an excellent reputation within the dental profession and has built up strong relationships with a large number of dental practices nationwide. We can develop these links further to provide a more comprehensive financial service tailored specifically to this market."

Study day. Prof Mike Wise provides a guiding light in aesthetic dentistry at Glasgow's Lighthouse

Wise words on aesthetics

One of the UK's leading names in restorative dentistry was in Glasgow recently to host a study day on aesthetics and implant-supported restorations.

Professor Mike Wise hosted the event at the Lighthouse in Mitchell Lane with an audience of more than 40 dentists in attendance. His presentation began with a look at diagnosis and the factors that influence dental aesthetics. He then looked at factors influencing the choice of ceramic for veneers, veneer preparation considerations and techniques, before covering the cementation of veneers on denine and enamel with illustrating case studies.

The lunch break saw delegates browsing the sponsors' stands, including DTS, Optident, Henry Schein, NSK and Taylor Defence Services.

After lunch, Prof Wise looked at the factors influencing the choice of ceramic for crowns as well as case studies showing the considerations and techniques involved with crown preparation.

Above: Prof Mike Wise with event organiser Ian Macmillan

The final session of the day looked at the aesthetic considerations for some implant situations as well as high density polymers – what they are, uses etc. He finished by looking at a case presentation featuring porcelain onlays for a wear case.

Prof Wise graduated from the University of London in 1969 and established his own private practice in 1973. As well as lecturing posts at the London Hospital Dental School, University of London and University College London, he has held courses and spoken throughout the UK and abroad for the last 30 years.

He is on the specialist lists for restorative dentistry and oral surgery and, until December 2011, was a visiting professor at the Eastman Dental Institute. He has now retired from clinical practice to concentrate on his teaching and mentoring commitments.

Glasgow specialist gives CT talk

PRESENTATION

Glasgow-based specialist orthodontist Dr Imran Shafi (pictured) was among the keynote speakers at the recent annual general meeting of the British Society for Oral and Dental Research.

The event, which marked the society's 60th annual meeting, was held in Bath and saw Imran present on 'Computer prediction systems for planning the surgical correction of facial deformities'. His presentation, which previously won the TC White Lecture Award, focused on his research undertaken at the University of Glasgow.

He received a certificate and the award during the Bath meeting from BSODR president Professor Tim Watson.

Imran said: "It was a particular honour to be able to make a keynote speech during this special anniversary meeting. From the feedback I've had, the lecture was well received."

NHS valuations stay higher than private

GOODWILL SURVEY

NHS dental practices across the UK continue to attract higher prices than private practices according to the latest goodwill survey results.

The survey, carried out by the National Association of Specialist Dental Accountants and Lawyers (NASDAL), covered the period April to July and showed that, on average, an NHS practice commands 105.2 per cent of turnover.

Previous NASDAL surveys have also shown that NHS practices secure more than 100 per cent of turnover, with private practices at or below 100 per cent. When the figures for valuations are compared to the figures for deals, NHS practices can fetch more than expected and private practices go for less than expected.

The valuation average for mixed practices was 100 per cent in the quarter ending July 2013 and the deals show an average price of 95 per cent.

It's a career of two halves

From playing Marilyn Manson in his practice to helping football club Clyde FC, David Macpherson is not your average dentist

PHOTOS: MIKE WILKINSON

For most people, breaking a tooth in a fall would be nothing more than an unpleasant memory. However, for David Macpherson, it inspired him to set out on a successful career as a dentist.

David, who is the principal dentist at Whitemoss Dental Practice in East Kilbride, describes the day in secondary school when he and his friends were "messing about" in a home economics class. He said: "I slipped on a piece of wet floor and hit the edge of a cooker with my face. I ended up at the dentist with my front tooth in half.

"As I was lying there I had a eureka moment of: 'This is what I should do'. I wanted to do something with the public and I didn't fancy a desk job. I was looking for something that was engaging and I was always quite good with my hands, so I just thought: 'Wait a minute, this is it'.

"I'm working with people, I'm working with my hands and I'm not sitting behind a desk doing paperwork... well, turns out I was wrong about the paperwork!"

After graduating from Glasgow Dental School in 1991, David was part of the first cohort to take part in the new vocational training scheme and he was fortunate enough to get a job just five minutes from his family home in Newton Mearns.

Following his VT year, David worked in general practice in north Glasgow for a year and then joined Whitemoss in 1994 as an associate. At the time, the principal was making plans for his retirement and was grooming David to become a partner in the practice. However, it dawned on David that it would make more sense if he took over the practice and the principal became his associate.

He said: "I hadn't heard of colleagues or peers changing roles before, but I asked him if it wouldn't make more sense if he became my associate. That way, his transition to retirement becomes a lot easier and I take on all the hassle. So we did it and it worked, we never had a bad word and it allowed me to immediately start to put my mark on the practice."

As soon as he took over, David put plans in place to transform the rather dated two-surgery practice into his vision of a modern clinic with patient care at its heart. "It was all about trying to make the place as non-dental as possible," he said. "At university, my elective was on phobic patients, because I had an interest in people that were nervous.

"We looked at all the senses – people don't tend to like the smell of the dentists, they don't like the sounds of the dentists and they don't like seeing nasty pictures.

David with Clyde boss Jim Duffy (right) and assistant manager Chic Charnley

So we decided to get rid of all these things. We introduced aromatherapy candles and music."

Moving away from the stereotypical "goldfish bowl in the corner and classical music", David regularly offers to play the patients' choice of music during their treatment, among other things, as an aid to relaxation. The Scotsman picked up on the story and this, inadvertently, led to him being mentioned on a French-Canadian Marilyn Manson fan website...

David explained: "I think the Scotsman used Marilyn Manson as it was the most unusual music we had played.

"Someone from the fanzine must have been Googling and came across the story. So, there I was in this fanzine. I had to translate it from French and there I was, the dentist who plays Marilyn Manson – which wasn't quite true, but it makes a good story, I guess!"

Since taking over, David has invested heavily in the practice, adding three surgeries, an LDU as well as a conservatory that is used as the waiting room. But it is not just the bricks and mortar that he has spent time and money upgrading. He has made sure that his staff are looked after and that they feel valued. David and the practice itself have picked up many awards over the years – including Dentist of the Year at the Scottish Dental Awards in May – a testament to the high esteem he is held in by his staff.

David's nomination for the Scottish Dental Award, and his recent nomination for the Best Boss in Britain Award run by Smooth Radio (he made the final 20), have both been surprises sprung on him by his staff.

He said: "When I won the Scottish Dental Award, I made a point of saying that this is a team effort. One individual can't achieve anything, it's all about teamwork.

"Both (nominations) were a complete surprise. I must admit, my first impression was embarrassment, but then you think about it for a moment and you realise what it means and how nice it is just to be put up for these awards.

"It's humbling, you don't do anything to get awards, you do what you do because you are driven. When people ask me why I do certain things, I tell them it's because I enjoy them.

Continued »

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"I've been a vocational trainer for 12 years, because I love doing it. That doesn't mean you don't have hiccups or problems, but, in general, it keeps you young, it keeps you invigorated and it keeps you engaged."

As well as a VT trainer, David also works for NHS Education Scotland part time, supporting potentially under-performing dentists. He holds mentoring and coaching accreditation and has regularly given evidence and written reports for the GDC.

He said: "It's a job I find very rewarding, because things can happen to dentists for a whole bunch of reasons. Whether it is home life or developing bad habits – nobody goes to work with the intention for something to go wrong.

"The diversity of problems I have been involved with are quite vast. Often, I am working with dentists that are anything from angry to suicidal, so it is incredibly rewarding when you get through the process with them. You are there as a mentor for them, as someone who is not judging them, just trying to share some of the experience that you have and put in place better processes."

Whitemoss was also the pilot for the first health promoting dental practice, a Lanarkshire initiative that involved, not just oral health promotion, but general health promotion. Although not directly related, this ties in quite nicely with David's other passion outside dentistry: his involvement with his beloved Clyde FC.

A third generation supporter, David was introduced to the Bully Wee as a small child and has been following them through thick and thin ever since.

Originally from Rutherglen, the club has something of a nomadic reputation in recent years since moving from Shawfield Stadium – its home since 1898 – in 1986. It ground shared with Partick Thistle and Hamilton before moving to Broadwood Stadium in Cumbernauld in 1994.

David, who has been the club dentist for many years, joined the board five years ago and, as well as his official role as director of fundraising, has been heavily involved in the ongoing negotiations to move the club to East Kilbride.

He said: "What we realised at the club is that there are three or four serious dental injuries a year – players get knocks, bangs in the head or face etc. Even before I was the club dentist I was getting asked to have a look at a broken tooth and so on.

"Then we realised that there are a few teams, like Chelsea, who actually have a club dentist and there was an opportunity there to get the word out – we've always been big on promoting and getting that message out as a practice."

David explained that although many footballers are clearly conscious of health and fitness, they are often unaware of the importance of dental health to their general health and wellbeing. From the first team down through the various age groups – under-19s, under-17s and u-15s – David gives valuable advice and support on oral health and diet, including the hot topic of sports drinks.

He has also registered a number of players and staff as patients, including the well kent face of Chic Charnley, Clyde's ebullient assistant manager. He said: "I've had a few characters in my chair over the years, including a few ex-Rangers and Celtic players. It's really nice and it's fun for me. I now have some really good contacts through the Scottish football world, from people who have been involved in the club at some stage."

In 2011, to coincide with Mouth Cancer Action Month, David contacted the British Dental Health Foundation and arranged for the club to sponsor the campaign and feature the Blue Ribbon Badge on the home shirt for the duration of the season. The following season, the badge was sported on the away strip, due, in part, to the fact that they would be playing Rangers at Ibrox twice that season and it offered maximum publicity.

He said: "I said to the board that, as a dentist, I am involved in promoting dental health. I have an ethical drive to get the message out there. The demographics were changing and, for the most part, mouth cancer was affecting young men.

"My attitude was, if I can raise awareness by doing something as simple as putting a blue ribbon on the back of a football shirt, then great."

As a result, David was invited down to Westminster for the launch of the Mouth Cancer Action Month campaign.

So, who would have thought that a chance slip on a classroom floor could lead to a career in dentistry, a mention in an obscure shock rock fanzine and being on the board of the football club he has supported since childhood?

However, while the origins of his career and certain elements of his life have been somewhat unusual, his professional desire, ambition and drive certainly haven't been.

He said: "I always had this deep ambition to do the best that I could in whatever I did. And that's what we did here. We decided to change the rules and try to be a wee bit different. And I think we have managed to do that quite well." ■

SPORT IS IN THE BLOOD

David is married with two budding teenage tennis star daughters, Hayley (17) and Tanya (15). His wife and children are currently living out in Barcelona as they pursue their dreams of careers as professional tennis players. David explained that his youngest has even trained at Sánchez-Casal – the same academy that Andy Murray trained earlier in his career. He said: "When the girls were younger, on numerous occasions, Andy would be on court either before, beside or after them. So, from that period onwards they grew up watching Andy play."

A life-changing experience

Hygienist/therapist Kirsty Sharp is part of a trio of Forth Valley dental professionals who embarked on an African adventure to take their vital skills and expertise to those suffering from serious oral conditions

In June, I headed off on a two-week expedition, along with dental nurses Gemma O'Malley and Hayley Robertson, to the Dodoma region of Tanzania with charity Bridge2aid, which specialises in helping those with no access to dental care of any description.

Since 2002, Bridge2aid (B2A) – the UK's fastest-growing dental charity working in developing nations – has trained over 220 local health workers in Tanzania in emergency dentistry, with their goal of more than 50 people a year learning essential dental skills having now been achieved.

This training has not only directly treated tens of thousands of people, but has also extended emergency dentistry services to those living in rural areas. An estimated 2.2 million people now live within reach of someone who can help to alleviate their pain.

More than 70 per cent of the world's population have no access to the simplest form of dental pain relief. B2A was founded to address this problem and is the UK's fastest-growing UK dental charity working in developing nations.

The charity's Dental Volunteer Programme (DVP) allows qualified dental professionals to pass their skills on to clinical officers to safely extract teeth. The programme began in 2004 and works with the Tanzanian government. B2A has also established a long-term development programme with the disabled and people affected by leprosy at Bukumbi Care Centre.

Gemma, Kirsty and Hayley play with a patient's daughter. Left: children who came to see the makeshift clinic

Before we set off, we raised more than £4,683 by staging events throughout Clackmannanshire. This helped to finance flights, accommodation and living costs, with any additional proceeds being donated to further the charity's work in the third world country.

We had planned the trip for more than a year and hosted fund-raising events in the local area, including a race night and an 80s disco. We also received generous donations from patients and workplaces and the businesses in the local community donated raffle prizes.

As soon as we arrived, we began working with dentists to deliver emergency dental procedures while also training local health workers, leaving a lasting legacy of our efforts there.

Over 13 days, our team – consisting of six dentists and four dental nurses – worked in remote rural clinics, developing the skills of clinical officers and delivering basic dental services to the community.


Miswak sticks are used as toothbrushes in Africa

We worked in two medical centres which were extremely basic with no electricity or running water, and a basic wooden chair in place of a dental chair.

We assisted the team by making sure the 'clinics' ran smoothly, including preparation of the anaesthesia, instruments and sterilisation – which involved the use a pressure cooker. We also assisted by holding heads during extractions and sometimes holding babies, as well as training the clinical officers in sterilisation techniques and oral health education.

Bridge2aid is a terrific charity as it not only treats dental pain but also teaches others the skills to deliver dental treatment to those who really need it after we are gone. It may be hard to imagine living with no access to a dentist but, for almost two-thirds of the world's population, that is a reality.

It is not uncommon for people to have to live with unbearable toothache for many years, which, as dental workers, we find very disturbing.

The trip was an incredible life-changing experience. It gave us all a great sense of achievement.

It not only helps people out of pain, but educates clinical officers who will be able to make a difference in their community after we have gone. The charity really does make a difference. We would recommend it to anyone remotely interested, it is such a well-run organisation and the sense of teamwork is fantastic.

"One 17-year-old walked 55 miles to get his tooth out and was so grateful"

The patients we treated are so grateful and appreciative that you are there to help and never complain after sometimes having toothache for years and walking for days to get to the makeshift clinics. One 17-year-old walked 55 miles himself to get his tooth out and was so grateful just to be seen. ■

ABOUT THE AUTHORS

Dental hygienist/therapist Kirsty Sharp trained at Glasgow Dental Hospital and School and currently works at Tooth+ and Platt and Common in Stirling.
Dental nurse Gemma O'Malley trained at Falkirk College and currently works at Macdonald and Morson in Alloa.
Dental nurse Hayley Robertson also trained at Falkirk College and currently works at Central Orthodontics in Stirling.

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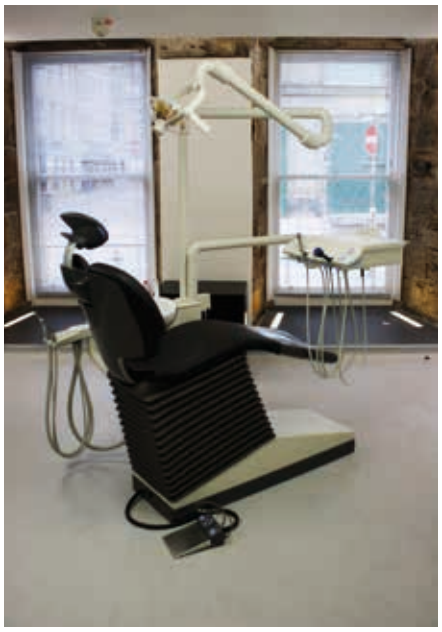
New horizons



Aberdeen-based private clinic opens second practice in Scotland's second city

Jacqueline Fergus and George Glover opened their practice on Union Street in Aberdeen in 1995 and have seen it grow into a successful, multi award-winning private practice.

From their spacious lounge with complementary refreshments to their use of the latest in digital imaging and X-ray technology, the team at Fergus and Glover pride themselves on keeping patient care at the heart of everything they do.

However, determined not to rest on their laurels, Jacqueline and George had always planned to grow the business. The question was how and where.

After much deliberation, they decided that there was neither the room nor the market to make the Aberdeen practice any bigger, so they started looking further afield. And, having held a number of courses in Glasgow, they thought Scotland's second city would be the ideal base for their sister practice.

They started scouring the city, looking at the city centre, the Merchant City and the West End for the ideal ground floor, shop front-style premises. In 2011, they came across a former retail unit on Hutcheson Street in the Merchant City.

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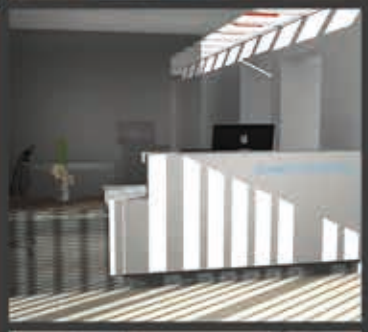

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Situated next door to the high-end audio and video retailer Bang and Olufsen, the unit presented a modern all-glass frontage and plenty of potential. The lease was signed in April 2012 and, at the beginning of the summer, they put the construction work out to competitive tender, with the building work starting in September last year.

The interior of the new practice was ripped out and essentially taken back to an empty shell. The floors were raised and ceilings lowered in order for the plumbing and electrical services to be installed. George oversaw the development and the overall concept of the design and build, with his practice manager Mikey Bateman running the project on the ground.

The reception and waiting areas manage to appear comfortable and welcoming, while still maintaining the contemporary design feel of the exterior. The two surgeries in Glasgow take many of their cues from the Aberdeen practice – clean lines, minimalism, high-gloss cabinetry and glass. The practice also features an LDU kitted out with all the latest equipment and stainless steel worktops, a dedicated OPT room and a private consultation room for patients to discuss their options with the practice's treatment co-ordinators.

The practice will offer all the same treatments and services that the Aberdeen practice currently provides, with George planning to work two days a week in Glasgow when the practice is up and running.

He will be joined by implant dentist Abid Faqir who will also be working two days a week and full-time hygienist/therapist Morag Powell who is relocating to Glasgow from Aberdeen.

Practice manager Mikey said: "We are always looking to explore new ways of working and I think a big benefit to having the two practices will be that we will be able to take the best bits of both practices going forward and integrate what works best into the other and so on.

"It's an exciting time for us. We can't wait to open the doors in Glasgow and start welcoming patients to the new practice." ■

Investing in its people

Glasgow laboratory's success leads to ambitious expansion plans

Leca Dental is a family run full service laboratory, known for its dedication to quality, value, embracing new technologies and investment in youth opportunities.

The company was founded eleven years ago by Tommy Leca and his son Martin who were, at the time, the only employees. However, since then the work force has increased from two to more than 50.

Both Tommy and Martin have always believed that the key to a successful laboratory is ensuring you have the correct balance of employing experienced, highly gifted technicians while also developing young people. To that end, since 2005, Leca Dental has recruited a minimum of two apprentices every year, ensuring that four days a week are spent in the laboratory learning all the right habits, the Leca way.

"Leca Dental has built a very reputable crown and bridge department"

The company has enjoyed a 100 per cent retention rate of all apprentices as they look to broaden their skill base and opportunities with the lab. All of the qualified technicians are GDC registered, with various members of staff travelling around the world to gain additional training and qualifications in, for example: implantology, E-Max and Valplast.

Based in Hillington, Glasgow, Leca Dental has six vans on the road offering a free daily pick-up and delivery service throughout Scotland's Central Belt, as far south as Dumfries and Galloway and as far north as Aberdeen. Clients further afield enjoy the benefits of a free UK postal service, many of whom are repeat customers that have moved away and have been unable to secure a laboratory in their local area to provide the same high standards as Leca Dental.

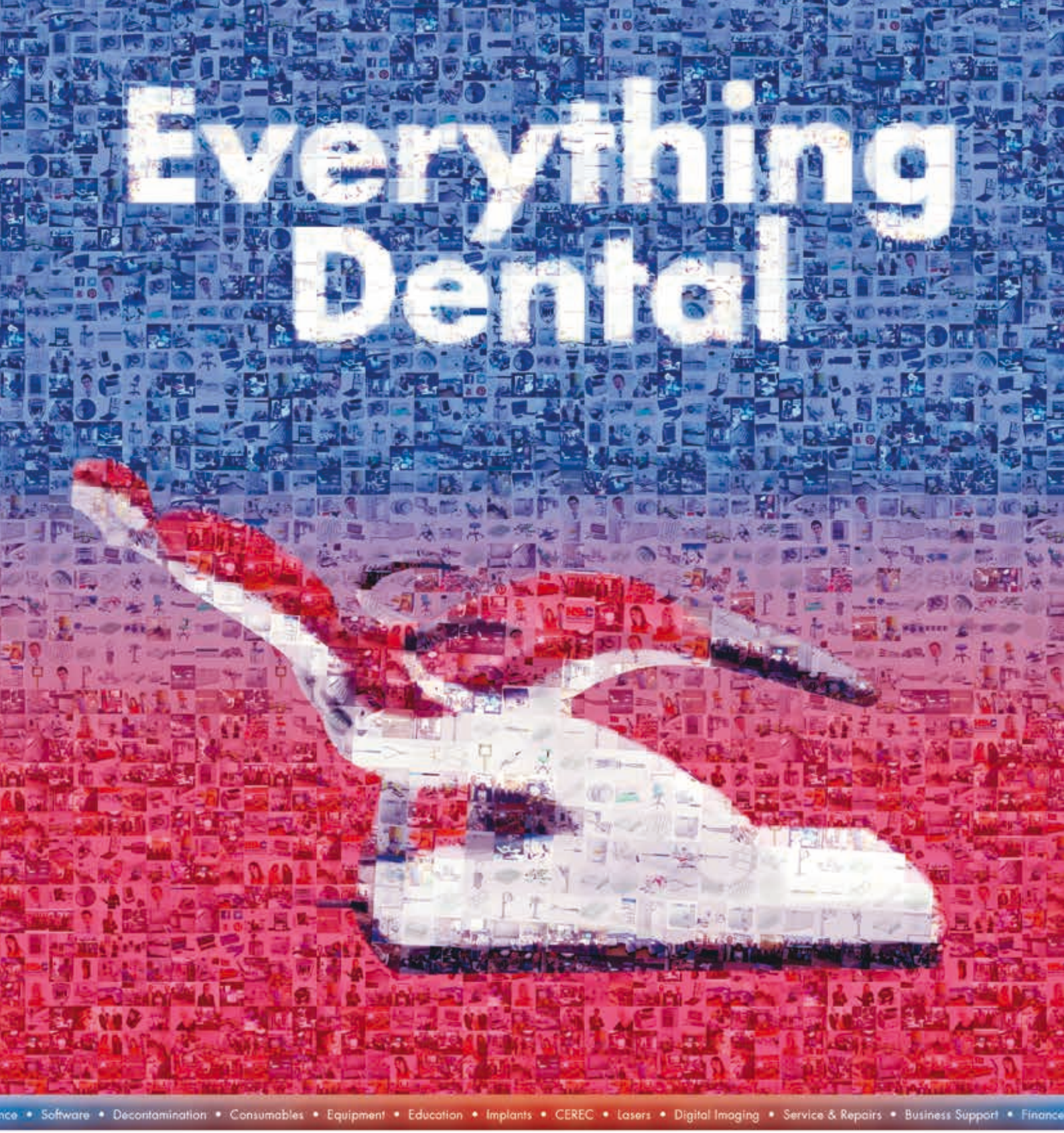
Originally better known as a denture laboratory, in recent years Leca Dental has built a very reputable crown and bridge department in addition to investing in a NobelProcera scanner to provide a range of implants, attachments and zirconia frameworks.

The company has recently invested in a barcode tracking system that will enable them and their clients to follow the progress of every single piece of work that comes into the lab. Each item of work will be assigned a barcode and this will be scanned at each stage of its journey through the laboratory, ending with the driver scanning and gaining a signature of receipt at the dental practice upon delivery.

This will not only ensure a robust audit trail, it will allow dentists to log in to their own private portal to track where each piece of work is, and when it is expected to be ready. The system is undergoing its final stages of testing before being rolled out to all customers in the coming months.

As Leca Dental's range of products and services has expanded and more staff have been brought on board to fulfil the work, it has become apparent that the business has outgrown the building it currently occupies. Tommy and Martin hope to stay within Hillington Park Industrial Estate and they are currently exploring the options that the complex offers them.

With scope to double the current size of building, Leca Dental have big plans to facilitate its continued growth while maintaining an exceptionally high level of service. ■



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Inspiring a community

When Bert Hay took over the dental practice in Kingussie, he decided a change of brand was needed

In days gone by, the only marketing dentists had to do (or, in fact, were allowed to do) was put up their plaque and wait for the patients to come in through the front door.

Things have moved on quite a bit from those days, with modern practices developing their brands and undertaking more and more sophisticated marketing and advertising techniques.

However, when it comes to changing the name of an established practice in a rural area, there is always going to be an element of uncertainty – would people be put off and see it as too big a change?

One dentist who has tested this theory is Bert Hay, from Inspire Dental in Kingussie. Originally known as Kingussie Dental Practice, Bert and his then business partner took over the business and its sister practice Aviemore Dental Practice in 2004 after the owner passed away. For the last five years, Bert worked solely out of Aviemore.

However, this summer, the opportunity arose for Bert to join forces with his friend Chris Barrowman and take over the running of the one-surgery Kingussie practice. Chris, who owns Infinityblu Dental Care in Pitlochry, has been friends with Bert since their days at Dundee Dental School and the opportunity to work together was too good to pass up.

Bert and Chris took over in July and set about revamping the practice. Their biggest decision was what to do with the practice name and, after lengthy discussions, they decided to change it to Inspire Dental.

Bert explained: "I think in the past there had been some reservations about changing the long-standing practice name, with concerns that long-term existing customers might become put off or confused.

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"However, we felt we needed something fresh to give the practice a brand new start, as well as a unique identity.

"We chose Inspire because we want to inspire the local community and because we, as dentists, are inspired by the advances in modern dentistry. We put a lot of work and a lot of budget into getting the brand right and getting the image out there. We are delighted with the way it has turned out and how it has been received."

With the brand logo and vibrant pink colour scheme agreed upon, the decision was made to close the practice for a week while the refurbishment was carried out. New floors were installed throughout the practice and the walls were resurfaced and repainted.

The reception desk was ripped out and a new contemporary desk was installed, complete with unique lighting features and branding. New chairs were also brought in and the dental chair was re-covered in the vibrant Inspire pink.

Bert and Chris invested in a new IT system, including a digital X-ray system, as well as new signage. They also added innovative touches such as fresh flowers, cups and saucers with the branding, SPF 20 lip balm with their logo and golf umbrellas and hessian shopping bags, complete with the practice livery.

Bert said: "Considerable time and investment was also put into developing a website to work alongside our initial marketing campaign. An active social media set-up has proven to be a key additional factor to our initial growth and community integration."

And, while it is still only a one-surgery practice, instead of four short days, Bert and his associate Niall Neeson have gone to six days a week, including three late nights. They will also have a dental therapist, Gemma MacLennan, working one day a week to offer a range of treatments for both adult and child patients.

Bert said: "We have three main aims: the customer, the team and our continual development. We wanted to make the practice really customer focused to make their experience as positive as possible.

"We also have a big focus on teamwork – making sure we are all pulling together and that, in turn, helps keep the standard of customer care high.

"Finally, our commitment to continual development as individuals, as a team and as a practice means that we are constantly improving and setting higher standards for our patients and staff." ■

For more information on Inspire Dental, visit www.inspire-dental.co.uk, follow them on Twitter @inspire_dental or 'Like' them at www.facebook.com/InspireDentalPractice

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When well respected Specialist Periodontist and Implantologist Dr Crawford Bain was offered a professorship in Periodontology at Dubai School of Dental Medicine, his primary concern was for the continuing care of his patients.

Having met Duncan Black 22 years ago and mentoring him earlier in his career, Crawford was confident that he held the experience, patient care and values that would ensure the continuing high standards of treatment that he was known for.

> **"It was vital for both myself and Angela that we handed the practice over to highly skilled individuals who share with me the strong ethos of comprehensive patient care"**
>
> *Dr Crawford Bain*

Dr Duncan Black *BDS MJDF RCS* has considerable experience in all aspects of Implant Dentistry and Advanced Restorative Care. Having practised for over 25 years, Duncan is dedicated to giving the highest standard of patient care.

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Dr Crawford Bain handing the reigns over to Dr Duncan Black.

Jose Armas will also join Duncan at the Somerset team. Jose is a Specialist Periodontist at the Glasgow Dental Hospital and will be supervising all perio referrals. Somerset Place will be happy to advise and treat any patients who have concerns with Periodontitis or Peri-implantitis.

Dr Jose Armas *MB BS BDS, MFDS RCPS (Glas), MRD Rest (Perio) RCS (Edin)* is a Specialist and Consultant in Periodontology at Glasgow Dental Hospital, where he also directs the School of Dental Hygiene and Therapy.

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Making a digital impression

Duncan Black explores the history and the development of intra-oral scanners in modern dental practice

When Dr Gordon Christensen called digital impressions part of the 'Current paradigm shift in dentistry' (Christensen, 2007), as usual he was ahead of the rest of the profession, certainly on this side of the Atlantic. Up until then, there had only been one system of digital impression machines available to dentists: CEREC from Sirona.

The theory of digital impressions in dentistry started with the French dentist François Duret, who first envisioned his theory in 1970 as a dental student, and finally produced a single crown on a willing subject (his wife) for the 1983 Academy of French Dentistry meeting. His original idea was to send the scanned information to a dental laboratory.

At the same time, the Swiss dentist Werner Mormann was inventing what became the CEREC system, producing a chairside crown in 1985. These two fundamental types of workflow persist today: a digital impression then a laboratory produced restoration and a digital impression then a chairside produced restoration.

In 2007, the Itero system came to market, the second generation of intra-oral scanner. This system now has produced over two million restorations in the USA alone. There have been many entrants to the market, but the main players are: CEREC (Sirona), Itero (Align Technology), True Definition (3M) and Trios (3Shape). The majority of these machines do not produce a crown at the chairside – only the CEREC can do that. Even Sirona has realised that a limited number of dentists are interested in the time investment and learning curve involved in milling your own restorations.

To my eye, hand-stacked porcelain by a skilled dental technician has a superior appearance, important in the anterior segment, but that is just my opinion.

These machines, however, do look good in the modern practice environment (Fig 1).

Why change?

All this is very interesting to anoraks like me, but why change? A recent study found that 44.2 per cent of dental impressions of prepared teeth submitted to three dental labs in the UK were unsuitable for making a dental restoration (Storey, Coward, 2013).

Dental impression materials are subject to distortion, tearing, and inadequate adhesive use, which pulls material away from trays. Trays that are too flexible contribute to inaccuracy. Let's not even mention moisture control. Polyether impression material is very popular with

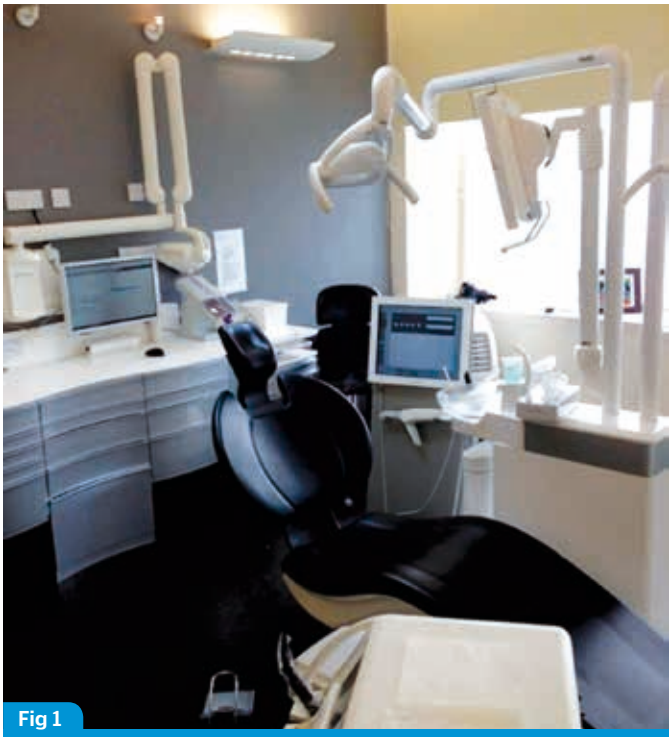

Fig 1
Trios in a modern practice environment

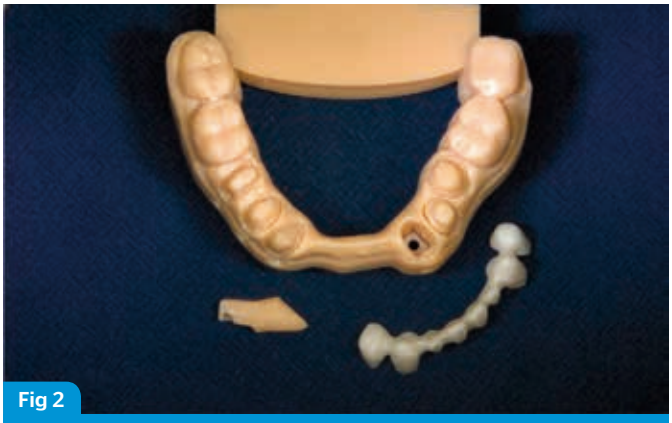

Fig 2
Printed models are very accurate

Fig 3
Radiographs show accurate fit of scanned implant

Fig 4
Scan flag in sterile packaging

Fig 6
Patient after some inital veneer placement

implant dentists. How many of us can guarantee that our impressions are cast within 24 hours, or are transported to the lab in an environment which has less than 50 per cent humidity, as per manufacturer's instructions? Or are they in the same bag as a wrapped wet alginate?

This is without beginning to list the things which could possibly go awry on the laboratory side: incorrect stone mixtures, voids in stone, dropped models, incorrect trimming of models, incorrect fitting of analogues to impression copings, etc.

The models produced with scanning show excellent detail and clear margins. There is also ample evidence in implant dentistry that it can be difficult to take implant fixture head impressions, in patients with limited opening for instance, but inaccuracy of conventional impressions has been shown to occur with increased implant depth and implant angle (Linkevicius, et al., 2012, Mpikos, et al., 2012).

This is without any reference to how our patients feel about having an implant fixture head impression taken. Again, studies show that there is a positive patient reaction to digital impressions in comparison to conventional impressions (Wismeijer, et al., 2013).

There is ample evidence already (Ender and Mehl, 2011, and Seelbach, Brueckel and Wöstmann, 2013) that digital impressions are very accurate and have potential to improve on the accuracy of conventional impressions. This is even more pertinent when conventional models would need to be digitalised for production of titanium or zirconia abutments (Almeida, et al., 2013, and Güth, et al., 2013).

Furthermore, Lee and Gallucci (2013) found that operators preferred taking digital implant impressions when in direct comparison with conventional impressions.

So much implant dentistry is now CAD/CAM designed. At the moment our impressions are cast in stone, trimmed and then digitalised for design of copings in titanium or zirconia. It makes perfect sense to avoid the middle step of casting and hand trimming and go straight to digital design. Technicians also trim and design digital models on a large computer screen, which is much easier for identification of margins and soft tissue contours. The printed models handle well and technicians like them. The preparations and margins are very clear (Fig 2).

The results for dentists are that restorations require less adjustment to fit, and there is a reduced number of remakes. From personal experience, I can attest to this. There is an excellent fit (Fig 3).

The added benefit for dentists working with the Trios is the flexibility of the machine. If, for instance, you are concerned about clearance of a preparation, it can give you a digital guide on screen. If more adjustment is required, you can 'erase' that small area and re-scan it.

You can examine the margins and shape of preparations prior to emailing the impression to the laboratory. The machine has a scanner head with an autoclaveable/ removable tip, which is easy to use (it is remarkable how many intra oral-scanning devices have non-autoclaveable tips!). The scanning process itself is very quick.

Also, a copy will be kept for all your models digitally. A great reduction in the amount of gypsum in your practice.

The results speak for themselves. Fitting times are much reduced in implant and in conventional crown and bridge work.

Workflow

In this article, I will describe the workflow that occurs when an intra-oral scanner is used in implant dentistry. I have been fortunate enough to have been the first UK dentist to use the 3M LCOS scanner (a second-generation scanner) and also the 3Shape Trios more recently (a third-generation scanner), which I use in practice today. It is used in all situations where conventional impressions for restorative work would be taken.

The difference between the Trios (and the new Cerec Omnicam), compared with machines of a previous generation, is that there is no need for 'powdering' the teeth before scanning. Previous generations of machine would require a layer of titanium dioxide powder to be sprayed over the teeth prior to scanning, otherwise it was unable to record those surfaces. This can make moisture control more tricky.

After implant placement and suitable time after second-stage surgery, an appointment is required for fixture head impression. A digital lab sheet is prepared on the Trios. Similar to a conventional lab sheet, this contains information such as patient details, delivery time and type of restoration. It also allows for all case information needed, including pre-op

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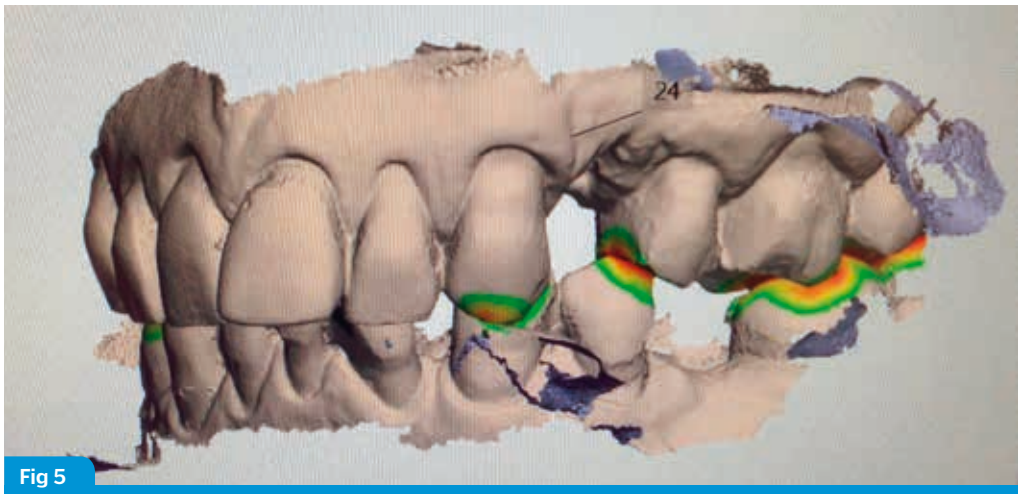

Fig 5
Scanned arches showing clearance guide

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Fig 7
Soft tissue profiles from implant

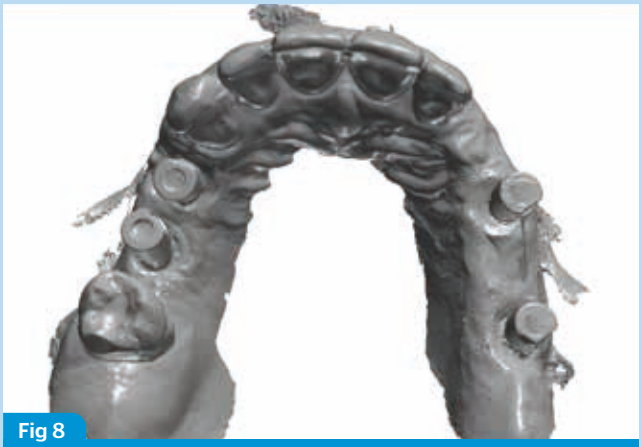

Fig 8
Scan flags secured to implant

Continued »

scans if wanted, or the scan of a wax-up in a more cosmetic case. This allows for shade mapping and annotation for individual teeth, if required.

The opposing arch is scanned, this usually takes 1.5 minutes. The operative arch is then scanned after removing the healing cap/caps. This gives a soft tissue impression as the machine is very good at picking up soft tissue contours. A small scan flag is placed in the implant and secured.

A 'scan flag' is a small plastic computer impression coping (Fig 4). There are currently scan flags for all major brands of dental implants. This gives the software not only the type of implant being restored, but its 3D co-ordinates and angulation. As usual, a check radiograph is taken to ensure full seating of the scan flag. The area around the implant is then rescanned. There is a bite scan which then occludes the digital models. This process usually takes a total of 2-4 minutes depending on the number of implants to be scanned.

There are several post-scanning features that are of use. You can review the scans and the scan information. If you suspect an area is inadequate, then you can erase it and rescan the area. There are also functions which check restorative space and occlusal contacts (Fig 5). After that all you do is press the 'send' button.

This information is then sent to your dental laboratory. The technicians will receive the information within 10 minutes and be able to review your impression and respond with a message back to you if there are any issues with it.

If you require a monolithic restoration, or a temporary restoration direct to an implant fixture head or on a titanium base, then the laboratory need no further information and can mill the restoration. However, depending on the case and what you wish, they will usually print a model. This can now be printed with soft tissue if required.

Any type of restoration can then be constructed, whether a gold-based crown, either screw or cement retained, implant bar restorations, zirconia or titanium abutments and crowns.

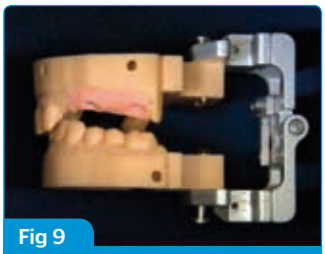

Fig 9
The soft tissue model on a hinge articulator

Fig 10
Retracted lips showing completed restorations

Fig 11
Scan flag attached to implant

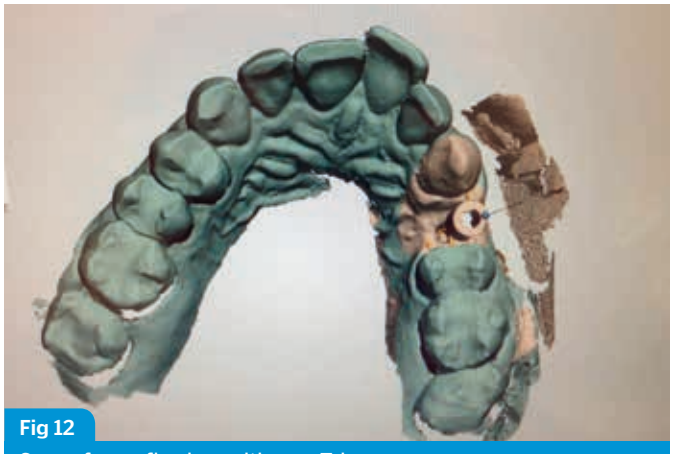

Fig 12
Scan of scan flag in position on Trios screen. Easy to inspect from any angle

Example cases

I have included a couple of cases to illustrate the workflow, and results of the Trios.

In the first case, the patient had been wearing a partial acrylic denture for several years. She was very unhappy with the appearance of her teeth. We undertook some preliminary veneer work on anterior teeth, which had some unsightly fillings (Fig 6). After implant placement and healing, I scanned the mouth and then fitted milled temporary crowns and bridges to increase the vertical dimension a little, increasing restorative space.

After further tissue maturation, I scanned again to ensure we incorporated the new emergence profiles in the final restorations. Figure 7 shows the scan on the technicians' screen where you can see the soft tissue shape. Figure 8 shows the same but with the scan flags in place. A printed model with soft tissue was produced (Fig 9), showing the model with soft tissue on one side and soft tissue removed showing anologues on the other. The patient was very happy with the result (Fig 10).

Continued »

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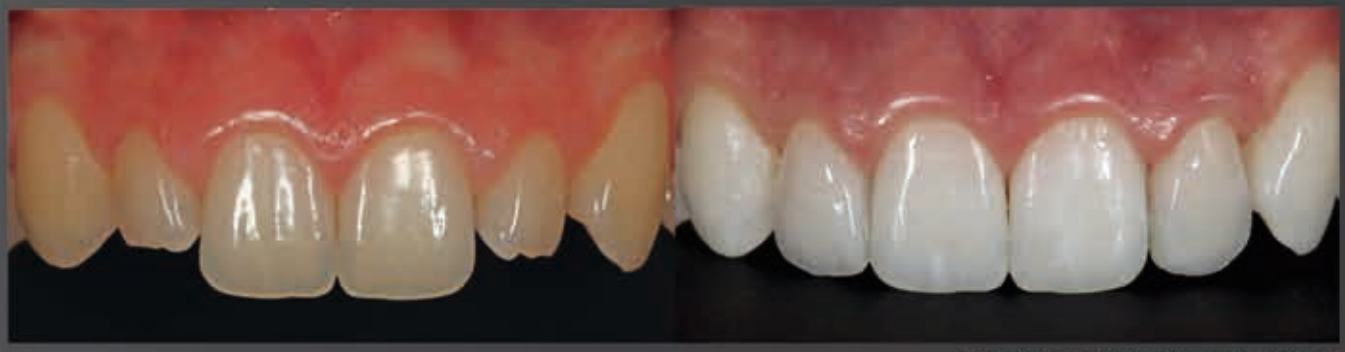

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The second case is a simple single tooth replacement. The patient attended with a failed post crown in tooth 24. Unfortunately, it had been left with a root fracture for a considerable time. The tooth was removed and, following healing, an implant was placed (Fig 11). A temporary Rochette bridge was constructed. After second stage surgery, a scan flag was inserted (Fig 12) and scanned to construct a temporary, milled from Telio CAD (Ivoclar Vivadent). The scan appears very clearly and it is easy to manipulate on the screen of the Trios (Fig 13).

The scan was sent in seconds to the dental laboratory. The technician imports the scan into the 3Shape software and designs the temporary crown. Figure 14 shows the manipulation of emergence angle. The temporary can be checked for excursive contacts on one of 5 'virtual' articulators (Fig 14).

The occlusal carving of the temporary can be finessed on screen (Fig 15).

The temporary was fitted and further tissue maturation was allowed. If required, additional material can be added to the Telio CAD temporary to build further tissue support. Another scan was taken to record the new emergence profile, and a final restoration was constructed: a screw retained zirconia crown.

If the final restoration is a monolithic one, for example full contour zirconia or Lava Ultimate restoration, then no model will need to be made. For a gold/porcelain or, as in this case zirconia porcelain, then a model will be printed and used in the construction of the final restoration (Fig 16). The patient was delighted with the try in of the restoration (Fig 17). However we decided improvements were needed and the final restoration had improved colour and length (Fig 18).

The future

Digital dental impressions are a clinically available technology that will revolutionise dental practice, both in patient acceptance and clinical efficiency. Improved communication with the dental laboratory will mean better restorations from both the patient's and the clinician's perspective.

It is time to change. It will be a gradual change but this is happening all over Europe and around the world. The UK is slowly changing as practitioners begin to see the benefits. As patients begin to hear about these technologies being available, they will also begin to demand their use.

I would like to thank Craig Smith of DTS for his excellent porcelain work. ■

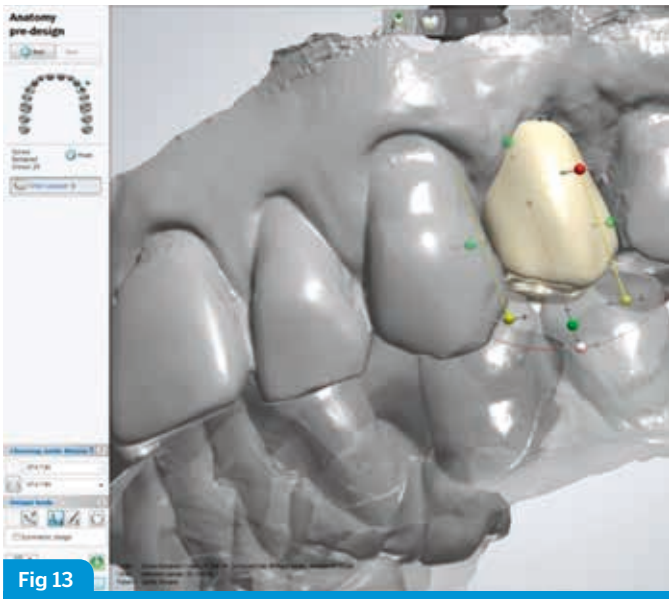

Fig 13
Designing the temporary crown on technician's screen

Fig 15
Refining occlusal carving on temporary crown

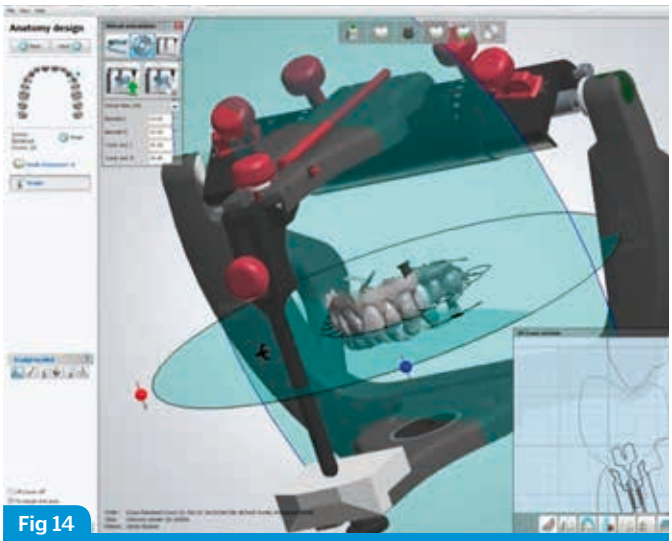

Fig 14
Designing occlusal surface of temporary crown, with the help of a virtual articulator

ABOUT THE AUTHOR

Dr Duncan Black BDS, MJDF RCS (Eng) is the principal dentist at Somerset Place Consulting. He is a member of the Association of Dental Implantology and the Academy of Osseointegration.

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Dr David J Lee

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Dr Paul Swanson

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- Summary of Surgical and technical aspects on the Day of Surgery
- Focus on marketing of the treatment protocol and initial review, hygiene, conversion to definitive and long term reviews, and lastly when the prosthesis needs replacement
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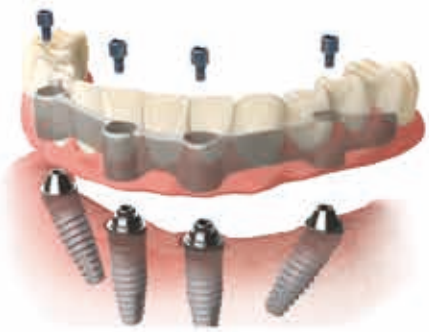

Both **Dr David J Lee** and **Dr Paul Swanson** have had many years of experience in implantology and both continue to mentor dentists at all levels of implantology. In the last five years they have treated almost 100 patients between them for full arch immediate load protocols with high levels of success.

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Tooth in a year and a half

While immediate implant placement and other accelerated treatment protocols have a place in the implant dentists' armamentarium, Crawford Bain presents a case that benefited from a little more time

The use of dental implants has become a mainstream treatment method in tooth replacement. In recent years, much emphasis has been placed on rapid restoration of the lost dentition with extraction, implant placement, grafting and restoration on occasion being combined in one appointment to allow the patient to minimise or eliminate time spent in a removable prosthesis. This has been variously described as 'Teeth in an hour', 'Teeth in a day', 'Diem' and 'All-on-4', as well as several other buzz phrases.

While shortened treatment protocols offer clear benefits in simple tooth replacement cases where rapid restoration of function is the primary objective and all necessary hard and soft tissues are present (ITI Classification "Straightforward"), they have potential shortcomings in more complex and aesthetically demanding situations, which fall into the ITI 'Advanced' or 'Complex' classifications.

This article presents a case where treatment over a protracted period of time results in an outcome which could not predictably be achieved with the currently popular more accelerated treatment approaches.

Case report

Patient RR was a healthy, non-smoking 44-year-old male, who presented with a complaint of an unaesthetic upper right central incisor, with extensive recession showing a large amount of darkened labial root surface. The situation was worsened by a high smile line and a porcelain crown contrasting dramatically with the root colour.

The patient had experienced periodic swelling at the apical part of the recession over a long period. There was also a history of trauma in his teens, leading to root canal treatment and a crown, and subsequent apicectomy in his 20s.

Clinical examination revealed an otherwise periodontally healthy, well looked-after mouth (Figs 1 and 2).

Diagnosis was of endodontic failure and possible root fracture, leading to loss of labial bone and soft tissue.

The treatment plan was essentially divided into three stages:

- Rebuilding the lost soft tissue
- Rebuilding the lost bone
- Replacing the tooth

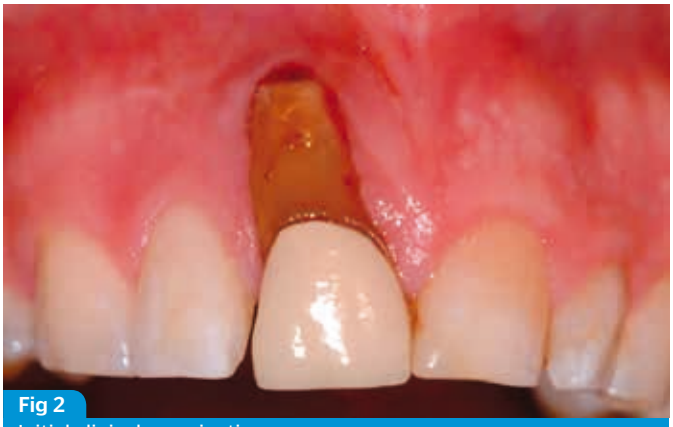

Fig 2 Initial clinical examination

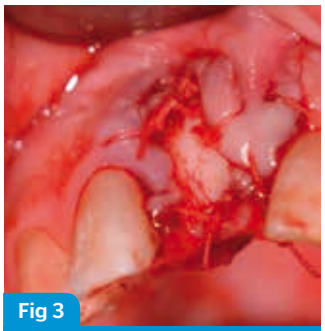

Fig 3 Bialteral pedicals using adjacent papilla to cover connective tissue surfaces of the tuberosity graft

Fig 2 One year on

Rebuilding the lost soft tissue

1. Fabrication of a tooth-borne immediate partial denture.
2. Extraction and the split root confirmed.
3. De-epithelialise the socket and ensure bone bleeding.
4. A connective tissue and epithelial graft from the tuberosity – using a distal wedge technique.
5. Bilateral pedicles using adjacent papilla to cover the connective tissue surfaces of the tuberosity graft (Fig 3).

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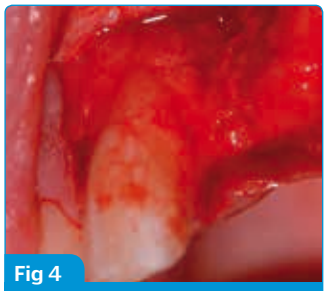

Fig 4
Underlying bone was curetted with a Rhodes chisel and a round burr to ensure bone bleeding

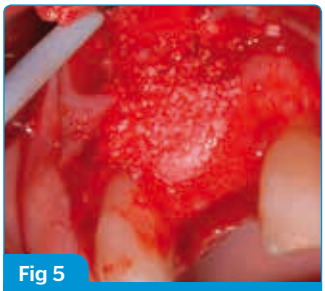

Fig 5
Endobon xenograft material was placed after being moistened with blood and saline

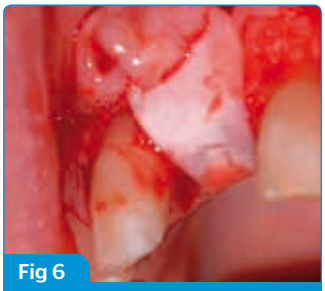

Fig 6
OsseoGuard xenograft membrane was trimmed and fitted once seated under the flap

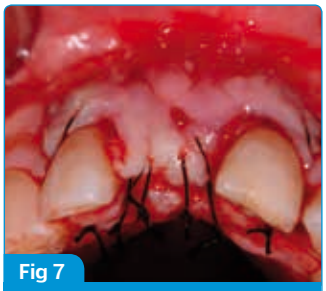

Fig 7
Flap sutured with 4-0 silk to achieve primary closure over the site

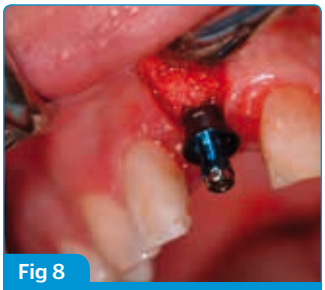

Fig 8
A 15mm Full Osseotite straight-sided hex implant is placed with an insertion torque of 45Ncm

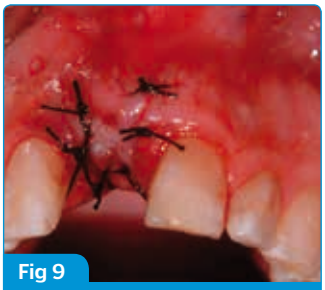

Fig 9
As the implant was largely in regenerated bone, no additional grafting material was required

Fig 10
Temporary cylinder and a clear crown form fabricated a temporary crown

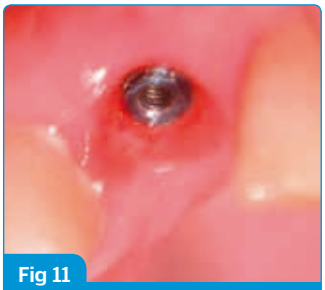

Fig 11
This was torqued to 20N/cm and cotton wool and Cavit placed in the access hole

Continued »

6. Fitting and adjusting as necessary the tooth-borne immediate partial denture.
7. Monitoring of soft tissue healing. Tissue from the tuberosity and adjacent papillae gives a better match than palatal tissue. We are ready to re-enter when incision lines are fully closed.

Rebuilding the lost bone

1. Re-entry was carried out at four months using a full thickness flap for access.
2. Underlying bone was curetted with a Rhodes chisel and a round bur was used on the labially-facing surface of bone to ensure bone bleeding (Fig 4).
3. Endobon xenograft material (Biomet 3i) was placed after being moistened with blood and saline (Fig 5).
4. OsseoGuard xenograft membrane (Biomet 3i) was trimmed and fitted once it seated passively under the flap (Fig 6).
5. The flap was sutured with 4-0 silk to achieve primary closure over the site (Fig 7).
6. The partial denture was adjusted and refitted after ensuring there was no positive pressure in the area of the grafted bone.
7. Monitoring of healing. Sutures were removed at two weeks and periapical X-rays taken at two and four months to check for good graft condensation and to ensure there were no voids in the graft material. The timing of implant placement will also depend on bone available beyond root apex position.

"We enjoy fast food... but prefer slower fine dining"

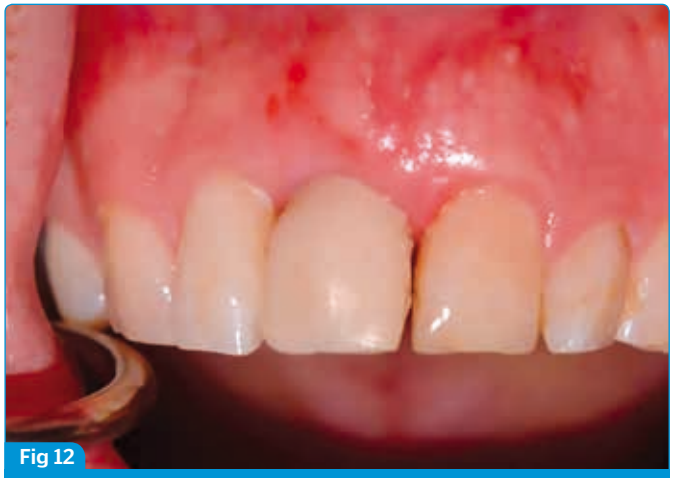

Fig 12
Four weeks' healing was allowed for gingival contour to be developed

Replacing the tooth

1. The graft was left to mature for six months then a full thickness papillae preserving flap was used to access the site, revealing excellent regenerated bone.
2. A 15mm Full Osseotite straight-sided external hex implant (Biomet 3i) was placed with an insertion torque of 45Ncm. Because the implant was largely in regenerated bone, immediate restoration was not attempted. No additional grafting material was needed (Figs 8 and 9).
3. After four months, exposure was carried out using a punch gingivectomy approach.
4. A temporary cylinder was seated and a clear crown form was used with cold cure acrylic to fabricate a temporary crown. This was Torqued to 20N/cm and cotton wool and Cavit placed in the access hole (Figs 10 and 11).
5. Four week's healing was allowed for gingival contour to be developed (a little longer would have been preferred, however the patient was moving away from the region) (Fig 12).
6. Pick-up coping impression was taken with Impregum injection into sulcus to capture emergence profile developed with the temporary crown. Occlusal records and shade were taken and agreement was reached with the patient on a midline diastema to improve symmetry (Fig 13).
7. The porcelain fused to metal, screw retained crown was tried in, and the fit and occlusion were checked then, after

aesthetics had been approved by the patient, a square Goldtite screw was torqued to 32 N/cm and access sealed with cotton wool and composite.

8. A final X-ray was taken and oral hygiene instruction and recall advice were given.

9. The patient returned one year later for a recall examination and X-ray and was still delighted with the aesthetic improvement (Figs 14 and 15).

Conclusions

This case report illustrates that not all tooth replacement problems can be managed by immediate or rapid implant restoration. While the concepts of immediate replacement and immediate loading of implant prostheses certainly has a place in our armamentarium, it is not applicable to all situations and is certainly a long way from being a panacea.

We may all enjoy fast food occasionally, but generally slower, more relaxed fine dining is preferred. It is perhaps appropriate to consider Dennis Tarnow's maxim: "Do one miracle at a time."

Acknowledgements

- All laboratory work by DTS Laboratory
- Annibale Coia referring dentist

ABOUT THE AUTHOR

Crawford Bain BDS DDS MSc MBA is professor of periodontics and programme director of graduate periodontics at Dubai School of Dental Medicine.

Fig 13
Pick up coping impression was taken with Impregum injection into sulcus

Fig 14
One year on

Fig 15
X-ray one year later

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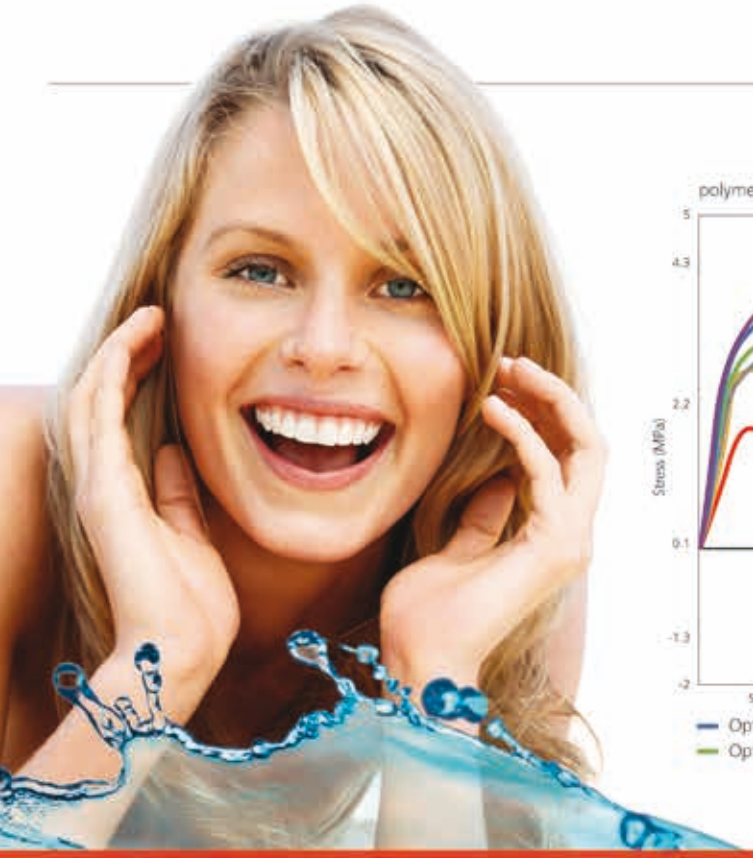

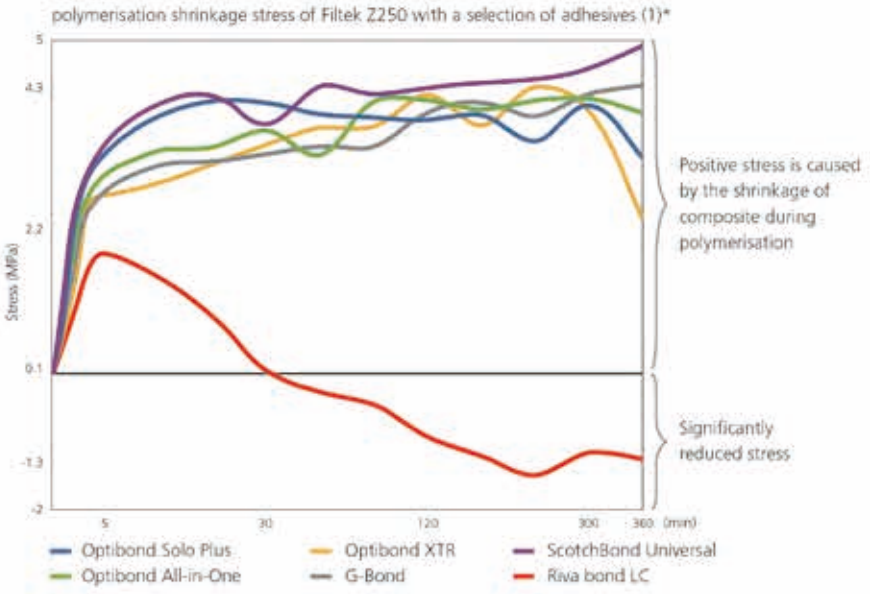

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Advanced techniques for membrane use in modern bone and tissue regeneration
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[1] Schwarz F et al. Clin. Oral Implants Res. 2008; 19 : 402-415

Managing aggressive periodontitis

Dr Jose Armas describes the management and treatment of a patient diagnosed with generalised aggressive periodontitis

The following case report describes the management of a patient with generalised aggressive periodontitis, combining non-surgical/surgical periodontal therapy, regenerative procedures, orthodontic and restorative treatment to address inadequate aesthetics.

Presenting complaint

Female patient, 42 years of age, referred by her general dental practitioner for the assessment and treatment of her periodontal condition. Main complaints for the last two previous years were:

- Inadequate aesthetics
- Tooth mobility
- Migration
- Bleeding on brushing
- Sensitivity.

Dental history

The patient had been an irregular attendee to GDP in previous years. This has improved in the last six months. The current oral care regime consisted of tooth brushing and the use of interdental brushes three to four times a day. No previous HPT for her periodontal disease.

Medical history

Fit and healthy 42-year-old female. No reported allergies. Non smoker and moderate alcohol consumption (16 units/week).

Examination

Extra-oral

Competent lips with a medium-high upper lipline showing full crown length of maxillary central and lateral incisor teeth when smiling, without any gingival display.

Otherwise, nil of note.

Intra-oral

Soft tissues were moist and healthy. Oral hygiene was adequate with minimal isolated supragingival plaque deposits, mainly located in the posterior interdental areas. There was no evidence of supragingival calculus, but there were generalised deposits of subgingival calculus.

Gingivae appeared generally erythematous and there was brisk bleeding on probing (BoP). Probing depths ranged between 3mm and 9mm. The majority of the dentition exhibited increased mobility and furcation involvement was evident in relation to the molar teeth. These findings are shown in Figure 1.

The dentition was heavily restored, predominantly with amalgam. Tooth 22 was restored with an all-ceramic crown. Tooth 12 appeared discoloured at the disto-incisal area due to the presence of a cingulum amalgam restoration. Tooth 46 presented with fracture of the amalgam restoration.

Occlusion

Class one incisal relationship in a skeletal class one. The maxillary incisor teeth were proclined with a presenting overjet of 4mm on tooth 12 and 3.5 mm on tooth 21, they also had a triangular shape and were spaced out approximately 1mm to 1.5 mm between all anterior teeth.

The maxillary tooth 21 was over erupted approximately 1mm. Dental maxillary and mandibular midlines were displaced by approximately 1.5mm to the left side and not coincident with the facial midline.

Additional investigations

- Full periodontal examination (Figure 1).
- Full mouth periapical radiographs (Figure 2).

The following findings were observed:

– Generalised moderate horizontal bone loss, ≥ 50 per cent, of the root length in both maxillary and mandibular arches. More advanced hori-

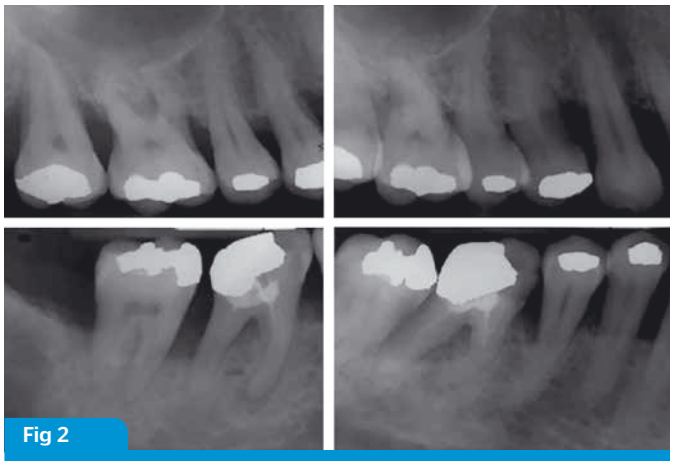


Fig 2 Periapical radiographs at time of initial presentation

X	D1	B2	.	.	.	.	.	FURCATION	.	.	.	.	.	M,B1 D2	M 1	.
X	2	1	1	1	1	1	1-	MOBILITY	1	1	1	2	2	1+	1 -	1-
X	8	7	4	9	8	7	7	POCKETS	7	8	8	7	7	7	8	5
8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
X	7	7	6	6	7	6	7	POCKETS	3	3	3	6	3	9	X	X
X	2	1	1-	1-	1-	1-	1-	MOBILITY	1-	.	.	.	.	1+	X	X
X	.	L1 B1	.	.	.	.	.	FURCATION	.	.	.	.	.	.	X	X

Fig 1 Periodontal pocket probing depths and tooth mobility recorded at initial presentation

zontal bone loss, ≥ 75 per cent, in the maxillary left quadrant.

– Vertical bone defects mesial aspect of teeth 37 and 42.

– Evidence of furcation bone loss present on the maxillary molar teeth and tooth 46.

– Evidence of endodontic treatment of tooth 22 with adequate apical obturation. This tooth was restored with a customised post-core of adequate width and length. There was no evidence of periapical pathology associated with this tooth.

– Tooth 46 showed evidence of endodontic treatment with inadequate root preparation and inadequate obturation. Both the mesial and distal roots had poorly condensed root fillings that were more than 15mm short of the radiographic apex. Periapical pathology was evident on the mesial root.

x	B1	B1						FURCATION						D1		
x	1	1	.	.	.	.	.	MOBILITY	.	1	.	1	1	.	.	.
x	5. . 66 .	.5. 5..	… …	… .4.	… …	… …	… …	POCKETS	… …	… …	… …	… …	… …	.3 6 ..3	… …	.3 3 ..3
8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
x	65 5 5. 6	64 . 6..	… …	33 3 . . .	… …	… …	… …	POCKETS	..5 …	… …	… …	… …	… …	… …	x	x
x	1	.	.	.	.	.	.	MOBILITY	.	.	.	.	.	1	x	x
x	B1	L2 B1						FURCATION							x	x

Fig 3 Six probing pocket chart

X								FURCATION						D2		
X	1	.	.	.	.	.	.	MOBILITY	.	1	.	1	1	.	.	.
X	.3. …	… …	… …	… …	… …	… …	… …	POCKETS	… …	… …	… …	… …	… …	… …	… …	… …
8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
X	… …	… …	… …	… …	… …	… …	… …	POCKETS	… …	… …	… …	… …	… …	… …	X	X
X	1	.	.	.	.	.	.	MOBILITY	.	.	.	.	.	1	X	X
X	B1	L1 B1						FURCATION							X	X

Fig 4 Six probing pocket chart taken at re-assessment post surgical phase therapy

X								FURCATION						D2		
X	1	.	.	.	.	.	.	MOBILITY	.	.	.	1	1	.	.	.
X	4.. …	… …	… …	… …	… …	… …	… …	POCKETS	… …	… …	… …	… …	… …	… …	… …	… …
8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
X	4.. 5..	… …	… …	… …	… …	… …	… …	POCKETS	… …	… …	… …	… …	… …	… …	X	X
X	1	.	.	.	.	.	.	MOBILITY	.	.	.	.	.	.	X	X
X	B1	L1 B1						FURCATION							X	X

Fig 5 Six probing pocket chart at review visit after supportive phase therapy

Diagnoses

- Generalised aggressive periodontitis
- Chronic periapical periodontitis due to failed endodontic treatment
- Failed restoration of mandibular tooth 46
- Missing teeth
- Inadequate aesthetics.

Treatment plan

- General dental practitioner to assess tooth 46 for repeat root canal treatment and full coverage restoration
- Hygiene phase therapy
- Re-evaluation
- Open root surface instrumentation as indicated
- Re-evaluation
- Orthodontic-restorative Treatment for aesthetic improvement
- Supportive periodontal therapy.

Hygiene phase therapy

Hygiene phase therapy was completed over eight visits. During this time, the patient developed generalised mild dentine hypersensitivity that was treated with a combination of topical application of desensitising agent with high content of sodium fluoride and prescription of high content of sodium fluoride dentifrice for daily use.

At re-evaluation after non-surgical hygiene therapy, the main complaints were:

- Generalised cervical sensitivity
- Generalised gingval recession.

Intraoral examination revealed excellent oral hygiene, with no supra gingival plaque deposits detected. Gingivae appeared pink and moist, with good tissue tone and evidence of generalised gingival recession of 2-3mm (Figure 3). Periodontal examination demonstrated residual probing depths of 5-6mm with increased mobility of several teeth as seen in the pocket chart shown in Figure 3. Slight improvement in the general sensitivity had been noticed since the high-fluoride desensitising agent had been applied.

The areas with persistent pockets were treated surgically. The grade two buccal furcation of tooth 16 also required regeneration with xenograft material (Bio-Oss, Geistlich) and a resorbable collagen membrane (Bio-Gide, Geistlich. The muco-periosteal flap was coronally advanced and sutured with polypropylene monofilament suture.

Four weeks after surgical instrumentation of the mandibular right molar area, the patient developed a lateral periodontal abscess. It was drained under local anaesthesia and a three-day course of Metronidazole 400mg was prescribed in conjunction with analgesia as required and chlorhexidine rinse twice a day.

Ten weeks after the surgical therapy was completed, the patient was reassessed. Complaints at this stage were:

- Generalised cervical gingival recession
- Large interdental spaces present in the maxillary anterior sextant.

Intraorally, the oral hygiene and supragingival plaque control was excellent. Minimal supragingival calculus deposits had reformed lingual to the mandibular incisal teeth. The periodontal examination of the full dentition revealed no pathological probing depths, no bleeding on probing and isolated increased mobility as shown on the pocket chart shown in Figure 4.

Continued »


Fig 6a


Fig 6b


Fig 6c


Fig 6d


Fig 6e


Fig 6f


Fig 6g


Fig 6h

Frontal and lateral intraoral views with the labial veneer in place on the left hand side and without on the right. Extraoral views with forced smile

Continued »

There was clinical evidence of a good response to surgical therapy with reduction in periodontal probing depths, mild gain of attachment, reduction of tooth mobility and improvement in the areas of furcation involvement.

Supportive phase therapy

The patient was placed on a supportive phase therapy programme with a dental hygienist on a three-monthly basis, with instruction to re-instrument deep pockets of ≥ 4mm that bled on probing. This can be a sign of re-colonisation of pockets. In addition, re-enforcement of the importance of good supragingival plaque control with daily use of interdental brushes. At the eight-month review, patient's main concern was the large interdental "gaps" present in the maxillary anterior sextant. The periodontal condition was good and stable as seen from the pocket chart in Figure 5. It was felt that the patient would benefit at this stage from a labial acrylic gingival veneer in order to address her aesthetic concerns.

"The result is acceptable considering the lack of contact points"

The result is acceptable considering the lack of contact points present between the lateral and central incisor teeth and thus the impossibility of filling the whole interdental space with the acrylic material. This was an interim measure prior to the orthodontic assessment and treatment (Figure 6).

During a tailored periodontal maintenance programme, the patient maintained excellent oral hygiene with a stable periodontal condition as seen from the pocket chart dated 20-10-09 (Figure 7). Tooth 17 showed isolated distal and buccal pockets of 5-6mm requiring additional non-surgical re-instrumentation under LA. Teeth 24 and 25 exhibited increased mobility of grade 1 requiring removal of the occlusal interference adjusting the occlusion in lateral excursions. Taking into account the excellent motivation of the patient and medium-term periodontal stability, an orthodontic opinion was sought to assess suitability for treatment.

X								FURCATION					D 2		
X	1	.	.	.	.	.	.	MOBILITY	.	.	.	1	1	.	.	.
X	.6.	...	...	...	...	...	...	POCKETS	...	...	...	...	...	...	...	...
8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
X	...	...	...	...	...	...	...	POCKETS	...	...	...	...	...	...	X	X
X	1	.	.	.	.	.	.	MOBILITY	.	.	.	.	.	.	X	X
X		L1						FURCATION							X	X

Fig 7 Six probing chart

Orthodontic-restorative treatment

Following an orthodontic assessment, the patient received maxillary and mandibular fixed appliances with additional interproximal stripping to reduce the interdental spaces in both arches, retrocline the maxillary anterior sextant to create contact points and intrude maxillary tooth 21 to align the incisal edge with the contralateral incisor tooth.

The patient was aware of the need of permanent retention in the form of palatal bonded wire. It was also made clear that, due to the shape of her maxillary teeth and the gingival recession as a result of the periodontal treatment received to date, orthodontic treatment alone would not remove the "black triangles". For that reason, restorative treatment in the form of composite additions mesial and distal to the central and lateral maxillary incisor

teeth, plus replacement of the all ceramic crown of maxillary tooth 22, should follow to obtain an overall better result.

Or, alternatively, continue with the labial gingival acrylic veneer (Figure 8a). Additional hygiene support was provided to avoid any relapse of the periodontal disease during orthodontic treatment.

Appraisal of the treatment outcomes

One of the keys for success in periodontal treatment is to make sure that the patient understands the etiological cause and evolution of his/her disease and the role that he/she has in it. Spending time at the first visit with the patient and giving them adequate time to process the information received will allow them to ask appropriate questions that concern them.

The patient must demonstrate good motivation, and maintain excellent supragingival plaque control to achieve periodontal stability overtime before the aesthetic and mobility concerns could be reviewed.

The maxillary molar teeth were treated differently. There is good evidence to support buccal furcation class two in molar teeth responding well to regenerative techniques. This is not the case for molar proximal furcations class two. In this case, the left maxillary molar teeth did not receive additional treatment after the surgical instrumentation. The proximal furcations were left to heal by repair. A targeted supportive therapy programme will guarantee the long-term stability of the periodontal disease for the molar teeth.

The provision of the labial acrylic veneer involving six units, although not ideal because of the proclined position of the maxillary teeth and the lack of contact points, has proved to be successful in addressing and improving the aesthetics of the maxillary anterior sextant as an interim measure.

A more pleasing result to attempt infill of the interdental spaces has required a combined orthodontic-restorative approach. Full commitment of the patient understanding the length of time that this type of approach involves and maintaining excellent oral hygiene during the orthodontic phase is paramount. Patients suffering from aggressive periodontitis must be closely monitored. If reinfection occurs, disease tends to have a more rapid progression than any other periodontal condition.

A tailored maintenance programme is of great importance to arrest at early stages any occurring reactivation that might take place. A three-monthly appointment seems to be an adequate regime. ■

ABOUT THE AUTHOR

Dr Jose Armas MBBS, BDS, MFDS (Glas). MRD (Perio). Specialist periodontist practicing at Somerset Place Consulting and consultant in periodontics at Glasgow Dental School and hospital.

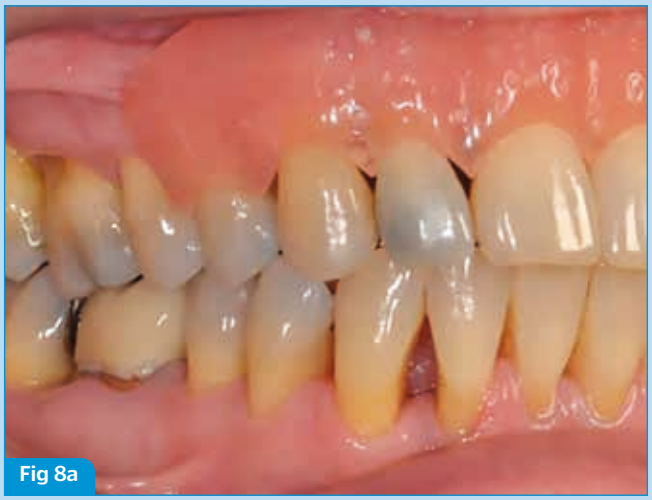


Fig 8a


Fig 8b


Fig 8c


Fig 8d

Post orthadontic treatment frontal and lateral intraoral views with labial veneer in place

Making their patients beam

Dundee orthodontic practice is striving for perfection every single day

Beam Specialist Orthodontic Practice's principal orthodontist Ruaridh McKelvey (known as Rhu) sums up his craft quite simply. "As specialist orthodontists, we perfect smiles using braces. It's all we do," he says. However, Beam do much more than that.

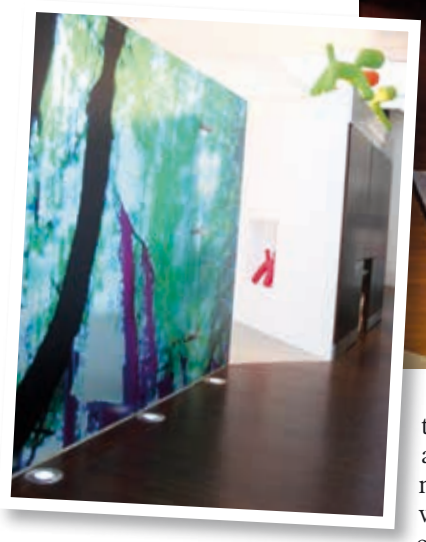
The energetic team at the Dundee clinic, who work with patients from throughout Fife, Stirlingshire, Perthshire and Aberdeenshire, as well as Tayside and Angus, don't just correct imperfections. They strive for perfection and, every day, go above and beyond what's expected – whether the 'customer' is an NHS dentist, NHS patient or a private patient.

Beam was unveiled in 2007 when Rhu and his wife Jane, a dentist and talented interior designer, set about converting the former Evangelical Church Hall in Dundee's buzzing Cultural Quarter into the state-of-the-art practice Beam is today.

A real 'Grand Designs' project, the result is simply stunning, with an open-plan, cutting-edge clinic enabling orthodontic therapists to work closely with specialist orthodontists, complemented by more private treatment spaces.

Speaking of the fantastic environment, Rhu said: "It's our wish that patients enjoy the process as well as the result of our treatments and Beam is the place to refer your own much-loved patients to. Quite simply, we'll care for them as you would expect and wish for your own kin. We've also created an amazing place to come to work and patients pick up on that as soon as they walk through our doors."

The success and ethos of Beam undoubtedly lies with the Beam team. Launching with one specialist orthodontist and two part-time nurses, the practice now employs a team of four fully-qualified and in-house trained orthodontic therapists, six orthodontic nurses, two receptionists, a practice business manager and a treatment coordinator.



Rhu said: "We are exceptionally proud of our team who are constantly working hard to reflect Beam's ethos and brand. It's instantly evident in the warm, enthusiastic and friendly environment that greets patients, whether they're private or NHS customers."

When it comes to NHS orthodontic treatment, Beam enjoy an excellent relationship with dentists along the east of Scotland, with only orthodontists on the GDC's specialist list looking after their patients' treatment planning and management. Beam understands the potential difficulties faced when referring to an outside team and values each patient referral.

Rhu explained: "We go to great lengths to ensure a seamless relationship with our referring dentists. We more than understand the daily pressures facing general dentists and work hard on perfecting our communication and feedback systems to ensure that we not only handle referrals professionally, but work successfully as a team, particularly on multi-disciplinary cases.

"Our orthodontists are easily available to discuss specific treatments and multidisciplinary cases, working alongside the dentists' own treatment aims, to make the restorative

outcomes as successful as they can possibly be."

Putting the clinical side of dentistry aside, Beam also prides itself on being a 'hub' for referring dentists, who can tend to feel isolated in their day-to-day working lives.

Through 'Beam Business Basics', Beam offers CPD verifiable meetings and events, which cover everything from key performance indicators and staff issues to patient engagement processes. Beam also offers in-house training for referring dentists' clinical support teams, be it clinical photography, impression taking or help achieving radiology exam practicals.

The hub provides a platform for informal sharing of ideas and experiences, with Beam sharing their own systems and knowledge often gleaned over years of involvement with their mentors at 'Breathe Dental Coaching'.

Jane said: "In the very early days of Beam, we were aware that the piles of paperwork were mounting and that the business side of things could become suffocating. That's when we joined Breathe Dental Coaching, run by former dentist Dr Simon Hocken. That saved our lives and became the catalyst for change and progress.

"We're eager to pass on the lessons we have learnt to other dentists who can easily find themselves swallowed up by the non-stop clinical and hugely administrative job that is NHS dentistry. We certainly haven't got everything right but it's good to share even the difficult experiences with others and learn from each other".

It seems that Beam never stand still, and are not afraid of trying the new, be it clinical or management techniques.

Jane continued: "As with the rest of life, the one certainty is change – that's something we are always happy to embrace at Beam and expect our team to be able to follow suit. We do constantly try to be the best we can be, and that is one fabulous advantage about being an independent owner-run creature – if something isn't working, then we try something new until it does."

And it's not all work, Beam also hosts regular informal social gatherings which allow for the much-needed and off-the-record interactions, and chances to discuss cases.

So what's next for Beam?

"Our vision is to open one or two more Beams," said Rhu. "The only sticking point is to pinpoint the people who 'get it' and who will honour the brand and do it justice which is why we're currently seeking an additional specialist orthodontist to grow the team, and bring a relentlessly positive attitude to work every day.


Rhu McKelvey

TESTIMONIAL

"Thanks to a great team, your skill and competence are one thing, but it's your warmth and empathy that make you outstanding." Patsy Whelehan, Beam patient.

"After much blood, sweat and tears – and a lot of investment! – I'm extremely proud of our Beam set-up and, underpinned by the passion which the entire Beam team share, truly believe that we've got the structure in place to move onwards and upwards." ■

Lucky number 13 for Edinburgh Orthodontics

Anniversary celebrations for Gilmore Street-based specialist clinic

Edinburgh Orthodontics has become a teenager! It is 13 years this month (October) since we opened for business at Gilmore Place. Over the years, we have become an established and respected member of the Scottish dental fraternity.

All our team are GDC-registered specialist orthodontists, who provide continuity of care for your patients from initial assessment to completion and retention of their orthodontic treatment. We believe that this continuity provides optimal care and quality of outcomes.

While we have embraced new developments in the specialty, such as miniscrew implant anchors and the digital technologies, we have continued to focus on using our specialist knowledge to provide an optimal treatment plan for each individual patient.

In an era when one is bombarded with the seductive promises of 'quick fix' branded orthodontic products, we believe that there is no substitute for specialist knowledge and experience in delivering quality orthodontic care.

As we can offer all systems, from conventional fixed appliances, through aesthetic ceramic systems, to Invisalign and hidden lingual braces, we can find an optimal solution that is appropriate to your patient's clinical problem and needs. Indeed, our specialist solutions can often be faster and less costly than the quick-fix branded products.

Your patients should only undergo orthodontic treatment once. We feel that it is important that all options are discussed with your patient to ensure an appropriate and optimal treatment. We are delighted to liaise closely with the referring practitioner either by phone, e-mail or meeting in person to optimise interdisciplinary care.

So, whether it is orthodontics for children and teens, quality aesthetic treatment for adults or complicated orthodontic/restorative cases, we have the knowledge and experience to help you achieve the best for your patients. ■

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Testimonials

"Gavin and I have worked together on many joint ortho/restorative cases over ten years. He has always given me what I have asked for. His rigorous attention to detail is what says him apart in my opinion."

Dr Martin Rennie BDS, Edinburgh

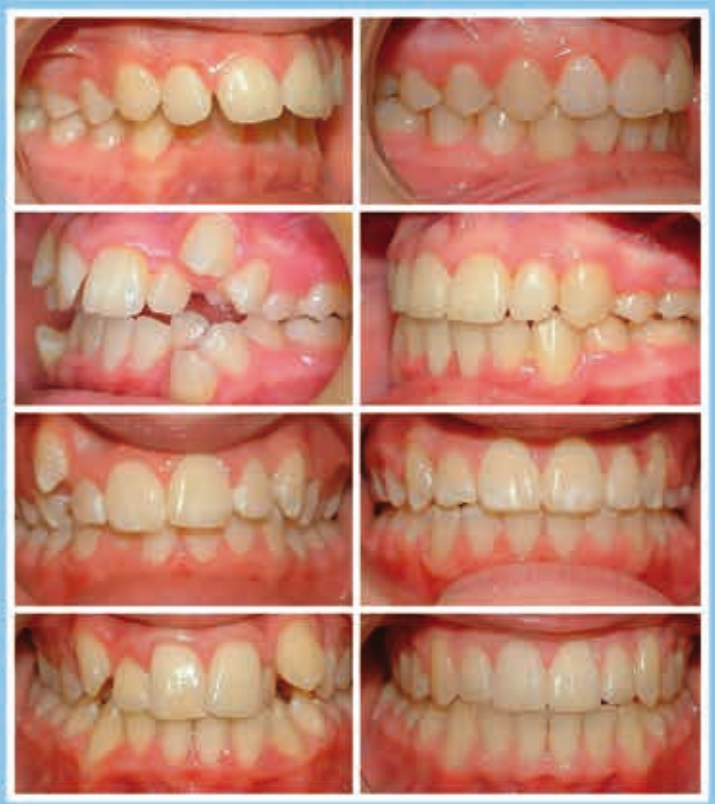
"I started referring patients to Gavin when he opened in Haddington. His results, for both children and adults, either on the NHS or Private, are excellent. He is a very approachable person and is a pleasure to work with; his communication with me, and with patients, is outstanding. His meticulous attention to detail and very high standards of work are unequalled."

Dr Pauline Stanhope-Jones BDS, Longniddry

I have known Gavin for over 20 years and now refer all my patients, children and adults to Gavin. All of them like the personable manner and clear explanations offered. Seeing the same face at each visit makes a huge difference. Gavin has also treated all of my children and they think he's cool! Highly recommend.

Dr Carol Fish BDS, Dunbar

Before **After**



All cases treated by Gavin Caves

ORTHODONTIC SPECIALIST
BDS (Edin), FDSRCS (Edin), MSc (Glas), MOrth (Edin)
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Ensuring great smiles

Gavin Caves Orthodontics is thriving in the heart of East Lothian

Gavin Caves graduated from Edinburgh University with his BDS in 1993 – receiving the class prize in orthodontics – and gained his FDS from the Royal College of Surgeons of Edinburgh (RCSEd) in 1996. He then completed his three year orthodontic specialist training in Glasgow, graduating with an MSc from the University of Glasgow and his Membership in Orthodontics from RCSEd in 2000.

Gavin has worked in specialist orthodontic practice in Edinburgh since 2000 and was also involved for many years with the clinical teaching of postgraduate students at the Edinburgh Dental Institute until starting his new specialist practice in Haddington in 2010. He is an examiner for the Edinburgh Royal College of Surgeons in MOrth.

Having spent 10 enjoyable years working in two of the largest specialist practices in Edinburgh (Scottish Orthodontics and Edinburgh Orthodontics), Gavin decided it would be great to start his own small, personal practice and realised the perfect geographical need for an orthodontist was in the heart of East Lothian, Haddington.

From one day a week, Gavin's practice has grown by word of mouth to become full time, with over 1,500 referrals received so far. Every patient is seen from start to finish by Gavin, whose meticulous attention to detail and friendly nature ensure that all of his patients have great smiles.

A comprehensive range of appliance types are available, from NHS fixed appliances for all ages to ceramic fixed appliances, Incognito Lingual appliances and Invisalign. ■

Gavin lives with his wife Marian, a part-time GP, and his three loud and amazing children – Hannah (8), Cameron (6) and Rachel (3).

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Saying a big thank you!

Glasgow Southside Orthodontics shows appreciation to its referring practitioners by expanding its team further to improve service

Glasgow Southside Orthodontics (GSO) wish to say a big thank you to all the dental practitioners who refer patients to us.

GSO was established in 2009 by Nadia Hajjaj and Fern Stewart and has steadily grown over the last four years.

At Glasgow Southside Orthodontics, our aim is to continually review and strive to improve the services we offer and at this stage in our development, we are delighted to announce the appointment of Lindsey Church who has joined us as a third specialist orthodontist.

Lindsey's appointment will help spread the workload and allow us to cut down the time between referral and initial assessment of the patients.

To make referrals as easy as possible, we have recently updated our Dental Practitioners' Referral Form on our practice website. Alternatively, we can be contacted by telephone, by e-mail or in writing (for this last option we can supply you with Referral Pads).

Again, thank you for your ongoing support and we look forward to continuing to offer you our best attention at all times.■

Above: Nadia Hajjaj and Fern Stewart (inset) Lindsey Church

Park life

Andrew McGregor, specialist orthodontist, outlines exciting changes at Park Orthodontics

The world has changed since 1972 when our clinic first opened on the southern side of Kelvingrove Park. It was the only specialist orthodontic practice in Glasgow and, since then, has been passed down to successive specialists, right up to the current partnership which commenced in 2012.

The practice has changed with the times; never more so than in the last year as we have modernised and improved the orthodontic experience.

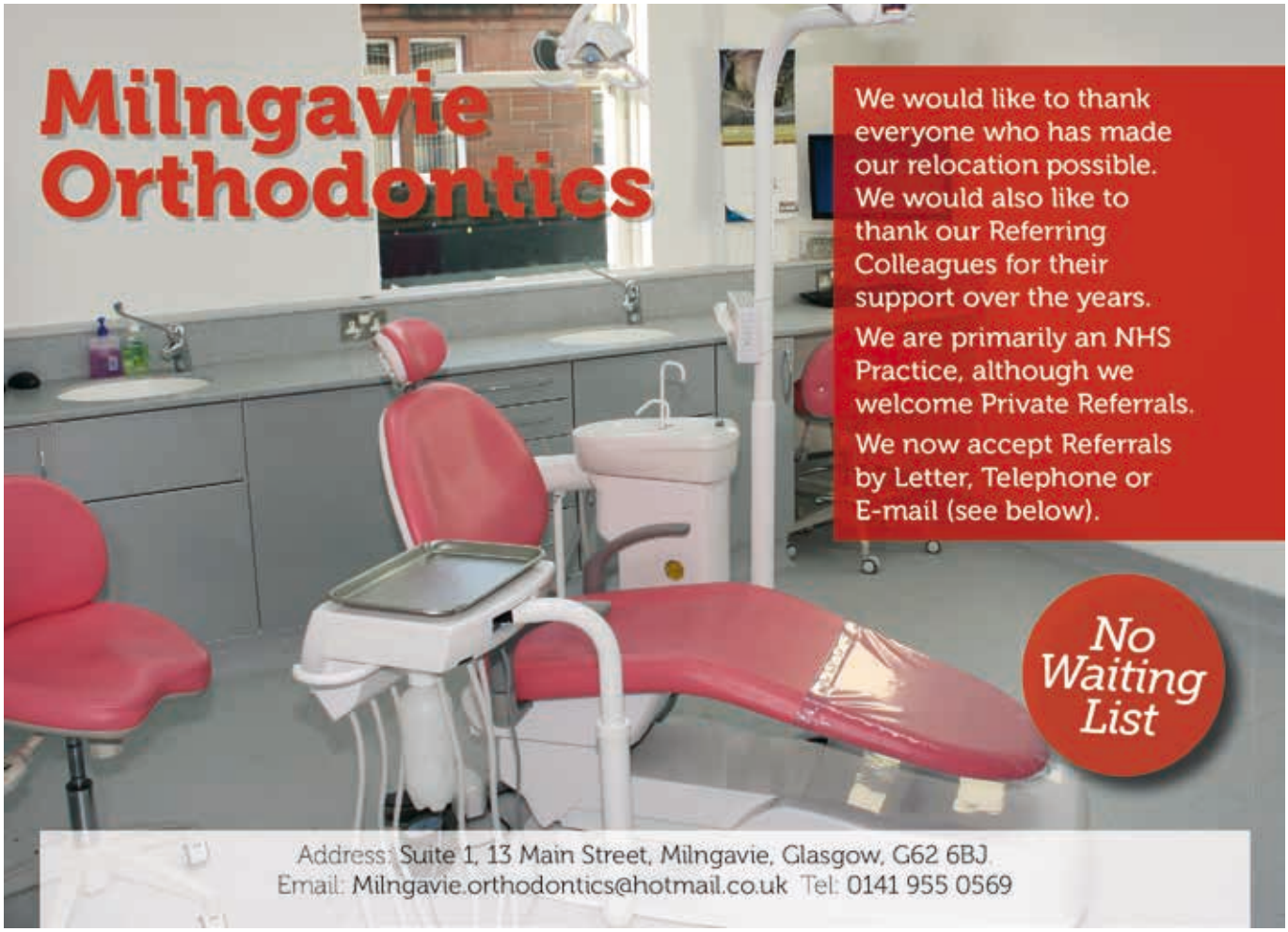
We're proud of our new waiting room which was completed in summer 2013. A big effort was made to keep the Victorian features of the West End property, while introducing new features such as a Smart TV, contemporary furniture and original art.

We've been updating our service too. NHS orthodontics still makes up the majority of our workload, but, as more adults are looking for aesthetic and discreet solutions to suit their lifestyle, we've seen a rise in the number of ceramic, lingual and aligner cases.

This has been an exciting challenge for us, allowing our clinicians to develop new skills with new appliances: lingual braces in particular are opening up possibilities to a whole group of patients who would previously not have considered orthodontic treatment.

We're also witnessing an increase in the number of referrals undergoing multi-disciplinary care, usually involving implants and bridges, which require pre-restorative orthodontics. Working closely with those providing the restorative work is something we enjoy and most importantly it's improving the final results for our mutual patients.

Throughout the 40 years of orthodontic provision, the focus has been on quality service to both patients and referring dentists. We keenly anticipate the next 40...■



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Patient care is top priority

Glasgow clinic boasts flexible appointment times and no waiting list

Giffnock Orthodontic Centre is a specialist orthodontic practice situated on the south side of Glasgow. Our practice has been established since 1986 and is conveniently located close to public transport routes to and from the city centre. We also have on-site parking for patients who wish to travel by car.

We offer NHS and private orthodontic treatments for adults and children including Invisalign, lingual (Incognito) and fixed appliances using metal and ceramic technology. From January we will have an additional specialist orthodontist joining our team, which helps to ensure that we have no waiting lists. By offering flexible appointment times to suit patient's needs and with free private consultations, any patient looking to find out about which treatments best suit their individual needs can do so without financial obligation.

The patient's journey is important to us and our aim is to ensure that each patient is given the time needed to understand their treatment options. Our trained treatment co-ordinators are a key part of our team who work alongside our two full-time orthodontists Yas Aljubouri (principal) and George Kantopoulos. They are ably supported by our orthodontic therapist Amanda Macrae. ■

For more information, contact our practice manager Valerie Noble on 0141 638 4150

TESTIMONIAL

"I have been referring my orthodontic patients to Giffnock Orthodontic Centre for many years. The service provided by Yas, George, and the team is first class.
"I always ask patients and parents for feedback and it is invariably extremely favourable. My own son recently required orthodontic treatment and I had no hesitation in sending him to see Yas, who has worked magic with his mild but tricky malocclusion."
Dr Valerie Bleau, Bleau & Small Dental Surgery

Going from strength to strength

Fifteen months after opening its doors, St Andrews Orthodontics continues to grow from strength to strength and provides an essential and welcome orthodontic service to the East Neuk of Fife and its surrounding area.

With the number of referrals increasing each week, the practice has increased its clinical hours to cope with demand, and there are plans to increase staffing levels to maintain the excellent service on offer.

Practice partner Nimo Rostami said: "Given the challenges that all colleagues have to bear – in a climate of NHS cutbacks and spiralling costs to meet new regulations – we have to confess it hasn't been an easy 15 months! The introduction of rationing based on IOTN scores, the removal, without any compensation, of the fee for repairing fixed appliances, and the introduction that no further NHS support is given to patients after they have been wearing retainers for a year are all examples of new rules that have challenged the ability of St Andrews Orthodontics to continue to provide orthodontics on the NHS.

"However, as part of the service to the local area, we continue to offer all categories of patients NHS treatment where possible."

The practice aim is to provide the best service to the patients and the referring dentists and thus continue to grow so more people can benefit from the service on offer. The staff work hard to ensure no waiting lists are in place and new patients

are seen at the soonest opportunity. Referrals are received by mail and telephone but are also possible via the practice website and email.

One goal is to work with referring colleagues to assist with their multidisciplinary cases. Whether by arranging joint clinics or individually tailored courses, the aim is to make it easier for referring practitioners to meet patients' demands.

The practice remains committed to providing NHS treatment, but also provides the latest array of options for those who would like to explore the latest in orthodontics that the NHS does not or cannot offer. ■

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DÜRR DENTAL

How do I ensure I don't miss an oral cancer?

Professor Graham Ogden talks about the aetiology and early detection of oral cancers

The early detection of oral cancer has now become a recommended topic by the General Dental Council for Continuing Professional Development. This is, in part, due to an increasing number of patients who are claiming (rightly or wrongly) that their dentist failed to diagnose their mouth cancer and, as such, are suing them for negligence.

One recent example considered in the High Court in England earlier this year, cleared the dentist, but not before his being accused of failing to identify the cancer on her gum at an early stage.

What can we do to help minimise such an event?

In America, the top reasons why a patient pursues a case of negligence against a dentist in respect of oral cancer are:

- Failure to make an early diagnosis
- Failure to refer to a specialist
- Claiming damages for the consequences of a failure to detect the cancer at an early stage
- A perception by the patient that the dentist had not taken their concerns seriously.

Key questions to consider when assessing the malignant potential of an oral lesion

1. What Risk Factors are present?

a)Tobacco

While the number of cigarettes consumed within the UK has dropped profoundly over the last 25 years or so (from a staggering 102 billion in 1990), the reduction in the number of smokers has not been as dramatic. Approximately 25 per cent of the population in Scotland still smoke.

Although novel approaches to certain groups have had some success (e.g. "Give it up for baby" – a smoking cessation intervention for pregnant women in Scotland, organised by Paul Ballard and NHS Tayside) there is still a long way to go. Clinicians should be actively involved in raising awareness of the potential detrimental effects of smoking on oral health and giving smoking cessation advice.

A key question to ask the patient with a clinically suspicious lesion is: "Do you smoke?" At least 75 per cent of oral cancers are associated with tobacco use.

With the increase in cost, many people are turning to hand-rolled cigarettes because they are cheaper, but they may lack an effective filter. Key additional questions include recording type of tobacco use, number of years they have smoked and daily quantity consumed.

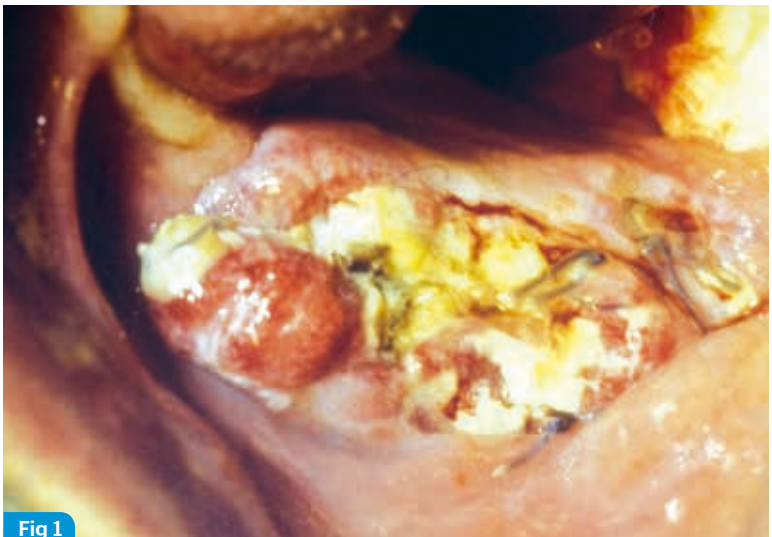


Fig 1

Typical textbook appearance of an advanced oral cancer Reproduced from Dental Update (ISSN 0305-5000), by permission of George Warman Publications (UK) Ltd.

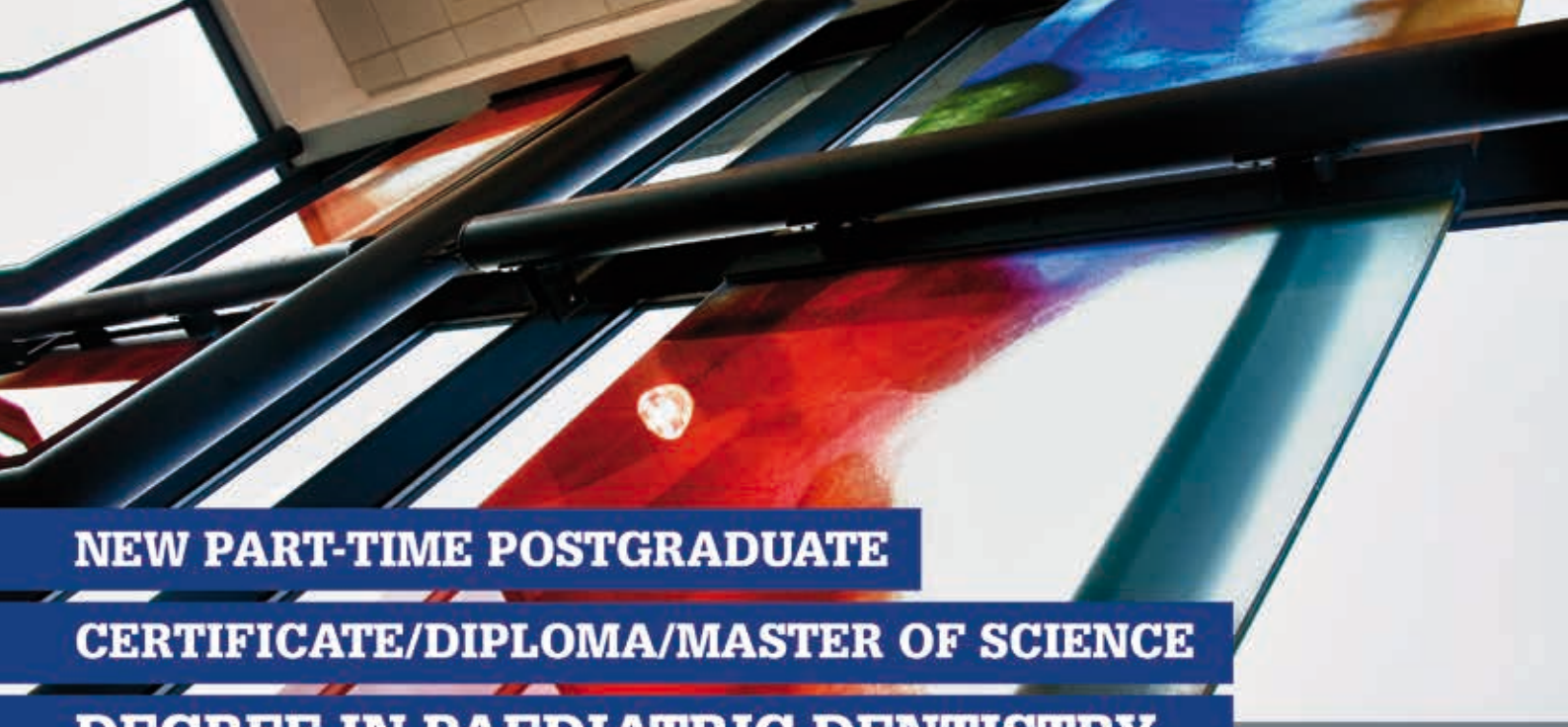
b) Alcohol

As with tobacco, it is worth asking about their use of alcohol, as this is an important risk factor for oral cancer, particularly when combined with tobacco use. The Government and indeed all the Royal Colleges, support the guidance as regard low risk drinking.

For men this is considered as no more than four units in a day or 21 units in a week (for women it is no more than three units in a day and 14 units in a week) with at least two days free of alcohol.

Obtaining a reliable alcohol history isn't always easy, partly because many patients don't know the alcohol unit content of what they drink, but also because we are often economical with the truth. Studies

Continued »



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The brand new Certificate/Diploma/Master of Science Degree in Paediatric Dentistry is the first within Scotland which has been designed specifically for dentists working within the Primary Care setting. The courses are planned with the busy practitioner in mind and are organised by the new University of Aberdeen Dental School and Hospital which offers state-of-the-art teaching facilities. All programmes are part-time and are taught by a small group of internationally- renowned, experienced and practicing healthcare professionals and researchers. Centred around a number of core courses, the programmes will allow dentists the opportunity to develop the practical skills needed to treat the child and adolescent patient effectively and importantly, will also allow plenty of time for informal case presentation and discussion of the participants' own patients.

Course Length

All programmes are part-time and as such, it will take one year to reach Certificate level, two years for the Diploma and a third year to complete the research module and attain the Master of Science Degree.

Method of Delivery

The courses are modular consisting of self-contained units and will require, on average, attendance for three days/course at the University of Aberdeen Dental School and Hospital; two of these will be at the commencement- and one day at the completion each course. Teaching will be delivered through small group seminar work and clinical skills laboratory practice with a variety of assignments being set throughout each course. There will also be the opportunity for one-to-one mentorship and discussions with course supervisors. In total, approximately 14 days/annum will be spent in Aberdeen Dental School.

Assessment

A variety of assignments, oral presentations and practical work will be used for continuous assessment and a viva undertaken at the completion of both the Certificate and Diploma.

Award of a MSc will be on successful defence of the research thesis.

Entrance Requirements

BDS or equivalent qualification recognised by the General Dental Council.

Access to child patients within their own dental practice.

Further Information

For further information and the application process please contact:

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Further details on the programmes can be found at **http://www.abdn.ac.uk/prospectus/pgrad/study/taught/paediatric_dentistry/**

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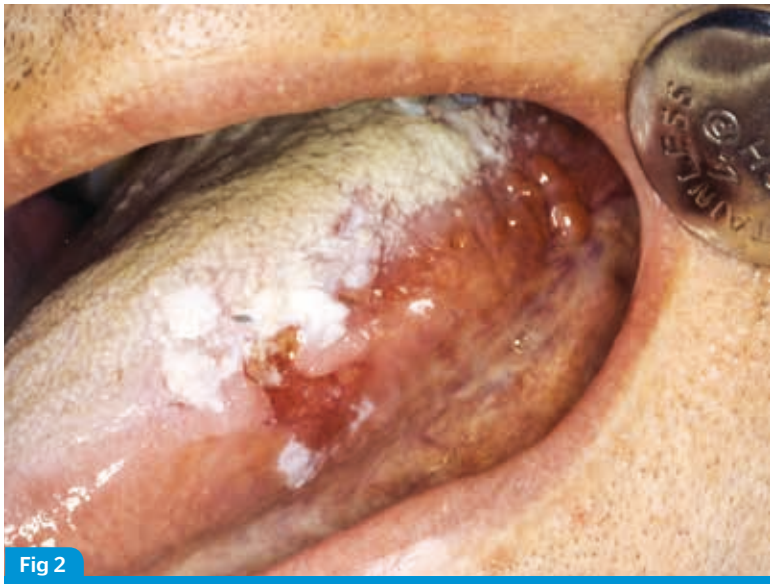

Fig 2
Note atrophic red area of early cancer surrounded by satellites of white keratoses

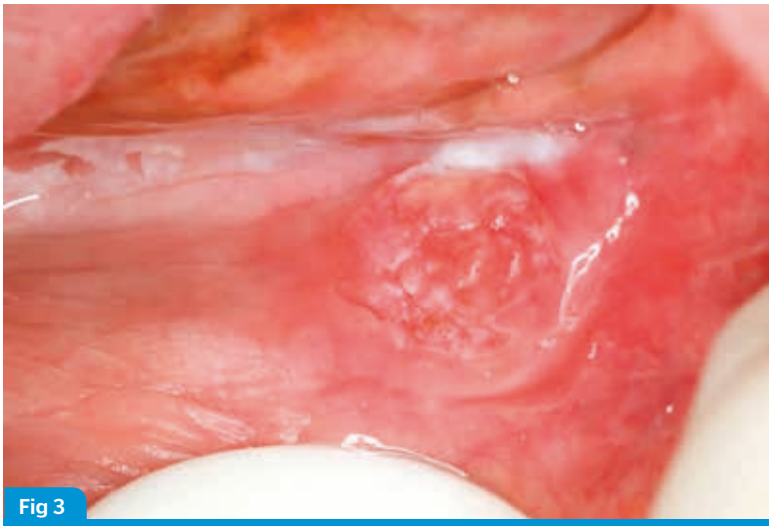

Fig 3
Early oral cancer affecting buccal sulcus. Note the areas of diffuse keratosis and atrophy surrounding the 'whorl' of slightly raised, reddened mucosa

Continued »

have shown that in the UK there is a 40 per cent underestimation of what people claim they drink, when compared with actual alcohol sales. We have gathered data regarding drinking habits and understanding of alcohol guidelines over several years during our annual Mouth Cancer Awareness Week campaigns at the University of Dundee. There is a tendency for students to underestimate the number of units of alcohol in a pint of beer. When this is combined with the frequency that they admit to binge drinking (defined as at least six units in any one session for women, and at least eight units for men), then many students would appear to be drinking at a level that would trigger a brief alcohol intervention.

The development of an appropriate intervention for dental practice is currently being explored (Shepherd S, et al Current practices and intention to provide alcohol-related health advice in primary dental care, British Dental Journal 211:322-3 2011 doi:10.1038/sj.bdj.2011.822).

2. What is the colour?
('Red is a mean mean colour')
While I'm sure Steve Harley didn't have oral cancer in mind when he wrote that song, it seems peculiarly apposite. Red is a far more significant colour when it comes to early

"Obtaining a reliable alcohol history isn't always easy... we are often economical with the truth"

manifestation of oral cancer.

Yet leukoplakia is often considered the most frequent precancerous lesion. By focusing on the white element, the issue of any surrounding erythema may be lost. Although much is made of the white patch, its malignant transformation rate is probably less than 5 per cent, whereas that of the erythroplakia is at least 80 per cent (far more significant).

Having said that, the most significant leukoplakias are those that are large and non homogenous. Far more important and more frequently associated with asymptomatic early oral cancer are the so called speckled leukoplakias (erythroleukoplakia).

3. What does the early oral cancer look like?
The early asymptomatic cancer presents in a far more subtle way than many of the textbooks might suggest. The identification of an oral cancer that has raised, rolled hard edges surrounding an area of ulceration that is oozing blood is an advanced lesion that hopefully no one would miss.

Unfortunately, by the time it has that appearance, such an advanced lesion has had plenty of opportunity to either invade surrounding tissues (such as bone) or metastasise to local, regional or distant lymph nodes.

Our attention as clinicians should be to focus on raising our index of suspicion. High risk sites in the UK are the so-called non-keratinising sites such as ventral tongue and floor of mouth. However, the routine screening and recording in the notes of the entire oral mucosa should be mandatory. Not only to help detect an early lesion, but also to help protect yourself from any claims of negligence that you failed to detect the cancer at an early stage.

Such a task that takes minimal time, requires no fancy expensive equipment, but yet could make such a difference to the patient's prognosis (if a cancer is there), is ignored at our peril. (The use of dyes or techniques based upon fluorescence or cytology are still being evaluated or have not proved to have the sensitivity or specificity to become adopted as routine tests).

Continued »

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Continued »

The recent high profile case in which the patient attempted to sue the dentist for negligence in failing to detect the oral cancer at an early stage was exonerated. He was greatly helped by the accuracy of his record keeping and screening of the mucosa.

Conclusion

The early detection of an oral cancer, can quite literally save that patient's life. In helping to raise your index of suspicion when assessing the malignant potential of an oral lesion you should consider:

- What risk factors are present? (NB tobacco and alcohol)
- What is its colour? (NB red)
- How long has it been present? (It should have healed in two to three weeks)
- Is it painful? (Pain is a relatively late manifestation, hence a non painful ulcer should arouse suspicion).

Remember, the early lesion is often asymptomatic (no pain, no ulceration, no bleeding).

Remember too that a patient is never too young to get oral cancer. One in 10 cases now arise in those below the age of 45 years. (See the Ben Walton Trust www.benwaltontrust.org) ■

For those who wish to get involved in raising awareness of oral cancer, for example during Mouth Cancer Awareness Week in November each year, then see the link to "You too can raise awareness of mouth cancer" www.benwaltotrust.org/pdf/mouth_cancer_awareness_booklet.pdf

"Remember... a patient is never too young to get oral cancer"

ABOUT THE AUTHOR

Prof Ogden is professor of oral surgery at the University of Dundee. His main research themes are aetiology (in particular alcohol) and early detection of oral cancer. On the GDC's specialist list for both oral surgery and oral medicine, he is currently president of the Association of British Academic Oral & Maxillofacial Surgeons (ABAOMS).

Prof Ogden is a former chair of the Special Advisory Committee for Oral Surgery, responsible for writing the curriculum for specialty training in oral surgery. He is also on the Medical Advisory Panel for Drinkaware and is now a vice dean (Dental Faculty) of the Royal College of Physicians and Surgeons of Glasgow.

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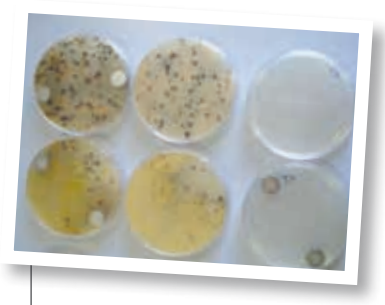
iOQ Services Ltd has recently been working with both NHS and private dental practices to ensure their compressed air is not adversely affecting patients, equipment and procedures. Although not novel, our services are relatively new to private surgeries and, quite often, the benefits of such testing and services are not well known. Poorly maintained or old dental compressors often produce air that is contaminated with:



- Water
- Oil
- Particulates
- Viable micro-organisms (see pic right).

Together, these can lead to infection, dissatisfaction and/or costly procedures to fix. Coincidentally, there has been a sharp increase in demand on modern dental practices to reduce potential risks to patients. The introduction of LDUs and water monitoring as per SHTM 01-04 (Part A and B documents are currently under consultation) will go some way to addressing the growing concern but, without legislation, dental air is still not tested regularly enough and can expose practices to some of the high risks outlined above. The NHS Guidance document (HTM 2022 Supplement 1) review is near to completion and will give clearer instructions to private dental practices on maintenance and testing requirements with many local governing bodies looking to include testing as part of the dental practice inspection.

Sign up to our mailing list at www.ioqservices.co.uk to make sure you receive our white paper on the guidance document and the implications it will have for practices like yours. Do not delay; quality testing of dental compressed air can you save time, money and patient satisfaction. ■

As the clock ticks down to the Scottish independence referendum, Jayne Clifford of Martin Aitken & Co looks at the potential financial implications

Scottish independence... a real mouthful

With less than a year to go until the 2014 referendum on Scottish independence, you can barely go a day without hearing another story from one side of the debate or the other. The main issue behind all of the stories is the conflicting research and comments that are made.

But what does this really mean for you and your dental practice? Without claiming to have a crystal ball, or coming down on one side of the fence or the other, there are two fundamental areas that need to be further examined if Scotland votes 'Yes' on 18 September.

Pensions

While there is no way to draw any conclusions, or even predict how this will be affected, it is a widely accepted key issue. Everyone wishes to be in the position that they feel comfortable and secure when they retire.

You, as practitioners, will be no different in what you wish for both yourselves, and your staff. However, as business owners, and with the upcoming auto-enrolment regulations, the ongoing cost of all of this will also be a significant factor.

With no firm outcome as to who will be responsible for the government-based pensions that are already in place, there is potential that this will have

a massive impact on the money available to the Scottish Government, should the referendum go in favour of the independence.

This itself may be an indirect cost to you and your practice. If the government has less funds available to distribute, then there may be a rethink of what grants and payments are available to NHS dentists. There will also be the potential that the criteria for these will be re-evaluated as a result.

In addition, there may also be the direct costs related to the actual contributions that are required to be made. Again, if this is a cost that rises, this will have a direct impact on you, your staff and the ability to grow your business. Recent quotes have suggested that National Insurance will continue to be paid in line with current regulations, but unfortunately with pensions, it isn't always as straightforward.

Tax

If pensions is a complex area, then tax has had even less said about it in the press, or by either campaigns. If you are working in partnerships or as a sole trader you are already subject to Income Tax at an ever changing rate, as well as VAT on most of the purchases for your business. And if you are an owner in an incorporated business you are also subject to Corporation Tax over and above that. Confused already?

Unfortunately there are no definitive answers to what will happen post referendum if changes are required. The 'Yes' campaign has predicted that there will be no significant tax changes given the proposed 'Oil Fund' approach that has been muted recently. Although, helpfully enough, the current government in Westminster has also said that this approach, similar to Norway, will not only result in higher rates of tax being needed to be paid, but also inflation.

Clearly there are some key questions which need to be answered by both parties. At Martin Aitken & Co we are in regular communication with business-owners about their concerns. I feel there are many issues which still need to be debated further and I'm sure the press coverage over the coming months will aim to do this. However, until then these are areas of consideration and concern with no definitive answers, yet. ■

Jayne Clifford, partner at Martin Aitken & Co, leads the specialist dentistry team. Jayne can be contacted on 0141 272 0000.

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Mark Fitzpatrick, Sandgate Dental Practice, Ayr

"I have worked with William Duncan since setting up my practice – I would recommend them to any dental professional – their support has been excellent"

Dr Ainsley Ness, Breeze Dental Clinic, Troon

Learn more, contact one of our dental sector specialists:
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T: 01292 265071 F: 01292 610246
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New standards

Michael Royden explains the GDC's latest advice on the use of social media in your practice

The GDC have issued Dental Team Standards which became effective at the end of September. The guidance covers a range of issues, and time will tell as to how they will be interpreted and enforced.

The standards are supplemented by some additional notes, one of which relates to social media, with three key areas covered:

Protecting patient information. No information which could identify a patient should be published without explicit consent. Even where information is anonymised, a patient could identify themselves and raise a complaint.

Maintaining appropriate boundaries. Social media allows communication barriers to be removed. However, if you use social media, you are opening your own comments up to public consumption. One key question is should friend requests from patients be accepted. My answer would be no. Accepting requests could impact on your professional relationship with a patient. I would also recommend not corresponding with individual patients via social media.

Social media policy. All dental professionals should comply with the internet and social media policies of their practice. Every practice should have a policy that is adequate to protect the practice and patients. This should be distributed to all team members with a clear message that compliance is essential.

Aside from these guidelines, we would also recommend that standard nine is considered when using social media. This states that all the dental team maintain appropriate personal and professional behaviour. This applies to both personal and business use. The impact on a person's professional standing should be considered when using social media, for any reason.

Many of the GDC Standards are in line with expectations prior to issue, but it is essential that all team members familiarise themselves with them. ■

Michael Royden is the partner who heads up the dental team within Thorntons Law LLP.

National recognition

Edinburgh-based accountants shortlisted for UK-wide awards

Stark Main & Co Dental has been shortlisted as Scottish Accountant of the Year in the British Accountancy Awards, and waits with bated breath to see if its scoops the award at the ceremony in the Tower of London in late November.

As the reigning award winner, its team is justifiably proud of this sustained recognition.

Among the many reasons its specialist dental sector team continues to be recognised nationally in this way is the difference it makes with its dental clients in helping them achieve absolute compliance, grow their practices and reduce their tax bills significantly.

As part of its genuinely proactive approach, it saved its dental clients an average of £25,000 last year and £86,000 for practice acquisitions.

As a 'taster' of its tax planning services and to celebrate its

awards shortlisting, the firm is offering the first 20 Scottish dental practices to respond a copy of its free tax busting guide and a free tax health check. Why not see if you could reduce your practice tax bills? Simply email ian@starkmaindental.co.uk to take advantage.■

AWARD WINNERS

British Accountancy Awards 2012 – *Scottish Accountant of the Year*
Practice Excellence Awards – *UK Small Firm of the Year 2012*
SBB Excellence Awards – *Employer of the Year 2011*
Accountants Club – *UK Firm of the Year 2011-2012*
Featured in the book *The UK's Best Accountancy Practices* (2011)

Pension deadline draws closer

Important changes regarding NHS pensions and HMRC protection are imminent. Financial adviser Jon Drysdale lays out the options

Dentists with NHS pension pots valued close to the Life Time (pension) Allowance (LTA) may need to act now to avoid a tax charge from April 2014. The current pension limit of £1.5 million allows a dentist to take NHS pension benefits of up to £65,000pa without liability. However, with the limit set to reduce to £1.25m next year, those taking pension benefits in excess of £54,000pa will be affected. Personal pension values also need to be considered in these calculations.

There are options available for those seeking to avoid the reduction to the HMRC lifetime limit. Here's our opinion on these:

Action one: Take your NHS Pension before April 2014

Effective, but drastic. This will crystallise the value of your NHS pension and trigger an immediate assessment against the current pension allowance of £1.5m. This action is likely to be of use to dentists with NHS pension benefits forecasted to be between £54,000 and £65,000pa.

Personal pensions must also be considered here. For example, a dentist with lower NHS pension benefits of £45,000pa but personal pension values of £165,000 will reach the limit at April 2014. Taking NHS pension benefits before the standard retirement date of 60 will incur a penalty, so a careful assessment should be made before doing this. Applying for your NHS pension can take up to four months, so don't leave it until the last minute.

Action two: Increase your NHS tax free lump sum

Not effective enough. Swapping NHS pension income for a larger tax-free lump can reduce your liability to the LTA. For every £60,000 of additional lump sum, you will lose £5,000pa of pension income and reduce the deemed total pension value by £55,000. In effect, you avoid a tax charge amounting to only £700pa.

This isn't a significant enough saving to appeal to most, unless you have a real need for additional tax-free cash.

Action 3: Apply for HMRC protection

Not as simple as it sounds. There are five forms of HMRC protection, some of which are no longer available or don't apply in certain situations. Fixed protection 2014 and Individual protection are the ones to focus on.

Firstly, you can't have these if you already have an existing protection certificate in place. The outcome is to fix your LTA at £1.5m beyond 2014. Rules apply preventing those with fixed protection from further pension accrual. In effect, you lose the protection if you continue to actively accrue pension benefits (NHS or personal).

This may be appropriate for some individuals and Fixed Protection will need to be applied for and accepted before April 2014.

Action 4: Accept a LTA charge

Worth considering. The LTA charge may not be as punitive as you think. For example, if you breach the allowance by £100,000, an annual deduction of £1,250 will be applied to your NHS Pension.

The key here is to assess whether taking your pension benefits early and/or applying for protection puts you in a better financial position than paying the charge. This requires some detailed analysis and calculations involving your NHS Pension, personal pensions and existing annuity income. A competent adviser with specialist NHS knowledge will be able to do this for you.

Action 5: Cap the growth of personal pension funds

Effective damage limitation. This is most likely to be suitable for those close to the LTA limit and with personal pension funds in excess of £100,000. Pension drawdown can be used to avoid a 'second test' of the LTA in future years.

This strategy involves crystallising your personal pension and drawing out sufficient income annually to freeze the value. This needs to be well managed and through a SIPP (self invested personal pension). Independent advice is needed to ensure investment risk meets your objectives.

I strongly recommend dentists seek independent advice on their proximity to the LTA. A good starting point is obtaining a forecast of NHS pension benefits. Advice will need to be tailored to individual circumstances. The comments in this article are based on current legislation and pension rules, which are subject to change. The article is not intended as individual advice. ■

JARGON BUSTER

Life Time Allowance (LTA): HMRC's limit on the value of your combined pensions.
HMRC protection: A way of locking into the current LTA.
Crystallisation events: Taking pension benefits from the NHS or personal pensions.
Annuity: An annual income purchased with your personal pension fund.
Drawdown: A means of extracting income from your personal pension without purchasing an annuity.
Open market option: Shopping around for the best annuity rate.
Tax free cash: A lump sum provided at NHS Pension age and/or 25 per cent of the value of your personal pension.

ABOUT THE AUTHOR

Jon Drysdale is an independent financial adviser and director of PFM Dental (Financial Advice). PFM Dental offers wealth management services exclusively for dentists. Please contact the author to discuss your individual situation. Jon can be contacted at www.pfmdental.co.uk or on 0845 241 4480.

Locator Over Denture Implant system

General Medical introduce the LODI (Locator Over Denture Implant) System from Zest, manufacturer of the world's leading implant-retained overdenture attachments, for just £112.12 plus VAT each.

The LODI system can be used to securely retain both maxillary and mandibular overdentures and is ideal for cases with narrow ridges, where there are financial considerations or when the operator wants minimal invasive flapless surgery.

Ready for immediate placement, self-tapping LODI implants are available in two diameters (2.4mm and 2.9mm) and three lengths (10mm, 12mm and 14mm) and are supplied together with Zest Locator Abutments with a choice of two soft tissue cuff heights (2.5mm and 4.0mm), 12 options in total.

Contact General Medical on 01380 734990, visit www.generalmedical.co.uk or email info@generalmedical.co.uk

Stay 'Up To Date' with Oral-B

Oral-B have released the dates for its next 'Up To Date' scientific exchange seminars and is inviting clinical dental professionals to attend a complimentary CPD-accredited evening event at Edinburgh's Heriot Watt University on 22 May 2014.

This year, Professor Iain Chapple will critically appraise the 'Brave New World' of 21st century dentistry and Prof Avijit Banerjee will discuss technologies used in the dental surgery that complement the minimally invasive, tooth preserving approach to caries management.

Spaces are limited and allocated on a first come, first served basis. To attend, contact Julia Fish on 07585-508550 or e-mail julia@ab-communications.com or register online at www.dentalcare.com

UP TO DATE | Prevention Knowledge CPD

Rinse with confidence

Following the introduction of Pro-Expert toothpaste, Oral-B is now launching a complementary mouthrinse, Oral-B Pro-Expert Clinic Line Rinse. This alcohol-free rinse contains cetylpyridinium chloride (CPC) making it effective against a broad range of bacteria commonly associated with plaque and gingivitis.

Moreover, the CPC in Oral-B Pro-Expert Clinic Line Rinse has a high level of bioavailability which increases both its efficacy and its durability. Oral-B's rinse is effective for up to 12 hours offering all day protection against plaque and gum problems. This makes it appealing to a broad range of your patients, including children (over six years), and those with sensitivity issues.

Safeguarding and Child Protection Pro CPD bundle

Following the GDC's recently updated Standards Guidance on dental teams' responsibilities towards child protection, ProDentalCPD has created a Safeguarding and Child Protection Pro CPD bundle.

Available to subscribers and non-subscribers, this premium bundle gathers together expertly produced material allowing you to contribute towards your verifiable CPD.

Successful completion of the bundle will mean your ProDental CPD certificate certifies you in Level 2 Child Protection, which is valid for two years.

The company also offers other bundles on core CPD topics, Radiography and Radiation Protection, and Disinfection and Decontamination, with more to follow.

Pro CPD bundles are available online and all you need to access them is an account with ProDentalCPD.

To protect your young patients while meeting your CPD requirements, contact the experts at ProDentalCPD today.

To learn more about Pro CPD bundles, contact ProDentalCPD on 0114 282 3509, or visit www.prodentalcpd.com/bundles

Obesity matters

Currently there are 15 million people in the UK classified as obese and this figure is set to rise. It is reported that half of UK males could be obese by 2030 if current trends continue.

Planning for the future has always been at the forefront of Takara Belmont's R&D programme and the company is pleased to report that the weight-lifting capacity of Takara Belmont's chairs has increased to 22 stones when a spittoon or over-the-patient unit is attached to the chair.

For standalone chairs, including the Clesta I and II, 037 Pro II and Clair chairs the limit has increased to 31 stone.

Takara Belmont chairs are therefore extremely strong and stable, so will meet the needs of certain bariatric patients.

For further information or clarification, call 020 7515 0333 or e-mail dental@takara.co.uk

Make your practice thrive

Practice Management in Dentistry – The Definitive Guide is a unique eLearning programme which has been carefully structured to provide its students with all that there is to know about running a dental practice that thrives.

The course has been produced by Healthcare Learning: Smile-on and is being sponsored by The Dental Directory, which is offering its customers an exclusive reduced price on attending the course.

The course is split into five areas: Money Matters; The Patient Journey; Team Leadership; Premises Management; and Marketing.

For more information on Practice Management in Dentistry – The Definitive Guide, speak with your local Business Consultant from The Dental Directory.

Contact The Dental Directory on 0800 585 586, or visit www.dental-directory.co.uk

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Product news

The complete package

Providing an array of solutions to organise and simplify daily tasks, Carestream Dental really can help your practice enhance productivity and long-term success.

The CS R4 Clinical+ Practice Management Software is the complete package, combining every aspect needed for a thriving business. From the appointment schedule, to patient records, to patient communication and automatic reminders, the software keeps everything in one place for convenience and clarity.

For quick and efficient diagnosis, all impression images and scans can also be integrated into the software, aiding treatment explanations to patients and optimising access to patient data for all authorised professionals.

Contact Carestream Dental on 0800 169 9692 or visit www.carestreamdental.co.uk

Begin as you mean to go on

As one CPD cycle comes to an end, another begins. Why not get the new cycle off on the right foot by joining the DENTSPLY Academy?

DENTSPLY Academy offers an extensive range of live webinars throughout the year and has more than 50 hours of archived webinars available to view online for free. Joining the DENTSPLY Academy offers dental professionals a way of gaining verifiable CPD without having to travel to lectures and seminars. Instead, students can gain their CPD when it suits them.

Upcoming webinars include 'Light Curing in Dentistry – A Brief History and Update with Dr Robin Mills' on 31 October and 'Local Anaesthetics – An Update For the Dental Hygienist with Dr Nigel Robb' on 14 November.

Contact www.dentsply.co.uk or 0800 072 3313

Tasty tooth protection

GC UK's extended Minimal Intervention range of products includes GC Tooth Mousse. GC Tooth Mousse is a water-based sugar-free topical cream that contains Recaldent. This topical paste will provide extra protection for the patients' teeth. It has been shown that the twice daily use of 1 per cent solution produced a 19 per cent reduction in enamel demineralisation (Reynolds, 1988).

There is a wide range of benefits for GC Tooth Mousse. It can be used immediately following bleaching, after ultrasonic, hand scaling or root planing, after removal of orthodontic brackets and following professional cleaning.

Contact GC UK on 01908 218 999 or e-mail info@uk.gceurope.com

Septalkan single use wipes

Scientifically developed for medical devices, Septalkan wipes are themselves a class 11b medical device and allow for the thorough cleaning and disinfection of both invasive and non-invasive medical devices and equipment.

Developed for use in higher risk areas, Septalkan are for use within the medical/dental surgical environment. They are active from contact, eliminating up to 99.9999 per cent of micro organisms that may be present on the device – and also the wipe itself – ensuring low risk from cross contamination.

Septalkan Wipes allow cleaning and disinfection in one simple operation.

Use and discard no rinsing required.

Septalkan wipes are now available through medical and dental wholesalers in a soft flow dispense pack containing 100 x (200mm x 180mm) spun-lace wipes saturated in solution

For comprehensive product information, ask your dealer or call Alkapharm customer service on 01785 714 919. Product information can be viewed and/or downloaded from the website, simply visit www.alkapharm.co.uk

Denplan hits £1 million milestone

With an established history of offering member practices practical and financial support, Denplan is celebrating lending more than £1 million through its Evolve loan scheme in the last 12 months.

With increased competition from state-of-the-art practices, Evolve loans are designed to enable Denplan Key Client members to update, refurbish and refresh their practices to offer a best in class patient experience, retain existing patients, as well as attract new ones. These loans have proved especially popular in difficult economic conditions with competitive interest rates and no arrangement fees.

For more information about Denplan Evolve loans, please call 0800 169 9962.

The surgical contra-angle handpiece with 45° head

The NEW WS-91 and WS-91 LG high-speed surgical contra-angle handpieces feature a 45° head and 1:2.7 ratio. The 45° head offers an ideal angle for surgical applications giving improved access to hard-to-reach operating areas and guaranteeing excellent visibility for treatment indications such as wisdom tooth extraction, precise tooth separation and apical resections.

Dependent upon the drive speed, the ratio of 1:2.7 ensures the optimal bur rotation speed. The WS-91 LG offers perfect LED+ daylight quality illumination. The 3-port spray guarantees cooling of the bur, tooth and bone. The new WS-91 also benefits from an improved scratch-resistant surface coating and can be fully dismantled for cleaning and sterilisation purposes.

For further information, call 01727 874 990 or email office.uk@wh.com

Product news

New self-etching and adhesive flowable composite

When restoring teeth as part of a minimally-invasive procedure wouldn't it be great to save additional time too?

DMG's new Constic self-etching and adhesive flowable composite eliminates both the etching and bonding steps and saves valuable time too. Post-operative sensitivity is also markedly reduced.

This new three-in-one flowable composite combines etching gel, bonding agent and flowable composite in one single product. Consequently, it eliminates both the etching and bonding steps and the associated time expenditure.

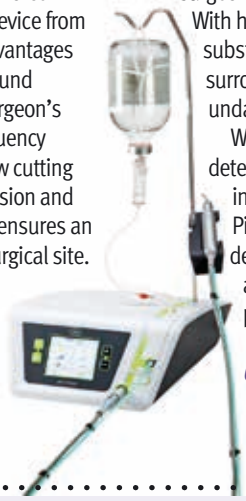
Contact DMG on 01656 789401 or email paulw@dmg-dental.co.uk

Minimally invasive, maximally effective

Piezomed is the new force in bone surgery. This device from W&H puts all the advantages of innovative ultrasound technology at the surgeon's fingertips: high-frequency microvibrations allow cutting with incredible precision and the cavitation effect ensures an almost blood-free surgical site.

Thanks to innovative ultrasound technology, Piezomed transforms the surgeon's working environment. With high precision, only the bone substance is removed and the surrounding soft tissue is left undamaged.

With automatic instrument detection, as soon as an instrument is inserted, Piezomed automatically detects the instrument and assigns it to the correct power class.



Contact W&H (UK) on 01727 874 990 or email office.uk@wh.com

The latest in innovation

W&H launched a number of new and innovative products at the recent BDTA Dental Showcase in Birmingham, including: the new Assistina 3X3, the most thorough handpiece cleaning and lubrication system currently available; the Piezomed, the minimally invasive, maximally effective surgical unit; and the new range of surgical handpieces including the WS-91, the first high-speed contra-angle handpiece with a 45 degree head and 1:2.7 ratio.

Also on show was the latest decontamination equipment range, including the ThermoKlenz washer disinfector dryer and Lisa steriliser as well as the Implantmed surgical system and the full range of oral hygiene products.

For more information, call 01727 874990 or contact your preferred W&H supplier.

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