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April/May 2013

Scottish Dental magazine

Kevin Lochhead on the show: "fabulous CPD... world-class speakers"

Page 18



















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Welcome

Editor's desk

with Bruce Oxley

Awards debate

With the shortlist for the Scottish Dental Awards being announced recently (see page 6), I thought this would be a perfect opportunity to continue the debate that continues to rage in the profession.

I have to say that I agree with many of the points that have been raised by the FGDP (Scotland)'s campaign against what they describe as 'unprofessional' awards.

We recently held our first judging meeting and, before any votes were cast, there was a long and detailed discussion of the aims and objectives of the awards themselves and an in-depth debate about the criteria that the nominees should be judged against.

The judging panel were at pains to point out that, by being involved, they are essentially putting their names to the awards, so we needed to make sure that everyone was happy to be involved from the outset.

We have made some subtle but important changes to the category names and judging criteria, and the judging panel has generously agreed to meet up after the awards to help us move them forward.

We want these awards to be as respected as possible and we will be outlining our plans to revamp the awards in the near future.

Be assured, we do not see this as a cash cow, we do not want to exploit the profession and we are willing to listen. Watch this space. ■

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

Contents

Front cover shows just a few of the world-class speakers on show at Hampden. From top (l-r) Carol Tait, David Jones, Arshad Ali, Stephen Jacobs, Constanze Boesel, Paul Stone, Helen Kaney, Ashley Latter, Paul Tipton, Jayne Clifford, William McLean, Martyn Amsel, Graham Ogden, Neil Morrison, Ian Jackson, Neil Taylor, Roy Hogg, Pierluigi Coli.

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Dr P Coli DDS, PhD, 104397
Specialist in Periodontics and Prosthodontics

Dr C A Bain BDS, DDS, MSc, MBA, 43220
Specialist in Periodontics, Prosthodontics and Restorative Dentistry

Prof G Lello FDS RCS(ED and ENG), FRCS(ED), PhD, 47314
Specialist in Oral Surgery and Maxillofacial Surgery

Dr F Veldhuizen BDS, MFDS RCS(Ed), M Clin Dent, MRD RCS(Ed), 72100 Specialist in Prosthodontics

Dr P Hodge BDS, PhD, FDS RCS(Ed), 56503
Specialist in Periodontics

Dr N Heath DCR, BDS, MSc, MFDS RCS(Ed), DDRRCR, 70569
Specialist in Oral and Maxillofacial Radiology

Mr M Paley BDS, MB ChB, FFDRCSI, FRCS, FRCSEd(OMFS), 64778
Consultant Oral & Maxillofacial Surgeon

Prof L Sennerby DDS, PhD, 72826
Professor in Dental Implantology

Mrs G Ainsworth BDS (Sheff '96) FCS RCPS Glas, 71932
MSc (Ed), MSurgDent(Ed) Specialist Oral Surgeon












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Nobel Biocare

Biting back

with Arthur Dent

Payback time

I was shocked to receive the "Dear Dentist" letter circulated to GDPs in early March by Practitioner Services Division (PSD). The letter was headed "Duplicate Registrations – recoveries and underpayments" and essentially it outlined how alleged overpayments would be recovered from GDPs in the payment schedule for February paid in March 2013, which was due to be paid a few days after receipt of the letter.

There was a theoretical possibility of a GDP receiving compensation for past underpayments, but I have yet to hear of any dentist in this position; all GDPs seem to have had money deducted for alleged overpayment which might have arisen in a number of ways. A patient may have left Scotland for another part of the UK or abroad, or a patient might have died and the dentist or PSD would have been unaware of this.

However, the most common reason for overpayments is likely to be a patient leaving one practice without notifying that dentist and registering with another GDP; in that situation PSD should have been able to detect the change and stop capitation or continuing care payments to the previous dentist, however, all too often, PSD's MIDAS computer has failed to do this and duplicate payments have continued to both dentists.

In the past, prior to April 2006, any duplications presented less of an issue because there was a registration period which would end after a maximum three years unless the patient returned to the practice to restart this cycle. However, with the introduction of "continuous registration" by the Scottish Government, there is now no default termination of a registration period, so the issues arising from duplicates are much more of a problem.

What is clear from the letter is that PSD's systems have in the past been incapable or at least inefficient at detecting duplications and so on. It seems action has now been taken to improve accuracy and efficiency at PSD and GDPs will welcome this – dentists want to be paid correctly and promptly. However, the sting in the tail is that PSD has recently been reviewing

"Very short notice was given to dentists of the details of clawbacks before deductions were made, leaving no time for dentists to check or challenge PSD's list"

dentists' payments back to 2006 and are reclaiming any alleged overpayments made since then.

This is unjust for a number of reasons:

- The situation was caused by the inefficiency of systems and procedures at PSD, not by dentists.
- It was exacerbated by the Scottish Government's introduction of continuous registration, with which most dentists disagreed.
- Very short notice was given to dentists of the details of clawbacks before deductions were made, leaving no time for dentists to check or challenge PSD's list.
- PSD has taken far too long to correct any errors; waiting seven years makes it very difficult for dentists to check the list.
- Deductions can only be taken from dentists who are still practising, many will have moved away, left or retired and will avoid clawbacks.

It seems grossly unjust that some hard-pressed dentists who remain loyally working within the NHS in Scotland are being penalised because of PSD inefficiencies and Scottish Government policy decisions. ■

DETAILS AND CONTRIBUTORS

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

Senior sub-editor
Wendy Fenemore

Sub-editors:
Chris Fitzgerald
Gary Atkinson

Design and production
Fiona Wilson

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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Paisley PA1 1JS
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Fax: 0141 561 0400
www.scottishdentalmag.co.uk

MOST ATTRACTIVE PRACTICE

Halo Dental Practice
Glasgow *(pictured top right)*

Scottish Centre for Excellence in Dentistry Glasgow *(pictured above)*

Philip Friel Advanced Dentistry
Glasgow *(pictured left)*

Your Perfect Smile Dental Clinic
Aviemore *(pictured right)*

The shortlist

SCOTTISH DENTAL LIFETIME ACHIEVEMENT AWARD 2013

Alex Littlejohn
Dental Technology Services, Glasgow

Arshad Ali
Scottish Centre for Excellence in Dentistry, Glasgow

Jillian Bruce
M&S Dental Care, Fort William

Ken Scoular
NHS Education for Scotland

DENTIST OF THE YEAR

Chris Barrowman, Infinityblu Dental Care, Pitlochry
Duncan Black, Halo Dental, Glasgow
David MacPherson, Whitemoss Dental Practice, East Kilbride
Philip Friel, Philip Friel Advanced Dentistry, Glasgow

BEST NOMINATED NHS PRACTICE

Bearsden Dental Care, Bearsden
Deveron Dental Centre, Aberdeenshire
Mayfield Dental Practice, Dalkeith
M&S Dental Care, Fort William

BEST NOMINATED PRIVATE PRACTICE

Halo Dental Practice, Glasgow
Infinityblu Dental Care, Pitlochry
Philip Friel Advanced Dentistry, Glasgow
Your Perfect Smile Dental Clinic, Aviemore

MOST VALUABLE CONTRIBUTION TO PATIENT CARE

Hari Lal, Dedridge Dental Centre, Livingston

Blackhills Clinic, Aberuthven – practice core philosophy

BEST NOMINATED REFERRAL/SPECIALIST PRACTICE

Beam Specialist Orthodontic Practice, Dundee
Blackhills Specialist Referral Clinic, Aberuthven
Glasgow Orthodontics, Glasgow
Scottish Centre for Excellence in Dentistry, Glasgow

DENTAL NURSE OF THE YEAR

Fiona Anderson, Scottish Centre for Excellence in Dentistry, Glasgow
Louise Fletcher, Dental FX, Bearsden
Justine MacDonald, M&S Dental Care, Fort William
Emma McMillan, Whitecart Dental Care, Glasgow

STUDENT DENTAL NURSE OF THE YEAR

Hayley Nicole, Cadden Dental Practice, Coatbridge
Amy McCabe, Cadden Dental Practice, Coatbridge
Ragan Horne, Brite Dental Care, Glasgow

DENTAL HYGIENIST/ THERAPIST OF THE YEAR

Elaine Anderson, Quadrant Dental Practice, Ayr
Karen Scott, Ross Memorial Dental Clinic, Dingwall

DENTAL BUSINESS MANAGER OF THE YEAR

Trudie Imrie, Blackhills Clinic, Aberuthven
Susie Anderson-Sharkey, Dental FX, Bearsden
Mark Fowler, Woodside Dental Practice, Glasgow
Margaret McMillan, Whitecart Dental Care, Glasgow

BEST NOMINATED DENTAL LABORATORY

Leca Dental Laboratory, Glasgow
Adair Dental Laboratory, Glasgow
A-Plus Dental Laboratory, Dundee
Dental Technology Services, Glasgow

AWARDS DINNER

The Scottish Dental Awards Dinner will be held at Hampden Park on Thursday 16 May, at the end of the first day of the 2013 Scottish Dental Show.

Hosted by radio broadcaster Peter Martin, the evening will begin with a drinks reception in the Millennium Suite before guests are invited upstairs to the Maxwell Suite for dinner.

Peter is a reporter with Sky Sports News and Talksport radio as well as being the host of the football phone-in on Central FM and PLZSoccer.com

He has been involved in broadcasting for nearly 20 years and spent six years working at Scottish Television on Scotsport and Scotland Today.

It is, however, his commentary on football matches that has brought him the most notoriety among supporters of the beautiful game. Perhaps his most famous night with the microphone belongs to Scotland's Euro 2008 qualifier in Paris. Peter's description of James McFadden's wonder strike to defeat France 1-0 in the Parc de Prince is a favourite of every Tartan Army fan the length and breadth of the country. "Pick it out, Landreau!" made its way onto Sky Sports' Soccer am programme and has racked up more than 500,000 hits on YouTube.

The awards ceremony will take place after dinner and Peter Martin will be joined on the podium by the judging panel, who will help present the awards alongside our sponsors.

Tickets for the Awards Dinner are available by calling Ann Craib on 0141 560 3021. Places are limited, so call now to avoid disappointment.

To find out more about the Awards, including details of the judging panel, visit www.scottishdentalshow.co.uk/awards

Oral B seminars


Professor Iain Chapple

CPD

There's still time for you to clock up two and a half hours of CPD at the current series of Oral B scientific exchange seminars being held across the UK.

The next in the series is at Edinburgh's Heriot Watt University on 23 April, followed by The Queen's Hotel in Leeds on 30 April.

The final seminars are at Southampton's Grand Harbour Hotel on 2 May and the Newcastle Hilton on 23 May.

Lecturing at the seminars will be Professor Iain Chapple – his theme is Myths and Deceptions in Periodontal Care – and Professor Avijit Banerjee, who will speak about Caries Management in the 21st century.

The question and answer session will be chaired by Dr Stephen Hancocks.

To register, email the names, GDC number, position, address, telephone and venue details of those wishing to attend to the event organiser Julia Fish at julia@ab-communications.com

You'll receive a confirmation email within five working days. If you don't, call Julia on 07585 508 550.


Professor Avijit Banerjee

Illegal whitening campaign takes off

Safety. Social media helps spread the message about illegal practice

A former Edinburgh dental nurse has started a campaign to outlaw illegal tooth whitening clinics that is gaining interest from across the UK.

Beverley Carlyle, who now works as a practice manager in Northern Ireland, first became aware of the problem of illegal 'whitening technicians' when she moved to Edinburgh in 2005 and has been surprised at how widespread it has become.

She said: "In my workplace, we were starting to see the devastating effects from whitening performed by these non-dental technicians. Often, chemical burns resulting in painful lips and gums and sensitivity were the driving factor for patients to present for emergency appointments and there was nothing we could do to help them."

However, after seeing a friend share an offer for tooth whitening on Facebook she clicked on the clinic's page and was shocked by some of the images they had posted. She was moved to start up the 'Stamp Out Illegal Tooth Whitening' page on the social network site and within 10 days had attracted more than 450 'likes' and reached more than 73,000 people through status shares. At the time of writing, there are more than 1,500 'likes' on the page.

"My ultimate aim is to get the backing of enough dental professionals so that we can target the companies providing the training to these 'technicians', get the message out to the public that it is not only illegal for these technicians to whiten their teeth, but it is also very dangerous.

"I also want to get trading standards and the GDC to buck up their ideas and give us a definite line of reporting, to find out why they can't investigate everyone – do they need help? Are they looking for volunteers to give up an hour a week for example to help collate information to make it easier for them? Who is going to enforce this legislation?"

To find out more about Beverley's campaign, turn to page 20.

"In my workplace, we were starting to see the devastating effects from whitening performed by these non-dental technicians"

Beverley Carlyle

Get ready for National Smile Month

COMMUNITY

Are you all set for national Smile Month (20 May to 20 June)?

There are plenty of things you can do to make your patients smile even if your practice is very busy – the great thing is they're easy and straightforward to do.

Smileys are cheap (£1.65 for ten) and a great way to have a laugh and talk about oral health at the same time.

A sponsored brushathon and other teeth-brushing challenges are a fun way to follow a healthy dental routine. National Smile Month encourages everyone to brush their teeth for the recommended two minutes twice a day.

Many schools include oral health in the curriculum, and you can get teachers involved with toothbrushing demonstrations, drawing competitions, a quiz, or get the children to write their own smiley poems.

A dental practice is a fascinating place with its equipment and terminology. Why not give people an education experience and show them how everything works with a series of open days?

National Smile Month posters are bright, eye-catching and will provide information about oral health in hospitals, schools, colleges and community centres.

An extensive range of National Smile Month products are available from the online shop to help you communicate, motivate and educate.

For more information, click on www.nationalsmilemonth.org

The golden years

CELEBRATION

Over 300 guests attended the Dental Ball in Glasgow recently – dubbed the 'Golden Ball' as it marked 50 years of the Glasgow Dental Students' Society.

The event, at the Glasgow Central Hotel, was attended by a number of GDSS presidents and alumni. Jeremy Bagg, head of the Dental School, proposed a toast to the GDSS and paid tribute to the work of the present committee, including the Staff Student President, Mr Neil Nairn.

He also referred to the ongoing work of the dental school in developing stronger links with its alumni, in conjunction with the University's Development and Alumni Office.

Bioteeth come closer to reality

RESEARCH

Scientists have developed a new method of replacing missing teeth with a bioengineered material generated from a person's own gum cells.

Current implant-based methods of whole tooth replacement fail to reproduce a natural root structure, and as a consequence of the friction from eating and other jaw movement, loss of jaw bone can occur around the implant.

The research is led by Professor Paul Sharpe, an expert in craniofacial development and stem cell biology at King's College London, and published in the *Journal of Dental Research*.

Research towards achieving the aim of producing bioengineered teeth – bioteeth – has largely focused on the generation of immature teeth (teeth primordia) that mimic those in the embryo that can be transplanted as small cell 'pellets' into the adult jaw to develop into functional teeth.

Remarkably, despite the very different environments, embryonic teeth primordia can develop normally in the adult mouth, and thus, if suitable cells can be identified that can be combined in such a way to produce an immature tooth, there is a realistic prospect bioteeth can become a clinical reality.

In this new work, the researchers isolated adult human gum tissue from patients at King's College, grew more of it in the lab, and then combined it with the cells of mice that form teeth. By transplanting this combination of cells into mice, the researchers were able to grow hybrid human/mouse teeth containing dentine and enamel, as well as viable roots.

PSD clawback is criticised

Registration. GDPs across Scotland receive PSD letter

The Scottish Government's decision to introduce continuous registration has been held up as one of the major reasons behind the recent 'clawback' of overpayments by Practitioner Services Division (PSD).

A letter, entitled 'Duplicate Registrations – recoveries and underpayments', was sent out to every GDP working in the NHS and outlined how overpayments were to be recovered. Dr Robert Donald, Chair of the BDA's Scottish Dental Practice Committee, said: "The BDA believes PSD's proposal to deduct monies from payments to practices to be both misguided and unfair and we are continuing to challenge it with legal arguments.

"We strenuously opposed the introduction of lifelong registration – which we believe is at the heart of the problems PSD is now attempting to address. It is particularly disappointing that dentists may suffer as a result of a decision that was imposed on them."

And one West of Scotland GDP, who doesn't want to be named, said: "Registrations are like LIBOR; everything hangs on it. Registration, and the monthly Capitation or Continuing Care Payments that goes with it, form the basis of all pay calculations for associates or assistants.

"It may be true that PSD think they only need to steal back this pay from each dentist, but it affects superannuation pay, maternity pay, seniority pay, thresholds for commitment pay and it also affects HMRC and your tax bill."

A spokesman for Practitioner Services said: "Continuous registration highlighted an issue and a level of error which had not previously been visible.

"The Regulations require that we recover all overpayments unless directed otherwise by Scottish Ministers. As part of the public services, Practitioner Services seeks value-for-money for the taxpayer.

"The data on which registrations are created and maintained are provided by dental practices, not PSD.

"Regardless of the source of any error, the Regulations require us to recover the overpayment."

Stub it out

SMOKING CESSATION

Smokers are more likely to kick the habit because of the effect smoking has on children.

That's the finding of a new survey carried out by the British Dental Health Foundation.

Almost a third of those surveyed (30 per cent) said they would stop smoking due to the effects it has on children. More than one in four (26 per cent) said the danger of developing mouth cancer was the reason they would quit, and less than one in five said they'd stop because of the risk of lung cancer.

Children are often exposed to second-hand smoke in the home, and particularly in cars.

Public health minister Anne Soubry has already called for smoking to be banned in cars carrying children on "child welfare" grounds.

Tobacco use is a major killer worldwide, and Dr Nigel Carter OBE, Chief Executive of the British Dental Health Foundation, hopes the one in three smokers in the UK who want to quit do so sooner rather than later.

Dr Carter said: "The research is clear-cut – smoking in any environment is harmful to you and those around you. Around one in six adults in the UK still smoke, and if they are doing so around their children it could have a catastrophic effect on their future health.

"Children see their parents as role models. If they are smoking, children are more likely to take up the habit. By stubbing out cigarettes now, not only will you stop damaging your body, you will stop damaging those around you."

Temporary registration guidelines redrafted

NEW REQUIREMENTS

The General Dental Council (GDC) has completed a review of temporary registration, and redrafted the guidelines that govern this type of registration.

The redrafted guidelines – which apply only to dentists – will come into effect on 1 August 2013. It means that a temporary registrant whose direction begins on or after this date will work under the redrafted guidelines.

Details of how the new requirements will affect those applying for the first time and those applying for renewal or restoration can be found on the GDC website.

Charity. Dentist to make fundraising trek

Dr Visocchi rises to the challenge

Youngsters from a Highland school are making a 300km trek across Scotland in May to raise cash for Horseback UK – a rehabilitation charity that works with wounded ex-servicemen and women.

Banchory dentist Dr Antony Visocchi – who, in past years, has helped with planning the route – has been persuaded this year to take part in the week-long trek from Mallaig on Scotland's west coast, to Aberdeen on the east.

He told *Scottish Dental magazine*: "The journey for the 14 S1 to S3 pupils will involve travel by boat, foot, mountain bike, maybe horse, open canoe and possibly rafts.

"The route has been chosen because it offers a remote wilderness experience and a great physical challenge through a variety of activities."

This year is the first time that a charity has been supported for a second time. In 2012, the pupils made a visit to the local Horseback UK facility in Royal Deeside, and were so inspired and humbled by the work and the service personnel that they went into overdrive to raise funds for the trip.

Horseback UK was created to provide a safe and secure environment to integrate serving personnel and veterans of the UK armed forces into the rural community, and inspire a meaningful and rewarding future.

Many of the forces personnel have suffered physical injury and/or acute stress as a result of their commitment to their country.

This year, four members of the organisation will join the pupils for the trip across Scotland. They hope to complete some of the trip on horseback which will add to the experience for the pupils.

Antony added: "I've been involved with the route planning over the past three or four years, but never actually made the trip myself. This year, my friend and Banchory Academy Depute Rector, Colin Nicoll, convinced me that you just have to seize the day, as these opportunities don't come around very often.

"Added to that, being able to raise money for such a worthwhile cause is great."

IndepenDent Care Plans and Wright-Cottrell have supported and sponsored Antony for the trip.

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Direct access decision is 'misguided', says BDA

The British Dental Association (BDA) has called the GDC's decision to remove the barrier to direct access for some dental care professionals misguided, saying it "undermines best practice in patient care".

The regulator made its decision following a full council meeting on 28 March with the changes coming into effect on 1 May. Kevin O'Brien, chairman of the GDC, said: "This decision has been made with patient safety as an upmost priority. Registrants treating patients direct must only do so if appropriately trained, competent and indemnified. They should also ensure that there are adequate onward referral arrangements in place and they must make clear to the patient the extent of their scope of practice and not work beyond it."

However, Dr Judith Husband, chair of the BDA's Education, Ethics and the Dental Team Committee, said: "This is a misguided decision that fails to consider best practice in essential continuity of care, patient choice and cost-effectiveness, and weakens teamworking in dentistry which is demonstrated to be in patients' best interests. Dental hygienists and therapists are highly valued and competent members of the dental team, but they do not undertake the full training that dentists do and on their own are not able to provide the holistic, comprehensive care that patients need and expect. Our fear is that this could lead to health problems being missed in patients who choose to access hygiene and therapy appointments directly.

"The decision also ignores the stated limitations of the literature review on which the decision has been based and goes against the findings of the GDC's own patient survey last year, which found that just three in ten people favoured a move to allow direct access.

"The undue haste with which the decision is to be implemented does nothing to alleviate the impression that this is an inadequately considered decision that is being pushed through without proper reference to the risks it creates."

"This is a misguided decision that fails to consider best practice in essential continuity of care"

British Dental Association

Sally Simpson, immediate past-president of the British Society of Dental Hygienists and Therapists (BSDHT), said: "Being granted permission to treat patients within our scope of practice without a referral or prescription from a dentist will lift previous barriers to oral care and enable our population increased choice in who delivers their dentistry, and access to the quality care and the particular skills provided by dental hygienists and dental therapists.

"The decision has been long awaited by the profession and as immediate past-president of the BSDHT, an organisation that campaigned so hard in support of direct access for its members and profession, I am delighted to finally see this groundbreaking change in the way we are permitted to practice supported and accepted by our regulator."

GDC talks at BDA Conference

SPEAKERS

The chairman and chief executive of the General Dental Council (GDC) will both be speaking at this year's British Dental Association (BDA) Conference in Manchester on 25-27 April.

GDC chairman Kevin O'Brien, who is originally from Edinburgh but is now based in Manchester, will give a presentation entitled 'Radical changes ahead – the GDC prepares for the future' alongside the regulator's chief executive Evlynne Gilvarry.

The presentation will aim to provide clarity on the GDC's work, future aims, strategy and how this may impact dental professionals, as well as arguing how the annual retention fee pays for patient protection.

The GDC chairman will also be appearing in the BDA's Training Essential Theatre to present 'Working to deliver dentistry in line with patient expectations'. This session will look at the council's corporate strategy, policy development and the current hot topic of the moment, direct access.

For more information on the British Dental Association Conference in Manchester, visit http://conference.bda.org

Awareness. Dental charity highlights the plight of patients in the developing world

Toothache can kill

Thousands of people in the developing world are still dying unnecessarily from untreated tooth decay, claims dental health NGO Bridge2Aid (B2A).

Speaking on World Oral Health Day (Wednesday 20 March), Mark Topley, CEO of B2A, said: "It is 2013 and people are still dying from untreated dental decay. Here in the UK we complain about a toothache, but usually we can get treated within a few days at max.

"The shocking reality is that three-quarters of the world's population have no access to even the most basic of dental services.

"Dental caries is one of the world's most common diseases. It causes debilitating pain and

drastically affects a person's ability to function."

Most developing countries don't have enough dentists: in Tanzania, where B2A is based, there is one dentist for approximately every 100,000 people (in the UK the ratio is 1:2,500).

In Rwanda, where B2A is about to launch a new project, there are just 11 dentists for the entire country. To make matters worse, these dentists usually live in cities and large towns, far away from remote rural communities where the help is needed most.

This lack of access to pain relief leads to chronic suffering, the loss of ability to work or support the family, withdrawal of children from school (to help support subsistence farming), and complications that can and do lead to death.

"Although access to a dentist in every town, every village remains a utopia," continued Mark, "we must all of us in the dental profession focus on relieving dental pain through training, so that local medics can carry out safe tooth extractions.

"Otherwise, literally, a toothache can kill."

For more information, visit www.bridge2aid.org

Wrigley launches online series

CONTINUING DEVELOPMENT

The Wrigley Oral Healthcare Programme has launched the first of a series of web-based continuing development sessions for dental professionals.

The series is based on the recent book *Saliva and Oral Health* by Michael Edgar, Colin Dawes and Denis O'Mullane.

The series – launched on World Oral Health Day 2013 on 20 March – will investigate the physiology of saliva and the mechanisms of its secretion.

Other topics are: xerostomia, salivary clearance and the protective functions of saliva.

Wrigley's UK Oral Healthcare Programme Manager, Louisa Rowntree, said: "We want to support dental professionals in their role as oral care educators."

Composite masterclass

NEW TECHNIQUE

Cornish dentist Jason Smithson visited Glasgow recently to present a two-day masterclass on posterior composites.

Smithson, who is developing an international reputation as a highly skilled exponent of direct resin 'artistry', presented to 26 delegates at the Hilton Hotel on 7 and 8 February. He demonstrated his 'simplified technique' which, essentially, uses only a probe and a microbrush to place the resin restoration and produce predictable and highly aesthetic restorations.

The event focused on posterior composite restorations, with Smithson presenting the techniques he developed and the evidence behind his rationale, before giving a demonstration. Using an operating microscope, delegates could copy

Jason's placement of direct restorations during the hands-on sessions.

Smithson has already agreed to return to Scotland for four days in November to teach his anterior composite resin techniques. Professor Michale Wise is coming to Glasgow on 4 October for a study day entitled 'Aesthetics for tooth and implant-supported restorations, covering diagnosis, treatment, choice of ceramics and techniques'.

For more information on these events, contact Ian Macmillan on 07900 803 738.

DCP study day

Education. Dental care professionals cover a wide range of topics

An overview of forensic dentistry, protecting vulnerable people, the risks and responsibilities surrounding direct access and an update in infection control were all covered at the latest DCP study day organised by NHS Education for Scotland.

Around 50 DCPs were at Hampden Park on 22 February for the event, which was opened by forensic odontologist Fiona Waddington.

Fiona, a GDP at Corsehill Dental Care in Stewarton, East Ayrshire, discussed the role of the DCP in forensic dentistry and how forensic dentists accurately age an individual. She also looked at how dental identification has been used in mass disasters such as the Boxing Day tsunami of 2004, using images and information from colleagues who were present during the aftermath of the event.

She also covered the often-harrowing subject of bite mark analysis, using her experiences and that of colleagues to illustrate cases of domestic violence, child abuse and even murder.

Helen Pattinson, consultant in special care dentistry at NHS Greater Glasgow and Clyde, then took to to the podium to present on 'Consent/ Incapacity and Protecting Vulnerable Groups'. She talked about the changes in legislation involving incapacity and consent as well as discussing the new Protecting Vulnerable Groups Scheme and how it impacts on DCPs.

Claire Renton, dental advisor with the MDDUS, then talked about the possible risks and responsibilities that direct access will bring to various DCP groups, before Lynne Cotter, infection control support dental nurse at NHS Education for Scotland, gave an update on infection control.

Occlusal society meeting

LATEST DEVELOPMENTS

The British Society of Occlusal Studies is holding a summer meeting on 21 and 22 June in Manchester.

The meeting will be titled "The latest in occlusion, orthodontics, TMD and orafacial pain".

Professor Tara Renton will speak on the first day to provide an update on classifications, diagnosis and research developments of TMD and orafacial pain.

Tara completed a PhD in trigeminal nerve injury at King's College London between 1999 and 2003 and has been the chair there since 2006.

Along with the Institute of Psychiatry at KCL and Imperial College, Tara and collaborators have established a leading research programme in trigeminal nerve injury and pain.

On day two, Dr Ambrosina Michelotti will discuss the relationship between occlusion, orthodontics and TMD.

This will include a critical review of the evidence and advice on the management of occlusal and orthodontic treatment in individuals displaying symptoms of TMD.

Ambrosina graduated in dentistry in 1984 and qualified as a specialist in orthodontics in 1991.

Since then, she has taught undergraduate and postgraduate courses in orthodontics and TMD at the University of Naples Federico II.

Her research interests are focused on TMD and orthodontics and she has published more than 130 papers worldwide.

A better effect with mannitol in the mix

LOCAL ANAESTHESIA

An improvement may be in order for the most common dental anaesthetic. The inferior alveolar nerve block is the most commonly used form of local anaesthesia for mandibular restorative and surgical procedures. A study found that the addition of the drug mannitol significantly increases the effectiveness of this anaesthetic.

The journal *Anaesthesia Progress* presents a study testing the efficacy of lidocaine with epinephrine compared with equal amounts of lidocaine with epinephrine plus mannitol. After injection of the anaesthetic, the subjects' teeth were electric pulp tested for sensation. Pain of solution deposition and postoperative pain were also measured.

Failure rates of 10 to 39 per cent for the traditional formulation of lidocaine and epinephrine have been reported. One reason may be that, because of the perineurial barrier around the nerve, the anaesthetic solution does not completely diffuse into the nerve trunk. With mannitol, the anaesthetic solution permeates the nerve trunk in greater amounts, increasing the efficiency of the anaesthetic.

Full text of study can be found at www.anesthesiaprogress.org/doi/full/10.2344/11-00040.1

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A definite highlight

Speakers Paul Tipton and Ashley Latter provided some of the highlights of last year's Scottish Dental Show. Here, they explain why they are coming back

With the Scottish Dental Show (16 and 17 May) just weeks away, we spoke to two of last year's most popular speakers about why they have decided to return.

Paul Tipton will be opening the show in the Hampden Park Auditorium with his keynote presentation 'The role of vertical dimension in facial aesthetics' on Thursday 16 May and he will also be first up on the second day of the show with a talk entitled 'Maximising the fit, aesthetics and maintenance in full arch bridgework placed on implants'.

The 'Selling Coach' Ashley Latter will also be speaking on both days in the Auditorium with two brand new talks written especially for the Scottish event.

What are your thoughts about appearing at the Scottish Dental Show 2013?

Paul Tipton (PT): I am really looking forward to attending the Scottish Dental Show. The show last year was a great success, more than 1,200 attendees, I believe. Being the only show of its kind north of the border, it's a great opportunity to catch up with friends and colleagues that I do not get to see very often.

Ashley Latter (AL): I am very excited. Last year was a great conference. It was well organised and well attended and the audiences were very appreciative about my talks. I presented twice last year and on both occasions, the room was full.

It was an incredible experience and a definite highlight of 2012 for me. I have so many clients who I have worked with in Scotland over the past 18 years, I really feel part of the Scottish dental community.

Your talks were very popular last year, how did you find the experience at Hampden?

PT: Hampden provided a great venue for the show last year. As both an exhibitor and speaker, I was able to benefit from both aspects of the show.

AL: The experience was magical. I had never been to Hampden before and, being a big football fan, it was an incredible experience, even though the stadium was empty. It really is a great venue, and everyone was so friendly.

How do Scottish audiences differ to others around the UK and elsewhere?

PT: To be honest, dentistry is dentistry, wherever in the world you teach it. I lecture regularly in Scotland, Ireland and England and don't find there to be much difference in the audiences.

AL: I remember on one of my talks there were around a dozen staff from one practice who gave me a big cheer at the start and at the end of my talk. That was very nice, that does not happen very often!

I find the Scottish dentists and their teams very appreciative about the work I do. I am now coming to Scotland around a dozen times a year to run my courses, the people in Scotland are some of the friendliest and most appreciative people in the UK. I love coming to Scotland and I have a lot of friends here, especially in Glasgow. I have had a few nights out in Glasgow and the city never disappoints.

"Hampden provided a great venue for the show last year"
Paul Tipton

Tell us a little bit about the talks you are going to be presenting and why people should come along to see them.

PT: In dentistry today, some of the concepts underpinning successful dentistry are often ignored. In

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my lectures, I often talk about the importance of occlusion in reducing failures and ensuring longevity of restorations.

This year I will be covering two topics, the first will discuss how excessive wear on teeth can lead to not only loss of tooth tissue, but also a loss in facial height with accompanying reduction of facial aesthetics.

I will use several case studies to demonstrate improvements in the occlusion and facial aesthetics. My second presentation will focus on maximising the fit, aesthetics and maintenance in full arch bridgework placed on implants.

AL: I am delivering two brand new presentations. The first one is called 'Same again or are you up for a Big Change in 2013?' In short, the presentation is all about that if you want different results, doing what you have always done won't get you there.

Many people live in a comfort zone, carrying on doing what is comfortable and expecting to get different results. It just does not happen. I am going to share with the audience what some of the best practices I work with are doing.

Some of these ideas are very innovative and different. This presentation is not for everyone, it is for dentists and their teams who are looking for a new idea to improve what they do. They are looking for the 1 per cent to get better.

My second presentation is all about talking money. It is called 'Talk money with confidence and achieve the prices your services deserve'. After training more than 6,000 dentists and their teams over the last 18 years on my 'Ethical Sales and Communication' courses, I find many dentists get hung up on talking money and many of them seriously undercharge for what they do. I am currently writing a book on this subject and I am going to share many strategies that will change their thinking and their mind set.

Both programmes are suitable to the whole team and they are both new presentations, with lots of new ideas.

Do you have anything else planned around your visit to Scotland? Work or pleasure?

PT: Yes, I will be going up to Crieff to review everything prior to the start of my new restorative dentistry course, which is starting shortly.

AL: I am working the three days beforehand in Glasgow and then straight to the Scottish Dental Show. I will be out on a couple of occasions with clients and I will be attending the awards ceremony as well. So I am going to be crazy busy.

We also have an exhibition stand this year. I might need a few days off to recover after! But I can't wait.

For more details on the Scottish Dental Show, visit www.scottishdentalshow.co.uk

Appealing to the whole team

Scottish Dental Show scientific chairman Kevin Lochhead has been talking about the event's lecture programme in a new video interview.

Kevin said: "We have been trying to bring together a programme that is going to appeal to everyone in the dental team – not just the dentists, which is classically how most conferences are run.

"I think that the Scottish Dental Show is a fabulous opportunity to get every member of the team together, and hopefully we have a programme that will appeal to absolutely everyone.

"The actual programme that we have compiled is very, very good and we have got some high-quality CPD. Classically you tend to find that to get the CPD that we need and that we are all obligated to achieve, we have to travel down south, which costs a lot of money and time out of the practice.

"With the Scottish Dental Show, clinicians from all over Scotland can gather in one place and get some fabulous CPD from some world-class speakers."

To see the video, visit www.scottishdentalshow.co.uk

Hands-on experience

Following on from the success of his hands-on workshops at the 2012 Scottish Dental Show, Arshad Ali will be bringing his study groups back to this year's event at Hampden on 16 and 17 May.

Arshad, who is the clinical director of the Scottish Centre for Excellence in Dentistry (SCED) in Glasgow, will be presenting two dentist-only workshops on 'Restoring dental implants' on 16 May. The following day, SCED's head nurse Fiona Anderson will be hosting two dental nurse-only workshops on 'Introduction to implants and restorative procedures'.

For more information on the workshops, visit http://bit.ly/SDS-lectures Places will be limited to 10 people per workshop so, to book your free place, email scottishdental@connectcommunications.co.uk with 'SCED workshops' in the subject line.

Whitening debate

Founder of a campaign against illegal tooth whitening clinics Beverley Carlyle explains why she decided to take action

Stamp it out!

How many times have you seen tooth whitening offered on your local high street or had a Groupon/daily deal offering whitening from as little as £49, drop into your email inbox?

Have you ever checked the advertisement or looked to see who was actually performing the treatment?

Chances are it's a self-styled whitening technician or bleaching specialist and not a GDC-registered dental professional.

Eight years ago, I relocated to Edinburgh from Northern Ireland and one of the first things I noticed was a clinic advertising tooth whitening "from £49". Their strapline was "Don't be making the dentists rich!" so it was safe to presume that there were no dental professionals working in those premises.

I was rather intrigued and phoned to enquire about it. I was told that it was the same power whitening system that was used by dentists and that it was 100 per cent safe and my teeth could be lightened up to 22 shades.

I must confess to feeling shocked that someone with no dental experience was performing power whitening, but even more shocked when the receptionist told me that they had four clinics operating in Scotland, all seeing upwards of 20 patients per day.

I picked up the phone and called the GDC to report illegal practice but was told that whitening was a grey area and they couldn't do anything about it.

As the years went on, more and more salons were arriving on the high street. You could even have your teeth whitened in the local tanning salon and video rental store...

This made me very concerned as I'd worked with the chair-side whitening agents and knew how easily they could burn the lips and gums if not applied carefully and if the patient was not kept under close supervision for the duration of the treatment.

In my workplace, we were starting to see the devastating effects from whitening performed by these non-dental technicians. Often, chemical burns resulting in painful lips and gums and sensitivity were the driving factor for patients to present for emergency appointments and there was nothing we could do to help them, other than advising them to wait until the burns healed and giving treatment for the tooth sensitivity.

I felt terribly sorry for these patients and advised them to report the clinic to the GDC and Trading Standards and make sure that their family and friends knew to stay away from them too.

I've had a Facebook account for a few years and in the last couple of years there has been an influx of business pages offering tooth whitening from mobile technicians, hairdressers, whitening clinics, many featuring before and after images to help draw in business. I have often shared such images on my wall with a reminder to my friends and family that tooth whitening should only be performed by a GDC registered dentist, hygienist or therapist and I've always had messages about them, mostly asking why it's unsafe.

At the start of February, a very close friend liked and shared an offer from a mobile whitening technician. She was offering a free treatment for Valentine's Day if she could reach 500 likes. I clicked onto the page and was shocked by the images I saw there. I was moved to do something immediately to warn people that it was unsafe so I started a Facebook page of my own. I called it 'Stamp Out Illegal Tooth Whitening', shared the images in the before and after folder from the whitening technician that was running her Valentine's deal and a message as to what the images were showing and why it was dangerous. Within three hours, I had over 90 likes and 32 friends had shared my page.

"You could even have your teeth whitened in the local tanning salon and video rental store"

Beverley Carlyle

The messages started to flood in. Reports of painful experiences people had received at the hands of such salons and technicians and people asking what could be done to stop it. I gave them links to the GDC website for reporting illegal practice and links to their local Trading Standards. I also asked them to contact their local MP or copy them into the report.

I posted a couple more images that I'd found on other business pages and within 24 hours, I had more than 200 likes and an inbox bursting with messages.

I was struggling to keep up with the page that weekend and, thankfully, dental professionals had taken it upon themselves to start replying to posts from members of the public and were posting up links to legislation, advising people on how to treat sensitive teeth, etc. I was overwhelmed by the support.

After four days, I had to take on another admin for the page – a dental hygienist who had been answering posts and spending a lot of time advising members on how to report the illegal practice. By the end of the week, I appointed a dental surgeon

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as a third admin and yet the three of us were still being overwhelmed by the amount of reports and messages we were getting. We were up to 900 likes within a week!

We decided that we had to get a strategy worked out quickly as to how to harness the support we were getting and try to bring about change. It is much bigger than protecting our profession, it is all about public safety and clearly the public are being put at risk when they entrust their oral health to these technicians.

We've found out that the training companies offer a one-day course in which the trainees are taught how to identify gum disease, caries, crowns/veneers/dentures, how to perform the treatment and finally how to market their business. This is taught over the space of eight hours and then the trainee receives a certificate allowing them to go out and provide power whitening.

They don't have to concern themselves with vaccinations, clinical waste contracts, decontamination protocol, CQC registration, first aid or CPR training. They have no regulation whatsoever and it seems that anyone with £1,500 to £3,000 can train and set up their business.

We have been shocked by how widespread the business really is. So far, we've uncovered two dentists not registered with the GDC offering whitening and training on how to perform whitening and a dental surgeon removed from the GDC register also selling whitening training. We've also witnessed whitening companies performing whitening en masse at a beauty show and bridal fair with no hand washing facilities, no gloves in evidence, no disinfecting or sterilisation procedures between clients, no medical history checking, no auditable trail of clients treated and the public isn't aware of anything out of order.

We've found salons advertising with fake awards on their windows and marketing material, misleading claims of "up to 28 shades lighter in 20 minutes", "whitening specialist using the only desensitising light in the UK", "trained by the top UK whitening specialist", "2011 Dentistry awards best whitening product".

They can look very professional and the public don't stop to check if these accreditations are real or false. One company even had a GDC number showing for the dentist providing the treatment and, when it was checked on the register, there was no such number in existence.

We have notified the GDC of everything we've uncovered so far and have put together templates for complaints to Trading Standards, MPs, magazines, health editors of national newspapers and email addresses for sending the complaints to.

I have been delighted by the support from the dental community and it's amazing how us pulling together has helped make some changes in the few weeks since the page was started.

We have managed to secure a statement from Groupon that it will no longer be running any deals without a GDC number for the person performing the treatment. Boots has also withdrawn a product from sale that allowed the purchaser to take their own impression and send it off to receive a custom-made bleaching tray and the syringes of whitening gel. And a whitening company was put under pressure to stand down from the Dentistry Show at the NEC in Birmingham, due to complaints from the dental community. The company in question has several whitening clinics that do not have any GDC registrants providing the treatment, but was hoping to branch out into mainstream dentistry and sell its products to GDC-registered dentists. The firm stood down from the show approximately 24 hours before it opened.

We have had interest from a television production company in covering the illegal whitening issue and they have already filmed undercover at a public event where whitening was taking place.

We were invited to speak at the Dentistry Show in Birmingham and Enlighten changed its programme of talks to include a debate on illegal whitening. The dental professionals in our talk were shocked by the images that we had uncovered and shocked to hear about how widespread the problem is.

We now have more than 1,500 members on our Stamp Out Illegal Tooth Whitening Facebook page and we need more help. We are asking that everyone shares and likes our page, uses the template letters on there to send reports of illegal practice to the GDC and Trading Standards and hopefully, with the support of the dental community, we can approach more companies such as eBay and Amazon to stop them selling illegal strengths of up to 36 per cent hydrogen peroxide to the general public.

We hope to get our message out to the beauty colleges so that all trainee beauticians know that they are wasting their money if they enrol in a tooth whitening course and that they will be at risk of prosecution if they undertake the treatment.

We will endeavour to get as much press and media coverage as possible to get the message out to the general public that they are endangering their health and oral health by visiting these technicians and, hopefully, people will respond and stop putting themselves at risk.

We hope to meet with the General Dental Council someday to find out what is happening and why there have only been a handful of prosecutions so far. Of course, we understand that the legislation was only changed in October 2012 and it is a lengthy procedure to collect evidence and put together a case to prosecute someone for the illegal practice of dentistry, but we hope to get some understanding as to how the reports are dealt with and what will be happening going forward.

In the meantime, our page will continue to receive reports and publish images that demonstrate the damage being done by non-dental professionals and we will continue to raise public awareness of the dangers of this unsafe, unregulated practice. For further information on what we've uncovered so far, letter templates and address for reporting, please visit our page and hit like and share.

We can't do without your support and with it, we can bring about a change. ■

Visit www.facebook.com/StampOutIllegalToothWhitening for more details.

ABOUT THE AUTHOR

Beverley Carlyle has worked in dentistry for 22 years, starting out as a dental nurse in Northern Ireland and working in both NHS and private practices. She had an interest in dental implants and worked alongside several implantologists for many years. Beverley decided to move into management and was given training in developing my team and managing the business, moving to Edinburgh in 2005 and working for the Scottish Dental Implant Centre before moving to manage two practices in Edinburgh for Integrated Dental Holdings. She relocated back to Northern Ireland in 2010 and has been working as a business development manager for Ballynahinch Dental Care.

Raising awareness

from Dunoon to Malawi

Nigel and Vicky Milne, from the Hollies Dental Practice in Dunoon, describe their recent aid visit to Malawi

It is a long way to Malawi from Dunoon but, in September 2012, we left the Hollies Dental Practice on the west coast of Scotland and visited Malawi with a charity named The Raven Trust to help them assess the dental need in Northern Malawi. The Raven Trust has been established for 15 years and has done lots of work, including the building of three dental surgeries in three separate mission hospitals in Ekwendeni, Embangweni and Livingstonia. However, these surgeries have never been able to run sustainable services.

We spent three and a half weeks trying to establish what is needed and how to go about setting up a service that would be helpful to these local communities. They cover a total population of around 300,000 people and, at present, two of the hospitals have no dental service at all and the third hospital in Livingstonia has a very basic service which consists of two clinical officers who, along with their other responsibilities within the hospital, take out teeth when it is required.

We found that the surgeries were poorly equipped with old and often not working equipment and little, if any, materials or consumables. We spent three days sorting out the surgery in Ekwendeni; this involved throwing out a lot of useless equipment which was beyond repair, sorting through lots of tools which had been donated by well-meaning dentists, cleaning and scrubbing the room and setting up suitable sterilising procedures before we managed to see some patients. We found that every mouth we looked in required some dental work as people who have some sugar in their diets have little money to spend on toothbrushes and toothpaste and most had never seen a dentist before. The average wage in Malawi is £1.42/day. A tube of toothpaste would cost a day and a half's wages with a toothbrush costing a further day's wages.

There is a huge need for dental services here as people have nowhere to go if they have dental problems and many people we saw had been suffering from dental pain for a very long time. We were able to donate some new and valuable equipment given to us by GDEC, which was gratefully received and hopefully will be put to good use eventually.

We found the experience very sobering and it has made us very aware of how lucky we are to live in a developed country where we take so much for granted. We have now joined with the Raven Trust and set up a sub charity called Smileawi with the hope that we can help the people in these areas.

Our main objectives are:

- to relieve pain and carry out basic dental treatment
- to equip, upgrade and maintain the dental facilities at the three centres
- to recruit, train and support local staff at the three centres
- to set up oral health promotion and preventive programmes
- to implement best practice
- to provide toothbrushes and toothpaste where possible
- to supply three portable units for remote dental clinics
- to encourage our dental colleagues to consider visiting Malawi for a working holiday
- to collect donations of money and resources to help support these objectives.

If anyone has anything they would like to donate, be it toothpaste, toothbrushes, dental equipment, materials, money or time, please get in touch with us at smileawi@gmail.com

Items can be uplifted by arrangement. We have already collected a dental X-ray unit from the RAH in Paisley!

In order to keep costs down, volunteers are asked to pay for their own travel, food and accommodation.

Over the festive period this year, we ran a Christmas Appeal at our dental practice and managed to raise £687, with more than 500 toothbrushes donated by our patients. Once again this was supported by the good people at NES with a further £70 donated from their Christmas card appeal.

This money will allow us to buy a portable dental chair and equipment to take out to some of the remote rural communities. ■

This article first appeared in the Winter 2013 edition of the British Dental Nurses' Journal

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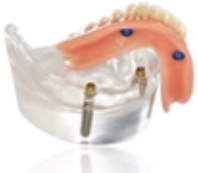

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DTS

A humbling experience

Scottish GDP Dr Ammar Al Hourani describes his experiences caring for Syrian dental patients housed in a Turkish refugee camp

In 2008, I spent two months of my elective year in Hama helping Syrian children who had little or no dental services. And, since qualifying as a dentist four years ago, I have always had the desire to go back to Syria.

Sadly, I never envisaged that I would go back so soon and in such altered circumstances to help some of the same Syrian children, this time in refugee camps in Turkey.

Two years of devastating conflict has, at the time of writing, claimed the lives of more than 70,000 people, internally displaced five million people and made one million people seek refuge in Turkey, Lebanon, Jordan and Iraq. My father and I felt that we in the Scottish community should try to extend a helping hand to those in desperate need.

We decided to leave the comforts of our homes and jobs in Scotland and organised a trip funded by us and contributions from Scottish-based charity Aid4All. We researched our trip and began a Scotland-wide fundraising scheme to pay for the humanitarian, dental and medical mission in the camps.

The charity had previously organised four successful aid missions to Lebanon, Damascus and Homs, helping to feed hundreds of families by distributing food parcels and providing funds for basic medical aid for children.

From November 2012, we began collecting any surplus dental equipment and materials from the local general dental practices in Forth Valley, as well as obtaining much-needed sponsorship from various dental companies, including GSK, Dentsply and Colgate, who kindly offered gloves, masks, visors, Fuji GI, composite, dental hand pieces and instruments, surgical equipment and needles/syringes.

We learnt from Aid4All that there was an overwhelming shortage of medically and dentally qualified personnel at the camps, which have seen rising numbers of injured crossing the borders from Syria. The camps' medical and dental services were already basic and under-equipped, but now they are overstretched. On occasions, simple and complex treatment, both medical and dental, was being performed by under-qualified staff.

In January of this year, my father and I, after months of planning and co-ordinating with several charities on the ground in Turkey, flew to Hatay, where we began our dental and medical aid mission. We were transported with all our equipment to Rehanli, a town situated only a few miles away from the Syrian camps. This was a sleepy, picturesque town which, since the conflict, has become home to 45,000 Syrians from Aleppo, Idlib and surrounding towns and villages.

The next morning we drove to the Syrian refugee camp. From a distance, the camp in Atma looked beautiful, tents clustered together in a dash of white on a brown hill with green rows of olive trees on either side as far as the eye could see. Close up, however, the campsite was disorganised with tents crammed so tightly together that there was very little room to even walk.

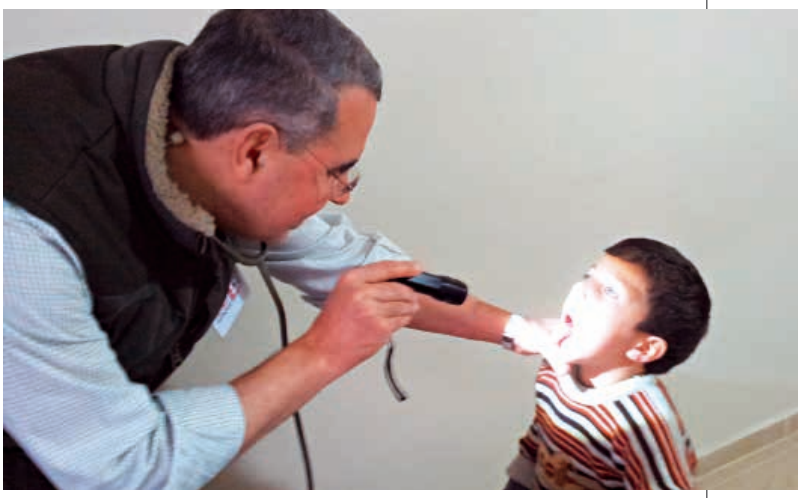
The temperature was close to freezing and the travelling was made harder by the muddy conditions as a result of the previous night's rain. My first impression of the camp was that there was a real sense of bewilderment. There was clearly no local authority or any aid agency in charge of running this camp; no co-ordination whatsoever, which naturally lead to confusion; and, to an extent, a lack of security.

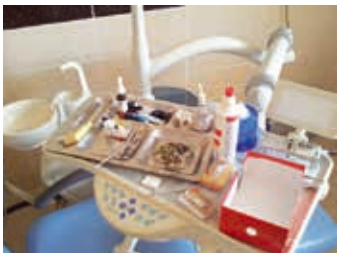
The overcrowding was unbearable, with tents sometimes shared by more than one family. The conditions were very basic with rudimentary sanitation and very little running water. I marvelled at the resilience of the human spirit. How people can cope in such a situation, adapt to this new environment and re-establish some semblance of their lives in an area and conditions unfamiliar to them was quite remarkable.

What struck me was the sheer numbers of children in the camps; this is a camp that is home to roughly 12,000 people, with as many as 50 per cent of them being children. These were children who have witnessed the harsh conditions of war, the tough conditions of the refugee camps and without any meaningful education for two years. This is not to forget the meagre winter clothing most had on. It was heartbreaking to witness, but, unfortunately, this was the reality that we faced.

That same day I was expected to volunteer at the dental clinic, which was set up and sponsored by a large group of Syrian diaspora in Germany. The dental clinic was based within a polyclinic which also had a paediatric drop-in centre, a geriatric clinic and pharmacy.

The dental appointments were based on a first-come, first-served basis and people would arrive early to register. The queue for dental registration was massive, highlighting the need for dental care in the camp. That is when it hit me





and I realised the magnitude of the task in hand.

When we arrived, we provided much-needed dental aid within the camps and in the surrounding districts. This included emergency treatment to alleviate acute pain, dental education for the kids in the camps through the distribution of toothbrushes/toothpaste and providing basic dental education as well as the distribution of powdered milk for newborn babies and baby clothes.

My father, working alongside other organisations, provided paediatric medical assistance by helping to build and equip the only purpose-build paediatric clinic in the camps to serve the local community. They also trained the local doctors and nurses with refresher courses as well as training staff on how to use the equipment provided.

The clinic was a far cry from what I was used to at my associate practice. For a start, the dental clinic was thinly kitted out and the materials on offer were ones I hadn't encountered before. There was a basic form of decontamination, limited instruments and the biggest obstacle was the lack of nurses – so there was no one to support me while I was examining and treating patients. I hadn't mixed or prepared any dental materials since I was at university, so treatment took longer than it would normally do.

"The majority of patients I saw were suffering from toothache as a result of gross caries"

Most patients I saw were suffering from toothache as a result of gross caries or secondary caries to large restorations. The caries rate was high and oral hygiene poor. Most of the adult patients were suffering from chronic adult periodontitis and most hadn't seen a dentist for more than two years. Clearly, with the stresses and poor nutrition they had endured, their dental needs were not their highest priority.

Dealing with patient expectations was quite tricky and was the most challenging aspect of my short stay. Most of the patients who had suffered from irreversible pulpitis were very keen on preserving the tooth and would ask for root treatment rather than extraction. This made a lot of sense from the patient's perspective as they know its going to be difficult to replace the missing tooth and a short-term solution for them seemed the best option.

However, this placed a huge burden on the clinic for many reasons, most notably there wasn't the material to continue the root treatment, and secondly, the patient would need more than one appointment, therefore potentially depriving someone with real toothache from accessing treatment. This would be unaffordable, long-term, and the cost to the clinic would spiral and therefore endanger the core dental service in the area.

Other than pain patients, I commonly examined patients who had commenced treatment in Syria and wanted the treatment to be completed. This comprised mostly fixed prosthodontic cases, but, unfortunately, there was very little we could do for these

Continued »

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cases for the same reasons discussed earlier. Also, there was no dental lab in Rehanli, the nearest one was in Antakya – 45 miles away.

During my stay, I was frustrated and saddened that I couldn't do more and reach as many people as I could, but I had to work within the limitations of the clinic and the resources available. On a daily basis, I would speak with the management staff but, like myself, their hands were tied. They wanted to do more but the challenging environment and the enormity of the task prevented them from taking an already remarkable and successful contribution any further. The potential is there and that brings great hope for the future.

One of the biggest daily challenges I faced was the high turnover of instruments. This placed a huge burden on the ageing sterilisation unit, so at times I had to close the clinic to replenish supplies. At the end of the first week, we found ourselves running low on all materials, so I had to scale back and become more insistent that the only patients I could see were acute pain patients. This was a low point of my trip, but I had no other choice.

My father worked at the paediatric drop-in clinic, which was on the same floor. This was convenient as it allowed me to speak to the children and their families about the importance of dental health and distribute some much-needed toothbrushes and toothpaste to the children in the clinic and waiting room.

Apart from my daily dental responsibilities, I had the joy, alongside my father, in helping to set up a purpose-built paediatric hospital in the camp. This was a project run by a well-respected charity in England called 'Hand in Hand for Syria'. The hospital had two floors – the ground floor had a drop-in outpatient paediatric clinic in the mornings with seven in-patient beds for management of acute and chronic paediatric cases, a small pharmacy, an in-house lab and a small neo-natal unit with four incubators and all the equipment required for the unit. The second floor is still under construction and will serve as an obstetric and gynaecology unit.

The most rewarding aspect of my entire trip was the distribution of much-needed powdered baby milk to the residents of the camp and surrounding villages. It was a good way to see how people were making the most of things under the conditions. The Syrian people are very warm, kind and hospitable and everywhere I went I was offered tea and any precious sweet treat. It showed remarkable courage and determination to keep spirits high.

The 10 days I spent in the camp was a humbling experience – one of the most rewarding in my life. I would like to thank everyone who made my trip a success.

I plan to go back again to the camps later on this year, and, as ever, would appreciate the support of the Scottish dental community for this mission. ■

To find out more about Aid4All and how you can get involved, visit www.aid4all.net or email aid4all@live.co.uk

ABOUT THE AUTHOR

Dr Ammar Al Hourani BDS MFDS RCSEdin graduated from Glasgow in 2009 and carried out his VT training in the Highlands followed by DFT in Dundee and six months as an SHO in the oral and maxillofacial department. He currently works at Tooth Plus in Stirling and Long and Gilmour in Bo'Ness. Originally from Damascus, Syria, he has lived most of his life in Scotland. His father, Dr Ghassan Al Hourani, is a consultant paediatrician at Forth Valley Royal Hospital.

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A Southern adventure

Grant Mathieson describes his recent visit to the P-I Brånemark Institute of South Africa

I was very pleased to be invited to the Advanced Implant Dentistry Course held in March 2013 at the Brånemark Institute in Johannesburg. This three-day intensive course covered both surgical and prosthodontic procedures in fine detail and concentrated on angulated and wide body implants.

Leading the team from the University of Witwatersrand were Professor Dale Howes for prosthodontics and Dr Greg Boyes-Varley for maxillo-facial surgery. They demonstrated live surgical and prosthodontic procedures including the use of zygomatic implants and immediate loading of a full arch maxilla. This course is sponsored by locally-based Southern Implants who have been at the forefront of developments into implant surface technology and angulated implant design. Zygomatic implant placement for extensive reconstructions were covered and gave an insight into the scale of challenges faced in South Africa with gunshot injuries and oncology.

"The course reinforced current dental implant practice in the UK with a preference for screw retained restorations and passivity of fit"

Grant Mathieson

The course reinforced current dental implant practice in the UK with a preference for screw retained restorations and passivity of fit. The use of angulated implants in the anterior maxilla is an ideal example of combining surgical and prosthodontic requirements for an optimal outcome. The reduced need for grafting and predictable palatal screw access are significant advantages with the use of the angulated Co-Axis fixture. These angulated implants are also advantageous in the posterior maxilla where there is a reduced need for sinus grafting and the necessity for angled abutment correction. Southern Implants have a vast selection of prosthodontic components to suit any clinical situation but I was interested to discuss the preference for passive abutments favoured by Prof Howes. This simple laboratory procedure has significant advantages in terms of passivity of fit and

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accuracy of the implant – abutment interface.

Prof Howes and Dr Boyes Varley have worked together and in collaboration with Prof Brånemark for many years and are continuing to publish excellent results with the use of a variety of implant fixtures including angulated and wide-bodied fixtures for immediate molar placement. The Max implant is not one for beginners but has a number of advantages both surgically and prosthodontically.

This course is a fantastic mix of didactic teaching, practical hands on sessions and the opportunity for discussion with vastly experienced clinicians. They have a great working relationship and a light-hearted approach to teaching, which made this course well worth the trip to South Africa. A factory tour at Southern Implants is part of this course and confirms their attention to detail with amazing quality control procedures.

South African hospitality was incredible with a braai on arrival and concluded with an escape out of Johannesburg to the Kwa-Maritane Bush lodge and a safari the following morning.

This was an amazing end to a thought provoking trip and I will be keen to put some new tips into my everyday clinical practice. ■

ABOUT THE AUTHOR

Grant Mathieson graduated from Edinburgh University in 1990 and has had a broad based career in NHS, university and specialist practice. He is a specialist in prosthodontics at Vermilion in Edinburgh, a part time visiting practitioner at Glasgow Dental School and an examiner for The Royal College of Surgeons of Edinburgh.

Conservation dentistry

Like many surgeries in Scotland, Kilbarchan Dental Practice was faced with some tough decisions when it came to complying with the LDU regulations.

As a thriving three-surgery practice with no room to expand, practice principal Sheila Macintyre's only option was to either convert a surgery into an LDU or relocate. However, as Sheila had utilised a grant from the Scottish Dental Access Initiative in 2006 to convert the attic space of the building into the existing third surgery, she was told she would have to repay the money if she then turned this surgery into an LDU.

So, the decision was made to relocate to a suitable site Sheila had identified just a few yards up the hill in the Renfrewshire village. She was granted permission to demolish and rebuild on the plot occupied by a run-down antiques shop. With Kilbarchan's status as a conservation village, the development had to be in keeping with the traditional style of the surrounding properties, while at the same time providing everything a modern dental surgery required.

Some of the staff at Kilbarchan Dental Practice

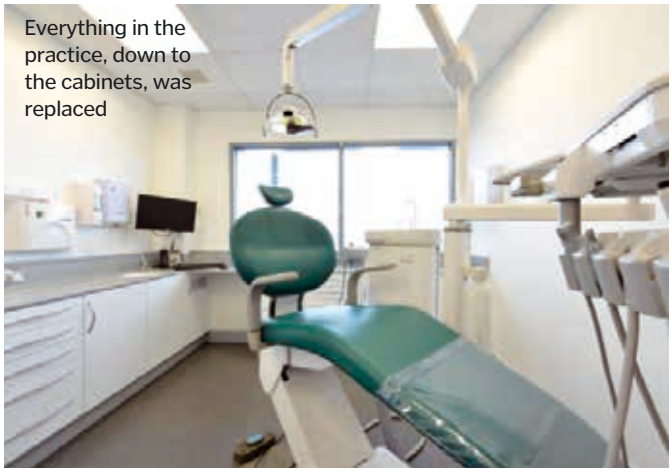
The relocated practice opened for business on 1 April and Sheila is delighted with the new five-surgery practice. She said: "I love it. We have had lots of compliments from patients since we moved. They seem genuinely impressed and one patient even remarked that it felt like a "posh Harley Street clinic" rather than a small NHS village dental practice."

Sheila has four associates working alongside her in the new practice's four working surgeries, with the fifth plumbed in and ready for a chair to be installed when the demand increases. They are predominantly NHS but also offer I/V sedation to existing patients and on referral, as well as aesthetic dentistry and other private treatments.

For more information, visit www.kilbarchandental.co.uk The new practice will be featured as the Practice Profile in the June/July issue of Scottish Dental magazine.

Pheonix rises

Although smoke damage from a fire in an adjacent unit rendered Carfin Dental Care's facilities unusable, a wholesale refurbishment over two months has brought big benefits, writes Bruce Oxley



Everything in the practice, down to the cabinets, was replaced

It's probably the moment every practice owner dreads – the phone call from the police in the middle of the night.

And, for Niall Sloan, it was just the beginning of one of the most testing periods in his professional life. The owner and principal dentist at Carfin Dental Care arrived at his practice at 2am on Friday 7 December 2012 after fielding a phone call informing him that the tanning salon next door to his practice had caught fire.

When he arrived at the scene, the fire was under control and, from first impressions, it appeared that the practice had survived any major damage. And, when he was allowed access a couple of hours later – albeit only armed with a torch – he started to hope that they might not be out of action for too long.

However, returning to the practice in the early morning sunshine, it became apparent that what had looked like minor smoke damage and a layer of soot in the early hours, was actually much more serious. Virtually every surface in the practice was covered in a film of, what looked and felt like tar, rendering all the equipment unusable, not to mention unsafe.

Niall's first thought was for his patients and he quickly got in touch with the health board to arrange for any emergency patients to be seen elsewhere. Appointments were cancelled for that day but a colleague in Motherwell – Thomas McGuiness from Dalziel Dental Practice – kindly let Niall use a surgery at his practice for three days the following week to see patients.

However, the scene at the Carfin practice was quickly turning from a clean up to a full-scale refit and it was clear that an alternative location was needed while the practice was literally taken apart and put back together again.

Niall got in touch with Mike Devine, director of salaried primary care dental services at NHS Lanarkshire, and enquired about the health board's mobile dental unit. Despite being out of commission for a few months, the surgery was in good condition and they managed to get a driver – a local taxi driver who had the right licence – who agreed to drive it from Coathill Hospital in the morning to the car park in front of the stricken practice, and back to the hospital in the evening.

For the next two months Niall and his two associates worked split shifts in the van, seeing patients from morning until night. The neighbouring hairdresser, which was untouched by the fire, let patients wait in their waiting area as the van could only fit one patient at a time.

The proximity of the van meant that Niall could oversee

"The practice is brighter and more colourful than ever before"

Continued »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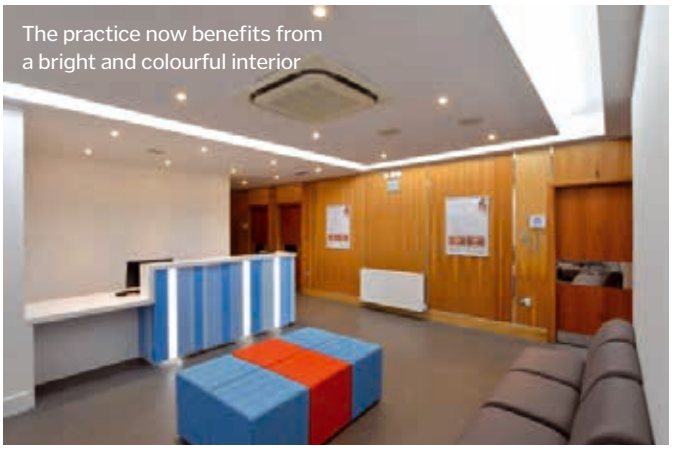
the extensive renovation work at the practice. Ironically, earlier in the year, Niall had been in touch with Farahbod at NV Design and Construction with a view to refurbishing and remodelling certain aspects of the practice. This meant that NV had plans in place and was able to hit the ground running, stripping out all the fixtures and fittings from the practice before Christmas. Everything, from the plaster on the walls to the radiators, the dental chairs and all the computer equipment had to be pulled out and scrapped. Luckily, Ian Wilson from IW Technology was able to rescue all the data from their computer system and load all the patient information onto a laptop, allowing the practice to carry on in as normal a way as possible.

New cabinetry and equipment was sourced through Henry Schein and new Takara Belmont chairs were installed.



The practice now benefits from a bright and colourful interior

The only things to survive were the goldfish and the doors, everything else was removed. The practice layout remained the same apart from one aspect that Niall and Farahbod had discussed prior to the fire.

They had spoken of turning the office at the front of the building into a new surgery and moving the reception area so that it faced the front door as opposed to around the corner as it previously was, incorporating a small children's play area into the bargain.

NV resumed work early in the new year and, after workers had stripped the practice back to the bare bones, industrial cleaners spent two weeks cleaning the shell and making it ready to be fitted out. The work then began to revitalise the practice and it was finished on 15 February, cleaned over the weekend and open to patients on 18 February.

Despite the obvious tribulations, Niall is now able to look back and pick out a few positives. The practice is brighter and more colourful than ever before, and they have managed to improve their systems and internal communications. During the refurbishment, they had a staff meeting at a hotel and looked at every aspect of the way the practice was run, from top to bottom and, Niall believes, those ideas have made a big difference to the way the practice will go forward.

If the very image of a phoenix raising from the flames is a little dramatic, what is for certain is that Niall and his staff have managed – with a little help from their friends and colleagues – to find the silver lining in what seemed like a very dark, and sooty, cloud. ■

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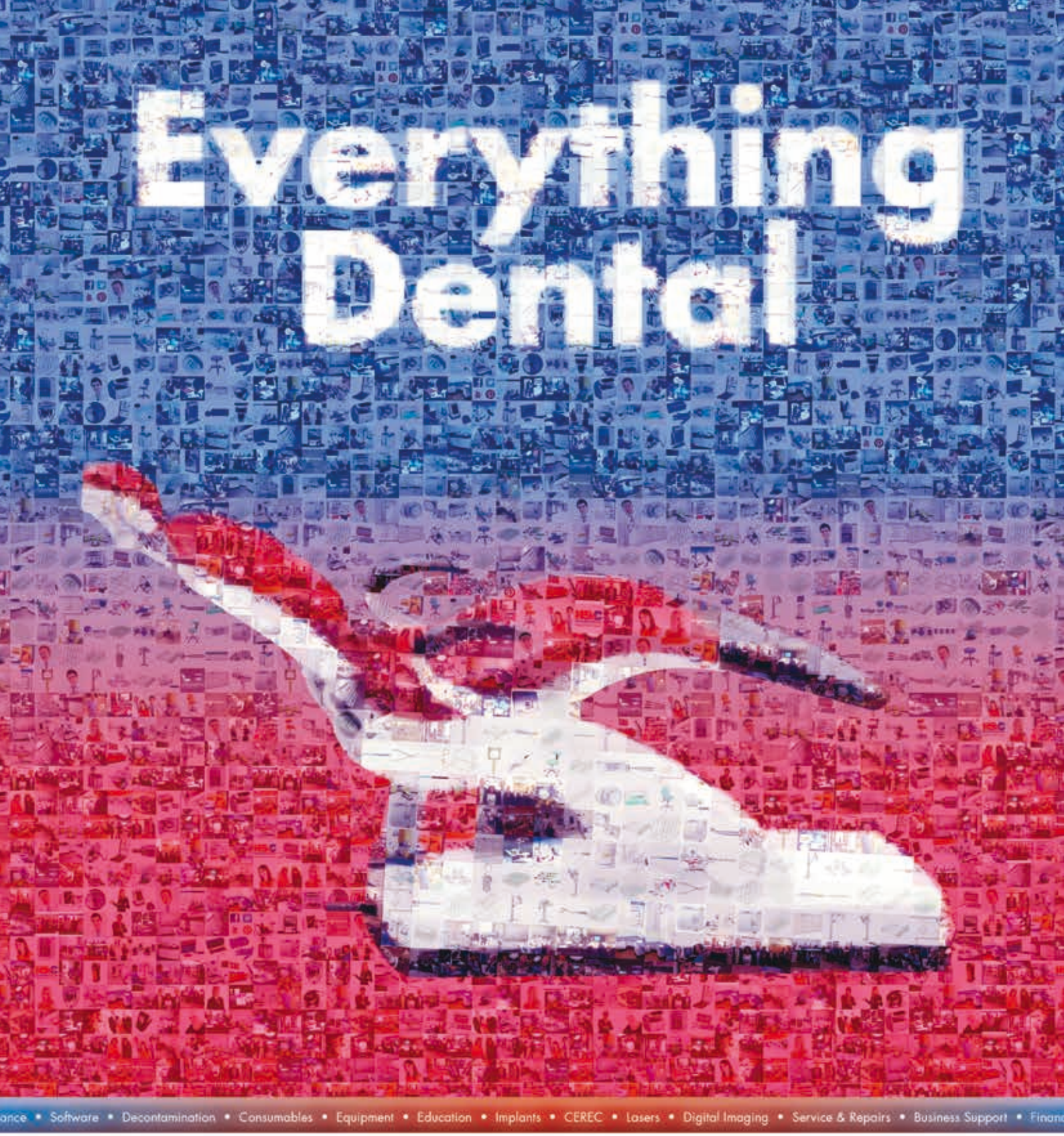

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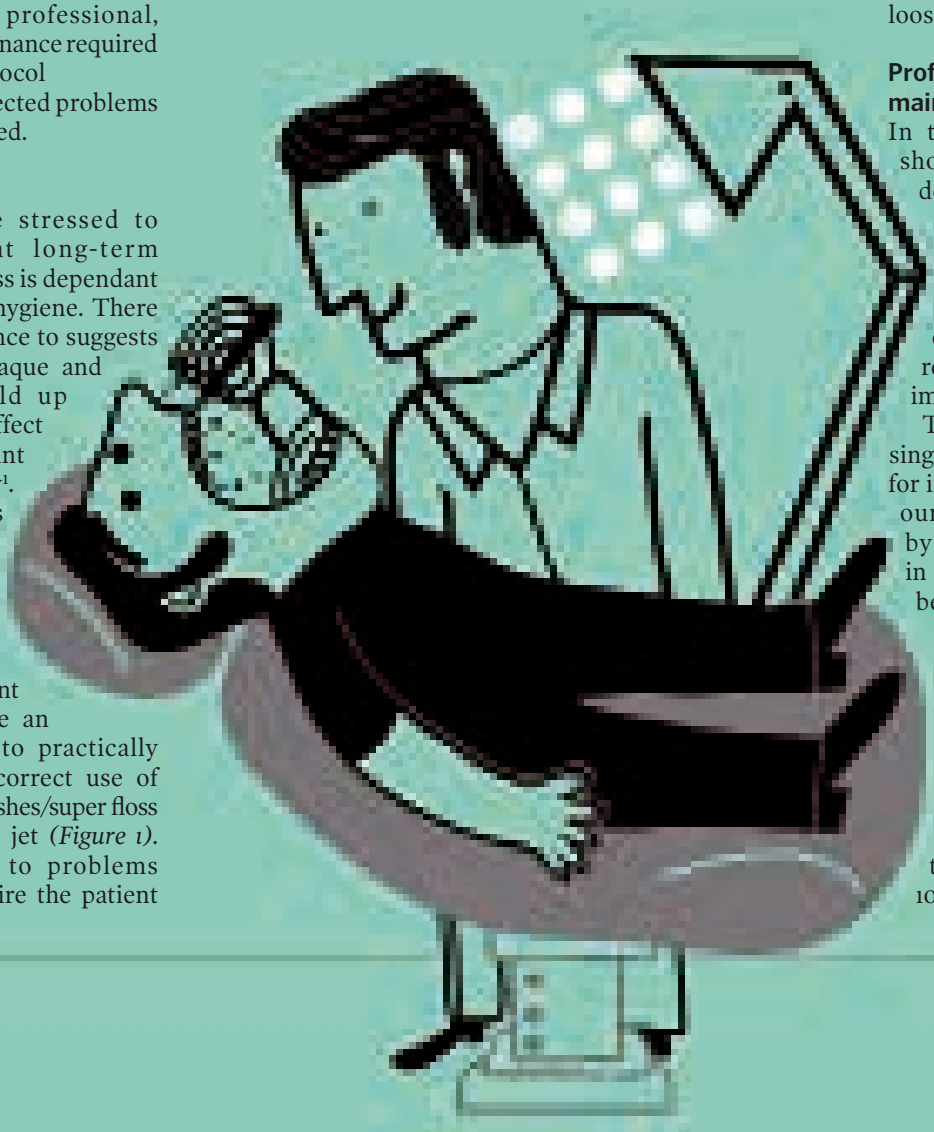
Maintenance and problems

In the last of his series of articles on the All-on-4 technique, Kevin Lochhead looks at the current regimes for maintenance and the most common problems encountered during and after treatment



Maintenance

At the outset of any treatment plan – be it implant or conventional – a maintenance plan must be addressed. This should include:

1. Suggested oral hygiene regime, and problems that could arise requiring investigation
2. Expected, professional, regular maintenance required
3. Review protocol
4. How unexpected problems will be managed.

Oral hygiene

It should be stressed to patients that long-term implant success is dependant on good oral hygiene. There is some evidence to suggests that heavy plaque and calculus build up can have an effect on peri-implant bone stability[1]. Bone loss is greater still for poor oral hygiene in bruxers and smokers.

Every patient should receive an appointment to practically demonstrate correct use of interdental brushes/super floss and the water jet *(Figure 1)*. With regard to problems that will require the patient to return for review, patients should be counselled to be alert to acute inflammation of tissue round the implants, pus exudate, unpleasant smell or pain when brushing/flossing.

Symptoms of parafunction should also be watched for – muscle pain, headaches, clicking joints, sensitive or loosening of opposing teeth.

Professional maintenance and review

In the first instance, this should be "needs based", depending on the patient's remaining dentition. An opposing periodontally involved arch will require a significantly more in-depth recall programme than an implant-supported bridge.

There is currently no single accepted recall regime for implant patients. We base our system on that used by the Brånemark clinic in Gothenburg, which has been successfully implemented for more than 40 years:

1. Initial review after one month – review oral health, occlusion and any concerns. Take baseline radiographs.
2. Review at one year, two years, five years and 10 years, with additional

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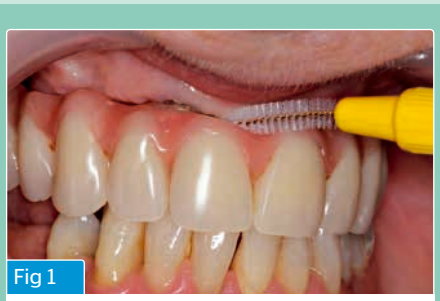

Fig 1
Access for interdental brushes is essential

Fig 2
Frank pus exudate on palpation indicates infection

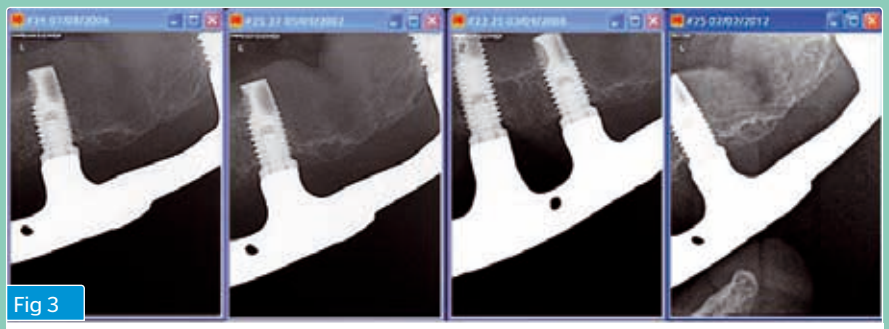

Fig 3
Monitoring of bone levels at baseline, one, two and five years

ABOUT THE AUTHOR

This article was submitted by Kevin Lochhead, specialist in prosthodontics and clinical director at Edinburgh Dental Specialists.

"Routine probing round implants is not encouraged unless a foreign body is suspected"

Continued »

interim reviews if issues are present.

This recall regime is specifically to address the implants and associated restorations. Patients are expected to continue to see their GDP for regular oral health and hygienist review appointments. Without any additional individual criteria, we would not expect them to be seen any more often than every six months.

Having a dental implant supported restoration should not mean any more recalls than normal.

Review protocol

At the allotted recalls, the following are checked:

a) Observation of peri-implant tissues for signs of poor oral health and inflammation

b) Palpation of tissues to check for frank pus exudate and bleeding. Note: with long tissue tunnels to the head of the implant, there may be a neutrophil exudate, which is quite different from the pus and blood associated with infection *(Figure 2)*.

c) Radiographs to monitor bone levels *(Figure 3)*. Note: routine probing round implants is not encouraged unless a foreign body is suspected. There is a degree of controversy in this and, as noted by Albrektsson[2], the different opinions seem to stem from whether the clinician's background is that of periodontist or prosthodontist. A recent UK consensus document from the ADI, compiled from a predominantly periodontal panel, suggests routine probing is essential[3]. In Europe, the latest Estepona Consensus Meeting (a predominantly prosthodontist panel including, Buser, Jemt, Albrektsson, Sennerby et al) advises against probing[4,5]. This is an extremely important area and clinicians must have a rational argument for their own in-house protocol. We have, as a practice, downloaded, reviewed and discussed the papers cited on both sides of the argument, and concluded that routine probing is not advised.

Dr Pierluigi Coli, a specialist in prosthodontics and periodontics, will be presenting an unbiased review of both sides of this discussion at the upcoming Scottish Dental Show, which all clinicians involved in managing patients with dental implants are encouraged to attend.

Management of unexpected problems

At the outset, patients are informed of the risks of implant failure and how this will be managed. Similarly, how fractures and refurbishment of the final bridge will be managed, together with the practice warranty and any costs associated.

Specific problems

As with all treatments, problems can and do occur. We have been offering the All-on-4, and full arch

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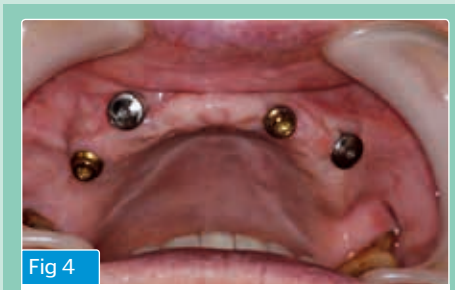

Fig 4
Implants placed too buccally

Fig 5
High lip line demands tissue resection to hide transiton zone

Fig 6
Apparent bone loss after integration – visible implant threading and no infection

Fig 7
Removal of failed immediately loaded implant

Fig 8
Original provisional with luted temporary cylinders, high incidence of fracture

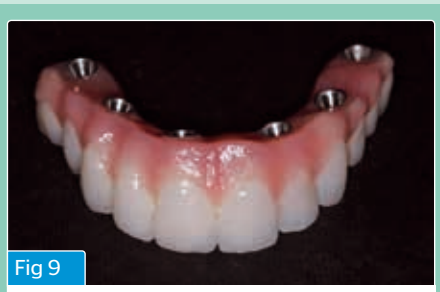

Fig 9
Homogenous casting provisional

Continued »

implant treatment for more than 15 years. As a result, we have had the opportunity to manage most problems which may arise.

Dental implant treatment has more research and literature than almost any other aspect of dental care and, in most instances, problems can be resolved. In addition to the general problems which can occur with implant planning, placement and restoration, there are some specific to the All-on-4 technique.

These problems can be loosely addressed as implant or restoration based:

1. Implant problems: Short term

• Failure to achieve primary stability – if only four implants are being used, in order to move to immediate loading, a minimum of 35ncm torque is required for all implants or a complete denture becomes the interim restoration.

• Failure to integrate – again if the minimum of four implants has been used and one fails to integrate, treatment cannot be completed until an additional implant is placed.

• Incorrect positioning – this protocol usually calls for alveolar and soft tissue resection. As such, fabricating a useful surgical guide is not usually possible. Fortunately, accurate implant positioning is not as important as with single or partial cases, but implants placed too far out of the arch can create oral hygiene and bridge fabrication challenges *(Figure 4)*.

• Lack of osseous reduction – without correct reduction, the transition zone can end up in the wrong place, creating the need for an unhygienic ridge lap or anterior cantilever *(Figure 5)*.

Long term

• Continued bone loss – this can be due to any one of more than 40 reasons (of which peri-implantitis is only one)[6] *(Figure 6)*. Treatment may be indicated, although ultimately may procede to:

• Loss of integration – with only the minimum number of four implants, not only replacement, but also fabrication of a new bridge will be required *(Figure 7)*.

• Fracture of implants and components – as yet, long-term survival data (more than 15 years) on four implants does not exist and mechanical failure must be anticipated as a possibility.

2. Restorative problems: Planning

• Aesthetic compromises in the transition zone – the high lip line must be accurately recorded and communicated to the surgeon or an unaesthetic restoration will result.

• Too few implants – this can result in a lack of posterior support; despite the financial attraction of using only four implants, tried and tested biomechanical implant protocols should be maintained and when sufficient bone is available additional implant support should be sought.

• Bruxism – this is cited as the single biggest risk factor in immediate loading. Micro motion results in implant failure. Bruxists should not be offered this treatment option[7].

Provisional restoration

• Unacceptable aesthetics – the goal is to fit the provisional on the day of surgery and not remove it until after boney healing. It is, therefore, essential that the required aesthetic information OVD etc. is gathered and transferred to technologists.

• Fracture – original protocols using temporary cylinders luted to a complete denture which is cut back, resulted in many fractures during the critical integration period *(Figure 8)*. As a result, a number of novel ideas have been postulated: e.g. fibre/metal reinforcement, custom casting and delayed delivery and our own homogenous one-piece acrylic casting *(Figure 9)*.

Definitive restoration

• Fracture of veneering material – using the standard protocol of a CNC titanium and resin bridge, an estimated 20 per cent of final bridges will suffer fracture of veneering material within five years[8] *(Figure 10)*. While there are porcelain-based solutions, these are considerably more expensive and there is a need for a more

Continued »

Fig 10
Fractured veneering resin

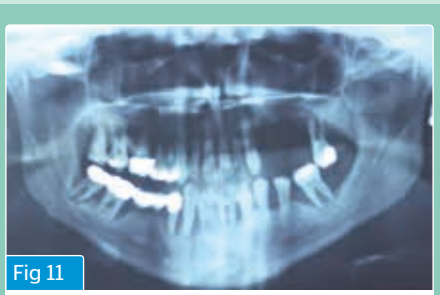

Fig 11
Clinical dilemma: is a 35-year-old patient with a history of periodontitis suitable for implant bridgework?

"While there are porcelain-based solutions, these are considerably more expensive"

Continued »

cost-effective and durable product.

• Phonetics – with a one-piece structure, involving a palatal bite plane, phonetic changes are always likely and, in a small number of patients, may never resolve fully.

The above is a summation of the most common problems encountered and should not be seen as a definitive list. Dilemmas still exist, such as young patients with advanced periodontal disease *(Figure 11)*. While All-on-4 can be an attractive, cost-effective solution, these patients have an expected lifespan longer than all current data on implant survival.

As a practice, we meet regularly to discuss the merits of treatment in such cases before offering definitive planing to patients. Advice on longevity of any treatment offered has to be realistic and guarded.

"While All-on-4 can be an attractive, cost-effective solution, these patients have an expected lifespan longer than all current data on implant survival"

Summary

With a well-trained and experienced team, using a well-researched and documented implant system, the All-on-4 technique is a predictable and cost-effective solution to full arch rehabilitation. It is not, however, a panacea and where possible, additional implants should be planned for. Problems can and do occur, patients need to be carefully counselled about the treatment journey, expected outcomes and long-term management.

These three articles have given a brief overview of the All-on-4 concept. In the scheme of implant dentistry, it is an advanced concept and should only be undertaken after the required training and experience has been gained. ■

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Jayne Clifford, of Martin Aitken Chartered Accountants, gives her top tips for managing your practice in the economic downturn

Make sure you're prepared

Throughout the country, businesses are still feeling the effects of the recession and, unfortunately, dental practices are now no different. As businesses, individuals and the Government are all re-assessing their priorities, this has started to impact on the dental sector within Scotland and the UK.

The recent changes by the NHS on the availability of grants for practices and a tightening on what type of treatments they will pay for, will have an impact on dental practices.

Cash is king

While it is always nice to see a healthy profit at the end of the year, there have been many profitable businesses that have struggled over the past couple of years due to one key issue: managing their cash flow. As businesses start to struggle, it is not uncommon to try to retain cash, either through not paying for items, or expecting payment up front. Luckily, there are a number of ways that you can manage this process.

Have regular contact with your bank relationship manager. It is better to be up front with them if you anticipate any issues, as this will allow you, with them, to work out a plan. Possible areas to discuss with them would be taking a 'Capital Holiday' on any funding you have from them and only pay back the interest element for a period, or renegotiating the terms of this. Remember, your bank wants to be a business partner and trusted advisor and therefore early and frank discussions are essential.

NHS income is fairly steady and is paid monthly. However, do familiarise yourself with recent changes in what treatments the health board will pay for, as this may impact your income and discussing matters, such as rent reimbursement with your advisors.

The level of income is not as readily predictable for practices that have large private fees. You could, therefore, consider ways to make it easier for patients to afford their treatment. This may be possible, for example, by offering payment plans and by linking with companies prepared to fund such plans.

As with banks, it is much easier to negotiate with creditors up front and agree extended payment terms than when it is too late. It may be possible to agree that all invoices be paid within 60 days as opposed to 30 days. However, it is accepted that this is easier said than done.

Know your business

Managing your cash flow is an essential part of knowing your business. However, it is also vital to be able to assess the profitability of your practice.

The thought of management accounts may be enough to send you to sleep. However, they are one of the best sources of information for you to monitor your practice. They allow you and your advisors to keep a close eye on the performance of the practice and therefore detect any issues sooner rather than later. Doing this will also allow your accountant to perform more effective tax planning exercises.

Many practices set budgets and forecasts on a monthly basis. What makes this process really effective is reviewing how the practice actually performed against budget, and the reasons for differences. This should allow you to identify where improvement can be achieved.

"Managing your cash flow is an essential part of knowing your business. However, it is also vital to be able to assess the profitability of your practice"

Jayne Clifford

Don't be afraid to make difficult decisions. In this climate, one of the hardest decisions can be around staffing. It is better to be up front with your employees and by doing this it may be possible to agree short term and temporary changes to terms (e.g. four day weeks, reduced associate percentages). These can avoid redundancies, or worse, in the long run.

Are you ready for changes in legislation, such as auto enrolment for pensions and RTI for payroll?

Know your patients

The simplest way to ensure your business survives is to fully understand the needs and demands of your patients. Sounds simple doesn't it? But, as human beings, everyone is unique. Speak to staff and patients to consider areas such as:

- if a large number of your patients work, offering evening sessions
- making appointments more family-orientated with the possibility of family bookings
- making the patients more aware of services out with the normal areas, such as teeth whitening.

While many of these ideas may seem obvious, we at Martin Aitken & Co would always recommend that you do the above with the advice of your advisors.

Early action may make the difference between growing your business and stagnating. ■

Jayne can be contacted at jfc@maco.co.uk by calling 0141 272 0000 or by visiting www.maco.co.uk

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PREPARATION FOR THE DIPLOMA IN **IMPLANT DENTISTRY**
10 May 2013, RCSEd

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TRI-COLLEGIATE MEMBERSHIP IN **SPECIAL CARE DENTISTRY EXAM PREPARATORY COURSE**
8 June 2013, RCSEd

This one-day course is to give guidance to trainees and trainers preparing for the Tri-collegiate Membership in Special Care Dentistry Examination. The learning style of the course will consist of lectures and breakout sessions which include mock examinations with feedback.

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24 & 25 October 2013, RCSEd

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- **£475.00 – Course Fee**
- **£425.00 – RCSEd Enrolled MFDS Exam Candidates**

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12 June 2014, RCSEd

A joint meeting between RCSEd's Faculty of Dental Surgery and The European Academy of Operative Dentistry. International speakers include Prof Reinhard Hickel (Munich, Germany) and Dr Niek Opdam (Nijmegen, the Netherlands) who will outline their approaches to decision making in restorative dentistry. Clinical cases before and after treatment will be presented and different speakers will discuss how they would have treated each case.

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Other features available with the E30 include the KaVo LED light, scaler and micromotor. All of the high spec components are easily added and KaVo

manufactured tried and tested parts, so that everything matches and works well together. The E30 is also made in Germany, is true to KaVo's excellent ergonomics, and as KaVo's entry-level unit, represents excellent value for money.

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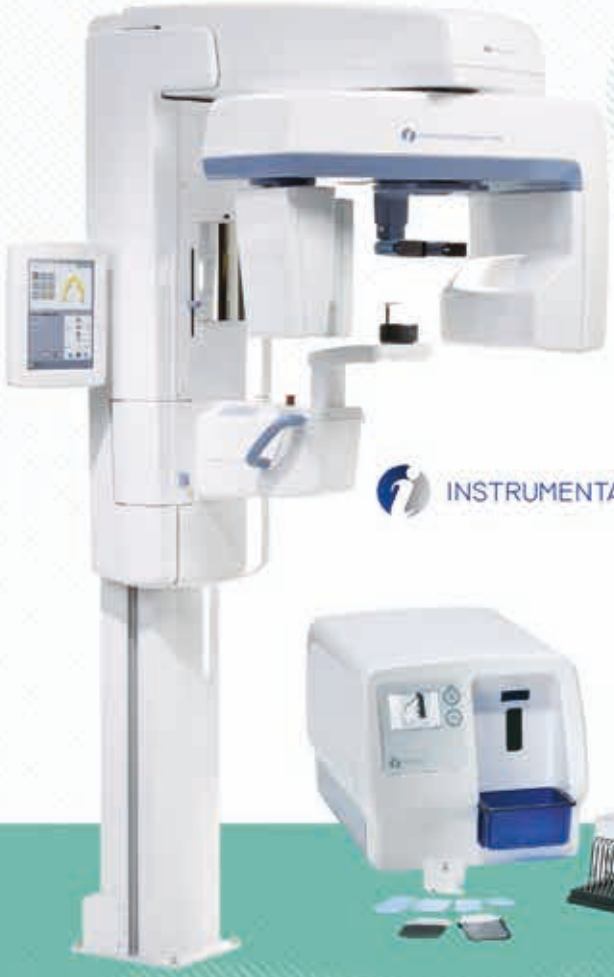

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With more than 20 years' experience as a dental technician working in labs in west and central Scotland, Paul McFall has decided to strike out on his own.

Paul started as an apprentice at DP Nova in Glasgow in 1991, qualifying in 1996. He was taken on full-time by the company, who were initially based in West Princes Street and then later on at a purpose-built centre in Seaward Street, in the crown and bridge department.

He was with DP Nova for 17 years, moving up to manage the gold department before leaving in 2008. From there, he joined Lincoln Ceramics in Lanarkshire and he said it was this move that proved to be a major catalyst for his career. He said: "This was a great move for me as they essentially retrained me and sharpened my skills. It was there that I first worked under magnification and it has been a revelation."

After two years in Lanarkshire he moved to HDL Dental Laboratory in Falkirk for 18 months before finding the perfect premises to start his own dental laboratory. In January this year, he came across a building in Baillieston that had formerly housed a computer repair workshop and, once the formalities were completed, he started converting it into a high-end dental laboratory. In just seven weeks, Paul and his team sourced the workbenches, equipment and machines they needed to begin work and they opened for business as Impulse Dental Laboratory at the end of February.

Paul has recruited two highly-skilled and experienced technicians to join his team: Stephen Heath, former head ceramist and manager at Diamond Ceramics, Adair Dental and Pearl White Dental Laboratory; and Brian McDonald, who spent 10 years at Lincoln Ceramics before joining Opal Dental Lab and then Impulse.

Together, they offer the full range of NHS and private crown and bridge work as well as being specialists in e.max all-ceramic crowns, an area that they have seen a big uptake since opening their doors.

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Trauma reconstruction in a digital age

By Dr E Eilertsen and Dr M Skinner

Today dental implants are considered a reliable and highly predictable treatment modality with favourable survival and success rates[1,2]. Even in areas of severe bone atrophy the advent of augmentation techniques has allowed for reliable implant placement in areas that were previously considered unsuitable[3].

Recently however, my team and I were faced with a challenge that forced us to rely on advanced technology and reconsider conventional surgical techniques in a bid to achieve a suitable outcome for this patient.

Background

This 40-year-old patient had been involved in a serious RTA in which she was the sole survivor. A copy of her report from the maxillofacial surgeon detailed: A LHS le Forte III unilateral fracture; bilateral Le Fort II fractures; LHS Le Fort I fracture; nasal bone fracture; and mid-palatal fracture. The mandible sustained a compound comminuted fracture of the symphyseal and parasymphysis, and a dento-alveolar fracture resulting in the loss of teeth 43, 42, 41, 31, 32. She has been struggling with her existing -/p, and has reduced masticatory function and aesthetics since.

Previous medical/ dental history

The patient is an otherwise fit and well lady, never smoked, takes no routine medications and has no known allergies. She has had routine dental treatment prior to and post RTA and is a regular dental attendee.

Extra-oral examination

There was no indication of any lymphadenopathy or TMJD, although minor facial asymmetry and tissue scarring was noted. She had a high smile line and medium resting lip line.

Intra-oral examination

She had an obvious large dento-alveolar bony defect in the anterior mandibular region. She had a thin gingival biotype with intra-oral scarring evident. Her -/p was ill fitting and inadequate for masticatory function.

Radiographs

The initial OPT *(Figure 1)* revealed evidence of good bony union to the initial injuries. However, a large bony defect was evident in the anterior mandible. At this time a CBCT scan was taken to determine the extent of bone loss, fracture union, and proximity of vital structures.

Treatment plan/ considerations

Due to the large bony defect in the anterior mandible, one of the treatment options was to consider referral to a maxillofacial unit for vertical augmentation utilising autologous bone from either the mandible or iliac crest to reconstruct the defect prior to conventional implant placement. However, the patient felt she had been through enough major surgery after the accident and was not prepared to risk some of the more common outcomes of such surgery.

Harvesting from the iliac crest can lead to significant donor site morbidity[4] as well as problems due to resorption of the graft due to it being of endochondral embryologic derivation [5]. While harvesting of the mandible can lead also lead to donor site morbidity including dehiscence and sensory disturbances[6].

At this time we considered utilising CBCT and CAD-CAM technology *(Figures 2 and 3)* to create a stereolithographic template to place two Ankylos implants in the available bone and mask the vertical defect associated with the final prosthesis with pink acrylic.

From the CBCT we could determine the optimum position for implant placement.

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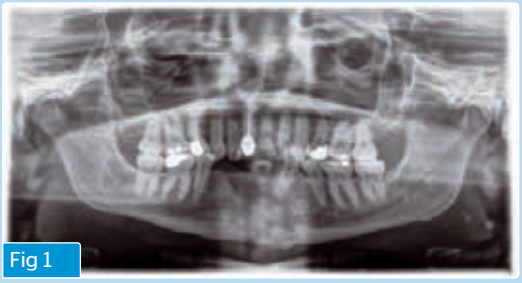
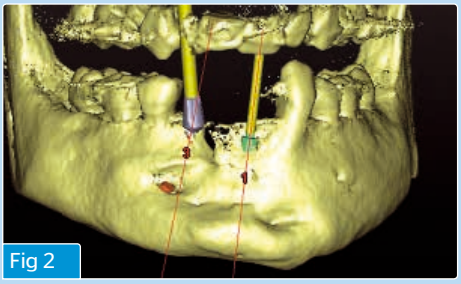


Fig 1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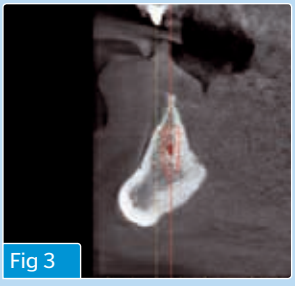
Fig 3

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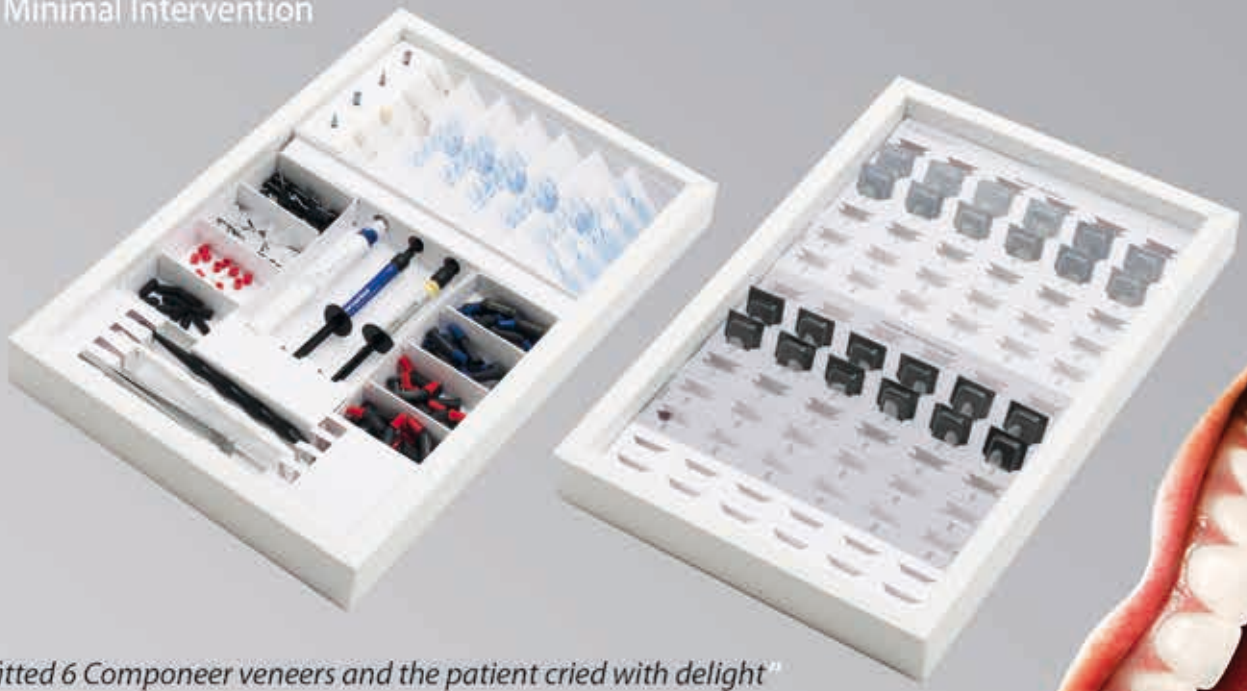

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Fig 4


Fig 5


Fig 6


Fig 7


Fig 8

Continued »

Due to the extent of bone loss we had to angle the implants, ensuring a minimum clearance from the mental foramen on the RHS[7], and ensure not to compromise the adjacent teeth. The CBCT also allowed for measurement of the Hounsfield units to allow an accurate analysis of the of the bone density to allow for optimum placement.

Procedure

A tooth borne stereolithographic stent fitted with Expertease guide rings was constructed by Materialise Dentsply Belgium. The patient was sedated using IV Midazolam and local anaesthesia was delivered.

Figure four shows the stent being seated and the osteotomy sequence being completed transmucosally as described by Dentsply *(Figure 5)*. Healing abutments were placed at the time of surgery *(Figure 6)* and new temporary denture seated clear of the surgical site. Healing was uneventful and the patient reported very minor post-operative discomfort, a common feature of flapless surgery[8].

The use of a flapless technique also is shown to improve the tissue profile and mucosal form around the implant[9]. The implants were restored after a period of osseointegration of approximately 12 weeks conforming to recommended clinical procedures[10]. Standard titanium abutments were placed and torqued to 25Ncm-1, *(Figure 7)* and a precious metal bonded to ceramic bridge was constructed and cemented in place. *Figure 8* shows the final prosthesis in situ.

Outcomes/maintenance

After a month, the patient was reviewed. She reports a vast improvement in her quality of life, masticatory function and aesthetics. She has been organised for 3/12 recall with the dental hygienist for continuation of her maintenance regime.

Personal reflection

The advances in software and scanners available today offer clinicians unprecedented accuracy[11-13], atraumatic technique and a reduced likelihood of post-operative complications[8,14]. This case demonstrates the use of the latest Sirona CBCT, Simplant Software and Ankylos Expertease Surgical kit.

Now, within 10 days, a virtually designed stent is manufactured and delivered with the planning all done before the patient arrives for surgery thereby making an otherwise complex procedure relatively straightforward. ■

ABOUT THE AUTHORS

Dr Eilert Eilertsen BDS, (top) is the practice owner of Eilertsen Dental Care in Inverness. The practice is an entirely private operation that offers both general dentistry and implantology (including referrals). Dr Eilertsen has over 20 years' experience in the field of Implantology.

Dr Mark Skinner BDS, MFDS RCS Ed, PG Dip (Implantology) (above) is the senior associate at Eilertsen Dental Care. Dr Skinner has worked alongside Dr Eilertsen for over two years is also available for implant referral.

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A comparative assessment of primary and secondary care costs in provision of NHS minor oral surgery service in Scotland. By Girish Bharadwaj

Balancing the costs of care

Oral Surgery is now a well-recognised dental specialty. It is an integral part of the wider speciality of maxillofacial surgery. Dento-alveolar surgery forms about 40 per cent of case mix in Oral and Maxillofacial Surgery (OMFS) units nationwide. A collaborative approach is needed to deliver quality and effective care, to help patient management and progression of the specialty.

Oral surgery as a dental specialty presents many advantages which can help to provide effective and less expensive care locally. It is a clinical speciality which can be practiced efficiently and safely in primary care with some of complex aspects of the practice carried out in the hospital sector. This in turn could help develop a model which facilitates appropriate allocation of resources.

There is limited availability of oral surgery specialist service within the primary care setting in Scotland. Details of hospital cost (average per patient) in Scotland are available from Information Services Division (ISD) – Cost book 2012[1] *(Tables 1-4)*. Cost of individual oral surgical procedures carried out by specialists in primary care at present is determined by codes laid out in SDR (Statement of Dental Remuneration)[2] mainly used to calculate item of service payments to general dental practitioners, which is updated from time to time by Practitioner Services Division, NHS Scotland. There is a distinct absence of objectivity in applying them as they are discretionary and applied by a dental advisor with little or no surgical experience rather than a specialist.

The author has conducted a case review of minor oral surgery specialist services in a primary care setup. This article highlights ongoing issues in the delivery of such services.

Methods

The study was conducted at a general dental practice in the Lothian area. A group of 83 consecutive patients who were treated by the specialist were included. Patients were divided into five groups: simple extractions, extraction with surgical flap, extraction with bone removal, removal of impacted wisdom tooth and removal of impacted wisdom tooth with division of roots.

Cost of the procedure was calculated with reference to SDR *(Table 5)*. This was subsequently compared with cost of the same specialist treatment in secondary care sector if the patient had to be referred.

Continued »

Table 1: Cost per episode as per Cost book 2012

1	Attendance at A&E department	£107
2	Attendance at an outpatient clinic	£115
3	Attendance for MRI scan	£216
4	Attendance for day surgery	£797
5	Treatment as a surgical inpatient	£3,120
6	Treatment in an intensive care unit	£8,702

Table 2: Cost per outpatient attendance (ISD 2012)

Outpatients (ISD 2012)		
Net Expenditure £000s	Cases	Cost per Case (£)
11,565	80,599	143

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Table 3: Total and average cost of day case attendance in secondary care OS		
Day cases (ISD 2012)		
Net Expenditure £000s	Cases	Cost per case (£)
4,949	4,563	1,085

Table 4: Total and average cost of inpatient attendance in secondary care OS		
Inpatients (ISD 2012)		
Net Expenditure £000s	Cases	Cost per case (£)
3,638	1,227	2,965

Continued »

Since it was a like-for-like comparison, application of any statistical test was not considered relevant.

Results

The results indicate a wide differential in the costing of services. It is difficult to compare accurately codes in primary care versus secondary care as they are not set on similar lines for the same procedure.

The basis for setting codes in primary care was found to be the level of difficulty of the procedure, commonly extractions. However, in secondary care it was based on whether the procedure was inpatient, day case or a simple consultation as an outpatient.

In other words, the same procedure performed under local anesthesia in a primary care setting would possibly cost 20 times (outpatient), 90 times (day case) or about 200 times (inpatient) more in secondary care.

Discussion

Broadly, there are some factors we need to consider to understand how oral surgery care is provided in the primary and secondary care sectors.

There are many situations in general dental practice where dentists may not be happy taking teeth out as they foresee complications. This results in referral to secondary care specialist, where they are treated as routine referral unless an airway or sepsis issue is present, which triggers emergency response. From a patient care perspective, extraction is probably the procedure which induces anxiety and even phobia in patients.

Minor oral surgery in secondary care differs in its perspective. Extractions are probably the least in terms of priority as they are dealing with complex cases in a secondary care unit such as a DGH (District General Hospital) based OMFS unit where these referrals are treated as routine and hence the patients end up waiting longer. Even if the patient is in pain with an attempted extraction, they can be seen only as routine as seeing them urgently and treating them is very difficult, taking in to consideration the number of referrals.

SDR allocations for minor oral surgery

There is a disparity of cost codes for similar procedures in primary and secondary care. Costs allocated in the SDR *(Table 5)* are a fraction of costs

Continued »

Surgery costs

Table 5

Procedure	Number of episodes	Cost per procedure (£)	Total cost (£)
Extractions: bone removal (premolar, molar)	14	37.85	529.90
Extractions with surgical flap	20	22.20	444
Extractions	43	7.67	329.81
Extractions additional fee per visit	25	6.50	162.50
Extractions: bone remove (impact L3rd molar+div)	3	55.00	165
Extractions: bone remove (impact L3rd molar no div)	3	46.40	139.2
		Total =	**1770.41**
		Cost per patient	**21.33**

Continued »

incurred if a patient were to be referred to a hospital specialist. SDR takes a very simplistic view of the surgical removal of teeth. It would be uncertain at times to predict if one tooth requires a simple extraction or more complex procedure.

If the patient has to pay a fee and is undergoing multiple extractions, it could lead to confusion if it turns out to be difficult. Going further, extraction is very important to prevent further infection and very critical or even life threatening if not performed at the right time. So why should the patient pay for it under NHS?

Discretionary codes exist for oral surgical procedures other than extractions. A fee is set by Practitioner Services, usually on prior approval. A dental advisor who may or may not have enough experience in dealing with complex oral surgery allocates a fee.

A long-drawn process for a simple episode of treatment will further cause delays. Routine enucleation of cysts, closure of oroantral fistula or communication and removal of benign lumps in the oral cavity have to be treated under one code with multiple sub divisions.

These procedures are routine and can be performed safely and efficiently in primary care. Any suspicious lesions (within limitations) may be biopsied as well, which can help speed up waiting times for a cancer diagnosis and further management in secondary care.

Oral Surgery Review 2010[3]

South of the border, oral surgery is contracted out to so-called dentists with special interest in oral surgery (DwSi), who are not necessarily specialists. This is an example of how a significant majority of procedures can be carried out in primary care, thus avoiding unnecessary delays and problems to patients.

A referral from a dentist is forwarded to a local contracting oral surgery service. PCT pays the specialist or DwSi directly and there is no charge to the patient. We need to be aware that there is uncertainty on

ABOUT THE AUTHOR

Mr. Girish Bharadwaj BDS MDS MFDS FFDRCSI is a specialist in oral surgery. He works at Ochilview Dental and Oral Surgery, Armadale and Meadowbank Dental Practice, Edinburgh. He is also an associate specialist at the Maxillofacial Unit, Queen Margaret Hospital, Dunfermline.
Email: drgirishb@yahoo.com
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what will happen after GP commissioning takes over the current process, shortly. The dentist is paid a certain UDA (unit of dental activity) even to make a referral.

Apart from this, in order to keep up with the 18-week RTT (referral to treatment)requirement, NHS trusts have to spend a lot of money clearing the current huge hospital waiting lists, which may mean out-of-hours operations in NHS hospitals or treatment at ISTCs (independent sector treatment centres). At the time of publication, data of costs involved in such treatments were not available to the author.

In general, there is an air of uncertainty over the future of NHS dentistry and how it can be funded as well as being able to provide high standards of care with ever-increasing healthcare expenses. It appears that the actual cost of providing a service delivering high-quality treatment is not consistent with the scale of fees set within SDR. The use of this scale has to be debated and appropriate changes made. It makes clinical and economic sense to give a serious consideration by the policy makers in Scotland as to how the services can be restructured to achieve efficiency.

The author has made considerable efforts to discuss this issue and obtain advice from a variety of professional and Scottish Government bodies.

SDPB (Scottish Dental Practice Board) has revised the SDR via a core working group on a cost-neutral basis, which is still with Scottish ministers.

SDPC (Scottish Dental Practice Committee) had taken a view that revision of SDR is not possible, unless a negotiation of item of service fees is considered. The reluctance of the board to consider an appropriate revision forced a unanimous withdrawal of SDPC from the core working group. In particular, the committee had concerns with the Scottish Government's attempts to achieve unreasonable cost neutrality as this failed to address properly the costing of the item of service fees, in particular more costly items such as extractions[4].

The service provided by NHS dental contractors is taxpayer funded and they are duty bound to provide high quality care. They are under constant scrutiny especially with regards to their claims.

We are in an era where the NHS is downsizing its expensive secondary sector and encouraging as much work as possible to be carried out locally. Unlike GMPs, who are paid a salary, the dentists are self-employed and, if more work has to be moved to primary care setting, then appropriate change is necessary to achieve efficiency.

Let us not forget if the government or the NHS is trying to protect diminishing resources, there is mileage in spending where outcomes are not simply better but less expensive.

Will the policy makers take necessary action to help resolve the situation? ■

Disclaimer: While the author has made every effort to state the facts, readers are requested to take a measured approach in arriving at any conclusions. More extensive study of the regulations is needed, which is beyond the scope of this article.

Acknowledgments: The author is grateful for the advice and input given by Ms Fiona Angus, senior policy advisor at the British Dental Association (Scotland).

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4. Personal Communication Senior Policy Advisor, British Dental Association Scotland.

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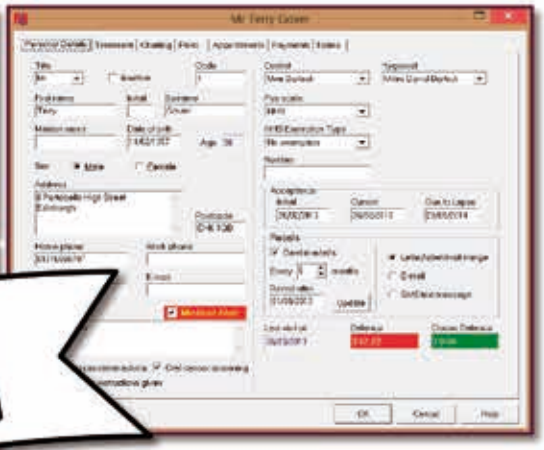

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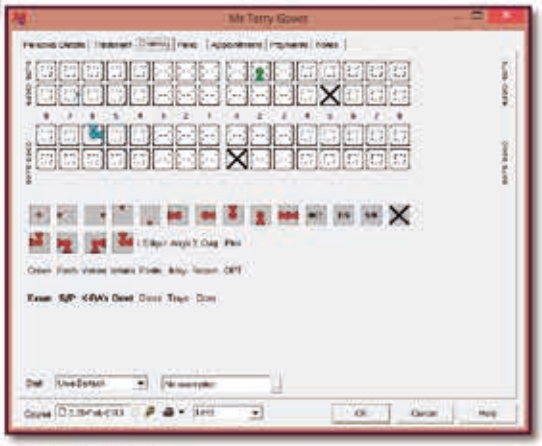

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The Reciproc system

By Paul Myers BDS (Newc), MFGDP(UK)

I'm a general dental practitioner with an interest in endodontics, working in practice in Newcastle. I was inspired in the first few years of my career by John Whitworth, Paul Wesselink and David Brown and developed my interest. I've been involved with undergraduate teaching at Newcastle School of Dental Sciences and postgraduate teaching in the Northern Deanery.

In 2006, I got an operating microscope in the practice and have been taking endodontic referrals since then. This article is about the Reciproc instruments and their use in re-treatment cases.

Looking at how instruments can be used in re-treatment of endodontic cases

We know from the work of Kakehashi in 1965 that bacteria are the cause of our problems in endodontic treatment. What we do, therefore, aims to remove the bacteria and their substrate as far as possible. Endodontic disease is a contained infection (Moller, Sundqvist); histological work from Nair has demonstrated that bacteria are within the root canal system and Nair states that treatment fails "when it fails to identify anatomy and eliminate bacteria to a satisfactory standard". Aside from cracked teeth and restorative complications we can usually get a good level of success by removing old root filling material, identifying and negotiating the anatomy and disinfecting the root canal system.

The Reciproc system claims to be a single-use instrument that does not need a guide path. Many endodontists will wince at the thought of introducing

Continued »

Fig 1
Reciproc R25 showing lumps of GP removed

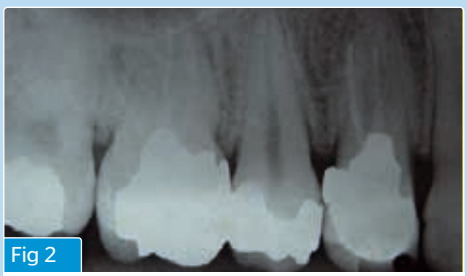

Fig 2
Pre-op radiograph of 16

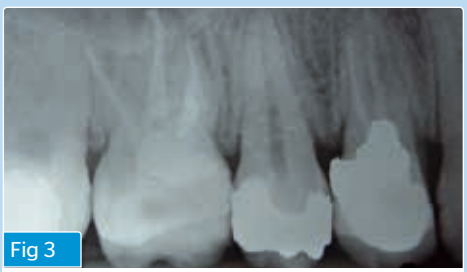

Fig 3
Post-op radiograph of 16 using R25 to remove the GP and R40 to prepare the canals

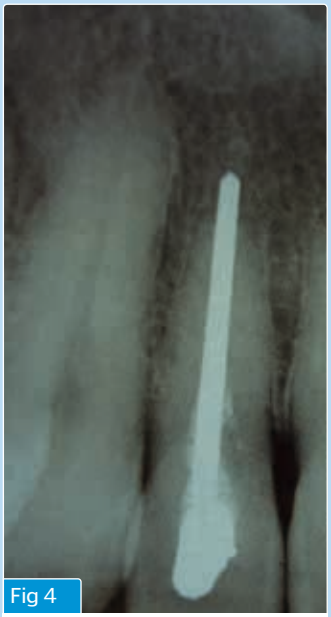

Fig 4
Pre-op radiograph of 12, silver point in situ

Fig 5
Silver point removed from the 12 with ultrasonic energy combined with R25 instrument

Continued »

an engine driven, Nickel Titanium (NiTi) instrument into a root canal without first investigating and negotiating it with a hand instrument.

The Reciproc system was designed by Ghassan Yared to be safe and effective, regardless of the experience of the operator. It uses a reciprocating motor that mimics the 'watch-winding' or balanced-force movements we often use with small instruments. Rotary instruments tend to fracture when they bind and the motor keeps turning them until they break.

The Reciproc instrument works by binding, but then unwinding and cutting so the torsional stress limit is not exceeded. Once introduced into the canal the instrument will follow the line of least resistance – the empty canal – and its shape keeps it centred in the canal. Three light pecks at a time between cleaning the flutes of cut debris will allow the instrument to advance, usually, in time, to the apex.

Where the canal is tight or has an abrupt curvature and the Reciproc instrument does not advance then a small hand file can be used to create a glide path – occasionally the preparation needs to be finished by hand.

After assessing the restorability of a tooth to be re-treated the next step is to identify all the anatomy. Usually canals will be obturated with gutta percha (GP) and this needs to be removed to enable thorough cleansing. I prefer to do this mechanically if possible *(Figure 1)*. Dissolving GP with a suitable solvent is another method and sometimes this is necessary if the GP is age hardened.

I find this often leaves a residue of liquid GP which gets into the corners and is really tricky to remove. As GP is softer than the surrounding root dentine the Reciproc instrument will follow this

"Ghassan Yared was working in war-torn Lebanon when he was inspired to develop the Reciproc instruments"

softer route, removing GP as it does so. Sometimes the end of the GP can be softened with a little heat to allow the instrument to get started but once started the GP comes out in lumps.

Using a slight rotating action on the handpiece you can often encourage whole GP points to come out. A brushing action can also be used which allows selective removal of dentine and the ability to sweep out chunks of old GP.

All this can be done using the R25 instrument, *(Figures 2 and 3)* the same that is used for preparation in 'normal' canals, ie no special re-treatment files are required. Once the GP is removed it is good to enlarge the canal further to remove infected dentine and create a flared, tapered shape which allows deep penetration of disinfectant irrigant. For this the R40 and R50 instruments are ideal.

Although these may seem large sizes, the difference from the R25 is not that great because the taper is greater over the first 3mm of the smaller tipped instrument than the larger ones. It is enough to allow some preparation of the canal walls throughout the length of the canal.

Working with an operating microscope allows us to see the complexities of the root canal system and it is sometimes surprising that we can clean such convoluted spaces at all. Clearly, the greater the volume of irrigant we can get into these areas the better the chance of success. Reciproc will prepare a good shape to allow you whatever irrigation regime you prefer.

The Reciproc system apparently causes very little extrusion of cut material beyond the apex and it does seem to draw debris back up out of the canal *(Figures 4 and 5)*. This action is useful for removing carrier based obturation systems such as Thermafil and 3D GP. I've also used it to tease out a large silver point that had already been loosened with ultrasonic energy although this is something that needs a certain amount of caution! I have seen footage of a fibre-post being removed using a Reciproc instrument but I haven't attempted this yet myself.

Ghassan Yared was working in war-torn Lebanon when he was inspired to develop the Reciproc instruments. One of his requirements, because of the war, was that his treatment needed to be carried out as quickly as possible – hence the single instrument. The whole system simplifies treatment and reduces the number of instruments but still allows high quality, predictable work to be carried out.

Although the individual Reciproc instruments are more expensive than those in other systems the overall cost is less because often only one will do the work of three or more in other systems. The only additional expenditure (albeit significant) is on a motor but for someone looking to invest for the first time or update a worn motor I would heartily recommend this system. ■

CEREC 3D and my practicing life

Jamie Newlands talks about the benefits of technology in a modern dental practice

Last year marked the 10th year of my career as a general dental practitioner after vocational training. It also heralded the launch of our new clinic and education centre in Glasgow Scotland.

It is quite scary to think how fast the last 10 years have flown by. How many injections, fillings and not-so-great dentures have been fitted (by me). It was also a fitting moment to look back at the defining moments within my career to date that had led to the new clinic becoming a reality.

As I write this, I am sitting in Stansted airport awaiting a connecting flight to Germany and then Liechtenstein. It is a welcome three-day break from patients, to be updated on Ivoclar Vivadent's latest additions to their CAD/CAM offerings and a sit down with the clinic's implant partner to discuss advances in CAD/CAM in dentistry. All in all, it should be the start of an exciting year in dentistry.

Looking back over the past 10 years, I feel lucky to have met and worked with the colleagues that I have, and can still remember the first time I saw CEREC 3D in action. I was a newly graduated, just out of VT dentist. Arguably, still very inexperienced but wanting to learn and improve constantly.

Then, one evening, I was invited to see this machine that made teeth. One hour later I was sold! Even though the huge price and learning curve were daunting, I put myself in the position of the patient. One visit and no impression. If this wasn't going to work, nothing would.

I spent the first few years using it as an inlay machine, as I repeatedly saw failing large composites and amalgams with inadequate occlusals schemes or open contacts. After gaining proficiency in posteriors, I started to dip my toe in with veneers and anterior crowns, until eventually it became the only way I restored single unit indirect cases. It has proven a reliable and trustworthy tool. A real practice builder that, to this day, I do not think I could work without.

Suffice to say the journey was a fun and challenging one. I now have the benefit of the latest software, latest scanners and materials such as emax. I also have the joy of seeing my eight-year-old CEREC work, knowing that it is outlasting my other restorations and making my daily practicing enjoyable, controllable, profitable and predictable.

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ABOUT THE AUTHOR

Dr Jamie Newlands BDS (Gla) LFHom RCH(Gla) is the clinical director of The Berkeley Clinic, clinical director of the Scottish Dental Education Centre and clinical director of Brite-Dental. To contact Jamie, email jamie@berkeleyclinic.com or visit www.berkeleyclinic.com

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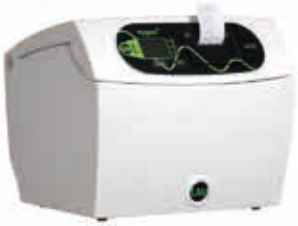

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Ms Nichola Parker is the Practice Manager of Barnet Dental Practice and a client of Carestream Dental. Recently, the practice has been using AutoPost, the online mailing service that takes care of paper correspondence to patients.

"It saves a lot of manpower – the amount of time otherwise spent on printing recalls, then folding, enveloping, stamping them and sending them out ourselves," says Nichola. "I think AutoPost is an ingenious idea to be perfectly honest, and it's really easy to use.

"We've got five surgeries, eight dentists and only two people at a busy reception. AutoPost saves us a lot of time and that's what sold it for me. It's certainly lived up to my expectations and I would definitely recommend it to other practices.

"Not only do you save time and stationery costs, but also the posting costs are reduced, which is a great benefit."

For more information, contact Carestream Dental on 0800 169 9692 or visit www.carestreamdental.co.uk

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Cleo II – it's the 'friendlier' option

Communication is key to achieving best practice in dentistry and any equipment that can facilitate this is essential. The Cleo II treatment centre from Takara Belmont excels in aiding the practitioner in meeting this goal. With ultra soft cushioning providing lumbar and ergonomic support from head to toe, even the most anxious of patients will feel comfortable.

The chair has been described by some as 'friendly'; its design helping to put the patient at ease so that you discuss options rather than telling them what to do. The fact that it looks like an armchair adds further reassurance – patients know how to get onto it for a start! With a removable, foldaway or rotating armrest, patient access for the very young and elderly is also easier. For the practitioner, the small footprint helps with movement around the chair.

For more information, call 020 7515 0333.

See more

The new 900 Series LED light from Takara Belmont offers practitioners great flexibility: the system is available in either a unit, ceiling or track-mounted option.

Not only does it illuminate the oral cavity with great clarity, but it also obviates the need for the portable light on your loupes which removes any shadow on your field of view, unlike portable lights, that frequently throw shadows.

The 10 shadow-less beams emit excellent light colour, making it ideal for colour matching as well as reducing eye fatigue. The light can also be adjusted to between 4,000 and 32,000 LUX to meet individual needs and the lighting requirements in practices that may not have the luxury of natural daylight.

The light also emanates less heat and consumes less power, offering an estimated 80 per cent power saving over a conventional bulb.

Recommend with confidence

Oral-B electric toothbrushes lead the way in clinical research, with over 225 studies and 140 clinical trials supporting both the product's efficacy and safety.

Indeed, the most recent clinical research published in the *American Journal of Dentistry*, has reinforced the efficacy of Oral-B's oscillating-rotating electric toothbrushes. When compared to Sonicare Diamond Clean, the Oral-B Triumph (oscillating-rotating) was found to reduce the number of bleeding sites by more than 34 per cent and there was also a 30 per cent greater reduction in gum line plaque.

Also, researchers conducted a patient perception assessment and found that The Oral-B Triumph had a higher rating than the Sonicare Diamond Clean.

NobelActive: 'it works beautifully'

Dr Paul Kletz owns and operates out of two dental practices – one in Woodside Park, North London, and the other is a nine-surgery practice in Bishop's Stortford. A member of ADI, Dr Kletz placed his first ever implant in 1987.

"I've been using NobelActive probably since the day it first came out," he said. "It's a great implant system, it has platform switching and it works beautifully. I use the implants for all anteriors and premolars in the maxilla and I like the wide platform for sinus grafting.

"NobelActiveTM gives good osseointegration but the most important thing is the primary stability, which is superb. If you are in favour of immediate loading, such as with All-on-4, you need something with good primary stability. I always use NobelActive for my All-on-4 cases."

For more information on Nobel Biocare, call 0208 756 3300, or visit www.nobelbiocare.com

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The Dental Directory is pleased to announce that its brand new Pricewatch catalogue is now available. With simply the best possible prices on more than 5,000 essential dental products from your independently verified best priced dental dealer, you can be sure you are receiving high-quality products at incredible prices.

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For more information, contact The Dental Directory on 0800 585 586, or visit www.dental-directory.co.uk

CAD/CAM has never been so economical

With a new impression system, Sirona offers dentists a very economical start to digital impressions. In addition to the acquisition systems with CEREC Bluecam and CEREC Omnicam, Sirona is now launching APOLLO DI.

The reasonably priced APOLLO DI features easy handling, precise imaging, and the proven Sirona Connect workflow.

The impression system includes an imaging unit, APOLLO Connect software, and the APOLLO DI intraoral camera, with which users can make digital impressions in a seamless workflow. A moisture-insensitive high-contrast spray is sprayed on the teeth very finely. Fine particles in the spray ensure high contrast and thus very precise images.

For further information, call Sirona Dental Systems on 0845 071 5040 or e-mail info@sironadental.co.uk

Low awareness of grazing risks

Dentists and hygienists across the UK were polled alongside consumers by sugarfree gum brand Extra to examine oral health understanding.

Nearly half (42 per cent) of the UK dentists and hygienists polled identified 'grazers' – people who eat small meals and snacks throughout the day – as one of the groups most at risk of developing oral health problems.

And the majority (84 per cent) believe that awareness of the oral healthcare issues surrounding 'grazing' is low. Snacking, rather than eating three meals a day, prevents the mouths' pH levels from stabilising and the acid attacks caused by food are more frequent and prolonged.

Louisa Rowntree, Wrigley Oral Healthcare Programme manager, said: "Dental professionals recognise that sugarfree gum is a vital addition to brushing twice a day."

For more information about the Wrigley Oral Healthcare Programme, visit www.wrigleyoralhealthcare.co.uk

Exciting news from W&H

With the Lisa 500 sterilisers, W&H now offers the option of rapid sterilisation of unpacked instruments, in addition to the proven Class B cycles and the gentle ECO B function, which minimises duration of instrument exposure to high temperatures.

So, why wait for your instruments to go through a standard cycle designed for a full load when the Lisa will self-adjust to your load size?

The new 'Fast 134 Cycle' offers the option of an even faster, more economical sterilisation cycle. The 'Fast 134 cycle' allows you to sterilise unwrapped handpieces as well as solid instruments in just 14 minutes.

To support customers, W&H Premium Care and Premium Careplus Service Plans ensure peace of mind. Get information and decontamination guidance at www.wh247support.co.uk

For more details, contact office.uk@wh.com or 01727 874990.

Next generation Invisalign

Align Technology has announced SmartTrack, the next generation of Invisalign clear aligner material. SmartTrack is a highly elastic new aligner material that delivers gentle, more constant force to improve control of tooth movements with Invisalign clear aligner treatment.

SmartTrack delivers a gentle, more constant force considered ideal for orthodontic tooth movements. Conventional aligner materials relax and lose a substantial per cent of energy in the initial days of wear, but SmartTrack maintains more constant force over the two weeks that a patient wears the aligners.

SmartTrack is now available in Europe, following its launch earlier this month. It is now the standard Invisalign aligner material for Invisalign clear aligner products in North America and Europe, as well as other International markets.

Precision performance and outstanding results

GC Europe has harnessed the best qualities of two great materials to form the next generation impression material: Vinyl PolyEther Silicone (VPES).

With EXA'lence GC solves a number of common problems related to impression taking. It has high elasticity and tear strength, combined with constant hydrophilicity and exceptional flow – the result being one of the most accurate impressions obtainable in the market today. EXA'lence is predictable in an unpredictable environment and virtually eliminates the need for retakes. EXA'lence provides an incredible level of detail that is paramount for optimal-fitting restorations.

Every aspect of EXA'lence's unique chemistry is designed to make it the ideal material for every dentist and technicians on the path to clinical excellence.

For further information, contact GC UK on 01908 218 999.

You'll never go back, or your money back!

Oral-B has launched its WOW campaign on packs of power toothbrushes. The company is so confident in its products that if the customer is dissatisfied with the performance of their brushes in any way, they will refund the cost of the unit within 30 days, even if they've simply changed their mind. The packs are emblazoned with the reassuring message that 'You'll never go back or your money back'.

Furthermore, whether the pack is purchased in dental surgeries or in retail outlets, the products have the same limited warranty. Providing they have a receipt for their purchase, customers can return the brush within two years in the unlikely event of malfunction. P&G will either rectify the problem free of charge or provide a replacement product at no extra cost.

Studies have shown the Precision Clean brush head to remove up to five times more plaque along the gum line versus a regular manual toothbrush.

A new angle on interdental cleaning

TePe Angle is the latest addition to the TePe Interdental Brush range. The TePe family includes the popular original range, the x-soft, and now the TePe Angle with its long handle and angled head. The range is available in packs of 25 for surgery use.

TePe Angle was developed to improve access to all interdental spaces, particularly in difficult-to-reach areas. The angled head gives access to posterior teeth without the need to bend the wire, thus enhancing their durability. The long and flat handle provides a stable, ergonomic grip and allows access palatal and buccally. It is available in six sizes.

For more information, call 01934 710 022, email infoUK@tepe.com or visit www.tepe.com/en

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