No.1 for dental professionals in Scotland
October/November 2011

Scottish Dental magazine

Scottish president to lead the BADN through troubled times
Page 35

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Light at the end of the tunnel

With the regulations on HIV positive dentists under review, we hear about one man's hope to revive his career
page 22

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Welcome

Editor's desk

with Bruce Oxley

It's show time

It gives me great pleasure to officially announce the launch of the Scottish Dental Show, to be held at Hampden Park on 24 and 25 May 2012.

Over the past couple of years *Scottish Dental* has gone from strength to strength as we have grown the magazine into the leading industry title in Scotland.

So, for everyone here at Connect Publications, producing a show of this nature seemed like the logical next step for us.

We have already secured three main show sponsors in the form of DTS, Colténe and IndepenDent Care Plans, and the exhibition hall is nearly full as the dental trade is coming out in force to support the new event.

But this won't just be a trade show, we have a busy programme of speakers and workshops offering – at the time of going to press – in the region of 16 hours of verifiable CPD over the two days. Starting with former GDC president and Edinburgh GDP Hew Mathewson, and including the likes of Ashley Latter, Aubrey Craig and many more. Delegates really will be spoilt for choice.

Like the magazine itself the show is free to all registered dental professionals, so register for your place today.

And don't forget to keep checking the website at www.scottishdentalmag.co.uk as well as our social media sites at Facebook.com/ScottishDental and @ScottishDental on Twitter for show news, updates and details of how to register online. For more details turn to page 6 of this issue.

I look forward to welcoming old and new friends to the show, so do head along and say hello.

I'd also like to take this opportunity to welcome a brand new columnist to the magazine. Due to unforeseen circumstances, our former scribe Spencer Wells has had to give up his column and we have recruited some new blood in the form of Arthur Dent.

Although he assures me he leaves his dressing gown at home when he heads to work in the morning... ■

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

Contents

October/November 2011

Edinburgh Dental Specialists

Edinburgh
Dental Specialists
Established 1994

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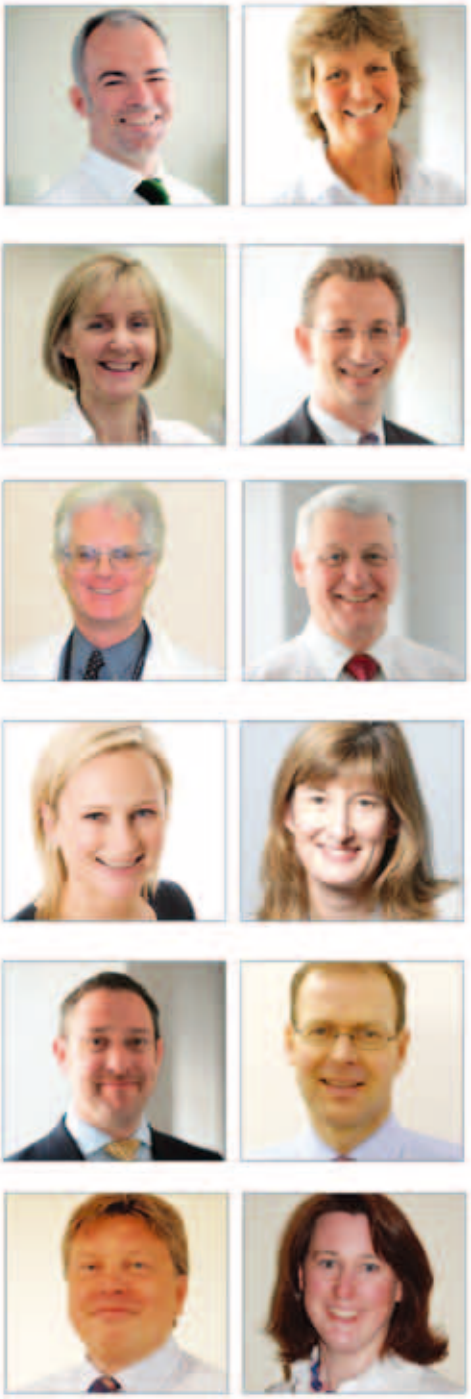
Specialist Oral Surgeon



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Nobel Biocare

Biting back

with Arthur Dent

Registration frustration

In August of this year, hundreds of UK dental practices found themselves short of qualified dental nurses. In some cases the shortage was quite drastic, resulting in reduced practice hours and affecting the availability of patient access to dental care.

So, what caused this desperate shortage of dental nurses? Was it the outbreak of a virulently infectious disease which curiously affected only dental care professionals? Was it the mass exodus of disgruntled nurses from an under-appreciated workforce? Or did they simply all take a holiday at the same time?

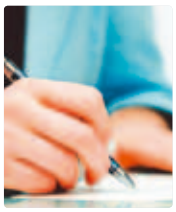
It was actually none of the above. The main reason for the thousands (yes THOUSANDS) of DCPs who were prevented from working was much more prosaic: they had forgotten to pay their annual retention fees to renew their registration with the GDC. I know, one of my dental nurses was among them and that's the reason I came to learn something about the situation.

After a brief ticking off from me and profuse apologies from her, we set out to discover what she needed to do to reinstate her registration. A 'lapsed' DN cannot work in a clinical situation until their name is restored to the register; they can perform reception and admin duties and even work on cleaning and decontamination procedures, but NO chairside assistance.

Firstly the nurse has a restoration fee to pay: £144 as opposed to £120 ARF, so £24 more. However, the second requirement is that the nurse has to reapply to join the register on a restoration application form which, among many other things, demands a character reference and a health certificate to be signed, again!

Now, when dental nurses first registered in 2009, the GDC did attempt to ease matters by allowing a dentist to sign the health certificate, provided it was a different person signing the character reference. But this sensible arrangement does not apply to applicants for restoration. Their health certificate MUST be signed by a doctor who has knowledge of them, presumably their GP, who requires to see evidence of immunisation status which is usually organised by occupational health.

All of this takes time to organise, submit and then more time for the GDC to process in advance of reinstatement. In the meantime, the dentist has to make other arrangements for chairside assistance, which might include using a less experienced trainee.



"Would Scotland be better off with a Scottish Dental Council?"

How can it be in the interest of patients to put so many experienced DNs out of commission? A financial penalty for tardiness is reasonable, but this just amounts to bureaucratic fascism.

Many in dentistry have been asking: "What is the point of dental nurse registration?" I have yet to speak to a dentist who has any enthusiasm for it and can't imagine any DNs enjoy paying a sizeable sum to the GDC every year. Where is the evidence of any benefit to patients?

The GDC has always been a target for criticism and, in May, Alison Lockyer resigned as GDC chair citing "matters which were causing (her) concern". A gagging order was placed on Alison and on council members and staff, so the exact reason for her exit may never be known. But those who know her say that Alison is a reasonable and fair GDP, so the suspicion falls on the systems and personalities at 37 Wimpole Street. Is this an organisation in which we can have confidence?

Or would Scotland be better off with a Scottish Dental Council? ■

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The Scottish Dental Show 201

All roads lead to Hampden on 24 and 25 May 2012 for the launch of a brand new dental event

If, like every aspiring young footballer and every up and coming rock band, you have dreamt of walking out at Hampden, then now's your chance as the first Scottish Dental Show heads to Scotland's national stadium on 24 and 25 May 2012.

With an exciting line-up of speakers and workshops that will deliver more than 16 hours of verifiable CPD over the two-day event, an exhibition area featuring all the major

SPEAKERS

The Scottish Dental Show will provide a great opportunity to add to your verifiable CPD points with a fantastic array of speakers and workshops.

Hew Mathewson, former president and interim chair of the General Dental Council, will give the welcoming address at the event on Thursday, 24 May. Hew, who was awarded a CBE in 2009, was head of the dental regulator from 2003 until 2009, when he handed over to Alison Lockyer. He currently works as a GDP in Edinburgh where he has been since setting up practice in 1977.


Hew Matthewson

Other speakers at the show include:

Ashley Latter, one of the most sought after speakers and coaches in the UK dental industry. In the last 15 years, more than 4,750 people have taken Ashley's 'Ethical Sales and Communication' course and he specialises in working with dental and orthodontic practices to improve the performance of the dentists and their teams.


Ashley Latter

Aubrey Craig, head of dental division and dental advisor for the Medical and Dental Defence Union of Scotland (MDDUS). Aubrey graduated from Dundee in 1987 and currently works as a partner in an NHS vocational training practice in Glasgow. He gained

2

SCOTTISH DENTAL SHOW 2012

manufacturers and suppliers in the industry, plus a social programme offering a chance to catch up with colleagues old and new, this is one event that is not to be missed.

And, with the event taking place during National Smile Month the show will provide a great opportunity to brush up on key aspects of your clinical and business practice in order to further improve your practice's oral health promotion strategy.

With around 60 exhibitors already confirmed, visitors to the event will be able to see first hand the newest product developments, advancements in technology and learn about the latest services and equipment on offer in the industry today.

Dental Technology Services, one of the largest full service laboratories in the UK, has generously agreed to become Platinum Sponsors of the Scottish Dental Show. Based in the east end of Glasgow, but with an international reach and reputation, they are the perfect partners for the inaugural Scottish conference and exhibition.

Our Gold Sponsors are Coltène, global leader in dental consumables and materials, while the Silver Sponsors are dental plans specialists, IndepenDent Care Plans.

The line-up of speakers at the Scottish Dental Show will be second to none, with former General Dental Council President Hew Mathewson on hand to give the welcoming address at the event. He will be joined on the podium over the two days by the likes of selling coach Ashley Latter, MDDUS's head of dental division Aubrey Craig, Edinburgh oral surgeon Dr David Offord, John Barry from The Dental Plan/Dental Business Academy, Neil Morrison and Roy Hogg from Campbell Dallas chartered accountants and Dr John Meechan, senior lecturer in oral and maxillofacial surgery at Newcastle University.

Several exhibitors have also agreed to send speakers and host workshops at the show so expect to see sessions from Optident, Dentsply, Coltène Whaledent, Enlighten and CADE, among others. ■

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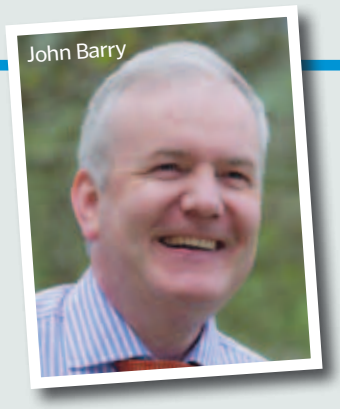

an FDS from the Royal College of Physicians and Surgeons of Glasgow in 1991 and an MPhil in medical Law from the University of Glasgow in 2001.

David Offord, oral surgeon and principal dentist at Vermilion Specialist referral clinic in Edinburgh. David has been on the GDC's specialist list for oral surgery since 2007, having held oral and maxillofacial surgery positions at hospitals in North Wales, London, Forth Valley and Fife. An experienced implant surgeon, he is also the ADI representative for Scotland.

John Barry, operations director of The Dental Plan and one of the founders of The Dental Business Academy. John was one of the first directors of the Highland Dental Plan in 1992, a founding member of IndepenDent Care Plans and former CEO of Isoplan.

John Meechan, senior lecturer in oral and maxillofacial surgery at Newcastle University's School of Dental Sciences.

Dr Komal Suri, clinical director of the Smile Design Dental Practice in Wendover, Buckinghamshire, where she focuses on restorative and aesthetic dentistry.

Roy Hogg and **Neil Morrison**, partners at Campbell Dallas chartered accountants with joint responsibility for the firm's healthcare business group.

Meet our sponsors

A brief introduction to the main sponsors of the Scottish Dental Show 2012

PLATINUM

Dental Technology Services (DTS)
DTS was founded in the east end of Glasgow over 65 years ago by William R Littlejohn. His son Alex joined the company as a 16-year-old and helped build the business up from a small family business into an international trading concern over the next 35 years.

William retired in 1969 but his grandchildren Sandy, Laurie and Graham have all joined the business over the years to become directors of the company.

Sandy and Laurie are both fully qualified dental technicians with Sandy overseeing production and quality control at the lab, while Laurie is in charge of the DTS digital laboratory. Graham joined the company on leaving university and is now in charge of marketing, administration, customer service and finance.

GOLD

Coltène
Coltène is a global leader in dental consumables and small equipment covering the whole dental treatment process. Dentists and dental labs worldwide rely on the company's products for implant-based therapies and dental reconstructions, as well as traditional therapies.

Coltène has been the leading developer and manufacturer of high-precision impression materials and innovative, aesthetically-pleasing filling materials since the mid-sixties.

Their product range includes the direct composite veneering system Componeer. This consists of polymerised, prefabricated nano-hybrid composite shells that combine the advantages of direct composite restorations with the advantages of prefabricated veneers.

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SILVER

IndepenDent Care Plans
Established in 1995 by dentists, IndepenDent Care Plans UK Ltd is a private dental care plan provider with a proven record within the dental industry, boasting a network of practices throughout the country.

IndepenDent has dental care plans that are tailored to the individual practice. Its plans will ensure dentists can offer their patients a customised plan that will provide them with ongoing quality care and treatment.

Years of experience in marketing dental care plans enables the team at IndepenDent to respond positively to your individual dental care plan requirements. This concept has been behind many successful dental care plans throughout the UK since 1995.

IndepenDent Care Plans – created by dentists...working for patients.

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Septodont
Coltène
Patricia Munro
Dolby Medical
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Edinburgh Dental Specialists
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Tooth whitening regulations agreed

PATIENT SAFETY

New regulations on the availability and use of tooth whitening products have been agreed by the European Commission and welcomed by the British Dental Association (BDA).

The new regulations mean that products containing over 0.1 per cent hydrogen peroxide cannot be provided directly to the consumer. Products containing more than 0.1 but less than six per cent hydrogen peroxide, will only be available to patients following examination and initial treatment provided or supervised by a dentist. Products with more than six per cent hydrogen peroxide remain illegal to use.

The agreement comes on the back of four years of lobbying by the Council of European Dentists (CED) following the recommendations put forward by the European Union's Scientific Committee on Consumer Products in 2007.

Dr Stuart Johnson, chair of the BDA's Representative Body and chair of the CED's working group on tooth whitening, said: "This long-awaited decision is good for dentists and their patients. It puts patient safety first by recognising the importance of examination by a dentist before whitening treatments are provided."

New chair to lead the GDC

Scottish orthodontist Kevin O'Brien has been elected chair of the General Dental Council (GDC), replacing his rival for the role Derek Prentice, who was appointed deputy chair earlier this year.

O'Brien, who has been an appointed registrant member of the council since 2009 will take up the post immediately, nearly five months after former chair Alison Lockyer resigned in controversial circumstances.

Alison Lockyer resigned on 6 May, citing "issues that have caused me concern" and prompting the BDA to comment on the "suddenness of Dr Lockyer's resignation" and calling for "clarification as a matter of urgency".

However, clarification was not forthcoming and both Dr Lockyer and the GDC have remained tightlipped about the specific circumstances that led to her dramatic resignation.

Lay council member Derek Prentice, currently the managing director of a consultancy firm and former assistant director of the Consumers' Association, was appointed as deputy chair in the interim and stood for the role of chair opposite O'Brien in this week's election.

Edinburgh-born orthodontist Kevin O'Brien appointed as Alison Lockyer's successor

Speaking about his election win, O'Brien, who is currently professor of orthodontics at Manchester Dental School, said: "I am very pleased to have been elected chair of the GDC and I look forward to leading this experienced and talented council in public protection – our key role. I look forward to working with my fellow council members and the executive as we make decisions to support improvements in fitness to practise and deliver important projects such as the reviews of standards and CPD."

The new chair is a former dean of Manchester Dental School (2004-2007) and associate dean of the faculty of medical and human sciences (2007-2010). He has previously worked with the GDC as chair of the specialist dental education board, a member of the strategic review of undergraduate training and chair of the GDC's education committee.

"I look forward to working with my fellow council members and the executive"

O'Brien will be in post until 30 September 2013, or until an appointed chair takes over, whichever is the soonest.

New dean for Dundee Dental School

APPOINTMENT

The former president of the International Association of Paediatric Dentistry has been appointed as the new dean of dentistry at Dundee Dental School.

Professor Mark Hector, who will also occupy a chair in oral health of children, replaces Prof William Saunders who will continue at the university and revert back to his academic and research activity.

Prof Hector first graduated in physiology and then, in 1981, in dentistry from Guys Hospital in London. He spent three years at the University of Bristol and Kings College, London, where he received his PhD. After three years of oral medicine and pathology at Guys Hospital Dental School he was recruited to The London Hospital Medical College as a lecturer in child dental health. He gained his Readership in 2001 and in 2002 he became professor of oral health of children at Barts and The London School of Medicine and Dentistry.

On his appointment, Prof Hector said: "I am absolutely delighted and very proud."

BADN cancels conference

DENTAL NURSING

The British Association of Dental Nurses (BADN) has been forced to cancel its national conference in Glasgow in November, due to funding problems and poor attendance figures.

The organisers have blamed the "current difficult economic climate" and that many dental nurses were unable to obtain funding from their employers as the main reasons for pulling the plug on the annual event.

Outgoing president Sue Bruckel explained that they managed to keep the costs of the conference the same since 2009, through sponsorship from the dental trade and as speakers were willing to waive their usual fees. However, as the BADN received no official funding – from deaneries or

NES, for example – it had to fund the event through sponsorship and delegates' fees.

She said: "The majority of general practice dental nurses have always had to pay themselves to attend conferences; and often have to take annual leave to attend as employers will not allow study leave or contribute towards the cost of their dental nurses fulfilling their CPD requirements.

"There has always been a core of dental nurses from other sectors of dentistry attending the conference, because employers such as deaneries have provided partial funding. However, this year, even that has been curtailed or withdrawn.

"This, together with the GDC's outrageous demand for £120 registration fee for every dental nurse, means that very few dental nurses are able to afford the conference."

The decision to cancel is particularly disappointing for Nicola Docherty (pictured), who was due to be inaugurated as the association's new president at the event. She will now be officially inducted at the BDTA Showcase in October.

Read an interview with the incoming president on page 35.

Special needs service is recognised

AWARDS

A pioneering paediatric dental service in the East End of Glasgow has been nominated for the NHS Greater Glasgow and Clyde Chairman's Award.

The special needs service at Bridgeton Health Centre, the brainchild of health improvement senior for oral health Debbie Connelly and senior dental officer Lyndsay Ovenstone, was only officially opened in July but has already been a huge success.

The award winners will be announced on 17 October.

Orthodontist placed under supervision

Concerns over clinical standards places six All 1 Smile Orthodontic Centres across the central belt under the spotlight

The owner of a chain of orthodontic practices throughout the central belt has been placed under conditions by the General Dental Council (GDC) after a string of complaints.

George Campbell, who owns six practices under the All 1 Smile Orthodontic Centres name, appeared before the GDC's Interim Orders Committee (IOC) at the end of August. An interim order for conditions was imposed upon his registration for a period of 18 months.

The case was brought before the committee as a result of concerns raised about Mr Campbell's clinical standards by orthodontic consultants at Glasgow Dental School relating to 13 patients.

The concerns involved inadequately planned and unnecessary surgical interventions in relation to the management of unerupted and ectopic teeth; missed diagnosis of root resorption associated with ectopic teeth due to the failure to supplement panoramic radiographs with intra-oral views; unacceptable treatment plans involving prescription of excessive, unnecessary or inappropriate extractions; and inaccurate recording of diagnostic information, which appeared to lead to inappropriate treatment planning.

A second complaint, made by an oral surgeon from a practice in Glasgow's Merchant City, highlighted areas of similar concern in relation to six further patients. These included patients who seemed to be dentally unfit to start orthodontic treatment; teeth that had been exposed and bonded, but re-referred for extraction without space creation or application of traction; requests to extract canines that were not particularly ectopic; undiagnosed damage to the roots of teeth adjacent to impacted teeth; and patients and parents not being aware of options for their treatment.

Mr Campbell's legal representative contended that a failure in communication had led to the complaints raised and that many of the allegations would not be substantiated. He also submitted that his client had adopted the correct professional approach and had already engaged with the orthodontic consultants with a view to remedying his practise.

The IOC made the distinction that its purpose is not to find facts or substantiate allegations, but to assess the nature and risk to patients.

However, the committee decreed that the allegations made were "undoubtedly serious" and ordered that Mr Campbell work under supervision of another specialist orthodontist for a period of 18 months.

Poor care identified

SUPERVISION

A dentist from Ayrshire has appeared in front of the General Dental Council after an investigation by NHS National Services Scotland that highlighted "multiple clinical failings".

Auchinleck practitioner Stuart Lennox Craig was accused of failing to provide a good standard of patient care in relation to 21 patients.

An interim order was placed on his registration meaning that he will be forced to work under supervision for 18 months.

Fraudster's suspension continues

INTERIM ORDER

A convicted fraudster who was jailed for faking his own death and attempting to claim nearly £2 million in life insurance has had his interim suspension continued by the General Dental Council (GDC).

Neil McLaren, formerly Emmanouil Parisis, was sentenced to five years in jail earlier this year for faking a car accident in Jordan, changing his name and starting a new life in Peterhead. He worked for two months at Queen Street Dental Centre in the town before he was arrested in June 2010.

His case was first heard before the GDC's Interim Orders Committee (IOC) on 3 August last year where he received an interim suspension for 18 months. It was reviewed and continued on 21 January this year and, following his conviction, the IOC convened to hear the case in his absence and continued the suspension for the remainder of the 18 month period.

The IOC determination stated that: "The continuation of an order is necessary for the protection of the public and otherwise in the public interest. To fail to take this course would, in the committee's view, harm the reputation of the profession.

"Firstly, because of the gravity of the criminal convictions. Secondly, because of the possibility of early release from prison, the absence of any interim order might lead to the registrant's return to practise."

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Clyde FC kicks off cancer campaign

AWARENESS

Scottish Third Division football club Clyde FC have kicked off Mouth Cancer Action Month in style by agreeing to wear the British Dental Health Foundation's (BDHF) Blue Ribbon Badge on their shirts.

The 'Bully Wee' will sport the ribbon throughout the 2011/12 season to help raise awareness of a disease that kills more people than cervical and testicular cancer combined.

Mouth Cancer Action Month will take place throughout November with the BDHF, in association with Denplan, calling on dental professionals to help educate patients about the disease under the tagline 'If In Doubt, Get Checked Out'.

East Kilbride dentist and Clyde FC director David MacPherson, said: "As a 'Community Interest Club', it gives me great delight in knowing that wearing the blue ribbon on our shirts and raising awareness of the disease that we're giving something back to the community. We are particularly looking forward to the start of the campaign itself, as there will be plenty of activity around that time."

Report highlights issues with General Dental Council processes

BDA critical of GDC after audit findings

The recent audit of the initial stages of the General Dental Council's fitness to practise process has identified a number of significant issues that will create further concern about the organisation's performance, according to the British Dental Association.

The audit, carried out by the Council for Healthcare Regulatory Excellence (CHRE) and published on 5 September, highlights issues with GDC processes, including inadequate information gathering, ongoing weaknesses in explaining the closure of cases, extensive unexplained delays in the referral of cases and poor recording and management of case information.

The review also stated that assurances by the regulator to address weaknesses identified by previous CHRE reports have either not been fully implemented, or have failed to have any noticeable effect.

Peter Ward, chief executive of the BDA, said: "This report is a catalogue of errors that asks profound questions about the GDC's ability to fulfil one of its core responsibilities. It does not reflect favourably on an organisation that has undergone significant change in recent years, with a poorly managed move away from professional self-regulation and a massive expansion in the professionals it registers.

"This report is a catalogue of errors that asks profound questions"

Peter Ward, chief executive, BDA

"The publication of the report comes on top of BDA concerns about the GDC's priority setting and is likely to damage the confidence of both patients and dentists in the body. It must now concentrate on addressing the concerns this report identifies and demonstrating it is a competent force in the regulation of dentistry. Dentists and patients need a regulator that they know is reliable, professional and fit for purpose."

In response, a spokesman for the GDC said: "The audit findings clearly highlight areas for improvement and the major reform programme currently under way is aimed specifically at addressing those deficiencies. We were pleased that the CHRE found no evidence of cases having been closed too early, or of closure decisions that were considered unreasonable – both are critical in terms of patient protection."

Implant pioneer joins Edinburgh practice

APPOINTMENT

One of the founding fathers of modern implantology and a veteran of the Brånemark clinic in Sweden has been recruited by a specialist referral clinic in Edinburgh.

Professor Lars Sennerby (pictured), right hand man to Professors Brånemark and Albrektsson at their pioneering implant clinic in Gothenberg, has joined Edinburgh Dental Specialists (EDS).

Kevin Lochhead, principal dentist at EDS, is delighted to welcome Lars to the practice. He said: "We are all really excited about the appointment of Prof Sennerby. As one of the pioneers of modern dental implantology his knowledge and expertise will be a fabulous asset to our skill base.

"He has a very clear and concise treatment planning philosophy backed up by sound evidence – remarkably most of which he has been involved in establishing. For example the various protocols for sinus lift techniques and immediate loading."

The link that led Prof Sennerby to EDS was provided by one of their resident specialists, Dr Pier Coli, who previously worked with him at the University of Gothenberg.

Prof Sennerby will divide his time between EDS and private practices in Sweden and Italy.

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Digital dentistry in the spotlight

TECHNOLOGY

The latest developments in digital dentistry were among the topics discussed at the first round of Autumn Seminars from Dental Technology Services (DTS) International.

The first three seminars took place at the company's Annfield Place laboratory headquarters in the east end of Glasgow and at venues in Edinburgh and Aberdeen, with further events planned for Ayr, Inverness and Galashiels in the coming weeks.

Following a short introductory presentation, delegates were split into small seminar groups dealing with different topics. Sandy Littlejohn, the company's lead dental technician, gave a workshop on implants for the general dentist, looking at CAD/CAM crowns in particular.

The head of DTS's digital division Laurie Littlejohn presented on the company's Opalite crowns and bridges, which are made from a solid block of zirconia and 90 per cent designed and manufactured in milling machines. He spoke about what can be done with the material and the advances that are on the way.

John McLaughlin, the company's technical co-ordinator, gave a workshop on complex cases and how to get the best results, including advice on shade matching and the best options for multiple restorations.

The problem of how to tell your patients about all the treatments you offer and the technology that sets you apart, was covered by Debra Murphy, managing director of Algiz Media. She spoke about how to market your practice and how to use the DTS Base software, which is free to DTS customers and allows you to create in-house brochures using the lab's own templates.

As well as the table presentations, the company had invited the manufacturers of oral scanners – 3shape, 3M Espe and Sirona – to showcase their technology.

Straumann attended but as the launch of its CADENT iTero scanner had only just taken place, they were unable to send a model in time for the Edinburgh and Glasgow events.

For more information on the Autumn Seminars, visit www.dts-international.com

Veterans benefit from NHS success

DONATION

An NHS dental practice in Erskine has donated £5,000 to a local veterans charity after they enjoyed a hugely successful first 18 months in business.

Erskine Dental Care opened in early 2010 with more than 1,000 patients on their books before its doors opened, due to a severe lack of NHS provision in the area. Less than two years later and it has registered about 6,500 patients.

Principal dentist Philip Byrne decided to make a donation to Erskine as a mark of respect and to share the centre's success.

He said: "There is a great community spirit in Erskine and this inspired me to make a gift to our local charity Erskine. I chose this charity not only due to its location, but also because of the respect I hold for the ex-servicemen and women of this country.

"I have visited on several occasions and enjoyed having a blether with D-Day veterans. The service that Erskine provides is, to my mind, invaluable. I hope that with the continued success of Erskine Dental Care, we can maintain a close relationship with this charity and assist them further in the future."

Erskine Community Fundraiser Alan Moss said: "Erskine is delighted to have such amazing support from the local business community and the donation of £5,000 from Erskine Dental Care will make a really big difference to our veterans.

"We thank all at the Erskine Dental Care Practice very much for their kindness and generosity.

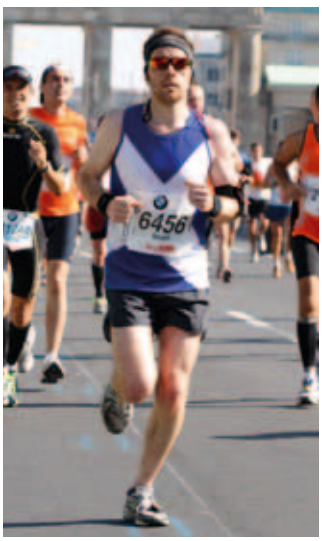
"Donations such as this ensure we can continue in our work of providing the highest standard of care to our residents, which they so richly deserve."

Going the distance

MARATHON

Despite only taking up running three years ago, Midlothian dentist Stuart Campbell has just completed his seventh marathon, this time at the world's fastest course.

The Dundee graduate headed over to Germany at the end of September to take part in the Berlin Marathon, one of the five world 'majors' alongside London, New York, Boston and Chicago.



Unfortunately Stuart was unable to better his personal best of 3:14:16, set at Nottingham's Robin Hood Marathon last year. He said: "It was pretty hot out there – 24 degrees, hot and sunny – so it made for a challenging marathon. My time was slower than I had hoped for but I have to be pleased, given the hot conditions."

Stuart caught the running bug on his 30th birthday and regularly runs the seven miles home from Loanhead Dental Practice, the practice he owns and runs with his wife Cheryl Pacitti, a few times a week.

His first full distance marathon was the Belfast City Marathon in 2009 and he has been back every year since, as well as taking part in the Loch Ness Marathon in 2009 and 2010 and Nottingham's Robin Hood Marathon last year.

Illuminated with science

Conference looks at the science of endo and perio failures

The British Dental Association's Scottish Scientific Conference took place in Dunblane recently with two internationally renowned speakers in attendance.

Professor Philip Lumley, who graduated from Dundee Dental School in 1980 and is currently professor of endodontology at the University of Birmingham, gave an overview of contemporary endodontic treatment in the first session and then spoke on the management of endodontic failure just before lunch.

In the afternoon, it was the turn of Professor Ian Needleman, professor of restorative dentistry and evidence-based healthcare at UCL Eastman Dental Institute, to speak firstly on managing periodontal health in dental practice and then on failures and referrals and what to do next.

Chair of the Scottish Council Robert Kinloch hosted the event which saw BDA President Janet Clarke give the opening address at the Dunblane Hydro Hotel. Kinloch, who is also the chair of the Scottish Dental Practice Committee, explained the importance of the event as he sees it. He said: "We see the Scottish Scientific Conference as the second event behind the national conference and we always look forward to seeing practitioners throughout Scotland being involved with it."

Janet Clarke gives her opening address watched by Robert Kinloch

PHOTO COURTESY OF BILL BRUCE AT DIFFERENTVOICE

And, despite a lack of VDPs in attendance – understood to be due to a lack of funding from NHS Education for Scotland – he insisted they were happy with the turnout. He said: "It is always disappointing if the numbers aren't there and if some of our younger colleagues can't make it.

"My understanding is that there were both timing issues and finance issues. Hopefully they can be solved in future years so that we can have more VTs in attendance.

"However, we're delighted with the turnout this year from the rest of the dental community in Scotland."

New drug prescribing guidance released

PUBLICATIONS

The Scottish Dental Clinical Effectiveness Programme has released an update to its Drug Prescribing for Dentistry guidance.

The second edition of the guidance brings together the latest information from the British National Formulary (BNF) and BNF for Children that is most relevant to dentists and presents it in a readily accessible, problem-oriented style.

For more info, visit www.scottishdental.org/cep

Former dentist in line for Labour deputy role

POLITICS

Former Glasgow dentist turned MP Anas Sarwar is the front-runner to be named the new deputy leader of the Labour Party in Scotland.

The Glasgow Dental School graduate could benefit from a rule change within the party that would allow MPs to stand as leader of the whole party in Scotland as opposed to just the Holyrood group of MSPs.

And, as a result, an elected deputy along the same lines is being proposed with Sarwar said to be a popular figure for the role among Labour politicians in both Westminster and Holyrood.

It is understood that MPs Cathy Jamieson and Margaret Curran as well as Glasgow MSP Drew Smith are backing Sarwar, who became one of the youngest MPs to be elected to parliament in May 2010 at the age of 27.

The fight for the Scottish leadership is thought to be boiling down to a three-way battle between Glasgow South MP Tom Harris, Glasgow MSP Johann Lamont and Eastwood MSP Ken Macintosh.

Sarwar graduated in 2005 and worked in practice for four years at Bidwell and Associates in Paisley before following in his father's footsteps and becoming a career politician. Mohammed Sarwar was the first Muslim MP in Britain when he was elected in Glasgow Govan in 1997. He was re-elected in 2001 and, following boundary changes in 2005, he won the new Glasgow Central seat that his son took over after victory in 2010.

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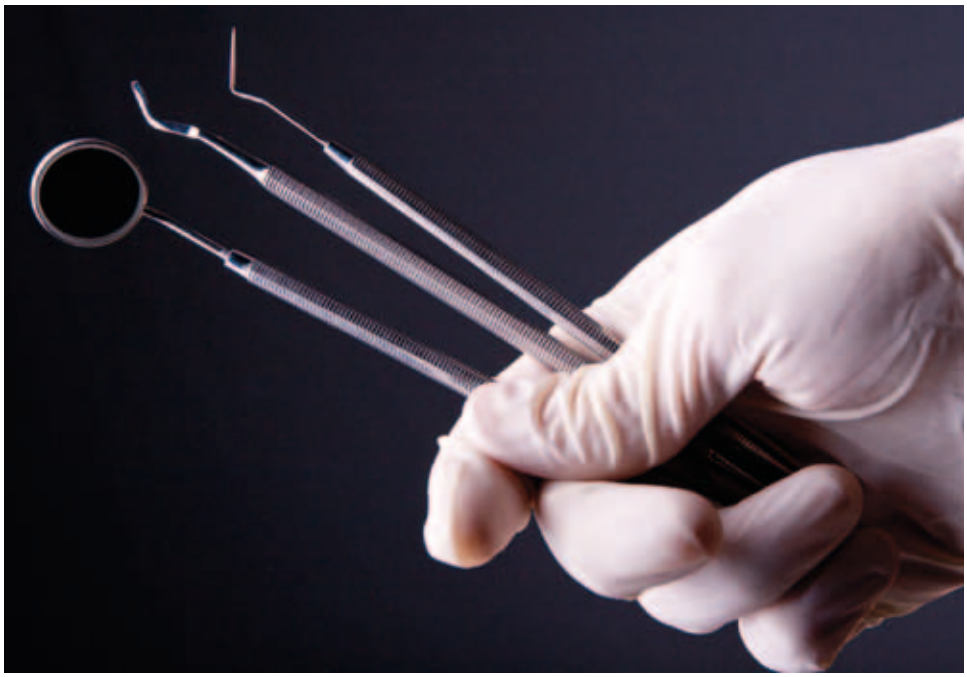
From the chairside

with Alison McKenzie

Because we're worth it?

"Dentists should increase pay and benefits for dental nurses"

Dental nurse forum



The topic of salary has always been an issue. It is unfair and demoralising that nurses with the same qualifications and experience should be paid different rates of pay depending on where they are employed. So, when I saw the above quote on a dental nurse forum it immediately caught my eye. However, after reading the text that followed, surprisingly my response was to ask: why should they?

The writer's argument: to achieve the goal dentists should give up the 'perks' i.e. holidays, flash cars, etc to generate money to invest in dental nurses.

Having worked in business 12 years prior to dental nursing, I am aware that any dental practice is a business and a business has to make a profit to survive. In order to do this costs have to be kept within budget and this includes dental nurse salaries.

Dentists are entitled to reap the rewards for the years of hard study and training; in addition they have the responsibility of the treatment and care of patients and also endure the constant updates and legalities involved in the profession. I once worked for a dentist who immediately asked me one morning which tooth he had extracted the day before on a patient because he had woken up suddenly in the night convinced it was the wrong tooth, it wasn't of course, but it is a perfect example of the stress involved.

However, dental nurses study hard too, some working full time with family commitments, to gain the qualification now required to stay in their chosen profession. They stand for long hours, some in cramped spaces, they work on reception, deal with complaints, reassure anxious patients and ensure a steady stream of clean instruments. They control stock, take x-rays, some still have the added risk of disposing of sharps (we all know full well that it is the operators task), between patients are expected to maintain all infection control procedures in minimum time, and to top it all are often grudged a cup of tea.

There are a minority of nurses out there of course who do not take a pride in the surgery, spend time gossiping, use mobile phones/internet in practice time and find other employment after gaining qualifications at the expense of the practice; their employers would be hard to convince that we deserve an increase at all.

"A good dental nurse is worth investing in, be it pay or benefits, to ensure they stay in the dentist's employment"

The debate about salary will continue and negative comments on internet platforms do more harm than good, whereas positive comments highlight the problem. The situation will only be resolved by an official regulated pay scale based on qualifications and experience and this can only be achieved by proper negotiation by the relevant bodies, the outcome of course must benefit both employer and employee.

Until then a good dental nurse is worth investing in, be it pay or benefits, to ensure they stay in the dentist's employment; alternatively an employer can be changed quite simply for additional pay or benefits. ■

By Bruce Oxley

Dentist Allan Reid accepted his 2007 HIV diagnosis but saw his career finished just months later when his profession couldn't do the same...

Keeping a positive outlook

All it took in the end was a brief phone call one afternoon in April 2008 and Allan Reid's career, as he knew it, was over.

A matter of weeks after leaving the surgery for the last time he was also homeless and facing a GDC professional conduct charge.

If you are unfamiliar with his story you could be forgiven for thinking the Glasgow Dental School graduate had severely injured a patient or been arrested for some serious crime. But no, all Allan Reid had 'done' was to contract a virus. However, the stigma surrounding this particular virus meant he was banned from working in his chosen profession of 17 years and left a legacy that he is still dealing with to this day.

Allan was diagnosed HIV positive at the end of 2007 after he had been advised to get tested by his former long-term partner, who had recently been in touch to tell him that he himself had received a positive diagnosis.

But, thanks in part to his work as a HIV-friendly dentist in the Lewisham area of South London – which has some of the highest levels of HIV in the country – Allan was relatively unconcerned about his own health. He knew that the advances in antiviral medicine meant HIV was no longer the death sentence it had been in the late 1980s and that he could live a long and healthy life, albeit on once-daily antiviral medication for the foreseeable future.

He explained: "It wasn't all doom and gloom for me as it might be for someone who didn't understand much about the condition. I knew that it was manageable and that I could deal with it. I knew if I was diagnosed early it can be treated effectively and I could be expected to live a normal, healthy life. So, in the grand scale of things it wasn't too big a deal, health-wise for me... The biggest impact for me was what an HIV diagnosis meant for my job."

What Allan was referring to is the Department of Health (DoH) guidance that prohibits HIV positive healthcare workers from carrying out exposure-prone procedures. And, as pretty much every procedure in dentistry is considered exposure-prone, a positive diagnosis meant that his career treating patients was over.

However, as Allan was up-to-date on the latest evidence surrounding the risk of HIV transmission between dentists and patients, his initial despair turned to frustration and then anger as he fully came to terms with what he describes as the discrimination he was faced with. He said: "Antiviral medication that can allow people to achieve an undetectable blood viral load has been around in the UK since 1997, and advances in treatment mean that 95-99 per cent of people taking these antivirals are undetectable.

"The evidence has been known anecdotally for many years and then shown over time in research studies that undetectable effectively means non-infectious."

This meant that even if there was blood-to-blood contact between

dentist and patient, which in itself is a rare occurrence, the chances of the HIV virus being passed on is negligible. With this in mind, and with the advice of a professional friend, he fatefully decided to keep his diagnosis secret and continue to work.

"By the time I had confirmation of my diagnosis I had a plan in place," he explained. "I had made the decision that I wasn't going to disclose. I had a friend who was a HIV consultant and he said that, in London especially, there were many healthcare workers – nurses, dentists, doctors – that do the same.

"They either don't go for testing and put their own health at risk because of what the implications will be for their job, or they test secretly and just carry on under the radar. He said to me: 'You are not alone in this, my advice is just to keep your head down. It's going to change fairly soon (the regulations), so just keep your head down and carry on.' "

However, his intention to stay under the radar was blown out of the water after only a few months when someone who he had confided his diagnosis with sold his story to the national press. Allan had told none of his colleagues in the dental world as he didn't want to put any of them in the position where they were withholding information, but he had told a handful of close friends.

When the story broke, on 16 April 2008, the decisive phone call just topped off what had been a bad day anyway. Allan explained: "It was just the worst possible day for it to happen – I was running so late with patients waiting and a bridge that I was meant to fit that hadn't come back from the lab – you know, your typical day from hell and then...

"The receptionist phoned through to the surgery at about 4.30pm and told me she had just had a strange phone call from the Health Protection Agency, saying they needed to speak to me urgently. I knew immediately what it was. I just knew."

"It wasn't all doom and gloom for me as it might be for someone who didn't understand much about the condition"

The HPA told him that Lewisham PCT had received a phone call from a journalist with *the Sun* claiming that he was HIV positive and was continuing to work. Allan decided to come clean, he said: "I had always said that if I was found out and confronted I would say that it was true, so I said yes it was actually true.

"So that was it, the ball was set in motion and I left the surgery for the last time that day.

"The PCT were just completely dispassionate, as they would be. There were no niceties, it was simple: my contract was gone and I was reported to the GDC."

Continued »

Continued »

Allan revealed that the level of support he received was practically useless. He was sent for an occupational health assessment but the person he saw had no notes on him from the PCT so he was unable to provide any help at all. He continued: "It was very badly handled, but by that time I knew that was the standard because I had heard stories of other dentists who had been through the same and their dealings with the PCTs.

"I think when they get that information, allied to *the Sun* story, they are running around like headless chickens, worried about mass panic. The perceived risks get blown out of all proportion and you are just in the middle of this terrible situation."

With no income and a hefty London mortgage to pay, Allan soon found himself struggling to make ends meet. He contacted his mortgage company and they suggested, as he had no way to continue making payments, a voluntary repossession. So, only two years after buying the house and spending countless hours renovating and redecorating, he was forced to hand back the keys and walk away. "This was the house for my retirement," he said.

"I wasn't planning on living anywhere else. This was my project to do up a house and stay there for the rest of my days."

With nothing tying him to the UK and a GDC case still hanging over him, Allan decided to stay with some friends in Italy for a while, to come to terms with things and try to figure out a plan for the future. He ended up staying for a year as his friends closed ranks around him. He said: "I had a really great support network of friends who were just completely outraged at my treatment.

"My Italian friends were especially outspoken and they often raged at the injustice whenever I was feeling down. So you really do draw strength from that.

"I was very lucky that my friends were there to rally round me when I needed them." Ironically HIV positive dentists in Italy are permitted to practice.

However, despite learning Italian and taking cookery lessons in the picturesque surroundings of rural Sardinia, where he worked in a friend's restaurant, Allan knew he would have to come back to the UK at some point and face the GDC hearing.

He had spent a great deal of time in that last year compiling evidence and making short trips back to the UK to meet his legal team.

So, aided by Professor Margaret Johnson of the Royal Free Hospital in London and former chair of the British HIV Association who agreed to act as an expert witness in his case, Allan took on the GDC panel and was shocked by their lack of knowledge about HIV.

He said: "There were two dentists on the GDC panel and one of them had to be twice corrected for referring to HIV as an airborne virus..."

The outcome of the hearing saw him given a rap on the knuckles for not following the guidance and given a suspension.

"But the important thing is what came out in the determination," Allan explained. "They acknowledged the risk of HIV dentists passing on the virus to patients is negligible. It was a landmark statement for them to make and a really good result."

"Every time I put forward another piece of evidence, and another, and another, not one time did anybody face me and place a counter argument. Not once"

After his suspension was lifted, as far as the GDC was concerned, he was fit to practise – except that the DoH guidance still precluded him from working.

And Allan's frustration just kept building, he said: "Every time I put forward another piece of evidence, and another, and another, not one time did anybody face me and place a counter argument. Not once.

"So you start to see that it isn't about risk, it's about public perception and keeping people happy. When you boil it down it isn't risk, it's discrimination."

But, despite his growing frustration, Allan decided to put his energies into doing something positive – going back to university to enrol on a Masters in Public Health at Imperial College London.

While there, he wrote his dissertation on HIV positive dentists in the UK and his dissertation supervisor was coincidentally one of the academics involved with drawing up the DoH guidance itself.

So, with the governments in Westminster and Holyrood currently reviewing the recent tripartite working group's report on the management of HIV-infected healthcare workers, it would appear that it is only a matter of time before the guidance is relaxed and dentists like Allan are allowed to work with patients once again. ■

BIOGRAPHY

Allan graduated from Glasgow Dental School in 1991 and worked in practices in Paisley and Glasgow before moving down to London in 2003.

He was diagnosed HIV positive in 2007 and hasn't worked in practice since April 2008.

He has continued to pay his Annual Retention Fee every year and was fully restored to the GDC's register in July 2009.

Since his diagnosis he has continued to accrue CPD points at his own expense, averaging up to 100 hours each year, despite not being able to work.

In January this year, he won a decision through the Press Complaints Commission to have *the Sun* story removed from the archives and from all online searches on the grounds it was out of line with the recommended guidance for reporting on HIV and AIDS in the media. *The Sun's* managing editor Graham Dudman conceded the reporting was scaremongering and even assisted in the further removal of stories in the *Evening Standard* and other local newspapers' online archives.

HIV: The story so far...

The retrovirus associated with HIV and AIDS was first identified in 1986. Ten years later a number of drugs had been developed which in combination could control the disease – a treatment known as highly active antiretroviral therapy or HAART. However, this was too late to alter the fate of an American dental patient named Kimberly Bergalis who died of AIDS

"The definition of 'exposure prone' placed dentistry in the same category as orthopaedic surgery"

in 1990. She was one of six dental patients who were believed to have been infected with HIV by Dr David Acer, a dentist in Florida who was known to have AIDS.

The facts surrounding this one and only presumptive transmission of HIV from a dentist to a patient have been the subject of an extended debate that has failed to establish the route of transmission in the six patients. Nor could any criminal intent be excluded on the part of the dentist.

Kimberly's slow demise was frequently documented in the press and on television. A play called Patient A (Lee Blessing) was written about the episode. Regulatory bodies in most countries responded to the extensive emotional coverage in different ways – some banned HIV-infected oral healthcare professionals from working outright, others promulgated updated infection control guidelines. In the UK the government and its advisors opted for the ultimate precaution. They decided to prohibit healthcare workers with HIV from undertaking procedures which were exposure-prone. The definition of 'exposure prone' categorised dentistry with orthopaedic surgery.

Apart from the case of Dr Acer, no other transmissions of HIV in the dental setting have been demonstrated. The data available from patient notification (look back) exercises support the conclusion that the overall risk of transmission of HIV from infected health care workers to patients is extremely low. Between 1988 and 2008 in the UK, there were 34 patient notification exercises. However, there was no detectable transmission of HIV from an infected health care worker to a patient despite 9,849 having been tested.

Since the Acer case over 20 years ago there have been two developments that have lead to a review of the precautionary response adopted in the UK:

- Advances in the medical management of HIV disease
- Significant improvements in infection control standards.

HAART, introduced in 1997, successfully diminishes viral replication and can lead to undetectable levels of HIV in plasma. Indeed studies have shown that HAART is sufficiently effective to protect (at least 96 per cent of the time) an uninfected partner when having unprotected sex with a person who has been taking anti-retroviral medication to treat their underlying HIV status.

Infection control standards in UK dental surgeries have been upgraded again with the universal adoption of HTM 01-05. In addition, the introduction of bodies like CQC and its equivalent in Wales, Scotland and Northern Ireland will provide a regular audit of those newly elevated infection control standards, thereby assuring the track record that has already be proven to successfully prevent transmission of blood-borne pathogens (in both directions).

The way is now open for the Department of Health to remove the punitive restrictions depriving dentists living with HIV from practising. The Government's Chief Medical Officer received the Tripartite Working Group's report on the management of HIV-infected healthcare workers on 20 April 2011 and it is likely we will see an announcement from the Department of Health on this subject in the near future, prior to a public consultation on the proposed changes. ■

ABOUT THE AUTHOR

David Croser was the clinical lead for the dental service dedicated to HIV patients in Kensington, Chelsea and Westminster. The service ran for 20 years under the auspices of the Community Dental Service.

David is now the communications manager at Dental Protection.

Rugby players need to be physically fit and strong to compete at international level... and, it transpires, they need healthy teeth too. Chris Fitzgerald speaks to sports dentist Fiona Davidson to find out why

Clean gums and **fair scrums**

There's an old rugby union joke that says if a prop forward is drooling out of both sides of his mouth then you have yourself a level playing surface – the inference being he has taken one too many knocks to the head over the course of his playing career.

And, while this is perhaps too stereotypical an adage for the modern game, there is still no escaping the fact rugby players at every level face a higher risk of injury than participants in most other contact sports.

But while a lot of focus in physical sports such as rugby is on the conditioning and nutrition of its participants, the health of their teeth can often be overlooked.

Yet if Dr Fiona Davidson has her way, the toothless grin of the battle-hardened flanker could well be a thing of the past.

Fiona owns and runs Smile-Plus Dentalcare, based in the leafy Edinburgh suburb of Corstophine. And, although it's a standard private dental practice in the main, thanks to Fiona it also places a real focus on sports dentistry too.

Sports dentistry, she explains, is essentially looking at the prevention of dental disease and injuries in athletes of all levels, with particular focus on elite and professional athletes.

"We work with athletes to provide dental screening and management, all in a bid to avoid chronic and acute infection, which could affect their overall performance," she said.

"We can prevent problems such as acute pericoronitis around partially erupted wisdom teeth, or pulpitis due to dental caries, causing problems at the wrong time, such as before an important competition."

And Fiona believes athletes aged between 18 and 30, the years in which professionals are in their prime, can be particularly susceptible to dental strife.

"Work still needs to be done in educating the players to attend their dentist regularly"

"Young men, especially, tend not to go to the dentist unless they have a problem," she said.

"Because they don't go to the dentist regularly, any underlying problems they do have can get worse. These things can then flare up into an acute phase when the person is under stress – such as when they have to fly a long distance to an event or when competing in an important tournament."

But to put the rugby-themed opening of this article into some perspective, Fiona is quite simply daft about the sport.

That is why she was in her element when invited by Scottish Rugby's head of medical services James Robson to be the official dentist for the national team in 2007.

"Initially, I just provided match-day cover at Murrayfield internationals, but my role has grown to one where I provide dental screening and education, as well as providing routine and emergency treatment, for professional rugby players in Scotland," she said.

This includes professional players with Edinburgh Rugby and Glasgow Warriors, in addition to the Scotland squad.

However, perhaps Fiona's biggest challenge came when she was asked to get the current national squad "dentally fit" for this year's World Cup in New Zealand.

"The International Rugby Board required all players to be signed off dentally prior to the World Cup," she said.

"I think, in the past, a lot of this type of screening has meant a dentist going into the dressing room with a mirror, just having a quick scan, and not doing X-rays or anything too thorough.

"This time, we've done a thorough 30-minute screening of each player, with X-rays if required."

And Fiona admitted screening the 38 players in the original extended squad proved interesting.

"Over half required some treatment so they could be signed off as 'dentally fit'," she said.

"The work mainly involved simple fillings, but some root canal work was required on the anterior teeth of two players due to previous trauma.

"Additionally, two players required root canal therapy on carious molar teeth." And

this proved Fiona's theory that not every young man is up for having a dentist rummage about in his mouth.

"Generally, quite a few players were poor attendees at their own dentist, only visiting when they had symptoms," Fiona said.

"Work still needs to be done in educating the players to attend their dentist regularly."

Fortunately, part of Fiona's role with Scottish Rugby is to host presentations for players on the importance of visiting a dentist regularly.

"I'm lucky that previous patients have become good ambassadors for me," she said.

"A good example of this is when one of the current senior squad, about three years ago, a week before the Six Nations, came to me with terrible toothache that had flared up suddenly.

"This had been caused by an acute dental abscess, which in turn was down to dental caries. He had not seen his own dentist for many years.

"Rather than give him antibiotics and wait for the tooth to settle prior to extraction, as I normally would, I had to take the tooth out there and then or he wouldn't have been able to compete.

"He now reinforces my message to his team-mates and I think a lot of people involved with the Scotland team, the medics and nutritionists, have learned that, although teeth seem trivial in terms of the bigger picture, they are capable of making a player unfit to play.

"You can spend years building up to one event through conditioning and nutrition, but if tooth pain flares up a few days before, it can prevent you from playing – or render you less than 100 per cent in terms of performance – and waste all that training.

"I think for this reason sports dentistry is becoming more important in the UK. It's been big in the US for a number of years, but now sporting bodies here are taking it seriously."

Fiona's rubbing shoulders with the sporting elite hasn't ended with the national rugby

Continued »

Continued »

side's participation in New Zealand either.

She is already assisting Tony Clough – the dental lead at the 2012 London Olympics – to co-ordinate the dental provision in the Athletes' Village and other events that require such cover.

"There are about 400 dentists and dental care professionals who have volunteered their time and expertise for the Olympic Games," she said.

"The Olympics will be massive. We'll have eight surgeries running full time in the Athletes' Village. In addition, we will be providing cover for events such as water polo and hockey, and there will also be a mouthguard programme."

Fiona and her team with Scotland international Alan Jacobsen

And mouthguards is an area Fiona is well versed in. She has spent time training with Dreve in Germany, the company that produces equipment for the manufacture of custom-made, pressure-laminated mouthguards, which Fiona and her team make for athletes.

"Dreve provide good, solid German engineering and I would say they have the best equipment for the manufacturer of mouthguards I've seen," she said.

"A lot of dental technicians use a vacuum machine in mouthguard production, which heats the plastic material so it goes soft and is then sucked down by a vacuum.

"Dreve's pressure laminator uses pressure instead of a vacuum and this provides a much tighter fit.

"We then trim the finished guard quite short, only as far as the first molar, and we do a lot of thinning on the roof of the mouth.

"You need the bulk of the mouthguard at the front of the mouth, but you don't want it to become loose. If you have a tight fit, you can make it thinner at the back, so the wearer can breathe, shout and speak with ease. Dreve's equipment allows for all of this to happen."

Mouthguards aside, Fiona conceded she has spent so long looking at athletes' mouths, she is now starting to become interested in their minds too.

"These people are very focused and very driven," she said. "I'd love to study sports psychology one day, if I get the chance.

"It would be great to see what makes these guys tick."

So, as well as Fiona's work being able to ensure our prop forward at the top of this article has a lovely set of gnashers, her remit may yet extend to preventing him being used as a human spirit level too. ■

WHY SPORTS DENTISTRY?

As bizarre as it sounds, Fiona's involvement in sports dentistry can be traced back to a cold wet Tuesday night in Rochdale.

Her father is an avid Bradford City fan, as well as being the team doctor, and he would take a young Fiona to some of the north of England's less exotic football locales, where she would sometimes watch the Bantams do battle in front of crowds of just 1,200 people.

But far from kill her affection for sport, as such an act would many a young girl's, Fiona said she loved it.

Fiona's father was also a keen rugby player, but she admits her love of the game didn't bloom fully until she was at university.

"I was at the Royal London Hospital and the team there won the Hospital's Cup," she said. "It was a big deal and received national press coverage. I got swept up in it all.

"My husband was a good rugby player too, as are my sons, so my love of the game has been kept alive through them.

"When the opportunity arose to become involved in sports dentistry it was too good an opportunity to miss.

"It was a real chance to marry a hobby I love with a profession I love."

BIOGRAPHY

Fiona Davidson graduated in 1986 from the Royal London Hospital and worked up to SHO level in Oral Surgery.

Following that, she has worked in general dental practice, including in Edinburgh, since 2001. She attended the only sports dentistry course in the UK at the Eastman Dental Hospital in London from September 2008 to June 2009. She is married with three teenage children.

She enjoys all sports, although rugby is her passion, and she tries to attend as many international games as she can.

Fiona bought an existing established practice in 2007 in Corstorphine, Edinburgh, and upgraded it, naming it SmilePlus Dentalcare. The practice is exclusively private and Fiona works with a team, including associate John Clydesdale, whose main interest is implant dentistry.

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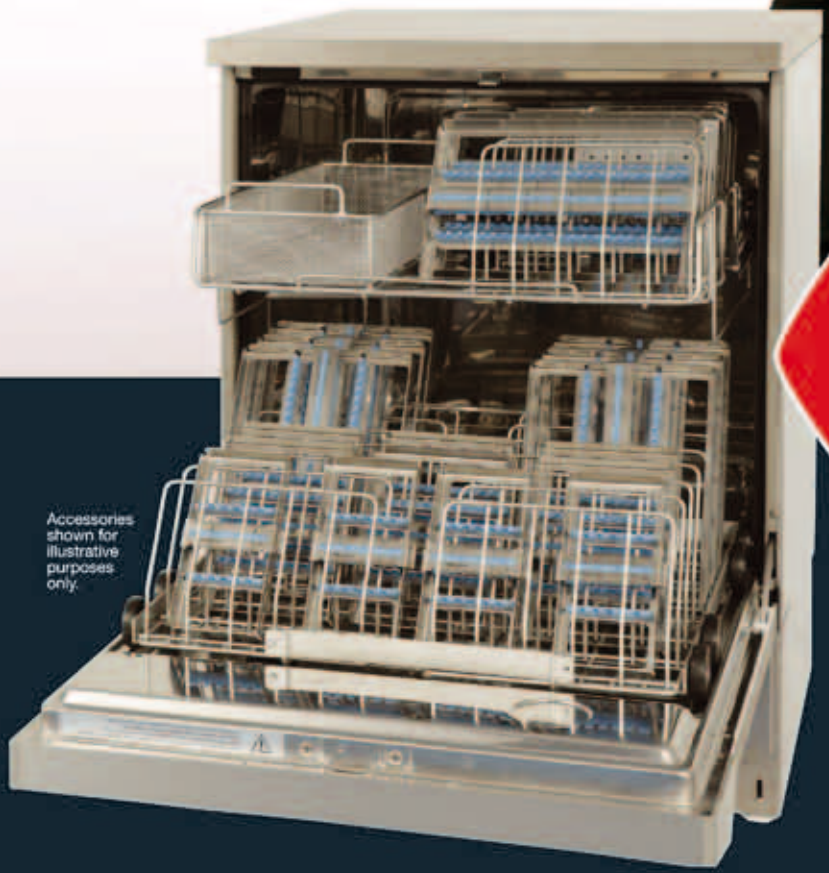

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Big challenges didn't dampen the spirits

New practic **with th**

Seeing your surgery flooded on the weekend before you open, by the river that shares your practice's name, could have been the final straw for Colin McClure.

However, Colin's laidback demeanour meant that he simply mopped up, assessed the damage and got on with the job of opening his south Glasgow practice on time and as planned.

Colin graduated from Glasgow Dental School in 2003 and, after working as an associate, most recently in Coatbridge, he decided that he was ready to try and strike out on his own. Along with his wife Carole, who is also a dentist, he started looking for premises in areas that were short of NHS provision.

After searching in and around Glasgow for the best part of a year he came upon a former solicitors office on Clarkston Road in the South-side of the city and decided this was the perfect location and building to start his practice-owning career. The nearest NHS practice had a full list and so there was a demand for another dentist in the locality.

However, not content with one life-changing event at a time, just weeks after Colin bought the building in September 2010, he found out that his wife was expecting twins. But, rather than let the stress levels rise, Colin explained that the happy news simply focused his mind on getting the practice right and making sure his, and his family's future, was secure.

Work began in November 2010 and, despite delays over the Christmas period caused by the bad weather and waiting for building warrants and planning permissions, it went ahead

of one practice in the south of Glasgow

e is going
e flow

(l-r) Colin, dental nurse Emma McMillan, associate Martin Carlin and practice manager Margaret McMillan (seated)

at a steady pace. With a crew of joiners, plumbers and electricians that had all known each other since primary school and had worked together on a regular basis, Colin explained that not only was the building process very efficient, it was also a lot of fun.

The internal structure of the building was to remain the same with room for a reception and waiting area, three surgeries, and an LDU on the ground floor with staff room, storage and compressors situated in the building's basement. The reception and

Continued »

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Colin's surgery face onto the main road and, with floor to ceiling windows, they have been frosted out to preserve patient privacy while maintaining a high level of natural light. The second surgery, occupied by dentist Martin Carlin, is situated further into the building but is fitted with daylight-effect light fixtures to ease the strains on both patient and practitioners' eyes.

One of the most striking effects in the two surgeries (the third is all plumbed in but not yet operational) is the use of child-friendly images on the walls that have been chosen to match the colours of the individual surgery chairs. For example, Colin's surgery features a picture from the Pixar film Finding Nemo, with the chair matching the orange hue of the lost clown fish. In Martin's surgery it is the aliens from Toy Story 3 that adorn the wall, with the chair matching the exact shade of the little green men.

Margaret at the practice's reception desk

With an opening date set for 16 July, an open day the Saturday before this and a practice inspection the day before that, things proved to be a little hectic in the final week. The crew volunteered to work late, often from six in the morning until 2am, all that week to make sure the practice was finished on time. Colin explained that the reception desk was only installed the day before the inspection and friends and family were enlisted to help with the final clear-up and even attend to loose fixtures and fittings.

The inspection passed off without incident and the open day saw about 70 patients signed up before the heavens opened and Colin got the news,

early on the Sunday, that there was over a foot of water in the basement of the building. Not great timing as the practice was due to open the following day. A flash flood from the nearby White Cart River allied to a high water table was thought to be responsible but, to Colin's relief, the water receded the same way it came, in a relatively short amount of time. Luckily the damage was negligible – the compressor was the main worry but it was slightly raised and suffered no damage – and fortunately the height of the basement ceiling, at just six feet, had precluded it from being used for any patient areas so none of the clinical sections were affected.

The practice opened as planned on 16 July and, with a further 100 patients signed up in that first week and nearly 600 by the end of the first month, they are well on their way to their year-end target of 3,000 patients. When they have reached that point Colin explained that they will make a decision on the third surgery – whether to bring in another associate or whether Carole moves from her current practice in Bishopbriggs.

"The reception desk was only installed the day before the inspection and friends and family were enlisted to help with the final clear-up"

Colin McClure

Colin and Martin are supported at Whitecart Dental Care by practice manager Margaret McMillan who had spent the last 25 years at Tom Gibbons' practice in Airdrie. Margaret left the same day Tom retired and is looking forward to her new challenge at Whitecart. She is joined by dental nurses Emma McMillan and Stephanie Smith.

And, despite all that has happened in the last year – good and bad – from becoming a dad and starting his first practice, to flash floods and last minute preparations for practice inspections, Colin insists that he would quite happily do it all over again. However, with no plans for any further practices now or at any point in the future, we'll just have to take his word on that one. ■

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Fighting for **their cause**

The British Association of Dental Nurses may have lost its flagship event for 2011 because of the difficult economic climate, writes Brian Henson, but it has gained a new champion for the profession

"The razzmatazz is less important than what I can do for our members once I take over as president"
Nicola Docherty

The decision to cancel this year's British Association of Dental Nurses (BADN) conference in Glasgow next month was as difficult as it was necessary.

The current economic climate and lack of funding for dental nurses from their employers saw delegate numbers falling sharply, despite the association's efforts to find sponsors and persuade speakers at the CPD event to waive their fees.

For one member of the BADN, the decision to cancel the conference was particularly poignant.

Nicola Docherty, senior dental nurse tutor and CPD tutor at NHS Education in Glasgow, was to have been installed as the new president of the association.

"I'm disappointed that the conference can't go ahead in my home town of Glasgow. It would have meant a lot to me to be installed as President in front of my peers, and I was looking forward to the whole experience. But the razzmatazz is less important than what I can do for our members once I take over as president from Sue (Bruckel)."

She added: "It's not only the

Continued »

VARIED CAREER

Nicola Docherty has been a dental nurse for almost 25 years.

After becoming a qualified science laboratory technician, she found her heart wasn't in it and entered the dental nursing programme.

"I joined a practice in Charing Cross, Glasgow, and worked my way up to be the senior dental nurse in the practice."

After a while, Nicola felt the urge to move on and worked in community care and, for a while, sold dental software. But she missed the patient contact, and so once again found herself employed in a dental practice."

It was while there that she saw an advert for a clinical management post at the Scottish Council for Postgraduate Medical and Dental Education (pre NHS Education Scotland).

It sounded like the ideal job for Nicola, with a strong educational remit, and she accepted when she was offered the post.

"In those days, options for advancement for dental nurses were pretty limited. You could do a post qualification, but that was about it.

"I wanted to help improve the CPD training regime, and the job allowed me to contribute to that.

"There was still some patient contact, because the courses involved dentists and vocational trainees in training."

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Continued »

BADN that's suffering from the spending cuts. A number of events have had to be cancelled recently around the country.

"The feedback we're getting from our members – and non-members – is that it's getting too expensive to attend such events – especially when they fall so soon after the General Dental Council's demand for its annual retention fee.

"Health boards and primary care trusts are not supporting their dental nurses to help them attend events – even when there's a large amount of Continuing Professional Development attached. Our own BADN conference would have carried almost two full days of CPD and I'm disappointed it's not going to happen after all the work people have put in.

"If our members – and non-members – can't get support from their employers then it makes it very difficult for them to attend."

Nicola's inauguration will now happen at the BADN annual general meeting that's been rescheduled to take place at the British Dental Trade Association's Dental Showcase in Birmingham on 22 October. She said: "I'm very grateful to the BDTA and to Phillips Sonicare for their generous sponsorship of the inauguration and the AGM.

"I'm looking forward to speaking to as many dental nurses as possible at the Showcase."

Nicola already serves on the National Examining Board for Dental Nurses, which takes her up and down the UK on a regular basis. She also line manages eight teaching staff at NHS Education, who are based in Oban, Dumfries, and Forth Valley as well as Glasgow.

As president, her travel expenses are set to soar still further as she attends meetings at the national headquarters in Lancashire and in London.

"One of the first things I'll be exploring with my BADN colleagues is our conference strategy, and how we can come up with some solutions for the future. And we'll be asking our membership for their views on how we go forward."

Scotland alone has more than 4,000 dental nurses in work, and she wants to see more signing up for membership. Nicola is also determined to raise the membership and the profile of the BADN nationally. "I aim to find out what our existing members really want from us, and hope that we can appeal to other people who are not yet members."

BADN members enjoy some significant discounts on such things as car insurance and holidays – thanks to some active campaigning by association staff – and indemnity insurance is another huge benefit for its members.

Nicola said: "I aim to make this a professional organisation that people will want to be involved in. They have worked hard for their professional qualifications – and we will be out there fighting for their cause." ■

Above: Nicola with the BADN's Northern Regional Coordinator Leigh Morrison

JOINING BADN

When she left practice, Nicola Docherty knew she needed to find some way to stay involved in dental nursing – and that's when she joined the BADN.

Before long she became the association's regional co-ordinator in Scotland. There, she found a number of kindred spirits among the members of the national council – people who, like her, take the vocation seriously and want to improve conditions for their peers.

Nicola admits: "I was nosy. I wanted to learn all I could about my profession. I wanted to know what was going on in areas outside my own patch, and I was lucky enough to be in a position, when the Scottish council transited to NHS Education Scotland, to be involved in the bigger picture."

She began to attend meetings of groups of dental nurses across Scotland, and to gather information about what they needed and wanted from membership of the association.

Family responsibilities led to Nicola being less active in the BADN. A colleague took over as regional co-ordinator, but three years later Nicola took up the role again.

By that time, Nicola's work role was also changing, with the responsibility to introduce Scottish Government directives to the dental profession, and before long she was a member of the association's national council.

It was during this period that the idea was raised that she might want to become the President, succeeding Sue Bruckel in the post. "It's a two-year tenure, and I've always known it will be a huge commitment... but I was delighted to accept."

Nicola has already spent the past year preparing for her new role. "As president-elect, I have shadowed Sue and she's been a terrific guide and mentor to me.

"Now I have to do a year on my own before the next president-elect is chosen and I will be expected to help her grow into the role, as Sue did for me."

We have been assessing the specific needs of Scottish dentists for the last two years and now its time for you to assess us...

World La

Not all artists work with a paint brush and palette... Take those who work at WORLD LAB U.S.A. in Irvine, CA, a dental-technical division of the Tokushinkai Group, which is the largest organization in the Japanese dental field.

In this cosmetic dental laboratory that specializes in fixed restorations, highly trained technicians create works of art in the form of veneers for cosmetic dentists around the globe. On the other side of the world, one of the company's other divisions, WORLD LAB Japan, is a full-service dental lab, while WORLD LAB China fabricates porcelain-fused-to-metal (PFM) crowns.

"Our philosophy is to provide the best quality restoration for the best price," said CEO Koji Yamakawa. "I believe we have been able to provide consistent quality restorations which save the dentist time and money."

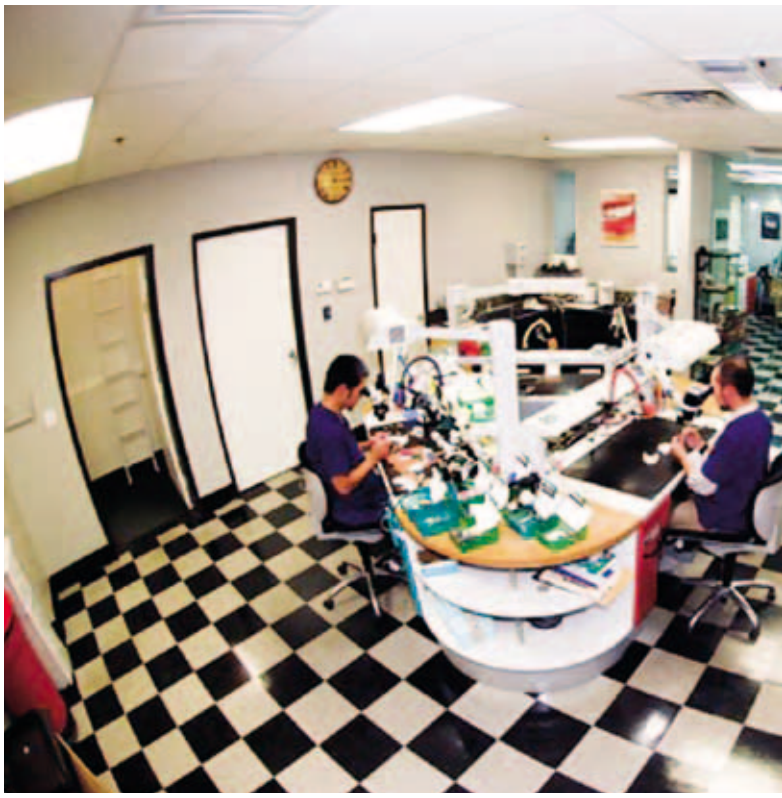
At WORLD LAB U.S.A., the goal is always to deliver quality and customer service. This applies to all three service levels that the company makes available: at its high-end division, Ultimate Styles Dental Laboratory, which specializes in cosmetic fixed restorations that require the highest level of skill; WORLD LAB's traditional service for fixed, which provides excellent value at a moderate price; and more recently, the Global Standard project that all Tokushinkai Group dental labs are promoting, which provides lower-cost, but high-quality PFMs by working with WORLD LAB China.

"For many labs that are based overseas, their only focus is price, but for us, we believe our quality is the result of the 1,000-plus hours per year of education and continued training that we give to each of our technicians," Yamakawa said. "There is no doubt that the dental field is getting more popular, and at the same time, the costs are rising. We believe the result of high costs is troublesome for dentists and the quality of most dental labs is not equal with their fees. I believe our laboratory will be an important factor in changing the dental industry."

WHO THEY ARE

Since 2000, WORLD LAB U.S.A. has been managed by Japanese dental technicians who were educated at Osaka University in Japan.

"In Japan, more than 8,000 new patients visit our dental practices every month"



Ceramic department in Irvine

The company's headquarters is based in Japan where it has a reputation for its quality of products. The Tokushinkai Group was established 25 years ago and it has quickly become the largest dental group in Japan. It has a total of 29 dental practices and has crossed the border into China.

"In Japan, more than 8,000 new patients visit our dental practices every month. Our main concern is comfort and quality for the patient," Yamakawa said.

In addition, there are five dental labs in Japan, China and the United States that support the parent company's new affordable global standard. With more than 200 dental technicians worldwide and growing, WORLD LAB technicians are the best of the best — artists, if you will.

"Having five dental labs, we have created a great education system for our technicians, which is our strong point," Yamakawa said. "It is difficult for most

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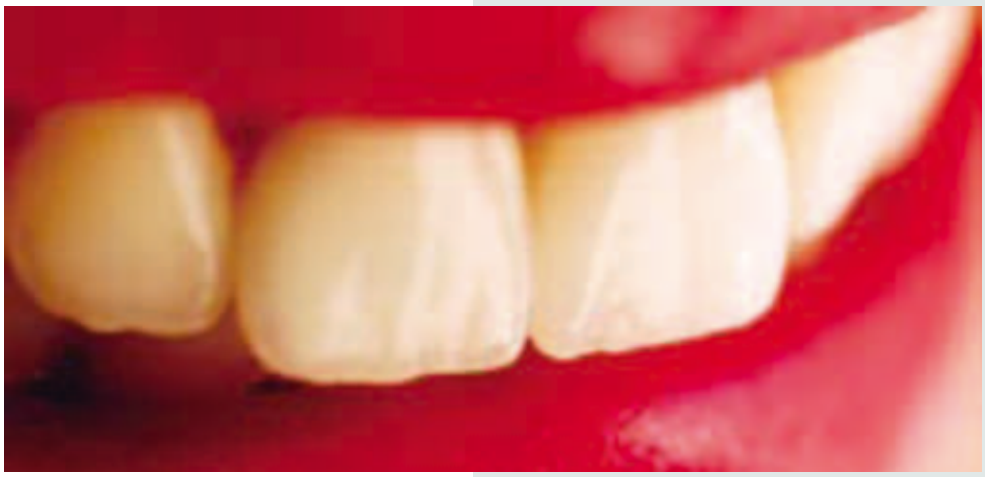
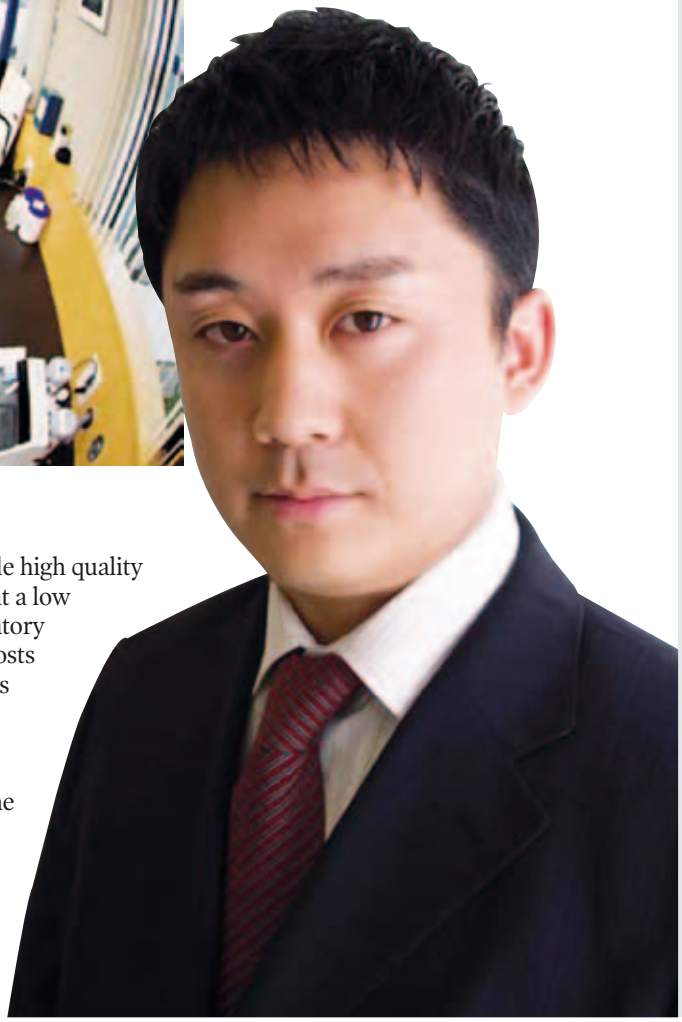


Smile restored by World Lab USA

"The higher the quality, the more expensive it is. Global Standard is the answer"



labs to provide high quality restorations at a low cost. A laboratory incurs high costs with materials and retaining good quality technicians. The higher the quality, the more expensive it is. Global Standard is the answer." ■

WORLD LAB SCOTLAND

Tokushinka's plans are to work with dentists throughout the UK offering both NHS and private options at a reasonable cost providing high quality work. Our products have already gained MHRA certification and we plan to expand the scope of world lab Scotland; who is already being used by several dentists throughout the UK by putting the weight of Tokushinkai behind it.

We have tested the market with World Lab Scotland for just over a period of two years and have been pleased to note the positive feedback gained, particularly as Scottish dentists put quality and materials above cost. It is our objective to work with theses dentists, to give them a product that they will feel comfortable and confident putting in to patient's mouths and at the same time create a fee that will allow them to work efficiently within the realms of the NHS

One particular dentist in Scotland we have been working with raised some valuable points and on that basis we would also look to provide seminars incorporating both Japanese and top British speakers. This always creates interesting debates and intrigue and in time we would look to add laboratories within the UK where the technicians are Japanese trained in keeping with the Tokushinkai ethos.

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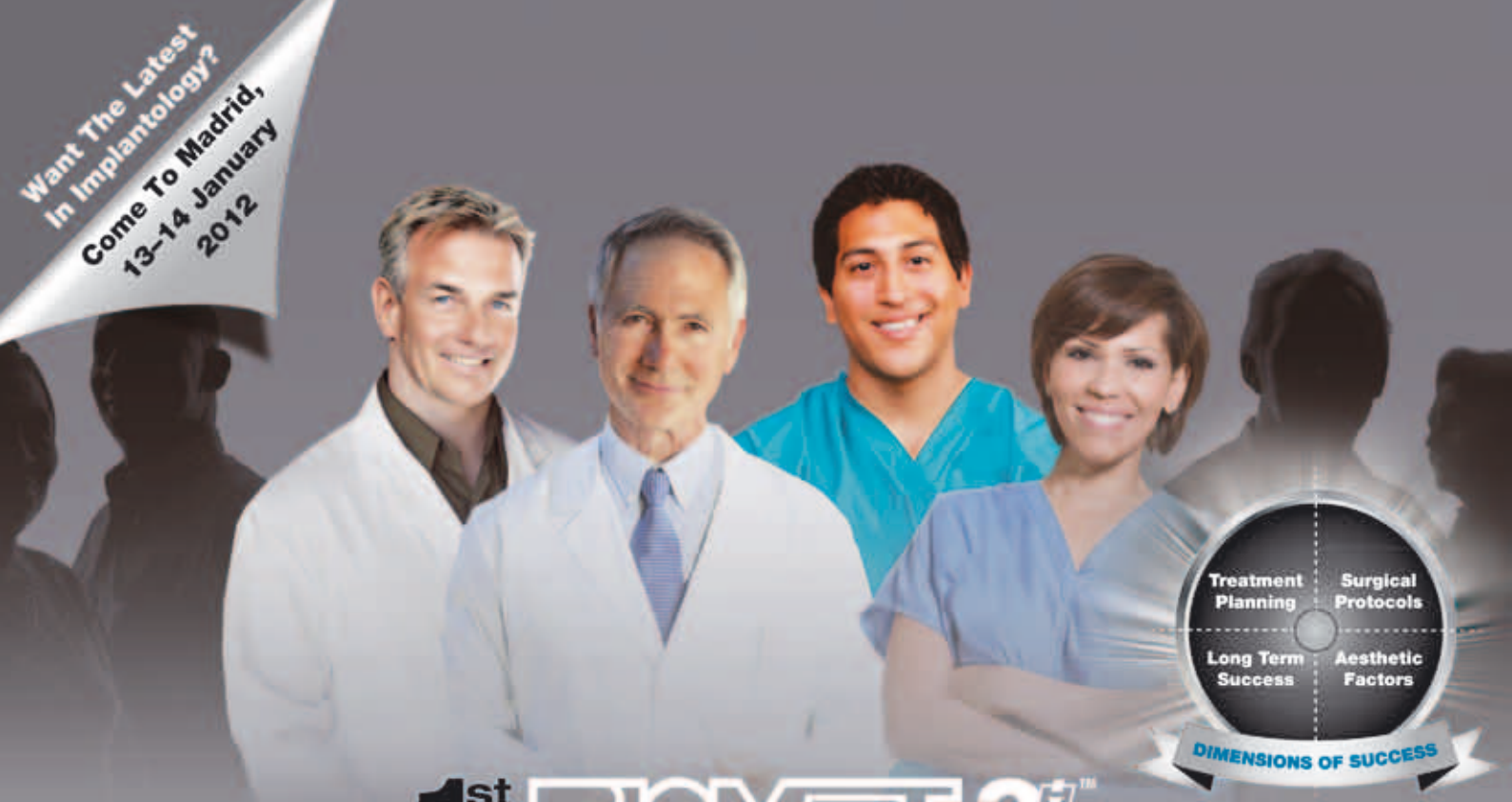

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In the second part of our look at a live course of implant treatment, Stephen Jacobs describes extraction and placement of the provisional bridge

Exceeding expectations

Update

In the last instalment of the treatment journey for our patient NC, we had established the overall dental status, and that both upper central incisors, due to an extremely poor prognosis, required extraction.

NC had also informed us that he was keen to avoid a partial denture at any stage, if at all possible, and it was established that the treatment option of choice was to be two dental implant-retained crowns. During this initial consultation and discussion, the fundamentals of the treatment plan were formulated.

Treatment plan

A detailed treatment plan letter was prepared, something we do for all cases involving the provision of dental implants. This letter should always contain the following:

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- the variety of possible treatment options
- a description of what a dental implant is and how they are to be used in that particular case
- any possible requirements for hard or soft tissue augmentation
- reassurance that although it involves surgery, and that this is relatively minor, some swelling, discomfort and bruising should be expected for a few days post-operatively
- a sequencing of the treatment stages, including an estimate of the time from beginning to end
- any risks and complications
- the implications of no treatment
- what is expected of the patient following completion of the treatment, including any follow-ups and aftercare
- the likely costs and settlement terms.

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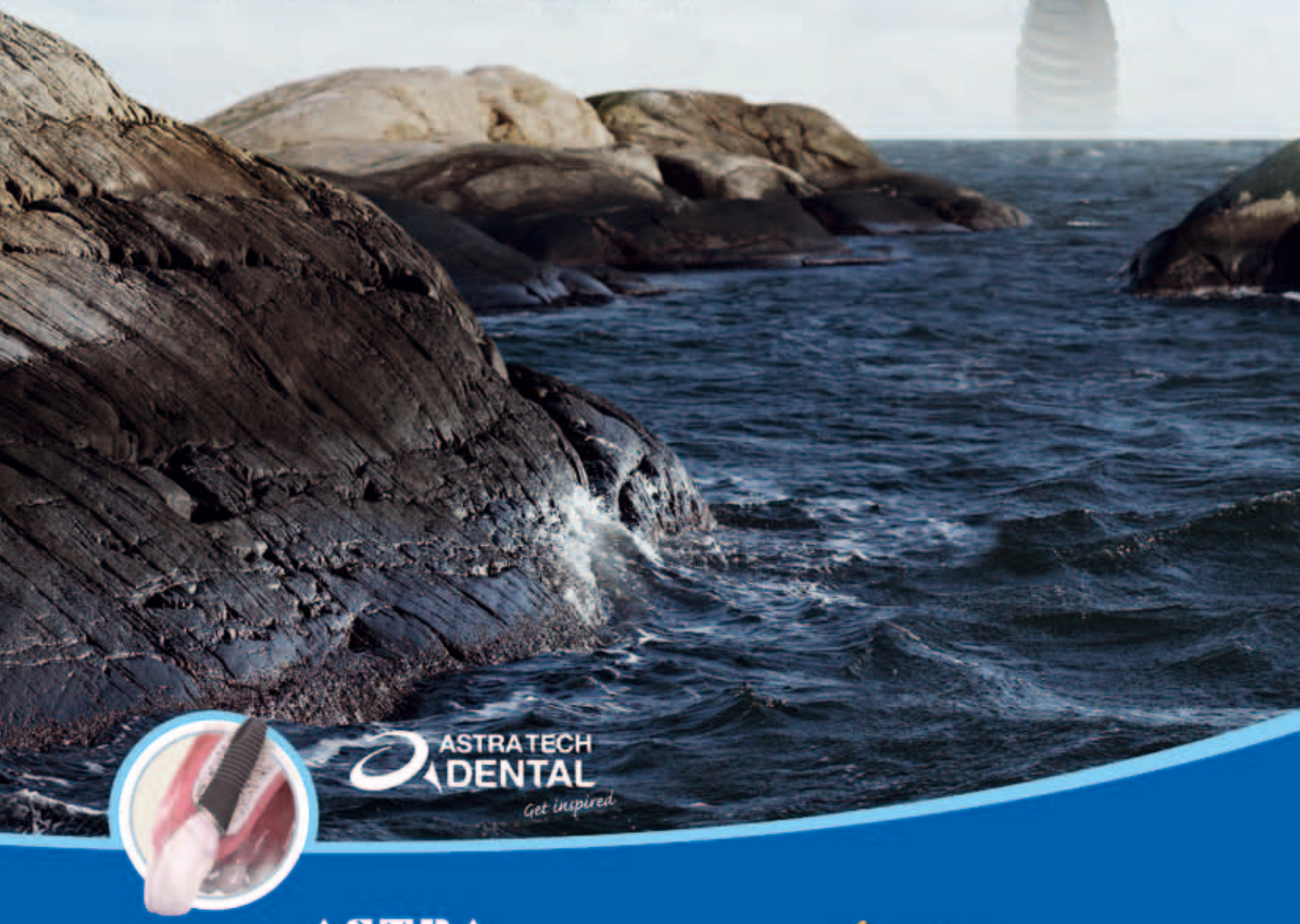

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Continued »

dures planned.

In the case of our patient, NC, the following treatment plan was formulated:

1. Remove two upper incisor tooth roots and fit provisional restoration
2. Two months after extractions, place two implants, in UR1, UL1. Bone augmentation to be carried out simultaneously
3. Following a suitable healing period, assess for need for soft tissue augmentation
4. Four months after placement, uncover implants and attach healing abutments
5. One month later, begin construction of provisional crowns on implants
6. Two weeks later, fit crowns on implants
7. Once we are happy with the shape, size, contour and gum condition, fabricate and fit the definitive crowns
8. Regular reviews and maintenance with a suitably trained hygienist.

In this particular treatment plan letter, special reference was made to the local and systemic risk factors for peri-implantitis and the fact that this was a case where there was an increased chance of this being a problem somewhere down the line, when taking into account the history and reasons for extraction.

Informed consent having now been obtained, NC then attended an appointment where impressions were taken for the provisional restoration and, fortunately, the very mobile 11 was not removed with the impression... This was a very real concern as the 11 was that mobile!

The dental laboratory selected for this case was Dental Technology Services (DTS), and following a discussion with Sandy Littlejohn, it was decided to construct an adhesive bridge out of reinforced GE composite, using the palatal surfaces of the two lateral incisor abutments, for the bridge to be adhered to.

One week later, NC returned for the extractions and fit. On informing the patient that we did not have a removable denture, but an adhesive bridge, he was delighted. Any time one can deliver something in excess of a patient's expectations is a positive and will enhance the dentist patient relationship; this was one such instance.

Following buccal and palatal infiltration with Lignocaine (2 per cent with 1:80,000 adrenaline), the two upper central incisors were gently removed. Normally, I would be using a combination of periotomes and luxators in order to preserve the bony housing. However, in this case with so much tooth mobility, it was only gentle elevation with a pair of bone rongeurs that removed these teeth.

The sockets were thoroughly debrided with hand instruments (a Lucas curette and a Columbia 4R/4L London design), to remove any granulation tissue and remnants of the periodontal ligament. Following this, the sockets were sounded with a Williams periodontal probe and in this particular case it was noted that there was the almost complete loss of the buccal plate of bone on the 11, with a smaller crestal defect on the 21.

Collagen sponges were placed into the sockets so that good haemostasis could be achieved prior to fitting the provisional restoration.

The adhesive bridge was tried in and checked for a good fit, aesthetics and occlusion. The palatal surfaces of the lateral incisors were etched/bonded with a one-stage bonding resin (G-Bond, GC) and fitted with a dual-cure luting medium (Rely X Unicem, 3M ESPE).

NC was delighted with the result and following issuing with verbal and written post-operative instructions, together with ongoing oral hygiene advice, the next appointment was scheduled.

Next issue

We shall be describing the final implant planning, the use of Cone Beam CT scanning, the placement of the implants and immediate follow-up.

Turn to page 45 to read about Patient NC's experiences, including how he coped with a dental crisis while driving across the Kingston Bridge in Glasgow...

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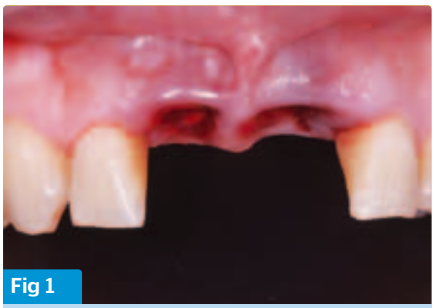

Fig 1
Extraction sockets

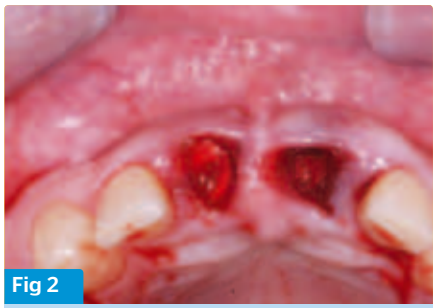

Fig 2
Extraction sockets with collagen sponges in situ

Fig 3
Provisional bridge on the cast

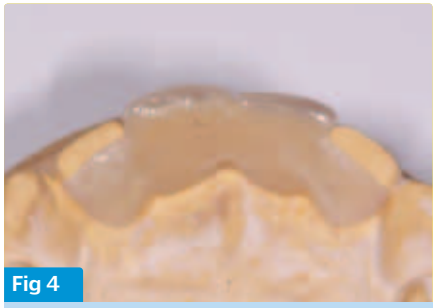

Fig 4
Palatal view of provisional bridge

Fig 5
Provisional bridge fitted immediately following extraction

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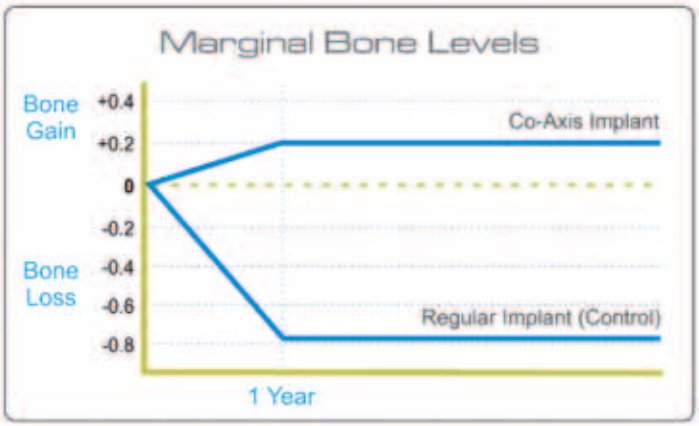

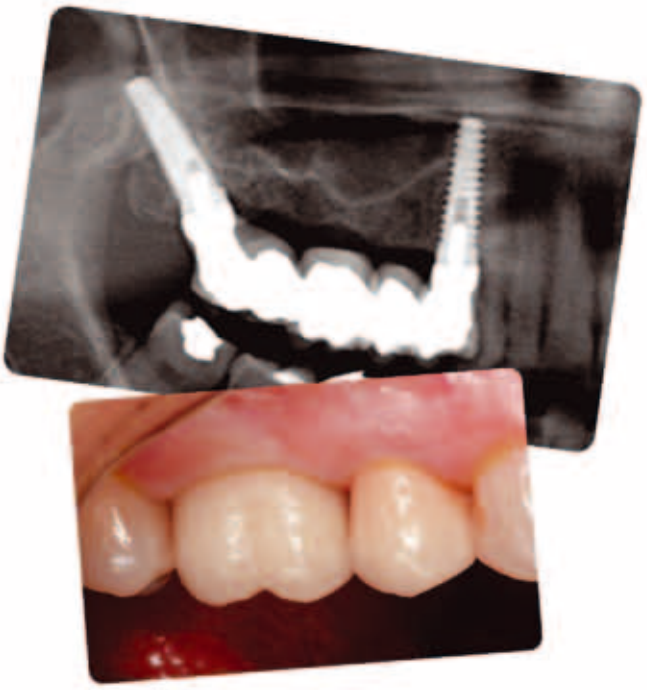

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Despite an embarrassing incident on the Kingston Bridge, Patient NC explains the difference his new temporary dental bridge has made

Bridge troubles

I don't know if many of you will have noticed, but using the 'F' word at volume – Gordon Ramsay style – tends to place a great deal of stress on your two front teeth.

Relevance? I've now discovered, to my enormous embarrassment, that it's highly preferable NOT to use this expletive when you no longer have your maxillary central incisors, but a perfectly formed bridge lightly held in place by adhesive to the adjacent laterals.

Result? On being 'cut-up' on the M8 approach to the Kingston Bridge by a young woman determined to turn her car at right angles to my own, inches from my front bumper, I unwisely decided to remonstrate (scream) at her and include the 'F' word in my tirade. The instant explosion of pressure behind the teeth had, what you might have already surmised to be, the obvious result: the bridge shot straight out of my mouth faster than you can say "-ck", hit the windscreen in front of me, and fell directly onto the dashboard, where it grinned back at me with a particularly amused look to it.

Instant panic. If one can be fined up to £2,000 for using a mobile phone while driving, what would the courts make of a driver steering through the early evening traffic mayhem with his knees, while using both hands to push his two front teeth back into place? I can't imagine the sheriff accepting the plea in mitigation: "But I looked ridiculous: I had to do something!"

However, miracle of miracles. The bridge that was so brilliantly constructed by the very clever people at DTS, slipped straight back into place and my vanity was assuaged, if not my pride; the hysterical look on the face of the woman in the car next to me who witnessed everything will live with me for ever...

Now, as I have said previously, I knew the teeth had to go but I was very concerned that I was to have a plate fitted. So, when I arrived to have the failing incisors removed, the wave of relief that swept through me when I discovered that the dreaded plate was not required cannot be over stated.

When the good Dr Jacobs showed me the little piece of genius that had been devised by DTS, I could have kissed someone... clearly not with the teeth out you understand.

"What would the courts make of a driver steering through the early evening traffic mayhem with his knees..."

It may be that I face other moments of embarrassment, the adhesive does have a tendency to weaken and pressure can leave the bridge needing to be reset every so often. But it is so dramatically better than having the plate that I would absolutely recommend it wherever and whenever possible.

Once again, communication has been a vital factor in this stage of the process. The old teeth are gone, the new bridge is working (most of the time), and the next stage to place the implants has been explained in sufficient detail for me to maintain my high level of confidence in the man who will soon start to drill deep into my skull (I'm a journalist, I exaggerate). More drink please, doctor! ■

The basic occlusal exam

Kevin Lochhead examines a topic that many dental practitioners can find confusing and challenging, but knowing the basics and being able to identify a physiologically stable occlusion is a must

An occlusal exam is something that we should all be doing, but there seems to be significant confusion between what we may have been taught as undergraduates and what seems to be applicable in practice.

For the majority of practitioners who have no interest whatsoever in managing occlusal problems there is still a need to be able to assess and carry out a simple occlusal exam that:

1. Is in keeping with their professional responsibility
2. Allows them the confidence of knowing when they can carry out restorative treatment without fear of inadvertently initiating problems
3. Quickly elucidates the 'problem' patient for appropriate referral.

What questions would we like our occlusal examination to answer?

1. Can I use the patient's existing occlusion?
2. Do I need to change the occlusion?
3. Am I at risk of initiating an occlusal problem?
4. How do I know if there is a joint problem that I should do something about?
5. Is this patient a bruxist who will break all my restorations?

In effect, the real question that the examination needs to answer is: Is this occlusion physiologically stable or pathological?

A physiologically stable occlusion allows for confident progression to restorative dentistry. A pathological occlusion on the other hand will require more in-depth analysis and planning and is where much of the confusion within occlusal concepts and theories lies.

This brief article describes how to easily confirm a physiologically stable occlusion. A basic occlusal exam for restorative dentistry should address four areas:

1. Extra-oral assessment
2. Intra-oral assessment
3. Load testing of the joints
4. First contact and slide from centric relation to position of maximum intercuspation.

Extra-oral assessment

The extra-oral assessment is primarily looking at the muscles of mastication and their effect.

- Does the patient suffer from headaches? If yes, ask about frequency, duration, location (there is a strong correlation between tension headaches and parafunction, especially if the patient reports waking regularly with headaches).
- Palpation of the muscles of mastication (as a minimum the 'trigger points' of masseter and temporalis).
- Range of movement

Continued »

"Extra-oral assessment is primarily looking at the muscles of mastication and their effect"

Fig 1
Assess full range of motion

Fig 2
Is there fremitus in lateral excursion?

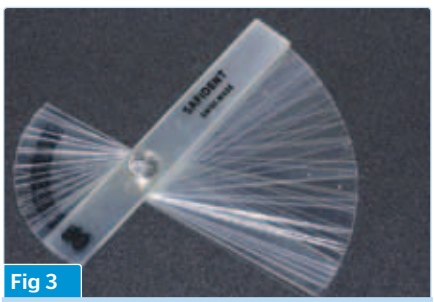


Fig 3
Leaf gauge

Fig 4
Using a leaf gauge to achieve centric relation

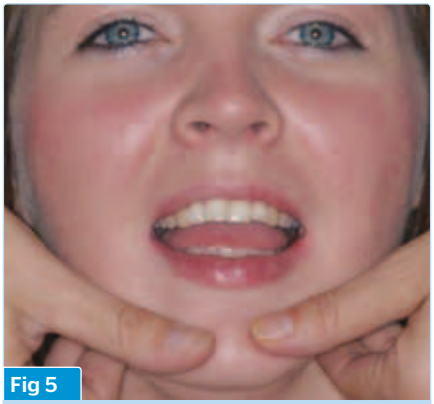


Fig 5
Bimandibular manipulation to load test the joints

"Remember that teeth do wear physiologically and that this can be diet dependant. Your older patients are going to exhibit greater wear than the younger ones"

Continued »

assessment – ask the patient to perform maximum unforced opening and left and right eccentrics. Look out for any significant limitations or deviation (Fig 1).

No headaches, no muscle pain and no limitations to the range of mandibular movements, suggests a physiological occlusion suitable for restoration.

Intra-oral assessment

Is there any pathological wear? Remember that teeth do wear physiologically and that this can be diet dependant. Your older patients are going to exhibit greater wear than the younger ones.

If there is wear, where is it? Molars, palatal surface of incisors or incisal edges? If there is significant wear but not where you are planning restorations, then you may not need to worry. Is there any tooth mobility which is unexplained by periodontal pathology? Is there fremitus? Ask the patient to close together and, while holding together, rub the teeth from side to side – do any teeth move? (Fig 2)

Are there any cusps missing? Is there a history of tooth fracture? Why were missing teeth removed? What condition are the existing restorations in occlusally?

No evidence of excessive wear, mobility or fracture suggests a physiological occlusion suitable for restoration.

Load testing of the joint

In order to load test the joint, it is necessary to find centric relation. This is the point at which a lot of the confusion can start as there are many different definitions, or descriptions, of where it is.

It is important to realise that centric relation is a conceptual

position, which relates to the position of the mandible to the maxillae. It really does not matter how you wish to describe it; all that is important is that everyone is talking about the same position (give or take a few microns).

For arguments sake, we will describe centric relation as the axis of rotation when the condyles are fully seated, in healthy joints.

It has absolutely nothing to do with the teeth or the muscles and, crucially, is inter and intra-operator repeatable.

There are different ways to achieve centric relation, either through manipulation or using an anterior deprogrammer such as a leaf gauge. Neither way can be learned from books articles or presentations, these are learned skills and need hands-on tuition for the operator to be confident in achieving them (Fig 3 and 4).

Once the patient is in centric relation, either the masseters are contracted by the patient or the condyles are forceably loaded. If this action causes pain, then joint instability should be considered (Fig 5).

No evidence of pain on loading suggests a physiological occlusion suitable for restoration.

First contact and slide from centric relation to position of maximum intercuspation

Once again, in centric relation, the mandible is hinged towards the maxillae until a tooth contacts. This is the first point of contact and it should be noted. The patient is then asked to squeeze the teeth together and the 'slide' noted. Anything more than a 0.5mm should be noted.

The significance of the slide from first contact is that the first contact is responsible for programming the muscles of mastication. Put another way; the existence of the first contact causes the muscles of mastication to move the mandible in such a way as to miss this first contact and achieve maximum intercuspation.

If you are planning to restore the tooth which has the first contact, and in so doing remove it, there is a real possibility that the muscles will reprogramme (proprioception changes). Immediate results of this could be:

- loss of the restorative space you just created
- a crown or filling that the patient feels is high and needs multiple adjustments for
- general discomfort with the bite
- inducement of parafunctional activity.

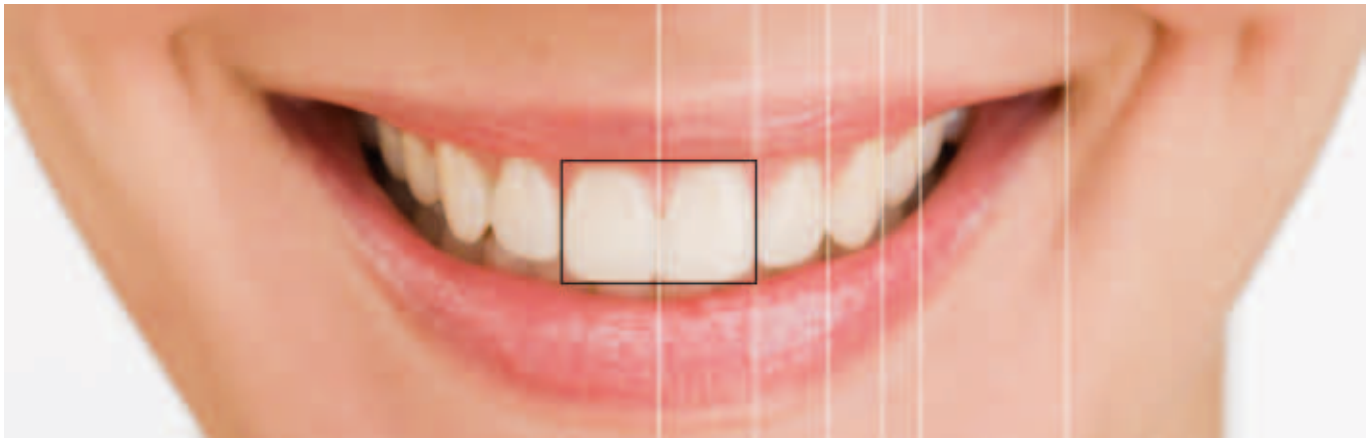
A slide of less than 0.5mm from first contact to maximum intercuspation, or first contact and slide on teeth that you are not planning to restore, suggests a physiological occlusion suitable for restoration. If all four areas are assessed, and no potential pathological conditions are found, then the clinician can progress confidently to treatment.

This simple occlusal examination quickly allows the clinician to establish whether an occlusion is physiological or pathological. In being able to carry this out there is a need for the clinician to learn the skills necessary in achieving centric relation and to have the confidence to do so every time.

This article was submitted by Kevin Lochhead, clinical director at Edinburgh Dental Specialists. The concepts and skills discussed are being addressed during a two-day hands-on occlusion course on 22 and 25 November 2011. ■

For further information on the course, simply scan the barcode opposite using a standard barcode app on your smartphone. Alternatively, e-mail gordonphilp@edinburghdentist.com to receive the course information.

The golden pro



Searching for the magic ratio,

by Dr Richard Holliday MFDS, Mr Mark Devlin FDS, FRCS, Mr Jeff Downie FDS, FRCS

Phi, the divine proportion, the magic ratio, the golden cut and the sacred geometry are just some of the names given to the number 1.6180339887498895. This occurs throughout nature and parts organised in this proportion are said to display greatest beauty and ultimate efficiency in function. It has been found in all aspects of our world from the spirals of galaxies and the harmony of music, to the breeding of rabbits and stock market rises and falls.

Proportion is an important aspect of good aesthetics and is regularly used consciously and subconsciously by dentists. Many have tried to measure beauty and set 'golden' rules but by far the most cited is the 'golden proportion'. This was first mentioned in the dental literature in 1978[1] and subsequently there have been many studies regarding the use of the golden proportion in various aspects of dental aesthetics.

More recent studies have challenged the 'golden proportion' and suggesting the golden proportion is not a single value but rather like a range[2]. Whatever your opinion, these are interesting and potentially very useful concepts which every dentist should be aware of.

The most well known relationship is the proportion between teeth widths. A golden proportion is present between the widths of the eight anterior teeth when viewed from straight on (not the actual width). The width of the central incisor is 1.61 larger than the lateral incisor which is 1.61 larger than the canine etc. This has uses in determining space requirements for incisor replacements.

Interestingly, there is also a relationship between the width of these anterior teeth, known as the anterior aesthetic segment, and the width of the smile. These buccal corridors provide a 'back drop' for the anterior aesthetic segment and is said to be most aesthetically pleasing when in golden proportion. These areas of darkness or neutrality, sometimes known as negative space, are useful in orthodontics and an important factor in giving prosthesis a natural appearance. The picture above demonstrates this relationship.

When specifically looking at central incisors their dimensions can be established using the golden rectangle. The width of two central incisors is in golden proportion to their height (black rectangle above). This is useful when reconstructing the smile, for example in patients suffering from significant gingival recession anteriorly. The golden rectangle can be used when constructing a gingival veneer to determine where to place the gingival margin and how much tooth to show. The golden rectangle is also found in many day to day shapes including playing cards, credit cards and windows.

Another use is the positioning of the incisal line when constructing prosthesis. In a relaxed face, with a free way space, the 'chin to lip line' (larger) is in golden proportion to the 'base of nose to lip line' (smaller).

There are several 'golden proportion' tools available to the clinician including a disposable plastic/paper gauge[3]. This comes in a variety of sizes to fit central incisors from 7-10mm in width. Additionally, software[3] is available for download which overlays golden proportion grids onto digital clinical photos to show the most aesthetically pleasing dimensions of the central, lateral, canine and pre-molar teeth.

These proportions are tools and not goals. They are a useful guide and should be used as part of a full aesthetic assessment. Chiche[4] describes the four factors of aesthetic composition: frame and reference, proportion and idealism, symmetry and perspective and illusion.

A technique using frames is used by artists to draw heads. They draw within a measured general frame and then refine this with measured inner frames and reference points. Teeth interact with

portion

three frames: the face, lips and gingival[4].

This concept of the golden decagon has been applied to faces by the mathematician and plastic surgeon Marquardt[5]. He designed face masks which fit these ratios and can be digitally placed over clinical photographs to determine how close a face is to the average.

A good example of this is that the width of the base of the nose compared to the width of the mouth should be 1:1.618.

It seems that facial attractiveness is founded in averageness and proportion. Clearly beauty is not average though and many studies have shown that the beautiful face is often distinctive by two or more striking features that fall out of the average such as beautiful eyes or perfect teeth.

When a patient attends the FACE clinic with an aesthetic concern we use these guiding principles to help us decide where the discrepancy lies and therefore what are the treatment options. These may range from non-surgical treatments such as botulinum toxins and fillers to orthognathic surgery to address the soft tissues and any underlying skeletal disproportion.

Facial plastic aesthetic procedures such as otoplasty, rhinoplasty rhytydectomy (face-lifting) and brow-lifting are often the key to providing facial harmony and rejuvenation.

As a group of surgeons and affiliated dentists we are convinced that by working together we can provide the highest standards of care and the best outcomes for our patients. We think that the dentition is the key stone to the face. ■

The FACE team are committed to education and collaborative working. We run regular educational evenings for GDPs and GMPs. Our next course will focus on non-surgical treatments and will cover the use of botulinun toxins and dermal fillers. It will run on Saturday 29 and Sunday 30 October. We look forward to meeting you there. To book please contact typhaine.mace@bmihealthcare.co.uk by email or by phone on 07850 929 322. The FACE team consults every Friday afternoon at BMI Ross Hall Hospital and by appointment in various dental practises within the West of Scotland. Appointments with Mr Jeff Downie or Mr Mark Devlin can be arranged by contacting the BMI call line on 0141 810 3151.

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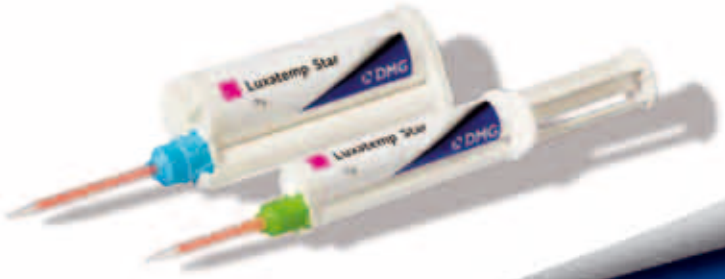

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The role of temporary restorations in aesthetic dentistry.
By Professor Guilherme Martinelli Garone, DDS, MSc and Professor Renato Burger, DDS

Successful temporary restorations

The demands of our patients regarding prosthetic restorations are constantly increasing. Thus, not only restoring the function, but also the aesthetic appearance of the smile, has become more and more important.

Not without reason, the many different advertising media portray a flawless, brilliantly white smile representing professional and social success. The alteration of just one tooth, the placement of a single crown, can have a significant impact on the patient's overall appearance, both positively and negatively.

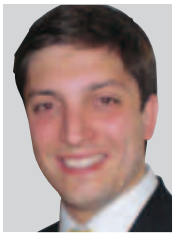
In order to define and match the expectations of the patient as precisely as possible, the application of temporary restorations has not only proven effective for protecting prepared cores, but also for simulating the desired final aesthetic result. Temporaries play an ever more important role within the dentist-patient communication process in aesthetic dentistry.

Case report

A 50-year-old patient was dissatisfied with the aesthetics of her smile. She was particularly bothered by the appearance of the crown on tooth 11 *(Figure 1)*. This porcelain-fused-to-metal (PMF) crown had been placed approximately 10 years earlier, following an endodontic procedure and the integration of a customized metal post.

The patient complained in particular about the dark margin of the crown, the lack of translucency and the shape of the crown itself. During the palatal examination, an exposed crown margin and cracks in the ceramic veneer were detected *(Figure 2)*.

An X-ray did not reveal any sign of apical inflammation. As the placement and marginal fit of the cast root post was judged to be clinically sufficient it was decided to leave the post in situ. Following fabrication of the evaluation models and an analysis of the initial situation, a restoration with an all-ceramic crown was planned. Since no corrections of the gingival margin were necessary and we would be able to prosthetically close the oversized interdental triangle, the existing crown was removed *(Figure 3)*. A temporary impression was taken with Status-Blue (DMG, Hamburg, Germany) *(Figure 4)* beforehand.



"Temporaries play an ever more important role within the dentist-patient communication process in aesthetic dentistry"

Professor Guilherme Martinelli Garone, DDS, MSc

Following removal of the old PFM crown, dark discolourations of the dentine were detected on the margins *(Figure 5)*, which could be completely removed in the course of the subsequent follow-up preparation. For the placement of the all-ceramic crown the existing cervical margin was widened. After finishing the preparation, the temporary impression was adjusted and the palatal margin extended accordingly *(Figure 6)*. With a Vita shade guide the shade for the temporary was chosen.

The temporary impression was filled homogenously and bubble-free with Luxatemp-Fluorescence (DMG, Hamburg, Germany) *(Figure 7)*, replaced in the patient's mouth and left to set in situ for two minutes.

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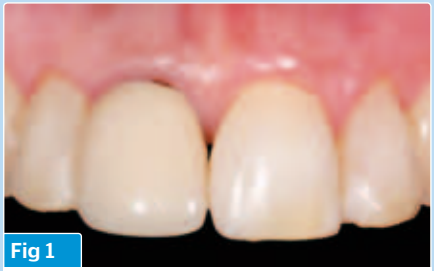

Fig 1
Initial findings – labial view

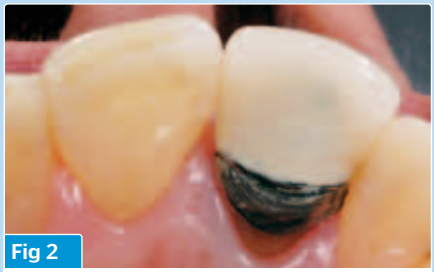

Fig 2
Palatal view – insufficient crown margin

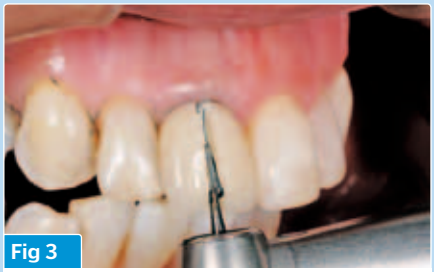

Fig 3
Removal of the old restoration

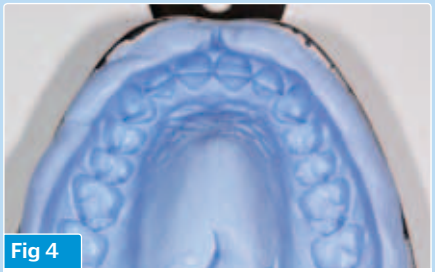

Fig 4
Impression for fabricating the temporary

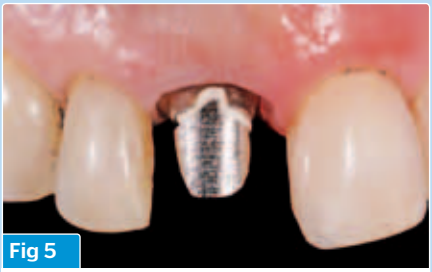

Fig 5
Core after the crown is removed

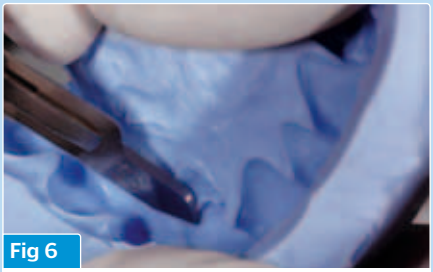

Fig 6
Preparation for the temporary restoration – shaping of the palatal margin

Fig 7
Filling the matrix bubble-free with Luxatemp-Fluorescence

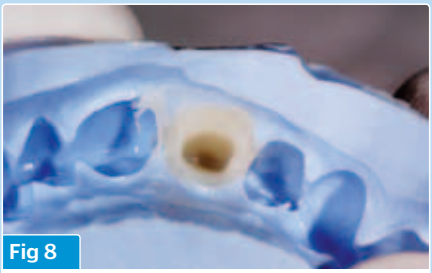

Fig 8
The temporary is left to harden in the matrix

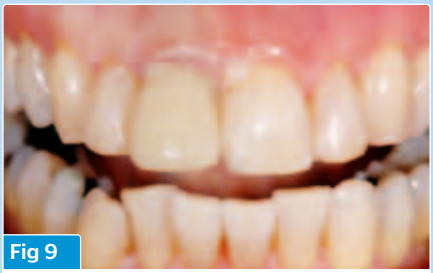

Fig 9
Review of the temporary

Continued »

During subsequent removal of the matrix the temporary remained inside the impression *(Figure 8)*. The Luxatemp temporary was removed from the matrix, repositioned and fit, shape and shade examined *(Figure 9)*. Subsequently, the surplus and excess material was removed. The finishing and final shaping of the temporary was performed outside the patient's mouth using burs.

In order to provide the patient with a preview of the final aesthetic result some material was removed from the facial surface of the temporary and the natural shading of the tooth was imitated using LuxaFlow-Fluorescence (DMG, Hamburg, Germany). Subsequent to finishing and polishing, the temporary was varnished with Luxatemp-Glaze&Bond (DMG, Hamburg, Germany) *(Figure 11)*. This sealer gives the temporary a natural glow, prevents discolourations and minimises bacterial colonisation on the temporary's surface. The temporary was cemented in situ with some eugenol-free temporary luting cement, TempoCemNE (DMG, Hamburg, Germany) *(Figure 12)*.

The patient wore the temporary for two weeks to get used to the new aesthetics, function and possible phonetic changes due to the reshaped palatal surface. During this time, modifications in shading, shape and function are possible so that the patient obtains an accurate impression of the final restoration and their wishes can be met.

The patient returned to the practice. She was very satisfied with the shape and function of the temporary so that the impression could be taken during this visit. In a first step, the

By means of simple techniques a satisfactory aesthetic result for the patient can be achieved

Professor Renato Burger, DDS

shade of the final restoration was selected in co-operation with the patient using a Vita shade guide. The patient wanted the shade of the final crown to be slightly lighter than that of the temporary, so instead of A2, B2 was selected. The impression of the opposing arch was taken with StatusBlue.

Since the preparation had to be extended subgingivally for aesthetic reasons, retraction cords were placed in the sulcus and left there for several minutes before taking the impression. A precision dual-mix impression was then taken with Honigum-Heavy and Honigum-Light (DMG, Hamburg, Germany).

The temporary was repositioned and the impressions sent to the Laboratory. *Figure 13* shows the final ceramic crown (Inceram, Vita, Bad Säckingen, Germany). It was tried-in and form and shade were

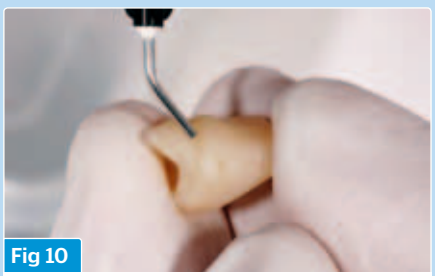

Fig 10
Characterisation of the temporary

Fig 11
Varnishing the temporary with Luxatemp-Glaze&Bond

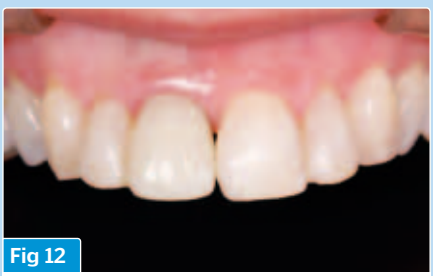

Fig 12
Seated temporary

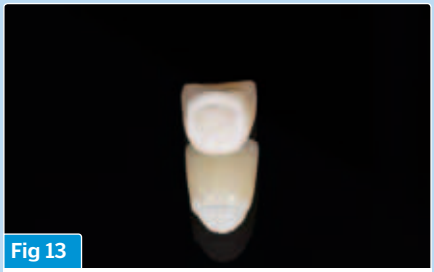

Fig 13
Inceram crown (Vita, Bad Säckingen, Germany)

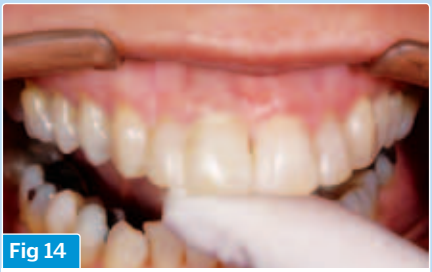

Fig 14
Cementation using Vitique adhesive luting cement

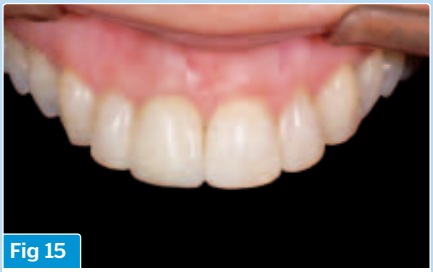

Fig 15
Final treatment result

discussed with the patient. The patient was very satisfied with the improved aesthetics so the crown was adhesively cemented. First, the prepared core was cleaned with a fluoride-free polishing paste. Then the crown to be cemented was cleaned with water spray and air, and saliva residue was removed with alcohol before the try-in. The core was also disinfected with alcohol.

In the next step, the dentine was pre-treated adhesively. Since Vitique (DMG, Hamburg, Germany) dual-curing cement was to be used, LuxaBond Total Etch (DMG, Hamburg, Germany), an adhesive system compatible with dual-curing cements, was selected. The appropriate enamel and dentine areas were first conditioned with 35 per cent phosphoric acid. Then the primer was applied, worked in and the excess removed by air. Subsequently, the bond-mix was applied. The crown was first conditioned with hydrofluoric acid and then silanised. The crown was filled with the luting cement in the shade selected beforehand, placed and correctly positioned (*Figure 14*). The Vitique luting cement system allows for precise shade selection in whichever cementation mode (light-curing or chemically curing) is used.

The try-in pastes can be combined with the respective variants and thus facilitate an exact visualisation of the final appearance of the restoration. In the next step, the excess cement was removed and the restoration light-cured for 10 seconds after which any fine cement surplus could still be removed. An Oxi-Stop gel was then applied and the cement light-cured once more.

Once the cement had fully cured, the entire crown area was checked for excess material which, if present, should be thoroughly removed. The interdental spaces were cleaned with dental floss. *Figure 15* shows the final result directly after cementation. The shade of the crown matches that of the adjacent teeth perfectly. The oversized and, therefore, very dark-appearing interdental triangle was adjusted and the dark edge removed.

Conclusion

By means of simple techniques a satisfactory aesthetic result for the patient can be achieved. The placement of temporary crowns is an efficient tool in the dentist-patient communication process. It facilitates a very realistic imitation of the desired result, gives the patient an impression of his/her future smile early on, and enables the practitioner to meet the patient's wishes and expectations in the final restoration very closely. Corrections of shape and shade during the wearing time of the temporary are easily possible, at any time, and quickly executed. The reshaping of the preparation lines and the choice of a highly aesthetic luting cement, offering selection of the desired shade beforehand, prevent negative effects of a mismatched cement colour on the final result. Thus, it is possible to achieve excellent aesthetic results even for such an aesthetically unfavourable initial situation. ■

"The placement of temporary crowns is an efficient tool in the dentist-patient communication process. It facilitates a very realistic imitation of the desired result"

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Bonded amalgams: the economical restoration

Jessica Docherty describes an alternative to conventionally placed amalgam restorations

The technique of bonding direct restorations such as amalgam to damaged tooth structure can provide the patient with an economical and minimally invasive solution to the problem of a damaged tooth.

In the current financial climate many patients may defer or decline dental treatment which they perceive as expensive. The restoration of damaged teeth using indirect restorations such as crowns or onlays may be one such example. These techniques incur laboratory fees and require considerable chairside time, resulting in their higher cost compared to direct restorations.

A further disadvantage of indirect restorations is the need for tooth preparation. This may increase the risk of structural or pulpal damage in the tooth being restored and incur further costs for the patient.

The aim of minimally invasive dentistry is that restoration of the tooth should be accomplished by the least damaging means possible. Using adhesive dentistry, the concept of bonding a direct restoration such as amalgam to a damaged tooth may help achieve these aims, while providing a more affordable alternative to a cast restoration.

Amalgam has been used in restorative dentistry since the nineteenth century[1,11] and continues to be one of the most widely used restorative materials in dentistry today[2] mainly due to its ease of handling, cost effectiveness and clinical serviceability[3].

Dental amalgam is a mixture of metals, consisting of liquid mercury and a powdered alloy composed of silver, tin, copper and other trace materials. Conventional low-copper amalgam compositions resulted in creep and low corrosion resistance largely due to the γ2 tin-mercury phase[4]. This γ2 phase was considered to be the least strong phase of hardened amalgam with these voids having a drastic effect on the strength and corrosion resistance[5].

Nonetheless, the conventional amalgam γ2 phase did have one benefit as it was thought that the corrosion products sealed the potential gap between the tooth-material interface[4-7] and decrease microleakage. The high-copper amalgams increased the copper content from six per cent to 10-30 per cent[4] in an attempt to reduce and eliminate the weak γ2 phase and with it increase the compressive strength, reduce creep and the susceptibility of corrosion.

Despite the well-documented clinical success of amalgam it is still far from ideal[8], the loss of the γ2 phase has eliminated the previous tooth-material seal and therefore the use of another material is needed to overcome this problem.

Figure one shows a conventional amalgam restoration exhibiting creep and recurrent caries around the margins due to microleakage of the material. These shortcomings of amalgam including poor appearance, lack of adhesion to tooth structure, the need to remove sound tooth tissue to achieve mechanical retention and the high incidence of tooth fracture are widely recognized[8].

The first documented attempts at increasing retention of an amalgam restoration was in 1897 when a technique using a thin coat of zinc phosphate cement on cavity walls and condensing amalgam immediately onto the wet cement was first described[9]. However, it wasn't until the 1980s when two Japanese manufacturers began to develop resin composite adhesives, which enhanced bonding to metal surfaces following air abrading,[10] that interest focused on bonding amalgam restorations.

The use of either Panavia F 2.0 (Kuraray) or Rely X ARC (3M Espe) as the resin bonding agent has been recommended by several authors for the bonding of amalgam restorations[4,11].

Technique

Tooth preparation is clean, dry and caries free (Fig 2). A lining, such as Vitrebond (3M ESPE), should be placed where indicated.

The tooth should be isolated with rubber dam to ensure excellent moisture control required when working with any dental resin.

If a matrix band is required around the tooth, a thin layer of petroleum jelly should be applied to the inside of the

Continued »

"In the current financial climate many patients may defer or decline dental treatment which they perceive as expensive"

Jessica Docherty

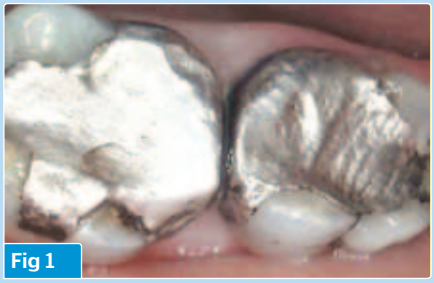
Fig 1

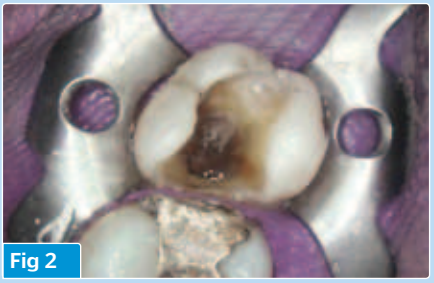
Fig 2


Fig 3

Continued »

band with a micro-brush to facilitate easy removal once the bonded amalgam has been placed (Fig 3).

The cavity is then etched with 35 per cent phosphoric acid for 15 seconds (Fig 4) and washed for 30 seconds to ensure that all the acid and the calcium phosphate precipitates created by the etching are washed away. The tooth is then dried with an oil-free air stream.

The dentine is then re-hydrated with a dampened micro-brush to facilitate wet dentine bonding. If not, the drying of the dentine can cause collapse of the unsupported collagen architecture inhibiting adequate wetting and penetration of the primer.

This is followed by the application of two layers of bonding agent, such as Scotchbond (3M ESPE), to the wet dentine (Fig 5). The first layer removes any residual water and begins to infiltrate the adhesive monomers into the etched dentine so when the second layer is applied, the fresh monomers re-dissolve the resin globules leaving a homogenous penetrative film[12]. This is gently air-dried for two seconds before being light cured for 20 seconds according to the manufacturer's guidelines.

The adhesive cement, in this case RelyX ARC (3M ESPE), is mixed as per the manufacturer's instructions and thinly applied to the cavity using a micro-brush (Fig 6). The resin is not light cured and the mixed amalgam is then packed immediately against the un-set resin (Fig 7).

Once the cavity has been bulk filled the matrix band can be removed and the restoration should then be burnished and carved using the same techniques as for a conventional amalgam. Time should be taken to carve and contour the amalgam to ensure that the cuspal anatomy is kept.

The rubber dam is then removed and the patient's occlusion checked. It is important to give the patient an opportunity to rinse their mouth and relax their muscles. Swallowing reintroduces the patient back into the intercuspal position (ICP) after keeping their mouth open for long periods of time. The occlusion should not only be checked in ICP but also in lateral excursive movements to ensure there are no sliding movements or guidance is on the new restoration to prevent excessive forces during functional loading.

Occlusion is best checked holding the articulating paper between Miller forceps and allowing the patient to close into ICP. A thin layer of petroleum jelly on the articulating paper helps the contacts to be clearly visible on the tooth and restoration surfaces. I would use one colour of articulating paper for ICP and a contrasting colour of articulating paper for lateral excursive movements. Any adjustments should be made accordingly.

Finally, the restoration as seen in figure eight can be polished with green and brown stones or a prophy air jet.

Advantages of bonded amalgams

- Reduced costs compared to cast restorations.
- Simple technique.
- Restorations can be placed in a single visit.
- More conservative compared to cast restorations.
- More conservative compared to conventional amalgam restorations as mechanical retention features such as grooves or pins are not required[4,21].
- Reduced microleakage and risks of secondary caries[2,4,13-18].
- Reduced post-operative sensitivity[19,20,22].
- Bonding can support weakened tooth structure.

Conclusion

There is strong evidence to support that bonding an amalgam improves the seal at the tooth-material interface compared to conventional techniques. It has been reported that reducing microleakage at the restoration margins helps to prevent recurrent caries at this tooth-material interface. Furthermore, the bonded amalgam restoration has also been shown to support weaker teeth with substantial tooth loss and is a useful technique for restoring unretentive cavities.

Bonded amalgam restorations, when compared with conventionally placed amalgam restorations, fulfil the principles of minimally invasive dentistry and provide the patient with an economical alternative to cast restorations by saving chairside time and laboratory fees. ■

ABOUT THE AUTHOR

Jessica Docherty qualified from Dundee Dental School in 2010. She is an LDFT at Loanhead Dental Practice in Midlothian and has an interest in adhesive dentistry.


Fig 4


Fig 5


Fig 6


Fig 7

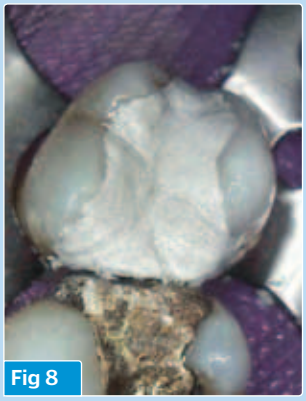
Fig 8

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General anaesthesia may be a thing of the past in dental practice but anxious patients aren't. Aldo Ceresa looks at the alternatives

Conscious issues on sedation

It is now ten years since the practice of general anaesthesia was stopped in dental practice. I recall at that time I, along with all the other dentists who offered general anaesthesia, wondered how we would cope with the patients who fell into the high anxiety category.

Reflecting back on those days it felt as if it would become very difficult to manage these patients, but we have – well almost.

For dentists practicing sedation, you will no doubt find that midazolam will not work on all patients. The patients that will be problematic are still those in the high anxiety category. It can be extremely stressful for the operator trying to undertake treatment on a patient who is moving about, moaning that they are not sleeping, weeping, and trying to push you away. This is a scenario that all dentists regularly practising sedation will have experienced.

Despite this, the vast majority of these patients will report that, after treatment, they do not remember any part of their treatment. The dose titrated to the patients will typically indicate readings of oxygen saturation levels in the range between 93 and 96, with a pulse rate ranging between 110 and 140 beats per minute. Clearly any attempt to increase the dosage would be fraught with problems.

The patient may still be unmanageable, with an increased risk of suppressing their respiration. Under these circumstances it is unwise to proceed and this is where one has to draw the line. Furthermore, patients requiring larger doses tend to have prolonged recovery periods, which is not desirable in a short-term outpatient setting.

When faced with this situation, the operator has to decide: either abandon the case, or carry on regardless. Proceeding with treatment will result with the practitioner enduring a stressful episode, with the possibility of being unable to complete treatment successfully. This will inevitably result in a prolonged recovery period and trying to pacify a distressed patient. Furthermore, the practitioner is then faced with the prospect of having to explain the patient's behaviour to their partner or escort, who may be concerned. It is not uncommon for female patients to be weepy following treatment with mascara lines running down their face. This further adds to the escort's anxiety. All of these factors will further add stress to the clinician.

The above mentioned scenario is based on a patient attending for conservation treatment. The picture is made considerably worse when the patient requires traumatic dental treatment. As you will be aware these patients are phobics and, as such, will inevitably require difficult extractions. Fear has kept this category of patients away from the dental surgery, and their dentition is ruined with widespread rampant caries as a result of very poor oral hygiene, a poor diet and a failure to attend for regular treatment.

"The picture is made worse when the patient requires traumatic dental treatment"

Aldo Ceresa, clinical lead at Cadden Dental Clinic in Glasgow

I am sure that dentists, who have attempted midazolam sedation on these patients, will be aware that treatment is impossible, when you add this to the list of the stressful behavioural patterns previously mentioned.

In my experience, it is this latter group of patients where midazolam sedation has not been effective in rendering the patient manageable for treatment. Often the treatment may involve multiple difficult extractions, some of which may be very traumatic for the patient. General anaesthesia was a very valuable method of patient management for this category of patient.

Of course, there was always the obvious category of patients where general anaesthesia was the method of choice:

- IV drug users
- patients on prolonged medication such as oral benzodiazepines or methadone
- patients who abuse alcohol
- patients who smoke drugs
- medical conditions which may preclude IV sedation in

the dental practice. Attempting to sedate these patients with midazolam is futile.

Fortunately, since 2001, a safe alternative method has been found to treat these categories of difficult patients.

Propofol was a drug primarily used in hospitals as an intravenous induction agent in general anaesthesia.

However, it was later discovered that by administering this drug in lower doses by an intermittent infusion technique, it had extremely good sedative properties.

It is now used worldwide in intensive care units to keep patients sedated for prolonged periods of time.

This method of sedation was achieved by the use of computerised delivery apparatus otherwise known as TCI (target controlled infusion).

This method slowly titrates a varying dose of propofol intravenously to the patient as set by the operating clinician. This system has now been translated into the dental practice and carefully maintains the level of sedation, allowing the dentist to undertake traumatic dental procedures safely on a relaxed patient.

Other major benefits of the use of propofol include reliable amnesia and an extremely rapid recovery period.

Propofol also has very good antiemetic properties, therefore reducing any likelihood of nausea or vomiting. The only disadvantage of this system for optimum results is that it requires a specialist anaesthetist to perform this technique.

There are two reasons for this requirement:

1. The delivery of the propofol has to be monitored constantly, ensuring that the patient is kept at a constantly appropriate level of sedation during treatment.
2. The TCI pump has to be calibrated to different settings for each patient individually.

Propofol is, to date, a widely accepted drug for use in sedation in dentistry.

It has been endorsed by the The Royal College of Anaesthetists in England, by the Scottish Dental Clinical Effectiveness Programme, by recent publications in Sedation in Dentistry, and recognised in Post Graduate Training in Dentistry. ■

ABOUT THE AUTHOR

Aldo Ceresa is the clinical lead at Cadden Dental Clinic in Glasgow. He has over 34 years' of experience in treating patients successfully under sedation having been instrumental in setting up the NHS sedation service at Glasgow Dental Hospital.

Programme Highlights

Pre-Congress
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- Is my patient ready for implants?
- Restorative success - from theory to practice
- Digital dentistry

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Implants in Practice

The Congress theme is 'Implants in Practice'. Implant dentistry is a team effort and the programme is aimed at a predominant membership of dentists in general practice and their team of technicians, clinical dental technicians and dental care professionals.

The two main Congress days are divided into four sessions; Marketing, Implant Surgery, Implant Prosthodontics and Digital Dentistry with parallel sessions for technicians, clinical dental technicians and dental care professionals and with an exciting list of speakers. In addition there is a Pre-Congress day with the famous clinical duo of Professors Daniel Buser and Urs Belser.

NHS Highland's Scottish first

Med Imaging Limited (Scotland) install first volumetric tomography in Scotland at NHS Highland

Raigmore Hospital within NHS Highland recently installed an Instrumentarium OC200D with Smartpad and volumetric tomography, Focus intra-oral unit and Vistascan intra-oral scanner.

Belford Hospital in Fort William also installed the OC200D.

Med Imaging Limited is an independent company with a Scottish office based in Cumbernauld. We have a dedicated network of specialised dental X-ray engineers and local customer management service available to answer all our customers' needs.

The OC200D, Digital Orthopantomograph with Cephalostat, offers the latest digital technology with a full range of projections, including segmentation. Accurate and stable five point patient positioning allows open view of the patient from the side, with three clear laser positioning lights.

The unit can be installed with the Cephalostat on the left or right side dependant on the room configuration. Automatic Spine Compensation and Dose-controlled Automatic Exposure Control are supplied as standard and generate correct imaging values using the full CCD dynamic range at the lowest possible patient dose. SmartNav navigation software provides easy selection of imaging programs with a touch-screen monitor and provides instant dynamic help with an animated patient positioning guide.

VT is a narrow beam volumetric tomography imaging tool that provides digital tomography with reliable measurements and excellent image quality.

In addition, a Focus intra-oral unit was installed offering a stable system which positions easily and stops when required with no drifting or repositioning, due to the Anti-Drift Mechanism in the scissor arm. Dose is calculated and can be shown clearly after every exposure on the Focus control panel. Vistascan Perio intra-oral scanner is a multi-slot scanner that triggers up to eight images, erases them and makes the plates available again in one single step. The images produced are excellent image quality and the unit takes up very little space and is very easy to use.

Above: (l-r) Radiographers Rebecca Ellis, Ruth Irwin and Jade Heneghen with Dawn Stewart, Med Imaging's sales manager (Scotland) and Naomi Ship, conventional imaging team leader

Naomi Ship, conventional imaging team leader at Raigmore, said: "We are very pleased with our new dental room. The DR equipment is easy to use with the great advantage of the Smart Pad which is ideal for rotational radiographers as a reference tool. The images are superb with excellent feedback from referring clinicians. The 3D VT is a new departure for us allowing greater diagnostic capabilities for a select group of patients."

Launch of Instrumentarium's Orthopantomograph OP300

The most comprehensive three-in-one platform is launched to celebrate 50 years of Orthopantomograph success. OP300 combines an advanced panoramic imaging system with either cephalometric, cone beam 3D or a combination of both, giving you an adaptable platform. The system can also be upgraded after the initial purchase.

Complete usability is confirmed with the large 10-inch touch screen to allow fast and effortless workflow. The multi-layer pan provides five panoramic images with only one scan, reducing possible retakes. Two fields of view are available – 6x4cm and 6x8cm with standard and high resolution possible.

A two dimensional scout view – Smart view – is taken prior to the 3D examination and guarantees precise positioning and eliminates the risk of retake exposures. OnDemand 3D software and 3D imaging software can be purchased with the OP300 or the customer can utilise their own 3D software, with a large number of companies offering compatibility with Instrumentarium equipment. ■

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Aesthetic marketing

The market for botox and dermal filler treatments continues to boom despite the recession and many dentists have, or are in the process of, adding these treatments to the list of services provided as a good income generator.

How well you market your facial aesthetic business is key to its success and the focus of a new masterclass organised by Inspired Cosmetic Training.

Delegates will hear from key experts from throughout the UK who will provide you with information on how to market facial aesthetics, namely botox and dermal fillers, as well as providing practical advice and lots of tips. Carolyn Fraser, course organiser said: "We felt there was a need for a masterclass like this which would provide the dentist and whole dental team with more in-depth knowledge on marketing and business aspects, and even if you are just thinking about offering these treatments you will still benefit from attending."

Delegates will see the latest treatments being demonstrated and gain advice from the clinical trainers, including Mr Taimur Shoaib, consultant plastic surgeon. Speakers include Julian Popple, marketing manager, QMED, a Galderma company. Julian is a leading figure in the facial aesthetics business with a wealth of experience and knowledge. Julian's talk will focus on understanding the customer, keeping ahead of the competition and top tips for building customer loyalty and getting new patients through the door.

Julian said: "It might be an obvious statement to make, but the key to expanding a company of any size during these difficult financial times is to identify a cohort of customers who will provide the maximum profitability in both the short-term and the long-term. How many of us actually spend time actively researching the market to prioritise potential customers to go after? I suggest very few, so now is the time to find out what your successful competitors are doing."

Simon Bennison, digital marketing manager, Alienation Digital, will also be providing an update on websites, web marketing and how to dominate Google. He will discuss whether your business really needs social media and how to use it to increase customers. ■

ABOUT INSPIRED COSMETIC TRAINING

Based at La Belle Forme Clinic, Glasgow's Inspired Cosmetic Training offers combined botox and dermal filler training courses throughout the year at foundation, int/advanced level. All courses are delivered by a team of consultant plastic surgeons who will ensure you have the knowledge and are competent to carry out these procedures to a high standard. We also offer refresher courses and a variety of masterclasses.

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There are better ways to deal with practice issues and patient complaints other than the courts or GDC hearings, says Kim Henry

Dentistry and mediation

Dentists have a lot of stress in their lives. If a typical day for you includes one, or several of the following scenarios, then mediation could be the answer for your practice:

Wake up around five. Can't get back to sleep. Thinking about work and problems.

No tunics ironed. Leave house. Partner says it's impossible to iron tunics if there are none in the house.

Arrive at work, no keys. Receptionist/dental nurse is late again.

First patient is early. You realise the lab hasn't sent back the work for the appointment and no one thought to check yesterday.

Later in the day a patient wants to make a major payment by credit card and you discover the machine hasn't been plugged in.

Your partner's grossings have been consistently lower than expected and this is posing a problem for practice development.

You discover that your highly qualified nurse has been offered another position and you desperately want her to stay.

About to leave surgery when that veneers patient from last week wants to talk because the result wasn't as good as she expected.

Late home again and tonight is a parents' night at school. In the dog house before the key even hits the door.

If any of this is familiar then you would probably benefit from some form of mediation to help you in your working life. This could help you deal with practice issues as soon as they arise and, by having a strategy and written procedure in place, it will enable patients to raise their concerns directly with you. Indeed mediation can help in any relationship where the parties want that relationship to continue, whether in working life or not.

What is mediation?

Mediation is a form of Alternative Dispute Resolution (ADR). This simply means settling issues of conflict without normal recourse to a court of law, or an appropriate tribunal. Mediation is the most flexible of these ADR techniques. It demonstrates the following particular advantages:

- It is entirely confidential between the parties.
- It can be carried out very quickly before matters escalate and the problem starts affecting the business.
- It involves less expense, as only the qualified mediator requires a fee.
- Parties agree an independent mediator who has knowledge of their business sector to help settle the dispute.
- The mediation is undertaken voluntarily, which makes it a positive choice for both parties from the outset.
- Parties choose where they want to mediate and how formal they want it to be.
- Any agreement concluded may be recorded in writing, which generally represents a variation in any contract the parties may have.
- Parties can return to the same mediator for a follow through session if some issues persist.

"If any of this is familiar then you would probably benefit from some form of mediation to help you in your working life"

How does mediation sit with the normal court process?

If at the end of the process either party wants to pursue the normal court route this is perfectly acceptable, as the mediation is regarded as without prejudice. Judges will often enquire in a case if mediation has been attempted, such is the pressure on court time and the publicly funded legal aid budget. Recourse to court represents the difference with the more formal arbitration where the decision of the arbiter is final.

Dentistry and mediation

Dental practice offers many situations where mediation could be used to help with issues in the practice. Firstly, it can be highly effective in dealing with staffing matters. Recourse to mediation can be written into the staff grievance procedure, and it is of benefit where there may be issues to address from both sides of the working relationship.

It can also be effective in dealing with underlying conflict between partners. This could be in relation to fee sharing and workload, issues over the direction of the practice or even issues concerning the handling of patient complaints involving clinical care.

However, professionals agree that

Continued »

Continued »

patient satisfaction is where mediation could be most effective as part of an overall practice approach to risk management, customer care and marketing strategy.

It is appreciated that while medical negligence cases can result in the pay out of large sums of money, the same is not the case in dentistry. Payments in successful cases simply do not reach the same levels. Yet, patients do get extremely upset when they feel they have been let down by a professional they trusted. Also, solicitors and expert witnesses will charge the same hourly rate regardless. It makes economic sense to look for a suitable alternative.

It would be highly sensible to include, as part of any treatment plan, a clause to say how matters are to be handled if the patient is dissatisfied. The letter which a patient signs agreeing the treatment and payment etc is a standard contract, and it is common now to have clauses in contracts to deal with such matters. Mediation could be agreed, or even arbitration, which would afford the dentist some peace of mind that in the event of any issues he was going to be given the opportunity to discuss a way to put matters right.

It would also give the patient some degree of confidence too that there was already an established route in place for raising difficult matters. Such innovations also represent clever marketing. In this competitive cosmetic dentistry market, most customers would want to know about the professional qualifications and experience of the dentist but would also want some indication that if treatment did not proceed smoothly, any concerns would be taken seriously and sensitively.

So, it just makes sense to have an avenue out there for resolving conflict with patients which doesn't involve a submission to the GDC coupled with a costly court action that might end up in the newspapers and damage your reputation. These are steps you can take to give yourself more control and your patient more confidence. After all, NHS patients have an established baseline procedure for complaints, so private patients should have at the very least similar provisions.

If dentists fail to embrace these new ideas themselves then it is only a matter of time before insurance companies and representative bodies consider making ADR compulsory because it makes such economic sense. The fact is the use of mediation in dentistry is not new. It is used extensively in the US. Also, a paper was delivered at a BDA conference in London some 10 years ago on this very subject, bringing these ideas onto the dental agenda.

Dentists now face extremely aggressive competition, which many other professionals have faced for some time. Perhaps these new market conditions will act as a catalyst to spark some change in the way dentists deal with conflict.

Mediation just makes sense. ■

ABOUT THE AUTHOR

This article was written by Kim Henry LLB, LLM,Dip LP, NP, Cert Mgt, Ass M Cl Arb. Kim has been a lawyer for almost 20 years. She has lectured, managed and worked in private practice, as well as the public and voluntary sector. She has experience of working with dental practices. She is the founder of Essential Mediation. You can contact her at kimhenry@essentialmediation.com

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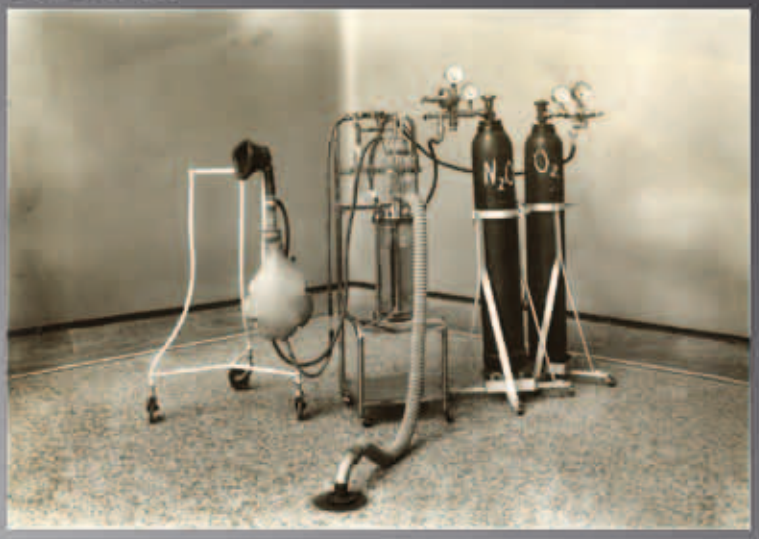

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Pension simplification just got complicated

Although the basic Annual Allowance framework remains in place, there are some important changes to the rules from tax year 2011/12 onwards. Alasdair MacDougall explains...

The Annual Allowance from tax year 2011/12 is £50,000, which initially is a fixed amount that may increase over the longer term.

For members of defined benefit occupational pension schemes, the value of defined benefit increases is calculating using a factor of 16:1 rather than the previous 10:1 basis for testing against the Annual Allowance.

What this means is that if accrued pension is greater than £3,125 for the year, there will be a breach of the Annual Allowance limits of £50,000 that will result in a tax charge at your highest marginal rate.

In-specie contributions

There has been much talk recently concerning in-specie contributions.

As well as making cash contributions, it is possible to transfer property into a Self Invested Personal Pension (SIPP), and, subject to HM Revenue & Customs' rules, receive tax relief on the full capital value.

This sound great in theory; however, there are a number of pitfalls to be aware of. The transfer of any property to a SIPP as a contribution would require each individual to have sufficient annual allowance available to them to make the contribution, which is currently capped at £50,000 for 2011/12.

Pension accrual from membership of the NHS Scheme would count towards this £50,000 limit, with the cash value of the benefit being determined by taking the change in accrued pension benefit over a 12 month period and multiplying by 16.

It may mean that the full value of the practice property could not be transferred into the SIPP in one transaction and may need to be spread over a number of years which would obviously add to the conveyance and other costs.

An alternative course of action could be that the practice sells the property to the SIPP; however, this would require the individuals involved to have pension funds of sufficient size to make the purchase. Once the property has passed from the practice to the SIPP, it is owned by the SIPP.

The rent paid by the practice to the SIPP would be eligible as a business expense for tax purposes. The rent paid forms part of your investment return, meaning that it does not restrict your ability to also make further individual contributions into the scheme.

Using a SIPP to acquire a commercial property can be very advantageous, but it can also be a complex process where a number of issues need to be carefully considered. It is essential that anyone considering such a transaction should take independent financial advice.

Tax relief

The blue parts of the Westminster coalition are making it clear that the 50 per cent income tax rate is a temporary measure, meaning that there is an the opportunity to make personal pension contributions and receive 50 per cent tax relief for earnings in excess of £150,000. In these times of austerity, an investment of 50 pence in the pound must be quite compelling.

Have your cake and eat it

Another issue vexing savers and investors at the moment is what is next for savings rates.

With the average bank account in the UK paying less than 2 per cent net, inflation of more than double this figure guarantees medium-to-long -term capital erosion.

Naturally arising monthly income funds offer both the prospect of medium to long term capital appreciation and high levels of regular income that can be taken on an arising basis, or can be reinvested to improve compound returns.

For example, Invesco Perpetual's Monthly Income Plus Fund has a distribution yield currently of 7.43 per cent. Purchased via an ISA, income distributions are tax-free. ■

"As well as making cash contributions, it is possible to transfer property into a SIPP"

Alasdair MacDougall

All figures and statistics are obtained from Invesco Perpetual.

The purpose of this article is to provide technical and generic guidance, and should not be interpreted as a personal recommendation. The article represents our interpretation of current and proposed legislation as at the date of publication. This may change in the future.

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Alasdair MacDougall is a Senior Financial Services Manager with Martin Aitken Financial Services Ltd and can be contacted on amd@maco.co.uk

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- Setting Standards for Dentistry, Thinking outside the Regulatory Box, *Mr Kevin Lewis, Dental Protection Ltd*
- Alternatives to Litigation, *Professor Sheila McLean, Glasgow (Core CPD)*
- Setting Standards - Necessary but not Sufficient, *Dr Jason Leitch, Scottish Government*
- Achieving Excellence in:
  - Dental Radiography, *Dr Donald Thomson, Dundee (Core CPD)*
  - Managing Medically Compromised Patients, *Dr Michael Escudier, London (Core CPD)*

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See the latest technological innovations

Visit W&H on Stand G07 at BDTA Dental Showcase 2011, NEC Birmingham, 20-22 October 2011, for the latest news and special offers on handpieces, surgical units, piezo scalers, washer disinfector dryers, sterilisers and servicing options.

There will be a number of new models on display, developed as a result of customer feedback. For example, you will be able to see the latest steriliser models, with Premier and Essentials range models to suit your budget and requirements.

As an extra thank you to our customers, we will be making sure that all customers who purchase a W&H product via our stand will receive a memento. Details will be circulated prior to the show, and will also be available on our stand.

In addition, W&H Xtra members will be entitled to some extra special offers on the day. We look forward to seeing you there!

For more information, visit www.wh.com

Plinth Dental's Gnatus deal

Now a full member of the BDTA, with a 20-year track record of serving the medical and healthcare sectors, Suffolk-based Plinth 2000 has established a business area dedicated to the dental equipment market, under the name Plinth Dental.

It has secured an exclusive distribution deal with one of the world's leading dental furniture and equipment manufacturers, Gnatus, to market and supply its dental sets, X-ray equipment and accessories in the UK, Ireland, Belgium and The Netherlands.

For more information on Gnatus chairs and equipment, contact Plinth Dental, Wetheringsett, Stowmarket IP14 5PP, tel 01449 767 887, email sales@plinth2000.com

Stay 'Up To Date' with Oral-B

Oral-B have released the dates for their next 'Up To Date' scientific exchange seminars and are inviting clinical dental professionals to attend a complimentary CPD accredited evening event at one of ten locations: London (3 Nov 2011), Portsmouth (10 Nov 2011), Birmingham (17 Nov 2011), Exeter (24 Nov 2011), Leeds (1 Feb 2012), Cardiff (9 Feb 2012), Bristol (28 Feb 2012), Warrington (12 Mar 2012), Newcastle (19 Mar 2012) and Edinburgh (Herriott Watt University, 26 Apr).

Prof Iain Chapple and Prof Philip Preshaw will be lecturing and the evening will be hosted by Dr Stephen Hancocks. As well as two verifiable hours of CPD every delegate is invited to enjoy a complimentary meal at the beginning of the evening and a free gift which retails at £150.

Spaces are limited so, if you would like to attend, contact Julia Fish on 07585-508550 or e-mail julia@ab-communications.com

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Philips showcases new innovations

BDTA visitors will be able to experience not one, but two new Sonicare products for themselves on the Philips stand (D07/08).

DiamondClean's launch marks a new milestone in the Sonicare range, taking sonic toothbrushing to its most sophisticated and successful level. It has five brushing modes, and this, coupled with a unique new brush head configuration and its core sonic technology, removes up to 100 per cent of plaque from hard to reach places.

Getting patients to floss regularly is challenging, so Sonicare AirFloss' pioneering microburst technology has been designed to increase ease of use while maximising interproximal plaque removal.

Tests show 86 per cent of patients find Sonicare AirFloss easier to use than floss and it removes up to 99 per cent more plaque in between teeth than brushing with a manual toothbrush alone.

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Sirona's latest treatment centre allows the dentist to make his daily practice as efficient and trouble-free as possible.

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For more information, contact Sirona Dental Systems by calling 0845 071 5040 or by emailing info@sironadental.co.uk

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GC UK will launch an exciting new product, FujiTemp LT, at the BDTA show.

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GC's range continues to grow with innovative products; GC will be showing you the benefits of EXA'lence VPES, which solves a number of common problems related to impression taking.

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

Less intense, alcohol-free

Johnson & Johnson has launched a less intense, alcohol-free version of Listerine Mouthwash – Listerine Zero.

The new product is alcohol-free for a less intense taste, but still contains the classic Listerine four essential oils: menthol, thymol, methyl salicylate and eucalyptol.

Listerine Zero kills up to 99 per cent of plaque bacteria in vitro, more than other alcohol-free, daily use mouthwashes.

In consumer tests, over 70 per cent of participants liked the milder taste of Listerine Zero.

For more information or for free samples, please contact Johnson & Johnson on 0800 328 0750.

Johnson & Johnson at Dental Showcase

A warm welcome awaits DCPs and dentists visiting the Johnson & Johnson display stand V13 at the Dental Showcase exhibition at the NEC Birmingham, 20-22 October 2011.

This is a very good opportunity for the whole dental team to learn more about Listerine, the role of mouthwash in oral hygiene and to try the latest addition to the Listerine range, Listerine Total Care Zero, at the rinsing booth on the stand.

This year, for the first time, the Listerine Team will be joined on the stand by our colleagues from ETHICON, a division of Johnson & Johnson Medical Limited, who will showcase their innovative wound closure products, including their unique range of absorbable antibacterial sutures.

For more information, please contact Johnson & Johnson on 0800 328 0750.

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Dürr Dental's reputation for quality is unquestionable, whether it's for imaging products, compressors, suction units or their range of disinfectants used to maintain their equipment.

Premium quality does not, however, need to be premium price. Dürr Dental now sell many of their disinfectants in large 10-litre canisters, making them much more economical than the 2.5-litre standard packs. You can save money on the following products – FD322, FD 333, FD 366, HD 410 and MD520.

Dürr Dental hygiene products are conveniently colour coded to identify each product's application – blue for instruments, green for surfaces, pink for skin and hands, and yellow for special areas, such as suction systems and amalgam separators.

In addition to their efficacy, all of Dürr's hygiene products are designed to be time-saving, practical and above all pleasant and gentle on the user.

For more info, call 01536 526 740.

Look no hands

The Hygowipe paper towel dispenser from Dürr Dental is designed to dispense paper towels without the operator touching the appliance. The Hygowipe Plus model, goes one step further, and gives the choice of dispensing either dry or wet paper towels that have been coated in one of three Dürr Dental disinfectants.

The unit uses an infrared sensor to detect a hand in its range. The length of the paper towel dispensed can be preset to the desired size. Users of the Hygowipe Plus can vary the wetness of the towel and when dispensed the unit intuitively applies the desired amount of disinfectant evenly to the towel, leaving the left and right edges dry so as not to hamper tearing off.

For more information, call 01536 526 740 or e-mail info@duerruk.com

Meta-analysis finds no link between mouthwash and mouth cancer

An independent quantitative meta-analysis of epidemiological studies by the prestigious International Prevention Research Institute (iPRI) has found no statistically significant association between the use of mouthwash containing alcohol and the risk of mouth cancer.

Lead researcher, Professor Peter Boyle, presented the results of the new study at the recent annual meeting of the American Academy of Oral Medicine (AAOM).

The iPRI research team undertook a comprehensive search for published studies which had sufficient information to allow adequate estimation of the relative risk and 95 per cent confidence levels. Eighteen full-text articles matched the study criteria and were included in the meta-analysis.

For more information, please contact Johnson & Johnson on 0800 328 0750.

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Scottish tutors (Aberdeen) Jacqueline Fergus and George Glover both hold a Master of Science in Implant Dentistry and are experienced GIFT regional tutors and mentors running courses from their state of the art facility in Aberdeen.

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World-class London implant presentation

The Art and Science of Implant Therapy, a three-day WS Fusion workshop by world-leading implantologists, Dr Hom-Lay Wang and Dr Marius Steigmann, will take place at the prestigious May Fair Hotel in London from 28 to 30 October 2011.

Sponsored by BioHorizons, which produces unique dental implant products, the presentation will cover predictable aesthetics, bone augmentation, soft tissue grafting and prosthetic modeling around dental implants.

On Friday 28 October, Professor Hom-Lay Wang of the University of Michigan, will discuss bone augmentation and implant surgery. And on Saturday 29 October, Dr Marius Steigmann, from Boston University, discusses soft tissue grafting and prosthetic driven implant therapy.

For more information and to book a place, visit www.biohorizons.com or contact the UK office on 01344 752 560 or infouk@biohorizons.com

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BioHorizons most advanced dental implant

BioHorizons' groundbreaking Laser-Lok 3mm dental implant system is now available to dentists throughout the UK – having been enthusiastically received by doctors in the USA when it was launched in 2010.

The latest Laser-Lok 3mm dental implant incorporates many special features following extensive development by BioHorizons utilising the latest micro-engineering techniques. It is the first 3mm implant with Laser-Lok technology to create a biologic seal and maintain crestal bone on the implant collar and is designed specifically for extremely small spaces in the aesthetic zone. It can be placed easily with 2.0mm and 2.5mm drills and the two-piece design offers restorative flexibility in narrow spaces.

New national sales manager for BioHorizons UK

BioHorizons, whose advanced implant technologies, biologic products and computer-guided surgery software is sold in more than 85 markets worldwide, has appointed Ken O'Brien to work as National Sales Manager from its UK base in Berkshire.

O'Brien, who has extensive experience in the medical devices industry, joins BioHorizons at a time of expansion for the company following the successful development of its Laser-Lok implant technology.

O'Brien says of his new role: "My passion is in consulting and partnering with dental practices to support them in growing, which with the support of BioHorizons products and their training programmes, I can now do more effectively than ever."

Call 01344 752 560, email infouk@biohorizons.com, or visit biohorizons.com

BIOHORIZONS

Dentsply Rewards

Like all businesses, dental practices are currently faced with challenging economic conditions.

DENTSPLY, the leading manufacturer of dental materials and equipment, recognises that being cost conscious need not result in compromises in quality. Practices are now being offered the opportunity to save money and trial new products through the popular rewards website – www.dentsplyrewards.co.uk

For each DENTSPLY product purchased through the rewards website, the practice earns DENTSPLY rewards pounds that can be subsequently redeemed for other DENTSPLY products. Tracey Carter of the Hilltop Dental Spa in Birmingham said: "The system is easy to use and the rewards on offer make the website superior to its competitors, because it allows you to gain rewards pounds to spend on new products in the future."

To register and start benefiting from your rewards today, visit www.dentsplyrewards.co.uk

Cochrane power brush confirmation

With an array of electric toothbrush designs available, dental professionals may find it difficult to determine which options provide the most effective outcomes for their patients.

However, much of the ambiguity was removed following the recent publication of the report from the Cochrane Collaboration which confirmed that: "Power brushes with an oscillating-rotating action reduced plaque and gingivitis more than those with a side-to-side action in the short term."

Cochrane reiterated the conclusions from its earlier review in 2005, stating that: "No other powered designs were as consistently superior to manual brushes."

Philips spotlights two new innovations in Bournemouth

The name Bournemouth could not be more appropriate for a dental meeting, especially one where delegates will have an opportunity to try not one but two new Sonicare products which will see their mouths reborn.

Typically a demanding audience to impress, Philips is encouraging hygienists and therapists to visit the brushing booths on their stand at the BSDHT Conference between 18-19 November 2011. As only by trying the latest innovations for themselves will they be able to appreciate the very real difference AirFloss and DiamondClean could make to their patients' oral health.

As dental hygienist Sally Goss commented: "It could not be simpler to use – anyone can use it, even someone who isn't dexterous and the minute you pick it up and switch it on, you know it means business. My mouth felt really, really clean when I'd used it."

For more information in advance of the BSDHT, please visit www.sonicare.co.uk/dp or call 0800 0567 222.

Pre-sterilisation cleaning in just five minutes?

Alkazyme enzymatic is a combined cleansing and disinfecting agent for the thorough cleaning and pre-disinfection of all reusable, immersible dental instruments prior to autoclaving.

When used in conjunction with a standard ultrasonic cleaner, a five-minute contact time is all that is required in order to render soiled instruments thoroughly clean and bright.

For comprehensive product information, visit www.alkapharm.co.uk To receive a free 100gm pack of Alkazyme, e-mail your practice address with ALKSAM in subject line to: free@alkapharm.co.uk

First support programme for hygiene therapists

In the modern age of greater professionalism and accountability, dental hygienists and therapists are now required to maintain standards and identify their learning and educational needs.

To help them immediately after graduating, Philips is launching the first transitional support programme for newly registered hygiene therapists at a seminar during the BDTA Showcase at the NEC on 20 October 2011.

The aim of the programme is to provide guidance and development in their learning journey.

This innovative pilot programme was launched this summer, based upon the guidelines of the General Dental Council's Standards for Dental Professionals and the preceptorship policies of the Nursing and Midwifery Council and the Health Professional Council.

For more information about the transitional support programme, visit the new dedicated website at www.philips.co.uk/dp

Free Zoom whitening treatments at the BDTA

Philips Discus Dental is running a contest at the BDTA which will award free Zoom teeth whitening treatments to six dental professionals. The Zoom whitening sessions will be performed twice daily at stands D07 & D08 between 20-22 October, where trade show delegates will be invited to witness, 'live and in person', the dramatic whitening results.

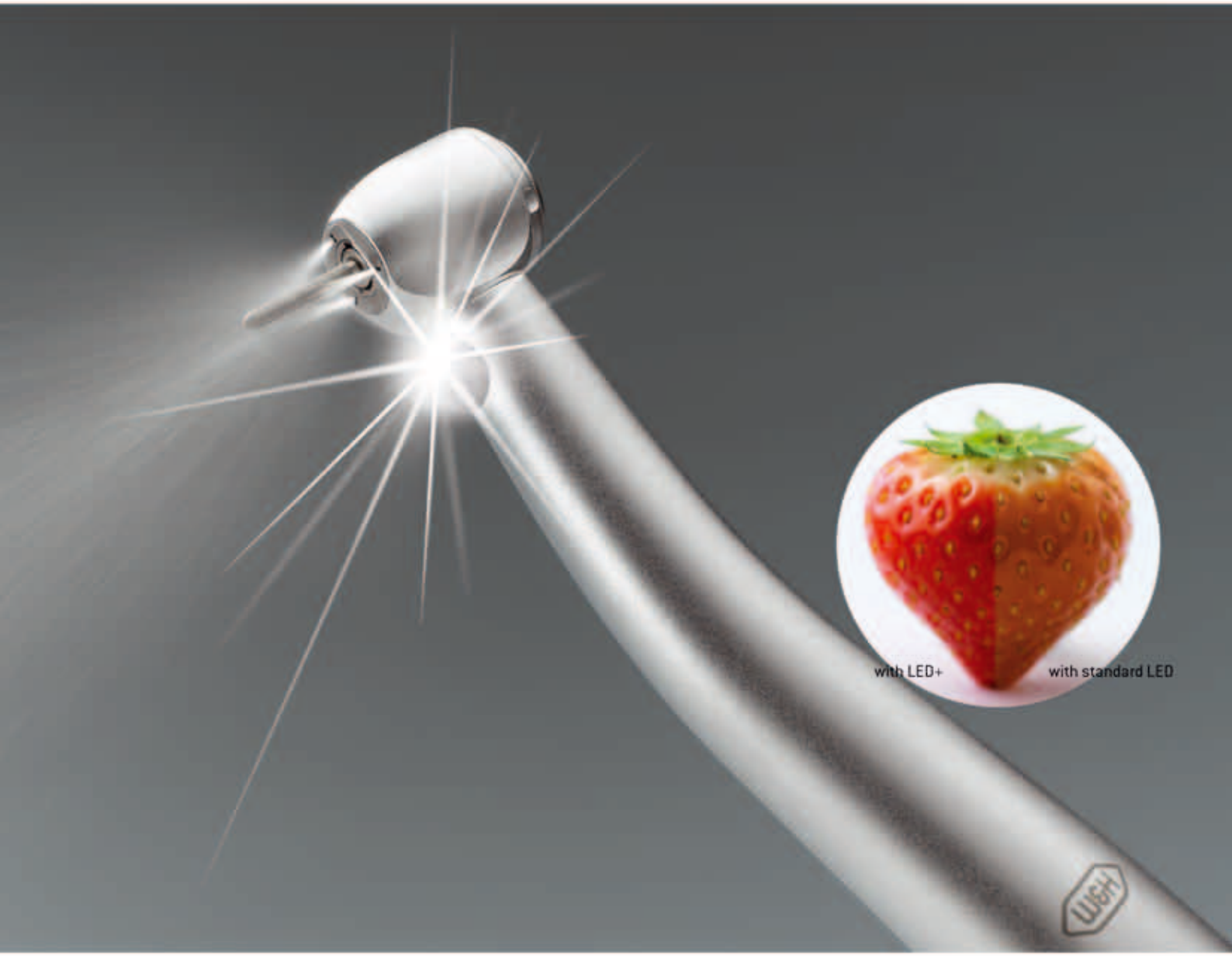
To enter, potential candidates are being asked to upload a copy of their smile and email it to the company.

To enter, simply email a picture showing your smile to catherinedomanski@positivecomm.com and including: your name; practice name, address and phone number; GDC number; day(s) you will be attending BDTA; and your email address.

PEOPLE HAVE PRIORITY

A bright idea!

Especially for non-optic dental units



If you thought you couldn't use optic handpieces just because you don't have optics on your dental unit, think again!

Alegra LED G turbines and contra-angle handpieces from W&H generate their own light - so you can use them on any dental unit, non-optic or optic. You don't even need to be an existing W&H user to benefit from this revolutionary technology, because models are available for all of the major connections. An extremely bright idea!

In addition, Alegra LED G handpieces have the very latest LED+ technology as standard, with the best colour rendering index on the market to ensure that colours in the mouth appear natural, which in turn enhances your working environment.

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alegra

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wh.com

A favourite among surgeons and clinicians

Dr Maria Hardman runs Advanced Dental Training, a state-of-the-art dental teaching centre in the heart of Oxford.

"NobelReplace is my preferred Nobel Biocare implant system." Maria said. "It features 'TiUnite' and 'Groovy' macroscopic grooves which both help osseointegration.

"Users benefit from an easy to follow placement protocol and the restorative aspect is also very straightforward. Given its simplicity, NobelReplace is a particularly good system for those practitioners who are just starting to place dental implants. I would highly recommend them to other clinicians.

"I have also found Nobel Biocare's representatives to be very well trained and supportive.

"The staff have good product knowledge across the whole of the company."

For further advice and technical info, please call 0208 756 3300 or visit www.nobelbiocare.com

Save up to 51 per cent on products with Value+

The Dental Directory has launched its biggest ever, promotional campaign: Value+ which will see prices slashed and savings of up to an astonishing 51 per cent on its competitors' published catalogue prices.

The Dental Directory has teamed up with some of the major branded product manufacturers and up until the end of the year will be offering fantastic savings on a vast range of popular brands

What's more, The Dental Directory price match policy means they will match any nationally advertised price on all like-for-like consumables, sundries and materials products.

For further information, speak to your local business consultant or call FREE on 0800 585 586 or visit www.dental-directory.co.uk

Practitioners' first choice

Aquasil Ultra impression material from DENTSPLY enables dentists to create accurate margins and strong impressions for highly aesthetic, indirect restorations.

It has been developed to provide prolonged flow characteristics during work time, giving you the assurance that the material will maintain a low viscosity without compromising mouth removal time.

Aquasil Ultra has been given a five-star rating by REALITY – a panel of leading independent experts – year after year, and is fast becoming the practitioner's first choice for use with the putty-wash technique.

Because of its short setting time, Aquasil Ultra helps increase

productivity within the dental surgery. It boasts an improved wettability, a 40 per cent higher tear strength than any comparable material on the market, and a lower risk of voids, bubbles, pulls and drags. It is ideal for creating accurate indirect restorations.

To arrange for a free Aquasil Ultra demonstration in your practice, please call 0800 072 3313 or visit www.dentsply.co.uk

40 years of best service and best value

The UK's number one full service dental dealer The Dental Directory is 40. The Dental Directory works as hard today as it did forty years ago, offering UK dentists the best service, best value and best product lines across all areas of dentistry.

The Dental Directory is UK only and has been family owned and managed and over the past 40 years. It has worked hand in hand with its customers providing relevant services resulting in The Dental Directory being the UK's dentist first choice.

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

BSDHT meeting wish list

Philips Discus Dental will be exhibiting at the BSDHT Conference between 18-19 November 2011 in Bournemouth and will be positioned alongside the Sonicare team for the first time at a BSDHT meeting since its acquisition. Their aim at the show is to encourage delegates to try some of their new and their most successful products for themselves, and to do this it has developed a menu of special offers.

Top of the wish list is the Zen Cordless Prophy Polishing System which is being offered to delegates for only £449 and along with their purchase they will be given a free box of Prophy Angles.

Philips Discus Dental is also offering anyone who buys twelve Duo Kits at the BSDHT conference a free Zoom Chairside Whitening Lamp while anyone who buys two or more Kits at the show will benefit from a 20 per cent discount.

There will also be special offers on Relief ACP, Insight and the company's range of curing lights.

For more information about Philips Discus Dental, please visit www.discusdental.com/uk

New thinking on clinical practice and procedures

For today's busy dental healthcare professionals, finding the time to fit in continuing education on top of the demands of practice, patients and family, can be a challenge. However, with major advances in technology, new thinking on clinical practice and procedures, it is essential to keep up to date.

The DENTSPLY Academy is run by experts in dental education, designed for busy professionals who want high quality continuing education.The courses earn verifiable CPD points and will help keep you ahead of the field.

For information, visit www.dentsply.co.uk/Academy.aspx, call 0800 072 3313 or email enquiry.uk@denstply.com

SMART

Control the power

The new, compact 'Cattani Smart' suction system combines unique, multi-level power and automatic speed control with the most effective cyclone amalgam separator available.

Advanced technology and a remote use keypad enable you to instantly control vacuum and airflow levels, at the touch of a button, from almost anywhere in your surgery. Optimising control can halve the machine's power usage, significantly reducing running costs and noise output but, without affecting performance.

Coming pre-wired, pre-programmed and completely assembled, with additional benefits that reduce maintenance time, 'Cattani Smart' is easy to use and extremely reliable. For a smarter suction solution, call now for details of your local stockist.

Designed for single surgery use

Call us: 01527 877997
e: smart@cattaniesam.co.uk
w: www.cattaniesam.co.uk/smart

UnoDent toothbrush

The Dental Directory is pleased to announce another addition to their exclusive UnoDent range, a toothbrush with integrated tongue cleaner!

The Brush (PAU 100) is medium bristled and ergonomically shaped with a rubber insert handle for improved grip.

Our suggested selling price per Brush is £1.25, offering you a healthy resale margin and a toothbrush that competes with supermarket chain own brand equivalents.

To find out more and receive your free sample, call Lynn Stevenson on 01376 391 154, or email Lynn at lstevenson@dental-directory.co.uk

UnioDent is the quality, value-for-money range exclusively available at The Dental Directory. To find out more about the UnoDent range, call 0800 585 586 or visit www.dental-directory.co.uk

ChemFil Rock for strong composite restorations

ChemFil Rock from DENTSPLY is an innovative glass ionomer restorative that offers clinicians a fast, economical alternative to composite restorations.

ChemFil Rock is an ideal choice for compromised situations. The unique zinc reinforced formula provides up to 25 per cent higher strength than other conventional glass ionomer restoratives and demonstrates earlier build up to fracture toughness within the first crucial few hours, giving you

the confidence in the longevity of the restoration and the patient superior wear resistance.

For more information, call 0800 072 3313 or visit www.dentsply.co.uk

Christmas is coming

It's fast approaching that time again, and Kemdent are delighted to announce their popular Christmas Hamper Promotion for 2011.

To qualify for a free Christmas hamper, Kemdent's customers need to spend £240 or more during November; a task which should present few problems given the wide range of offers on surgery products currently available.

Three sizes of Christmas hamper are available, and the more you spend on Kemdent products in November, the larger your hamper will be!

For further information on the Christmas hamper promotion or to place orders, call Helen or Jackie on 01793 770256 or visit our website www.kemdent.co.uk. Follow us on twitter: www.twitter.com/kemdent

Trust The Dental Directory for hygiene

The Dental Directory is the UK's largest dental product supplier stocking more than 26,000 product lines, so it should come as no surprise that we have one of the most comprehensive ranges of general hygiene products available.

All with free next day delivery our general hygiene range consists of everything you need to prevent cross infection and comply with the latest decontamination guidelines.

Trust... The Dental Directory

So, for all your infection prevention and practice hygiene needs, call The Dental Directory on 0800 585 586 or visit www.dental-directory.co.uk

Amazon vouchers

It has now been six months since Oral-B introduced their exciting new Pro-Expert toothpaste to the dental profession. The response has been phenomenal and the feedback extremely positive. As part of the launch practices were sent 150 x 15ml samples to distribute to patients as well as educational leaflets and larger tubes for their own use. Included within this was a pad of 50 Amazon vouchers.

These vouchers allow patients to receive 33 per cent discount for any professional model purchased through Amazon. The professional models differ from the retail ones in that they contain additional replacement heads as well as an educational DVD. The vouchers expire June 2012.

Now, those practices who like to recommend Oral-B power brushes, but do not want to stock them, can recommend in confidence, knowing their patients are purchasing a top model at a great price.

To order more Pro-Expert samples, visit www.oral-b.co.uk/professional or call 0870 242 1850.

The future of sterilisation monitoring

STERIS, a global leader in decontamination and infection control, has recently announced major new investment in its Albert Browne Ltd subsidiary, helping to ensure the future development of this world-class and globally trusted brand of sterilisation monitoring products.

Already at the forefront of sterility assurance with its renowned Bowie Dick tests and TST Control products with the unique Intelligent Ink Technology offerings, this additional funding will allow further expansion of the Albert Browne range in a number of market sectors.

For more information, please visit www.steris.com

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