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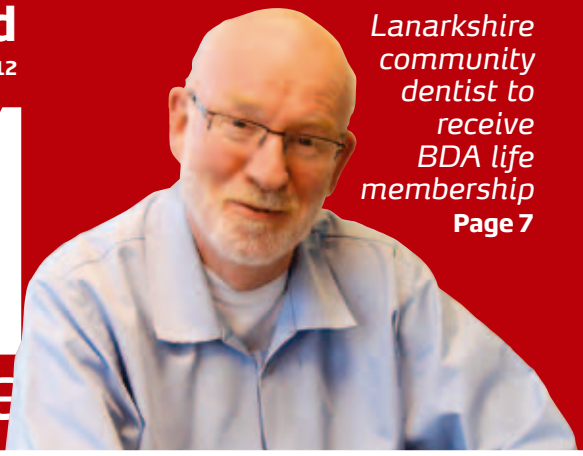
August/September 2012

Scottish Dental magazine



Lanarkshire community dentist to receive BDA life membership
Page 7

Back to basics

Paul Tipton talks about the motivation behind setting up the BARD **page 18**

LIVE CASE STUDY - PART FIVE

The treatment journey continues **Page 44**

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ISSUE 4, VOL.3

Welcome

Editor's desk

with Bruce Oxley

Building trust

A recent survey of 1,000 consumers (page 11) has placed dentists at the top of a customer service league table, ahead of general medical practitioners and waiters, among others.

And, while consumer surveys and straw polls such as this should be taken with a pinch of salt, positive news stories about the profession should be welcomed.

All too often dentistry is portrayed negatively in the mainstream media, as it is so often an easy target for lazy journos...

However, the survey results tie in quite nicely with two other articles in the magazine this month. On page 24 Ashley Latter talks about communication and the importance of listening to what your patients want, and on page 27 Caroline Holland explores the idea of emotional negligence.

Caroline quotes the unfortunate experiences of an American patient who developed lingual nerve damage after a routine visit to her dentist to have two teeth filled.

She was inspired to start up a blog, where she recounted her experiences of chronic pain and relying on medication just to get through the day, not solely because the dentist made a mistake, but because he ignored her complaints and failed to deal with her pleas for help in the weeks that followed.

What's key to this is that she is not so much angry with the accident itself, but with the dentist's lack of concern afterwards. Hugh Harvie and Kevin Lewis of Dental Protection often speak of cases that could easily have led to a court appearance or a letter from the GDC had the dentist reacted differently to a problem sitiuation. But, the fact that the dentist in question admitted he was at fault and was seen by the patient to have gone out of his way to fix the problem, led to a happy patient in the end – poor initial treatment or not.

Everyone makes mistakes, that much is clear, but how you respond to them and how strong your level of trust is with that patient, can make all the difference.

Strong relationships and a level of trust will not just protect you from negligence claims – emotional or clinical – they could also improve your bottom line. Ashley Latter points out that, by simply listening and showing an interest in your patients needs and wants, you could improve your uptake of private treatments.

How many times have you pre-judged or assumed a patient wouldn't want a specific treatment because of their demeanour or how they are dressed?

Go on, be honest... ■

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

Contents

August-September 2012

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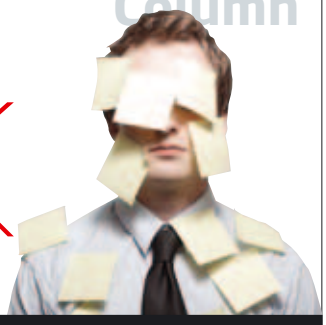
Biting back

with Arthur Dent



What's the score at the BDA?

The British Dental Association (BDA) is the principal representative and negotiating body for dentists in the UK. A majority (around 23,000) of dentists on the GDC register are BDA members, however, the BDA's negotiations with the UK Health Departments and others affect ALL dentists, BDA members or not.

What happens at the BDA affects all of us too, so how many of us are aware of the major changes which have recently taken place in the organisation of the BDA? Sources at the BDA indicate that changes were forced upon the organisation because it had (inadvertently) been operating illegally for many years, in breach of trade union and/or company law.

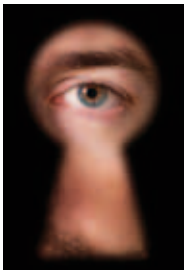
The problems arose from the fact that the BDA is both a trade union and a limited company and so must comply with both sets of legislation. Since 2000, the BDA had been governed by a Representative Body of about 80 people, mostly directly elected by the membership.

This body acted as the Principal Executive Committee (PEC) under trade union legislation and the body then elected an Executive Board of about 18 from among its own number. Exec Board members were registered as the directors of the BDA under company law.

This seemed a convenient and sensible arrangement: the Exec Board met monthly to deal with management matters, while the Rep Body met three times in the year and made strategy and governance decisions.

That was the theory. However, BDA insiders say that in practice, there were frequent tensions between the Exec Board and Rep Body about relative responsibilities and who had the final say in certain matters. This was despite the fact that the board was a sub-set of the body, so many members attended meetings of both committees. Essentially, it was a power struggle between the two groups and they sought legal opinion on which was one was 'top dog'.

The legal advice was that the PEC and the board should not be two separate bodies but had to be one and the same entity and, under trade union law, the PEC must be directly elected by the members. The association went through a period of 'navel-gazing', deciding how it would structure its governance and management in a legal manner. Would it retain the Rep Body as the PEC, but then have about 80 directors? This provided an interim 'fudge' while arrangements were made for the long-term solution, which was to be a directly elected PEC/Board of 15 members.



"Problems arose from the fact that the BDA is both a trade union and a limited company"

Elections have been held and the new PEC took control on 1 July. There are some big names among them: former Exec Board chair Susie Sanderson, former FGDP Dean Russ Ladwa and also Alison Lockyer, who last year resigned as GDC chair.

The new PEC chair is Martin Fallowfield, a private practitioner from Peterborough. Martin has many years' experience on the Exec Board and has led many BDA projects. On the positive side, he wishes to see the BDA becoming more proactive rather than reactive; however, he seems much more interested in viewing the BDA as a company rather than a trade union. Indeed, during the navel-gazing process, he expressed opinions in favour of promoting BDA company activities and sidelining its representative functions.

During the consultation process, the message came loud and clear from the BDA grassroots that members saw its trade union functions as paramount. The PEC must not lose sight of this.

The profession is watching! ■

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Event. Bookings already strong for next year following success of this year's exhibition

Scottish Dental Show heads back to Hampden

Following overwhelmingly positive feedback from the dental profession and the dental trade, the Scottish Dental Show will return on 16 and 17 May 2013.

The two-day event, held at Hampden Park on 24 and 25 May this year, saw more than 1,200 people attend the 40-plus speaker sessions and visit more than 100 exhibition stands.

The 2013 show will be returning to the home of Scottish football and, with more than 60 stands already reserved for the 2013 show, the appetite among the dental trade is clearly there. However, after extensive consultation, the event organiser Connect Publications – publishers of *Scottish Dental* magazine – has decided to make a few changes.

Bruce Oxley, editor of *Scottish Dental*, said: "We've listened to feedback from delegates, exhibitors and speakers and we are sure that next year's event will be better than ever.

"The overwhelming response was that this is a much-needed event and we've been bowled over by some of the praise for the first show. But we know that, while 2012 was a great success, it wasn't perfect and there are a few areas that we can address and change to make sure the experience is as worthwhile and enjoyable for everyone."

Bruce explained that the signage, catering and layout of the two main halls will be overhauled and the speaker programme scaled back.

"While most people were impressed with the comprehensive free speaker programme, many thought that it didn't allow them as much time to enjoy the exhibition as they would have liked," said Bruce.

"The speaker programme will be altered in 2013 to allow for more time in between sessions and fewer overlaps so that delegates can get their verifiable CPD and have enough time to peruse the trade stands at their leisure."

More information on the 2013 Scottish Dental Show will follow in due course. Check the Scottish Dental magazine website www.sdmag.co.uk in the coming weeks and months for details.

We asked, and you replied

FEEDBACK

More than 80 per cent of respondents to the Scottish Dental Show feedback survey rated the event as either good or excellent and nearly 90 per cent said they would probably be returning next year.

In terms of satisfaction with the event, just over 80 per cent said they were satisfied, with 30 per cent of those saying they were extremely satisfied with the inaugural show.

The online survey, which was emailed out to all delegates who registered online at the show website, found that 82 per cent of respondents felt that the selection of companies exhibiting at the show had met their expectations.

Just under 90 per cent of people rated the choice of speakers as either good (44 per cent) or excellent (45 per cent) and the vast majority of respondents (64 per cent) indicated that they preferred the show to stay on a Thursday and Friday as opposed to a Friday and Saturday.

Bruce Oxley, editor of *Scottish Dental* magazine and whose publishers Connect Publications organised the show, said: "I'd like to say a big thank you to everyone who took the time to answer the feedback survey and I promise that we will use this information to make next year's show as relevant and enjoyable as possible for everyone.

"A number of people commented that the registration process, both online and on the day, could have been smoother, so we are taking steps to address this for the 2013 show. Another area of criticism was the catering at the venue, so we are working with Hampden to improve what we can offer delegates on the day."

For updates on the Show, follow us on Twitter @ScottishDental or 'like' us at Facebook.com/ScottishDental

Nurses column p17 | Ashley Latter p24 | Live case study p44 |

Bowing out with honour

Award. Recognition for 25 years of service

Lanarkshire community dentist Jackie Morrison is to be presented with life membership of the British Dental Association at their annual honours and awards ceremony in October.

The former president of the national Community Dental Services (CDS) group of the BDA is retiring at the end of the year and has already started winding down his commitments with the association. For more than 25 years Jackie has been a key player in the Scottish division and the national CDS group, as well as the West of Scotland Branch of the BDA.

He is a former chairman of accredited reps of Scotland, former secretary of the Scottish division of the CDS and he has recently stepped down from the CDS management committee in London.

Jackie, who graduated from Glasgow in 1978 and joined the community dental service in 1990, found out at the and of July that he was to be given the award. He said: "It's a great compliment, a fantastic compliment from the association. I've always done my best to work hard for the association, both the West of Scotland branch and the CDS group."

"I think they are glad to be getting rid of me!"

Jackie Morrison

In typically modest style, Jackie tried to play down the honour. He said: "The award is for mechanical stuff, such as organising meetings and arranging guest speakers, that sort of thing, rather than doing any sort of ground breaking research or things like that. It is simply for work I've done for the association.

"To be honest, I think they are just glad to be getting rid of me, so they are giving me a wee award!"

As for the future, Jackie insists that his six wonderful grandchildren and his beloved allotment will keep him more than busy in the coming years, as well as his involvement in the music and arts scene in his native Lanarkshire.

BADN conference heads for Blackpool

NURSES SUMMIT

The 2012 National Dental Nursing Conference – the last before the end of the five-year CPD cycle for those dental nurses who registered before August 2008 – will be held at the Blackpool Hilton on 24 November 2012.

The new one-day format is being trialled in accordance with dental nurses' responses to the BADN's recent survey. "Holding a one-day conference allows us to keep the cost down," said BADN President Nicola Docherty.

"This year, with generous sponsorship from the BDTA, the conference registration fee is less than £50 for BADN members, and offers 4.5 hours of verifiable CPD.

"Topics include the core subjects of decontamination, medical emergencies and radiography, as well as oral cancer, hypnodontics, communication skills, special care, the end of the CPD cycle and, of course, the keynote address by GDC chair Kevin O'Brien."

The conference registration fee also includes lunch, refreshments and a pre-lunch Zumba session.

Also in accordance with the survey results, there will be no Presidential Dinner this year. Instead, delegates can join Nicola and other BADN Council members at an informal dinner at iconic fish and chips restaurant Harry Ramsdens, just beneath Blackpool Tower the evening before Conference.

"Conference registration is less than £50 for BADN members, and offers 4.5 hours of verifiable CPD"

Nicola Docherty

For more information, visit www.badn.org.uk/conference where there is a link to the on line registration

Dangerous X-ray unit bought by UK dentist

WARNING

The Health Protection Agency (HPA) has issued a warning to dental professionals across the country after it came to light that a UK practitioner had purchased a potentially dangerous hand-held X-ray machine from China.

The HPA's Dental X-ray Protection Service (DXPS) recently obtained an example of the Tianje Dental 'Falcon', which is priced at just £205 on eBay. The unit is not CE marked and the DXPS issued the following statement: "The example tested demonstrates a number of serious deficiencies, the most worrying of which is a lack of sufficient shielding in the X-ray tube which could (under circumstances of high but realistic radiographic workloads) give rise to operator doses in excess of the IRR99 annual dose limits and could even lead to localised deterministic effects."

The statement also said that "the unit did not meet the expected standards of construction and electrical safety" and the HPA recommended that this particular model be prohibited by regulators.

Communication matters

Blog. GDC chairman discusses importance of sharing information

The chairman of the General Dental Council (GDC) has highlighted the importance of good communication in his latest blog entry.

Edinburgh-born professor of orthodontics Kevin O'Brien (pictured) attended the All Party Parliamentary Group on Dentistry's summer reception at the House of Commons recently and communication was at the centre of discussions.

The All Party Group is chaired by dentist Sir Paul Beresford and its remit is to provide members of Parliament with information on important aspects of dentistry.

The recent Office of Fair Trading report was discussed at the reception with Martin Fallowfield, chairman of the British Dental Association's principal executive committee, highlighting the importance of communication and giving the association's view of the report.

Prof O'Brien said: "Our own research with patients has found that, while important in its own right, communication appears to underpin every other issue and concern arising in the discussions and its importance cannot be overemphasised.

"I certainly am aware of this in my clinical role as a dentist and I find that when I am explaining complex care, I need to revisit my advice several times to ensure that my patients understand the care that we are discussing with them.

"We are taking this on board as we revise our core ethical Standards"

"The use of information leaflets following a consultation does make a difference. Nevertheless, many of our patients are still not 100 per cent clear on what they have been told. We consider that communication is very important and not only is it one of our standards, it is embedded in our new curricula for all members of the dental team.

"Communication is a core component of pre-registration training as set out in Preparing for practice – dental team learning outcomes. We are also taking this on board as we revise our core ethical Standards for Dental Professionals, which set out the behaviour and expectations we have of our registrants."

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Olympic spirit at Aberdeen practice

In true Olympic spirit, 12 intrepid runners from various nations took part in a charity fun run in aid of a North African children's charity on the eve of the London games.

Organised by the team at Oldmachar Dental Care in Aberdeen, the runners, from Poland, Germany, Turkey and Scotland, undertook a 5k run along Balmedie Beach.

The runners – who included the practice mascot Dr Croc – were raising money for Dental Mavericks, a charity dedicated to improving the oral health of children in Morocco. The winning time was 20.06 minutes by a colleague and friend of the practice, Tomasz Waszkiewicz, with practice principal Verena Tunn-Salihoglu's dad Dr Ulf Tunn finishing second in 28.30 mins.

Verena said: "We raised nearly £300 thanks to generous sponsorship. It was an unforgettable event which definitely will be repeated!"

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Interview p18 | Emotional negligence p27 | CPD article p35 |

Report. CHRE acknowledges progress made but highlights areas to be addressed regarding fitness to practise

GDC progress noted by regulator

The Council for Healthcare Regulatory Excellence (CHRE) has given qualified praise to the changes made by the General Dental Council in light of last year's damning report.

The publication, issued at the beginning of July, notes the GDC's "changes to its established processes, as well as its new processes, policies and systems to enable [the GDC] to become a more effective regulator".

The CHRE acknowledged that improvements have been made, especially in the Fitness to Practise (FtP) procedures, but it noted there has been little evidence of improved outcomes. The report notes that during 2011/12, progress has been made and evidence of improvements will be looked for in the next audit, which will cover the initial stages of the FtP process.

However, despite the encouraging progress, there are still two areas of the Standards of Good Regulation that have not been met by the GDC. These are the timeliness of FtP case progression and the quality of FtP decisions. The CHRE noted that the timeliness of case progression is improving, but it does not yet meet the standard it expects.

GDC chief executive Evlynne Gilvarry, left, said: "We welcome this report and the acknowledgement of the progress we have made over the past year. We agree with the CHRE on the further measures necessary to increase the rate of progression of fitness to practise cases and to bring about further necessary improvements in the handling of cases."

Chair of the GDC, Kevin O'Brien, added: "I'm very pleased that the CHRE has recognised the improvements made. This is down to the hard work of the executive management team, all the staff and the council. We are aware of what remains to be achieved and we have a single focus on that this year."

The CHRE also reported that it will shortly publish its advice to the Secretary of State for Health into the allegations made by Alison Lockyer following her resignation last year.

Sutcliffe retires from Ben Fund post

BENEVOLENT FUND

Retired east of Scotland dentist Professor Philip Sutcliffe has stepped down as vice-chairman of the British Dental Association's Benevolent Fund.

The announcement was made at the fund's Annual General Meeting held at the BDA offices in London and chaired by BDA president and patron of the fund Dr Frank Holloway.

Dr Mavis Phipps was elected as vice-president of the Benevolent Fund, the highest honour the charity can bestow, in recognition of her service over the past 23 years. An engraved gavel was also presented in memory of Ian McIntyre, former chairman of the fund, who died last year. Dr Bill Nichols succeeded Prof Sutcliffe as vice-chairman and Dr Ros Keeton was appointed treasurer.

To find out more about the Fund, contact Sally Atkinson on 020 7486 4994 or email dentisthelp@btconnect.com

Dentists top customer service league table

SURVEY

Dentists provide far better customer service than all the other professions, according to new research published.

The study of more than 1,000 consumers showed that 47 per cent said they thought dentists have a good customer service attitude, compared with just 27 per cent who voted for doctors and 30 per cent for waiters. The study, by Results International, also revealed that people are more than twice as likely to get good customer service from dentists as opposed to bar staff, who were applauded by just one in five consumers (20 per cent).

Second in the list of good customer service providers were hotel receptionists and hairdressers on 39 per cent, followed by supermarket checkout employees, with 31 per cent of people praising their service.

The list of professions with a bad customer service attitude was topped by council workers, with 40 per cent of respondents highlighting their poor attitude. They were followed by post office employees (30 per cent), the police (27 per cent) and supermarket checkout employees (27 per cent).

Paul Stephenson, managing director of Results International, said: "The high-performing professions (dentists, hairdressers, beauty therapists, hotel receptionists and waiters) are performing roles where customer service sits at the heart of the delivery. It's defined in the role and is what the customer is buying."

To download a free copy of Results International's Report – 'Is Your Customer Service World Class?' visit www.resultsinternational.com

Skye's the limit for £1.1 million dental clinic

Investment. New facility welcomed by islanders

The youngest registered patient at Portree Dental Clinic on Skye officially opened the £1.1 million practice recently.

Five-month-old Darren Gillies of Linicro near Portree, unveiled a plaque in the waiting area, with the help of his mother, Moira. She said: "It's fantastic to have a new facility like this close to our home when many people have to drive long distances to visit a dentist. I work in Portree and have another child at school in Portree, so the new clinic is really convenient for us.


The new surgery at Portree

"I was pleased but surprised when Darren was asked to open the new clinic, especially as he didn't have a single tooth when I received the letter! His first tooth is just coming through now. And I'm sure it will be interesting for Darren to be able to say he officially opened the clinic when he's a bit older."

The new clinic has replaced the two-surgery temporary clinic that the salaried team on the island had been using in Bayfield. A part-time dentist has already started, joining the two full-time dentists already at the clinic, and there are plans to recruit another member of the team to fully utilise the three surgeries.

The waiting list for Portree currently stands at 1,140 and NHS Highland will shortly be offering some of these patients access to NHS dental care, starting with those who have waited the longest.

NHS Highland associate medical director Ken Proctor said: "The opening of this new facility enables us to offer access to NHS dental care to the population of north Skye and is a step towards ensuring that better health can be enjoyed by everyone living in this area.

"The local dental team has been patiently waiting for this development for sometime and will now be able to offer first class care from a state-of-the-art facility."

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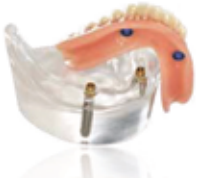
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LDC conference motions and awards

Event. Lifetime achievement award for four dentists

The annual Conference of Scottish Local Dental Committees (LDCs) passed a number of motions at their two-day event held at the Stirling Management Centre.

Among them was a condemnation of the registration of NHS patients by the Salaried Dental Service at recently built dental access centres built by health boards. The motion, proposed by the Fife LDC, stated that the use of public funds to provide a service in direct competition to existing, independently funded NHS practices is unacceptable.

Other motions included: concerns about the overproduction of dental graduates; a demand that all terms of service obligations concerning audit, clinical governance or quality initiatives cease until fully supported; a call for the GDC to be funded by the government as it represents the interests of the public and not the profession; a demand for PSD to provide an appropriate permanent filling option for pregnant women; and a call for all running costs of LDUs to be funded by the Scottish Government.

At the pre-conference dinner, four dentists were presented with Lifetime Achievement Awards. They were: Frank Angell, Greater Glasgow and Clyde LDC; Hew Mathewson CBE, Lothian LDC; David Collington MBE, Lanarkshire LDC, and Ogilvie Nicoll, Fife LDC.

The theme of the conference, which for the first time was offering verifiable CPD, was 'The Way Forward for Dentistry in Scotland' and included GDC chairman Professor Kevin O'Brien and Public Health Minister Michael Matheson MSP.

David Collington receives his award from Laura Milby

Conference Chair Laura Milby said: "This was the minister's first engagement with the profession and although the Scottish Government had allowed us a very short time slot, we seized the opportunity to have the general dental practitioner's voice heard loud and clear. We look forward to further interaction."

Highland dentist elected SDPC chair

APPOINTMENT

Dr Robert Donald has been elected as the new chair of the British Dental Association's (BDA) Scottish Dental Practice Committee (SDPC).

Dr Donald's predecessor, Dr Robert Kinloch, has been elected to the BDA's new Principal Executive Committee (PEC) and, as such, is no longer eligible to serve as SDPC chair.

This will be Dr Donald's second spell in the role, having previously served as SDPC chair between 2003 and 2005.

Dr Donald qualified with honours from Edinburgh in 1983, spending 18 months in a training position at the city's dental hospital before

entering general practice. He was awarded the Diploma in General Dental Practice in 1992.

A long career in dental politics has seen him represent the profession locally and nationally. He is secretary of Highland Local Dental Committee and a member of the BDA's General Dental Practice Committee (GDPC) and its Legislation subcommittee. Outside the BDA, Dr Donald is a non-executive director of the MDDUS.

Dr Donald said: "It is a huge honour to be elected to serve again as chair of the Scottish Dental Practice Committee.

"This is a testing time for dentistry in Scotland, with practices under significant financial and regulatory pressures. Recent years have seen successive Scottish governments' commitment to dentistry result in some real progress."

Dr David McColl, the principal of an NHS practice in Glasgow, has been elected to serve as vice chair of SDPC. He graduated from the University of Glasgow in 1987.

CPD reminder for DCPs

CPD CYCLE

More than 40,000 dental nurses, technicians, hygienists and therapists are now into their final year of their first five-yearly CPD cycle.

The 41,500 registered Dental Care Professionals (DCPs) who were registered on or before 31 July 2008 have until 31 July 2013 to complete 150 hours of CPD, of which 50 hours must be verifiable.

The GDC sent out a letter to 57,000 DCPs registered before 1 August 2011 at the end of June asking for declaration forms detailing the number of hours they have completed.

These were sent to registered addresses, so if you have not received yours, visit www.egdc-uk.org to complete your hours online and to update your registered address.

At the end of a CPD cycle, the GDC may ask for documentary proof of all verifiable CPD completed and a log of general CPD hours. As well as keeping proof of vCPD and written proof of general hours, the council recommends that registrants keep CPD records for five years after a cycle in case of audit.

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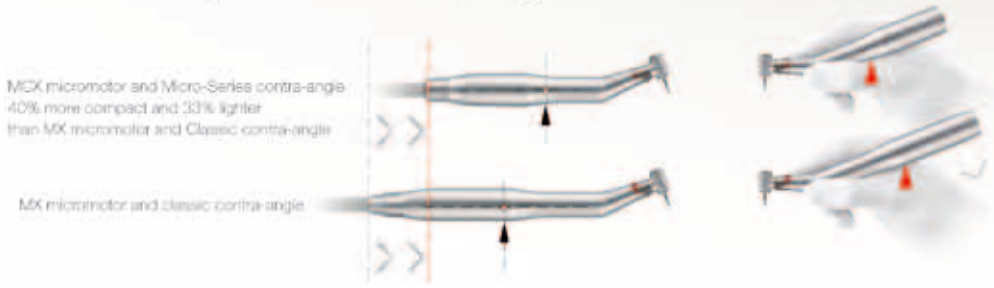

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From the chairside

with Alison McKenzie

Get out the accident book?

A small blend of idiocy combined with a large dose of stupidity was afoot as I set up for a composite filling. As I detached the nozzle from the bottom of the etch dispenser, I accidently pressed the syringe top, resulting in a sudden explosion of the contents, splattering the worktop, sink and floor, everywhere, in fact, but the dappens dish sitting on the worktop.

A small incident perhaps, but what if that particular event had happened when a patient had been sitting in the chair without safety glasses on or someone had been standing beside me? Perhaps I would have been looking at an entirely different scenario. Despite how careful or organised you are, accidents happen and when they do, it is too late to decide whether you are adequately insured. I have always been a member of the British Association of Dental Nurses (BADN), one of the main reasons, apart from the other benefits they offer, is the excellent indemnity insurance that they provide for dental nurses. I know that I have adequate cover against 'Medical Malpractice', 'Legal Defence Costs' and 'Death, Permanent Disability or Permanent Retirement'. I also have extra cover for taking radiographs and working chairside during implantology.

But do dental nurses really need to pay for their own or are they sufficiently covered by their employers? A recent survey revealed that 26 per cent of dental nurses don't have cover and 62 per cent were included in their employers.

Although dental nurses are not required to have their own policy it is their responsibility to check that they have the appropriate cover (some may want it to cover extended duties). The advantage of arranging one's own indemnity insurance is peace of mind that the right cover and support is available in the event of a claim against them. The disadvantage, of course, is the expense, but weigh up the cost of insurance against the possible cost of a compensation claim and this should not be an issue if you wish to take this route.

Dental nurses choosing to rely on their employers are solely responsible for checking that they are adequately covered and should not just assume that this is the case. It is up to the dental nurse to obtain this proof from their employer: all General Dental Council (GDC) registrants are required to provide proof of adequate indemnity cover in the event of a patient making a claim against them, or in the event of a fitness to practise complaint to the GDC. Although this is a cheaper alternative, there are other points to be considered i.e. conflict of interest, employer support or the scenario of a claim being made after change of employment.

If you are unsure of your indemnity insurance requirements, information is available on the GDC website from their liability fact sheet

Whichever scenario you choose, indemnity insurance is your responsibility, so have you arranged your own? Or do you have proof that you are included in your employer's cover? ■

"A recent survey revealed that 26 per cent of nurses don't have cover and 62 per cent were included in their employers"

By Bruce Oxley

Restoring a back-to-basics approach

Paul Tipton, President of the British Academy of Restorative Dentistry, tells *Scottish Dental* how he aims to bring much-needed but neglected techniques back into use

Despite still being in its infancy, the British Academy of Restorative Dentistry (BARD) has already managed to spread its wings across the UK and around the world.

With 11 study clubs already established around the country, including Edinburgh, the academy has also developed four worldwide affiliate branches in Greece, Cyprus, Poland and Sudan.

Inaugural BARD president Paul Tipton explained that the academy came into existence less than two years ago following concerns he and a few colleagues – including Linda Greenwall, Tony Kilcoyne and Adam Toft, among others – had about the quality of restorative teaching at both undergraduate and postgraduate level. He said: "We were despairing at the quality of restorative dentistry teaching that goes on these days in dental hospitals and the quality of the dentists who are qualifying. I think that is both north and south, although I think over a period of time, the teaching up in Scotland may have been better, thanks to the work of people such as Professor Richard Ibbetson in Edinburgh."

Paul explained that they felt there was a real need to get back to basics, with concerns over taking amalgam out of dental schools being a big driver.

Paul Tipton

"Some of the fundamentals of good restorative dentistry, that you can't leave out as a practising dentist, are just not being taught"

Paul Tipton

He said: "That would mean that the graduates won't be using amalgam at all, so they will just be using composite. Posterior composite is probably the most difficult technical skill for a young graduate or an undergraduate to do. So they are going to be asked to do posterior composites everywhere that amalgams are at the moment. The alternative is that they are going to put glasionomer in teeth, so either way the nation's teeth are going to start suffering."

He also added that graduates don't get any occlusal training and are not trained on things such as bridge design. "So, some of the fundamentals of good restorative dentistry, that you can't leave out in practice, are just not being taught," he said. "Everyone is going cosmetic crazy and minimal intervention crazy. Of course, that is fine for a patient who only needs a little bit of work doing, but we all know that there are an awful lot of people who have massive amalgams and already have crown and bridgework, and dentists are just not being trained in how to deal with these people.

"So the aim of the BARD is just to get back to teaching some good-quality restorative dentistry techniques that maybe the dental hospitals and especially the younger graduates just aren't doing at the moment."

Paul is one of the most well-known and respected names in restorative dentistry, not just in the UK, but also internationally. He is a specialist prosthodontist and has established a series of Tipton Training Academies in Manchester, Leeds, London and Dublin.

As a young man, he was a keen cricketer and between 1974 and 1978 he opened the batting for Lancashire County Cricket Club and enjoyed five years as a professional. He explained that his decision to follow a career in dentistry was down to the fact that his ability and ambition didn't quite match up. He said: "I think I came to the realisation that, at best, I would only ever be a county cricketer. I didn't really feel that I had the ability to go on beyond that.

"Also, the life of a county cricketer in those days was pretty mundane. You didn't get paid a lot of money and in the winter time, most of the professionals went on the dole, so it was not really an inspiring career choice. As a kid it seemed a great idea, but as I got into it and I realised that I wasn't going to play for England, I thought I'd better do something else."

Halfway through his spell at the club, Paul enrolled at university in Sheffield to study dentistry and when the term was over, he came back to Lancashire to play the second half of the season. After graduating in 1978, Paul carried on playing on a semi-professional basis with Cheshire until a back operation on his 30th birthday put an end to his paid playing days.

He still turns out for the veterans on a regular basis and he believes there are definite parallels to be drawn from his cricketing career and his dental career. He said: "I think it is all down to hard work, really. As a cricketer, you have to put in the hard work, you are practising all the time – if you don't, you don't get anywhere. And it is the same with dentistry – you have to practise it, work hard at it and go on lots of courses. That's the same as a cricketer having lots of sessions in the nets.

"The great parallel is that I worked really hard to get to the top of cricket by and I probably took that same work ethic into dentistry."

Paul has used this formidable work ethic in order to bring about the establishment of the BARD and he has already spoken at study clubs in Stoke-on-Trent, mid-Cheshire, Liverpool and, most recently, in Edinburgh at the end of May. The chairman of the Edinburgh branch, Midlothian GDP Stuart Campbell, explained that it is Paul's ability to distil complex techniques into easy-to-digest talks and courses that makes him stand out. Stuart said: "He makes the complex simple and he brings things back to first principles so that, while some of his slides and the treatment plans he is carrying out appear to be very complex, he is able to break them down into their component parts.

"A further advantage of his teaching is that he relates the scientific literature to clinical dentistry, which really reinforces evidence-based practice. And he puts just as much effort explaining the simpler techniques as he does the complex ones."

Stuart got to know Paul after attending three of his year-long restorative courses in Manchester over the past few years

Continued »

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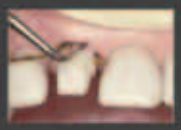


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Dr. Annette O'Donovan, Limerick

"I found Paul to be an excellent lecturer and team motivator. His practical tips are especially useful in everyday practice"
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Continued »

and joined the academy in autumn last year as the chairman of the Edinburgh section. He said: "I think the aim is to widen and deepen knowledge of restorative dentistry among the profession and therefore improve our clinical practice. We would like to encourage like-minded dentists to get together at meetings on a regular basis to discuss and chat about our needs and wants.

"As well as that, we plan on having high-quality speakers, such as Paul and other affiliates of the BARD, come to talk to us. So we aim to get them up to Scotland and learn from them."

Paul explained that, although there is already a British Society for Restorative Dentistry (BSRD) that has been around for more than 40 years, its membership is predominantly hospital dentists and academics.

He said: "We wanted to make this a bit more wet-fingered and practical as opposed to hospital based. We wanted to get away from hospital consultants being there lecturing to GDPs. We wanted wet-fingered dentists themselves to be lecturing to each other and in the organisation of the academy.

"The BSRD has been around for some years, so we are the new kids on the block. We aim to put on proper courses and CPD, do certificates and diplomas eventually as well. We want to give people a pathway that is not via the hospitals or the Royal College of Surgeons, but another pathway where they can get decent accreditation."

And Stuart explained that meeting up with peers and colleagues at events such as study clubs is a vital learning tool. He said: "I think it is important simply because you can learn so much from your fellow practitioners. Most clinicians will have faced similar challenges in general dental practice. The way we manage and deal with them can be helped immensely by chatting with others.

"But we shouldn't lose sight of what the scientific data is telling us and meetings such as these are important in encouraging practitioners to use the dental literature for solutions to clinical questions. Having clinicians like Paul critically reviewing the dental literature is extremely helpful."

One of the main benefits of the Edinburgh study club – if it proves successful – is the fact that Scottish dentists will have access to top-quality courses and qualifications without travelling down south. As Stuart said: "The main aim of the study club is to share knowledge and promote understanding of restorative dentistry. If we can encourage people through the BARD to gain further qualifications, then I think that would be great.

"However, at the moment, that would involve attending courses down south. But, if we do get enough interest, I know Paul would be keen to look into the possibility of doing something in Scotland."

By training dentists in the "science of restorative dentistry and occlusion", Paul explained that the wider BARD 'mission' is to help the nation's teeth. He said: "The nation's teeth are in a shocking mess. We see it day in and day out. Many dentists out there are trying their best, but they don't really have the skillset to know or do what is required. So we are aiming to give dentists some of these abilities using good-quality materials that last.

"Cosmetic dentistry can be fantastic, but there is no way cosmetic dentistry lasts as long as restorative dentistry. Talking to graduates, very few of them have the ability to do three-quarter crowns or gold onlays. These are the sort of restorations that last the longest and it is something of a dying art."

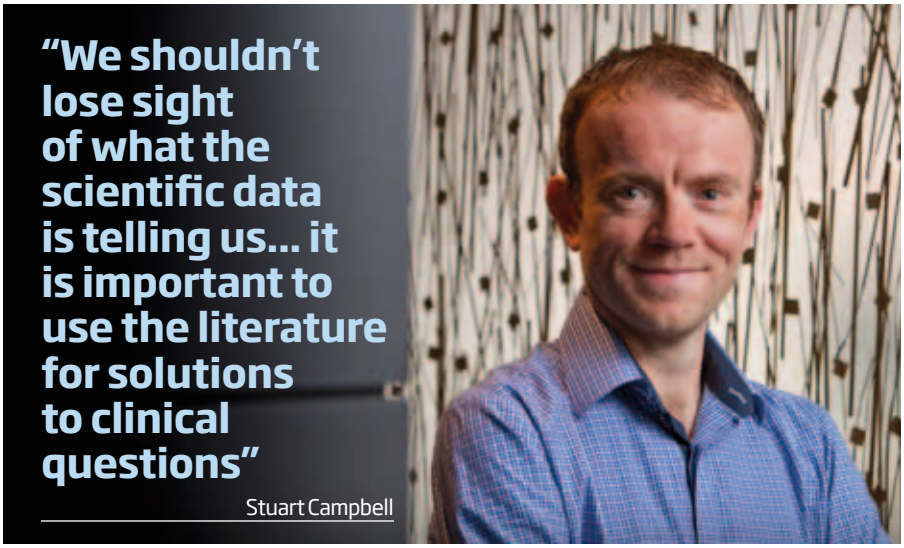
And despite the rise in cosmetic procedures, Paul and his colleagues in the BARD believe that there is a real need for good-quality alternatives. He said: "What we are trying to say is that not everyone in the world wants cosmetic dentistry. There is a certain age group – late 40s into the 50s and 60s – who want something that will last. They want longevity rather than a white filling that will need replacing in seven or eight years. But those people don't really seem to be catered for."

The BARD is open to anyone in the UK who is interested in restorative dentistry and who want to learn more about the discipline. But, as well as UK dentists, BARD has attracted interest from Europe and Africa.

Through his lecturing and teaching overseas, Paul has come into contact with many dentists who wanted to know more about the new academy. So far they have four worldwide affiliates in Greece, Poland, Cyprus and Sudan.

Paul explained: "It came about from me flying off here, there and everywhere and finding out that dentists in other countries have exactly the same problems: their undergraduate curriculum is maybe not as good as it should be, or as good as it was.

"It is just a worldwide movement to try to get quality dentistry done for patients and not necessarily cosmetic dentistry. Cosmetic dentistry is very good in the right situation, but you can't overplay cosmetic dentistry. Sometimes you need to go back to quality long-term materials."



The academy actively espouses a back-to-basics approach, but Paul said the system down in England means that restorative dentistry is becoming increasingly rare.

He said: "With the NHS system of UDAs, there is less and less restorative dentistry being done on the NHS. You get the same UDA for a root filling as you do for taking a tooth out, so you take the tooth out.

"I did crown and bridge work on the NHS and I like to think that, in the nine years I spent in the NHS, I helped many patients using some quality restorative work on the NHS. But nowadays it just doesn't get done." ■

Paul is speaking at the next Edinburgh Study Club in November, details at www.bard.uk.com

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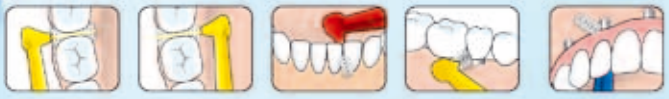

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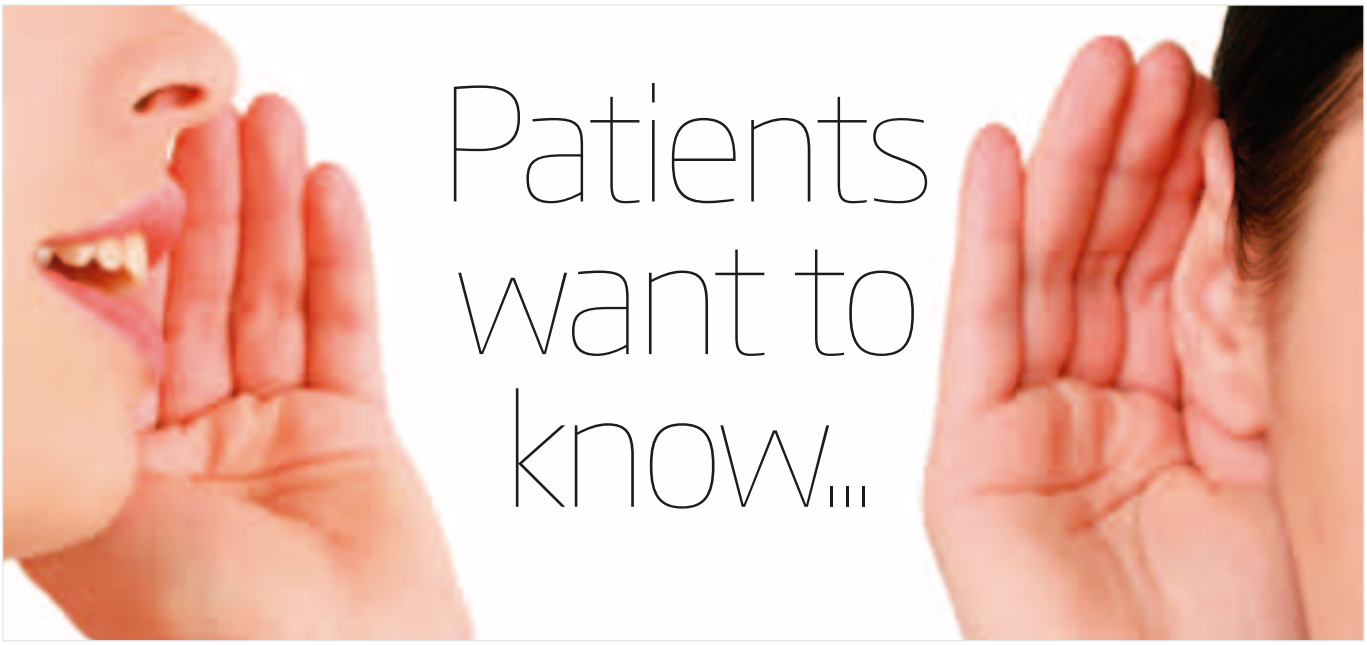
Making assumptions about your patients could result in them missing out on a preferable treatment. Ashley Latter explains why it's best to ensure you outline all the options available



what's in it for me?

Recently I have been coaching many NHS dentists who are looking to improve their sales of private treatment. I believe this is becoming increasingly important as NHS funding is not increasing and, with the ever-increasing costs of running a practice, many dentists are seeking out other forms of income.

I have been thinking of writing an article on this topic for a while now, but today, as I watched the news on TV and listened to the radio about the complaints from patients, supposedly around 500,000 of them, whose major beef is that they feel they have insufficient information from the dentists about their choice of treatment options, regarding their entitlement to receive particular dental treatments on the NHS, it has prompted me to write this article. In this two-part article, I am going to share some simple communication strategies that will help you in this instance. These strategies and tips can also help you when you are explaining all forms of treatment.

As I listened to both sides of the discussions, to me it is all about communication between the patient and the dentist, or possibly the lack of it.

When I am coaching dentists, particular NHS dentists on my two-day Ethical Sales & Communication Programme, they always ask me for help on how to sell private treatment as opposed to the NHS option. So in this article, I am going to share with you some of the tips and strategies to help you when you are presenting one course of treatment as opposed to another. This information can be used in other situations and is not just applicable to NHS dentistry.

The most important thing I want to get across is not to make any assumptions on whether a patient will go for the private option or not. How many times have you prejudged a patient on what you feel they can or cannot afford? Perhaps you look at how they are dressed, their general appearance and consider where they live? I find in every programme that I have delivered in 20 years, this is one of the most common mistakes dentists tell me they make. You see if you prejudge a client then you are literally forcing them down a path, without allowing them to see what other choices they have. My view is that it is not up to the dentist to decide what the patient can or cannot afford – let them decide for themselves. Present both options and allow them to say yes or no to the private one.

"How many times have you prejudged a patient on what you feel they can or cannot afford?"

For the purpose of this article, let's say you have done an exami-

nation and consultation and the patient requires a crown on her front teeth. The first thing you need to do is put yourself in your patients' shoes and see things from their point of view. You need to communicate at their level and also in a language that they understand.

The other thing you need to do when you are presenting both options is not to rubbish the NHS option. If you are still receiving income from the NHS, then it is unethical to do this. It says that you have no belief in the products and services that you provide. So what does a patient want to hear when you are communicating to them? It really is quite simple. They want to know:

1. What are the major differences?
2. What's in it for me? In other words what are the major benefits of having a private crown? People don't mind paying for the private crown; they just want to know what they are getting for their money.

This is where your technical knowledge comes into play. You have to inform the patient of the difference and how they will benefit.

So let's say, for example, the private crown is a porcelain crown. You start off by telling the patient a feature of it. For example, these crowns are made entirely out of porcelain and they can look very natural and are most often used for front teeth.

So far so good. However, patients do not buy features; they are more interested in benefits, so if you don't tell them, they will have to work it out for themselves. Dentists often think that the patient will know what the benefits are. They don't – you have to tell them. So tell them that the major benefit will be that it will match the rest of their teeth. It blends in with the rest of their teeth.

Now you can go one step further, by informing the patient of another benefit which is often known as an advantage or the benefits of the benefit. This is not an easy statement to get across, but in short, it is the patient experiencing the benefit in their real life. For example, you let them know what they can now do that they possibly couldn't before. It is the benefit of the benefit. As I have already said, this is not easy to get across, but if you can, it really is very powerful communication. The main thing is that this part of the communication addresses normally the emotional reasons why patients will buy and this, of course, is the most powerful.

So a quick summary when presenting treatment options to NHS patients:

1. Do not make assumptions – if you do this you are writing off your clients
2. Communicate on the level of your patients, wear their shoes
3. Do not talk too technical – they will not understand
4. Explain the difference using benefits and advantages
5. Be enthusiastic.

If you follow the above protocol, then you should increase your uptake of private treatment and have more people saying yes. ■

ABOUT THE AUTHOR

Ashley Latter specialises in coaching dentists, orthodontists and their teams to develop their ethical sales and communication skills, customer care and developing high-performance teams. He is the author of *Don't Wait for the Tooth Fairy – How to Communicate Effectively & Create the Perfect Patient Journey in your Dental Practice.* To learn more about his programmes and also to sign up for his FREE email newsletter please visit www.ashleylatter.com

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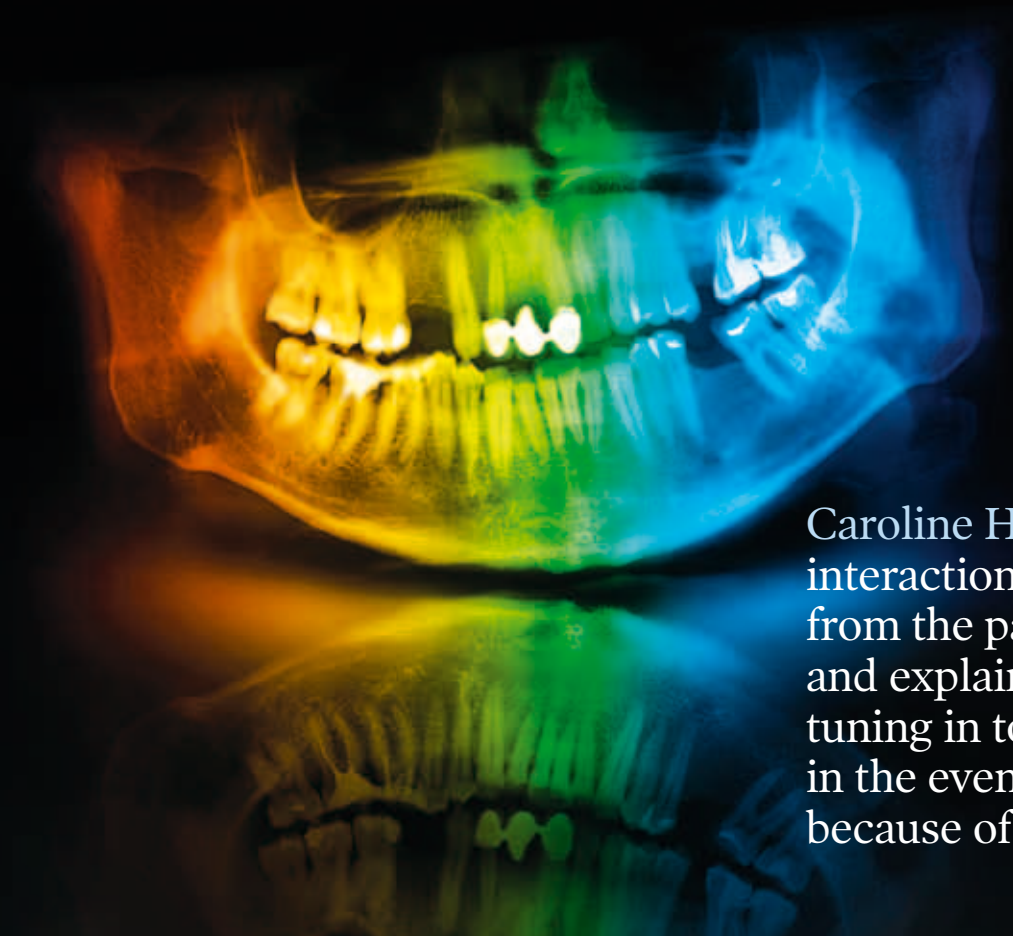
Avoiding emotional negligence



Caroline Holland looks at interactions in the dental setting from the patient's perspective and explains the importance of tuning in to the patient's needs in the event that they are injured because of a clinical mishap

Jane is an American woman in her mid 40s. She started her online blog (bit.ly/K5YX5M) after a dental appointment went horribly wrong and she became a reluctant authority on lingual nerve damage. Here is the resume of her first entry:

'I went for a routine dental visit to have two fillings. I left with a puzzling injury I'd never heard of, which would end up causing me severe pain all over my face, tongue, mouth, and throat, in addition to migraine headaches and earaches, which caused me to lose my job. It completely obliterated my social life and changed an active, happy, healthy single mom into a chronic pain sufferer who needs to be medicated to get through every day.

'(Lingual nerve) injury can happen any time a dentist or oral surgeon doesn't take proper care. Everyone's anatomy is different, so the nerves aren't always in exactly the same place, but dentists know this, and are taught in dental school how to handle this and to react when a patient complains because something may have occurred to injure the nerve.

'However, in my case, my appointment was on the last day of the year, and it was a packed house, with everyone trying to get their dental work done before the new insurance deductible started for 2010. The dentist rushed the procedure and accidentally injured me, but worst of all was that he ignored my complaints afterward and all my pleading for help with the pain for weeks afterward.'

Not alone

Jane's story is not an isolated incident, as you can tell if you read the comments from her online followers and visit the other forums and blogs on the internet. While nerve injury is mercifully still unusual, advanced dental procedures, such as implants, have created an additional risk. At a leading clinic in the UK for patients who have suffered a nerve injury, more than 70 per cent suffer neuropathic pain. Unlike other dental injuries which can usually be rectified through restorative treatment, nerve injury can be a life-long affliction.

It's no surprise that Jane is hurt and angry. What is surprising, however, is that she appears far less upset by the accident itself than by the dentist's lack of concern after the event. She accepts that mistakes can happen.

Continued »

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What she can't accept is that the dentist ignored her complaints.

Support

In line with the growing recognition that people who have suffered an accident or witnessed terrible events may need therapy to recover emotionally, there is now help available in some countries for patients who have suffered dental nerve damage. One psychiatrist, who runs a clinic for dental patients affected by nerve damage, spoke at a Dental Protection event last year. She commented that patients who are supported by their dentist tend to cope better than those who felt abandoned by the clinician responsible for the injury.

What do we learn from this? Firstly, failure by the healthcare provider to empathise amounts to emotional negligence. Secondly, the betrayal of trust which underpins emotional negligence is harder to bear than clinical negligence. We can deal with an aspect of our care going wrong but it's much harder to deal with the clinician who doesn't explain what has gone wrong and fails to express concern and regret.

Trust

Interestingly, surveys have been carried out which show that for the patient, the most important consideration in their choice of dental practice is trust. It's not price, location, cleanliness, or the waiting room decor; it's the fact that they trust the dentist and the clinical team.

I have always felt that the patient-dentist relationship, at its best, is a special one. Why is this? Why should a dentist have a fundamentally different role in the lives of their patients than, say, doctors, podiatrists or opticians?

I have some theories. Firstly, a visit to the dentist always involves an internal examination. This is not necessarily true of an appointment with other healthcare providers. For the examination to proceed, the patient must lie back in the chair and surrender themselves to their dentist. (A dental nurse will be on hand, not just to assist, but to act as a chaperone. This too is peculiar to dentistry.)

"According to the UK Adult Dental Health survey, 12 per cent of people here suffer from extreme dental anxiety"

Caroline Holland

Secondly, it is extremely difficult for the patient to know if their dentist is providing excellent dental care, so they must trust this is the case. A patient's relationship with their dentist is often stronger, more enduring and more rooted in trust than the relationship they have with any other healthcare provider.

Anxiety

Certainly, the absence of trust and a phobic response are closely linked. According to Tim Newton, the only professor of psychology as applied to dentistry, one of the most common concerns among the phobic patients he treats is trust. "Patients need to be able to believe and trust that their dentist will listen to them, respect their requests and give them a degree of control over their dental care. Often a lack of trust has arisen because of a traumatic experience in the dental or medical setting."

Anxiety deters many people from going to the dentist. According to the UK Adult Dental Health survey, 12 per cent of people here suffer from extreme dental anxiety. And only 50 per cent of the population sees a dentist.

Positive feelings

But this article is about those of us who want to have a positive relationship with our healthcare providers. People like me. People like Jane. If her dentist had cared for her, acknowledged the mishap, attempted to put right the problem, referred her for specialist help, it's possible he would still be her dentist.

One theory has been expounded by Eric Weiner in his book: 'The Geography of Bliss.' He argues that the best predictor of happiness is trust. If people trust the people around them, friends, and family, and if they trust their government, then they will score highest on the happiness surveys.

How do we build trust?

According to Professor Newton: "Building trust takes time and communication skills – most importantly listening and respecting the patient's concerns, not belittling them, and planning treatment that respects the patient's wishes. Give patients some sense of control by offering choices, such as what they would like to do first, giving them the suction to hold, a choice of music in the background (or no music), or by teaching them the stop signal."

Given that dental patients are usually open-mouthed and unable to converse, dentists and hygienists are in a position to control communication. While treatment is under way, you can explain what you are doing, what will happen next and what the outcome will be.

Dental professionals who fail to communicate effectively – especially on cost and about choices – are unlikely to have the full confidence of their patients. My own dentist placed a filling at my last appointment without telling me it was an amalgam. I have no objection to amalgam, but I do mind that I was not informed or offered a choice.

There was no adverse outcome from my treatment, but what if there had been? What would my dentist have done then? I would like to think that she would follow the advice of another blogger, a dentist whose online name is The Curious Dentist.

He describes the 'light bulb moment' when he realised that he should not beat himself up when something went wrong, especially if the mishap was out of his control. The turning point for him was a new epithet: "Every mistake is an opportunity for greatness."

His blog continues: "Rather than dreading to look our patients in the eye to deliver an apology, we should face them with confidence. Our confidence stems not just from our knowledge that mistakes and complications are bound to happen, but also from the knowledge that we get to show the patient our character and integrity."

If you can only look into your patients' mouths and not into their eyes, perhaps it is time for some training in communication and leadership? To have the trust of your patients, whatever might occur, is a privilege. You lose it at your peril.

This article originally appeared in Teamwise 13, one of the regular publications available to DPL members alongside their professional indemnity. www.dentalprotection.org

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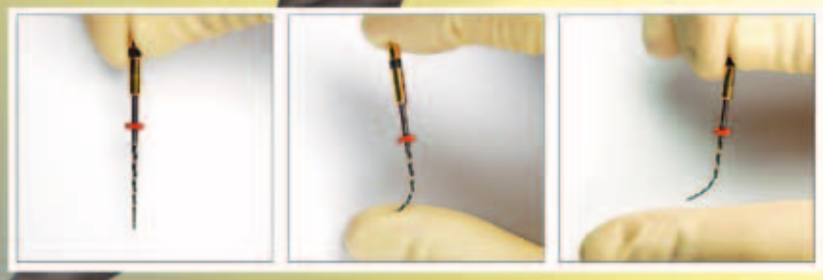

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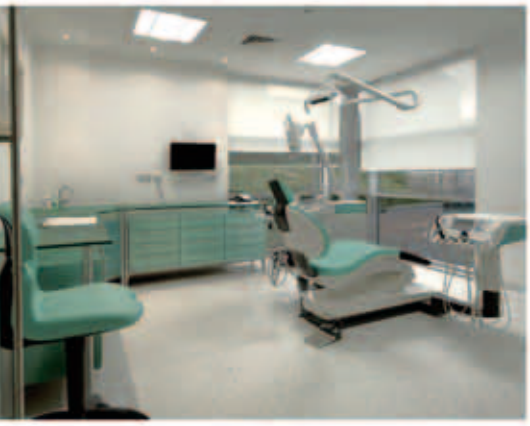




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Creating a friendly practice

Former government scientist Homayoun Halavat-Kar entrusted his old friend Farahbod Nakhaei to design and build his first dental practice in Glasgow, and is delighted with the final result

Having met more than 30 years ago at University, Homayoun Halavat-Kar and Farahbod Nakhaei have joined forces again to create a brand new dental practice in Glasgow's west end.

Homayoun qualified as a bacteriologist from Strathclyde in 1985, the same year Farahbod finished his architecture degree and the two men have stayed in touch ever since. After completing his PhD in Birmingham in 1990, Homayoun carried out a three-year post-doctoral research post with the Ministry of Agriculture, Fisheries and Food.

However, after becoming disillusioned with a role that involved a large element of animal experimentation, Homayoun returned to Glasgow to study dentistry, qualifying in 1998. He completed his VT in Kettering, staying there for eight years as an associate, before moving to a practice in Oundle, Cambridgeshire.

Three years ago, he had a brief spell at a practice in Wishaw with the aim of finding a potential practice to start out on his own. However, the appointment didn't work out and he headed back down south after a few months.

But, despite this setback, the drive to own and run his own practice was strong and he was keen to move back to the Glasgow area. It was a friend who spotted the site of what was to become Anniesland Essential Dental Care and Homayoun quickly contacted his old friend Farahbod, who in the intervening years had set up NV Design and Construction (NVDC), to have a look at the new development.

The building was a new-build flatted development with retail units for let on the ground floor. Farahbod and his team were enlisted to report back on whether it would be suitable for converting into a dental practice. As he was still in full-time practice in England, Homayoun signed the lease sight unseen – with help from his cousin's firm Katani and Co Solicitors – on two neighbouring retail units eight months ago and NVDC were contracted to design and fit out the practice.

"Dr Kar was looking to create a very clean, professional-looking space with an element of colour"

Farahbod Nakhaei

After a stop-start first phase, while change-of-use paperwork and finances were finalised, work began in earnest in February. Farahbod explained that the first challenge was to figure out the most effective way of knocking through the

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two spaces and combining the units. As a result, one side of the divide houses the clinical areas – the three surgeries, the LDU, as well as the disabled toilet. The other side houses reception, waiting room, staff areas and ancillary spaces.

The second challenge was raising the floor of the surgeries to accommodate all the services required to serve a dental chair. As the shop units had a solid concrete floor, there was no way to run suction and drainage from the base of the chair without raising the floor by a few inches.

Once the layout and the main building work was completed, the fit out began and NVDC's flair for design started to come to the fore. As Farahbod explained: "Dr Kar was looking to create a very clean, professional-looking space with an element of colour to reflect his caring personality, as well as a bit of fun. Most of the walls were painted white but we used a nice lime colour to bring an element of freshness and to impact on the space, so it didn't look overly clinical. It created a bit of warmth and the colour acts as a guiding device for the patients."

The 'shop front' of the practice (left) and one of the bright new surgeries (inset)

The lime green colour is featured in the reception desk and then on the wall that leads to the hallway down which the clinical areas are situated, creating a 'visual clue' to how the flow of the practice works.

The surgery that was fitted up against the shop front meant that a solution to protect the privacy of patients while maintaining as much natural light as possible needed to be found. This was done with dense films on the shop front as well as black films along the lower half of the window to incorporate the practice logo.

The practice opened in early April and Homayoun is delighted with the end result. He said: "The final product is fantastic. So many patients have made comments and they speak very highly of the work that has been done.

"It has certainly exceeded my expectations, and I am absolutely delighted." ■

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Challenging complete **denture construction**

If planned and executed carefully, removable prosthodontics can be just as satisfying and predictable as fixed, says Kevin Lochhead

Fabrication of complete dentures is often seen as one of the least favoured aspects of dental practice. But it doesn't have to be.

There is certainly a significant amount of 'art' in the design and construction of dentures as well as the 'science'. Critical to success is not only your knowledge but that of your dental technologist – one of you (preferably both of you) needs to be interested in the art of achieving natural aesthetics.

Our position at Edinburgh Dental Specialists is that the clinician should take the lead in the artistic aspect of the design. Complete dentures are the perfect testing ground for smile design theories and concepts. Unlike placing veneers on teeth, if the patient is unhappy with the end result you can start again without any biological sacrifice and with much less financial loss. An hour or so setting teeth up directly in the patients mouth can teach you a vast amount about dental aesthetics.

Like every aspect of dental care, there are levels of service that you can offer. Four 15-minute appointments may be appropriate in undemanding, straightforward cases but will surely be wasted time for all parties in more complicated examples. The following case history describes the examination and treatment progression for the construction of new complete dentures in a long-term denture wearer. In this example, dental implants are used to aid retention. This, however, should not change the design and fabrication process.

Case history

65-year-old female, edentulous for 40yrs; last set of dentures fabricated two years ago.

Presenting complaint:

- mobile lower denture
- unnatural aesthetics
- chronic ulceration of denture bearing area in the mandible
- chronic headaches and facial pain attributed to trying to "control" lower denture
- feeling of teeth biting "too close together"
- inability to eat effectively and concerns over nutritional deficiency.

Examination

Extra oral:

- class II skeletal relationship
- tenderness of masseter and temporalis muscles
- full range of motion but inability to manipulate to centric relation confidently due to muscle tension
- lip competency with insufficient support to upper lip from upper denture
- high smile line showing unnatural pink acrylic *(Figure 1)*
- reduced occluso-vertical dimension (OVD).

Intra oral

Existing f/f –

- upper stable with good retention
- lower unstable and not fully extended, soft liner evident
- denture bearing area:
- upper mucosa healthy with good height and width anteriorly and posteriorly - no flabby ridge *(Figure 2)*
- lower – thin minimally keratinised mucosa with severe ridge resorbtion and active mentalis *(Figure 3)*
- significant wear of both upper and lower posterior teeth – all cusps flattened.

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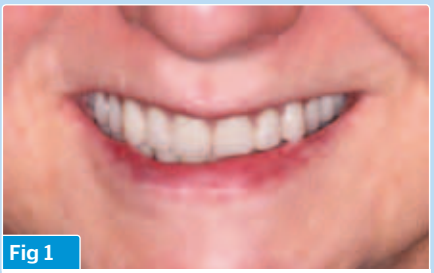

Fig 1
Original smile

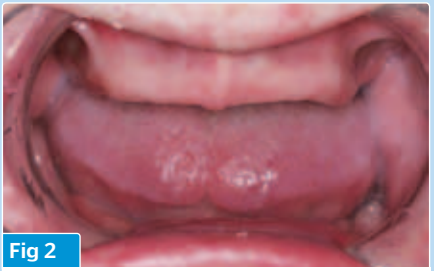

Fig 2
Good width and height to upper ridge

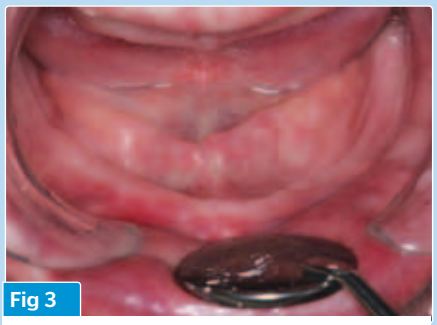

Fig 3
Severely resorbed lower ridge with minimal keratinised tissue

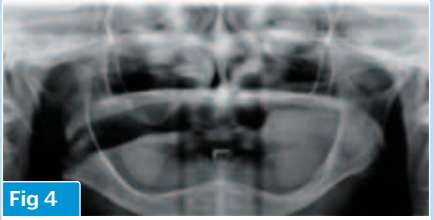

Fig 4
OPG radiograph

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The patient presented in some distress primarily due to her feeling that her problems were insurmountable. She had investigated dental implants previously but, due to the severe ridge resorbtion, was of the opinion that this was not possible. She had had many sets of dentures over the years with each becoming progressively less satisfactory.

In a complete denture case it is essential to try and assess what improvement can be achieved by fabrication of new dentures and whether these improvements will benefit the patient sufficiently to warrant starting the treatment in the first place. The worst case scenario being: fabrication of new prostheses and an unhappy patient, which will have wasted everyone's time and most likely result in a return of fees to the patient. Better not to have started at all.

In this case, the existing upper denture was well retained and the patient informed that, while we would expect to achieve a similar level of retention, improvement could not be guaranteed. The only improvement that could be anticipated in the upper would be aesthetically.

In the lower, the existing restoration had significant limitations being under-extended and aesthetically poor. It was the patient's wish to open her vertical dimension which would increase the height of the lower, potentially destabilising it further. It was necessary therefore to explain that in all reality the only improvement that she could confidently expect to achieve would be that of improved aesthetics. This would need to be the agreed reason for proceeding with new dentures.

No conversation on complete dentures is medicolegally complete without a discussion on the possibility of dental implants. The McGill[1] consensus has stated that the minimum level of care for an edentulous patient should be a complete upper denture and an implant supported lower. This is a radical change from general practice as the understanding is that patients should be guided to an implant overdenture before even experiencing a complete denture. The reasons are sound:

1. significant improvement in masticatory efficiency and, as a result, general health
2. reduction in mouth pain and ulceration
3. improved confidence in social activities – eating, talking, kissing etc.

In this particular case, while there was severe ridge resorbtion, palpation of the anterior mandible suggested about 10mm of ridge height still being present below the thin residual ridge and similar width. This justified an OPG radiograph which confirmed sufficient bone for two implants to support an overdenture. *(Figure 4)*

Full discussion of implant therapy and what to expect ensued. In discussion it was explained to the patient that as well as the aesthetics it would also now be possible to confidently:

1. reduce the chronic ulceration
2. increase the vertical dimension without destabilising the dentures
3. improve masticatory efficiency and ability to eat more appealing foods
4. possible reduction in headaches and facial pain as she would not be fighting to hold the lower denture in place. The effect of the active mentalis muscle would be negated.

These were sufficient benefits for the patient to proceed with a full surgical consultation and treatment plan. The surgeon felt that it may also be possible to place four implants for a full arch fixed bridge but we did not think that this would offer any significant additional benefit to her and she elected to proceed with placement of two implants for an overdenture.

Treatment plan:

1. surgical placement of two dental implants in lower anterior mandible
2. possible immediate loading at the time of surgery
3. after successful integration, fabrication of new F/F at increased OVD.

At the time of surgery, two

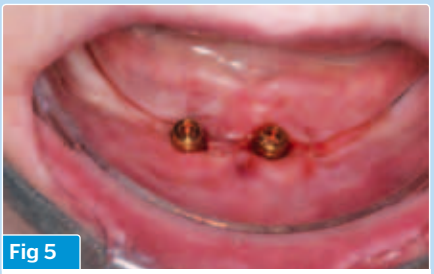

Fig 5
Implants with attachments immediately after placement

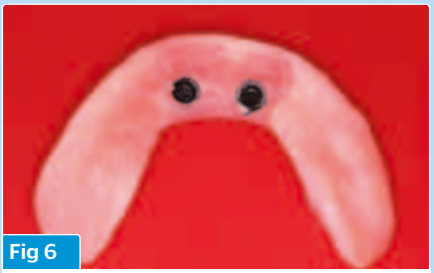

Fig 6
Attachment housings added to original denture

Fig 7
Posterior pivots

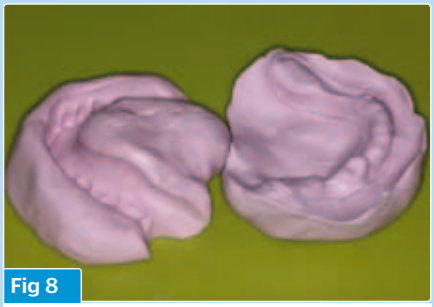

Fig 8
Lab putty to copy dentures in clear acrylic

Fig 9
Bite registration using acrylic copy dentures

13mm implants were placed with bicortical fixation for good primary stability. Nobel Biocare 'Branemark system' parallel walled external hex MkIII implants were used – these are the most scientifically documented implants, with over 40 years of publications on their safety, predictability, clinical success and longevity. It was decided that patient comfort during healing would be much improved if an immediate loading protocol was followed. The patient's denture was adjusted and relined to incorporate the special attachment housings. This process was made considerably easier by the minimal incision for implant placement. *(Figures 5 and 6)*

Immediate loading, while attractive for the patient, needs to be considered carefully, with the relevant literature being reviewed. The obvious main drawback is that, should an implant fail, not only is treatment delayed while another implant integrates, but there are the additional costs of the restorative components which have may have also been used and you may not be able to use again.

In this case, post operatively the patient had no bruising or swelling and immediately felt the benefit of implant retention.

After six weeks for tissue stabilisation, fabrication of the final prostheses were carried out.

Initially it was necessary to establish relaxation of the TMJs for accurate jaw registration and also to establish the correct OVD.

The only occlusal splint that can be used effectively with a denture patient is a pivot appliance. Here, pivots were added posteriorly to the lower denture and progressively adjusted until the desired OVD was achieved (this was established entirely through aesthetics and the patients feedback). *(Figure 7)*

Over 2-3/12 the pivots had the desired effect of relaxing the muscles of mastication sufficiently to establish a reliable CR record.

Despite having the advantage of the implants for retention, there is really no excuse for taking shortcuts or compromising the design and fabrication of the final restorations. Optimum extension should be achieved to aid stability and smile design concepts used to establish the patient's wishes. With complete denture construction, the aesthetic guidelines of Earl Pound[2] are especially useful.

If a patient is a class II skeletal relationship, you will be unlikely to achieve a good aesthetic outcome unless a class II incisal relationship is similarly followed, which is what was done in this case.

Denture fabrication proceeded as follows:

1. both dentures were copied in clear acrylic and extended where necessary with green stick compound. This is an extremely useful method of fabricating custom special trays which can be used to record the OVD at the same time. *(Figure 8)*
2. undercuts were removed and space created for the reline material.
3. the OVD was recorded with a silicone bite registration material *(Figure 9)*
4. reline impressions were taken using a thin wash addition cured silicone *(Figure 10)*
5. the patient met with the technologist and clinician to discuss desired personalised aesthetics
6. try-in of final dentures
7. fit of dentures and chair side addition of special attachment housings.*(Figures 11, 12, 13, 14, 15)*

Material and component considerations

With all acrylic work we use a high impact acrylic which is made by Heraeus (Pala Express). This material is actually a cold cure formulation which also lends itself to processing of acrylic work on implant hybrid bars, much reducing the incidence of fracture.

One of the challenges using a cold cure material is incorporating natural staining to the surface. Heraeus do produce their own stains for the Pala system, these however are 'paint-on' to the final denture, which we find to be less natural than the 'sifting' technique. With the sifting technique, layers of acrylic powders are built up with monomer into

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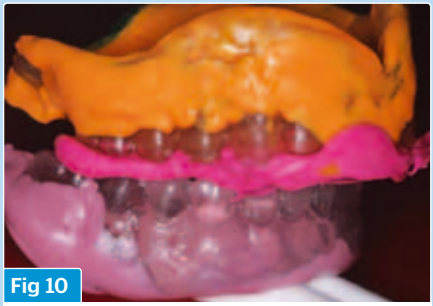

Fig 10 Light and medium body PVS to record denture bearing area in CR

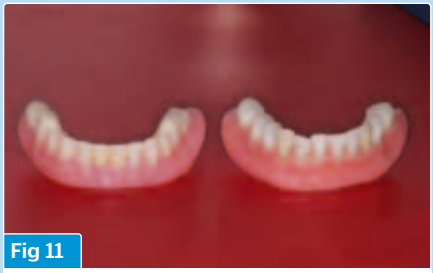

Fig 11 Showing change in height from original denture

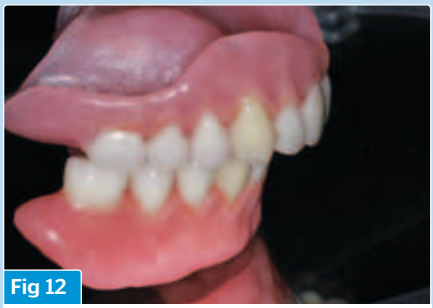

Fig 12 Completed dentures with large OJ

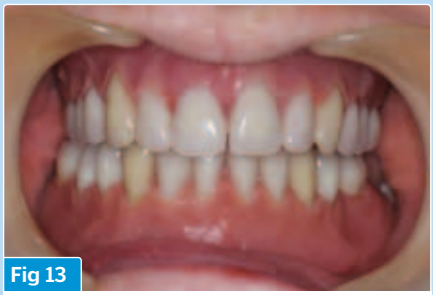

Fig 13 Fitted, stained and contoured dentures

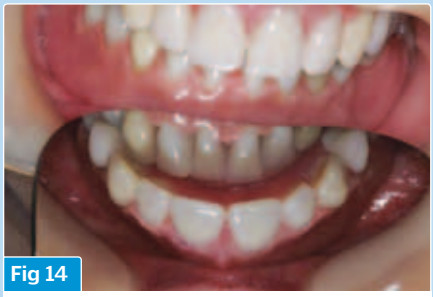

Fig 14 Maintenance of class II OJ

Continued »

the boiled out flask, before the base acrylic is processed.

With the PalaExpress material this can still be done despite the 'staining acrylic' being heat cured. The PalaExpress will still perform if taken to the required temperature to cure the stains. Staining built up in this way is extremely durable.

As the stains are surface based it is essential that the finish surface is not adjusted or overly polished at finishing. This process is aided by the use of 'flexistone', a silicone rubber used to protect the flange of the denture during processing, which results in a clean, porosity-free surface being produced every time.

'Locator' attachments are available for most implant designs. They are our preferred overdenture attachment not only because of the ease with which the attachment caps be changed (and varying degrees of grip achieved) but our experience over the last 15 years shows that the housing in this denture very rarely loosens, which was a regular problem with ball attachment housings (chair and lab processed).

On review, the patient was very pleased with the result achieved, feeling that they had exceeded her expectations and given her more confidence in all areas of life. ■

This article was submitted by Kevin Lochhead of Edinburgh Dental Specialists. Special thanks to Prof Lars Sennerby for his surgical skills and the technologists at Edinburgh Dental Implant & Ceramic Laboratory. Scotland's first synergistic mentoring course for restoring implants begins in September - contact Kevin at kal@edinburghdentist.com

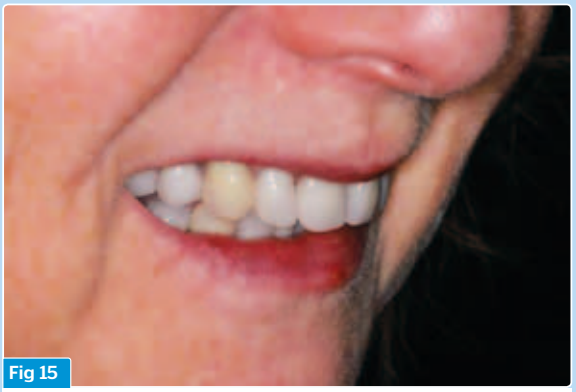

Fig 15
Final result

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Pound E Quintessence International 1976 Nov;7(11):33-8

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2. To show how replacement of dentures should only be undertaken once patient and dentist have agreed on the improvements that can be realistically achieved
3. To be aware of material options and the benefit of implant retention.

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Removable prosthodontics

CPD questions

Q1. If implants are used for retention what shortcuts in denture construction can be expected?

a) Full denture extension is not required
b) Secondary impressions can be avoided
c) The technician can do all the treatment
d) None
e) Adjustments are never necessary.

Q2. What does the McGill consensus recommend as the minimum standard of care for an edentulous patient?

a) Fixed upper and lower implant bridges
b) Lower 2 implant overdenture against a complete upper denture
c) Lower 4 implant fixed bridge against an upper denture
d) Lower complete denture against an upper overdenture
e) Complete upper and lower dentures.

Q3. Increasing the vertical height of a lower complete denture will result in:

a) Increased movement of the upper denture
b) Increased ulceration
c) Fracture of the denture
d) Bad things happening
e) Destabilising of the lower denture.

Q4. Benefits of implant retention of a lower denture include:

a) Increased confidence with social skills, eating, kissing etc
b) Reduced ulceration
c) Ability to increase the OVD without destabilising the denture
d) Improved masticatory efficiency
e) All of the above.

Q5. In a skeletal class II case:

a) An incisal class 1 occlusal relationship should always be achieved
b) Increased overjet is acceptable if it provides the aesthetic improvement required
c) Overbite should always be reduced
d) An edge to edge solution is preferable
e) Incisal relationship is unimportant.

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Quick, easy and **aesthetically superior**

A user report from a practising dentist, Dr Meike Laage, Halstenbek, Germany, on glass fibre reinforced post systems, using DMG's LuxaPost, LuxaBond-Total Etch, Silane and LuxaCore Z-Dual system

After an endodontic treatment, the hard tooth tissue is, in many cases, significantly reduced and weakened after caries removal and the establishment of the access cavity. It is, therefore, often necessary to establish additional retention for the post-endodontic treatment restoration.

An endodontic post for stabilisation and retention should be used if the endodontically treated tooth has a defect on more than two surfaces. Several post systems are available, which are distinguished from each other by their material of construction, form and cross-section.

The newest generation includes glass fibre reinforced composite posts such as the LuxaPost system by DMG, which was evaluated here.

A big advantage of glass fibre reinforced composite posts over other systems is their modulus of flexibility which is similar to that of dentine. Stress generation can therefore be minimised and root fractures, which are a significant risk especially when metallic screw systems are used, can be avoided.

In addition, adhesive bonding of glass fibre reinforced composite posts guarantees a permanent bond that can help stabilize the dentine walls, especially if they are thin. The conical form of the post ensures good fitting accuracy and minimal substance loss, while their transparency supports high value treatments which are aesthetically pleasing.

The LuxaPost system consists of glass fibre reinforced composite posts in three different sizes (1.25 mm, 1.375 mm and 1.5 mm diameter) with drills adapted to these diameters, a depth marker and a measuring board. Colour-coding guarantees the correct assignment of the post and corresponding drill.

The application of Silane ensures a good bond between the post and the luting cement.

The post can be adhesively bonded in the root canal using the LuxaCore Z-Dual luting cement, after the post has been silanized with Silane and the tooth prepared with LuxaBond-Total Etch. The core can then be rebuilt using LuxaCore Z-Dual.

Continued »

Fig 1
The complete DMG system - LuxaCore Dual Z, LuxaBond and LuxaPost

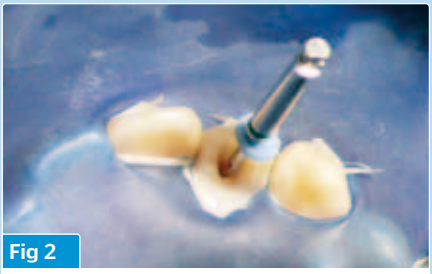

Fig 2
Preparation of the post hole

Fig 3
Testing the fit of the LuxaPost

Yet even closer to nature – LuxaCore Z.

No other core build-up material comes closer to the natural properties of dentine than the new LuxaCore Z-Dual: This premium composite for core build-ups and post cementations cuts like dentine. LuxaCore Z-Dual is the first material of its category that combines true DMG-patented nano technology and zirconium dioxide. With LuxaPost, the new glass fiber reinforced and pre-silanized composite post, DMG offers the perfect partner for LuxaCore Z-Dual.

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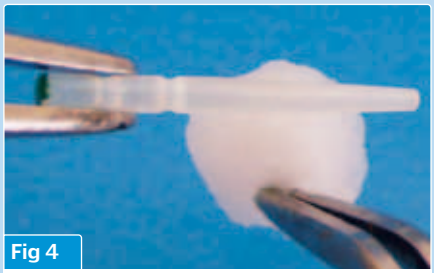
Fig 4
Degreasing the LuxaPost with alcohol


Fig 5
Conditioning the canal and the access cavity

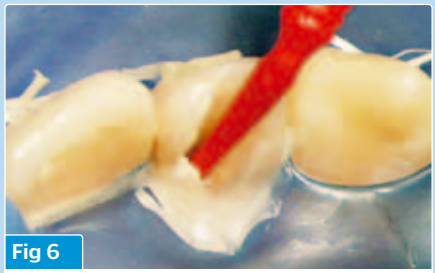
Fig 6
Application of the PreBond

Continued »

Case study

The patient presented with an endodontically-treated tooth 22. The tooth, which was to be restored later with a crown, exhibited a large amount of substance loss due to caries.

Approach

The length of the post was determined with a digital X-ray image, using the measurement function of the software program, and the root canal was subsequently prepared with the appropriate drill at 20,000rpm and water cooling.

Paper points were used to dry the canal. The post was then seated in the canal and correct positioning was checked via another X-ray.

The appropriate post was then used to test whether it made a good contact over the full course of the canal. If desired, the post can be reduced to the desired length using a diamond bur. Following this, the LuxaPost was prepared for adhesive bonding. For this purpose, it was degreased with alcohol and then silanised. I used Silane by DMG, which consists of two components and is mixed in equal quantities immediately before use. After a contact time of one minute, the excess was blown off and the prepared post was put aside ready for use.

This was followed by conditioning the cavity (enamel and dentine) using DMG etching gel, which can be inserted safely down to the bottom of the cavity with a cannula. After 60 seconds' contact time of the phosphoric acid on the enamel or 15 seconds on dentine, this was washed off. I used a water-filled disposable syringe with an obtuse Endo-Luer cannula.

The canal was then dried with the help of paper points before the PreBond, from the dual-hardened LuxaBond-Total Etch system, was worked into the etched tooth surface using an Endobrush for 15 seconds. Any excess material was blown off or removed from the canal lumen using paper points.

A drop of each Bond A and B was then mixed together and worked into the tooth substance using an Endobrush for 20 seconds. Attention must be paid to the fact that the curing time of the luting cement in the root canal can be shortened through contact with the PreBond and that consequently, it may become difficult to insert the post fully or even at all into the canal. Excess material must therefore be blown off coronally and absorbed from the canal using paper points to avoid a large puddle of bonding liquid forming at the bottom of the canal. If desired, the post can also be wetted with the bonding material.

The post was then coated with the luting cement – in this case with dual-curing LuxaCore Z-Dual. The luting cement was also applied to the root canal and the post was then inserted in the canal. If desired, the bonding agent and cement can then be polymerized with the help of a curing light, which is transmitted down the root canal by the translucent LuxaPost. Afterwards, the core was rebuilt with the help of LuxaCore Z-Dual. A control X-ray should be performed in each case.

Summary

The DMG system for post-endodontic treatment is simple to use and produces consistently good results.

The drills are very smooth-running during preparation and remain sharp for all the posts in the kit. The posts themselves are excellent for aesthetic treatments because the shades are not affected by a dark metal core.

The use of dual-curing bonding agents, as well as luting cements, guarantee curing even in deep canals that are difficult to reach with a curing light. The Endobrush is especially user-friendly for the application of the bonding agents in the canal. Its shape enables penetration of the brush head deep into the canal. The dual function of LuxaCore Z-Dual as luting cement and as a core material simplifies handling and shortens the treatment time. The subsequent preparation of the core is simplified and significantly smoother due to its drilling characteristics, which are similar to those of dentine.

Overall, this is an extremely promising, user-friendly concept for post-endodontic treatments. ■

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Fig 7
Applying LuxaBond to the canal and cavity


Fig 8
Insertion of the LuxaPost


Fig 9
Rebuilding the core with LuxaCore Z-Dual


Fig 10
Curing the whole post and core restoration with light

Expect the unexpected

In part five of our look at a live course of implant treatment, Stephen Jacobs describes the second stage surgery as well as an interesting complication...

In the last article, I described the sub-epithelial connective tissue graft that was carried out in order to increase the soft tissue bulk labial to Patient NC's implants. A healing period of several weeks was allowed, which was uneventful, and figure one shows a good increase in volume as compared with the situation prior to the graft, seen in figure two.

Second-stage surgery

Now we are ready to carry out what is known as second-stage surgery, where the implants are uncovered and temporary healing abutments placed. This provides a further opportunity to increase soft tissue bulk, labial to the implants and in the aesthetic zone, my preferred technique is to make a semi-circular incision around the palatal part of the abutment. This allows me to bring some of the palatal tissue across to the buccal.

The cover screws are located and removed, being replaced with the healing abutments. In NC's case, we used a flared 4mm height abutment, which was able to support the soft tissue that was reflected from the palatal side *(Fig 3)*. The provisional bridge was adjusted and re-bonded. I must add that by this stage, the bridge wings were significantly worn, lacking retention and as a result required regular re-bonding. NC and I were now very keen to get to the next stage.

Bearing in mind that we were planning provisional crowns, I did not need to wait for full soft tissue healing, and so planned the impressions for two weeks later and figure four shows the healing abutments at this stage.

Impressions

The healing abutments were removed and revealed an excellent soft tissue collar with a view down into the internal conus of the Astra Tech implants *(Fig 5)*. Pick-up impression copings were attached *(Fig 6)* and a rigid stock tray customised so that the guide pins of the copings were protruding through the holes prepared *(Fig 7)*.


Fig 1

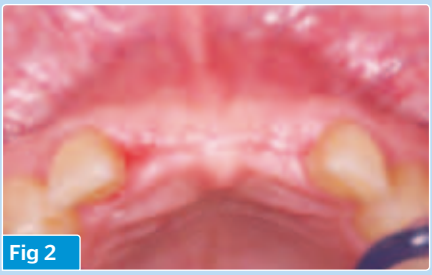
Fig 2

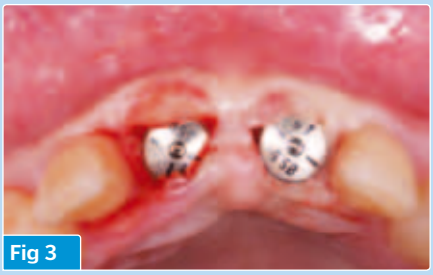
Fig 3

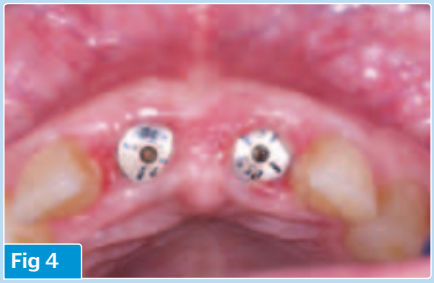
Fig 4

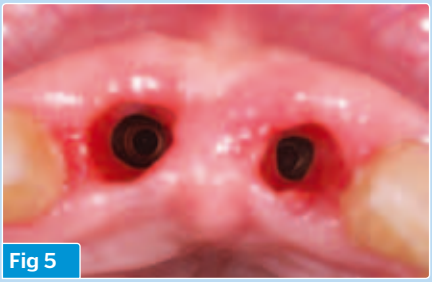
Fig 5

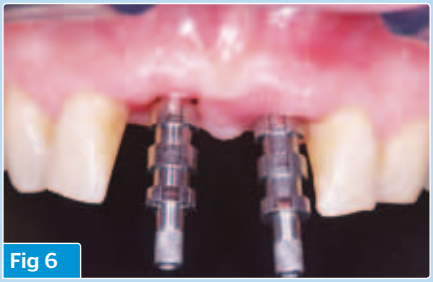
Fig 6


Fig 7


Fig 8

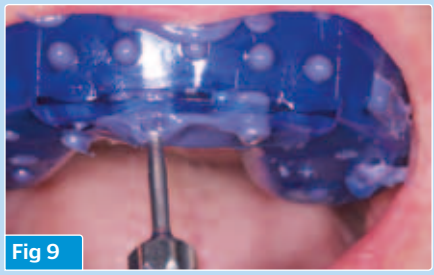
Fig 9

An impression was taken using Impregum (3M ESPE), this material providing the rigidity that is so important for implant work *(Fig 8)*, the guide pins unscrewed *(Fig 9)* and the impression tray removed *(Fig 10)*. The healing abutments were re-attached and the bridge re-bonded.

Provisional crowns

There are many materials, techniques and approaches for provisional restorations on implants, especially bearing in mind the digital and technical revolution that we are witnessing, and on discussion with Sandy Littlejohn (DTS International, Scotland), he suggested a new material that they were using for provisional restorations on teeth, called Telio-Cad, which is an acrylate polymer that uses CAD/CAM milling technology. We discussed this with our patient NC and, in the interests of bringing the reader of this case series the latest in technology, we decided to go with this... a decision that was going to come back to bite us fairly soon.

Knowing that we may be pushing the limits with this new material, the crowns were linked together for added strength, and all looked very nice on the model *(Figs 11-13)*. The provisional bridge and healing abutments were removed for the last time (hopefully), and the linked provisional crowns tried in.

As can be seen, they are screw-retained as opposed to cement-retained. This is very much a hot topic in implant dentistry as screw-retention is becoming more widely recommended, following many years of cemented restorations being the restoration of choice. The reason for this seems to be the increasing desire for predictable retrievability and the prevalence of peri-implantitis which, according to some scientific articles, can be attributed to up to 70 per cent of this disease. I now am placing increasing numbers of screw-retained restorations.

The crowns were tried in and fitted *(Figs 14-17)*, with the screws being torqued to 25Ncm using an electronic torque driver (NSK), and the access holes sealed with PTFE tape and temporary filling material *(Figs 18 and 19)*.

"The appearance of these provisional crowns was excellent and NC was delighted to finally have some fixed teeth"

The appearance of these provisional crowns was excellent and NC was delighted to finally have some fixed teeth. Figures 20, 21 and 22 show the provisional crowns in place and, being linked, the accessibility of an interdental brush was important to establish *(Fig 23)*.

NC was travelling to France the following day for the summer, and

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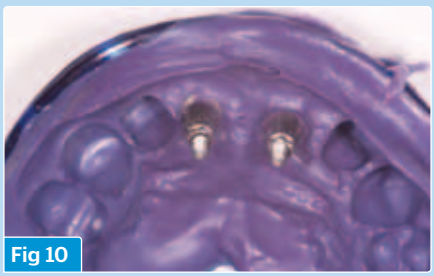
Fig 10

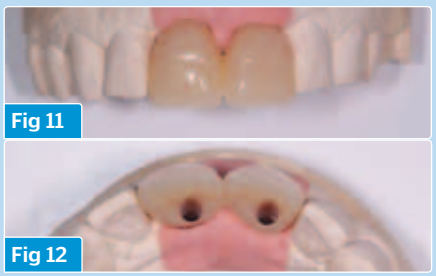
Fig 11

Fig 12

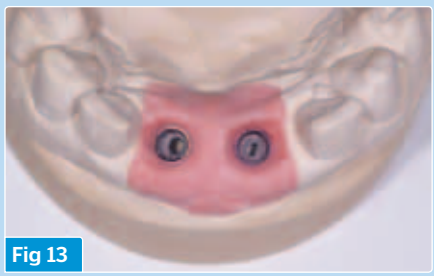
Fig 13


Fig 14


Fig 15


Fig 16

Fig 17

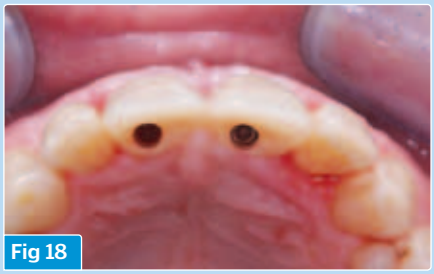
Fig 18

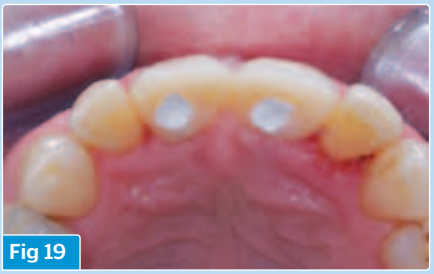
Fig 19

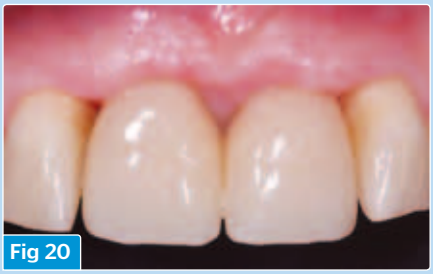
Fig 20

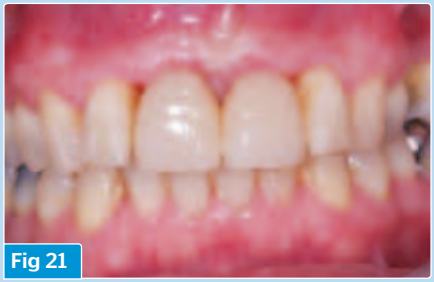
Fig 21

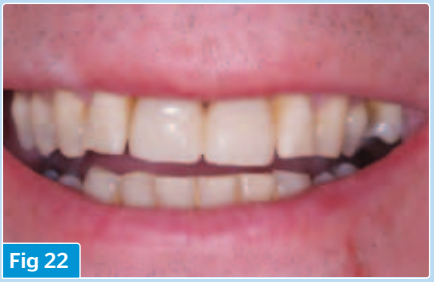
Fig 22


Fig 23

Continued »

everyone, the team at Dental fx, DTS and not to mention our patient, were extremely happy with our work and we all gave ourselves a big pat on the back, not knowing the disaster that was about to strike.

Disaster strikes!

A few weeks passed and I was tidying up some loose ends, finishing off some key treatment plans prior to my annual vacation two days later, when I received a distress call from NC. As you will read in his article, he was sitting on his terrace enjoying the sun, the view, some appellation contrôlée.... and an olive stone. A 'crack' was felt and the provisional crowns had loosened, falling out soon after.

I could not understand what had actually happened and I had to turn detective to establish the cause. It is not unheard of for a screw-retained crown to loosen, but they generally feel loose for some time before actually coming out, but for two linked screw-retained crowns to suddenly fall out, something more serious clearly had happened.

Next on my list of possibilities was a screw fracture, something that I seem to spend more time these days having to deal with. But, for two screws to fracture in a relatively low stress situation? The mystery deepened. Implant fracture was also unlikely with these particular implants.

NC sent a picture of the crowns to me – the advantage of a smartphone!

"I would like the reader to just consider which implants they are using and how easy it would be to source a dental clinician in another part of the world"

I was unable to see any part of the screws inside the crowns in the implant/abutment interface region, there was no sign of them, so screw fracture was ruled out.

I then assumed that the part of the provisional crowns that actually engaged inside the internal conus of the implant had fractured and sheared off, leaving the screws inside the implants, and most importantly intact.

There are many messages and morals to this story, such as using restorative materials that have been tried and tested in these situations and having a spare provisional restoration available, being among them. But just as important was the use of an implant system that is widely used and has long-term documented success rates.

There are so many implant systems out there nowadays, all vying for our business, and while my remit does not allow me to compare or recommend any particular implant, I would like the reader to just consider which implants they are using and how easy it would be to source a dental clinician in another part of the country, or world, who can help one of their patients out, by having the correct equipment, drivers and components. It was only because I was using one of the main implant systems, that I was able to facilitate the management of this emergency.

Because we had used this particular implant, I contacted the company and my colleagues at Astra Tech in the UK, sourced an experienced user of their system near NC at Perpignon, France, who was able to see NC immediately and help us out. He reported that my hunch of the fractured abutment interface was indeed correct. He removed the screws, which had not fractured, and the fragments of Telio-Cad from within the implants, and attached healing abutments.

We had DTS make some new crowns, using acrylic on titanium temporary cylinders and these were sent to France, so that within two days, our 'French dentist in shining armor' was able to fit the new provisonal crowns without NC needing to get on a flight home.

So, in summary, my grateful thanks go to the dentist in France, Astra Tech, DTS and FedEx, not to mention a very understanding patient. It was certainly an interesting lesson to learn.

As I write, all appears well, and in the next article we shall have a look at the new provisionals and move on to the definitive crowns. ■

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The French connection

As he enters the home straight in his journey towards a working pair of front teeth, Patient NC describes a holiday experience to forget...

So, the day has arrived. And what a blessed day it is. I have two perfect, front teeth that look like they belong there and work: they actually work! No more tearing into food with the side of my mouth, no more covering up the smile with a hand to protect the innocent from the crooked gnashers holding on to my gum by the skin of... well, you all know the story.

But the final phase – well almost – has not, you will be surprised to learn, been without incident. Nothing in this story could ever have been straightforward. My fault, not that of the extraordinary people whose combined skill has brought about an amazing result.

What happened this time, I hear you groan? Well... let's start at the beginning. The good Dr Jacobs removes the healing caps – painlessly – and in go the new, if temporary, crowns that have been built by the talented craftsmen at DTS.

As an aside, if you ever want a glimpse of the future, you simply must take a trip to the DTS laboratory in Glasgow's East End – Duke Street, to be precise. The equipment and materials they are using there will blow you away. I kid you not.

However, back to my tale. In go the temporaries and I am thrilled beyond all reason. Because, 1. I can throw away the bridge that is now so used it holds for all of three days before coming apart, 2. I can stop being terrified of it dropping out during meetings, 3. I can now go to France and eat as much crusty baguette as I like with my TWO FRONT TEETH!

Ooh, La, La! Not quite! Now, I've been warned to be careful with the new boys: "Take it easy, don't bite on anything ridiculously hard," I'm told. But non. I have a few too many glasses of plonk and savage an olive I think is hollow. Not good. I feel something go and, to my utter despair, it's the temporary crown. The sheer force of the jaw (I'd no idea it could generate that much pressure) has snapped the teeth at the screw points.

"I feel something go and, to my utter despair, its the temporary crown"

And where am I? La Belle France. What do I not have? Two front teeth, any relationship at all with my darling wife, and finally and most importantly, a dental lab and a dentist. Catastrophe!

Well, not to the boys from DTS or my NBF (new best friend), Stephen Jacobs. A surgeon in Perpignan (a stunning place by the way) is located. An appointment is booked. New teeth are made in 24 HOURS and all the necessary supporting materials shipped out to France for next day delivery.

Now, as everyone knows, the health service in France is manifique. So, within two hours of the teeth arriving at the surgery, I'm in the chair and out in half an hour back out into the sunshine with my face returned to its socialising best. Thrilled? I could have danced naked down the Champs-Élysées. On second thoughts, I'll spare everyone that. But you get the picture.

Today, I sit with my mouth restored. I only now have to get the final crowns set in place after a little colour work has been done.

It has been the most amazing journey. I truly did not expect to reach this point. And it is all down the extraordinary talent of Stephen Jacobs and his team in Bearsden and the support of the amazing people at DTS. Merci boucoup.

Now, where's that crusty baguette? ■

Implant care

Maintaining the implant patient in general dental practice

The scope of this article is to help support general dental practitioners, dental hygienists and therapists who are seeing an increasing number of patients with implant-retained prostheses.

By Marilou Ciantar

Dental implant treatment has become standard clinical practice. The reliability and predictability of osseointegration in conjunction with improved soft tissue surgical procedures has led to an increasing number of patients seeking replacement of missing teeth with implant-retained prostheses.

In the UK, about 150,000 implants are placed each year. This means that all general dental practitioners, as well as dental hygienists and therapists, will inevitably become involved in the maintenance of patients with dental implants.

It is a misconception to think that implant care commences after implant surgery; rather it begins long before.

The cause of tooth loss will vary from patient to patient and is usually due to one or more of the following: caries, failed previous restoration/s or periodontitis. From a periodontal context it is important to state that not all periodontally involved teeth should be extracted and replaced with implant-retained restorations.

While it is sometimes difficult to accurately predict the prognosis of some periodontally 'questionable' teeth, traditional periodontal treatment can be used to treat moderate[1] and even advanced cases of periodontitis[2]. Long-term studies of patients treated for periodontitis and maintained on a strict supportive periodontal care programme have confirmed that such treatment regimes can be very successful[3,4,5,6]. Indeed some studies have monitored and reported on the success of such treatment for as long as 22 years[3].

While the success rates for implants in periodontally susceptible patients are acceptable (up to 90 per cent), the duration of such studies cover a mean follow-up period of 10 to 11 years[7,8,9,10]. The dental implant should not be considered a panacea, especially since recent evidence from the implant literature highlights the increasing problem of peri-implant diseases[9,11] i.e. peri-implant mucositis (defined as inflammation of the peri-implant mucosa) and peri-implantitis (defined as peri-implant mucositis with associated peri-implant bone loss[12,13]).

Thus while implants are a good treatment option to replace missing teeth, they should never be used to 'treat' periodontitis as this frequently leads to one problem (periodontitis) being replaced with another (peri-implantitis). Furthermore, while periodontal treatment can be successful, there is currently no reliable and predictable treatment for peri-implantitis[14,15].

The aim of this article is to provide the general dental practitioner, hygienist and therapist with practical maintenance advice for patients who are about to undergo or who have received implant treatment.

The management of such patients falls into three phases:
a) before implant placement
b) during implant treatment phase
c) after implant restoration.

Fig 1a

Fig 1b

Periodontal pockets could be easily missed if periodontal probing is not performed (a). The importance of BPE cannot be overemphasised (b)

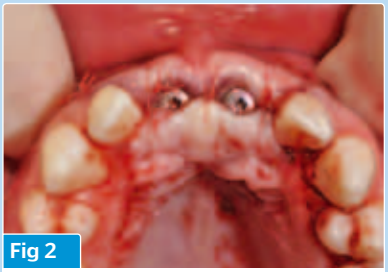

Fig 2

Immediate post-operative period: the patient is given post-operative instructions and reviewed two weeks later

Fig 3

Good periodontal and peri-implant health in a patient where the UL1 was replaced by an implant-retained crown

Patient management prior to implant surgery

A sound and healthy periodontium is an absolute prerequisite prior to implant surgery. An assessment of periodontal health should be performed in all patients. Indeed any routine oral examination performed by a dentist, hygienist or therapist should include a basic periodontal examination (BPE) as part of the soft and hard tissue examination[16,17,18,19]. This method of screening the periodontium will immediately detect underlying periodontal problems *(Figure 1)*.

Periodontal disease must be treated prior to the patient receiving implant treatment. The removal of the dental biofilm forms the cornerstone of non-surgical periodontal therapy[20] and this can be implemented in general dental practice.

A high standard of oral hygiene has to be achieved as poor oral hygiene has been shown to be a common risk factor for periodontitis and peri-implantitis[21]. After an active phase of periodontal treatment, which may also include periodontal surgery, the patient is enrolled on a supportive maintenance therapy (SPT) programme. This is different from the 'routine' scale and polish and should be tailored to the patient's needs. Other risk factors for peri-implantitis include a previous history of periodontitis and smoking, which also need to be addressed during this phase.

Patient management during implant treatment phase

Some patients might attend to see their dentist, hygienist or therapist during this healing phase either for a routine visit or possibly due to symptoms arising from the surgical site.

1. Bruising and swelling: most often patients have some degree of bruising or swelling in the immediate post-operative phase which is to be expected; the extent will vary between patients and between different surgical sites (swelling is usually more pronounced in the maxillary anterior region). Patient reassurance that the symptoms will subside after a few days is all that is needed in most cases. If, however, the clinician is concerned about the risk of infection and possible wound breakdown, antibiotics need to be prescribed and the patient should be asked to see the surgeon who placed the implant.
2. Oral hygiene: patients are usually given verbal and written post-operative instructions *(Figure 2)*. They are asked to refrain from brushing or flossing the surgical site in the immediate post-operative period (for two weeks after the surgery) and given a mouthwash to reduce bacterial load. After this period, oral hygiene is gently reintroduced using a soft toothbrush (for another two week period). Some toothbrush manufacturers have specific brushes intended for use during this phase. After this, the patient should be able to resume regular oral hygiene procedures.
3. Post-operative pain: post-operative analgesics are routinely prescribed for every patient, however at our practice, both surgeons find that patients are usually pleasantly surprised about the lack of pain after having had implant surgery.
4. Implant healing abutment or cap: there should be no attempt at removing or "testing" either the implant or healing components during this healing phase as the bone attachment to the implant surface is very immature and easily disrupted.
5. Suture removal: The patient is usually seen by the surgeon for a post-operative review and suture removal 10-14 days after the surgery. For those patients who are referred to another practice and who live a considerable distance from the latter, it might be more convenient for them to see their dentist for this first post-operative review appointment. The sutures used are resorbable or semi-resorbable and these will resorb in about 10-14 days. However, practical experience dictates that this varies between patients. If the sutures linger, the patient can start to find this irritating; provided the surgical site has healed well, the sutures can be removed by the dentist.
6. Temporary restoration during healing period: in the case of missing teeth in the aesthetic zone, most patients will have either a partial denture or bridge to temporarily restore the space during the healing period. These should not exert any pressure either on the implant or bone grafted area.
7. Sinus grafts: patients might experience a slight nose bleed on the day of surgery especially when bending forward; this is of no consequence. Patients are usually advised to sleep propped up with a couple of extra pillows on the day of the surgery and to avoid any increase in intra-nasal pressure e.g. nose blowing.

If there is any concern during this healing phase, the dentist is best advised to contact the surgeon who placed the implant.

Patient management following implant restoration

The high standard of plaque control achieved prior to implant surgery has to be revised and maintained post-surgery and applied to teeth and implants. The importance of this cannot be overemphasised if periodontal and peri-implant diseases are to be avoided. If the patient were enrolled on a SPT programme prior to implant surgery, this will be standard practice *(Figure 3)*.

The formation of dental biofilms on teeth or implants is very similar in their respective microbial compositions[22]. A pattern of disease similar in its initiation and progression to gingivitis and periodontitis has been observed in the case of peri-implant mucositis

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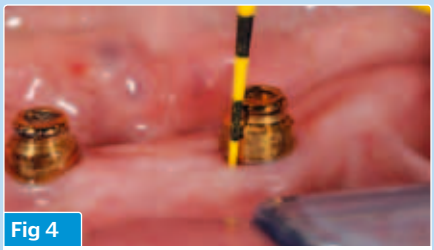

Fig 4
Peri-implant probing should be performed at every routine visit

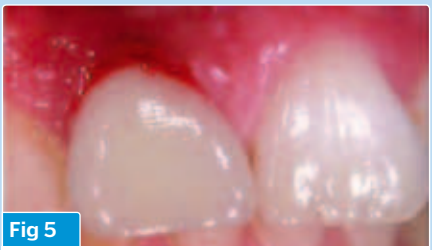

Fig 5
Peri-implant mucositis around the UR1 implant crown

Fig 6
Radiograph showing extensive bone loss (peri-implantitis) around the LR6 implant

Continued »

and peri-implantitis[23,24]. Clinical studies in animals have shown that during the same experimental time frame, the apical extensions of inflammatory connective tissue in peri-implant mucositis and peri-implantitis seem to be larger (i.e. extend more apically) compared with gingivitis and periodontitis respectively[25,26]. This is possibly because the connective tissue capsule, guarding the inflammatory zone and characteristically seen in gingivitis and periodontitis, is lacking in the tissues around implants.

Furthermore, in the case of implants, the inflammatory lesion was seen to extend into alveolar bone implying a greater extension compared to the periodontitis lesion[26].

The clinical implications of these findings signify that maintenance of peri-implant health is paramount and that early diagnosis of peri-implant disease is imperative; in the latter case treatment should be commenced without delay.

An assessment of the peri-implant tissues should be performed shortly after the implant is restored (baseline) and at every recall visit *(Figure 4)*. Following a visual inspection of the soft tissues around the implant, the same diagnostic parameters used in periodontal reassessment are recorded namely:

a) peri-implant plaque
b) peri-implant probing depth
c) peri-implant bleeding on probing (BOP)
d) peri-implant suppuration
e) mobility of the implant
f) bone loss around the implant.

Probing around the implant using a metal or plastic probe should be performed using a light probing force (0.2–0.3N); this will not damage the junctional epithelium around the implant. A peri-implant probing depth up to 3mm and which does not bleed on probing signifies peri-implant health.

The only exception to this is a probing depth of up to 5mm interdentally in the aesthetic zone (interdental papilla). Provided there is no BOP and no increase in peri-implant probing depth compared with the baseline, then this is accepted as being healthy. As is the case in periodontal reassessment, the absence of BOP is an indicator of stable peri-implant conditions[27].

If peri-implant health is present, then no further treatment is required. The patient should be informed of the clinical findings and advised to continue with plaque control measures; prophylaxis of the implant (using a polishing cup and a non-abrasive paste), completes the peri-implant and periodontal reassessment.

If BOP is detected around the implant with probing depths of 3mm, this signifies the presence of peri-implant mucositis i.e. a reversible inflammatory reaction in the soft tissue surrounding a functioning implant[12] *(Figure 5)*. Immediate action needs to be taken to prevent this progressing to peri-implantitis. Upgraded oral hygiene measures need to be demonstrated to, and implemented by, the patient; this includes flossing and brushing subgingivally around the implant. Any calcified deposits should be removed with non-metal instrument tips. If, in addition to BOP, peri-implant probing depths are in the range of 4-5mm, the additional use of chlorhexidine gel applied subgingivally twice a day for three to four weeks is advised after which the peri-implant tissues are reassessed. If health of the peri-implant tissues has been restored, then prophylaxis will suffice.

If BOP is accompanied with an increased peri-implant probing depth (>5mm) a radiograph needs to be taken; suppuration may or may not be present. Radiographic evidence of bone loss confirms the diagnosis of peri-implantitis[12] *(Figure 6)*. Treatment consists of improved oral hygiene techniques and use of chlorhexidine gel as outlined above and, in addition, antibiotics are prescribed if suppuration is evident; however, since peri-implant surgery might be required when a diagnosis of peri-implantitis is made, such cases should be referred to a specialist without delay.

Mobility of an implant can present soon after implant placement signifying a lack of osseointegration. Alternatively it can arise as a late presenting feature confirming loss of osseointegration of the implant and the only outcome is removal of the implant. Pain around an implant is a rare and unusual presentation.

Radiographic examination following prosthesis installation and/or after one year in

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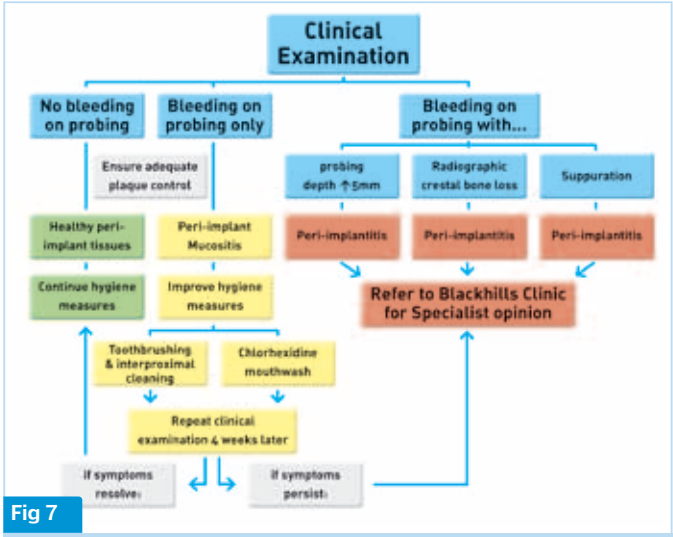

Fig 7
Blackhills Clinic implant maintenance record form

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function, provides a baseline record of peri-implant bone levels. The inherent shortcomings of two dimensional imaging are that it lacks standardisation and detects bone loss in interproximal areas only. Follow-up radiographic investigation is indicated when peri-implant probing depths exceed 5mm.

All patients undergoing implant surgery at our implant clinic are assessed for periodontal health and any disease is treated accordingly prior to implant surgery. After the implant placement and prosthesis installation, a record of baseline parameters is noted on an implant maintenance record form before the patient is discharged back to the referring dentist. An implant assessment algorithm is enclosed with the record form *(Figure 7)*.

Once an implant patient is discharged back to the dentist, the general dental practitioner, hygienist or therapist should provide an individually tailored supportive maintenance care programme encompassing both periodontal and peri-implant reassessment in order to prevent initiation of disease or its recurrence. Some suggestions for a programme in general dental practice are:

1. patient education in continuing to maintain good periodontal and peri-implant health
2. the patient's brushing and flossing techniques should be checked and revised accordingly
3. periodontal and peri-implant probing at each recall visit
4. professional plaque control measures and instrumentation as indicated by the clinical findings
5. planned recall visits, the frequency of which is based on patient's susceptibility to disease
6. referral to a specialist if the patient's treatment needs are out with the remit of the general dental practice.

The role of the dental hygienist or therapist in providing treatment and maintenance care is crucial. In the author's opinion, hygienists and therapists should be involved in patient care prior to implant surgery as this highlights the importance of the patient maintaining a high standard of plaque control both before and after surgery. Furthermore it will facilitate the post-operative maintenance care programme. ■

Full references for this article are available on request or by visiting http://bit.ly/implantcare

ABOUT THE AUTHOR

Dr Marilou Ciantar is a specialist periodontist and oral surgeon at Blackhills Specialist Referral Clinic, Aberuthven, Perthshire. She welcomes referrals for periodontal treatment, implant surgery and oral surgery, including treatment under sedation for anxious patients. Marilou is also senior clinical teaching fellow in oral surgery at Aberdeen Dental School.

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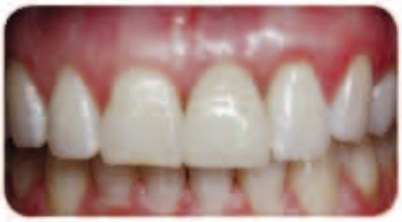

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SPMP09051 REV F AUG 2010

Implant update for GDPs

New developments mean improved results for patients, reports Tariq Ali

The continued growth of implant dentistry will undoubtedly mean that as general dentists, we will regularly come across patients who either require implants or have been treated with implants.

The demands of our patients are changing and, although the UK has lagged behind the rest of Europe in the number of implants placed, the rate of growth is still expected to be 18.6 per cent in 2012 (MRG).

As dental professionals, it is expected that we offer the full range of treatments available and we need to be aware of the dental implant option and the unmet demand that exists in the UK. Patients will seek advice from their general dentist, who has skilfully looked after their health for a number of years and has built up a trusted relationship. It is the patient's own dentist who will often drive this discussion and is best placed to advise the patient on the best course of treatment.

Dental implants have been shown to be predictable with many advantages over a more conventional approach. With this comes the need for further training and information so that we can pass this knowledge on to our patients and be able to contribute to their treatment. Unfortunately, there is very little undergraduate training in the UK, while postgraduate training is lengthy and inevitably costly. This article aims to give an overview of implant therapy, the terminology and the stages involved, so that dentists are more confident when discussing implant therapy with their patients.

Stages of implant therapy: Treatment discussion and options

This is no different from any other treatment discussion and is dependent on the individual clinical situation and the patient.

Take, for instance, a common occurrence such as a failing post crown on an upper lateral incisor tooth. The options for the patient include:

1. no treatment
2. restoration with a partial denture
3. restoration with conventional or resin retained bridge
4. restoration with an implant retained crown.

The disadvantages of the more traditional options are numerous and include destruction of adjacent sound teeth, food trapping, the need to remove the restoration for

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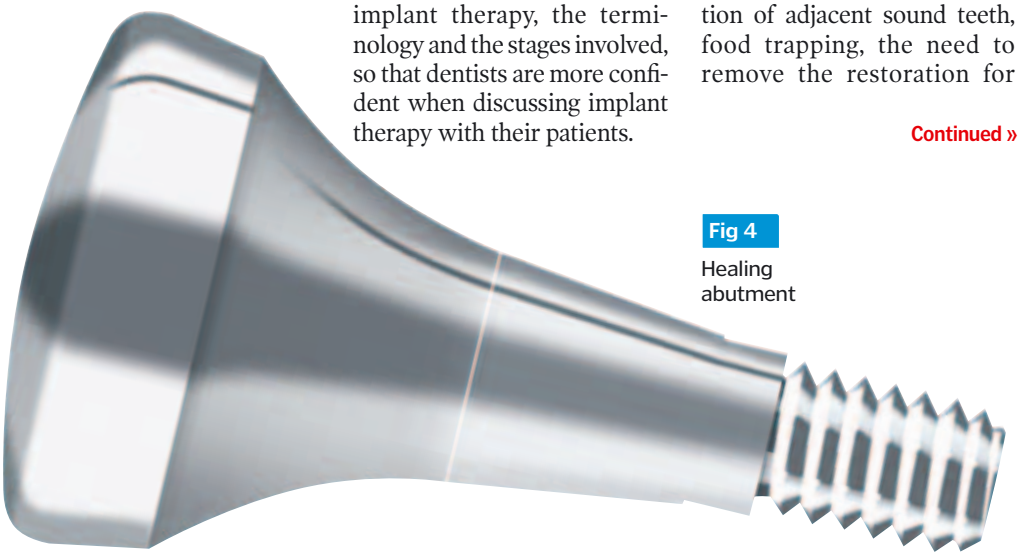

Fig 4
Healing abutment

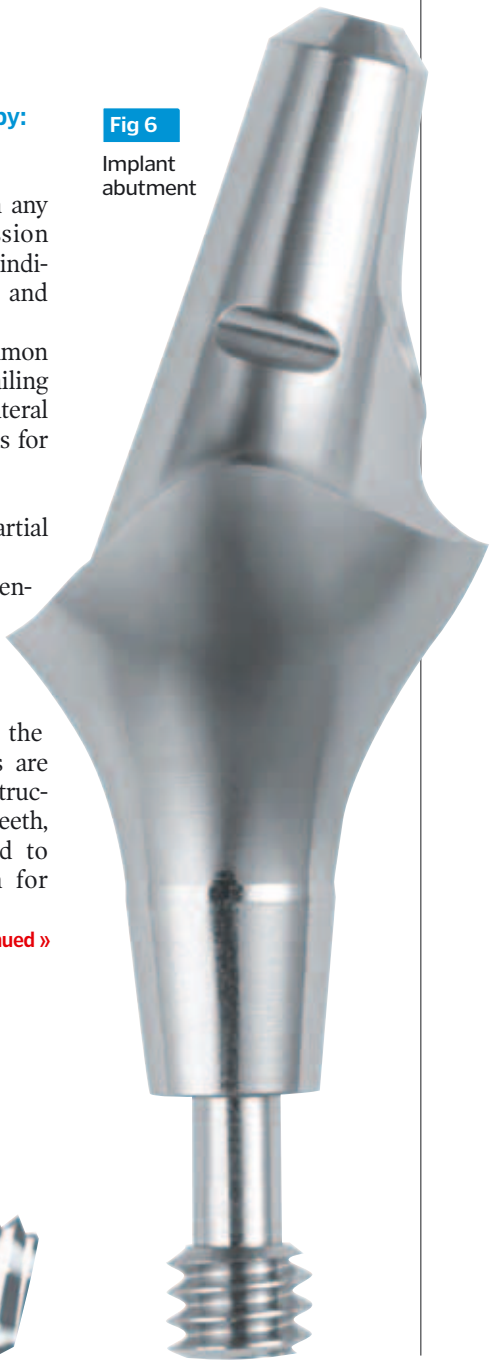

Fig 6
Implant abutment

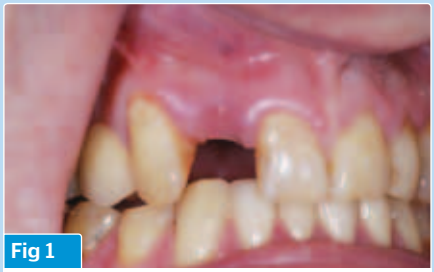

Fig 1
Missing UR2

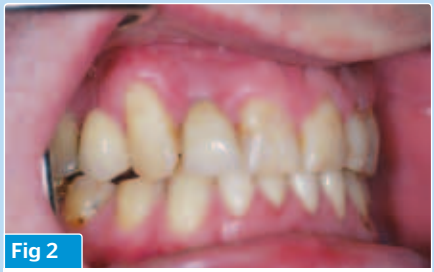

Fig 2
Implant restoration

Fig 3
Rochette bridge

Continued »

cleaning and possible periodontal problems related to dentures.

The implant option has the advantages of being a fixed restoration while maintaining the alveolar bone and integrity of the adjacent teeth. We often perceive implants as the expensive option and while the initial outlay is high, implant therapy has been shown to have a longer-term cost benefit when compared to conventional fixed bridgework[1].

These factors all stack in favour of the implant-based restoration being the treatment of choice for our patients *(Figures 1 and 2)*.

Patients will have differing views on their treatment and the demands of each patient will naturally vary. It will often be dependent on their personality, their views of dental health and the part this plays on their general wellbeing. Patients will have concerns before embarking on an advanced course of treatment. Common questions include: Will it be sore? How long does it take? How much does it cost? Who carries out the treatment?

These concerns will vary as patients respond differently to the prospect of losing a tooth. For some it will be devastating and will impart a sense of loss while others will simply find it a minor inconvenience. However, it is the duty of every dentist to offer the patient a full range of options and it is essential to be able to justify the reason for the treatment proposed[2]. Stating that "we do not offer that treatment here" is not justification for not offering the implant option. A full discussion of the patient's options is likely to determine their treatment choice.

For many patients, a replacement tooth – which doesn't affect other teeth, maintains alveolar bone and looks and feels similar to the natural tooth – is the treatment of choice irrespective of financial outlay.

So what next? The classic option is to refer to an implant dentist who carries out all of the treatment and returns the patient back to their dentist once treatment is completed. Certainly a straightforward way of working, especially if, like many colleagues you are busy treating patients and running a business.

"For many patients, a replacement tooth is the treatment of choice irrespective of financial outlay"

A newer way of working is for the patient's own dentist to be involved in the implant therapy. The patient is referred to the implant dentist to carry out the surgical aspects of the case and the referring dentist then restores the implant. This requires a close working team relationship between the referring dentist and the implant dentist and often is of benefit to all parties involved.

The patient will gain from accessing the surgical expertise of the implant dentist, with the convenience of attending their own dental practice for the restoration. The GDP gains from being involved in implant treatment, which brings with it an increase in knowledge, professional satisfaction and financial gain.

Assessment and treatment planning

The discussion that has already taken place with the patient's own dentist forms part of the assessment process and is integral to the ongoing consent process. X-rays, study models and investigations such as CT scanning will be carried out to assess the feasibility of implant therapy and to provide a treatment plan. This can be a lengthy process, ensuring that the patient is presented with a well thought-out plan that they are fully comfortable with.

Tooth extraction and ridge preservation

The amount of bone available at the implant site is key to the treatment proposal. Before embarking on an extraction, it is of benefit to be aware of the replacement option and plan accordingly. Once we know that the implant is to be placed, then atraumatic extraction is essential to preserve the surrounding alveolar bone. A careful approach with the use of periotomes and luxators helps to maintain the bone levels around the socket.

Often, but depending on the individual case, there will be a period of time to allow the hard and soft tissues to heal sufficiently. During this time, the patient will wear a temporary restoration. It is important that the temporary restoration does not impact on the healing site and, as such, patients are often provided with temporary restorations not normally seen in general practice such as a hybrid bridge or rochette bridge *(Figure 3)*.

Due to the lengthy nature of implant therapy, these temporary restorations are often worn for a long period of time. They can, in fact, be used to guide the restoring dentist on ideal tooth form, emergence and tooth position.

If the bone is deemed to be deficient after extraction, a number of options are available to augment the site for implant placement. Again, this will depend on the individual case and can include bone grafting, sinus grafting, ridge expansion and GBR (guided bone regeneration). The implant dentist will, of course, advise on the best course of action.

Implant placement

At the appropriate time, the patient will undergo implant surgery. It is certainly possible to place an implant at the time of extraction. This will have the benefit of preserving the bone

and reducing the number of surgical visits for the patient; however, it is only indicated in certain circumstances.

Once the implant has been placed, a cover screw is fitted to seal the internal chamber of the implant while the implant integrates. The soft tissue is then sutured down so that nothing is visible in the mouth. The patient will be reviewed regularly after surgery to ensure adequate healing.

Once the implant has integrated (normally three to six months after placement), then the implant can be exposed and the patient undergoes the second stage of implant surgery to expose the head (top) of the implant. A healing abutment/sulcus former *(Figures 4 and 5)* is placed which holds the soft tissues and shapes it ready for an impression. The healing abutment can also be placed immediately after implant placement, so negating the necessity for a second surgical procedure.

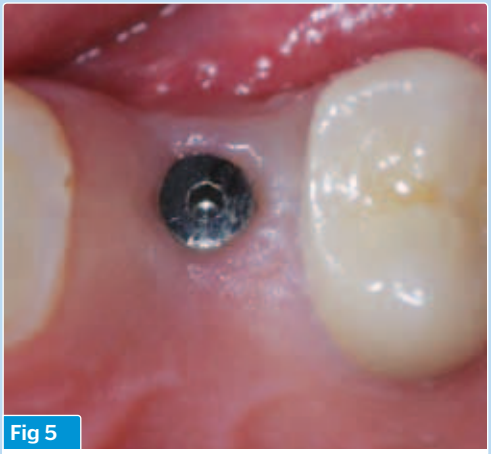

Fig 5
Healing abutment in situ

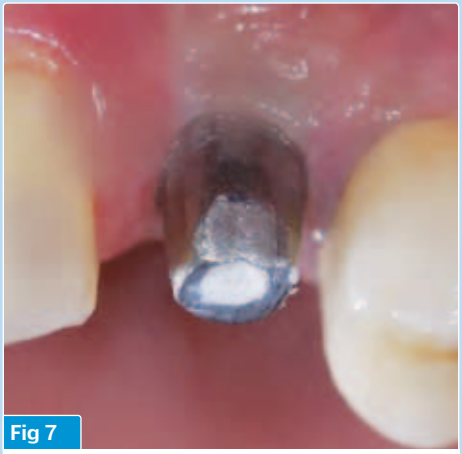

Fig 7
Implant abutment in situ

Restoration

Once the implant has integrated and the soft tissues have matured, the healing abutment is removed and an impression is taken of the implant and transferred to the lab. This impression is then used to choose the appropriate abutment and fabricate the crown. An abutment is a cylindrical connector, which is screwed into the internal chamber of the implant *(Figures 6 and 7)*. The crown is then made to fit the abutment.

There are various types of abutments, including stock abutments, cast abutments, milled abutments and CAD/CAM abutments. A variation on this is to fit a transitional acrylic crown on the abutment, which is easily altered, with the aim of shaping the soft tissues around the implant to ensure the correct contours and papillae formation. It is feasible for a patient to wear this acrylic crown for a number of months.

The final implant crown is then made and cemented over the abutment. A temporary cement (such as TempBond) is usually used so that the restoration can be easily retrieved. Another type of implant crown known as a screw-retained restoration is commonly used, whereby the crown is screwed into the internal chamber of the implant. This type of crown can be identified by a small filling on the occlusal surface of the implant crown, which covers the access hole to the retaining screw.

Maintenance

The patient will be returned to the referring dentist for regular examinations and hygiene treatment. Regular reviews with the implant dentist are needed to ensure the health of the implant.

Implant dentistry is certainly a rewarding field to be involved in and the benefits to our patients are there for all to see. The growth of implants is certain and with it will come pressures on the GDP to cater for this need. It is hoped that this article will give those not yet involved in this type of treatment some valuable background knowledge. ■

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1. Bragger U, Krenander P and L and N (2005) Economic aspects of single-tooth replacement. Clin Oral Impl Res 16: 335-341
2. GDC Standards for Dental Professionals.

ABOUT THE AUTHOR

Dr Tariq Ali BDS (Glas) DipImpDent RCS (Eng) graduated from Glasgow University in 1998. He has been involved in implant dentistry for the past eight years and has trained at the Royal College of Surgeons England, attaining the FGDP Diploma in Implant Dentistry. He is involved in mentoring and accepts referrals for implants at his practice in Bishopbriggs, Glasgow (0141 762 3954).

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Cumbernauld dentist Scott Edwards has refreshed his surgery, writes Bruce Oxley

Breathing new life

With the last refurbishment carried out back in 1997, Cumbernauld dentist Scott Edwards had come to the realisation that his surgery at The Village Dental Practice simply needed a new lease of life.

Despite being perfectly happy with the set-up, equipment and layout of his workspace, he recognised that the chair, cabinetry and general fixtures and fittings were, in his words, "past their sell-by date".

After speaking to Joyce and Ian Scott at CEI Dental, he was told that the average lifespan for a good quality dental chair is in the region of 13 to 15 years. With his chair approaching its 15th birthday, Scott acknowledged that the time was right to freshen things up a bit. He also realised that if he bought a new chair now, it might see him through to the day he hangs up his handpieces for the last time. He said: "I'm 45 so my intention was to get another chair that will last me the 15 years till I retire, hopefully, at 60. My plan was that, if I put a chair in now, I'll get the maximum benefit of it until I retire."

One of the main sticking points with refurbishing his surgery was that, quite simply, Scott didn't want the hassle of arranging and overseeing the


Advertising feature

CEI CASTELLINI

Left hand

Right hand

The original refurbishment was featured in the November/December 1997 issue of *Scottish Dentist*

work. So, this is where Joyce took over. She advised Scott on the new chair, flooring options, work surfaces and new lighting, and even project managed the whole refurbishment from start to finish.

Such was Scott's trust in Joyce that the work was carried out during his annual summer holiday in the last two weeks of July. He came back and was straight into work with no delay, delighted with the finished result. He said: "It was a totally smooth transition so, when I came back after my holiday, I could walk back in as if nothing had changed.

"Joyce couldn't do enough and put in an amazing amount of effort, totally above and beyond my expectations. Along with her husband Ian, who is the engineer, they were just so flexible and helpful. They did everything I asked of them and more. Nothing was too much trouble."

Joyce contracted ARC Dental who carried out all the building work, plumbing, flooring and ancillary jobs under her watchful eye. Alongside the brand new Castellini duo plus chair, Arc installed Corian work surfaces, new flooring and D-Tech daylight lighting in the ceiling. A new intra-oral camera means that Scott can explain treatments and diagnoses to patients with greater clarity using the screen attached to the light arm.

The initial 1997 refurbishment was featured in the pages of Scottish Dentist, the forerunner to Scottish Dental magazine. The previous owners of CEI (then CEI Enterprises) had fitted both Scott and his partner Howard Smith's chairs. As Howard was left-handed, and Scott right-handed, it provided the perfect photo opportunity (see pic).

Scott decided to go with Castellini again this time for a number of reasons. He said: "I went with Castellini because I'd used them for the last 15 years and they have been very reliable. I looked around at other companies, but for reliability and the appearance, it looks fabulous.

"Some other chairs can look plasticky, but this looks like it is built to last. I've heard stories of younger dentists who are only putting in dental chairs that might last them four or five years before they will have to replace them.

"But I had the same chair for 15 years and it never let me down. So, I would rather have something that was built to last rather than something flimsy that would fall apart." ■

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Unwrapping the whole package

With the December 2012 deadline for decontamination compliance looming, most, if not all, dental practices in Scotland will now have their LDU and decontamination systems in place.

And, after the initial financial 'hit' of setting up the LDU and all that that entails, the everyday reality of servicing, validation and inspection has become clear. What Health Improvement Scotland and the Scottish Government Health Directorate decide about inspections and regulations remains to be seen, but one thing that practitioners can control is the servicing of their equipment to keep it running as efficiently as possible, for as long as possible.

Autoclave Engineering is a service agent you can trust, providing a personalised, efficient and friendly service that won't break the bank. Headed up by experienced engineers Neil Anderson and Adam Peterson, they have more than a decade's worth of experience in the decontamination and biomedical equipment industry. They are devoted to the service, repair and maintenance of all makes and models of decontamination equipment available on the UK market. From bench-top autoclaves to walk-in sterilisers and through to compressors, washers and amalgamators, they can provide a custom solution to meet the requirements of dental practices big or small.

Working throughout Scotland and across the UK, Neil and Adam have built up an envious reputation in the industry, and count Glasgow Royal Infirmary, Stobhill Hospital and the Victoria Infirmary as regular long-term clients. With a strong background in the NHS and pharmaceutical industry they have, over last five years, expanded to include the dental industry. They offer 24/7, 365 days a year cover, 24-hour response time and free advice, all without the limitations of a servicing and repair contract.

They have a strong focus on keeping up to date on the latest legislative changes

across a number of business sectors in order to be able to offer advice and guidance on all aspects of your decontamination needs. They meet or exceed all statutory and regulatory requirements and have the procedures and processes in place to ensure that they continue to maintain these high standards.

Neil said: "We believe in offering a quality and cost-effective service to our clients and therefore do not charge excessively on emergency repair services as countless other manufacturers and service providers do.

"By trusting your contracts to Autoclave Engineering you have the peace of mind in knowing that all your contracts are covered, cost effective and that you as the client are at the centre of what we do."

Neil and Adam have developed strong working relationships with a number of decontamination suppliers including Dental Decontamination Ltd and Dürr Dental, and are able to offer advice and training on the range of their products and services. (more info/details?)

As well as quarterly, six-monthly and annual servicing packages based on the manufacturers guidelines, the company also offers a drop and collect servicing option when it is not ideal for an engineer to be on site, due to space or time pressures. Whether the equipment is due a service pressure vessel inspection, repair or testing to HTM, they have two designated drop-off points where you can bring your equipment to them.

Autoclave Engineering is also able to offer calibration and testing services alongside the repair and breakdown, servicing, pressure vessel inspection and advisory services. The engineers also keep a vast amount of stock to ensure that their clients' downtime is kept to an absolute minimum. Any parts they don't have to hand, they can guarantee them the next day.

As part of their independent advisory service, Neil and Adam are happy to give advice on products, equipment and service contracts offered by various suppliers and manufacturers. As Neil says: "We are independent of the manufacturers so we can offer reliable advice on the models and services available. We don't want you paying out more than you actually need to." ■

For more information on Autoclave Engineering, visit their website www.autoclave-engineering.co.uk

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Invest wisely

Make sure that your money is working for you. By Kate Scheer, marketing communications executive, W&H (UK) Ltd

Any purchasing decision made, in these times of austerity, is made with a certain degree of reticence. It is imperative that your purchasing decisions are considered so that you make the right decisions when investing in your practice.

Survival in this period of decline makes it absolutely necessary for all purchases to be right for your current needs. Your money must work for you, especially where the survival of your business is dependent upon growth and profit, only attainable through prudent investments.

Individual manufacturers need to be offering their customers sound advice to assist them in making the right choice. Companies supplying high quality products and backup, with UK-based support services, are looking to the future for their customers and in doing so, helping them build an efficient and profitable business.

This can be done in a number of ways. Not only should your chosen supplier be giving you the assistance in selecting the right products to suit your individual needs, but also the best method of funding your purchase. So it is worth asking about finance including rental schemes such as the one offered by W&H which includes future maintenance costs, as these may prove beneficial both from a tax and cash flow perspective.

There are a number of issues facing you where investment in your practice is imminent and necessary. The implications of the new recommendations and guidelines for appropriate decontamination facilities may be far wider and mean the purchase of not only the decontamination equipment, but also enough handpieces to allow you to put in place an efficient and effective process.

With many less invasive techniques coming and going, there is as yet no real alternative to the rotary cutting instrument. For this reason, the dental profession should be looking to gain the best possible value from the new innovations in cutting instruments, to improve their working environment especially considering the product is a long term investment with high user interaction. Investment in a handpiece that suits you is an essential part of the efficient functioning of the practice, so pay particular attention to some fundamentals when selecting and using your preferred handpiece.

It is important that as dental professionals you look to offer your patients quality care, which comes from using high quality, reliable products, while remembering that you spend many hours per day holding your handpiece. So what should be important when selecting a handpiece? Your priorities when making your choice should be the influence it will have on your patients, yourself and your team.

A smaller handpiece head for easier access, reduced levels of noise and vibration all result in greater comfort for both practitioner and patient. Ergonomics is important as you should consider whether your choice will reduce the risk of repetitive strain injury and cumulative trauma disorders. Look for a handpiece design which is comfortable and easy to hold without stress to the hand or fingers, such as the W&H Synea range.

Handpiece lumination has improved beyond recognition with the advent of LED. The colour rendereing index (CRI) is an important aspect of artificial illumination with a perfect colour rendition having an index value of 100. Therefore you need to be looking for a handpiece that offers a CRI of more than 90, which will give you the rich colour contrasts you need for a life like view.

Choose carefully as there are many different offerings giving varying levels of enhanced

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visibility and reduction of eye stress. Select an LED that offers daylight grade lumination as it is kinder on your eyes, gives improved visibility, better colour definition and reduced heat, such as the W&H LED+ handpieces. Some handpieces, such as the W&H Alegra, offer an integrated LED generator allowing you to enjoy LED technology regardless of the motor or coupling you are using.

Only purchase handpieces that adhere to current regulations for health and safety and those that are both thermo-washer disinfectable and sterilisable.

Good quality handpieces, made by good quality manufacturers, are easy to recognise and should be supplied with at least a one-year warranty as standard. It has been proven over many years of research that the higher the quality of the handpiece, the superior the performance over longer periods of time.

It is therefore worth investing wisely and looking after your investment. If the handpiece or manufacturer chosen does not meet the above criteria, then it is not likely to offer long-term value for money. To prolong the useful life of your handpieces and to protect both the patient and the team from the risk of cross contamination, it is important that the dental team follow a strict infection control regime.

When selecting your handpiece, it is worth identifying whether the manufacturer can meet all your needs, whether they are able to offer a full range of products, local service support, care and maintenance training and the appropriate solutions for decontamination. You should be given guidance on the products available to assist you in looking after your handpieces, such as automatic handpiece care systems like the Assistina which provides a fast and effective cleaning and lubrication procedure.

So, when investing in your practice, you should be making the right decisions to maximise the safety of your team by not asking them to manually clean contaminated sharp instruments. Therefore it is prudent to invest in a thermo-washer disinfector dryer such as the ThermoKlenz from W&H to support your decontamination regime.

Remember, you get what you pay for so it is always worthwhile making a sound investment and purchasing a well-established, well supported brand known for quality and reliability. You are responsible for the safety of your team, so don't let them take risks. Invest for a safer, more efficient future. ■

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Decontamination Pod for dental clinics and practices

Equipment. Struggling to find space for a decontamination room? Why not look at the innovative new Decontamination Pod?

Plandent Ltd is part of the Planmeca group and supplies quality dental products to the UK, including Planmeca and Belmont equipment, as well as engineering and maintenance service plans.

Plandent has been in partnership with Custom Design Cabinetry for a number of years. The furniture manufacturer provides bespoke solutions for dental surgeries for best practice and decontamination compliance. It works with Plandent's team of nationwide equipment specialists providing high-quality bespoke dental surgeries and decontamination facilities.

Custom Design is a UK-based company approved to fabricate Corian and Samsung Staron products for the dental and medical industry. Its products, which include the Pod, are built to exacting standards in its own UK workshops from raw materials to the finished product. Working together, Plandent can offer individual design, robust furniture and keen prices to provide solutions for all.

One solution to finding space for that separate decontamination room is the Decontamination Pod.

It is a neat, contemporary, space-saving way of conforming to decontamination guidelines. Built by Custom Design, it is available from Plandent directly or via the NHS supply chain.

It is a "revolutionary" product which provides a solution within a 1.2 metre diameter footprint. It incorporates three Corian sinks, put-down area, inspection area, illuminating magnifying glass, filters clean air, reverse osmosis (built-in) and ultraviolet anti-bacterial pass-through hatch.

Features include:

- Ultraviolet, anti-bacterial pass through hatch
- Three Corian sinks (one dedicated to hand washing) with associated taps, traps and waste
- Filtered clean air
- Put-down inspection area
- Reverse Osmosis system built-in
- One touch button to rotate the Pod 180° and allow access and use of the two separate sides – clean and dirty
- Moulded solid doors, all constructed using an anti-bacterial solid surface material
- Clean autoclave area
- Storage space and shelf.

Constructed to also accommodate:

- 1 x bench-top autoclave*
- 1 x bench-top washer disinfector*
- 1 x automated oiling system (with air line facility).*

**Not included – will suit most leading brands.*

Price includes site visit, delivery, installation to pre-prepared services and manufacturers' two-year warranty.

Example of services required

- Waste pipe
- Hot water supply
- Cold water supply
- Compressed air supply
- 32A, single phase 230V supply.

Service plans are available and provided by the manufacturer, Custom Design. These include regular service visits, parts and labour.

The UK patent-protected pod is fully compliant with decontamination guidelines, is cylindrical in shape and has two separate compartments – dirty and clean. The dirty side houses two Corian sinks (wash and rinse), surfaces for preparation and inspection, as well as services for a handpiece care system, such as the Nitram DAC, W&H Assistina, KaVo Quattrocare or NSK Care3. There is space for most leading brands of bench-top autoclave (vacuum or non-vacuum) and bench-top washer-disinfector. (These items are not included.)

Plandent advises to discuss the specification of your reprocessing equipment; each Pod is manufactured to order and can be made to accommodate additional air lines if required.

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Continued »

Technical information:
The Pod takes up approximately 1.2 metres diameter of floor space and there is a removable upper ring light canopy of approximately 1.4 metres.

The total height is 2.3 metres, and total weight 500kg. It will span standard joists, however, the suitability of the floor can be discussed at the site visit. If additional floor strengthening is needed, it is always recommended to consult with a suitably qualified builder.

The outer material is all solid surface (anti-bacterial), and the inner material is again all solid surface Corian. It is only available in white.

For ease of access, delivery and installation, the pod comes in four sections.

The internal motor drives the Pod 180° and there is a n automatic internal actuator for height adjustment for the autoclave. There is an automatic in-built water leak sensor, together with a door open sensor for safety.

The Pod is fully British CE certified and is approved and available through the NHS supply chain.

Various purchase options are available, but all include delivery, installation, and manufacturers' two-year warranty. Details of the full service plan are also available.

Contact Plandent for a visit from a member of the dental equipment team to see if this is the answer to your separate decontamination area. ■

Call Plandent on 0800 027 9599 or e-mail equipment@planmeca.co.uk to find out more. To see the Pod in action, search YouTube for Decontamination Pod. Visit Plandent at Stand H07 at the BDTA Showcase.





iLearn@the BDA

BDA
British Dental Association

The British Dental Conference and Exhibition is renowned for its high quality lectures and seminars. To widen the accessibility, the BDA has made a number of these sessions available to view online as part of the iLearn webcast portfolio.

Twenty sessions can be viewed and include both clinical and non-clinical related topics such as:

- Endodontics
- Periodontics
- Dental photography
- Dental anxiety
- Teeth whitening
- Occlusion
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- Stress management

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- Decontamination

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Serving your patient's endodontic needs - for a lifetime of service.

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Alastair MacDonald
BDS (Glasgow), MSD (Indiana)

Alastair established the referral practice in 1995. He is involved in postgraduate endodontic education, is an active member of the AAE and chairman of the Scottish Endodontic Study Group.

Introducing...
William McLean
BSc (Hons), BDS, PhD, PG Dip (Endodontology)

William joins the practice in 2012, bringing many years of endodontic experience to the team, as well as a history of research and publication.

2 Clifton Street, Glasgow G3 7LA **Tel:** 0141 331 0088 **Email:** endodontist@mac.com **Web:** www.macendo.com

SybronEndo

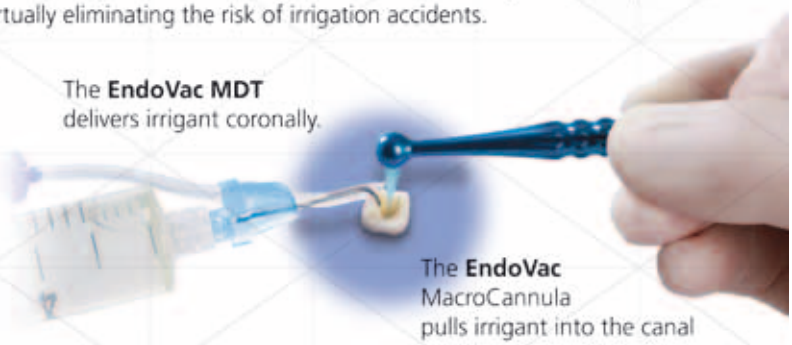
EndoVac2

Apical Negative Pressure Irrigation System

SybronEndo is proud to offer the latest and safest technology in endodontic irrigation – the EndoVac system. This true apical negative pressure irrigation system presents a unique and safe new way to irrigate during root canal treatments.

Unlike positive pressure systems which use cannulas or side-port needles, the EndoVac is a true apical negative pressure system that draws fluid apically by way of evacuation. Irrigation solution and debris are sucked away from the apical foramen, providing exceptional cleaning while virtually eliminating the risk of irrigation accidents.

The **EndoVac MDT** delivers irrigant coronally.



The **EndoVac** MacroCannula pulls irrigant into the canal and evacuates gross debris.

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*plus VAT of 19%

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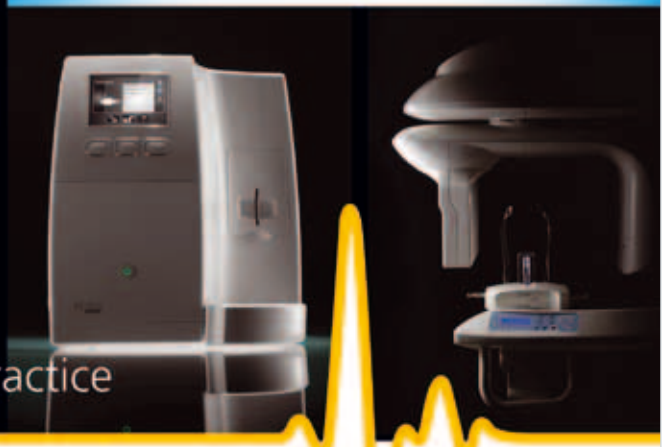

For more information or to place an order please call **0800 169 9692**
email sales.uk.csd@carestream.com
or visit **www.carestreamdental.co.uk**

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CS R4 Clinical+ practice management software is constantly working to help your practice function as smoothly and efficiently as possible. And when you've closed for the day CS R4 Clinical+ goes on working, backing up your data, updating your software and preparing your system for the next working day. In fact, CS R4 Clinical+ is central to the success of every modern dental practice.

A voyage of discovery

The British Dental Trade Association's (BDTA's) annual Dental Showcase is expected to see more than 300 exhibitors and 10,000 dental professionals from 4-6 October at ExCel in London.

The 2012 event's theme is 'A voyage of discovery' and the show will feature many of the biggest names in the industry in the UK and abroad, all displaying their latest innovations and services.

This year, in response to a recent survey carried out by the Dental Technologists Association, a programme of leading UK technicians will be speaking to delegates on Saturday, 6 October. The experts, including John Wibberley, Mark Bladen, Larry Browne, Steve Taylor and David Smith, will bring their own expertise and guidance on topics such as case planning for crown and bridge and implants, demonstrations on ceramic techniques, CAD/CAM design and the use of the latest materials.

The Live Theatre will also return to the main arena, with topics including 'Hypnosis for Dentistry' delivered by Dr John Butler and Sharon Waxkirsch from The Institute of Hypnotherapy for Medical and Dental Practice as well as 'Fast, Cosmetic Ortho for GDP's' by Dr Anoop Maini. Other topics will include facial aesthetics.

There will also be a programme of complimentary mini lectures taking place throughout the show, on a range of topics as varied as handling medical emergencies, CEREC and Computer Guided Implantology and financial management for your practice.

Various companies will also be giving talks on their products and how to use them most effectively. Attending these mini-lectures will count towards verifiable CPD, making them an even more worthwhile investment of your time.

To find out more about the BDTA Dental Showcase, including a timetable of mini-lectures, stand plans and latest news, visit www.dentalshowcase.com

W&H for the latest in technological innovation and unbeatable promotions

Visit W&H on Stand K15 at Dental Showcase for the latest news and special offers on handpieces and decontamination products, including exciting new handpieces in the Synea range, the award winning innovative Proface caries detection system, surgical units, piezo scalers, washer disinfector dryers, sterilisers and servicing options.

W&H are launching a number of new and innovative products, developed as a result of working with customers to meet the needs of a busy practice, including an exciting new range of exceptional handpieces.

Decontamination equipment including the ThermoKlenz washer disinfector dryer and Lisa steriliser are available for an affordable monthly fee under our new rental scheme. The Implantmed surgical system is unbeatable for precision, ease of use and reliability.

Also, see live demonstrations of the Tigon+ ultrasonic treatment unit and our endodontic range by experienced clinicians.

For more information on W&H products and services, including W&H rental schemes, visit Stand K15 or call 01727 874 990.

Absolute flexibility

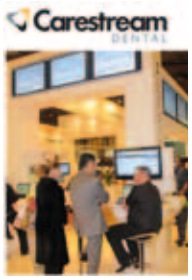
The W&H range of handpieces offer absolute flexibility to meet the needs and budgets of each dental practice. With the unbeatable Synea range and the Alegra range, which includes the Alegra LED turbines that not only generates its own LED light, but is also available to fit on a range of different connections - from fixed connection to coupling-based instruments for smooth rotation and quick release.

A full range of coupling-based models are available - so you can have LED light with your existing coupling – even if you have a non-optic dental unit!

In addition, W&H handpieces, including Synea and Alegra LED turbines, are thermo washer disinfectable and sterilisable, and come with a scannable etched data matrix code as standard – making W&H the ideal choice for everyday use according to the latest decontamination best practice guidelines.

For further information on W&H products and services, please contact W&H (UK) Ltd on 01727 874 990 or email marketing.uk@wh.com

Discover more from Carestream Dental at Showcase 2012



Visit Carestream Dental at the BDTA Dental Showcase (Stand C08) and find out how the latest advances in dental software and equipment can dramatically improve patient care and practice profitability.

The event takes place at London's ExCel from 4-6 October. At the Carestream Dental stand, delegates can discover:

- CS R4 communication tools: new launch, supporting dentists to communicate effectively with their patients
- CS 8100: new launch, offering the simplicity of compact panoramic imaging.

Talk to the team about the huge range of market-leading solutions on offer.

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

Verifiable CPD at Showcase stand M03

DENTSPLY will be keeping audiences interested at the BDTA Dental Showcase 2012 (4-6 October), with a full programme of sessions that promise to keep delegates engaged.

Thursday 4 October will see a series of short Restorative Materials Update lectures, focusing on the latest filling, Friday's lectures will focus on an Instruments and Ultrasonic Equipment update, while Saturday will provide a Restorative Materials Update.

You can register in advance for these at dentsply.co.uk/showcasecpd

To learn more about how DENTSPLY's range of innovative products can make your working life easier and help you increase the satisfaction provided to your patients, visit DENTSPLY at stand M03 at BDTA Showcase 2012.

Contact us at dentsply.co.uk or 0800 072 3313 Access webinars and products demonstrations and earn CPD at dentsplyacademy.co.uk

Denplan – supporting your practice team to achieve your business goals

Every practice deserves the efficient dedication of a business partner that understands its needs. Visit stand H04 at the BDTA Dental Showcase and see how Denplan not only operates seamlessly with your practice, but can also help you achieve your business goals with our innovative approach, regulation support and value-added services such as free marketing consultancy.

We have over 25 years' experience working with the whole dental team and recognise the growing importance of the practice manager's role. That's why we've arranged a bespoke practice manager event on 5 October at the Novotel London ExCeL, offering the latest regulation support, interactive product news, and practical business and marketing training – all with verifiable CPD.

For more information about Denplan's practice manager event, please email pressoffice@denplan.co.uk, or call 01962 827931. For more details of Denplan's business support services, please go to www.denplan.co.uk or call us on 0800 169 9962.

Pioneering education and innovation

Visitors to the BDTA Dental Showcase between 4-6 October are being offered the chance to gain CPD for attending lectures on the Philips stand.

An education lecture theatre is being erected on Stand K16 and underlines the company's commitment to learning. Stand speakers include Professor Damien Walmsley, who is giving talks on ultrasonics and The Cochrane Report.

Also speaking at the show will be Zaki Kanaan (pictured), Philips' Dental Advisor, and who will be demonstrating the latest tooth whitening technology and techniques.

For more information, visit the stand K16. If you can't attend, visit www.sonicare.com or www.philipsoralhealthcare.com Preregister for talks by calling 0800 032 3005 or 0800 0567 222.

A must-see exhibitor

Visitors to the DENTSPLY stand M03 at the BDTA Dental Showcase (4-6 October) can learn more about DENTSPLY's research and development initiatives, earning CPD while they find out more about its range of market-leading products such as SDR (Smart Dentine Replacement), ChemFil Rock, Citanest and WaveOne.

Delegates can look forward to special DENTSPLY Academy presentations at the stand by Dr Louis Mackenzie on ChemFil Rock and SDR. For hygienists and therapists, the stand will also feature an extensive range of DENTSPLY's periodontal hand instruments.

The stand will also host daily lectures on restorative and periodontal techniques, with verifiable CPD, delivered by Alison Grant of Bristol Dental School, Dr Constanze Boesel of DENTSPLY, and Dr Louis Mackenzie. To register for these lectures, visit: dentsply.co.uk/showcasecpd

Contact us at dentsply.co.uk or 0800 072 3313, earn rewards against purchases at dentsplyrewards.co.uk, access webinars and products demonstrations and earn CPD at dentsplyacademy.co.uk

Follow the crowd to The Dental Directory at Stand A04

Premier league full service dental dealer The Dental Directory will be welcoming the masses to its stand at the UK's largest dental exhibition.

The British Dental Trade Association's Dental Showcase 2012 is set to attract more than 10,000 visitors from the dental community – many of whom are expected to head straight to The Dental Directory to see the best of its dental units, digital imaging systems and latest promotions.

A team of experts from The Dental Directory will also be on hand to show its products and share their knowledge. The BDTA Dental Showcase will take place from 4-6 October at ExCel London.

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

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BOC Healthcare can assist your dental practice with the provision of emergency resuscitation equipment.

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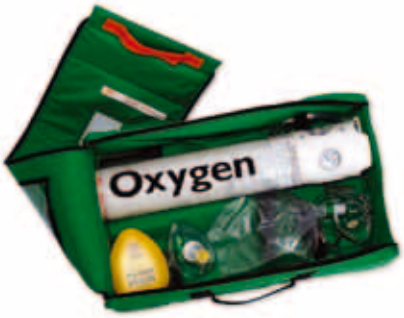
* Depending on location



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"An excellent thorough grounding for any budding implantologists or experienced operators, with evidence-based references. The course is provided by two experienced and enthusiastic implantologists, in a first class facility." KC Chan, Dental Practitioner, Glasgow

The **GIFT Continuum** teaching programme is an on-going series of specific dental implant based topics that can be attended in any order, delivering units of information that combine to form the building blocks of a course that may be expanded to a postgraduate degree.

Regional and International Training
Training is delivered via a network of regional and international teaching centres. Facilities are appropriate to the practice of implant dentistry, providing the highest quality teaching environment and standard of clinical training.

Theoretical and Clinical
This course is ideal for those practitioners who wish to incorporate implant treatment into their practice, to advance their implant knowledge or consolidate existing expertise, but who are unable to commit to a degree programme. This does not preclude the delegate from following the degree programme at a later date and credit will be given towards the University of Warwick MSc and diploma courses in Implant Dentistry. Both MSc and diploma are registerable with the GDC as additional professional qualifications.

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.

GENERAL IMPLANT FORUM & TRAINING GIFT

For further information on Gift Continuum, visit www.gift.org.gg

Tel: 07738 737879 Email: aberdeenimplants@btinternet.com

GC introduce the next generation of flowables

GC Europe has announced the launch of two superior flowable materials; G-ænial Universal Flo and G-ænial Flo.

Unlike other flowable composites the GC materials have a higher filler load and a homogeneous dispersion of fillers. The resulting strength and wear resistance are key features of these materials, opening up the potential for a broader use than standard flowables.

G-ænial Universal Flo is radiopaque and features a high viscosity, making it ideal for placement in class I-V restorations. Essentially, it looks like a flowable but behaves like a restorative. Its indications are for direct restorations, minimum intervention cavities and fissure sealing. This material is highly thixotropic and stays neatly in place holding its shape for ease of use.

Contact GC UK on 01908 218 999.

Seize the initiative with dfyt.com

As dedicated dental professionals, patients are at the heart of everything we do. But while we may dedicate our lives to treating and educating patients in the best oral hygiene practises, many still fail to change their toothbrush every three months.

Now dfyt.com is here to help! dfyt.com (don't forget your toothbrush) is a subscription-based delivery service that delivers high quality, great value oral hygiene products straight to patients' doors.

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For dental enquiries email conor@dfyt.com, for sales email graham@dfyt.com

Low price cross infection confidence from The Dental Directory

Now is the time to prepare your practice for the winter flu season, when the risk of cross infection is as high as ever, a task The Dental Directory has just made a lot less expensive.

The UnoDent CHI015 FFP3D valved respirator is the ideal face mask to reduce cross infection risks in dental practices. It protects practitioners and patients from transmission of the H1N1 bird flu virus, SARS and other highly pathogenic viruses. It also provides 99 per cent particle filtration efficiency to provide protection against non-toxic and low to high toxicity solid and liquid aerosols, such as oil mist.

Now on half price promotion, with a box of 10 masks costing just £6.47, the FFP3D represents excellent value for money.

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

7 GDC registered specialists
Referrals welcome for Dental implant treatment, fixed & removable prosthodontics, periodontolgy, oral surgery, endodontics and Cone Beam CT scanning

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"Share the care with a Specialist"

Clean and shining bright in minutes

Alkazyme enzymatic for the thorough cleaning-pre-disinfection of all reusable, immersible dental instruments prior to autoclaving.

It provides rapid cleaning action when used in conjunction with an ultrasonic cleaner. A minimum five minute contact time is all that is required to render used instruments thoroughly clean and shining bright.

Alkazyme continually disinfects the contaminated 'wash water' as created through the cleaning action and is very economical, with just five grams of Alkazyme with ordinary tap water making one litre of enzymatic cleaning/disinfecting solution.

Available from your usual dental sundry supplier in both 750gm loose powder and tubs of 100 easy dose water soluble sachets.

For comprehensive product information and safety data, visit www.alkazyme.com

Fixodent further improves lives of denture wearers

Fixodent launches Dual Protection offering an improved quality of life for denture wearers. It seals out five times more food particles compared to no adhesive, so that patients can continue to eat whatever foods they like. Its formulation inhibits the build-up of plaque, prevents denture soreness and reduces the incidence of oral malodour, keeping breath fresh for up to eight hours. It provides strong lasting hold for up to 13 hours.

To support the dental profession, Fixodent has produced information leaflets to share with the denture wearers, it offers practical advice on concerns such as eating and speaking, as well as tips on how to remove and care for dentures.

This information is available to professionals free of charge from your Fixodent representative. If you don't know who your representative is to obtain the leaflets please call the helpline on 0870 242 1850. Alternatively, you can order them directly from the website www.dentalcare.com

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aspd
You do the dentistry, we do the business.

Practice sales may be buoyant in Scotland – but who is buying?

The process of selling your dental practice should never be underestimated. For many practice owners this will be the final opportunity to significantly add to their retirement pot. Martyn Bradshaw, Director of PFM Dental, identifies the likely type of purchasers and their differences

The most successful dental practice sales tend to be those that are planned well in advance. This is important for the smaller practice, being sold to a dentist wishing to work there, and larger practices suitable for body corporates.

It is important to understand that each type of buyer will look at the practice in a different way, although profitability remains as important as ever. Understanding your potential purchaser can allow you to enhance the value.

Open market sales

Regardless of whether the practice is NHS or private, there is usually a good level of interest from dentists wishing to work at the practice as the principal.

Smaller practices generally sell relatively quickly and there is often no requirement for the principal to stay at the practice after completion. However, some purchasers are happy for the principal to stay and see this as an advantage.

As the purchaser is likely to be working in the practice, location and desirability usually have a significant bearing. Historically, dentists have often considered the value of dental practices as related to a percentage of turnover. However, profitability is as important, if not more important than the turnover because it directly impacts on the personal income of the new principal.

Selling to associates

This can often be a principal's preferred method where there is an encumbered associate, usually because it appears to be the 'easiest' option.

There can be a delicate working relationship with the associate, and a number of principals dislike directly negotiating the price and terms of the sale. On occasions where they do, they may feel in a vulnerable position and are at risk of giving in to the demands of the associate, meaning a reduction in the actual value or terms.

As a sales agent, we are asked to get involved with an increasing number of sales to associates, which ring-fence the principal from the negotiation process. This also brings the benefits of speed and reassurance as we often negotiate finance on the associate's behalf, liaise with the solicitor and generally advise during the process. We therefore encourage any principal in this situation to seek expert advice.

Body corporates

Larger practices are often deemed to be a suitable purchase for body corporates and in some situations the corporate route can be attractive. Notably, there has been an increase in corporate transactions over the last 12 months in Scotland (you may have spotted the IDH caravan outside the Scottish Dental Show at Hampden in May). However, their assessment of value is purely driven by financial information and private buyers may still yield a higher price.

The valuation for a body corporate largely relies on the projected profitability of the practice under their ownership known as EBITDA (earnings before interest, tax, depreciation and amortisation). This is the 'super profit' that the practice generates after adding an associate expense for the principal's gross fees and making a number of other adjustments.

The location is to some extent less important for a body corporate and therefore areas with traditionally less demand may benefit more from the corporate route.

It is also important to consider the timescale in which you wish to retire. Most corporates will require the principal to remain at the practice post-completion. This requirement differs depending upon the purchaser, but generally timescales are longer for a private practice and potentially up to five years. With careful planning there are a number of ways to reduce your commitment to the practice, although this needs to be addressed well in advance and during the planning stage. ■

ABOUT THE AUTHOR

Martyn Bradshaw is a Director of PFM Dental dealing with the sales and valuations of dental practices throughout England, Scotland and Wales.
PFM Dental is one of the leading sales agents and have been established since 1990. The company deals with dental practice sales to body corporates, associates and open market sales. If you wish to discuss the potential sale of your practice, please contact Martyn to see how PFM Dental can help,
Martyn.bradshaw@pfmdental.co.uk www.pfmdental.co.uk

SoloCem new from Coltene

Coltène has pleasure in introducing the new self-adhesive, dual-cured and radiopaque resin cement, SoloCem.

This self-adhesive cement reduces the number of steps by the direct application from the automix syringe into the root canal and the restoration saving time. Two different mixing tips are available, short fine and short super fine for the direct application into the root canal.

SoloCem needs no bonding before the application and can be used immediately thanks to the ready-to-use mixing tips. SoloCem also has excellent shear bond strength, less shrinkage and contains antibacterial zinc oxide.

Available in two shades, Dentin and White Opaque which is ideal for post cementation.

For further information, call 0500 295 454 ext 223/224, or visit www.solocem.info

SOURCE1uk has now launched

SOURCE1uk is a UK-based, fully interactive internet dental database, which covers everything to do with dentistry.

It features recruitment with a free dental jobs board and recruitment consultancy; education through training courses, memberships, journals, articles, a forum and dental schools; classifieds from service providers, practices for sale and dentalBay.

For patients, there is the 'find a dentist' facility, whether they are cosmetic, general dentist, specialists, facial aesthetic practitioners as well as dental insurance and general information.

The website is simple and easy to use.

To register, visit www.source1uk.com or for more information contact Ryan Howorko on 020 8546 2935 or email info@source1uk.com

Competition winners

A weekend away in Salzburg was the prize for the winners of W&H's 20th anniversary competition.

Husband and wife dental team Mark and Carolyn Chrimes were also presented with a new personalised W&H TA-98 CLED dental handpiece at the company's factory in Burmoos.

The couple were put up in the Gmachl Spa Hotel, Bergheim. After a day's sightseeing in Salzburg, the couple were taken to W&H's facility. They were shown around the on-site museum on the history of W&H's handpiece technology.

They were also given an overview of the company's latest products as well as a tour of the manufacturing and testing facilities. Mark was then presented with his laser-etched personalised handpiece by W&Hs Klaus Maier.

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NEW to the range is the Cattani Aria, ideal for one, two or three surgeries. Very compact and quieter to run, the Aria compressor is fully HTM2022 compliant as standard and includes an hour meter for accurate servicing.

Cattani oil-less compressors are supplied with a 5 year guarantee for all components (subject to servicing terms and conditions). For a space-age power solution, call now for local stockist details.

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Handpiece care and maintenance products from W&H

W&H have an exciting range of handpiece care and maintenance and decontamination products which have been developed as a result of working with customers to meet the needs of a busy practice.

These include the Lisa, Lina and MS Sterilizers, to suit individual budgets and requirements, along with the W&H Multidem.

The Assistina is the handpiece maintenance unit for automatic internal cleaning of spray channels and lubrication of all handpieces and motors. The ThermoKlenz offers guaranteed cleaning consistency due to the regulation of water temperature and detergent concentration.

W&H also offer Premium Care and Premium Careplus Service Plans for W&H decontamination products to ensure peace of mind.

For further details, please contact office.uk@wh.com or 01727 874 990.

Polymerisation and more

Coltène would like to present the new Coltolux LED Pen with interchangeable attachments to combine two instruments in one: the LED polymerisation attachment and the LED Mirror attachment with cold light for improved visibility.

This compact, cordless and ergonomically designed hand piece is a pen-style for easy handling and acoustic signals mark the start of polymerisation with start and stop sensor button, simple 'plug and play' system. The Coltolux LED Pen works with all composites, is autoclavable and the optional mirror attachment has an integrated LED Light for improved visibility in the working area.

For further information, call 0500 295 454, or visit www.coltene.com

New appointment focuses on dental distributor network

The Gast Group – a member of the IDEX Corporation's health and sciences division – has given business development manager Andrew Lidington additional responsibility for its JUN-AIR range of compressors and compressed air accessories, in a move that will support the national and regional dental market in the UK and Ireland.

Andrew's focus will be to ensure that product and service levels available to JUN-AIR's UK dental distributors reflect the company's position as the premium compressor brand in the UK dental sector.

As well as launching its iQdryer – a new desiccant air dryer for the dental market – JUNAIR will also continue to support its two national distributors and network of regional distributors at this year's BDTA's Dental Showcase exhibition in October.

For further information on JUN-AIR's dental range, including the new iQdryer, call 01527 504040, email gastgroup.uk@idexcorp.com or visit www.jun-air.com

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ChairSafe alcohol-free disinfectant

Buy any ChairSafe product before September and receive 50 per cent off.

ChairSafe alcohol-free disinfectant is available in a 500ml spray, a 200ml foam dispenser, and one-litre and five-litre refill containers. Five litres is available at the discounted price of £25.45 + VAT.

ChairSafe adsorbs and penetrates cell walls of bacteria, fungi and the envelope of viruses.

The Department of Health guidance recommends dental chairs be cleaned between patients to minimise microorganism dispersal. ChairSafe products should be used for daily disinfection of surfaces surrounding patients (e.g. dental chairs, door handles, work surfaces).

For information on special offers and the full range of Kemdent disinfectants, ChairSafe, PracticeSafe and InstrumentSafe, visit our website www.kemdent.co.uk To place orders, call Helen on 01793 770256.

Four heads are better than one

Dürr Dental's intra oral camera provides dentists and patients with windows into dental disease.

One versatile aspect of the VistaCam iX is the interchangeable head. Four heads are available, one providing high-resolution images, one for close-ups of up to 100x zoom, a Proof head for diagnosis with a colour-coded scale, and an LED curing light. Data transmission is fully digital via USB, or functions as a stand-alone version. The ergonomic head rotates fully, so oral cavities become easily accessible, and motion sensors operate the camera to ensure efficient usage.

For more information, call 01536 526740.

Courses in advanced implant surgery techniques

Nobel Biocare is dedicated to teaching dental professionals the latest techniques, such as the 'Advanced Implant Surgery Techniques to Optimise Aesthetics and Functional Results'.

The course is available at locations throughout the UK and Ireland and the programme is suitable for endodontists, general practitioners, oral surgeons, periodontists and prosthodontists.

The one-day course is £175 + VAT and provides six hours of verifiable CPD. It can be combined with the 'Options and Decision Factors for Implant Prosthetics' as a two-day course, priced £275 +VAT with 12 CPD hours. All course materials and refreshments are included.

For more details, contact Nobel Biocare on 0208 756 3300 or visit www.nobelbiocare.com

Advanced conical connection and platform shift

The NobelReplace family has been expanded to include two new implants: a conical connection and platform-shifting connection.

The NobelReplace Conical Connection combines the well-proven NobelReplace tapered implant body, which mimics the shape of a natural tooth root, with a secure internal conical connection that gives a tighter seal between the abutment and implant interface, resulting in higher soft tissue stability and maintaining crestal bone. It also provides maximum restorative flexibility, as it is suitable for use with standard abutments and individualised CAD/CAM NobelProceraTM abutments.

The second new implant NobelReplace Platform Shift incorporates the easy-to-use element of the internal tri-channel connection, together with the benefits of platform shifting. The tri-channel connection offers accurate and predictable abutment replacement. It provides tactile feedback and ease of alignment.

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

Helping you to help your patients

GC's Gradia Core and Fiber Post system allows you to complete an aesthetic core and post luting with minimum tooth preparation.

With the smallest possible post size the remaining tooth structure is maximised, with the result of less stress and an avoidance of weakening of the root, which may be a cause of RCT failure.

Gradia Core dispenses directly into the canal and direct core build up. Being thixotropic, the material will not slump, which is particularly useful when used in the upper jaw; with Gradia Core the core can be quickly and easily formed in just one appointment.

Providing very strong support for the prosthesis, shrinkage is minimal to avoid stress factors and being radiopaque, Gradia Core and Fiber Posts are easy to detect on radiographs.

For further information contact GC UK on 01908 218 999.

Take Control with the Optima MX2 INT from Bien-Air

Thanks to Smart Logic technology, the Optima MX2 INT control unit from Bien-Air offers ultimate regulation of power, linearly and without vibration, ensuring you are in control of speed, torque and reversal at all times.

The Optima MX2 INT is intuitive and adapts to most dental chairs. Being versatile, the control unit offers 10 pre-programmed modes for restorative work and 10 sequences for endodontic work.

Optima MX 2 INT drives the new LED MX 2 Micromotor. MX 2 is shorter and lighter than its predecessor and accepts Bien-Air's new Micro-Series contra-angles, as well as standard contra-angles. The combination of both the MX 2 and Micro-series is a reduction in the length of 30 per cent and a weight reduction of 23 per cent.

For details, call 01293 550 200 or visit www.bienair.com

Dental Protection

Fair subscriptions

Scottish members of Dental Protection do not subsidise members in other parts of the UK, nor other parts of the world. Scottish members have a much better claims experience, and it is only right that Scottish dentists should see the benefit of this.

Also, in a big, financially strong organisation like Dental Protection there are more members to share central overheads – allowing each member to pay a smaller contribution and leaving more money with which to provide additional membership benefits.

So a full-time general dental practitioner in Scotland pays 37% (almost £900) less to be a member of Dental Protection than colleagues in the rest of the UK while enjoying loads of additional services like free CPD in a variety of forms for the whole dental team.

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For more information:

W: www.dentalprotection.org
T: 0845 718 7187
E: member.help@mps.org.uk

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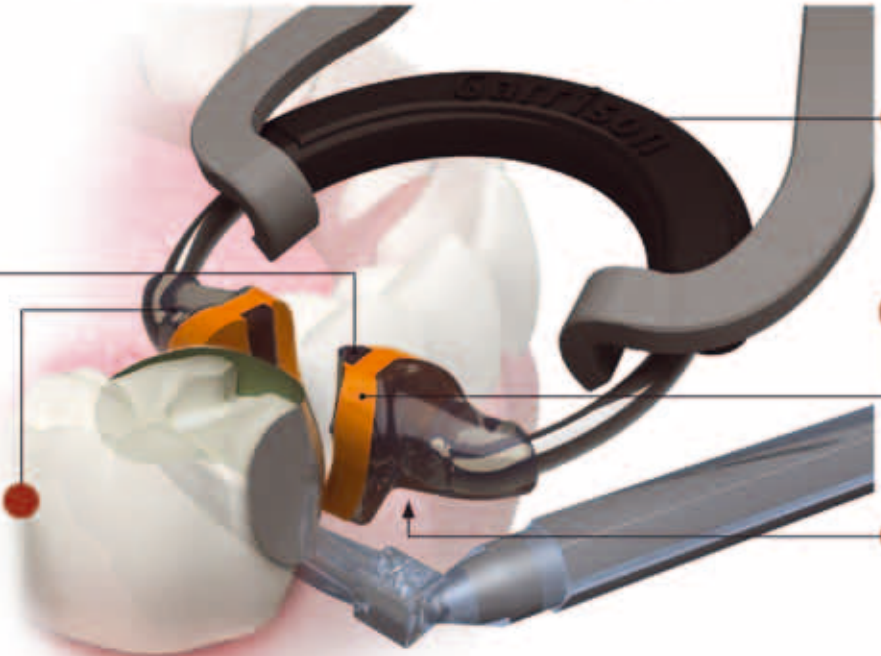

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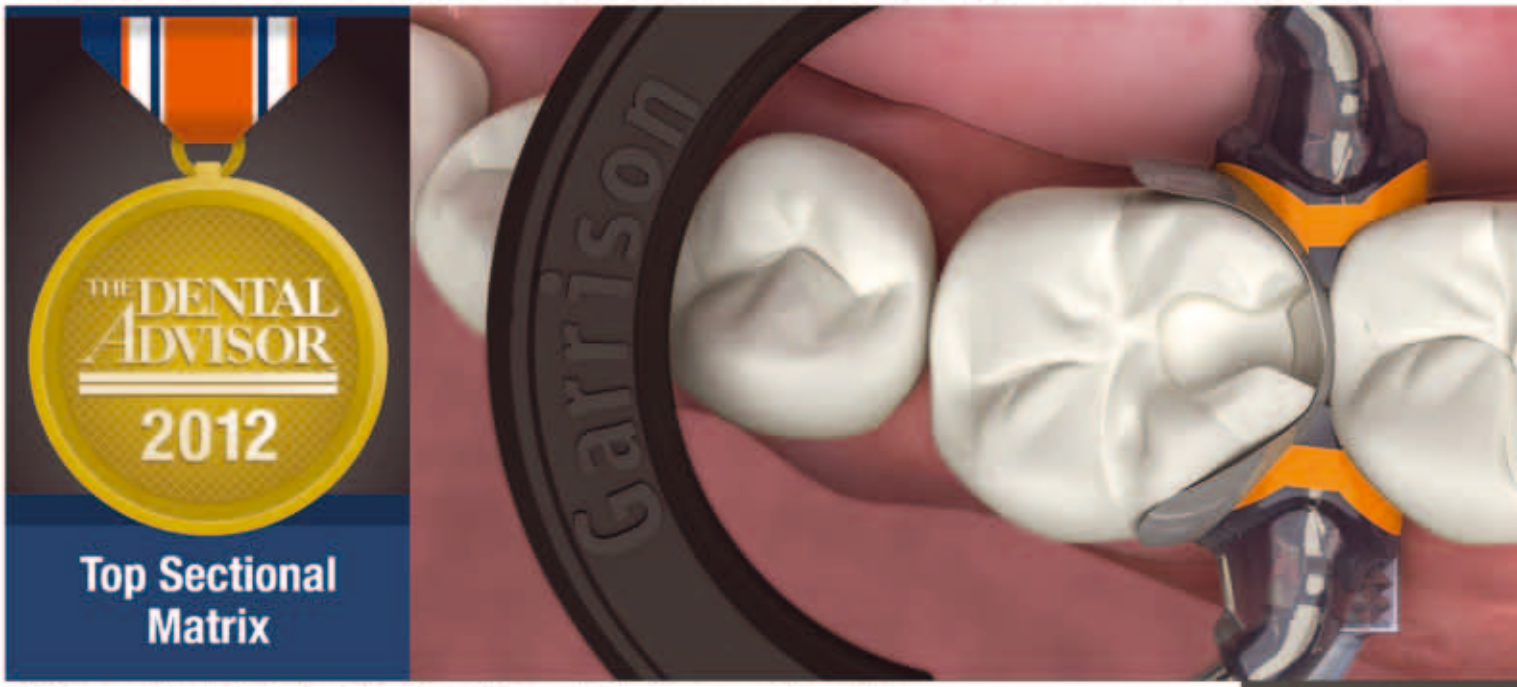
For further information or to order please call Garrison Toll Free at Tel. 0800 011 2738.
The products are available through all major UK retailers or directly through Garrison Dental Solutions.



*All offers are valid until 31st October 2012 and are subject to availability. All prices are subject to VAT.

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Dental Solutions

ABRIDGED PRESCRIBING INFORMATION: SEPTANEST 1:100,000

COMPOSITION: Articaine Hydrochloride 4%, Adrenaline (INN: epinephrine) tartrate expressed as base 1:100,000.

THERAPEUTIC INDICATIONS: Local or loco-regional dental anaesthesia in patients of at least 4 years in case of classic or muco-gingival operations or dental surgical procedures where bone removal is necessary.

DOSAGE AND ADMINISTRATION: For most common operations, one infiltration with 1.7 ml is sufficient. Do not exceed the equivalent of 7 mg articaine hydrochloride per kilo of weight. Dosage in children should be commensurate with their weight. The recommended dose in 20 kg child is about ¾ cartridge of 1.7 ml or ½ cartridge of 2.2 ml and in 40 kg child is about 1.5 cartridge of 1.7 ml or 1 cartridge of 2.2 ml.

CONTRA-INDICATIONS AND PRECAUTIONS FOR USE: Hypersensitivity to any local anaesthetic agent or any component of SEPTANEST. Do not use SEPTANEST in patients who have experienced bronchospasms after administration of products containing sulphites, patients with deficiency in plasma cholinesterase activity, patients receiving MAOI or tricyclic anti-depressants, patients in whom general anaesthesia might be required to complete the procedure and in children under 4 years of age.

SPECIAL WARNINGS: SEPTANEST should be used with caution in patients with hepatic disease, thyrotoxicosis, cardiovascular disease, abnormalities of cardiac conduction, epilepsy, and in diabetic patients. Intra-vascular injection is strictly contra-indicated. Resuscitative equipment, anti-convulsant medicines and other resuscitative drugs should be available for immediate use. The product should only be used in pregnancy when the benefits are considered to outweigh the risks. Breast feeding should be avoided for 48 hours after use of SEPTANEST.

ABILITY TO DRIVE AND USE MACHINES: No demonstrated effects upon motor coordination, however subjects who suffer adverse effects should not drive or use machines until symptoms have resolved.

INTERACTIONS: SEPTANEST should be administered with caution to any patient receiving drugs with sympathomimetic properties or with agents whose therapeutic actions may be antagonised by adrenaline. Articaine should be given with caution in patients receiving an antiarrhythmic agent.

UNDESIRABLE EFFECTS: Hypersensitivity, over dosage or intra-vascular injection may result in excitatory or depressant manifestations of the CNS, depressant cardio-vascular reactions, respiratory and allergic reactions. . Patients with peripheral or hypertensive vascular disease may develop ischemic injury or necrosis.

PHARMACEUTICAL PRECAUTIONS: Store in the original container, below 25°C. Protect from light. PHARMACEUTICAL FORM: Solution for injection contained in 1.7 and 2.2 ml dental cartridges.

LEGAL CATEGORY: POM.FOR FURTHER INFORMATION CONTACT:-

THE PRODUCT LICENCE HOLDER:
SEPTODONT LTD,
Units R&S, Orchard Business Centre,
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Dr C A Bain BDS, DDS, MSc, MBA, 43220
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Mr M Paley BDS, MB ChB, FFDRCSI, FRCS, FRCSEd(OMFS), 64778
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Prof L Sennerby DDS, PhD, 72826
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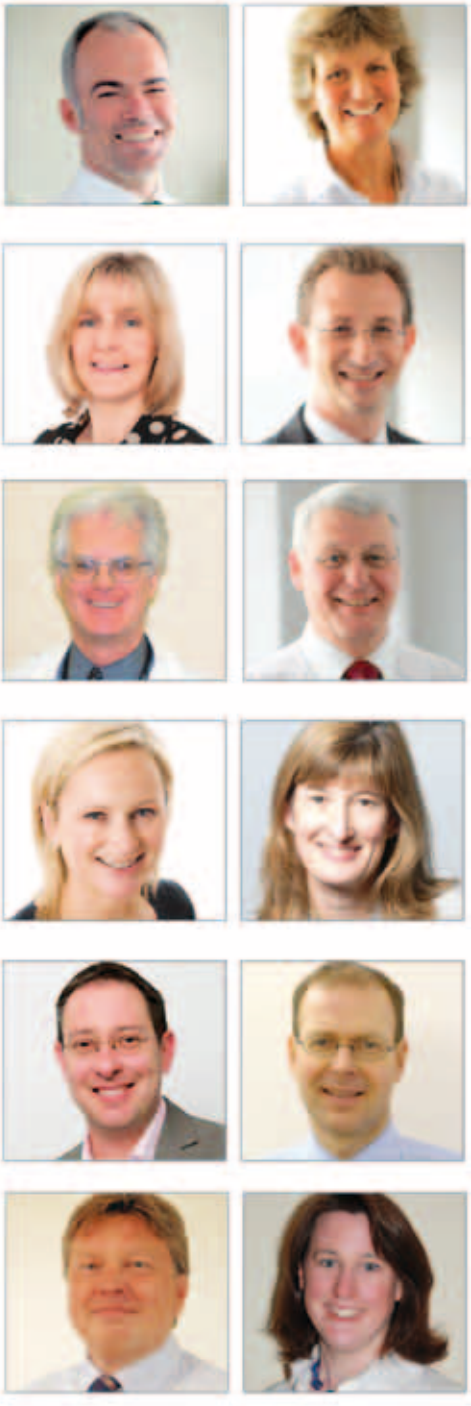

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