No.1 for dental professionals in Scotland

June / July 2012

Scottish Dental magazine

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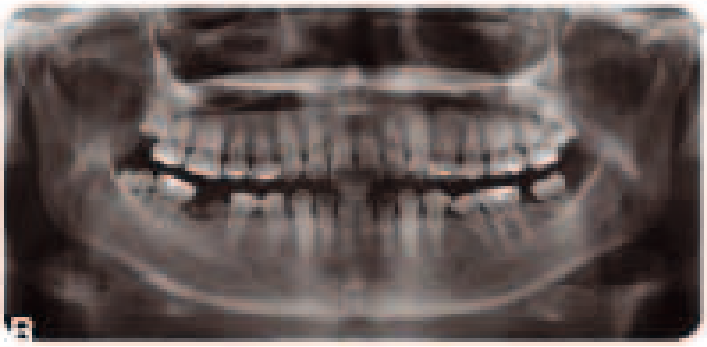

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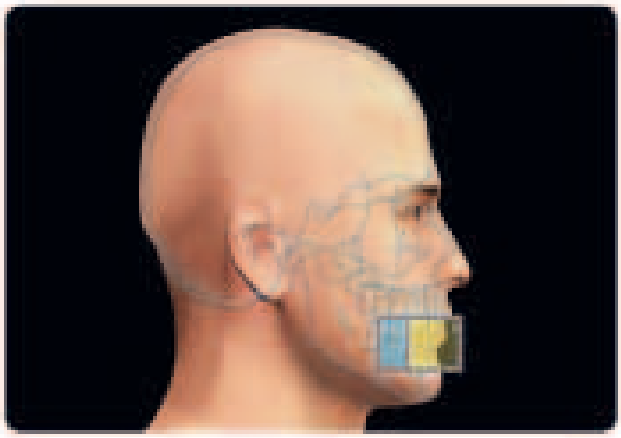

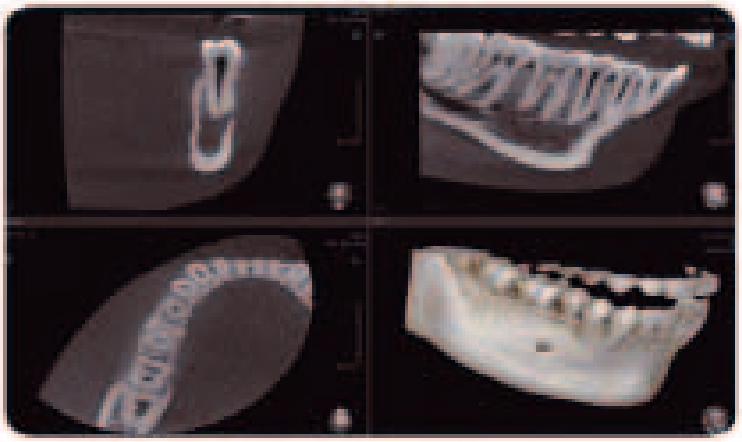

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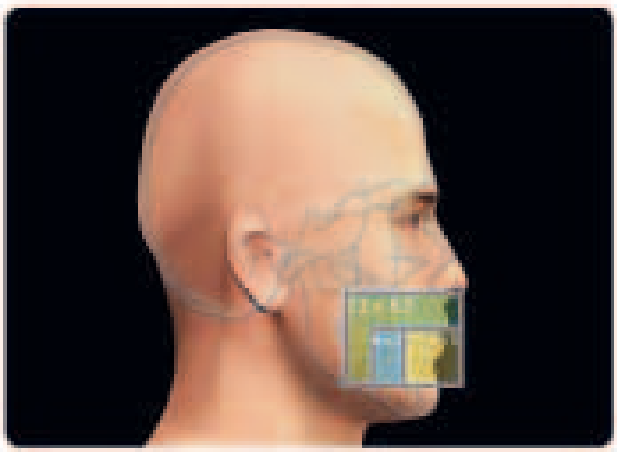

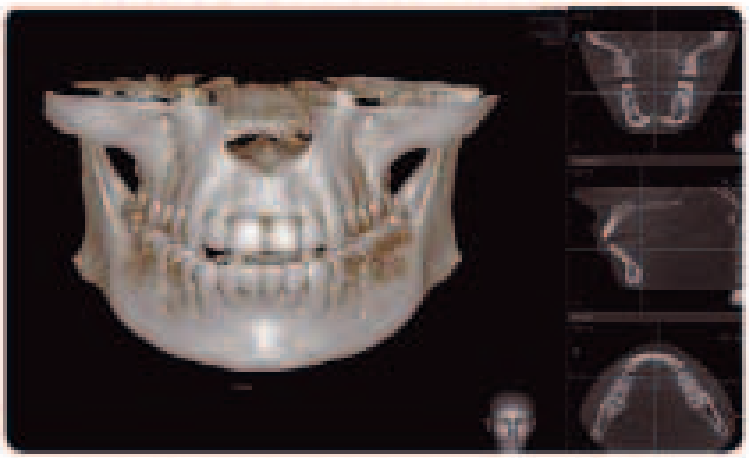

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Editor's desk

with Bruce Oxley

Thank you!

With more than 1,200 people in attendance, the first ever Scottish Dental Show proved to be a roaring success.

I'd just like to take this opportunity to say a big thank you to all the delegates, exhibitors and speakers who came along to Hampden Park on an unseasonably hot two days at the end of May.

Without the support of the profession and the dental trade, events like this simply wouldn't happen, so again, thank you.

We have been getting a great deal of informal and anecdotal feedback so far and, alongside a more in-depth email questionnnaire that will be sent out shortly, we will use this to make sure that next year's event is even better.

Planning for the 2013 Scottish Dental Show is already well under way, and we will announce details of the date, venue and speaker line up in the coming weeks and months.

If you turn to pages 6-10 you will see a review and some of the highlights of the two-day event, including some great pictures from our photographer Mike Wilkinson.

I thoroughly enjoyed meeting and talking with dental professionals and exhibitors alike over the course of the show and I hope you all found the show to be a useful addition to the dental calendar.

One of my personal highlights of the show was the reaction of our Scottish Dental Lifetime Achievement Award winner, Professor William Saunders. He genuinely didn't think he was going to win, so the look on his face as he came up to the podium was priceless.

I'm sure you will all agree that he is a very worthy winner and a thoroughly nice guy to boot. Although, I'll repeat my ascertion that all of our nominees would have been great winners, it is just a shame that only one person could win.

Another special moment was Septodont arranging for their speaker John Meechan to have a kickabout on the Hampden Park pitch. Well, when I say on the pitch, it was an astroturf patch next to the pitch, but John was like a little kid as he posed for some photgraphs next to the hallowed turf!

Elsewhere in this issue we have an interview with Tayside orthodontic consultant Grant McIntyre, Ashley Latter talks us through what he told delegates at the Scottish Dental Show and the latest Scottish Dental Round Table event, in association with SUSANdental.com, tackles quality management and the business of dentistry. ■

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

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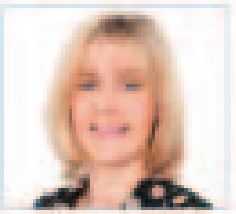



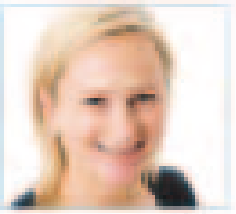
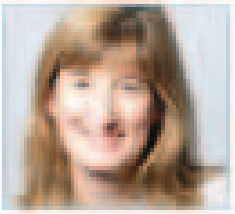



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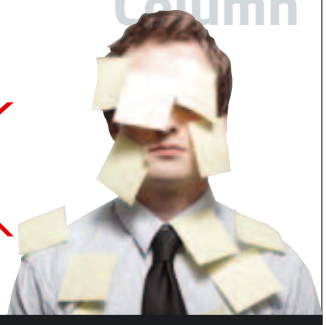

Show me the money

The Review Body on Doctors' and Dentists' Remuneration (DDRB) has, since 1971, held an annual review of healthcare economics in order to make recommendations to the UK health departments on pay and fee uplifts. The DDRB listens to evidence from the health departments, NHS employers and trades unions including the British Dental Association (BDA).

For general dental practitioners' GDS fees the DDRB takes into account the effects of practice expenses such as materials, lab costs and DCPs' salaries.

In 2010 the UK coalition government announced a public sector pay freeze during the period 2011-13 (other than for workers earning less than £21,000 per annum). Thus the DDRB could not announce any pay increases for doctors or dentists during this period but it has maintained a watchful eye on the economics of the healthcare sector. GDS fees contain a percentage for dentists' salary and a larger percentage for practice expenses.

In 2011 the Scottish Health Department specifically requested the DDRB to look at the expenses of general dental practices working in the NHS in Scotland. The DDRB published its 40th annual report on 13 March and its recommendation was that an uplift of one per cent be applied to item-of-service fees in Scotland for 2011-12, and a further compound increase of 1.38 per cent to be applied for 2012-13.

The following day the Scottish Health Department issued a letter which stated:

"We are currently considering the recommendation on dental practice expenses and hope to be able to make a decision by the end of March."

Well the end of March came and went and, at the time of writing, there has been nothing but a deathly silence from the Scottish Government. The chair of the BDA's Scottish Dental Practice Committee (SDPC) Robert Kinloch has written to the Chief Dental Officer seeking urgent confirmation that the DDRB's recommendations will be implemented in full and as soon as possible; BDA Scotland continues to press for a response.

It will not have escaped your notice that the financial year 2011-12 has been and gone on 31 March and we are now in 2012-13. The delay in getting a firm recommendation from DDRB is now being compounded by the slow response from Scottish Government. Clearly the fees for 2011-12 can no longer be uplifted, so a backdated increase will have to be applied which must also impact on other fee-dependant calculations such as seniority payments, practice allowances etc.

"The Scottish Government must not add insult to injury by further delaying these meagre increases"

And what of practitioners who have now left the GDS since 2011-12 – those that have sold their practices, retired or moved on – how will they be recompensed? The longer the announcement is delayed by Scottish Government, the more difficult it becomes to accurately recompense dentists for their outstanding expenses.

GDS practices are hard-pressed because of rapidly increasing costs and expenses which the DDRB's paltry recommendations will barely compensate. The Scottish Government must not add insult to injury by further delaying implementation of these meagre increases.

Every GDP in Scotland must already be crying "SHOW ME THE MONEY!" ■

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1 year, 6 issue subscriptions: UK £60; overseas £75; students £30.
Back issues: £5, subject to availability.

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ISSN 2042-9762

Scottish Dental magazine
is published by
connect publications

Studio 2001, Mile End,
Paisley PA1 1JS
Tel: 0141 561 0300
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www.scottishdentalmag.co.uk

The sun shines on the first ever Scottish Dental Show

Dream debut. Hampden Park played host to a successful first event

Despite blazing sunshine and the lure of the golf course, more than 1,200 dental professionals descended on Hampden Park last month (May 24 and 25) for the inaugural Scottish Dental Show.

The two-day event was officially opened by Public Health Minister Michael Matheson MSP who, in keeping with his health brief, chose to walk to the venue from his home nearby! Accompanied by the Assistant Chief Dental Officer Tom Ferris, the minister was introduced by Connect Publications' managing director Alan Ramsay. He outlined his government's vision for the future of Scottish dentistry before handing over to Edinburgh GDP and former GDC president Hew Mathewson, who gave a short welcoming address.

The event itself saw a packed trade show with more than 100 exhibitors spread over three halls and an exciting speaker line-up comprising of more than 40 lecture sessions and hands-on workshops, with up to 12 hours of verifiable CPD available.

Some of the speaker sessions were standing room only with the likes of Ashley Latter, Paul Tipton, Bob McLelland, John Meechan and Elaine Halley packing them in. Paul Tipton, who spoke on Friday morning, said: "The Hampden Park venue was special and the football pitch in the background was very impressive. The array of speakers the show attracted was testament to the importance this show has in the Scottish and British dental calendar."

And Ashley Latter, whose two talks attracted nearly 300 people in total, said: "The warmth of the delegates and their enthusiasm to want to learn was apparent the whole time I was there. At every stage I was made to feel so welcome, it felt like a second home. Count me in for next year!"

"The array of speakers the show attracted was testament to the importance this show has in the Scottish and British dental calendar"

Paul Tipton

Margaret has the luck of the draw

As promised, all delegates registering on the Scottish Dental Show website were entered into a free prize draw to win a new iPad and the winner was drawn on the Friday afternoon, just before Elaine Halley's lecture.

The lucky delegate was Margaret McMillan of Whitecart Dental Practice in Glasgow, who was presented with her new toy by Ann Craib of *Scottish Dental magazine*.

Alison picks up her award flanked by Chick Young and Bruce Oxley

Smiles better

As it was National Smile Month during the show, it seemed fitting to give out an award for smile of the day in recognition of the brightest and best the exhibition had to offer.

The winner of the Thursday Smile Award was presented at the evening drinks reception to Alison Smith of Glasgow Orthodontics, while the Friday award was given to Tracy Ruck of Smiles Imaged4U.

Tracy with Ann from *Scottish Dental magazine*

Prof Saunders with Chick Young and Bruce Oxley

A worthy winner

The first ever Scottish Dental Lifetime Achievement Award was the centrepiece of the evening drinks reception held on the Thursday evening in the Baird Suite. Alan Ramsay again welcomed delegates, speakers and exhibitors to the event before introducing *Scottish Dental magazine's* editor Bruce Oxley.

Bruce introduced the four nominees – Graham McKirdy, Hew Mathewson, Dr Jim Rennie and Professor William Saunders – by saying: "I'm delighted to say that the four men nominated by their peers and fellow professionals ticked all the boxes and, it is no exaggeration to say that they would all have been very worthy winners."

He then announced Professor William Saunders, former dean of Dundee Dental School, as the winner of the 2012 Scottish Dental Lifetime Achievement Award. Prof Saunders was presented with a crystal trophy and a membership of the Scotch Malt Whisky Society.

Speaking after the event, Prof Saunders described the moment he heard his name read out: "I was completely overcome. In fact my wife Jenny was very worried about me because I was so surprised. It is so unusual for a clinical academic to be awarded such a prestigious accolade over high profile general dental practitioners.

"I was completely overcome. In fact my wife Jenny was very worried about me because I was so surprised"

Professor William Saunders

"I'm very pleased and I think it is good that a clinical academic has been recognised in this way. Because we do work jolly hard, it is a different sort of work to general practice, but we do work just as hard."

BBC Sport's Scottish football correspondent Chick Young then took to the stage and had guests clutching their sides as he recounted tales and anecdotes from his life and career in Scottish football.

CPD Update

We are currently processing the hundreds of CPD certificates from the show. If you are still waiting for yours, please bear with us as we work our way through them. They will be sent out via email along with the GP214 form for claiming CPDA and your feedback questionnaires in the very near future.

Any questions, please email scottishdental@connectcommunications.co.uk and one of the Scottish Dental Show team will be happy to help.

Delegates arriving in the beautiful May sunshine


Pierluigi Coli's presentation 'Trauma from occlusion'


Abid Faqir talks implants

Dentistry on at Hampden


John Meechan shows off his football skills


The Minister gets to grips with the technology


Pierluigi Coli

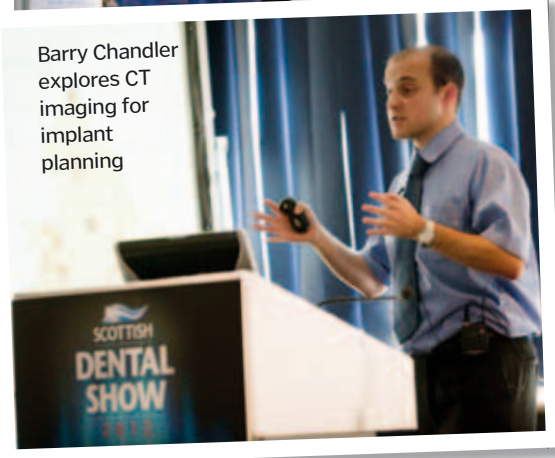
show Park

(From left) Bruce and Ann from Scottish Dental magazine, Michael Matheson MSP, Connect Publications MD Alan Ramsay and Hew Mathewson

Public Health Minister Michael Matheson addresses delegates

Ashley Latter gives his business tips and advice

Platinum Sponsors DTS are all smiles



Barry Chandler explores CT imaging for implant planning

Here are just a few of the things that delegates, speakers and exhibitors told us about the Scottish Dental Show 2012:

Don't take our word for it...

An important event in the calendar

"I really enjoyed the Scottish Dental Show. Firstly, the Hampden Park venue was special and the football pitch in the background was very impressive. The array of speakers the show attracted was testament to the importance this show has in the Scottish and British dental calendar.

"All the organisation was first rate and very relaxed and courteous and I was really impressed by the turnout on such sunny days.

"I would love to speak again at the event next year."
Paul Tipton

"A big thank you for organising such a terrific event. I thoroughly enjoyed both days and am already looking forward to next year – hopefully it will become an annual fixture. I certainly left Hampden with a great feeling of national pride having seen some of the tremendous dentistry being carried out in Scottish practices."
Murray Ettle, GDP from Dumfries

"What a great show. Well done for putting it all together."
Grant Matheson, Vermilion

"I though the dental show was excellent and I have told everybody that. I thought the contribution made by the trade was first rate and the lectures were excellent. I thought the whole set up was first rate and very much to be recommended."
Professor William Saunders

"The exhibition proved to be a great opportunity to meet with existing and prospective clients and provided a valuable chance to see what everyone else in the industry is doing.

"Since the show we have had significant interest and enquiries, not just from the local area but also further afield for our services."
Tommy Leca, Leca Dental Laboratory

"Congratulations to the team for a really well organised show."
Cattani

"Count us in for next year. Apart from some sore feet, it was a great show."
Dental Directory

"Just wanted to say thank you for a fab, well organised show. Well done, it was great, and book us a stand for next year!"
Dentsply

Ashley warms to Scottish delegates

"I just want to say how much I enjoyed the Scottish Dental Show. The warmth of the delegates and their enthusiasm to want to learn was apparent the whole time I was there. At every stage I was made to feel so welcome, it felt like a second home. Count me in for next year. I had a smashing time."
Ashley Latter

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"More than a man for all seasons"

OBITUARY

Colleagues, friends, family and patients have all paid tribute to Clarkston practitioner John Dunn, who was tragically killed in a road traffic accident on 17 April.

In his obituary, published in *The Herald* on 30 April, Brian Lynas wrote: "With his fair-mindedness and innate ability 'to walk in the other man's moccasins', he would be the first to say that in every tragic accident, there will always be two victims and two victims' families."

Lynas continued: "Johnny Dunn was more than a man for all seasons. He was a man for every day packed with maximum input in all areas of his life. He was never a yesterday man. He will always be to his family and friends a man who lived for the present."

He is survived by his wife Carol, his children John Bernard, Joseph, Ruth and Richard, his mother, three brothers and a sister.

BDA criticises inquiry

Research. OFT report "takes simplistic view of dental care"

Dr Susie Sanderson

The British Dental Association (BDA) has strongly criticised the Office of Fair Trading's (OFT) inquiry into dentistry, saying it fails to fully understand the profession.

The association also expressed disappointment at the way the publication has been reported in the mainstream media, arguing that "the OFT's own acknowledgement of the high levels of patient satisfaction with dental care appear to have been set aside in favour of headline-grabbing statistics".

Dr Susie Sanderson, Chair of the BDA's Executive Board, said: "Research by bodies including the regulator of dentistry, the General Dental Council, confirms that the vast majority of patients are happy with the care they receive. The Office of Fair Trading's own research also confirms this to be the case.

"Where patients do have concerns about their care, it is clearly important that they have an effective complaints process. This is helpful for dentists and patients alike and dentists support the goal of making the process as simple as possible.

"The delivery of effective dental care is all about good communication between dentists and patients. That communication will not be enhanced by the OFT's headline-grabbing approach to publicising this report. That it has chosen to ignore what it knows about patient satisfaction and instead focus on a very small number of cases where it believes it has identified problems is disappointing.

"This report treats dentistry purely as a market, and dental care as a commodity. In doing so, it has taken a simplistic view of dental care that fails to take into account the huge sums of money dentists invest in surgeries and ignores the unique role in screening and diagnosis that dentists are trained to perform. Dentistry is not a commodity; it's the delivery of healthcare to real patients. Failing to understand that serves neither dentists nor patients well."

Tayside orthodontist is honoured by RCSEd

HONOURS

Tayside consultant orthodontist Grant McIntyre was one of five individuals honoured for their outstanding achievements in dentistry at a ceremony at the Royal College of Surgeons of Edinburgh (RCSEd).

Dr McIntyre received a Fellowship in Dental Surgery without Examination alongside Dr Randy Huffines, director of geriatric dentistry at Tennessee's VA Medical Centre.

Two other individuals received Honorary Fellowships in Dental Surgery – Paul Sharpe, Dickinson professor of craniofacial biology and head of the Department of Craniofacial Development at King's College London, and Stina Syrjanen, professor of oral pathology at Turku University in Finland.

Professor Wayne J Sampson, P Raymond Begg chair in orthodontics at the University of Adelaide, received the Fellowship in Dental Surgery ad hominem.

Grant McIntyre picks up his award from RCSEd's dental dean Prof Richard Ibbetson

Dean of the Dental Faculty at The Royal College of Surgeons of Edinburgh, Professor Richard Ibbetson, said: "The Royal College of Surgeons of Edinburgh is delighted that our guests have joined us to receive three of the College's most prestigious awards.

"They have each made unique and lasting contributions to education and advancement in dentistry."

From the chairside p23 | Round Table p28 | Practice profile p37 |

Report. Patients are 'avoiding visiting dentist' due to confusion over charges, report says

Cost of treatment plans

Dentists are failing to clearly explain to patients what the cost of their treatment will be.

And that fact is leaving cash-strapped consumers wary of having their teeth checked.

A report by health insurers Simplyhealth found that 34 per cent of Scots say they avoid going to the dentist because the costs are too high – and they do not understand in advance what they are going to be charged.

Scottish dentists are reportedly the worst in the UK for failing to explain costs – with six in ten adults north of the border saying they have not ever noticed that dental prices are explained to them or are clearly displayed in their dental practice, compared to less than half elsewhere.

Only 27 per cent of people said that during their check-ups they have been given a written treatment plan that included charges, while almost a quarter of patients said they do not believe what they are charged for dentistry treatment is good value for money.

"This means that a significant proportion of British adults may be neglecting their dental health because of the pressure they are feeling financially. This is a worrying statistic that may prove to have long-term negative consequences for dental health in the UK," said the report.

"Patients should ask plenty of questions, so they are able to make informed decisions about their dental health"

James Glover

However, despite fears over charges, the availability of NHS dentistry is on the rise, according to the report.

Only 16 per cent of people say they have struggled to find an NHS dentist, compared to 29 per cent last year and 39 per cent in 2010.

"It is important that patients understand the dental treatment they are being advised to have and the costs involved if they are to value the care they receive," said James Glover, spokesman for Simplyhealth.

"Patients should ask plenty of questions, so they are involved and able to make informed decisions about their dental health."

Dental nurse association lobbies on CPD tax relief

TAXATION

The British Association of Dental Nurses (BADN) has launched a campaign to lobby Her Majesty's Revenue and Customs (HMRC) over tax relief for nurses' CPD costs.

As it stands, HMRC do not accept that costs dental nurses incur while undertaking CPD do not qualify for tax relief, despite the fact that dentists, hygienists, therapists and technicians do qualify for tax relief.

In response to correspondence from BADN chief executive Pam Swain, Exchequer Secretary to the Treasury, David Gaulke MP, wrote: "HMRC do not accept that all training expenses incurred by the (dental nurse) employee will now qualify for tax relief. Expenses must be incurred exclusively as an intrinsic part of the performance of duties.

"On the basis of the information provided (BADN briefing note to Mr Gaulke), the CPD training referred to does not have the characteristics mentioned above.

Nicola Docherty

"No deduction is due for the costs of continuing professional education. That is so even if participation in such activities is compulsory, and failure to do so may lead to the employee losing his or her professional qualifications, and/or their job."

However, BADN president Nicola Docherty pointed out that: "Dentists, hygienists, therapists and technicians who are self-employed or business owners are allowed tax relief on their CPD costs. However, HMRC is refusing to acknowledge that CPD expenses for dental nurse employees are in fact 'incurred exclusively as an intrinsic part of the performance of duties'.

"This is blatantly unfair, as tax relief on CPD costs is denied to those most in need of it. BADN is calling on other dental professional associations and the GDC to support this campaign in order that tax relief on CPD costs is afforded to all registered dental professionals."

The BADN is urging dental nurses and their colleagues to visit their website at www.badn.org.uk where they can download a letter to send to Mr Gaulke and their local MP in support of the campaign.

'Healthy' drinks can be bad for teeth

SURVEY

People in the UK are significantly misjudging the amount of sugar in popular drinks, particularly those perceived as "healthy" options, according to research by the University of Glasgow.

Some 2,005 people from across the UK were asked to estimate how many teaspoons of sugar were in some of the UK's most popular drinks. While people generally slightly overestimated the amount of sugar in carbonated drinks, they significantly underestimated the sugar levels in a milkshake, a smoothie, an energy drink and a variety of fruit juices – by nearly 18 teaspoons for one popular pomegranate juice drink.

For more visit: www.gla.ac.uk/news/headline_230642_en.html

Time for new oral health aspirations

Conference. SDPC chair challenges Scottish Government on dental services

The Chair of the BDA's Scottish Dental Practice Committee, Dr Robert Kinloch, has challenged the Scottish Government to set new aspirations for oral health and dental services and support dentists in achieving them.

Much has been achieved since the publication of the Dental Action Plan in 2005, but this was not a time for resting on laurels, but instead for new challenges to be set and met, he warned. He also applauded successive administrations at Holyrood for the constructive, consistent approach they have taken in recent years, arguing that this approach is a major factor behind the progress that has been made.

Dr Robert Kinloch

At the annual conference of Scottish Local Dental Committees (LDCs) in Stirling, Dr Kinloch commended the efforts of the Scottish Government since the publication of the Dental Action Plan, but set out a number of measures which could be taken to further shape and develop the way that patients are cared for. These included the extension of the Childsmile programme and a renewed commitment and action to improve the oral health of older people and disadvantaged groups.

Dr Kinloch also warned that there must be investment in the IT infrastructure across general dental practice to help provide the information about Scotland's oral health necessary to underpin the development of strategies to fight inequalities.

Stressing the importance of prevention, he reminded delegates of the long-term cost savings that can be achieved by investing in preventive approaches to care and urged the Scottish Government to demonstrate it recognises that in its spending decisions.

Dr Kinloch also stressed the need for action on the conclusions of the 2010 workforce report, including improved, more regular monitoring of Scotland's dental workforce, and urged the Government to recognise the increasing expenses in dental practice and provide support to dentists as they confront this issue.

Aberdeen graduates begin their careers

GRADUATES

Aberdeen University's first dental school graduates are preparing for jobs at surgeries across Scotland.

The 15-strong group were among the first users of the new building, which was opened at Foresterhill by First Minister Alex Salmond and Health Minister Shona Robison in January 2010.

Many have secured places in practices around Aberdeen, Inverness, and the west coast, where they will complete a vocational training year as part of their entry into the NHS after celebrating the end of their four-year postgraduate course in July.

Course representative Alison Ingram said the team would make a big difference to people's dental health. She said: "Traditionally, patients in the north-east had to turn to private dentist surgeries for treatment, but there will now be more choice. With a new injection of graduates, hopefully there will be a fresh boost for the dentistry community in the north east."

One of the future dentists, Karen Gallacher, 27, said: "The group has got on really well and we are going to miss our time together when we graduate."

Jolyon Marsh, 27, said: "Although I applied to a number of dental schools in England, I wanted to stay in Scotland. We see patients from our first year, a lot earlier than some students, and so I feel prepared for working in a dental practice."

Stonehaven wins Good Practice Award

A Stonehaven dental practice has been recognised under the British Dental Association's Good Practice Scheme.

The Arduthie Dental Practice has been working towards the award for the last 12 months. The team has put in a lot of effort to ensure the practice complies with the 100 set criteria. The Good Practice Scheme is designed to ensure excellent standards of clinical care and customer service.

Kenny Jones, owner of the surgery, said that involving patients is an important part of the set-up at the practice.

Practice manager Susan Adams said everyone feels the practice is running more efficiently and standards of care have improved as a result of the award scheme.

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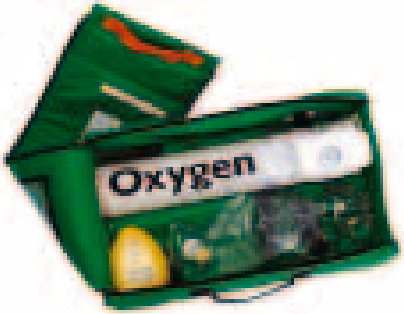

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Meeting. Paul Tipton is guest speaker as capital plays host to country's first study club

The BARD plays to Edinburgh crowd

Dr Paul Tipton was the guest speaker at the first study club meeting to be held in Scotland for the British Academy of Restorative Dentistry (BARD) recently.

The Edinburgh study club was held at the Apex European Hotel in the capital where more than 20 dentists heard a comprehensive overview on bridge design from one of the most respected names in the country.

The Edinburgh branch of the BARD is chaired by Midlothian GDP Stuart Campbell, principal at Loanhead Dental Practice. He was delighted to welcome Dr Tipton, who is president of the academy, to Scotland to hear him speak.

He said: "The feedback from all the attendees was very good. It was very well received. Bridge design is a massive subject and he managed to condense it into two hours and gave us a comprehensive overview of every type of bridge, their preparations, indications and contra-indications for most situations.

"Paul manages to make the complex simple and he brings things back to first principles so that, while you may look at some of his slides and the treatment plans he is carrying out and think they appear to be very complex, he breaks them down into their component parts so it is easier to understand."

Stuart has known Dr Tipton for about four years after attending a number of his year-long restorative courses in Manchester. He explained that the aim is to hold quarterly meetings with top speakers, but if the study club is successful, he hasn't ruled out running post-graduate courses up in Scotland.

He said: "The BARD offers post-graduate awards to dentists in the form of certificates, diplomas and even an MSc in conjunction with the University of Warwick. At the moment that would involve attending courses down south.

"If we get enough interest, I know Paul would be keen to look into the possibility of doing something in Scotland, if we can get the numbers"

However, if we get enough interest, I know Paul would be keen to look into the possibility of doing something in Scotland, if we can get the numbers."

For more information on the BARD and future study clubs in Scotland, visit www.BARD.org.uk

Three steps to managing risk

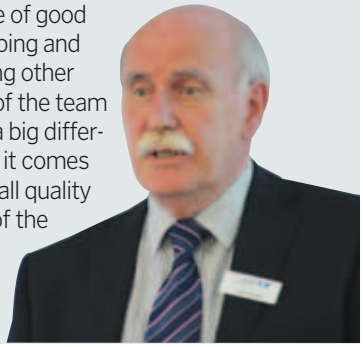
ROADSHOW

The 2012 Dental Protection (DPL) Horizons roadshow rolled into Inverness and Stirling in May with the aim of making delegates think differently about risk management.

DPL's Scottish head of dental services Hugh Harvie (pictured) and Dundee graduate and dento-legal adviser Alasdair McKelvie presented 'Three steps to heaven', a seminar aimed at providing practical advice to help dental professionals in practice, as well as keeping them safe from the various dento-legal threats and challenges they are likely to face throughout their careers.

Topics covered on the night included the importance of rapport – complaints and litigation are far less likely in patients who like you or think that you like them, for example; the principles of valid consent and how to avoid suggestions that patients were 'talked into' treatment.

Other areas Hugh and Alasdair covered included the dos and don'ts of effective, reflective listening; working within your competence; and cases from the files of DPL from around the world illustrating the importance of good record keeping and how utilising other members of the team can make a big difference when it comes to the overall quality and value of the records you are keeping.



Antimicrobial prescribing

The Faculty of General Dental Practice (UK) launched its new standards book; Antimicrobial Prescribing for General Dental Practitioners, at the British Dental Conference and Exhibition on 27 April.

Dean of the FGDP(UK) Russ Ladwa said: "This is a very timely book. I was at a talk on the non-surgical treatment of periodontal disease, where the speaker talked about the over-prescription and misuse of antimicrobials. As a profession, we need to ensure that antimicrobials are only prescribed when necessary and in the right dosage."

Covert recording risks flagged up

LEGISLATION

There's a warning to dentists that the law offers little or no protection from patients covertly recording consultations. Patients are within their rights to record consultations and could use the information obtained to challenge their dentist's actions.

The increasing use of smartphones makes it easier for patients wishing to secretly record a dental appointment and UK-wide dental defence organisation MDDUS advises dentists to keep clear, comprehensive and accurate records of consultations so they can justify their actions in court if necessary.

"A dentist might think a patient would require their permission to record a consultation and that any recording made covertly was illegal," says MDDUS dental adviser Rachael Bell.

"However, this is not the case. When a patient seeks a consultation with a dentist, the information being processed is almost exclusively relating to the patient.

"Under the Data Protection Act, that data is therefore personal to the patient. By recording it, that patient is merely viewed as processing their own data."

It is likely that any recording would be covered by section 36 of the Data Protection Act, which states that: "Personal data processed by an individual only for the purposes of that individual's personal, family or household affairs (including recreational purposes) are exempt from the data protection principles".

For full details of the GMC guidance, click on the link http://bit.ly/lqlcc4

"It is likely that any recording would be covered by section 36 of the Data Protection Act"

Rachael Bell, MDDUD adviser

British Bite Mark launch

NHS and private dental patients in the UK are being offered the opportunity to find out where their new crown, implant, denture or veneer was made. It follows the launch of the 'British Bite Mark' by the Dental Laboratories Association aimed at reassuring patients that their appliance meets the UK regulatory requirements.

A significant number of UK dentists have been sending prescriptions to dental laboratories in the Far East to help reduce overheads, rather than using the traditional route of dental laboratories in the UK.

The Dental Laboratories Association has had a logo designed that it says will help inform patients that their dental appliance has been manufactured in the UK and meets its regulatory requirements.

Richard Daniels, Chief Executive of the Association, said: "Sourcing crowns, bridges, dentures and veneers from dental laboratories in the Far East just to save money isn't acceptable without making the patient aware."

New iPhone app for drug prescribing

An iPhone app to help support drug prescribing in primary care dental practice has been launched by the Scottish Dental Clinical Effectiveness Programme (SDCEP).

The Dental Prescribing app, which is also available on iTunes to download for iPad and iPod touch, provides mobile access to the latest information compiled by the British National Formulary (BNF) and BNF for Children (BNFC).

Based on the popular *Drug Prescribing for Dentistry* guidance produced by SDCEP, the app gives advice on the management of a range of dental conditions in an easy to use, problem-oriented style.

Drug regimens are displayed in a 'prescription-like' format to aid prescribing for both adults and children in primary care and, for the first time, are linked to the BNF website for information on drug interactions.

Advice on the management of medical emergencies, including drug administration, is also provided.

Professor Jan Clarkson, director of SDCEP, said: "This novel guidance format allows dental professionals to access up-to-date information on dental prescribing from their mobile devices and to link to the appropriate drug interaction information on the BNF website."

Dr David Felix, dean for postgraduate dental education at NES, said: "This new way of delivering prescribing guidance will appeal to many in the dental profession and will build on the success, popularity and usefulness of the printed guidance. By promoting the development of new thinking and facilitating the adoption of evidence-based practice, SDCEP's work continues to make an important contribution to the modernisation of dental services."

For further information, visit www.scottishdental.org/cep

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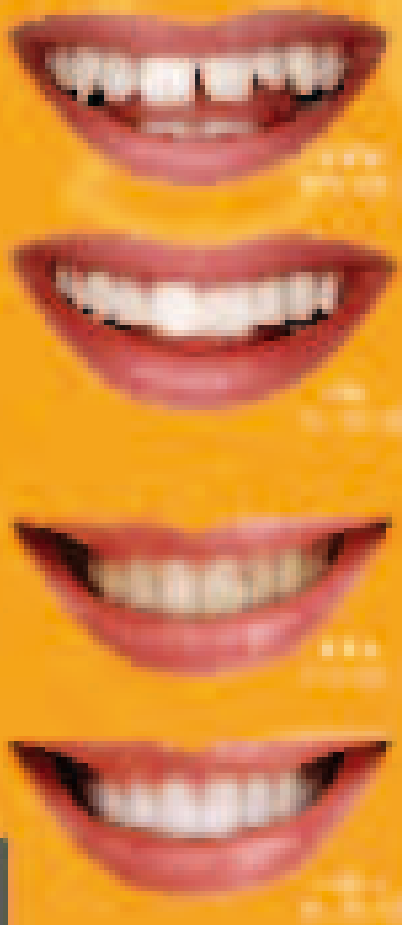

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COLTENE

Something to chew on!

Learning. Professors share knowledge at scientific exchange

There was plenty of food for thought dished up for delegates at the final scientific exchange seminar of the season, sponsored by Oral-B and held at the Conference Centre at Herriot-Watt University in Edinburgh.

About 200 dentists, hygienists and therapists heard lectures by two of the UK's leading researchers – Professors Iain Chapple of Birmingham Dental School and Philip Preshaw of Newcastle University.

Prof. Chapple engaged his audience with a talk on the importance of periodontal health to general health and wellbeing.

He presented new evidence from a large and unique cohort of more than 1200 patients who have been monitored for over 40 years, and illustrated how our lifestyles impact upon longevity and how our day-to-day behaviours drive inflammation in our bodies.

He said: "We need to start looking at our patients' lifestyles in relation to their periodontal status, and trying to give them general lifestyle advice, particularly in relation to nutrition, exercise and weight loss. We must also start thinking more about our patients' general health and how oral health can reflect that."


Iain Chapple


Philip Preshaw

Prof. Preshaw's talk also focused on patients' lifestyles – particularly the worldwide epidemic of obesity, which increases the risk for conditions such as diabetes and cardiovascular diseases. There is emerging evidence, he said, that obesity may increase the risk for periodontitis. Both are pro-inflammatory conditions, and inflammation is at the heart of the links between them.

Later, he said: "As dentists, we've carried out root planing for years, but the responses aren't always optimal. It's not just about the plaque, it's about the inflammatory response as well. The difficulty is in getting an effective treatment that also manages inflammation. I think in future, we'll move towards reducing inflammation as a target outcome rather than just reducing plaque levels.

"Biochemical markers of information, perhaps in saliva, may hold the answer. We're doing studies in the area and trying to identify key molecules. Once we know what those are, we can incorporate the findings into some kind of reliable chairside device that dentists can use."

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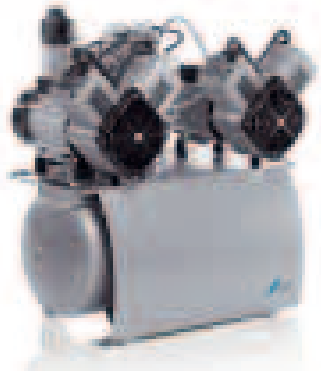

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DÜRR DENTAL

From the chairside

with Alison McKenzie

Get organised for 2013

It doesn't seem that long ago that my first article for this magazine was published on the subject of registration, and now we appear to have arrived full circle as the subject is upon us again.

For some dental nurses, 31 July may represent the necessary juggling of budgets to make way for the annual retention fee or for others the rush to search out extra CPD as a final addition to their end of the year declaration.

So, now is the time to make sure all personal details are up to date with the General Dental Council (GDC) to ensure that any information on this subject is received in plenty of time. The easiest way to do this is by accessing its website, where details can be checked or changed and direct debit forms completed in order that the payment date will not be missed.

Remember that CPD hours should be declared annually. So far, almost 6,000 registrants have failed to declare any (*GDC Gazette* – spring 2012). The major difference this year for dental nurses who registered in 2008 is that they are nearing the end of their five-year CPD cycle in 2013. This includes me and 41,499 other dental professionals. It is easy to allow CPD commitments to slip – it was only after reading the ERS research survey on attitudes towards continuing professional development (available on the GDC website) that I was encouraged to check my own CPD portfolio, and finally completed the piled articles on my desk.

Dental nurses are now required to complete 150 hours of CPD and this must include 50 verifiable hours, with the remainder non-verifiable. The recommended core subjects include medical emergencies, radiography and radiation protection, disinfection and decontamination. Also recommended are legal and ethical subjects and customer handling.

All certificates and completion of CPD evidence should be logged in the form of a portfolio which should be kept for five years after the end of the cycle in which they were completed, as dental nurses may be asked to produce it for a random GDC audit.

"CPD hours should be declared annually. So far, almost 6,000 registrants have failed to declare any so far"

It is important that we complete registration and CPD requirements on time, otherwise we risk losing our registration and the ability to work as dental care professionals. The procedure to reapply to get back on to the register will take time and, in addition, there is an added restoration fee on top of the ARF fee, each affecting the employer and dental professional.

Despite the added responsibilities and costs, the combined registration, annual retention fee and continuing professional development is a small price to pay. Registration not only allows us to be recognised as dental care professionals, but the CPD portfolio and five-year cycle also serves as a personal development plan and a record of training showing a commitment to increase skills and knowledge which benefit not only the practice and dental nurse, but, more importantly, increases standards and patient confidence. ■

Interview
By Bruce Oxley

Pursuing an **opportunity**

Honoured by the Royal College of Surgeons of Edinburgh, orthodontic consultant Grant McIntyre tells *Scottish Dental* that it's all down to one man – his uncle

Tayside orthodontic consultant Grant McIntyre was recently honoured by the Royal College of Surgeons of Edinburgh with a Fellowship Without Examination. It was recognition of the contribution he has made to the MFDS exam, the MOrth exam and the work he will do for the College in the future.

However, Grant revealed that the inspiration that set him on a path to becoming one of the leading hospital orthodontists in the country, was visiting his uncle's practice in Johnstone, Renfrewshire, as a child. A west-coaster by birth, Grant grew up in Paisley and decided midway through his school years that a career in dentistry was for him.

He said: "My uncle was a bit of a role model for me, an independent professional who was able to make a contribution to the local community and that really sparked my interest.

"Unfortunately, he passed away when I was still in dental school, so he didn't see me graduate, which was a real shame."

At dental school in Glasgow, Grant found the area that really grabbed his attention was orthodontics. He explained: "I really enjoyed orthodontics and, on graduation (in 1993), I thought, the opportunity is there for me to pursue it. So I decided that it was the career that I wanted within dentistry and I started to plan my career jobs to fit my aim."

His VT year in Biggar in the Borders provided the final confirmation for Grant that a life in general practice wasn't for him. He said: "It wasn't a negative experience at all, in fact it was wholly positive. Dentistry in practice has two elements to it, obviously there is the dental care itself but there is also the running of the business and all the pressures that come with that.

"That actually confirmed for me that orthodontics was the route for me. It was a positive decision in that I wanted to spend time with patients rather than running a business."

After VT, Grant moved away from Scotland and embarked on an SHO job in oral surgery and orthodontics in Wigan and Manchester. After a year in the north-west, he embarked on the primary fellowship with the Royal College of Physicians and Surgeons of Glasgow and then returned to Glasgow Dental Hospital to complete the Fellowship in Dental Surgery.

It was at this point Grant applied for specialty training in orthodontics, which brought him to Dundee and opened up the Tayside chapter in his life. Apart from a couple of years completing his orthodontic training in Glasgow, he has been based in the City of Discovery ever since. He completed his PhD in Dundee, examining the craniofacial shape of parents of children with a cleft lip and palate, a subject that he has continued to focus on through his career.

He said: "In actual fact, when it came to looking for a consultant post, I was keen that the job would allow me to provide orthodontic care for children with a cleft lip and palate. Luckily I am still doing this today and I am still enjoying the interaction with the patients and their families."

Grant explains that the other main driver behind his clinical work is being part of the orthognathic surgery team. He said: "As well as the cleft lip and palate patients I am also on the orthognathic surgery team, working with people with fairly significant skeletal deformities. For both the patients with clefts and the orthognathic patients, quite often the satisfaction that they express at the end of the treatment really gives me a huge buzz. That's a big driver for me."

"My uncle was a bit of a role model for me... an independent professional"

Grant McIntyre

Grant mentioned that he also enjoys orthognathic surgery planning and, as well as doing cephalometric planning, he is often to be found in the laboratory discussing individual cases and planning the occlusion on an articulator with the technical staff.

Away from clinic, Grant is also the training programme director for the orthodontic specialty registrars based in Dundee and he explains that he enjoys seeing the trainees through from the start of their training to their future careers in either specialist practice or to a consultant post. He said: "In the time I have been the programme director, it has been hugely satisfying to see our trainees start off as very inexperienced in orthodontics, but finishing specialty training as highly skilled and highly qualified orthodontists."

As well as this, Grant explained that he is also currently the chair of the specialty training committee for orthodontics at NES and is also involved to a lesser degree in undergraduate teaching and in foundation years training. He attributes his interest in learning and teaching to his parents, both of who were involved with education – his mother being a primary school teacher and his father a college lecturer in mechanical engineering – and they both discouraged him from a career in education. He said: "It is funny that my parents both said to me, the only career you shouldn't contemplate is education, and here I am with it occupying quite a bit of my role these days."

Grant's other interest is research, and it's something he admits to spending more time on than he should. "Being involved in studies investigating fixed appliances, tooth-size discrepancies, 3D imaging of smile aesthetics, CAD-CAM for cleft lip and palate patients, the Scottish cleft lip and palate electronic patient record,

Continued »

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electronic orthodontic referrals and two Cochrane reviews requires several hours at the laptop each week when I shouldn't really be working," he admits. But the discovery aspect of research and publishing the research findings is something he enjoys.

Moving away from research, when asked about his thoughts on the introduction of the Index of Orthodontic Treatment Need (IOTN) in Scottish orthodontics, Grant believes that it hasn't made as big a difference as was possibly expected. He said: "A couple of years ago I was part of the Scottish Government Orthodontic pathways group, and at that stage we did discuss within the group the introduction of IOTN 3.6 and what would that mean for Scottish orthodontics.

"To be honest I don't think it has made a huge change to the patients I see on a day-to-day basis. I think the ebb and flow of referrals would be there anyway. It is a fairly arbitrary threshold but it is probably what most orthodontists are working to and I don't think it will make an enormous difference across the board."

And the anticipated wave of patients being turned down for orthodontic treatment just hasn't materialised. He said: "I haven't seen that and I certainly haven't heard that from my colleagues in specialist practice."

Grant has been involved with the Tayside appeals process and he believes it is working well. He said: "I think it is fair and right that there is an appeals process but ultimately if the appeal is not successful then the patient will have to either accept that they are going to have some sort of minor malocclusion or they have to seek private treatment.

"Unfortunately, at the end of the day there is not an endless amount of money available, especially in the midst of this recession we find ourselves back in again."

The economic situation of working within a consultant post also means that there are a number of technologies available to private clinicians that Grant and his colleagues in the NHS hospital sector are unable to take advantage of. He said: "It would be brilliant if we could provide lingual orthodontics within the hospital service. I think that would really extend me as a professional and that is something that I am really conscious that I do miss out on. Some days I wonder whether I should do some private practice, but then I think 'where would I fit it in?'"

"It is a fairly abitrary threshold... I don't think it will make an enormous difference across the board"

Grant explained that they don't have the opportunity to use aligner-type appliances either, but for many of the cases that they treat, he concedes that it wouldn't be entirely appropriate.

Looking to the future, Grant acknowledges that the main challenges facing orthodontics in the hospital system are the age old problems of missed appointments and simply getting compliance among patients to actually wear the retainers they have been given. ■

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Taking care of business

Do dentists have enough business expertise? And what quality management system can help? These were the questions up for debate at the recent *Scottish Dental* round table, writes Bruce Oxley

Held on the eve of the Scottish Dental Show, the latest Scottish Dental Round Table evening focused on quality management and a unique new piece of software.

Drs Andy Toy and John Barry hosted the event and Andy set the scene for the evening with a short presentation on the benefits and challenges of adopting modern standards of quality management into general dental practice. Referencing Professor J Edwards Deming's research on Total Quality Management, Andy established how this business model enables dentists to provide ethical, high-quality dentistry, while still making a profit.

Total Quality Management can be distilled into the phrase, 'doing the right thing right, first time, every time'. Dental practices should focus on being effective, efficient and consistent if they wish to increase the quality of their service and raise their profits. Andy explained that in his experience, it is the development of consistency that can provide the most improvement in a practice team's performance. This requires an initial investment in the creation of practice systems, with written procedures to improve quality control and practice communication and, crucially, enable the business to evaluate its performance.

Andy went on to report Deming's research which showed that 85 per cent of all business problems were due to inadequate or missing

systems, and only 15 per cent were the result of poorly performing workers.

He said: "This is a wake-up call for those dentists who have a tendency to blame their team if something goes wrong. It is often easier to blame someone else rather than take the time and trouble to build a really good system."

He continued: "Successful practices develop practice systems that place the patient at their centre. This enables the whole team to understand the relevance of written procedures and audits to their daily work. Quality management becomes central to their work and essential for high-quality dentistry, not an irritating extra imposed by management."

Once practices have understood this, he said, they then face the challenge of making their quality management systems accessible to the team.

"A system held in folders on the practice manager's shelf is unlikely to be at the forefront of the mind of even the most well-meaning team member," he said.

At this point in the evening, Andy revealed the revolutionary, new quality management system known as SUSAN (Simple to use, Unique to your practice, Systems driven, Always updated, Never absent). He described how this cloud-based information software platform's intuitive and powerful design allows every member of the team to quickly access a wealth of quality management tools – including interactive procedures, training videos, audit and reference materials (such as COSHH, financial and HR). "Having SUSAN at hand to help every team member allows the dentist to put quality management at the heart of their practice and to raise both quality and profits," he said.

Following Andy's presentation, the conversation quickly turned to business and the business of dentistry. Dr John Barry posed the question as to why there is no business element on the average dental schools' curriculum.

Edinburgh GDP Hew Mathewson said: "In some schools they have tried business stuff on the curriculum, but it is not examined and therefore it has taught the students not to turn up because they are not interested.

"It is often easier to blame someone else rather than take the time and trouble to build a really good system"

Andy Toy

"It is not a subject that the NHS tends to invest money in and that's because it does not recognise that you don't do good dentistry in a badly run practice."

David Foster, managing director of Braemar Finance, explained that he has been involved with dental finance since 1984 and he has spoken regularly to final year students and VDPs in that time. He said: "Through experience, it is obvious that speaking to newly qualified dentists about how to run a business is not relevant as most will not even consider starting their own practice for at least five years after graduation. Many will simply switch off.

"Instead I have found that a general appreciation of the world of finance as well as understanding and managing money is of greatest relevance at this early stage in their careers, and I have tailored my talks to reflect this."

Hew Mathewson then said that he never ceased to be astonished at the ignorance of the profession on financial matters, both professionally and personally, to which Andy Toy responded: "You have got to understand that education is not about filling an empty vessel. When they are ready to learn the teacher arrives, and you just hope it's the right teacher."

John Barry said: "I've seen people who are in real trouble, but it really frustrates me when I see guys who are earning £100k a year and have not got a penny and I know people who are on £15k a year who have savings. That frustrates me about the level of, I don't think it's ignorance, I think it's incompetence."

Alan Walker, director of general

Continued »

MEET THE PANEL

Andy Toy
CEO of The Dental Business Academy

John Barry
Operations director of The Dental Plan and director of the Dental Business Academy

Nicola Docherty
President of the British Association of Dental Nurses

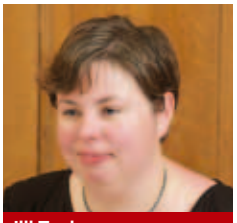
David Foster
MD of Braemar Finance

Andy Hadden
Dento legal adviser and board member of FGDP(UK)

Ian Matheson
MD of Wright Health Group

Hew Mathewson
GDP from Edinburgh

Charles Ormond
GDP from Falkirk



Jill Taylor
President of the Association of Dental Administrators and Managers

Alan Walker
Director of general dental practice education for the west of Scotland

Continued »

dental practice education for the west of Scotland, said: "It is absolutely true they will only go to the well if they are thirsty and when John is saying that someone calls him in when they are in trouble, that is because they have a need. They can contextualise what you are telling them at the time and that could be at quite different times. Tax might be their focus this year, appraisal might be in two year's time."

"We have to start with the kids in dental schools, or am I wrong?" asked John Barry.

To which Hew Mathewson responded: "The dental school curriculum is grossly crowded and is increasingly badly taught in overcrowded dental schools by overworked academics.

"My own thought is that there should be a compulsory module and the moment you want to own a practice then you have to do this module and pass an online assessment. It needs to be there, but what happens is that people sail into buying and owning practices without that basic business skill."

Jill Taylor, president of ADAM, said: "The biggest difficulty I found as a practice manager was that you didn't know where to turn. You think you are doing the right thing but you're fumbling about in the dark. If there was a resource that you could go to then I would certainly have welcomed it in practice."

Hew Mathewson then brought up the issue of government cuts in dentistry. He said: "We know there are cuts coming, you don't have to be a genius to see that there are more and more dentists in Scotland and a fixed budget.

"I think unemployment will really bite after 1 August. I advertised a job which went on the BDJ website two weeks ago tonight and I have had 60-plus applicants."

The conversation then turned towards training and Charles Ormond, a GDP from Falkirk, asked about SUSAN's online training components, commenting that: "I don't think that there is any substitute for hands on training of a practical procedure in the practice, rather than watching it on a video."

BADN president Nicola Docherty agreed, stating that NES has a DVD for medical emergencies training but that they are still recommending that dental professions do at least one face-to-face training session. John Barry responded by explaining that the training on SUSAN is best used to supplement face-to-face training. "Learning doesn't happen in one event, learning happens by repetition," he said.

He said that he would rather his staff look at something like medical emergencies four times a year including a face-to-face session, something that SUSAN can facilitate and record to make sure that the staff member has done the training.

Hew Mathewson then remarked that some colleagues complete much or all of their CPD online. "It becomes very easy to hide away, fill in a questionnaire and get it all badly wrong and still get the CPD," he said. "It is only when you are exposed on a hands-on course that you are challenged."

The question of dentists supporting their staff members' training, in terms of money and time, was then tackled. Nicola Docherty said: "We have actually got dental nurses who have to pay for their pre-registration training."

And David Foster responded by saying: "Out of a hundred sets of accounts we would probably see two where training is a recognisable item in the expenses column. It just doesn't appear."

The table then turned their attention back to dentists as businessmen and women with John Barry saying: "The dentist is an accidental businessman. What gets in the way of dentistry is money. If the dentist wants to do dentistry, they will do the best treatment they could possibly conceive for every patient that walks in the door. But that is not reality. Reality is we have to have this debate about what somebody can afford. Even on the NHS."

Alan Walker then asked: "Are we slowly moving away from the situation of the dentist being the sole business manager, towards them delegating things?"

John Barry commented that some practice managers are simply not allowed to do their jobs by a dentist who "doesn't know what he doesn't know". To which Jill Taylor responded by saying: "Quite often they are given the title of practice manager and they are dumped out onto reception and expected to be a receptionist with a practice manager's title."

"If you are not in charge of a budget, you are not managing," said John Barry.

"You are just given a title and the blame," agreed Hew Mathewson.

Nicola Docherty then asked: "Is

"Learning doesn't happen in one event, learning happens by repetition"

John Barry

it a control thing though? A dentist I worked with called me his practice manager, but it was just a title. You can appreciate that it is his business...”

Hew Mathewson agreed, but said he believed that dentists have to delegate to somebody and this is where leadership skills are called into question. He said: “A dentist is supposed to be a leader of a team. That is misleading, they should be saying at dental school that you are training to be a leader of the clinical team, not the whole team and that is part of the problem.”

Andy Toy agreed, saying that he says to young dentists: “The only reason I need to employ a dentist (over a DCP) is to be a leader and if you haven’t got leadership skills I don’t need you. I need a leader of a clinical team – that is the only reason I need a dentist right now.”

Ian Matheson, managing director of Wright Health Group, then said: “A friend of mine has just retired after being in practice for more than 30 years. He said you are not a truly qualified dentist until you have been mentored in good disciplines and methodologies in a practice for five years. This emphasises the key role of the mentor within the practice and the broad experience factor in order to become a proficient practitioner.”

Andy Hadden, dento-legal adviser and board member of FGDP(UK), returned to the earlier point of dentists not having enough financial knowledge by saying: “We also see some entrepreneurs coming through who want to run dentistry very much as a business and the main aim, not surprisingly, is to make money.”

“I believe that audit is probably the most powerful management tool there is”

Andy Toy

John Barry expanded on the point: “Can I draw a distinction Andy? A business is something that is sustainable. What you are describing, and I understand it exactly, is exploiting the cash cow until you kill it. And that’s not business. A dental business has to run on ethical lines and make a profit to be sustainable.”

To which Andy Hadden said: “But the type of treatment that some people do is almost unethical. You may well joke about what in the past would be called the amalgam free practice, well we are going to be heading for the enamel free practice soon, with some of these people.”

Andy Toy then turned the attention back towards the practice managers, asking Jill Taylor and Nicola Docherty what the level of support is for them in the average practice. Both agreed that it is changing for the better with Nicola Docherty saying: “It is about education, it is about educating the practice owners to trust their practice managers and to allow them to gain a qualification.”

And Jill Taylor then said: “Going back to what we were talking about earlier, with the current economic crisis, I think for practices that can’t afford a practice manager, SUSAN is the next best alternative.

“A lot of practices are having to make cut backs and this is a way for them to have everything in place but without a full time or a part time member of staff.”

John Barry then explained that the more people using SUSAN, the ‘smarter’ the software becomes, creating a “resource that is going to be unbelievable”.

“When people see all of the things that SUSAN can offer – all the training resources, all the CPD resources, all the information, all the tools, there is something in there for everyone that makes it worthwhile. There is enough in SUSAN to excite everybody.”

Andy Hadden then asked: “How would you sell this to the practices that already have all the systems in place?”

“They don’t,” replied John Barry. “Some of them have a lot, but SUSAN fills in all the gaps.”

Andy Toy said: “If they recognise the importance of systems then this makes it all the more accessible, powerful and with the added extra of regular updates.”

Ian Matheson then brought up the question of internal quality audit, asking Andy and John how SUSAN can help “close the loop”?

Andy replied by saying: “I am one of the most experienced dentists involved with audit in the UK. Over the last 15 years or so, I’ve advised more than 1,500 dentists with their audits.

“I personally believe that audit is probably the most powerful management tool there is. We can make it easy for people to carry out audit using SUSAN, because we can provide them with the resources that they need, not just the procedures but then the ability to audit those procedures. We are already building that in.”

And John said: “The great thing is that we can close the loop. There is nothing that we can’t do with this product in terms of its versatility. And as we grow it will become even easier to make it even better.”

“That’s the message,” said Andy. “That is absolutely the message – we build a community.” ■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Avoid the recession and prosper

Ashley Latter, the author of *'How to Communicate Effectively & Create the Perfect Patient Journey in your Dental Practice'*, offers some suggestions from his recent Scottish Dental Show presentations on how to buck the trend and prosper in the recession

Don't take part in the recession, you have my permission. I can still hear the words now in my ears, as my sales manager gave me some sound advice on a one-to-one appraisal, and this was 20 years ago.

At the time I was a consultant for the Dale Carnegie Training organisation in Manchester. I had just had another poor month figures-wise and I was blaming everyone but myself for my poor performance. The number one excuse was the recession. My manager soon put me straight. As he quoted the other consultants' figures – they were all very good – he told me don't take part in the recession. This is still one of the best pieces of coaching I have ever received.

Twenty years later, we are living in another prolonged recession, with no end in sight. The economic destruction of the last few years is still continuing and it is making business life treacherous. Whether you like it or not, 2012 will be survival of the fittest. From the crossroads, there are two choices. Path one, stay as we are and hope for the best (hope and prayer have never been great business strategies). Or path two, which is the path where you embrace up-to-date marketing and sales strategies – this is the path that secures your future and a business that will thrive.

There is no middle path anymore. Here is a reminder of some of the strategies I shared with my delegates at the recent Scottish Dental Show.

Receptionists ARE the most important people in your practice

The receptionist is the most important person in your practice. They can make or break whether a patient visits your practice or not. Every enquiry into your practice is potentially worth £3,000 at least, if they stay with you for say 10 years. That does not include referrals of family, friends, or having any treatment done. Another thing to think about is that if a patient is contacting you about your services, they are probably ready to make a purchase.

Does your reception team answer the telephone as if the patient is worth £3,000? I recently did eight mystery shop telephone calls to practices enquiring about their services and prices. Not once did the receptionist ask me to make an appointment.

Train them; they are the most important people in your practice. They can make or break how successful, or unsuccessful your practice will be.

Marketing – how many legs has your business got?

To fill my programmes I undertake over 14 different types of marketing. These include:

- sending two newsletters out each month
- writing articles
- speaking at conferences
- asking for referrals
- following up with clients after my courses and more.

How many marketing activities are you undertaking in your practice? A chair has four legs. If one breaks, the chair can potentially fall down. That is the same for your business/practice, so you need to be undertaking at least six different marketing strategies to ensure that you maintain patient numbers and also grow them at the same time. Marketing is full time - to be done all the time, not just when you are quiet.

Understand that selling is not pushing products and services to patients – it is all about asking questions

Sales legend Zig Ziglar once said: "You will get all you want in life if you help enough other people get what they want." You know what, it is true!

To me, sales is all about giving your patients what they want and need and in doing so, it will give you the income you want, need and deserve.

Ask lots of questions, listen attentively to their answers and watch what they do.

Never talk to your patients about what you do and can offer, ask questions, be quiet and they will then tell you what they want. Yes, want, because that is what patients spend money on, things that they want. There are probably thousands of pounds worth of opportunities in your existing database if you ask them lots of questions.

The biggest mistake dentists and sales people make is that they try and sell the services before they truly find out what the patient (customer) requires. It is the biggest sin and, when you do this, patients think they are being sold to.

So, my advice is to get into the habit of asking lots of questions and become an outstanding listener. When you do this, then you become a world-class solution provider and not a salesman. No one likes to be sold to!

Pick up the telephone

Seventeen years ago I rang two dentists six weeks after they had taken one my courses, to see how they were progressing and if they needed any help. Since then I have delivered my two-day 'Ethical Sales &

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Communication Programme' to more than 5,500 delegates worldwide, spoke at every major UK dentistry conference, written two books, have friends all over the world and have an incredible lifestyle. All because I made two telephone calls. Have you ever made a purchase and then received a telephone call from the sales person, or the company, just to say thank you and to see if you are enjoying the service or product that you purchased? I think it happened once in my life and when it did it made a real impact on me.

So, why not call a few patients a day at home to see if they are okay, especially if they have had a challenging procedure, and just ask them if they are alright and is there anything you can help them with? It will take probably less than five minutes to do per patient, but think of the impact it will have. Your patients will be not only impressed, but over the moon. They will tell their friends.

Now, if you did this say three times a day, five times a week, over 52 weeks, you will touch and be impressing over 750 patients. Do you think that will make an impact on your relationships?

So pick up the telephone... it is good to talk!

Websites – no one cares that you have nice and friendly surroundings

Most dentists make the mistake of seeing a website as something that they "need to do" or even as a necessary evil. If you think like that it will cost you an awful lot of money.

The vast majority of websites don't make money and a lot of research has taken place showing that the average time before a potential client leaves a website is eight seconds. In other words you have only got eight seconds to capture the interest of your client and keep them on your site. If the front page of the website talks all about you, how long you have been in business for and that you have a friendly team with lovely surroundings, who really cares?

My advice is that you must see it as a very important part of your marketing because it can generate a significant amount of income to the practice. Please do not shove it onto your 'web-guy' who often is a designer and not a marketing expert. They might make your website very pretty and dynamic, but is your website 'sales prevention' or is it 'creating opportunities'?

So, please visit your website/homepage and take the eight second test. Be absolutely ruthless! Does it engage you to want to visit all the other pages, or does it bore the pants off you? Your potential clients are interested in what you can do for them, not about you.

Ask for referrals – if you ask, people will say YES

I could write a 10-page article on asking for referrals, but one thing for sure is it is the easiest way of growing your new client base and, at the same time, it costs virtually nothing, just a thank you card or small gift.

Ask all your nice patients for referrals and they will introduce you to their nice friends. That is how the world ticks and you will be surprised at the results. Just by asking it will significantly increase the opportunities of receiving and generating more patients. At the moment they might think you are full.

If you ask for referrals and keep doing this every day, you will build up a steady stream of new patients. What you need to do is to thank the people that refer new patients to you. Simply by sending a thank you card and maybe a small gift, such as bunch of flowers for women, or book to a man you will delight your referrers and it just might encourage them to send you more.

After all, how do you feel when you receive a thank you card and a small gift as a thank you? It does not happen that often.

Market yourself to the high end of the market – that's where the money is

William 'Willie' Sutton (1901-1980) was a profligate US bank robber. During his 40-year criminal career he stole an estimated $2 million. For his talent at executing robberies in disguises, he gained two nicknames, 'Willie the Actor' and 'Slick Willie'. He is famous for his answer to why he robbed banks: "Because that is where all the money is."

There is still a large percentage of the population, where this recession is having no impact at all on their incomes and life styles. They still spend money like they always have done and are still doing very well. My advice is to market to these people. Ensure that your patient base is made up of the high end of the population. ■

ABOUT THE AUTHOR

For the last 20 years, Ashley Latter has personally coached more than 5,750 dentists and their team members on his two-day 'Ethical Sales & Communication Programme' all over the world. He is also the author of two books, the latest of which is called *How to Communicate Effectively & Create the Perfect Patient Journey in your Dental Practice*. To receive his FREE email newsletter, which is read by 10,500 people every month, please visit www.ashleylatter.com to register.

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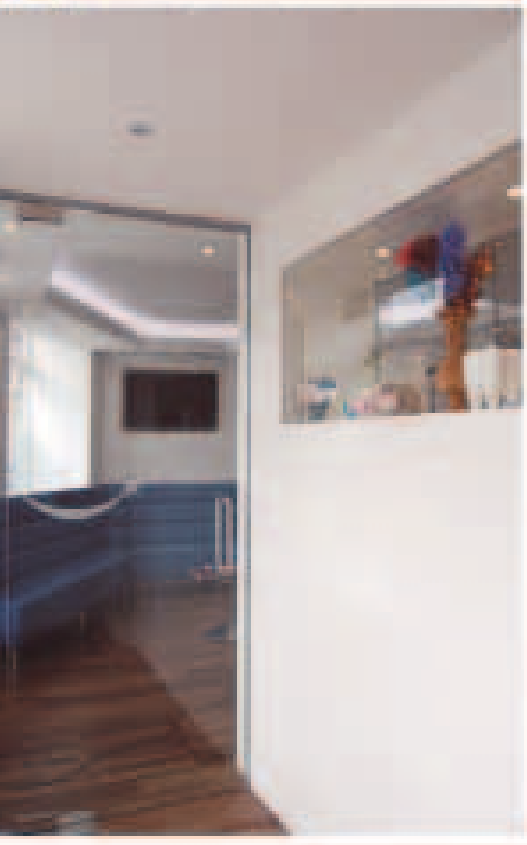

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M-Brace-ing a new practice

When he bought the property in Bathgate earmarked for his new orthodontic practice, Raja Mahesh knew it would take a considerable amount of work before the building would be ready to welcome patients.

However, little did he know that it would take as long as two years and include some major reconstruction work, including replacing or repairing the vast majority of the woodwork in the building.

Mahesh, who opened his first M-Brace Orthodontics practice in Glenrothes in June 2010, bought his second property at 2-4 North Bridge Street in February 2010. He hired Farahbod Nakhaei and his team at NV Design & Construction from the outset and together they set about bringing the building up to standard.

As it turned out, there were a couple of initial stumbling blocks that needed to be overcome before the building control application could be granted. The first problem was in relation to disabled access. As the practice was situated over two floors, Mahesh and Farahbod had to argue their case against installing a lift – which, as well as being prohibitively expensive, would have taken up a significant amount of space. They argued that, with one surgery downstairs and all staff and patient facilities being situated on the ground floor, disabled patients could easily be seen in the downstairs surgery and if they were to hire a disabled member of staff, they would be able to work solely on the ground floor.

The second stumbling block to getting the building warrant was the original wooden staircase that was situated in the centre of the building. Building control regulations for new dental practices prohibit wooden staircases for fire safety reasons and, as such, it needed to come out. The plan that Farahbod and his team came up with was to remove the staircase and install a new metal stairway in the back corner of the building, meaning that the floorspace taken up by the old central wooden stairwell, could be better utilised on the ground and first floors.

Above (from top): The exterior of the new practice, surgery number one and the reception area

With all paperwork in place by May 2011, work started in September of that year. However, no sooner had work began than it became apparent that the whole building was infested with woodworm. The more the workers explored the woodwork, the bigger the problem was found to be, as Mahesh explained: "When I bought the premises I knew it had problems, but the extent of it took us all by surprise. At one point during the construction, you could stand on the ground floor and see the roof two storeys above you. The building had been stripped to its shell."

After having a clean asbestos survey report, all the floorboards in the building had to be pulled up, skirting boards ripped out and everything that was salvageable had to be treated to ensure it stayed free from woodworm for the foreseeable future.

On top of that, it was clear that the entire ground floor structure was badly affected with damp. Farahbod and his team removed all the rotten floorboards and replaced them with a concrete floor. There was also a small amount of structural strengthening that was needed on the gable wall at the rear of the practice but, with the building dating back to 1856, Farahbod explained that a certain amount of subsidence is not uncommon.

All the walls and loft spaces were insulated and all the windows were replaced with double-glazed wooden sash and case windows to maintain the original period feature.

The main structural work was completed in January 2012 to allow

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the electricians and plumbers to get in and rewire the building and install all the new pipework required in a busy orthdontic practice. Under Farahbod's watchful eye, all the different trades – which also included IT solutions from Ian Wilson at IW Tech – were managed carefully to make sure that they could all get on with their jobs without tripping over each other.

When you walk into the practice it is not obvious at first that any major reconstruction has taken place. The building itself is a corner plot and the advantages in having three front facing walls also means that the interior is not made up of multiple right angles and sharp edges.

And, it is only when you get up onto the first floor that the scale of the job becomes apparent. Through the door from the new stairwell in the rear corner of the building, you enter a spacious landing with doors to the two upstairs surgeries, the LDU, office and small laboratory. Mahesh explained that this was the area taken up by the original stairwell and you get a sense of how the building has changed.

Farahbod explained that it always helps when clients have a clear idea of what they want. He said: "We are the facilitators. We are here to help the client get what they want so we show them all the options and help them to decide what is best for them."

With another practice already open in Glenrothes, Mahesh had a clear corporate identity, so the blue and white colour scheme was relatively straightforward. Farahbod was able to use 3D visualisation software to show Mahesh a computer-generated image of his new practice before work started so he could choose from dozens of different colour and lighting schemes to get the best look and feel for the practice.

Mahesh said: "I must say the final look is very close to what I was shown on the 3D imaging software."

All three surgeries in the practice have been arranged with the same layout to allow for ease of use and transfer of staff between surgeries. Integrated cabinets and storage units give the surgeries a very clean and uncluttered look, while having everything close at hand for the staff.

Technology is another big consideration in the new practice, starting with a touch-screen self check-in facility at reception, through to flatscreen televisions in the ceiling above the chairs to occupy child patients and an integrated communications system that allows iPod and radio, phones and the tannoy system to be accessed centrally and from each surgery.

Mahesh said: "I had a very clear idea of what I wanted from this project and, despite a few obstacles in the beginning, we have managed to achieve this and I am delighted.

"Farahbod and his team have created an interesting, bright and professional practice that my staff, patients and visitors alike are thoroughly impressed with." ■

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Selling or buying a practice?

The figure '60' has been popular lately with the focus on the Queen's Diamond Jubilee, but it is also a figure that looms in many dentists' minds as an age at which – or by which – to retire. With many practitioners being members of the 'Baby Boomer' generation there are a significant number of dentists considering packing away the drill and mouthwash.

But these individuals have worked hard to build a good practice and are seeking to realise the value of what they have created – can they do so? Clearly the first thing to do is identify someone to sell to; it could be to younger partners, or it could be another practice looking to expand. Either way, the purchaser is likely to need some financial assistance and the reality is that the banks are lending at lower rates than pre-recession, when 100 per cent loans were not difficult to find. Now, 80 per cent is a good loan.

Many practices now have to be much more commercially orientated than in the past, with investment in IT and staff resourcing increasing all the time. In general, younger dentists are more oriented towards this approach and the need to invest. Therefore, those seeking to retire might look at the trade-off of selling at a slightly reduced rate, thereby avoiding the need to invest further in the practice. The purchaser can put together a business plan based around their investment intentions, with banks being more receptive to the returns identified in a business bought at a lower price but with growth potential.

The advice of an objective third party, such as an accountant, can be helpful. Realistic valuations of the business itself and of any property involved, plus creative structuring of payments, can be effective in closing the lending 'gap' and help achieve a satisfactory outcome for buyer and seller. ■

Paul Thompson

Paul Thompson is a partner with accountants and business advisers, Scott-Moncrieff. To contact Paul email paul.thompson@scott-moncrieff.com or phone 0141 567 4500

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R£LAX for implants

Dr David Offord and Dr Louise Henvey explain how an implant training programme can benefit practices' bottom line

Vermilion, the referral clinic that opened in west Edinburgh one year ago, has introduced an implant training programme called R£LAX which has already resulted in a number of its referring dentists now restoring single implant cases.

The idea behind R£LAX is that the GDP refers a patient who has a single tooth gap or failing crown. The implant is placed by the specialist at the referral hub; the patient then returns to their own dentist to have the implant impression taken and the crown fitted.

Vermilion has launched this initiative in conjunction with Dentsply Friadent, through hosting a series of R£LAX nights, which offer free training in the Ankylos implant system to help get GDPs started in dental implant restoration for straightforward single-tooth cases.

Historically, a GDP would refer an implant case to a specialist clinic for both the implant surgery and the restoration, but increasing numbers of dentists are finding that restoring their own implant cases is an excellent practice-builder. In addition to being able to offer their patients a wider range of restorative options and enhancing their long-term patient relationships, dentists are discovering that restoring dental implants can create a new and profitable revenue stream for their clinic. Undertaking the restorative phase of the treatment enables general practitioners to benefit from the continuing expansion of the implant market without having to learn how to place dental implants.

"Restoring dental implants can create a new and profitable revenue stream for clinics"

David Offord

David Offord, a specialist in oral surgery and practice principal at Vermilion, has hosted a number of R£LAX evenings over the past year with his specialist prosthodontist colleague, Grant Mathieson. The events, which normally attract about 10 to 12 referring GDPs and include food and refreshments, start off in the seminar room where delegates learn the basics of case selection and treatment planning.

GDPs are taught how to take an Ankylos implant impression and how to fit a screw-retained implant crown, before they move through to the surgery to observe Grant with an implant patient who is scheduled

for implant impressions or crown fit. The next part of the evening involves a practical session where attendees get their gloves dirty with impression copings and trays, and actually take an implant impression on a model. Finally, it is back to the seminar room for a recap and questions.

The capital outlay to the practitioner in getting involved in restoring implants is nil, while the typical profit per implant crown is £500. Attendance at the R£LAX evenings at Vermilion is free (including 2.5 hours of CPD), and once the GDP makes their first referral, they will receive an implant prosthetics kit from Dentsply worth £605, which contains everything they need to restore Ankylos implants. Their first case can be carried out at their own practice with the Ankylos representative, or if preferred, at Vermilion under the watchful eye of prosthodontist Grant Mathieson.

It is of paramount importance that these single-tooth cases are carefully vetted as to their suitability for implant novices to treat. Through the Vermilion refer and restore programme, David and Grant work very closely with referring colleagues to ensure they are tackling suitable cases. However, in many instances, where the patient is missing a tooth or has a failing post crown, for example an upper premolar, it is perfectly within the reach of dentists who take complex impressions every day for conventional crowns and bridges, to restore a successfully integrated dental implant.

A simple poster from Ankylos in the waiting room, or at the foot of the dental chair, is often all that is required to alert patients to the fact that implant treatment is now available at the practice. Patients are often delighted that their dentist, whom they like and trust, can offer implant restoration, and where the practice is some distance from the referral hub, it is a fantastic service for GDPs to be able to offer this treatment locally.

The evidence from Vermilion, and from a number of referral practices in England where the R£LAX concept has taken root, is that restoring implants is a highly effective initiative in the middle of a recession, particularly as it is bringing in new revenue streams for practices which hitherto had no income from dental implants.

One dentist who has benefited from the R£LAX programme is Louise Henvey from St John's Road Dental Practice, which is located just five minutes along the road from Vermilion. Louise said: "I have found the R£LAX evenings at Vermilion to be both enjoyable and informative. David and Grant have created an environment that is not only conducive to learning but also interesting and fun."

She added: "My knowledge of implants prior to this programme was mainly theoretical, having had the basic undergraduate training of what implants are, materials available and the indications and contraindications for their use. My postgraduate training involved assisting in the placement of implants, mainly for the edentulous lower ridge to aid denture wear, but was in a surgical setting rather than the restorative side."

As a GDP, Louise finds her main focus is restoring and preventing dental disease. With an aging population and patients retaining teeth for longer, it is often difficult 'keeping things going' when you know that dentures are just round the corner. When she found out about Vermilion and the refer and restore initiative, it opened a new and attractive prospect for both Louise herself as well as her patients.

She adds: "For me, it allows new skills to be learnt in a supportive environment and for these skills to be honed under close supervision. For my patients, they feel at ease knowing that their GDP is involved in the treatment, whether it is in the planning stages of more complex cases or when restoring single implants."

Louise also revealed the close proximity of Vermilion to her practice is an added bonus. However, David and Grant are always at the end of the phone when needed, and generally there is a great emphasis on communication with the GDP at each stage.

Louise continued: "This is important as it keeps me in the loop after the referral is made, right through to treatment completion. I feel that the hands-on experience at the R£LAX evenings has prepared me well for my first case, which is later this month. Using the implant kit and seeing how each component part fits together really helps to demonstrate the process of how to take the impression and fit the implant crown.

"At one of the evenings, there was a live demonstration of fitting the implant crown on a patient. I have been reassured that it is simpler than fitting a conventional crown, and additionally, a representative from Dentsply is on hand to come along to the practice at the impression and fit appointments, just to ensure everything goes to plan."

Louise feels the refer and restore approach offers something new for her whole practice, both in terms of a new source of revenue, as well as attaining new knowledge and skills for the whole team. The ability to restore in the practice often appeals to the patient who may feel more comfortable in a known dental environment, having attended for routine examinations for many years previously, and having built up a trustworthy relationship with their dentist. Financially, Louise also feels there is flexibility in the setting of fees which means it can be more cost-effective for the patient to have the implant restored in the practice while ensuring a healthy profit margin.

She said: "To be able to offer restoration of implants in practice has advantages for both the patient and the dental team and it gives the opportunity to become more involved in the treatment planning."

Continued »

ABOUT THE AUTHORS

Dr David Offord, BDS MFDS Dip. Con.Sed. Specialist in Oral Surgery
Dr Offord graduated from the University of Edinburgh in 1994, and is a registered specialist in oral surgery. In June 2011, Dr Offord launched Vermilion – The Smile Experts, a specialist referral clinic located in west Edinburgh where he operates in collaboration with his specialist colleagues within Vermilion, as well as referring dental practitioners throughout Scotland.
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Dr Louise Henvey, BDS MFDS
Dr Henvey graduated from the University of Glasgow in 2004, and later gained her MFDS from the Royal College of Surgeons, Edinburgh in 2006. Dr Henvey joined St John's Road Dental Practice as a GDP in 2006 and has a particular interest in restorative and cosmetic dentistry.
St John's Road Dental Practice, 176-178 St John's Road, Edinburgh, EH12 8BE, 0131 334 2704, www.stjohnsroaddentist.com


Fig 1

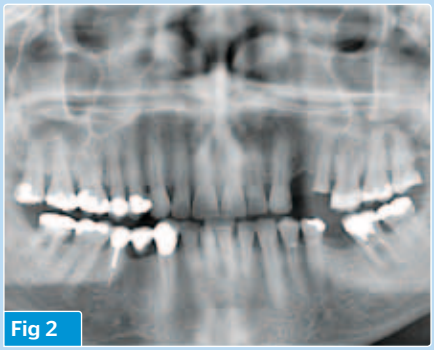


Fig 2


Fig 3

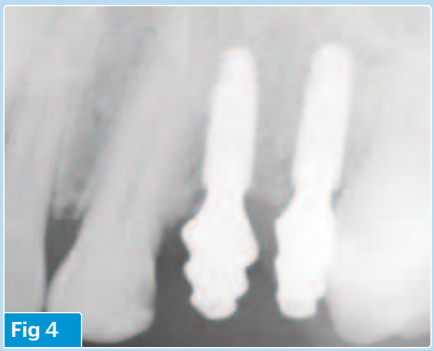


Fig 4


Fig 5


Fig 6


Fig 7


Fig 8


Fig 9

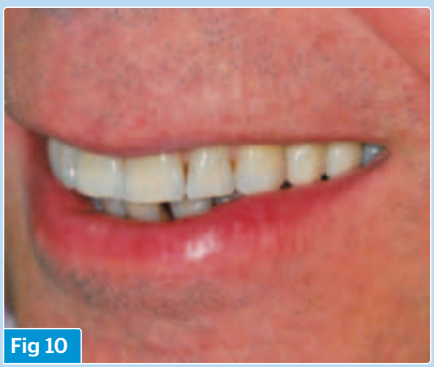


Fig 10

Continued »

CASE REPORT: SCREW-RETAINED CROWNS TO RESTORE 24, 25

The following case, from the team at Vermilion, highlights the five steps involved in restoring a typical case with screw-retained crowns.

Patient: 56-year-old man, fit and well, no known drug allergies, no medications, non-smoker.

24 missing for over 10 years. Bridge abutment 25 fractured root on 9 November 2011, rendering two-unit cantilever bridge non-viable *(Figure 1 and 2)*.

Step 1 – Consultation: 16 November 2011

Restorative and surgical consultations with prosthodontist Grant Mathieson and oral surgeon David Offord. Given this patient's heavy bite, and the history of the failed cantilever bridge, it was recommended that two implants be placed to retain two implant-crowns.

Step 2 – Implant surgery: 8 December 2011

Surgery with David Offord. Extraction 25 root, flapless immediate placement of implants at 25 and 24. The implants were two Ankylos A11 implants (diameter 3.5mm, length 11mm). Both achieved excellent primary stability. Two healing abutments were placed finger-tight for trans-gingival healing.

Step 3 – Implant impressions: 16 February 2012

The Ankylos 3.0b sulcus formers are removed to reveal a healthy gingival tunnel to the implant head *(Figure 3)*.

The implant impression copings are seated into the implants and checked on a radiograph prior to the impression being taken *(Figure 4)*.

This is usually the first radiograph obtained of the implants, allowing the restoring dentist to check that the impression copings are fully seated within

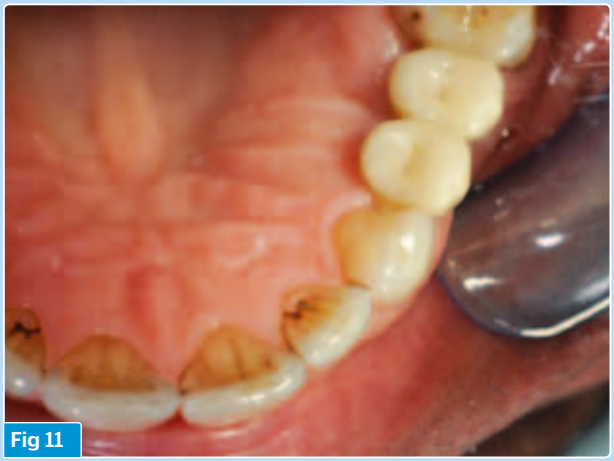


Fig 11

the implant, and to record the baseline bone levels around the implants.

Implant impressions were obtained by prosthodontist Grant Mathieson (Impregum Penta Soft Quick with stock Dentsply impression tray) *(Figure 5)*.

A shade is taken in the usual way. Technicians greatly appreciate receiving an email containing a photograph of the shade tab alongside the adjacent teeth *(Figure 6)*. This case was sent to Visage Dental Laboratory, Glasgow.

Stage 4 – Fit crowns: 8 March 2012

This is the day the patient has been waiting for! Four months following his bridge failure, the gap is restored.

Figure 7 shows the implant model containing two laboratory analogues. *Figure 8* shows the screw-retained porcelain-bonded crown with titanium abutment, and *Figure 9* shows the screw access holes within the occlusal surface of the crowns.

The crowns are torqued into place on the implants at 15Ncm, and the screw access holes are filled with Clip, a provisional material. This allows the patient to live with the crowns for a few weeks, to be entirely sure they are happy with the shade, bite etc before the screw holes are definitively filled with PTFE tape and composite.

Screw-retained crowns avoid issues of excess cement being extruded into the peri-implant mucosa, and are fully retrievable, in other words, they can be easily removed at any time if a problem with the restoration is encountered.

Step 5 – Review and implant maintenance: 22 March 2012

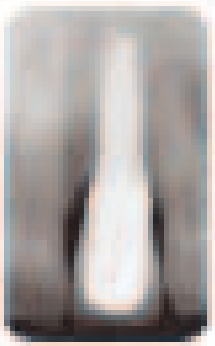
The Clip is flicked out of the screw holes, the screw torque is re-checked, PFTE (plumber's) tape is placed over the screw head, and the screwhole is restored in composite. *Figures 10 and 11* show the final result.

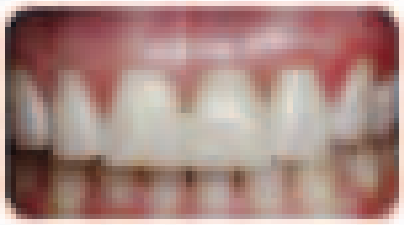
It is of critical importance that the patient fully understands what he or she must do on a daily basis to maintain the health of the peri-implant tissues.

At Vermilion, after the review appointment with Grant Mathieson, the patient will have an appointment with dental hygienist Colette Ballantyne. Colette will coach the patient on how to maintain their implants, and advise what products are best suited for cleaning in their individual case. ■

The next RELAX night takes place at Vermilion on Thursday, 21 June from 7pm to 9.30pm. Call Valerie Henderson on 0131 334 1802, to book a place, or email smile@vermilion.co.uk

aesthetics enhanced by technology





Laser-Lok® tissue response at 8 years post restoration showing superior vertical bone & tissue maintenance.*

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*[redacted]

Six of the best for **implant success**

Dr Avik Dandapat BDS(Birm), MFGDP(UK), Dip.Imp.Dent RCS(Eng)

describes placing a screw-retained prosthesis based on six dental implants, in a 70-year-old patient unhappy with her current denture

The patient attended our clinic in 2011. She was in her 70s and had recently lost the upper retainer teeth on her partial chrome denture. She was extremely distressed with her new full upper denture and wanted a long-term solution.

History of complaint

Over the last five years she had worn a partial chrome denture retained by three teeth. These teeth had progressively deteriorated and were recently extracted by her GDP. They had added to the existing chrome denture making a very bulky and heavy upper full denture.

Medical history

Apart from suffering from Bells Palsy and having a distinct lack of facial muscular function related to the left side, the medical history was unremarkable.

Extra-oral examination

- TMJ appeared sound and no pathology detected on examination
- Lymph nodes: clear
- Muscles of mastication: appeared normal and with functional limits
- Facial muscles: exhibited atrophy on the left side and the reduced function of the following muscles:
  - depressor anguli oris
  - mentalis
  - zygomaticus major and minor.

The most distinct element we observed was when the patient smiled only the right side of the muscles used in smiling was functional. However, the patient was aware of this and understood that we would work in harmony with the current neuromuscular function.

There also was an obvious loss of maxillary bone and support to the soft tissues. A decreased OVD was also present. All of these issues were however corrected by the use of a well-constructed full denture replacing these areas and supporting the soft tissue.

Intra-oral examination

Soft tissues were clear and free from any pathological signs. Dental examination found that the lower dentition was stable, oral hygiene was good and BPE no more than one. Heavily restored molars and another eight remaining teeth present.

Patient discussion

After the examination, we discussed the various forms of treatment available with the patient and also potential levels of investment required. The options were as follows:

1. a complete upper denture
2. an upper denture retained

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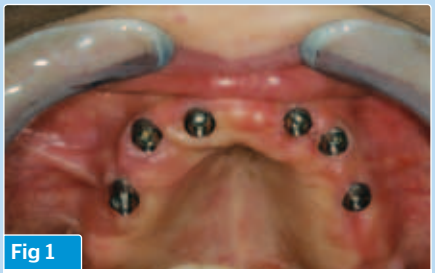

Fig 1 Six DIO SM implants placed in the upper

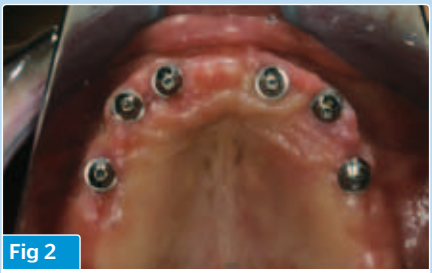

Fig 2 Six DIO Multi-Unit screw-retained abutments placed

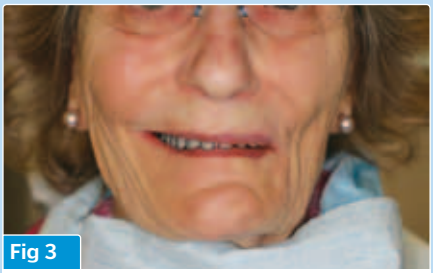

Fig 3 MediMatch framework try-in


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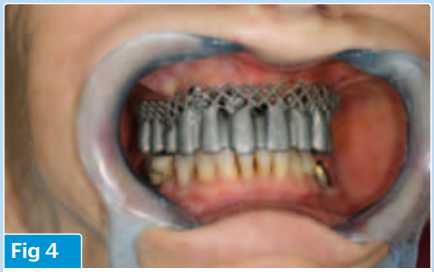

Fig 4
Framework try-in close-up

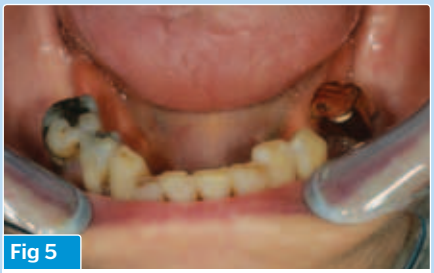

Fig 5
Lower jaw condition

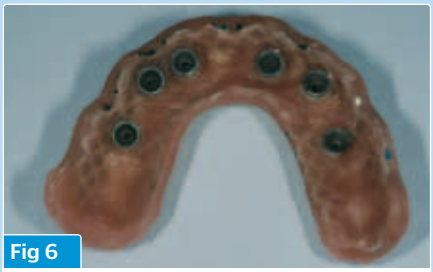

Fig 6
Hybrid acrylic-composite prosthesis fabricated with screw-retaining inserts

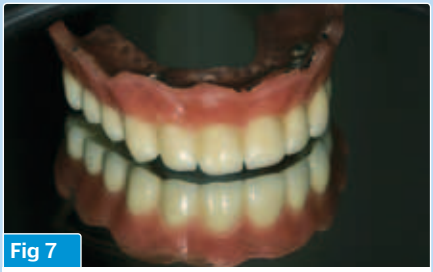

Fig 7
Hybrid acrylic-composite prosthesis

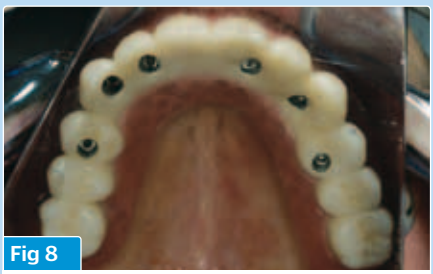

Fig 8
Final fixation of the prosthesis

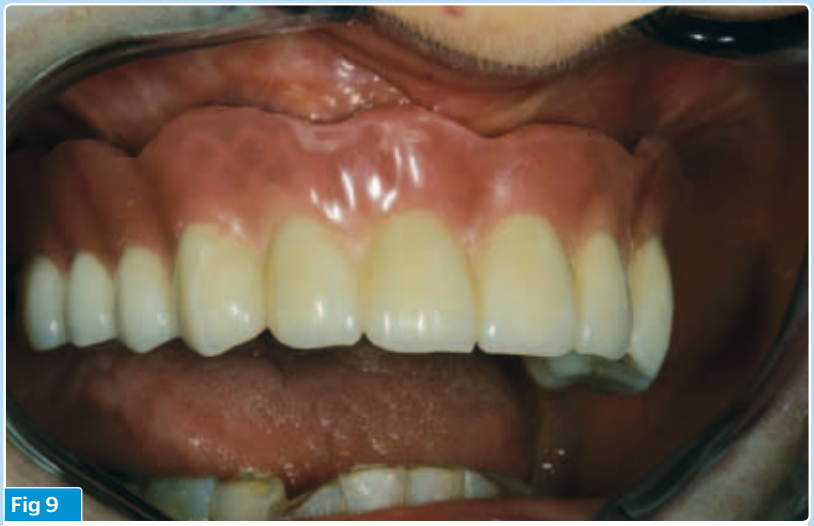

Fig 9
Prosthesis and lip repositioning

Continued »

by four implants and splinted with a bar
3. a screw-retained hybrid bridge on six dental implants replacing facial support and utilising prosthetic replacement of tissue support but with no grafting or sinus work
4. A full hard and soft tissue reconstruction with hip grafting and up to eight dental implants and a cement-retained bridge.

After discussion the patient opted for the screw retained prosthesis based on six dental implants and decided against extensive and invasive reconstructive surgery. From this point the treatment plan could commence.

Initial tests

1. Impressions
2. face bow record
3. photographs
4. study models and new temporary denture made to correct OVD, bite and to evaluate tissue support required
5. CT Scans of Upper Jaw with correct prosthesis in position to study hard tissue relationship and correct tooth position. Also required in order to ascertain the degree of bone volume/density present.

Surgical considerations

In such cases my approach is firstly to ascertain the corridor of bone that lies between the medial wall of the maxillary sinus and its position. In order to gain this information one must be familiar with the manipulation of the CT scan image. Often RAW data is needed to draw the correct cross sectional curve along the desired axis of Implant placement. Pre-Formatted scans on some software platforms may not allow the operator to manipulate this curve.

The corridor of bone exists in most patients and can accommodate a longer implant fixture whereby the cervical implant head can lie distal to the apex of the implant hence negating the need of a sinus graft and allowing the implant to be placed more distal in the arch.

For inexperienced implant dentists a surgical guide to triangulate this position exactly is an absolute requirement. In practice this area can be marked out as the zygoma has a distinct curvature on exposure of the maxillary jaw. Where the curvature or bulbosity starts is usually the position of the medial wall of the maxillary sinus, then by use of osseotomes/bone expanders, drills and re confirming this position can be achieved in two ways.

Perforation into the sinus via the lateral wall and palpation of the medial wall and mark points at 3,6,11mm - or by intra oral X-rays and check the osteotomy site for perforations during surgery. I recognize these are not ever as accurate as a CT-guided stent and the author would always recommend a bone supported stent in these cases as apposed to a soft tissue supported guide.

The other consideration is the space along the horizontal plane to place

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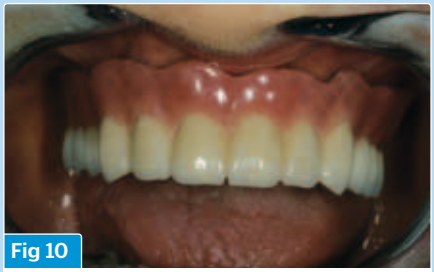


Fig 10
Prosthesis and lip repositioning

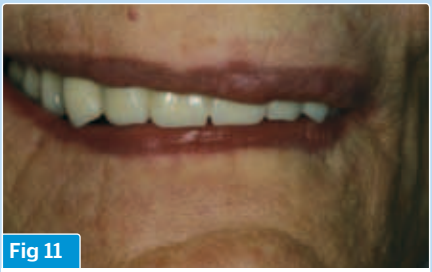


Fig 11
Completed smile

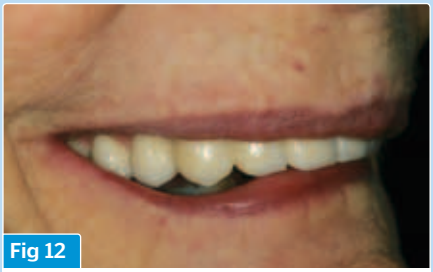


Fig 12
A very happy patient

Continued »

four or up to six implants. Although there is a lot of literature relating to "all-on-4" techniques, the author prefers where possible to place six implants due to the fact that if a failure occurs (it is currently accepted that two in every 100 or 2 per cent will fail) there is a backup and one can still fabricate a reliable final prosthesis on five or four implants, if equally spread along the arch.

One must also consider the A-P (Anterior-Posterior) spread of the implants. In such cases there must be adequate A-P spread to allow for favourable loading of the prosthesis as, using this technique cantilevering will be required in most cases.

Healing

After placement of the six DIO SM dental implants a postoperative OPG was taken and the denture relined with soft reline material over the healing abutments. I opted for transmucosal healing as we achieved high levels of primary stability on all the implants. In this case the distal implant on the right side entered the sinus space and we performed a Summer's Lift. The patient was allowed to heal for a period of five months with the temporary relined denture.

Prosthetic protocol

After the healing period, all implants were checked using a periotest to measure osseointegration. The readings were as follows:

- UR3 Implant = -7.0
- UR2 Implant = -6.9
- UR1 Implant = -5.0
- UL1 Implant = -8.0
- UL2 Implant = -5.0
- UL3 Implant = -6.0

From the readings, we could see that all implants had osseointegrated well and showed no pain, mobility, infection, loss of bone or exposed titanium intra orally. We then carried out the following sequence for restoration:

1. Fixture head impressions linked in a special tray. Using floss and GC pattern resin to link impression screws.
2. Try-in of the DIO Multi-Unit angled screw-retained abutments with lab-made positional jig to ensure abutments are parallel.
3. New impression of the Multi-Unit angled abutments and X-ray verification of correct seating. Again these are linked using GC pattern resin and also a verification jig made by the lab to verify accuracy of model prior to metal framework construction.
4. The denture was relined again over the new abutments.
5. Metal framework try-in – screw retained and checked for passive fit using the Sheffield test. Re-verification of the midline, re-bite registration, a new face-bow record, intra-oral and extra oral photography to give the technician sufficient data to make the teeth and an idea of degree of soft tissue support required.
6. A hybrid acrylic-composite prosthesis was then placed and checked intra-orally for aesthetics, lip support and bite. I had decided to provide a balanced articulation type of occlusal scheme.
7. Final fixation of the prosthesis and detailed written and oral instruction given to the patient. One must consider cleanable spaces and your lab must understand this and allow for the patient to be able to clean the spaces underneath the area around the implant heads. We provide a Waterpik and review the hygiene habits at three, six and 12 months post placement.
8. The screw holes then filled with cotton wool followed by flowable composite.
9. Post operative follow ups at three, six and 12 months with regular dental checks on lower dentition and follow-up x-rays yearly to determine bone levels after baseline OPG taken. ■

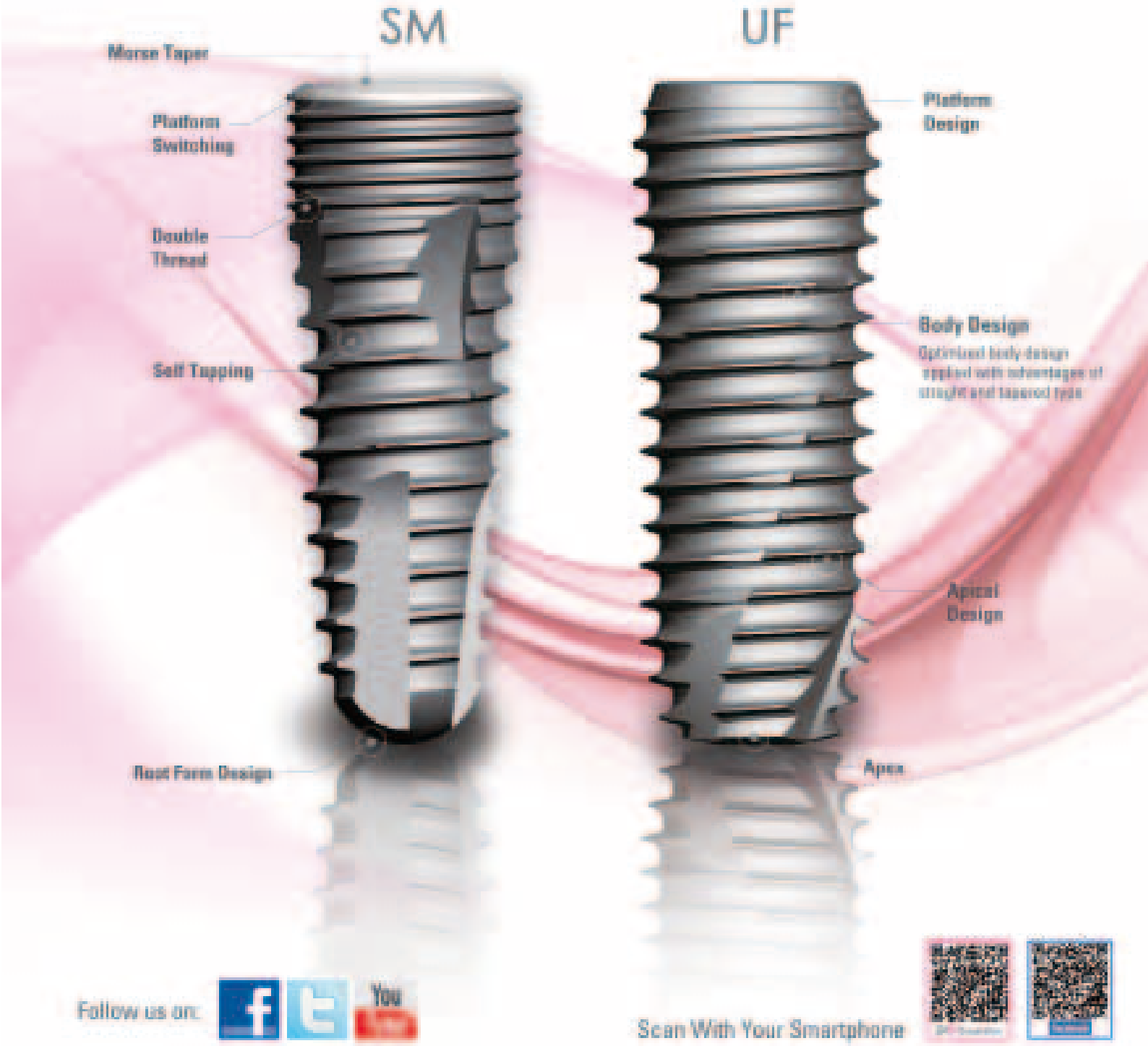
"For inexperienced implant dentists a surgical guide to triangulate this position exactly is an absolute requirement"

Dr Avik Dandapat

ABOUT THE AUTHOR

Dr Avik Jonathan Dandapat qualified from Birmingham University and went on to complete his MFGDP(UK), the Diploma and Advanced certificate in dental Implantology from The Royal College of Surgeons of England in 2006 in Cohort 3 of the course. Avik has been an ADI mentor for the past eight years and a mentor for both DIO Implant and Ankylos. Avik actively lectures at the FGDP(UK), internationally for DIO Implants, ADI members forum, Ankylos Implant members forum and is active ADI study club lecturer in dental implantology. At present Avik runs two practices in Reading, Berkshire and 121 Harley Street, London. His focus is solely on implant and reconstructive dentistry. Currently Avik is studying toward his MSc in Implant dentistry from Manchester University.
Avik would like to thank his Lab – Medimatch UK (www.Medimatch.co.uk) and the dental implant manufacturer – DIO Implants (www.DIOUK.com).

DIO



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Immediate implant placement

Placing an implant into a fresh extraction socket is less invasive for patients and gives excellent results, reports Dr Tariq Ali

As dentists, we find ourselves in an exciting era of therapeutic change with the availability of dental implants. This brings with it a number of challenges and, as our patients become more aware of their implant options, there is a desire to expedite treatment with the minimum number of surgical procedures.

This article discusses the rationale and clinical stages of immediate implant placement.

Immediate implant placement can be defined as implant placement into a fresh extraction socket. It is now a well-accepted technique. Gomez-Roman et al[1] demonstrated a 97 per cent implant success rate that is comparable with the more conventional delayed approach. The technique is less invasive than a delayed approach, while maintaining bone and reducing overall treatment time.

A 29-year-old woman was referred by her dentist for implant treatment to replace a failing retained deciduous tooth *(LLE – Figures 1 and 2)*. The patient's main concern was that she was moving abroad and wished treatment to be completed within four months. Medically, the patient was fit and healthy, a non-smoker with no parafunctional habits.

Careful assessment was carried out with appropriate radiographs, CT scanning and diagnostic wax ups. CT scanning *(Figures 3 and 4)* provides valuable information in cases like this, showing the ridge morphology, amount of available bone, root morphology and position of any anatomical structures such as the IAC.

Rationale and treatment plan

The patient was presented with the various options to replace the failing tooth and she decided on an implant. From the information available, an immediate implant and restoration were indicated.

The favourable indications for immediate implant placement and restoration in this case are:

- short roots and adequate bone volume
- no parafunctional habits and therefore excessive load on the osseointegrating implant
- adequate keratinised tissue as the gingival biotype can be difficult to control
- no pathology. It is certainly possible to place implants in sockets with chronic periapical pathology[2]. However, careful debridement is required. Immediate placement is contraindicated in areas of acute infection
- meets patient's expectations and timeframe.

By using a transitional restoration at the time of implant placement (immediate restoration), the soft tissues can be contoured, so developing the emergence profile for the final crown. An added benefit of immediate loading is the maintenance of bone levels around the implant[3].

Immediate loading is only possible in the presence of primary stability and it is important to the treatment plan in case this is not achieved. If primary stability is not achieved, then the immediate loading must be abandoned. The wound can be closed with a vascularised pedicle flap or free gingival graft. A healing abutment can be used which is of sufficient height and width to fill the wound.

However, it is necessary to ensure that the patient does not place any force on this abutment. It is possible

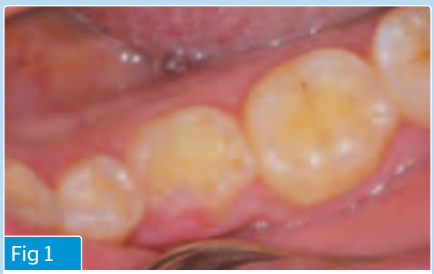

Fig 1
Failing LLE

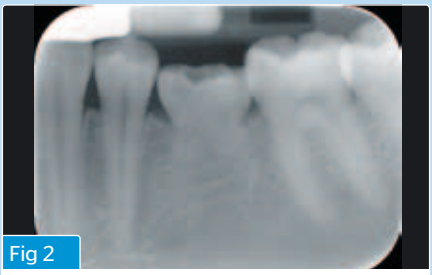

Fig 2
PA failing LLE

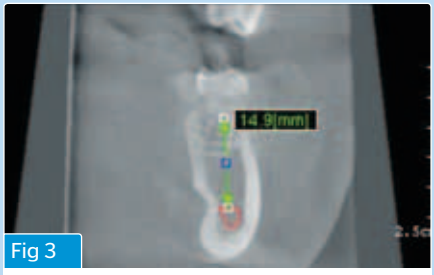

Fig 3
CT scan showing bone profile

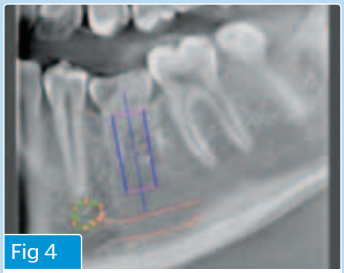

Fig 4
CT planning position of mental foramen

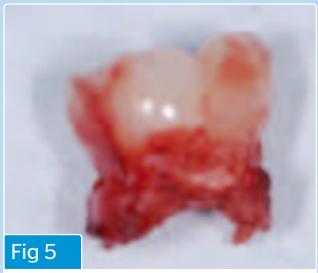

Fig 5
Extracted LLE

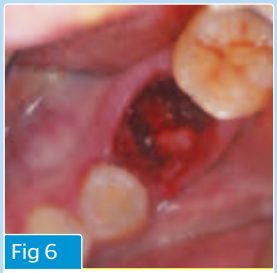

Fig 6
LLE socket

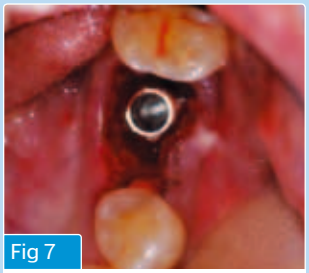

Fig 7
Implant placed in socket

to use a temporary restoration such as a resin retained bridge (Rochette), with the advantage of being able to manipulate to soft tissue contours. Dentures are not recommended as they transmit forces to the implant and can harm the healing soft tissues.

The patient was also consented for a delayed placement protocol if immediate placement was not possible e.g. compromised socket due to the loss of buccal bone. Careful discussions with the patient ensured that she was aware of all eventualities.

It is also important to plan the final restoration before surgery. It is important to meet the patient's expectations and so a diagnostic wax-up was produced to give the patient an idea of the final result.

It was explained to the patient that the opposing teeth had over erupted and this would lead to a smaller tooth similar to the deciduous tooth. The patient was happy and stated she would prefer this. The patient was consented for adjusting the upper teeth to accommodate the implant crown if necessary.

Treatment sequence

The LLE was extracted *(Figure 5)* as carefully as possible with a scalpel introduced into the sulcus followed by periotomes and luxators. The socket *(Figure 6)* was evaluated with a blunt probe to ensure intact margins, showing the site to be favourable for implant placement. An implant was then placed in a subcrestal position in the centre of the socket and in close contact with the bony margins *(Figure 7)*. This ensures that the bone level is maintained around the implant[4].

As the implant was placed with good primary stability, a permanent abutment was then attached within the prosthetic envelope. It is an advantage to have a number of abutments available with different collar heights and angles. This is especially relevant in the anterior maxillary region when the angulation of the implant is easily corrected with an angled abutment[5]. Attaching the final abutment prevents bacterial ingress and bone loss associated with repeated component/abutment attachment and removal used in other techniques[6].

A pre-fabricated hollow transitional acrylic crown, designed from the diagnostic wax-up, was then fitted with temporary cement *(Figures 8 and 9)*. The transitional crown was designed to fill the socket. This stabilises the blood clot, prevents food/bacterial ingress and supports the soft tissues during the healing phase. It is important that the crown has only light contact in centric and not in lateral excursions and that the patient is instructed on a soft diet so as not to overload the implant.

This crown can be altered if necessary to shape the soft tissues and develop the emergence profile. The patient can feed back any issues with this crown, so informing the dentist and technician on the design of the final restoration. In fact, on review, the patient felt the transitional crown was too large and stated she could feel it with her tongue. It was adjusted on the labial side and the height was reduced. The patient felt more comfortable with this.

After three months, the implant was fully integrated and the soft tissues healed with good contours *(Figure 10)*. A conventional impression (medium-bodied monophase material in a metal rimlock tray) was taken of the abutment and matured soft tissues. This was then sent to the laboratory for the final restoration.

The design of the final crown is based on the satisfactory transitional crown. The crown was fitted with temporary cement (Tempbond) and a final radio graph taken *(Figures 11,*

Continued »

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).

Fig 8
Pre-formed transitional crown

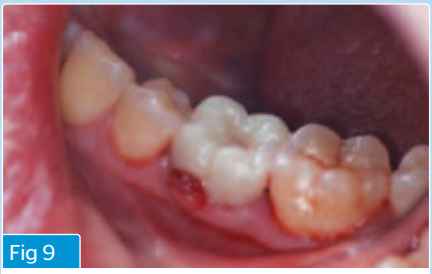

Fig 9
Transitional crown – immediate restoration

Fig 10
Soft tissues shaped ready for final impression

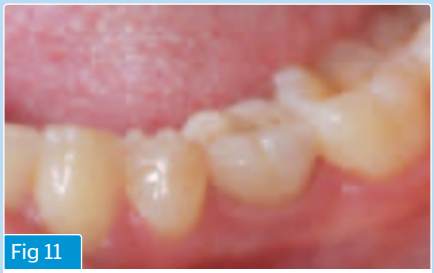

Fig 11
Restored implant

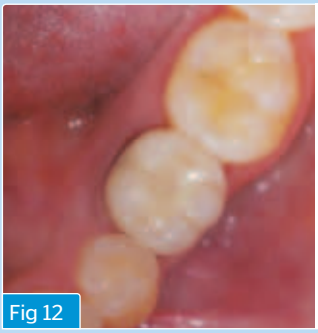

Fig 12
Restored implant

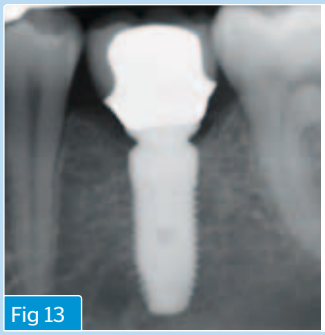

Fig 13
PA of restored implant

Continued »

12, 13). The patient was instructed on oral hygiene and a maintenance protocol was established.

Conclusion

Immediate implant placement and restoration is a demanding technique. However, it can be seen from this case that it produces predictable and satisfactory results when planned carefully and carried out using well-established protocols. ■

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Teeth whitening made simple

Teeth whitening strips are the most popular form of whitening treatment in the USA and they are now available in dental practices in Scotland through WhiteWash Laboratories, who first introduced their teeth whitening strips to the UK in 2010.

Teeth whitening strips use the same whitening gel to whiten teeth as tray whitening. The main difference between the two procedures is the method of delivery of the whitening gel. Whitening strips are a one-size fits all whitening treatment that use flexible plastic strips that mould perfectly to the patient's teeth. The whitening gel is pre-applied to these strips, which means that application is a foolproof procedure from the point of view of the user. Sensitivity is also limited due to the optimum amount of whitening gel being pre-applied to the strips. The strips are applied for one hour, every day, for two weeks.

They usually cost around £50 so are great for patients who can't afford tray whitening; opening up a new revenue stream for your practice. There is no need to take impressions so there is reduced clinical time on the part of the dentist – this also means that they are a great additional treatment to sit alongside tray/in-surgery whitening for top-ups etc. They are also particularly beneficial for patients who can't wear trays due to a sensitive gag reflex or those who want to start whitening straight away.

Whitewash strip

It's important to note that whitening strips aren't meant to replace tray or in-surgery whitening. Instead, they are meant to be sold alongside other whitening procedures to cater for those patients who have a smaller budget.

Studies have shown that 80 per cent of patients say that they wish their teeth were whiter. If 80 per cent of your patients aren't having whitening treatment with you then it's likely that the main reason for this is cost. Whitening strips are much more affordable to the patient and can help solve this problem. ■

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The Liquid Smile whitening pen takes just one minute to apply at night and can give noticeable results in less than 14 days

Paint it on

Patients are directed to apply at night, after brushing and flossing. Teeth are to be dried with a tissue before painting a thin layer on the front of each tooth surface in the smile region. They need to keep a wide smile for 30 seconds so the gel will dry on the teeth, then they can relax and go to sleep!

Liquid Smile fits into the evening brushing and bedtime routine. It takes about a minute to apply, and you can go to bed without rinsing.

Food and beverages will cause staining with any whitening procedure. Hot and cold can also affect sensitivity. This is why it is recommended for bedtime applications, so that patients comfortably avoid ingesting such teeth-staining products as coffee, tea, red wine, berries, tobacco, etc. immediately after the whitening procedure.

The whitening procedure is recommended at night, when saliva flow decreases and the gel will stay on teeth for longer. This allows the gel to work at full concentration and bubble away stains faster. If used once per night until finished, the treatment will usually last about 14 days.

The whitening procedure is recommended at night, when saliva flow decreases and the gel will stay on teeth for longer

Most people start to see results after several applications, some see immediate results after the very first night depending on tooth colour.

Whitening and sensitivity

Pain from whitening procedures is a direct result of dosage and exposure. During the research and development of Liquid Smile, particular attention was paid to creating the right dosage of hydrogen peroxide – powerful enough to ensure professional whitening without creating sensitivity.

Liquid Smile's common sense approach to whitening also reduces exposure time. Most in-office and take-home tray systems require an hour or more of exposure. Liquid Smile's single daily dosage reduces exposure time to hydrogen peroxide to just 15 minutes. There are no uncomfortable trays which can also cause gum sensitivity.

Lights used in whitening DO NOT WHITEN teeth. The gel does. Lights dehydrate teeth which give exaggerated initial results and cause sensitivity. Liquid Smile eliminates these problems. ■

CASE STUDY

Erin McIlroy

"I had always fancied getting my teeth whitened, but I was a bit wary of getting it done at the dentist, partly because of price, and partly from what friends and family have said.

"My mum has had whitening treatments before that have given her a fair bit of sensitivity straight afterwards and I was keen for it to be as pain-free as possible!

"I was attracted to Liquid Smile because it was simple and would fit in with my busy schedule. It was also important for me that it was more affordable than other options I'd looked at out there.

"While I'm not particularly self-conscious about my teeth, I had started to notice that they weren't as white as they used to be, so I wanted to see what this whitening fuss was all about.

"Using the kit was very simple and I managed to fit it into my bedtime routine quite easily. Even when I was away from home or if I had stayed out late, I managed to apply the gel as it was so quick and easy to use. However, I did spend more time smiling into the mirror than I usually do!

"I made sure I followed the instructions to the letter and I had no sensitivity or adverse reactions at all. I started noticing a difference after just a couple of applications and, although my teeth weren't particularly stained, it has given me a bit more confidence. Some people have even asked me on a few occasions 'Is there something different about you?'"

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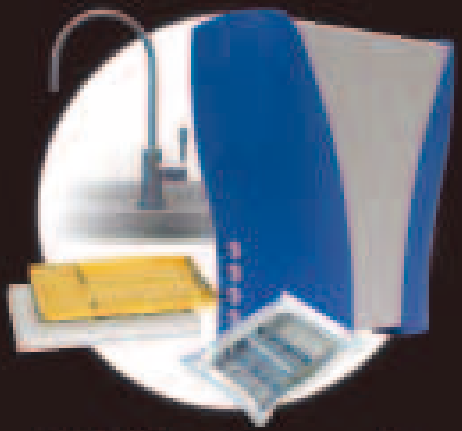

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Invest today for a **safer tomorrow**

Why get a washer disinfector for practice instruments? And if you do decide to invest in one, what should you look out for? Malcolm Card, has the answers

As we all know, decontamination is a hot topic, with current guidelines being now being rigorously upheld by bodies such as the CQC, RQIA, HPS or HSE, certainly in some regions.

The need to know what is available, how to prolong the useful life of your instrumentation and how to protect both the patient and the team from the risk of cross contamination is now, more than ever, unavoidable. It is important that the dental team follows a strict cross-infection regime in accordance with current infection control guidelines.

The use of thermo-washer disinfector dryers such as the ThermoKlenz from W&H is currently a topic of much debate and discussion, but if you consider the fact that a member of your dental team is manually cleaning soiled and contaminated medical instruments with sharp protrusions – a task which is neither enticing nor effective, particularly for those actually doing the cleaning – the question, 'to have or not to have?' becomes clearer.

If you are looking to achieve 'Best Practice' and are currently asking your staff to hand-wash instruments, it is time you looked at purchasing an automated washer disinfector as recommended by current guidelines.

So why purchase an accredited thermo-washer disinfector manufactured for purpose? The thermo-washer should ideally be manufactured from high-grade stainless steel, with the chamber of AISI 316 quality; this is to prevent corrosion by ensuring it can cope with the strong detergents used and the heavy amount of use within a busy dental practice.

Thermo-washer disinfectors are sophisticated medical devices: thorough cleaning is achieved by very high water flow rates, created by a powerful pump at high pressure. Process control is an essential feature that regulates and controls the various stages of the cycle. Temperature is regulated to ensure it is below 45°C during the initial stages to prevent possible coagulation of protein; it is then raised to above 60°C at which point the detergent or cleaning agent is introduced into the process.

Detergents are formulated and validated for particular machines and developed to take into account the cleaning efficacy for the cycle profile and the necessity to minimise damage to instruments, so it is strongly advised to use the detergent that the thermo-washer disinfector manufacturer recommends. Once the

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cleaning phase is complete, the machine drains to waste outlet to prevent any damage from residual detergent.

The thermal stage starts by further elevating the temperature, typically to just over 90°C, possibly lower if the manufacturer has selected a longer 'hold' time. Drying is then applied to the instruments by several methods, but to keep cycle times to a minimum, the preferred method is by forcing hot air into the chamber in conjunction with a built-in condenser which removes the majority of moisture with just a minimal ingress into the decontamination room.

When looking to purchase a thermo-washer disinfector, please be aware of the medical standards and guidance demanded of the thermo washer disinfector manufacturers, not applicable to a domestic appliance. These are necessary as the machine has to reliably and reproducibly process contaminated items in a medical environment. The cycle must be monitored at all stages and a printed or data record stored for the required period.

"It is important that the dental team follow a strict cross-infection regime in accordance with current infection control guidelines"

Malcolm Card

Specialist machines have the facility to process a quantity of handpieces using specially designed racks that force water through the narrow lumens. This should be supplied as standard with a range of appropriate racks and baskets. While it may not be current advice in your area, it is prudent to purchase a machine that has such facilities to maximise your investment and fully future-proof your practice. If appropriate racks are not supplied as standard, it is advisable to check that they are available as a retro-fit option in the event that guidance changes.

As with any equipment purchase, your chosen manufacturer's representative will be able to advise you on product specifications and whether it is suitable for your requirements.

Take the opportunity to ensure that the quality of the machine satisfies your needs and it is fit for purpose. Check if it has a service and validation protocol for daily and monthly testing by the user and an annual testing protocol performed by your test or service engineer.

Look at the cost of consumables which should be readily available from the supplier or distributor and do not be tempted to use non-recommended detergent or accessories as they may not be validated to be effective in a dental environment or work in conjunction with the machine.

There may not be national or regional demands for automated cleaning, but by integrating a high-quality thermo-washer disinfector into your decontamination process, you will not only reduce the risk of sharps injuries to your team, but you will also be

introducing a reproducible, validatable, medically effective washing process, that will ensure you are doing the best you possibly can to reduce the risk of cross infection among your patients and your team – and that has to be a good thing.

When investing in your decontamination facilities, you should be looking for complete solutions from one supplier. Within the dental practice, practitioners and their teams are all very aware of steam sterilisation of instruments and equipment that are used for invasive procedures.

However, several important factors are required in order to achieve a sterile state and a safe load:

1. The sterilisation temperature band, normally 134°C to 138°C
2. The quality of steam that produces moist heat and a saturated steam
3. The time this temperature is held for: a minimum of three minutes holding time.

These three critical criteria are where we get the term TS – Time, Steam and Temperature, which you may have seen describing chemical indicators, Helix Test kits and Bowie Dick packs.

Very often, air removal as a subject is overlooked, but without this important phase none of the above three criteria would be totally effective in sterilisation, making a decontamination procedure ineffective and failing to gain the end result: properly sterilised instruments to ensure staff and patient safety.

There is no debate about the fact that handpieces are hollow instruments. Therefore the instructions for use recommend the use of a vacuum machine.

We are all taught at school that water boils at

Continued »

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100°C (or 212°F!) – yet our instruments need to be sterilised between 134°C and 138°C. This means that we have to raise the temperature of the steam by putting it under pressure – and the steam has to be in contact with ALL surfaces of the instrument, to achieve sterilisation.

With a hollow instrument, this means that the steam has to contact ALL of the surfaces within the internal tubes – and this cannot be done within the three minute holding time if they still have air or fluids in them, therefore the instrument has to be fully purged. A vacuum steriliser is necessary to evacuate the internal tubes, leaving the way clear for steam to penetrate.

If the instrument was put into a downward displacement (N type) machine instead, air is not removed by drawing it out under vacuum, so is not as complete – which means that there could still be air and fluids remaining within the internal tubes, preventing steam from contacting all surfaces, and hence there is a risk that the instrument could have been through a sterilisation cycle but is not actually sterile.

Pouched loads can remain in a sterile condition for a period of storage prior to use. This varies from country to country, therefore we advise that you check your local guidance as it could be six months or one year.

Although there are many differing views of what the current regional guidelines require, I hope that this article clarifies what should be considered best practice. For more information regarding the issues of decontamination within your practice, you should contact a specialist decontamination supplier for advice.

If you are looking to purchase decontamination products, it is well worth choosing a decontamination solution where the equipment supplier offers full expert service and customer support backup.

There are a number of suppliers, choose those that offer added value such as full technical teams and extras like the W&H 24 hour support site at www.wh247support.co.uk

Choose a supplier who takes your decontamination needs seriously. ■

"If you are looking to purchase, it is well worth choosing a decontamination solution where the supplier offers full expert service and customer support backup"

Malcolm Card

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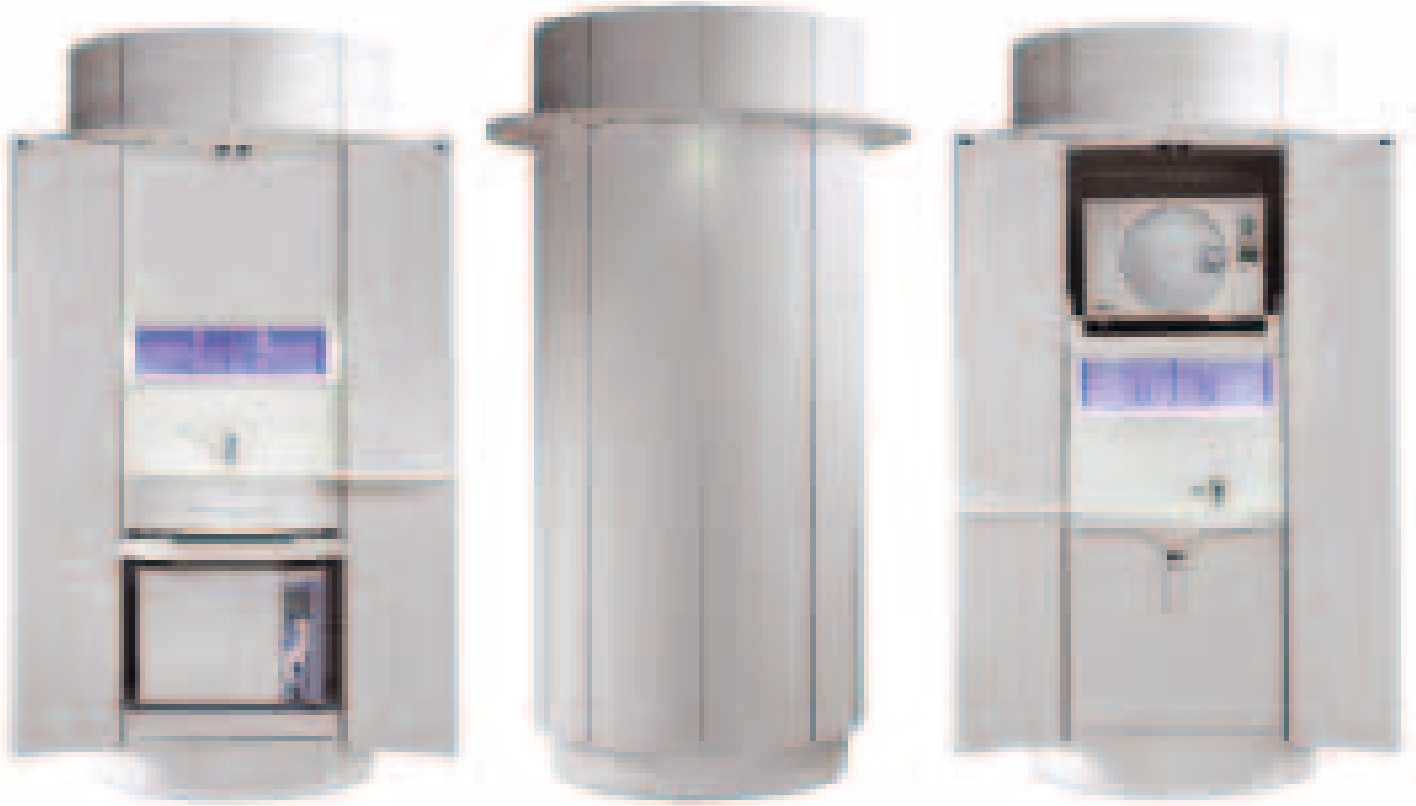

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John Kanca to return to Scotland

After an absence of more than 10 years since his last visit, NHS Education for Scotland (NES) is bringing John Kanca back to Scotland to present a 'Masterclass in Adhesive Dentistry' on 12 October in Glasgow.

Dr Kanca is recognised as a pioneer and world-class authority on all things to do with adhesive dentistry. His extensive research and materials development is based on his continued experience in clinical practice, being one of a rare and special group who combine world-leading research with real-world clinical practice. He maintains a thriving practice in Middlebury, Connecticut, USA, specialising in aesthetic and cosmetic dentistry.

Those who have listened to John Kanca's presentations before have hailed them as a clinical practice-changing experience. East Kilbride dentist Tom Lamont said: "John Kanca's presentation was one of the best I have heard. He presents dental materials in an exciting, practical and understandable way."

Dr Kanca participated in the first study to validate the etching and bonding of dentine, making it the everyday procedure we all use today. He has developed, and co-created, many well-known and leading-edge bonding systems over the years. He discovered 'Wet Bonding' and went on to create the fourth generation of bonding systems and the concept of pulse activation of composites.

The Crowne Plaza Hotel

He has published more than 70 articles and many abstracts, and presents at many major dental conferences around the world. In April this year, he was a headline presenter at the BDA Conference in Manchester. His current research interest focuses on preventing defects in deep Class II restorations and how glass ionomers really work.

The masterclass in Glasgow will be an all-day event, attracting two sessions of CPDA for eligible dentists and six hours of verifiable CPD. NES is bringing Dr Kanca to present at the Crowne Plaza hotel in Glasgow. This is one of the city's premier four-star hotels located on the banks of the Clyde close to the SECC.

The masterclass will be a must for those seeking to place the finest restorations possible with the fewest difficulties.

Among the topics covered during the presentation will be:

- the principles of adhesion, including an overview of all available resin bonding systems
- the best and easiest method for creating a properly wet-etched dentine surface
- the sealing of crown preparations
- evaluation and treatment of tooth pain and post-operative sensitivity
- placement techniques for all classes of restorations
- the best use of flowable resin composites
- the truth about deep posterior restorations
- current ceramics and how best to bond to ceramic and to the tooth
- recommendations about where to use which kinds of materials
- best activation lights, whitening and the things one might want to have in one's armamentarium.

As a result of attending this event, delegates should be able to:

- maximise the performance of resin bonding agents
- place large durable resin composite restorations
- be able to evaluate and treat different types of tooth pain
- be able to generate outstanding posterior contacts in resin composites
- be able to place sensitivity-free restorations
- know why and how to seal crown preps
- Eliminate sensitivity in crown and preps. ■

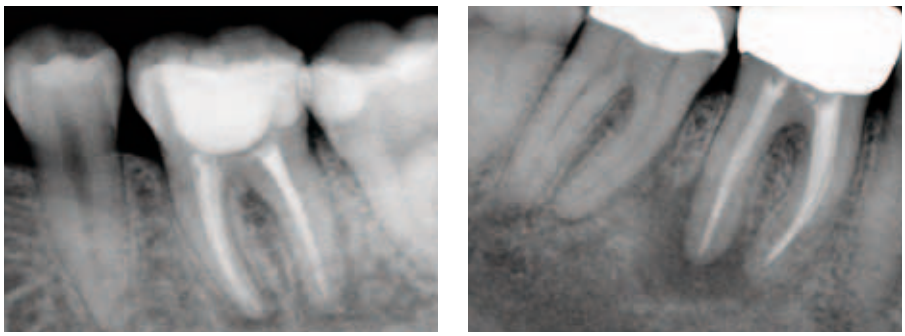
HOW TO BOOK

The 'Masterclass in Adhesive Dentistry' is being held in the Argyle Suite, which has a separate entrance from the main hotel facing the Clyde Auditorium. There are car parking facilities which will cost £5 for the day for any delegates attending the event. Included in the cost is a two- course hot buffet lunch in the One Restaurant. There will also be an opportunity to meet, discuss and view products from a variety of dental representatives. Those booking before the end of June will be entered into a prize draw for products up to the value of £250. The concurrent DCP conference being held on the same day is already fully booked.

To book your place, sign on to the Dental Portal at: www.portal.scot.nhs.uk and search for 'Masterclass'. As this is an NES event, the cost is being kept as low as possible. The course fee will be £175, including lunch.

Six months with the Reciproc system

By Stephen Martin BDS, PG Dip, MJDF RCS (Eng)



36 and 46 prepared with Reciproc and obturated with warm vertical condensation

The Reciproc system

Many readers will be aware of the new reciprocating single file techniques available to prepare canals safely, efficiently, and effectively. The Reciproc system by VDW was released in 2011 as a result of the work done by Ghassan Yared using a single rotary Nickel Titanium file in a reciprocating action to prepare canals[1]. Following this ground-breaking work, the Reciproc system was developed.

Reciproc works on a simple concept of alternating clockwise and anti-clockwise movement to advance down the path of the canal, as passively as possible, thus reducing risk of transportation, and dramatically reducing the risk of instrument fracture. The file is constructed of a heat treated nickel titanium alloy, 'M-Wire', which further reduces the risk of instrument fracture due to its resistance to cyclic fatigue and increased flexibility. The reciprocating action of the file itself is by no means new, and is simply an extension of the balanced force, or watch-winding action that will be familiar to users of hand file preparation techniques[2]. This preparation technique is in many ways a more natural way to prepare a canal than 360 degree rotation of a file.

The system is designed to allow complete preparation of most canals with a single file, in many cases with no glide path required. This is clearly a great advantage over many rotary systems, which involve multiple files, at significant cost, which must be discarded after a single use. The single use concept is incorporated into the Reciproc file design, as the instrument has a plastic band on the shaft which cannot tolerate autoclaving. Files are provided in gamma radiation-sterilised blister packs.

The Reciproc technique

There are three available Reciproc files with differing apical diameters of ISO 25, 40, and 50. The appropriate file size is selected based on the pre-operative radiographic appearance of the canal or canals to be prepared. Once the file has been selected and access achieved under rubber dam isolation, the selected Reciproc instrument is used in an in and out pecking motion for a maximum of three pecks.

The file should then be cleaned and the canal thoroughly irrigated with Sodium Hypochlorite. A K file should then be used to ensure that there is still canal patency. The Reciproc Instrument is used repeatedly in this way until the canal has been prepared to approximately 2/3 of its estimated working length. At this stage after further irrigation the working length should be determined either radiographically or with an Electronic Apex Locator.

Preparation can then be completed with the Reciproc file to length in the same manner if the canal is passively negotiable with a number 10 K file. In more difficult cases, where a number 15 K file cannot be passively introduced to length a glide path preparation should first be carried out up to a size 15 K File before completion of preparation with the Reciproc Instrument. The coronal flaring of the canal can also be carried out with the same instrument by using it in an outward brushing motion, in the same way as one would use a Gates Glidden or intro rotary file.

"This technique is in many ways a more natural way to prepare a canal"

Stephen Martin

Advantages of the Reciproc system

The Reciproc system has clear advantages over both traditional hand filing and rotary instrumentation. By effectively mechanising the same movements as area carried out in hand filing a canal, all the advantages of speed of preparation and efficiency are gained without the risks of instrument fracture and canal transportation that many practitioners associate with mechanical canal preparation. So it is an ideal instrument for those who may have held back from rotary instruments because of these concerns[3].

The system is extremely easy to use, with no file sequence to learn, and no changing of torque or speed settings. This simplicity of use and the speed of preparation[4] have the major advantage of allowing more time for irrigation of the canal system, which is the key to successful endodontic treatment.

The nature of the single file system means there is a clear cost advantage over any of the available rotary systems, and removes the frustrating experience of discarding expensive instruments which have often hardly been used.

Recommendations for new users of the Reciproc system

I would always encourage use of at least a number 10 K file to approximate WL as, in my opinion it is a good idea to have some tactile feel of the canals prior to intro-

ducing a mechanised file. This also allows patency to be checked and any potential difficulties that are not apparent on the pre-operative radiograph to be assessed.

Gauge canal diameter apically with K files and prepare accordingly. It is important that the apical part of the canal has some mechanical preparation. K files can be used to enlarge the apical part of canal if required, rather than using a further Reciproc if, for example, an R25 progresses too passively to length, K files size 30 or 35 could be used to finish the apical preparation, without significant increase in cost or time.

Similarly if after the canal has been prepared to the selected Reciproc size and a matched GP master cone goes beyond the working length when tried in, the apical part of the tooth should be prepared further by hand filing, and an appropriate size of GP master cone selected.

Matched GP cones to Reciproc Instrument Sizes are available, but as in other systems these are not to be assumed to provide 3D obturation. Compaction of GP and use of accessories in cold techniques or warm vertical compaction of GP will create less voids and a less sealer heavy obturation.

As with any instrumentation system, the Reciproc system is not appropriate for all canals. In cases of extreme curvature and where blockages or ledges need to be negotiated, or in extremely narrow canals hand files or other systems may be required.

The effectiveness of the irrigation can be improved by a variety of measures such as using warmed sodium hypochlorite, or activating the irrigant to improve penetration, either sonically or ultrasonically[5].

Summary

I thoroughly recommend Reciproc to any practitioner keen to improve safety, predictability and cost effectiveness of endodontic treatments. As with all new systems there is an initial set-up cost, and a learning curve. The Introduction Kit which includes the VDW Reciprocating motor comes with a number of files, paper points and GP points, as well as plastic training blocks to try out the system in vitro. I would advise that the system be used first on a number of extracted teeth until the practitioner feels comfortable and confident with the technique. This will however in my experience not take long and the Reciproc system will quickly become the first option for most endodontic treatments. The Reciproc system is exclusively available from Quality Endodontic Distributors, the very well known and reliable endodontic suppliers. ■

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The lightbulb moment

Dr Neil Harris describes how he had a moment of clarity while on a course at The Dawson Academy

Throughout dental school we were taught many things that are no longer relevant to our day-to-day lives working in a general dental practice. All the names of the bacteria that exist in a periodontal pocket, a classification for all the cysts of dental origin or the neural pathology of pain; and many more things that I have forgotten with the passing of the 20 years since I graduated.

In those 20 years I have found the area of dentistry that I have a passion for – cosmetic dentistry. I learned the different aspects of smile design, the different types of veneer preparation, the best adhesives, etc. The list goes on.

Given how many course I have undertaken, it still amazes me that nobody explained to me, at any point during my dental career, the fundamental relationship between the teeth, muscles and jaws, and the effect that this has on the patient's wellbeing and the longevity of our dentistry.

It wasn't until I spent time at the Dawson Academy UK, with Dr Ian Buckle and Dr DeWitt Wilkerson, in 2010 that the mechanics of the jaws were explained, and how this "TMJ-Occlusal system" affected all parts of dentistry.

They helped me fit all the pieces of the jigsaw puzzle together into a defined, structured learning pathway that I could take back to my practice. The Dawson systems ensured that when any patient approached me I could deliver ideal functional and aesthetic dentistry that I knew would last.

The Dawson Academy separates its courses into four modules which gradually build to give you the full picture of 'complete dentistry'.

I remember being sat in a class of 20 people, in the Comprehensive Examination and Records module, with Dr Buckle describing the relationship between the teeth, jaws and muscles, when suddenly everything I had learned in the last two decades suddenly fitted into place – what I always describe as my lightbulb moment!

Throughout the weekend course I was shown techniques that allow you to accurately record the elusive point known as centric relation, and ensure that all the information I recorded at the examination would allow me to go on and deal with all of the issues diagnosed; even in the most complicated cases.

It also left me knowing I was on the cusp of discovering how to develop and formulate treatment plans for my patients that could solve many of the problems seen day to day, such as tooth wear, why teeth break, why jaw joints click and when this is serious. I couldn't wait to get back and learn more!

During the following module I learned how to develop the skills to treatment plan every case using the Dawson systems (Treatment Planning module). The systems are designed to ensure that a treatment plan is developed to deliver optimum outcomes from functional, aesthetic, biological and structural perspectives.

The following module covered the dark art of equilibration (Equilibration module), along with splint therapy. By the end of this weekend we had a full understanding of all the different types of splint to use and the clinical situations where they are best used. Dr Buckle also managed to explain equilibration to all the students on the course which allowed us to complete a trial equilibration on models.

The final course showed us how to prepare teeth for veneers, crowns and direct composites using modern minimal preparation designs (Restoring Anterior Teeth module). With the increasing number of wear and erosion cases walking into practices, being able to restore anterior teeth in a minimally invasive way is an essential tool to have.

There is also a lot of time spent on the design of provisional restorations so that you can be sure that the final prostheses are perfect for function, aesthetics and phonetics.

Because of the Dawson UK courses, my practicing life has changed, allowing me to understand my patients' problems on a much higher level, and provide them with solutions that will work long term.

Most importantly the relationship doesn't end the moment you leave the building; the team at the Dawson Academy UK are also on hand to mentor you after the course and help you start developing the systems within your practice.

If you really want to help your patients, practice better dentistry and have more successful dentistry then The Dawson Academy UK is the place to start. ■

ABOUT THE AUTHOR

Dr Neil Harris is the clinical director at HRS Dental Care in Gloucestershire. Neil's practice opened in 2004 and has been amalgam free since 2006. His practice focuses on cosmetic dentistry, TMJ-occlusal problems, implant dentistry and adult orthodontics. He is a member of the American Academy of Cosmetic Dentistry, the British Academy of Cosmetic Dentistry, The Association of Dental Implantology, the British Dental Association and Gloucestershire Independent Dentists. He is also a mentor for the Dawson Academy UK, helping teach aspects of occlusion and TMJ problems to students from all over Europe. Dr Harris is a Director for the British Academy of Cosmetic Dentistry and is lecturing on the BACD/BDTA Roadshow at the BACD regional meetings throughout the year.

Dr Neil Harris

Face the music

Following a ruling by the Court of Justice of the European Union, Sam Price, Associate at Morton Fraser LLP, asks: are PPL and PRS now toothless when it comes to music licensing for dental surgeries?

The Court of Justice of the European Union (CJEU) recently ruled[1] that Italian dentists who play music free of charge in their private surgeries are not liable to pay licence fees to the Italian collecting society Societa' Consortile Fonografici (SCF).

In the wake of the SCF ruling, the UK's two collection agencies, the PPL and PRS, both hastily issued statements asserting that the case did not impact on their right to collect licence fees from UK dentists.

Does that view stand up to independent legal scrutiny? In my view, the answer is a qualified yes. I will return to the remaining point of likely practical interest – why and to what extent that "yes" is qualified – at the end of this article to encourage the reader to bear with me through the following short analysis of the relevant UK law.

The SCF case considered whether playing music in dental surgeries for the benefit of patients constituted a "communication to the public" for the purpose of an EU Directive (the Rental and Lending Directive), which requires all EU Member States (as a minimum standard) to provide copyright owners with a legal right to "equitable remuneration" when their music is communicated to the public.

"The CJEU concluded that patients in private dental surgeries did not constitute a 'public' for the purpose of the Rental and Lending Directive"

Sam Price

Although the term "communication to the public" has previously been interpreted broadly by the CJEU to include activities such as providing radios in hotel rooms or showing films in a pub, the CJEU concluded that patients in private dental surgeries did not constitute a "public" for the purpose of the Rental and Lending Directive.

Relevant factors included the limited number of patients present in a practice at the same time and the fact that broadcasting music to patients was not considered profit-making in nature, because it could not reasonably be expected to impact on a dentist's income.

Existing UK copyright law in this area goes further than the minimum EU requirements by giving copyright holders the exclusive right to authorise or prohibit third parties from publicly performing their music.

The PPL and PRS's right to claim royalties when music is played in public derive from this exclusive right under UK copyright law known as the "public performance right"[2], which has not been harmonised at the European level.

For the purposes of the public performance right, a large volume of UK case law, developed over close to a century, indicates that, generally speaking, only playing music in the family or domestic context would not constitute performance "in public".

Accordingly, while to the best of my knowledge, the specific scenario of a dental surgery has not been considered by the UK courts, existing case law strongly suggests this setting would be considered "in public" under English law.

Several legal commentators have speculated that the SCF decision may lead to a legal challenge to the UK position. The possibility of a challenge cannot be discounted and many will feel that the CJEU's specific reasoning in relation to dental practices should be given cognisance in the UK courts. My personal view, however, is that any challenge faces an uphill struggle for two reasons.

Firstly, because of the large volume of existing UK cases giving the phrase "in public" a wider meaning; and secondly, because I think that there is an evident distinction to be drawn between the meaning of the phrases "the public" and "in public", which may support giving them differing scopes, even within the same legislation.

In conclusion, therefore, while the SCF case may have brought into sharp relief the question as to whether giving UK copyright owners the ability to monetise the playing of their music in settings like a dental practice is justified, it has not served to invalidate PPL and PRS's current position. ■

REFERENCES

1 Societa' Consortile Fonografici (SCF) v Marco Del Corso (case C-135/10)
2 Copyright, Designs and Patents Act 1988, section 19 (Infringement by performance, showing or playing of work in public).

ABOUT THE AUTHOR

Sam Price is an Associate at Morton Fraser LLP specialising in Intellectual Property, Technology and Commercial Contracts.

BioHorizons presents its European Symposium

BioHorizons invites you to join an international group of well-respected speakers for its European symposium in Rome between 18 and 20 October 2012.

Addressing a wide range of dental implant topics including implant aesthetics, implant complications and tissue regeneration, the symposium presents the perfect opportunity to stay on top of the latest treatment options and remain aware of what techniques and products are supported by peer-reviewed research.

The event will include presentations from Carl Misch, Michael Pikos, Jack Ricci, Sonia Leziy and Brahm Miller.

Also, expanding on previous years' offerings, the 2012 schedule incorporates a biologics forum on the Thursday afternoon (18 October).

To find out more about this exciting event, including details of the topics to be covered, please visit www.biohorizons.com/symposium-series-Italy-2012.aspx.

For further details about BioHorizons, a company dedicated to developing evidence-based and scientifically proven products, visit www.biohorizons.com, call 01344 752560 or email infouk@biohorizons.com.

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Careful planning is necessary to ensure your practice isn't at risk in the event of a shareholder's marital split, warns Roger Mackenzie

When partnerships break up

Roger Mackenzie

While most dental practices continue to operate under the traditional partnership structure, incorporation as a limited company may sometimes be recommended as a more effective vehicle for running the practice.

Typically, financial issues, including potential tax savings, will drive the decision.

The perceived lack of flexibility of an incorporated company as opposed to a partnership business may be a downside, as can the administrative and legal costs involved in transferring to a corporate structure and the ongoing administrative burden.

Yet one issue that may less frequently arise in conversations with advisers when considering the most appropriate structure is the potential impact of incorporation in the event of the separation or divorce or dissolution of civil partnership of one of the shareholders in the business.

In Scotland, matrimonial property is an asset which is acquired after the date of marriage but before the date of the couple's separation (with the exception of gifts or inheritances).

In a situation where a partner in a dental practice joined the partnership prior to marriage, the value of that share in the partnership would not fall under the definition of matrimonial property and therefore would not be subject to fair sharing on divorce.

However, where a practice operating as a partnership decided to incorporate during the course of the marriage, the shareholding acquired after marriage would become part of the pot of assets to be shared. In other words, property that was not available for division would have been converted by the act of establishing the new business entity.

The dentist shareholder would still be able to point towards a source of funds argument, and argue that even if the shares acquired were matrimonial property, they emanated from pre-marriage sources.

However, such arguments are notoriously unpredictable and can often result in costly and acrimonious litigation which can drag out over many years.

The process will also often involve a valuation of the shareholder's interest in the business, usually by separate independent forensic accountants instructed by lawyers in the divorce action. Few businesses relish coming under that sort of scrutiny.

That is not to say that the business would never require to be valued in a scenario where the interest is not matrimonial property. A spouse may still try to advance a case to argue that the husband or wife has been economically advantaged to their corresponding disadvantage. Usually this might involve one party sacrificing their career to look after children or perhaps working unpaid for the spouse's practice. To attempt to quantify the financial advantage claimed, it may still be necessary to value the share in the business.

It is worth noting that for those in a cohabiting relationship, there is no equivalent to the matrimonial property regime and all arguments for financial provision have to be based on an exercise balancing each party's financial and non-financial contributions and the advantage and disadvantage that has resulted.

How can these problems be avoided? An important consideration is to get financial and legal advice that looks beyond just the dental partnership as a business, to properly get to know the people involved and their particular family circumstances.

If discussion revealed difficulties in a practitioner's marriage or that they were about to start a relationship, the advice ought to be tailored accordingly and could involve recommending a pre or post-nuptial agreement.

If it is too late for preventative action then, fortunately for divorcing parties, there is a growing movement among family lawyers in Scotland which is rejecting the adversarial approach and embracing a collaborative ethos.

With a recognition that few parties emerge satisfied from suit shredding, emotionally charged separations, the collaborative approach offers a forum for family law matters to be dealt with by promoting open dialogue and focusing on achieving a solution which leaves the separating parties on reasonable terms and with their dignity intact. ■

ABOUT THE AUTHOR

Roger Mackenzie is a solicitor in the Maclay Murray & Spens LLP business and family wealth team, specialising in family law.

RTI – what does it mean to you?

This month, Tricia Halliday considers some topical points for dental practitioners as employers

The taxman is asking all employers to spring-clean their payroll data to prepare for Real Time Information (RTI). Within the next 18 months, it will become as familiar to you and your practice as PAYE.

RTI is a new way of submitting payroll data to the tax office. Instead of sending in the PAYE information annually after the end of the tax year, employers will have to submit the payroll data online on every occasion the payroll is run. This will allow the taxman to understand who is being paid what amounts, and what PAYE is due, on a real-time basis.

The details of employees' pay will be passed to the Department for Work & Pensions, to allow the amount of Universal Credits (which are replacing Tax Credits from October 2013) paid to workers to be adjusted on a monthly basis.

RTI will be compulsory for all employers and pension providers by October 2013.

Before payroll data can be accepted under the RTI system, it must be 'clean'. That means having an accurate date of birth, full official name (not just initials or nickname) and correct National Insurance number, for each and every employee. If the data for one of your employees does not agree with that on the tax office computer, the submission of the payroll data under RTI may fail, and you may get fined.

It will take some time to check the details of every employee and obtain the missing details, so it would be best to start this task as soon as possible.

Automatic Pension Enrolment delayed for small businesses

Dental practices will already know that they have to start enrolling staff into workplace pension schemes shortly. The Government has, however, announced that firms with fewer than 50 employees will get more than a year extra to comply with the new rules.

The starting date for automatic enrolment has been postponed from April 2014 to May 2015 to help small businesses. The enrolment process for bigger employers is still due to begin in October 2012.

The Government recognise that small businesses are operating in tough economic times, so they are softening the timetable for implementation to give them some additional breathing space. They are still committed to ensuring employees of small businesses get the chance to save, and employers will still have to contribute.

The one-year delay will affect the 44 per cent of employees who are employed in firms employing fewer than 50 people, and this covers almost all dental practices. Such employers will eventually have to contribute at least 3 per cent of their employees' salary, with the employee adding at least 4 per cent.

An Employer NICs Holiday – what is it?

The Government previously announced a new Regional Employer National Insurance Contributions (NICs) Holiday for New Businesses. Under this scheme, for a limited period and subject to meeting certain conditions, new practices may still qualify for a deduction of up to £5,000 from the employer NICs that would normally be due – for each of the first ten employees they take on.

The NICs holiday is available to new businesses that started during the period from 22 June 2010 to 5 September 2013. However, as the scheme itself didn't start until 6 September 2010, you can only deduct employer NICs due on earnings paid between then and 5 September 2013.

You can apply for the NICs holiday if your practice is located within designated areas of the UK at the time your business starts up. The included countries and regions are: Northern Ireland, Scotland, Wales, East Midlands, North East, North West, South West, West Midlands, Yorkshire and Humber.

In most cases, there should be little doubt about whether your practice is located in a qualifying region, but in some instances, your principal place of business may not be clear. If you have more than one surgery, your principal place of business will be where you carry out the greater part of your work. If your business is split equally between surgeries, then the location you use as your administration centre/main surgery will be considered to be your principal place of business.

In most cases, it should be very clear that your new business is genuinely new. However, if your dental practice has, for example, recently changed ownership or was formerly part of another established practice, then you'll need to confirm that it doesn't fall into one of the excluded categories before going on to apply for the holiday.

If your business is eligible, the NICs holiday will run for 12 months from the date your business started. During this time, the first ten employees you hire are potentially 'qualifying employees' for the purposes of this scheme. This scheme could save new practices a significant amount of money. ■

ABOUT THE AUTHOR

Tricia Halliday is a tax partner at Martin Aitken & Co. Tricia is contactable at ph@maco.co.uk, by telephone on 0141 272 0000, or you can find out more about Martin Aitken & Co by looking at their website www.maco.co.uk

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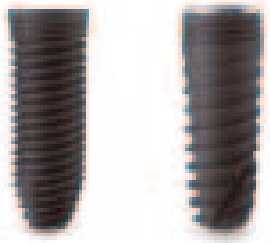

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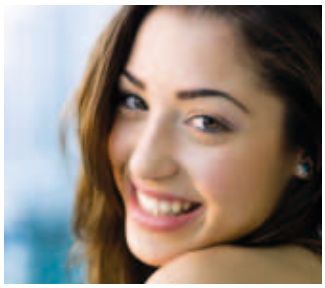

an electric drive still performing 3D, but with a sweeping rather than oscillating-rotating action.

For more details and information on free trials, please call 0870 2421850 or sign up to Oral-B's new website www.Dentalcare.com

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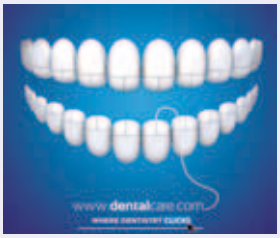


Dentalcare.com is Oral-B and Fixodent's biggest online resource serving the needs of Dental Professionals for over 15 years in different parts of the world.

After extensive redesign and redevelopment Oral-B is now launching Dentalcare.com in the UK with UK-specific material. Developed by dental professionals for dental professionals, the new website has been designed to provide intuitive, easy access to a wealth of resources relevant to every aspect of UK dentistry.

Dentalcare.com helps dental professionals provide exceptional oral care to motivate patients. Your patients hope to maintain good oral health for life. With your guidance and recommendation they can gain a more decisive control over their oral health.

www.dentalcare.com is your one-stop-shop.

Extra Ice White Mint

Wrigley's has added a new flavour to its hugely successful Extra oral care brand.

Extra Ice White Fresh Mint is the latest addition to the Extra Ice range, joining Extra Ice Peppermint, Extra Ice Spearmint and Extra Ice White. The four Extra Ice flavours, along with the Extra range and Orbit Complete, make up Wrigley's sugarfree oral care range.

The Wrigley Oral Healthcare Programme is developing a range of on and offline resources for dental professionals with the focus on educating patients on the benefits of sugarfree gum.

As part of its continuing commitment to helping to improve oral health in the UK, Wrigley was a platinum sponsor of this year's National Smile Month, run by the British Dental Health Foundation.

For more information, visit www.wrigley.com/uk/oralhealth

Innovative marketing for your practice

TePe Angle was developed to improve access to all interdental spaces, particularly in difficult to reach areas. The angled head gives perfect access to posterior teeth without the need to bend the wire, thus enhancing their durability. The innovative clip strip allows even small practices to display the Angle brush in an effective and space-saving way.

TePe Angle is available in six colour-coded sizes – pink through to green. All

TePe interdental brushes have plastic coated wires for safety and come with a hygienic cover. The handles are made from recyclable polypropylene.

SPECIAL OFFER
Order a pre-filled clip-strip during June and get 12 packets for the price of 10 (comes preloaded with two packs of each colour).

For more information, email info@molarltd.co.uk, visit www.molarltd.co.uk or call 01934 710 022.

The Unique TePe Implant Care

Molar Ltd is pleased to highlight a uniquely-designed brush for implant care. The TePe Implant Care is the latest addition to their wide range of specialist dental products, all developed in collaboration with the dental profession.

The TePe Implant Care brush is an innovative brush with a unique design for easy access. The angle of the neck provides improved access to difficult-to-reach surfaces of implant abutments.

The slim shape of the

brush head facilitates cleaning in even very narrow areas. Soft, end-rounded filaments ensure gentle cleaning, with the characteristic user-friendly TePe brush handle.

With the fantastic feedback received from the profession, we are confident that the TePe Implant Care brush will meet the needs of implant patients.

For more information on the Implant Care brush, or TePe's Implant product range, including patient leaflets, please contact the team on 01934 710022 or email info@molarltd.co.uk

Seeing is believing with GC Tri Plaque ID Gel

New to GC UK's product range is Tri Plaque ID Gel. As the name suggests, Tri Plaque ID Gel allows you and your patient to identify areas of plaque in three easy steps.

GC's Tri Plaque ID Gel quickly identifies new, mature and acid producing biofilms. This unique gel also highlights exactly where the bacteria are most active by disclosing the acidic pH. This additional information will be a great help in your daily practice to motivate your patients to improve their oral hygiene.

The Gel is colour coded for easy identification: blue/purple – old plaque (more than 48 hours); red/pink – newly-formed plaque; and light blue – high risk plaque.

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

Perfect fit and occlusal accuracy

Diamond Micro Luting Cement Capsules are the latest addition to the popular Diamond range of GIC restoratives.

These resin-reinforced luting cement capsules have excellent mechanical properties and aesthetic appearance, so they are well suited for luting high-strength ceramic crowns based on zirconium oxide and other similar materials often used in prosthetic treatment.

Diamond Micro Luting Cement Capsules have many advantages, including excellent adhesion, high physical strength, low linear expansion and superior marginal integrity. The micro-fine powder in the capsules allows an extremely thin film thickness for perfect fit and occlusal accuracy.

To find out more about the range of offers on all Diamond Glass Ionomer Cements, click onto the Kemdent web site www.kemdent.co.uk

Hands-free system

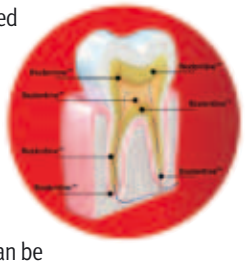
The ambidextrous Anthos R7 is the ideal choice of highly adaptable, modular treatment centre and is available from your premier R7 distributor Henry Schein Minerva.

The variety of R7 configurations means the chair makes effective use of available surgery space and in just a few simple moves can be converted to either a right-handed or left-handed unit, making it compatible to all user requirements.

The R7 can be completely controlled from the dentist element, nurse's element, the chair itself or from the multifunction foot control which allows handpiece speed regulation, chair adjustments and chair programme access for a completely hands-free operation.

For a showroom appointment call 08700 10 20 41, email sales@henryschein.co.uk or visit www.henryschein.co.uk

All-in-one and bioactive



Septodont has announced that bonding composite onto Biodentine during the same appointment has been proved safe and effective.

The first all-in-one bioactive dentine substitute, Biodentine can be used whenever dentine is damaged – both for crown and root applications. Helping with the remineralisation of dentine, preserving pulp vitality and promoting pulp healing, Biodentine fully replaces dentine with similar biological and mechanical properties.

A case study involving a one-year clinical follow-up demonstrates that the functional integrity of the full restoration is maintained when the composite is bonded onto Biodentine 12 minutes after the start of mix. After one year, the restoration showed zero defects and the radiograph showed no secondary caries.

Please visit www.septodont.com or contact your local Septodont representative for further details.

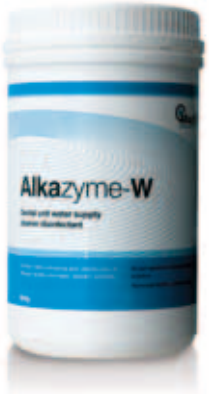
Alkazyme-W

Alkazyme-W is a combined cleaning and disinfecting agent for the weekly decontamination of the integral dental chair-side water supply.

It is simple to use, say the makers. A 15-minute weekly routine service clean with Alkazyme-W is all that is required to ensure the dental unit water supply unit remains free of bacterial contamination, thus ensuring 'clean water in – clean water out'.

A unique combined enzyme-based detergent/disinfectant system rapidly removes bio-film contamination, leaving all internal surface areas thoroughly clean and disinfected.

Each 500gm tub of Alkazyme-W allows for up to 100 service applications. It is non toxic and fully biodegradable.



Alkazyme-W 500gm concentrate is available from all dental sundry suppliers. For comprehensive product information on Alkazyme-W go to www.alkapharm.co.uk

No dramatic alterations

Dr Graham Magee of Chester Dental Implant Centre uses Nobel Biocare dental implants in his surgery.

Dr Magee said: "I have been involved with Nobel Biocare since 1993. The service I receive from Nobel Biocare has always been excellent and I have a very good relationship with the territory manager in my area.

"I mainly use NobelSpeedy Replace parallel walled implants which offer exceptional flexibility. The system allows me to choose the most appropriate implant I need to use at the time of surgery and if anything needs to be changed there is no need to make dramatic last minute alterations to the treatment plan. The TiUnite surface is also very effective."

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

Mortara Dolby exclusives

Stirling-based medical equipment supply and service company Mortara Dolby has announced an exclusive agreement with DentalAir Services UK Ltd to introduce its complete range of oil free compressor packages into Scotland.

Derek Gordon, Service Director of Mortara Dolby, commented: "We are excited at the prospect of offering compressed air as a part of our services. The agreement with DentalAir gives us what we consider to be the best range of equipment available, with added features of:

- standard sterile bacteria free air
- five-year warranties
- pressure systems written schemes with every new package.

"All our engineers have undertaken full accredited technical service training at DentalAir and we are looking forward to adding this missing dimension to our services."

Tomorrow's digital technology today

The Dental Company

sirona.

Made in Germany

Detect more caries and detect it earlier with the

CARIESCAN PRO™

The World's Most Accurate Caries Detection Device.

CarieScan PRO's 94.8% rate of accuracy in detecting hidden caries makes it far and away the most precise caries detection tool in the world. The CarieScan PRO allows you to locate more caries and locate it earlier, therefore increasing both preventive and restorative work – improving your bottom line. CarieScan PRO represents an evolution in accuracy for the dental industry and a tool you can trust for doubt-free diagnoses.

For more information on our Special Offers*, Money-back Guarantee*, or Free Trial* options please contact us on 01382 560 910 or info@cariescan.com

Or visit us at: **www.cariescan.com/uktrial**

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