No.1 for dental professionals in Scotland

February/March 2013

Scottish Dental magazine

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Leading light

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Editor's desk

with Bruce Oxley

Get in touch

Every issue I invite you, the dear reader, to get in touch if you have anything you want to get off your chest. Over the years, I have had my fair share of complaints, queries and, every now and again, a note of praise.

However, I had a funny feeling when we sent the Dec/Jan issue to the printers that my inbox would be a little busier than usual, and I wasn't disappointed.

The article written by Inverness-based dentist Eilert Eilertsen proved to be a particular talking point with a number of you getting in touch to register your points of view. We've cherry picked three of the best and printed them on page 20-21 in what I hope will be a regular letters section of the magazine.

This does, of course, depend very much on the dental profession getting in touch and letting us know what is good and what is bad in the Scottish dental scene. We really are keen to hear your views and we will make every effort to reply to all correspondence and print as many as we can in the magazine.

My contact details are at the end of this column and we now also have a comment box underneath every story on our website (www.sdmag.co.uk) so you can have your say straight away after reading and see what other people think about specific news stories, features and clinical articles.

You can also message us on Twitter – @ScottishDental – or Facebook.com/ScottishDental and apparently we still accept snailmail too. The address is below.

In other news, registrations are now being accepted online for the 2013 Scottish Dental Show. All you have to do to reserve your free place is visit bit/ly/show-registration and fill in your details.

You will receive an e-ticket in the post and you will also be automatically entered into a free prize draw to win a brand new iPad mini.

The 2013 Show is promising to be even bigger and better than ever with a great line-up of speakers from across the UK. Turn to page 6 for more details.

Nominations are also open for the inaugural Scottish Dental Awards (page 7) and we have already seen a great deal of interest in this free-to-enter event. There are 12 prestigious categories but the deadline is not far away – 1 April at 5pm – so if you want to nominate a collleague or team, then log onto bit.ly/dental-awards as soon as you can.

For more info visit Scottishdentalshow.co.uk

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

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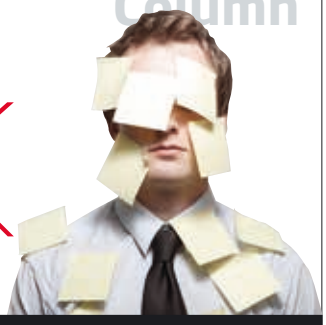

Specifically teeth

By now, we have all heard that Practitioner Services Division (PSD) is introducing a new GP17 form to be used to submit claims for any courses of treatment starting from 1 April 2013. We are told that the main reason for the new version of the form is to permit the recording of "tooth-specific data" on the GP17.

Now, I might be missing something, but I was under the distinct impression that we GDPs had been recording tooth-specific data on GP17 forms for as long as I can remember. Not only tooth-specific data, but also tooth *surface*-specific data; thus, when we performed most types of filling restoration, we had to chart on the GP17 the tooth and surface(s) filled.

This system seems to have served us very well for many years, so it is something of a mystery why the Scottish Government has seen the need to suddenly, and within a very short timescale, cobble together a new and rather unfamiliar GP17. This process has taken merely a matter of weeks to draft the new form and test it on PSD's systems.

There has been no time for piloting by REAL dentists and staff in their practices, nor has there been time for the companies manufacturing clinical IT systems to adapt their systems to print the new forms. This means that any practice using a clinical IT system will have to hand-write the GP17 when applying for prior approval – something of a retrograde step!

Another retrograde step is that the new GP17 no longer has any facility for noting which tooth surfaces have been restored during a course of treatment. This presents potential problems. For example, a GDP places a ULim resin restoration and that tooth already has a ULid resin, if a subsequent Dental Reference Officer (DRO) examination were performed, how would the DRO know which filling had been claimed?

Furthermore, if, a few months later, the same GDP had to replace the ULid resin, this second claim might be disallowed because the new GP17 does not allow the GDP to record that a different surface has been restored on that tooth.

It will be the hard-pressed GDPs and staff who will be left to cope with yet another half-baked plan

The profession's representatives (BDA/SDPC) have been involved in discussions with the Scottish Government and PSD about the new GP17 and I understand they have grave reservations about the design of the new form and about the haste with which it is being introduced with no time for proper testing and piloting, and very little time for educating dentists and staff about it. Indeed, I understand the form was still in draft stage with changes under discussion while the staff training roadshows were already under way.

It is difficult to understand what the Scottish Government and PSD hope to gain from the development of such a deficient new GP17, and why there has been such an indecent rush to push for its introduction by 1 April, but once again, it will be the hard-pressed GDPs and staff who will be left to cope with yet another half-baked government plan. ■

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NEW FOR 2013

Show returns to Hampden Park in Glasgow on 16 and 17 May

Registration for the 2013 Scottish Dental Show opened at the end of January and at time of writing there were already more than 400 people signed up to attend.

Featuring a packed trade show alongside a speaker programme offering up to eight hours of verifiable CPD and boasting some of the biggest names in Scottish and UK dentistry, this is an event that is truly not to be missed.

Restorative dentist and president of the BARD Paul Tipton will be opening the event on Thursday 16 May and he will be followed over the next two days by speakers contributing to four conference streams: dentist, dental business, DCPs and technicians

Scientific chairman Kevin Lochhead, clinical director of Edinburgh Dental Specialists, said: "The appeal of the Scottish Dental Show is the wide variety of topics being covered and the calibre of the speakers. Whether it's four-handed dentistry, clinical excellence, retirement planning or business succession, delegates are interested in, the wealth of knowledge and support will be there.

"Those attending can walk away inspired with new ideas that they can take back and implement in their own practices."

Registration is free and couldn't be easier, just visit bit.ly/show-registration and fill in your details. You will then be entered into a free prize draw to win an iPad mini.


Ashley Latter


Paul Tipton

SPEAKERS TO INCLUDE:

- Paul Tipton
- Ashley Latter
- Kevin Lochhead
- Arshad Ali
- Mark Oborn
- Alistair MacDonald
- Ian Jackson
- Paul Stone
- Robbie Lawson
- Pierluigi Coli
- David Cunningham
- Lars Sennerby
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- Stephen Jacobs
- Crawford Bain
- Prof Graham Ogden
- Irene Black
- Christine Young
- Helen Kaney
- Neil Taylor
- Barabara Lamb
- Dr Mike Busby
- Iain MacArthur
- Neil Morrison

Celebrating the best of Scottish dentistry

SCOTTISH DENTAL AWARDS 2013

Get nominating for the first Scottish Dental Awards

AWARDS

Time is running out to nominate your colleagues, peers and practices for a Scottish Dental Award, with the deadline for entries set for 1 April.

The inauguaral Scottish Dental Awards will take place on the evening of 16 May at Hampden Park in Glasgow at a glittering awards ceremony.

Nominations are free and must be submitted on the Scottish Dental Show website before 5pm on the deadline day. All you need to do is write a short citation describing who you are nominating and why they deserve to win an award.

The nominations will be collated and a shortlist will be compiled to be set before our distinguished panel of judges. They include Chief Dental Officer Margie Taylor, BADN President Nicola Docherty, Kevin Lochhead of Edinburgh Dental Specialists, University of Edinburgh senior lecturer Margaret Ross, GDPs Kieran Fallon and John Glen and ADAM president Jill Taylor. *Scottish Dental magazine* editor Bruce Oxley and sales manager Ann Craib complete the panel.

The judges will convene to decide on who should be declared winner in 12 prestigious categories ranging from Dentist of the Year and Lifetime Achievement Award, through to Most Valuable Contribution to Patient Care

Bruce Oxley, editor of *Scottish Dental magazine* which is published by Scottish Dental Awards organiser Connect, said: "This is a fantastic opportunity to highlight the work of a colleague or friend, to reward your team for their hard work throughout the year, or to simply show appreciation and give recognition to an individual who has dedicated their career to their patients."

"This is a fantastic opportunity to highlight the work of a colleague or friend"

Whatever your reason, nominating someone or a practice for a Scottish Dental Award couldn't be easier. Simply visit bit.ly/dental-awards and fill in the details of who you would like to put forward.

Unlike other awards ceremonies, nominations are free and all we ask for is a short history of the individual or practice as well as a citation of no more than 500 words detailing why you think they should win a Scottish Dental Award.

AND THE CATEGORIES ARE...

Scottish Dental Lifetime Achievement Award 2013
Nominees for this award will have made a significant contribution to dentistry in Scotland and the wider world throughout their career.

Scan this QR code to put someone forward for a gong

Dentist of the Year
Nominees for this award will have shown an exceptional level of patient care and leadership over the past year.

Best NHS Practice
The winning practice will provide not only high-quality dentistry, but also an outstanding commitment to its patients and the National Health Service.

Best Private Practice
How has your private practice gone above and beyond for your patients and staff?

Best Referral/Specialist Practice
This category will recognise the outstanding work of a practice working at the very highest levels of skill and expertise.

Dental Nurse of the Year
Nominees for this award will be invaluable members of the practice team, with a proven ability to build relationships with patients and colleagues.

Student Dental Nurse of the Year
Open to all Scottish students and nurses who qualified in 2012/13. Nominations should be based on both academic and clinical achievements.

Dental Hygienist/Therapist of the Year
Nominees should have made a significant difference to their patients' oral health care, motivation and routine.

Dental Business Manager of the Year
Does your practice have a practice manager or administrator without whom the practice would just fall apart?

Best Dental Laboratory
We're looking for the lab that provides the best service and works in perfect harmony with their dentist colleagues.

Most Attractive Practice
This category aims to showcase beautiful surroundings that help patients and staff enjoy their time at the practice. Pictures are essential for this category, so please provide the best quality images you have.

Most Valuable Contribution to Patient Care
What innovation, technique, or service have you provided to make a significant difference to the treatment you provide? Open to individuals, teams and practices.

MDDUS appoint Angiolini to the board

Former Lord Advocate and Solicitor General of Scotland Dame Elish Angiolini QC has been appointed as a non-executive director on the board of the Medical and Dental Defence Union of Scotland.

The organisation's chief executive Gordon Dickson said: "I am delighted that Dame Elish will be joining the board. She brings a wealth of experience that will contribute enormously to the board's work as the union continues to grow and develop."

With almost 30 years' experience in the profession, Dame Elish is one of the most high profile and influential figures in the UK legal world, being the first woman, the first procurator fiscal and the first solicitor to hold either of the posts of Lord Advocate and Solicitor General.

One of the murals in the clinical areas at the dental school

Artist works with local children to create murals

ART PROJECT

An innovative art project aimed at reducing anxiety among paediatric patients has been installed at the University of Aberdeen Dental School.

Artist Susan T Grant worked with local school children from Mile End primary school to create 'Forecast'. Using dichromatic vinyl on walls and ceiling tiles, the artwork consists of huge weather symbols which change colour as you walk past.

In one of the treatment rooms at the dental school there is also a weather animation designed to distract young patients during procedures.

The art project was a partnership between sick children's charity the ARCHIE Foundation and Grampian Hospitals Art Trust which centres on the provision and commission of artworks for the benefit of patients in Grampian healthcare settings.

David Cunningham, CEO of the ARCHIE Foundation, said: "It is crucial that young people and their families are helped to feel calm in medical facilities.

"In many cases, a child who is calm in their surroundings can be treated more easily and have a more comfortable experience."

Online protest gathers pace

CHALLENGE

E-petition collects more than 100 dentists' signatures

An online petition set up to protest the latest amendments to the Statement of Dental Remuneration (SDR) has gathered more than 100 signatures and has been submitted to the Scottish Government.

The e-petition was set up at ScottishDentists.org by a group that describes itself as: "...a simple, non-profit voluntary organisation made up of kind, caring dental practitioners within Scotland.

"Our aim is also simple; to give these individuals a united voice in order to coordinate, consult and even challenge regulations enforced on us by relevant authorities."

The latest round of amendments was announced on 26 November and the e-petition was started on 6 December. Some of the comments left by those signing the petition reveal the level of concern and anger among the profession.

One signee, from Aberdeen, wrote: "Dentistry on the NHS is hard enough to break even performing a good or even adequate standard of dentistry. With no increase in the SDR fees and progressive negative changes this will only worsen as costs and overheads forever increase.

"I understand these are tough financial times, but this is going to drag everyone into further financial problems and ultimately affect patient care."

Another, from Dundee, said: "Scottish Government should be looking after the patients – in the long run this goes the opposite way. To keep our heads above water the patients will suffer. We choose to work within the NHS to provide a good quality service to those who have the highest demands. How do you suggest we do this or are you happy to accept you are promoting inadequate healthcare?"

One Glasgow dentist wrote: "It is becoming increasingly more difficult for those professionals who are trying to work with honesty and integrity under the NHS. We work hard and pay our taxes, so why are we being penalised?"

Visit www.scottishdentists.org to view and sign the petition.

Former chair comments on findings of a report into issues raised by her resignation

PSA report on GDC investigation

REACTION

The report by the Professional Standards Authority (PSA) on its investigation into the concerns raised by former GDC chair Alison Lockyer, has received a mixed response.

Indemnity organisation Dental Protection Ltd (DPL) has reacted "with interest and some concern" to the findings of the report, which runs to more than 250 pages.

A press release from DPL stated: "One cannot fail to be shocked and deeply concerned at some of the internal processes exposed by the report and surprised that the Professional Standards Authority could have found them acceptable.

"There can be few registrants who would want to have been placed in the situation that Alison Lockyer found herself in, and it is perverse that she would have experienced a much fairer process and far better legal protection as a registrant facing Fitness to Practise (FtP) procedures than she did as the chair of the GDC."

The former chair herself released the following statement in reaction to the report: "I am pleased that a light has been shone on some of the problems to which I was seeking to draw attention and if, as a result of this, the task of my successors is easier, I can take considerable comfort from that."

However, the GDC released a statement welcoming the report saying it "rejects allegations that the GDC failed in its statutory duties".

It continued: "Following a thorough investigation which began in September 2011, the report rejects the allegations made against the GDC and its staff.

"It found that, while there were weaknesses in the GDC's governance and fitness to practise processes during 2009 to early 2011, the GDC did not fail patients then, and is on the right track now."

To view the Professional Standards Authority report in full, visit bit.ly/PSA-report

BDA welcomes mercury decision

UN TREATY

The BDA has welcomed the approach of a United Nations treaty that aims to reduce mercury pollution, describing it as "sensible" and "pragmatic".

The treaty, which was agreed on 20 January at a meeting of the United Nations' Environmental Programme's Intergovernmental Negotiating Committee in Geneva, sets out a phasing down approach in the use of amalgam fillings over an "appropriate time period".

It had been feared that the treaty would require a complete phase-out of amalgam use at short notice, something the BDA had lobbied against. The association argued that more time was needed for oral health prevention programmes to be implemented and produce effects, and for suitable alternative dental filling materials to be developed.

Drs Stuart Johnston and Susie Sanderson, members of the BDA's Principal Executive Committee, led international lobbying on behalf of dental associations in campaigning for a pragmatic approach.

Dr Johnston, who led the FDI World Dental Federation Dental Amalgam Task Team at the negotiations, said: "Dentists in the UK recognise the environmental imperative to minimise mercury emissions, but it was important that this treaty took account not just of the environmental agenda, but also of the need for dentists to care for their patients.

"We are pleased to see that this treaty has taken a pragmatic view, acknowledging that the phase-down approach advocated by the World Health Organisation is a sensible way to make progress.

"The final treaty strikes a sensible balance, clearly setting out an aim for reduced use of mercury, while recognising the unique contribution it makes to oral healthcare. It also recognises the important role that prevention can play in improving oral health and reducing demand for fillings."

Syrian refugee camps get Scottish support

Charity work to aid survivors of Syrian civil war

AID WORK

A Scottish GDP and his paediatrician father have just returned from a two-week stint working in Syrian refugee camps in Turkey.

Dr Ammar Al Hourani, who works at Tooth Plus in Stirling and Long and Gilmour in Bo'ness, and his father Dr Ghassan Al Hourani, a consultant paediatrician from Forth Valley Royal Infirmary, travelled to Turkey with Scottish refugee charity Aid4All.

Ammar, whose family hailed from the Syrian capital Damascus, was stationed in two villages on the Syrian border, Rehanya and Killis, where mobile dental clinics had been set up to care for the 150,000 refugees who have been displaced since the Syrian civil war began in March 2011.

Ammar at work in Turkey

The work involved treating and educating patients as well as training local dentists. He said: "I can honestly say that this was one of the most amazing experiences I have had, as well as the most saddening. The refugee camps are in a desperate state and although deemed among the better facilitated camps they still had chronic shortages of all forms of aid.

"On a daily basis I would see six patients an hour for nine hours. It's unrelenting and never-ending work, patients' oral hygiene is poor, dental education and motivation is low and the rate of caries is high."

Ammar's father oversaw a large project to help build a paediatric unit in one of the camps as well as taking part in the vaccination programme.

Ammar said: "There is a huge need for all forms of aid in the camps, as well as social aid projects such as schooling for the kids."

www.aid4all.net

Health boards meet decay target

The latest figures from the National Dental Inspection Programme have shown that for the first time all NHS boards in Scotland have met their targets in relation to primary school pupils.

The Scottish Government's target was for 60 per cent of primary one pupils to have no obvious signs of decay and all 14 boards have now met or exceeded this aim. The national average now stands at 67 per cent of P1 pupils, and overall improvement of 3 per cent since 2009/10.

Public Health Minister Michael Matheson said: "This tremendous progress is the result of our significant investment in children's dentistry over recent years.

"It is also tribute to our work with the British Dental Association and the commitment of Scottish dentists, nursery and school staff and parents to deliver the Childsmile programme.

"However, it is extremely important that we continue this work as we know that the best way to improve the nations dental health is in childhood."

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Many happy returns for Braemar

To mark the company's 20th anniversary, Dundonald-based Braemar Finance held a series of prize draws around the country, giving away £4,000 in the process.

Eight dentists were among the winners, including Ken Provan from Eden Dental Practice in Inverness whose name was drawn at the 2012 Scottish Dental Show at Hampden. The other lucky dental professionals, who each picked up £100 John Lewis vouchers were: Adam Silan, James Robson, Anna Shortt, Christo Robbertse, Claire Agbodu, Philip Oag and Graham Browning.

David Foster, managing director and a company founder, said: "Thanks to everyone who entered the draw and congratulations to the winners."

New diploma course aims to plug the gaps

Dental technology qualification is launched

EDUCATION

Dental technology students Marc Buchan and Sally Trusser

An innovative new dental technology course has been launched in Aberdeen aiming to plug a gap in the provision of training for technicians.

The diploma in dental technology will use a range of learning methods to serve students who live in remote and rural areas and who are in full-time employment.

It is open to those employed as dental technician trainees and includes a mix of online, workplace and face-to-face elements. Students will study the course on a part-time basis over three years with workplace supervision from a registered dental technician.

As well as online elements, the programme also includes two days' attendance at the state-of-the-art University of Aberdeen Dental School and Hospital each month. Modules on the course include dental laboratory skills, anatomy and physiology, orthodontic technology and designing and manufacturing dental appliances.

The diploma is the result of a collaboration between the University of the Highlands and Islands, the University of Aberdeen Dental School, NHS Grampian and NHS Education for Scotland.

Christmas lecture focuses on charity

TALK

Charity in dentistry was the theme of the 2012 Christmas lecture held by the Dundee section of the BDA at the University of Dundee's Dental Education Centre.

Five speakers were invited to present on the subject. Dr Shona Mason, specialty dentist (restorative) with NHS Tayside, Dr Colin Levey, dental foundation trainee with NHS Greater Glasgow and Clyde and Dr Gareth Blair, associate dentist at High Street Dental Care in Montrose, discussed their volunteer work in Peru with the Vine Trust.

Then Dr Christopher Southwick, senior dental officer with NHS Fife and Dr Nicola Milligan, vocational dental practitioner at Bridge of Earn Dental Practice in Perth, discussed their efforts in Burundi with Dundee-based charity Mission International.

Dr Mason talked about the Amazon Hope medical boat as well as her experiences with the Vine Trust over several years. Dr Southwick spoke about Mission International's work delivering dental care to some of the poorest and most deprived people in the world. Burundi, he explained, has only 11 dentists caring for a population of nine million.

(l-r) Dr Ewan Mackessack-Leitch BDA Dundee Section treasurer, Dr Christopher Southwick, Dr Nicola Milligan, Dr Gareth Blair, Dr Shona Mason, Dr Colin Levey, Dr Jonathan Bowman BDA Dundee Section secretary

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Specialist in Endodontics

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Specialist in Periodontics and Prosthodontics

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Nobel Biocare

Fellowship honour for Glasgow dentist

ITI APPOINTMENT

Jordanhill dentist Colin Burns has been appointed as a fellow of the International Team of Implantologists (ITI) following a meeting in Switzerland at the end of last year.

The ITI was founded in 1980 and has more than 13,000 members and fellows worldwide, including more than 750 in the UK.

Colin, principal dentist at Crow Road Family Dental Care in Glasgow, has been a member of the ITI since 2005 and, as well as being an ITI Mentor and ITI Registered Speaker, he is also the director of the Glasgow ITI Study Club. More recently, Colin has been appointed as UK and Ireland ITI Section study club coordinator with UK and international commitments. He is responsible for 40 study clubs and 150 events, with a membership of 800.

In January, Colin graduated with a masters degree with merit in implantology from Warwick University and he has been accepting implant referrals from colleagues for a number of years. He said: "Implantology has allowed me to broaden my clinical horizons and provide treatments for my patients that are life-changing.

"I love the predictability of implantology with ITI protocols and I look forward to the future and the remarkable growth in digital dentistry that lies ahead."

Colin is running a course on 6 and 7 September with Allan Pirie from Clifton Dental Clinic called 'Foot in the Door'. The introduction to implant dentistry course will feature theory as well as practical and hands-on elements.

Correction and apology

The news article that appeared on page 13 of the December/January issue of *Scottish Dental magazine*, headlined 'Two new specialists at Vermilion', incorrectly referred to Dr David Jones and Dr Zannar Ossi as specialists.

This was an editorial error by *Scottish Dental magazine*. Neither clinician is yet on the GDC specialist list. However, their practice at Vermilion is limited to endodontics and prosthodontics respectively.

We would like to apologise for the error and for any inconvenience caused.

For more about Vermilion, visit www.vermilion.co.uk

Struck off for making dishonest claims

A Glasgow dentist has been struck off by the GDC for filing inappropriate claims to NHS Greater Glasgow and Clyde health board over a period of eight years.

Thomas Alan Shanks of T Alan Shanks & Associates at Shettleston Road, Glasgow, and Main Street, Baillieston, made dishonest claims for the provision of tissue conditioner, special trays, identification markers and domiciliary visits between 2000 and 2008. At the hearing, the chairman of the GDC's professional conduct committee said: "You made these claims for significant financial benefit and you did so dishonestly. The claims were made substantially, but not exclusively, in respect of patients who were exempted from making a payment in accordance with the relevant rules. These were not one-off claims. The dishonesty was repeated on a regular basis over a lengthy period of time."

GDC removes Glasgow dentist from register

The committee noted that there were a number of detailed testimonials submitted on Mr Shanks' behalf from patients and colleagues speaking highly of his abilities, standard of treatment and general professional conduct. However, the committee ruled on 11 February that he was to be struck off with the committee chairman concluding: "The system for making claims against the NHS depends on the probity of the dentists who stand to benefit from the payments made. Your abuse of the system is a very serious matter. It is fundamental that patients are able to trust dentists.

"The committee was not satisfied that you have demonstrated insight into the serious nature of your behaviour. Your dishonesty is highly damaging to your fitness to practise and to public confidence in the dental profession."

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Blackhills CLINIC

Brian Stevenson

8th Specialist for Blackhills Clinic

Brian Stevenson is the 8th Specialist to join the clinical team at Blackhills Clinic. Brian is a Specialist and Consultant in Restorative Dentistry at Dundee Dental Hospital and will now also be working at Blackhills Specialist Referral Clinic just outside Perth. The clinic provides a full range of adult dental care (except orthodontics) and Brian, who is also a registered Specialist in Endodontics, will work alongside the other Specialists at Blackhills to provide a highly regarded referral service to dental colleagues and their patients across Scotland and beyond.

Brian graduated from the University of Glasgow in 2000 and spent the first few years of his career as a General Dental Practitioner in Edinburgh. He subsequently completed a PhD at the University of Edinburgh whilst working and teaching at both Edinburgh and Glasgow Dental Hospitals. He undertook an accredited five year training in Restorative Dentistry at Dundee and Aberdeen Dental Hospitals. He has been employed as a Consultant in Restorative Dentistry at Dundee Dental Hospital since 2011.

At Blackhills Clinic patients are often seen by more than one Specialist at 'combined clinics', ensuring the appropriate expertise can be called upon to deliver the highest standards of the most appropriate care whatever the clinical situation. There is also a considerable level of expertise in all aspects of implant dentistry with a combined total of over 80 years experience in this demanding discipline. This expertise is often sought by colleagues referring cases where implant treatment carried out elsewhere is unsatisfactory or failing.

Referrals can be made on-line (www.blackhillsclinic.com), by email or by post.

The Specialist team at Blackhills:

Oral Surgery	**Paul Stone** BDS (Hons) Lpool, FDS, RCS Ed (60534) **Marilou Ciantar** BChd (Hons) Malta, MSc Lond, PhD Lond, MFDS RCS Eng, MFD RCS Irel, FFD RCS Irel (84070)
Prosthodontics	**Ken Watkins** FDS, DRD, MRD RCS Ed (46937) **Adela Laverick** BDS (Hons) Lond, FDS RCS Eng, MSc Lond (66211)
Restorative Dentistry	**Chris Allan** BDS, FDS, RCPS, MRD RCPS Glas (46065) **Brian Stevenson** BDS PhD FDS (Rest Dent) RCSEd, MFDS RCSEd FHEA (77605)
Periodontics	**Marilou Ciantar** BChd (Hons) Malta, MSc Lond, PhD Lond, MFDS RCS Eng, MFD RCS Irel, FFD RCS Irel (84070)
Endodontics	**Julie Kilgariff** BDS MFDS RCS MRD RCS(Endodontics) (78002) **Brian Stevenson** BDS PhD FDS (Rest Dent) RCSEd, MFDS RCSEd FHEA (77605)
Dental & Maxillofacial Radiology	**Donald Thomson** BDS (Hons) Edinburgh, FDS RCSEdin, DDR RCR (70079)

www.blackhillsclinic.com

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"Share the care with a Specialist"

Dentists urged to act before audit deadline

ADVICE

The MDDUS is urging dentists across Scotland to take immediate action to ensure they meet their audit requirements by the July deadline. Any practices failing to do so could be at risk of breaching their NHS Terms of Service says the defence organisation.

NHS dentists should have recently received written advice from the regional postgraduate dental education directors detailing their audit obligations and warning that most practitioners are required to complete 15 hours of clinical audit by the end of July 2013. It also highlights the fact that health boards now have access to practices' audit activity and may choose to intervene where necessary.


Doug Hamilton

MDDUS dental adviser Doug Hamilton said: "There appears to be concerns about the volume of audits which have been submitted to date.

"The regulations have always empowered health boards or NES to require evidence of audit compliance. However, the recent circular advises practitioners that health boards can now access this information and may scrutinise this aspect of clinical governance at practice inspections.

"Failure to complete 15 hours of audit by 31 July may therefore impact upon a practice's income or may even be regarded as a breach of NHS Terms of Service.

"Constructing an effective audit can be a slow process. Therefore, dentists who have fallen behind with their audit activity should take action."

CPD deadline is looming

There are less than six months left before the first cycle of CPD ends for nearly 40,000 DCPs across the UK and the GDC is urging registrants to make sure they are up to date.

On 31 July 2013 they must have completed 150 hours of CPD – including 50 hours of verifiable CPD – and they will have until 28 August to declare the hours they have completed or risk losing their GDC registration.

The regulator is in the process of contacting all the DCPs affected and a dedicated webpage (http://bit.ly/CPD-resource) has been set up on the GDC site to help them meet its requirements.

So far 15,085 (38 per cent) DCPs have logged more than the minimum hours, while 4,380 (11 per cent) DCPs have failed to log any hours.

New to *Scottish Dental magazine*, these letters pages are a forum for you to discuss the issues of the day and respond to anything that piques your interest

Agree to disagree

I read the article entitled, 'After the feast cometh the famine' published in your Dec 12/Jan 13 issue (p28) with great interest. Dr Eilertsen is my uncle and indeed the reason I ended up in the dental profession myself. However, my career path has gone in a different direction from Dr Eilertsen's, and my views on the future of our profession differs possibly as a result.

Currently, I am the principal dentist and owner of a four-surgery, predominantly NHS practice in the West Lothian town of West Calder. I am also a vocational trainer to newly qualified dentists and through this I meet many dentists who are in similar circumstances and who share similar views to myself.

I bought my first practice in 2006 and immediately set about upgrading it to meet with the latest requirements for decontamination and disability discrimination. I moved premises in 2009, expanded from two surgeries to four and I have recently installed a crown and bridge laboratory.

I have created five new jobs, taking my total staff to 11. My point is that all this would not have been possible without grants I received from the NHS. I received a £150k grant with the condition I take on 3,000 new NHS patients. Since opening three years ago we have grown our patient numbers to over 7,000, despite West Calder's population only being 5,000!

We provide a valuable service to our local community and I'm confident in saying that our patients are pleased with the way that the NHS grant has been spent. Moreover, I would argue that it has been a good investment from the taxpayers perspective, due to the new tax payers created and increased tax revenue as a result.


After the feast
cometh the famine

Dr Eilertsen argues that more private dentistry would be a good thing and that healthcare budgets should be slashed. I would argue that it was NHS dentists 'turning private' back in 2006-08, to capitalise on the economic boom, who suddenly closed their doors to NHS patients, that caused a lot of the current problems we find ourselves in.

During those boom years it was virtually impossible to find a dentist who would take on NHS patients. Overnight, dentists who had patient lists of up to 3,000 were reducing their list sizes dramatically and hiking their charges up exponentially to compensate. I remember dentists turning 'amalgam free' overnight and, instead of providing an occlusal amalgam for £8 on the NHS, were suddenly charging £300 for a porcelain inlay.

Where were ordinary folk supposed to get treatment done if they couldn't afford thousands for their treatment?

"During those boom years it was virtually impossible to find a dentist who would take on NHS patients"
Paul Roberts

The Government's answer? Flood the market with more dentists and therapists. When I qualified in 1998 there were 45 students in my class. This year's crop of graduates had 65. Glasgow has also upped its student numbers and Aberdeen is now turning out about 20 dentists too.

To compound the problem, all those 'private' dentists (most of them still treated NHS kids and exempt adults) have re-opened their doors to NHS patients now that the private bubble has burst. The result, dental students graduating with up to £50k of debt and poor prospects for finding work. I feel it would have been far better to have had more regulation to prevent dentists selecting their patients during the boom years and then returning, cap in hand, to the NHS when the bubble bursts.

With regard to the quality of dentistry provided by NHS or private dentists, I have found that bad dentists do bad dentistry, irrespective of the system that they are governed by.

Dr Eilertsen has an award-winning practice and deserves the success he has worked so hard to achieve, but his model is not one that can be repeated nationally. ■

Yours sincerely,
Paul Roberts

Arguments on NHS dentistry 'ill advised'

It is a shame that Eilert Eilertson's arguments about the merits of provision of NHS dentistry to the population of Scotland was marred by a degeneration into ill-advised hyperbole.

It was with dismay that I read that, in his opinion: "A rash of therapists, who at best are half trained and at worst do not understand the beneficial role that a hygienist has to play in high-quality long-term dental care, have been pushed through."

As one of a team of tutors who are responsible for the training and teaching of therapists to BSc level, I can only surmise that Dr Eilertson had by this point in his writing, become carried away with his own erudition and thus displaced reality with a fantasy of his own construction.

I will be extremely interested to see any and all documentation supporting Dr Eilertson's assertions as to the 'half-trained' nature of therapists to which he refers, as will the recently departed delegation from the General Dental Council who, just this year gave this school full sufficiency for dental registration for the next five years following an exhaustive process of inspections.

I am also sure that the University of the Highlands and Islands, who validate the Bachelor of Science degree awarded by the school would want to examine any evidence Dr Eilertson has of the paucity of the training our students receive. (Noting, of course, that this is the same educational level to which dental graduates are trained).

"I can only surmise that Dr Eilertson had by this point in his writing, become carried away with his own erudition"

I would be delighted to make Dr Eilertson's concerns available to the General Dental Council. I am sure that they will be interested in his derogatory remarks concerning an entire class of qualified dental professionals. I am sure that he was simply being rude and unprofessional and had no intention of actually bringing his profession into disrepute.

Alternatively, a retraction and apology would be considered an appropriate response. ■

Yours sincerely,
D Monks, Dental Tutor,
UHI School of Oral Health Science, Inverness

Article a comedy of errors?

RE: After the feast cometh the famine, *Scottish Dental magazine*, Dec 12/Jan 13, p28

I was locked between irritation and amusement at the above article in the latest issue.

Some of what the author says about PFIs and fluoride I agree with, as I argued in the early 1970s (Fife LDC) that only basics should be provided on the NHS and that did not include crowns, bridges etc.

But I do wish he had explained more about the low tax economy in the Far East and how it translates to the West.

Many Scots died in two World Wars to enable my neighbour down the road to be a Muslim, my other neighbour to be a Communist, and myself a Druid! That's how I intend to keep it.

"The author is wasted in dentistry, he should do stand-up comedy or go into politics!"

I think it is 'rather off' to 'insult' people who have done their best for the NHS all their lives; in my case 48 years.

The author is wasted in dentistry, he should do stand-up comedy or go into politics!

As EM Forster said: Two cheers for democracy (but still hoping for three!). ■

Regards,
Lachlan B MacDonald
BDS, Paisley

Stem cell correction

I refute the statement in the Dec 12/Jan 13 issue of *Scottish Dental magazine* that Callum Graham is the first practitioner from Scotland to bank stem cells from his daughter's teeth! I harvested stem cells from both my son and daughter's deciduous teeth six years ago. ■

Kind regards
Jaine Maclean, GDP, Dunoon

Editor says:
We stand corrected, we should have stated that Callum was the first "as far as we were aware".

We would like to hear from anyone else who has been involved in stem cell harvesting. Please get in touch using the contact details above.

Colin Burns

We put ITI Fellow Colin Burns of Family Dental Care Glasgow under the spotlight

Q. What do you love most about your job?
Interacting with patients, getting to the root of their issues and developing strategies and treatment plans to provide what they need. Implant dentistry is a wonderful journey and my training has allowed me to meet some truly inspirational colleagues around the world. I love the travel, it's allowed me to see some smashing places.

Q. If you weren't a dentist, what would you be?
At home more often! Wow, who knows? I always thought running a book shop or a record shop would have been me, but I guess they won't be around for much longer! Let's say... teacher.

Q. Best piece of advice you've ever been given?
In surgery, "One miracle at a time" – Professor Danny Buser from Bern University.

Q. On a day off, what would we find you doing out of the surgery?
Clinical day off: working on ITI matters, preparing lectures, presentations, reading. Dental day off: losing my temper on the golf course!

Q. Who's your hero (dentistry or otherwise)?
In dentistry, Frank Schwarz. His research on implant surface technology, regeneration and implant maintenance is top drawer. And he's a really nice, laid back guy. Out with dentistry, the golfer Bernhard Langer. Both are German – a coincidence?

Q. If you could relocate your practice to any time or place, where would it be?
2025 – I think digital dentistry could be really exciting by then. I'd have the practice near a beach in Florida, a short drive from Sarasota – great place, good restaurants, wonderful golf.

"I'd have the practice in Florida, a short drive from Sarasota – great place, good restaurants, wonderful golf"

Q. Favourite film (doesn't have to relate to dentistry..!)
The Perks of Being a Wallflower – stunning movie, great book, loved the soundtrack.

Q. Favourite tipple of an evening?
Diet Coke, or good Italian wine. I'm afraid my tastes are expensive. I'll go for Brunello or Gattinara.

Q. Favourite food?
I love everything at Andrew Fairlie's Restaurant in Gleneagles. However, it is a bit pricy, so I'll go for my wife's lasagne.

One city, three days, a world of experience

A wide range of speakers is lined up for this year's event

The decision to stage this year's British Dental Conference and Exhibition at the ExCeL exhibition centre means it will be the most accessible to many Scots delegates since the event was held in Glasgow in 2009. A direct flight from Aberdeen, Dundee, Edinburgh or Glasgow to London's City Airport, followed by a five-minute taxi ride, will allow many visitors to reach the venue in less than two hours.

But, aside from the scale of the event, the range of business and clinical expertise on offer, the amount of CPD available, and the chance to see the world's leading dental technology in one place; what will entice dentists in Scotland to book their flights?

The headline speakers, from as far afield as America and as close to home as Dundee, will be high on many delegates' lists. Giving his first lecture in Great Britain, US expert aesthetic practitioner Dr Robert Lowe will discuss advanced aesthetic restorations, clinical treatment planning and problem solving, and composite restorative dentistry. He is one of only 50 dentists in the United States to receive diplomate status on the American Board of Aesthetic Dentistry.

Bart Van Meerbeek, Professor in Biomaterial Sciences at the Conservative Dentistry department of the Catholic University of Leuven, Belgium, will deliver two sessions on adhesion and ceramics, while general dental practitioner and director of Dawson Academy UK, Dr Ian Buckle, will discuss occlusal principles for daily practice. This year's 'expert endo' session will be led by Mark Hunter of the University of Manchester.

Inspirational speaker Andy McMemeny and inset, Nicola Innes

But, while the big-name speakers may be the obvious attractions, it's in the depth of the event that many attendees will find the factor that clinches their decision to attend.

With its higher and increasing prevalence in Scotland, changing trends in head and neck cancer will be an area of concern to many. A session chaired by the new BDA director for Scotland, Pat Kilpatrick, will address this issue.

Dentists' more traditional foe, decay, will be in the sights of the University of Dundee's Dafydd Evans and Nicola Innes in their Saturday afternoon presentation: 'Dental caries: new approaches to managing the auld enemy'.

A legal perspective will be on offer on Thursday in Professor Richard Goldberg's lecture on dental malpractice and no-fault compensation. A professor of law at Durham University, Richard Goldberg will look at the potential implications of the introduction of a no-fault compensation scheme in Scotland.

Another big draw to look out for will be inspirational speaker Andy McMemeny. Famous for running 66 marathons in 66 days in 66 cities, raising money for charity and breaking a world record in the process, Stirling-born Andy also brings with him considerable business experience, having worked in senior management at organisations with turnovers of £1.3 billion and £500 million.

The exhibition hall also has much to offer. As well as the regular mix of exhibitors, product launches, show offers and competitions, 2013 will see the return of the technology-focused innovation zone and the demonstration theatre, which will feature re-enacted scenarios presented by a range of experts and demonstrations on phantom head simulators. For those who prefer their learning bite-sized, the training essentials theatre will offer 30-minute lectures covering subjects including decontamination, online marketing and motivating behaviour change in patients.

On Thursday evening, the exhibition hall will host the first of a series of social events with evening drinks and a charity auction. The Friday night party will this year draw on the heritage of East London by taking place in a converted tobacco warehouse. Music will be provided by Uncle Funk, performing a selection of disco classics. ■

The event takes place from 25–27 April. To view the full programme and book tickets, visit www.bda.org/conference BDA members are entitled to a free one-day ticket. Anyone attending for two or three days can also register a DCP to attend free of charge.

Marcin working with the Zeiss operating microscope

Under the microscope

Spring Grove's Polish endodontist on his love of magnification

Endodontist Marcin Paradowski is almost evangelical when it comes to magnification. And the story of how he fell in love with working with microscopes shows how far he is prepared to travel to make sure his patients get the best care possible.

After graduating from the Dental University in Szczecin in the north west corner of Poland in 1999, Marcin then worked in private practice as well as undertaking intensive training in oral surgery at the hospital in Gorzow Wlkp.

During this training, Marcin had the opportunity to work with consultants in ENT, opthalmology, general surgery, plastic surgery and maxillofacial surgery, assisting in many operations from head to toe.

He explained that he even had the chance to amputate a leg and help with a stomach resection with reconstructions, all as part of his oral surgery training. While working with eye surgeons he discovered his love of magnification. Marcin takes up the story: "It was about 10 years ago and I had to ask a favour from one of my dentist friends if I could use his microscope to treat one of my patients. I couldn't see properly what was going on in the tooth so I thought this was the perfect opportunity to use a microscope.

"So I packed my patient into the car and drove 200km to my friend's surgery and, with his help, I did my first root canal treatment under the microscope. It was an awesome experience and two weeks later I had my first scope in the surgery in Poland."

Since that time, Marcin uses loupes routinely for all general dentistry and a microscope for all endodontic procedures and restorative work: "I just can't live without it," he said.

Marcin moved to the UK in 2005 to a position at The Hollies Dental Surgery, a mixed NHS and private practice in Dunoon, where he has been ever since. In 2006, he started his endodontic training in the north west of England at the University of Chester, initially gaining a diploma and more recently graduating with an MSc in endodontics this year.

He has been involved with vocational training for the last four years, running study days at the postgraduate centre at Glasgow Dental Hospital in endodontics. He started taking referrals for endodontics and surgical endodontics at Spring Grove Clinic last year where he has access to a state of the art Zeiss operating microscope.

He said: "I am delighted to have joined the team at Spring Grove. I have already learned so much in a short space of time from restorative treatments to observing maxillofacial and implant surgery.

"I really think that being able to use the Zeiss will improve my skills immeasurably and help many more patients to retain their own teeth." ■

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By Bruce Oxley

Bruce Oxley talks to the new director of the Edinburgh Dental Institute, Professor Angus Walls

Breaking with tradition

Despite growing up in a family full of medical professionals it wasn't a foregone conclusion that the young Angus Walls would follow in his parents' footsteps. The new director of the Edinburgh Dental Institute (EDI) was born into something of a family dynasty of doctors with his grandfather working as a surgeon, both parents working as medical practitioners and both aunts also doctors.

However, despite medicine seemingly running through his family's veins, witnessing his father's life as a GP in the north east of England in the 1960s and 1970s actually turned his head away from that particular career path.

He said: "I think it is just an awful lifestyle, or at least it was at that time. So I was looking for something that I could do which would allow me to use what I thought were my skills at the time, and yet still carry on with that caring approach that was part of the family ethos.

"I was always quite good with my hands, so I chose dentistry."

Born in Gateshead, Angus enrolled at the nearby Newcastle University to study dentistry in 1974, graduating in 1979. Upon qualifying, Angus decided that he wanted to strike out on his own and leave his native north east and live away from home for the first time in his life.

"A lot of that was serendipity. Jobs simply came up in the right place at the right time"

Professor Angus Walls

He moved to what he describes as "a good old fashioned rotating house job" in Bristol for six months before heading north to Stoke-on-Trent to work in the oral and maxillo-facial surgery department of what is now the University of North Staffordshire NHS Trust which, at the time, was one of the best around. Having worked as an SHO in Stoke for a year, Angus decided that oral and max-fac surgery, while a great experience, wasn't what he wanted to do long term.

He said: "I thoroughly enjoyed the job but I didn't like the lack of continuity in patient care. I found that not having some form of longitudinal relationship with some of my patients was quite dissatisfying. So I decided that wasn't for me."

It was at this point that he decided to head back to Newcastle for a number of reasons, not least to just get it on his CV. At the time it was almost a given that graduates would do a house officer job at the

"The new blood post triggered an interest in me as to the problems of ageing which I still find fascinating"

Professor Angus Walls

EDINBURGH BOARD AGREE NAME CHANGE

At a board meeting in December it was agreed to change the name of the Edinburgh Postgraduate Dental Institute (EPDI) to the Edinburgh Dental Institute (EDI).

Prof Walls explains: "The rationale for the change is that we have a hygiene and therapy school, so we have undergraduates and calling it the postgraduate institute is no longer valid.

"Also, the NHS function has always been Edinburgh Dental Institute and having the EPDI and the EDI was just confusing, people didn't know what the two things did and what the differences were."

university they graduated from, but Angus had moved away to stretch his wings at that point in his young career. During a few interviews, the question popped up and Angus decided that, while he was confident he had moved away for the right reasons, there may be an underlying question mark as to why he hadn't worked there.

He explained: "I always feared there was this hidden agenda where I felt people might think 'is this guy such a toerag that they didn't want him?' So I felt I needed to go back to Newcastle to just have the Newcastle stamp on me as a postgraduate rather than just as an undergraduate."

Angus moved back to the north east in January 1981 and his appointment at the EDI in January 2013, ended a spell of 32 years at the same university. "A lot of that was serendipity," he said. "Jobs simply came up in the right place at the right time and, to be honest, you tend not to move away unless there is a good reason."

After 18 months of house jobs, Angus completed his Fellowship and moved into a research programme funded by the Medical Research Council. Over the following three years he worked alongside paediatric dentist Professor John Murray and dental materials scientist Dr John McCabe. The PhD subject that Angus undertook was looking at different ways of managing caries in childrens' teeth.

In 1985, Angus was appointed to a lecturers post at the university as part of a new scheme called 'New Blood Lectureships' that aimed to bring younger lecturers into an academic environment. The two other new blood appointments in the UK were Prof Eddie Lynch, now head of dentistry at the University of Warwick and Prof Jennifer Kirkham Pro Dean for Research and Innovation in the Faculty of Medicine and Health at Leeds University.

Eight years later Angus, now a senior lecturer, was looking for a chair post and for the first time since moving back up to Newcastle it looked like he might have to leave to further his career. However, the head of his department then announced his resignation to take up a post in Hong Kong. Angus applied and was successful.

He said: "That was really the reason I stayed in Newcastle, the jobs came up at the right time and, particularly for a clinical academic, if you have a research programme that is well established, it does disrupt it if you move.

"You probably set back your research by a couple of years every time you change posts. Some people change posts regularly and for them it must be a relatively easy thing to do, but for me the opportunities came to stay in Newcastle so I decided to stay."

Angus developed his research interests in dental materials during his PhD studies and the New Blood Lectureship that was themed around the oral healthcare of the older patient, sparked an interest in gerodontology that lasts to this day.

Prof Walls explains: "The new blood post really triggered an interest in me as to the problems of ageing which I still find absolutely fascinating. Both on a population and societal basis in terms of how we are going to cope with the older population and the growth of the older population, but also how we as dentists are going to face

Continued »

Continued »

different challenges, different populations with different health needs and how we are best going to address that."

A former president of the British Society of Gerodontology, Prof Walls was awarded the Distinguished Scientist Award from the International Association of Dental Research in Gothenburg in 2003 for his work in the field.

He said: "For me it was one of the most important moments of my professional career because it meant that, internationally, my peers felt that the work that I was doing and have continued to do since then, was contributing significantly to our knowledge and understanding of the oral health problems of the older person."

Prof Walls became director of research for the school of dental sciences in Newcastle in 2008 and was instrumental in setting up the Centre for Oral Health Research at the university around three years ago. Then, when Professor Richard Ibbetson announced his resignation from the EPDI in late 2011, the stage was set for Prof Walls to end a proud association with Newcastle University that spanned three decades.

He took up post in January and said that his decision to finally leave was quite simply to take on "that one last challenge in my working life," he said. Prof Walls explained that he is currently in the middle of appointing five new posts and he has been encouraged by the injection of much-needed funds by the University of Edinburgh to allow him to do this.

And, while he acknowledges that following the first director of the institute and a man who had been in post since 1999 is a daunting prospect, it is one he is more than ready for.

He said: "I'm sure my leadership of EDI will be different, I hope it will be as effective and I hope it will allow EDI to develop as a provider of postgraduate training and education for dentists both in Scotland, the rest of the UK and worldwide." ■

To find out more about the EDI and the courses available, visit www.dentistry.ed.ac.uk

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Lack of equipment, poor facilities and sweltering heat didn't stop Hari Lal from putting his dental skills to vital use in Kenya

Dentist in the desert

In a normal day's dental work it's fair to say that getting up close to a giraffe and speaking Swahili do not feature prominently. But these are just two of the unique experiences I encountered when I took a month off work to volunteer in Kenya.

I have always believed that helping those in need is one of the most important things in life and I was keen to do something that could also make use of my skills as a dentist. It was this thought that prompted me to contact the co-ordinator of Grace-patt Ecotours Kenya, Patrick Karimi (who runs the company with his wife Grace), to find out more about their dental internship project. And, after hearing about the poor state of dental care in the deprived area of Malindi, I decided I wanted to help.

To prepare for my month-long trip into the unknown, I spent a few weeks gathering up as many dental supplies as I could. I was taken aback by the generosity of companies such as Wright Cottrell, Colgate and Oral-B and others who kindly donated items including gloves, masks, visors, filling material, disinfectant wipes, toothpaste, toothbrushes and scrubs as well as toys and stickers for the children.

With everything I'd need carefully packaged, it was finally time to set off for Kenya. I arrived in Nairobi after an almost -nine-hour flight to be warmly greeted by Patrick who took me to a transit house for the night where I hoped to shake off any jet lag. The following day he took me to the Sheldrick elephant orphanage and a giraffe centre where we had the chance to see these beautiful animals up close. It certainly made for an unusual and enjoyable introduction to Africa.

From there, it was time to go to work and a rather hot and bumpy seven-hour bus ride took me to the town of Malindi on the country's south-east coast. On the bus I met hospital co-ordinator George Mumba who took me to meet the family whose home I'd be sharing for the next month. Staying in a traditional African home really added to my experience with my friendly hosts introducing me to traditional African food and culture as well as teaching me some basic Swahili.

Hari Lal teaches one of many youngsters about the importance of brushing

Once I'd settled in, it was time to go to the hospital dental clinic where my adventure really began.

Deprivation

I was given a position within Malindi District Dental Department leading a small team consisting of myself, a fourth-year dental student and a dental nurse. As a government-run hospital, the patients who came for treatment were unfortunately worse for wear financially as well as dentally. The majority came from nearby villages and I was surprised at the large number who presented medically with HIV.

The prime treatment we carried out was extractions – sometimes multiple in the same patient – and there were several patients with facial trauma seen in other departments who presented for dental review. More unusual tasks included providing treatment for prisoners or

Continued »

ABOUT THE AUTHOR

Hari Lal graduated from Glasgow Dental School in 2010 and works as a dentist in Dedridge Dental Centre, Livingston

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Continued »

carrying out age assessments for patients involved in court cases.

Unfortunately, facilities in the clinic were limited. In addition to the dental chair being broken and the drill being inoperable, there was a lack of instruments, gloves and masks. The sweltering heat only added to the challenging environment. Despite the difficulties, I knew this was the best it was going to get, thanks to limited government funding.

Each morning, at least 10 patients would queue outside the clinic, mostly complaining of toothache that had kept them up all night. Around half the patients didn't even own a toothbrush, never mind regularly brush their teeth. The dental student, Steve, acted as my interpreter as very few patients spoke English. I had learnt the basics in Swahili and could say things like open wide, extractions, pain, numb, filling, and bite together. Mornings were like a conveyor belt of patients but it was rewarding knowing they were leaving with the source of the pain removed.

Outreach

The afternoons in the clinic were quieter, so I arranged to promote dental health in the community with Steve. We visited three local schools, speaking to packed classes of 70 and 150 pupils, plus a whole school of 1,000 pupils aged 10 years or older.

With the aid of the blackboard, demonstration models, posters and Steve's language skills, we covered topics including tooth structure, diet, brushing, fluoride, caries, periodontal disease and hand hygiene, both in English and Swahili. The pupils seemed keen to learn and we quizzed them at the end, offering prizes and samples for those answering correctly.

It can be difficult to know how effective these kinds of visits are, particularly as many villagers struggle to afford even basic dental supplies, but I was pleased to find out that several of the pupils we had spoken to visited Malindi District Hospital to get their teeth checked. During the visits, community health workers listened and took notes with the aim of continuing to deliver dental health education to other schools. I am happy to report that two more schools have been visited by these dental health promoters.

"I learnt the basics in Swahili and could say things like open wide, pain, numb, filling and bite together"

Looking back on it, the whole experience was a real challenge and took me out of my comfort zone. But, spending a month in such conditions has really opened my eyes to the problems of government-run dentistry in Kenya and I would urge other dentists and dental students to consider volunteering.

I have made some cracking new friends for life and had the privilege of treating patients in great need of treatment, as well as helping to educate schoolchildren about the importance of prevention. The experience definitely enhanced my clinical skills as well as giving me a glimpse of the other face of dentistry. ■

With thanks to Patrick and Grace Karimi
www.gracepattecotourskenya.org

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Gracepatt Ecotours Kenya
The tour and travel company operate medical/dental missions and internship programmes. It is looking for general volunteers as well as clinicians holding medical/dental qualifications.
www.gracepattecotourskenya.org

Bridge2Aid
This UK dental charity was set up in 2002 and works to improve dental care and access to pain relief for the people of Tanzania. It has trained more than 160 local health workers in emergency dentistry and continues to train a further 50 per year. Through its Dental Volunteer Programme, qualified dental professionals travel to Tanzania to pass on their skills.
www.bridge2aid.org

Mercy Ships
The UK charity operates a number of hospital ships, staffed by a volunteer crew, serving more than 150 ports in developing nations around the world. Its dental programme welcomes volunteers to treat dental and oral diseases and provide education and training for some of the world's most deprived populations.
www.mercyships.org.uk/dental

Other useful links include:
www.christianreliefuganda.org
www.smiletrain.org
www.dentaid.org
www.dentalprojectperu.org
www.kausaywasi.org
www.fitfortravel.nhs.uk

Practice support

Ken Scoular, Alan Whittet and Doug Stirling update on a resource from SDCEP to aid practice management

The demands of running a Scottish dental practice in 2013 are many and complex. To help with this, the Scottish Dental Clinical Effectiveness Programme (SDCEP) has produced a Practice Support Manual (PSM).

This manual supports practice management and organisation in primary dental care in Scotland by providing up-to-date advice on a range of topics that are essential for running a dental practice. This information is provided via the PSM website, www.psm.sdcep.org.uk

Initially launched in 2010, the PSM brings together information that is relevant to dental practice from current legislation, professional regulations, guidelines and the opinion of experts and experienced practitioners, and presents it in a practical manner to:

- assist the smooth running of a dental practice;
- encourage the involvement of the whole team in practice management and organisation;
- facilitate staff induction and training;
- facilitate practice development planning;
- promote best practice;
- help compliance with current legislation and professional regulations;
- support the preparation for, and successful completion of, a practice inspection;
- help practices meet the National Standards for Dental Services;
- enhance patient care and safety.

The PSM is also:

- an excellent learning tool for the Vocational Trainee Test of Knowledge;
- a handy reference tool for all dental practice managers – particularly those participating in the NES General Practice Managers VT Scheme.

What's in the PSM?

The PSM provides advice on a range of non-clinical topics. Brief background information and actions for the dental team are included for each topic, together with optional supporting tools to aid implementation, such as template forms, information sheets and policies.

The PSM also provides checklists that practices might find helpful as a summary of what is advised for each topic. The checklists are also a means of allocating responsibilities among the dental team, which should help to improve the efficiency of running a dental practice.

The topics currently included in the PSM are: Ethical Practice; Record-keeping; Communication; Risk Management; Health and Safety – General; Health and Safety – Infection Control; Radiation Protection; Disability Equality; Medical Emergencies and Life Support; Audit and Significant Event Analysis.

The PSM does not address financial management and employment legislation, and practitioners and practice managers should seek alternative professional help in dealing with these complex issues.

Who is the PSM for and what does it cost?

Although the PSM is written primarily for

principal dentists and practice managers who are responsible for managing a dental practice, the smooth running of a dental practice involves, and depends on, the whole team. Therefore, the content is of relevance to all members of the dental team, and all team members are encouraged to use it. The PSM is freely available to dental professionals in Scotland.

Why use the PSM?

One of the aims of the PSM is to support dental teams to prepare successfully for practice inspection. This is especially relevant as a new form of practice inspection is currently being introduced. All practice team members who contribute to the inspection process will find the PSM a helpful resource for checking the latest legislation and regulations and for bringing the practice's documentation up to date.

An example – Radiation Protection

Although dental radiography delivers a very small radiation dose, risk does exist and dentists have a duty of care and a legal obligation to protect the public, their staff and their patients from potential harm associated with exposure to radiation.

This section of the PSM provides brief guidance to facilitate the safe use of ionising radiation by dental practitioners in accordance with legal requirements with relevant information, useful checklists and templates to enable legislation compliance.

Who created the PSM?

Several dental practitioners with many years' experience of owning and running primary care practices have contributed to the advice within the PSM.

They have generally also multi-tasked with other roles in education, working with NES, as DPAs or in the Dental Practice Board.

Input has also been provided by several topic-specific expert bodies and specialists. Configuring the PSM as a website has been led by members of the SDCEP team including Doug Stirling, Sam Rutherford and Trish Graham.

While the PSM aims to give up-to-date advice on practice matters, there are always changes to guidelines, legislation and professional regulations. Practitioners and their teams should be aware of this and their responsibility as healthcare professionals to ensure their decisions are appropriate to their individual dental practices and the care of their patients.

The PSM website

You can find the PSM at www.psm.sdcep.org.uk Access to the full content requires an account. If you don't have one, click the 'New users register here' button on the home page and follow the instructions.

First-time users might find it helpful to view the video introduction that is mentioned on the home page. It includes a description of how to create a personal account or an account for your whole dental team. ■

Dental Protection

Fair subscriptions

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

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Quality assured

Glasgow dentist Colin Gardner explains how he came to be recruited as an assessor for the BDA's Good Practice Scheme

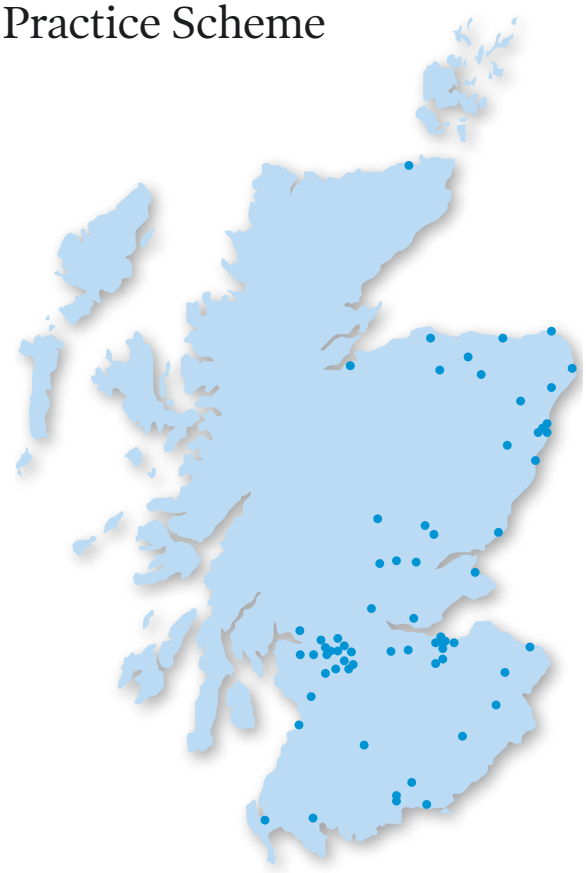
The British Dental Association has expanded its pool of Good Practice Scheme assessors with five new recruits located in Scotland, including myself. The assessors, from across the whole of the UK, are trained to carry out on-site assessments to ensure that practices are meeting the Good Practice Scheme standard.

From spring 2013, all new applications for membership of the Good Practice Scheme will be visited by an assessor and the BDA is also introducing on-site assessments on a three-year cycle for existing members. Anne Bender, Head of the Good Practice Scheme, said: "In total, 24 new assessors have been recruited to expand our existing pool. These are dentists and practice managers who have demonstrated skills in assessment and have the expertise to support us in delivering this essential element of quality assurance for the BDA Good Practice Scheme.

"Furthermore, our assessors are skilled in providing support and guidance to practices in meeting nationally recognised standards. With more than 1,800 member practices across the UK and 90 in Scotland, this is an important development for us and for our members."

Good Practice Scheme assessors in Scotland include dentists with NHS, private, corporate and community dental service experience and are located in Edinburgh, Dumfries and Glasgow. Both practice managers have formal management qualifications, are experienced trainers and are located in Dunfermline and Ayrshire.

Personally, I am quite excited by my new role. I see it as an opportunity to use my career experience in professional mentoring and business management. I believe that peer assessment with good honest acknowledgement of strengths and weaknesses supported by our own professional association, the BDA, can facilitate valuable development for individuals, for practices and for the broader profession. I'm really looking forward to visiting practices in Scotland.



BDA Good Practice Scheme
COMPLIANCE | QUALITY | BELONGING

Above: Good Practice Scheme member practices in Scotland

Like most GDPs, I started my career as an associate. Within 18 months, I became a partner in a four-surgery practice where I remained for the next 10 years before joining a private dental body corporate for four years, heading a large team and then working as a civilian dentist for the armed forces and prison service while looking for a suitable practice to buy.

That opportunity came in March 2008 when I took over Botanics Dental Care in Glasgow's west end. There had been a dental practice on the site for more than 40 years and the fact that I was only the third dentist that many of the patients had attended in their lifetime was testament to both patient loyalty and the standard of care they had previously received. However, I felt a need to make changes, to develop the clinical practice and also the management of the business.

Installation of a new dental unit and full computerisation with the associated staff training was the easy bit – everything is relative. I also introduced a raft of clinical and managerial protocols, together with systems to update these at regular intervals. It was important to me that these systems should be flexible, allowing evolution and change at regular intervals, but also as and when events might highlight a shortfall or an opportunity for further improvement. This would require the involvement and input from every single member of our team.

Yet there was still something missing for me. As a single-handed practitioner, there was no other dentist on site to discuss and compare ideas with. While I was confident that the changes I had introduced were positive and overall improved the level of care that we as a team could provide for our patients, there was little assistance available for me to measure this against to ensure we were doing the very best that we possibly could.

It was in early 2009 that I investigated the BDA Good Practice Scheme after I spoke to them at a conference. Following a discussion with their representative, I ordered

Continued »

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the CD-ROM which contained all the information necessary to help me implement protocols in every aspect of a general dental practice. All we had to do was embed it and ensure that every member of the team understood what was involved in its implementation and evolution going forward.

Sounds simple? If any of you have heard Chris Barrow talk or seen his social media comments, you'll have heard the phrase: "If what we are doing was easy, everybody would be doing it."

All in all, it took the team six months to make a successful application and we gained our membership of the Good Practice Scheme in September of 2009. Our three-year renewal came around in September 2012, we made a successful re-application and are now in our fourth year of membership.

When applications were invited for the role of Good Practice Scheme Assessor, I decided to put my name forward and, following an interview and additional training, I and four other colleagues in Scotland were announced as the latest certified practice assessors. It is important to make a distinction between the terms 'assessor' and 'inspector'.

The intention of the assessor is to highlight any areas for development that may come to light during an on-site practice assessment. Let's remember, applicants have put themselves, their teams and their businesses forward voluntarily and we want to assist them through collaboration so that the practice is successful. This whole process is voluntary, not mandatory.

"The intention of the assessor is to highlight any areas for development that may come to light during an on-site practice assessment"

The sign is an indication that a practice meets high industry standards

There has been a lot of debate in the dental press over recent years about the seemingly excessive amount of regulations and the onerous, time-consuming nature of it all. In the UK today there are several bodies involved in regulation: the GDC, NICE, HSE, Environment Agency, Dept of Health; CQC/HIS/RQIA/HIW.

Some dentists have argued that managing the expectations of the regulators takes them away from the far more important clinical role. While I can empathise with that view, I also believe that the changes being brought in are intended to benefit and safeguard our patients and the team, which should be the goal of every dentist. Instead of bemoaning the fact that these changes have come, and indeed more will be coming, embrace them and adopt a proactive approach in implementing them. My experience has been an improved standard of care for my patients, hugely improved morale and sense of self-worth for all team members, and subsequently, a more enjoyable workplace.

The Good Practice Scheme has five sections:

1. Patients
2. The Practice Environment
3. The Team
4. Monitoring Quality
5. Business Management.

Within these five sections there are 121 requirements. A fantastic resource for all would-be members is the BDA Expert – it details the requirements with guidance models and links to help you get started and complete a practice self-assessment.


Colin Gardner

There will be a short series of articles over the coming months, aimed at highlighting the scheme requirements with tips and advice on how best to achieve them. While some of this will be mandatory in order to make a successful application, it is not intended to be prescriptive; rather it is guidance and should be adapted to the individual's practice.

Conclusions

I qualified at a time when vocational training was voluntary, not a requirement; general anaesthetics were frequently carried out in general practices (pre-Poswillo report); undergraduates were taught that the use of (latex) gloves was only necessary for extractions and surgery; autoclaves were often sited within the surgery and nobody had even heard of LDUs.

It was commonplace for associate dentists to work under the terms of a verbal agreement only, without the legal protection of a formal written contract. Frequently, new trainee nurses would be taken into surgery without any training on their very first day in a practice. If memories of these days make you dewy-eyed with nostalgia, then possibly the Good Practice Scheme is not for you. I hope instead that these memories fill you with a desire for compliance, quality and belonging. ■

For more information about practice assessment and joining the BDA Good Practice Scheme, see www.bda.org/gps or call 0207 563 4598.

Starting out on a new journey

Two well-travelled dentists settle down to a new practice life in St Andrews, writes Bruce Oxley

Even taking into account his proud nomadic ancestry, Iranian-born dentist Nimo Rostami admits that he has taken a fairly circuitous route to his current home as co-owner of St Andrews Orthodontics.

Graduating from the National Medical and Dental University of Tehran with a DDS in 1994, Nimo entered a post-graduate programme in dental materials at Claude Bernard University in Lyon, before moving to Germany to work as a dental officer at Ramstein US Military Airbase in Kaiserslautern.

He then moved to the UK, initially to Dundee. But before settling in Scotland, he took on a number of hospital posts in maxillofacial surgery and orthodontics across the country culminating in specialist orthodontic training at The Royal London Dental Institute, where he graduated in 2003. Nimo then moved back up to Scotland to work in orthodontic practice.

His partner at St Andrews Orthodontics, Nicholas Baker, also has taken an interesting route to the Fife town, courtesy of a six-year stint in the Royal Navy as a dental officer. Nick joined up on graduating from Dundee in 1985 and, by the time he left the Navy in 1991, he had risen to the rank of lieutenant commander.

Upon entering general practice, he realised that he enjoyed working with children and developed a special interest in orthodontics. He is currently working towards an MSc in orthodontics at the University of Warwick on a part-time basis.

Nimo and Nick met while working for a chain of orthodontic practices on the east coast and decided to join forces and set out on their own. They identified St Andrews for a number of reasons, but most importantly because the Fife town at that time didn't have a specialist orthodontic practice and they saw an opportunity to fill the gap.

The bright and airy waiting room

"We wanted a modern, bright and welcoming practice and this is exactly what we have made"

Nimo Rostami

After investigating a couple of locations, including a one-pub, they came across a former computer college not far from the St Andrews Community Hospital in the south of the town. Nimo explained that it took them a while to gain planning permission, partly because of the layout of the interior and to comply with disability access requirements, as the practice was located on two floors.

The contractors had to move a lot of internal partitions and erect internal walls to make up the waiting room, ground floor surgery, X-ray room and disabled toilet downstairs, along with two other surgeries upstairs, a staff room and small lab. Work was finished in the summer and the practice inspection was passed in June, allowing for their first patients to be seen the same month.

Nimo and Nick decided on

Continued »

Surgery one at the Fife practice

Continued »

one chair per surgery – unlike some orthodontic practices who use a multi-chair layout – as they felt it was important to give their patients as much privacy as possible. And, to ensure the surgeries let in as much light as possible, the walls of the downstairs surgery and the internal wall upstairs have been designed with frosted glass panels, to let in light but to preserve privacy.

The practice has also invested heavily in technology over and above the clinical equipment. Patients have the option of signing in for their appointment at a touch-screen computer and the practice website allows referring dentists to keep up to date with their patients' progress online quickly and securely. Dentists can also refer online.

Nimo and Nick have a surgery each and the third

The former computer college has been transformed

surgery, while plumbed in and ready to go, is being used as an office while the list grows. Nimo explained that there is also room to expand into the attic space, should they need to in the future.

He said: "It's nice to have the option but we are delighted with the way the practice has turned out. We wanted a modern, bright and welcoming orthodontic practice and this is exactly what we have made." ■

Quality guaranteed

iOQ Services Ltd is the first company in Scotland offering independent verification on the quality of compressed dental air, using specialist equipment and methodologies.

The company is led by registered medical gas quality controller Chris Dove who has a background in hospital pharmacy services and specialising in quality control. He has more than eight years' experience in all aspects of medical and dental systems and has written guidance documents for both NHS Lothian and NHS Scotland's Pharmacy Quality Assurance Group.

Chris conducts his testing in accordance with the NHS

Removing the confusion around testing air quality

Estates HTM 0201 guidance document and the European Standard for the quality of dental air. All tests are carried out using certified test equipment and detector tubes. Each compressor receives a certificate of compliance if testing is successfully completed. If unsuccessful, a report will detail deficiencies and suggest corrective action.

The quality testing of dental air is widely discussed with some confusion surrounding it. It has been described variously as: Air Purity Tests, Pharmaceutical Air Tests and Quality Air Checks. The testing performed should verify the Identity, Purity and Quality of the air produced against the European Pharmacopeia standard, which is used to define the quality of the dental air.

The testing of air emitting from a dental compressor is not a statutory requirement within the NHS hospital environment, orthodontists or operating theatres at this time. However, if an incident was to occur, it would be the dental practice's responsibility to explain why the NHS guidance document was not implemented.

HTM 2022 (supplement 1) discusses dental compressed air and provides further details of air quality requirements for dental practices in hospital settings. The HTM 2022 is currently under review in consultation with the BDA. ■

iOQ also provides site compliance surveys/audits and microbial testing on compressed air. For more information, visit www.ioqservices.co.uk

Case histories

In the second article in his All-on-4 series, Kevin Lochhead looks at a typical case

In the last article, we looked at the principles and history behind the All-on-4 dental implant concept. In this article, I will outline a typical case and how the practical aspects of the treatment progresses.

As a practice, we have, over the last 15 to 20 years, carried out full arch implant rehabilitation in, quite literally, hundreds of cases.

As explained in the last article, we have seen, over the last five years, a gradual move from delayed (three to six months) loading of the implants to immediate (same day) loading.

This is quite different from the 'teeth in a day/hour' procedure which found favour a few years ago and had significant limitations.

Critical differences between All-on-4 and 'teeth in a day/hour'

'Teeth in a day/hour' advocates fitting of the final bridgework on the same day that the implants are placed. Cone Beam Computerised Tomographic (CBCT) information gained at the planning stage is used to fabricate a surgical guide which, sufficiently accurately for the procedure, allows placement of the implants (usually without the need for raising a flap).

The guide is used, prior to surgery, by the laboratory to fabricate the final bridgework such that everything comes together on the day. Without going into detail, the reader will appreciate that there are many potential pitfalls with such an approach.

All-on-4 by contrast involves fitting of a provisional bridge on the day of surgery. Due to the frequent need for teeth to be extracted and the residual ridge to be resected, on the day the use of a surgical guide is rarely possible. CBCT is usually not necessary. The final bridge is fabricated after confirmation of successful integration of the implants and complete tissue healing.

Please note that some dental practitioners have been advocating the use of the provisional bridge as a long-term solution. This should be avoided if at all possible, as the unsuspecting patient will likely incur significant additional costs at

Continued »


Fig 1

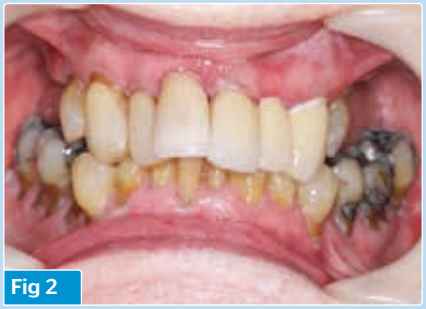
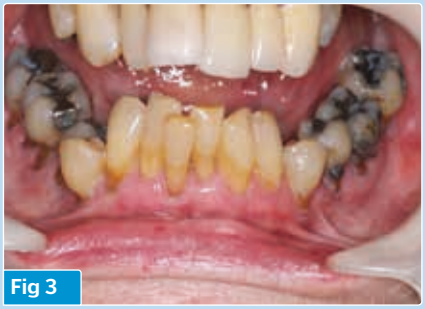


Fig 2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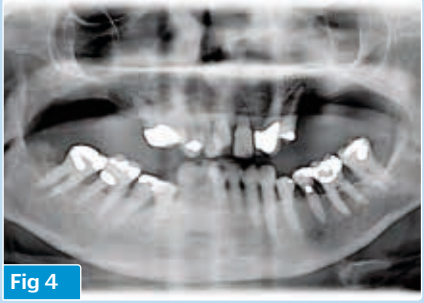
Fig 4


Fig 5


Fig 6

make the switch

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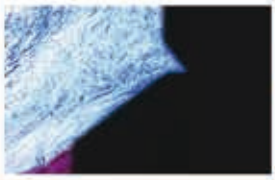

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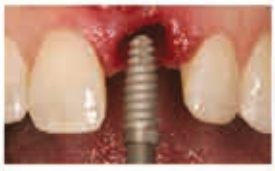

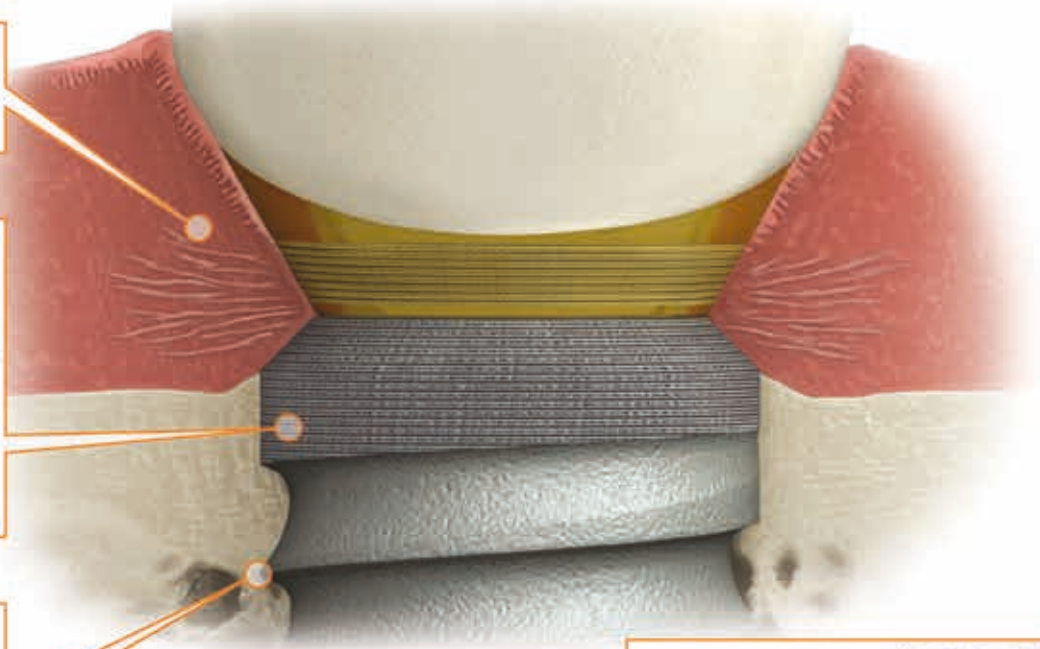

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Fig 7


Fig 8


Fig 9

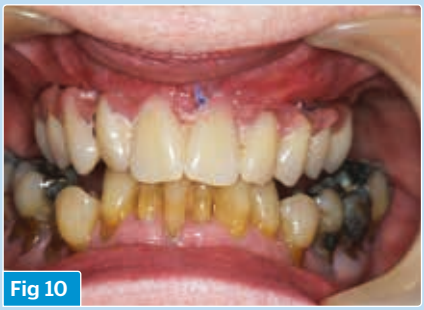
Fig 10

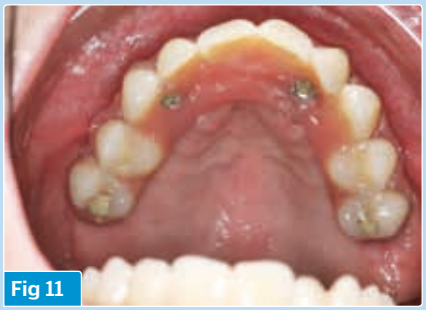
Fig 11


Fig 12a

Continued »

a later date when the 'provisional' restoration fails.

All-on-4 case history

A 74-year-old female in good health presented with an inability to eat comfortably due to mobility of remaining upper teeth. Her dental history revealed that she had developed periodontitis in her 20s and for over 50 years has been "managing" her periodontal condition. She has had specialist periodontal treatment in both North America and the UK.

Treatment has comprised deep scaling, root planing, subgingival curettage and flap surgery, with regular hygienist appointments throughout. The patient is well motivated in carrying out required oral hygiene measures and has been determined to keep her teeth as long as possible.

There has been continued slow progression of the disease process and tooth loss. The patient has delayed inevitable loss of remaining upper teeth as she does not wish for a complete denture.

Patient's additional concerns:

1. Does not wish for a complete removable denture
2. Significant anxiety over loss of remaining teeth
3. Has "hidden" her smile for many years and would like to improve the appearance (fig 1)

Examination found eight teeth remaining in the upper arch, 70-90 per cent bone loss, all G2/3 mobility. There were 14 teeth remaining in the lower arch, with 30-40 per cent bone loss and minimal mobility, heavily restored dentition, with no active caries, and good oral hygiene but plaque deposits evident (fig 2).

TMJs were healthy, with full range of movement and no pain on loading in centric relation.

Occlusion was unstable, with only two posterior contacts on mobile teeth. Centric relation and centric occlusion were not coincident. No evidence of parafunction.

Class II div II occlusion with deep overbite. Upper anterior teeth have drifted labially and imbricated, lower anteriors have over-erupted with compensatory alveolar overgrowth (fig 3).

In terms of aesthetics, the patient had a medium smile line, although she reported never showing her teeth through years of hiding unfavourable dental aesthetics.

Additional investigations for treatment planning:

- full dental and periodontal charting
- mounted models in centric relation
- OPG radiograph (fig 4).

"Treatment has comprised deep scaling, root planing, subgingival curettage and flap surgery, with regular hygienist appointments. The patient is well motivated in carrying out required oral hygiene measures"

Treatment options:

1. conventional – complete upper denture
2. implant – implant retained overdenture or fixed implant bridgework.

Treatment discussion

Over a number of appointments, the patient elected for a fixed implant bridge using the minimum number of implants (four). Conventional delayed placement was something that the patient wished very strongly to avoid. As she met the criteria of:
a) sufficient bone height in front of the sinuses and below the floor of the nose
b) not showing any evidence of parafunction
c) manageable aesthetic transition zone
d) accepting of the limitations.
The All-on-4 procedure was then suggested and agreed upon.

Challenges

Every case has unique concerns. In this particular situation, the challenges faced were primarily restorative:
a) anticipation of the patient's final smile line and vertical dimension
b) how to manage the complete overbite.

Continued »

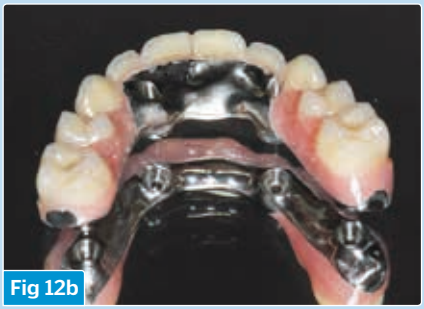
Fig 12b

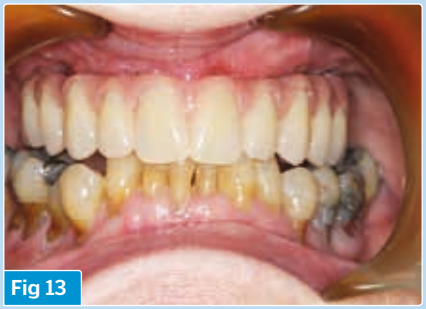
Fig 13


Fig 14

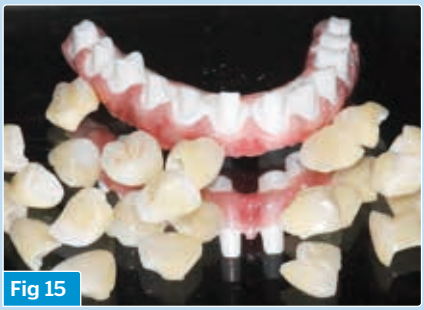
Fig 15

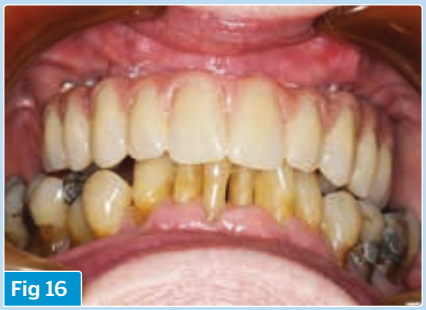
Fig 16


Fig 17

Continued »

Treatment progression

Surgical consultation – this is an essential stage where, separate from discussion on the overall plan, the surgeon discusses in detail the planned procedure, fully covering the processes involved and gaining informed consent. The surgical staff also have the opportunity to meet with the patient and reassure her about any concerns and anxieties that she may have outlining how they will care for her on the day.

Day of surgery

1. Implant placement – on the day of surgery, under zoned aseptic and sterile conditions, the remaining teeth are removed and the remaining ridge carefully debrided and recontoured (fig 5). The anterior borders of the sinuses are mapped and the 30-degree angled posterior implants placed first, attempting to engage cortical bone in the floor of the sinus and floor of the nose.

Generally, placement starts in the region of the second premolar, with the implant angled to the canine region. The anterior implants are placed in the positions of the lateral incisors, but this is adapted depending on available bone. The anterior implants are placed vertically using the incisal edges of the lower teeth as a reference point (fig 6). Two 15mm implants were placed posteriorly and two 13mm implants anteriorly. All implants were regular platform NobelActive implants. All implants must tighten to >35Ncm if an immediate loading protocol is to be followed. In this case, torques of 50Ncm were recorded for all implants.

2. Abutment attachment – the goal of implant positioning is a screw-retained final restoration where the access holes are to the palatal. This is facilitated through the use of 30-degree angled abutments on the posterior implants. While it is possible to work at fixture head level on the anterior implants, abutments are also used in order to raise the restorative level to tissue level. This makes for a far easier and more comfortable restorative procedure for the patient (fig 7).

3. Bone grafting and tissue resection – sockets are filled with bone grafting materials in order to anticipate a rounded ridge for good bridge adaptation. In most cases, there is significant soft tissue remaining that needs to be resected in order to allow close adaptation to the implant abutments and residual ridge. Failure to do so results in excessive ridge height and likely compromise with the transition zone and oral hygiene measures (fig 8).

"The surgical consultation gives the surgical staff the opportunity to meet with the patient and reassure her about any concerns and anxieties that she may have outlining how they will care for her on the day"

4. Working impressions and recording of vertical dimension – in this particular case, there was little usable aesthetic information from the remaining upper dentition. An 'open tray' working impression using polyether impression material and a special tray was carried out. Vertical dimension was recorded in centric relation – this is essential as it allows control of the anterior guidance in the provisional restoration.

The OVD was estimated based on extraoral aesthetics and lip competence. Healing caps were placed on the abutments and the patient escorted to the recovery room where they are waited on by the support staff.

5. Laboratory steps – a working model is cast and mounted on an articulator. The technologist sets up the teeth according to the previously decided aesthetic parameters. In this case, these were based on required overjet and overbite, using the lower anteriors and photographs as reference points. There are no functional cantilevers at this stage.

Due to lack of technical support, the original protocol called for adapting a prefabricated denture by luting it to metal cylinders intraorally and cutting back the flange area. While an understandable procedure of necessity, this has a number of limitations, not the least of which is the discomfort for the patient as the

local anaesthetic wears off during the lengthy procedure.

Using a denture also results in significant weakness in the provisional bridge where the cylinders are luted, as well as where the individual denture teeth are bonded. We have developed a process whereby the bridge is a homogenous acrylic structure 'poured' in tooth-coloured acrylic and backed with high-impact denture base material.

We have had no fractures with more than 100 cases fabricated in this way, compared with significant fractures when the compromise approach is used (fig 9).

6. Securing the provisional bridge – this is a short procedure of approx 15 minutes with minimal patient discomfort. The retaining screws are torqued to the manufacturer's final setting and access holes sealed. Occlusion is adjusted to even contacts spread across the implants with 'flat' guidance. In this case, due to the deep overbite, it was decided to only create contacts on lower 3-3 and reduce the posterior 'step' with the Dahl principle (figs 10 and 11)

7. Post-operative instruction and guidance-home care advice is given and a review appointment made before patient discharge. Essentially the patient is advised on a soft diet for the first four to six weeks, which is the critical implant integration period. Oral hygiene consists of chlorhexidine soaks three times a day, for one to two weeks until initial soft tissue healing and the patient can brush and 'flush' under the bridge. All patients are provided with a waterjet to aid home care.

Review and follow up

1. A surgical review is arranged for one week.
2. Dental hygienist and oral health consultant appointments arranged.
3. Critically, the provisional bridge is not removed until definitive restoration is required or other problems arise.

Definitive restoration after three months

Various options for finishing the restoration are available and will depend on the patient's wishes. The standard is a CAD/CAM milled titanium bar veneered with denture teeth and high-impact acrylic (figs 12, 13 and 14). If sufficient space is available, and the patient elects for it, individual porcelain crowns can be fabricated and luted to a zirconium or titanium framework (fig 15).

As the implants have now been confirmed to have integrated successfully, the final bridge is extended with bilateral cantilevers to the first molar position, the usual occlusal criteria for posterior cantilevers being followed.

The complete overbite was managed through use of the Dahl concept, whereby initial occlusal contacts were on lower 3-3 only. Review appointments confirmed contact of the posterior units (figs 16 and 17). ■

ABOUT THE AUTHOR

This article was submitted by Kevin Lochhead, specialist prosthodontist and clinical director at Edinburgh Dental Specialists. Implant surgical expertise provided by Martin Paley, Prof Glenn Lello, Prof Lars Sennerby and Gillian Ainsworth.

All technical work by the technologists at Edinburgh Dental Implant Laboratory.

The next article will cover maintenance procedures as well as problems and complications.

Not just a plug and play

It is important to have your washer disinfector installed and commissioned by an expert

Dolby Medical is well under way deploying about 350 washer disinfectors into dental practices throughout Scotland. The interaction with dentists, practice managers and dental nurses has been fantastic with everyone fully engaged and offering to work hand in hand with Dolby to ensure this addition to the decontamination cycle is welcomed "or at least is prepared for".

Dolby has a dedicated internal customer services team, based centrally at our office in Stirling, who co-ordinate site works with either our own contractors or your own appointed contractor to ensure site readiness ahead of installation.

Once installed an appointment is then made to commission and validate the machine to the required guidelines outlined in SHTM 2030. It's worth mentioning that every washer disinfector installed within a dental practice in Scotland should be commissioned to this standard, thereafter testing is in line with the manufacturer's guidance.

The commissioning itself is carried out by a fully trained, qualified and accredited service engineer using only approved, state-of-the-art datalogging software. A complementary piece of software known as TQ soft is then used to build the 'commissioning report', something you require to have with your machine in preparation for a practice inspection or anyone querying the cycle profile of the machine.

Just two of the washer disinfectors that Dolby Medical is supplying across Scotland

This report is vital as it's used as a comparison for not only the operators carrying out their daily tests, but also the service engineer to ensure the machine is still operating within specifications at the time of its annual re-validation – not to mention the fact the machine must have only the approved cycle profile to ensure consistent cleaning. Commissioning is normally spread over two days where staff training and the handover of the machine takes place. A log book and test products are also issued while the training is carried out.

These test products play a pivotal role within your practice as the operator has the responsibility of testing the machine periodically themselves, between the annual visits from our service engineers.

Should these periodic tests detect residual protein, then Dolby should be contacted immediately and we will take action. This safeguard ensures that your machine is operating within manufacturer specifications and ultimately guarantees your staff and patients that the machine and process is operating consistently and safely.

The machines themselves have a cycle time of around an hour dependant on a number of factors, all of which is advised by Dolby engineers. Each washer disinfector is supplied with the standard chamber furniture, however various levels of configurations can be achieved to best suit the needs of the practice and the way in which the practice handles and processes instruments. Advice on this can be obtained from our engineers or via our technical advisory service.

If you do not as yet have a washer disinfector, there could not be a better time to contact us to receive details of offers we have running. For a period of time, the discounted unit cost the health board achieved with such large buying power is now our base price to any practice not involved within this programme. ■

"Every washer disinfector installed in a dental practice should be commissioned to this standard"

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Now is the time for action

Peter Bacon discusses the importance of dental unit water line cleaning

The advent of the new Combined Practice Inspection (CPI) checklist that came into force on 1 January 2013, makes it imperative for practices in Scotland to be fully aware of the remit of future practice inspections.

The CPI checklist incorporates health board and vocational training inspection items and includes items from the National Standards for Dental Services, combining them into a single user-friendly document designed to guide practices through every area of inspection.

Available online, the checklist can be used as a guidance template and includes details of the areas in which specific policies should be in place, categorising each according to 'essential', 'best practice' and 'for information', enabling practice managers and dentists to prioritise actions.

Section 8 of the CPI checklist is concerned with infection control and specifically refers to "Biocides used to flush waterlines" as being an "essential" requirement.

This aspect of a practice inspection reinforces the need for Scottish practices to proactively engage with a protocol to remove biofilm from dental unit water lines (DUWLs) and provide evidence of an ongoing maintenance programme.

Although the checklist does not provide a recommended level below which contamination should be kept, in England HTM01-05 guidelines specify this to be <200cfu/ml.

Biofilm

The term biofilm refers to a collection of microorganisms that adhere to a surface and are surrounded by a protective and adherent slime (known as the extracellular matrix) which is secreted by the bacteria. Biofilms are particularly prevalent in water containing low concentrations of solids and low levels of nutrients. As well as DUWLs, biofilm can be found in streams and rivers, cooling towers and piped water systems etc.

Biofilms form when a few individual bacteria in the planktonic state in water, adhere to a solid surface such as the wall of a pipe or tube. The initial attraction to the surface is weak, but subsequent bacteria continue to adhere directly to those already attached. This in turn increases adhesion and enables more planktonic bacteria to adhere easily to the film, and so the process continues, increasing levels of biofilm and causing water quality levels to fall.

Biofilm contamination of dental unit water lines

So why is the problem of biofilm so prevalent in dental practices? Well the truth is that DUWLs provide an ideal environment for the growth of bacterial biofilm:

• The materials used for tubing are selected for their non-toxic

Continued »

Fig 1
Before treatment

Fig 2
After treatment with Bioclear

ABOUT THE AUTHOR

Peter Bacon is a chartered chemist and Fellow of the Royal Society of Chemistry. He has been involved in the formulation of speciality chemicals for over 30 years, working for both large and small organisations.
Peter joined Quadralene in 1993 and has been technical director since 1995. His spare time interests include family holidays, cycling, music, cinema and guitars.

Continued »

properties and flexibility to suit the mechanical operation of dental units. Low toxicity to humans also means low toxicity to bacteria.

• The small-bore tubes used in dental units provide water at a typical flow rate of 30ml/min. The behaviour of water flowing through a tube means that the linear flow rate decreases from the centre of the tube to its wall. Low linear flow rates favour bacterial adhesion.

• Water only flows through the tube when instruments are in use, causing minimal disruption of the growing biofilm.

• When instruments are used or the system is flushed, fresh liquid is brought into contact with the film, bringing with it nutrients and new recruits to join the film. The liquid moving towards the distal end of the system carries bacteria released by the maturing film along with excreted matter.

• Dental surgeries are normally maintained at "room temperature" for the comfort of patients and staff. This is good news for the film-forming bacteria as they can thrive in this temperature range.

The evidence for the potential problems caused by biofilm contamination in DUWLs has been in the professional arena since the early 1960s. However, the death of an Italian woman in February 2012, reported in *The Lancet*, brought the issue firmly back under the microscope. The CPI checklist now makes it incumbent on dental professionals to take the necessary precautions to minimise possible contamination and ensure that the water to which patients and staff are exposed is treated accordingly.

Effective and proven solution

Although the checklist also regards as "essential" the

flushing of waterlines after each patient, it is widely recognised that this alone is insufficient to remove the threat of biofilm contamination. The challenge for those responsible is to find a biocide that meets all the needs of the dental practice in terms of ease of use, reliability and safety and yet is highly effective in controlling and preventing biofilm and is not harmful to the treatment centre itself.

Research and development undertaken at Nottingham University School of Biosciences has clearly demonstrated the efficacy of one such product against the bacteria that make up biofilm, inhibiting re-growth and enabling a dental unit water line system to maintain water quality of <200 cfu/ml, subject to input water quality.

As part of the research biofilm was grown in a flow cell using bacteria obtained from a dental unit water line sample and allowed to develop for 10 weeks, the images (above left) show that the Pseudomonas aeruginosa biofilm was effectively removed by a biofilm remover (Bioclear) flowing through the cell.

Regular monitoring

Although the CPI checklist does not offer any indication of the frequency with which biocides should be used in DUWLs, there is space to record such activity and the routine use of effective products will provide clear evidence of 'best practice'. Part of a practice's protocol should also be the regular monitoring of DUWL contamination and again there are a number of solutions available.

One such solution is the 3M Clean-Trace Hygiene Monitoring System, which has been widely used in the food safety sector for many years. Access to this technology via Henry Schein Dental's account managers provides an instant and highly accurate indication of the quality of both input and output water in a dental practice, enabling practices to take immediate remedial action where necessary.

For those preferring to monitor samples themselves, the use of dip slides provide a simple test which when exposed to sample water and incubated for up to three days will give an indication as to the level of bacteria present in the sample.

There is also now the opportunity to use a specially designed Biofilm Testing Kit, which includes sample bottles and a freepost envelope – samples are sent for laboratory testing and results returned within 72 hours of sample receipt.

Conclusion

The use of biocide is making a huge contribution to the prevention and control of biofilm in the dental practice and any Scottish practice not yet routinely using a product, such as Bioclear, for this purpose must do so as a matter of urgency. Regular assessments must now also form an intrinsic part of practices' infection control protocols and provide valuable evidence to satisfy inspectors and give peace-of-mind for those ultimately liable for the well-being of patients and staff. ■

"The evidence for the potential problems caused by biofilm contamination in DUWLs has been in the professional arena since the early 1960s"

More information on compliance and the use of Bioclear can be found on a video posted on www.dentisan.co.uk
Water assessments can be arranged by contacting Henry Schein Dental on 08700 10 20 43.
Testing kits are available from Kent Express on 01634 87 87 87.

Get to the root of the problem

Specialist endodontist Carol Tait outlines the latest treatments and techniques in the field

As an experienced, specialist endodontist, surgery has continued to be a regular part of my clinical practice, offering high success rates for teeth that would otherwise be extracted. There are many referrals for surgery, however, that are not always appropriate and root canal retreatment may be the preferable option. This article will describe the indications for surgery and the techniques that are used to obtain an optimum result.

The aim of root canal treatment is to access, clean, disinfect and shape the root canal system. This should remove necrotic debris and reduce the number of microorganisms, allowing the canals to be sealed to prevent further reinfection. Published success rates vary from 37 per cent to 91 per cent[1], and can be described as no clinical signs or symptoms, and radiographically, bony healing of a previous periradicular radiolucency with a normal periodontal space around the root.

Persistent periradicular radiolucencies of endodontically treated teeth are caused by intra-radicular infection, extra-radicular infection, foreign body reactions, true radicular cysts, fibrous scar tissue and vertical root fractures. Root canal retreatment should always be considered before surgical intervention, which is not a substitute for incomplete debridement and inadequate endodontics.

Indications for surgical endodontics

- Previous root canal treatment has failed and retreatment is not possible or will not correct the problem. In the case of a post-retained crown, an assessment should be made as to whether or not this can be safely dismantled. Most posts can be removed using ultrasonics providing an adhesive resin cement has not be used (Figures 1a, 1b, 2a, 2b).
- Anatomical deviations that have prevented complete cleaning and obturation
- Procedural errors such as ledges, blockages, perforations, file breakages and overfills
- Exploratory surgery to aid with identification of vertical root fractures
- Failure of previous surgery often completed using traditional techniques (Figures 3a, 3b).

Surgical endodontics is not indicated:

- when root canal retreatment is possible
- difficult anatomical factors such as proximity to neurovascular structures, thick cortical bone and difficult access
- when assessment using cone beam CT shows a defect such as resorption or perforation is not accessible for surgical repair
- inadequate periodontal support
- non-restorable tooth
- complex medical history.

The high success rates that are obtained require highly trained, experienced clinicians and the equipment, materials and techniques as described below.

Surgical microscope

The use of magnification, illumination and microsurgical instruments has changed the traditional 'blind' procedure commonly referred to as an apicectomy into one that is visually dominated and, therefore, extremely accurate. The microscope is based on Galilean principles that focuses on infinity and, therefore, unlike loupes, allows treatment for long periods of time without causing eye fatigue[2].

Magnification

The eyepiece, binoculars and magnification changer determine magnification. The eyepiece is available with 6.3, 10, 12.5, 16 and 20 magnification powers. The 12.5 is recommended for endodontic practice. Diopter settings from -5 to +5 allow adjustment for accommodation and refractive error of the clinician.

The binoculars are used to project an intermediate image into the focal plane of the eyepiece. They are set at the correct interpupillary distance for the operator and are available at different focal lengths. The longer the focal length, the greater is the

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Carol Tait BDS Hons, MSc, MFDS RCS Ed, MRD RCS Eng, is a specialist endodontist at Edinburgh Dental Specialists and senior clinical teacher in endodontics at Dundee Dental School.

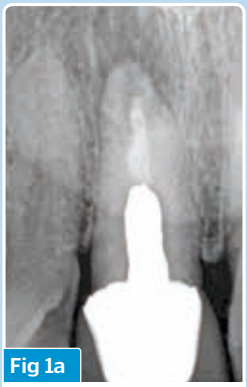

Fig 1a Tooth 11, post-retained crown and periradicular pathology

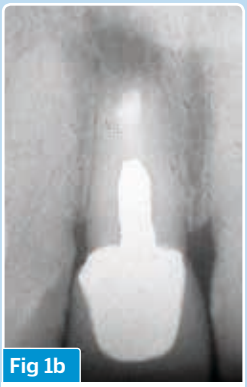

Fig 1b Tooth 11, post-retained crown following surgery

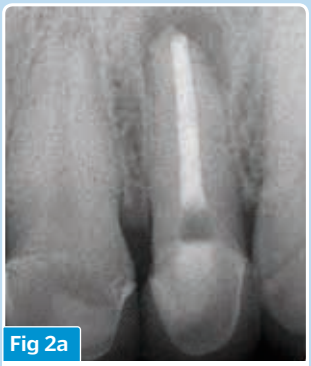

Fig 2a
No bony healing one year following RCT suggesting a radicular true cyst

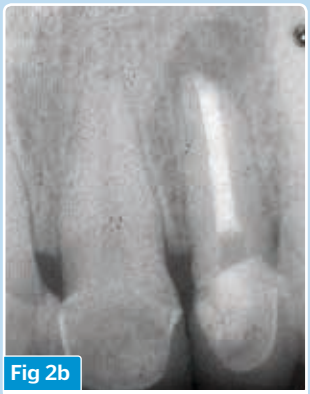

Fig 2b
Following surgery, a large cystic lesion was removed

Fig 3a
Previous surgery with amalgam root end fillings

Fig 3b
Following surgery and MTA root end fillings

magnification, but the narrower is the field of view. The focal length of the objective lens determines the distance between the lens and the surgical field. A typical working distance would be 25cm for a 250mm lens.

Binoculars are available with inclinable tubes of up to 180° to accommodate virtually any head position. The magnification changer is located within the head of the microscope and is available in three or five step manual changers, manual zoom or power zoom changers. Before using the microscope, it must be made parafocal. Most surgical microscopes allow magnification from x3 to x30. With high magnification, the focal depth is shallow and this is used only for inspection of fine detail (fig 4).

Illumination

The light provided is two to three times more powerful than surgical headlamps. Most microscopes now use xenon bulbs that project a bright, warm light against bone and soft tissues. A beam splitter can be used to supply light to a camera or auxiliary observation tube.

Fig 4
Surgical microscope

Fig 5
CK1 microblade

Documentation

Photographs and videos can be recorded and used for patient information, and dental education.

Soft tissue management:

Local anaesthesia

This eliminates pain during surgery and also causes haemostasis, which is of equal important when using magnification[3]. Buckley suggested the use of 2 per cent lidocaine with 1:50,000 epinephrine[4]. This causes activation of alpha-receptors in the arteriolar muscles, submucosa and periodontium causing vasoconstriction.

This local anesthetic is not licensed for use in the UK and, therefore, 4 per cent articaine with 1:100,000 epinephrine can be used as an alternative with an additional infiltration of 2 per cent lidocaine with 1:80,0000 epinephrine above the tooth requiring surgery. Articaine, because of its thiophene ring and additional ester ring, has been shown to have a greater ability to diffuse into the tissues.

Flap design

A sound knowledge of the anatomy of the gingival tissues is important prior to deciding on the type of incision and flap design. Healing by primary intention can be achieved by using complete and sharp incision of the tissues, by avoiding trauma to the reflected tissues and by preventing drying of the surgical site[5].

Recommendations for flap design:

- The flap should provide adequate access to the surgical site, and allow sufficient blood supply to the mobilised and non-mobilised tissues.
- The flap should not cross a bony defect and the relieving incisions should be placed over concave bone surfaces and should end at the mesial or distal line angles and curve so that the incision meets the free gingival margin at 90° to the gingival contour. The other end should not enter the mucolabial fold.
- The base should be as wide as the free edge and relieving incisions should be vertical following the direction of the vessels.
- The periosteum should be raised with the flap.

Flap designs include semilunar, submarginal mucoperiosteal and papilla-based. Semilunar is of historical interest and has no place in modern surgical practice. Since first being described by Velvart in 2002, the papilla-based incision has now become the flap design of choice[6].

It consists of two vertical relieving incisions, connected by the papilla-base incision and intrasulcular incision in the cervical area of the tooth. The papilla incision is performed using a microblade such as a CK1 (fig 5).

This comprises a shallow first incision at the base of the papilla and a second incision directed towards the crestal bone (fig 6).

Continued »

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Elevation and retraction

A sharp, small elevator is placed at the junction of the horizontal and vertical incisions with the concavity towards the bone, (fig 7). The periosteum should be completely reflected to prevent bleeding, diminish pain and inflammation and aid with healing. Many retractors are either too narrow or convex at the tip. This can contribute to trauma of the flap or soft tissues. The Kim-Percora or the Rubinstein retractors will give better anchorage.

Hard tissue management:

Osteotomy

On many occasions, following flap retraction, a bony defect will be present in the cortical bone that will allow access to the root apex either without bone removal or with minimal extension of the borders of the defect. The osteotomy involves removal of cortical and cancellous bone to gain direct access to the apical and also the lateral aspect of the root when required.

When removing bone, the generation of heat should be avoided by using a surgical round bur and copious irrigation of the area using saline. The bur should be used with a light brushing action. The use of magnification allows the clinician to easily differentiate the difference between bone and root surface, (fig 8).

Root end resection

This is considered critical to the overall success of surgery. The majority of unfilled lateral canals are located within the apical 3mm of the root and, therefore, 3-4mm of the root end should be exposed by the osteotomy[6]. This is resected 90° to the long-axis of the root using an Impact Air surgical handpiece 45° and a Lindemann bur, (fig 9). High magnification can be used in conjunction with staining using methylene blue to ensure the root end has been completely resected and removed.

Surgical curettage

This should remove the soft tissue, granulomatous lesion, consisting of lymphocytes, plasma cells, macrophages, foreign bodies and epithelium. The source of periradicular periodontitis is not located in the soft tissue lesion, but within the root canal system, therefore there is debate over whether or not all of this tissue has to be removed. Certainly this should be attempted and carried out as quickly as possible to prevent unnecessary dehydration of the tissues. Haemostasis is directly related to removal of the soft tissue and a clean, bony crypt will be easier to manage when placing the root-end filling. The soft tissue lesion is undermined using small curettes and dissected away from the crypt. The resected tissue should be sent for histopatholgical examination.

Root end preparation

The root end is inspected at high magnification for the presence of cracks and, in the case of multi-rooted teeth, the presence of an isthmus. Ultrasonic tips are used to remove root canal filling material from the apical 3mm of the remaining root (fig 10). The cavity is inspected using a micromirror (fig 11) and the softened, apical gutta-percha vertically compacted using a microplugger (fig 12).

Root end filling

Prior to placing the filling, the bony crypt is lined with a cotton wool pellet impregnated with epinephrine (fig 13), which will maintain a dry field.

While materials such as amalgam, Intermediate Restorative Material,

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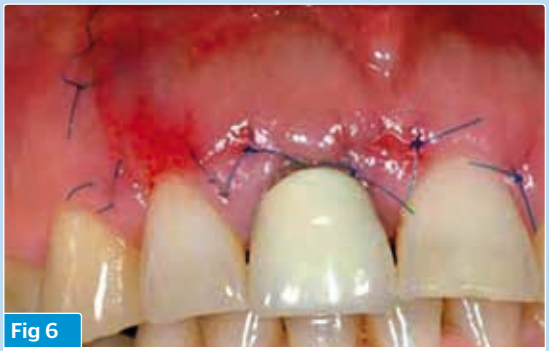

Fig 6
Papilla-based incision following repositioning and suturing using 6-0 Prolene

Fig 7
Tissue elevator

Fig 10
Diamond coated ultrasonic tips

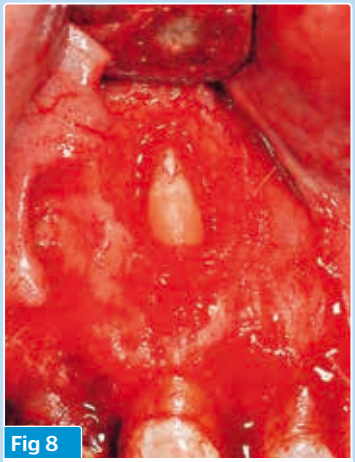

Fig 8
Root apex exposed following osteotomy

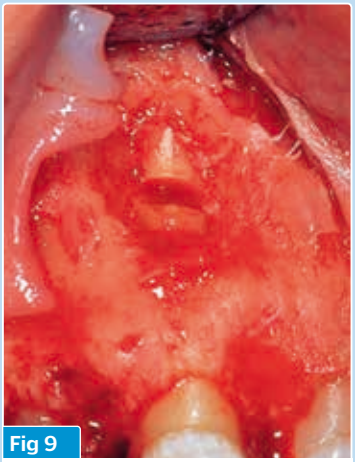

Fig 9
Root end resection

Fig 11
Micromirror

Fig 12
Microplugger and microburnisher

Continued »

super ethoxybenzoic acid, glass ionomer and composites have been used, these materials do not satisfy the requirements of an ideal root-end filling material.

Mineral trioxide aggregate (MTA) (ProRoot), developed in 1995, is now considered the material of choice (fig 14). The powder consists of fine hydrophilic particles that, when mixed with water, forms a colloidal gel that solidifies in approximately three hours. The sealing ability, antibacterial effect and bio-compatibily have all been tested. MTA has also been shown to encourage cementogenesis around the resected root end[7 8 9 10].

The material is placed in a carrier (fig 15) and deposited at the root end, where it is packed into the cavity using micropluggers. The cavity should be slightly over-filled and the excess removed using a damp cotton pellet. The material can then be smoothed using a mircoburnisher and the pellet removed.

Treatment of bony defects by Guided Tissue Regeneration (GTR)

Healing of a wound can either be by repair or regeneration. Repair will not fully restore normal architecture or function, while regeneration uses barrier membranes and bone-grafting materials to encourage the growth of surrounding tissues while excluding unwanted cell types.

Wound healing after endodontic surgery involves hemostasis, coagulation, inflammation, proliferation, regeneration or repair and remodelling or maturation. Granulation tissue formed during the proliferation stage is essential and regeneration requires progenitor or stem cells, growth factors and local factors such as adhesion and protein molecules.

"Healing should occur by primary intention with no pain"

Bone replacement grafts can be:

- Osteogenic – living bone cells present in the graft material
- Osteoinductive – encourages undifferentiated cells to become osteoblasts
- Osteoconductive – guides the reparative growth of natural bone.

Grafts can be categorised as follows:

1. Autogenous

These are the gold standard and are taken from a remote site from the same host. They are osteogenic, osteoinductive and osteoconductive.

2. Allografts

These are genetically dissimilar members of the same species and are normally freeze dried bone. This type of graft is osteoinductive and osteoconductive.

3. Xenografts

Tissue is taken from one species and placed into another. This can be either bovine or porcine. The material is processed to remove the organic constituents and is osteo-conductive, e.g. Bio-Oss.

4. Alloplasts

A synthetic or inert foreign body that is implanted into host tissue. This type of graft is osteoconductive and examples are hydroxyapatite, beta-tricalcium phosphate, calcium sulphate, non-ceramic polymer and bioactive glass.

Membranes are used to exclude epithelial cells and connective tissue fibroblasts to allow regenerative cells to repopulate the area and are thought to have some benefit in the treatment of buccal dehiscences. The barrier prevents migration of junctional epitheium and is therefore directed at the periodontal tissues rather than periradicular regeneration.

Bio-Gide is an example of a collagen membrane of porcine origin. It consists of two layers. The superior layer, which faces the tissues is cell occlusive and prevents

Fig 13
Epinephrine cotton pellets

Fig 14
Mineral trioxide aggregate

Fig 15
Map carrier

invasion of connective tissue cells into the membrane-protected space. The porous layer faces the bony defect and promotes cell integration.

A 'through and through' lesion occurs when both the buccal and palatal cortical bone have been damaged as a result of apical periodontits or apical surgery. It is most likely that this type defect will heal by connective tissue scar formation. There is no conclusive evidence that placing a membrane barrier in large through and through defects has a better long-term outcome.

A systematic review of GTR by Tsesis et al. in 2011[11] concluded that, although there were slightly better outcomes, these were not statistically significant and only beneficial in large periapical lesions and 'through and through lesions'. Pecora et al. 2001[12] demonstrated that the addition of calcium sulphate in the treatment of a 'through and through' lesion improved the clinical outcome by acting as a scaffold to induce new bone formation.

Suturing and wound closure

Healing should occur by primary intention with no pain or inflammation. The reflected tissue flap should

Continued »

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LEADING REGENERATION

Continued »

be kept moist during the surgical procedure to prevent shrinkage that will make repositioning difficult and may require additional incisions of the apical periosteum.

The flap should be gently handled and repositioned passively in the correct position. Polypropylene (Prolene) or Polytetrafluoroethylene (Tevdek) sutures are recommended as these cause minimal inflammation and promote rapid healing (fig 16).

Microsurgical needle holders are used and a surgeon's knot, double overhand, then single underhand in the opposite direction, will prevent slippage (fig 17).

The flap should be compressed with damp gauze to reduce the coagulum to a thin fibrin layer between the repositioned flap and the cortical bone. Sutures are normally removed after three days to prevent epithelisation of the suture tract.

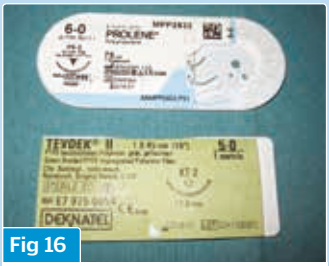

Fig 16
Sutute suitable for flap closure

Fig 17
Needle holders and scissors

Clinical outcomes

Over 70 studies have been published reporting on the outcome of apical surgery. Many of these used poorly standardised materials and methods and, since their publication, new techniques have evolved with the introduction of magnification and illumination that make these success rates less relevant to todays practice.

Following surgical endodontics, teeth should be reviewed after one year. The definitions of treatment outcomes can be described as follows:

Successful (healed)

Complete healing, radiographic and clinical normalcy. Included in this category is scar formation.

Incomplete healing (healing in progress)

A persistent radiolucency in the absence of clinical signs or symptoms.

The presence of clinical signs or symptoms and incomplete bony healing.

Uncertain healing (persistent disease)

Presence of signs or symptoms combined with a reduced or persistent radiolucency.

A review by the Cochrane collaboration in 2008, entitled *Surgical versus non-surgical endodontic re-treatment for periradicular lesions*, included three studies[13]. The paper concluded that the initial advantage of surgery appears to disappear if the follow-up is prolonged for four years. It also quite rightly stated the fact that surgery can isolate but not completely eliminate endodontic bacteria from the root canal system.

A systematic review carried out by Torabinejad et al. in 2009 compared outcomes of nonsurgical retreatment and endodontic surgery[14]. Success rates for surgery was higher at two to four years (77.8 per cent), compared with retreatment (70.9 per cent). At four to six years this was reversed, with surgery 71.8 per cent and retreatment 83 per cent. This paper concluded that retreatment offers a more favorable long-term outcome.

Tsesis et al. 2009 published a meta-analysis of the literature looking at the outcome of surgical endodontic treatment performed by a modern technique[15]. Eleven articles were included and concluded that surgery was successful in 91.4 per cent of cases.

Conclusions

Surgical endodontics will continue to be a part of specialist endodontic practice. The results are predictably high when using the techniques described in this paper.

Dentists should therefore consider this treatment for their patients in cases where a coronal approach to retreatment is not possible.

"Dentists should therefore consider this treatment for their patients in cases where a coronal approach to retreatment is not possible"

The Royal College of Surgeons of England has recently published Guidelines for Surgical Endodontics that the reader may also find useful. see it online at bit.ly/RCSsurgicalendo ■

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A stone's throw away

East Kilbride practice relocates, quite literally, to the other side of the road

"Patients and staff are delighted and everyone is coming into work with a big smile on their face"

Iain Maudsley

Ever since they took over St Leonards Dental Practice in East Kilbride nearly 10 years ago, Iain Maudsley and Brian McMillan have been aware that relocation was a necessity to move the practice forward.

Based in a leased one-story property in St Leonards Square, the original practice was of limited space and in an area of the town that was crying out for redevelopment. Iain explained that the landlords had explored several plans for redevelopment over the years, but due to a range of factors – not least the ongoing recession – nothing got off the ground.

Iain and Brian had spruced up the practice, knocking down a wall and reconfiguring the layout to an extent, but they were always mindful that they would probably be moving at some point, so a major refurbishment simply wasn't feasible. However, their hand was forced with the announcement from the Scottish Government that practices looking to relocate to meet the LDU requirements had to be up and running by December 2013. This meant that they could no longer wait for the square to be redeveloped, but it raised another problem: where to move to?

Taking their practice name from the area of the town that they were situated meant that it wasn't an option to move out of St Leonards. They needed to find a nearby building or piece of land and it just so happened that the answer was staring them in the face.

Across the road, no more than a few yards away was a small plot of land next to the local church. Iain and Brian contacted Allied Surveyors Scotland and they reported that it would be a viable possibility. The church were approached and they were interested in selling the land on the condition that the practice resurfaced the car park situated to the rear of the plot and adjacent to the main church building.

Plans were lodged with South Lanarkshire Council in June 2011 and approved six months later, meaning that Iain and Brian were given the green light to purchase the land at the beginning of last year.

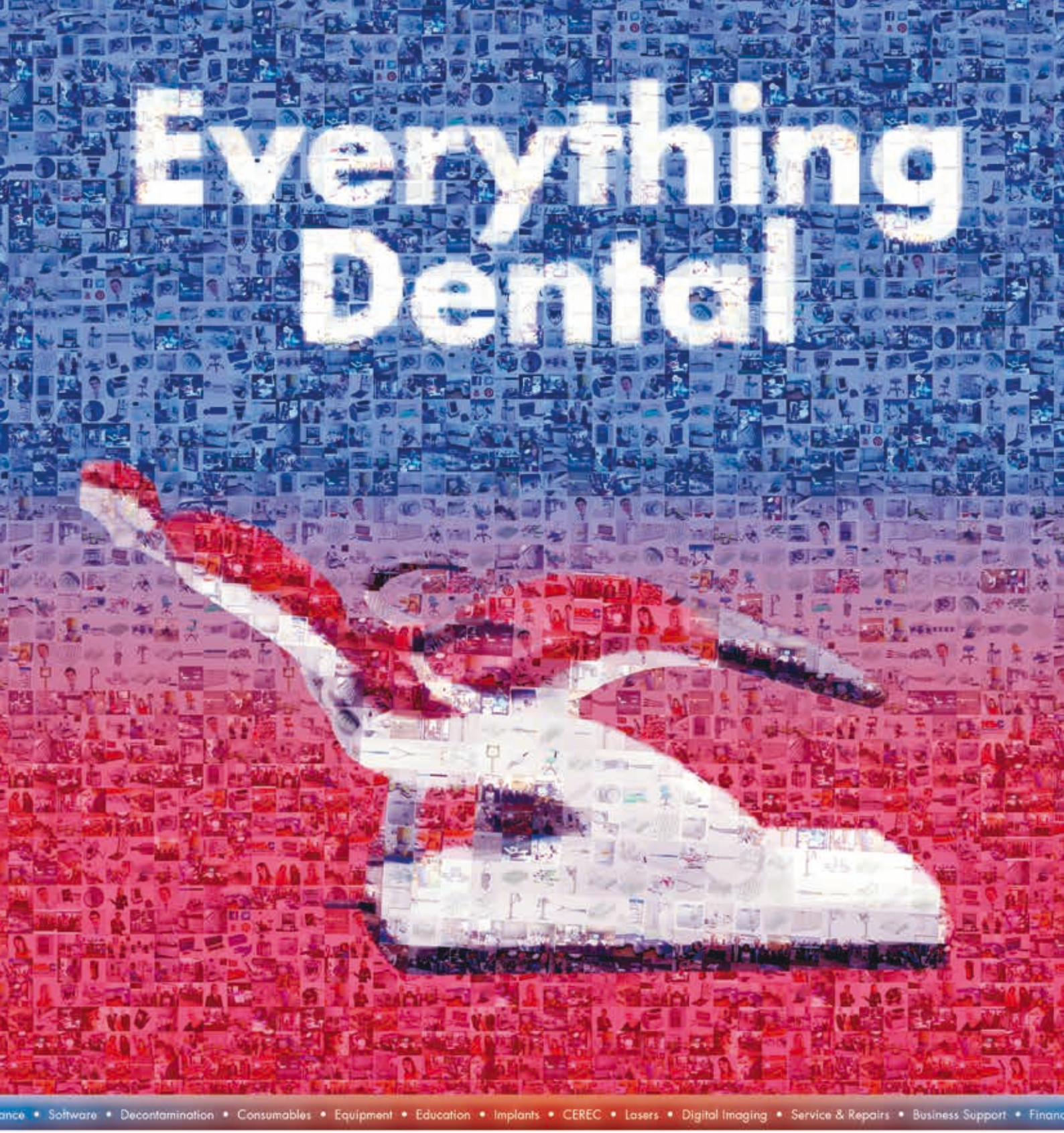
Constructors Dickie & Moore were taken on to build the new practice, with work starting in March 2012. Iain said: "We wanted a firm we could trust to do a great job and they haven't let us down. From the start they've been fantastic."

Funding for the practice came in the form of a six-figure grant from the Primary and Community Care Premises Modernisation Programme and a considerable loan from Clydesdale Bank. Iain and Brian were advised by their lawyers Miller Samuel and accountants Martin Aitken and Co during the whole process.

Iain and Brian had tasked Allied Surveyors to deliver the biggest practice possible on the land available. The old practice featured four surgeries and the wish list was for the new building to consist of six surgeries, a dedicated practice manager's office, staff block and a reception area and waiting room that was spacious and light.

Dickie & Moore finished work on time and on budget in November 2012 and the practice was open to patients the following month. Iain and Brian sourced all their new chairs and other equipment through Henry Schein. Although a committed NHS practice, they do offer a range of private treatments including implants that are placed by Brian. As a result, they utilise a range of high-tech equipment including the VistaScan digital scanner from Dürr Dental.

The official opening was carried out by Chief Dental Office Margie Taylor on 1 February and Iain explained that everyone involved was absolutely delighted with the outcome. He said: "We have been given a new lease of life. We were very much on top of each other over the road so this is great. Patients and staff are delighted and everyone is coming into work with a big smile on their face." ■



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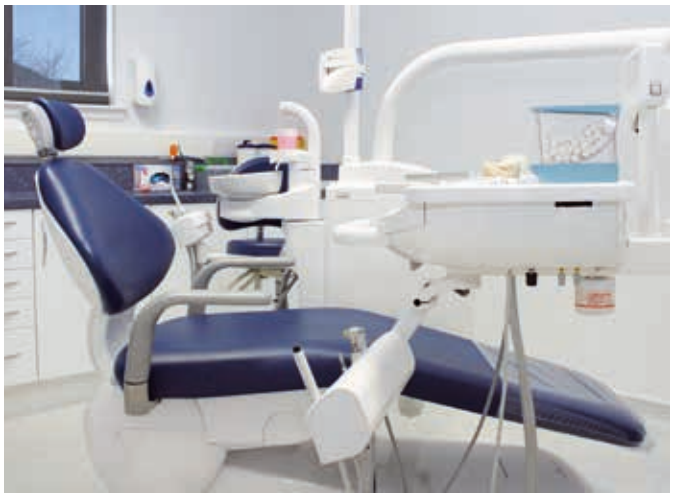
Dickie & Moore work hard to maximise value by finding the most intelligent and creative ways to deliver outstanding buildings. This is shown perfectly in the recently delivered St Leonards Dental Practice project in East Kilbride.



The building was traditionally built and finished with a mixture of facing brick, render and Siberian larch. The contract period was 24 weeks, and Dickie & Moore were pleased to deliver the project on time and to the exacting standards required in a dental environment.

Careful consideration had to be given to the installation of dental equipment and in particular the dental chairs. With experience from several other projects, Dickie & Moore worked closely with Henry Schein, ensuring the valued equipment was installed carefully.

The new building has a very bright and welcoming reception area, with a corian desk, and curved glass screen providing a contemporary feel. The ebony veneer doors to the surgeries provide a high quality look and feel, and with an overall high quality finish hopefully patients' minds are temporarily diverted from the thought of the dental drill. ■

No blame compensation

As dentists, it is your duty to your patients to ensure you are fully covered against claims that may arise

Negligence law and the law in relation to professional indemnity are changing fast. Conventionally, when a patient sues a general dental practitioner, it is for the patient to prove negligence and causation in order to obtain damages as a result of the negligent act or omission.

The No-Fault Compensation Review Group has recommended that the Government should consider establishing a scheme in clinical cases similar to the 'no blame' system in Sweden. It would appear currently that the scheme proposed by the Review Group has no eligibility criteria to filter claims or cap awards; that may result in a substantial increase in the cost of dealing with such claims. The proposal would nullify the necessity of the pursuer to prove negligence.

Ensuring that patients injured as a result of dental treatment are compensated appropriately without the need to go through a court process is to be commended. However, will the proposals just facilitate the paying out to patients who make a claim? The current reforms proposed by the court-appointed Personal Injury Users Group are very embryonic in development and further reform where negligence is sidelined will increase the number of litigants and place pressure on the premiums that dentists pay.

Patients will always have the right to litigate in the conventional sense; however, introducing a no-fault scheme will create an expensive two-tier system. Fortunately, factual and legal causation will always be required to be proved. A salutary lesson is found in New Zealand where, following the introduction of a no-fault scheme, the claims liability rose from $644 million to more than $2 billion in four years.

As of 25 October 2013, the UK regulator "must ensure that systems of professional liability insurance, or a guarantee or similar arrangement that is equivalent or essentially comparable as regards its purpose and which is appropriate to the nature and the extent of the risk, are in place for treatment provided on its territory". This is the law as stated in European Directive 2011/24/EU.

What this means for dentists is you must have in place malpractice insurance or a guarantee or something similar to a guarantee that covers patients' claims if they are made. If you are in doubt about what cover you really have, you should read your policy of insurance if you have one. If you do not have a policy of professional liability insurance, it begs the question: why not?

The differences between discretionary cover, full or partial, and a policy of insurance are vast. Please ensure you are fully covered in law for claims that may arise as a result of your practise of dentistry. There is no excuse for not having full cover or a guarantee for your work. ■

"If you do not have a policy of professional liability insurance, it begs the question: why not?"

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Neil Taylor BDS LLB Dip LP is a dentist (66597) and worked predominately in NHS dental practices in Glasgow for 13 years. He is also a solicitor in Scotland (29445), a former member of the Faculty of Advocates, head of dental services for TDS Ltd and loss adjuster for Hiscox Ltd.

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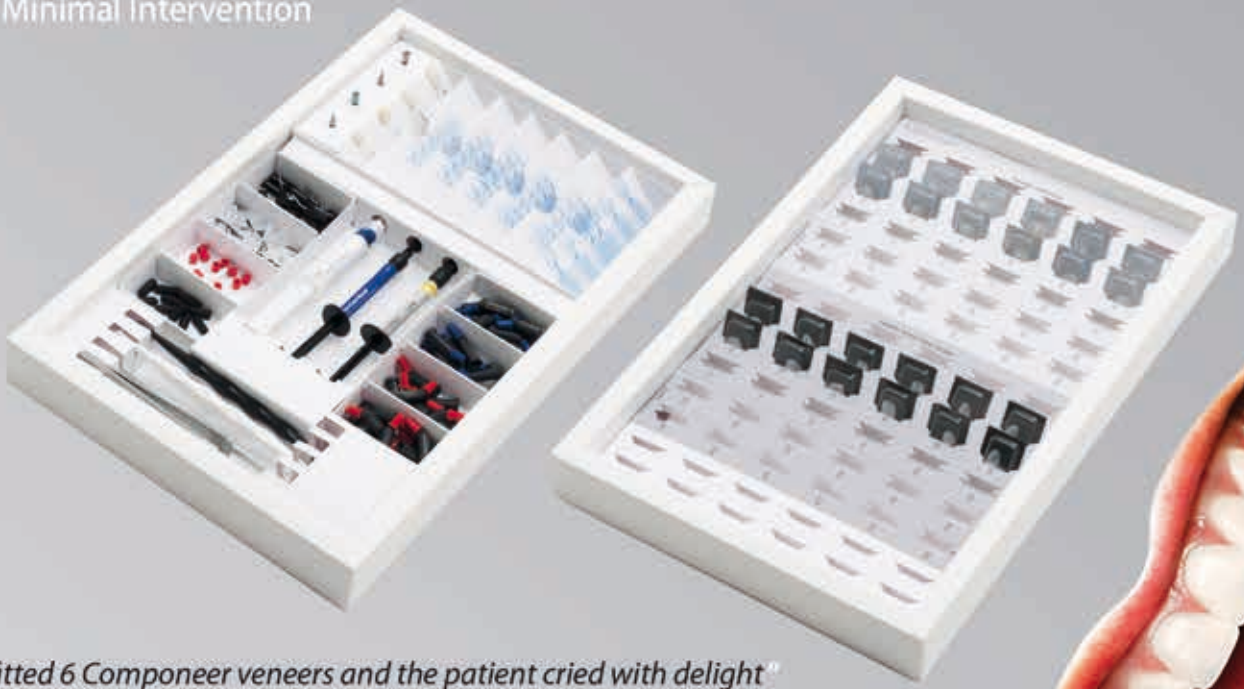

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Alasdair MacDougall explains how to gain greater control over your funds

Flexible drawdown

In the December 2010 Autumn Tax Updates, the Government announced the introduction of a facility to allow unlimited pension income drawdown, as long as members could satisfy a few requirements.

This is referred to as 'Flexible Drawdown' and has been available since 6 April 2011. Historically, Income Drawdown has been restricted by reference to tables produced by the Government Actuaries Department (GAD).

Since the introduction of Income Drawdown rules, maximum income had been capped at 120 per cent GAD for individuals under 75. From 6 April 2011, the maximum has been reduced further to 100 per cent GAD, although in his recent Autumn Statement, the Chancellor announced it would revert back to 120 per cent with effect from 26 March 2013.

The pensions industry has seen the increasing lack of flexibility around the income options as one reason why many have been put off pension planning.

To qualify for Flexible Drawdown, a number of conditions must be met:

- No contributions can be paid into Money Purchase Schemes in the tax year Flexible Drawdown is taken. Also, the individual cannot be an active member of a defined benefit scheme when electing for Flexible Drawdown.

The minimum income requirement (MIR) threshold has been set at £20,000 and is the same, regardless of age, sex or marital status. It is due to be reviewed by the Treasury at least every five years. Future reviews of MIR levels will only affect individuals starting Flexible Drawdown. Once qualified, there will be no further testing.

Pension income that counts as "Relevant Pension Income" includes:

- State Pensions – including Basic State Pension and State Second Pension
- Scheme Pensions – normally provided by a Final Salary (Defined Benefit Scheme)
- Lifetime Annuities – where a guaranteed lifetime income is purchased from an insurance company.

Pension income that does not count towards Relevant Pension Income includes:

- Conventional Drawdown, Purchase Life Annuities or Scheme Pension from a SSAS.

It is important to note that while there is no age restriction on Flexible Drawdown, apart from the normal minimum pension age, individuals in Flexible Drawdown will not be eligible to accrue further tax-relieved pension savings.

As many dentists are members of the SPPA they should be able to satisfy the minimum income requirement of £20,000 a year by virtue of pension income from that source. Many will have Money Purchase Pension Funds elsewhere – personal pensions, retirement annuity contracts, AVCs and FSAVCs – and may wish to consider Flexible Drawdown to 'strip out' income from these funds at an accelerated rate.

'In and straight out' – if you have a relatively small fund, or have need to take the entire fund, then you can put funds into a Flexible Drawdown Plan and straight out in one lump sum. Twenty-five per cent will be tax free, with the balance taxed at your highest marginal rate.

'In and out over a number of years' – regardless of fund size, you can stagger payments out over a number of years, ensuring greatest flexibility and tax efficiency.

'Phased flexible drawdown' – gives control over income, while maximising death benefits before the age of 75, offering access to income and avoidance of 55 per cent tax charge on death on unvested funds.

Pension payments withdrawn using Flexible Drawdown are treated in exactly the same way as normal drawdown and are taxed at member's marginal tax rate. This will be an important consideration for members, as large pension payments will trigger a potential tax liability of up to 50 per cent. ■

"The pensions industry has seen the increasing lack of flexibility around the income options as one reason why many have been put off pension planning"

Alasdair MacDougall

ABOUT THE AUTHOR

Alasdair MacDougall Dip PFS is a director with Martin Aitken Financial Services Ltd.

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

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Figures obtained from Scottish Widows, A J Bell, Axa Wealth and Skandia.

NSK... at the heart of your practice

More than eight decades in the business have seen NSK build a solid reputation for quality precision instruments

In 2013, NSK will have been established for 83 years, and this significant achievement is a celebration of the aspirations of its founder, Keiichi Nakanishi, whose passion it was to establish handpiece micro engineering as an art.

Throughout these industrious years, the company's focus has been on creating elegantly designed, high-performance, durable, precision instruments that are constantly being improved and enhanced as new production technology is introduced, and this has resulted in NSK's now global recognition.

A solid reputation for quality

NSK's strategy is based on a solid reputation of quality coupled with durability, supported by ongoing research and development, and the absolute commitment to the dental profession. This is further underpinned by NSK's commitment to after sales service, to ensure the product supplied is delivering at every level. This strategy is clearly paying off; in the past 10 years, sales have grown by 250 per cent, with 80 per cent of its revenue coming from outside Japan.

State-of-the art production

The NSK handpiece range totals 650 models with a variety of clinical applications. Each new model takes around 18 months of development from original design to market release. Some 835 employees are involved in the production of 2,300 handpieces every day, and the production process is elaborate and intricate, each one being produced from around 60 different components.

Importantly, NSK maintains control of the quality of the end product because it produces 90 per cent of all its precision parts in house.

Attention to detail

The results are lightweight, quiet, compact units; the fastest rotation of all handpieces with perfectly concentric rotation; innovations in response to advances in infection control and prevention; vibration elimination; longer lifespan and durability, higher accuracy and a more comfortable dexterity and compact design. And, crucially, all the products remain very competitively priced.

"Angela understands the importance of selecting the right handpiece"

This attention to detail and a passion for perfection within NSK has remained the key focus for all these years, helping to build lasting ties within the dental community.

Alexander Breitenbach, Managing Director, NSK United Kingdom Ltd, said: "We have seen significant growth of the NSK product portfolio in the UK and Ireland and this is testament to the quality of NSK products, coupled with our unmatched service and support."

The NSK Scottish team

NSK has a fundamental understanding that people are at the core of a successful business and have built a team of select sales and support staff who have an understanding of dentistry, coupled with expert product knowledge, to ensure customers are given exemplary levels of service and support.

Angela Glasgow heads up the Scottish regional team for NSK, and she is certainly a well-known and respected territory manager who understands how important the selection of the right handpiece can be to a dentist or DCP. Angela initially trained at Glasgow Dental Hospital as a dental nurse, and then went on to work in both general practice and in the community before moving into dental sales, where she has more than 25 years of experience. Dominie Curran joins Angela as NSK's product specialist for the north east, southern Scotland and Northern Ireland

and brings to her role more than 11 years' experience in the dental industry, in both direct and telephone sales.

Both Angela and Dominie visit practices and liaise with dealers to bring the dental team the most knowledgeable insight into the latest innovations from NSK. In addition, they are both available to carry out in-practice training on correct care and maintenance procedures.

In support of Angela and Dominie is the NSK service and repair team headed by Simon Nicholson, NSK UK service manager. Simon and his team are NSK factory-trained and use NSK original parts to service and repair handpieces.

NSK no-obligation 10 day 'try before you buy'

NSK have many of their products available on a 10-day 'try before you buy' basis. This ranges from turbines and handpieces to surgical motors and ultrasonic scalers, as they understand the importance of having a chance to get a feel for a new piece of equipment.

NSK are also committed to giving clinicians the opportunity to try the latest state-of-the-art equipment. For example, a micromotor, coupled with a 1:5 speed increasing contra-angle, could provide a viable alternative to a turbine, delivering a quiet, high-torque combination that ensures efficient tooth preparation with amazing control and accuracy.

NSK equipment rental

Cash is king when it comes to the financial management of any dental practice, so when it comes to purchasing even small equipment such as handpieces, it can often be beneficial to spread the cost by taking advantage of a rental scheme, as this can have a more

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Continued »

positive impact on cash flow. Additionally, when looking to purchase new equipment, consideration should be given not only to the initial capital cost, but also the ongoing running and servicing costs.

Renting equipment from NSK for a fixed monthly fee offers practitioners the opportunity to use the latest equipment without the need to outlay a capital sum, and provides total transparency and predictability of the running costs and outgoings as the rental includes all servicing, and even accidental damager cover.†

With NSK's rental scheme, you no longer need to consider whether you can afford to buy a new handpiece or other small surgery equipment. Simply choose the NSK products you require and they will make all the necessary arrangements with your preferred dental dealer, all covered in easy monthly payments.

NSK products available to rent:

- Ti-Max Z Series
- Ti-Max X Series
- S-Max M Series
- NLX Plus Portable Micromotor
- VarioSurg Ultrasonic Surgical System
- Surgic Pro Surgical Micromotor
- Varios Ultrasonic Scaler
- Endomate DT & TC2
- Prophy-Mate neo Air Polishing System
- Care3 Plus Handpiece Maintenance System.

By selecting an NSK product, you can be assured that you are working with the very best equipment, supported by a team who understand clinical practice, and at the heart of everything, NSK's desire to maintain its long-lasting relationship within the dental community. ■

For more information about NSK products and services, contact either Angela on 07525 911 006 or Dominie Curran on 07541 864 641 or your preferred dental supplier. www.nsk-uk.com

†Business use only, subject to status. Rental is arranged through our finance partners Snowbird Finance Ltd.

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Scotland leads way for on-line booking

By Ben Flewett, general manager at Software of Excellence

We all know that the internet is a convenient, immediate and simple way to search for products and services, and as the population as a whole becomes increasingly familiar with the internet and mobile technology, it's important for Scottish dental practices to understand how to best take advantage.

It's not just marketing spin that tells us that as individuals we are getting busier – our own lives are evidence enough that the desire for immediate gratification is driving an intense need for things to happen at a rapid pace.

"Your patients are using the internet and mobile technology to help make more efficient use of their time on a daily basis"


Ben Flewett

In a non-dental context your patients are using the internet and mobile technology to help make more efficient use of their time on a daily basis, and recent figures, released by the Organisation for Economic Co-operation and Development (OECD), show that six out of 10 British adults now use the internet to buy a wide range of products. This figure is twice the average of the OECD's 34 member states, (which

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includes the US, Germany, Australia and France) and makes British people the biggest online shoppers in Europe. In 2012, Britons spent £68.2 billion on the internet, an increase of almost £10 billion on 2010, and is equivalent to £2,180 for every adult in the country.

The growth in mobile technology is also driving the expectations of the public to demand convenience and speed and without doubt, changing people's habits. Data from Google published in 2012 showed that 45 per cent of adults now own a smartphone and just over half of these say that they use the phone to access the internet every day (source: http://econsultancy.com/uk/nma-archive/54619-uk-smartphone-ownership-nears-50).

Alongside this rapid expansion in internet usage, the diversity of applications is also growing and the rise in online booking in the last five years is marked. The eTRAK quarterly benchmarking report, which summarises booking data from hotel chains worldwide, illustrates a significant shift from traditional to online channels and reports that in Q3 2010, internet bookings for the top 30 hotel brands reached 56.9 per cent of total bookings made.

But is booking a dental appointment the same as making a hotel reservation? Well, the evidence is that it is becoming increasingly so. The more familiar consumers become with the format and technology that allows online booking, the more likely it is that the reach of these applications will develop. And so we have reached the point where both the public appetite for on-line booking and the availability of technology have converged, resulting in the opportunity for practices to make themselves accessible at a time that suits patients without the constraints of opening hours.

There is often a feeling within the dental profession that "if it ain't broke, don't fix it", and this isn't a view limited to dentists. But this attitude does not take account of those hidden frustrations that patients experience when they call the practice to find the phone line engaged, nor does it empathise with patients who receive less than perfect service when a receptionist is constantly interrupted to answer an incoming call. Ten Scottish practices are now using online booking to aid both recalls and attract new patients and are having some encouraging results; one practice in Glasgow has booked more than 50 new patients in the two months since going live: clear evidence of the demand for this type of flexible service.

Dentistry is increasingly defined by its ability to meet patient demands and online booking is one of those advances in which practices that seize the initiative are likely to have a tangible competitive advantage. So how does a forward thinking dental practice get ahead of the game and fully apply this new technology?

The on-line appointment booking facility within EXACT addresses the shortcomings of other on-line booking facilities, by fully integrating with the practice's recall process. The software identifies patients due for recall on a daily basis according to criteria defined by the practice. It then automatically sends recall messages via email or text prompting the patient to access the online booking engine, which details available appointment times with the patient's own clinician. The patient selects the desired appointment and the software automatically reserves the appointment, updating the calendar in EXACT in real time and sending confirmation to the patient.

It can take between three and five minutes to book a recall appointment over the telephone and booking in new patients takes even longer. Online booking recovers this 'lost' time for the practice as patients take full control for the appointment booking process. A practice in Aberdeenshire for example has been using on-line booking for one month and booked almost 300 patients, thus saving approximately 25 hours of reception time, which can now be more valuably spent providing high quality service to patients. Practices using online booking are also reporting that patients like the non-intrusive nature of online recall and the flexibility of when and how they book appointments.

This innovative software can also be used as an effective website tool to capture prospective patients when they are browsing your website providing a means of immediately booking a new appointment when interest is high. With free registration for patients in Scotland, the new patient booking widget transforms the practice website into a 24-hour receptionist, which is being found to be especially useful when filling short notice gaps in the appointment book.

Online booking technology is opening up the digital world to every dental practice in the UK. Those who are at the forefront have embraced both the concept and the practical application and are now benefiting from their investment. Those who continue to believe that patients will never want this type of service are in serious of danger of being left behind and need to look outside their normal sphere of experience for the opportunities that exist there. ■

One practice in Glasgow has booked more than 50 new patients in the two months since going live

For more information, contact SoE on 0845 345 5767, or visit www.soeidental.com

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Denjoy DenApex apex locator

This battery power unit is self calibrating, has a 0.1 mm length determination and has five different settings of apical adjustment around the minor diameter for excellent working length determination.

The large LCD display has a real-time graphic of root canal and a beep alarm to indicate the apex when the display number on the LCD is below 2mm. The file holders and contrary electrodes are autoclavable for cross infection control.

Priced at only £165.00 plus VAT, the DenApex Apex Locator offers outstanding value for money.

For more information, call Andrew Carr 01485 529363, email fairdent@btconnect.com or visit www.fairdent.co.uk

Covering all the bases

The innovation of Oral-B Pro-Expert toothpaste lies in the synergy of the combination of the two main ingredients which provide the united strengths of stannous fluoride's antimicrobial properties and polyphosphate as a gentle cleaning agent to inhibit calculus and stains.

Oral-B also manufactures a range of electric toothbrushes and refill heads. Their flagship model, the Oral-B Triumph with SmartGuide incorporates novel compliance-enhancing technology using a unique remote display and comes with a broad range of oscillating-rotating refill heads. Oral-B also have the TriZone power brush refill head which gives patients the opportunity to keep a manual feeling while taking advantage of the benefits afforded by power technology.

Dental professionals are also encouraged to visit Oral-B's website – Dentalcare.com – designed to provide intuitive, easy access to a wealth of resources relevant to UK dentistry.

Show stoppers

Visitors to Takara Belmont's stand at this year's Dentistry Show won't need any assistance navigating their way into the new tbCompass Treatment Centre; with a delivery unit that can rotate behind the chair, it provides an easy and unobtrusive welcome. Nurses will also benefit from this feature as it provides the ideal position for essential clean and prep work.

The unique centrally mounted pivoting mechanism allows the tbCompass to convert easily from right to left handed use in less than 90 seconds, without the need for any tools.

Also taking centre stage at the show will be the company's new 900 Series LED operating light. As with their treatment centres, these are built to last and provide excellent light output over their projected lifetime, which is a staggering 40,000 hours or around 25 years for the average user.

To see how each could assist your work in practice, visit Takara Belmont on stand J40 or call 020 7515 0333.

Honest, impartial computer advice

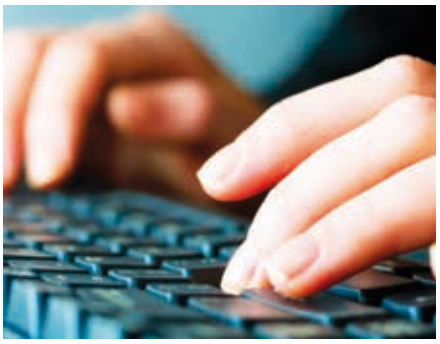
If you are a complete novice, or even if you think you are quite technology savvy, the world of computer systems for dental practices can be quite daunting.

From identifying the right equipment for your needs to installing software and making sure all your terminals and network connections are up and running, it is a task that is often best left to the professionals.

With a proven track record servicing various businesses in Scotland, Ruramet Computer Services prides itself on offering honest and impartial advice, something that is invaluable when looking for a computer partner for your practice.

Established since 1999, Ruramet offers a free one-hour, no-obligation site visit or telephone consultation to establish your needs and it offers a range of service plans from pay-as-you-go agreements to annual contracts that can be amended or cancelled at just a few months' notice.

The company is an expert at setting up systems as well as computer repair,



network and data recovery, so it is perfectly placed to work with practices that are looking to computerise, or improve and maintain their existing set up.

Clients can take advantage of free telephone and remote access support, meaning that many problems can be fixed quickly and without the need for a site visit. If a call-out is required, then the majority of work can be undertaken on site, thus reducing downtime.

Ruramet is familiar with all the latest technology, including iPhone and other smartphones, as well as tablets and other gadgets. It only supplies high-end servers and work stations, ensuring that you have the best equipment that will not only do the job it needs to, but will also be reliable and long lasting. All equipment comes with three-year warranties at competitive rates.

As well looking after all your computer hardware, Ruramet can ensure that your equipment is running the right programmes and at the optimal level of performance.

The company also offers domain registration and website design services, so if your website is needing a facelift or you are not yet a resident of the internet, Ruramet Computer Sevices can sort you out with anything from a one-page info home page to a fully interactive and informative practice website. ■

Visit www.ruramet.co.uk today and find out what Ruramet Computer Services can offer your practice.

Advancing Implant Knowledge Through High Quality Courses

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

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

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

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

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

GENERAL IMPLANT FORUM & TRAINING GIFT

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

Tel: 07738 737879 Email: aberdeenimplants@btinternet.com

Absolute flexibility

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

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

Now with W&H LED you can benefit from excellent lumination on optic or non-optic units.

In addition, W&H handpieces including Synea and Alegra LED turbines are thermo washer disinfectable and sterilisable, and come with a scannable etched data matrix code as standard.

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

LODI system from Zest

General Medical introduce the Locator Overdenture Implant (LODI) System from Zest, which can be used to securely retain both maxillary and mandibular overdentures.

The LODI system is ideal for cases with narrow ridges, where there are financial considerations or when the operator wants minimal invasive flapless surgery.

Ready for immediate placement, self-tapping LODI implants are available in two diameters and three lengths together with Zest Locator Abutments and a choice of two soft tissue cuff heights.

Order 20 implants (only £2,690.88 inc vat) and receive a free surgical kit plus core tool and torque wrench, value over £1,142 inc vat. Offer ends 31 March 2013.

Visit generalmedical.co.uk or email info@generalmedical.co.uk

Innovation in periodontics

Deppeler will be exhibiting at the Dentistry Show in Birmingham from 1 to 2 March 2013, and at the IDS in Cologne from 12 to 16 March.

Inventor of the famous M23 scaler, an instrument that has revolutionised dental procedures around the world, Deppeler will unveil for the first time at the Cologne show the latest innovation in its perio range.

In Birmingham and Cologne, delegates will be able to discover and test for themselves Deppeler's easy-sharp sharpening system.

And, exclusively at the IDS in Cologne it will present new products in its Cleanext handles range, a number of new double-sided titanium instruments and a ground-breaking innovation in the field of periodontology.

Pink Line products at unbeatable prices

With an unrivalled stock of over 27,000 different dental products available, The Dental Directory is the UK's largest full service dental dealer. Its range of products cater to all specialist needs, including a fantastic array of reasonably priced orthodontic products.

Many of The Dental Directory's specialist orthodontic products are featured in the Inside Ortho brochure. The brochure includes many Pink Line products, a new range of high quality orthodontic products that offer high quality at outstanding value. The Pink Line range includes items such as molar bands, archwires and bracket systems.

Call 0800 585 586, or visit www.dental-directory.co.uk

DTE D7 Ultrasonic Piezo Scaler

Manufactured by one of the largest scaler manufacturers in the world, this scaler, which is suitable for scaling, periodontal and endodontic procedures, has a Satelec compatible, detachable, autoclavable handpiece.

Complete with eight tips and a tip holder, the DTE D7 also has its own independent water supply, giving it great flexibility.

Priced at only £285.00 plus VAT, the DTE D7 Ultrasonic Piezo Scaler offers outstanding value for money.

For more information, call Andrew Carr on 01485 529 363, email fairdent@btconnect.com or visit www.fairdent.co.uk to see the full range of scalers, tips and handpieces.

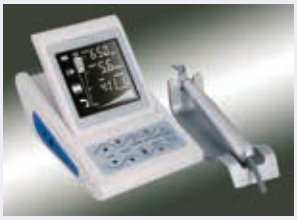
Denjoy Safendo endo motor

The Safendo endo motor is a root canal treatment device which uses a brushless electric motor with a speed range of 150 to 2,000 RPM to more accurately control speed and torque.

The unit has a built-in apex locator, comes complete with foot pedal, file holders, hooks, charger, motor rest and a 1:1 contra angle handpiece and is suitable for all types of NiTi File.

In the process of root canal treatment, when the file reaches the apex, the unit will stop working automatically. The auto reverse function ensures that if torque exceeds the pre-set value, the file will reverse automatically to avoid perforation or break-off. Priced at only £375.00 plus VAT, it is outstanding value for money.

For info, call 01485 529363 or email fairdent@btconnect.com or visit www.fairdent.co.uk



Product news

BACD announces its 10th annual conference

The British Academy of Cosmetic Dentistry (BACD) will hold its 10th annual conference on 6-8 November 2013 at The Hilton London Metropole Hotel.

Entitled '10 years on: the evolution of the smile', the conference will bring together a group of highly regarded speakers from around the globe to share their passion and expertise in the field of cosmetic dentistry. Speakers will cover a range of topics designed to showcase just what can be achieved with the latest in ethical, minimally invasive approaches

Visit www.bacd.com, email Suzy Rowlands at suzy@bacd.com or call 0207 612 4166.

Merger is implant treatment boost

A new company has been formed which will accelerate growth in dental implantology in the UK and Ireland. DENTSPLY Implants is already providing stronger support to help dental professionals increase implant treatment volumes.

The company is improving patient access to dental implants, introducing new prosthetic solutions and providing more postgraduate skills development for every member of the dental implant team.

DENTSPLY Implants combines the strengths of DENTSPLY Friadent and Astra Tech Dental. The new company offers a comprehensive product range including trusted implant systems backed by more than a quarter of a century of continuous development: ANKYLOS, ASTRA TECH Implant System and XiVE, as well as ATLANTIS CAD/CAM abutments and ATLANTIS ISUS CAD/CAM superstructures.

Visit www.dentists4implants.com

G-aenial from GC

G-aenial is a versatile composite material with outstanding invisible aesthetics. Gradia users have been more than satisfied with their material of choice over the years, and those that have already tried G-aenial are very satisfied with the improved results and easy handling.

With natural reflectivity G-aenial allows you to create beautifully invisible restorations with one shade. This micro hybrid composite material incorporates a new forward thinking shade concept includes an age related choice of enamel colours. Three inside shades are available for more complex shading, allowing you to create an invisible restoration.

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

An invitation to lunch

Oral-B's popular 'lunch and learn' sessions are CPD accredited so all team members can earn one hour of verifiable CPD in the comfort of their own practice. The meetings are ideal for those who want to learn more about the latest developments in power brushing and toothpaste including clinical support and marketing opportunities.

Oral-B will endeavour to visit on the most convenient day for the practice and will provide a one-hour presentation focusing on clinical data behind their products. As the presentation takes place at lunchtime, Oral-B will provide lunch for all team members present.

Access to the internet has led to an increased interest and awareness among consumers regarding matters of oral hygiene, and it is hoped that these informal sessions will allow staff members to learn about Oral-B's products and ask any questions they might have in a relaxed environment with as little disruption as possible to their normal working day.

For info contact your local rep or call 0870 242 1850.

Three world-class professionals in LA

Tif Qureshi and James Russell recently delivered a training course for the Inman Aligner in LA, where they were delighted and humbled to be joined by three of the most influential professionals in dentistry – Pascal Magne, Ross Nash and Rick De Paul.

Renowned for their exceptional skills and for leading the way in minimally invasive ceramics, cosmetic veneers and short-term fixed orthodontics respectively, all three clinicians have attended the course to gain hands-on experience with the Inman Aligner and to achieve certification.

Visit www.straight-talks.com or phone 0845 366 5477

New Synea Fusion handpieces

The excellent NEW Synea Fusion range offers great performance at an attractive price, with proven quality and reliability, building on the already established and respected reputation of the W&H Synea brand. W&H range of handpieces offer absolute flexibility to meet the needs of each dental practice.

Synea Fusion offers the choice of a midi (Ø 11.5 mm) and a mini (Ø 10.0 mm) head turbine along with a 1:1 contra-angle, 1:5 speed-increasing contra-angle, 2:1 speed-reducing contra-angle and 1:1 straight handpiece. The new ergonomically designed Synea Fusion range offers powerful and reliable performance, all turbines have ceramic bearings and all optic turbines offer improved illumination using LED+ technology.

For further information, contact W&H (UK) Ltd on +44 (0)1727 874990 or marketing.uk@wh.com

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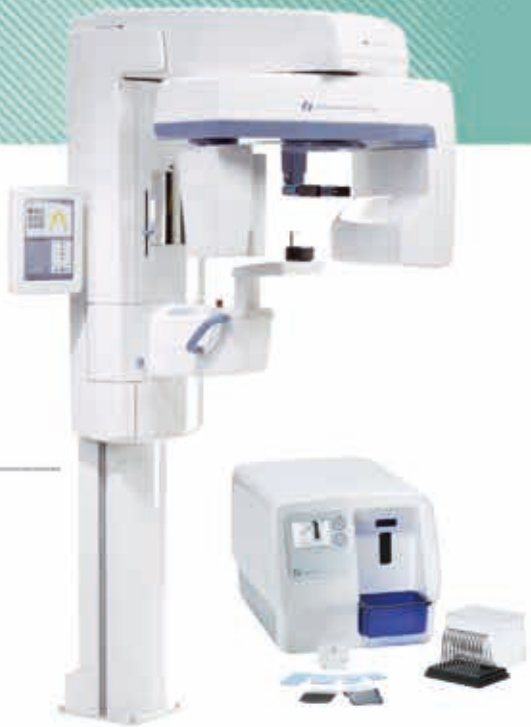

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Meanwhile, the anatomically formed backrest and seat cushion cradle your patients by reducing pressure points, providing exceptional support and comfort.

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"An inspirational experience"

The DENTSPLY Train the Trainer course seeks to recruit endodontic specialists or dentists with a special interest in endodontics.

Those invited to attend will be currently using DENTSPLY products in their day-to-day endodontic treatment and already training, lecturing or holding study clubs on the matter. The course is held in the DENTYSPLY Maillefer Head Office in Ballaigues, Switzerland. By attending the course the dentist will become a DENTSPLY Maillefer certified trainer.

For info, visit dentsply.co.uk or 0800 072 3313

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For exceptional quality of life for your patients, choose the innovative All-on-4 from Nobel Biocare. The solution provides edentulous patients, or those requiring extraction, with a fixed prosthesis.

The All-on-4 solution requires two straight anterior implants and two posterior implants positioned at an angle to securely fit a screw-retained prosthesis. The technique avoids the need for sinus lift procedures and nerve repositioning while maximising available bone, significantly increasing the number of patients who can accept implant treatment.

For further information, call 0208 756 3300 or visit www.nobelbiocare.com

Stronger, safer, simpler

Designed for optimum performance, UnoDent Resin Mirror Handles are made from an improved material that is lightweight, strong and more tactile. The material is non-slip, which ensures a firm grip and maximum control throughout treatment.

User comfort is also considered as UnoDent Resin Mirror Handles are ergonomically designed so that the user has a comfy grip of the implement and doesn't run the risk of developing an RSI.

They are autoclavable up to 134°C, can be put through a washer disinfector and have a stainless steel insert for the mirror heads.

They are also latex-free, making them safe for anyone who is sensitive to latex to use.

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

First for comfort

When reclined in one of Takara Belmont's new soft cushioned chairs you know that great thought has been given to your comfort. The gentle contours and softly padded upholstery offer the ultimate in luxury, helping patients remain relaxed and comfortable throughout their treatment.

This upholstery is available on the Clesta II and most recently launched tbCompass Treatment Centres with the option for the Cleo II available from Spring. The designs of all models are logical and are intended to facilitate treatment as well as provide a relaxing experience for your patients.

The tbCompass, for example, has a delivery unit that can rotate behind the chair, to provide an easy and unobtrusive welcome for your patients.

Free CPD with Oral-B

The most recent edition of the popular publication Dental Summary Review (DSR) was released in October 2012 providing dentists, hygienists and therapists with three hours of complimentary CPD. DSR is published by Oral-B to provide a digest of some of the most interesting and stimulating research that has recently been published. Papers have been taken from a plethora of journals to provide readers with an overview of current research in a range of subjects in clinical dentistry and practice management.

The publication is edited by Dr Stephen Hancocks OBE and is available to download to all UK dentists, hygienists and therapists at Dentalcare.com

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