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Pages 03, 09 and 28
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EDITOR'S DESK

When I was a child my father had a friend who smoked cigars, constantly. He said they were much healthier than cigarettes, you didn't inhale the smoke, so there was much less chance of getting lung cancer. My mother explained that a) this wasn't true and b) it was more than lung cancer that smokers had to beware of, primarily, for cigar smokers, oral cancer.

It was the first time I had heard of oral cancer, but there was much less awareness of it then. There is a lot more awareness now. Sadly, this is driven by the increase in incidences. The number of cases in the UK has grown by 49 per cent in the last 10 years and 135 per cent in the last 20 years. It is now the 11th most common cancer in UK men and the 16th most common in UK women, with 45 per cent of cases diagnosed in people 65 and over. But, the demographics are changing. More cases are being diagnosed in younger cohorts, and cases in women are increasing. However, data cited by the BDA for Scotland shows that 90 per cent of cases could be prevented and that survival could be improved from 50 per cent to 90 per cent with early detection. Focus on prevention and early detection then: easier to write than do perhaps.

Dentistry is unique as it provides a regular touchpoint for the public. The value of this for early detection is incredible. Yet, more than 40 per cent of cases present first to GMPs. Anecdotal evidence suggests there are two reasons for this: firstly, the public still don’t understand the breadth of dental training and expertise, so don’t think about going to their GDP with concerns about their oral (as opposed to dental) health; and, secondly, people are not attending their dental appointments regularly enough for issues to be spotted. Surely though, patients can be educated to take on some responsibility for early detection? It is important to raise awareness and encourage people to learn how to spot symptoms, but it can’t replace regular checking at dental appointments. Oral cancer diagnosis is difficult even for professionals who see cases regularly. The advice to the public must be: if you see anything suspicious, get it checked.

Two of the three main causes of oral cancer are alcohol and tobacco, and this where the public really can have an impact by stopping smoking, eating more healthily, and cutting down on alcohol. Except, it’s not as simple as that. Change needs a significant public engagement and education campaign, and a public health and private sector infrastructure that supports individuals to live healthier lifestyles. It also needs investment in smoking cessation and alcohol advice programmes.

The third major cause is HPV. It seems incredible that it still hasn’t been confirmed that the HPV vaccine will be introduced for boys in Northern Ireland as it has in the rest of the UK and in Ireland. New powers have been legislated for now to help address the current political stagnation, so surely the vaccine should be agreed as early as possible. Particularly as it has just been announced that there will be no catch-up programme in England, and no commitment to one in Scotland. Governments are relying on herd immunity to protect people, but that simply won’t happen if not enough people, of both genders, are vaccinated. Put simply, oral cancer is preventable. My parents’ generation didn’t know the risks and thought cigars were ‘healthy’. I hope that people in my children’s generation will know what to look out for, who to see about their concerns, know the risks and how to mitigate them, and have the added protection of HPV vaccinations as standard.

Sarah Allen is editor of Ireland’s Dental magazine. To contact Sarah, email sarah@connectcommunications.co.uk or follow @sarelal on Twitter.
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YOUR SMILE. OUR VISION.
As 2019 starts, we welcome a new year and a new beginning. There is much to look forward to in the coming year. We hope that the new Oral Health Policy provides evidence informed principles which will aid all of our patients. We hope too that the necessary (and very long-awaited) Dentist Act will appear – and also reflect the changes to our profession at large since the current legislation, which is now 34 years old.

As most oral health professionals are aware in Ireland, we have a lot of work to do educating our patients of the importance of oral health, particularly to reverse a lot of the decay and periodontal disease that resulted from effective removal of the PRSI and DTSS schemes in 2009/2010. These schemes (now re-instated) are inherently flawed in their ability to respond comprehensively to patients treatment needs – but do at least improve access for patients to basic dentistry.

However, the larger question should be – how successful is the message getting home in relation to the broader importance of oral health in general?

In thinking about this, I think of hotels. Many of you will attend conferences during 2019. In checking in to various hotels, I am often struck by something. Something so obvious that I often use it as a barometer to the general population’s attitudes to dentistry in general. When you check in to a high-end hotel, you will be greeted by high-thread cotton sheets, super-plush towels and various high-end toiletries such as “nourishing shampoos”, “revitalising conditioners”, “exfoliating soaps”, and other exotica. Have you guessed what’s missing? Toothpaste!

I am amazed that toothpaste does not feature in the battery of goods available. To add to the puzzlement, many hotels have the temerity to place luxury chocolates on the pillow.

This got me to thinking about the criteria for four-star and five-star hotels – both at home and abroad. Failte Ireland has a comprehensive four-star classification check list, which includes soap, towels and toilet paper – but no mention of toothpaste. In the US, the Diamond Star classification makes no mention of toothpaste or mouth-rinses.

This may, however, reflect the findings of an Irish Dental Association (IDA) survey in 2014. It found that 94 per cent respondents thought that oral health was important – but 60 per cent would attend the dentist only when they “really need to” – the inference being not to attend for preventive check-up or routine maintenance. The survey also showed that only just over half of respondents were aware of the free dental check-up via government schemes, but only one-third availed themselves of it.

In another study, (Whelton et al., Oral Health of Irish Adults, 2007) it was reported that less than one-fifth (18 per cent) of young adults were found to have healthy gums. The findings also highlighted that this figure slipped to just 8 per cent for adults between 35 and 44.

I am not advocating that the placement of toothpaste in hotels is going to turn the tide on oral health, but rather highlighting the fact that toothpaste/oral health care is absent from the “luxuries” of a hotel echoes customer demand and expectation coupled with a general perception of the importance (or lack thereof) of oral health.

When we couple the above information with another IDA finding which reports that a Eurobarometer Report on Oral Health (Special Eurobarometer 330, February 2010) showed that Irish people topped the European Union league for consuming biscuits and cakes (28 per cent reported eating them often, compared to the EU average of 18 per cent). It makes you stop and think about the uphill challenge we have with getting the oral health message out there.

We often spend so much time repairing the damage done by our refined sugar dietary intake that we sometimes lose sight of the bigger picture, the causative nature, and, most importantly, the preventive education piece that we as a profession can provide.

So next time you find yourself in plush hotel, think about the toothpaste – oh and don’t forget your toothbrush!
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Oral cancer rates are increasing across the UK and, in recent months, there has been a significant drive to raise awareness of it among health practitioners, politicians and the public. This has included the national Mouth Cancer Action Month in November, the launch of the BDA Scotland’s Oral Cancer: Plan for Action, and the annual Cancer Focus Northern Ireland Men’s Health Conference, where oral cancer was a key topic raised by Dr Gerry McKenna, Chair of the Northern Ireland BDA Hospitals Group.

Everywhere, the calls have been the same. For the public: be alert, know the signs, visit your dentist regularly, if you see anything you are worried about get it checked. For politicians: understand the issue and invest in the strategies, infrastructure and joined-up services to support early detection and prevention.

The focus on these two elements is critical, as oral cancer is, of course, a largely preventable disease, with data from Scotland suggesting that nine in 10 cases could be prevented. The same data also shows that survival can be improved from 50 per cent to 90 per cent with early detection.

In Northern Ireland, however, cases typically present quite late, which indicates that there is an issue with patients accessing care at an early stage. Late presentation not only decreases survival rates but also means that there is a significant requirement for oral rehabilitation, and specialists are often faced with having to provide care after large surgical resections.

With many late stage presentations appearing in

Key facts

- There were about 8,300 new cases of oral cancer in the UK in 2013 – that’s 21 cases diagnosed every day
- The number of cases has grown by 49 per cent in the last 10 years and by 135 per cent in the last 20 years
- In males in the UK, oral cancer is the 11th most common cancer, with around 5,100 cases diagnosed in 2013
- In females in the UK, oral cancer is the 16th most common cancer, with about 2,500 cases diagnosed in 2013
- Almost half (45 per cent) of oral cancer cases in the UK each year are diagnosed in people aged 65 and over (2011-2013)
- Northern Ireland population: 1.8 million
- 2010-2014 NI Cancer Registry data shows an average of 311 head and neck cancer cases per year (males 216, females 95) in Northern Ireland
- Areas with high deprivation (Belfast) correspond to higher incidence rates
- Areas with lower deprivation (Northern and South-Eastern Trust) correspond to lower incidence rates
patients with historic issues with alcohol and tobacco abuse, it is also critical that sufficient resources to be available for effective smoking cessation and alcohol treatment services, after all, alcohol are two of the three major causes of oral cancer.

Another issue is that patients often present to GMPs rather than GDPs – 25 per cent of Stage 1 and 44 per cent of Stage 4 cancers. This phenomenon is not unique to Northern Ireland, but it does suggest that more needs to be done to encourage the public to understand the role of their dentists in oral cancer prevention and detection, and to ensure that the public also understand the importance of regular attendance at dental check-ups.

To halt and, hopefully, reverse the increase in cases it will be important to target those individuals who do not engage regularly with oral, or perhaps any health services, as well as raising awareness of the early signs of suspected oral cancer to encourage dental visits. However, changing the behaviour and understanding of individuals requires significant, sustained and ongoing investment in major education and engagement programmes. It also requires wholesale change to how people view their interactions with the dental profession and access to dental services.

Another worrying trend, which can be seen clearly in Northern Ireland, is an increasing incidence in younger age groups. Early, anecdotal evidence seems to suggest that it is the third of the three major causes of oral cancer driving this trend, namely HPV. It is no surprise, therefore, that there is significant concern that the Department of Health in Stormont has, as yet, provided no clarity as to whether the HPV vaccine will be extended to boys, as is the case in England, Scotland, Wales and most recently the Republic of Ireland.

Speaking at the Cancer Focus event, Gerry McElwee, Head of Cancer Prevention, Cancer Focus NI, made the seriousness of the situation clear: “There is clearly a very real danger that boys in Northern Ireland will be left behind – and therefore remain at risk of potentially life-threatening diseases. The department should consider using new powers recently legislated for at Westminster to ensure local boys are not disadvantaged, as it is a decision that sits squarely in the public interest. There’s an urgent need for an implementation plan to enable the roll-out of a vaccination programme for local boys by next September. This should include a catch-up programme for boys which parallels that available for girls and vaccine uptake.”

There is no doubt oral cancer needs significant focus, and it is to be hoped that the recent drive has done much to raise awareness in the media, with the public and with those who determine healthcare policies and practices, that oral cancer is a growing problem and one that cannot be ignored or dealt with through simple public health initiatives.

Tackling this requires real investment in infrastructure and resources, major cultural changes and a willingness by governments and others to listen to the dental profession and finally accept that, in the words of Robert Donald, BDA Scotland Chair speaking at the launch of the BDA’s oral cancer action plan, dentists “are not tooth-smiths, we are oral physicians”.

To really move forward, it will require the further involvement of and consultation with the dental profession, as well as major investment and commitment from governments, politicians, the NHS and other stakeholder organisations. Tackling oral cancer is complicated and multi-factorial, but there is much than can be done with the will, the investment and the commitment of everyone.
Do you know which of these is cancer?

Even for experienced professionals, never mind the patients, recognising and diagnosing oral cancer is notoriously difficult.

At the Scottish Dental Show last year, the audience at a lecture on oral cancer recognition and referral were shown these clinical slides of various oral cancer signs. The lecturer asked them to say which they would refer as high risk, an exercise, as it turned out, that proved very difficult for participants.

Slides that everyone agreed could only be malignant proved to be benign, and slides which showed cases that looked innocuous were quite the opposite. So, can you identify these conditions? (Answers below)

Recognition of head and neck skin cancer: A guide for GDPs – p28

The answers:

1) denture stomatitis, benign;
2) early tongue cancer;
3) large alveolar cancer;
4) large drug-related ulcer, benign;
5) lichenoid reaction with fungal infection, benign;
6) peripheral giant cell granuloma, benign;
7) retromolar cancer;
8) small floor of mouth cancer.
The Faculty of Dentistry of the Royal College of Surgeons in Ireland (RCSI) has said it would welcome a new National Oral Health Policy from the Department of Health. However, it has also expressed concerns, particularly around the education and training of dentists.

Although the faculty examines approximately 900 students each year, and more than 2,000 of its graduates work in the profession, it says its views have not been sought by the department as it developed the national policy.

The Dean of the Faculty, Dr John Marley, has set out its concerns on training gaps and urges these to be resolved in the department’s policy. These include:

- The inadequacy of specialist and consultant training of dentistry in Ireland
- The lack of an intern year (foundation year) to support and mentor newly qualified dentists
- The lack of mandatory continuing professional development (CPD) for dentists to maintain skills and knowledge.

Dr Marley noted: “We look forward to the new policy addressing fundamental flaws in how we further educate and train dentists in Ireland. “Currently, our newly qualified dentists do not receive the support and training they need in their first year in practice, while more established dentists do not have sufficient opportunities to keep their skills up to date.”

The faculty urged the department to make a number of elements part of its policy:

- Compulsory intern year of foundation training
- Adequate resources for specialist and consultant training of dentists across all disciplines – this training, as in medicine, should be funded by the HSE/Department of Health
- Compulsory life-long learning and development (CPD) for all dental professionals, in line with medical colleagues.

Dr Marley added: “Ultimately, providing Ireland’s dentists with the best training is about ensuring that patients receive the safest, most efficient and effective care.”

Official response: ‘Gaps in training have been considered’

The Department of Health has responded to the RCSI concerns. A spokesperson said: “The National Oral Health Policy is due to be published early in the new year after approval by government. The aim is to develop models of care that will enable preventative approaches to be prioritised, support the public to access care, enable them to have best oral health, and support interventions appropriate to current and future oral health needs. Throughout policy development, stakeholders and dental professionals have been briefed and had the opportunity to put forward their views. The RCSI Faculty of Dentistry ... was invited to participate at a consultation day in May 2015. Three representatives attended.”

The spokesperson pointed out that a research project was commissioned for the policy through 2017, and all dentists on the Dental Council register were invited to comment on recommendations.

She added that the CEO and President of the Faculty had been invited to a meeting at the department in September 2018 but were unable to attend. Plus, a RCSI representative participated in a meeting to discuss briefing, actions and implementation of the policy.

She concluded: “Gaps in training, both undergraduate and post-graduate have been considered and were alluded to in briefing to the faculty. The RCSI Faculty of Dentistry will be an important partner as we move from policy development to implementation.”
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DA Northern Ireland has welcomed the decision by the Department of Health (DoH) to undertake a major review of the Regulation and Quality Improvement Authority (RQIA) and the policy and legislation that underpins healthcare regulation.

NIDPC Chair Richard Graham and BDA NI Director Tristen Kelso recently met officials from DoH Quality, Regulation, Policy and Legislation Branch as part of a pre-consultation stakeholder meeting. A DoH discussion paper produced as part of the review acknowledges the existing, “uniform approach to registration and inspection” and developments in regulation policy, as well as existing “gaps” mean a radical overhaul of the policy and legislation underpinning RQIA is necessary.

Richard Graham said: ‘Being classified as ‘independent hospitals’, and subject to annual inspections despite being considered ‘low risk’, while we see three-yearly inspection periods elsewhere, has perpetuated the feeling among GDPs that the inspection regime is overly onerous, and not fit for purpose.

“We welcome the root-and-branch approach as proposed, not least the acceptance of moving to a ‘right-touch’ regulatory regime, and acknowledgement of the issues associated with dental practices being classified as independent hospitals.”

BDA NI has been calling for the 2003 Order to be reviewed. A chance to meet DoH officials was secured after representations to the Permanent Secretary. A move to inspections every two years appears to be in the offing in the short-term, subject to sign-off by the Permanent Secretary. An opportunity to further extend this will be part of the latest review.

Tristen Kelso added: “While this process is still at an early stage, we welcome the opportunity to engage with the DoH in shaping the future of regulatory policy.”

Call for commitment

It’s time for Northern Ireland authorities to show commitment to NHS dentistry, BDA Northern Ireland has claimed.

A delegation from its Dental Practice Committee met representatives from DoH, Health and Social Care Board and the Business Services Organisation on 3 December.

On the agenda was the future sustainability of NHS dentistry in Northern Ireland. Among other things, the BDA is calling for immediate implementation of the DDRB recommendation 2018/19, reinstatement of commitment payments and an annual quality improvement scheme, and a simplification of the practice allowance.

CDS contract approval: arrears to be paid

Northern Ireland Department of Health Permanent Secretary Richard Pengelly has confirmed that Department of Finance (DoF) approval is in place to move forward on implementing the new Community Dental Service (CDS) contract.

This includes paying arrears owing to the 2015/16 and 2016/17 awards. Meanwhile, a remit is to be submitted by the Department of Health for 2017/18.

In a letter to BDA Northern Ireland, Richard Pengelly said an implementation group will be established to finalise the terms and conditions of service, and oversee assimilation processes associated with the new contract.

An implementation workshop has been scheduled for early January; however, it could take several more months before back payments are received.

Grainne Quinn, Chair of BDA Northern Ireland Salaried Dentists Committee, said: “Considerable delay in implementing the new contract has had a very real impact on morale in the community dental service, on top of the many other pressures being faced.

However, we welcome confirmation that another significant hurdle has been cleared in the form of receiving DoF approval.

“Our priority will be in ensuring community dental colleagues receive all the backpay they are entitled to, and the new contract is fully implemented as quickly and smoothly as possible. Certainly, our aim is that this can all be completed before the end of the current financial year. Our hardworking, dedicated CDS colleagues deserve no less.”
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FEATURE
MENTAL HEALTH

WHAT LIES BENEATH

Dentists are reporting worryingly high levels of stress in numbers far above the national average. There is evidence to suggest that this is leading to an increasing number of suicides within the profession. The stigma around suicide means it is not often discussed, but one charity is trying to change this.

Words: Andrew Collier

The dental profession is often viewed with envy. Outsiders perceive it as an ideal career: interesting, socially worthwhile, well-paid and bringing huge personal satisfaction.

But they don’t see what lies beneath. For some practitioners, dentistry is delivering little but misery. High levels of stress, worry about negligence claims and even low pay are taking their toll, driving them into depression – and worse.

A recent research paper commissioned by the British Dental Association highlights the issue of mental health well-being in dentistry. Covering Great Britain, the study looks at the causes of stress, burnout and mental illness.

Among the factors identified are pressure from regulators, patient expectations, self-employment, isolation, social pressures, work conditions, boredom and even the NHS itself. As a result, participants reported low morale, low patient care, a decline in professional standards, having to change career and early retirement as being among the outcomes.

Barriers to accessing support are seen as an important issue. “At what point do you just give up and realise that this – or perhaps any – career just isn’t suitable?” said one dentist who took part. “As soon as you start looking at the cracks the whole thing falls down and you are left with nothing.”

The problem of stress is seen as particularly acute in Northern Ireland, which was not part of the recent GB survey. At least eight dentists in the province have committed suicide in recent years. Given that there are only just over 1,000 people working in the profession in the north, this is an alarmingly high level and reflects the serious pressure individuals are under.

The British Dental Association’s Branch President in Northern Ireland, Martin Curran, recently hosted an evening seminar on stress and suicide in Belfast along
with Michael Mansfield QC and Yvette Greenway, co-founders and trustees of the charity SOS Silence of Suicide.

Both Michael and Yvette have experienced loss in this way, most recently Michael’s daughter Anna in 2015. The silence, stigma and shame surrounding suicide and mental health in general made them realise more talking, listening and understanding was needed and so SOS Silence of Suicide was formed.

Yvette explained that SOS started as a support group, travelling all over the country and inviting people with an interest or who had been affected by the issue to come along and share their thoughts, feelings and experiences. As well as dentists, the charity has held sessions with lawyers and in schools and prisons.

SOS is the only charity she is aware of that brings together anyone affected by this issue, including those bereaved by suicide or contemplating it and individuals who have attempted to take their own lives.

“BEING A DENTIST CAN ACTUALLY BE QUITE A SOLITARY JOB, WITH PATIENTS COMING THROUGH EVERY FEW MINUTES. IT CAN FEEL QUITE ISOLATING”

YVETTE GREENWAY, SOS SILENCE OF SUICIDE
“Discussing things can create quite upsetting situations, but people do like participating, especially when they realise they are not as isolated as they thought,” she added. “The people they meet may not be known to them, but those people understand the issues and what they are going through perfectly.

“The BDA is very mental health-aware and has strong support mechanisms for members of the profession, which is fantastic.”

She continued: “We were asked to go over to Belfast to talk to dentists, and the evening was really successful. It was a good turnout, though there were concerns about those who weren’t there and were under huge stress, trying to do their jobs and working long hours while attempting to look after their own mental health at the same time.

“Being a dentist can actually be quite a solitary job, with patients coming through every few minutes. It can feel quite isolating. Do you get out for lunch and if not, does someone go out and bring you a sandwich back?

“It’s about that kind of human factor – looking out for and caring for each other. The best thing anyone can do, whether it’s a dentist or anybody else, is to take an interest in somebody else – to ask if they’re OK and if there’s anything else they can do.”

Interacting with patients in the surgery as well as colleagues in dentistry can help both sides in identifying mental well-being issues, Yvette said. The important thing is to talk about it.

“It can be like lighting a touch paper. It may create a two-way exchange that is beneficial to both sides. Once people realise they can speak freely, without being judged, open and honest discourse follows easily. Some people just want to listen, others simply wish to be heard,” she said.

“Communication is really important. We can only eradicate this problem by not feeling ashamed about it. Our message is not to be frightened. Don’t stop talking and listening.”

The BDA survey has shown that some 40 per cent of dentists are affected by worryingly high levels of stress. In the general population, the figure is much lower at 15 per cent.

Martin Curran, a Belfast-based specialist in oral surgery, said there is no evidence that this means a higher level of suicides, though he added: “We know that younger dentists are leaving the profession because of the pressure.”

He cites figures from Queen’s University Belfast (QUB) showing that at least five students who qualified last year have left dentistry already. “They have gone into a job and found they can’t cope. It’s getting to the point where dentists won’t recommend any longer that people come into the profession.”

Why, though, are professionals literally under suicidal levels of stress? “One reason is fear of complaints or litigation. They are under time pressure requiring them to see more and more patients, and that’s particularly true of younger practitioners working for corporates.

“The demands of patients are also becoming more and more problematic. People believe they have a right to have treatment carried out to 100 per cent standards every time. There’s also the issue of difficult patients, long hours and the increase in paperwork. Everything has to be done sequentially, and people are finding it very difficult to keep up.”

As if this were not enough,Martin added, regulatory costs are also increasing. Last year, a medical doctor paid a yearly retention fee of £425. This year it went down to £380. A dentist pays £890. This is partly, he said, because the General Dental Council is spending a fortune on investigations.

“It’s making dentists risk averse. They won’t do something in case they have a problem. A lot of younger practitioners are sending patients to hospitals even to get very simple work done.”

Income is another issue: it has fallen by more than a third in real terms in the last decade, impacting on the ability of practice owners to fund the necessary equipment. “It has also dropped here because there’s no functioning assembly in Northern Ireland. That means a pay increase for the community dental service can’t go through and it’s been sitting like that for the last three years.”

How can these issues be addressed? The Belfast seminar followed Michael and Yvette’s strategy, attempting to deal with the problems head on by
discussing them openly. It discussed the language and stigma around suicide, stressing it was an illness and inviting the 70 people present to talk about their own experiences.

A framework document is now being put together by a number of health-related organisations, including the BDA, examining how dentists might be able to train to help share their stresses and mental pressures with each other.

“We need to be looking after our colleagues. Suicide is the ultimate in terms of stress,” Martin Curran said. “It can build on dentists until they just can’t see a way out. It’s very hard to get at those people, so we’re trying to offer the help before they get to that stage.

“I speak to a lot of dentists, and it may be that I meet one who has got a problem. Sometimes they’ll talk about it and I can then direct them to an organisation that can help. But people having suicidal thoughts are often very good at masking these things.

“The meeting we held was about that process of communication and stressing that it’s good to have a conversation about it.”

More details at www.sossilenceofsuicide.org
On high alert?

Our ‘flight or fight’ response in the face of imminent life-threatening danger has enabled humankind to survive so far. But this distress signal from the brain can greatly aggravate modern-day stress and anxiety, and it needs to be managed.

Sabre-toothed tigers may have died out 11,000 years ago but no one has told the amygdala – the primitive part of our brain that controls our conditioned ‘flight or fight’ response. While this response was vital for early man’s survival in order to react to danger, in today’s world the workings of the amygdala can contribute to the build-up of stress and anxiety.

Most people have experienced this ‘flight or fight’ response – pounding heart, short breaths, tense muscles and sweating – but these physical effects usually fade once the threat or difficult situation passes. However, if you are constantly stressed your body stays in a state of high alert and you could be in danger of developing stress-related symptoms.

On the whole, stress is a mechanism designed to protect us by helping us to respond quickly to ‘dangerous’ situations: typically perceived pressures from a new or unexpected situation or event; something that threatens our wellbeing; or a situation that gives us a feeling of loss of control.

In most circumstances this stress is helpful as it gives us the energy and perseverance to ‘push through’, for example, to get up in front of people and give a speech or make it to the finish line of a marathon.

We all encounter different levels of stress in our everyday lives, from crossing the road to meeting a tight deadline at work, but there are situations that can heighten our stress levels, such as relationship breakdowns, insecurity at work, bereavement, coping with a serious illness or financial problems.

Living with heightened levels of continual stress can cause us to feel permanently in a fight or flight state. Rather than helping to push people through this situation it can actually overwhelm them, making people feel they are unable to cope. This can lead...
Strategies to relieve stress

Belly breathing. Breathe in through the nose to fill your lungs from the belly upwards. Inhale for a count of five, hold for five and exhale over five. Repeat until you feel more relaxed.

Muscle relaxation. When you are stressed the body tenses up. To relieve this, tense up various muscle groups for a count of 10, then relax. Start with the scalp, forehead, muscles around the eyes and work methodically down the body through various other muscle groups in the shoulders, upper and lower body, legs, arms, feet and hands.

Mindfulness. Take a break and walk in a natural environment, like a park, wood or by a river. Focus on the natural sounds around you and block out any other thoughts.

Relaxation. Take a warm shower or bath, download a relaxation/meditation app and take time to chill out.

Exercise. Reuben advises that exercise, together with healthy eating, is one of the best ways to combat stress. He said: “The extra oxygen, raised heart rate and endorphins you get from exercise really helps the whole body relax, and it also gives you a good appetite and results in a good sound sleep.”

Symptoms of stress

Stress can affect how you feel emotionally, mentally and physically, and also how you behave.

How you may feel emotionally
- overwhelmed
- irritable and “wound up”
- anxious or fearful
- lacking in self-esteem.

How you may feel mentally
- racing thoughts
- constant worrying
- difficulty concentrating
- difficulty making decisions.

How you may feel physically
- headaches
- muscle tension or pain
- dizziness
- sleep problems
- feeling tired all the time
- eating too much or too little.

How you may behave
- drinking or smoking more
- snapping at people
- avoiding things or people you are having problems with.

For stress-busting techniques, visit: [www.nhschoice.org](http://www.nhschoice.org)
Get more exercise
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Access all areas

Rural communities need health services like the rest of us, but attracting dental professionals to live and work among them appears to be a hard sell. But what is the reality of practising in remote locations?

Words: Stewart McRobert

Over the last few years, various reports on healthcare workforces have highlighted that there is a continuing difficulty in recruiting to posts that serve remote and rural populations.

In Scotland, for instance, this poses a significant potential issue as, according to Scottish Government figures, 70 per cent of its land area is classified as “remote rural” with a further 28 per cent classified as “accessible rural”. Seventeen per cent of Scotland’s population resides within this rural land area, with more over 55-year-olds living in remote rural areas than in any other type of area.

The need to provide accessible dental services to such people living rurally is clear, but it seems that living and working remotely and rurally may not be attractive to dental professionals.

Those electing to practice in urban, densely populated areas cite concerns around access to support and allied services for their patients; potential issues with accessing their own professional training and CPD; and the more personal issue of maintaining personal and professional distance with their patients while living in smaller, more isolated communities.

Those that work in remote and rural areas, however, clearly do not feel the same. Instead, they talk about the breadth of practice they can undertake; the strong professional relationships they can build with their patients; and the quality of life available to them personally. With more and more training and CPD available on-line, and access to courses in an increasingly wide variety of physical locations, training doesn’t seem to be an issue either.

Of course, the attractiveness, or not, of working in remote and rural areas is really down to the individual, but there is no doubt that accessing services can be an issue for patients.

Many people living and working in rural communities have professions which operate outside the more urban 9-5, and work in locations where taking an hour off to pop for a check-up is simply impossible.

But what does this mean in reality, and what is life really
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like for dental professionals who choose to provide services to them? We spoke to two dental professionals to find out more.

**Island life**

It’s part of the ethos at the Institute of Dentistry at the University of Aberdeen – give senior students clinical experience through outreach in remote and rural locations. So, it was no surprise to final-year students Hannah Cousins and Anmar Al-Ansari when they were told that they would be part of an outreach programme at the Western Isles Dental Centre in Stornoway during early 2017. Instead, the eye-opening came when they had completed their placement and realised that life as a dentist there is far from bleak and windswept.

“Spending time in Stornoway has been one of the highlights of our dental journey so far,” said Hannah. “Having the opportunity to explore a new place, and experience an alternative clinical setting, has been crucial for personal and professional development.”

Both began with few pre-conceptions: “I didn’t know what to expect of the location,” said Anmar. “I knew it would be a very different environment from the one I’m used to, and I was a little apprehensive about treating a population where everyone knew everyone else.”

Hannah explained: “I’m from London originally and many of the places I’ve explored during my time in Aberdeen are new to me. I tried to go with an open mind and take it for what it was.”

They found a dental centre in Stornoway that is part of the town’s hospital campus. It has 12 surgeries and is staffed by half a dozen dentists. The public dental service based there is the only place on Lewis and Harris – and surrounding islands – where you can receive dental treatment, though there are plans to set up a general dental practice in the near future.

“People on the islands recognise that it is more difficult to deliver a service in a remote and rural community and, since access to services was historically poorer than it is now, they appreciate the service they receive,” said Hannah.

Anmar added: “Dentists we spoke to did say there is the potential for professional or social isolation. Therefore, among other things, you have to be proactive in involving yourself in the community.”

After completing their outreach, the pair compiled a list of the benefits they believe can be had from practising in this type of remote and rural location.

- **Consistency** – being able to treat generations of families and build a lasting rapport with them provides great job satisfaction
- **Community** – a sense of togetherness in the dental team and between clinicians and patients cements a positive working environment
- **Career** – compared with the mainland, healthcare professionals have more autonomy in terms of career development and shaping of the service.

“I would never have thought about practising in somewhere like Stornoway before I went there. Now, I would certainly consider it,” said Anmar.
Recognition of head and neck skin cancer: A guide for GDPs

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Introduction
The role of the GDP in the early recognition and management of oral cancer is well recognised and the subject of annual GDC core continuing professional development.

The old adage of a GDP seeing one oral cancer in a practicing lifetime has recently been called into question.

This may now be more accurately reflected as one case per 17 years of practice exposure.

ISD figures suggest 2,000 cases of oral cancer per year, though not all will see a GDP prior to diagnosis. In cutaneous malignancy, ISD figures for 2016 recorded nearly 13,000 cases of melanoma, squamous cell carcinoma (SCC) or basal cell carcinoma (BCC), in Scotland. If this is extrapolated to head and neck presentations, this represents nearly 8,000 patients with cutaneous malignancy potentially presenting to GDPs, allowing for earlier diagnosis and appropriate onward referral.

The head and neck are affected in up to 80 per cent of BCCs, 60 per cent of SCCs and between 22 per cent and 14 per cent of melanomas, the difference being sex dependent.

The aim of this paper is to equip GDPs with the knowledge to facilitate recognition of potential skin cancers and the confidence to make an appropriate onward referral.

Malignant melanoma
Definition
Cutaneous malignant melanoma (MM) is a malignant tumour of neural-crest derived cutaneous melanocytes. Melanomas can arise from a pre-existing pigmented lesion or from previously normal skin. It is both locally destructive, has a propensity to metastasise and is the major cause of skin cancer mortality. Early treatment of the disease is more effective and involves less morbidity. These factors make clinician education, patient education and prevention of the upmost importance.

Epidemiology
MM is the fifth most common cancer in women and the sixth most common in men in Scotland. There were 1,383 cases registered in Scotland in 2016 with an age-standardised incidence of 26.8 per 100,000 and 162 deaths were attributed to the disease. There has been an increase of the incidence from 2006 to 2016 of 15.2 per cent and a decline in mortality from the disease of 11.5
per cent. In terms of bodily distribution 22 per cent of melanomas present on the head and neck region in men and 14 per cent in females.

**Pathology**

Melanomas are subdivided into types on the basis of clinical features and pathology.

**Superficial spreading malignant melanoma (SMM):** This is the most common type of melanoma. Characteristics include an asymmetrical pigmented lesion with irregular borders, irregular pigmentation. Patients may report a growing lesion, a colour change within the lesion, bleeding, crusting or a change in sensation in relation to the lesion.

**Nodular melanoma (NM):** This is the second most common type of melanoma. NM can present as a firm papule, nodule or plaque. Approximately 50 per cent have the typical dark pigmentation commonly associated with melanomas. The remaining 50 per cent are hypo/amelanotic and pink-red in colour. The surface of the lesion may be smooth, rough or crusted.

**Lentigo maligna melanoma (LMM):** The next in terms of frequency is LMM. This commonly presents on the head and neck region of elderly patients. This is the only type of melanoma that is well recognised to develop from a pre-existing lesion that is a form of melanoma in-situ termed lentigo maligna (LM). Classically LM presents as a slow growing tan/brown macule or patch, which progresses on the surface of the epidermis prior to any growth into the deeper layers of the skin. Patients may report a pre-existing pigmented freckle or patch that has changed size, shape or colour.

**Desmoplastic type melanoma (DM):** This is an uncommon variant of melanoma, accounting for less than 4 per cent of primary cutaneous melanomas. It has a higher tendency for persistent local growth but less frequent nodal metastasis? Clinically DM can be a challenge to recognise as it often presents as amelanotic nodules or plaques, or as ill-defined scar-like lesions. As with LMM it is commonly found in the head and neck region.

**Aetiology and risk factors**

Solar radiation has been recognised as a cause of melanoma. Exposure to high levels of sunlight in childhood, intermittent unaccustomed exposure and ultraviolet exposure due to sun beds are thought to have a role to play. Other risk factors include a large number of benign naevi and a tendency to freckle (fair-skinned individuals). (Figures 1 and 2)

**Clinical Presentation:**

Clinical diagnosis of melanoma can be difficult, but they can generally be related to areas of previous sunburn. Any suspicious pigmented lesion should be examined in a good light with or without magnification. As an aid to diagnosis of pigmented lesions, SIGN recommends clinicians should be familiar with the seven-point or ABCDE checklist for assessing lesions and that health professionals should be encouraged to examine patients’ skin during other clinical...
examinations. A check of the skin of the head and neck region could be incorporated in to a general dental check-up.

Seven-point checklist
Refer people using a suspected-cancer pathway referral (for an appointment within two weeks) for melanoma if they have a suspicious pigmented skin lesion with a weighted seven-point checklist score of three or more.

Weighted seven-point checklist
Major features of the lesions (scoring two points each):

- change in size
- irregular shape
- irregular colour.

Minor features of the lesions (scoring one point each):

- largest diameter 7mm or more
- inflammation
- oozing
- change in sensation.

ABCDE
Asymmetry – the two halves of the area may differ in shape
Border – the edges of the area may be irregular or blurred, and sometimes show notches
Colour – this may be uneven. Different shades of black, brown and pink may be seen
Diameter – most melanomas are at least 6mm in diameter. Report any change in size, shape or diameter to your doctor
Expert or Enlarging – if in doubt, check it out! If your GP or GDP is concerned about your skin, make sure you see a consultant dermatologist or skin cancer surgeon.

The presence of any major feature in the seven-point checklist, or any of the features in the ABCDE system is an indication for referral. The presence of minor features should increase suspicion, as some melanomas will not demonstrate major features.

Any suspicious lesions should be referred to the secondary care, to be assessed by dermoscopy by a health professional trained in this technique.

Investigations
In order to obtain a diagnosis of melanoma, a tissue sample is required for histopathological examination. A suspected melanoma will be excised in its entirety with a 2mm clinical margin and a cuff of fat. If this is not possible, a punch biopsy or incisional biopsy of the most suspicious area will be performed. Biopsies should not be performed in primary care. When the pathology report is available, the initial staging will dictate whether further investigations are warranted.

Not all patients that develop melanoma require any further investigations other than excisional biopsy. Individuals with melanoma over a certain stage will have directed CT examinations prior to surgery.

Patients over a certain stage may be offered a sentinel lymph node biopsy (SLNB). This involves an injection of a radioactive substance and dye, which will highlight the lymph node or nodes to which cancer cells are most likely to spread from a primary tumour. Once identified, these nodes can be excised utilising a relatively small skin incision to establish if there are, in fact, cancerous cells that have already metastasised from the primary lesion. SNLB at present is a prognostic tool rather than a technique to improve survival rates.

Treatment
In terms of the primary lesion, surgery is the only curative treatment for melanoma. The histopathological examination of the biopsy will establish the thickness of the melanoma in millimetres, otherwise called the Breslow thickness. This measurement will determine the extent of the lateral margin that is excised around the site of the original skin lesion, this may range from 5mm for in situ disease through to 2cm for thick > 4mm melanomas. This, of course, has to be limited with head and neck anatomy.

Basal cell carcinoma
Definition
Basal cell carcinoma (BCC) is a slow growing malignant epidermal skin tumour, which is locally invasive but rarely metastasises. The morbidity associated with BCC is due to tissue invasion and destruction, which can be particularly problematic in the head and neck region when lesions are close to structures such as the eyes and nose. If neglected it can cause extensive damage, require radical treatment and ultimately can be fatal.

Epidemiology
BCC is the most common form of cancer in humans. The incidence increases with age and the most significant aetiological factors
appear to be genetic predisposition and exposure to ultraviolet radiation. More than 80 per cent of BCCs occur on the head and neck.  

Pathology
There are a number of clinical variants of basal cell carcinoma with a diverse presentation in terms of clinical appearance and morphology.

Nodular basal cell carcinoma comprises the majority of cases and predominately occurs on the head and neck region. It presents as an elevated nodule or nodules with a pearly surface with telangiectasia on the surface and periphery. The lesion may ulcerate or have a cystic element.

Superficial basal cell carcinomas present as a thin erythematous plaque. They are scaly and can appear eroded and crusty. A shiny periphery to the lesion can be identified on stretching the surrounding skin.

Morphoeic or sclerosing basal cell carcinoma presents as a yellow-white waxy lesion with poorly defined edges, and the skin involved may be depressed. As with other variants of BCC, it may be associated with localised telangiectasia.(Figures 3-10)

Diagnosis
BCC will be predominately diagnosed clinically. The accuracy of diagnosis can be aided by good light, magnification and dermatoscopy performed by an experienced clinician. If there is any doubt in diagnosis a biopsy can be performed. Imaging techniques such as CT or MRI scanning are reserved for patients in whom there is suspicion the tumour has invaded bone or other anatomically important regions such as the orbit.

Treatment
There are a wide variety of
management options for basal cell carcinoma. Treatments can be divided into surgical and non-surgical techniques.

**Surgical options**
Excision with a predetermined margin involves excision of the BCC with some surrounding normal tissue. Small (<20mm) well-defined lesions excised with a peripheral margin of 4-5mm have a clearance rate of approximately 95 per cent. Larger and less well-defined lesions may require a wider peripheral clearance.

Mohs micrographic surgery involves staged surgical resection of a lesion and examination of the specimen’s margins after each stage to ensure complete excision and extremely high cure rates.

**Non-surgical options**

**cryotherapy**
Liquid nitrogen cryosurgery uses extreme low temperatures to destroy the tumour and surrounding tissue. The disadvantage of non-surgical options is no tissue for histology.

**Photodynamic therapy**
Photodynamic therapy is used in superficial BCCs where a chemical is activated by light of a predetermined wavelength leading to local tumour destruction.

**Radiotherapy**
Radiotherapy can be used as a primary treatment, but requires patient co-operation and is less frequently used as a primary modality.

**Squamous cell carcinoma**

**Definition**
Primary cutaneous squamous cell carcinoma (cSCC) is a malignant tumour, which may arise from keratinising cells of the epidermis or its appendages. It is both locally invasive and has the potential to metastasise to other organs of the body. A commonly cited percentage is 5 per cent of patients go on to develop regional metastasis. Tumour factors such as increased thickness, fat invasion, diameter over 20mm, along with the patient factor of immunosuppression place individual patients in a high-risk category of developing metastasis. High risks clinical sites include the ear and scalp.

**Epidemiology**
SCC is the second most common skin cancer in the UK and worldwide, with up to 60 per cent involving the head and neck.

About 5 per cent of cSCCs in the UK metastasise, with lesions on the lip most likely to do so.

**Clinical presentation**
The appearance of SCC is variable. The classic presentation is of an indurated nodular keratinising or crusted tumour with rolled borders that may ulcerate or as an ulcer without evidence of keratinisation. Other non-typical appearances include the growth of a keratin horn or nodule with an intact surface. As such, any new enlarging ulcer, mass, red patch or non-healing lesion on the skin should be treated with suspicion. More than 50 per cent of cSCCs occur on the anterior scalp, forehead and ears, with the lip being another common site.

Although the metastasis rate is low, patients with cSCC can present with regional disease. The parotid region is the most common site followed by the neck.

Any head and neck mass should prompt a head and neck skin examination as well as an intra-oral exam. (Figures 11-14)

**Diagnosis**
As with BCC the initial diagnosis of cSCC can be on a clinical basis or histologically from a biopsy. In the case of rapidly enlarging clinically suspicious lesions, these may be excised with the appropriate surgical margins to avoid any delay in treatment.

**Treatment**
Surgical excision is the treatment of choice. In low-risk, well-defined tumours, a margin of 4mm gives clearance in 95 per cent of cases. High-risk tumours should be excised with a margin of 6mm.

Radiotherapy can be considered in cases where the patient is unwilling or unable to tolerate surgery, and in unresectable cases.

**Referral of suspected skin cancers**
Dentists can refer suspected skin cancers, such as SCC or malignant melanoma to the patient’s GP or directly to their local oral and maxillofacial surgery department. This should be sent as an urgent referral under the two-week rule. BCCs, unless large or site critical, are usually referred on a routine basis.

**Conclusion**
Skin cancers are common in Scotland and often present on the head and neck, therefore dentists, who will often see patients more regularly than GPs, are in an ideal position to incorporate screening for suspicious skin lesions into their routine extra-oral
examinations. This paper gives an outline of the three main forms of skin cancer, including how to recognize them and how they will be managed in secondary care. Early recognition and referral of patients with these lesions will lead to improved outcomes.

ACKNOWLEDGMENTS

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Fig. references

Figure 10: Morphoeic BCC
Figure 11: Solar keratosis
Figure 12: SCC ear
Figure 13: SCC cheek
Figure 14: Infected SCC scalp with additional solar damage

References

1. SIGN: Cutaneous Melanoma Guideline, March 2017
2. NICE: Suspected Cancer: Recognition and Referral, June 2015
3. ABCD-Easy guide to checking your moles. British Association of Dermatologists
5. Steel B.J. Skin cancer – an overview for dentists. British Dental Journal May 2014; Vol 216; No 10; 575-581
7. Halpern AC. Hanson LJ. Awareness of, knowledge of, and attitudes to non-melanoma skin cancer (NMSC) and actinic keratosis (AK) among physicians. Int J Dermatol 2004; 43: 638-642
Top tips for practising evidence-based dentistry

Niall McGoldrick BDS, MFDS RCPS(Glasg), Derek Richards BDS, FDS, MSc, DDPH, FDS(DPH)

Introduction
Implementing the best available evidence and enabling positive sustainable change in practice is an enviable goal for anyone providing healthcare services. In this final article of a three-part series we will discuss applying the evidence and methods of evaluating the outcome, as the final two parts of taking an evidence-based approach. These final two parts are arguably the most important but are often perceived as the two most difficult to achieve.

In general dental practice there are any number of barriers to implementing effective change, including the healthcare system, the will of staff, patient expectations and time available. That said, this stage does not need to be overly complex but it does need to be planned and there are a number of tools we can use to deliver evidence-based dentistry to each and every patient. This article is focused on giving some practical advice and pointers.

Systems thinking
Any challenge is easier when it is broken down into smaller chunks. So think of what you are trying to achieve, then the process that takes place to get to that goal and the system it is part of. Everything we interact with is a system, and there are processes within that system. As soon as we walk out the door in the morning we begin to interact with systems, and we start processes.

The footpath network is part of a national infrastructure system with which we interact; queuing for a coffee at the train station is part of a small local system, the surgery at work is a complex local system with many interacting and moving parts. Within these systems there are various different processes; for example, the footpath network has a series of pedestrian crossings, the process to crossing the road will often start by pushing a button and waiting for the green man on the traffic lights, but, of course,

Figure 1: Process map for crossing the road
it is often a lot more complex than this.

In order to understand the system and how best to implement evidence within a system, you need to be able to map the processes you are thinking of changing and determine what might influence the application of evidence. This is called process mapping. Once you have the map, then you can think about the possible barriers to applying the best evidence and equally think about what would enable application of best evidence. The ultimate system makes it easy to do the right thing without relying on humans to do so. Equally, an effective system can make it difficult to do the wrong thing.

Figure 1 illustrates how a process map for crossing the road might look. This map is very simple and doesn’t take into account all potential choices or influences, but it should give you an idea of how to go about constructing a process map (see left).

Let’s return to our clinical example of our paediatric patient in practice whose parent has withheld consent for fluoride varnish application. After completing parts 1, 2 and 3 of an evidence-based approach, (1: Asking the right question, 2: Searching for the best available evidence, 3: Critically appraising the evidence), and based on the evidence found, we are confident that for this child, fluoride varnish application would be the best approach to prevent decay. The current barrier to you doing so is the lack of consent from the parent. We need a pragmatic solution to the problem, and providing the information only at the time of application at chair side may not be the best solution.

There are many different elements of the system and processes that lead up to that point that could influence the outcome. The appointment booking, check-in, walking to the chair, interaction between you the child and the parent. How many members of staff have been parts of the process? Any change will need to take the system, processes and staff into account. Likewise, there have been a number of tools used, including IT, telephones and dental instruments that also need to be taken into account. A good way to visualise the process and possibly facilitate brainstorming sessions with staff is to again create a process map, similar to Figure 2 (right). This figure is quite obviously simplified, as in reality there are many more influences and choices.

So thinking of the system, the processes and the current barrier, how about if a leaflet had gone out with the appointment in advance that explained the benefits of the treatment to the parent, would it
have helped? This could be a change idea to test out in the practice. There are a number of ways that you could implement and evaluate this change.

We will look at a few methods at our disposal. First: Quality improvement methodology.

What is quality improvement (QI)?

QI is an approach we can use to build change into processes and systems that is sustained. It is a new kid on the block in dentistry, but it has been around in healthcare for more than 30 years and for much longer in industry.

The first formal introduction to QI in Scottish dentistry was through the Scottish Patient Safety Programme in 2016.

Our healthcare colleagues working in the acute and other Scottish primary care services have been doing QI for just over 10 years now. We have some catching up to do, but the benefit is that we can learn from those that have gone before. There are plenty of QI success stories published in a bespoke journal for QI, BMJ quality and safety – access it here: https://qualitysafety.bmj.com/

QI methodology and science take a pragmatic approach to implementation of change in a system, focused on tests of change and clear measures so we understand the implications of any change. This controlled approach to implementing change is ideal for use in dental practices. QI is also ideal for finding ways to implement best practice that is supported by evidence.

There is a level of skill and knowledge required to maximise all the QI tools available. NES has developed a number of useful resources that can be accessed online to help navigate QI and can be accessed here: https://learn.nes.nhs.scot/2272/quality-improvement-zone/qi-tools/process-mapping

Changes to the SDR in October 2017 mean that dentists can now include quality improvement work where this would have been traditionally audit activity.

Peer review

Another method to achieve the final two parts of an evidence-based approach might be to use peer review. This is a process of collaborative working with colleagues to establish a group that facilitates peer-to-peer discussion. It involves practitioners outside your practice and could bring a fresh point of view to the processes in your practice. NES has laid out some advice on the requirements of a peer review group on their website, have a look here: http://www.nes.scot.nhs.uk/education-and-training/by-discipline/dentistry/areas-of-education/professional-development/quality-improvement-activity/peer-review.aspx

If done correctly this approach can be used to fulfil quality improvement hours.

One way to use peer review to improve care might be for discussion and implementation of the updated SDCEP guidance on paediatric dentistry that has recently been published 1.

You could establish a local group of dentists to come together and discuss the guidance, using it as your standard of care and benchmarking against it, then working together to make changes that will benefit patients and improve the quality of care.

In our example of using a leaflet as a test of change, the practice down the road might have more success in winning parents over because they give the leaflet out with appointment letters rather than when they arrive at the reception desk. Or they might have more experience of paediatric dentistry and could share some tips on behavioural management and helping kids accept treatment.

Behaviour change models

Sometimes implementation can come up against a lot of barriers and it seems like there is no path through all the issues and reasons not to change. Susan Michie’s research group at University College London has produced a number of models and theories that could be helpful.

The TRIADS (translational research in a dental setting) team uses some of these methods alongside guidance development and implementation of SDCEP guidance 2. Thinking about barriers to change, it is sometimes down to the physical confines of the working environment or maybe it is the people within it. There are various methods for helping to work through the barriers and understand how to break them down and facilitate positive behaviour change.

The theoretical domains framework is made up of 14 domains that can help you understand what the barriers are...
by providing a framework to create questions from 3.

For example, the first domain is knowledge, questions in this domain might look like: Do practitioners know that new SDCEP guidance for paediatrics has been published? The second domain is skills; a question in this domain might be: Do dentists in the practice know how to place a Hall crown?

Once you gain answers to these questions you can begin the frame ideas and develop facilitators that will enable application of evidence-based practice and guidance. That might be issuing each practitioner with the guidance and arranging a team meeting to discuss it, changing pro-formas on the surgery operating system to include risk assessments that hadn’t been previously included or arranging for the practice to have a training day on fitting Hall crowns. You can only come up with effective solutions if at first you understand the real underlying barriers. You can read more about the TDF in a free open access journal here: https://implementationscience.biomedcentral.com/articles/10.1186/s13012-017-0605-9

Evaluating the outcome further
All of the approaches above have evaluation built in. The usual go to mechanism for measuring and evaluating change tends to be a traditional style audit of pre- and post- intervention data collection. This is an effective method of evaluating an outcome, but it only gives a snapshot, usually of quantitative data, of an ongoing process.
and dynamic system. This type of audit activity still has a place to ensure standards are met and identify areas where there could be improvements but we shouldn’t be restricted to it.

There are many other ways of evaluating outcomes and presenting evidence of effective change. It is important though, to distinguish between process measures and outcome measures. In the fluoride varnish example, a process measure might be the number of successful applications of varnish applied, but the outcome measure would be the reduction in caries rate or continued prevention of caries for the patient. Having the ultimate health outcome in mind throughout the project is important, as after all everything the project is striving to achieve is to improve the quality of care we provide to patients and improve their health.

Qualitative feedback from staff on a new process is an important measure when evaluating outcomes and could be gathered in staff meetings or in questionnaire form. Staff often come up with pragmatic and innovative ideas that might not have been thought of previously.

Gathering patient feedback is another very valuable measure. The Scottish Government’s Health and Social Care standards provide some useful questions and themes to base outcome markers on 4.

An example of the headline outcomes in the document are ‘I have confidence in the people who support and care for me’ and ‘I am fully involved in all decisions about my care and support’. The document is worth a read; the standards are meant to compliment already existing standards set out by various legislative bodies.

Staff and patient feedback could be combined with quantitative data as part of the evaluation of a project in your practice. Returning to QI, the method of quantitative data collection in QI uses a sustained approach to data collection. QI has a programme of active data collection taking place throughout the change process. Instead of collecting large amounts of data at two time points, QI asks that you collect smaller amounts of data at more regular time points. This provides greater levels of regular feedback that can help you understand the implications of any changes you have made earlier.

Conclusion
The three articles we have published in this magazine should give you a good basis for moving forward and practicing evidence-based dentistry. Providing high-quality care and sustaining it is the end goal. Backing up your clinical decision-making and informing your treatment plans with evidence will inevitably help you achieve that. Hopefully the top tips in these articles help you to do that.

If you are further interested in the implementation of evidence in practice and want to be part of testing ideas more formally, then the Scottish Dental Practice Based Research Network will be of interest to you, check out their website to find out about their current projects how to get involved: http://www.sdpbrn.org.uk

References
CLINICAL INTRAORAL SCANNERS

Intraoral scanners in dentistry – an update on digital technology

With the introduction of the first intraoral scanner, CEREC (Chairside Economical Restoration of Esthetic Ceramics) by Dentsply Sirona in 1985, dentistry was offered an exciting alternative to conventional means of impression-taking. Since then, digital technology has developed, resulting in faster, more accurate and smaller scanners than ever before.

As of writing, approximately 15 separate intraoral scanners are available from a variety of companies – all competing within a fierce, growing market. In 2014, the global intraoral scanner market was valued at US$55.3 million, estimated to expand with an annual growth rate of 13.9 per cent from 2015 to 2022.1

Intraoral scanners have gained traction within the orthodontic speciality, with restorative dentistry following suit. Intraoral scanning technology aims to address fundamentally multiple contemporary clinical issues, including the intuitively error-prone volumetric changes of impression materials and the expansion of dental stone.

This review will provide an overview of the advantages, limitations and clinical applicability of intraoral scanners and serve as an introduction for those unfamiliar with this technology.

Firstly, it is pertinent to discuss the technology of intraoral scanners. The objective of an intraoral scanner is to record precisely the 3D geometry of an object, to allow this to be subsequently used to produce customised dental devices. The fundamentals of intraoral scanning relate to structured light being cast upon an object to be scanned by a handheld device. Images of the object of interest are then captured by image sensors within the handheld scanner and processed by software. This results in the production of a point cloud which is further

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<th>Limitations</th>
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<td>Enhanced patient comfort</td>
<td>Initial learning curve</td>
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<td>Gag reflex management</td>
<td>Unable to displace soft tissue – marginal inaccuracies</td>
</tr>
<tr>
<td>No physical study models requiring storage</td>
<td>Expensive hardware/annual software agreement</td>
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<td>Streamlined workflow</td>
<td>Unpredictable for extended edentulous sites</td>
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<td>Predictable for single teeth/implants/short span bridgework (&lt;5 units)</td>
<td>Unable to register dynamic soft tissue relationships</td>
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<td>Immediate preparation feedback in high magnification (undercut/margin depths)</td>
<td>Requires laboratory familiar with digital technology</td>
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<td>Improved patient communication</td>
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The advantages and limitations of intraoral scanning technology
analysed by software to create a 3D surface model, also known as a mesh. The most widely used output file is the STL (stereolithography/standard tessellation language).

Numerous technologies exist to process scan data including: triangulation, confocal, active wavefront sampling (AWS) and stereophotogrammetry.

Triangulation works by the concept that the point of a triangle (object of interest) can be calculated knowing the positions and angles of images from two points of view.

Confocal technology relates to the acquisition of focused and defocused images from selected depths – the sharpness of the image infers distance between points and is related to the focal length of the lens.

AWS needs a camera and an off-axis aperture module. The module moves around a circular path centred on a point of interest – the distance and depth information are derived from a pattern produced by each point.

Stereophotogrammetry estimates all co-ordinates through analysing images using an algorithm – relying on passive light projection and software as opposed to active light projection and expensive hardware.

No matter the imaging processing technology, this data is then constructed into a virtual 3D model. The major challenge of this is rendering a point of interest taken at multiple angles. Accelerometers within the handheld scanner allow distances and angles to be measured between images, with extreme points eliminated statistically, culminating in the production of an STL file suitable for further use to create the custom dental device.

The accuracy of an intraoral scan is paramount for a well-fitting custom dental prosthetic. This is assessed through the values of “trueness” – being the measured deviation from the actual value and “precision” – the repeatability of multiple measurements.

These terms were defined by the International Organization for Standardization – standard 5725-1. Studies investigating accuracy of intraoral scanners should ideally include both measurements, to adequately represent both how “correct” a scanner is, as well as how predictably similar its measurements are.

In 2016, Ender and co-workers, and other studies, demonstrated intraoral scanner trueness of between 20 µm and 48 µm and precision between 4 µm and 16 µm.

Later, in 2017, Imburgia et al. reported scanner trueness and precision in the region of 45 µm and 20 µm respectively for the most accurate scanners tested. To put these figures into perspective, conventional impression trueness and precision is generally reported in the region of 20 µm and 13 µm respectively. In its totality, the literature currently reports intraoral scanning is at least as accurate as conventional methods of impression-taking, subject to the complexity of the clinical case.

A common finding is that of partial scans being the most reliable and accurate, when compared to full arch scans. When scanning over five units (implants or teeth), the data would suggest scanning is not as predictable as conventional impressions. Full arch scans are shown to suffer distortion, specifically at the distal end of the scan. Therefore, the scanning of extended preparations or the edentulous mandible is at high risk of error. Shorter scan distances therefore yield the most accurate results.

It is evident that intraoral scanners can achieve errors of...
consistently less than this value (in single tooth and limited span situations), giving clinical validity.

**Advantages**

Intraoral scanning provides many advantages for the clinician within single unit, tooth or implant supported restoration or full arch appliance (such as orthodontic retainers or aligners 26-28) situations. Digital records of the patient obviate the need to store plaster models. This has positive implications for storage and consumable costs 27. This data also allows the clinician to easily and accurately monitor changes within the dentition over time – for example, tooth wear or orthodontic relapse 5.

It has been evidenced by multiple authors 7,11,27,29 that intraoral scanning results in less patient discomfort compared to conventional impressions.

Patients also prefer scanning to conventional methods of impression-taking 28,30 and gag reflexes can be avoided. There is a modest improvement in chairside time 30,31 with a reported average scan time of between four and 15 minutes 4 however greater time saving is gained through the elimination of certain following laboratory steps. A small quadrant scan is ideal for a single restoration 9,32.

Scans of prepared teeth can be scrutinised by the clinician at extreme magnification and software overlays of undercuts/preparation depths are available, with potential for improved clinical outcomes as a result. Files can be directly emailed to the laboratory – thus avoiding the need to physically post an impression. The dental technician can also assess the impression in real time and request another scan to be taken – avoiding an extra visit for the patient 33,34.

Certain problematic sections can be retaken thus avoiding the need to retake a full impression. Patients are shown to feel more involved with treatment and are interested in scanning technology – serving as a good advertising tool 35-37.

**Limitations**

Limitations exist within the practice of intraoral scanning however. As previously mentioned, scanning is currently predictable only within limited parameters. Full arch implant retained prostheses, extended bridgework and complete dentures are currently not supported by compelling evidence. In relation to complete dentures, a predictable dynamic impression of soft tissue borders, muscle attachments and mucosal compressibility is currently severely limited by technology 2.

There is an accepted learning curve in relation to intraoral scanning. It has been reported that subjects with a greater affinity for the world of technology will find the technology easier to adopt than those without this affinity 36,38,39.

Issues arise in the detection of deep margins of prepared teeth 39 as light cannot record the ‘non visible’ areas of the preparation 2 as normally conventional impression material may be able to displace the gingival margin and record valuable data, following the retraction process. As with conventional impressions, blood or saliva may obscure important margins 40.

With good technique and speed, it has been reported one can overcome many of the reported limitations 15,29. The issue of
reflective restorations or teeth may also arise. This can result in disruption of the matching of points of interest within the software – resulting in an inaccurate 3D model.

This can be counteracted by changing the orientation of the scanner to increase diffuse light, using a camera with a polarising filter or coating the teeth in powder. Powder coatings (aluminium oxide) can add a variable thickness of up to 90µm, and further issues arise if taking a full arch scan as powder inevitably gets mixed with saliva – resulting in time spent cleaning teeth and reapplying powder.

The scan path can also affect the quality of the scan and can result in lost tracking. This should ideally be at a constant distance from the point of interest and moved in a fluid manner, avoiding jerky or fast movements – this can be clinically challenging.

When scanning and tracking is lost, one should return to an area easily recognisable by the software – for example, the occlusal surface of a molar – to predictably re-establish tracking.

If scanning a complete arch, multiple small interocclusal records appear to be the most predictable method of achieving accurate articulation or a small scan of the anterior sextants, as described by a 2018 study.

The initial expense and management costs of hardware may also be prohibitive – the average intraoral scanner costs between £13,000 and £31,000. An annual update agreement may also exist to “unlock” STL files for use of the laboratory – this again has an associated cost.

As more scanners reach the market, it is likely these costs will become more competitive and attractive to new adopters.

**Conclusion**

In conclusion, intraoral scanning presents a viable alternative to (and occasionally outperforms) conventional impression techniques within the confines of strict case criteria.

Despite being in its late “innovator” and “early adopter phase”, intraoral scanning has shown great potential within restorative dentistry, orthodontics and more recently guided implant surgery (combined with CBCT).

Many of its limitations can be circumvented with good clinical technique. Technology, potentially prohibitive costs and market inertia currently prevent its routine use in a wide array of clinical situations.
References


4: Emilia Taneva BKaCAE. Issues in Contemporary Orthodontics. 2015.


10: Jacob HB, Wyatt GD, Buschang PH. Reliability and validity of intraoral and extraoral scanners. Prog Orthod. 162015.


31: Gjelvold B, Chrcanovic BR, Korduner EK, Collin-Bagewitz I, Kisch J. Intraoral...
41: da Costa JB, Pelogia F, Hagedorn B, Ferracane JL. Evaluation of different methods of optical impression making on the marginal gap of onlays created with CEREC 3D.

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Ideas, Insight and Inspiration

Get ahead. Start your 2020 vision now

Alun K Rees

My grandmother described New Year’s Resolutions as “piecrust promises – easily made, easily broken”. As 2019 dawns, probably with similar resolutions for many of us, now is the time to start looking further ahead.

So. What is your 2020 vision?
Imagine it’s 1 January 2020. What will have had to happen during the previous 12 months for you to have made good progress in achieving your three and five-year goals?

How is your life looking? What changes and improvements have happened in your career and personal life to make the future better for you and all those around you?

I started this way because there is more to resolve and resolutions than wishing and hoping. Change takes planning, detail, energy and commitment.

Unfortunately many dentists tend to take life as it comes, accepting the cards they are dealt. The reason could be because of the historical nature that dentistry worked.

It used to be a reactive career, patients attended when they had problems; the dentist fixed them either with repair or by removing the offending tooth. Eventually when enough teeth had been taken away, false ones were provided.

That model evolved as hygiene improved and we trained patients to attend routinely for “check-ups”, the dentally aware mostly kept their teeth for life, but we were still reacting to disease.

For many, the game has changed, and dentistry has become far more proactive, patient driven and elective in lots of ways. It can still sink into the six-month cycle, or rut, if you allow it, and the only difference between the rut and a grave is the depth.

“Many people lead lives of quiet desperation, and die with their song still in them.” That line, attributed inaccurately to Victorian Henry Thoreau, remains true today. Neither is his countryman William James wrong with his advice, “To change one’s life, start immediately, do it flamboyantly, no excuses.”

If either of these aphorisms rings bells for you, it’s time to make plans to start a better 2020 by introducing changes, small and large, over the next year.

How to go about it? By taking Steven Covey’s advice to “Start with the...
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end in mind”, because if you have no idea where you are heading then it’s certain that you aren’t going to get there. Get going with the positives; take time on your own to describe your life at the start of 2020.

What is your 2020 vision? Using the following eight headers, either write an essay or using bullet points to detail the good things that will be happening – career, finance, family, health and fitness, fun/recreation, friends, personal development and spiritual. Write in the present tense – these things are happening. The areas are taken from a coaching tool, “The wheel of life”, which is freely available on line.

I have evolved a professional wheel of life for dentists to help them with the exercise with a business focus. If you would like a copy, email me.

Once the “future self” document is written, it’s time for commitment so share it with those close to you.

Next, start to look at what needs to be done to make progress with your goals over the next three months, the next month, the next week and finally ask yourself what you need to do today to make progress.

Every day, revisit your goals and take at least one action which will move you forward.

So far, so good, and all positive. I am not daft enough to think that everything will be 100 per cent positive; change is never easy, especially if you are introducing changes into a business where others are affected.

The next exercise to help you is to examine your day-to-day life and ask yourself what and where you are tolerating; Thomas J. Leonard described tolerations as “the things that bug us, sap our energy and can be eliminated”.

Leonard said that many of us carry our tolerations around like a noble burden, but it’s an expensive source of self-esteem. Tolerations drain you and inhibit your success, most of us have dozens or even hundreds of them; they can be compromises in life, often things that we don’t realise are weighing us down until they are removed.

Next exercise is to ask yourself the following five questions. What am I going to stop? What am I going to do less of? What am I going to keep doing? What shall I do more of? What am I going to start doing? Why doesn’t everybody do this if it’s so easy? Simple answer, because it isn’t easy. Change demands persistence, inertia is easy, momentum is essential for change and that demands starting a stationary object.

Whatever you do, take steps, small, medium or large. Reflect on what you have achieved and measure your progress from the start. Then with hard work and application your 2020 vision will become your reality.
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It’s the sales, stupid!

Do you know what it takes to drive and grow a highly profitable practice?

Richard Pearce

Governments stand and fall by the economy (many believe) and hence James Carville’s now infamous phrase, “It’s the economy, stupid”, coined during Bill Clinton’s Presidential Election campaign of 1992. A practice’s success or otherwise is largely governed by the level of its sales. Here we will discuss why this is, and therefore what you need to focus on, to ensure you have a growing, highly profitable practice.

Costs in the practice are highly predictable. The benchmark percentage of costs as a ratio of sales should be well known to every owner: Associates – 45 per cent; materials – 7 per cent; labs – 7 per cent; and staff – 19 per cent.

You can work out your overhead costs per surgery per day. Fixed costs/number of surgeries x working days in the month; £250-£600 per surgery per day (depending on where you are and assuming you pay a market rent/mortgage). Your biggest cost is staff, and we will assume that you have an engaged and effective team paid market rates. It also assumes you have a procurement policy that ensures you receive ‘best value’ from your other suppliers such as accountant, digital marketing agency etc.

So now we need to get ‘granular’ with where the ‘sales’ come from. This means we need to know every ‘producer’s’ average daily yield/production/gross. We’ll call it ADY. Coupled to this we need to know what our plan membership delivers each month and other revenue streams e.g. practice allowance (in NI).

Armed with above numbers we can see that if an associate grosses £500/day (and a surgery costs £250/day) that their contribution is to overheads … but that’s all! So, we need to have an ADY target for each ‘producer’ contributing to the overall profit target. The ADY that is achievable is based on the services (treatments) provided, the charges, the hours/days worked in a week and the demand (how many new patients, recall rates).

It is interesting to note how consistent in production rate most clinicians are. I’ve seen a £90k/month dentist produce that month in, month out, +/- 3 per cent and the same with a £15k/month dentist. Therefore, any increase in ADY only happens with a change in one or more of the drivers of ADY.

So how could a meaningful increase in ADY be achieved? Here are some ways.

• Create treatment clinic zones in each clinician’s book. Start with one hour in the morning and one hour in the afternoon. Then only allow treatment to be scheduled into those times – NO CHECK-UPS!
• Track progress.

Calculate ADYs for every clinician every month and then review with each individual. Remember, ‘Don’t expect, what you don’t inspect’.

• Buy an intraoral camera and ensure all associates quickly start to use it. Then ensure they learn how to use the images they are capturing to clearly show and describe to the patient where dental problems could be developing.

• Work faster! Remove any rate-limiting steps such as an ineffective nurse who can’t quickly provide notes that hardly need any updating from the clinician.

• Invest £5,000 in a new website. Then spend £1,500 per month on SEO and PPC for the treatments you can deliver with great, evidenced outcomes.

• Employ an automated system to get Google reviews so you have at least 100 reviews and 10 new ones per month.

If your practice profitability is below where you need it to be, then it’s the sales, stupid! Get the right people, with the right skills and the right equipment, then market them effectively. Easy to write but a little more complicated to implement; you will almost certainly need some help.

Richard Pearce – www.smartpractices.co.uk
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*In vitro study of LuxaCrown; N. Albrecht, S. Duy, Germany, FEB 2016
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Relief from the Irritation and Discomfort of Fixed Appliances and Aligners

OrthoDots® CLEAR

Moisture-activated clear silicone wax for applying to individual areas of fixed braces or aligners that cause irritation

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<th>Features &amp; Benefits</th>
<th>OrthoDots® CLEAR</th>
<th>Traditional Dental Wax</th>
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<td>Sticks and stays the best with moisture-activated adhesive</td>
<td>✔</td>
<td>✗</td>
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<td>CLEAR (17x more transparent than dental wax)</td>
<td>✔</td>
<td>✗</td>
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<tr>
<td>20x more pliable than dental wax</td>
<td>✔</td>
<td>✗</td>
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<td>Best for use on all appliances (including clear aligner trays &amp; attachments)</td>
<td>✔</td>
<td>✗</td>
</tr>
<tr>
<td>Individually packaged for hygienic use (for safe in office &amp; patient use)</td>
<td>✔</td>
<td>✗</td>
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ADHERENCE
The adhesive system used in OrthoDots® CLEAR is moisture-activated, meaning that it not only initially sticks the best in the very wet conditions around orthodontic braces, but it also stays in place much longer than dental wax.

OrthoDots® CLEAR provide effective relief for patients with appliances, allowing them to eat, drink and sleep with 24 hour protection and comfort.

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The EyeSpecial C-III creates excellent high-resolution images for all indications and applications of dental photography. This compact camera for one-handed use with intuitive LCD touchscreen control features a 12-megapixel CMOS sensor for fast imaging at high frame rates.

SHOFU’s next-generation camera, which weighs only 590 grams, sets new standards for photography in dental practices.

For further information please contact Shofu UK on 01732 783580 or sales@shofu.co.uk

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For further information contact your local dental dealer or DMG Dental Products (UK) Ltd on 01656 789401, email info@dmg-dental.co.uk or visit www.dmg-dental.com

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Kemdent is starting the New Year with fantastic offers on its popular surgery product ranges. During January, dental practices can buy 4 x 200g Kemdent Prophylaxis Paste and receive 30% discount. Offer price: £4.12 + VAT each.

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UnicLine S

by heka dental

Unicline S - Even more ergonomics

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HEKA DENTAL
EXCEPTIONAL CHAIRS
FOR EVERYONE

John Cussen from Quintess Denta reports on Heka Dental’s 2018 Open Day

In September, delegates from dental companies throughout Europe and as far as Australia, Canada and New Zealand came together to visit Denmark’s world-renowned dental treatment centre manufacturer Heka Dental for its exclusive distributor-only event at its factory just outside Copenhagen. Representing Ireland, John Cussen of Quintess Denta, Heka Dental’s exclusive Irish distributor and service centre, attended the event to learn more about Heka Dental’s latest innovations, and he reports on them here.

Pioneering concepts
Heka Dental is renowned throughout the dental industry for being the first to introduce new features and working methods to dental treatment centres. Heka Dental is an innovative and pioneering company to work with, and it has introduced many new technologies, which have revolutionised dental chairs. For instance, it was the first to use processor-controlled instruments, the first to make a fully automatic suction cleaning system and the first to build an entire treatment centre in moulded aluminium.

With its latest state-of-the-art UnicLine S treatment centre, the company has introduced even more ergonomic advances, including the unique “Light Ergonomic” concept.

Delegates were filled with anticipation to view the latest enhancements to the range. Bjørn Friis of Heka Dental wowed everyone with an update on the unique features and benefits of the UnicLine S Treatment Centre.

Heka Dental works with industry and academia to keep up to the date with the latest research and technological advances. Based on the latest scientific research, the company incorporates best working practices for the clinician into every product it makes.

Education and training are key to the Heka Dental offering. A number of speakers delivered informative presentations covering various areas to give a better understanding of the important role ergonomics play in the daily working life of a clinician.

These included: “Embodied communication, trust and heartfelt leadership” by Associate Professor Helle Winther, University of Copenhagen; “The future and internet of things in dental business” by Carsten Beck, Director/Futurist from the Copenhagen Institute for Future Studies; and an update on the unique features and benefits of the UnicLine S Treatment Centre by Bjørn Friis.

However, the most important one of all was “Working ergonomically in dentistry” by Jacqueline Bos, a physical therapist and ergonomist from BBO-ergo in Holland. BBO-ergo is an organisation that provides training courses in ergonomics in the workplace and assists in designing or adapting workplaces to achieve optimised ergonomic efficiency.

What you need in a chair
Jacqueline lectures internationally on dental ergonomics and the specific aspects for dental specialisations such as endodontics, periodontics, orthodontics, paediatric dentistry, microsurgery and dental hygiene. Her presentation provided evidence-based information about the physical load in dentistry and ergonomic guidelines in order
to achieve optimised ergonomic efficiency. She then translated these principles into practical advice about what dental teams need to do in order to achieve a healthy way of working. She then went on to talk about the physical load in dentistry, which is due to an uncomfortable work position, primarily caused by neck rotation, curvature of the spine and an uncomfortable arm position.

In order to decrease the load, clinical staff need to adopt neutral positions and also alternate their movements, which helps them to decrease the static load, overcoming the problem of a reduced oxygen flow into muscles and the build-up of lactic acid etc. This can be achieved by either working standing up, which a unit such as UnicLine S enables you to do, or by being seated.

Patient positioning is very important. If the back of the patient’s chair is inclined, the dentist needs to move forward and bend forward in order to see and gain access to the patient’s mouth. This leads to discomfort.

Therefore, the patient should be positioned in a horizontal position so that their mouth is directed towards the dental team, with more leg space under the chair for the dentist and assistant. The only contraindications for placing a patient in the horizontal position is if they are overweight or pregnant, but this only represents about 6 per cent of all patients. The 80:20 rule applies here. If you have to adjust your position for just 20 per cent of your patients, you will still have the ergonomic benefits for 80 per cent of them.

Heka Dental units can be adjusted so that patients are held in the ideal horizontal position, unlike many other brands where the legs are left hanging down which leads to lower back pain. Jacqueline said that you need a dental unit that allows you to work at the optimum height for both the tallest and shortest dentist. She concluded her presentation by saying that the UnicLine S treatment centre is the most ergonomically advanced and efficient treatment centre available on the market.

Light ergonomics
In another presentation, Oluf Christian Olsen highlighted the unique benefits of the UnicLine S treatment centre including its innovative “light ergonomics” concept.

He pointed out that every dentist wants to maintain their focus on the patient’s mouth. If they have to look away, for example to check the instruments’ settings, they have to refocus again when they look back at the patient’s mouth, which takes time and is tiring. This problem has been solved by Heka Dental because this essential information is illuminated on the patient’s napkin, thereby enabling the dentist and assistant to see the settings for the active instrument from the corner of their eyes; and stay focused on the patient’s mouth without having to look around. Heka Dental have termed this “light ergonomics” because it avoids straining the eyes by constantly having to change focus and light intensity. It works brilliantly!

James Pattison of Radiant Dentistry said: “We recently purchased two Heka Dental chairs from Quintess Denta. After evaluating all the offerings available, we chose Heka Dental chairs for their quality and comfort. We have worked with Quintess Denta for years and find them great to deal with. I would have no hesitation in recommending the Unic Line S from Heka Dental.”

Is it time to upgrade your dental chair? Why not trade in your old chair and upgrade to the latest, ergonomically efficient offering from Heka Dental? Finance can be arranged enabling you to spread the cost over time.

For more information on the latest offerings from Heka Dental, visit their website www.heka-dental.com or contact the exclusive Irish distributor Quintess Denta on 028.68628966 (NI) or 01-6918870 (Ireland)
2018 has been another fantastic year of growth for Quintess Denta. With offices in Fermanagh and Dublin, this home-grown company is destined for big things in 2019.

Grand Morse from Neodent, a Straumann Group Brand, has gained remarkable traction in 2018 and is set to continue throughout 2019.

A lot of dental practices have moved over to the Neodent offering for its simplicity and value for money.

A major selling point for dentists is the business, marketing and clinical mentoring available through Quintess Denta. Not only will Quintess Denta provide you with the marketing materials you need to educate patients, a key differentiator of their approach is in team education.

“It is vitally important that everyone working in the practice learns about the implant system, so they can answer questions or recommend the offering to suitable patients,” explains Ian Creighton, Implant Products Manager with Quintess Denta.

Building on its endodontic portfolio, Quintess Denta was delighted to take on the Micro Mega range of endo products, including the popular One Curve and One G rotary files, in addition to their range of equipment including the Endo Ultra, Dual Move Motor and Apex Locators.

While the company is experiencing massive growth, the personal service that customers are familiar with still remains.

So, whether you need a handpiece repaired, are looking to replace your dental chair, would like to introduce implantology to your practice or just want to order some rotary files, one call does it all!

To learn more, contact Quintess Denta on 01-6918870 (Dublin Office) or 028-68628966 (NI Office) or visit their website with over 3,000 items to choose from www.quintessdenta.com
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Spring 2019 Postgraduate Dental Education Programme

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Time: 8.30am – 1pm
Venue: Albert Lecture Theatre, RCSI
Admission: €50 per module. Discount offered when multiple modules booked. See website for further details - www.facultyofdentistry.ie

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Please see Faculty of Dentistry website for details: www.facultyofdentistry.ie
*Advance registration will be required as places are limited