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SUMMER 2022

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Page 22

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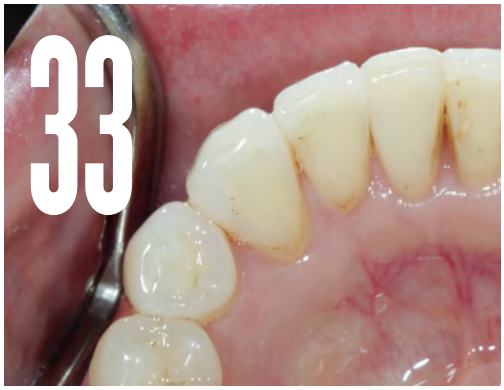

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THE MAGAZINE FOR DENTAL PROFESSIONALS IN IRELAND

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Facing the facts

Provision of healthcare in general is always challenging for governments, and the HSE has not had its problems to seek of late

The huge ransomware cyber attack on the HSE in May last year caused major disruption to all of its IT systems. As it still works to recover from this, we now have the news that its Chief Executive, Paul Reid, is to step down later this year. On top of all this, of course, the organisation has had Covid to deal with. Its employees – and the government – would probably be grateful for a period of calm.

If they are looking for that, they probably won't find it in the world of dentistry. As we report in this issue, recruitment of dentists has never been lower and investment in Irish dental schools is urgently required.

The newly installed president of the Irish Dental Association, Dr Caroline Robins, wants wide-ranging reforms within the profession before it faces a crisis. The answer, she believes, is for the Government to invest in recruitment, retention and training of public dentists, as well as a new medical card scheme.

Things are apparently little better north of the border, with the waiting list for NHS patients stretching from six weeks to an alarming eight months.

The British Dental Association's former Northern Ireland Branch President, Martin Curran, says the service is now under real strain. If surgeons, practitioners and patients work together, he believes those most in need of treatment can be prioritised for appropriate care, whether it be private or public.

On other pages, we preview the Annual Scientific Meeting of the Royal College of Surgeons in Ireland in Dublin. The Dean of the college's Faculty of Dentistry, Professor Albert Leung, previews the October event, which will have the theme 'Same Problems, New Directions'.

We also carry a report on the EuroPerio10 gathering in Copenhagen, attended by more than 7,000 oral healthcare professionals from more than 100 countries.

It brought together the global periodontal community for the first time since the pandemic and featured speeches, research presented in more than 900 scientific abstracts with topics including artificial intelligence and emerging issues, and an exhibition.

In addition, the pioneering first European guideline on how to treat advanced periodontitis at stage IV was announced and discussed.

There's also a fascinating look at sustainability – one of the biggest issues of our time – and how the dental sector can contribute to the debate.

> "AS WE REPORT IN THIS ISSUE, RECRUITMENT OF DENTISTS HAS NEVER BEEN LOWER AND INVESTMENT IN IRISH DENTAL SCHOOLS IS URGENTLY REQUIRED."

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Consent concerns

In today's ever-changing world, where social media is omnipresent and our decisions are scrutinised constantly, the thorny issue of consent is now more than ever firmly front and centre

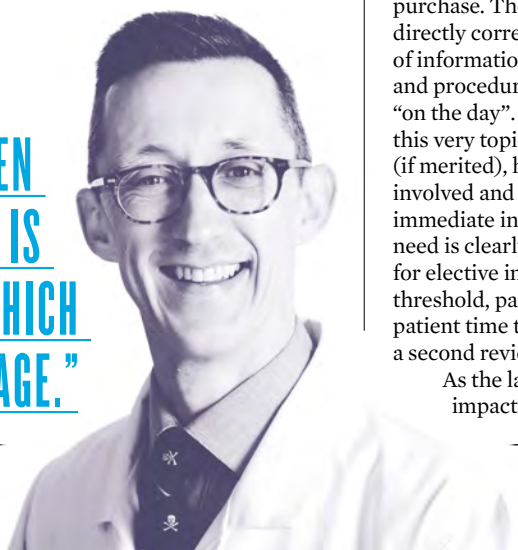
Consent for dental treatment is at the heart of what we do in terms of dental service and treatment. Current thinking on consent has yielded a helpful definition: *"...the giving of permission or agreement for an intervention, receipt or use of a service or participation in research following a process of communication about the proposed intervention"*. This is (as with all involved definitions) a little unwieldy (to say the least), but the spirit of its meaning is evident.

When we examine the elements that constitute consent, we usually see the following domains: decision-making capacity, disclosure of information, understanding, voluntariness and agreement. Each individual element is required to establish consent.

I, more than anyone, understand that pressures of time, time management and patient management mean that the subtle nuances of these elements can be hard to singularly define, identify and satisfy. The busy dental surgery can be a place of constant "go", but making sure patients are fully informed and capable of reaching a decision is kernel to securing consent – and treatment acceptance. It is also self-evident that acceptance of treatment means that alternatives have also been discussed. Our colleagues in the indemnity world are better versed to discuss such intricacies – but working at the coal face is a great teacher, too.

The updated Assisted Decision Making (Capacity) Act (2015) commenced in June 2022. A new guidance document, issued by the HSE, it is worth reviewing as it clearly elucidates some of the more involved elements of consent. For those of us working with vulnerable patients, there is significant guidance for "Decision Making Representatives" – and an entirely new vocabulary/glossary which clearly outlines patients and carers' roles.

> "ONE TENET WHICH HAS BEEN GIVEN ALMOST CERTAINTY IS THE AGE OF CONSENT – WHICH REMAINS AT 16 YEARS OF AGE."



From close reading of the available material, a review of the new Act, and from discussing this with experts in the field, it appears that there is a concerted effort to allow more autonomy to each patient. Those who, under previous legislation (and practice) may have been considered to lack any capacity, may now have their wishes and consent more appreciated via this new legislation.

One tenet which has been given almost certainty is the age of consent – which remains at 16 years of age, in keeping with the 2013 Act. Previously in practice, it had been the custom by many to assume that for those under 18, consent is sought from family, next of kin, carer, responsible person etc.

> "AS THE LAW COMMENCES, TIME WILL TELL THE FULL IMPACT AND CONSEQUENCE OF THESE CHANGES."

At the heart of all of the advice on consent rest two important, fundamental truths – information and the ability to absorb/understand and reflect. A review of the Royal College of Surgeons' Advice (England) will show that they advocate that consent is obtained *"....prior to surgery...(with)... sufficient time and information to make an informed decision."* They also strongly suggest *"... the timing and duration of the discussion should take into account the complexity and risks... and a written (version)... which enable(s) them to reflect and confirm the decision"*.

This idea of a "cooling off period" is akin to mortgage purchase. The literature is quite specific on this, and directly correlates the complexity/risk to the amount of information and (importantly) time between consent and procedure. This can have implications for treatments "on the day". There is much debate in legal circles on this very topic – and when to proceed to intervention (if merited), having just met the patient. While less involved and lower risk procedures can certainly support immediate intervention (particularly when treatment need is clearly demonstrable), it can be harder to justify for elective interventions which hold a higher risk threshold, particularly of permanent injury. Giving the patient time to reflect, with written information or even a second review, can safely eliminate that challenge.

As the law commences, time will tell the full impact and consequence of these changes.

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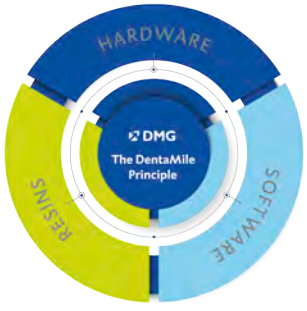

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Call for dental reforms

The Irish government has been urged to reform its troubled medical card scheme and replace it with a new process that is fit for purpose and reflects modern dental practices and standards

THE IRISH DENTAL ASSOCIATION is demanding urgent change as recruitment of dentists is at an all-time low and investment in Irish dental schools is urgently required.

Dr Caroline Robins, the newly elected President of the IDA, is asking for sweeping reforms within the profession before it reaches crisis point.

"We need the government to intervene in the recruitment and retention of public dentists and to invest in the training of dental students," she says.

The association believes that reform of both the Dentists Act and the state's medical card scheme is needed to counter the risk of people leaving the profession in even greater numbers.

Dr Robins continues: "The pressure from dental patients will not and cannot be relieved until proper investment is made. We need the government to intervene in the medical card scheme, public dentist recruitment and the training of dental graduates immediately before we reach crisis levels.

"Dental practices are unable to deal with the volume of patients that are arriving at their clinics and recruitment of associate dentists, dental hygienists and dental nurses is at an all-time low."

Clinics need to be properly staffed in order to meet the needs of patients and offer the very best to them, she says.

"The two dental schools in UCC and TCD do not produce an adequate number of dentists to meet patient demands. The dental school in Cork has been long promised but not delivered, leading to further anxiety for patients seeking care.

"We have consulted the HSE and Department of Health officials in recent months to pursue the development of a totally new medical card scheme – one that meets both the needs of dentists and patients."

Oral surgery backlog

THE BDA'S former Northern Ireland Branch President Martin Curran has said the service is creaking under the strain of a backlog in oral surgery cases.

Writing on the BDA website, Mr Curran said the easing of lockdown was seeing patients returning to practices while the gap created by Covid had increased cases of tooth decay.

He revealed the waiting list for NHS patients has increased from six weeks to more than eight months.

And he claimed the backlog left no option but to prioritise treatment to clinically vulnerable patients, orthodontic cases and emergencies.

Toothache, he said, is not classed as a medical emergency and routine extractions were not covered under the oral surgery pilot as they are deemed level one cases.

But he insisted: "If we all work together, patients, practitioners and surgeons, we can guarantee that the patients most in need of treatment can be prioritised for care, whether private or NHS."

> "THE WAITING LIST FOR NHS PATIENTS HAS INCREASED FROM SIX WEEKS TO MORE THAN EIGHT MONTHS."
>
> MARTIN CURRAN

Kildare shortages

PATIENTS are finding it "impossible" to get hold of a doctor in County Kildare or Country Laois, a Sinn Féin TD has told the Dáil.

South Kildare deputy Patricia Ryan made her allegation during a chamber debate on investment in higher education, saying there was a skills gap in local dental and medical clinics.

Ms Ryan claimed that staff shortages could be seen through the health services and these were a direct result of the indifferent attitude to education pursued by successive governments.

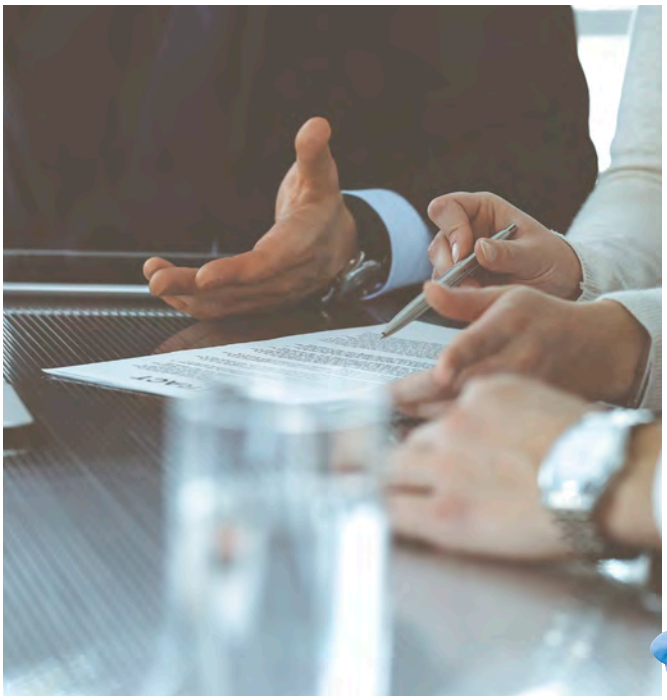
She told her fellow deputies: "One only has to read a newspaper to know that we are experiencing a severe skills shortage," adding "Trying to get an appointment for a doctor or a dentist in Kildare or Laois is impossible.

"I have people coming to me who have to go to Carlow for treatment."

The Minister for Higher Education, Simon Harris, responded by saying that a range of policies setting out a vision and direction for funding were now in place.

Plea for action in the North

Leaders' fears over contract



LEADING FIGURES in the BDA have called for urgent action over contract reform.

Northern Ireland Director Tristen Kelso and Ciara Gallagher, Chair of the Northern Ireland Dental Practice Committee, said there was massive concern over the future of Health Service dentistry.

Writing on the BDA website, Mr Kelso pointed to the rising costs of dentistry due to inflation on materials, lab fees and retention of staff, and he also claimed the situation was being made worse by delays in the implementation of the DDRB uplift.

He added it was getting harder to guarantee equality in the workplace when working under a contract that was designed for a different workforce to the one we now have.

The article revealed the BDA had written to Chief Dental Officer (CDO) Caroline Lappin, confirming its commitment to engage in new contract discussions and that representatives had attended a contract reform meeting in May.

Mr Kelso wrote: "The department must address the underlying reasons behind the collapse in morale and crisis of confidence to begin to transform GDS into an attractive and aspirational option."

In a separate article, Ms Gallagher said it was vital to have a vision for what the new contract would look like and that it would have to be "endorsed by the original principles of the NHS – from cradle to grave".

She added: "The stakes are high but I think it's all to play for, as the state of Health Service dentistry in Northern Ireland can't get any worse.

"The last time contract negotiations were initiated was six years ago – in 2016 – and that went nowhere. This cannot be allowed to happen again, the future of health service dentistry depends on it. This is therefore a pivotal moment. It represents a once-in-a-lifetime opportunity to get the new contract for Health Service dentistry right – not just for us, but for future generations."

Orthodontists lack support

ORTHODONTISTS in Northern Ireland are lacking vital support in the wake of the Covid pandemic, according to the British Dental Association.

The fact that they were able to maintain higher levels of activity than those in general dentistry while the virus was spreading may have been hugely useful to patients, but it has resulted in less support from the Financial Support Scheme (FSS).

With the Rebuilding Support Scheme now under way and society now living with Covid, the BDA is questioning where this lack of parity leaves orthodontists.

The problem has arisen because specialist orthodontic practices were able to adapt to the pandemic by changing many of their procedures to be non-aerosol generating.

This meant treatment could be provided but the result was less support from the FSS, leaving many practitioners facing a referrals gap.

A spokesperson for the BDA said this lack of parity left many specialist orthodontists feeling disappointed, adding: "It is grossly unfair that we have not received the same enhancements that were seen in other areas of dentistry throughout the past two years."

Dentistry failing in Northern Ireland

The number of examinations carried out by NHS dentists in Northern Ireland has fallen by more than half because of the Covid pandemic, according to startling new figures

THE OVERALL drop of 61 per cent came as the British Dental Association warned that National Health Service dentistry was not a sustainable business model and that patients were going to suffer as a result.

The organisation has also warned that the NHS cannot survive under its present model of funding.

The Chair of the BDA's Northern Ireland Dental Practice Committee, Ciara Gallagher, commented: "Since we have opened up again, we haven't seen a lot of patients for two years – and a lot can happen in someone's mouth in two years."

She added: "What we're finding is that people who would have come in and had their check-up and a clean are now coming in with treatment needs. So they need to return maybe two or three times when they didn't have to before.

"For that one patient there are probably five or six examinations that we are not getting to carry out."

If an extraction was needed because a tooth could not be saved, the amount dentists were paid by the Department of Health was less than a hairdresser would receive for a cut and blow dry or a beautician would earn for gel nails, Ms Gallagher said.

"At the moment NHS dentistry is not a sustainable business model. The contract is out of date and ultimately the patients are going to be the ones who suffer and we don't want that."

She added: "We want to look after our patients. We want to do Health Service dentistry but we are finding as we go back to our old funding model we are going to be pushed out."

> "SINCE WE HAVE OPENED UP AGAIN, WE HAVEN'T SEEN A LOT OF PATIENTS FOR TWO YEARS – AND A LOT CAN HAPPEN IN SOMEONE'S MOUTH IN TWO YEARS."

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VSSAcademy continuing dental education

MSc Clinical Implantology

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The world of dentistry continues to change. Patients have increasing expectations and there is more that Dentists can do to meet their wishes and needs. The future is bright for the dental practitioner with enhanced skills working either within the National Health Service or privately. Dentistry is moving towards the establishment of local clinical networks where the dentist possessing additional skills can look forward to a career with greater professional rewards. With the ever-increasing emphasis on the delivery of high quality in primary care, completing one of our postgraduate MSc degrees will allow you to play a strong role in provision of dental treatment in the future. UCLan's Dental Implantology programme provides the busy General Dental Practitioner with a part-time educational route to acquire the skills and knowledge required to undertake more complex and interesting cases in practice. This programme focuses on contemporary practice, evidence-based principles and systems to ensure an optimal outcome for both the patient and practitioner.

Course delivery - This course is made up of virtual classrooms, live webinars and contact days that take place mostly on Saturdays in Glasgow. Clinical supervision days take place at our Regional Training Centres throughout Scotland and Northern Ireland.

Course Overview

Module DX4016 Clinical Implantology Year 1.
MSc course introduction followed by 13 days of lectures and hands-on tutorials:

September 2022:	MSc Course Induction. Two-day virtual MSc in Clinical Implantology course induction. Preston Campus.
1st Oct 2022:	Treatment planning and case selection. Face to face contact day with hands-on workshops.
22nd Oct 2022:	Basic sciences for Implant dentistry. Pre-recorded lectures; live webinar discussions.
12th Nov 2022:	Implant Design. Pre-recorded lectures; live webinar discussions.
3rd Dec 2022:	Surgical skills for Implant dentistry. Face to face contact day with hands-on workshops.
7th Jan 2023:	Occlusion. Pre-recorded lectures; live webinar discussions.
28th Jan 2023:	Restoring Implants. Pre-recorded lectures; face to face contact day with hands-on workshops.
18th Feb 2023:	Digital Workflow in Implant Dentistry. Pre-recorded lectures; face to face contact day with hands-on workshops.
11th March 2023:	Bone Defects. Pre-recorded lectures; live webinar discussions.
15th April 2023	Complications and their management & Revision. Pre-recorded lectures; live webinar discussions.
6th May 2023:	Case reports. Case Report Presentations covering Case selection & treatment planning – each delegate to present one case.
20th May 2023:	Cadaver course. Face to face contact day with hands-on surgical skills workshops.
To be completed before 28th Feb 2023:	CBCT Masterclass. 2 days, consecutive. Day One: On-line Module; Day two: Contact day. Choose from a selection of dates.

Module DX4017 Utilising the evidence base – completed online

Module DX4016 End of year Assessment
Date TBC.

Complete 5 Clinical days - supervised clinical practice.
You will assess and plan appropriate treatment for patients. Includes: case assessment and treatment planning, including use of radiographic stents and CBCT.

Module DX4026 Clinical Implantology Year 2.
Complete 10 Clinical days - supervised clinical practice. Includes: case consultation, implant placement, GBR procedures, restoration, follow up.

Module DX4027 Research Strategy. Prepare and submit a 8,000-word clinically orientated research project, which may take the form of a mini systematic review.

Final examinations.

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Out-of-hours provision

The BDA has welcomed steps towards reintroducing an out-of-hours service

IN A STATEMENT on its website, the BDA said a letter to GDPs inviting them to sign up to emergency dental clinic rotas would come as a relief to many since the lack of out-of-hours provision had affected GDP and work-life balance.

The organisation said it was vital the service was up and running as soon as possible.

The rotas will cover only Belfast, South Eastern, Southern and Northern LCG areas – with no provision identified in the West.

The BDA said: "It is important that Western GDPs, via their LDC, take up the offer to engage with the Strategic Planning and Performance Group (formerly HSCB) around what provision they wish to see in place going forward."

The group added the low rate of remuneration for those who sign up was a cause for concern and would be highlighted in contract negotiations.

RQIA inspection change welcomed

A change in frequency of Regulation and Quality Improvement Authority (RQIA) inspections from every year to every two years is "a win for the profession", according to a BDA official.

NIDPC and RQIA sub-group member Susan Nelson said the change, which came into effect on May 1, had been requested for a long time.

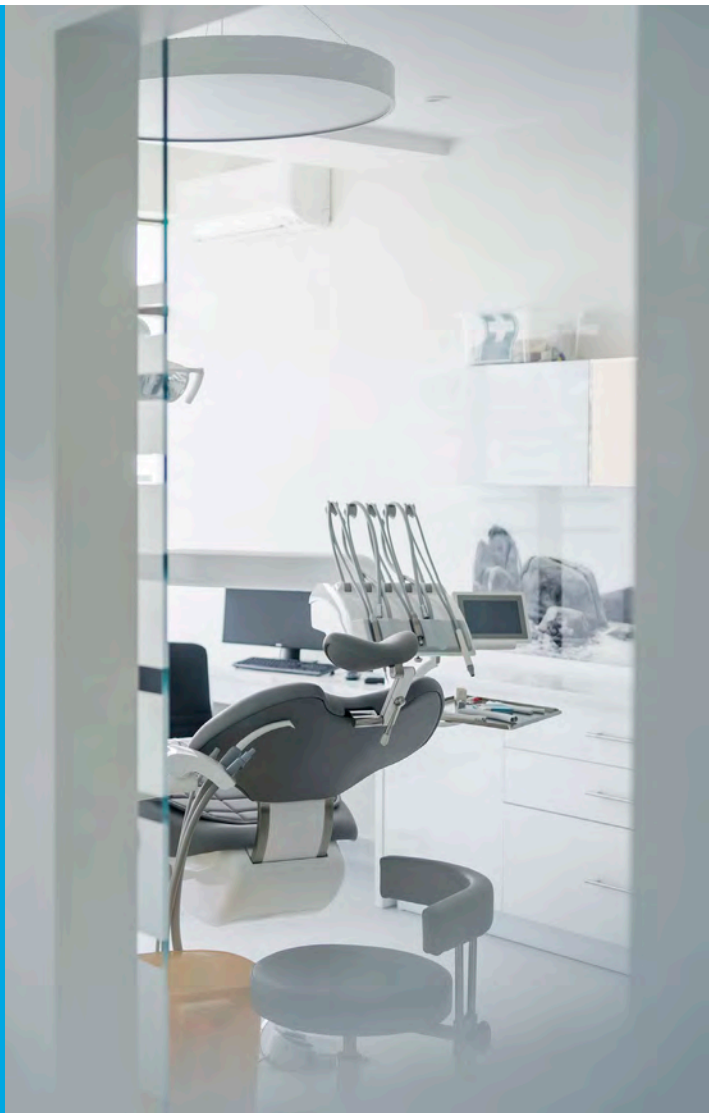
She added it was not about dodging oversight and dentists are "diligent, risk-averse, methodical professionals and our reputation is precious to us". Ms Nelson said the RQIA will now inspect half of the registered dental practices during the 2022/23 inspection year and the remainder during the 2023/24 inspection year.

On occasion, however, there may be a requirement for additional inspections above the minimum frequency.

Ms Nelson said: "The change is a clear demonstration of the power of political engagement.

"When a small NIDPC delegation met with the Health Minister in October 2021, a clear commitment was made. Six months later, that commitment became law."

> "WE ARE DILIGENT, RISK-AVERSE PROFESSIONALS AND OUR REPUTATION IS PRECIOUS TO US."



Credit or voucher system suggested

RELATIONS BETWEEN the public, dental providers and government could be rebuilt with the help of a credit or voucher scheme, according to a prominent academic.

Ciaran O'Neill, Professor of Health Economics at Queen's University Belfast, has produced an independently commissioned research paper concluding that such a scheme would bring necessary reform to the current practices and fee structure.

This in turn, he says, would mean they met modern standards.

The annual cost of a scheme offering a voucher or credit towards dental care of between €100 and €500 would be €108 million and €232 million respectively.

It would give medical card holders access to the increased care and treatment that is currently available to them only in emergencies.

The CEO of the Irish Dental Association, Fintan Hourihan, said: "There is currently one dentist per 2,000 medical card patients - this cannot be allowed to continue.

"It is incumbent on the government and HSE to reform this scheme urgently and the model set out by Professor O'Neill deserves consideration."

> "THERE IS CURRENTLY ONE DENTIST PER 2,000 MEDICAL CARD PATIENTS – THIS CANNOT BE ALLOWED TO CONTINUE."

Change at the helm for Kulzer

A LEADING industry figure has announced his retirement after a successful association with the dental sector spanning more than three decades.

Kulzer, the UK's market leader in composite restorative and impression materials, has announced that David Miller, Managing Director for UK and Ireland, is to retire after 17 years with the company.

Phil Castrofilippo has been appointed to lead the organisation through the next stage of its transformation journey. He joins Kulzer from Zimmer Biomet, where he has held a senior leadership role as Commercial Director, Northern Europe.

Mr Miller said: "Kulzer's aim to be the 'lifetime partner of our customers' has developed through a deep understanding of the evolving needs of dental professionals and their patients, and I am proud to have played a part in turning this vision into reality. It is satisfying knowing how the Venus brand has helped our customers achieve the combination of superior handling and long-term mechanical performance with excellent aesthetics."

Mr Miller joined Kulzer in 2005 and under his leadership the company has become the UK's market leader in composite restoratives and retained a market-leading position within the impression materials segment.

He said: "The years have flown by and now is the time for me to hand over the baton to Phil and the team to take the business forward. I've been extremely privileged to work in partnership with some of the most talented dental professionals."

Mr Castrofilippo said: "I am delighted to join Kulzer and am looking forward to working with the company's talented and successful team. Throughout my career, I've been guided by the goal of improving and advancing care offered to patients.

"I am confident that by continuing to drive innovation we will be able to deliver accessible, flexible and personalised solutions that address both customer and patient needs."

David Miller (left) and Phil Castrofilippo

DATES FOR YOUR DIARY

2022

28-29 JULY
Preventive Dentistry and Dental Public Health
London
https://tinyurl.com/2dbhaj8p

11-13 AUGUST
International Symposium on Dental Hygiene
Dublin
www.isdh2022.com

16-17 AUGUST
Dentistry, Dental Implants, Dental and Orthodontic Supplies
London
https://tinyurl.com/2w5mejmc

22-23 SEPTEMBER
International Conference on Dentistry
London
https://tinyurl.com/2bhenu8m

7-8 OCTOBER
BADT Conference 2022
Crewe
www.dental-tribune.com/event/badt-conference-2022

13-14 OCTOBER
Restorative and Aesthetic Dentistry
London
https://tinyurl.com/56uxea2t

10-12 NOVEMBER
BACD
Newport
https://bacd.com

18-19 NOVEMBER
Periodontics and Preventive Dentistry
London
https://tinyurl.com/4cfk9rhk

9-10 DECEMBER
Restorative Dentistry and Oral Implantology
https://tinyurl.com/yrcjsu6e

Note: Where possible this list includes rescheduled events, but some dates may still be subject to change.

The alliance was launched in June with a sponsored scientific session at EuroPerio10

Oral-B and Straumann announce alliance

Oral-B and Straumann, two of the world's leading oral care companies, are proud to announce a new global alliance with a purpose to elevate the importance of prevention in periodontal and peri-implant health

THE ALLIANCE will set new standards in quality scientific education for dental professionals and help their patients achieve better long-term outcomes.

The Oral-B Straumann partnership has a long-term goal of delivering a holistic programme of scientific events, professional courses, webinars and publications, co-created with and delivered by the world's leading experts and thought leaders in dentistry.

The alliance was launched in June with a sponsored scientific session at EuroPerio10 Copenhagen – the world's leading congress in periodontology and implant dentistry – where both companies also presented their recent innovations for periodontal and peri-implant patients: Straumann Biomaterials solutions ranging from enhanced wound healing and bone regeneration, to soft-tissue management and wound care and Oral-B iO Specialized Clean brush head, Oral-B iO10 and iOsense to empower patients in effective self-care.

"As patients around the world invest in dental implants, they need to recognise that self-care around implants is just as important as around their natural teeth.

The Oral-B/Straumann alliance will play an important role in enabling ongoing dialogue between dental professionals and their patients so both understand the most up-to-date science on prevention of implant-related diseases and promotion of periodontal health", said J. Leslie Winston, Vice President, Global Health Care R&D, Procter & Gamble.

Ari Zucker, Vice President, Global Head of Biomaterials, Straumann Group, added: "Prevention of tooth or implant loss is for many years an important topic for us in the Straumann Group. As one of the world's leading dental implant companies, we work closely with experts from the research and clinical fields to address the issues caused by peri-implantitis and periodontitis.

The Alliance with Oral-B complements our efforts and offers a solid ground for further scientific and educational activities that will enable more dental professionals to improve their patients' lives."

MSc in Clinical Implantology

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Don't just take our word for it! We asked our alumni how they would describe their experience of learning with VSSAcademy on UCLan's ***MSc in Clinical Implantology***

VSSAcademy - What would you say to anyone considering joining this course?

"Don't hesitate to join this course. You will not regret it. It's incredible. Dr Fadi, Alan and Annemarie have been absolutely amazing. They are always on hand to help and are so approachable. I never felt in the dark. After completing it you will understand what a well-thought-out, professional and organised process they have put together."

"Even through the struggles of Covid they have always been one step ahead. I feel so confident in the knowledge I have gained from Dr Fadi and the visiting professors – they provide you with everything you need to succeed. The course is second to none. You need to do it."

"Go for it. Great course, great teachers. By the end you will have the confidence and knowledge to start placing implants safely."

"I would highly recommend this course for anyone planning on doing implants. It gives you a very good understanding of different levels of complexities starting from the surgical to the restorative phase in different clinical situations. It provides a very clear outline of steps involved in treatment planning, which is one of the most important steps in the implant treatment process. Once you finish the course you have a clear understanding as to which cases are most suitable to start on and which cases can be a bit challenging."

"Do not hesitate! It's brilliant! I have done a few implant courses in the past but the strong academic aspect forces you to work a bit more and learn the art of implantology properly. The knowledge I have gained will help me for the rest of my career!"

> "THEY PROVIDE YOU WITH EVERYTHING YOU NEED TO SUCCEED. THE COURSE IS SECOND TO NONE."

VSSAcademy - What did you find most useful about the way this course was delivered? (Blended learning - recordings, webinars, hands-on sessions)

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"Online videos, consolidating knowledge in seminars, excellent hands-on practical sessions."

"I enjoyed the face-to-face sessions because we were able to do hands-on work for both the surgical and restorative phases. At the same time, the webinars were brilliant because I could listen to them at my own pace."

"The separate modules enabled me to consolidate the new information before we moved to the next level. The blended learning was most certainly beneficial as we were able to refer back to the knowledge and information all the time."

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BES launches online resource

Endodontics: Basic Principles and Application in Practice is a set of open access presentations

WORDS
WILL PEAKIN

The British Endodontic Society has launched a set of resources, developed in collaboration with NHS Education Scotland (NES), to support final-year students, graduates and primary care practitioners.

Endodontics: Basic Principles and Application in Practice[1] is designed to be accessible, interactive and dynamic, said Professor Alison Qualtrough, senior lecturer at the University of Manchester and a council member of the British Endodontic Society.

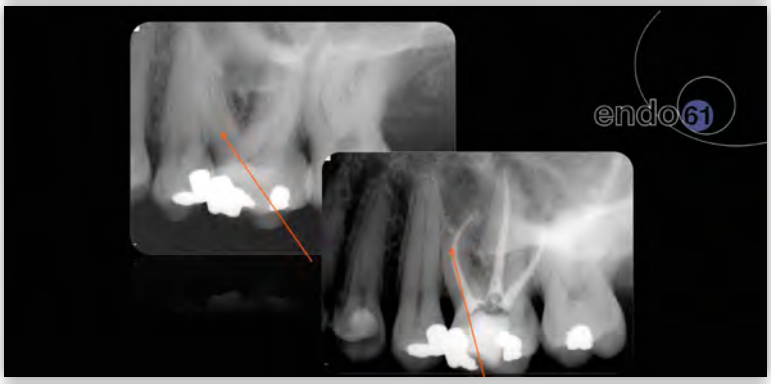
"For several years there has been national, if not international, concern relating to the limited experience of graduates by the time they move into Dental Foundation Training – particularly experience in endodontics, in relation to other areas," she said. "Some of the cases our undergraduates face are complex and these days, for example, an undergraduate is more likely to treat a patient requiring molar root canal treatment rather than the more simple anterior tooth, as may previously have been the case."

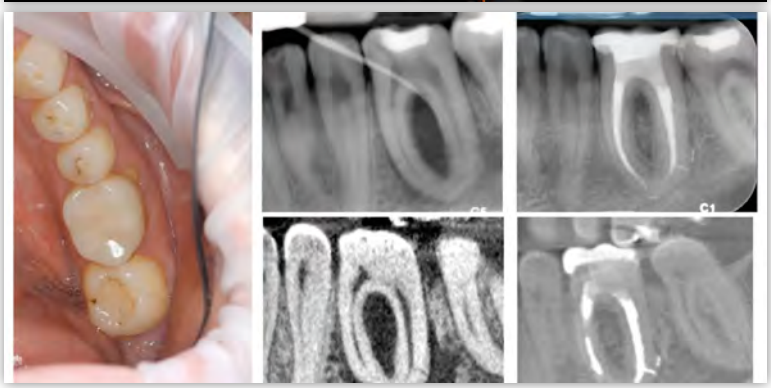
The resources –with new ones to be added in the future – include presentations on the following:

- **Management of Deep Caries and the Exposed Pulp** – with Phil Tomson, Head of Conservative Dentistry and Endodontics, Senior Clinical Lecturer and Honorary Consultant, Birmingham School of Dentistry
- **Dental Trauma** – with James Darcey, Consultant in Restorative Dentistry, University Dental Hospital of Manchester
- **Access Cavities** – with Sanjeev Bhanderi, Specialist Endodontist and Senior Lecturer, University of Liverpool
- **Irrigation** – with Will McLean, Senior Clinical Lecturer and Honorary Consultant in Endodontics, Glasgow Dental Hospital and School
- **Nickel Titanium Instruments in Endodontics** – with Mark J Hunter, Specialist Endodontist Practitioner
- **Obturation** – with Mr Mark J. Hunter, Specialist Endodontist Practitioner
- **Post-Endodontic Restorations** – with Noushad Rahim, Special Interest in Endodontics, based at King's College London
- **Risk Management in Endodontics** – with Alyn Morgan, Senior Clinical Teaching Fellow at Leeds Dental Institute.

"The resource has a wide scope, is evidence-based and is comprehensive," said Professor Qualtrough. "It's been a while in development so it's a pleasure to see it come to fruition. We've had fantastic support from the team at NES, without whom I don't think the project would have reached this point."

Professor Qualtrough urged those engaging with the resource to "browse, enjoy, share and feed back".





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[1]https://learn.nes.nhs.scot/59573/dental-cpd/educational-resources/endodontics-basic-principles-and-application-in-practice

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[1] If haemostasis cannot be achieved after full pulpotomy, a pulpectomy and a RCT should be carried out, provided the tooth is restorable (ESE Position Paper, Duncan et al. 2017)
[2] Taha et al., 2018

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Bocouture® (botulinum toxin type A (150 kD), free from complexing proteins) 50/100 unit vials. Prescribing information: Please refer to the Summary of Product Characteristics (SmPC) before prescribing. **Presentation:** 50/100 units of Clostridium Botulinum Neurotoxin type A, free from complexing proteins as a powder for solution for injection. **Indications:** for the temporary improvement in the appearance of upper facial lines in adults below 65 years when the severity of these lines has an important psychological impact for the patient: moderate to severe vertical lines between the eyebrows seen at maximum frown (glabellar frown lines) and/or moderate to severe lateral periorbital lines seen at maximum smile (crow's feet lines) and/or moderate to severe horizontal forehead lines seen at maximum contraction **Dosage and administration:** Intended for intramuscular injection. Unit doses for BOCOUTURE are not interchangeable with those for other preparations of Botulinum toxin type A. Bocouture may only be administered by physicians with suitable qualifications and the requisite experience in the application of Botulinum toxin type A. The intervals between treatments should not be shorter than 3 months. Reconstitute with 0.9% sodium chloride. ***Glabellar Frown Lines:*** Total recommended standard dose is 20 units. 4 units into 5 injection sites (2 injections in each corrugator muscle and 1 injection in the procerus muscle). May be increased to up to 30 units. Injections near the levator palpebrae superioris and into the cranial portion of the orbicularis oculi should be avoided. ***Crow's Feet lines:*** Total recommended standard dosing is 12 units per side (overall total dose: 24 units); 4 units injected bilaterally into each of the 3 injection sites. Injections too close to the Zygomaticus major muscle should be avoided to prevent lip ptosis. ***Horizontal Forehead Lines:*** The recommended total dose range is 10 to 20 units; a total injection volume of 10 units to 20 units is injected into the frontalis muscle in five horizontally aligned injection sites at least 2 cm above the orbital rim. An injection volume of 2 units, 3 units or 4 units is applied per injection point, respectively. Paralyzing of lower muscle fibers by injecting BOCOUTURE near the orbital rim should be avoided to reduce the risk of brow ptosis. **Contraindications:** Hypersensitivity to the active substance or to human albumin or sucrose. Generalised disorders of muscle activity (eg. myasthenia gravis, Lambert—Eaton syndrome). Infection or inflammation at the proposed injection site. **Special warnings and precautions:** It should be taken into consideration that horizontal forehead lines may not only be dynamic but may also result from the loss of dermal elasticity (e.g. associated with ageing or photo damage). In this case, patients may not respond to botulinum toxin products. Should not be injected into a blood vessel. ***Bocouture should be used with caution:*** if bleeding disorders of any type exist, in patients receiving anticoagulant therapy or other substances that could have an anticoagulant effect. Not recommended for patients with a history of aspiration or dysphagia. ***Bocouture should be used with caution:*** in patients suffering from amyotrophic lateral sclerosis, in patients with other diseases which result in peripheral neuromuscular dysfunction, in targeted muscles which display pronounced weakness or atrophy. Patients or caregivers should be advised to seek immediate medical care if swallowing, speech or respiratory disorders occur. Hypersensitivity reactions have been reported with Botulinum neurotoxin type A products. If serious (e.g. anaphylactic reactions) and/or immediate hypersensitivity reactions occur, appropriate medical therapy should be instituted. Too frequent doses may increase the risk of antibody formation, which can result in treatment failure. The potential for antibody formation may be minimised by injecting with the lowest effective dose given at the indicated minimum intervals between injections. Bocouture should not be used during pregnancy unless clearly necessary and unless the potential benefit justifies the risk. Bocouture should not be used during breast-feeding. **Undesirable effects:** Usually, undesirable effects are observed within the first week after treatment and are temporary in nature. Undesirable effects may be related to the active substance, the injection procedure, or both. Usually, undesirable effects are observed within the first week after treatment and are temporary in nature. Application related undesirable effects include localised pain, inflammation, paraesthesia, hypoaesthesia, tenderness, swelling, oedema, erythema, itching, localised infection, haematoma, bleeding and/or bruising may be associated with the injection. Needle related pain and/or anxiety may result in vasovagal responses, including transient symptomatic hypotension, nausea, tinnitus and syncope. Undesirable effects of the substance class Botulinum toxin type A include localised muscle weakness is one expected pharmacological effect of Botulinum toxin type A. Blepharoptosis, which can be caused by injection technique, is associated with the pharmacological effect of Bocouture. ***Toxin spread:*** when treating other indications with Botulinum toxins, undesirable effects related to spread of toxin distant from the site of administration have been reported very rarely to produce symptoms consistent with Botulinum toxin type A effects (excessive muscle weakness, dysphagia, and aspiration pneumonia with a fatal outcome in some cases). Undesirable effects such as these cannot be completely ruled out with the use of Bocoututre. ***Hypersensitivity reactions:*** serious and/or immediate hypersensitivity reactions including anaphylaxis, serum sickness, urticaria, soft tissue oedema, and dyspnoea have been rarely reported. Some of these reactions have been reported following the use of conventional Botulinum toxin type A complex either alone or in combination with other agents known to cause similar reactions. ***Glabellar Frown Lines:*** Common: headache, Mephisto sign (lateral elevation of eyebrows). ***Crow's Feet Lines:*** Common: eyelid oedema, dry eye, injection site haematoma. ***Upper Facial Lines:*** very common: headache, common: hypoaesthesia, injection site haematoma, injection site pain, injection site erythema, discomfort (heavy feeling of frontal area), eyelid ptosis, dry eye, brow ptosis, facial asymmetry, Mephisto sign (lateral elevation of eyebrows), nausea. For a full list of adverse reactions, please consult the SmPC. **Overdose:** Symptoms of overdose Increased doses of Botulinum neurotoxin type A may result in pronounced neuromuscular paralysis distant from the injection site with a variety of symptoms. Symptoms may include general weakness, ptosis, diplopia, breathing difficulties, speech difficulties, paralysis of the respiratory muscles or swallowing difficulties which may result in aspiration pneumonia. In the event of overdose, the patient should be medically monitored for symptoms of excessive muscle weakness or muscle paralysis. Symptomatic treatment may be necessary. Respiratory support may be required if paralysis of the respiratory muscles occurs. Chemical and physical in-use stability has been demonstrated for 24 hours at 2 °C to 8 °C. From a microbiological point of view, the product should be used immediately. If not used immediately, in-use storage times and conditions prior to use are the responsibility of the user and would normally not be longer than 24 hours at 2 °C to 8 °C, unless reconstitution has taken place in controlled and validated aseptic conditions. **Legal Category:** POM. **List Price: Ireland:** 50 U/vial €110.00, 50 U twin pack €220.00, 100 U/vial €195.00, 100 U twin pack €390.00 **Market Authorisation Number:** PA 1907/003/001, PA 1907/003/002 **Marketing Authorisation Holder:** Merz Pharmaceuticals GmbH, Eckenheimer Landstrasse 60318 Frankfurt/Main, Germany. **Further information available from:** Merz Pharma UK Ltd., Ground Floor Suite B, Breakspear Park, Breakspear Way, Hemel Hempstead, Hertfordshire, HP2 4TZ. Tel: +44 (0) 333 200 4143.

Adverse events should be reported. Reporting forms and information can be found at www.hpra.ie for Ireland. Adverse events should also be reported to Merz Pharma UK Ltd at the address above or by email to UKdrugsafety@merz.com or on +44 (0) 333 200 4143.

*Botulinumtoxin type A, purified from cultures of Clostridium Botulinum (Hall strain)[1]

References: **1.** BOCOUTURE® (incobotulinumtoxinA) Summary of Product Characteristics. Merz Pharmaceuticals GmbH. **2.** Vistabel® (onabotulinumtoxinA) Summary of Product Characteristics. Allergan Ltd. **3.** Dysport® (abobotulinumtoxinA) Summary of Product Characteristics. Ipsen Ltd.

M-BOC-IE-0014 Date of Preparation: March 2022

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Sustainability:

How can the dental sector contribute?

Professor Paul Batchelor, Dental Group Chair at the Centre for Sustainable Healthcare, explores the issue

While sustainability has entered the lexicon of everyday language, its precise meaning and the key issues surrounding it can appear vague. Without this understanding of meaning, trying to address issues becomes almost impossible. This article attempts to overcome the lack of clarity by providing a definition of sustainability and how the dental sector can potentially contribute to what is becoming one of the most critical issues of our time.

What is meant by sustainability?

In broad terms, sustainability refers to the actions taken to ensure that the activities of the current generation in meeting their needs have no, or minimal, impact on the environment. The key document influencing current policy on sustainability was published by the Brundtland Commission titled *Our Common Future*. The report recognised three pillars to sustainability: the environment, the economy and society. For the environmental pillar, the underlying philosophy was underpinned by a need to reduce the current human consumption of natural resources to a level at which they could be replenished. The economic pillar referred to the ability of communities to maintain their independence, not least to secure sources of livelihood. The third pillar, social sustainability, meant access to resources to keep their community and society healthy and secure.

The United Nations, as part of its role in sustainability, established a knowledge hub to provide guidance on sustainable development issues, one of which centres on health. Although high level, the material presented covers a wide range of activities highlighting how individuals and agencies can help and engage in the challenges. Indeed, FDI World Dental Federation (FDI) has published a issued a statement on sustainability in the dental sector.

How can the dental system contribute?

Dental care delivery is provided in the vast majority, through a series of small businesses. However, the actual dental ecosystem is far wider. The day-to-day running of a dental practice requires energy, materials and transport, to name but three items. Each of these businesses can contribute through initiatives that help create a sustainable environment in a logical process similar to those found in a business plan. The first step is to understand the impact that the business is having: how much waste is the business creating, issues such as energy usage within a practice, the use of materials and their packaging. A good example of this is the work by Duane et al. (2017).

Following on from understanding the issues, opportunities for addressing the problems need to be identified and while no two dental practices are ever the same, potential solutions would have common themes. For example, are there opportunities for using (more) sustainable materials? How might energy usage be both reduced or more reliant on renewable sources? Are there ways to explore how patients use services and do opportunities for health promotion programmes exist at differing sites as opposed to one-to-one interventions?

The dental professions can contribute to sustainability both within their professional roles, but also as individuals. Sustainability is not simply about the environmental aspects; it also involves the economic and societal aspects. A number of these lie outside of the control of the profession but government can make contributions, perhaps not least with appropriate contract reform. To tackle these and other issues, including how COVID-19 has impacted and what lessons are being learnt, the college ran a webinar in February. For those with an interest, the Centre for Sustainable Healthcare also runs a programme on some of the key issues and how it relates to dental care.

Summary

Sustainability has grown in importance with the recognition of the negative impact that uncontrolled economic growth is having on the planet, the negative consequences of which would be felt not just by present generations but those of the future.

All societies have now recognised the importance of managing the environment to help address the negative consequences of unchecked growth, but also how developments in the economy and society can also contribute. Provision of health care, including oral health care, is a fundamental right and government needs to work with the profession to ensure that care arrangements are developed in a manner which is coterminous with sustainable goals.

Each individual dental care worker can contribute to helping achieve the sustainability goals, both through their professional roles and as individuals on a day-to-day basis. While such contributions may appear to be small or even insignificant, together they will make a major contribution to a better world, not just for the present, but also the future.

REFERENCES

See https://cgdent.uk/2022/02/24/sustainability-what-is-it-and-how-can-the-dental-sector-contribute/

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Faculty of Dentistry RCSI and the American Academy of Pediatric Dentistry

Dublin, 28-29 October 2022

WORDS
PROFESSOR ALBERT LEUNG

The Faculty of Dentistry of the Royal College of Surgeons in Ireland (RCSI) is delighted to welcome you to this year's face-to-face Annual Scientific Meeting (ASM) at the impressive surrounding of the RCSI campus in Dublin, which the Faculty jointly organises with the American Academy of Pediatric Dentistry (AAPD) with the theme 'Same Problems, New Directions'.

October 2022 will be a unique and special occasion to attend when the FoDRCSI shall be working closely together with the AAPD, in a true transatlantic alliance, building on our friendship and common academic endeavours, bringing this unique quality programme to colleagues not only from both sides of the Atlantic, but also the rest of the world.

Delegates at this joint symposium will have the opportunity to enjoy some impressive Trans-Atlantic academic collaborations, eminent scientific presentations, high-quality debates, and research findings presented by early career researchers. There will also be the opportunities to take part in two bespoke pre-conference hands-on clinical skills sessions in Practical Oral Surgery utilising the novel inverted classroom learning techniques and cone-beam computed tomography (CBCT) from prescription to interpretation, at the award-winning National Surgical and Clinical Skills Centre at RCSI.

There will also be the splendid and unique generosity, warmth, and hospitality RCSI and AAPD

Professor Albert Leung
Dean, Faculty of Dentistry RCSI

> "THERE WILL ALSO BE THE SPLENDID AND UNIQUE GENEROSITY, WARMTH, AND HOSPITALITY RCSI AND AAPD WILL JOINTLY OFFER."

“THERE WILL BE AN ANNUAL FACULTY DINNER AT THE END OF THE CONFERENCE, PLUS OPTIONAL DAY-TRIPS AND EVENTS THROUGHOUT.”

will jointly offer in so many ways. Colleagues from the RCSI Scientific Committee and their counterparts from the AAPD have put together an excellent line up of speakers presenting different themes highlighting, the clinical challenges for paediatric and even adult patients, and contemporary solutions and directions in which Dentistry in 2022 and beyond is evolving and advancing for the benefit of our patients.

The AAPD speakers will be represented by Professor Amr Moursi, Professor Jessica Lee, Professor Tim Wright, Professor Juan Yepes, and Dr Kimon Divaris.

The RCSI speakers will be represented by Professor John Walsh, Professor John Marley, Dr Kathy Harley, Dr Dympna Daly, Dr Pat Cleary, Dr Andrew Bolas, Dr Tiernan O’Brien, Dr Jane Renehan and Professor Tatiana Botero.

Professor John Walsh and Dr Kimon Divaris will be jointly delivering the prestigious Edward Leo Sheridan Lecture on the past, present and future of Paediatric Dentistry.

The Conference will be held on 28 October (Friday) and 29 October (Saturday), with the pre-course clinical skills day on 27 October (Thursday). There will also be a scientific poster competition open to delegates.

Apart from the scientific programmes, the RCSI/AAPD also host a welcome reception at the Guinness Storehouse which is open to all delegates. There will be an annual Faculty Dinner at the end of the Conference, plus optional day trips and events throughout.

For further details or to register your attendance, please go to **asm.facultyofdentistry.ie**
We look forward to welcoming you to the meeting.

EuroPerio10 meeting

More than 7,000 oral healthcare professionals from over 100 different countries travelled to Copenhagen to attend EuroPerio10, the world's leading congress in periodontology and implant dentistry

The four day event, organised by the European Federation of Periodontology (EFP), brought the global periodontology community together for the first time since the Covid-19 pandemic.

The Chair of the gathering, Professor Phoebus Madianos, described it as "the Olympic Games of dental congresses". He added: "EuroPerio10 attracts the best speakers, scientists and clinicians from around the world.

"This is the main event organised by the EFP and the growing success of EuroPerio is mainly due to the scientific programme, which delivers the present and future in the science and practice of periodontology and implant dentistry."

Original research was presented in more than 900 scientific abstracts, with 41 scientific sessions on emerging issues of interest for practitioners, scientists and academics.

There were more than 130 top speakers from over 30 countries, and in excess of 110 companies attended the industry exhibition.

Research topics included the role of artificial intelligence in the diagnosis and treatment of periodontitis. New evidence was also presented on the links between gum disease and heart conditions, diabetes, premature birth and lung function and the long-term outcome of periodontal treatment.

In addition, the groundbreaking first European guideline on how to treat advanced (stage IV) periodontitis was announced on the first day of the congress and explained in detail for the first time.

"Periodontitis has a huge impact on people's lives, with bleeding gums, loose teeth, halitosis and substantial or even complete tooth loss if left untreated," said Professor David Herrera, EuroPerio10 Scientific Chair and lead author of the main paper on the new guideline.

"Those affected can experience difficulty eating and speaking clearly, and some feel ashamed, frustrated and vulnerable. However, as new evidence shows, most advanced disease can be successfully treated and teeth maintained in the long-term."

Approximately 1.1 billion people worldwide had severe (stages III and IV) periodontitis in 2019, making it the most common chronic inflammatory non-communicable disease.

A chronic form of gum disease, it is caused by bacteria that accumulate on the teeth. Inflammation starts in the gums then progressively destroys the ligament and bone supporting the teeth, causing them to loosen and fall out. The guideline focuses on the most advanced stage of the disease.

> "THERE WERE MORE THAN 130 TOP SPEAKERS FROM OVER 30 COUNTRIES, AND IN EXCESS OF 110 COMPANIES ATTENDED THE INDUSTRY EXHIBITION."

Clinical assessment of advanced periodontitis includes five components:

1. Evaluate the extent of the breakdown of structures supporting the teeth, aesthetics and the ability to chew and speak.
2. Establish the number of teeth already lost due to periodontitis.
3. Determine which remaining teeth can be saved.
4. Assess all factors in the mouth which could hinder or enable retention of teeth or placing implants, such as spaces without teeth and the availability of bone.
5. Ascertain the patient's overall prognosis, including the probability of disease progression or recurrence and risk factors such as smoking and diabetes.

Treatment aims to control inflammation and prevent further damage of the supporting tissues of the teeth as well as restoring tooth function.

Therapy begins with the recommendations for stages I to III periodontitis, which include good oral hygiene, not smoking, controlling diabetes and professional cleaning of the teeth above and below the gum line to remove bacteria.

Additional treatments for stage IV disease can involve orthodontic therapy to straighten or move teeth and construction of prostheses to replace missing teeth, either supported by teeth or by dental implants.

Prof Herrera added: "Extracting teeth to place dental implants is not a reasonable option if teeth can be retained. Behavioural change is one of the pillars of therapy and the patient's motivation and compliance are extremely important for success.

"This includes toothbrushing, cleaning between the teeth, sometimes using a mouth rinse to reduce inflammation, not smoking, and controlling blood sugar for those with diabetes."

He continued: "The benefits of periodontal therapy extend beyond the mouth to improved nutrition, quality of life and systemic health, such as better control of blood sugar in patients with diabetes due to the two-way relationship between diabetes and periodontitis."

The EFP President, Professor Andreas Stavropoulos, said that the new guideline for stage IV periodontitis meant that for the first time in history there were now European recommendations for the interdisciplinary and evidence-based management of all stages of this disease.

"Application of the guideline is expected to improve the quality of periodontal treatment in Europe and worldwide. The EFP will be working with its 37 member national periodontology societies to translate and adapt it to the local context."

The EFP is a non-profit organisation dedicated to promoting awareness of periodontal science and the importance of gum health.

www.efp.org

> "EXTRACTING TEETH TO PLACE DENTAL IMPLANTS IS NOT A REASONABLE OPTION IF TEETH CAN BE RETAINED."

TRUST... AND WHEN IT STOPS

WORDS
ALAN K REES

Too often disagreements are allowed to fester, leaving a situation where there is no turning back

"Confucius told his disciple Tau-king that three things are needed for government: weapons, food and trust. If a ruler can't hold on to all three they should give up weapons first and food next." So starts Onora O'Neill's first BBC Reith Lecture in 2002.

My work regularly brings me into contact with people who have been hurt in some way. They may have had arguments or been involved in disputes, either personal or in business with others. Ninety five times out of a hundred, the problems could have been avoided or minimised, meaning that both parties retained their dignity and decorum.

Too often, disagreements are allowed to grow, resulting in a situation where there is no turning back. From my early days as a clinician and in latter years a "trouble shooter", I have come across disputes and the subsequent fall out.

My first post in general practice was in a busy 100 per cent NHS practice that would be known as an "amalgam factory" these days. I took over a surgery where one of the founder members had worked until his departure. I learned that a dispute between the partners, which started small, had grown until it had a life of its own. Eventually there were legal hearings, with both sides represented by barristers. One of the remaining partners, "Q", told me, "the money didn't matter, it was the principle". The principle came at a cost, a five-figure sum, not insignificant in 1981. I didn't enjoy working there, Q could be challenging, critical and was very competitive; he knew he was the best dentist in the practice and told anyone who would listen, including his other two partners. I lasted longer than most associates but eventually Q stopped me seeing new patients because his book was getting thin: I discovered this when a receptionist told me. I asked him about it and he suggested that I "sharpen my probe". Could he not have explained this to me himself? I asked. He said it was his practice and if I didn't like it, I knew what I could do. I gave three months notice and moved on, wondering if I could have done things differently.

Three years later, working in another practice with a principal who had recently taken control, I had a problem with the fit of a couple of crowns and rang the laboratory. I discovered they hadn't made them; in fact they weren't doing any work for the practice. In spite of my completing lab prescriptions in good faith, the work was being diverted under orders of the new "boss" to a cheaper laboratory. Again, it was news to me. Again, I gave notice and this time they decided to lock me out after a few weeks, as I was "being disruptive". In both cases, trust had been lost.

Since then I have heard dozens of stories where there has been a breakdown in relationships because one or both parties have been less than completely honest, either with the other party or with themselves.

I have been asked by lawyers to help when both sides are deadlocked. It came as a surprise initially that most reasonable solicitors would advise their clients to explore a negotiated outcome in order to avoid escalation and massive fees.

Of course in every business, and personal relationship, there will be disagreements. But there are things that you can do to avoid or at least minimise problems. Ask yourself whether you are worthy of trust and if you trust the other person involved. In the UK & Ireland, trust in any dental system that involves government is at an all time low. The replacement of trust in professionalism by inspections typified by the CQC in England has further undermined confidence.

Management structures have eroded trust; the introduction of targets has resulted in a blurring of what good performance means. The growth of corporates has resulted in an evolution of relationships, not always for the better. Of course everyone must have a contract, in writing, but any contract is open to interpretation. As one of my favourite lawyers pointed out to me, "the longer and more detailed the contract, the more there is for me or my colleagues to pick away at and challenge". One test is clarity. Do you and your colleagues both understand what you are agreeing? Is the language clear to both sides?

Above all, communication and contact are essential if a relationship is to endure. All circumstances change and the context of relationships vary. We are expected to show empathy to patients, what about to each other?

Baroness O'Neill says she doesn't want more trust as such, but aims to have more trust in the trustworthy, but not in the untrustworthy. Are you trustworthy? Are you seen to be trustworthy? Can that trust survive testing?

> "ARE YOU TRUSTWORTHY? CAN THAT TRUST SURVIVE TESTING?"

Alun K Rees BDS is The Dental Business Coach. An experienced dental practice owner who changed career, he now works as a coach, consultant, trouble-shooter, analyst, speaker, writer and broadcaster. He brings the wisdom gained from his and others' successes to help his clients achieve the rewards their work and dedication deserve.

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Orthodontic treatment of an adult patient with a history of previous orthodontic treatment and gingival recession

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A 29-year-old female presented in November 2019 at The Orthodontic Clinic, Aberdeen. Her main concern was the "twisting of the upper front teeth". She was also concerned about the health of her gums as she had been told by her dentist that she was "brushing too hard".

She was keen to improve her aesthetics, which affected her self-confidence, but ultimately she was more concerned about the "long-term health of her teeth and gum tissues".

The patient's medical history was non-contributory. Her general health condition was good, she did not take any medications, had no known allergies and was a non-smoker. She had mentioned during the history-taking interview that she had undergone previous orthodontic treatment as a teenager, having had upper and lower fixed appliances with the loss of upper premolars, with treatment lasting approximately two years, from her recollection. She failed to wear her retainers and was now aware her teeth had become crowded again. She also reported that she had subsequent problems with recession affecting her lower right central incisor although had no symptoms. When she became pregnant, she reported that her gum condition deteriorated and she felt that she was becoming more prone to generalised recession, albeit with no symptoms.

Extra-oral examination:

- Class 2 mild-moderate skeletal pattern
- Average Frankfort-Mandibular Planes Angle
- Average facial proportions - Normal lower face height
- No asymmetry

Intra-oral examination:

Teeth present:

765 321/123 567
7654321/1234567

- Upper 4s missing (extracted as part of previous orthodontic treatment)

BPE scores:

1/0/0
0/2/0

- Oral hygiene fair
- Supra-gingival plaque and calculus deposits lower 2-2 with bleeding on probing from LR1 (labially)
- No pockets greater than 3.5mm
- Gingival recession was noted mainly in the upper and lower anterior regions, particularly at LR1 and UL1 (2mm) Recession noted on labial/ buccal aspects of:
- 1mm on UR2, UR3, LR7, LL1, LL2, LL3, LL7
- 2mm on UR1, UR6, UL1, UL6, UL7, LR6, LR2, LR1, LL6
- Thin periodontal biotype
- No mobility noted

Occlusal features:

- Class 2 division 2 incisor relationship
- Overjet 2mm, Overbite 50%
- Molar relationship RHS Class 2 (1/2 unit), LHS (Class 2 3/4 unit)
- Canine relationship RHS Class 2 (1/2 unit), LHS (Class 2 3/4 unit)
- No crossbites
- Lower centreline to the right by 1.5mm

Figure 1.
Pre-treatment extraoral and intraoral photographs

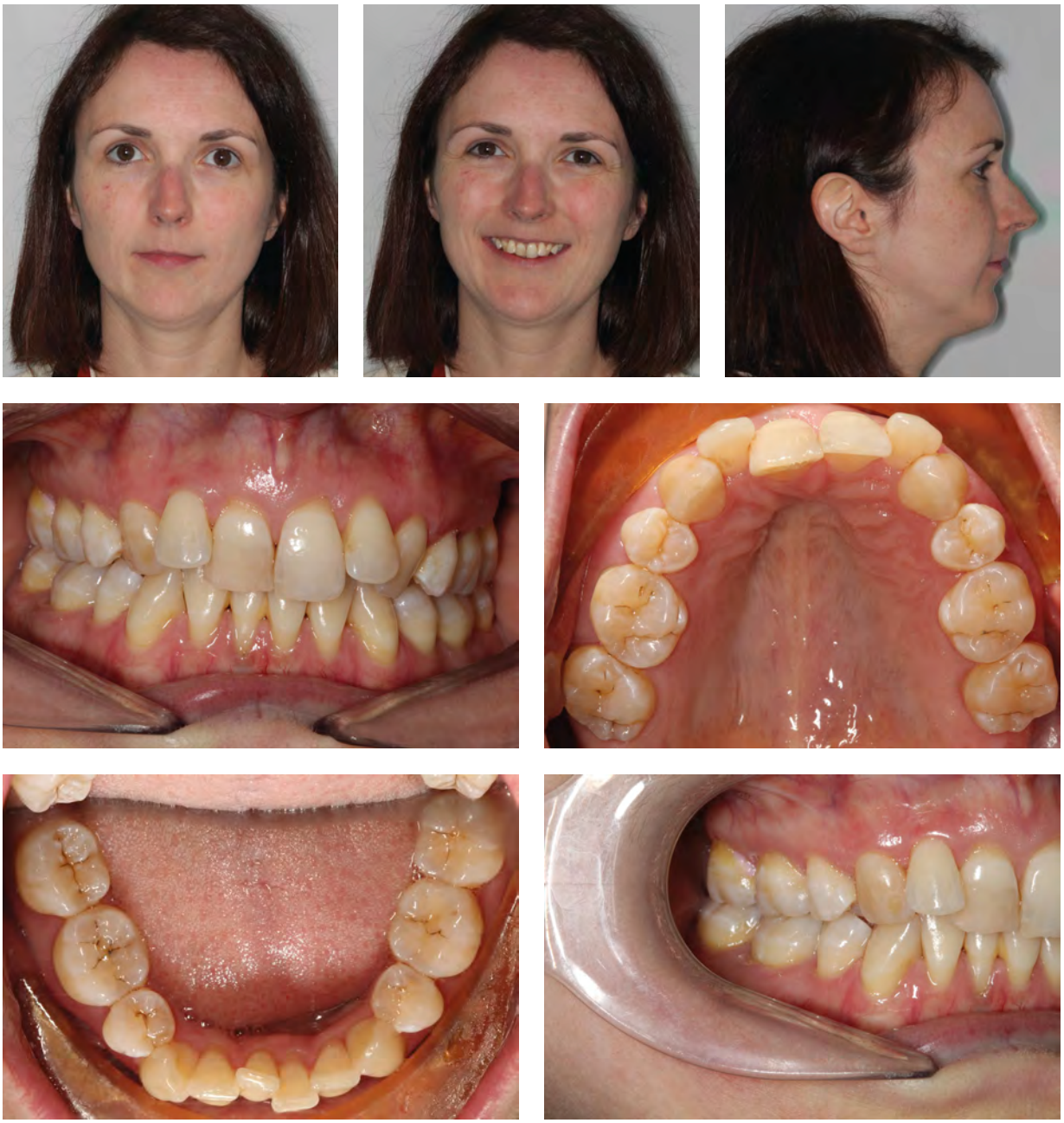
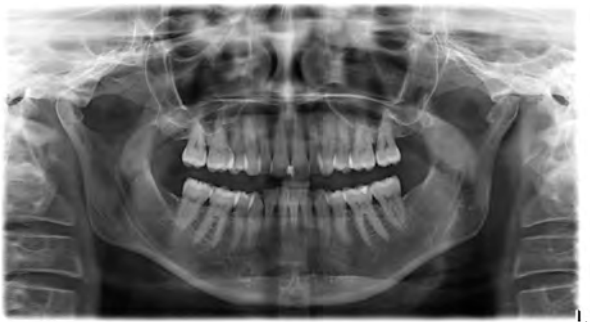


Figure 2.
Pre-treatment panoramic radiograph



Treatment Plan

1. Oral hygiene instruction
2. Full mouth scaling
3. Upper and lower fixed or Invisalign appliances
4. Upper and lower fixed and removable retainers to maintain the orthodontic result

The patient was informed that the treatment would take approximately 18 months with the expectation for the maintenance of excellent oral hygiene throughout, with regular visits for adjustment of her braces (every six to eight weeks). Following her active orthodontic treatment, she would require long-term (lifetime) retention to maintain the orthodontic result. The patient was warned of the usual risks of orthodontic treatment (decalcification, root resorption, loss of vitality, relapse), but especially of the potential for progression of the recession and the need therefore for close monitoring of this.

The orthodontic treatment objectives were essentially to improve overbite, relieve crowding and align both arches while being respectful of the periodontal tissues (it was important that there should not be any worsening of any areas of recession):

1. Secure optimal oral hygiene before starting orthodontic treatment
2. Eliminate dental crowding, intrude the upper centrals, level and align the teeth.
3. Obtain ideal overbite and overjet
4. Achieve a mutually protective functional occlusion
5. Retain the orthodontic result.

The periodontal treatment objectives for this patient consisted of the delivery of initial debridement, followed by customised oral hygiene instruction, and then the maintenance of good oral hygiene. The initial periodontal therapy was directed towards providing an environment conducive to long term maintenance:

1. Initial visit to the general dental practitioner for full mouth scaling
2. Maintenance visits for scaling as necessary thereafter.

After discussion and considering the risks and complications, the patient decided to proceed with treatment, opting for upper and lower fixed appliances. She was duly consented to treatment, and she opted for a combination of upper ceramic brackets and lower metal brackets.

After her visit for full mouth scaling with her dentist, she was first seen for review, and it was found that the patient was maintaining a good level of toothbrushing, and her interdental cleaning was significantly improved. BPE scores were found to be 0 in each sextant, except in the upper right, where it scored as 1.

Treatment progress

Orthodontic treatment started in November 2019 and was completed in April 2021, with an overall treatment time of 17 months and requiring 9 visits.

Pre-adjusted edgewise brackets (0.022x0.028- in, MBT prescription, upper ceramic brackets, lower metal brackets) were bonded to all the teeth.

Upper and lower 0.014-in nickel titanium archwires were placed and treatment progressed up to 0.019x0.025-in stainless steel archwires. Initial alignment followed by levelling in the upper and lower arches was achieved in nine months. Upper and lower 0.019x0.025-in stainless steel archwires were maintained for eight months in order to fully express the torque. Resultant spaces were closed using power chain and Class 2 elastics.

At the debond appointment, oral hygiene was good, with BPE scores of 0 in each sextant and no progression of recession from her initial presentation.

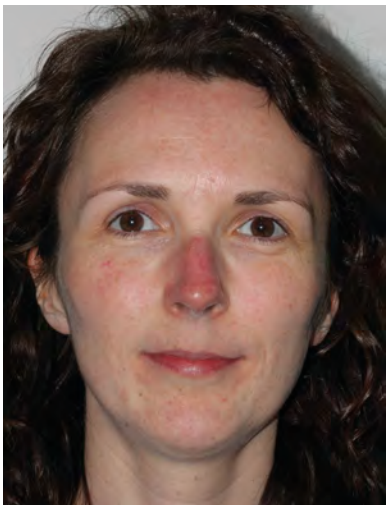
In terms of retention of the orthodontic results and long-term follow up, both removable (vacuum-formed) and fixed wire retainers were used in both the upper and lower arch to aid long-term stability and because of the good compliance of the patient with her oral hygiene. Follow up was carried out on a three-monthly basis (and will continue for up to two years) to monitor retention and six-monthly hygiene visits with her dentist have been recommended in the long-term. The patient was instructed to wear her removable retainers on a full-time basis for two weeks and then to continue wearing the retainers at night indefinitely.

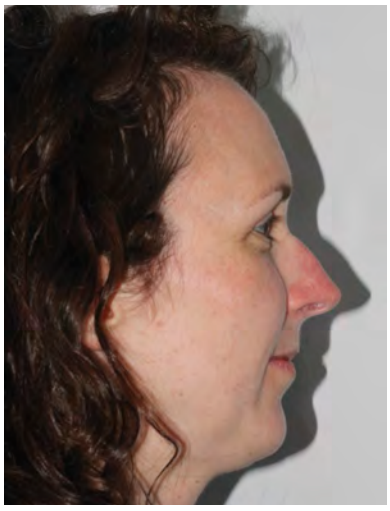
Treatment results

Figure 4 shows the final outcome of the case. The post-treatment frontal photograph showed that there was significant improvement of her facial aesthetics and her smile. The facial profile was also improved minimally with increased upper lip support following the new position of the incisors.

The patient was more confident overall and felt her bite was more comfortable and that she was able to maintain her oral hygiene more easily.

Figure 4. Post-treatment facial and intraoral photographs





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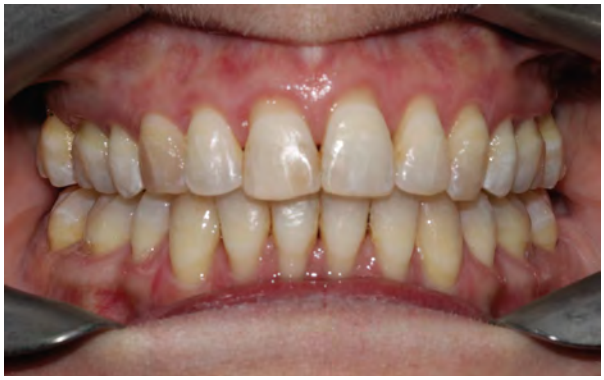
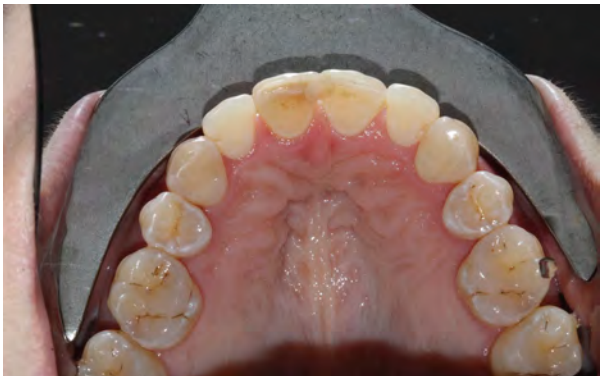
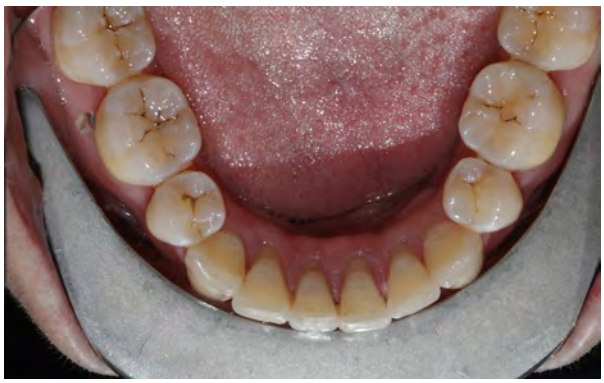
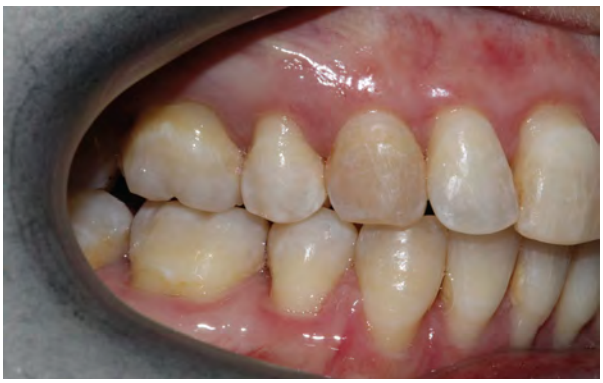
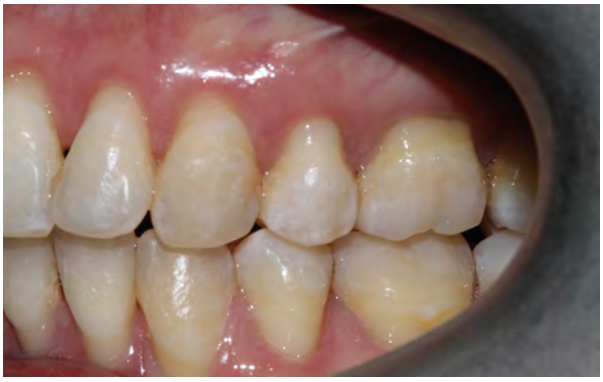






Discussion

Gingival recession is a common condition characterised by the displacement of the gingival margin apically from the amelo-cemental junction (ACJ) and the exposure of the root surface to the oral environment. For a patient, gingival recession usually creates an aesthetic problem and fear of tooth loss due to progressing destruction, and it may also be associated with dentine hypersensitivity and/or root caries, and cervical wear.

The aetiology of gingival recession is multifactorial. Several factors may play a role in recession development, i.e., excessive or inadequate teeth brushing; destructive periodontal disease; tooth malpositioning; alveolar bone dehiscence; thin and delicate marginal tissue covering a non-vascularized root surface; high muscle attachment and frenal pull; occlusal trauma; lip piercing; and iatrogenic factors related to reconstructive, conservative periodontal, orthodontic, or prosthetic treatment.

In this case, it seemed that there was a correlation between the gingival recession and past orthodontic treatment, and it was suggested that orthodontic tooth movement may have led to recession, although it cannot be considered as the sole or primary reason for this. Predisposing factors of recession include thin gingival tissues, decreased alveolar bone crest thickness, prominent root surface, buccally positioned teeth, and bone dehiscences. This patient had a thin periodontium and this was certainly a risk factor in her past and present treatment.

In terms of orthodontic treatment planning, these risk factors made it important to carefully control the amount and direction of orthodontic forces. Forces were kept light, gradual and applied to groups of teeth rather than single units. Archwires were changed in a step-wise fashion, and only carried out once the previous wire was passive.

In the lower arch, the curve of Spee flattened by the proclination of lower incisors and extrusion of lower posterior teeth, correcting the overbite.

The placement of glass ionomer "bite props" placed on the occlusal surface of the lower molars eliminated occlusal trauma from the upper incisors on the lower incisor brackets and helped facilitate correction of the deep bite.

The upper arch was aligned by proclination and some expansion. There was some transient increase of the overjet which was corrected by simultaneous proclination of lower incisors and intrusion of the upper incisors, together with Class 2 elastics.

Conclusion

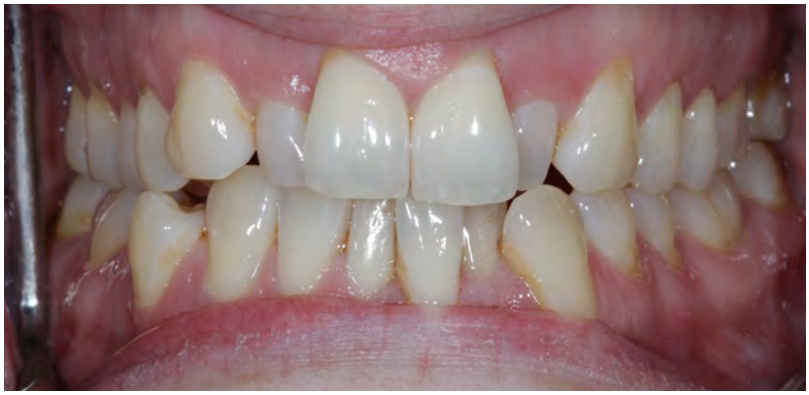
Management of patients with recession (or those who have predisposing factors that make recession a risk) can be a challenge for the orthodontist. The importance of the patient having good oral hygiene before, during and after orthodontic treatment, as well as the careful application of orthodontic forces, are significant factors in allowing the improvement of the function, aesthetic and periodontal health of the patient.

Declaration of patient consent

The author certifies that they have obtained the appropriate patient consent. The patient has given her consent for her images and other clinical information to be reported in the publication.

Patient's simple case of anterior alignment using clear aligners and a digital workflow

Dr Sami Butt
Principal, S3 Dental, Haywards Heath



The patient was unhappy with her lateral incisors which were tucked behind the centrals

A female patient in her early 40s presented to the practice. She was unhappy about the appearance of her prominent anterior teeth – especially the laterals, which were tucked behind the centrals – and she had quite a lot of crowding in the lower arch. The patient was seeking options for aligning the anterior teeth without fixed appliances, as she wasn't keen to have wires and brackets given her age and lifestyle.

A full dental history was taken, with no issues or abnormalities detected. The comprehensive oral health assessment also demonstrated no concerns, with no active disease or existing restorations.

Before treatment

After treatment

Treatment planning

To begin the treatment planning phase, clinical photographs and intraoral scans were taken with the 3Shape Trios scanner. These were quickly and easily uploaded to the ClearCorrect® Doctor Portal (Straumann Group), where an initial treatment simulation was produced. This is used to ensure the suitability of the case for treatment in this manner and to give the patient a visualisation of what the final result could look like for informed consent. The technology also integrates very well to ensure a smooth and efficient digital workflow from start to finish.

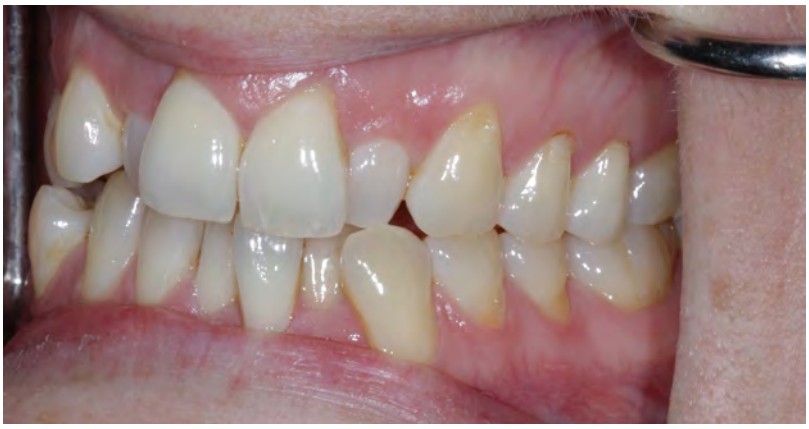
At this point, the entire treatment sequence was explained to the patient in detail, describing all the potential benefits, limitations and risks. There were two main concerns that needed to be communicated. The first was that the central incisors were quite triangular in shape, which increased the chance that black triangles would form as the teeth moved. The second potential issue was some existing gingival recession that could become worse during alignment. Both these issues were explained to the patient, who was happy to take the risk. She had the opportunity to ask any questions and once completely happy, provided consent to proceed.

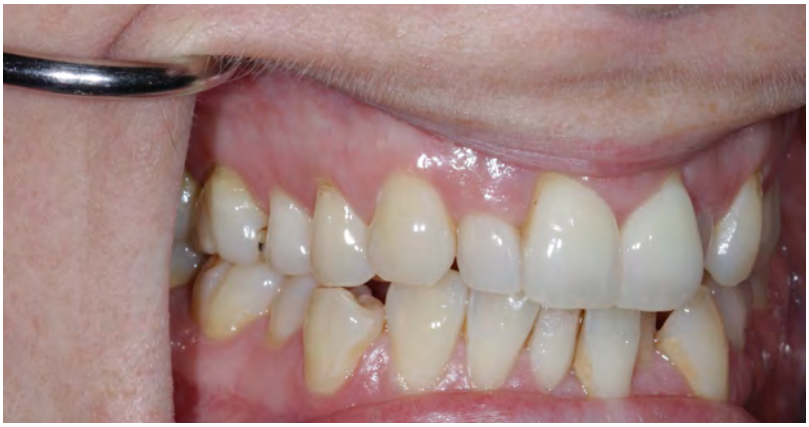
Treatment provision

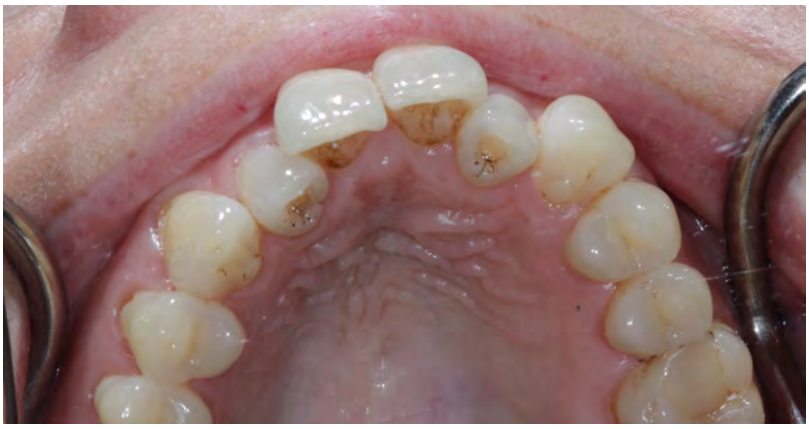
The ClearCorrect® aligners were fabricated and returned by the laboratory, and the first was fitted on the patient. She was shown how to safely place and remove the aligners and was instructed to wear them for at least 22 hours per day. The Unlimited treatment option was selected and we ended up using a total of 26 aligners throughout the course of treatment.

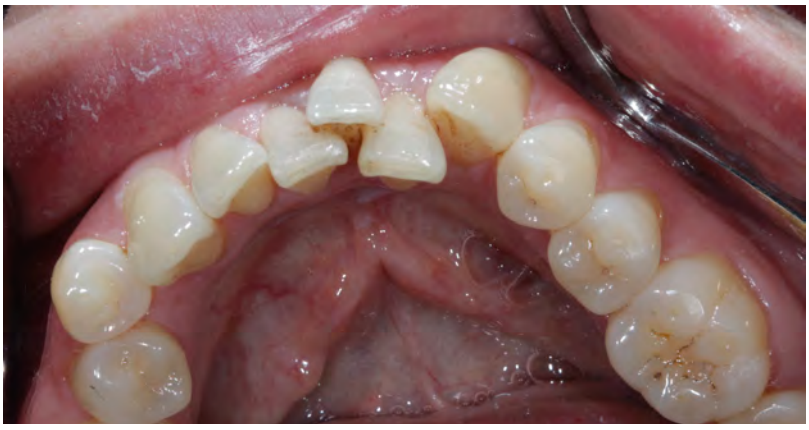
The patient returned to the practice every few weeks for review and for interproximal reduction (IPR) to be performed to create space for tooth movement. Overall, 2.5mm of IPR was completed progressively. Engagers were placed on the UR3, UR1, UL1 and LR3 at six weeks into treatment to encourage the desired movement/rotation.

The patient's compliance with wearing the aligners was excellent and treatment proceeded as planned. Alignment was very nearly finished when the UK went into its first national lockdown, but the patient was able to continue wearing her final aligner to prevent the teeth from relapsing. I was in contact with her and explained that we would need to wait until she could visit the practice to remove the engagers and take a final impression for the retainers,









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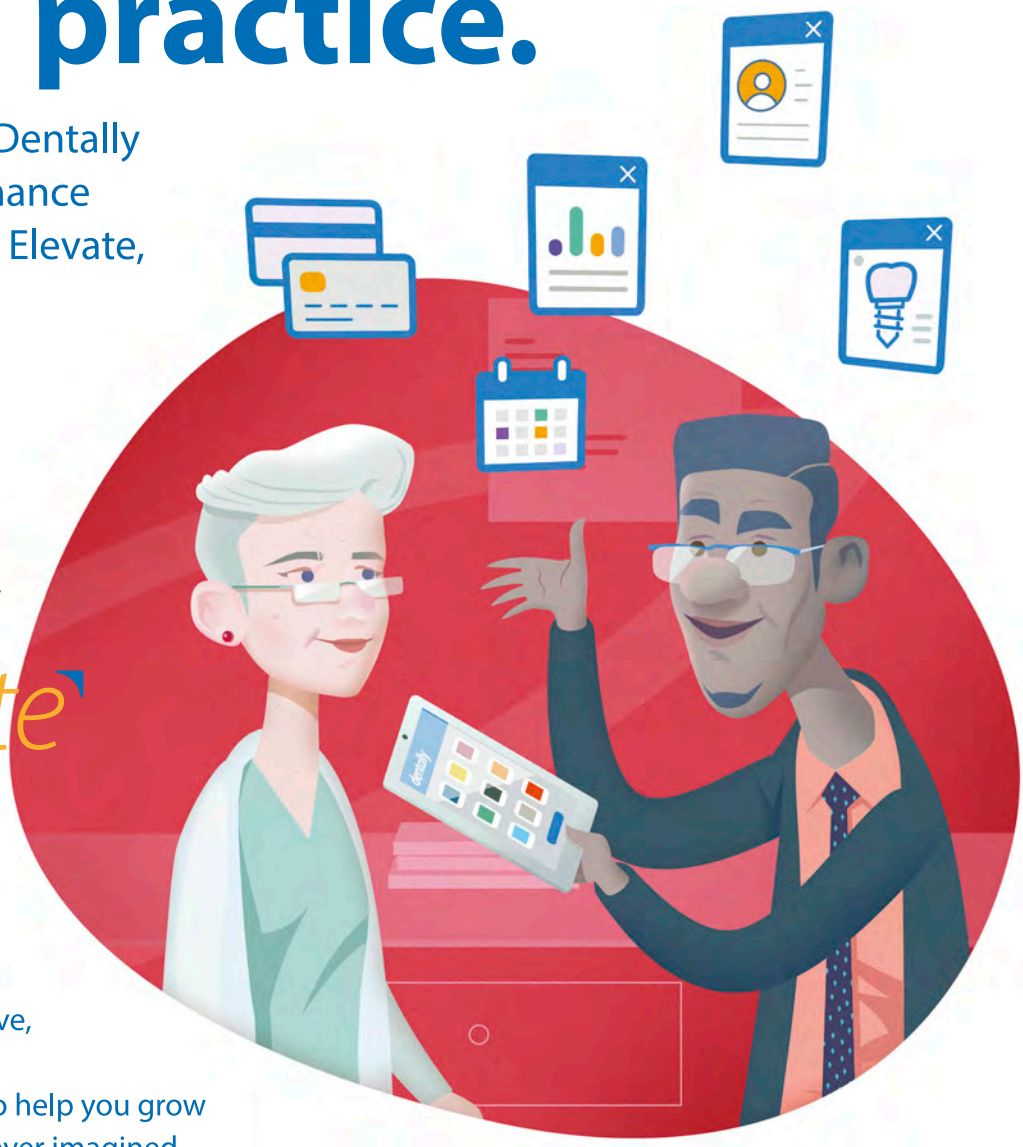

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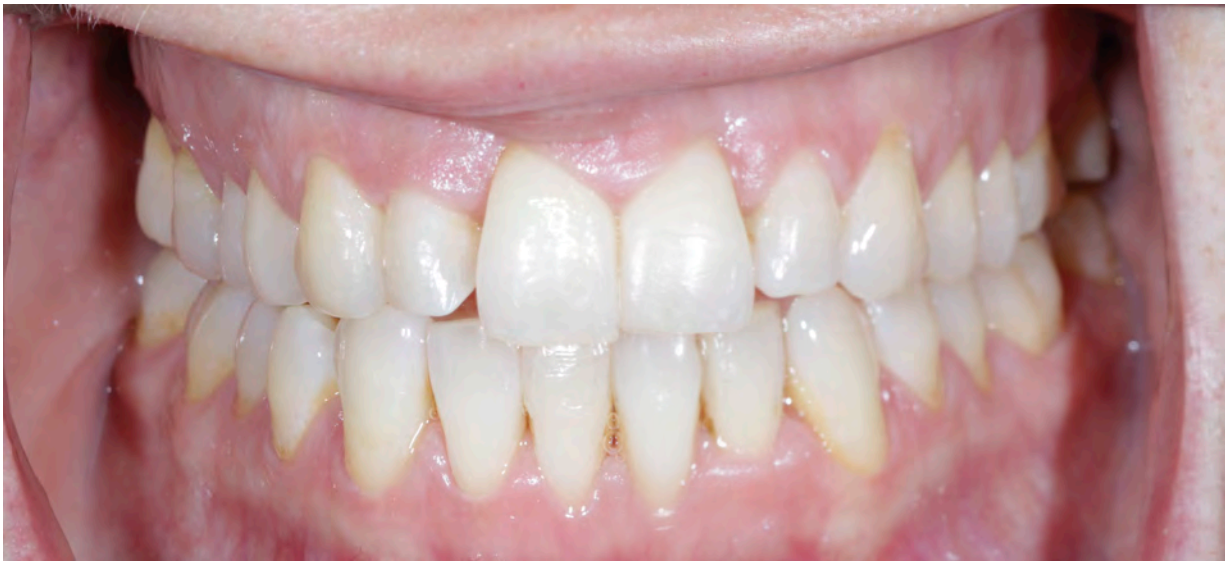
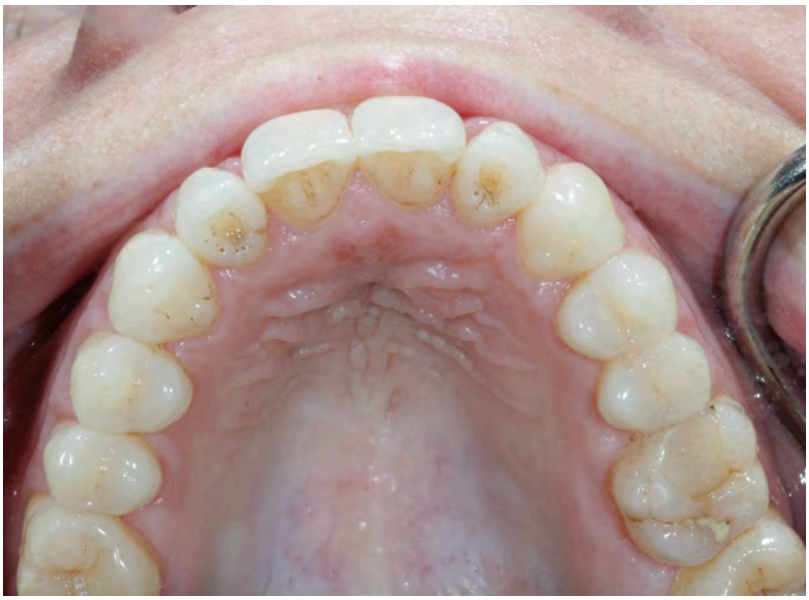


which she understood. Providing an extra level of security, we would have been able to make and send out a new aligner if hers had broken at all during lockdown, though this wasn't necessary.

Though the patient's oral hygiene remained good throughout treatment, her love of tea and coffee did cause some staining on the teeth. Once the world has settled down slightly and some more normality returns, she hopes to come back to the practice for some aerosol removal of the surface stains and possibly also some tooth whitening. However, even without these finishing touches, the patient is extremely happy with what was achieved with alignment only.

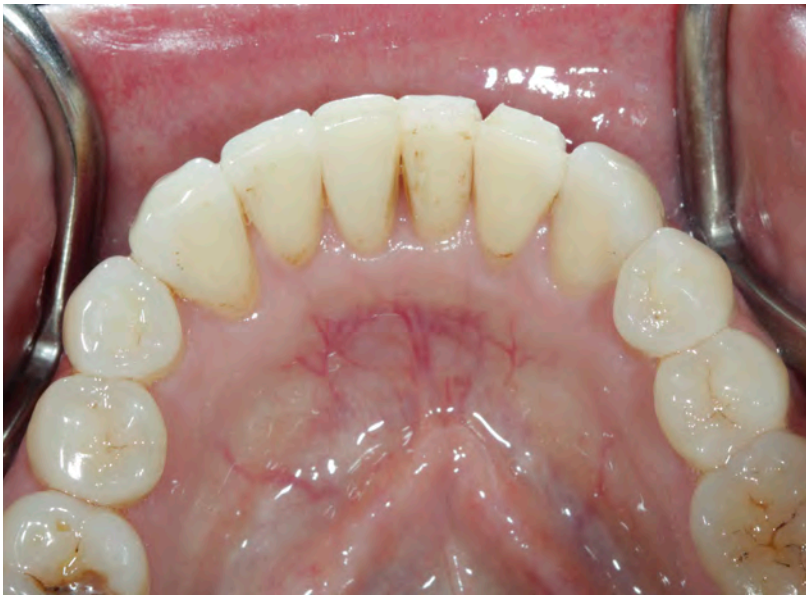


Case review

In hindsight, when reflecting on the post-treatment images, I would have liked to tweak the lateral incisors a little more. However, the patient didn't see this as an imperfection and, as it was her decision to stop treatment, I had to respect that. As I have said before, patients are often happy to conclude alignment before the clinician, but this is only because we scrutinise the smallest clinical details that sometimes don't matter to the patient.

I was also pleased to find that the two initial concerns I had about this case did not turn out to be a problem. Black triangles did not form, although the central incisors are still a little prominent.

This patient would be a good candidate for block bonding and contouring in the future if she is interested as an effective follow-up treatment. In addition, the gingiva remained stable during alignment and no further recession occurred.



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› ORAL B

ORAL-B IO™ 10 WITH IOSENSE™

Give your oral health routine a smart upgrade

Oral-B® is pleased to announce the iO™ 10 with iOSense™, which is set to revolutionise the way we brush our teeth with a personalised experience like never before. It is accompanied by a smart device called iOSense, which offers real-time guidance with the aid of AI and a personalised brushing experience that ensures healthier gums and teeth. It guides you when to brush: the iOSense has a timer for optimal brushing time and a Wi-Fi clock. It also tells you where to brush: the intuitive iOSense lights mean you'll never miss a spot. And last, but not least, it tells you how to brush: the Oral-B® App tracks your goals and provides personalised feedback after every brushing.

Oral-B® iO's revolutionary micro-vibration technology removes 100 per cent more plaque than a manual brush to give you that professional clean feeling, at home, improving your oral health and contributing to better overall body health. Using iO10 is also a truly sensorial experience that will transform the act of brushing into something you have to do into something you want to do.

The Oral-B® iO 10 Design comes in two new galactic-inspired brush designs, cosmic black and stardust white.

www.oralb.co.uk/en-gb/join-oralb-io10-waitlist

› ORAL B

IO SPECIALISED CLEAN HEAD

Oral-B has launched a head to fit their iO range of electric toothbrushes called Specialised Clean. It features tufted bristles for cleaning around implants and interdental spaces. Periodontist Dr Amit Patel tried the head in advance of launch and found it helped patients access and clean hard-to-reach areas. He added: "It helped patients improve their oral hygiene around their implants, too". He selected ten implant patients to test-drive the head. Those who were showing evidence of bleeding on probing and inflammation of the peri-implant tissues were given the brush for three months and re-evaluated clinically and with an open-ended questionnaire.

The feedback was positive, and patients said their teeth 'had never felt cleaner' and that their gums felt better with no associated bleeding.

Some suggested it was far easier to use the head in the posterior region interproximally than interdental brushes, especially if they had larger spaces. Clinically, all patients showed a significant improvement in bleeding on probing around their implants due to the reduction in plaque in these sites. "On-going periodontal therapy is well supported by patients using the Oral B iO and the Specialised Clean head has a role in the maintenance of their implants," he said.

If you would like a sample of the new brush head, please contact your local Oral-B Territory Manager for more information or call 0870-2421850 or email customerservice@dentalcare.co.uk.

› CARESTREAM

THE CS 8200 GOES NEO

Building from the success of the popular CS 8200 3D CBCT system, Carestream Dental has recently launched a new variation – the Neo Edition.

Combining the accessibility of the standard edition with new streamlined acquisition workflows and exclusive features, the CS 8200 3D Neo Edition is the pinnacle of power and performance.

Benefit from absolute 2D/3D imaging versatility, the broadest range of fields of view for systems in its category and unique software such as CS MAR – Carestream Dental's imaging module that reduces the appearance of metal artifacts for truly dynamic diagnoses.

Want to find out more? Please contact the team at Carestream Dental today.

For more information, contact Carestream Dental on 0800 169 9692 or visit www.carestreamdental.co.uk For the latest news and updates, follow us on Facebook and Instagram @carestreamdental.uk

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The use of ultrasound technology in aesthetic medicine practice and training

by Dr Simon Ravichandran

Dr Simon Ravichandran has been involved with Merz Aesthetics as a key opinion leader for more than a decade. From his perspective, Merz has been a driver of innovation in the field both in terms of the products they develop and their commitment to education.

With a technology-driven approach to teaching, Merz Aesthetics have incorporated a program of education based around visualisation with ultrasound that brings to life the textbook concepts we typically learn about.

My journey with ultrasound

We started using ultrasound in our clinic – Clinetix, Glasgow – in about 2010. This was about the time that we started to inject deeper into the tissue planes and use cannulas alongside needles. We had a clinical device for vascular mapping, and we thought we could use that to see if we were right about the placement of our products. Was it in the right place? In the correct tissue plane? What I found was I wasn't always where I thought I was. In fact, I was practically never where I thought I was.

Initially, we found the ultrasound helpful in speeding up the learning curve with the new techniques that were evolving at the time. We also found it a useful tool from time to time when dealing with complications.

For me, the learning process was initially slow, but this was a long time ago. I'm not a radiologist, and there wasn't much available in terms of cranial/facial scanning courses at that time, so I gradually became familiar with the appearance of the different tissues and the different fillers over a long period of time.

My first device actually cost me a lot of money and weighed as much as that same suitcase filled with bricks. It had really poor resolution with grainy green images that honestly were really difficult to interpret.

Now with the latest handheld, high-resolution, high-frequency devices, we can see so much more. These wireless devices can be carried around in a pocket, like a mobile phone, and produce much better images. It's made it so much faster to learn and faster to scan with greater clarity and confidence.

The skill of recognising and interpreting the images just comes with repetition. With each patient I now scan, I can see a little more, which enables me to identify the smaller muscles in the face and visualise the distribution of the arterial networks with relative ease.

"Ultrasound has now become a routine part of my treatment plan, just like putting on a seatbelt in a car, and I won't run an aesthetic clinic without it"

I've realised that there are so many variations in the blood supply to the face, and we can never truly predict where we might cause a significant bruise or a vascular occlusion. I've modified my treatment plan based on what I see on the scan enough times to now feel that I'm essentially flying blind without it. Ultrasound has now become a routine part of my treatment plan, just like putting on a seatbelt in a car, and I won't run an aesthetic clinic without it. We use it for facial mapping, patient education and our own development. It allows us to tailor our treatment plans individually for every patient to get what we feel is a more effective, optimal result.

In the right plane

Just from the routine scanning of patients presenting to our clinic, we can demonstrate that filler intended for the deep plane of the midface can actually be within the Superficial Musculoaponeurotic System (SMAS). And filler intended for the interfacial, or the plain of the temple can sometimes be subcutaneous, intramuscular or intrafascial, rather than interfacial. Ultrasound guidance means that we can see the tip of the cannula in the right place whilst we inject, rather than finding out afterwards that we have a suboptimal result.

This applies to the area, but what I've really found useful is using this guided injection method for the cheeks and for the temples. For the cheeks, when I thought I was in the deep plane, occasionally I actually found I was within this mass, Superficial Musculoaponeurotic System (SMAS). So I can reposition, get in the right place, use less product and get a much better aesthetic result. For the temples, ultrasound guidance means that I really can be sure that I'm in that interfacial plane when I want to be. And when I'm injecting on the bone, I can make sure I'm in a place that's effective and has no visible vasculature.

Visualisation means greater accuracy, greater effectiveness and greater safety of dermal filler implantation.

This advertorial is sponsored by Merz Aesthetics UK & Ireland

Now every patient undergoing a dermal filler procedure has an ultrasound scan, and it's usually done immediately before the treatment, although we can sometimes do it at the consultation. The primary goal is to identify any vascular patterns that may make me consider my approach, particularly in the lip area where we've already found patients with very superficial superior labial arteries, where we would definitely be using a cannula over a needle and still be injecting with a degree of slow caution.

For particularly technically challenging areas, I often use the ultrasound for guided injection as well. For example, to ensure sure that I'm in the correct planes and away from blood vessels. Examples would be the forehead and the temples, and the nose. The other area of interest for us is the management of complications. Being able to identify dermal filler and resolve with injection under ultrasound guidance means that I can be so much more confident in the outcomes of my treatments.

A vital training tool

A common theme in many of our teaching programs, both for Aesthetic Training Academy (ATA) and Merz, is a respect for and understanding of the anatomy of the patient. Now, that doesn't just mean understanding the names and the branches and relations of a blood vessel or a nerve but also being aware of all the potential anatomical variations that may occur and could potentially be a problem.

That you need to know that is a truism, but given that you have no way of knowing what variations a given patient may have, the teaching can sometimes be more off-putting than useful. So bringing into play a simple, effective method for identifying your patient's nasolabial artery, for example, and more so a method that the practitioner can use in their own practice with relative ease, suddenly makes that teaching more informative, more useful, more applicable, and more engaging.

The use of ultrasound imaging in teaching with Merz Aesthetics and ATA really brings to life the concepts we talk about and gives the delegate an extra dimension of understanding.

How to get started

We used to give presentations and run training courses using ultrasound, and we used it mainly as a teaching aid because it was impractical to suggest that every clinic should have its own device. With modern ultrasound technology, this is no longer the case.

My advice is to buy an ultrasound device or borrow one, then pick an area that you are familiar with and get started. The basic principles of ultrasound imaging are that hyperechoic tissues bounce the signal back, and they're white. Hypoechoic tissues allow the signal to pass through, and they're dark. Fat is hypoechoic, water is hypoechoic, and muscles are mostly cells filled with water. Collagen fibres don't have much water in them. They're dense, and they bounce the signal back.

Then pick something simple and big, like the masseter muscle, hold the probe over it in different orientations and try to identify the structures, the skin, the fat, the muscle, and then the facial pedicle. Find those blood vessels and then look for the bone. And the bone is very dense. There's no water, and it's very hyperechoic, so it's white. Do it a few times over the same areas and the same structures until you can always recognise them. And that's the process of training your brain to interpret the light and dark images and build those into a representation of the tissues that are there. Then start moving into a different area and find a similar stepwise process to identify those structures and keep going.

In conclusion

Ultrasound imaging brings us to the next evolutionary step in aesthetic medical practice. No longer having to inject blindly means that we have the ability to identify and avoid larger blood vessels, reducing the risk of bruising and potential vascular compromise.

Patients attending a practice where ultrasound imaging is used routinely can be confident that their practitioner is using every tool in the box to ensure that they have an effective treatment. Using ultrasound means that we can position our dermal filler exactly where we need it to be, meaning better aesthetic outcomes and potentially less product.

We have already chosen the product with the best radiological profile for bio integration, and we use the products with a really good profile in terms of inflammatory reactions. We do this because we want the best for our patients, which means our patients trust us. Adding ultrasound is another obvious and visible step in the process. So, in addition to improving outcomes, reducing risk, improving the aesthetic outcome, we're also improving trust alongside confidence, which itself leads to higher patient-reported satisfaction.

I think we're approaching the point where guided injection and vascular mapping will become part a normal part dermal filler injections.

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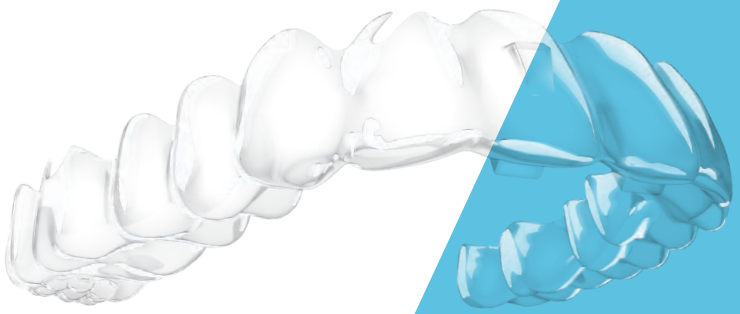

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