DENTAL HEALTH
The Journal of the British Society of Dental Hygiene and Therapy

THE TREATMENT OF LOCALISED GINGIVAL RECESSION

ROOT CARIES AND THE OLDER PATIENT

ORAL HEALTH AMONG NANYANG POLYTECHNIC
The mission of BSDHT is to represent the interests of members and to provide a consultative body for public and private organisations on all matters relating to dental hygiene and therapy. We aim to work with other professional and regulatory groups to provide the highest level of information to our members as well as to the general public.

The Society seeks to increase the range of benefits offered to members and to support this with a clear business and financial strategy. The Society will continue to work to increase membership for the benefit of the profession.

EDITOR
Heather I. Lewis,
19 Cwrt-y-Vil Road
Penarth, Cardiff CF64 3HN
Email: editor@bsdht.org.uk

BSDHT NATIONAL ENQUIRY LINE
Tel: 01788 575050
Email: enquiries@bsdht.org.uk

ADVERTISING SALES
Fay Higgin
Email: sales@bsdht.org.uk

CLASSIFIEDS & JOBLINE
Tel: 01788 575050
Email: enquiries@bsdht.org.uk

PUBLICATIONS COMMITTEE
Alison Lowe
Patricia Macpherson
Emma Pacey
Elaine Tilling
Miriam Khan
Marina Harris

EDITORIAL BOARD
Andrew Gould
Ian Dunn
Kenneth Eaton
Fiona Collins

Annual Subscriptions for non-members: £90.00 per annum
UK 6 issues including postage and packing. Air and Surface Mail upon request.

© Dental Health – The British Society of Dental Hygiene and Therapy 2017. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, mechanical, photocopying or otherwise without the prior permission of Dental Health.

Views and opinions expressed in Dental Health are not necessarily those of the Editor or The British Society of Dental Hygiene and Therapy.

This magazine has been Carbon Balanced, saving 1336kg of carbon and preserving 112.22 sq. metres of land.

Printed on Regency Satin by:
Cross Printmedia, Newport Business Park,
Barry Way, Newport, Isle of Wight PO30 5GY.
Tel: 01983 524885  Email: info@crossprint.co.uk
Editorial
From the President
Regional Group News
BSDHT Indemnity
What students have to say about studying Dental Hygiene and Therapy
BSDHT OHC 2016
BSDHT Dental Research Poster Competition 2016
Great conference - great reunion!
Another 500 miles for smiles
Sign posting to excellence...The BSP’s Good Practitioner’s Guide to Periodontology
Withdrawing your services
The secret of goal based planning
Root caries and the older patient
The treatment of localised gingival recession
Behaviour and attitude to oral health among Nanyang Polytechnic
Clinical Quiz
CPD
Oracle
Recruitment

www.bsdht.org.uk
British Society of Dental Hygiene and Therapy
Promoting health, preventing disease, providing skills
FREE VERIFIABLE CPD LECTURES

UP TO DATE

PREVENTION | KNOWLEDGE | CONTINUED EDUCATION

NEW LECTURE SERIES
Scientific Exchange Seminar for Dentists, Hygienists and Therapists*

‘The Recession Obsession’

Philip Ower

‘Clinical Strategies to Prevent and Manage Dental Erosion’

Professor Nicola West

Venues

LONDON
Thursday 3rd November.
Hilton Hotel,
Watford,
WD25 8HA

EDINBURGH
Monday 14th November.
Houston Hotel,
EH52 6JS

BRISTOL
Monday 21st November.
Aztec Hotel,
BS32 4TS

BIRMINGHAM
Monday 20th February.
St John’s Hotel,
Solihull,
B91 1AT

LEEDS
Thursday 9th March.
Village Hotel North,
LS16 5PR

MANCHESTER
Thursday 27th April.
Copthorne Hotel,
M50 3SN

NEWCASTLE
Thursday 4th May.
Hilton Hotel,
Gateshead,
NE8 2AR

Register on-line: www.dentalcare.co.uk/uptodateseminars

For enquiries please email: customerservice@dentalcare.co.uk
The dentalcare.com customer service number is: 0870 242 1850

Registration and buffet from 17.45

Evening concludes at 21:00

Every participant receives 2.5 hours of Verifiable CPD

* Oral-B offer free CPD support to all. Other members of the dental team can gain three hours of free verifiable CPD by requesting a copy of ‘Dental Summary Review – Team Issue’. You can get these from your local representative. If you’re unsure who your representative is, please call 0870 242 1850.
Money, money money…

A very Happy New Year to all our readers. Here at Dental Health the team is looking forward to the coming year and continuing to provide you with a journal that updates, motivates and inspires you to be the best clinician you can be.

At the OHC in Belfast, last November, the Publications Team carried out a survey among delegates to discover if we are doing just that - supplying you with what you need to do your job. We were so pleased with your willingness to engage with us that we have extended our short survey for the next few weeks on line. By now, you should all have received an email inviting you to respond. Please do take the time to answer our short questionnaire – your feedback is really important to us.

Please also remember to visit the website regularly to read the news updates in DHContact ONLINE.

One rather controversial piece of news that I bring to you is from the Cabinet Secretary for Health Wellbeing and Sport in Wales, Vaughan Gething, who has announced that NHS Bursaries for eligible dental hygiene and therapy students will continue to be available in Wales in 2017/18. This is great news for those students about to embark on their chosen career pathway.

Similar to dental students who have signed up to the armed forces for a number of years post qualification, it is proposed that the bursary awarded will be based upon individuals committing in advance to taking up the opportunity to work in Wales. It has been suggested that this may be for a period of two years.

If this is indeed the case then this offer of a bursary to fund study, with the expectation of a guaranteed job, must be welcomed and will be attractive to prospective students. Welsh Government is obviously wishing the Senedd to be seen to be investing in those individuals who want to make a commitment to the NHS and delivery of dental healthcare in Wales. So let’s hope that they will do just that… create jobs for Dental Hygienists and those dually qualified in hygiene and therapy for the first two years of their careers.

Similarly, in England, Dental Hygienists and Therapists, along with nurses, midwives and other Allied Health Professionals are funded through the NHS scheme and Health Education England (HEE), which offer living costs and student tuition fee support. However there is great disparity in the method of awarding these bursaries in England and it has been decided that they will end this summer for many health care professional groups. The exception is Dental Hygienists and Therapists where the bursary will remain in place, for the time being. This will allow a period of time for the HEE workforce team to review alternative funding methodologies.

It appears that alongside these reforms in England, the Government will be introducing apprenticeships for dental healthcare workers to widen further access to these professions whilst maintaining the value of degree-level study: a term that is causing a great deal of confusion.

Whatever your point of view on this subject, there will of course be many who wonder why dental hygiene and therapy students are not subject to the same student fees system as thousands of other undergraduates, who graduate with £20-40K of debt.

Of course nothing is straightforward when it comes to policy and I believe the detail is still to be ironed out. However, whatever changes ensue it is essential that an appropriately funded pathway is available to ensure that the best individuals can pursue a career in dental hygiene and therapy, regardless of their personal circumstances.

BSDHT will continue to contribute to the discussions and I will keep you informed through the pages of the journal and in DHContact ONLINE.

Heather Lewis
Editor, Dental Health
I would like to begin by wishing all our members a very happy New Year.

I hope those of you who attended our Oral Health Conference in Belfast last November all enjoyed it as much as I did. It was hugely successful with our delegate numbers in excess of the previous years in Birmingham and Liverpool. The OHC 2016 brought delegates a host of world renowned speakers with a diverse programme that encompassed the theme ‘perspectives’. The fantastic social programme included the President’s reception in the beautiful surroundings of the historic Belfast City Hall.

I would like to thank Michaela O’Neill for all she has done over the past two years as President of our society. I know we are all very grateful for her hard work, determination and professionalism and we cannot thank her enough. At the AGM Julie Deverick stepped down as Honorary Secretary, a position she has held for three years. I am delighted to announce that Julie is not lost to the society and was elected President Elect. Nominations were put forward for the position of Honorary Secretary and I would like to congratulate Alison Lowe who was the successful candidate, voted by you our members. I look forward to working with both over the next two years.

Valuable bonus for members

The AGM also showcased BSDHT’s ‘big reveal’, and I know this has caused quite stir on social media since. If you are not already aware, BSDHT will now be providing indemnity cover for our members! An additional cost to your membership fee, the combination of your membership to your professional organisation and annual indemnity will still be less expensive than the cost of some other widely available indemnity policies. Ours is a bespoke policy for Dental Hygienists and those dually qualified in Dental Hygiene and Therapy.

At the AGM our members approved the motion that we would no longer provide free membership for the first year post qualification based on the fact that there is very little uptake of this offer. Furthermore, generally it may be perceived as being of little value simply because it is free of charge. With the additional offer of our new indemnity policy it was also decided that it would be unfair that new graduates would be able to benefit from this without actually paying for membership.

BSDHT in 2017

Besides the bespoke Indemnity policy which will benefit all our members, BSDHT will be moving into its own premises this coming year. This will give the society some roots and a place we can call our own. The next six months are going to be busy ensuring the premises are fit for purpose: a smooth transition as we leave Smile house with all the staff in place ready to hit the ground running is a priority. We have consulted with our accountants to ensure that this is a viable option and it was agreed that this will save money in the long term. Premises have already been sourced providing office space and a board room that is big enough to hold our Executive and full Council meetings, saving costs to the society. It will also be beneficial to host some of the many meetings we have with companies and other bodies that we work closely with in our own offices. I will endeavour to keep everyone updated as this progresses.

In the year ahead I think it may be a good time to look at the regional groups, this is something we have already discussed at an Executive level as numbers are slowly declining. We feel it may be time to reassess the format of how these meetings are run. So if any of you out there have any strong views or ideas please do not hesitate to contact us. This will be discussed at Executive and Council and taken to the regional groups so we can all bring ideas to the table.

There are many projects and issues that we will continue working with, one being prescribing rights. We are hoping to keep Michaela
involved with this as it is probably going to be a long process and she has been there from the start and has done much of the background work.

So how are we going to do all of this?

Well, team work and grit and determination is what is required in my opinion. Someone once said grit is “a combination of passion and perseverance for a singularly important goal.” I feel we have a very cohesive Executive team and all have different strengths that we bring to the table. I look forward to continuing this working relationship over the next two years.

The running of BSDHT is absolutely a team effort: Executive, Council, Publications, Administration, PR, President, President Elect, our Regional Groups and you our members. Many of you give up your time willingly on a voluntary basis and we thank you for this. We are also supported by many of the dental companies with whom I intend to continue forging strong links and good working relationships.

Within the short weeks that I have been your President I have been busy meeting with many individuals and organisations including the GDC regarding a profession-wide complaints handling initiative, the BDA discussing direct access and The Dental Professionals Forum. I look forward to representing you all over the next two years.

Helen Minnery
BSDHT THAMES VALLEY AUTUMN MEETING AND AGM

DATE: Saturday 24th September 2016

VENUE: Jury’s Inn, Oxford

SPEAKERS: Mr. Mike Wheeler, Dr. Maher Almasri and Dr. Tracey Crook

SPONSORS: As always a big thank you to all our sponsors: Biogia, Dentsply, GlaxoSmithKlein, Oral-B, ICON, TePe, CTS, Dentaid, Johnson & Johnson, Swallow, 3M ESPE and Optident.

This meeting was a very special one as our group celebrated 20 years of Thames Valley Regional meetings. There have been many changes over the years and it was great to celebrate this with fellow members. Our day began with a trade exhibition from our very generous sponsors, a superb opportunity to network and talk to the various representatives about their products.

Our first speaker, BSDHT Past President Mike Wheeler, looked back at the last 20 years in his fascinating account of how our role has developed within the profession and how it will continue to develop in the future. It was amazing to learn how attitudes have changed and how much more of an integral part of the dental team we have become. Mike’s experience in many different fields enabled him to illustrate this in an interesting and illuminating presentation. He made the point that we must always do our utmost to provide quality care and treatment to our patients but be aware that in the future, similar to the current situation, many dentists from Europe will practise in the UK as dental hygienists. This creates more difficulties in finding jobs, especially for our new dually qualified graduate colleagues.

At the AGM changes to the committee were announced: Chairperson - Simone Ruzario; Secretary - Sara Reid, Council Representative - Diane Stevens. Ruth Grant and Sarah Turnbull remain as Treasurer and Trade Liaison Officer respectively. We are ever thankful to our long standing members who have worked tirelessly to ensure our meetings have continued with enjoyable and productive experiences for members.

Our second speaker was Dr Maher Almrasi who is based in Oxford. The first part of the lecture consisted of an outline of the many highly advanced techniques which he and his university colleagues are using. Tissue regeneration and engineering have quite literally changed the lives of many patients and it really was incredible to see what has been achieved.

Lunch followed with a celebratory glass of bucks fizz for all, accompanied by the trade exhibition and many raffle prizes. One of which was a complimentary ticket for the Oral Health Conference in Belfast on 18th and 19th November in Belfast, and a few lucky members had a free Swallow Montana Jack scaler hidden under their chairs!

Part two of Dr Almrasi’s talk continued after lunch, detailing how growth factors are used to regenerate and improve sites of trauma and disease, enabling patients to save teeth and /or implants and continue to function normally. This area of scientific development was illustrated very well.

Our third speaker of the day was Dr Tracey Crook, an extremely experienced physiotherapist. She shared with delegates the importance of good posture and advised how we can change our habits to prevent many musculoskeletal injuries. We were all encouraged to try various exercises and it was enlightening to be shown techniques to make life more comfortable for ourselves and also to prevent our working life being cut short with needless pain and injury.

All in all, the day was a great mixture of topics, with really diverse and fascinating speakers, all of which used their long term experience to share in our 20th anniversary meeting and make it a very special one. This provided members who attended with five hours verifiable CPD and an additional two hours general CPD at our trade exhibition.

Sara Reid
The BSDHT is pleased to announce the launch of BSDHT Indemnity, a new insurance policy developed especially for dental hygienists and dental therapists.

This product is unique in the market as it is the only policy in the UK specifically for hygienists and therapists. Usually insurance policies include dentists, who typically have a higher exposure of risk and therefore increase the chances of a higher premium.

BSDHT Indemnity, which launched in December, is an exclusive offering for BSDHT members and can be purchased at any point in the year.

This bespoke policy has been designed by the BSDHT and Howden, a Chartered insurance broker with a specialist Care and Medical team.

Michaela O'Neill, Immediate Past President BSDHT said: “Indemnity is such an important requirement within healthcare and dentistry, but to be truly effective, that protection must be tailored to an individual’s needs. The BSDHT has a long-standing reputation for representing the best interests of practising dental hygienists and those dually qualified in dental hygiene and therapy, and by launching this bespoke insurance plan we want our members to feel both confident and reassured that there is a policy that is specifically built for them.

“Being a low exposure and low risk group, it’s unfair for dental hygienists and dental therapists to have to incur the higher premiums of typical insurance policies and

BSDHT Indemnity seeks to correct this.

“We are always looking for new and innovative ways to increase the range of benefits offered to our members and BSDHT Indemnity is an excellent example of this. This is an exclusive BSDHT member benefit that is competitively priced even when including your membership fee. We sincerely hope that our members will take advantage of this new policy.”

Adam Burr, Divisional Director, Howden Care & Medical division said: “As an insurance broker specialising in the medical sector we are delighted to collaborate with the BSDHT to deliver this bespoke indemnity product. Having drawn on the expertise of both organisations, and having spent time researching BSDHT members, we are confident that the offering will be well received.”
In my view, there is only one thing missing from the professional organisation that is BSDHT, and that is the voice of our student members. As the BSDHT Student Representative on Council, I feel strongly that the professionals of tomorrow are given the opportunity to share their concerns, achievements and experiences.

In this article, I have asked three students from three universities to answer a few questions to share with their fellow BSDHT members about what is currently happening in the student world.

Q. What do you find the most interesting part of learning to be a dually qualified dental hygienist therapist?
A. Every part of the course is great, from time spent on clinic to building my knowledge and skills in lectures. But I enjoy the practical side of it the most as this is when I get to apply the knowledge I have learnt in lectures and get to put it into action! – Anneka Kumar, University of Edinburgh

Q. What do you think students want to know more about in the dental hygiene and therapy world?
A. The running of a dental practice, and the coding systems for the NHS in each UK country. Also post qualification options. - Emily Januszewski and Amanda Connell, University of Highlands and Islands

I am currently starting a research module on the need for self development and stress management programmes for dental professionals, and I think this is particularly important for students. I think knowing more about how to cope with the stress that our profession can bring will help lots of people. Also an introduction to the business side of dentistry would be nice, and the possibilities of owning our own dental surgeries. – Lauren Oconnor, University of Essex

Q. Do you think the public needs to be more aware of periodontal diseases and the risks?
A. During my time on clinic I have found that many people suffer from periodontal disease. They know they have it but don’t seem to be educated about the risks and importance of plaque removal and home care. As it is one of the two most common dental diseases, people need to be aware of the signs and prevent it earlier on before they lose teeth and it starts impacting on their quality of life. – Anneka Kumar, University of Edinburgh

Yes because many members of the public think bleeding gums are normal and are uneducated about how to deal with it as well as how it can affect the rest of the body as well as the mouth. - Emily Januszewski and Amanda Connell, University of Highlands and Islands

Q. What is the best part of your course so far?
A. I am constantly out of my comfort zone but I have developed beyond my own expectations. I love the way that Essex is structured as we get a lot of real life experiences and I believe that this is a huge advantage. – Lauren Oconnor, University of Essex

Q. What are your plans after completing your course?
A. Most likely we will complete a VT year which we think should be compulsory. - Emily Januszewski and Amanda Connell, University of Highlands and Islands

I am interested in the Perio MSc and in opening my own clinic. – Lauren Oconnor, University of Essex

So there we have it, a few questions answered by a few students currently studying to become future dental hygienists and therapists. I hope it enlightens professionals into the world of the current students.

Please contact me with any ideas on any areas of student life you may have for future issues of Dental Health.

Email: amberojak23@hotmail.com
BSDHT Oral Health Conference and General Assembly of Members 2016 was held on the 18th and 19th of November, in the Waterfront Hall Conference Centre in Belfast.

Over two days, delegates were treated to a varied and packed scientific programme from a number of world renowned speakers, both on the main stage in the plenary sessions and in the parallel sessions, which included hands-on workshops. A superb exhibition was supported by our colleagues in the industry providing delegates with the ideal opportunity to learn about new products and innovations at their leisure.

The Poster Competition, supported once again by Waterpik, was central to the exhibition hall and it was encouraging to note how this has grown. (You can read more about those on page 16).

All delegates were invited to join with the BSDHT Research Group which held an informal meeting of minds for discussion over lunch on Saturday. Anyone interested in being involved in research was warmly welcomed to join this group of inspiring, enthusiastic and passionate individuals for support and guidance in taking the first, or next, steps in getting involved in practice based research.

A social programme included a breakfast meeting on Friday which was ideal for those colleagues who may have been attending alone, or for the first time. This proved to be particularly popular with some recently graduated colleagues who used it as a meeting point for a reunion. The President’s reception was held in the beautiful Belfast City Hall and was a spectacular end to the first day.

For those of you who were not there, here are some of the main points and take home messages from the conference, kindly provided by some of the speakers.

Professor Janet Lord: Inflammaging - Are you as old as your cytokines?

The main points made by Prof. Lord were:

1. Increased systemic inflammation is a feature of ageing (inflammaging) and contributes to many age-related diseases;
2. Ageing of the immune system contributes to inflammaging;
3. Inflammaging is not inevitable and can be prevented by lifestyle.

Delegates’ take home message:
Old age does not have to be spent in ill health and our lifestyle choices can extend our lifespan and healthspan.

Mr. Chris Butterworth: Implant supported orofacial rehabilitation of the cancer patient

The main points made by Mr. Butterworth were:

1. The management of head and neck cancer patients is highly complex and requires a multi-disciplinary team approach;
2. Osseointegration has revolutionised our ability to rehabilitate patients following ablative surgery to the mouth and face;
3. The placement of implants during the initial cancer surgery significantly increases the speed with which patients can be rehabilitated and provides for stable and retentive prostheses in the presence of distorted anatomy.

Delegates’ take home message:
Modern day multi-disciplinary working within the field of head and neck cancer is a rewarding and challenging area of practice facilitated by close working links between all members of the team. The role of the hygienist in assisting with the maintenance of implant supported prostheses is very important and paramount to the ongoing success of these extremely difficult prosthetic treatments.

Professor Anthony Roberts: The Empire strikes… plaque!

The main points made by Prof. Roberts were:

1. Mechanical plaque removal remains the mainstay for periodontal health;
2. Adjunctive chemical plaque control has a role to play for some patients;
3. The choice of adjunct depends on the clinical situation - one size does not fit all!

Delegates’ take home message:
Clinicians should carefully examine the evidence supporting novel therapeutic strategies.

Mrs. Juliette Reeves: Nutritional manipulation of chronic inflammation – new concepts in oral-systemic disease associations

The main points made by Mrs Reeves were:

1. Chronic diseases are underpinned by inflammation;
2. Post prandial spikes in glucose and lipids are significant causes of chronic inflammation and elevate the expression of pro-inflammatory cytokines;
3. Vitamin D modulates the innate and adaptive immune response and may down regulate the inflammatory response, putting a
THE ONLY* SENSITIVITY TOOTHPASTE THAT DELIVERS...

- Instant* relief
- Long-lasting relief
- Recommended cavity protection† (1450 ppm)

BRING IT ON
THREE BENEFITS ALL IN ONE

ppm = parts per million.
*Available in the UK and Ireland. †When toothpaste is directly applied to each sensitive tooth for one minute.
physiological brake on inflammation;

4. Variations in response to lifestyle, genetic and environmental factors influence the human microbiome which may explain why disease manifests and progresses differently in some individuals than others;

5. Environmental shifts may cause pathological changes to the balance of the oral microbiome resulting in a transition from health to disease.

Delegates’ take home message:
In recent years there has been increasingly more evidence establishing the possible role of nutrition in the aetiology of periodontal disease. An increasing body of evidence suggests poor nutrition as a modifiable risk factor associated with chronic diseases and inflammation of the periodontal tissues. There is also a growing body of research considering the role of the oral microbiome and probiotic therapies as interventions for chronic inflammation, periodontal and systemic diseases.

These unique factors may help explain why disease may manifest and progress differently in some individuals than others and indicate a role for nutritional intervention strategies.

Mr. Leo Briggs: A series of lectures entitled: How diverse is your career? Dento-legal careers for hygienists and therapists

The main points made by Mr. Briggs were:

1. There are opportunities for dental hygienists and therapists to expand their careers to incorporate dento-legal work;

2. The opportunities at the moment are slightly limited but it is likely that more opportunities will arise in future;

3. It is important to have an interest in dento-legal issues if you want to pursue a dento-legal career.

Delegates’ take home message: Get some training and look out for any opportunities that arise.

Mr. Daniel James: Are you living the dream?

The main points made by Mr. James were:

1. Do not leave it to chance;

2. Plan for your future;

3. Review your plan.

Delegates’ take home message: In order to achieve your goals you have to understand what they are. By planning for your future you can understand, appraise and know when your goals have been achieved and surpassed. By working with your financial planner you can start the process of building your life plan and keeping it on track.

Ms. Mary McGrath: Pay attention to me pay attention to your teeth

The main points made by Ms. McGrath were:

1. It is very important to understand how normal memory works in order to understand how and why it deteriorates as a result of dementia;

2. Very early on in the development of dementia, before short-term memory loss emerges, people lose their ability to divide their attention and multi-task, which has a detrimental effect on memory function and personal independence;

3. Dental surgeries and clinics must be dementia-friendly environments that enhance good attention and communication that in turn allow the successful management of patients at all stages of the dementia process.

Delegates’ take home message: Dementia is an equal opportunity disease that can come to anybody’s door!

Ms. Maria O’Rourke: From horses to humans

The main points made by Ms. O’Rourke were:

1. Look for options to combine a career in Dental Hygiene with a past time and passion to create another career;

2. Describing basic dental treatment in a horse;

3. Oral health is vital to the overall health and the well being of a horse, as it is in humans.

Delegates’ take home message: There are many opportunities to further and combine a career with Dental Hygiene using your dental hygiene skills and qualifications.

Ms. Marina Harris: Stress and the dental hygienist and therapist, is it all in a day’s work?

The main points made by Ms. Harris were:

1. The results of the first study to examine stress and well-being in dental hygiene and therapy students;

2. BSDHT members attending the session, reported similar levels of high psychological well-being to that reported by students in the study;

3. High levels of stress can also be accompanied by high levels of positive well-being.

Delegates’ take home message: the pursuit of a career in dental hygiene and therapy may contribute to a sense of meaning in life.
Encouraging and empowering its members to become key players in research, the British Society of Dental Hygiene and Therapy (BSDHT) held its Annual Poster Competition, sponsored by Waterpik at the Oral Health Conference 2016. Speaking from the Waterfront Conference Centre at Belfast, the President of BSDHT, Michaela ONeill said:

“This competition is all about recognising the invaluable contribution that both dental hygienists and those dually qualified in dental hygiene and therapy make in the world of dental research. With a wealth of achievements, it’s really important the BSDHT continue to acknowledge, praise and shout about this work, along with the role that they continue to play within the profession.

“We have seen some innovative and clinically applicable research in the poster competition this year demonstrating a remarkable contribution and level of commitment to oral health and hygiene.”

The competition was led by Emma Pacey from the BSDHT Research Group and Publications Committee. She is passionate about promoting research within the profession and said:

“This competition provides a platform for registrant and student dental hygienists and hygienist therapists to showcase their work. It’s about recognising the contribution they make to the world of research and celebrating the achievements of our profession. The quality of research has increased year on year, as has the diversity of methodologies on display. Looking to the future, it is noteworthy that we have more student entries this year than ever before.”

The impressive display of posters represented individual and group research projects in oral health and hygiene covering subjects such as: Promoting oral self care for children and parents, obstructive sleep apnoea and its effect on the oral cavity, the trigeminal neuralgia patient, and the dental anatomy of wild and domestic animals, to name just a few. Each entrant delivered a poster presentation to the judging panel, which comprised of Ian Dunn, Specialist Periodontist and Senior Clinical Teacher at Liverpool University, Marina Harris, past president, lecturer and academic currently undertaking a PhD at University of Portsmouth; and Deborah Lyle Director of Professional and Clinical Affairs at Waterpik International, Inc.

The winners were announced at a ceremony in the main auditorium and the esteemed academic, Deborah Lyle, presented the awards. Danielle Shaw from Queen Mary University of London, Bart’s and The London Dental Hospital received The Student Award and a £250 voucher with her poster on “Aesthetic Management of Non-Carious Enamel Hypoplasia Using Minimally Invasive Dentistry.” The Registrant Award Highly Commended and £250 voucher was awarded to Phoebe Purcell, Dental Hygienist and Camille Cronin, Lecturer at University of Essex for their poster entitled “Oral Health in Care Homes: A Patient and Public Involvement Project in the Local Community.” And, Kay Franks, Lecturer at the University of Newcastle, Australia received the First Award: a beautiful engraved crystal vase and a £500 voucher for her research and poster on “Entry knowledge of Bachelor of Oral Health Therapy students on diet, nutrition and preventive oral health care.” The entrants were delighted to be recognised for their outstanding efforts and Michaela ONeill said:

“On behalf of the BSDHT, we are tremendously thankful for the generosity and support that we have again received from Waterpik International Inc., donating some brilliant prizes and enabling us to achieve this.”

The BSDHT showed evidence of its continued support into research and development, which enables the profession to be at the forefront of evidence-based practice. Furthermore, it is hoped that this interesting and motivating competition has inspired other members to get involved.
LOGGING on to the members’ area, you will see the box below on the screen

Complete the boxes using the following information:

User name: your full name, no abbreviations, no spaces, all in lower case eg dianamarysmith. Password: your BSDHT membership number.

If you need clarification of the details we have on file – first name, middle name (if provided) and membership number – please contact BSDHT on 01788 575050.

Let us know what you think about the new site by clicking the ‘contact us’ button in the top right hand corner.

The recent BSDHT Oral Health Conference 2016, held in Belfast last November, was the perfect setting for our 25 year reunion.

Guy’s Dental Hospital class of 1990-91 are still all in regular contact and twenty-five years on we are all proud to be practising dental hygienists! We had a fantastic weekend making new friends, bouncing ideas off one another and our colleagues, updating our skills and knowledge and remotivating one another ready to step back into practice on Monday morning.

We would encourage all our hygienist and therapist colleagues to attend their regional group meetings this Spring and definitely put the date for Harrogate in the diary - 3rd and 4th November 2017.

The BSDHT regional meetings and annual conference are such an easy way to keep in touch, remain motivated while inspiring us all to be the best professional we can be.

See you in Harrogate!

**Top photo:**
Left to right: Terrie Seppings, Gwyneth Brabyn, Sue Pienaar, Ella Morgan, Anna Guntert and Karen Wallder.

**Below photo, back row left to right:**
Elma Papathomas (Tully), Ruth Lovering, Terrie Seppings (Spratley), Gwyneth Brabyn and Jane Neal (Willis).

**Below photo, front row left to right:**
Sue Pienaar (Hodge), Ella Morgan, Anna Guntert and Karen Wallder (Underwood).

Missing is Sharon Fisk . . but she does live in New Zealand!
ANOTHER 500 MILES FOR SMILES

Four years ago, Christina Chatfield rose to her own challenge of walking 500 miles to raise awareness of mouth cancer, walking from her home town in Scotland to Brighton, where she lives and works. In June she set off again, this time to walk the pilgrims’ route to Santiago de Compestella in Spain, clocking up another 500 miles. Her drive was the need to raise awareness that boys need to be vaccinated against HPV. This is the final stage of her journey, taken from her personal blog.

The Compostela: the Pilgrims Passport to Santiago 800km

The Pilgrims Passport, written in Latin, and loosely translated, is a document that states that “the person named therein has come out of a pious motivation to the Cathedral in Santiago to revere the remains of St. James”.

I had taken my millionth step with only ninety nine kilometers to go to Santiago; my Compostela was within my grasp. Did I deserve my Compostela? I would have certainly earned it having walked the distance. Had my motivation for walking the Camino changed? No! I was still walking for mouth cancer, but it has become clear that this pilgrimage was as much for me as it was for the charity I was doing it for.

Sarria is the last point at which you can join the Camino in order to receive your Compostela from the monks. You need to complete a minimum 100 km, and it will take five days to do it from Sarria. We left Sarria on the Monday morning thirty one days after I had left St Jean on my own, but now there were eight of us heading to Santiago together, and those that were not with us were in our thoughts. We had dinner that evening with Lyn and Ian again.

This lovely couple were taking a rest day at last and would arrive in Santiago the day after us. Our sights were set on Friday 24th and spirits were high. My son Michael was flying out to meet me in Santiago. Our original plan had been that he would walk the first 100 km with me, but sad personal circumstances prevented this from happening.

Meeting me outside Santiago and joining us for the last part of this walk is my good friend and life coach Chris. We have come a long way since we started talking four years ago on those early Monday mornings on Brighton seafront. It seems fitting that both he and Mike are there with me at the end.
I have grown so much, learnt so much and learnt to let go of so much along the way of St James, but my biggest growth, and the toughest, has been forgiveness. We all carry so much in our lives that it weighs us down. Asked if I had “found Jesus” and whether I am “about to start preaching to others” I must answer that I have found inner peace for myself. Yes, the quiet of the church at Rabanal, before I walked in the rain up to the Iron Cross had an impact, as have the wonderful people I have met along the way- the words of Donna in my head, “…you are a strong women, you can do this”, I cannot explain. You would have to walk in my foot steps and those of the thousands of people who have walked before me to understand.

I learnt quite early on, through the emotions I was feeling and the tears I cried (lots of them to start with, they would not stop, often while I was walking on my own) that I needed to forgive myself. I did not know that before I came, but along the way I realised that in order to do that I had to forgive others. That does not mean I will ever forget, or understand why things happen. I said in my first piece of writing that people do this for many reasons, and the conversations I had with these people are deeper, open and more honest than I would normally have with people I have just met. It is true that most are dealing with a tragedy or some traumatic experience in their lives. You cannot help but empathise and reflect on your own reasons and get a perspective on how you can move forward. Meeting Alex and Kathryn, these amazing young women, made me realise I had to stop looking back and had so much to look forward to, so many people to share it with and, most important, three fantastic children of my own – Lori, Mike and Ross. Sometimes things happen, life has an unexpected way of taking things from you or putting obstacles in your way, but you need to stay positive and move forward, one foot in front of the other, day after day. Kathryn, is having a tumour operated on when she returns home, on July 27th. Doctors believe it to be benign, and Alex, while studying Public Health at University was raped. Out of this whole experience these two friends have taught me the most, and I will never forget leaving Leyre walking with them both, just the three of us, listening to “I am light” by India Aria, a song played to Alex during her trauma yoga therapy. A song that united us there and then. She found the strength and the support to write her now published paper for her Degree of Masters of Science in Public Health “Knowledge and Perceptions of Sexual Assault and Rape Among Peer Health Educators on a University Campus”. Two very brave, positive and caring young women, a credit to their families and to anyone who has the honour of having them as a friend. I am so excited they are travelling to Brighton to see me on July 14th before they return to California. My journey as it turns out is two fold in terms of the charity and my personal growth, although on reflection they go hand in hand as to who I am. I found out from Donna, the retired American litigation lawyer I met on day 10, walking with her daughter Grace to Belorado, that 2016 was declared a Holy Year of Mercy by Pope Francis, a very important year for pilgrims in both Rome and Santiago de Compostela. It also means that the Holy Door of the Cathedral Porta Santa is open for the Year of Mercy. My journey will take me through these doors when I complete the 800 km walk and my son Michael will be there to meet me. I carry the love and thoughts of the rest of my family and friends with me.

Walking to Portmarin we pass the marker for the last 100 km. The first part of the day has a steep climb with lovely woodland paths passing through beautiful small hamlets adding to the ambience of the day. At the highest point is Pena dos Corvos with panoramic views over the reservoir that was the original site of Portomarin. Sixty years ago the important memorials and buildings were taken apart stone by stone and reassembled when the town was relocated high on the hill, and the valley was flooded to create this reservoir. From Pen dos Corvos there is a steep descent, we cross the reservoir and then climb the steps through the gates on the other side. That night we all had dinner together watching the sunset over the reservoir.

The final 100 KM: The Camino Provides

One of the amazing things about this walk are the “pop ups” – the donations, relying on goodwill, that you suddenly come across just when you need fresh water, a coffee or someone to chat with. Round the corner, in the middle of a wood, on top of a hill and often in the middle of nowhere.
We all walked in to Santiago together. I had taken 1,215,305 steps for mouth cancer and walked the 800kms of the Camino de Santiago (in fact I walked over 1,000kms but who is counting!). I do still have to complete the commitment I made so there has to be one last walk next year. Serendipity might play a part here, because the South Downs Way starts in Winchester, and the cathedral at Winchester is the start of the Pilgrims’ Way in England. The cathedral itself is the largest gothic style cathedral in Europe, based on the style of Burgos. Hopefully some of my Camino family will join me in helping to raise awareness for Mouth Cancer and the HPV element of it, pushing for vaccinations for all. Interestingly Alex’s degree is in Public Health and she teaches sex education to adolescents. They all knew very little about mouth cancer prior to this walk. The day I walked to Rabanal, I walked the afternoon with Patricia from Australia. She had had dinner with us the night of the day that Jim, Ed and I met Alex and Kat. She had thought about why I was walking and asked that afternoon about her friend in Australia. He is 72 and going through radiotherapy and chemo for throat cancer. He had never smoked. She said she would read up on this with interest. Remember HPV is responsible for 5% of all cancers worldwide. It’s the easiest sexually transmitted virus, and research suggests it might even be transferred through French kissing. 80% of the population will have it. For most, our immune system will deal with it, but for some it will cause cancer. In fact HPV is overtaking smoking and drinking as a risk factor for mouth cancer and it is no longer an older persons’ disease. Mouth cancer kills more people than testicular and cervical cancer combined, due to late detection. HPV mouth cancers do not usually present until the fourth decade, although the first seed will lie deep within the tonsillar tissue. You cannot screen for HPV in the mouth like you can in the cervix, because the tonsillar tissue is 2 ft by 2 ft of folded tissue. So if we are to catch mouth cancer early, and prevent people from losing their lives (or if not their lives, it can take their face, tongue, taste, speech and function). We all have to have more knowledge, be more aware and get the health of our mouth checked out every year, whether we smoke or not.

Awareness costs money, charities need it – The Oral Health Foundation is an independent charity (not for profit) dedicated to improving oral health and wellbeing around the world. For more than 40 years they have continued to provide expert, independent and impartial advice on all aspects of oral health directly to those who need it most. The team there are long-standing campaigners for mouth cancer action. All donations and money raised go to the Mouth Cancer Awareness section of the charity.

From my own perspective, my son Michael was referred last year for a lump in his throat. He was seen, had a scan, and recalled to check for two additional lumps. I went with him. He received a full mouth and throat cancer screen, with HPV in mind. At no point was anything explained to him. They were thorough, they looked down the back of his throat and tongue, felt around his jaw, the back of his ears, down his throat, but no communication as to why. No mention whatsoever of HPV. The Maxillo Facial Unit shares the same waiting room as the a the Brighton and Hove Sexual Health and Contraception Service but there was no literature anywhere about mouth cancer and HPV. This has to change.

If I have touched, or reached out to any of you, please show your support by making a donation. Please also download the template letter and send it to your MP to show your support for the campaign to get all boys vaccinated against HPV – girls are already.

Thank you for sharing your experience with me. James Pauline, Columba, Catherine, Maurice, Kathryn, Tim, Elsa, Pernille, Donna Grace, Lyn, Ian, Philip, Jane, Jim, Ed, Alex, Kathryn, Geordie, Melissa, Tanith, Diane, Phylis, Margaret, Patricia, Roisin and Henry.
In this first in a series, Dental Health aims to bring you some guidance towards achieving clinical excellence. The subject of this issue is periodontology. Phil Ower, BSP President, explains all about this excellent resource.

The British Society of Periodontology’s (BSP) new ‘Good Practitioner’s Guide to Periodontology’ (GPG) has an interesting history; way back in 2011 the BSP launched the ‘Young Practitioner’s Guide to Periodontology’ (YPG). This free 30 page document, edited by Ian Needleman and Elaine Giedrys-Leeper, was conceived as a digest of what we felt was the most clinically relevant information that would be needed by a newly qualified dental graduate to manage patients with periodontal disease in general dental practice. It was primarily designed with the vocational dental practitioner (or VDP as they were called then) in mind, in an attempt to bridge the gap (or gulf?) between university training and general clinical practice. It was initially produced as a hard copy, printed document that was physically given to all VDPs during their vocational training year. It was quickly perceived as essential reading for clinicians. As it found its way into practices and was seen by other members of the practice team we suddenly found that that we were getting requests from dentist principles, dental hygienists and therapists for copies. We put it up on our old website as a freely-downloadable pdf and there it remained until earlier this year.

It had an update as a second edition and it has been hugely successful - translated into German, 9,000 print copies sent out since 2011 and during 2015 alone the pdf was downloaded 41,664 times!

As the BSP developed its new website for 2016 we knew that we wanted to update the YPG as a third edition but we also knew that it had to be bigger and better; as it happened, at the end of 2015 I had a chance meeting with a BSP member, Fiona Clarke who, as well as being a teacher at a London teaching hospital, was also a founder of Atlas Education, a company specialising in the development of e-learning programmes for the health sector. This seemed like a great opportunity not just to completely revise the YPG but also to turn it into an interactive e-learning programme that could sit on the BSP website. With Fiona as project manager, Ian Needleman as editor-in-chief and two members of the BSP’s Early Career Group, Manoj Tank and Praveen Sharma as principle scribes, the team set to work. We were also very lucky to have Henry Schein, our publishing partner, on hand to provide their design and publishing resources. Everyone involved was hugely enthusiastic about the project and thanks to all their efforts we launched the new GPG at Henry Schein headquarters in central London last September. With expanded content, new illustrations and extra chapters (for example on implants and peri-implant diseases) the document is now over 50 pages in length and it has a new name - swapping ‘Young’ for ‘Good’ we can no longer be accused of being ageist!

Since its launch the GPG has been downloaded thousands of times and already we have had a request to translate it into Norwegian. One of our overriding aims was to continue to provide the GPG as a free resource - it can be downloaded free as a pdf from the BSP website and the two hour interactive e-learning programme can also be completed for free, although if you want to claim the CPD hours you either need to be a BSP member or pay a small charge for a certificate. We are also providing hard copies of the document, on application, for which a small postage charge applies. So if you haven’t got your GPG yet do it now!

The BSP’s Good Practitioner’s Guide’ can be downloaded in pdf or completed in e-learning format by visiting www.bsperio.org.uk. Hard copies can be requested by contacting admin@bsperio.org.uk or calling Helen on 0844 335 1915.
Sometimes, for a variety of reasons, you may decide that you need to end your professional relationship with a patient or suggest that they seek further treatment elsewhere. This may result, for example, from a lack of government funding necessary for the provision of care to the patient, if the treatment required is beyond your capability, if the patient refuses to co-operate with your advice, or if the patient is violent or aggressive to you or your colleagues.

Clinicians are always responsible for their actions, whether they are working to the prescription of a dentist or if they are treating the patient through direct access. Regardless of this, if the trust between you and a patient breaks down and you are finding it difficult to treat them to an acceptable standard, it is important to take your time to think through your obligations before you make a final decision to end the professional relationship. It is also important that the situation is sensitively managed.

According to the General Dental Council (GDC), you must consider the following before ending a patient-clinician contract and ceasing to provide service to them:

- Your decision should not be based on a complaint the patient has made about you or your team
- You are satisfied that your decision is fair
- You can justify your decision and are prepared to explain your reasons for ending the professional relationship to the patient in writing
- You will assist the patient to make arrangements for their ongoing care.

You must also take care to not refuse treatment to a patient on the basis of race, gender, social class, age, religion, sexual orientation, appearance or disability.

Avoid conflict

When a professional relationship breaks down, there is a risk that you could appear dismissive, lose your temper or imply blame if the patient has refused to accept your advice or voiced a lack of confidence in you. However, it is important to remain professional at all times and not let your emotions influence your choice of words, however difficult this might be. A few ill-chosen words spoken in the heat of the moment can result in months - or years - of subsequent repercussions if you end up being sued or facing a complaint to the GDC or other agencies.

You should therefore never part company with a patient in anger or simply because your pride has been hurt.

Be proactive

When informing the patient of your decision, a useful approach may be to suggest that there has been a ‘communication breakdown’. Explain that it is important they have complete trust and confidence in their clinician, and it therefore might be better if they make a fresh start with someone else. Focusing on the ethical conflict element means that the situation becomes less personal, and neatly avoids blaming either party.

You may also like to make it clear that your decision to withdraw from providing treatment is in the patient’s best interests, rather than your own. In this case, make the necessary referral arrangements, keep the patient informed, and resist the temptation to make any ‘smart’ comments in your correspondence with the new clinician, in the patient’s clinical records, or worse still, in any direct communication you have with the patient.

Denying access to care can cause unnecessary delay until a colleague elsewhere accepts them, so ensure your decision will not contribute to the patient’s condition worsening.

Difference of opinions

Situations may arise where you feel unable to continue with a patient’s care and treatment because of a serious difference in the suitability of the treatment being requested by the patient.

In these situations you should aim to discuss your concerns with the patient at the earliest possible opportunity and explain why you feel it is necessary or desirable to ask them to seek treatment elsewhere. While in some cases you may like to suggest possible sources of such treatment or even arrange a referral, in others this may be ill-advised. If in doubt, seek specific advice from indemnity provider.

One out, all out

Another kind of conflict arises when you wish to discontinue your
professional relationship with one person, but you also have other patients who are related to them (such as a spouse or child). If you feel that it would be difficult or embarrassing to continue treating the related patients, then you may think it best to end your relationship with them also. However, you must be careful not to breach patient confidentiality when doing so, as you will likely require consent from the original patient to sufficiently explain to the relatives why you are also ending your relationship with them.

In some situations, saying farewell to one member of the family makes it highly probable that you will not be seeing any of the others again – but do not assume that this will always be the case. Each patient has an individual relationship with you and has a right to expect the same professional consideration and courtesy.

Settling the balance

If you have not yet completed the patient’s treatment, consider whether they will be financially disadvantaged by your decision, may have grounds for believing that they paid you for something that you failed to provide, or will have to pay a second clinician to complete the treatment that you started. Rather than avoiding the issue, which may leave the patient to jump to wrong conclusions, be proactive so the patient understands where they stand regarding the cost of the remaining treatment.

In some cases, you may like to make arrangements directly with the clinician completing the treatment so that any further or outstanding financial transactions do not leave the patient out of pocket.

In summary, ending your professional relationship with a patient – and possibly also their family – can be a stressful experience for all parties involved. Remember to stay calm, act professionally at all times, consider what is in the best interests of the patient, and contact your indemnity provider if you are unsure of your obligations.

ABOUT THE AUTHOR:
Joe Ingham is a Dentolegal Adviser at Dental Protection, and provides practical advice for clinicians considering withdrawing their treatment or services.

INVITATION TO BECOME BSDHT COUNCIL OBSERVERS

BSDHT Council would like to invite any interested BSDHT members to apply for the role of Council Observer.

Council agreed that it would make the work of the BSDHT Council more transparent to members if Council meetings were to be opened to invited observers.

A number of members of the Society may attend full Council meetings purely as observers, although numbers will be limited due to space. Applicants will be accepted on a first come basis and no expenses will be paid. Meetings are held twice a year in Birmingham.

THE NEXT MEETING WILL BE HELD ON THURSDAY 19TH JANUARY 2017.

To register your interest please contact the President, Helen Minnery on 01788 575050 or email enquiries@bsdht.org.uk
Financial planning isn’t just about saving for retirement or taking out income protection, nor is it just for the super-rich. Effective financial planning helps you organise your money, enabling you to do more with it. By starting this process early in your career, as a young hygienist, you can look forward to a more stable and exciting future.

Start with the end in mind

A common request from BSDHT members is to set up an income protection policy and a pension plan. Of course these are important, but they’re only tools of the trade to help protect. Financial planning doesn’t stop there.

Your current finances, income, outgoings, and of course your ambitions need to be considered in order to make the most of financial planning. What do you want to achieve? By prioritising your goals, you can start to think about what you want in the short, medium and longer-term.

By talking your aspirations through with an Independent Financial Adviser (IFA), you can begin to see how your finances can support your goals - the earlier you start, the more you can do without compromising your lifestyle.

The right tools for the job

At the start of your career, investments can seem like a luxury for those with more disposable income. However, the potential for reward shouldn’t be ignored.

Whether it’s affording a luxury holiday, buying a house or funding your children’s education, all financial tools should be considered in order to build your tailor made plan. Bear in mind that cash ISA’s can help with short term goals and investment ISA’s can be a good place to start with medium term goals. For the long term, pensions provide a solid base for your retirement.

Remember, different investments carry different tax advantages and potential access restrictions. Discuss these with an IFA to ensure that you understand which course of action will be most beneficial.

What makes a good financial plan?

Your financial plan is your first step, but here are some things you’ll want to check to make sure you get it right:

- Focus on your objectives
- Understand that nothing is set in stone. As time goes on your priorities are likely to change. Your financial plan is flexible and will need to reflect any changes to your circumstances
- Measure your success. A good financial plan will have within it a point at which you’ll know when you’ve reached one or more of your goals. At this point either you or your adviser should initiate a review to look at your next objectives
- There are different types of Financial Adviser. An IFA has no restrictions to the provider or products that they are able to advise you on

Lloyd & Whyte are specialist IFA’s who are appointed by the BSDHT to advise members about their finances. Having worked with healthcare professionals for over 20 years, they have an in depth knowledge of how to help professionals achieve their goals. If you would like to set up a financial plan or discuss a current plan, you can contact Lloyd & Whyte on 01823 250 750 or through their website at www.lloydwhyte.com

Lloyd & Whyte (Financial Services) Ltd are authorised and regulated by the Financial Conduct Authority. Registered in England No. 02092560. Registered Office: Affinity House, Bindon Road, Taunton, Somerset, TA2 6AA. Calls may be recorded for us in quality management, training and support.

It’s important to take professional advice before making any decision relating to your personal finances. Information within this article is based on our current understanding of the legislation and can be subject to change in the future. It does not provide individual tailored investment advice and is for guidance only.
Abstract

Life expectancy in the UK is increasing. Thirty-three percent of children born this year will live to be 100. The percentage of adults in England with no natural teeth dropped from 28 per cent in 1978 to 6 per cent in 2009. Surveys show that these longer living older people and their surviving natural teeth are at increased risk of root caries. This article describes the risk factors, diagnosis and management of root caries, with particular emphasis on the older patient and the ageing process itself.

Introduction

Dental caries is a disease process which demineralises tooth structure. Caries, initiating in enamel, is more commonly associated with children. However, root caries occurs on the exposed cementum or dentine of the roots of teeth, often of older people. As the numbers of people reaching older age is increasing and as more people are keeping their teeth into old age, the prevention and management of root caries lesions has assumed greater importance in recent years.

Ageing is defined as “an age-dependent or age-progressive decline in intrinsic physiological function, leading to an increase in age-specific mortality rate (i.e. a decrease in survival rate) and a decrease in age-specific reproductive rate.” This progressive decline is frequently accompanied by an increase in morbidity. Consequent frailty and disability may lead to life style changes which may also affect the patient’s ability to carry out oral hygiene procedures or maintain a previously stable, healthy diet. Our older patients, therefore, should not be judged as ‘old’ by an arbitrary number of years, but rather by their ability (or inability) to maintain their life style.

Risk factors

A recent meta-analysis has revealed that the only markers which are consistently able to be shown as predictors of root caries are increasing age, the previous root caries experience of the patient and the presence of plaque. Among other factors shown to be less consistent markers of root caries prevalence are saliva flow rate, medication use, poor diet and denture wearing.

Previous root caries experience will clearly not be helpful in identifying those experiencing their first root caries lesion. The presence of plaque, however, is relatively easily identifiable. Consequently any exposed root surface which is covered in plaque or potentially plaque retentive should be considered at risk of root caries.

Local plaque retentive factors which are of relevance include:

- The presence of a denture
- Over erupted teeth
- Tilted teeth
- Poor contact areas

Age

Increasing age has been shown to be a marker of increased risk of root caries. The most recent Adult Dental Health survey in the UK found that, “The proportion of adults affected with root caries varied by age, with 1 per cent of adults aged 16 to 24 affected compared with 11 per cent of adults aged 55 to 64 and 20 per cent of adults aged 75 to 84.”

However, studies which show this have defined old age as being 65 years or more. Clearly older people are likely to have a greater number of at risk root surfaces than younger people, due to a history of periodontal attachment loss over their life span. However, rather than considering chronological age itself, it is useful to consider what bodily changes happen with increasing age.

Surveys show that after the age of 65, healthy life expectancy is about 10 years (Table 1). The remaining years are likely to be typified by increasing ill health and frailty. Dental caries is recognised as a lifestyle disease, and the changes in lifestyle brought by increasing frailty, such as dietary changes and loss of manual dexterity and grip strength, are likely to increase the risk of root caries.

The teeth which last into old age can be considered healthy survivors, although many will have some exposed root surfaces. Compared to enamel, the at-risk surfaces, which will have either been restored in earlier years or have become resistant to caries due to continual uptake of fluoride, of many of these roots will be relatively newly
exposed to the challenge of the oral environment. Consequently a patient who loses some manual dexterity due to musculoskeletal disorders or a stroke will probably have difficulty in maintaining previous levels of plaque removal. The relatively newly exposed roots will therefore become at greater risk of demineralisation. A patient who is no longer as mobile as previously may no longer be able to maintain their previously healthy diet. Bereavement of a spouse will often lead to dietary change, such as less regular meals and an increased propensity to comfort eat and snack between meals. Medication which causes dry mouth will alter the oral environment. The drastic lifestyle change involved in moving to a residential care facility is obvious.

Clearly, therefore, although root caries is crudely associated with increasing age, it may be better associated with the lifestyle changes enforced by increasing frailty rather than the chronology itself.

Diagnosis
Root caries is diagnosed visually by tactile means and radiographically. Root caries tends to start as a small circular lesion but spreads in a band around the circumference of the root, leading eventually to weakness, pulpal damage and decoronation.

Appearance
Root caries will appear as a discoloured area at or below the cemento-enamel junction on an exposed root surface. The colour can vary from yellow to dark brown or black. The position of the lesion in relation to the gingival margin may be relevant as one study found that active lesions were more likely to be found close to the gingival margin. The same study showed that colour was not related to texture. Root caries lesions will commonly be covered in a layer of plaque and may also be visibly cavitated.

Texture
Root caries lesions will vary in texture to a sharp probe. Hard lesions will have the same hardness as the surrounding dentine. Leathery lesions are described as being able to resist the removal of an inserted sharp probe. Soft lesions have the texture traditionally associated with active dentinal caries and not resist the removal of a probe. However, the International Caries Detection and Assessment System (ICDAS) recommendations are that a sharp probe is not used as it may damage any remineralisation process. A BPE probe is recommended instead. Both leathery and soft lesions are considered to be active.

Approximal lesions can be difficult to detect with a sharp probe. Concavities on the root surface may be confused with cavitated lesions. Again, a ball ended probe such as a BPE probe, drawn carefully across the mesial or distal surface of a root, may identify the margins of a cavity.

Radiographically
Approximal root caries lesions will show as a radiolucent area extending from the medial or distal root surface towards the pulp. Root caries lesions need to be carefully distinguished from radiographic cervical burn out. In cases of doubt, consideration could be given to taking a second radiograph, from a different angle, which will often eliminate a burn out effect, but not a root caries lesion.

Patient assessment
Patient assessment begins when the patient is collected from the waiting room. If the patient is a regular attender, changes in the patient’s speed of rising from a chair or their gait in walking to the surgery, may be signs of increasing frailty. A weaker grip to a handshake may be a sign of increasing frailty.

Social history is important to identify any changes of lifestyle, as indicated above.

Medical history may identify changes of medication and in particular medication which may be responsible for a drier mouth. Many drugs can affect the flow of saliva and include some prescribed to treat conditions of the following:

- Cardiovascular system
- Gastrointestinal system
- Central nervous system
- Genitourinary system
- Skin
- Eyes, including eyedrops
Alternative medications with similar effects, but which do not induce xerostomia, are sometimes available and as appropriate and with consent, communication with the patient’s physician may bring about a relevant alteration to the drug regime.

Dry mouth is frequently caused by medication, but other causes such anxiety or Sjögren’s syndrome should be borne in mind. It is sometimes useful to have a record of the patient’s xerostomia and the Challacombe Scale may aid the clinician to make a score of between 1 to 10, utilising pictures and descriptors of the clinical appearance of the mouth.

Careful examination of all exposed root surfaces should be made, visually if possible or by tactile means if the surfaces are hidden. Radiographic examination is indicated if surfaces are at risk but not readily visible intra-orally. Horizontal bitewings are the most useful. Vertical bitewings may be appropriate if there is evidence of significant bone loss. Rotating the X-ray film or plate through 90° should show all the surfaces at risk. However, in a full arch of teeth, sometimes four films are necessary - one anterior and the other posterior for each side. Root caries is evident radiographically as a radiolucent area spreading from the root surface, towards the pulp.

Restorative treatment

Root caries on the buccal surfaces of teeth is usually easily accessible. Softened dentine around the periphery of the cavity can be removed with a sharp excavator or a round bur in a slow hand piece. In view of the normal cervical constrictions of most teeth, root caries is often close to the pulp and care should be taken about how much diseased dentine should be removed from the floor of the cavity. The cavity can be restored with either glass ionomers or composite. If the cavity is close to the gingival margin and moisture control is difficult, then glass ionomer is the material of choice.

Root caries on the approximal surfaces of posterior teeth can be difficult to access. If access is obtained buccally, it is difficult to visualise, difficult to ensure that all the peripheral caries has been removed and even more difficult to place the restorative material. Access though the coronal surface is highly destructive of tooth tissue if there is no previous coronal restoration. If there is an existing coronal restoration such as a crown or an amalgam, ideally this would be removed to access the proximal root caries. Visualisation is still difficult at the base of such a deep cavity and it should be remembered that root caries spreads in a band like manner around the tooth and that the disease process will often extend further both lingually and buccally than coronal caries, potentially undermining the buccal and lingual cusps. Restoration frequently involves adaptation of a matrix band to allow it to extend to the gingival margin of the cavity. A sandwich technique, placing glass ionomers at the base of the proximal box and then restoring coronally with a material of choice is often useful.

Prevention

Whether a population approach (all patients over the age of 65) or a targeted approach (aimed at those identified as at risk), the preventive strategies for adults are clearly laid out in the document ‘Delivering Better Oral Health’ (tables 2 and 3). When applying fluoride varnish, application to all root surfaces is an obvious priority and a knowledge of root anatomy is important.

Since the presence of plaque has been consistently shown to be a risk factor for root caries, plaque control assumes great importance in the prevention of root caries. Removing plaque consistently over time from the surface of root caries lesions has been shown to change the appearance and arrest the caries process.

In delivering oral hygiene education to older patients care needs to be taken to ensure that the patient can grasp a toothbrush satisfactorily and comfortably. An electric toothbrush may be more effective for the frail older patient, with its bulkier handle and moving bristles. Adaptations to manual toothbrush handles to make them bulkier and easier to hold are simple to provide in the surgery. Interdental cleaning aids, such as floss and interdental brushes, are particularly difficult to grasp and care should be taken to ensure that patients can use the recommended systems. Denture wearing is recognised as a risk factor for root caries and a useful system for cleaning dentures has been suggested by Faigenblum utilising silicone putty and a denture box.

If standing at a bathroom basin is tiring for the patient, suggesting that a stool or chair is placed near the sink may be helpful.

Conclusion

In a recent consensus report, Momoi et al suggest that the management of root caries is different to that of coronal caries. Coronal caries, they suggest, is managed by ‘diagnosis and treat’. Root caries is a longer term process - ‘diagnosis and long term management’. As we know that one of the most statistically significant markers of root caries is previous root caries experience, then having identified and managed the lesions, the patient remains at risk. Increasing age and its associated frailty are other recognised risk factors. Long term management strategies for any patient who is identified as having a history of root caries should therefore be considered essential. Similarly the healthy surviving teeth of any patient going through life style changes due to illness, disability or increasing frailty should also be considered as being at risk of root caries and long term management strategies put in place.
Life expectancy (LE) and disability free life expectancy (DFLE) at age 65 in the UK (2008-2010). Adapted from ONS10

<table>
<thead>
<tr>
<th></th>
<th>LE</th>
<th>DFLE</th>
<th>DFLE as a proportion of LE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>17.8 years</td>
<td>10.4 years</td>
<td>58.3%</td>
</tr>
<tr>
<td>Females</td>
<td>20.4 years</td>
<td>11.2 years</td>
<td>54.6%</td>
</tr>
</tbody>
</table>

Table 1: Life expectancy (LE) and disability free life expectancy (DFLE) at age 65 in the UK (2008-2010). Adapted from ONS10

Prevention advice for adults

All adult patients

- Brush at least twice daily with a fluoridated toothpaste
- Brush last thing at night and on at least one other occasion
- Use fluoridated toothpaste containing at least 1,350 ppm fluoride
- Spit out after brushing and do not rinse, to maintain fluoride concentration
- The frequency and amount of sugary food and drinks should be reduced

For adults at higher risk

- All the above + use a fluoride mouthrinse (0.05% NaF) at a different time to brushing

Adapted from Delivering Better Oral Health12

Table 2: Prevention advice for adults. Adapted for Delivering Better Oral Health12

Professional interventions for adults at risk

- Apply fluoride varnish to teeth twice yearly
- For those with active caries, prescribe a daily fluoride rinse
- For those with active caries, prescribe 2,800 or 5,000 ppm fluoride toothpaste
- Investigate diet and assist to adopt good dietary practice

Adapted from Delivering Better Oral Health12

Table 3: Professional interventions for adults at risk

References

11. http://www.challacombescale.co.uk (accessed 16th November 2016)
16. About the Author:

Paul Hellyer BDS MSc is Honorary Teaching Fellow, University of Portsmouth Dental Academy. Paul has spent several weeks over the past few years as a volunteer in Africa for both Bridge2Aid and Mercy Ships and in 2014, visited a dental school in Borama, Somaliland on behalf of King’s College London and the charity THET.

Correspondence:

e-mail: paul.hellyer@port.ac.uk

28 CLINICAL DENTAL HEALTH
A 24 year old female presented with isolated localised recession (Fig. 1) in the lower right lateral, which had been present for some years. The patient found this area to be cosmetically unsatisfactory. In addition she found the soft tissues around the area uncomfortable and very difficult to clean, and reported that she suffered from repeated bleeding. The patient was healthy with no relevant medical history and a non-smoker.

The patient was acceptable to the idea of surgical treatment and the likely outcomes and potential possible consequences of any treatment, in addition to the consequences of not treating the area, were discussed in detail. Following this discussion and a period of reflection a report and written estimate was provided in the form of written consent.

The significant consequence of this two site procedure can be that the palate is often very painful postoperatively. Careful management of the patient and their expectations during this phase is therefore essential.

The procedure

On the day of surgery careful and complete local anaesthetic at the surgical sites was undertaken. The initial phase of treatment then began with the excision of the inflamed tissue at the gingival margin of the defect (Fig. 2).

Treatment options

There are a number of treatment options in cases such as this which include: localised conservative treatment and maintenance; soft tissue graft with a xenograft potentially of porcine origin; or allograft of human origin; local soft tissue transposition flaps, either lateral reposition flaps or advancement flaps; extraction of the tooth and replacement following bone grafting and soft tissue grafting, with either a dental implant based restoration or a bridge.

The pros and cons of each procedure were discussed at length with the patient and we finally agreed to proceed with ‘state of the art treatment’ at this time; an autologous connective tissue free graft from the patient’s palate repositioned in a split thickness flap at the site of the defect.
A split thickness flap was developed extending significantly to at least one tooth’s width either side of the defect. Once a pouch had been developed, the dentine of the exposed tooth was curetted and cleaned (Fig. 3). Removal of the smear layer at this stage can usually be carried out.

New instrumentation was then utilised, i.e. new blades to ensure clean margins are assured, and a standard trap door incision was carried out on the palate, again under local anaesthetic. The zone of soft tissue from distal of the canine to the first molar provides the ideal character graft.

A collagen free graft was carefully dissected out using sharp dissection techniques and placed to one side in sterile saline on a sterile surface (Fig. 4). The size of the required graft was dictated by the size of the defect at the recipient site and measurement of the graft is easily undertaken using a guide or periodontal probe. A graft of sufficient size was made to provide significant overlapping of the split thickness flap, thus providing the essential rich blood supply. The soft tissue graft was then inserted into the split thickness flap in the lower anterior region and carefully placed (Fig. 5).

Careful suturing was carried out to ensure the graft was in the correct position ensuring good overlapping between the periosteum beneath and the free epithelium/connective tissue graft on the labial aspect (Fig. 6). This large area of close apposition is essential to the blood supply of the graft and its stability for the long term. Careful suturing was undertaken ensuring the papillae were in the correct position and the sutures were tension free.
The donor site in the palate was also carefully sutured to achieve good apposition of the tissue to aid primary healing (Fig. 7), in addition to detailed suturing of the defect/graft complex (Fig. 8).

Written postoperative instructions were given to the patient, specifically that the palate would be very painful and oral hygiene instructions were provided. Follow up was arranged for two weeks later (Fig. 9).

The sutures were removed and further assessment of the donor surgical site was made on the palate (Fig. 10).

The lower labial aspect assessment was made eight weeks later when maturation of the soft tissues was more carefully judged (Fig. 11).
Conclusion

This is a very predictable treatment option which can produce good soft tissue profile colour and coverage. It should be emphasised that the assessment of cases and case selection is the key to this procedure. Choosing the wrong cases - cases that are too ambitious, patients with incorrect medical history or patients who smoke - can all lead to significant problems and indeed make the defect worse. A good knowledge of the anatomy of the area in detail, and understanding of the different layers involved in the procedure, is absolutely essential for good long term results.

The advantage of this soft tissue graft from the patient’s palate is that it is an allograft and with the correct pluripotent cells it has excellent potential to mature into the correct keratinised tissue, with good colour and character.

However, it should be understood that we have not corrected this completely at each anatomical level. There is no cementum, periodontal ligament, woven bone or bone complex over this area where the defect was noted and covered. There is however, tight, healthy, well-perfused soft tissue and this should give good longevity.

Patients must be advised that the best possible long term results are achieved in a healthy mouth. It is therefore imperative that an excellent homecare regimen is followed and a regular appointment with the dental hygienist are absolutely essential. It is vital that the patient takes ownership and that they understand that success going forward is now in their hands.

References


ABOUT THE AUTHOR:
Adrian Binney BDS, FDS RCPS, MScD Specialist in Periodontics

CORRESPONDENCE:
email: Adrianbinney.co.uk

The first dental probiotic for gum disease is now available in the UK

BioGaia ProDentis contains a natural bacteria which clinical studies show rebalances the oral microflora and can improve gum health. BioGaia ProDentis is available as lozenges and can be used as an adjunct to scaling and root planing for patients with chronic periodontitis.

For product SAMPLES and/or more information contact catriona.curl@biogaia.co.uk or text +44 (0)7494 492139
To order www.biogaia.co.uk

COPY DATES FOR DENTAL HEALTH

1ST FEBRUARY FOR THE MARCH ISSUE

The Editor would appreciate items sent ahead of these dates when possible.

Send your contributions to: The Editor, Heather Lewis,
19 Cwrt-y-Vil Road, Penarth, Cardiff CF64 3HN
or Email: editor@bsdht.org.uk
Abstract

Background: Statistics show that Singapore has a low ratio of dental professionals to clients. Support from across the disciplines of health care workers could assist the dental profession with early identification and intervention of oral health issues which may support a holistic approach to oral health education.

Methods: The Hiroshima University-Dental Behavioural Inventory (HU-DBI) was used as a survey tool to determine the attitude and behaviour of a target group. The survey of 20 dichotomous responses (Yes/No) was distributed to School of Health Science (SHS) and School of Business Management (SBM) students from Nanyang Polytechnic (NYP) the latter group acted as the control. The quantitative estimate of higher HU-DBI scores indicate better oral health attitudes and behaviours. Data was analysed using the analysis of variance with the statistical significance set at p < 0.05. An additional two questions were added to gauge the students’ interest in including oral health education within the existing curriculum and to assess the changes in attitudes and behaviours after clinical placements (if applicable).

Results: A total of 485 completed survey questionnaires were collected and tabulated. Results showed that students from the Diploma of Dental Hygiene and Therapy (SHS) had the highest score of 7.42, followed by students from SBM with a score of 5.91 Diploma in Nursing (SHS) had the lowest score of 5.52.

Conclusion: The study shows that student primary health care providers at NYP; Singapore have lower than expected attitudes and behaviour towards oral health. This may influence their interaction with their patients whose oral health condition may exacerbate their prescribed scope of practice.

Keywords: Oral health, attitude, behaviour, curriculum, health science students, dental, paramedical, nursing, HU-DBI survey, Singapore

Introduction

Understanding the importance of oral health care reflects on the behaviour of healthcare providers and their attitudes towards their own oral health. All healthcare practitioners should be able to give general advice on how to maintain good oral health, however many healthcare practitioners address their patients’ needs solely based on their prescribed scope of practice.

In an ideal situation, patients should be able to receive basic oral health information by any healthcare professional and then be referred for expert advice and/or treatment if required.

HU-DBI is a survey tool developed by Kawamura to investigate dental health behaviour, attitudes and perceptions in several countries including China and Britain, across various faculties. There is, however, insufficient data regarding oral health attitudes and behaviour among students in Singapore.

Oral health is an important attribute to the overall health and well-being of an individual. Singapore has a population that has tripled in 30 years from 1.889 million in 1965 to 5.535 million in 2015. The aging population also continues to increase with 13.1% citizens aged 65 and above as compared with 12.4% in 2014.

There is a greater need for more health care providers as oral diseases remain prevalent in society.

Research has shown that periodontal disease puts a person at a higher risk of having various health diseases such as, diabetes, coronary heart disease and adverse pregnancy outcomes. Hence it is important that all health care practitioners be well educated and armed with preventive information and health promotion strategies.

In daily practice, health care practitioners come into contact with a substantial number of patients from diverse backgrounds and age groups. Equipped with good personal oral health knowledge, health practitioners can be instrumental in primary health care strategies.

Two major factors that help to shape attitudes and health behaviours have been identified, one is the learnt experience of an individual and the other is the culturally determined attitudes of an individual. Leant experience is the equivalent of the individual’s learning curriculum with regards to dental education and the culturally determined attitudes are established by non-dental educators.

For a long period of time, oral health has been preconceptualised to issues related to the teeth only. Over the past few decades, multiple studies have been done to prove this preconceptualisation of oral health to be inaccurate. The definition of good oral health taken from the World Health Organization is “Oral health means being free of chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects such as cleft lip and palate, periodontal (gum) disease, tooth decay and tooth loss, and other diseases and disorders that affect the mouth and oral cavity.”

Over the past 50 years, Singapore has been efficiently providing the public with preventive, effective and affordable dental care. In the late 1950s, all public water supply was fluoridated with 0.7ppm fluoride, with a study done by Loh in 1996 proving that dental caries in children was lowered by 30%. Also, in tandem with the development of primary and secondary schools, dental clinics were also developed within the schools’ development plans. There are
The availability and accessibility to oral healthcare in Singapore has been structured with care by the government, however, a 1996 study by Loh and Low has shown that oral health promotion for home and professional care should be targeted at the adult population, particularly the older age groups. Lack of financial resources or insurance coverage is a serious barrier to access. McCaul found that psychosocial factors influenced dental hygiene behaviour. It is well known that socio-economic status and level of education affects the periodontal status of a person. Also, compared to medical insurance, there are not many companies offering dental insurance plans to the public.

The perceived value of a person is an important part of the belief system that causes lower utilisation of dental services with 39% visiting the dentist at least once in two years. There is also evidence that oral health behaviour of children and adolescents could be influenced by family background particularly in relation to that of the parent’s education level.

Across health professions, there is a growing appreciation of the need to address patient care systematically and holistically. The use of non-dental healthcare professionals in the promotion of oral health, can contribute substantially to improve oral health and identify oral health problems and diseases.

Non-dental healthcare professionals are often in a good position for early identification of oral health conditions and to refer patients for appropriate examination, diagnosis and treatment. Nurses in Lesotho reported positive attitudes towards the provision of oral health education. It was recommended that oral health be given greater attention in the nursing curriculum, with more clinical hands on training in examination and diagnosis of oral diseases.

Mehl stated there is a need to strengthen the position of oral health in the education of allied health professionals, especially nurses, to meet the future challenges in oral health. Knowledge of health in the education of allied health professionals, especially nurses, is considered to be an essential prerequisite for health-related behaviour. Literature comparing oral health attitudes and behaviours between paramedical, medical and dental/oral health students indicated a need for an intervention program to cater to the needs of the students due to the poor oral health attitudes discovered through the study.

However, Sharda (2010), stated that “The results indicate that the knowledge was not enough to influence the oral health behaviour, but behaviour showed linear relationship with attitude of the students.” This shows that the need for intervention in health care students should not be only knowledge based, but rather be directed at improving their oral health behaviours.

There appears to be a significant difference between the attitude and behaviour of non-dental healthcare professionals and dental healthcare professionals. This indicates a need for an improvement or an improvement to the current curriculum in terms of oral health education. In reference to the aims and objectives of our research, a local evaluation of the attitude and behaviour of NYP SHS students is required to determine the need for an intervention program to improve the attitudes and behaviours to oral health.

Aims and objectives

The purpose of this study is to evaluate the self-reported oral health attitudes and behaviour among students of SHS and SBM using a modified HU-DBI.

The aim of this study is to:

1) Identify the oral health behaviour and attitude among NYP SHS students.

2) Determine the need for an oral health intervention program within the NYP SHS curriculum.

Research methodology and data analysis

A total of 600 surveys were distributed to students in the School of Health Sciences and School of Business Management, Nanyang Polytechnic, Singapore. Courses in School of Health Sciences include: Diploma in Nursing, Diploma in Social Sciences, Diploma in Occupational Therapy, Diploma in Physiotherapy, Diploma in Dental Hygiene and Therapy, Diploma in Diagnostic Radiography and Diploma in Radiation Therapy (Figure 2).

Participation was voluntary and all information provided was kept confidential. Demographic information was obtained including age, gender, course of study and year of study.

A modified English version of HU-DBI survey which consists of twenty dichotomous responses (yes/no) was used in this study (Figure 4), with 12 graded responses (marked as ‘#’) and 8 ungraded responses. The maximum possible score is 12. Two additional questions about exposure to clinical attachments and the need for an oral health education program were included.

A total score was calculated based on the response to each item. Higher scores on the HU-DBI indicate better oral health attitudes and behaviour.

The data was entered into SPSS version 23.0 for statistical analysis. The data was analysed for frequency distributions. Group comparisons were made using Independent Sample t-Test for all data. The p-value was set at p ≤ 0.05.
Results

The total number of responses collected was 485, (Figure 2). When comparing the average score of respondents across the various specified courses, it is noted that students from the Diploma in Dental Hygiene and Therapy (DHT) have scored expectedly higher compared to the other health science courses and students from the SBM (Figure 3).

The data was further analyzed into three groups, namely:

a. School of Business Management

b. School of Health Sciences (Including DHT)

c. School of Health Sciences (Excluding DHT)

When comparing the average HU-DBI scores across the different groups and year of study amongst SHS students, no significant differences were found in the scores that average 5.72 (Figure 5 and 6)
I don’t worry much about visiting the dentist
My gums tend to bleed when I brush my teeth*
I worry about the colour of my teeth
I have noticed some sticky white deposits on my teeth*
I use a child sized toothbrush
I may have false teeth when I am old*
I’m bothered by the colour of my gums
I think my teeth are getting worse despite my daily brushing*
I brush each of my teeth carefully*
I have never been taught how to brush by a dentist or hygienist*
I think I can clean my teeth well without toothpaste*
I often check my teeth in a mirror after brushing*
I worry about having bad breath
It is impossible to prevent gum disease with toothbrushing alone*
I put off going to a dentist until I have pain or discomfort*
I have used a dye to see how clean my teeth are*
I use a toothbrush which has hard bristles
I don’t feel I have brushed well unless I brush with hard strokes
Sometimes I feel like I take too much time to brush my teeth*
I have had my dentist tell me that I brush very well
Were you ever on clinical attachments?
Do you think an oral health educational program is needed and will be beneficial to your future interaction with your patient regarding oral health?

Question 21 was made applicable to SHS students only, where over 300 of the respondents had been to a clinical attachments at the time of the survey (Figure 7).

In question 22, the majority of the survey participants thought that an oral health educational program should be included in the curriculum. (Figure 8)

Overall, there was a significant difference in the mean scores ($p < 0.05$) when comparing SHS (without DHT) with SBM students – 5.72 and 5.91 respectively.

This indicates a deficit in oral health behaviour and attitude from aspiring healthcare professionals which may adversely affect the behaviour and attitude of the clients they encounter on a daily basis.
Discussion

This study was designed to assess levels of self-reported oral health attitudes and behaviour of students who will join the future pool of healthcare practitioners. The survey was confined to the School of Health Sciences, Nanyang Polytechnic, Singapore, therefore the data is not representative in pure statistical terms. However, the sampling of these students may be indicative of the oral health attitudes and behaviours of other students studying in health related courses in Singapore. It would be interesting to discover if this is representative of health care students in the UK.

Conclusion

The results indicate a need for stronger emphasis on oral health to aid the healthcare professionals in patient management and help Singapore meet the oral healthcare demand of the rising aging population.

More research is needed on the existing health science curriculum to determine the current scope and ability to include information that will shape the attitude and behaviours of future allied health care workers.

Further study is also needed on a national scale and across a diversity of sample groups. This research may provide the basis for comparison and reference.

References

**NEW!**

**PROPHY PASTE**

- Contains xylitol + Gluten Free
- Powered by baking soda, a time-honored ingredient, that is recognized for its ability to whiten, brighten & neutralize pH
- Color coded for easy identification

**PROPHY CUPS**

- Engineered specifically for the unique requirements of the European dental professional
- Exterior ridges remove interproximal stains
- Proprietary rubber offers greater flare for a better polishing experience
- Internal webbing conforms to the tooth surface and reduces splatter

*Request your samples and learn about more products at www.youngdental.eu*
A female patient in her early fifties attending a hygiene visit, tells you how unhappy she is with the colour of her teeth and asks if there is anything that can be done to improve the appearance.

Q1. What is the cause of her discolouration?

Q2. What type of tooth whitening treatment would you recommend to achieve an improved and acceptable result?

Q3. Which tooth whitening product would be appropriate for use, specific to discolouration?

Q4. Before you proceed with the patient’s treatment, what two things must be carried out to ensure you provide safe and appropriate treatment?

ANSWERS TO CLINICAL QUIZ NOVEMBER 2016

Q1. What two aspects of the patient’s social history are important?
A.1 Smoking habits and alcohol consumption

Q2. Give a feature of the history of the lesion that should be included.
A2. Site

Q3. Give two clinical signs that should be included.
A3. The size of the lesion
   The appearance of the lesion to include colour and texture.

Q4. In addition to details of the history and appearance of the lesion, what other clinical findings should be included?
   Duration of lesion.
   Findings on palpation.
   Clinical diagnosis

The winner is: Imogen Wood
Dental Health is pleased to include a Continuing Professional Development (CPD) Programme for its members who are required to show evidence of CPD hours spent.

The Programme is formulated in accordance with the guidance of the UK General Dental Council’s regulations which now require all registered UK hygienists and therapists to undertake CPD and provide evidence of the equivalent of 10 hours per annum of verifiable CPD. The questions in this issue will provide 1 verifiable hour for those entering the CPD programme.

Aims and outcomes
The aim of the January 2017 Dental Health Continuing Professional Development Programme is to provide the opportunity for dental hygienists and dental hygiene therapists to learn about aspects of the following subjects: Root caries and the older dental patient and Behaviour and attitude to oral health among Nanyang Polytechnic, School of Health Science students. The anticipated outcomes are that dental care professionals will be better informed about methods, techniques and procedures of these subjects and that they might apply their learning to their practices and the care of their patients.

Members wishing to enter the Programme need to log on to wwwbsdht.org.uk and select CPD. Register if you have not yet done so, or Login if you have already Registered, and go to the Take CPD section. Certificates can be printed for the Programme in each issue, or stored in a personal ‘Global’ account and printed at any time. There is no charge for this service.

Alternatively, members may complete the answer sheet overleaf (or a photocopy). Return it with a cheque for £11.75 (£10 +VAT) made payable to BSDHT, to: BSDHT, Smile House, 2 East Union Street, Rugby, Warwickshire, UK CV22 6AJ. Responses must be received before 28th February 2017 as the answers will be given in the March 2017 issue (Volume 56 No 2).

Members from whom fully completed forms and appropriate cheques are received will receive a certificate for 1 hour of verifiable CPD with the answers to the questions.

Pass rate is 85%
1. Please PRINT your details below:

First Name*

Last Name*  Title

Address*

Postcode*

Tel:

Fax:  BSDHT Membership No*

Email:  GDC No*

*Essential information. Certificates cannot be issued without all this information being complete.

2. TICK the answer to each question for each article you select. You may complete one or two articles.

<table>
<thead>
<tr>
<th></th>
<th>CPD article 1</th>
<th></th>
<th>CPD article 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>a</td>
<td>b</td>
<td>c</td>
</tr>
<tr>
<td>Q2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q6</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Please either remove this page, or send a photocopy to:

BSDHT CPD Programme, BSDHT, Smile House, 2 East Union Street, Rugby, Warwickshire, UK CV22 6AJ together with a cheque for £11.75 (£10 + VAT)

Or complete online FOR FREE at www.bsdht.org.uk

Answer sheets must be received no later than 28th February 2017. Answer sheets received after this date will be discarded as the answers will be published in the March issue of Dental Health.

Feedback

We wish to monitor the quality and value to readers of the BSDHT CPD Programme so as to be able to continually improve it. Please use this space to provide any feedback that you would like us to consider.
### SPRING 2017 BSDHT REGIONAL GROUP MEETING DATES

<table>
<thead>
<tr>
<th>Regional Group</th>
<th>Date</th>
<th>Venue</th>
<th>Contact the Secretary</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>18th March 2017</td>
<td>Hallmark Hotel, Cambridge, CB23 8EU</td>
<td>Juliette Reeves</td>
<td><a href="mailto:bsdht.east@gmail.com">bsdht.east@gmail.com</a></td>
</tr>
<tr>
<td>Jersey</td>
<td>No Meeting</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>London</td>
<td>11th March 2017</td>
<td>Friends House, 173 Euston Road, London, NW1 2BJ</td>
<td>Mala Kanan</td>
<td><a href="mailto:londonsecretary@bsdht.org.uk">londonsecretary@bsdht.org.uk</a></td>
</tr>
<tr>
<td>Midlands</td>
<td>18th March 2017</td>
<td>Hilton, East Midlands Airport</td>
<td>Joanna Ericson</td>
<td><a href="mailto:midlandssecretary@bsdht.org.uk">midlandssecretary@bsdht.org.uk</a></td>
</tr>
<tr>
<td>North East</td>
<td>18th March 2017</td>
<td>Holiday Inn, Leeds</td>
<td>Clare Fox</td>
<td><a href="mailto:nergsecretary@gmail.com">nergsecretary@gmail.com</a></td>
</tr>
<tr>
<td>North West</td>
<td>11th March 2017</td>
<td>Mandec, University Dental Hospital, Manchester, M15 6FH</td>
<td>Karen McBarrons</td>
<td><a href="mailto:northwestsecretary@bsdht.org.uk">northwestsecretary@bsdht.org.uk</a></td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>25th March 2017</td>
<td>Radisson Blu Hotel, The Gasworks, Belfast, BT72 JB</td>
<td>Bridie Sergeant</td>
<td><a href="mailto:northernirelandsecretary@bsdht.org.uk">northernirelandsecretary@bsdht.org.uk</a></td>
</tr>
<tr>
<td>Scottish</td>
<td>25th March 2017</td>
<td>Radisson Blu Hotel, 301 Argyle Street, Glasgow, G2 8DL</td>
<td>Jane MacConnell</td>
<td><a href="mailto:scottishsecretary@bsdht.org.uk">scottishsecretary@bsdht.org.uk</a></td>
</tr>
<tr>
<td>South East</td>
<td>8th April 2017</td>
<td>David Saloman’s Centre, Tunbridge Wells</td>
<td>Catherine Fry</td>
<td><a href="mailto:souttheastsecretary@bsdht.org.uk">souttheastsecretary@bsdht.org.uk</a></td>
</tr>
<tr>
<td>Southern</td>
<td>4th March 2017</td>
<td>Holiday Inn, Winchester, SO21</td>
<td>Donna Brien</td>
<td><a href="mailto:secsouthern@gmail.com">secsouthern@gmail.com</a></td>
</tr>
<tr>
<td>S West &amp; South Wales</td>
<td>25th March 2017</td>
<td>Hilton Newport</td>
<td>Stephanie Sherwood</td>
<td><a href="mailto:swwsecretary@bsdht.org.uk">swwsecretary@bsdht.org.uk</a></td>
</tr>
<tr>
<td>South West Peninsula</td>
<td>25th March 2017</td>
<td>The Buckerall Lodge, Exeter</td>
<td>Jade Hutchinson</td>
<td><a href="mailto:southwestsecretary@bsdht.org.uk">southwestsecretary@bsdht.org.uk</a></td>
</tr>
<tr>
<td>Thames Valley</td>
<td>11th March 2017</td>
<td>The Jury Inn, Oxford</td>
<td>Sara Reid</td>
<td><a href="mailto:thamesvalleysecretary@bsdht.org.uk">thamesvalleysecretary@bsdht.org.uk</a></td>
</tr>
</tbody>
</table>
**BSDHT SWSW REGIONAL GROUP SPRING MEETING**

**DATE:** Saturday 25th March 2017  
**VENUE:** Coldra Court Hotel by Celtic Manor NP18 2LX

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30-09:00</td>
<td>Registration &amp; Trade Exhibition</td>
</tr>
<tr>
<td>09:00-09:15</td>
<td>Welcome and Council Rep Presentation</td>
</tr>
<tr>
<td>09:15-10:45</td>
<td>Jane Peterson Direct Access: Setting up oral healthcare visits for elderly in care homes</td>
</tr>
<tr>
<td>10:45-11:45</td>
<td>Cardiff University Student Presentations</td>
</tr>
<tr>
<td>11:45-12:15</td>
<td>Trade and Refreshments</td>
</tr>
<tr>
<td>12:15-13:15</td>
<td>Tim Ives Shut your Mouth - mouth breathing</td>
</tr>
<tr>
<td>13:15-14:15</td>
<td>Lunch &amp; Trade Exhibition</td>
</tr>
<tr>
<td>14:15-14:30</td>
<td>Alison Grant 60 minutes to Biofilm Blast Off</td>
</tr>
<tr>
<td>15:15-15:30</td>
<td>Refreshments</td>
</tr>
<tr>
<td>15:30-16:30</td>
<td>Phil Owers TBC</td>
</tr>
<tr>
<td>16:30</td>
<td>Certificates &amp; Feedback</td>
</tr>
</tbody>
</table>

**REGISTRATION FEES:**  
BSDHT Members £55.00, Buddy £50.00  
APPLY BEFORE 13 MAR 2017: Non Members/Dentists £80.00  
Students £10.00  
LATE REGISTRATION: £97.00  
BSDHT BUDDY: Bring a Buddy who hasn’t attended in the last 2 years and pay £50 each (Buddies must be BSDHT members)

**BSDHT THAMES VALLEY REGIONAL GROUP SPRING MEETING**

**DATE:** March 11th 2017  
**VENUE:** The Jury Inn, Oxford

**PROGRAMME:**

- 8.00: Registration and Trade
- 09.15: Welcome Address
- 09.30: Ms. Susan Njie - Dento Legal DDU
- 10.30: Council Report
- 11.00: Break and Trade exhibition
- 11.30: Prof. Tara Renton - LA update
- 12.30: Lunch and Trade exhibition
- 13.30: Raffle
- 13.45: Ms. Faye Donald - Air Polishing and Guided Biofilm Therapy
- 15.00: Comfort Break
- 15.15: Ms. Marina Harris - The impact of stress in our daily hygienist role. A survey will be completed by members and the outcome of this will be incorporated into the talk. This will be part of a research comparison with Marina’s current students.
- 15.15: Questions and answers
- 16.30: Meeting closes

The BSDHT app is available to download free from i-tunes. Visit the app store and click on ‘BSDHT’ to download the app.

There are currently 8 modules available: News; About BSDHT; My CPD; My PDP; Facebook; Twitter; BSDHT Website; Contact us.

Your Society is one step ahead of the rest!
Studies suggest that worn toothbrushes remove less plaque, particularly with respect to approximal sites as old, splayed toothbrushes are less able to gain access to these important areas. With Oral-B power toothbrushes, it is a combination of the head and handle configuration, which work in perfect synergy, to give the user the ultimate clean. The small round head mimics the action used in dental prophylaxis as it gently contours each tooth.

Convincing patients to change their toothbrush regularly is not an easy task and can be a sensitive subject. In an effort to encourage more frequent replacement, and to ensure your patients are using the correct head, Oral-B has produced a Refill Pack containing 25 CrossAction samples attached to cards, which reinforce your oral hygiene instruction. These are available free to hygienists to distribute to their patients. Gifting such an item to a patient not only generates a lot of good will, it also ensures they have the tools necessary to keep up the good work between appointments! If you would like a pack please contact your Oral-B representative. If you are unsure who your representative is call 0870 242 1850.

Oracle has always been aware of the critical role played by hygienists and therapists in improving the nation’s oral health. However good a toothbrush or toothpaste is, it needs proper instruction to ensure its health benefits are maximized. Oral-B has launched its ‘Dental Hygiene Heroes’ campaign to recognize and elevate the role played by hygienists in oral health education.

Oral-B has listened to the hygiene community over the years. When concerns were raised over patients’ ability to brush correctly with a power toothbrush, the company created ‘Test Drive’, which gives hygienists the chance to try a toothbrush on their patient, and ensure they’ve mastered the correct technique, before it’s purchased. This initiative has been accredited by the BSDHT. The company also supports the association by appointing leading academics to lecture at both regional and national BSDHT meetings.

Oral-B has made it easier for dental professionals to get hold of samples (both for themselves and their patients). Access to CPD has also been broadened. These are just some examples demonstrating commitment to the campaign, but there will be more support over the coming year. Look out for the ‘Dental Hygiene Heroes’ logo to see how Oral-B is helping to raise hygienists’ profile and support them in their day-to-day work.

The consumption of soft drinks, fruit juices and sports drinks continue to rise. The erosive nature of these drinks is well documented, which begs the question of what can be done to provide protection against their damaging effect. One study found that toothpaste containing stabilised stannous fluoride provided significant acid protection over that provided by conventional fluoride products. This is strongly attributable to the high bioavailability of stannous fluoride in the formula. It is believed that toothpastes containing this ingredient produce a protective barrier layer that remains on the tooth for hours after the products use. It is this, the authors conclude, which helps protect enamel against the initiation and progression of dietary acid attack.

Oral-B Pro-Expert toothpaste contains a combination of stabilised stannous fluoride and sodium hexametaphosphate. Professor Nicola West has commented that, “Patients susceptible to erosion would benefit from 2x daily use of fluoride toothpaste with stabilised stannous fluoride, such as Pro-Expert”.

Whilst it is hoped that education on the damaging effects of acidic drinks will go some way in controlling the problem of erosion, providing protection against the effect of such drinks will help individuals retain their enamel. Unlike the supply of these damaging beverages, once enamel’s gone, it’s gone!

BERKSHIRE

**Maidenhead.** Friendly, motivated hygienist required to join our preventive team in independent practice. 1 day per week (Monday or Tuesday) plus 1 Saturday morning per month, starting February 2017. Must be gentle and have a great rapport with patients. Suitable for newly-qualified. Interested? Please contact Sophie on 01628621810, Sally on 07843375845 or e-mail on sallyshimmin@icloud.com

**Reading.** An enthusiastic dental hygienist is required to join a well-established private practice on a 2-3 days basis. A minimum of 2 years’ experience is essential. Please send your CV to info@markhamassociates.co.uk or contact 01189502275.

DORSET

**Blandford Forum.** Part time dental hygienist or therapist required in a prestigious private dental practice. Very established list of regular patients, very experienced staff, fully computerised. alaskahousedental@gmail.com

**Poole.** Hygienist/therapist required one day a week preferably Tuesday for a private surgery in Lower Parkstone. Nursing support provided. Apply by email: John@moonfleet.co.uk

HAMPSHIRE

**Winchester.** Experienced Hygienist required for Winchester City Centre Practice for a Tuesday and/or a Friday. Please phone 07786 634400 for more details.

MIDDLESEX

**Staines-Upon-Thames.** Looking for a Wednesday Hygienist for our private computerised practice in Staines, Middlesex. Starting Jan/Feb 2017. £30-35/hour based on experience. Option to increase days. email: rikesh95@gmail.com

MIDLANDS (WEST)

**Birmingham.** Dental Therapist required 2 to 4 days per week. Private practice, Direct Access, full scope of work. Nurse provided, 2-3 patients per hour, full support given. Please email CV with photo ID to info@scottarmsdentalpractice.com

OXFORDSHIRE

**Oxford.** Help! Where have all the hygienist gone? Hygienist urgently required for Private Practice 1-2 days per week. Good motivator with a gentle touch. Please ring 01865 552978, email: oxfordddental@btconnect.com

SURREY

**Woking.** An excellent position for a Dental Hygienist/Therapist within a team of multidisciplinary specialists is available in Woking, Surrey. You will work closely with our experienced Prosthodontists and Periodontist in a modern and well supported environment. The position is initially available for maternity cover. Please email your resume or any queries to kim@dental.pb.co.uk

**Brighton.** Part-time hygienist required for busy well established mixed practice in Brighton Central location, very good rates. Please send email and CV to: dentistman2000@yahoo.co.uk

**Chichester.** We are a fully private dental practice looking to recruit an experienced Dental Therapist for 2 days a week initially. Please send CV FAO Practice Manager: markethousesurgery@btconnect.com

**Petworth.** Gentle, personable hygienist required for private practice in Petworth to replace long standing colleague. Possible days required Mondays and Fridays. For further information please contact Amanda/Nicola on 01798 343552 or email your cv to donovansdental@tiscali.co.uk

**Steyning, nr Worthing.** Hygienist/Therapist required for busy Private Practice. 3 days per week. Mondays, Tuesdays and ideally Thursdays. Established busy list. 30 minute appointments. Email: manager@downhouse-dental.co.uk / call 01903 813212.

**Worthing.** Dental hygienist vacancy. Full or part time position available, to the right candidate. Strand Dental is a long-established purpose built private practice in Worthing on the South Coast. A great opportunity to join our successful team. You will be working closely with our general dentists, Periodontist, Implantologist, and Orthodontist, to deliver excellent care to our patients. For further information, please contact Mrs Alexandra Linton, Practice Manager on 01903 238249 or via email: alex@strand-dental.co.uk.

WILTSHIRE

**Westbury.** Hygienist required Tuesdays for small friendly private practice with even friendlier patients. Good communication skills a must, along with relevant registration paperwork. 30 minute appointments and negotiable pay rate. Email Carl Roberts - haynesroaddental@btconnect.com / Tel 01373 865084
REGIONAL GROUP TEAM

**Eastern**
Chair: Gulab Singh  
Email: gulab_singh@yahoo.com 
Secretary: Juliette Reeves  
Email: bsdht.east@gmail.com 
Treasurer: Sarah Dennison  
Email: eastern treasurer@bsdht.org.uk 
Trade Liaison: Sarah Dennison  
Email: eastern treasurer@bsdht.org.uk 

**Jersey**
Chair: Katie Park  
Email: jerseychair@bsdht.org.uk 
Secretary: Tammy McArdle  
Email: jerseysecretary@bsdht.org.uk 
Treasurer: Pam Currie  
Email: jerseytreasurer@bsdht.org.uk 
Trade Liaison: Vacant 

**London**
Chair: Dawn Sherry  
Email: londonchair@bsdht.org.uk 
Secretary: Mala Kanan  
Email: londonsecretary@bsdht.org.uk 
Treasurer: Sarah Murray  
Email: london treasurer@bsdht.org.uk 
TLO: Suzanne Dymant  
Email: london tlo@bsdht.org.uk 

**Midlands**
Chair: Emma McCormack  
Email: midlandschair@bsdht.org.uk 
Secretary: Joanna Ericson  
Email: midlandssecretary@bsdht.org.uk 
Treasurer: Lucy Williams  
Email: midlandstreasurer@bsdht.org.uk 
TLO: Jenny Whittaker  
Email: midlands tlo@bsdht.org.uk 

**North East**
Chair: Greta Compton  
Email: nergchair@btinternet.com  
Secretary: Clare Fox  
Email: nergsecretary@btinternet.com  
Treasurer: Kerry Robinson  
Email: nergtreasurer@btinternet.com  
Trade Liaison: Sharron Parr  
Email: nerg treasurer@btinternet.com 

**North West**
Chair: Kai King  
Email: northwestchair@bsdht.org.uk  
Secretary: Karen McBarrons  
Email: northwestsecretary@bsdht.org.uk  
Treasurer: Cath Clarke  
Email: northwesttreasurer@bsdht.org.uk  
Trade Liaison: Natalie Golden  
Email: northwesttlo@bsdht.org.uk 

**Northern Ireland**
Chair: Lorna McGrath  
Email: chairbsdhtni@gmail.com  
Secretary: Brigid Sergeant  
Email: northernirelandsecretary@bsdht.org.uk  
Treasurer: Paula McAtamney  
Email: treasurerbsdhtni@gmail.com  
Trade Liaison: Michelle McWilliams  
Email: trade liaison@bsdht.org.uk 

**Scotland**
Chair: Hazel Cameron  
Email: scottishchair@bsdht.org.uk  
Secretary: Jane MacConnell  
Email: scottishsecretary@bsdht.org.uk  
Treasurer: Debbie Dewar  
Email: scottishtreasurer@bsdht.org.uk  
Trade Liaison: Tricia Steele  
Email: trade liaison@bsdht.org.uk 

**South East**
Chair: Katharine Bryce  
Email: southeastchair@bsdht.org.uk  
Secretary: Catherine Fry  
Email: southeastsecretary@bsdht.org.uk  
Treasurer: Miranda Steeples  
Email: southeasttreasurer@bsdht.org.uk  
Trade Liaison: Vickie Brickle  
Email: southeast liaison@bsdht.org.uk 

**South West and South Wales**
Chair: Alison Lowe  
Email: swsw treasurer@bsdht.org.uk  
Secretary: Karen Smith  
Email: swswsecretary@bsdht.org.uk  
Treasurer: Paula McAtamney  
Email: treasurerbsdhtni@gmail.com  
Trade Liaison: Michelle McWilliams  
Email: trade liaison@bsdht.org.uk
So is TePe EasyPick™.

TePe EasyPick™ promotes a healthy new on-the-go dental habit, making it easy for patients to remove trapped food when they eat out.

- Comes in two tapered sizes for easy cleaning of all interdental spaces
- Handy travel case format encourages frequent on-the-go use
- Increases the likelihood of habit formation*

Order from your wholesaler today. For more information visit tepe-easypick.com

*Frequency of use increases the likelihood of habit formation (Lally et al 2010.)
NO COMPROMISE

ORAL-B PRO-EXPERT
PROFESSIONAL PROTECTION
featuring breakthrough
Stabilised Stannous Fluoride technology

CLINICALLY PROVEN TO PROTECT ALL
THE 8 AREAS YOU CHECK MOST

Plaque
Gum Problems
Sensitivity
Caries
Halitosis
Enamel Erosion
Tartar
Staining

www.dentalcare.com