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.

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There are so many reasons to be a proud hygienist or therapist.

We celebrate each and every one of them.

We have a renewed commitment to help you do what you do best. Tell us why you’re proud to be a hygienist or therapist at Dentalcare.com

We ❤️ Hygienists & Therapists
The general election on June 8 is only a few weeks away and we hope that the newly elected government, whichever party that may be, will recommit to the Soft Drinks Industry Levy, commonly referred to as the Sugar Tax, as outlined in the 2017 Finance Bill.

I am writing this the day before the Finance Bill is to be debated in the Commons (Tuesday 25 April), and passed into law before the dissolution of this Parliament. It is essential that the Soft Drinks Industry Levy continues to be part of this Bill and we can only hope that Ministers recognise the urgency and that no further amendments are required. Any amendments would result in a lengthy delay to the levy becoming law, possibly until next year.

However, as we wait to hear the outcome there is some encouraging news to be shared. Last week it was announced that NHS England and its leading suppliers have agreed to join forces and cut the number of sales of sugary drinks in hospitals in England.

NHS England has asked all retailers with hospital outlets to limit carbonated sugary drinks to no more than 10% of the total beverages they sell, by next April. Companies that do not comply will face a total ban on selling sugary drinks in hospital shops. WHSmith, Marks & Spencer, Subway and Greggs have all agreed to cut the proportion of sugary drinks they sell in their hospital shops in England.

Furthermore, new national incentives for hospitals and other NHS providers have been introduced to encourage them to improve food on their premises. Progress has already been made in the last year to cut all price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS), end advertisements of these foods on NHS premises, stop sales at checkouts and ensure healthy food options are available at all times, including for those working night shifts.

With the likelihood of a sugar tax becoming law, many manufacturers are now busy reformulating their products. However, despite encouraging news from Lucozade Ribena Suntory (LRS), that they have reduced the sugar content of their products by 50%, LRS’s advertising campaigns have now taken a new direction. The company states that the reformulations may impact on patients who drink their products to manage diabetic hypoglycaemia or other inherited metabolic conditions. They point out that the addition of aspartame (a source of phenylalanine) will mean that some LRS products are no longer suitable for patients with phenylketonuria (PKU). The new formula will have subsequent implications for those who use Lucozade Energy for glucose tolerance tests.

The company has now sent out to all NHS health boards across the UK information and materials to communicate this fact to the relevant teams in their local region. They have helpfully included a raft of literature and posters which include a large image of a bottle of Lucozade for display in public areas. Cynics may consider this move a tactical advertising ploy?

Other news from the US is encouraging and recently published figures indicate that a tax on sugar-sweetened beverages in Berkeley, California has resulted in a fall in sales by almost 10%.

We must hope for the sake of the nation that whichever party is in power after June 8 it continues to be advised by those healthcare workers on the frontline; whether the issue is childhood caries or obesity, the Soft Drinks Industry Levy is a good starter for (Number) 10.

In the meantime it’s Action on Sugar - Sugar Awareness Week: 15th - 21st May, 2017.

Heather Lewis
Editor, Dental Health
Spring is upon us and the initially quiet beginning to the year has now changed with the season; the pace of work has gathered momentum and my diary is now quite busy. Since the last issue of Dental Health was published I have judged the entries for the Dental Awards; interviewed for BSDHT administration staff; commented on the GDC consultation “Shifting the Balance...” on behalf of BSDHT; attended the GDC Complaints Handling Workshop; attended the Association of Dental Groups (ADG) Bursary Awards; met with the new PCOs to plan our OHC in Harrogate; and met with many of the dental companies for forward planning on how we can work together in the coming year.

BSDHT Staff

As we prepare to move into our own premises, BSDHT needs to employ its own administration team. I am delighted to announce that Sharon Broom will be our Director of Operations and will be working alongside Selina Vegad. Both Sharon and Selina have worked with BSDHT at Smile House and have a solid understanding of how our organisation works, which will make for a smooth transition. We look forward to continuing working together.

Prescribing

As you are aware, BSDHT has collaborated with the British Association of Dental Therapists (BADT) to ensure a strong united voice as we apply for prescribing with exemptions. Exemptions mean that we would potentially be exempt from needing a prescription to deliver certain prescription only medicines (POM), such as local anaesthetic, topical anaesthetic and fluoride varnishes. Many of us have experienced the severe limitations placed on our inability to prescribe, and the impact it has on both patients and the profession. Patients may present with different needs on the day they attend for treatment than what was initially expected. When this happens we then have to call on the prescribing dentist to amend the prescription, or, if the prescribing dentist is unavailable, we are then unable to carry out the necessary treatment. Being permitted to prescribe would prevent these scenarios; the dentist would be able to go about their working day without the added complications of having to leave their patients to prescribe something we are entirely capable of providing. This would ensure that our patients receive the treatment they require and leave the practice happy, with the patient-professional relationship firmly intact.

Immediate past president Michaela O’Neill explained the process in March 2016 issue of Dental Health. Since that time progress has been made and it has been agreed that Michaela and Fiona Sandom, immediate Past President of BADT, will be the leads on this project on behalf of our profession. I am delighted to announce that last month we were given the green light by the Department of Health to move forward to the next phase with the ultimate aim of providing the required POM to our patients without having to first get a prescription from a dentist. This is fantastic news! However, this is only the beginning and both BSDHT and BADT now need to hear from the considerable voice of our profession to drive the change. We need to build our case for the need for prescribing responsibilities across the profession.

We want to hear how the lack of prescribing responsibilities has impacted your day to day working life. Have you had to send away a patient with incomplete or no treatment because you could not get a prescription? The more examples of cases we have for the cause, the louder the voice we have. Please email your experiences and the impact it had on both you, the patient and the practice to prescribing@bsdht.org.uk There are no guarantees that we will get this, and we are going to have to fight hard for what we need.

This will not just benefit BSDHT and BADT members, but it will impact on all dental hygienists and dental therapists for generations to come. It will also benefit the dentists we work with. So please speak to colleagues and find out how it has affected them and encourage them to tell us.
However, I cannot stress enough how complex and time consuming the process is. Most other professional bodies in similar situations have found that they needed to employ one person over the course of one day a week, at least, while others have appointed a dedicated individual for the role, employed four days a week. Both BSDHT and BADT agreed that this would be an enormous financial drain on our professional organisations and we needed to look at alternative ways to fund this. It has been agreed that Michaela and Fiona will lead and drive this project forward and therefore they will require funding for one day a week each, possibly for the next two years. A fair solution may be to fund this project by fundraising via Crowdfunding. We have around 7,000 dental hygienists and dental therapists on the register, if every one of those registrants made a one off donation of £10.00, this would ensure that we could fund and drive this project forward and have the best possible chance of achieving our goal to be able to prescribe and provide our patients with the treatment they require. Details will follow of the crowdfunding page and how you can donate.

Events

BSDHT will not be having a stand at BDA this year, but I will be there representing BSDHT. Also council member Diane Rochford will be speaking on the Friday 25th May on behalf of BSDHT in the personal development theatre. The title of her presentation is “Tooth whitening: a dental hygienist and dental therapist’s perspective.” We will be on stand N60 at the Dentistry show on the 12th and 13th May. Representatives from the Howden group will also be there to answer any questions you may have about the new bespoke BSDHT Indemnity policy and give you a quote. I will be chairing the Friday session in the Hygienist and Therapy Symposium where you can listen to speakers such as Phil Ower and Juliette Reeves. The full programme can be found on the Dentistry Show website.

Helen Minnery
The 2017 First Smiles initiative, developed by BSDHT in response to the ongoing children’s oral health crisis in the UK, is due to run again next month on Friday 16 June.

BSDHT members are encouraged to visit schools and nurseries across the UK to deliver fun and accessible lessons to children on the importance of good oral health, teaching youngsters the necessary habits needed to maintain a healthy smile for life.

Simone Ruzario, Thames Valley Regional Representative and Publications Team member, was involved in last year’s First Smiles Initiative. This is what she had to say:

I carried out First Smiles over a number of sessions, because I was visiting a range of class groups in Lancot School in Bedfordshire near where I live. I engaged with 181 children in nursery, reception and Year 1 classes.

The children were brilliant, they were really motivated and wanted to learn and share what they knew about oral health and hygiene. Many of the children had visited a Dentist.

So many of the parents thanked me for the school visit and I was happy to hear that the children were quickly putting into practice at home what they had learnt with me in school.

I would like to thank BSDHT for implementing such a great and worthwhile initiative and Oral-B, TePe and Curaprox for their generous donations of toothpaste and toothbrushes.

The BSDHT’s aim is to mobilise our members, the clinicians on the frontline in dentistry, to use your unique skills and knowledge to make a difference to children’s oral health. The initiative is open only to dental hygienists, dental therapists and students who are BSDHT members.

BSDHT members who wish to take part and make a difference can find out more about First Smiles at wwwbsdht.org.uk/FirstSmiles.
**BSDHT SOUTHERN REGION**  
**SPRING MEETING**

**DATE:** Saturday 4th March 2017  
**VENUE:** The Holiday Inn, Winchester  
**SPEAKERS:** Paul Thirwell, Sonia Jones,  
**SPONSORS:** Thanks to AWB Textiles; Dentsply Sirona; ICON; Oral-B; TePe and Trycare

Registration, tea and coffee began at 9 am followed by our first speaker of the day - **Paul Thirwell** on the subject of **Cardio Vascular Implantable Electronic Devices (CV IED’s)**.

Paul shared his knowledge with humour and utilised a selection of ‘dummy’ models of each CV IED for us to pass around, which was really helpful.

These included examples of:

- **Linqs** – which are placed subcutaneously
- **Pacemakers and ICD’s** (Implantable Cardioverter Defibrillator) - these are screwed into the lining of the heart and can both be single or dual chamber.

Paul highlighted the people who are more likely to get infections with CV IEDs and those more likely to need AB cover.

Importantly, the current requirement for distance between a CV IED and an ultrasonic scaler is 6 inches (15cm). If at any point during treatment the clinician is concerned then the cardiac unit should be called. All patients with a CV IED will carry a card with them at all times with phone numbers and other information.

Our second speaker followed the coffee break. **Sonia Jones** discussed **the laws that govern dental radiography**.

Sonia suggested essential reading on radiography for Dental Hygienists and Therapists, she talked about radiation protection and legislation including IR (ME)R 2000.

We then covered in depth the publication, IRR 1999 – This had 44 regulations and 192 pages! It addresses the ‘equipment’ involved in dental radiography and came into force on 1st January 2000. It covers essential legal requirements, so to use dental radiography you must:

- Notify and obtain permission from the HSE;
- Complete a risk assessment;
- Have a contingency plan;
- Restrict the dosage (AARA/ALARP);
- Complete training;
- Have a legally appointed person (always the senior dentist);
- Have an RPS (Radiation Protection Supervisor) and an RPA (Radiation Protection Advisor);
- Have local rules.

The IE (ME)R 2000 Essential Legal Requirements is a piece of legislation that protects the patient and came into force on 13th May 2000. We discussed the various responsibilities of:

- The employer;
- The referrer;
- The practitioner;
- The operator.

Within IR(ME)R 2000 you must ensure:

- Justification - if the x-ray is not justified DO NOT do it;
- Optimisation – you must aim to obtain the best quality of radiograph to ensure ALARA/ALARP;
- Limitation - the dosage should not exceed set limits.

Sonia talked about lead protection and the fact that in 1994 the NRPB said that lead aprons do not protect against radiation scattered internally. Lead aprons can however be useful for carers, and thyroid collars are still useful.

After lunch the raffle was drawn and then Helen Horsfield, Council Representative presented her report from Council. **Sonia** also presented the final lecture of the day: **oral manifestations of infectious diseases (why cross infection control is paramount)**.

A working definition of cross infection control was offered and aspects of HTM0105 and CQC Infection Control Reg 12: safe care and treatment. Best practice requirements for all dental practices was then highlighted.

Sources of infection and the microorganisms involved were discussed along with transmission, immunisation and immunocompromised patients.

To end, Sonia presented a series of clinical slides with images of some oral manifestations of bacterial infections and viruses.

A really interesting day was had by all - engaging speakers, lots of friends and colleagues to catch up with, and our colleagues in the trade to visit throughout the day.

**Sonia Thomas**
BSDHT THAMES VALLEY REGIONAL GROUP

SPRING MEETING

DATE: Saturday 28th February 2017

VENUE: The Oxford Hotel, Oxford

SPEAKERS: Dr Richard DeCann, Dr Shekha Bhuva, Dr Brian Murray

SPONSORS: A very big thank you to our sponsors; AWB textiles; Blackwell; Dentaid; Dentsply; Dentyl Active; GSK; Henry Schein; Johnson and Johnson; Optident; Orascoptic; Survival 32; Swallow; TePe; Velopex and Waterpik; Dental A-Z sample drop; Piksters – sample drop

Our day started brightly with a well subscribed trade exhibition, and we are truly thankful to our trade for continuing to support our meetings. We had further time during our coffee and lunchtime for delegates to visit the trade exhibition. Registration went smoothly and there was time for coffee before our opening address.

Our newly elected Thames Valley council representative Simone Ruzario, followed the welcome address, updating our region with the council report. There was good feedback from the delegates especially since it was her first delivery of the report.

Our first speaker Dr Richard DeCann was our main speaker of the day providing us with a two part lecture. He was very entertaining and with the topic of radiography he had most, if not all of us at some point in laughter. His delivery of this topic is quite unique.

He started with the background of radiation and reminded us it is Europe who wants us to stay updated, not the GDC. We covered the basics of radiation from health and safety, patient safety and the extension of scope of practice for DCP’s. It was definitely a thought provoking discussion especially when it came to the different types of cell damage. We covered legislation, the difference between IRR (workplace safety) and IMER 2000 (patient safety). He encouraged us to go back to our work environments and find out if regular risk assessments are taking place and if not carry out a risk assessment regarding surgery layout and radiographic equipment. His second part of the lecture covered more radiology thus focusing on IMER 2000 and carrying out quality assurance, including audits.

After lunch our second speaker was Dr Shekha Bhuva a Specialist in Periodontology, she gave a lecture on managing deep pockets. This lecture covered the fundamentals of periodontal disease, systemic diseases, smoking and outcome objectives from carrying out periodontal treatment. Dr Shekha covered the importance of early detection and good treatment planning - there have been 170 litigious periodontal claims between 2008 and 2012 in the UK, it is vital we have good protocols in our dental practices.

Our last speaker of the day was Dr Brian Murray, is a Consultant in Older Adult Psychiatry presenting on the subject of where dental health meets mental health. This lecture covered mainly the different types of Dementia. We were offered tips on what to lookout for if a patient maybe displaying signs of early dementia. We were also encouraged to think about the carer, especially if the carer is also elderly and caring for someone with advanced dementia, they may be unaware that there is a problem. It is important to have a good dental care plan and prevention and oral hygiene instruction are key to preventing complications. Dementia is an important issue and the medical and dental professions need to work together.

We had an excellent day full of insight and enlightenment from our brilliant speakers. Our day awarded 5 hrs Verifiable CPD, with the trade exhibition giving 2 hrs Non-Verifiable CPD.

Simone Ruzario

WE ASKED YOU…

During the OHC in Belfast last year, and then throughout the month of January on line, we asked you our readers a number of questions relating to our BSDHT publications.

A total of 554 of you took the time to respond of which 393 (70.94%) said that they read Dental Health ‘all of the time’, 159 (28.70%) read the journal ‘some of the time’ and 2 (0.36%) members told us that they ‘never’ read the journal.

We hope you all find something of relevance to your daily practice in this issue.
WANT TO PRESENT YOUR WORK?

ORAL HEALTH CONFERENCE & EXHIBITION
3rd and 4th November 2017
Harrogate International Centre

The British Society of Dental Hygiene and Therapy (BSDHT) would like to invite colleagues to submit posters for the OHC 2017.

Please complete the ‘Poster Submission Form’ which can be found on the BSDHT website.

All posters submitted for the OHC 2017 will be entered into this years poster competition where there will be prizes for the ‘Winner’, ‘Runner Up’ and ‘Best Student’ submission.

BSDHT welcome your support and participation.

* terms and conditions apply, please contact the BSDHT office for details

We would love to have as many of you involved in this competition as possible.

Some of you are familiar with writing posters. Some of you may be familiar with viewing a poster display when you attended a previous OHC. For those of you who are contemplating getting involved we have lots of support and help available to you.

In the meantime here are some ideas which may stimulate your creativity and get you started.

Why not consider some of the following areas to explore: a research topic; a literature review; a case study; a clinical audit; or a service evaluation.

Please visit www.bsdht.org.uk
For more information please contact enquiries@bsdht.org.uk
You may, by now, have noticed the efforts we have been putting in to publicising the BSDHT Indemnity policy, which is a policy that you need to take out in order to practice in the UK as a Dental Hygienist or Dental Therapist.

Great, you might think, but what does this mean to me?

Before your eyes glaze over: “it’s one of those things I have to do, but I don’t know why…I am not interested…” just take a second to think about this.

Your Society, the BSDHT, with your fellow practitioners on the Executive Committee as your representative, have designed this policy to serve us, the membership – not anyone else.

This tailored made policy covers our full scope of practice, including lasers, with the option of adding cover for Botox and use of fillers, and a legal help desk as and when we need it. For the vast majority of members who have asked for quotes so far it has worked out cheaper than their existing insurer.

It really is a no-brainer for Dental Hygienists and Dental Therapists, once you remove the expensive people from the equation, ie dentists, it’s bound to be cheaper!

So what’s holding you back?

If your policy is not due for renewal yet, just drop a line to Holly at BSDHT@howdengroup.com with your contact details and the month your current renewal is due. That’s it! They will then get in contact with you in good time to remind you and you can take it from there. Your money and time saved – what’s not to like!

BSDHT member Roy Anthony took out a policy recently and had this to say in an email to Howden:

“My brief contact experience with Howden has been very favourable.

As a BSDHT member the new advertisement highlighting the link between my Society and your company was timely as my indemnity was due for renewal.

My initial email enquiry was dealt with promptly and Holly very quickly provided a very competitive quote and the necessary paperwork was simplicity itself.

The brief phone calls again with Holly, have been professionally and pleasantly dealt with and the indemnity was put in place as quickly as I would like, and saved me approximately 28% on my original indemnifier’s quote.

It is a leap of faith taking on a product new to the market and away from the established indemnifiers as the solidity of the product will only truly be tested in a court of law but I trust that BSDHT has researched the product on our behalf and have found Howden to be worthy associates.” [Reproduced by kind permission unedited.]
Recently the third and fourth year students at the University of Edinburgh took part in a campaign organised by the charity, ‘Let’s talk about Mouth Cancer’. It was a highly educational and hugely rewarding experience for all of us.

During the morning we were involved in various workshops looking closely at the signs and symptoms of mouth cancer. We also learnt about the importance of a referral letter, gaining some top tips on how to go about writing one.

We then split into groups and collaborated on a presentation to educate various groups of the general public, before then going to visit them in the afternoon.

We all gained so much from teaching people how to check their own mouths for symptoms of mouth cancer and educating them about what to look out for. Some of the people we engaged with had never heard of mouth cancer.

This whole experience made me question whether we should be doing more to educate the general public about mouth cancer. Most of the people we met were shocked to learn about the causes, such as chewing tobacco, smoking and the fact that if you combine smoking and drinking alcohol together you are at a much higher risk of developing mouth cancer.

The people we spoke with had no knowledge whatsoever of mouth cancer prior to our presentations. I left with the impression that they were really interested in learning about the different types of red and white patches that can occur in the mouth and other oral lesions, such as lichen planus or lichenoid reaction.

I believe that it would be of great help to the general public if there were more publications released and more educational days like the one we participated in to help educate and spread awareness. We are very quick to talk about the risk factors of smoking but we need to be constantly proactive, particularly with the younger generation where incidences of mouth cancer are increasing.

Perhaps if people knew what they were looking for in their mouths they would be more aware and present for help if they were worried or unsure, rather than not knowing what to look for and ignoring it.

Overall it was a very rewarding day for a relatively new charity and we hope to be able to do undertake more activities like this in the future.

Amber Ojak is the UK BSDHT student representative.

If you have any issues or topics to discuss, either related to your study or clinical practice, please contact Amber at: amberojak23@hotmail.com
National Smile Month:
Put a smile on your patient’s face!

The Oral Health Foundation, is delighted to announce the return of National Smile Month for 2017, with the campaign promising to bring with it a summer time of smiles right across the country.

This year the UK’s largest and longest running oral health campaign takes place between 15 May and 15 June and aims to increase awareness of important oral health issues and make a significant difference to the well-being of millions of people.

Supported by thousands of individuals and organisations, National Smile Month promotes three key messages at the heart of good oral health; brush your teeth last thing at night and at least one other time during the day with a fluoride toothpaste, cut down on how often you eat sugary foods and drinks, and visit the dentist regularly, as often as they recommend.

With the days starting to get longer and the sun finally warming up as we count down the days to National Smile Month the charity is calling on dental and healthcare professionals to help spread smiles and key oral health messages even further than ever before.

CEO of the Oral Health Foundation, Dr Nigel Carter OBE, spoke about why professionals should get involved in 2017.

Dr Carter said: “This is your opportunity to help spread some smiles and improve oral health in the UK. As we enter what is amazingly the fifth decade of National Smile Month the charity is calling on dental and healthcare professionals to help spread the word about the importance of good oral health and a good oral hygiene routine, with your help, we can herald even greater improvements.

“With your support the campaign reaches more than 50 million people each year and we are delighted to see how many of you actively get involved in National Smile Month.”

National Smile Month 2017 sees the return of the now iconic smiley, something which Dr Carter believes symbolises exactly the purpose of the campaign.

“Elements such as the smiley enable us to have a real impact. Alongside education, National Smile Month is about having fun and reaching out to people to drive their interest in oral health.

“Share your #MySmileySelfie with us on social media and show how you are helping to provide better oral health for all.”

National Smile Month is being supported by some of the nation’s best-known brands and retailers. Oral-B is the platinum sponsor of the campaign, with further support from Wrigley’s Extra, POLO® Sugar Free, Philips and Regenerate.

Visit www.smilemonth.org/register to support and take part in National Smile Month. Registration only takes a couple of minutes and is completely free, by registering you will receive our amazing National Smile Month Registration Pack which includes everything you need to kick start your personal campaign.
The late Dr Gerald Leatherman played a very important part in promoting the role of the dental hygienist as one of the pioneers of preventive dentistry in the UK. Described as ‘The Father of World Dentistry’ by Dame Margaret Seward he dedicated his professional life to raising the profile of both the dental hygienist and dental health promotion. He was actively involved with the British Dental Hygienists’ Association (now BSDHT) from the start and played a leading role in the establishment of the first dental hygiene training school in England. Following his retirement from the office of President of the BDHA in 1957 he was appointed Honorary Vice President until his death in 1991.

The Dr. Leatherman award is held in the highest regard by this profession. It is the only award nominated and agreed upon by your peers. It reflects true dedication, professionalism and determination for the greater good of all the profession. Nominees do not have to be high profile, in fact past winners have ranged from those who worked tirelessly behind the scenes to those who laid the foundations for the society we know today.

The last worthy recipient was Juliette Reeves in 2015. If you know of a worthy candidate please contact enquiries@bsdht.org.uk for terms and conditions and a nomination form. Please note we do not accept self-nominations; you must be nominated by your colleagues. All completed forms must be with us by June 30th 2017 and the successful applicant will be notified in October.
The Importance of Income Protection

BSDHT PUBLICATIONS TEAM MEETS…

DAVID THOMPSON, CHIEF EXECUTIVE OF DG MUTUAL

Q: Can you explain, what is an Income Protection policy?
A: This is a policy that will provide you with income if you become ill, or have an accident and are unable to work. It will give you peace of mind to focus on recovery, not financial worries. Depending on the policy, Income Protection could provide a maximum of 50-65% of your pre-tax earnings.

Q: Can you tell me why income replacement policies are important for dental hygienists and dental therapists?
A: Any professional needs to ensure that in the event of illness or accident a replacement source of income is available. It is best to be prepared.

Q: Are they suitable for both employed and self-employed dental hygienists and dental therapists?
A: The policy is best suited to self-employed persons but can be designed to meet with employed contracts with restricted sick payments. All policies can be tailored to meet your requirements.

Q: With direct access there are now more dental hygienists and dental therapists who are setting up their own business – how will income protection help them?
A: Income Protection is vital to meet your normal regular financial commitments if you have one source of income and you have to have time away from work. Those who have set up your own businesses will have fixed costs (eg rent etc) that still need to be paid, regardless of whether you are working or not.

Q: Are there many companies who offer income protection?
A: All major insurance policies provide an Income Protection policy, along with smaller specialist companies such as Mutual companies.

Q: What is a Mutual Company – what does that mean?
A: A Mutual company is owned by and run for the benefits of its members. All profits are invested in the business and their members.

Q: What types of policies are available?
A: Many sorts of policies are available from Day One Cover to a fixed deferment period and cover can be tailored to reflect individual requirements.

Q: Who are the policies aimed at? Newly qualified dental professionals or those with more experience?
A: Policy cover can be changed as careers develop so providing a level of cover suitable to your current income levels. Hence a policy can be adapted to suit changing circumstances throughout your entire working life.

Q: Many newly qualified dental hygienists and therapists may not have much money when they start working. Can you tel me how much these policies costs?
A: Cover can start from £10 a month and can be tailored to suit your individual requirements.

Q: Is income replacement only available to the dental profession?
A: The cover applies to any worker but some specialists offer bespoke products for the dental profession.

Q: How do I choose the best provider?
A: You should check if the company has a good record of quickly settling claims. Also check that the company has been in the industry for a good length of time. Word of mouth is always a good recommendation so it is a good idea to ask colleagues who they use for their cover and their experience of their provider.

Q: Do some providers offer other benefits?
A: Some Mutual companies offer a policy that pays a lump sum out at the end of the policy regardless of any claims made.

Q: Does your company have any offers or incentives?
A: We are happy to offer all new members a 50% reduction in the first 3 months to get you started. Please visit our website for further information www.dgmutual.co.uk.

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. diamarysmith. 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.
On first impressions, the table of contents and colour coded sections allows for easy navigation through this book; information is divided appropriately into chapters making it easy to work strategically through the content, which is especially helpful for students when using a textbook to revise for examinations. The format makes it also useful for qualified dental hygienists and therapists who require a textbook as a reference guide.

Within each chapter the text content is well structured, with subheadings and bulleted lists where appropriate. As well as containing information on all injectable local anaesthetic solutions, the textbook also covers topical anaesthetic agents (including Oraqix) in detail. Other major topics include: pharmacology, pre-anaesthetic assessment, drug doses, syringe preparation, anatomical considerations, injection techniques, LA for the child and adolescent, complications, legal considerations and risk management.

Colourful and fully detailed diagrammes make it easier to understand complex processes in neurophysiology. Illustrations such as summary graphs, tables, flow diagrammes and mouth charts are also used effectively to break up the text and display information in an easy to learn style. There are many full colour clinical photos in the textbook detailing step by step local anaesthetic procedures, which are an excellent visual aid for students who are grasping LA techniques for the first time.

This textbook has been developed in the USA and therefore contains mock papers to aid US students prepare for their examinations. Despite this it is still an essential aid for students in the UK due to the range of topics covered in brilliant detail. However, those also studying or currently practising therapy will benefit from reading this book to supplement their reading list with another textbook covering LA for restorative procedures, and helpful techniques for administering LA in those paediatric patients requiring extractions.
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SIGN POSTING TO EXCELLENCE...
RECORD-KEEPING - AS EASY AS ABC

Andrew Hadden

The FGDP(UK) has published a 2016 revision of its guide, Clinical Examination and Record-Keeping, providing clinicians with a practical and balanced view of what to record. When previously revised in 2009, with the aim of ensuring practitioners include more detail in their records, the view was taken that, “if it ain’t in the notes it didn’t happen”.

However FGDP(UK) received feedback from practitioners that the aspirational standard was misinterpreted as being a basic standard, and practitioners felt they were being unfairly accused of poor record-keeping. Consequently, the 2016 version has been written from the perspective that, “plenty of things happen in the surgery that would not usually be recorded in the notes.” For example, a clinician would not always record that treatment was uneventful. The opportunity was also taken to update the guidance in the light of changes in standards of examination. It recognises that most records are now electronic and has included a chapter with further detail about electronic records.

The new edition fully revises the details to be recorded in the different types of clinical examination. The examination of a ‘new patient’ is split into two chapters: the first describing the detail that can be gathered prior to the patient seeing the clinician, and the second describing the chairside examination, although recognising that many clinicians carry all this out at the chairside. A chapter describes what to record at a ‘recall’ examination, and a further chapter describes what to note at the different types of ‘emergency’ visit, such as ‘trauma’ or ‘pain’. A further chapter describes what to record when patients are referred or received for further care. There are several helpful appendices, including sample medical history forms, summaries of details required for carrying out extra-oral and intra-oral examinations, information about periodontal screening, and more. One of the most helpful items is a chart giving a summary of the recommendations.

The book is helpful in the issue of patient consent to care. In broad terms, for a patient to give valid consent, they must be given sufficient information from which to make a balanced decision about their treatment. This means the clinician should assess the patient as a whole, make a diagnosis, and then discuss with the patient the reasonable treatment options along with the risks and benefits, including the option of having no treatment; the patient decides on their care. This book guides the clinician through the examination, to diagnosis, and allows the clinician to select and record appropriate treatment options, risks benefits, record the discussion and outcome. This therefore assists greatly in preparation of a treatment plan.

To help make a distinction between essential (or ‘baseline’) practice and the aspirational (or ‘gold standard’) practice, the detail to be recorded has been categorised. A chart, outlining these recommendations for information to be recorded has been added. This has graded the information as follows:

- **A**: Aspirational
- **B**: Basic
- **C**: Conditional

**A** recommendations represent the ‘gold’ standard. These items are included for completeness but are not essential.

**B** recommendations represent basic information that should normally be recorded.

**C** recommendations apply when an item is conditional. For example, in a ‘trauma’ examination, it would not usually be necessary to record smoking habits unless this was related to the situation.

It is hoped that by clarifying the required standard, a practitioner would not be censured for failing to meet a grade **A** recommendation.

Revision of this book has taken into account that dental hygienists, dental therapists, and clinical dental technicians can now see patients directly without the need for examination and referral by a dentist. They should therefore find the descriptions of examination and record-keeping invaluable in guiding them through the stages of examination, diagnosis, valid consent, and agreeing a treatment plan with their patient.

**View the guidance for FREE online**

As part of the FGDP(UK)’s Open Standards Initiative, the full text of this guidance, along with a selection of other publications, can be viewed for free online at: [http://www.fgdp.org.uk/OSI/open-standards-initiative.ashx](http://www.fgdp.org.uk/OSI/open-standards-initiative.ashx)

The hard copy version is also available to purchase for £30 (free P&P) for FGDP(UK) members, or £35 (plus P&P) for non-FGDP(UK) members.

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Andrew Hadden is a general dental practitioner and dento-legal adviser with an indemnity organisation. He has been involved with FGDP(UK) since it started in 2002, where he has served on all committees and as Vice Dean.

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THE EFFICACY OF ESSENTIAL OILS: AN UPDATE

Gemma Barker

Following the recent publication of ‘Essential oils-containing mouthwashes for gingivitis and plaque: Meta-analysis and meta-regression’ in the Journal of Dentistry, this article revisits the evidence supporting the daily-use of an essential-oil mouthwash as an adjunct to mechanical cleaning.

As the General Dental Council’s ‘Standards for the Dental Team’ document states: ‘You must provide good quality care based on current evidence and authoritative guidance’. In addition, evidence-based dentistry (EBD) is globally accepted as the ‘gold standard’ in healthcare delivery.

Adding to the body of evidence supporting the use of a mouthwash containing essential oils as an adjunct to mechanical plaque control (MPC), one of the most recently published meta-analysis is that from Haas and colleagues (2016).1

Mindful of the need for high-quality, evidence-based results, the authors acknowledged that although previous systematic reviews had demonstrated the efficacy of essential oils in a mouthwash used adjunctively: ‘Nevertheless, important characteristics of these reviews were not reported according to consolidated standards currently disseminated and required, limiting their interpretation. Moreover, variations in EO [essential oil] effects may be due to relevant variations across reviews regarding methodology, number of included studies and analysis.’

In an effort to overcome these potential shortcomings, Haas and colleagues (2016) chose to explore the high heterogeneity found in earlier meta-analysis using meta-regression commands, alongside a systematic review to assess randomised clinical trials, testing the efficacy of essential oils as an adjunct to mechanical cleaning in comparison with a placebo and cetylpyridium chloride (CPC).1

The questions asked by the researchers were:

- ‘Is there an additional anti-plaque […] effect of EO containing mouthwashes as adjunct to daily oral hygiene when compared to placebo in patients with gingivitis?’
- ‘Is there an additional anti-plaque […] effect of EO containing mouthwashes as adjunct to daily oral hygiene when compared to mouthwashes with cetylpyridium chloride (CPC) in patients with gingivitis?’
- ‘Is there an additional anti-plaque […] effect on interproximal sites of EO containing mouthwashes as adjunct to daily oral hygiene when compared to placebo in patients with gingivitis?’
- ‘Is there an additional anti-plaque […] effect on interproximal sites of EO containing mouthwashes as adjunct to daily oral hygiene when compared to flossing in patients with gingivitis?’

From a total of 3045 citations, 16 studies were used for the meta-analysis and meta-regression. Mean Quigley-Hein Plaque Index (QHI) revealed that scores were lower for the EO plus MPC when compared to the use of a placebo alongside MPC; reductions in plaque were 32% greater for EO plus MPC over a placebo plus MPC.

These results enabled the authors to conclude: ‘The decreases in QHI […] observed in the EO + MPC group, compared to placebo + MPC in interproximal areas, were significantly different and in favour of EO + MPC. EO + MPC compared to CPC + MPC resulted in clinically lower levels of plaque […]’.

Examining the heterogeneity observed in previous studies, Haas and colleagues (2016) wrote: ‘[…] it was found that percentage of males and mouthwash supervision in a trial affected the differences between EO and placebo for plaque, and provision of oral hygiene instruction affect the results […]. These findings may be found only by chance, but some explanations may be considered. Specifically for plaque, the provision of mouthwash supervision in a trial resulted in lower QHI levels in the placebo group probably as a result of a Hawthorne effect. On the other hand, QHI levels for the EO group in a trial was higher if the percentage of males was >35%; which may be a result of lower oral hygiene standards in males than females leading to a reduction on the effect of EO. The combination of lack of supervision and ‘35% of males in a trial was associated with even larger differences between groups in QHI.’

In clinical terms, Haas and colleagues (2016) found: ‘Mouthwashes containing essential oils should be considered the first choice for daily use as adjuvants to self-performed mechanical plaque control.’

‘Expected benefits may be clinically relevant and may also reach the interproximal area.’

In addition, it was considered that dental healthcare professionals, ‘[…] may expect lower effects of EO in males than females, and should be persuasive with patients to follow the correct prescription and mode of use of the mouthwash.’

Building on knowledge

These findings seem, therefore, to support those of previous research groups that have explored the efficacy of EO mouthwash on plaque levels.

For instance, in 2015, Araujo and colleagues published the first meta-analysis to show the clinically-relevant benefits of an essential oil-containing mouthrinse in site-specific areas of the mouth, when used as an adjunct to mechanical cleaning over a six-month period.

The primary aim of the meta-analysis was: ‘[…] to compare the efficacy of combined mechanical oral hygiene and use of essential oils containing mouthrinses with that of mechanical oral hygiene [alone] […]’, using the percentage of sites identified as maintaining gingival health at six months as a basis.

A secondary purpose was, ‘[…] to examine treatment effects using other summary measures based on the plaque index (PI).’

Finally, Araujo and colleagues (2015) assessed and then described a number of possible causes of diverse treatment outcomes among study findings.

Ultimately, ‘The results of the responder analysis suggest that after six months of use, clinicians could expect that approximately […] 37% of participants would have at least 50% of sites without plaque (PI = 0 or 1). In addition, the implementation of a long-term oral care routine that provides seven times greater odds for plaque-free sites […] can be compelling information for the clinician when educating patients on the appropriate oral care routine.’

The outcomes of the meta-analysis support the notion that using an essential oil-containing mouthrinse on a daily basis offers a clinically relevant benefit beyond that offered by mechanical cleaning alone.

Other examples of systematic reviews to have demonstrated the efficacy of an adjudge EO mouthwash have come from Gunsolley (2006), Boyle et al (2014), and Serrano et al (2015).

Gunsolley (2006) found, ‘[…] strong evidence that anti-plaque […] agents are efficacious. Coupled with reports showing that the relative efficacy of these agents is similar to that of flossing, these results suggest that to help achieve optimum oral health, adults should add an anti-plaque […] agent to their oral hygiene regimen.’
Building on this view, Boyle and colleagues (2014) demonstrated that quantitative assessment of data exploring mouthwash use and the risk of common oral conditions supports the use of mouthwash in preventing dental plaque, exploring the differences between chlorhexidine, cetylpyridinium (CPC) and essential oils.6

They were able to conclude that that over a period of less than three months, mouthwashes containing chlorhexidine are the most effective of the preparations considered, resulting in a reduction of dental plaque.9 However, when used for six months or longer, essential oil mouthwashes equalled or exceeded the effect of chlorhexidine in controlling plaque as an adjunct to standard care.6 It was also found that mouthwashes containing CPC may also be effective, but less so than chlorhexidine and an essential oil formulation.6

As for Serrano and colleagues (2015), they published a systematic review on anti-plaque agents, investigating the clinical possibilities offered by such adjuncts.7

They concluded that: ‘The adjunctive use of chemical plaque control, together with mechanical control, offers advantages in terms of […] plaque levels control.’7

They also stated: ‘When it comes to the selection of a proper format to deliver the antiseptic agent, the results suggest that mouthrinses may provide better results.’7

There would therefore seem to be a case to be made for the use of an essential oil mouthwash as an adjunct to mechanical cleaning, which has been substantiated not only, most recently, by Haas and colleagues (2016), but also Gunsolley (2006), and the research teams headed up by Boyle (2014), Serrano (2015) and Araujo (2016).1,4,5,6,7

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References
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*US dental professionals
**Management of extensive dental caries in children**

L. Reeve-Brook and R. Parkes

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**Introduction**

Dental therapists (DT) are important members of the dental team and are increasingly being utilised in the treatment of children. The General Dental Council (GDC) Scope of Practice states that DT are able to provide direct restorations in primary and permanent teeth, complete pulpotomies on primary teeth, place preformed metal crowns (PMCs) on primary teeth and extract primary teeth.

Dental caries remains prevalent in childhood, the 2013 UK Child Dental Health Survey found that 31% of 5-year-old children had obvious decay experience and 13% had extensive decay. Extensive decay in 5-year-old children is considered to be when there are five or more teeth with decay extending into dentine; three or more teeth with obvious decay; any unrestorable carious teeth; or any history of sepsis resultant from dental caries.

The impact of this level of decay is felt on an individual and national level. The process of dental caries left untreated will ultimately lead to pain and infection. In a recent oral health and quality of life (OHQoL) study, 79.7% of children with dental caries had experienced pain and 35% had difficulty eating. Other studies have shown that children’s mental health and wellbeing is negatively affected by caries and academic performance in children with dental problems has shown to be less than those without. In 2013/14 there were approximately 46,500 admissions of children and young people to hospital for dental treatment under general anaesthesia (GA). It has been estimated that a staggering £30 million is spent annually providing this treatment under GA. Dental caries is largely a preventable disease and even once established can often be easily treated.

All children are at risk of developing caries but a proportion are at an increased risk (Table 1). These children should be identified to allow targeted prevention and appropriate treatment planning. A caries risk assessment considers the risk that a child will develop caries in the subsequent three years. This assessment should include sociodemographic factors, previous decay experience, dietary habits, oral hygiene (including fluoride use) and medical history.

This article is intended to guide the Dental Therapist in the most appropriate management of dental caries in children, focusing on comprehensive treatment planning, prevention and treatment with obvious decay; any unrestorable carious teeth; or any history of sepsis resultant from dental caries.

The impact of this level of decay is felt on an individual and national level. The process of dental caries left untreated will ultimately lead to pain and infection. In a recent oral health and quality of life (OHQoL) study, 79.7% of children with dental caries had experienced pain and 35% had difficulty eating. Other studies have shown that children’s mental health and wellbeing is negatively affected by caries and academic performance in children with dental problems has shown to be less than those without. In 2013/14 there were approximately 46,500 admissions of children and young people to hospital for dental treatment under general anaesthesia (GA). It has been estimated that a staggering £30 million is spent annually providing this treatment under GA. Dental caries is largely a preventable disease and even once established can often be easily treated.

**Radiographic examination**

Radiographic examination is essential in early diagnosis of carious lesions and prevention of progression to pulp involvement. Radiographic views also allow accurate treatment planning and selection of appropriate treatment options. The radiograph of choice is bitewing radiographs using an appropriate size film from age 5 years. Once the first permanent molars have erupted it is usually possible to use a size 2 film, however if the child struggles to tolerate then a size 1 or 0 may be used. Figure 1 shows a left bitewing radiograph of a 6-year-old boy which revealed caries affecting upper and lower left first primary molars which were not clinically evident.

According to the FGDP guidance children deemed to be of high caries risk should have bitewing radiographs taken on a 6-12 monthly basis until there are no new or active carious lesions and the child has entered a lower risk status group. Alternative views include lateral obliques. When extraction of a primary tooth is planned bitewing radiographs are appropriate as sufficient root morphology can usually be seen.

---

**TABLE 1: FEATURES THAT WOULD MAKE A CHILD AT A HIGH RISK FOR DEVELOPING CARIES (ADAPTED FROM NICE, 2004)**

| Social History | • Socially deprived  
| • High caries in siblings  
| • Low knowledge of dental disease  
| • Irregular attendance  
| • Low dental aspirations  |
| Medical History | • Medically compromised  
| • Disabled  
| • Kerostomia  
| • Long term canogenic medicine  |
| Dietary Habits | • Frequent sugar intake  
| • Regular sugary snacks  |
| Use of Fluoride | • Not drinking fluoridated water  
| • No fluoride supplements  
| • No fluoride toothpaste (or toothpaste not at correct level of F-)  |
| Plaque Control | • Infrequent, ineffective cleaning  
| • Poor manual control  |
| Saliva | • Low flow rate  
| • Low buffering capacity  
| • High S Mutans and Lactobacillus counts  |
| Clinical Evidence | • New lesions  
| • Previous premature extractions due to caries  
| • Carious anterior teeth  
| • Multiple restorations  
| • No fissure sealants  
| • Fixed orthodontic appliances  
| • Partial dentures  |
Several guidelines exist on the prevention of caries in children\textsuperscript{11–13} and according to these, all children require the following preventative advice:

- Oral hygiene instruction (OHI)
- Brush twice daily for 2 minutes
- Use an age appropriate fluoride toothpaste:
  - Children over 3 years 1350-1500ppm fluoride
  - Children under 3 years no less than 1000ppm fluoride
- “Spit, don’t rinse”
- Supervised brushing if under 7-years-old or if not confident with brushing habits
- Dietary advice
- Foods and drinks containing sugar should be restricted to meal times
- Drink only water or milk between meals
- Snack on sugar free foods, e.g. carrots, peppers, cucumber, breadsticks, cheese
- Advise on hidden sugars (e.g. in fruit yoghurts) and acidity of some drinks (e.g. sugar-free squash)
- Application of fluoride varnish (5%) twice a year if over the age of 2 years

Children at high risk of dental caries require OHI, diet advice and fluoride varnish application at every recall visit. Those over the age of 3 years should be recommended 1350-1500ppm fluoride toothpaste. Fissure sealants should be applied to pits and fissures susceptible to decay, these must be maintained at subsequent appointments and repaired if needed.\textsuperscript{11–13}

**Fissure sealants**

Fissure sealants are effective at reducing pit and fissure caries in the primary and permanent dentitions.\textsuperscript{18} Resin-based sealants should be the first choice and applied to the pits and fissures of all erupted permanent teeth. This should include palatal pits of maxillary incisors, which can be particularly prone to developing caries.\textsuperscript{11} It is important that sealants are monitored and topped up when worn to the point of exposing fissures.

If a child is unable to tolerate the placement of resin-based sealants or when placement of a sealant of a partially erupted tooth is difficult, glass-ionomer cement (GIC) can be used as an interim sealant.\textsuperscript{11,12} However, the retention of these is less successful compared with resin sealants, so careful monitoring is needed. The GIC sealant can be applied using the finger technique whereby the material is placed on the tooth with a finger and covered with petroleum jelly before moisture contamination.

**Fluoride varnish**

Fluoride varnish has been shown to have a substantial caries inhibiting effect\textsuperscript{19} and so it is recommended that all children over the age of 2-years should receive fluoride varnish twice a year and those at an increased risk should receive application 3-4 times a year.\textsuperscript{11,13} When placing fluoride varnish it is important to follow the manufacturer’s instructions to ensure that the correct dose is delivered. Where there is evidence of interproximal enamel caries fluoride varnish should be applied to these surfaces using floss.

**Management of caries in primary teeth**

Treatment of caries in primary teeth is essential to prevent pain and infection. When a tooth has signs of irreversible pulpitis (e.g. abscess, sinus, inter-radicular radiolucency, constant pain) pulp therapy or extraction is indicated. Caries in primary teeth must not be left untreated – however treatment may not include conventional caries removal and restoration. Figure 2 shows a flow diagram of the decision for treatment options for a carious primary tooth. Options for treatment include; complete caries removal and restoration, partial caries removal and restoration, preformed metal crown (PMC) placement and non-restorative cavity treatment (NRCT).\textsuperscript{11}

**Complete caries removal**

Complete caries removal aims to remove all infected dentine from a tooth and restore function. This is considered best practice for small one or two surface restorations.\textsuperscript{14} Local anaesthesia is advisable unless the cavity is minimal. Access to the carious lesion should be achieved using a high-speed handpiece, followed by caries removal with a slow-speed handpiece and hand excavation. If there is a risk of pulpal exposure then an indirect pulp cap should be placed with a suitable material (e.g. Setting calcium hydroxide (CaOH), GIC). Conventional GIC materials should not be used as they have a high rate of failure.\textsuperscript{11,20,21} Recommended restorative materials
include composite, compomer, resin-modified GIC and preformed metal crowns (when using the traditional technique).11

The traditional technique of PMC placement involves complete caries removal under LA with a mesial, distal slice and occlusal reduction before PMC cementation.22

Partial caries removal

The aim of partial caries removal is to remove enough infected enamel and dentine to allow a marginal seal to be created.23 This reduces the need for LA and the risk of pulpal exposure24, however this technique relies on a good marginal seal and so excellent isolation is needed during adhesive restoration placement. This is suitable where there is a high risk of pulpal exposure with complete caries removal, for example with anterior cavitated lesions and occlusal lesions on primary molars.11,24 It is not suitable when margins extend subgingivally and where good isolation for bonding techniques is not possible.

Access to the carious lesion can be gained with a high-speed handpiece. This is followed by superficial caries removal to below the enamel-dentine junction (EDJ) with a slow-handpiece or hand excavation. Restoration using adhesive materials and fissure sealant of all restoration margins should follow.11

Preformed metal crowns

Preformed metal crowns can be placed using either the traditional technique following complete caries removal or using The Hall Technique.22,25,26 The Hall Technique has been shown to be more superior to conventional restorations and is more readily accepted by children.24 It relies on sealing the carious lesions to prevent progression.27,28 Local anaesthesia is not needed and the technique is well accepted by children.

Orthodontic separators are usually required 3-5 days prior to crown placement to allow sufficient interproximal space (Figure 3). These can be easily placed using two pieces of floss to pull the separator taut and then “floss” between the contact points before removing the floss strings.27 This can sometimes be uncomfortable, particularly when the gingivae are inflamed from food packing in the area. Topical anaesthetic placed on the separator before placement can be a useful adjunct. The patient should return 3-5 days later for removal of the separators and PMC placement. Once the correct size PMC has been chosen (that with adequate “spring back” when pushed gently to the contact points), the crown is filled with a GIC luting cement and pushed firmly over the tooth. The child should then be instructed to bite firmly onto a cotton wool roll.

FIGURE 2: FLOW DIAGRAM TO SHOW THE DECISION MAKING PROCESS WHEN DECIDING IF A PRIMARY TOOTH IS RESTORABLE AND WHICH RESTORATION TECHNIQUE TO USE (ADAPTED FROM SDCEP GUIDELINES, 2010)
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placed over the crown. It can be useful to have a trial run biting on the cotton wool roll whilst the luting cement is being mixed. Excess cement should be removed and the contacts flossed.

Non-restorative cavity treatment

Non-restorative cavity treatment (NRCT) is an emerging management technique that relies on the reduction of the cariogenic potential of the oral environment. This aims to arrest the carious lesion and prevent further progression. It is essential that there is excellent plaque removal and fluoride use in order to arrest the lesion. This technique is commonly used in Holland.

NRCT requires removal of carious enamel and dentine with a high-speed handpiece and hand excavation. This includes the opening of an occlusal lesion and a slice preparation to allow the lesion to become self-cleansing. Fluoride varnish should subsequently be applied.

Balancing and compensating

‘Balancing extraction’ is extraction of the contralateral tooth with the aim to preserve symmetry of the developing occlusion. Some situations when balancing should be considered are when a deciduous canine is planned for extraction or has been lost due to eruption of the permanent lateral incisor. Balancing may also be considered when a centre-line shift is developing following unilateral extraction of a deciduous first molar. Each case should be considered and weighed against the risk of inducing anxiety in the child.

‘Compensating extraction’ is when the same tooth on the opposite arch is extracted to prevent overeruption and to preserve the inter-arch occlusal relationships. These are not needed with extraction of primary teeth. If there is any doubt over balancing and compensating extractions then an orthodontic opinion should be sought.

Pulp therapy in primary teeth

Pulp therapy aims to preserve a primary tooth with pulpal involvement free from pain and infection until it is naturally exfoliated. Indications include irreversible pulpitis, non-vital pulp and signs of pulpal involvement. Generally when a child presents requiring pulp therapy there are multiple teeth in need, in these cases it must be considered if the child will be able to cope with the amount of dental treatment required and the benefits of retaining a deciduous tooth over extraction.

Local anaesthesia

Local anaesthesia is recommended when extraction is planned or when cavity preparation will include removal of sound dentine, as these procedures are likely to cause pain. Infiltrations are the most commonly used technique when anaesthetising primary teeth. All children should be given the opportunity to see the LA syringe before use and allowed to ask questions about its use – this will help prevent mistrust and allow the child to feel a part of “sending their tooth to sleep”. Topical anaesthesia (e.g. 20% benzocaine gel or 5% lidocaine

Figure 3: Orthodontic separators placed mesial and distal to the lower left second primary molar to create adequate interproximal space for PMC placement.

COPY DATES FOR DENTAL HEALTH

1ST JUNE FOR THE JULY 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
CLINICAL

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 WEDNESDAY 13TH SEPTEMBER 2017.

To register your interest please contact the President, Helen Minnery on 01788 575050 or email enquiries@bsdht.org.uk

References

Review and recall

Once a planned course of treatment has been completed a recall can be set according to the caries risk status. The National Institute for Health and Clinical Excellence (NICE) recommends a recall interval of between 3-12 months. The shorter recall intervals reserved for children of a higher risk to all enhanced prevention.

Conclusion

Dental caries in children poses many challenges to patients, their parents/carers and the dental team caring for them, despite it being a preventable disease. If left untreated dental caries can lead to pain and infection which can result in sepsis and damage to developing permanent teeth. The main aim of treatment is to manage the existing carious lesions in the most appropriate way for the child and to prevent future caries development.

As can be seen from this article, many options exist for managing dental caries in the primary dentition and there is no single management strategy that is suitable for each and every child. By assessing the child’s caries risk status, one can guide preventive strategies and treatment appropriately to meet the dental needs of the child. Appropriate treatment planning is paramount, involving the child and parent in decision making.

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UNDERSTANDING PAIN AND ITS MANAGEMENT

Z. Yonel, N. Pancholi, M. Abdelwahab, P. Taneja

Introduction

Pain is an experience learnt from an early age. It is the body’s way of alerting us to things that have the potential to cause damage to our tissues. The International Association for the Study of Pain (1994) defines pain as:

“An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.”

There are a number of ways that pain sensation can be described, for example sharp, dull, constant, fluctuating, etc. The nature of the pain sensation can help to diagnose the possible cause as the clinical signs and symptoms can help to identify the underlying pathophysiological mechanism involved.1

With an inherent nature of trying to avoid painful factors, it is no wonder why some people do not enjoy going to the dentist. So much so they avoid it altogether, or develop anxiety when the need comes to attend.

The IASP definition identifies that pain encompasses a number of factors, and in turn allows us to start to understand why dental pain is unique. The environment of the dental clinic coupled with dento-alveolar neurological innervation can impact on both sensory and emotional factors.2 Psychologically, the dental surgery environment, with its ability to provide sensory overload (e.g. the noise of an ultrasonic scaler), is understandably a unique environment that many people automatically associate with pain.3

Transmission of pain

Within the human body are specialised sensory receptors known as nociceptors.4 These receptors are also found throughout the orofacial region, for example the tooth pulp, temporo-mandibular joints, oral cavity and facial skin.5 The signals that originate from the nociceptors in the orofacial region are transmitted into the trigeminal nerve, and its ganglion. This transmission/convergence is thought to be one of the causes of referred pain.4 There are two main types of nerve fibres that allow the transmission of pain signals, and are classified according to their diameter and conduction velocity. These are Aδ and C-fibres. Aδ fibres are those responsible for transmitting the sensation of sharp pain and are wider with a faster conduction speed than C-fibres. In contrast, C-fibres produce a dull aching pain when stimulated.4 Both types of fibres can be activated by a number of stimuli, for example, thermal, mechanical or chemical.

Measuring pain

Pain is difficult to measure objectively. Two people who are subject to the exact same stimulus may experience and report different levels of pain. To understand and record a patient’s perception of pain before and during an intervention, and to ensure efficacy of pain management regimens, it is essential to use a reproducible method, or methods. This can be achieved by utilising one or more of a number of validated scales and questionnaires which aim to measure pain intensity.7,8 Such scales rely on predetermined descriptors, or anchor points, to help describe the painful sensation.9,10 When comparing pain scores in a patient (e.g. over time), or comparing between patients (e.g. in a clinical trial), it is important to utilise the same scale(s), with the same anchor points, so that data can be compared. There are numerous ways to measure pain and therefore understanding the treatment planned will help to identify which scale should be used.

Commonly used pain intensity scales include; the Visual Analogue Scale (VAS), where pain intensity is represented by a mark placed by the patient on a line of set length, the Verbal Rating Scale (VRS), which uses 4 or 5 set words to describe pain intensity and the patient selects the most appropriate word, and the Numerical Rating Scale (NRS), which is similar to VRS but uses set number values instead.11 Such scales rely on predetermined descriptors, or anchor points, to help describe the painful sensation.12 When comparing pain scores in a patient (e.g. over time), or comparing between patients (e.g. in a clinical trial), it is important to utilise the same scale(s), with the same anchor points, so that data can be compared. There are numerous ways to measure pain and therefore understanding the treatment planned will help to identify which scale should be used.

Pre-operative pain management

According to the Adult Dental Health Survey, 9% of dentate adults reported pain related to their teeth, while 8% of dentate adults reported that they had experienced pain in their mouths fairly often or very often in the 12 months on completion of the survey.13 To allow the appropriate management of an individual’s pain, an accurate diagnosis is essential. For this to be established a thorough history is required which not only focuses on the nature of the pain, but also the patient’s medical, past dental and social history. The reason for this is that it should not be overlooked that psychological factors can have an influence on pain experience and response.14,15 Treatment can often involve direct and local measures which often provide the patient with relief, for example the extraction of a painful unrestorable tooth or extirpation of a pulp. However, when direct measures alone do not suffice, the addition of analgesics may be required.

The British National Formulary (2015)16 contains a section dedicated to the management of dental and orofacial pain and is a useful reference guide for healthcare professionals. In addition, the World Health Organisation (WHO) published an analgesic ladder which, although originally designed for the management of pain in oncology patients, has been adapted for the management of generalised pain.17 The principle of this modified analgesic ladder is based upon five straightforward recommendations for the appropriate use of analgesics in order to ensure maximum treatment efficacy. It is not only applicable to cancer patients, but can be used for all patients experiencing acute or chronic pain requiring analgesic intervention; including dental pain.

The use of pre-operative analgesia in the prevention of post-operative pain, “pre-emptive analgesia,” has been discussed in the literature with regard to numerous surgical disciplines.18,19

Peri-operative pain management

When a patient attends for treatment and is due to undergo a dental procedure it is imperative that due consideration is given to the management of the patient’s pain. Fear of pain is a factor which patients often cite when exploring barriers to the uptake of dental care.20 It is therefore necessary to ensure that due care and consideration is given to minimising the patient’s level of discomfort.

A common method of managing peri-operative pain is with the use of local anaesthetic agents (Table 1). These can be applied topically or administered as infiltration or nerve blocks in order to established more profound anaesthesia where required.
Given the psychogenic component of pain, the literature does suggest that non-pharmacological methods should be considered in addition to pharmacological methods in the management of both peri-operative and post-operative pain.

Some suggested methods include relaxation techniques, sedation, music therapy, cognitive behavioural therapy (CBT) and even acupuncture, (Table II).

<table>
<thead>
<tr>
<th>Local anaesthetic agent</th>
<th>Indication and route of administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lidocaine</td>
<td>Lidocaine hydrochloride 2% (with 1:80,000 adrenaline) is frequently used in dentistry. It has a rapid onset, low-toxicity, low incidence of allergy and is cost effective.</td>
</tr>
<tr>
<td>Articaine</td>
<td>Articaine is an amide and is hydrolysed quickly in the blood, hence the risk of systemic intoxication is lower than with the other dental anaesthetics. In comparison to Lidocaine, Articaine has a faster onset and shorter half life, therefore lower toxicity. A number of studies suggest that this anaesthetic is superior to conventional anaesthetics in controlling procedural pain when delivered via block injection or by infiltration.</td>
</tr>
<tr>
<td>Prilocaine</td>
<td>A shorter acting anaesthetic solution (19). Prilocaine comes in plain varieties, therefore avoiding adrenaline, and also as prilocaine with felypressin.</td>
</tr>
</tbody>
</table>

Post-operative pain management

Post-operative dental pain is well recognised, in particular following surgical dental procedures where a degree of morbidity is to be expected. When prescribing analgesics, consideration must be given to the type and severity of pain, along with any pre-existing relevant medical history. The prescribed medication(s) need to provide an adequate level of pain-relief with minimum unwanted side effects. Common analgesics that are available to dentists to prescribe are paracetamol, ibuprofen and dihydrocodeine.

There are more than 30 Cochrane reviews that have evaluated randomised trials, assessing the analgesic efficacy of medications used after dental treatment (20-21). It has been suggested that mild to moderate pain is often suitably managed by the appropriate and optimal doses of non-opioids such as paracetamol 1000mg and ibuprofen 400/800mg, or a combination of the two. Although combination of NSAIDS is unwise, the addition of paracetamol to a NSAID regime is acceptable as they have different mechanisms of action. (22)

Regardless of pain severity following medical or dental intervention, it has been suggested that pain medication should be taken at regularly timed intervals as opposed to waiting for the onset of pain. Utilising paracetamol and ibuprofen in combination in this manner helps maintain a better level of pain control and allows for the addition of an opioid to the regime to manage “breakthrough” pain if required. The amount of opioid required is usually minimal when paracetamol and ibuprofen are used in this combination. (23)

In addition to medications which can be prescribed for post-operative pain management, the use of long-acting local anaesthetics may be of benefit in some cases. (24) One study comparing bupivacaine (0.5% with 1: 200,000 adrenaline) with lidocaine (2% with 1: 80,000 adrenaline) for extraction of third molars found that, for the initial four hour post-surgical period, those in the bupivacaine group reported no pain post-operatively compared with the lidocaine group (in which 100% of subjects reported pain and required analgesics within the first four hours following surgery). By eight hours post-surgery 30% of the bupivacaine group still reported having no pain. Furthermore, the total intake of post-operative analgesics was reduced in the bupivacaine group. (25)

An additional method that has been advocated to aid post-operative pain is cold therapy (cryotherapy). The literature describes a number of cryotherapy modalities, from the use of ice/cold gel packs, to devices that deliver continuous cooling through facemasks. (26) In the vast majority of cases the benefits of cryotherapy far outweigh the risks involved and this can prove to be a cost effective treatment modality. (27)

It is thought that cryotherapy has a direct effect on nerves; the reduction in temperature local to the site of the procedure slows the conduction velocity of the nerves, and therefore the excitation threshold for depolarisation increases. These signals which are transmitted are done so more slowly. The overall effect is a reduction in both the transmission and reception of painful stimuli by the brain.

The cold also reduces the responsiveness to stretching of muscle spindles by reducing the stimulation of nociceptors. This leads to fewer muscle spasms and hence a reduction in the pain signals transmitted. (28) Cryotherapy also reduces inflammation and swelling. The cold induces a sympathetic reflex which in turn results in vasoconstriction of arterioles and leads to a reduction in oedema. (29) The reduction in swelling and inflammation as a result of cryotherapy can indirectly reduce pain levels, as inflammation results in tissue damage and the release of chemicals which depolarise nociceptors. Reducing the inflammation can reduce the amount of depolarisation, and lessen the extent of the pain felt. (30)

Conclusion

Pain plays an important physiological role in alerting us to things that can cause tissue damage. Its complex nature, and the fact that it is determined by multiple factors, means pain can be perceived differently between individuals, and also makes it challenging to measure objectively. Having an understanding of the mechanisms involved in pain provides insight into its origin, and can help decide how best to manage it.

In the dental setting, pain control is very important in order to make the experience of undergoing dental treatment more comfortable for patients. It can
When choosing the best means of pain management, it is very important to take into consideration all contributing factors on a case-by-case basis. Therefore, pre-empting and managing pain at different stages of a dental visit or procedure, using different pharmacological and non-pharmacological methods, is crucial.

**References**


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Helping patients to create a goal vision for optimal oral health

Contemporary studies indicate that unless they are experiencing pain or discomfort a sizeable proportion of the general population avoids regularly attending dental appointments because they suffer from feelings of anxiety. The mouth and oral cavity are physiologically and psychologically highly sensual areas of the body and it is therefore unsurprising that some patients may feel uncomfortable and vulnerable during dental treatment. Any unpleasant experiences or thoughts they might have may fuel further feelings of anxiety and perpetuate their avoidance behaviour.

Most clinicians would agree that ideally we want to achieve more than just relieving our patients of their discomfort or pain. Helping our patients understand why they are in pain and how to prevent future dental discomfort encourages them to take ownership of their oral health and subsequently can result in real improvements in their oral health. However, it is frequently difficult to differentiate between pain, discomfort and anxiety as often they are directly related to one another.

Our patients can generally be subdivided into three categories, those who feel relaxed during dental treatment; those who are dentally anxious but cope with treatment; and those who are dentally phobic and experience anxiety to such an extent that they avoid dental care. The anxious patients can be challenging to treat but ought to be considered as vulnerable patients who need help and support to overcome their anxiety.

As dental professionals many of will have heard or read about behavioural strategies, such as Cognitive Behavioural Therapy (CBT), but it is likely that most of us have had no real training, or experience in putting these into practice with our anxious patients.

The SMART concept is a useful tool that is often employed when using a non-pharmacological approach to treatment, such as CBT, and can be easily utilised in our daily practice. The SMART goals are defined as - S: Specific, M: Measurable, A: Agreed, R: Realistic, T: Time specific.

Assessments

By using the SMART goal-setting concept in a novel way we can structure our sessions and hopefully help them to overcome some degree of their anxiety. An example of a SMART goal setting can be seen below:

<table>
<thead>
<tr>
<th>SMART goals</th>
<th>Tasks</th>
<th>Sessions/times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific</td>
<td>My job is to help you with your dental issues or concerns as well as treating your teeth. How can I help you?</td>
<td>S-10 minutes during first session with every new patient</td>
</tr>
<tr>
<td></td>
<td>• Is there anything you would like me to know about your teeth or gums before we start your treatment?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Are you experiencing any discomfort?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Are you worried or concerned about any aspects of your dental treatment?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Knowing about your general health, what would you like me to know about your dental history?</td>
<td></td>
</tr>
<tr>
<td>Measurable</td>
<td>A detailed, comprehensive medical-dental history, would include;</td>
<td>Medical history pro forma would be given to the patient before they attend for treatment via post and/or email. This would be reviewed with the patient at the beginning of their appointment.</td>
</tr>
<tr>
<td></td>
<td>• Smoking, alcohol and medication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Modified Dental Anxiety Scale (effective way to identify at a glance the patient’s concerns), As recommended by Newton &amp; Buck (2000), a good model of dental anxiety assessment. Patients with a high score, over 19, on MDAS would be treated as highly anxious and they would be asked to complete further questionnaires OHIP-14.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• List of medications and attention to the ones with known side effects impacting on oral health as well as anti-depressants. Further questionnaires OHIP-14 and/or HAD would be given.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Details of home care regime - tooth brush, interdental aids, toothpaste used etc.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Begin to establish a picture/profile of the problems that may be challenging before treating each individual then develop initial case formulation accordingly.</td>
<td></td>
</tr>
</tbody>
</table>
Agreed

Agreeing with the patient on a unique specific goal is essential prior to any dental treatment. By this stage anticipated barriers or challenges would have been identified. To set a collaborative relationship to achieve short and long term goals, the patient needs to know how help and support can be obtained accordingly. At this stage to reach agreement on specific goal between clinician and patient the following sources would be offered:

- General health related information and how it affects dental health
- MDAS specific items to be discussed and what help can be achieved accordingly (tools such as relaxation, distraction, tell-show-do, enhancing sense of control, stop signal, allowing choices, environment changes, cognitive reconstruction, positive reinforcement, anxiety ladder and thought record, etc.). Also identifying low, moderate and high dental anxiety would be helpful for future dental appointments.
- Dental examination employing different scales e.g. bleeding score or 6 PPC, etc. to identify dental issues. Then involving the patient in each score journey to make sure they have an understanding of their mouth and ways to prevent oral disease. Issues such as tooth decay, gum disease etc. would be identified verbally and reinforced in a leaflet they could read later.
- Oral health regime/ habits would be established to suit each individual.
- The established profile of the patient’s problem would be discussed. If dental problems are related to unhelpful thoughts or beliefs then CBT would be a good way to achieve improved oral health for that patient. The problem could vary between, “my gums bleed when I brush hard” to “I hate coming to the dentist”. As long as both agree the problem and that it needs to be addressed then the next step becomes easier to take. Agreement with the individual on their suitability for the therapy would also depend on their level of dental anxiety. Newton et al (2012) established low, moderate and high dental anxiety should be identified before commencing any treatment.

Realistic

By evaluating the first session within 30 to 40 minutes a team of two has been formed with one main goal to achieve, “better oral health”. By now the patient should realise that he/she is in control/charge of their dental condition as well as some form of graded exposure (As allowing practitioner to look at his/her mouth/teeth by holding mirror). The following tasks would be a way for encouragement and monitoring future plans:

- Mini homework - from reading a leaflet to relaxation techniques.
- Request patient consider what would be helpful to discuss in the next visit in addition to usual dental treatment?
- Dental treatment would be carried as the patient allows according to MDAS score/ anxiety ladder and/or level of dental anxiety (low, moderate and high).

Time Specific

By this point the specific dental problems as well as level of dental anxiety are identified. It is difficult to phrase specific time or treatment for individual but the following outline would be a guideline:

<table>
<thead>
<tr>
<th>Dental anxiety</th>
<th>Dental problems</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Low</td>
<td>4 to 6 months</td>
</tr>
<tr>
<td>Low</td>
<td>Moderate / high</td>
<td>Immediate to 3 months</td>
</tr>
<tr>
<td>Moderate</td>
<td>Low</td>
<td>3 to 4 months</td>
</tr>
<tr>
<td>Moderate</td>
<td>Moderate / high</td>
<td>Immediate to 1 month</td>
</tr>
<tr>
<td>High</td>
<td>Low</td>
<td>Immediate to 1 month</td>
</tr>
<tr>
<td>High</td>
<td>Moderate / high</td>
<td>Immediate to 1 month</td>
</tr>
</tbody>
</table>

Patients with moderate to high dental anxiety would be treated similarly to the CBT toolkit according to their specific dental fear concerns. Tools such as a ‘thought record’ are useful and could be used to identify specific beliefs and also a way to involve patient with their own care pathway.

Conclusions

There are many varying factors which impact on the behaviour of patients and knowledge of theoretical behaviour models can help to understand some key issues.12,13 Effective use of scales and models via questionnaires help to identify a patient’s behaviour and assist in reducing barriers to care.14,15 Their responses to the questionnaires help the patients to articulate and share their concerns. A friendly approach, the delivery of treatment in a confident way and the establishment of effective relationships helps put patients at their ease and assist towards effective treatment.14,15 The ability of the clinician to empathise with the patient, especially with anxious individuals or those holding negative attitudes to dentistry, can result in increased patient satisfaction.14,15

Anxiety also has adverse effects on cognitive function, causing weakening of memory, task performance and concentration.

Compassionate conduct, careful selection of treatment modalities and individual alternative management strategies, rather than pharmacological approaches, should allow further reappraisal and thus resolve some of these problems.

However there are obviously limits to how successful this approach will be and one study15, found that some patients require formal psychological approaches. More research into patient preferences, educational and service developments will surely continue to find ways to improve treatment modalities for dentally anxious patients. Clinicians have a duty of care to their patients and ought to be able to recognise those patients who are dentally anxious or suffer psychological disturbances and where necessary refer to specialist dental and clinical psychology services.

It is possible to treat a large proportion of patients by cognitive behavioural therapy alone, and training practitioners in the
applications of psychological methods for the treatment of anxious patients should be encouraged. It is important to identify the factors that enable the patient to undergo emotional and behavioural changes and reduce high, maladaptive levels of anxiety to normal, accepted levels of stress.

All ideas and reflections with particularly the focus on goal setting for patients working towards improved oral health should be encouraged among dental care professionals.

ABOUT THE AUTHOR:
Ellie recently completed a course in Cognitive Behaviour Therapy (CBT) for adults with dental anxiety at Kings College University of London. Her future plans now include putting into practice some of the CBT concepts with her all her patients with the aim of improving their oral health. She firmly believes that non-pharmacological or psychological treatments for dental anxiety are an option that, when given a choice, some patients will prefer.

CORRESPONDENCE:
Email: ellie.kani@kcl.ac.uk

References:
The Government plans to introduce a new ‘sugar tax’ which will target the soft drinks industry and aims to reduce consumption of drinks with added sugar.

1. When is this expected to take effect?

2. What are the two categories of soft drink targeted and what is the levy on them?

3. Which groups of soft drinks will be exempt?

4. According to the findings of the Child Dental Health Survey 2013, England, Wales and Northern Ireland [NS], published in March 2015, what percentage of 15 year old children had “obvious decay experience” in their permanent teeth?

Q1. What other clinical information do you need to assist diagnosis?

A1. Is it painful? How long has it been there? Have there been any previous episodes? Is it a solitary lesion? Can he remember traumatising the area?

Q2. What would you do next?

A2. Reassure the patient. If it is painful suggest topical chlorhexidine spray. Review in two weeks.
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 May 2017 Dental Health Continuing Professional Development Programme is to provide the opportunity for dental hygienists and dental therapists to learn about aspects of the following subjects: Management of extensive dental caries in children and Understanding pain and its management.

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 www.bsdh.org.uk and select PAPER 1: MANAGEMENT OF EXTENSIVE DENTAL CARIES IN CHILDREN PP23-29

1. In line with the GDC’s Scope of Practice, which of the following statements is false?
   - A. Dental Therapists are permitted to provide direct restorations in primary and permanent teeth
   - B. Dental Therapists are permitted to complete pulpotomies on primary teeth and place preformed metal crowns (PMCs) on primary teeth
   - C. Dental Therapists are permitted to extract primary teeth
   - D. Dental Therapists are permitted to extract permanent teeth

2. Which of the following statements is false?
   - A. Extensive decay in 5-year-old children is diagnosed when caries extends into the dentine of at least two teeth
   - B. Extensive decay in 5-year-old children is diagnosed when caries extends into the dentine of at least five teeth
   - C. Extensive decay in 5-year-old children is diagnosed when there are at least three teeth with obvious decay
   - D. Extensive decay in 5-year-old children is if there are any non-restoreable carious teeth present

3. Which of the following statements is false?
   - A. A recent study revealed that 79.7% of children with dental caries had experienced pain and 53% had difficulty eating
   - B. A recent study revealed that 90.7% of children with dental caries had experienced pain and 53% had difficulty eating
   - C. Children’s mental health and wellbeing is negatively affected by dental caries
   - D. Recent figures reveal that approximately 46,500 children were admitted to hospital to undergo dental treatment under general anaesthesia

4. Which of the following statements is false?
   - A. A caries risk assessment considers the risk that a child will develop caries in the subsequent three years
   - B. A caries risk assessment should include sociodemographic factors and previous decay experience
   - C. A caries risk assessment should include, dietary and oral hygiene habits (including fluoride use) and medical history
   - D. A caries risk assessment does not necessarily need to include a medical history

5. Which of the following statements is false?
   - A. Children over the age of 3 years should use a toothpaste with 1350-1500ppm fluoride
   - B. Fluoride varnish (5%) should be applied twice a year to children over the age of 2 years
   - C. Those children considered to be at a high risk of dental caries require fluoride varnish application at every recall visit
   - D. GIC sealants are easier to apply and just as effective as resin-based sealants

6. Which of the following statements is false?
   - A. The Hall Technique is superior to conventional restorations
   - B. The Hall Technique is more readily accepted by children
   - C. The Hall Technique seals the carious lesions to prevent progression
   - D. The Hall Technique requires local anaesthesia infiltrations

PAPER 2: UNDERSTANDING PAIN AND ITS MANAGEMENT PP31-33

1. Which of the following statements is false?
   - A. Nociceptors are specialised sensory receptors
   - B. The signals that originate from the nociceptors in the orofacial region transmit to the trigeminal nerve, and its ganglion
   - C. This transmission may cause referred pain
   - D. C-fibres produce a sharp pain when stimulated

2. Which of the following statements is false?
   - A. According to the Adult Dental Health Survey, 9% of dentate adults reported pain related to their teeth
   - B. According to the Adult Dental Health Survey, 5% of dentate adults reported that they had experienced pain in their mouths fairly often
   - C. Psychological factors can influence an individual’s pain experience and response
   - D. The British National Formulary (2015) contains a section dedicated to the management of dental and orofacial pain

3. Which of the following statements is false?
   - A. Objectively, pain is easily measured
   - B. There are a number of validated scales and questionnaires available to measure pain intensity
   - C. Validated scales measure the quality of care provided, as they can be considered as patient-related outcome measures (PROMS)
   - D. The Visual Analogue Scale allows the patient to place a mark on a line of set length to represent pain intensity

4. Which of the following statements is false?
   - A. Lidocaine hydrochloride 2% (with 1:80,000 adrenaline) has a rapid onset, low-toxicity, low incidence of allergy and is cost effective
   - B. Articaine is an amide and is hydrolysed slowly in the blood, hence the risk of systemic intoxication is lower than with other dental anaesthetics
   - C. Prilocaine is a shorter acting anaesthetic solution
   - D. Lignospan is the proprietary name for Lidocaine

5. Which of the following statements is false?
   - A. CBT is a treatment rationale with an emphasis on the role patient’s can play in controlling their own pain
   - B. CBT provides pain coping strategies
   - C. CBT produces significant changes in measures of pain experienced
   - D. CBT does not produce significant changes in measures of pain experienced

6. Which of the following statements is false?
   - A. Mild to moderate pain is often suitably managed by the appropriate and optimal doses of non-opioids
   - B. The amount of opioid required is usually minimal when paracetamol and ibuprofen are used in combination
   - C. Cold induces a sympathetic reflex which in turn results in vasodilatation of arterioles leading to an increase in oedema
   - D. Cryotherapy reduces inflammation and swelling
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   CPD article 2

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   Q2  a  b  c  d  Q2  a  b  c  d
   Q3  a  b  c  d  Q3  a  b  c  d
   Q4  a  b  c  d  Q4  a  b  c  d
   Q5  a  b  c  d  Q5  a  b  c  d
   Q6  a  b  c  d  Q6  a  b  c  d

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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.
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- Great for improving patient compliance

Available in 3 sizes for a whole mouth clean

If patients are motivated enough to clean their teeth for two minutes, twice a day, they’re going to want to be rewarded with good oral health, particularly good gingival health. As well as the right technique, they also need to be using the right products. Just as you want your washing machine and detergent to work in harmony, so too do you want a toothbrush and toothpaste to give the best possible outcome.

Oral-B’s Genius toothbrush works in synergy with Oral-B’s Pro-Expert toothpaste. The Genius brush will almost certainly improve a patient’s technique ensuring the user brushes for the right length of time, does not apply too much pressure and, most importantly, never misses a zone! There is no excuse for non-uniform brushing as real-time guidance is given to improve their technique.

Using the washing machine analogy, Oral-B’s Pro-Expert is the ‘Ariel’ to its Genius power toothbrush. It’s the inclusion of stabilised stannous fluoride that makes the difference. This powerful ingredient gives Oral-B’s Pro-Expert toothpaste a long-lasting antimicrobial action as it inhibits antimicrobial growth as well as reducing the ability of bacteria to ‘stick’ to tooth and gum surfaces.

The inclusion of sodium hexametaphosphate is also beneficial as it protects against calculus formation, as well as staining, thereby reducing a further cause of plaque retention on the roughened surface of the calculus. The combined force of these two plaque reducing agents, alongside the mechanical action of the Oral-B Genius help protect against gum problems.

Young Innovations is expanding into Europe

The American dental manufacturer Young Innovations is driving its involvement in Europe forward. In November, it opened a European central office in Heidelberg and it is currently launching its Young Dental and Zooby product lines. The company is headquartered in Chicago and a market leader in many fields in the USA and also manufactures brand products for top global dental distributors.

Dave Sproat, the CEO of Young Innovations (pictured), explains “Our brands MicrobrushÆ and DryTipsÆ are already known in Europe. There is also a high demand for our prophy products and therefore we have decided to officially introduce Young Dental and Zooby and make our expertise in professional dental cleaning available”. 

About Young Innovations

Young Innovations is a leading developer, manufacturer and retailer of high-quality dental products. The American company has its headquarters in Chicago and its European central office is located in Heidelberg, Germany. It also has other facilities located in the US states of Missouri, Wisconsin, California, Indiana, Illinois, as well as in Ireland. The company was founded in 1900 and was acquired by Linden Capital Partners in 2013.

Mail: info@youngdental.eu  www.ydnt.com
Most people think they’re brushing their teeth for the recommended two minutes, twice a day, but now, thanks to the Oral-B App 4.1 we can see for how long those using Oral-B’s Genius electric toothbrush, are actually brushing.

Over 1.5 million people have downloaded the app globally since the Genius brush was launched last year. The average time dedicated to brushing is a whopping 2.22 mins. 88% of all users brush for over two minutes and 91% brush using Bluetooth in 91% of all their brushing sessions.

Designing an app to sync the camera function of a mobile with the unique technology in the Genius toothbrush was not without its challenges. Initial concerns were that some people might be reluctant to take their phone into the bathroom; however, research had indicated that 74% of people do, and 24% of people would even answer a call whilst in the bathroom!

Other design challenges included the ability to utilise two-way communication — the app needed to receive brushing data and report it back to the user in a clear, predominantly visual form. Simplicity was key. The app also needed to allow patients to work in conjunction with dental professionals (with the former’s consent) so that professionals could programme brushing routines in the app to help improve technique and behaviour.

Patient oral health depends largely on patient compliance. This new app provides patients with motivation, guidance and tracking of their brushing patterns to give them more control and accountability over their own oral care.

In support of soft tissue management

Johnson & Johnson, the makers of LISTERINE®, are delighted to present Professor Nicola West speaking on the topic of soft tissue management at this year’s BDA conference.

Professor West, Head of Periodontology, Professor and Honorary Consultant in Restorative Dentistry at the University of Bristol, will cover topics including managing the soft tissue health of your patients now, securing their future health, and delivering this within the constraints and demands of running a successful dental practice.

Delegates may attend Professor West’s presentation on Thursday 25th May at 14.15-15.15 or Friday 26th May at 11.45-12.45.

Johnson & Johnson are the makers of LISTERINE®, which has variants that are suitable for daily use as an adjunct to mechanical cleaning to help deliver an optimised daily prevention regimen. In addition the LISTERINE® Advanced Defence range is available to help dental professionals deliver advanced treatment outcomes for patients.

For further information, please visit stand C13 to speak to a member of the LISTERINE® Professional team.
Philips extends its connection with the dental profession

Philips Oral Healthcare will be launching BreathCare at the Dentistry Show, highlighting its expertise in connected technology to breathe new life into the treatment of halitosis. Also revealed will be an uber stylish new Sonicare toothbrush which builds on the healthcare and behavioural changes brought about by the connectivity innovation and technological wizardry initiated with Sonicare FlexCare Platinum Connected. Philips will also be spotlighting its unique three-phased tooth whitening approach.

Philips is supporting Juliette Reeves discussing Nutritional Manipulation of Chronic Inflammation; Dr Zaki Kanaan on whitening, and Dr Ben Atkins on how behaviour change in the dental practice can make oral health profitable.

Visit Stand J30 for an extensive daily programme of talks and panel discussions with dental experts.

Impressive Results

“I bought a Waterpik® Water Flosser for my husband and I have been really impressed with the difference it has made to his oral health,” says Janet McCarthy, a dental hygienist at Riverside Dental Surgery in Norfolk.

“It’s definitely something I recommend to patients, especially for those with bridges or implants.”

An easier-to-use alternative than string floss, the Water Flosser has also been shown to reduce gingivitis by up to 52% more than traditional floss. When used with the Plaque Seeker® Tip, which is especially designed to clean well around implants, crowns and bridges, a clinical study has shown that the Waterpik® Water Flosser is up to 2 times as effective for improving gum health around implants vs string floss. Visit www.waterpik.co.uk.

GUIDELINES FOR AUTHORS

Log on to the BSDHT website for full guidelines on how to publish your work in the journal. Alternatively contact the Editor. Email: editor@bsdht.org.uk
An Effective Alternative

Wisdom Toothbrushes at The Dentistry Show 2017

Do some of your patients struggle with wire interdental brushes?

Are you looking for an effective alternative you can trust to recommend to them?

Wisdom Clean Between Rubber Interdental Brushes feature a flexible, tapered design with unique and super soft micro-fine filaments that glide easily between the teeth, around orthodontic appliances or around crowns or bridges. Removing food debris and plaque as they go, the brushes are clinically proven to reduce gingival disease.¹,²

Completely wire-free they provide an ideal solution for patients who find wire interdental brushes uncomfortable or challenging to use correctly. Available in three sizes, the brushes are ideal for use in interdental spaces of various dimensions.

Don’t miss Wisdom at The Dentistry Show 2017! Stand M82!

Visit www.wisdomtoothbrushes.com or call 01440 714800

² Prof. Dr. Petra Ratka-Krüger et al, Clinical trial of a metal-free interdental brush. University Medical Centre Freiburg, Germany. Pub Nov 2010.

89% of Dental Professionals agree that “dry mouth is on the rise”¹

During February Oralieve® have been asking Dental Professionals about their experience of patients with dry mouth and the results are in. Out of the 621 Dental Professionals who answered our survey:

- 80% of Dental Professionals are seeing more than 5 patients a month with dry mouth and 44% are seeing more than 10 a month
- The main causes of dry mouth are; types of medication taken, polypharmacy, Sjögren’s syndrome and mouth breathing at night
- 89% agree dry mouth is on the rise

Recommend the Oralieve® Dry Mouth Relief product range for effective relief from dry mouth. Available from www.oralieve.co.uk and Dental Directory.


BSDHT APP NOW AVAILABLE ON ANDROID TOO!

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!
**AVON**

**Bristol.** Hygienist wanted for maternity cover from 31st July 2017 in Bristol for 9-10 months. Surgery available Tuesdays and 3 x Wednesdays per month. Please email CVs to latikatandon@dental-touch.co.uk

**BERKSHIRE**

**Reading.** I am looking for a hygienist to cover maternity leave on Wednesdays from the 1st July 2017 until to 31st December 2017. Please send your CV to Hesami2008@yahoo.com

**DEVON**

**Plymouth.** Dental Hygienist sought to work Mondays and Wednesdays in a friendly predominantly private practice in Plymouth. Please email info@armadadental.co.uk.

**HAMPSHIRE**

**Fleet.** Experienced Hygienist wanted 1-2 days/week to replace retiring colleague in periodontal referral practice (July start). Please email CVs to: pm@heathdentalsuite.co.uk

**Winchester.** Friendly family practice looking for a Dental Hygienist one day a week (Wednesdays). No nurse and a hourly rate £32 to £35. Contact arbouredental@gmail.com or call 07920043091 for further information.

**MIDDLESEX**

**Sunbury-On-Thames.** Hygienist required every Thursday and one Saturday a month in busy, fully equipped practice, SOE and established patient list. Please email cv to post@sunburydental.co.uk or call 01932783208. Excellent rates.

**SOMERSET**

**Bridgewater.** Family owned friendly practice looking for a dental hygienist two days a week. Twenty minute appointments with a nurse and all the benefits of being employed. Send CV and covering letter to Heather Finkle at office@cornhilldentalpractice.co.uk

**Bath.** Part-time dental hygienist/dental therapist required Mondays and Thursdays to cover maternity leave from May 2017 in private Bath city centre practice. Tel 01225 421096 or email greenparkdentist@gmail.com

**SUFFOLK**

**Ipswich.** Dental Hygienist required for 3 days a week at our well established, private town centre practice. We are looking for an enthusiastic, experienced hygienist to join our team. Start date ASAP. The candidate must be fully qualified and registered with the GDC and hold their own personal liability insurance. Please email your CV to office1@harbourdentalcare.co.uk

**SUSSEX (WEST)**

**Crawley Down.** Dental Hygienist required for well established, friendly private practice for 1 day a week (Mondays) starting beginning of July. Please forward CVs to email nicolaturner1964@gmail.com

**East Grinstead.** We are looking for a friendly, ethical and motivated hygienist/therapist to join our team in East Grinstead. 2 days a week flexible, 8am-5pm. Percentage room remuneration. Start May 2017.

**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

**Wolverhampton.** Part time hygienist required for private practice in Wolverhampton. Hours flexible but ideally 2 days per week. Please email CV to clive.gibson@lansdownecentre.co.uk or phone 07944787890

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DENTAL HEALTH
**Dentomycin® - designed to work deep below the surface**

When it comes to periodontitis, root planing and scaling are only the tip of the iceberg.

When pocket depth exceeds 5mm, Dentomycin® Periodontal Gel is a particularly effective adjunctive treatment for treating adult periodontal disease. The anti-inflammatory gel gets to the heart of the problem by eliminating key pathogens and inhibits harmful bacterial collagenases.¹

In a controlled double-blind, multi-centre study on 90 patients, mechanical treatment plus Dentomycin® Periodontal Gel showed an average 42% pocket depth reduction in just 12 weeks², healing the pocket by inhibiting degradative collagenases³ and enhancing connective tissue attachment⁴. And with its easy-to-use, pre-filled applicator, Dentomycin® Periodontal Gel delivers the gel directly into the periodontal pocket so that it can get to work quickly.

**Dentomycin®**

2% w/w Periodontal Gel
Minocycline (as hydrochloride dihydrate)

**Find prescribing and ordering information at:**
www.owwarehouse.co.uk/dentomycin

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PLAQUE CONTROL: ‘GOOD’ CAN BE BETTER

THE PROVEN ORAL CARE COMBINATION

A combined analysis of 29 clinical studies on essential oils has been published in the *Journal of the American Dental Association*. This showed that after 6 months of using LISTERINE®, after brushing and inter-dental cleaning, 37% of patients had at least half their mouth free from plaque, compared with only 5.5% of those who just brushed and used inter-dental cleaning.¹

LISTERINE® contains a unique anti-plaque agent, 4 powerful essential oils. These penetrate the plaque biofilm to kill 97% of bacteria left behind after brushing.² For some patients ‘good’ can be better.

To see the full study visit [http://jada.ada.org/article/S0002-8177(15)00336-0/abstract](http://jada.ada.org/article/S0002-8177(15)00336-0/abstract)