A Great Day Out!

DENTAL RADIOGRAPHS
What is normal anatomy?

BSDHT POSTER COMPETITION
The winners

SECURING MY PHD FUNDING
by Susan Bissett
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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9
Dr. Gerald Leatherman Award

34
Dental effects of prolonged thumb sucking

27
A Great Day Out!

ON THE COVER...

Editorial 5
From the President 6
Dr. Gerald Leatherman Award 9
BSDHT New Regional Group 11
Regional Group News 12
Obituaries 14
BSDHT Poster Competition 15
A Dentiad Trip to Uganda 16
President’s Inaugural Speech 18
Securing My PhD Funding 24
A Great Day Out! 27
Chemotherapeutics in practice 29
Dental radiographs: what is normal anatomy? 32
Dental effects of prolonged thumb sucking 34
Accessing the excess: localised periodontal disease - a consequence of stagnant resin cement 36
The impact of orthodontic therapy on patients with periodontal disease 38
Clinical Quiz 41
CPD 42
Diary Dates 44
Oracle 47
Administration 49
Recruitment 50

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BRITISH SOCIETY OF DENTAL HYGIENE AND THERAPY
Promoting health, preventing disease, providing skills

A Great Day Out! Launching the BSDHT App at the OHC in November 2013

ON THE COVER...
EUROPERIO 8
JUNE 3-6, 2015
ExCeL, LONDON, UK

Join the World's leading Conference in Periodontology and Implantology!

Over 100 of the World's top speakers in Periodontology and Implant Dentistry will present the latest information, clinical tips in the field for the whole dental team.

Lecture streams targeted specifically for General Dentists, Hygienists, Academics, Periodontal and Implant Specialists will run throughout the meeting.

Check out the programme now.
The coming year looks set to be a big one for Periodontology in the UK; EuroPerio8 - the World's Leading Conference in Periodontology and Implant Dentistry - is coming to town! We expect to be welcoming over 8000 delegates from across the dental team to London in June for what promises to be the biggest and best conference of its type ever to be held in Europe, and we hope you will want to be there to enjoy it too.

The European Federation of Periodontology (EFP), in collaboration with local partners the British Society of Periodontology (BSP) and the British Society of Dental Hygiene and Therapy (BSDHT) are very proud to be hosting this exciting event at London ExCeL from 3rd - 6th June. We have put together an exciting inclusive clinical and scientific programme for the dental team.

The EFP have organized EuroPerio conferences every three years since 1994. From relatively modest beginnings in Paris that year, the conference has grown massively in stature and impact and is now the most important meeting in the European calendar for any dental professional with any interest in Periodontology and Implantology. EuroPerio7, held in Vienna in 2012 attracted 7500 delegates from 95 different countries and was generally considered by delegates to have been a huge success. We have always attracted many hygienists to EuroPerio meetings, particularly from the host country. This is the first time the meeting has come to the UK and we expect to get huge support from Dental Hygienists in the UK. The central role that you play in the practice of Periodontology in the UK, and the great strength and enthusiasm of the BSDHT and its membership, has resulted in a fruitful collaboration in the planning of this project.

Venue
EuroPerio8 will take place at ExCeL London. This award winning venue offers superb facilities and is one of the best venues of its type in Europe. At the London 2012 Olympics it had around 500,000 visitors in just over 2 weeks! The enormous exhibition space will be occupied by stands from over 100 sponsors and exhibitors.  

Scientific Programme
We have over 100 top international speakers in the main programme who will share their knowledge, expertise and opinions. Throughout the meeting four main lecture programmes will run simultaneously. One of these programmes, which we have called “Contemporary Practical Periodontics” has been specifically designed for Hygienists, DCPs and GDPs working in primary care dentistry. It will focus on nonsurgical periodontics and related issues. Specific topics in this programme include: plaque control; instrumentation; smoking and other risk factors; medical history; antimicrobials; halitosis; implant maintenance and peri-implant disease; other diseases of the periodontal tissues; and patient outcomes. Some of the world’s top experts in these fields will discuss these important topics.

Some other very notable highlights include:

- **“The Sound of Periodontitis”** - this video film of patients’ own perceptions of having periodontitis will be premiered in this session, combined with an interactive discussion session with patients, opinion formers and dental professionals. We believe this is the first time such a Patient and Public Engagement Session has been held on the topic of periodontology in the UK and is likely to have many lessons for us all.

- **International Journal of Dental Hygiene Research Session.** A session run specifically by the IJDH for Dental Hygienists on research methodologies.

- **Plenary Lecturer - Professor Steve Jones FRS.** We are delighted to welcome the famous geneticist, author and TV broadcaster who will deliver his lecture intriguingly titled “A Geneticist’s apology: nature, nurture or neither?.” Professor Jones is a superb lecturer and widely regarded as one of the best popular science communicators in the UK.

- **Networking events**
  In addition to the scientific programme we hope that all delegates will get time to enjoy themselves. On Wednesday afternoon the Opening Ceremony will include some good British entertainment, and will be followed by a Welcome Reception. Thursday evening we have the Conference Party with refreshments and dancing to a live band; Saturday night we have a grand Gala Dinner at the iconic Royal Courts of Justice building in London.

Check out our website [www.efp.org/europerio8](http://www.efp.org/europerio8) for full information about the programme, registration and all other matters. We have heavily discounted registration rates for dental hygienists, and also single day registration rates for hygienists only. Early bird registration rates close on February 27th 2015. We hope to see you in London!

**Francis Hughes**  
Professor of Periodontology, Kings College London.  
Chair, EuroPerio8.
FROM THE PRESIDENT

Hello and welcome to 2015. I would like to wish everyone a Happy New Year, and I hope you will join me in looking forward with great excitement to the year ahead.

Our annual conference, which took place in November, was once again a great success with delegates enjoying contributions from a wide variety of excellent speakers. We had some incredibly positive feedback, particularly from students, and I look forward to welcoming them to our next conference.

I am delighted to formally announce that Helen Minnery is our new President Elect, the democratic choice of BSDHT members at the AGM. I look forward to working with her throughout my term as President. Working as President Elect with Julie Rosse has prepared me for my role as president and I can’t thank her enough for all she has done for our society, and also for me personally. Julie achieved so much throughout her two year term of office, and will continue to work for the society in her role as Regional Group Co-ordinator.

OHC 2014

At the AGM we also held a membership-wide vote on three key issues, and the outcomes are as follows:

1. To approve the BSDHT Council recommendation that employment insurance is provided as a membership benefit for all full BSDHT members
   For: 542 Against: 22 Abstentions: 1

2. To approve the BSDHT Council recommendation that complimentary student membership is extended to newly qualified members for one year post qualification
   For: 495 Against: 68 Abstentions: 2

3. To approve the BSDHT Council recommendation that the Honorary Treasurer and Honorary Secretary receive financial recompense for part of the working week
   For: 526 Against: 38 Abstentions: 1

It is a great pleasure to tell you that Julia Brewin was awarded the prestigious Gerald Leatherman Award - a popular choice with delegates.

Once again we had an increase in entries for the poster competition and I look forward to seeing them expanded into papers for the Annual Clinical Journal.

I would also like to thank the team behind the scenes for making the conference such a success. Many hours go in to preparation and it is tribute to their enthusiasm that the Society continues to grow.

We have to thank Sue Adams and her team who have stepped down from our administration position after working with BSDHT (and BDHA) for 10 years. We will miss them terribly but welcome our new administration company. Please note our new number is 01788 575050
Running a society of this size takes a lot of time. It needs a strong and cohesive team and I am excited to be working with such passionate and hardworking peers on the Executive, Council and Publications teams. Together we can better our society and in turn our profession. I spoke of my views for our profession in my inaugural address and I hope to have some news on how this is developing in the not too distant future.

The year ahead

As you know, over the past few years we have been working with the relevant bodies to iron out the anomalies that Direct Access highlighted. We have helped bring about some big changes in the field of diagnosis and radiography and even though we have been working hard on prescribing rights it has been very slow moving. We have had a PGD developed for our members but with the demise of the PCTs we are struggling to get an adequately experienced Pharmacist to sign them. This was only ever intended to help us in the absence of prescribing rights: obtaining limited prescribing rights has been ongoing and is the goal. As a practising clinician I find this situation frustrating. We will keep driving this forward and hopefully, by the end of my tenure, we will have achieved our goal.

Later this year we are co-hosting EuroPerio8 with the BSP in London. This is a great honour as we are the first dental hygiene and therapy society to do this in Europe. It highlights the esteem in which we are held by our colleagues. You will notice that this time there is not a separate Hygienist programme; this wide ranging all encompassing programme will have areas of interest for all members of the periodontal team. There is an early registration incentive for dental hygienists opting for full attendance to EuroPerio8 and a daily rate for Friday or Saturday. A price of 260 euros will get you the complete June 3 to 6 package, if you book before February 27th. After that, until May 13th, you can still take advantage of a discounted price of 315 euros. For full details of registration prices, please visit www.cfp.org/europerio8/registration.

Michaela O'Neill
President
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Julia Brewin was the worthy recipient of the BSDHT's Dr Gerald Leatherman Award in recognition of her immense contribution and commitment to the profession of dental hygiene over many years.

Julia qualified as a dental hygienist in 1989 from the Eastman Dental Hospital. She worked in a large specialist referral private practice in Harley Street following qualification until 2007, when she set up a very successful independent dental hygiene referral practice in London W1.

Since 1991, Julia has also been an enthusiastic and inspirational Tutor, working part time at the Eastman Dental Hospital where she now teaches the Dental Hygiene and Dental Therapy course.

Jane Nichols, a fellow Tutor at the Eastman Dental Hospital has known Julia in a professional capacity for thirteen years. She says: “I have admired Julia’s professionalism at close quarters, not only as a remarkable team leader but also as an inspiring teacher to the many students who have been under her care.

As a very gifted communicator her teaching role has been hugely successful. Her very wide professional experience is a rich source of sound knowledge, which she passes on so ably for the benefit of others.

She is a naturally warm and compassionate individual who is always prepared to go that extra mile to help those around her, whether it be towards struggling students, patients or her colleagues. But at the same time maintaining the standards required in her role as a professional”.

Alison Franc adds: “As a student currently studying dental hygiene and therapy at the Eastman Dental Hospital, I have been tutored by Julia Brewin for the past two years. She is an inspiration to me both in a personal and professional capacity.

Her teaching style combines an unwavering enthusiasm for the subject with a genuine sincerity of faith in her students’ abilities. She goes above and beyond the standard role of tutor and shows immense support and personal interest in her students, which is indicative of her wonderfully empathetic and encouraging personality. Professionally, Julia embodies the career we all hope and strive to emulate and her humbleness in her achievements shines as an inspiration in itself”.

Lecturing extensively in the UK including at both national and regional BDHA/BSDHT conferences and meetings, Julia was one of the first Dental Hygienists invited to speak at a BDA conference and in 2009 spoke at a meeting at the Royal College of Surgeons in Glasgow. From 2000-2005 she also ran a series of courses developing from what had started as a trial (supported by Dentsply) where she spoke to a small group of delegates. This trial was so successful that ‘Part Two’ and ‘Part Three’ courses were added. This was at a time when there were no courses for dental hygienists and therapists and was even before CPD was requested by the GDC. She travelled around the country from Belfast to Cardiff to Cornwall. In addition, Julia took part in the GDC DCP Registration Roadshows before the GDC Register was opened to include additional DCP members, covering England, Scotland, Wales and Ireland.

Working with the dental company Dentsply, Julia helped lead a group of dental professionals in creating the Refinement range of periodontal instruments and helped design a scaler which was named after her- the Brewin scaler.

Since qualification, Julia has been a very active BDHA/BSDHT member at both regional and national level. For some years she was the Secretary of the BDHA/BSDHT London Regional Group. She has served on BDHA Council as an Elected Council Member and as a Regional Group Representative on Council. From 2000-2012, Julia was a well-respected and enthusiastic contributor to the BSDHT Publications Committee.

Julia’s contribution to our dental profession also includes her involvement with the General Dental Council (GDC) over the last twenty years. Initially she was elected to the Dental Auxiliaries Committee in 1993. After this committee was disbanded, Julia was elected, then subsequently appointed, to the GDC Council. After the first reorganisation of the Council, Julia was appointed to the GDC’s independent Investigating Committee where she has contributed for the last nine years.

Julia has also undertaken charitable work by being part of a Dentaid charity trek to Southern Italy and where she climbed three volcanoes. For quite a few years she was involved with Crisis for Christmas and recently she walked a marathon by taking part in the Breast Cancer Moon Walk.

Since qualifying twenty-five years ago, Julia’s enthusiasm for her chosen career has never waned. She gives her all to every endeavour she gets involved with and always finds time to encourage, motivate and support others to get the best out of themselves. She is a credit both to the Society and to her profession.
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Setting up the Jersey regional group

I was first approached about setting up a regional group on the island by a fellow Hygienist who had already taken the initial steps to get things up and running. She then decided to end her career as a dental hygienist to pursue other avenues and asked if I was willing to take it over.

I thought it was extremely important for us to be recognised as a professional body on the island and so jumped at the chance of being there at the beginning. I was delighted to be elected as Chair and with the help of our Secretary and Treasurer we have got off to a great start.

In Jersey we currently have 13 Dental Hygienists serving a population of approximately 97,000, so we are all pretty busy. We agreed that if nothing else, it was going to be great to get together as a group of like-minded people to discuss the professional challenges we often come across.

Currently in Jersey we face another obstacle in that the law under which we are governed prevents us from working fully within the GDC’s scope of practice. This means we are unable to carry out certain procedures/treatments that we have been trained and are fully competent in. It also means that Dental Therapists are unable to work on the island. Since setting up the regional group we have been involved in the consultation process to get the law amended and brought up to date with current GDC legislation. This will mean that in the very near future we can do everything that we have worked and trained so hard for.

The law amendment will also allow us to enjoy the benefit of being able to offer Direct Access which the dentists that I work with are really looking forward to.

Living on an island can also make it more difficult for us to get appropriate and relevant CPD as this can often involve travelling off island, which of course incurs extra cost. As a group we are working hard to bring more CPD events to Jersey. As our group consists of only 13 members, paying for speakers to come over is proving to be a bit tricky so we may have to rely on people who are able to get sponsored to come and visit us. We are however working on putting some more CPD in place next year by using our annual subs as well as the generous grant from the BSDHT.

So far I have really enjoyed the journey of setting up our regional group and am looking forward to what the future brings.

Please feel free to email me: katieparky@yahoo.co.uk
The day started with SPONSORS: Thanks to all our sponsors
Leigh Ann Randell, Mike Pemberton, Juliette Reeves, Sally Simpson and Mandec – Manchester Dental Education Centre

**DATE:** 4th October

**VENUE:** Manedec – Manchester Dental Education Centre

**SPEAKERS:** Mike Pemberton, Juliette Reeves, Sally Simpson and Leigh Ann Randell

**SPONSORS:** Thanks to all our sponsors

The day started with Dr Mike Pemberton - Oral Cancer, potentially malignant disorders and common oral medicine conditions. Oral cancer is on the increase so as clinicians we have to be aware of early presentation therefore referring accordingly gives the patient chance of survival. Risk factors include smoking, alcohol (a combination of which puts the patient at higher risk) and HPV virus 16 which has been linked to oropharyngeal cancer. Examination has to be extra oral and intra oral and if any abnormality is detected then referral should be made to your local Oral Medicine Department. Referrals should be submitted on a NHS HSC203 head and neck cancer referral form https://www.dental-referrals.org/wp-content/uploads/2012/09/NEWMAN-HSC-REFERRALFpub1.pdf.

The next speaker was Juliette Reeves – Systemic and Oral Health Associations: Exploring the Nutritional Connection. Juliette informed us how we can consume anti-inflammatory foods packed with anti-oxidants to reduce the Reactive Oxygen Species that can cause cell damage in our system. The associated tissue destruction can have an impact on our patients’ periodontal health. The talk paved the way for us as clinicians to not only speak to our patients about plaque control but to help them with embarking on a healthier lifestyle to improve their oral health, from the inside. Juliette can be found at http://www.peri-nutrition.com/ for courses and features regarding nutrition.

Next to speak was immediate Past President Sally Simpson – Everything you wanted know about implant maintenance but were afraid to ask. Sally covered the assessment of implant health and clarified our questions on monitoring and recording of peri-implantitis. She addressed concerns over peri-implantitis and where the hygienist fits in between the treatment and prevention of this disease. Also the importance of team work in managing the implant patient, the recording of detailed dental records and adhering to a set treatment protocol.

Last to speak was Leigh Ann Randell – Posture and the Dental Hygienist/Therapist. Leigh Ann provided an insightful presentation on just how bad our posture is during the working day and the photos of us doing just that were proof in themselves! Having suffered musculoskeletal disease (MSD) Leigh Ann runs courses on how to correct our bad habits that can lead to this condition, which can then impact on our working practice, finances, stress levels and wellbeing. We are taught how to utilise dental loupes, surgery layout and instruments ergonomics and how to correct the working position of patient, operator and nurse.

We thank our trade sponsors again for supporting BSDHT. Money raised in the raffle went to our charity The Ben Walton Trust http://www.benwaltontrust.org/contact.html

Yvonne Derbyshire
(Outgoing Chair)

**BSDHT SOUTHERN AUTUMN MEETING**

**DATE:** Saturday 27th September

**VENUE:** Salisbury District Hospital

**SPEAKERS:** Tim Ives, Amit Patel, Rumana Husien

**SPONSORS:** Thanks to all our sponsors

On this lovely autumnal day, we were privileged to have three interesting, experienced and informative speakers.

Tim Ives provided our first lecture entitled, Shut your mouth, grabbing our attention straight away! I think we all sat there not daring to open our mouths, partaking in “nose breathing” as Tim discussed mouth breathing - the signs to look out for, and the benefits of trying to transform patients from mouth to nose breathing. Fascinating facts included an increased intake of oxygen, lower pulse rates, cures for asthma and snoring. Tim also discussed a number of aids to help transform mouth breathers, such as chin straps to be worn at night. This led onto the short film about a boy called Connor and how he was diagnosed with ADHD. Following assessment and treatment from a Dr Sheldon in the USA, who believes there’s no such thing as ADHD it’s just simply that these children are sleep deprived, he was subsequently diagnosed with Sleep Disorder Breathing(SDB), whereby his behaviour positively altered and he was no longer disruptive. Tim also talked about the children treated in Chernobyl who had limited medical supplies, so they were trained in nose breathing which led to reduced asthma. Tim also suggested further reading on subjects linked to mouth breathing.

Our second speaker, Dr Amit Patel updated us all on Peri implant disease. Amit talked about PI mucositis and PI implantitis and discussed the most effective instrumentation methods to obtain healthy tissues around implants, including the use of an air abrasion unit with glycerine based aerosol perio powders for subgingival use. Amit also showed us some amazing videos of surgery he has performed, including the retrieval of a tooth from inside the maxillary sinus. It was fascinating to be able to see the lining of the maxillary sinus intact and pulsating during a surgical procedure.

With statistics such as a million implants placed annually worldwide,
and approximately 600 different systems used, treatment of implant patients is becoming more common. Delegates left feeling more confident about using metal and ultrasonic scalers when needed at inflamed implant sites.

Our third speaker Rumana Husien provided a brief overview and revision on Cavitron instrumentation, discussing the beneficial effects of microstreaming and also the maintenance and care of the unit and tips. Delegates were able to inspect the variety of tips available, with the pink slim line being the hot favourite. We were given an insert card to measure and check the effectiveness of our cavitron tips at work. As a follow up on implants we were shown the implant cavitron tips which have plastic cones placed on the end of the tip which are removable and disposed of after treatment.

A good day with great lectures, verifiable CPD and a chance to network with friends and colleagues.

Our Spring meeting will take place on Saturday 7th March 2015 at our alternating venue, the Holiday Inn, Winchester see you there.

Jane Peterson

BSDHT SOUTH EAST
AUTUMN MEETING

DATE: Saturday 20th September
VENUE: David Salomons Centre
SPEAKERS: Christine Mcleavy, Alison Eyden
SPONSORS: thanks to our sponsors

The meeting began at 8.45am for registration for the 58 delegates, providing time for breakfast refreshments and a visit to the many sponsors’ stands.

Our Chairperson Kat Brice formally opened the meeting at 9.30am. Kat welcomed the first speaker Christine Mcleavy whose presentation was entitled Local anaesthesia - an update.

Christine outlined the following:

- The different types of local anaesthetic available for use in the dental surgery.
- The medical history implications in the choice of anaesthetic used, especially when the use of adrenaline is contraindicated.
- The medications that a patient may be taking that the operator needs to be aware of.
- Ways of minimising the risks when administering a local anaesthetic.
- The maximum dosage of LA to be used and the way to estimate the maximum dose that may be used according to the patients weight.

Christine sees many ‘needle phobic’ patients in her clinic so gave us a detailed description of her ‘needle desensitising’ programme and explained how following the 7 steps of this programme led to all her patients being able to accept a local anaesthetic with confidence.

a Show topical anaesthetic, smell, try on lip, tongue.

b Show and hold cartridge. Use appropriate language.

c Show and hold syringe.

d Show and hold syringe.

e With cap over the needle, topical placed syringe is placed next to mucosa.

f As above but cap off.

g LA may be given

Our second speaker, Dr Alison Eyden’s subject was, X- Rays – From Production to Protection. Alison defined exactly how X – rays are and discussed how they are produced. One interesting fact to note is that 84% of all radiation is natural radiation while 16% is man made (14% being medical in origin).

Alison asked us to complete a quiz that helped us all put the risks of radiation in perspective. Some of the answers to the questions were very surprising and also quite alarming.

She also talked about the justification of taking an X – Ray and the optimisation of X-Rays. This included:

- Reducing the patients dose to the lowest possible.
- Ensuring clinical evaluation is always made.
- Having an excellent technique.

Alison concluded her lecture by briefly outlining the IR/ME/R requirements.

Janet Scott
OBITUARIES

PEGGY BARDSELY
PRESIDENT BRITISH DENTAL HYGIENISTS’ ASSOCIATION 1982 - 1984

It was with great sadness that Members and the Council of BSDHT learned of the death of Peggy Bardsley. Peggy trained as a dental hygienist in Manchester, qualifying in 1973. As a dental hygienist she saw her role as contributing to the improvement of her patients’ dental health, whilst at the same time developing professional and communication skills - a philosophy that she maintained throughout her working life. Peggy enjoyed all aspects of dental hygiene; working in general dental practice and in specialist periodontal practices where she was a highly valued member of the dental team.

Peggy had always lived in the Manchester area until her husband Tony’s work base was re-located to London in 1974. They were both fond of the theatre and enjoyed the opportunities that living in the city offered them. Peggy and Tony were a very close couple and after Tony’s death Peggy had a difficult time coming to terms with life without him. He was her soul mate and had encouraged and supported her throughout her career, particularly during her time as President of BDHA.

Peggy had always been an active member of what was then BDHA and on moving to London soon became a member of the London Regional Group and was invited to join the AGM programme committee. Lyn Ralph, Chair of the London Group at that time, recently said of Peggy: “She was a lovely, lively, thoughtful person who I had great fortune to know in my early years as a dental hygienist, and later when Peggy became President of BDHA and we (The London Group) arranged the AGM at the Cumberland Hotel at Marble Arch. It was a great scientific meeting followed by a dinner and limbo dancing. It was all fantastic fun and a great experience for which I thank Peggy.”

Peggy enjoyed her time in office and said that she had gained an increase in self-confidence during her time as President. She was full of enthusiasm for her profession and for BDHA. She was a great ambassador for the Association, emphasising the professionalism of dental hygienists.

Peggy represented the Association at meetings of other dental professionals and derived a lot of pleasure from speaking to their officers and members. She also represented BDHA nationally and also internationally, when she attended the Ninth International Symposium on Dental Hygiene held in Philadelphia in the United States. This was an exciting time for dental hygienists as the International Liaison Committee, which had been founded by an international group of enthusiastic dental hygienists who sought collaboration for educational and professional development opportunities, was exploring the idea of becoming a more formalised International Federation of Dental Hygienists.

Rosemarie Khan

LINZAY CLARK 1990 -2014

Linzay Clark Dip Orth Ther RCS Edin. and Student Dental Hygienist, University of Bristol.

Linzay was born and raised in Inverkip, Scotland, and knew from a very early age she wanted to have a career in Dentistry. Linzay qualified as a Dental Nurse in 2010, then specialised in orthodontic nursing. She qualified as an Orthodontic Therapist in 2012 from Bristol Dental Hospital. It was following this training that Linzay fully recognised her long term career aspirations, applied and was accepted to train as a Dental Hygienist.

Linzay was a conscientious and diligent student, always seeking to attain the highest levels of achievement. She also threw herself into student life and was well known in dental social circles. Her lust for life was infectious, often instigating others to take up cycling, walking or involvement in student social events.

Linzay was excelling in her training as a Dental Hygienist when her life was tragically cut short following a sudden and unexpected complication of an underlying heart condition. Her passing will leave a huge space in the lives of those who knew and loved her. Indeed, the loss of such a passionate, capable and modest young student is a loss to the whole dental profession.

Linzay’s funeral took place in Greenock, Scotland on Wednesday 26th November and was attended by so many of Linzay’s friends and family.

A memorial service is being planned for early January at Bristol University. If you would like details of this service please contact Donna.Parkin@uhBristol.nhs.uk. Donations can be given to the Cardiomyopathy Association by visiting https://www.justgiving.com/Linzay-Clark/

Bristol University and the School for DCP training would like to extend its heartfelt sympathy to her family.
This year’s BSDHT Oral Health Conference and Exhibition delivered an array of exciting educational opportunities for modern dental hygienists and therapists. A packed two-day programme of dedicated lectures provided a variety of industry updates and clinical information to help delegates take their practice to the next level.

The Poster Competition, sponsored by Waterpik International, gave professionals and students the chance to demonstrate their knowledge and understanding of a topic of their choice. Delegates were encouraged to research a subject of particular interest to them, and then design an A2 poster explaining their findings and how these may help them enhance the care and treatment they provide patients. Thirteen fantastic entries were displayed at the Conference, where delegates presented their conclusions to a judging panel of three highly respected professionals in the field: Director of Professional and Clinical Affairs at Waterpik International, Inc., Ms. Deborah Lyle; Dean of the Cardiff University School of Dentistry and President British Society for Oral and Dental Research, Prof. Mike Lewis; and Senior Clinical Lecturer, NIHR Clinician Scientist and Honorary Consultant in Dental Public Health, University of Manchester, Dr. Paul Brocklehurst.

Having grown year on year, the Poster Competition 2014 saw the largest number of entries to date and all participants truly excelled themselves in the quality of material provided. Topics ranged from the health risks of waterpipe smoking to psychological interventions regarding self-oral care, comparison of medieval and post-medieval oral health and improving patient engagement for enhanced dental health.

When it came to determining the winners, the judges had a tough decision on their hands and were all impressed with the time and effort that had been dedicated by participants. About the competition, Emma Pacey, member of the BSDHT’s Publication Team, commented:

“I’m delighted that, since its inception, this year’s competition has seen the largest number and highest quality of competition entries. We’d like to thank Waterpik who have once again sponsored the competition this year, as well as all the judges for their time, attention and expert judgement. Finally, we would like thank our members who have submitted posters this year.”

The winners of the Poster Competition received a Waterpik® Water Flosser and a cash prize, and were announced as follows:

- First Place was awarded to Petros Mylonas, praising his poster entitled “Denture hygiene: evaluating quality and management at the Birmingham Dental Hospital”.
- Second Place was awarded to Emma Fisher, for her poster entitled “Implementation of delivering better oral health: audit of dental hygiene and therapy clinics”.

With four student entries in the competition, these were judged separately and a winner was also picked from the group:

- The Student Prize went to Bairbre Pigott-Glynn for her poster entitled “Current and future work practices of dental hygienists in Ireland”.

Congratulations to all the participants and especially to the winners, and we hope that future Poster Competitions will continue building on the success of 2014.

For more information on Waterpik® Water Flossers please speak to your wholesaler or visit www.waterpik.co.uk. Waterpik® products are widely available in Boots and Superdrug stores.
A DENTAID TRIP TO UGANDA
Caroline Clitter

In mid-October I returned from equatorial blue skies of Uganda to cold, grey skies of the UK; however, I’ve also come home to hot, powerful showers!

There were eight of us from the UK undertaking a Dentaid trip. As you are aware Dentaid is a charity dedicated to improving the world’s oral health. It targets dental care to rural areas in partnership with local dentists. It provides support to dental professionals in over 260 projects, in many countries. Often in third world countries Western sugary drinks and snacks are readily available but fluoride toothpaste and toothbrushes are expensive.

A lunchtime BA flight from Heathrow in September, arrived at Entebbe airport at 23.10 [a two hour time difference]. BA are generous with baggage allowance, if going with a charity and we found ourselves coping with 23 kg bags; I had a 23kg Dentaid dental chair to manhandle!

Guarding against Ebola
Countries blighted with Ebola were thousands of miles away but clearly not so far by plane. Passengers filled in a health questionnaire; on disembarking we were met by officials who sprayed our hands with hand gel, then our temperature was taken before we moved onto passport control. By contrast the UK did not take precautions against Ebola until over three weeks later.

Our Ugandan driver met the tired eight of us from the UK with a tired looking 20 seater bus. He drove us to a guest house, which cost £15 for a night’s B&B. After room allocation we crashed into bed only to be serenaded until 6.00 a.m by a disco from next door. Here was the only time we had meat at breakfast; food generally during the trip was vegetarian, simple but ample and tasty.

Dental Clinic
For the first clinic our UK team were joined by four Ugandan dentists. We went to a prison for under 18’s. Shockingly, some infants are there - orphans ‘swept’ off the street or a step-parent who declares a child ‘difficult’ and leaves them there.

Our allocated room was basic with no electricity, so natural light and torches were utilized, as it was throughout our clinics. We undertook ‘stand-up’ dentistry at a very fundamental level. The team takes all it needs, including chairs and tables.

We set up to:
• triage - child sat on a desk facing the operator
• treat - chairs manned by dentists, therapists and hygienists
• apply topical fluoride varnish - using regular chairs
• give post-operative care [after extractions]

The team saw over 130 patients including children from 5 - 17 years, staff and a few from the community: all were triaged and accepted treatment, if needed. Treatment choices are limited to: XLA; scale; topical fluoride; simple fillings - there was one rechargeable handpiece. Extractions under local anaesthetic and fluoride applications comprised the majority of treatments.

We had uniforms, instruments and all the consumables we needed. In this instance a few older boys were encouraged to help: the triage person had a ‘scribe’, others interpreted and kept the queue in order. Many mouths were good as their diet is restricted but often sugar cane is available. Most people in rural areas do not own a toothbrush; the local dentists showed us how to prepare and correctly use a cleaning stick. Sadly, many children learn to ask tourists for ‘sweets’.

In mid-October I returned from equatorial blue skies of Uganda to cold, grey skies of the UK; however, I’ve also come home to hot, powerful showers!
Ugandan dentists

Over the three weeks, we worked with several Ugandan dentists. They undertake a three year qualification course - rather sensibly - suited to the Ugandan population. They are then placed in government funded clinics; sadly their support system is poor, often without supplies of sundries, including essentials like LA. Dentaid left consumables for the dentists who worked with us, to enable them to continue in their practice.

Masaka

The next base was in Masaka. Whilst driving there through very beautiful countryside we crossed the equator. The hotel consisted of thatched roundels and cost £30 for B&B. Whilst in Uganda we were asked to preferably wear skirts and not to show cleavage, so when using the local transport to the restaurant - a small motor-bike [boda-boda] - we had sit side-saddle and grip the rear handle. Only a mile to go, so not too speedy! We had a good buffet meal with a drink which cost £6 per person.

River of Life Church

On Sunday morning we attended a busy church service and were introduced to the congregation which ‘advertised’ the dental clinic. On Monday we set up in the Church, here some 4 year olds had carious a’s, b’s and often d’s - many needing XLA. It was interesting to see that some 15 year olds had 32 teeth and others aged 10 had 28 teeth.

Another clinic day

On this day the team treated people in Sango Bay Refugee Camp, there are over 4,000 in the sprawling camp. UNICEF are involved and have large tents, used as classrooms. When our bus arrived many children ran to wave, they hanker for an empty water bottle. We went only as a pain relief clinic. The Camp had previously been visited by one dentist - just the once and a nurse visited weekly. However, we were not overwhelmed so we took the opportunity to give oral health information to children and teachers, we always involved teachers. We applied fluoride to 80 children; the same number of adults were seen for treatment. Interpreters from the Camp helped and no-one was turned away.

Uganda Lodge

The following centre was in a rural area at Uganda Lodge, a guest house and social enterprise business; all its profits are invested in community projects. We stayed at a cost of just £10 per night including food. Ruhanga Development School with 450 pupils and a medical centre are close by. The latter employs a Ugandan Doctor - unfortunately not speaking the local language - and two nurses, who do. Ugandans speak 33 different languages with English as the national language. Adults are charged for services, albeit very small amounts; they are encouraged not to rely on hand-outs from Muzungus [white people]. Whilst there, the team saw children from several local schools, teachers and adults from the community.

We left two Ugandan dentists, who had worked with us, to man a clinic - one day a week, in the medical centre. Dentaid left a dental chair, instruments and sundries to start them off. The equipment is loaned so if the clinic fails it will be given to another rural dentist.

Most days there was blue sky until mid-afternoon, then black clouds formed when it often rained for a short time. We were in the ‘short rain’ season; the rain is torrential, it is no wonder the many un-tarred roads get into a decrepit state.

Church

On my last day, in Kampala, I stayed at a guest house, before a mid-night flight and was invited to go to a Catholic church which would not be out of place in the UK, it was brick built with stained glass windows. The priest had been in Europe for three months and returned saying: “Africa is not poor but hygiene could be better.” The congregation were encouraged to smile, not shake hands and told to use detergent when washing and “hands must be washed more.”

During my stay I was able to have a weekend safari with others from the team and at the end I remained to undertake a gorilla trek ... all most exciting!

Poor oral health is cited as a ‘top ten’ health issue affecting quality of life in middle and low income countries; for information please look at the Dentaid web pages.
Good morning everyone. I am delighted to be here, you will all be pleased to hear me say those four magic words – this will be short!

During the five years that I have been a member of the Executive Team I have been fortunate to learn and be inspired by the hard work, professionalism, dedication and teamwork of everyone involved in the running of our BSDHT - exec and publications teams, councils and presidents.

The position of President is a demanding one and after a hectic two years as President Elect, I have had just a little taster of what's to come.

I cannot thank Julie enough for her valuable input to BSDHT. She has been true to her Yorkshire roots, hardworking, honest and all delivered with a sense of humour. As you have already heard she has achieved a great many things in her tenure and - although she's only tiny - she has left big shoes to fill...

Over the time I have known her we have become very good friends. We share many of the same qualities, the main one being a passion for our profession. Well, you would need that to do this job!

She has done all she can to make sure I'm prepared for this role and for that I am grateful. I have the added advantage that I will not be saying goodbye to her as Julie will still be staying on in her role as Regional Group Co-ordinator. Her knowledge of the constitution is enviable and I'm glad I won't have to learn all of it off by heart!

To show our appreciation to Julie for all her hard work and dedication, I would like to present her with a little something from all at BSDHT!

It is a privilege and an honour to take on the mantle of President for such an esteemed and well respected society.

It's something I would never imagined possible when I started my career as a Dental Nurse. I worked in a practice in Newcastle Co Down, where we smoked in the reception area and warmed our apple tart up in the hot air oven at lunch time. How things have changed...!

It's hard to believe I have come from there and now stand here as your President, the first person from Northern Ireland to become President of BSDHT. This is a very proud moment for me.

I trained at Kings in London and I believe I am the third BSDHT President to be taught by Bill Crothers. He instilled in us a level of respect for our position which I have never forgotten. It has taken me to where I am today because I believe our role is vital within the dental team and I want everyone else to recognise and respect this too.

It is a very new and exciting time for BSDHT; we have a newish executive team, we are starting with a new administration team and have a Business Development Manager (BDM) and a PR company. We are moving on to a more modern and sound business footing and hope to modernise the database in line with our accountancy package. This will help to make the running of the society much easier, less costly and more time efficient. We hope to update the website to make it even more user friendly and easier to keep up to date.

There always will be much for us to do in order to maintain our position in dental politics and provide support to members.

At present we are receiving conflicting messages from the various Departments of Health: money is tight and each department is restructuring their budgets to suit. Some have been very supportive of hygiene and therapy. The Centre for Workforce Intelligence published a report which provides an evidence base for planning the future DCP workforce, looking ahead to 2025. Their report indicates a likely "steep increase in demand" for dental hygienists and the dually qualified. Compare this to Northern Ireland where they have the possible closure of the only school of Dental Hygiene looming!

What message does this give to the general public? What benefit is this to the oral health of our communities? I believe we need to work on highlighting the benefits of our role throughout all aspects of the community.

I would like to see our profession have uncomplicated and straightforward access to those of our community who are dentally neglected. At present 1 in 6 people are aged over 65; by 2050 it will be
1 in 4. There is an increase in the amount of diagnosed dementia cases with this expected to grow as more is learned on the effects of brain ageing. These patients are usually cared for in residential care homes and many have still got all their teeth. Good oral health is essential for these patients to help maintain normality, in eating, speech and minimising infections which can exacerbate confusion. I would like to see the NHS provide funding for these patients to be cared for by us. At present the care they receive is sporadic at best and yet we are ideally placed to help.

Raising the profile of our profession is one of my aims. I have a three fold approach to this

1. Europe: Regardless of the Prime Minister’s reluctance, we still need to work more closely with Europe. By not having a voice in Europe, we did not get considered in the tooth whitening legislation. Now, despite being suitably trained, we cannot decide if a patient can have their teeth whitened. If we had a presence in Europe then the EU would have had to consider us. Do not let this happen again. EU law affects us more than we realise and if we want it to reflect our situation we must have a strong voice in Europe. To this end Julie and I have spoken with other societies in Europe and hopefully we will bring some news on that in the future.

2. Utilising our PR Company: BSDHT would like to raise our profile with the general public and I have been in talks with them to run a project to highlight our profession. We want to make more people aware of who we are, what we can do and, most importantly, that we can be seen directly.

3. I want our profession to develop: I’d like to see our members become more involved in research. Research is necessary to develop and grow our knowledge and the techniques we carry out. The posters on display in the registration area highlight the talent pool we have in our members. We want to encourage this and help where we can. I would also like to see developments in our education so that those of you with an interest in specific areas can go on to achieve “specialisms” in these areas. Those working on this at present have my full support as I believe this will help to strengthen and cement our place in dentistry.

BSDHT has always been professional, persistent and ahead of all others when it comes to moving this profession forward. There is still much to be done to increase our level of autonomy. We have been working on gaining prescribing rights, but this will take time. We have managed to change the dental hygiene and therapy undergraduate education on radiography in line with dental undergraduate aims and learning outcomes.

I will endeavour to keep you all informed about the work your society does on your behalf. I echo the message from past presidents for you to let us know of your concerns in the workplace by keeping those lines of communication open and in return all I ask of you is to read the information we send out in the journal, ezine, emails, website, facebook postings and twitter.

If you have an issue but do not voice it, it will go nowhere. Being proactive and sharing your thoughts is constructive. The more voices we have saying the same thing makes us impossible to ignore. On your own your voice will be lost, in large numbers your voice will be heard. I urge you to work with us, your society, to improve our future and have our voice heard.

Thank you and I hope you enjoy the rest of the conference.
SOCIETY NEWS

OHC LIVERPOOL 2014

UBSDHT

From supportive beginnings to being in charge: sharing the learning
Professor Cynthia Pope CBE, FDS
Oral Health Conference & Exhibition 2014

Liaise with GMP re medication
Monitor for candidal infection, lymphoma
You may recall an article I wrote in Dental Health in March 2011 about studying for my Masters in Clinical Research at Newcastle University. Well, since then, my research journey has progressed and I would like to share with you how I came to successfully secure funding to do a PhD.

I would like to start in the summer of 2012 when I had just submitted my Masters thesis. The first six months of 2012 had been a relentless phase of data analysis and writing. My bedroom walls were covered in post-it notes and quotations from the interviews I had been conducting, and the floor was hidden under piles of papers and books! I was delighted to have submitted my thesis, though I couldn’t help thinking ‘…but what now’? I always thought that other people did Masters and Doctorates, and now I was on the way to getting a Masters qualification myself! Could I really take this further and go for a PhD? Here, in diary format, is what happened next…

**July 2012: How can I get funding?**

A PhD takes at least three years, and requires substantial funding – to cover salary costs for the researcher, consumables, running costs, tuition fees… everything costs money, and that has to be found from somewhere. So, I had meetings with one of the tutors from my Masters course, to discuss the types of funding that might be available. Choosing which funding stream would be the right one for me was not clear and they are all highly competitive. However, this lady inspired me, as she was originally a nurse and then a midwife, who studied her way to PhD level; she now works in clinical academic career development for nurses and midwives. She mentioned a National Institute of Health Research (NIHR) Clinical Academic Training (CAT) Programme which has been set up for nurses, midwives and allied health professionals (AHPs). It sounded ideal as you study whilst working, expanding your knowledge and skills to enable you to carry out PhD research in your own specialty area.

Much to my dismay, after making enquiries, I found out that I was not eligible to apply for this funding. Why? Surely DCPs would be able to apply under the umbrella title of AHP? However, when I looked into it, the term AHP actually refers to a specific group of professions that are registered with the Health and Care Professions Council (HCPC). There are 16 healthcare professions registered, including midwives, art therapists, drama therapists and therapeutic radiographers, but DCPs are not on this list and thus they cannot apply for the NIHR CAT funding.

My reaction? Outrage! I felt unfairly excluded – it was a huge disappointment. The next deadline was August 2012, so even if I had been eligible to apply, there was no way I was going to make it this year anyway. Accepting that I had a year to wait for the next funding call, I decided to make enquiries about gaining inclusion for DCPs. This took a lot of time - who could I call about something like this?

**February 2013: Starting to get ‘political’**

I wrote to the Director of Nursing Health Education England (HEE), at the Department of Health (DH). My letter was on BSDHT headed paper and was co-signed by the President, Julie Rosse. In my letter, I asked for DCPs to be added to the list of AHPs, thus securing their eligibility for the CAT funding programme.

The very next day, no less, I received an email reply! My letter had been forwarded to someone who deals specifically with the CAT Pathways Programme. Although the reply was polite, it basically said that the NIHR CAT programme was funded by the Chief Nursing Officer for England and consequently, as I am a DCP, I should apply for funding allocated to dentistry. The thing is, an equivalent scheme to the NIHR CAT scheme, but specifically designed for DCPs, doesn’t exist!

A heavy fog of despondency fell upon me. Was that it? The end of my dream to do a PhD? However, I was soon to have a breakthrough, as a few days later I received an email from the Director of Nursing HEE herself, suggesting a phone call to discuss my case in more detail. At a prearranged time, she rang me from her mobile, having pulled into a layby, as she was on her way to a meeting. She was receptive, supportive and encouraging. She suggested that I speak with Prof Jimmy Steele, Clinical Lead for our local NIHR Research Network, and the Chief Dental Officer, Barry Cockcroft.

Both Jimmy and Barry were very supportive. Barry explained that HEE plans to support clinical academic career programmes across all clinical and public health professions, including dentistry, with the aim to develop a more flexible workforce which is receptive to research. He acknowledged my disappointment but said that basically, I had to wait, as training would be developed in the future that DCPs could apply for. This was, of course, great news, but waiting was not something I was prepared to do; and to be honest, I had long since decided to work on an NIHR Doctoral Research Fellowship (DRF) application in parallel with the lobbying I was doing with HEE/DH.

**April to December 2013: Applying for an NIHR Doctoral Research Fellowship**

The NIHR DRF funding is open to anyone working in healthcare, which sounds perfect, but having my application considered alongside those from doctors, dentists, health economists, statisticians etc made me feel like I wouldn’t stand
a chance. The NIHR funding schemes are highly competitive, with no guarantee of success. That is something you just have to accept, but when you consider that an application takes a year or thereabouts to put together, you want to feel like you have the best chance you can. I had little choice in the matter though; I had a good idea for my research project and I just had to go for it. My PhD project follows on from my Masters research and aims to develop ways to better inform people with diabetes about their increased risk of periodontitis, and the importance of periodontal treatment as part of overall diabetes care.

Planning my project, how it would be structured, who would supervise it, and who I would collaborate with, took a lot of thought. This is not an easy process. Talking to as many people as possible, people who are experts in their field, is important, and although an honour, it can be very intimidating. At first I was so incredibly nervous, and the only certainty I had was that I was sure to do or say something stupid! Truthfully, I did have some tough times as I worked to convince people of the importance of my research: I have had my project ideas thrown into the bin in front of me (literally!), and it was very stressful. At the same time, I was writing like crazy. I lost count of the number of phone calls and meetings I had in relation to my project. I secured four supervisors, one who will oversee it all and one for each of the three phases of my project. I liaised with various healthcare professionals and people with diabetes, who agreed to be members of my project steering group (which will provide advice as the project progresses). I met with various university personnel, some on numerous occasions, particularly a statistician, an advisor from the Research Design Service, a Public and Patient Involvement officer, staff from the finance department, and the University Intellectual Property advisor. I identified various training courses which would provide me with the knowledge and skills I need to carry out my research. I also secured the help of Diabetes and Primary Care Research Networks in the North East and North Cumbria and South West Peninsula regions of England by liaising with their respective Clinical Leads. Exhausting! And, all of this had to be detailed in my application!

**January 2014: Application submitted**

I finally submitted my application! All 142 sides of A4 (not an exaggeration, it really was that huge). I felt ecstatic, but I also felt quietly anxious as the application that I had worked on for so long (sweat and tears, literally!) had gone and its fate was now out of my control.

**May 2014: Shortlisted for interview**

I received an email to say I had been shortlisted for interview. I was astounded to have got his far! But now, I had to prepare for the scariest interview of my life, in which I had to present my research to a panel of 15 research experts, followed by 20-25 minutes of questions.

The next few weeks were very hectic and, really fairly awful. I had a series of mock interviews arranged with various senior professors in the University. It felt like I was standing in front of a firing squad over and over again. Colleagues would try to reassure me if I had a bad interview, as they said it would make me stronger and more resilient on the day of the real interview. Some questions I was asked literally had no answer, but I still had to respond, and say something. I had to learn to think on my feet and be prepared to stand my ground despite the onslaught of questions.

**June 2014: Interview day**

The day my future depended on had arrived. I was in a hotel in Leeds, where the interviews were being held, pacing the floor and wringing my hands! At times, I had really questioned the process I had been through that led up to this day; but I have to say all the preparation, the difficult practice interviews and humiliating moments had toughened me up. After what I had been through, surely there could be nothing worse, and, in fact, the real interview was decent enough. The panel were reasonably friendly and the questions were fair. I came out feeling like I had done my best and could do nothing more, and headed home.

**July 2014: success - funding received!**

I opened an email that said I had got it! I was completely blown away. I couldn’t believe it and didn’t know what to do with myself at all…so, I just got on with my day as normal. It took ages to sink in. As the days passed, I got used to hearing myself talking in terms of having successfully secured my PhD funding (£0.25M). It was two years since I had started on this path. It had been a long struggle, but definitely worthwhile.

I am due to start this month and will continue to work part-time, though I will spend most of my time on my PhD. I am team lead for the Dental Clinical Research Facility at Newcastle Dental Hospital. My job involves the management of research staff, the running of the facility and working on dental research projects. It is a busy job, but does have flexibility, thus allowing me to do the PhD. I aim to complete my PhD in four years, which is going to be a challenge, but one that I am very excited about. I am passionate about my project and cannot wait to work with healthcare professionals and patients towards getting an oral health intervention incorporated into the routine management of diabetes.

**Susan is Team Lead Dental Clinical Research Facility, Level 4, Dental Hospital, Richardson Road, Newcastle upon Tyne. NE2 4AZ**

Address for correspondence: Email: s.m.bissett@ncl.ac.uk
WHAT IF YOUR CHILD HAD TOOTHACHE AND NO HOPE OF HELP?

With this message, dental charity Bridge2Aid hopes to increase vital support this year, making it possible to provide access to dental treatment for millions more people in need in East Africa.

Dental caries is an extremely prevalent disease globally. But because access to treatment is so readily available, many people living in developed countries don’t even think about it. Yet it is the world’s most common disease, with woefully inadequate numbers of personnel available to address it in developing countries. If left untreated, complications can and do lead to death.

Chief Executive Mark Topley asks: ‘What if your child had toothache and no hope of help? With not even the most basic dental service available for the majority of people living in the rural areas of places like Tanzania, there are countless untreated dental problems. And more than half of people with toothache and no access to basic treatment will develop complications; sometimes, very sadly and shockingly, the complications lead to death.’

However, Bridge2Aid is making a big impact – by training local health professionals already based in villages to extract teeth and relieve pain. And it works – over the past 10 years Bridg2Aid has demonstrated success in both Tanzania and Rwanda, making access to treatment available to over 3 million people. Health professionals trained by Bridge2Aid have shown they can immediately address 98% of dental problems.

You can help people in pain today. For only £5, you could give ongoing access to pain relief to a whole family in East Africa. Please visit www.bridge2aid.org/whatif to join with Bridge2Aid in its mission to make access to simple, safe, emergency dental treatment available to all.
A GREAT DAY OUT!

On Friday 21st November 2014, a fabulous initiative brought UK Dental Hygiene and Therapy students together in partnership with Colgate Oral Health Network and BSDHT.

All schools were invited to give their hygiene and therapy students the day off from their studies so that they could join in being part of the largest dental hygiene and therapy-led conference in the UK. This was a great way for those just coming into the world of dentistry to see how a major conference works, and how they too could become involved in the future.

A plethora of diverse lectures saw the students broaden their learning and knowledge through this educational initiative, as well as having a chance to win some fabulous prizes in our Treasure Hunt, or BSDHT raffle.

All students were fed and watered, as well as picked up (at the crack of dawn, some of them!) and taken home at the end of the day armed with a wide range of knowledge and an even wider range of samples of the amazing array of products out there available to them!

A great day out was had by all, and we certainly enjoyed having them!

One student, Jamie Lockley reports,

The Colgate Oral Health Network initiative to offer dental hygiene and therapy students the chance to visit the OHC free of charge worked out great. With the exception of the pre-dawn start to the day, the coaches laid on for us made getting to the OHC very straight forward.

As a cohort, the Teesside University students agreed that visiting the OHC was beneficial and many stated that they would return to future conferences after they had qualified. The group highlights seemed to be: getting a chance to speak to students at other dental schools and share experiences, staying abreast of future changes that shall affect our professions and future clinical practice, and listening to some of dentistry’s movers and shakers.

My own personal highlights were Minimal Intervention Periodontics by Ian Dunn, and the research findings presented by Dr. Paul Brocklehurst.

All in all, an enjoyable and informative day.
THE CLASS OF ’77

We were delighted to read about Freda Rimini’s surprise 80th birthday celebration in November’s Dental Health.

Freda trained our cohort in 1977. The joint civilian and RAF dental hygienist training course lasted a mere 48 weeks way back then! Such a short time compared to the dual hygienist/therapist course of today.

In that time strong friendships were formed, as we laughed and cried our way through the trials and tribulations of a very intense course. We qualified in the December and all went our separate ways.

However the majority of us remained in touch, culminating in yearly get togethers: we take it in turns to choose a venue each time, ranging from Cornwall to North Yorkshire. Our husbands and partners have also become firm friends.

We hope that the years will be as kind to us as they have for Freda. A few of our gang were lucky enough to go to her 80th, and she hasn’t changed a bit!

Jane Whyte
email: janeannwhyte@googlemail.com

Back row: Judith Crabtree, Shirley Lupton, Pat Andrews, Buhari, Tish Hinchley, Fiona Clark & Jane Whyte
Front row: Pat Norman, Linda Ball (tutor), Sqn. Ldr. John Coventry, Flt. Lt. Freda Rimini, Barbara Goth

Class of ’77, present day
This article will discuss the rationale behind the use of chemicals to control dental plaque, and critically discuss some chemicals currently available for this purpose.

Introduction

Plaque bacteria are the primary aetiological factor for inflammation of the gingivae\(^1\). Considering that plaque-induced gingivitis always precedes the incidence of periodontitis, the prevention of periodontal diseases depends upon the control of sub and supra gingival plaque biofilm. Gingivitis and periodontitis are bacterial infections\(^2\), and since most bacterial infections within the body can be brought under control using various chemical agents, it is reasonable that we seek for agents to combat the plaque biofilm. Mechanical removal of plaque through frequent and efficacious brushing and interdental cleaning are the principal means of thwarting periodontal diseases however, some individuals ‘lack the dexterity, skill or motivation’ for mechanical plaque removal\(^3\), which has encouraged the commercial market to produce agents designed to control the plaque biofilm.

There is a plethora of chemical products available to inhibit dental plaque. They generally fall into one of three categories: antibiotic, antimicrobial or antiseptic based. The most widely recognised are listed in table one, which provides an outline for this article’s theme. The products available for controlling dental plaque are vast and capacious but for the purpose of this piece only the most significant will be discussed. This paper intends to deliberate the rationale behind the use of the chemical agents to control dental plaque, and will critically explore the chemicals currently available on the market for this purpose.

Systemic antibiotics

Systemic antibiotics are not used routinely for plaque-induced gingivitis or periodontitis, but are selectively recommended for aggressive periodontitis or acute periodontal infections.\(^4\) They are not largely indicated because mechanical therapy is sufficient when carried out efficiently, especially when combined with periodontal instrumentation and control of local contributory factors. It has been suggested that overuse of antibiotics can lead to bacterial resistance, bacterial rebound and possible unwanted side-effects.\(^5\) When prescribing systemic antibiotics for a patient it is essential that any perceived benefits outweigh the disadvantages and since bacteria in the oral cavity cultivate so rapidly, it is worth considering that control of a chronic disease would require drugs being administered for many years.

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<td>Local delivery</td>
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<td>Chlorhexidine (CHX)</td>
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<td>Chlo-site</td>
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<td>Amine alcohols</td>
<td>Delmopinol</td>
<td>Mouth-rinse</td>
<td>Decapinol</td>
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Table one: Chemical agents available
Local delivery chemicals

Local delivery agents can be sustained release agents (up to twenty four hours) or control release agents (up to fourteen days) that consist of either antibiotic, antimicrobial or antiseptic chemicals that are embedded in a carrier material. It is applied locally to the pocket where the carrier material adheres to the pocket internally and dissolves over time producing a steady release of product. The principle logic behind this method is to subject subgingival bacteria to therapeutic levels of the medicament for a prolonged period. They are indicated for use in localised non-responsive sites, as an adjunct to periodontal instrumentation. Local delivery chemicals can easily wash away from the pocket due to the presence of crevicular fluid, saliva or ingested fluid which may limit its contact with the subgingival bacteria, rendering its function insubstantial. The most recent systematic reviews analysed by Matesanz-Perez et al. show that the improvement in pocket depth only ranges from between 0.1mm to 0.4mm, which makes the therapeutic impact of these products questionable.

Home-use products

The rationale for home-use agents stems from the principle that whilst it is theoretically possible to maintain a level of oral hygiene sufficient to control gingivitis and periodontitis using mechanical methods, research shows that the vast majority of people are unable to accomplish this on an on-going basis, which is reflected in epidemiologic studies of gingivitis. The agents available for this purpose have taken a multiplicity of forms over the years and many of them are treated with scepticism because of their limited or transitory effects in the oral cavity. The protective mechanism of biofilm produces an extracellular slime layer that acts as a barrier, and is believed to prevent chemicals from penetrating the bacteria, which then in turn limits the extent to which chemicals can infiltrate the biofilm. Some evidence however, suggests that these products have some anti-plaque properties that can affect freshly formed plaque biofilm. There are many home-use products that function as delivery devices for plaque control and anti-gingivitis agents, namely toothpastes, gels and mouth-rinses. Of all of these, toothpaste may be considered the ideal vehicle, by virtue of its widespread use and twice-daily application; however, the complex formulation presents a challenge to therapeutic levels of the medicament for a prolonged period. They are indicated for use in localised non-responsive sites, as an adjunct to periodontal instrumentation. Local delivery chemicals can easily wash away from the pocket due to the presence of crevicular fluid, saliva or ingested fluid which may limit its contact with the subgingival bacteria, rendering its function insubstantial. The most recent systematic reviews analysed by Matesanz-Perez et al. show that the improvement in pocket depth only ranges from between 0.1mm to 0.4mm, which makes the therapeutic impact of these products questionable.

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Mouth-rinses have been classified and are described as first, second and third generation agents. First generation agents have limited substantivity and are thus short acting; they typically demonstrate a 20 - 50% plaque reduction. The second generation agents demonstrate good substantivity as they are retained by the oral tissues. They exhibit slow release properties and can reduce plaque bacteria to between 70 - 90%. The third generation blocks the binding of micro-organisms to the tooth, but has poor substantivity and reduces plaque by up to 35%. There are countless different home-use products on the market; the most pertinent are listed in table two as an example of chemicals that are currently available from the different generation groups.

Of the many mouth-rinses available on the market, research shows that phenol-based rinses held a position for many years as the vanguard of the anti-plaque and anti-gingivitis agents, until the advent of mouth-rinses containing Chlorhexidine, which was a major breakthrough. More recently the number of formulations that claim to have anti-plaque and anti-gingivitis activity has increased, and much emphasis has been placed on such substances as an adjunct to, or indeed to replace, conventional tooth-brushing techniques in short-term circumstances, the most noteworthy ones are discussed here.

Essential oils

Evidence shows that these mouth-rinses can help control plaque biofilm effecting between 20 - 34% reduction in plaque, and they can lessen the severity of gingivitis by between 28 - 35%. The method of action is by disruption of the integrity of the cell wall and inhibition of certain bacterial enzymes. It has a profound lack of plaque inhibitory effect due to poor oral retention, and is hence less effective than Chlorhexidine. The side-effects of these chemicals have been described as a burning sensation and bitter taste.

Chlorhexidine

Chlorhexidine is recognised as the gold-standard chemical agent for biofilm control. The research shows the severity of gingivitis can be reduced by 50 - 70% and reductions in plaque from between 43 - 61%. It is considered to be the most effective anti-microbial agent for long-term reduction in plaque biofilm and gingivitis. It is a bactericidal agent that is effective against both Gram-positive and Gram-negative bacteria and binds via adsorption to different surfaces in the oral cavity as well as the pelvic and saliva. It is slowly released over time in a concentration that will continue to kill bacteria, demonstrating its high substantivity. It has the ability to inhibit the early stages of plaque formation. It is also poorly absorbed by the gastrointestinal tract and it therefore displays very low toxicity with no permanent retention in the body. The primary method of action is through disruption of the integrity of the cell wall. It has been reported to cause altered taste sensation, dryness, superficial desquamation, oral mucosal erosion, discoloration of the teeth and tongue, possible enhanced supragingival calculus formation, a tingling sensation of the tongue, and anaesthesia-like effects. For these reasons it is only indicated as a substitute for mechanical control for short periods of time.

Patient Indication:

a. Special needs patients – immunodeficiencies, physical and/or mental impairment
b. Post-surgical care – during healing period

<table>
<thead>
<tr>
<th>First Generation</th>
<th>Second Generation</th>
<th>Third Generation</th>
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<tr>
<td>Antibiotics, Phenols (EO), Quaternary ammonium compounds, Triclosan, Sanguinarine, Oxygenating agents, Povidone iodine, Fluorides</td>
<td>Bisbiguanides (CHX)</td>
<td>Delmopinol</td>
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c. Following trauma with or without intermaxillary fixation used to treat jaw fractures, or following cosmetic surgery

d. Acute oral mucosal or gingival infections – NUG/P, aphthous ulcers

e. Candidal infections – oral and/or appliances

**Delmopinol**

This chemical has the unique ability to inhibit the formation of plaque biofilm, while possessing little effect on the bacteria, which avoids the disruption to the balance of bacterial flora. In clinical trials, Delmopinol rinses have demonstrated plaque reductions of between 9.3 - 35%, and gingivitis reductions of up to 18%. The suggested mechanism of action is its interference with plaque matrix formation and reduction of bacterial adherence. This causes the plaque to be more loosely bonded to the tooth so that it would be more easily removed by mechanical cleaning procedures, and is usually recommended as a pre-rinse. Unfortunately it is less effective than Chlorhexidine on plaque and gingivitis. The adverse symptoms include: transitory numbness of the tongue, tooth and tongue staining and the Humber, and for Ivoclar Vivadent.

**Conclusion**

The evidence presented suggests that there is little value in the use of antibiotics applied systemically or locally for the consistent control of plaque biofilm, due to the rapid turnover of bacteria and the cleansing effects of saliva. The adjunctive practice of home-use products can result in some reduction in plaque and gingivitis. However, the use of chemical agents with anti-plaque action, even as adjuncts to oral hygiene, seems to be of only partial value since mouth-rinse do not appreciably penetrate into the plaque biofilm. They do show some explicit benefits when used as adjuncts to control gingival inflammation, especially in acute situations; post-surgically and during periods of interrupted oral hygiene practices. Nevertheless, all of the products may have the potential for producing unwanted side-effects ranging from the production of a cosmetic nuisance, such as staining to mucosal burning and taste disturbance. Therefore, the availability of a multitude of chemical products for controlling dental plaque render the decision as to the suitability of a particular product a complex task. Although many popular mouth-rinse claims to help to control dental plaque and gingivitis, they should only be used for a short time and only as an adjunct, because ultimately, when meticulous mechanical plaque control is performed, any additional benefit of a chemical agent is minimal.

**About the author:** Carolyn is studying dentistry and working towards an integrated masters and bachelor of dental surgery, and a bachelor of science (MChD/BChD, BSc). Currently Carolyn is an ambassador for Wrigley Oral HealthCare and she frequently writes academic articles for publication. She also lectures for NHS deanery in Yorkshire and the Humber, and for Ivoclar Vivadent.

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**References**


Dental radiographs: what is normal anatomy?  
Nicholas Drage

Intra-oral radiographs are commonly taken to help diagnose dental disease. It is important the radiographs are high quality to maximise the diagnostic yield. It is vitally important that normal anatomical features can be identified, since until the normal radiograph appearance is known, disease cannot be identified. This article presents a 'mini atlas' of periapical radiographs and the normal anatomical features that may be seen on them.

Maxilla

**Figure 1.** Periapical radiograph of the upper central incisor region showing the outline of the nasal cavity (black arrows), and the incisive canal (white arrows).

**Figure 2.** Periapical radiograph of the upper central incisor region showing the median palatine suture (white arrows) and the soft tissue outline of the nose (black arrows).

**Figure 3.** Periapical radiograph of the upper central incisor region showing the anterior nasal spine (white arrows) and the incisive foramen (black arrows).

**Figure 4.** Periapical radiograph of the upper left lateral incisor showing the soft tissue outline of the alar of the nose (black arrows).

**Figure 5.** Periapical radiograph of the upper right canine region showing the floor of the nasal cavity (hard palate) (black arrows), and the outline of the maxillary antrum (white arrows).

**Figure 6.** Periapical radiograph of the upper right molar region showing the floor of the nasal cavity (hard palate) (white arrows), and the floor of the maxillary antrum (black arrows).

**Figure 7.** Periapical radiograph of the upper left molar region showing the zygomatic buttress (black arrows), and the maxillary tuberosity (white arrow).
Mandible

Figure 8. Periapical radiograph of the lower central incisor region showing the lingual foramen (black arrow).

Figure 9. Periapical radiograph of the central incisor region showing the mental ridge (black arrows), and the genial tubercles (white arrows).

Figure 10. Periapical radiograph of the lower right lateral incisor region demonstrating a normal neurovascular channel (black arrows).

Figure 11. Periapical radiograph of the lower premolar/molar region showing the upper margin of the inferior dental canal (black arrows), and the mental foramen (white arrow).

Figure 12. Periapical radiograph of the lower right molar region showing the inferior dental canal (black arrows).

Figure 13. Periapical radiograph of the lower left third molar region showing the external oblique ridge (black arrows), and the internal oblique ridge (white arrows).

About the author: Nicholas Drage is Consultant in Dental and Maxillofacial Radiology at the University Dental Hospital, Cardiff. His main interests are cone beam computed tomography, salivary gland imaging and interventional sialography, and has published several articles in these fields. He is co author of 'Essentials of Dental Radiography and Dental Radiology' and 'Radiography and Radiology for Dental Care Professionals' and is President-elect of the British Society of Dental and Maxillofacial Radiology.

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Thumb sucking is a very common childhood habit with three quarters of infants sucking their thumb in their first year. Indeed, sucking the thumb is considered normal behaviour for babies and can even start in the womb. Ultrasound scans have observed babies in the womb sucking their thumbs from 28 weeks gestation.

As dental health professionals we often see children whose occlusion has been affected by a digit sucking habit. The effects of prolonged digit sucking can have a detrimental effect on a developing occlusion. And yet the effects of thumb sucking are usually reversible up until the ages of 6-7 years, because children still have their deciduous teeth. If thumb sucking continues beyond the age of seven, when the secondary teeth are erupting, permanent dental damage can occur. Persistent (more than 6 hours per day) thumb sucking can also lead to speech problems such as lisping and imprecise pronunciation (especially of Ts and Ds). Once the habit has been broken natural improvement of the teeth can occur within six months. If the habit breaks before the adult dentition becomes established (age 7/8) the child is unlikely to have caused any long term damage to their teeth.

In 2010 I co-founded a Thumb Sucking Clinic in London. After years of treating both children and adults who had sucked their thumbs well into their teens and subsequently endured long complex courses of orthodontics, often involving extractions of adult teeth, it made sense of treating both children and adults who had sucked their thumbs well into their teens and subsequently endured long complex courses of orthodontics, often involving extractions of adult teeth, it made sense.

The majority of dental experts agree that a thumb sucker younger than five should not be pressured to stop. Most children will simply grow out of the habit. As the secondary dentition begins to erupt at around age 6-7 years, the developing occlusion often exhibits classic features common to digit-suckers (Figure 1).

The effects have been summarised as follows:

- proclination of maxillary incisors,
- retroclination of mandibular incisors
- reduced overbite or anterior open bite, which is frequently asymmetric
- posterior crossbites due to narrowing of the upper arch.

The openness of the bite can manifest in a protrusive tongue activity during swallowing. If the protrusive tongue activity is the cause rather than the result of the anterior malocclusion, elimination of the habit results in correction of the anterior malocclusion.

Persistent digit sucking causes largely dentoalveolar change, together with some minor effects on the skeletal pattern. Indeed, Bowden found that there was a statistically increased proportion of Skeletal II dental base relationships in children with a digit-sucking habit.

Significantly, 61% of 10-year-old digit suckers have a serious malocclusion. Thus in addition to the oral health benefits, early elimination of a digit sucking habit is recommended on health economic grounds.

A Northamptonshire study revealed that even mild anterior open bite can have both aesthetic and functional implications for a child as well as requiring complex and prolonged orthodontic treatment.

In severe cases future orthognathic surgery may even be necessary - combined orthodontic/orthognathic treatment not only carries risks for the patient, but is costly to the NHS.

Many of the children who attend my clinic wish to give up the habit though most persistent thumb suckers find it extremely hard and the older the child the more ingrained the habit becomes. I often hear parents say their child has tried several times to give up but becomes very distressed, and unable to fall asleep.

There are generally two groups of digit-suckers you will see in practice. The first wish to give up their habit but need help – these children are usually very responsive to any advice from a health professional. The second group are often unaware that their persistent habit is wreaking havoc to their occlusion. Their parents may view the habit as ‘cute’ and see no harm in their 8 year old sucking their thumbs. If the occlusion shows any of the classic features, offering advice and support can be invaluable.

**Essential advice to parents and children**

1. Show the child and parent the effects of their habit using a handheld mirror;
2. Take intra-oral photos to chart the effects of cessation;
3. Discuss the habit with the child – explain clearly what might happen to the teeth if he keeps sucking his thumb;
4. Home remedies such as placing a glove, sock or thumb guard (Figure 2) before bedtime, painting the thumb with various foul tasting substances can be successful if combined with positive reinforcement and encouragement; advise parents to praise the child when they are not sucking their thumb rather than scolding them when they are;
5. Recommend a progress chart;
6. As most children suck their thumbs when they are tired or bored, advise keeping their hands busy!

Whatever your method of delivery, always remember that the child needs your and their parents’ support and understanding during the process of breaking the thumb sucking habit. It is amazing what a
few words from a dental health expert can do for a child! I often get parents call up the next day to say that whatever I said to their child has magically made them break their habit overnight. Most children are unaware how their little thumbs can affect their mouth and teeth and react in a very positive manner when this is demonstrated to them (Figures 3 & 4).

If the child is unsuccessful in breaking the habit after a few sessions with you, recommend they see a dentist or orthodontist – consideration may be given to fitting a habit breaker (Figure 5). Habit breakers vary in design – a tongue crib is the most common. It is a fixed appliance that keeps the tongue positioned posteriorly and also prevents the thumb resting against the palate. The habit usually stops within days but I normally recommend the appliance remain in the mouth for approximately six to nine months to ensure the habit is completely buried. In cases where the patient has an openbite, this reduces spontaneously after treatment with a habit breaker.

About the author: Runa Mowla-Copley practises orthodontics in a specialist practice, Quadrant Orthodontics in Knightsbridge and Richmond. Runa co-founded a Thumb Sucking Clinic in 2010 and has been interviewed as an expert on the effects of thumb sucking by BBC and European radio, American television as well as national press. She is also author of the successful children’s fiction ‘Charlie’s Thumb’ – an illustrated story on the perils of thumb sucking.

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References
Abstract
Periodontal disease encompasses a range of conditions, from gingivitis to more advanced destructive periodontitis. If not diagnosed, and subsequently managed appropriately, periodontal disease can have serious consequences resulting in loss of teeth and the supporting alveolar bone. The purpose of this case report is to highlight the importance of removing excess cement from the interdental space, following cementation of indirect restorations, to enable the patient to clean in the area and prevent iatrogenic periodontal inflammation.

Introduction
Localised iatrogenic factors can exacerbate periodontal disease and if not eliminated can lead to disease progression and inevitable tooth loss. Local factors include the presence of calculus, rough prosthesis including crowns and bridge work and overhanging restorations. The invention of adhesive resin cements has been a breakthrough in restorative dentistry allowing the operator to employ a conservative approach to tooth preparation - only possible due to retention and strength conferred by bonding. This case report highlights the importance of removing excess cement to prevent its long term stagnation causing localised periodontal inflammation and disease.

The case
A 49 year old male patient with well controlled diabetes type II presented to the dental surgery for a routine examination. Clinical examination revealed good oral hygiene and a stable dentition. A localised pocket of 7mm with bleeding on probing on the distopalatal and distobuccal aspect of the UL6 was noted. Detection of a plaque retentive factor was noted on probing with a standard BPE probe. Bitewing and periapical radiographs of the tooth revealed a radio opaque body interdentally between the UL6 and UL7. An initial supragingival and interdental scaling with an ultrasonic scaler was carried out. This did not smoothen or remove the plaque retention factor suggesting that the radio opaque body was not simple calculus and strongly adhered somewhere in the interdental space.

Treatment
Assessment of previous notes and radiographs disclosed a cementation of a full porcelain CAD/CAM milled crown six months previously. The crown was placed with resin based dual cure cement. Following full mouth detailed pocket charting in accordance with British Society of Periodontology Guidelines (BPE) a treatment plan to embark on localised root surface debridement treatment was agreed on and carried out. The ultrasonic was used interdentally at a higher power than normal to dislodge the excess cement. The site was probed to ensure smooth advancement of the probe. A post operative periapical x-ray was also taken to ensure a clean interdental region between the UL6 and UL7.

Post operative
The patient was prescribed Chlorhexidine Gluconate 0.2% mouth rinse twice daily for two weeks post operatively. Oral hygiene instructions including flossing and use of interdental brushes were recommended. A review appointment was organised for the patient in three months time.
At the review appointment the distopalatal and distobucal aspects of the UL6 were probed. A significant reduction in pocket probing depth was seen at 4mm (reduction of 3mm). No bleeding on probing was observed. Oral hygiene was reinforced particularly in the affected region and a further three month review of the area was suggested and accepted by the patient as the long term management of the pocket site.

Discussion

Local plaque retentive factors have been long implicated as an aetiological component initiating periodontal inflammation through plaque retention. They hinder access to the gingival crevice and prevent effortless maintenance of oral hygiene. The management of such cases must always begin with careful identification and then modification or elimination of the plaque retentive factor. In the case of overhanging restorations this may involve smoothing or even replacement of the entire or part of the restoration. Detailed pocket charting as well intra oral x-rays should be taken at this stage.

Initial therapy should start with non surgical periodontal treatment which includes a full mouth scaling and removal of supragingival calculus. An intensive oral hygiene regime should be tailored for each individual patient’s needs along with the recording of plaque and bleeding scores for monitoring purposes. Oral hygiene should be monitored for compliance and areas of pocketing of 5mm and over with bleeding on probing should be further investigated and root surface debridement treatment embarked upon. Patients should be reviewed at a three monthly interval to reassess not only pocket probing depths but also adherence to oral hygiene instructions. A detailed pocket charting should be carried out at this stage for accurate measurement of pocket depth reduction.

When cementing indirect restorations the operator must ensure that excess cement has been removed from around the prosthesis and adjacent dentition. In the case of dual cure resin cement interdental flossing prior to light cure is essential to ensure a clean interdental space.

About the author: Azim graduated BDS from the University of Birmingham, School of Dentistry. Following a vocational training year he worked in Oral and Maxillofacial Surgery posts at Basildon & Thurrock University Hospital and Broomfield Hospital in Chelmsford, Essex. He is now a full time associate at a practice in Kent with a view to pursuing a career in periodontology.

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References:

The impact of orthodontic therapy on patients with periodontal disease

Sarah Nicoll

Introduction

Working as part of a cohesive multidisciplinary team is often essential within dentistry to provide the optimum treatment for the patient. As orthodontic therapy becomes more accessible to the adult population it is worth considering its impact in those patients whose oral health has already become compromised through periodontal disease; every orthodontic intervention has a periodontal dimension.1-3 A selection of papers from the freely available literature were reviewed to explore the relationship between periodontics and orthodontics.

Key words: orthodontics; orthodontic therapy; periodontal disease; interrelationship, periodontics and orthodontics.

Method

A search of the existing literature was undertaken in Wiley online library; Science Direct; NHS Knowledge Network; Google Scholar; Dental Update; Pubmed; and a variety of available textbooks and journals. Twenty five papers published in English between 1970 and 2013 were initially identified. These related to the management of a patient with periodontal disease while undergoing orthodontic therapy. For the purposes of this paper I will only discuss four.

Results

In a study by Eliasson et al.,4 the group investigated the impact of orthodontic treatment on the periodontium by studying patients with a history of periodontal disease. This researchers hypothesised that patients with a predisposition to periodontal disease may have an increased activity of osteoclasts, which would result in increased loss of attachment.

This study included 20 patients with advanced stages of periodontal disease. All patients underwent a phase of periodontal therapy; this included OHI, fine scaling and root surface debridement, prior to the commencement of the trial. At the initial appointment oral hygiene, PD, bone levels (radiographs) and gingival inflammation were recorded. Study models were taken for orthodontic assessment. The researchers were specific in the methods and materials of this examination. Teeth with poor prognosis were extracted and the patients were continually motivated with OHI throughout their periodontal treatment phase.

One tooth in each quadrant of the maxillary arch was used as a control in the study and subjected to the same OHI, but no orthodontic treatment was carried out on these teeth. The researchers decided that any periodontal surgery required should be carried out following completion of the orthodontic treatment - surgery prior to orthodontic treatment would affect tooth movement. The orthodontic treatment was initiated 4-6 months following completion of the periodontal treatment.

The results revealed that at the initial exam there was no difference between the control teeth and the teeth which were going to be moved orthodontically. Following completion of the periodontal treatment the researchers found no significant changes. PD measured between 3-7mm with no difference measured in the controls. The exam carried out after orthodontic treatment revealed a slight reduction in gingival inflammation but no change in PD or bone levels were recorded between the control teeth and the teeth which received orthodontic treatment. The researchers concluded that if periodontal therapy in the presence of good oral hygiene is carried out, no loss of attachment will occur during orthodontic therapy.

Boyd et al.5 compared orthodontic treatment in a group of 20 adolescents: one group exhibited healthy periodontal tissues and a second group exhibited clinical attachment loss (CAL). They noted 10 individuals with >12 interproximal areas with 2mm CAL and a history of periodontal treatment classified as generalized periodontitis.

Periodontal treatment was carried out in the group with generalised periodontitis. Following treatment it was found that 6 of the participants had 10 teeth classified as periodontally hopeless with PD of 6mm or greater. (Current guidelines focus on preservation of the dentition through maintenance therapy rather than deeming teeth to be hopeless due to increased loss of attachment.)6 The 10 adults with a healthy periodontium had to have a maximum of 2 sites interproximally with a PD of 2mm or less.

The 20 adolescents selected for the study did not exhibit periodontitis as classified by the researchers. All participants had their periodontal status assessed prior to orthodontic treatment then again at 1,3,6,12 and 18 months during treatment and then again at 1,3,6 and then 12 months post-orthodontic treatment. Despite these assessments only the baseline and 3 monthly post-orthodontic treatment results were used to record PD. The researchers did not specify what was assessed during all other interims. Graphs were included to show the plaque, gingival and bleeding indices. All had large standard deviations and only three recordings on each graph were classed as statistically significant. The researchers also stated that they did not include the teeth with PD of 6mm or greater within the study, which may have influenced even the findings based on current guidelines. All recordings were carried out by the clinician, which provided continuity in the findings. OH was reinforced at every visit and the patients with periodontitis received SPT every 3 months during orthodontic treatment.

The researchers found that the adolescents’ OH was poorer than the adults during treatment and both had excellent OH post-ortho treatment. They found that adults with reduced (but healthy) and normal periodontal support could undergo orthodontic treatment without loss of attachment. However, this may have been affected by the researchers failing to include teeth with PD of 6mm or greater in their study. This study placed emphasis on the importance of excellent OH during orthodontic treatment.

A second study investigated the influence of orthodontic treatment on periodontal tissues in adolescence. Kloehn and Peifer undertook a periodontal examination of their subjects prior to treatment, and every
In a study of 108 participants, Artun\(^8\) researched the effect of long-term to periodontal disease.

Information regarding those orthodontic patients with a predisposition to undertaking the orthodontic treatment. The study concluded that the incisal aspect was easier to access when brushing.

A limiting factor in this study could be that CAL was only measured on the lingual aspects of the lower anterior teeth, whereas a six point pocket chart may have offered a better indication of how the retainers affected the periodontal health of these teeth. Furthermore, the paper does not state whether or not the participants exhibited periodontal disease prior to undertaking the orthodontic treatment. The study concluded that the placement of these retainers to prevent relapse of orthodontic treatment causes no apparent damage to the hard and soft tissues adjacent to the wire.

**Conclusion**

There is a general consensus in the literature reviewed that a patient requiring orthodontic treatment and exhibiting periodontal disease can be managed through effective plaque control and supportive periodontal therapy: orthodontic therapy is not necessarily contraindicated in such patients. However, in general terms, the sample sizes in the studies available are small and low on the hierarchy of evidence and larger scale studies would provide the robust evidence needed that orthodontic therapy does not impact negatively on patients with periodontal disease.

**References**


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References

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This machine can be used in the clinic to measure a patient’s blood glucose.

Q1. What condition is associated with raised blood glucose?

Q2. How may blood glucose be controlled?

Q3. Give three oral manifestations of raised blood glucose.

**ANSWERS TO NOVEMBER’S QUIZ:**

1. The history and appearance suggests that this is probably not a malignant lesion but a differential diagnosis would require histological examination.

2. Reassure the patient and refer on for a second opinion.

Send your answers to the Editor by 28th February. The first correct answer out of the bag wins a top of the range Triumph Oral B Toothbrush (retailing at £150) courtesy of Braun Oral B.
**CPD PROGRAMME**

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

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

**Aims and outcomes**

The aim of the January 2015 Dental Health Continuing Professional Development Programme is to provide the opportunity for dental hygienists and dental hygiene therapists to learn about aspects of the following two subjects: Chemotherapeutics in practice; Dental effects of prolonged thumb sucking in order to progress their knowledge and expand their professional range in relation to their personal development and to their patients.

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.

**CPD QUESTIONS FOR PAPER 1: CHEMOTHERAPEUTICS IN PRACTICE PP29-31**

1. Which of the following statements is true?
   A. Systemic antibiotics are occasionally used for plaque-induced gingivitis, when the benefits outweigh the risks
   B. Systemic antibiotics can be used instead of periodontal instrumentation
   C. Systemic antibiotics are selectively recommended for aggressive periodontitis
   D. In chronic disease systemic antibiotics can be administered for many years

2. Which of the following statements is true?
   A. Local delivery chemicals release their agents over anything up to 14 weeks
   B. Local delivery chemicals are ideally used for localised non-responsive sites
   C. When chemicals are delivered locally they are able to stay in place due to crevicular fluid forming a protective network
   D. The improvement in pocket depth after using chemicals locally makes their therapeutic impact use surpassed other methods, such as systemic delivery

3. Which of the following statements is true?
   A. First generation mouth-rinsets typically demonstrate 20-40% plaque reduction
   B. Second generation mouth-rinsets can reduce plaque by 70-95%
   C. Third generation mouth-rinsets have poor substantivity and only reduce plaque by 35%
   D. Fourth generation mouth-rinsets are the most superior and can reduce plaque by 99%

4. Which of the following statements is true?
   A. Phenols, Triclosan and Delmopinol are the most prevalent first generation mouth-rinsets
   B. Bisguanides are classed as the gold standard in mouth-rinsets, despite their adverse effects
   C. Mouth-rinsets are always considered by the public as an adjunct to mechanical cleaning
   D. Oxygenating mouth-rinsets are the most efficient second generation mouth-rinsets

5. Which of the following statements is true?
   A. Essential Oils work by disrupting the integrity of the cell wall and inhibition of certain bacteria
   B. Chlorhexidine works by disrupting the integrity of the cell wall and inhibition of certain enzymes
   C. Delmopinol works by interfering with plaque matrix formation when there is an increase of bacterial adhesion
   D. Delmopinol has a unique ability to inhibit the formation of plaque biofilm whilst having little effect on bacteria

6. Which of the following statements is true?
   A. Side effects of Essential Oils are: a burning sensation and a bitter taste
   B. Side effects of Chlorhexidine are: discolouration of teeth and tongue, supragingival calculus and enamel erosion
   C. Side effects of Chlorhexidine are: taste perturbation, superficial desquamation and numbness of the mucosal tissues
   D. Side effects of Delmopinol are: supragingival calculus formation, discolouration of teeth and tongue, and taste perturbation

**CPD QUESTIONS FOR PAPER 2: DENTAL EFFECTS OF PROLONGED THUMB SUCKING PP34-35**

1. What percentage of infants under the age of 12 months sucks their thumb?
   A. 25%   B. 55%   C. 70%   D. 75%

2. Up until what age are the effects of thumb sucking reversible?
   A. 12 months   B. 3 years   C. 7 years   D. 12 years

3. Which of the following is not classically seen in prolonged thumb suckers?
   A. Proclination of maxillary molars
   B. Proclination of mandibular molars
   C. Retroclination of mandibular incisors
   D. Reduced overbite

4. What percentage of 10 year old thumbsuckers have a serious malocclusion?
   A. 25%   B. 32%   C. 61%   D. 63%

5. Which of the following is not considered effective in helping the child break the habit?
   A. Discussing with the child the detrimental effects of their thumb sucking
   B. Intra-oral photos to chart their progress
   C. Positive reinforcement
   D. Pressuring young children to stop

6. How long is it recommended that a habit breaker is worn?
   A. 3-6 weeks   B. 6-9 weeks   C. 3-6 months   D. 6-9 months
ANdwers to the cpd questions in dental health - volume 53 no 6 of 6 november 2014

**Paper 1: Infection Control: where are we now? pp23-25.**

1. D 8,000
2. D Decades
3. A Inoculation injury
4. B Legionnaires disease
5. D A wound should be scrubbed clean and antiseptic applied
6. A It is asked to consent to being tested for the presence of BBV

**Paper 2: Recent trends in the management of erosive tooth wear and dentine hypersensitivity pp26-28.**

1. A Epidemiology
2. C 29.4%
3. C Candida albicans
4. A Nerve stabilisation or desensitisation and occlusion of exposed dentinal tubules
5. A 5% potassium nitrate and 0.454% stannous fluoride
6. D Decrease dentinal permeability by precipitation of calcium fluoride crystals inside the tubules, thereby occluding exposed tubules

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

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

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

Or complete online **FOR FREE** at wwwbsdht.org.uk

Answer sheets must be received no later than 28th February 2015. Answer sheets received after this date will be discarded as the answers will be published in the March issue of Dental Health.

**Feedback**

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

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NON-SURGICAL PERIODONTAL THERAPY - WHAT IS STOPPING YOU FROM GETTING THAT GOOD RESULT?

SPEAKER: Deepak Simkhada, dental hygienist/therapist
DATE: Saturday, 17th of Jan 2015 9am - 12 pm
VENUE: 2 Hogarth Road, Earl's Court, London
CPD: 3 hours verifiable
COST: £45
CONTACT: bookingnspt@gmail.com or call Deepak on 07868 703790

TO ALL DENTAL HYGIENISTS

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Complete the boxes using the following information:
User name: your full name, no abbreviations, no spaces, all in lower case eg. dianamarysmith. Password: your BSDHT membership number.
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Periodontal Disease
How do you measure success?

Dentomycin offers:

- **42%** reduction in pocket depth after 12 weeks\(^1\)
- **broader spectrum** of antibacterial action\(^2\) with greater all round activity than metronidazole or tetracycline
- **conditioning of the root surface**\(^3\)
- **improved healing** through inhibition of degradative collagenases\(^4\)
- **enhanced connective tissue attachment**\(^5\)
- **effective treatment** of chronic periodontitis which has been associated with cardiovascular diseases\(^6-9\)


Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard and for Ireland email: medsafety@hpria.ie.

Dentomycin abridged prescribing information. Please refer to the Summary of Product Characteristics before using Dentomycin 2% w/w Periodontal Gel (minocycline as hydrochloride dihydrate). Presentation: a light yellow coloured gel containing minocycline as hydrochloride dihydrate equivalent to minocycline 2% w/w. Each disposable application contains minocycline HCI equivalent to 10mg minocycline in each 0.5g of gel. Uses: Moderate to severe chronic adult periodontitis as an adjunct to scaling and root planing in pockets of 5mm depth or greater. Dosage and administration: Adults – Following scaling and root planing to pockets of at least 5mm depth. Gel should fill each pocket to overflow. Application should be every 14 days for 3-4 applications (e.g. 0, 2, 4 and 6 weeks). This should not normally be repeated within 6 months of initial therapy. Use only one applicator per patient per visit which should be wiped with 70% ethanol between applications to each tooth. Avoid tooth brushing, flossing, mouth washing, eating or drinking for 2 hours after treatment. Elderly – As adults, caution in hepatic dysfunction or severe renal impairment. Children – contraindicated in children < 12 years. Not recommended in children > 12 years. Precautions: Closely observe treatment area. If swelling, papules, rubefaction etc. occur, discontinue therapy. Should not be used in pregnancy and lactation unless considered essential. Side-effects: Incidences are low and include local irritation and very rarely diarrhoea, upset stomach, mild dysphoria and hypersensitivity reactions. Storage: 2°-8°C. Legal category: POM. 

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

Dentomycin 2% w/w Periodontal Gel is Distributed by Henry Schein UK Holdings Ltd, Medicare House, Gillingham Business Park, Gillingham, Kent ME8 0SB Tel 020 7224 1457 Fax 020 7224 1694. Date of preparation: November 2014. Registered Trademark BLA/DEN 24
Conundrum

Do you have any burning questions or need reassurance on current practice? Well, you might want to visit the Hygienist Hub for advice and support. The most recent postings are on the Community Café section of the hub, however, a plethora of information is also stored under ‘All Comments’. Chat you may have missed covers topics as diverse as treating patients under sedation and the availability of NHS treatment under direct access.

One recent conundrum concerned the use of ultrasonic scalers with patients who have a pacemaker. The enquirer asked whether there are some that can be used with such patients. Advice from the Hub’s resident experts erred on the side of caution, saying that unless you have the written consent of the cardiologist you ought to play it safe and stick to hand instruments.

Having a central resource to ask questions, or post interesting facts and findings will become invaluable over time, particularly for younger, less experienced hygienists and therapists. Chances are if you’re pondering something, others will be too. Maybe you don’t have a comment, but just want to voice an opinion. Well now’s the time to do so, and the hygienist hub is the ideal forum. Visit www.dentalcare.co.uk/hygienisthub/home

Caries Reduction

The positive effects of fluoride-containing toothpastes as a defence against dental caries are well documented. Stannous fluoride was the first scientifically recognised fluoride and in recent years has been stabilised and combined with sodium hexametaphosphate, to provide additional protection.

Stabilised stannous fluoride protects teeth against caries in two ways. Firstly, it strengthens enamel and dentine to inhibit demineralisation and promote remineralisation. Secondly, it has the ability to reduce the incidence of Streptococcus mutans. Thus the anti-caries effect of such formulations includes a combination of physical chemical effects and antimicrobial actions.

Oral-B Pro-Expert toothpaste utilises stabilised stannous fluoride, which makes it a mighty force in the fight against caries.

The Corrosion of Erosion

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

Oral-B Pro-Expert toothpaste contains a combination of stabilised stannous fluoride and sodium hexametaphosphate. Preventing enamel loss is just one benefit of Pro-Expert. Laboratory and clinical studies have confirmed its ability to inhibit bacterial growth, reduce the ability of bacteria to adhere to tooth and gum surfaces and to affect their metabolic processes. For more information or samples contact your Oral-B representative.

It also helps protect against plaque, gum problems, caries, calculus formation, dental hypersensitivity, staining and oral malodour.

Whilst it is hoped that education on the damaging effects of acidic drinks will go some way in controlling the problem of erosion, providing protection against the effect of such drinks will help individuals retain their enamel.
New Year, New Resolutions!

A new year will invariably herald a new set of good intentions, so why not encourage your patients to ensure better oral hygiene is one of them? What people say they do and what they actually do varies widely. The epidemiology of gingivitis and periodontal disease clearly indicates that many people do not brush well, so how might their chances of improving their oral hygiene be increased?

Oral-B’s new SmartSeries electric toothbrush is the ideal tool to encourage compliance as it allows dental professionals to programme patients’ brushing routines onto their mobile to ensure they follow professional guidance between appointments. Control is firmly passed to the patient, but under the guidance of dental professionals. Brushing duration, mode and problem zones can all be highlighted and the information easily retrieved. Moreover, the brush can store up to 20 brushing sessions so you don’t need to have your phone in the bathroom; the data will simply be transferred the next time the app is connected to the toothbrush!

With patients’ consent, professionals can now access brushing data to gauge the level of compliance and help patients identify areas for improvement. Now there’s no excuse for failed resolutions!

Gasp of Cold Air

Experienced by a wide cross-section of the population, most notably when eating or drinking cold or sweet food, or taking a gasp of cold air, hypersensitivity is caused by nerves which are stimulated in the dentine layer of teeth exposed by tooth wear or periodontal disease.

A minefield of products is available to help a sensitivity sufferer, with ingredients like Potassium Nitrate, Strontium Chloride, Arginine and Novamin.

Oral-B’s Pro-Expert All Around Protection toothpaste brings long lasting relief to thousands of dentine hypersensitivity sufferers thanks to the inclusion of stabilised stannous fluoride. This ingredient acts by partially or completely blocking the tiny dentinal tubules of which dentine is composed, thereby also blocking the stimuli causing the painful nerve impulses. Repeated use helps to build a strong barrier by occluding the tubules more & more, leading to a decrease in sensitivity.

While reducing hypersensitivity is just one of the comprehensive range of oral health benefits delivered by Oral-B Pro-Expert toothpaste, for sufferers of the painful condition, it will probably be enough by itself! Rigorous laboratory and clinical research supports the benefits of stabilised stannous fluoride toothpaste in controlling dentinal hypersensitivity.
**WEST SUSSEX**

**Horsham.** Hygienist required in modern well equipped mixed practice. Wednesday or Friday. Occasional Saturday would be ideal. Immediate start. Visit www.carfaxdental.com or email carfaxdental@aol.com for more information.

**East Grinstead.** St. James Practice. Hygienist required in a well equipped private practice. 2 days with scope for more. Send your CV/letter to rahulnehra@thesmilegallery.co.uk starting date January 2015.

**SUFFOLK**

**Haverhill.** Hygienist required one day per week in Haverhill, Nr Cambridge. Please send CV to Practice Manager, Henderson House, 3 Wratting Road, Haverhill, Suffolk, CB9 0DA. Email dentists@hendersonhouse.org.uk

**BUCKINGHAMSHIRE**

**Aylesbury.** Hygienist required Tuesday and Fridays from January 2015. Will consider candidates for both or either days. Contact info@denta-care.com or via telephone on 01296 424 037

**WEST MIDLANDS**

**Birmingham area.** Dental Therapist required one day per week with opportunity to increase - Locum cover required initially on Thursday’s. Direct Access, full scope of work. Nurse provided, full support given. Please email CV with photo ID to info@scottarmsdentalpractice.com.

**SOMERSET**

**Glastonbury.** Caring Hygienist required for 2-3 days per week in Denplan/Private practice. Newly qualified welcome. Apply to: abbeydentalglastonbury@gmail.com

**NORTH WEST**

**Manchester.** An opportunity has arisen for a Therapist or Hygienist to join Intertek CRS, part of the Intertek Group PLC, a leading Contract Research Organisation specialising in the clinical evaluation of oral care products

**Job Title:** Clinical Assessor

**Salary:** Available on request

**Hours:** 37.5 hours per week,

**Location:** Multi-Sites in Manchester (M16 and M15) and occasional travel to other NW sites as required.

**Holidays:** 25 days per annum (pro rata)

**Job Spec:** Primary responsibilities would be to act as a clinical assessor to determine the efficacy and safety of novel oral care products using a variety of clinical indices, collect clinical samples and to organise and execute clinical trials for a range of multi-national clients. Applicants must be highly organised with excellent attention to detail and be able to communicate well with co-workers, clients and members of the public.

**Qualifications/experience:** Qualified dental hygienist or therapist. Computer literate with some experience of excel and word packages. Send CV & covering letter to steve.thorn@intertek.com

**Closing Date:** 25th, January 2014

**GIBRALTAR**

**Marina Bay.** Full time hygienist required in private practice in Gibraltar. Starts February. Full book - 40% of gross. Minimum 3 years’ experience. E-mail: finaledent@gibtelecom.net

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**If not please contact enquiries@bsdht.org.uk and update us**

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