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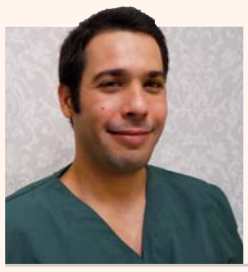

INTERVIEW

Dr Stefanos Morfis about the situation of dentists in Greece and the reasons he has chosen to leave his home country in order to start working in the UK.

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GRADUATION

Dental Tribune contributor Aws Alani explains why entering the field has become a minefield for the younger generation of dentists.

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COSMETIC TRIBUNE

Read the latest news and clinical developments from the field of cosmetic dentistry in our specialty section included in this very issue.

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Introducing a treatment coordinator: The Bridge to case acceptance

By Lina Craven, UK

You might think that in financially challenging times the last thing you need is a new member of staff. For a practice to thrive and prosper in a difficult financial climate, however, it has to become more efficient, more competitive and more profitable. One way to do that is to introduce a treatment coordinator (TC) into the team or if you already have one then to offer appropriate training. This is a relatively new role to the European market, but in the US, where the role is a central part of any practice, it has proven to dramatically add value to the patient experience, reduce in chair time and increase case acceptance.

The introduction of a well-trained TC will change your entire approach to new patient care, as well as increase profitability. While many practices know how to attract patients, their case acceptance ratio is low. The first contact, first visit and follow-up are the most important elements of the new patient process, yet they frequently represent a wasted opportunity because of a lack of skill, focus, time or all three.

In my experience, a major downfall of practices is the unwillingness of practitioners to delegate the new patient process to staff, or what we call the TC role. This is often due to a wide range of factors, including the practitioner's perception that the patient wants communication on his or her treatment to come from the practitioner, the perception that patients pay to see the practitioner, a lack of trust to empower staff or time to train staff, and the financial implications of introducing the new role.

Relinquishing new patient management to well-trained staff is not a new trend, although its application has been limited in Europe. However, patients' expectations, competition for private work and the team's demand for career progression and job satisfaction are key drivers for introducing the TC role.

The TC concept

A TC is someone in your practice who, with the right skills and training, will facilitate the new patient process. He or she bridges the gap between the new patient, the practice and the staff. The TC promotes and sells the practice and its services by demonstrating their true value to prospective patients, frees up the practitioner's time, increases case acceptance ratios and, resultantly, increases practice profits.

Consider the time spent by the practitioner with the new patient and calculate how much of that time is non-diagnostic. A TC can often reduce up to 60 per cent of practitioner–patient time. Rather than this being a barrier to patients—which is indeed what many practitioners perceive to be the case—in my experience, patients actually feel much more at ease with the TC and therefore better informed. Doctor time is not always doctor time. As a typical example: if an new patient appointment is 30 minutes, but the clinical part is actually only 15 minutes, there is potentially 15 minutes still available. Think about the impact an additional 15 minutes for every new patient in the appointment diary could have.

A good TC will manage all aspects of the patient journey, from referral to case start, and potentially increase your case starts. He or she is the first point of contact. People buy from people, so the development of a relationship and establishing of rapport between the TC and the new patient are crucial to the success of your conversion from referral to start of treatment. The TC informally chats to the new patient prior to consultation. This helps not only to foster rapport but also to gain a better idea of the patient's needs and wants.

I recommend to all my TCs to be present at the consultation to listen and understand clinically what is and is not possible in order to allow the TC to determine how he or she will conduct a top-notch case presentation.

The TC carries out the case presentation, reiterates the treatment options available to the patient, discusses these, answers any questions the patient may have, and clarifies proposed treatment. He or she also discusses the informed consent, shows before and after photographs of similar cases, and addresses any barriers or concerns the patient may have.

The TC also explains the financial options and determines the most suitable payment method for the patient's needs, as well as prepares the walk-out pack. The value of a walk-out pack should not be underestimated and should reflect the values of the practice, including all information the patient needs, the finance agreement or contract, diagnostic report, photographs of the patient (an excellent marketing tool), informed consent and anything else the practitioner feels adds value to the consultation.

Too many new patients are lost due to lack of follow-up. A good TC follows up and provides monthly information on patient conversions to assist with strategic planning. All practices should have a patient journey tracker.

Filling the role: An internal solution?

There are no hard and fast rules. It depends upon the size and aspirations of your practice and the qualities of existing members of your team. If you have a team member who fulfils the characteristics of a TC and he or she wants the challenge, then the answer is yes. Keep in mind that you may well need to fill that person's current position.

Some practices streamline job descriptions allowing them to create the new role without having to hire another staff member. Whether it is a full-time role or not depends upon various factors, including the size of the practice; the number of practitioners, chairs and patients; and the profit aspirations. Many practices implement the role and monitor its progress and impact. This often helps the team to accept the change and gives the practitioner the opportunity to assess any training needs of the TC and to access how remuneration will be affected.

The role of your TC should fit in with your practice's culture and aspirations for patient care. However you choose to implement the role, the only guarantee is that you will benefit enormously. Augmenting your team with a well-trained TC can reap tremendous rewards for you, the team and your patients. A TC's tailored and personal approach to care, follow-up and communication with patients fosters trust and increases patient satisfaction and retention.

***Lina Craven** is founder and Director of Dynamic Perceptions, an orthodontic management consultancy and training firm in Stone in the UK, and has many years of practice-based experience. She can be contacted at info@linacraven.com*

BDA calls for radical action to lower Britain's sugar intake

By DTI

LONDON, UK: Lately, there have been increasing efforts to curb Britain's high sugar consumption. Although the British Dental Association (BDA) has welcomed Tesco's recent announcement that it is banning high-sugar drinks from its shelves, the association has called for action that goes further than "symbolic" concessions and urged government to follow the recommendations of the report by the Scientific Advisory Committee on Nutrition (SACN).

"Finally we're seeing big retailers waking up to the sugar crisis. That's progress, but these symbolic gestures should not disguise the fact supermarkets are still banking on the nation's sweet tooth," Dr Mick Armstrong, Chair of the BDA, said.

"The recent obituaries for Capri Sun, Ribena or Percy Pigs are designed first and foremost to fill up column inches and Twitter feeds. PR stunts should not blind government, parents or health practitioners to the need for real, co-ordinated action to address Britain's addiction to sugar," remarked Armstrong on Tesco's plans to take added-sugar drinks out of the children's juice department starting in September.

Tesco's plans echo recent recommendations in the Carbohydrates and Health report, published by SACN on 17 July, which advises reducing the daily energy intake of sugars from 10 to 5 per cent. The report also recommends that consumption of sugar-sweetened drinks be minimised and of fibre be increased.

According to the health experts, 5 per cent of daily energy intake is the equivalent of 19 g or five sugar cubes for children aged 4–6, 24 g or six sugar cubes for children aged 7–10, and 30 g or seven sugar cubes for those aged 11 and over, based on average diets.

The SACN findings, established by a group of independent experts that advises government on matters relating to diet, nutrition and health, offer the first wide-ranging look at the relationship between sugar consumption and health outcomes in the UK since the 1990s.

Other national statistics have shown that British children especially are consuming unhealthy amounts of free sugars—the nutrient-free refined sugar added to products such as sweetened drinks—in their daily diet. At 30 per cent, soft drinks accounted for the majority of sugar in the diet of 4- to 10-year-olds, the 2014 National Diet and Nutrition Survey found.

Soft drinks and juices are especially harmful to the teeth, since they tend to be very acidic, which makes the teeth particularly vulnerable to both dental decay and tooth erosion. Aside from posing oral health risks, a diet rich in free sugars has been linked to obesity and Type 2 diabetes, among other conditions.

With reference to the SACN recommendations, the BDA has called for radical measures to cut Britain's sugar intake, including lowering the recommended daily allowance, and action on marketing, labelling and sales taxes. The BDA has launched an online petition addressed to Prime Minister David Cameron, inviting both health professionals and patients to lend support to SACN's proposals at *Change.org*.

"We have an historic opportunity here to end Britain's addiction to sugar. The government now has the evidence and a clear duty to send the strongest possible signal to the food industry, that while added sugar might be helping their sales, it is hurting their customers," Armstrong said. The complete SACN report can be accessed at *https://www.gov.uk/government/publications/sacn-carbohydrates-and-health-report*.

Rare case of amnesia linked to root canal treatment

By DTI

LEICESTER, UK: In March 2005, a 38-year-old British soldier stationed in Germany lost his ability to form new memories after undergoing a regular root canal treatment. To this day, he is unable to remember anything for longer than 90 minutes, although his brain is completely intact and he suffered no trauma that could have caused the amnesia, according to his doctors.

"I remember getting into the chair and the dentist inserting the local anaesthetic," the man, who wishes to remain anonymous, told the BBC. Since that moment, he remembers nothing. Every morning, he wakes up thinking that he is still a soldier stationed in Germany in 2005, waiting to visit the dentist for root canal surgery.

The German dentist only realised after the treatment, which was without complications, that something was wrong with the patient. He was pale, disoriented and struggled to stand up. As his condition did not improve, he was brought to hospital where he stayed for several days. In the beginning, he was not able to remember anything for longer than a few minutes.

The doctors' first suspicion was that a bad reaction to the anaesthetic had caused a brain haemorrhage. However, they could not find any evidence of injury. Finally, the patient and his family returned to England, where Dr Gerald Burgess, a clinical psychologist from Leicester, took over the case.

According to Burgess, a form of anterograde amnesia would have been the most obvious explanation for the man's condition. In this case, the hippocampi, the brain regions responsible for the consolidation of information from short-term memory to long-term memory, are damaged so that memories can no longer be formed and stored correctly. Yet, the man's brain scans showed no abnormalities. Thus, another possible explanation would have been a psychogenic illness. Burgess conducted detailed psychiatric assessments in order to determine whether the man had suffered any trauma. However, Burgess found that his patient was emotionally healthy and his wife confirmed that there had not been any traumatic events in the man's life prior to his dentist visit in 2005.

Burgess continues to research his patient's rare case of amnesia, currently suspecting that the brain's synapses might play an important role. Each time a memory is formed and transferred to long-term memory, the synapses are rebuilt, which involves the production of new proteins. This protein synthesis might be blocked in the case of Burgess' patient, keeping him from generating any new long-term memories. In order to further research his hypothesis, Burgess is examining five similar cases of mysterious memory loss without brain damage from the medical literature. These cases might provide an answer to why the root canal treatment appears to have triggered the man's memory loss. All of the cases are in some way related to a period of psychological stress during a medical emergency. "It could be a genetic predisposition that needs a catalyst event to start the process," Burgess told the BBC.

"One of our reasons for writing up this individual's case was that we had never seen anything like this before in our assessment clinics, and we do not know what to make of it, but felt an honest reporting of the facts as we assessed them was warranted, that perhaps there will be other cases, or people who know more than we do about what might have caused the patient's amnesia," Burgess stated.

The case report by Burgess, titled "Profound anterograde amnesia following routine anesthetic and dental procedure: A new classification of amnesia characterized by intermediate-to-late-stage consolidation failure?", was published online in the *Neurocase* journal on 15 May.

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PUBLISHER:
Torsten OEMUS

GROUP EDITOR/MANAGING EDITOR DT AP & UK:
Daniel ZIMMERMANN
newsroom@dental-tribune.com

CLINICAL EDITOR:
Magda WOJTKIEWICZ

ONLINE EDITOR:
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ASSISTANT EDITORS:
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DENTAL TRIBUNE INTERNATIONAL
Holbeinstr. 29, 04229, Leipzig, Germany
Tel.: +49 341 48474-302
Fax: +49 341 48474-173
info@dental-tribune.com
www.dental-tribune.com

Regional Offices:

UNITED KINGDOM
Baird House, 4th Floor, 15–17 St. Cross Street
London EC1N 8UW
www.dental-tribune.co.uk
info@dental-tribune.com

DT ASIA PACIFIC LTD.
c/o Yonto Risio Communications Ltd,
20A, Harvard Commercial Building,
105–111 Thomson Road, Wanchai
Hong Kong
Tel.: +852 3113 6177
Fax: +852 3113 6199

DENTAL TRIBUNE AMERICA, LLC
116 West 23rd Street, Suite 500, New York,
NY 10001, USA
Tel.: +1 212 244 7181
Fax: +1 212 224 7185

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Research uses virtual reality technology to train dental surgeons

By DTI

HUDDERSFIELD, UK: A University of Huddersfield researcher is harnessing the latest virtual reality technology to help oral and maxillofacial surgical trainees practise complex dental surgeries. His project aims to provide accurate 3-D visualisations of human anatomy and surgical procedures using Oculus Rift, a virtual reality head-mounted display.

Indian-born Yeshwanth Pulijala is a qualified dental surgeon. During his training, he was confronted with the problem of poor visualisation of dental procedures in the operating room. Being aware of these shortcomings in surgical training, as well as passionate about 3-D design and technology, he relocated to the UK to pursue postgraduate research on the use of advanced technology to improve health care.

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During his master's studies on 3-D medical visualisation at the University of Glasgow, Pulijala created a mobile app called SurFace that provides patient education in corrective jaw surgery. This inspired him to explore the potential of virtual reality for surgical education, using Oculus Rift. A commercial version of the device is expected to be released in the first quarter of 2016. However, Pulijala, who is currently studying for a PhD at the University of Huddersfield, was able to obtain the developer version for his research.

Learning through observation and hands-on participation is an important part of the education of surgical trainees, and medical and dental students, according to Pulijala. "During these sessions the trainees learn by observing the procedures in real time," he stated. "But the problem is that not everybody can see what is happening. This is especially the case in crowded operating rooms where surgical trainees perform multiple duties.

Also in surgeries confined to oral and maxillofacial zone, as the structures are complex and densely enclosed in a confined space, it is very hard to observe and learn. Further, a reduction in surgical training hours is severely affecting the training of surgeons," Pulijala pointed out.

As a result, he continued, four out of ten surgical trainees are not confident in performing a procedure. Therefore, he is developing a tool that enables them to participate virtually in an operation. His PhD project aims to provide trainee surgeons with close-up, unrestricted 360-degree views of a surgical procedure, yielding the potential to improve surgical training substantially.

"If you are a trainee surgeon, wearing an Oculus Rift, you will see the surgical procedure in an operating room environment and also be able to 'touch' the skull of the patient and interact with it," Pulijala said. He is currently developing the project concept and producing working prototypes. In the longer term, he envisions a system that will enable surgical trainees to practise and perform virtual operations. "But at the moment it is about creating a high-quality visualisation, interacting with the patient's data and seeing their anatomy in great detail," he concluded.

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"I do not see how the situation can improve"

An interview with Dr Stefanos Morfis, Greece

Educated in Manchester and a dentist at heart, Dr Stefanos Morfis opened his first practice in Athens five years ago, right at the beginning of the debt crisis in Greece. Five years later, he is selling it owing to the economic circumstances and is planning to register with the General Dental Council in order to start working as a dentist in Britain. *Dental Tribune* had the opportunity to speak with him recently about the situation of dentists in his home country and the reasons he has chosen to leave.

Dr Stefanos Morfis

Dental Tribune: **Dr Morfis, with the recent referendum on the austerity measures proposed by the EU and the resignation of Minister of Finance Yanis Varoufakis, the debt crisis in Greece has heated up again. Can you describe what impact the crisis has had on dentistry in your country?**

Dr Stefanos Morfis: When one looks back 10–15 years, dentistry actually used to be quite a prosperous business in Greece. Since many dentists received their education in countries like England, Germany or the Netherlands, the level of dentistry was quite high. What we have seen during the last ten years or so is that fewer people are visiting the dentist because of their financial situation and they only go when they are already in pain.

You have to know that, unlike in the UK or other European countries, most dental care here is private. Since many cannot afford treatment in Greece, they travel to other countries, like Macedonia, where they receive cheaper, but lower quality, treatment. Recently, I heard of two patients who died after undergoing a tooth extraction there.

Owing to the lack of money for treatment, caries levels are very high and, although we are fully aware of its benefits, there is very little money for any kind of preventative dentistry. This is only done at university level.

Consumer prices in Greece are soaring owing to the strict regulations. Have prices for dental treatment also gone up?

In contrast to everything else in Greece, prices for dental treatment have actually gone down in the last five years. While one could charge €50 or more for a composite filling in 2003/2004, today there are quite a number of dentists who are performing fillings for just €20.

This trend is facilitated by the majority of patients, who are only looking at price and not at what kind of material is being put in their mouth. Do not ask even me what kind of fillings they use sometimes! But how can one work professionally and ensure quality for patients at these prices?

With having to compete at such low prices, can you actually live on your income as a dentist in Greece?

Ten years ago, our income was almost double what it is now and the cost of living, materials and education were much cheaper. Living in Athens now is like living in London, but with five times less income. That is why many now meet their educational needs online by attending free webinars. What is really troubling is that more and more dentists are being forced to sell their practice for half the price. That includes me. Ironically, my practice will be taken over by a dentist from Britain.

You are planning to work in the UK. When are you going to leave?

I am currently in the process of registering with the General Dental Council and planning to leave Greece in November. I did my postgraduate studies at the University of Manchester's School of Dentistry and I have worked in several practices over there.

The austerity measures will allow Greece to stay in the EU. In your opinion, is there any possibility of the situation improving?

There are positive examples, like Ireland and Portugal who were able to recover from the recession a few years ago. I hope to be proven wrong, but I do not see how the situation can improve in Greece. Politicians come and go, but the people remain the same. If we do not drastically change how things are run in this country, in a few years I guess it will be impossible to recover.

Would you go back if things start to improve?

I would like to, but I think it will be very difficult. I have a family to look after now and I want the best for my little son. At 35, I am at the best age to be productive and achieve things in my live. I have always felt a love for the dental profession and therefore want to dedicate my life to it.

Thank you very much for taking the time and all the best for your future.

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Update on dental amalgam guidelines

European Commission recommends use of alternative materials for fillings

By DTI

BRUSSELS, Belgium: Many countries around the world, European countries in particular, have seen a shift away from the use of dental amalgam in oral health care and an increase in the use of alternative materials over the past years. The European Commission recently acknowledged this trend and published an updated version of its opinion on the safety of dental amalgam and alternative restoration materials.

The new document is an update of the 2008 opinion and aims to assess the safety and effectiveness of dental amalgam and current alternative materials by evaluating the latest scientific evidence.

While in 2008 the European Commission and the Scientific Committee on Emerging and Newly Identified Health Risks concluded that both types of material are generally considered safe to use, they now recommend that the choice of material be based on patient characteristics. In accordance with the objectives of the Minamata Convention on Mercury, the committee now recommends using alternative materials in children and pregnant women.

The committee further stated that the systemic effects of elementary mercury are well documented and it has been identified as a neurotoxin, especially during early brain development by a number of studies. Mercury has also been associated with adverse health effects in the digestive and immune systems, and in the lungs, kidneys, skin and eyes. Nevertheless, the evidence for such effects due to dental amalgam is weak, according to the committee.

The new recommendation is also based on the findings that dental amalgam fillings may cause mercury poisoning in genetically susceptible populations. Some genetic variants appear to impart increased susceptibility to mercury toxicity from dental amalgam.

Studies involving dental health care personnel have indicated that mercury exposure from dental amalgam during placement and removal may cause or contribute to many chronic illnesses, as well as depression, anxiety and suicide. However, exposure of both patients and dental personnel could be minimised by the use of appropriate clinical techniques, the committee stated in its opinion report.

However, current evidence does not preclude the use of either amalgam or alternative materials in dental restorative treatment. The committee acknowledged that there is a need for further research, particularly with regard to neurotoxicity of mercury from dental amalgam and the effect of genetic polymorphisms on mercury toxicity. In addition, the committee concluded that there is a need for the development of new alternative materials with a high degree of biocompatibility. The full report, titled "The safety of dental amalgam and alternative dental restoration materials for patients and users", can be accessed on the website of the Scientific Committee on Emerging and Newly Identified Health Risks.

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CROWN24
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"Bring more patients into practices"

An interview with Crown 24 Directors Rupa Shah and Sandy Shapira, London

Crown 24 UK has made a significant impact in the UK dental laboratory market since it started three years ago. *Dental Tribune* had the opportunity to speak with Rupa Shah and Sandy Shapira, directors of the company, about their unique marketing concept and how they manage to assure the highest quality at a significantly lower price.

Dental Tribune: With Crown 24 UK, you promise that dentists and patients are able to have dental prostheses fabricated at much lower costs. How do you achieve this price advantage?

Rupa Shah: Our concept is very simple. While we offer the premises of a fully equipped dental laboratory based in London, all the manufacturing is done in China. The production there allows us to offer a better price to dentists and patients. If the benchmark for the UK is £250, for example, we are able to provide laboratory work that is up to 60 per cent cheaper than comparable work done here in the UK.

How do you assure quality that is comparable to UK standards?

Sandy Shapira: Since Crown 24 UK is the daughter company of a business that started in Switzerland five years ago, our dental laboratory in London can offer proven Swiss standards of control.

Based on that, we have implemented a strict monitoring and evaluation process for each phase of manufacturing. The finished products sent from China are subject to final quality control inspection by our UK-based senior technicians registered with the General Dental Council.

This process allows us to provide a five-year guarantee to all our customers.

What kind of laboratory work does Crown 24 UK offer at present, and do you cover CAD/CAM too?

Rupa Shah: We currently carry out crown and bridge work, implantology and prosthetics. We even provide a CEREC machine free to dentists, so they can send us their digital data as they are used to.

What are the prospects for your business?

Rupa Shah: You probably know better than I that dentistry, particularly in the UK, is a struggling business. Many practices are having difficulties sustaining their business owing to the lack of patients. At Crown 24, we advertise to both dentists and prospective patients, so patients first contact us directly and we can then pass their information on to the dentists. The general goal is to bring more patients into practices.

Thank you very much for the interview.

Crown 24 UK Ltd
Rowlandson House
289–293 Ballards Lane
London, N12 8NP
Tel.: 0800 1522338
info@crown24uk.co.uk
www.crown24uk.co.uk



Photos showing production in China. © Crown 24 UK

UK spin-out launches crowdfunding campaign for no-drill tooth repair tech

By DTI

PERTH, UK: Teeth restored without drilling is the dream of almost every dental patient. A new approach developed in Britain that utilises an electrical current to remineralise the tooth promises exactly that. Reminova, the developer of the technology, has now announced the start of an equity crowdfunding campaign for UK and the US in an effort to raise £0.5 million to bring it to market.

It will be the first fundraising campaign of its kind to target shareholders in both countries simultaneously. If reached, the sum will be used to expand the company's development and operational team and to seek strategic partnerships with dental companies interested in selling the technology, Reminova executives said. Initial clinical studies are also planned.

Left to right: Professor Nigel Pitts, Dr Chris Longbottom and Dr Jeff Wright of Reminova.

Reminova expects a potential market for the device of 700,000 dentists worldwide. In a press note released at the start of the campaign, the company said that individuals who are interested in becoming shareholders will have 60 days to contribute to the project. The minimum investment is £1,000 for those from the UK or Europe and US$5,000 for Americans.

In return, they will help to get rid of drilling in dentistry and transform global dental health.

"With their help and investment, our tooth rebuilding treatment could be available to patients within three years," predicted Reminova CEO Dr Jeff Wright.

According to Reminova, its technology prepares damaged tooth enamel in such a way that the ions of minerals required to remineralise the tooth, such as calcium and phosphate, can be pushed to the deepest parts of lesions faster. This remineralisation process is stimulated by short electronic pulses emitted by a specially developed instrument, which is estimated to cost less than £10,000 once it enters the market.

"With our treatment you can top-up your natural teeth enamel whenever you need, just as you'd service your car when it needs a bit of loving care," Wright said.

Reminova claims to currently hold or to have applied for 17 patents for the technology, which was first presented to the public in 2014. A King's College London (KCL) spin-out, the company is based in Perth in Scotland and managed by tooth decay experts, including KCL Professor Professor Nigel Pitts and dentist Dr Chris Longbottom.

Ivoclar updates dentists about latest materials and treatment protocols

By DTI

Leicester, UK: For years, the International Centre for Dental Education from Ivoclar Vivadent has been offering dental education and training for dentists and dental technicians in the UK. At its anniversary celebration in June, over 200 came to Leicester to celebrate the Centre's achievements and update themselves on the latest materials and treatment protocols, such as the company's IPS e.max system.

Focusing on innovation in dental design, renown dental technician and Ivoclar Vivadent Global Opinion Leader Oliver Brix from Germany presented a series of case reports involving the materials and ranging from single tooth restorations to full mouth rehabilitations. State-of-the-art protocols and critical steps to ensure long-term success were also presented by Dr Markus Lenhard from Switzerland.

Leading UK experts such as Chris McConnell, Rob Lynock, Alan Casson and Carl Fenwick, further provided live demonstrations to illustrate the revolutions that are taking place in composite dentistry with advanced products, such as the light-curing lab composite SR Nexco Paste, IPS e.max frameworks with the fully automated injection-mould-ing device Ivobase and the Tetric EvoCeram Bulk Fill system.

In addition to legal, ethical and practical issues surrounding the selection of patients for implants and the placement and management of the peri-implant site presented by dental hygienist Donna Shembri from Huddersfield. Oldham dental technician and Ivoclar Vivadent Opinion Leader John Wibberley addressed the aesthetic and functional needs of the patient when creating restorations, while he explored the principals and materials used in the customising of denture teeth, gingival contouring and gingival staining.

Following this, dental technician Phillip Reddington from Leeds further educated delegates on 'high-performance polymers' which are considered as a replacement for materials such as metal and zirconia in framework fabrication and are increasingly used to manufacture hybrid composite/ceramic restorations.

Since 2011, the ICDE has been offering education for dentists in its Leicester premises. Based close to the M1, the facility provides state-of-the-art dental surgery for live demonstrations and a fully equipped lecture theatre that can hold up to 40 participants. A full list of courses and seminars is available at the centre's website.

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