Member Newsletter

bsspd

The digital revolution in Prosthodontics

BSSPD Conference London 2017

6th & 7th April
155 Bishopsgate
London

The British Society of Prosthodontics Newsletter, Volume 22, February 2017

President's Editorial

Michael Fenlon

It is my privilege to welcome you to the first Newsletter of the British Society of Prosthodontics of 2017. Your Society has been very active over the last few months.

The PanDental Society Conference, held on 11th and 12th November in Birmingham, was a great success. The PanDental Society Conference is a triennial joint meeting involving the British Society of Prosthodontics, the British Society for Periodontology, the British Endodontic Society and the British Society for Restorative Dentistry. The four Societies jointly organise the Conference. This year the Societies ran parallel specialty specific sessions on Friday 11th in conjunction with 3D presentations of complex clinical procedures on Saturday 12th. The Conference Dinner on the Friday night was well attended. The British Society of Prosthodontics made an impressive contribution, and delegates enjoyed an excellent conference.

The 2016 - 2017 British Society of Prosthodontics webinar series is well under way with regular webinars until the summer. The webinars attract up to a hundred participants for each presentation. Many of those are regular participants, however, other members have never partaken in any webinars. The webinars cover a range of Prosthodontic interests and are given by experienced Prosthodontists and other specialists with particular expertise in their respective fields. Webinars are free to members and signing up to webinars on the Society website is easy. A library of previous webinars is available to members on the Society website so you can access webinars that you may have missed. For our regular webinar participants please keep up the good work and spread the news to other members. For members who have never been involved in a Society webinar, I highly recommend them to you. Try signing up to a webinar of interest to you. You will not be disappointed.

The highlight of the British Society of Prosthodontics year is the Annual Scientific Conference which will be held in London on Thursday 6th and Friday 7th April 2017. The theme of the conference is the digital revolution in Prosthodontics. We all have seen the beginning of the digital revolution in Dental Technology and the effect it has had on Dental Technicians. Many restorations are now milled, printed or sintered with dramatic consequences on price, quality and turnaround time. In time all models, articulators and impressions will be digital, with digital design and manufacture ushering in the end of the traditional dental laboratory. The consequences of the digital revolution on clinical practice of Prosthodontics will be even more dramatic. Digital scanning technology is replacing impression materials, inter-occlusal registration techniques and shade capture. A sound understanding of the capabilities

and limitations of these new clinical technologies is essential for the digital Prosthodontist. For example, when making an impression of a crown preparation, it can be problematic to be sure that the margins of the impression are adequate. Digital scanning offers a a full screen, high definition, three dimensional representation of the crown with every detail, including bur marks, steps on margins and other imperfections on display. While this is a great help in refining preparations, the final digital impression becomes part of the patient digital record, and should there be a problem of a medico-legal nature involving the crown, the high definition 3D image of the crown preparation will be available for the plaintiff's barrister to comment on.

On the first day of our Conference we have three important speakers on digital Dentistry. Professor Petra Gierthmuhlen, from the University of Dusseldorf, will speak about the use of digital technology on the clinical management of complex Prosthodontic rehabilitation for patients. Dr Rupert Austin of Kings College London will give a British perspective with his presentation on digital Prosthodontics. Dr Andrew Keeling of the University of Leeds will bring his expertise to bear on the subject of accuracy in digital Prosthodontics. For anyone who is planning to be a clinically active Prosthodontist or general Dentist in ten years' time, attendance at these presentations is highly recommended, if not essential. Most of our hard clinical skills in Prosthodontics are about to become obsolete and we cannot afford to be left behind.

Many of the clinical techniques we all learned as undergraduates are already obsolete. The area of Minimally Invasive Dentistry (MID) will revolutionise the treatment of dental caries over the next decade, hopefully stopping the restorative (tooth destruction) cycle. Professor Avi Banerjee from Kings College London will share his expertise with us on the merits of MID.

While dental caries is a waning disease, tooth surface loss is a multifactorial disease, and with patients retaining their teeth into old age, it is becoming an increasing challenge for Prosthodontists. We have a world class expert speaking to our Conference on tooth surface loss, its aetiology and its management, in Professor David Bartlett of Kings College London.

Dr Subir Banerji will demonstrate techniques for producing long lasting composite restorations in the aesthetic zone.

Gastro-Oesophageal Reflux Disease (GORD) is widely recognised by dentists to cause erosive tooth surface loss. What is less well known is that GORD also presents a high risk for patients developing carcinoma of the oesophagus, larynx, pharynx and base of tongue. Dr Rebecca Moazzez is a researcher of international stature from Kings College London on GORD and its consequences. She will demonstrate how the dentist may be the first person to diagnose GORD because of the oral manifestations, and with appropriate interventions may save patients from the long-term risk of these unpleasant cancers.

Quality of life will be explored in relation to treatment of head & neck cancers by Professor Simon Rogers of Edge Hill University. Additionally, Professor Tim Newton will explore the influence of Prosthodontic interventions on patients' quality of life.

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Dental educational material tends to be written, still photograph or video material. These formats are essentially two dimensional. Prosthodontics requires complex three dimensional learning, spatial awareness and understanding. Professor Charles Goodacre of Loma Linda University is an international authority on the use of three-dimensional teaching and learning materials. His presentation will be of exceptional value for clinical teachers, both of undergraduate and postgraduate students, and for mentors and tutors of specialist trainees.

The conference venue, 155 Bishopsgate, next to Liverpool Street, is a modern conference centre allowing parallel presentations. This permits the Society to provide a tailored programme for Foundation Dentists, parallel competition presentations and free presentations. The Conference dinner will be held at the Institute of Engineering and Technology on the river Thames with iconic views of the London Eye and the Houses of Parliament. It is a short walk from the conference centre. Preferential rates for accommodation in a range of reasonably price and more luxurious hotels near the venue have been arranged. London is one of the great cities of the world with its museums, galleries, theatres and historic landmarks, it is well worth a visit. London has excellent transport links with every part of the United Kingdom and beyond.

I look forward to seeing all of you at the London 2017 Conference.

Michael Fenlon

BSSPD Prize Winners 2016

Danny Watts and Mark Howe

In-Practice Award: Mark Howe

In-Practice Award for "A Restorative Dental Risk Index – The use of evidence based heuristics in clinical risk assessment/ communication".

As dentistry and patient expectations become more complex the profession needs a simple and accurate way to assess clinical risk and communicate that outcome clearly to our patients. The current indices are very complex for use in general practice and may be too subjective to be useful in presenting complex information to patients. I propose to investigate whether an evidence-based numerical approach would be: Simple to use, Reproducible between operators irrespective of experience and Helpful in objectively communicating with patients, to improve valid consent.

The aim of the study is to determine the utility and feasibility of use of a new index of restorative risk. An index, based on long term international restorative survival studies that are translated into a simple algorithm will be used to create a 'forcing-strategy' to reduce operator bias and create an audit trail to assess initial dental health prognosis and future treatment options. To test the hypothesis there needs to be series of well-powered non-clinical trials utilising a range of moderately complex, anonymised restorative case presentations (synopsis histories, relevant charts, intra-oral images and study casts). However the initial stage is to pilot the index and refine it. In this in pilot study, three groups will be tested: restorative consultants, experienced general practitioners and final year dental students.

Participants will initially assess the cases, devise and record a prognosis using their usual system manner. The index method will then be presented and the same cases assessed again using the scoring system.

With assistance of statistical support, the results can then be compared and contrasted between these groups and feedback invited from the candidates relating to ease of use and applicability to a busy clinical environment. The intention is to disseminate the results in a peer reviewed dental journal.

If this pilot study into feasilibilty and utility is successful then appropriate ethical committee approval will be sought to apply the index to the clinical situation, to determine if the objective scoring system improves patient understanding of the prognosis for their dentition compared to the clinicians' usual form of communication.

Heraeus-Kulzer Prize: Danny Watts

I won the BSSPD's Heraeus-Kulzer prize 2016 for a paper entitled "The factors affecting the decision to support fixed partial dentures (FPD) with teeth and/or implants". The paper evaluated the evidence base available surrounding these factors, which included the differing survival rates of FPD designs, the differing risk of complications, the length and location of the span, condition of abutment teeth, occlusal considerations, time considerations and the ability to place implants. Although in reality these factors will combine and interact to present unique clinical situations, an understanding of the evidence supporting each factor is vital for clinicians to effectively evaluate the situation at hand and, with the patient's valid consent,

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News Bites

Jennifer Jalili, Editor

New webinar series

We are pleased to announce that our new series of 7 live webinars for 2016/2017 are now available to book and remain free of charge for BSSPD members (£10 per webinar for non-members). Sessions include:

- Wear necessities: an update on tooth surface loss (James Field)
- Prosthodontics-orthodontic interface (Stephen Brindley)
- How an understanding of dental adhesives and tooth heterogeneity can enable restoration of missing tooth structure with direct composite resin (Richard Foxton)
- Restorative Management of Cleft Patients (Poonam Kalsi)

For futher information and booking on these webinars please visit our website.

Roy Storer

Our longest standing member Roy Storer sadly passed away on 11th November. He had been suffering from vascular dementia. He joined the society in 1954 and was president in 1968. Our condolences go to his family.

Help needed

Mark Howe has started a MSc at the Centre for Evidence-based Medicine, University of Oxford. One of his research areas is in restorative longevity. Mark received the BSSPD In-Practice Award last year but is having difficulty finding someone to help / collaborate on his project. If you feel that you can contribute to his progress, please get in touch directly.

Are your details correct?

Please ensure that you let Kirstin know (admin@bsspd.org) if any of your contact details change. Login to our website to check your email address is correct as most of our member communication is via email. Also check you postal address so that you receive your journals, newsletters, etc.

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undertake the treatment option that is in the patient's best interests. I was both surprised and thrilled to be awarded the BSSPD's Heraeus-Kulzer prize. Alongside the prestige of winning a national award from one of the longest-serving specialist dental societies in the UK, it helps to set your CV apart from the crowd as well as provide networking opportunities. Furthermore, in the process of writing the paper, I discovered a passion for restorative dentistry and found that my clinical knowledge surrounding implants and bridges greatly developed. For this reason alone, I would definitely recommended any dental student to enter the competition; winning it would simply be an added bonus!

New equipment grant

Mrs Meena Ranka, Royal Preston Hospital

It's all smiles in dentistry at RPH thanks to Rosemere

The restorative dental team at Royal Preston Hospital is all smiles after receiving a £20,000 grant from Rosemere Cancer Foundation to spend on new equipment to help them treat patients diagnosed with mouth cancers.

Patients undergoing surgery and/or radiotherapy and chemotherapy for mouth cancers often require care from the hospital's restorative dental team before, during and after their treatment as the disease and radiotherapy can alter the mouth's anatomy and affect speech, swallowing and chewing. Radiotherapy treatment can also cause a dry mouth and patients are sometimes advised to have teeth extracted before radiotherapy to prevent post treatment complications.

All smiles among the RPH's restorative dentistry team with Consultant in Restorative Dentistry Mrs Meena Ranka (front, far right) giving the thumbs up to its Rosemere award for new equipment.

Mrs Meena Ranka, Consultant in Restorative Dentistry at the Royal Preston Hospital, which treats not only local patients but also those from throughout the whole of Lancashire and South Cumbria as the region's specialist restorative dental centre, said: "Understandably, oral cancer has a major impact on patients' quality of life. It is most common in the 50 to 74 years age group. Approximately 60-70% of these patients need dental treatment prior to their oncology treatment. Owing to improving survival rates and the ageing population, we will see many more patients in the future.

"Our aim is to try our best to ensure treatment provides patients with a pleasant experience, good outcomes and improvement in their quality of life. The new equipment for implantology and endodontics that we are now able to buy will help us do this."

Rosemere Cancer Foundation spends the donations it receives on important equipment like this, research and training that cannot be funded by the NHS.

The charity strives to bring world class cancer treatments and services to local cancer patients throughout Lancashire and South Cumbria via their local hospitals and the region's three specialist treatment centres. These specialist centres are the Rosemere Cancer Centre at the Royal Preston Hospital, which provides all local radiotherapy treatment, Blackpool Victoria Hospital for blood cancers and the Royal Blackburn for liver cancers.

It also funds those things that can make the cancer journey a little more comfortable such as free access to complementary therapies for all newly diagnosed patients. For further information, visit its website at www.rosemere.org.uk

Impression tips in implant dentistry

Nigel Rosenbaum

Restoration of missing teeth is now routinely undertaken with implant based restorations. Advances in technology has provided clinicians with a plethora of restorative options, which has broadened the treatment planning choices, and expanded the solutions available. This has impacted in both the options available to restore a particular dental situation (in terms of planning how many implants and where they need to be) as well as the options available to restore a particular implant situation.

A common solution for the edentulous patient is often an overdenture, and this will involve technicians fabricating prostheses, which will need some connection to the implant abutments/superstructure. This is frequently connected in the mouth, often using a chemically cured acrylic resin at room temperature.

Implant based restorative solutions other than over dentures will require the fabrication of a model, with replicas of the implants embedded in them. In order to create such a model the clinician must either take a conventional implant impression, or a digital file is created by scanning.

The purpose of this article is to provide the reader with a few tips for acquiring the most accurate conventional impressions, with few retakes. The impression needs to transfer the critical parameters of the implants, and their spatial relationship to each other and the surrounding dental structures. The transfer of these parameters needs to be accurate and includes the precise orientation (rotational) as well as 3 dimensional positioning, through a process of impression taking. The reader is encouraged to read the BDJ paper for a broad introduction (Bhakta, Vere et al. 2011). The impression is typically achieved using a pick up technique (closed tray) or transfer coping (open tray) both requiring a transfer component being attached to the implant. Frequently this item is metal, often titanium, or a disposable plastic component, which is connected to the implant itself (implant level or fixture head), or to an abutment (abutment level). The transfer component itself must be highly dimensionally accurate, in that there needs to be minimal 'play' with the connection.

The key requirements from the impression are to pick up the transfer component in an accurate and stable manner, to enable precise transfer to the model stage (Lee, So et al. 2008) (Wostmann, Rehmann et al. 2008). Implant restorations demand a high level of accuracy, there being little latitude in the system. This is the most common area for errors, which frequently, relate to failure of accurate component connection, leading to delay, frustration and expense. Having spent 15 years guiding dentists through the prosthetic phases of implant dentistry I reveal my top 10 tips for effective impression taking.

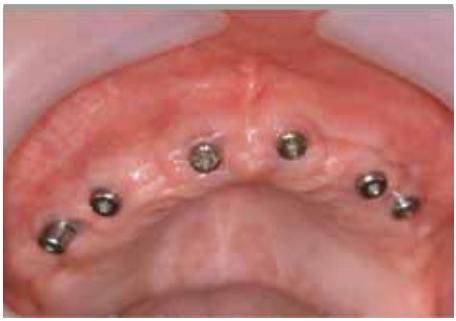

Image 1: Primary impression required over healing abutments to fabricate custom tray

Top Tip 1

Spend the time when taking the impression, making sure that necessary components and screwdriver(s) are to hand before you start. Seating the component may not be easy, and if the connection is sub gingival local anaesthesia may be necessary. Seat the component then tighten by hand. Confirmation that the component is seated is required; slightly unscrew (1/2 turn) the component whilst watching the body of the transfer component. The body of the component should not rotate, when the screw is loosened, movement of the coping suggests the component is not engaged, and this must be corrected prior to impressions taking. Ensure that the screw is retightened. Assuming that the transfer has finite rotational symmetry, the coping will typically engage the implant connection in one of a small number of orientations, as a consequence of it being 'indexed'. Implant connections that transfer no rotational information do not suffer with this issue, but cannot be used to restore single implant crowns. Uncertainty at this stage needs to be addressed, if in doubt take a radiograph.

Top Tip 2

Use a custom tray wherever feasible. The accuracy of the process will increase. It should be significantly easier to seat a custom tray, as this will have been fabricated to deal with any copings which project beyond the contours of a stock tray, which are after all, only made to fit around teeth. Custom made impression trays are of particular benefit when restoring multiple implants, where an open tray technique is recommended. The frequently suggested tip of connecting components together with floss appears to lack sufficient beneficial evidence (Baig 2014). See image 1.

Image 2: Impression material syringed onto teeth, mucosa and around copings

Top Tip 3

When using a stock tray there are a number of options, but in general terms a rigid tray is required. The use of metal trays is well documented in 'crown and bridge' impression taking, but has an obvious limitation in implant dentistry. The requirement for an opening in a metal tray has been addressed by the use of removable apertures, however these typically only remove directly above the crest/occlusal surface, which may not allow sufficient latitude where the implant axis is orientated to the buccal. The amount of angulation these trays can cope with is quite limited, however the length of the impression coping will exacerbate any angulation, limiting the use of these trays. The orthodontic trays we use have proven to be sufficiently rigid and readily adaptable for use with an open tray technique.

Top Tip 4

The impression material needs to pick up the contours of the mucosa, and any remaining teeth as well as firmly secure

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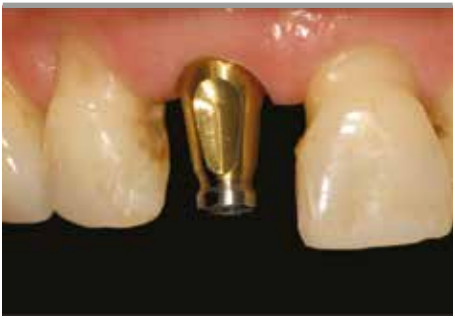

Image 3: Closed tray impression coping - place wax into screw head.

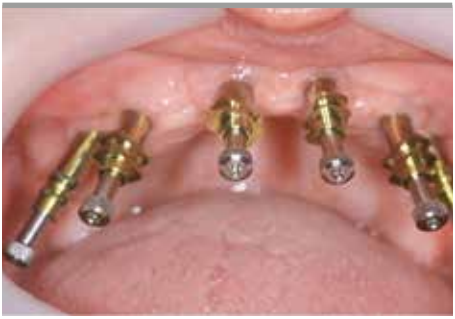

Image 4: Open tray impression copings

the transfer component. This is often in a challenging environment, with muscle tension, retching, general jaw movement, the tongue and a copious volume of saliva all competing to ruin your best efforts. Relax the patient, explain the process, including the time aspect as this can be a while. Supine or upright, as per patient wishes. Get the patient to wiggle their toes, anything to distract from the focus of keeping their mouth still. Dry the components, and at least occlusal surfaces of any remaining teeth, just before the impression material is syringed onto the surfaces. Keep syringe tip within body of impression material to help reduce air inclusions. Don't forget to block out difficult areas, such as pontics. See image 2.

Top Tip 5

When talking a closed tray impression place a smear of wax into the screw head of the impression coping screw. The purpose off this is to prevent the forming a pimple of impression material, which may hinder reseating of the impression coping. See image 3.

Top Tip 6

When taking open tray impressions there needs to be a barrier to prevent impression material leaking out of the aperture where the impression coping exits. Wax has historically been used for this purpose being readily available, simple and cheap. There have been a few alternatives, such as the Miratray Implant (Hager Werken, Duisburg, Germany) which comprises a plastic stock tray with a film barrier over the whole 'occlusal' surface. These have worked well, and we continue to use them occasionally. See images 4 and 5.

Recently we have replaced wax with a cheap simple solution, which avoids the health and safety pitfalls that a naked flame attracts, and is quicker than attempting to melt wax with 'safe' hot air devices, where the emphasis appears to be safe rather than hot. The solution we advocate is to create apertures for impression copings as normal, check the tray in the mouth, to ensure that the impression copings can be positioned though the holes, with sufficient depth to stabilise the component in the material. The holes are then sealed with Micropore surgical tape (3M). This is a readily available paper tape, which has sufficient resistance to keep impression material within the tray, yet has the appropriate 'tearability' to allow the impression coping to perforate the tape sufficiently. Simple, cheap, and much quicker than the alternatives. See image 6.

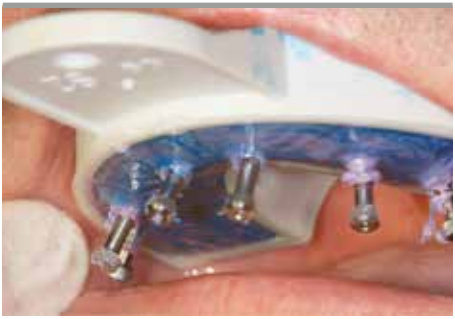

Image 5: Miratray Implant, 'open' tray impression

Image 6: Custom tray with apertures for impression copings; sealed with Micropore tape

Top Tip 7

Use a smear of lubricant over the skin. Vaseline or KY jelly, on a gauze, to prevent impression material sticking to face. Particularly beneficial when using polyether impression material, which have an amazing ability to stick firmly to beards and woolly jumpers.

Top Tip 8

Use the appropriate adhesive for the tray and impression material. Spread thinly and evenly, including 5mm over border and allow to dry. This could be accomplished with your now otherwise redundant hot air device.

Top Tip 9

Look after impression properly. Disinfect correctly. Reseat impression coping if you wish, but remember the technician will need to remove it, unless you have already attached an implant replica. Reseating the impression coping too many times risks damaging the accuracy of the model. Package well, with clear instructions for technical aspects in a polythene bag within impression package. Preferably hand directly to dental laboratory, or post using a tracked service such as special delivery.

Top Tip 10

Whilst there is a large choice of impression materials, there are some tips for getting the best impressions. In practice we use a monophase polyether material (Impregum, 3M ESPE), mixed using the Pentamix Automatic mixing unit. This unit guarantees an homogeneous mix, without air inclusions and a reproducible setting time. We time every impression.

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A Retreat from 'the Front Line'

One clinician's journey by Bryan Murchie

When I first qualified from University as an undergraduate, all I could foresee was an apparently care free and uncomplicated life stretching ahead of me on a clearly defined course.

While fully prepared to work hard and become a trusted professional, I still felt that I would eventually settle into a safe and comfortable routine. A 9am till 5pm career, working five days per week and the prospect of the occasional on-call rota shifts, which did not overly concern me. My patients would be a happy bunch of people and would mostly be pleased and grateful that I could help relieve their suffering, with the occasional thank you card for my hard efforts. The most important thing was that I had achieved my dream and graduated. The honorary title of 'Doctor' (Dr) was mine and I could finally set sail into the smooth, uncharted world of general dentistry. Interestingly, at this particular point in my life, the only form of experience I had gained, with respect to the general dental practitioner (GDP), were short and infrequent visits to observe their daily routine practice in my fifth (and final) year. Myths and hearsay must have also been a prevailing factor that was protecting my idyllic dream, because when I look back in quiet horror of how naïve I was, it is obvious that I lacked any real insight into this new and challenging world. I am sure many can relate to the late nights in the library studying and desperate attempts to obtain the suitable number of patient cases to qualify, therefore, what would come after graduation day was at the furthest recesses of my mind.

'A Stormy Night' oil on canvas reproduced with kind permission from the artist Eve Whittle. This painting reminded the author of the difficult decisions that may lie ahead during one's career and with life in general, but a bright future will always lie ahead.

During the first post-graduate year, I began my one year vocational training programme; of course there is the alternative option of the two year training scheme which intertwines hospital with general practice. Throughout this time I encountered strange, if not, uncharted lands. I felt that the practice setting was much more hands-on deck and pressured compared to the relatively relaxed demeanour of secondary care that I was used to. However, I was undeterred, my faith did not falter and I kept steadfast to my compass which was set for the final destination of 'fully qualified GDP'.

The training year passed without concern, it was a well organised programme and I was adequately supervised with a good support network. The transitional phase from hospital to practice was now finished and I felt ready to take on the new challenges ahead. The only problem now was that there was no longer any back up and I was the captain of this ship. Almost as if with immediate effect the dynamics of my situation dramatically changed. The trainer no longer came in to the surgery to check my work, see I was surviving ok or even to bring me the occasional cup of coffee. I was now an official member of the GDP club and

it felt both exciting, but a little daunting in the same instance.

The first wake up call to my new found situation came to light when a fixed-fixed bridge prosthesis, which I had recently fitted, did not entirely meet the patient's very high expectations. The senior GDP came in and very briefly looked at the case, but no longer gave the advice and guidance I had come to naturally expect. This sparked a new dilemma, if I did not know the answer then there was no one wanting, nor willing, to take on board a case filled with potentially hazardous consequences. This was not a teaching hospital, it was a job and the next two patients were sitting eagerly in the waiting room. I had arrived at my destination; however, the island was not as big or fruitful as it had appeared from a distance and I had definitely overlooked the nearby medico-legal locker bay with dangerously lethal rip tides concealed within the water and inhabited by litigious sharks.

Over the coming months and years I kept tirelessly pushing ahead with my original agenda. I assumed that things must improve if I was determined enough and continually gave it my best each and every day. Whilst general practice has many plus points and luxuries not afforded in other careers, for some unknown reason it did not suit my personality traits, despite what appeared to fulfil all my criteria on paper. When you take into consideration a normal 40 hour working week and that most people will be in their career for a minimum of 30 years, it is important to positively connect with that dominating aspect of your life. This overwhelming thought, among many others, were initially shrugged off as nonsense and a natural reaction to all the recent changes in my life. However, over time, the doubts grew and grew, which eventually evolved to a point where I could not ignore them any further. In these situations, a practitioner can opt for one of many different routes (see 'key points' table overleaf). Unbeknown to me at the time, I would eventually change my bearing and choose the option which would end up with me turning back to where I came from, namely the dental hospital.

I elected to do some research around this issue and I decided to embark on a part time (and hugely expensive) post-graduate programme. During this time I began to truly appreciate the value of knowledge, which I had underestimated in the earlier undergraduate years. I slowly took note of the obvious facts, which was when someone else imparts their wisdom, it is a blue print crafted from an accumulation of all the past mistakes made by themselves and others before them. All the relevant solutions are then presented in an easily understood manner, which can be used to successfully negotiate the rough tides ahead and avoid the pearls of the deep. If you take notice and appreciate the value of experience! This knowledge had a huge impact on me as a clinician and I knew then that something greater was happening at this moment, which went far beyond what I had initially anticipated. I now had a new set of coordinates and a reinvigorated mind-set, which I would follow even if it meant reaching the edge of the flat world.

This made sense to me; so much so that once I had graduated with distinction I did not have the passion to go back to my old routine in general practice. The box of Pandora was opened and life could not continue as it had before. On one side, I had the easy life I always thought I wanted along with money and a predictable routine,

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Key point

Dental Career Options Within and Outside of General Practice

If one finds themselves contemplating life outside of dentistry in general practice, or simply want a change to their daily routine, then they are faced with the following options (please note that these have not been listed in any particular order):

- Full time post in secondary and/or tertiary dental care – all specialties are a minimum of 3 years via StR training posts, this includes the 13 specialties; Paediatric dentistry, Dental Public health, Restorative dentistry, Prosthodontics, Orthodontics, Periodontics, Endodontics, Oral Surgery, Oral medicine, Special care dentistry, Oral microbiology, Oral and maxillofacial radiologyand Oral and maxillofacial pathology

- Part time role in secondary care, such as visiting GDP teaching undergraduates.

- Privately funded specialty training. This includes an MSc or MClinDent course which covers a wide range of dental specialties. However, they are more limited and do not include oral medicine, oral microbiology, oral and maxillofacial pathology/radiology or special care dentistry. Consideration must also be given to funding, where courses generally last 2-3 years.

- Change in career – This may include training to become oral and maxillofacial surgeon (OMFS) which is considered a medical specialty. One may even decide that they wish to follow a career pathway in medicine instead. Another alternative is to contemplate a career entirely unrelated to dentistry or recognised by the GDC.

- Consider the business aspects of general dentistry, for example buying and maintaining a practice(s).

- Make changes within the general practice – it may be an option to consider focusing more on the clinical areas which excite you most. This may be complimented with a part time post-graduate training programme to further enhance your skills and learning.

It is important to reflect on the advantages and disadvantages of each, such as the associated costs, time factors and commitment levels required. It has to be practical and achievable without setting yourself up for failure. Remember that no one career pathway has any value over the others, it is a personal decision.

but this was tainted with many risks and uncertainties. Whereas, on the other hand there was the huge gamble of moving city (or even country), the much reduced salary and potentially losing status and control of my clinical environment. Furthermore, I was slightly older now and considered whether this would play a role in the psychological game, where I could be the oldest one surrounded by much younger trainees.

I decided it was worth the risk and I was very fortunate to be accepted for a hospital post of my choice. Gathering together with my newly acquired wisdom and understanding of the world I ran at this opportunity with both arms wide open. Within a few months of the new training position, I sat in pensive thought after a long consultation clinic. It had been a long day, I had a large pile of letters to dictate

and all my patients had be challenging cases referred from the surrounding general practices. Only one thought ran through my head as I sat in the quiet of the night with only the vague sound of students in the background discussing their patient cases. I questioned why I had not done this sooner. It became clear, it all led back to my undergraduate days and the assumptions that I had wrongly made based on my own beliefs, not facts and experiences.

With hindsight, I should have considered all the aspects of dentistry from day one. It was my mistake, no one else's. I could try to point the finger, but it would be in vain and without any purpose or reason. I could take solace in the fact that I had found my calling in the end, with perhaps a much greater appreciation for the equipment, time and expertise that I had secretly craved all those years. They always said life was never a straight line from A to Z, but I never thought I would be one of the people to fall into that category because I had my 'perfect' plan. Like a child who thinks that they are invincible and has no concept of fear or the consequences of their actions. I too strode out of that dental hospital unaware of the impact my choices would have on my long-term career and happiness. Money and predictability are not for everyone, as unbelievable as that phrase may sound it is the truth.

In summary, there is precious little guidance out there for newly qualified dentists in terms of managing their expectations long-term in the general practice setting. I have presented this short story to you and if it helps even one person contemplate their life choices at an earlier stage in their life then this article has been worth it. The overall message I wish to convey is sometimes what sounds like an ideal plan and what works for the majority, is not necessary right for you. Be realistic, look at your character traits and what drives you to get up out of that warm bed every morning. If you strive to learn and teach with a desire to be a part of a bigger team then hospital may be your destiny too. Alternatively, if this is not the case then general practice may be your calling. Remember that either option is perfectly acceptable with there being no ideal career pathway. It is of the author's opinion that a young graduate should experience both clinical environments and make an informed decision.

Therefore, it may be wise to consider the two year training programme immediately after qualification. It is recommended to have a full appreciation for the role primary, secondary and tertiary care have in the NHS system, as one could not survive without the other.

Let's make one thing clear, general practitioners are the specialists of their field. However, not everyone can last under the constant fire which they endure on a daily basis and that is one of the reasons why I chose to retreat from primary care, or as I call it 'the front line'.

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Health Point foundation

Rosie Pritchett

Health Point foundation has 15 established outreach clinics providing essential dental treatment to tens of thousands of refugees in camps in Northern Greece. It is a grassroots, non-profit, volunteer relief organization providing medical and dental services to refugees regardless of religion, race and nationality.

I had initially booked flights for a couple of weeks lounging in the sun on a Greek island. However, after reading about the charity in the British Dental Journal I felt intrigued to gain first-hand experience of the current crisis. Thus I changed my plans to include volunteering for a week across

refugee camps based in the outskirts of Thessaloniki. On arriving at the airport I met up with another volunteer from Scotland, and after dropping luggage off at an AirBnB we headed to the base camp to meet the rest of the team.

The charity operates on a solely volunteer basis with dentists, translators and ground co-ordinators each donating various amounts of time. Whilst away I worked with three dentists from the UK, a ground co-ordinator from the USA, and two translators – one from Saudi Arabia and one from Syria.

After seeing a lot of 'The Jungle' in Calais on the news what first struck me was that although basic, the government run camps in Thessaloniki were tidy and well organised. This makes sense as many of the people I spoke to had been there for over a year and a large majority were families. Young, unattached refugees are more likely to find a means of moving on. Although living standards were acceptable, with sanitation, food and water available, there was a perceptible sense of frustration in the camps.

Most of the people I spoke to had left their homes, careers and lifestyle to spend days on end languishing in a tent with their life on hold. Refugees are unable to seek employment in Greece and the children weren't attending school. Most people have travelled to Greece via overcrowded boats, arriving on the island of Lesvos. One man in

his twenties I spoke to was hoping to travel to Germany or stay with relatives in Holland. Some are seeking counterfeit passports as the official routes are too slow.

The 'professional' status of many of the refugees is reflected in the dental care needed. Most patients were regular attenders in their home countries with an unanticipated number seeking routine periodontal maintenance. We found that most shortages at the end of the day were with glass-ionomer cements rather than extraction forceps. This was much to the amusement of one of the oral surgeons who joined us and ended up doing some of their 'first drilling and filling in years'.

The breadth of oral hygiene was similar to any general practice life. Toothbrushes and toothpaste were available with some maintaining good levels of oral hygiene and others falling short. There were, of course, mouths with large numbers of unrestorable teeth. In particular I remember a young girl who would most likely be referred for full clearance of her deciduous teeth under general anaesthetic in the UK.

Health Point Foundation welcomes volunteers for as much, or as little, time you have to spare, or like me, fitting volunteering within a pre-planned holiday. They are in need of qualified dentists, dental nurses, Farsi and Arabic speakers. There is further information and a donations page on the website http://healthpointfoundation.org/projects/dental-point/ or alternatively contact dental@healthpointfoundation.org

Future BSSPD webinars...

Friday 24th February 2017
Wear necessities: an update on tooth surface loss

Friday 31st March 2017
How an understanding of dental adhesives and tooth heterogeneity can enable restoration of missing tooth structure with direct composite resin

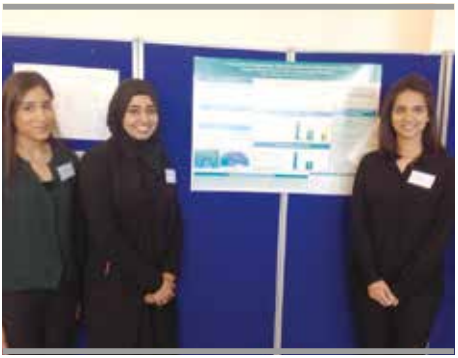
Thursday 27th April 2017
Restorative Management of Cleft Patients

Thursday 4th May 2017
Prosthodontics-orthodontic interface

Evidence-based dentistry project

Ayesha Ali

A group of 3 Foundation Dentists from London won a joint-1st prize for their Evidence-Based Dentistry project which was focused in the field of Fixed Prosthodontics.



The Clinical Audit titled "Is the Quality of Impressions Taken for Extracoronal Restorations Within General Dental Practice Of an Appropriate Standard?" was presented by Ayesha Ali, Humaa Kazim and Ayesha Mansha at the London North-East DFT scheme's annual Evidence-Based Project Day, organised by the Training Programme Director Sana Movahedi.

The entrants were required to carry out a clinical audit within general dental practice, make a scientific poster and then present the findings to a panel of judges which included Dr Peter Briggs, a Consultant in Restorative Dentistry and Specialist in Endodontics, Periodontics, Restorative Dentistry and Prosthodontics who is well respected for both his clinical work and his extensive contribution to dental research.

The audit was carried out across 3 general dental practices in East London over 6 months, with the aim being to assess if various factors such as different impression-taking techniques, different impression trays and different impression materials affected the quality of extra-coronal restorations. This audit, which focused on an original topic, enabled all of the North East Trainees to appreciate the fundamentals of impression-taking in a simple, understandable format.

The authors of the audit spoke of how the project has enabled them to improve their own clinical work, which in turn motivated them to create a Toolkit for their peers, a step-by-step guide on how best to achieve the desired results during impression-taking. As young dentists, the process has inspired them and shown them the importance of exploring audit and research in order to improve the knowledge and clinical care of both themselves and of others.

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