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# Laboratory

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**Spring 2026** / Volume 20 / No 2

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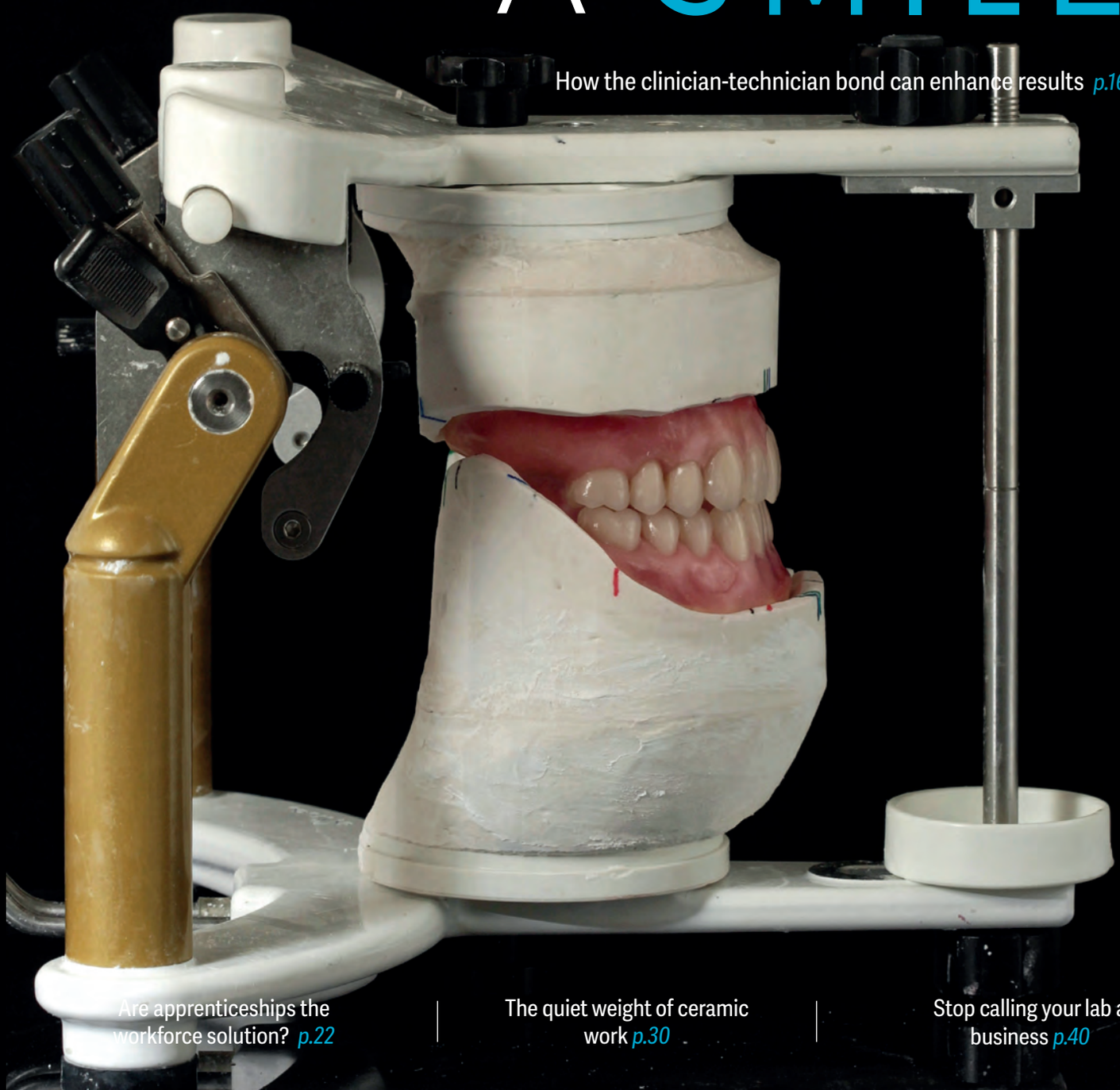

How the clinician-technician bond can enhance results *p.16*

Are apprenticeships the workforce solution? *p.22*

The quiet weight of ceramic work *p.30*

Stop calling your lab a business *p.40*

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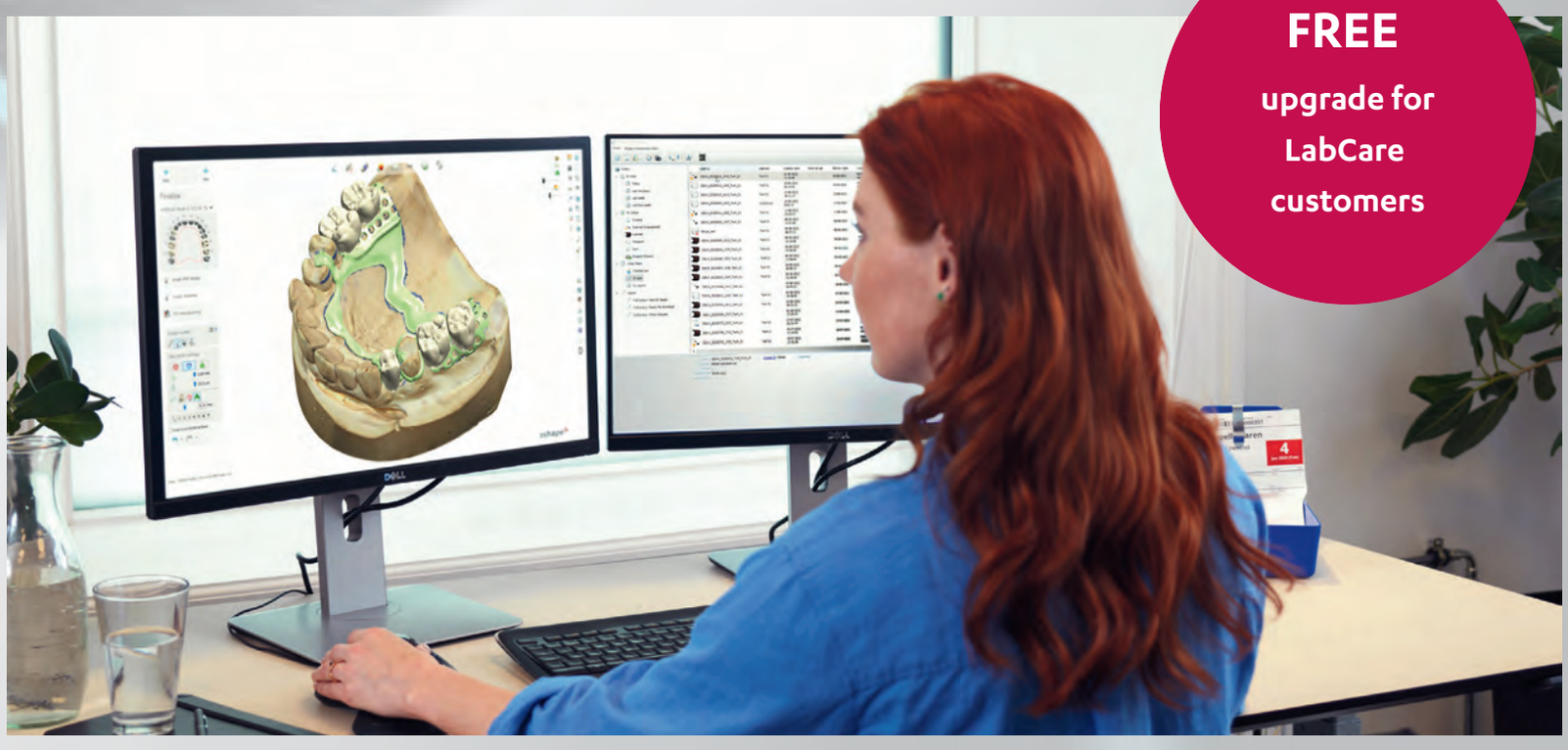

# Navigating the friction of progress

**MATT EVERATT**
Editor-in-chief

Spring always feels like a season of progress.

Longer days, renewed energy, and in dentistry, we are experiencing a continued acceleration towards digital workflows, new materials, and evolving ways of working.

On the surface, everything points forward. But progress isn't always as clean as it looks.

## THE DIGITAL CROSSROADS

This edition sits at an interesting crossroads.

On one hand, the digital evolution of our profession continues at pace, however technology is only ever as good as the process around it.

On the other, Nina Frketin explores something more fundamental, the relationship between dentist and technician. A relationship that, when it works well, is the invisible backbone of good clinical outcomes.

And when it doesn't, is often where things quietly unravel.

Andrea Johnson's contribution stopped me in my tracks. Her piece on how the UK increasingly relies on charity to fill the gap in basic dental and medical healthcare is uncomfortable reading, and deliberately so.

In a profession accelerating towards digital sophistication at one end, the reality at the other end of the spectrum is stark. It deserves our attention.

## THE PACE OF AUTOMATION

Outside of dentistry, I've spent time recently working closely with investors and innovators at the forefront of AI and digital platforms.

The pace of change in those conversations is genuinely startling. Tasks that would have taken entire teams months can now be done in seconds.

That kind of acceleration forces a different way of thinking, about value, about where human expertise really sits, and about what parts of a system should never be handed over to a machine.

For our profession, that question is becoming more urgent by the day.

## BRIDGING THE GAP

I'm particularly excited to share that the *Bridge the Gap* podcast is almost here.

Our launch episode, 'Where have all the technicians gone?' is coming very soon, and I think it's going to spark exactly the kind of conversation our profession needs to be having out loud.

This issue, as always, is a reflection of a profession that operates with precision, often without visibility.

The invisible professional, quietly holding together outcomes that patients and clinicians depend on every day.

Thank you to everyone who has contributed and to those continuing to push the profession forward, often without recognition, but never without impact.

**GET IN TOUCH**
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Laboratory

VOL 20 NO 2, SPRING 2026

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**MISSION STATEMENT**

*Laboratory* nurtures connection, passion and quality within the dental technician community by showcasing inspirational individuals, best practice and technical brilliance.



*Laboratory* is printed by Buxton Press.

Subscription enquiries and back issues –
Call 01923 851771
Email subscriptions@fmc.co.uk

Finlayson Media Communications,
Hertford House, Farm Close, Shenley,
Hertfordshire WD7 9AB


ISSN NUMBER: 2053-5465





# Are we seeing the price of progress?

I am delighted to share that I've stepped in to take over the reins of *Laboratory* magazine from Lucy for the time being.

It is an incredibly exciting time to be getting my 'teeth' into the laboratory sector, especially as the industry undergoes such rapid technological transformation.

From the brief time I've spent immersing myself in this world already, it's clear that the profession is home to a wealth of brilliant personalities and truly inspiring characters.

I'm looking forward to connecting with many of you and hearing your stories over the coming months as we continue to champion the vital work happening at the bench.

Switching tone slightly, it's obvious to me that the norm for dental laboratory owners is a relentless climb in overheads. Between global supply changes and the persistent volatility of the energy market, the financial pressure is only increasing.

Regardless of temporary truces or shifting headlines, energy prices are trending in only one direction – up.

For a sector as power-intensive as dental labs – where furnaces, milling machines and 3D printers often run around the clock – energy has transitioned from a background utility to an aggressive outgoing.

So, what does this mean for the UK lab community?

The laboratory has traditionally been the member of the dental team that absorbs every incremental price hike, quietly thinning its own margins to avoid rocking the boat. If dental labs want to continue to simply weather the storm by absorbing these costs, the storm will eventually win.

However, could this actually be an opportunity in disguise?

Looking forward, the labs that will thrive over the next decade aren't those hunkering down; they are the ones leaning into the value of their expertise.

This is the time to move away from the race to the bottom on price and start competing on premium service (see Jenna Ellis' article on page 30).

Competitive pricing, might catch the eye, but more and more dentists I speak to value partnerships and working relationships, as well as quality work.

There's an opportunity to repackage and offer a superior, predictable product at a price that reflects the reality.

Dental practices value consistency and technical excellence above all else. If you provide a service that saves them chairside time and yields better patient outcomes, they will pay for it.

Let's stop being the 'poor' relation and start showing off about how dental labs are the innovators!

**SEB EVANS**
Editor of *Laboratory*

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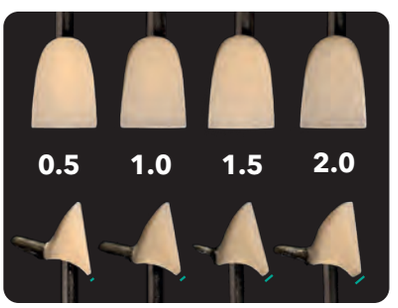


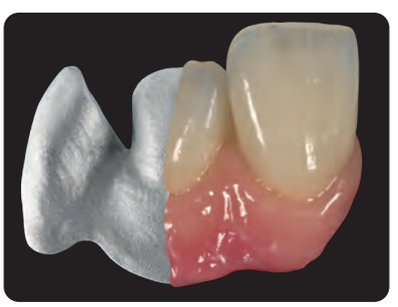

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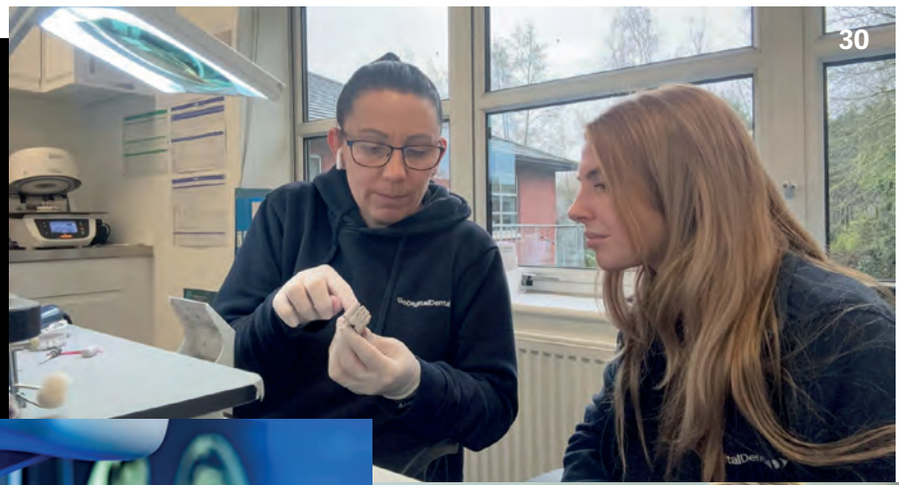


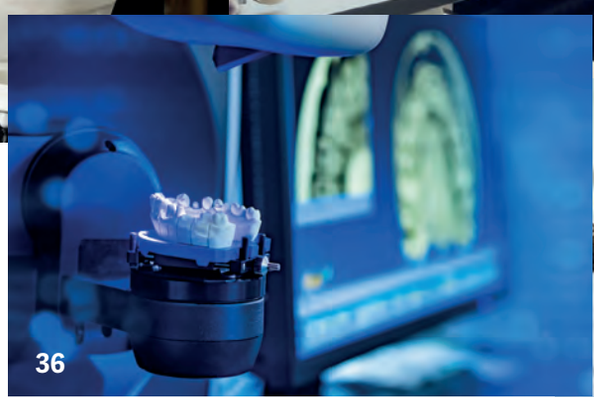



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# *Laboratory*'s Lab Experts panel

Presenting ***Laboratory*'s** editorial board – the Lab Experts helping to nurture connection, passion and quality within dental technology

**CRAIG MARK BROUGHTON**

**Clinical dental technician and managing director, CMB Dental Laboratory**

**ASHLEY BYRNE**

**Associate director, Byrnes Dental Laboratory, part of the Corus group**

**MATT EVERATT**

**Editor-in-chief, *Laboratory* and strategic technical consultant, S4S**

**NINA FRKETIN**

**Dental technician, Queensway Dental Laboratory**

**ANNA MUNRO**

**Dental technician, Southend University Hospital**

**ELEANOR PITTARD**

**Managing director and co-owner, Hive Dental Laboratory**

**EMILY PITTARD**

**Clinical dental technician, clinical director and co-owner, Hive Dental Laboratory**

**KASH QURESHI**

**Clinical dental technician and managing director, Bremadent Dental Laboratory**

**DANIEL SHAW**

**Maxillofacial prosthetist and laboratory manager, Chesterfield Royal Hospital**

**LOLA WELCH**

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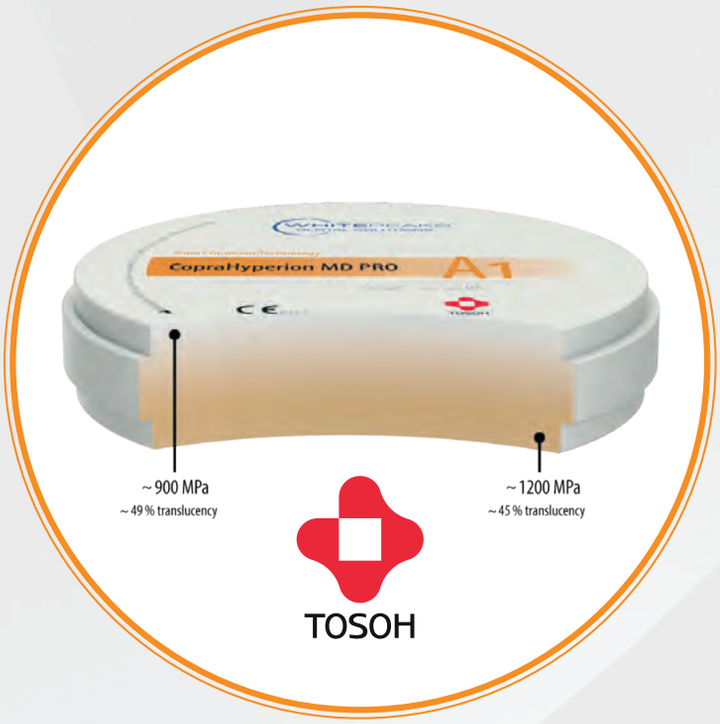


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# ORE overhaul could deliver 'five-fold' rise in overseas dentist

The General Dental Council (GDC) has announced a significant overhaul of the Overseas Registration Examination (ORE).

It promises to quintuple the number of internationally qualified dentists joining the UK register.

With new arrangements set to begin in September 2026, the regulator aims to expand capacity to 1,500 successful candidates annually once the system reaches full maturity.

## BREAKING THE BOTTLENECK

For years, the ORE has been a point of frustration amongst many dental practice owners.

Limited sittings left thousands of overseas-qualified clinicians in professional limbo.

The new contract with UCL Consultants (UCLC) marks a shift toward a 'consistent and predictable framework'.

The numbers are ambitious:

- Part 1 places will increase from 1,800 in 2025 to 2,400 per year
- Part 2 places will rise from 720 to 944 in the first year, hitting 1,500 by year three.

In 2024, only 354 dentists joined the register via this route.

If these projections hold, the GDC is attempting to industrialise a process that has historically been a trickle.

## THE WORKFORCE PIPELINE

With roughly a third of the UK register currently consisting of overseas-qualified dentists, international recruitment is no longer a temporary fix – it is a vital pillar of the workforce pipeline.

GDC chief executive, Tom Whiting, framed the move as part of a 'long-term plan' to support the wider dental workforce strategy.

However, while increased exam capacity is a welcome 'scale-up', the profession will watch closely to see if the quality of the assessment remains robust and if the clinical infrastructure exists to support this sudden influx of new registrants.

For practices struggling with recruitment, these figures offer a glimmer of hope.

# NHS contract clawback at £900 million in past two years

A BBC investigation has highlighted a £900 million of clawback because 'dentists instead prioritise private work'.

The BBC found that one pound in every seven that NHS dentists were paid over the past two years was returned as clawback, amounting to a total of £900 million.

It said that these findings 'explain why despite record sums being set aside for NHS dentistry, so many patients are struggling to get [a dental appointment]'.

Clawback levels peaked in 2024 at £479 million, reducing slightly to £457 million in 2025.

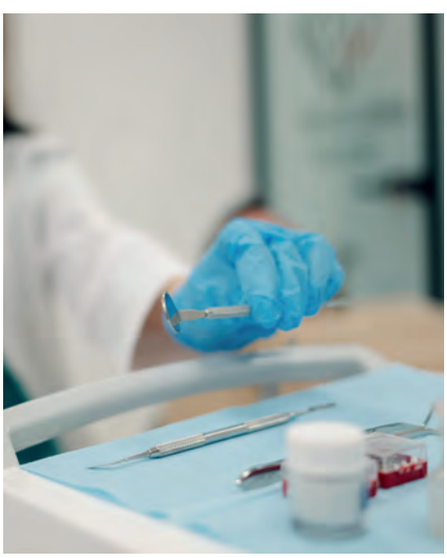
The levels remain much higher than previous levels, which stood at £169 million in 2021 and £139 million in 2020.

The British Dental Association (BDA) stressed that the returned budget was due to 'the broken contract dentists are working within'.

It said: 'These unused funds have long been the traditional excuse from successive governments for not funding NHS dentistry appropriately.

'This clawback is the result of chronic underfunding.

'Dentists are now losing money delivering NHS care, and unable to fill vacancies.'



# Funding increase for Northern Irish dentistry deemed 'insufficient'

While dental experts have acknowledged the 'significant efforts' of the health minister in securing a funding increase, they also stressed that 'this cannot be the end of the road'.

The health minister has confirmed an increased support fund from £1.6 million to £2 million for dental practitioners who continue to provide health service dental care in Northern Ireland.

This will be accompanied by funding to uplift some dental fees and continuation of the Enhanced Child Examination Scheme – which provides a one-off payment for seeing new patients aged 10 or younger.

In March, data released by the General Dental Council (GDC) revealed that dentists in Northern Ireland were delivering a lower proportion of health service dentistry compared to colleagues in the rest of the UK.

The findings also suggest that levels of health service provision are dropping fastest in the Northern Ireland region.

The British Dental Association (BDA) Northern Ireland said this lack of health service commitment was due to a 'fundamental mismatch between fees paid by the government, and the true cost of providing modern dental care'.

The association stressed that this funding gap is now 'entirely unviable', causing many practices to lose money through providing

health service care.

## 'NHS DENTISTRY IN NORTHERN IRELAND IS ON BORROWED TIME'

In addition to the pledged funding, the BDA called for fundamental reform of the dental payment system.

Ciara Gallagher, chair of the BDA Northern Ireland Dental Practice Committee (NIDPC), said: 'We're on the same page as the minister.

'He doesn't pretend these measures on their own will address all the challenges facing dentistry in Northern Ireland.

'Elements of this package are clearly hard-won but are insufficient to draw a line under the crisis we now face.

'Ultimately, this isn't a "stabilisation" plan if it can't bring struggling practices back from the brink.

'Our executive must now go further and faster and focus on the fundamentals.

'Dentists need to see a future in the NHS and know they won't lose money treating NHS patients.

'NHS dentistry in Northern Ireland is on borrowed time.

'We need to see more honesty, alongside real urgency and ambition if it's going to survive.'

# 'Absolutely shocking': Welsh contract rollout draws criticism

The Welsh NHS dental contract rollout has been lambasted by the BDA, with practice managers left scrambling for information on the morning it came into force.

The British Dental Association (BDA) said 'poor communication' meant that the new contract had come into force 'utterly untested'.

Individual practices in Wales reportedly did not receive final details of the changes from health boards until just days before they were due to work under the new contract.

An anonymous practice manager at a mixed practice in north Wales found this short notice 'absolutely shocking'.

She said: 'It's not the health board's issue – they didn't have any information to give us until the last minute.

'For previous changes we've always had posters displaying information for patients a month in advance.

'I'm still getting my head round everything this morning and the changes have already happened.'

The government is thought to be working on a patient information leaflet, though this is still yet to be published.

In particular, practices have struggled to understand the care package system and what level of treatment would change the price that patients have to pay.

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# Imitating natural aesthetics in partial prosthetics

Fabio Manazza and Federico Presicci present a mandibular partial restoration, demonstrating how pre-coloured zirconia and strategic gingival layering can overcome the aesthetic challenges of bone loss and recession


**FABIO MANAZZA**
Dental clinician

**FEDERICO PRESICCI**
Dental technician


A dentist commissioned the Dental Laboratory Antonio Lazetera (Italy) to manufacture a mandibular partial prosthesis on implants for a middle-aged patient suffering from gingival recession and bone loss due to periodontal disease.

The dentist had previously removed the compromised teeth LL2-LR3 placing two implants (Figure 1).

Due to the severe gingival recession, the restorative team opted for a reconstruction with white and pink aesthetics.

In this case, gingival reconstruction was crucial to create a natural effect and a healthier restoration, avoiding disproportionately long teeth.

Focusing on the dental-technical perspective, the main challenge of this case was to create a restoration that could integrate delicately in the patient's mouth by imitating the colour of residual dentition and tissues and by reproducing the exposed roots in the final restoration.

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**GDC anticipated outcome:** C

**CPD hours:** One

**Topic:** Complete dentures

**Educational aims and objectives:** To demonstrate the biofunctional prosthetic system.

This article qualifies for one hour of enhanced CPD. Turn to page 46 to answer the questions.

## DIGITAL DESIGN AND PROTOTYPING

The dental technician in charge of treatment, Federico Presicci, designed a prototype using the Zirkonzahn.modifier design software.

The software features new set-up concepts and extensive individual design options, and includes several modules dedicated to model production, mock-ups, bite splints and full dentures (Figure 2).

After designing the prototype, the gingival part was added to the tooth set-up.

The design was imported into the Zirkonzahn.modellier software to be finalised and milled using Temp Basic resin (Figures 3-7).

Through the prototype, the dentist ran all functional and aesthetic aspects intraorally, paying special attention to the tissue area (Figures 8-9).

After the dentist's approval, the final zirconia restoration was produced using the same set-up used for the prototype, since no changes had to be applied (Figures 10-12).

Using the Model Maker module included in Zirkonzahn.modellier, models were also designed then printed with the P4000 System for 3D printing.

The system comes as a pre-configured package composed of printer, post-curing lamp, resin and software.

Thanks to the pre-set parameters, it ensures a uniform and smooth workflow.

## MATERIAL SELECTION

Prettau 2 Dispersive zirconia (A2) was selected as the restorative material.

This zirconia combines a high flexural strength with a natural colour gradient, making it particularly suitable for monolithic designs.

'Prettau 2 Dispersive allows me to concentrate more on individual characterisation, with the certainty that I am working on a predictable and reliable colour base given by the zirconia', says Federico Presicci.

'This material also shows high translucency values, which help me to recreate a more natural-looking incisal effect, which I usually intensify with colouring liquids for a more individual result.'

## REFINEMENT AND CHARACTERISATION

After milling, the zirconia restoration was reduced in the gingival area for subsequent layering with ceramics.

The teeth were kept monolithic and slightly refined to create a more natural texture (Figures 13 and 14).

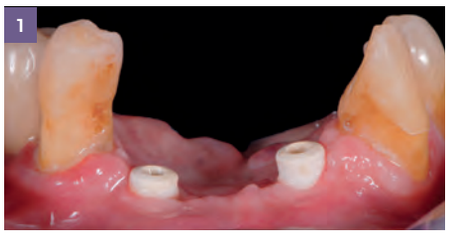



**FIGURE 1:** Initial situation. The patient suffered from gingival recession and bone loss due to periodontal disease. The dentist removed the compromised teeth LL2-LR3 and placed two implants


**FIGURE 2:** Creation of the restoration set-up in Zirkonzahn.modifier

Tooth characterisation was performed using Zirkonzahn's Colour Liquids (Figures 15-17).

The colouring step was carried out with special attention, in order to simulate as naturally as possible the shade of residual dentition.

'The greatest challenge was the characterisation of the zirconia canine, which I had to copy and recreate with high precision to mirror the residual tooth' says the dental technician.

The reference shade guide used was Ivoclar Vivodent PE, since it contains special shades that were noticed in this patient case. In particular:

- The canine showed the 4C colour of the shade guide, which was reproduced by mixing 50% of Colour Liquid A4 with 50% of Colour Liquid C4
- The colour of the four incisors was slightly clearer, it corresponded to the 1C shade of the Ivoclar Vivodent PE guide and to the A3 of the VITA shade guide.

## SINTERING AND FINAL LAYERING

After the application of Colour Liquids, the restoration was sintered in the Zirkonofen Turbo (Figures 18-21).

The sintered restoration was then placed on the milled model to start characterisation with ICE Stains 3D by Enrico Steger (Figures 22 and 23).

The following colours were used: a mixture of Base A, orange and brown to reproduce the roots colour, blue and violet to imitate the natural enamel in the incisal part.
The manual work continued with the application of ceramics in the gingival area (Figures 24-29).

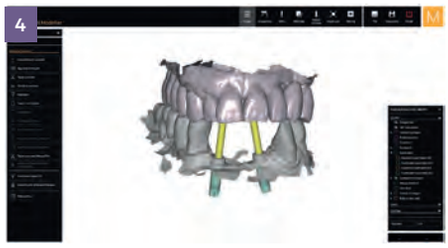
## CONCLUSION

The final result (Figures 30-31) appeared well integrated in the patient's mouth and the dental technician, dentist and patient were totally satisfied.

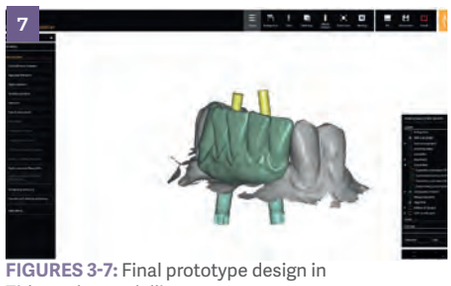
Tissues and teeth perfectly mirrored natural residual dentition.

The imitation of natural root exposure through reproduction of the root shade helped to recreate a very natural and patient-specific restoration.

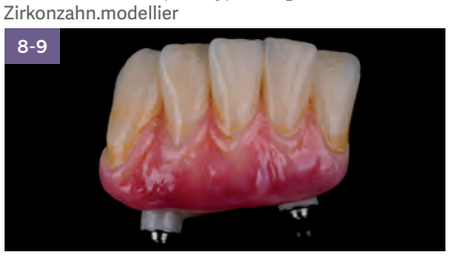
The choice of the right dental material, an eye for detail, and highly trained manual skills were important factors that contributed to the success of this zirconia restoration.

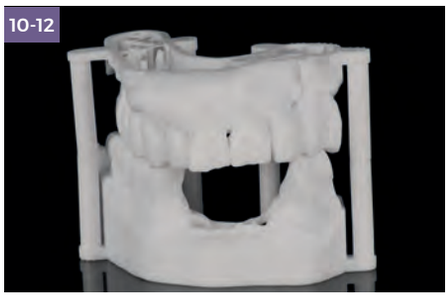


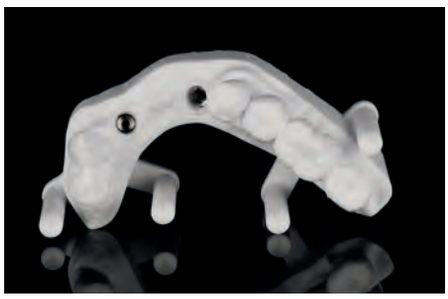




**FIGURES 3-7:** Final prototype design in Zirkonzahn.modellier

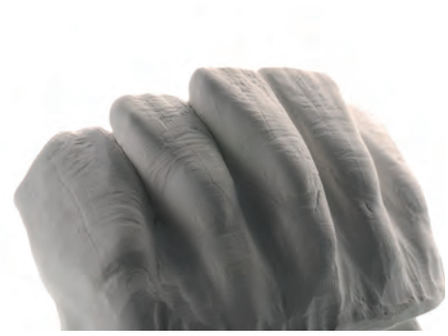



**FIGURES 8-9:** The prototype milled in Temp Basic resin

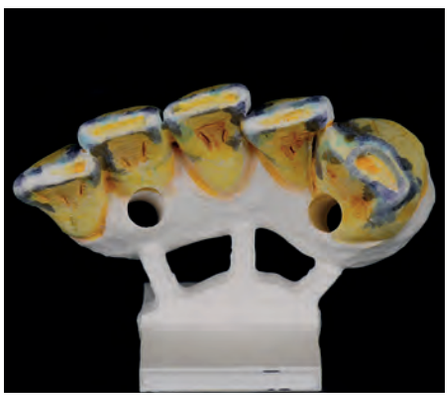


**FIGURES 10-12:** The printed models and the zirconia restoration milled based on the prototype setup

**FIGURES 13-14:** The restoration milled in Prettau 2 Dispersive zirconia. The zirconia restoration was reduced in the gingival area for subsequent layering with ceramics. The teeth were kept monolithic and slightly refined to create a more natural texture

**FIGURES 15-16:** Characterisation of the monolithic teeth with Colour Liquids. The greatest challenge was the colouring of the zirconia canine, which had to be copied and recreated with high precision to mirror the residual tooth

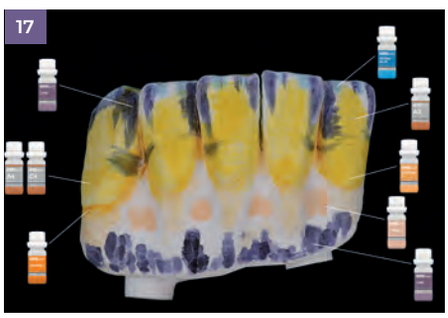
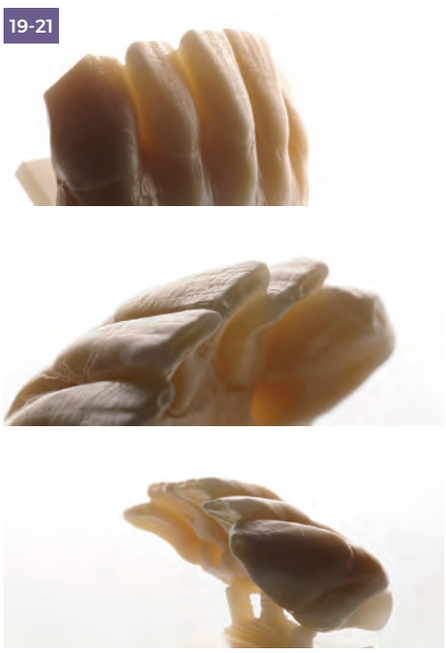
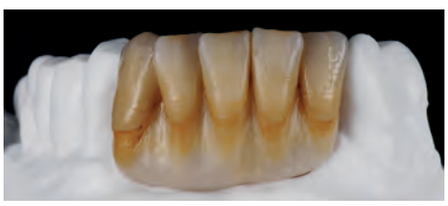



**FIGURE 17:** Colouring schema with Colour Liquids

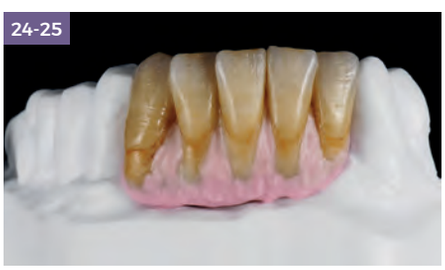

**FIGURE 18:** With Zirkonofen Turbo, smaller restorations can be sintered even in just 75 minutes, reducing electric consumption by 81% and cutting processing time by 84%. The furnace is equipped with pre-set sintering programs. In addition to the pre-installed programs, the user can easily and quickly create individual programs directly on the touch display of the furnace as well as via the mobile Zirkonzahn.app, which can also be used to monitor the furnace remotely



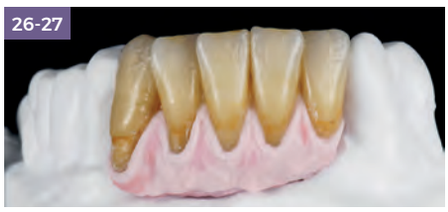

**FIGURES 19-21:** The zirconia restoration sintered with the Speed program in the Zirkonofen Turbo

**FIGURES 22-23:** The sintered structure on the model before and after characterisation with ICE Stains 3D by Enrico Steger




**FIGURES 24-25:** Application of Tissue five and six to imitate the darkest area close to the mucosa; result after sintering




**FIGURES 26-27:** Application of Tissue two and three to create volume and texture structure; result after sintering


**FIGURES 28-29:** Application of Tissue one to correct the tooth necks and perfect the texture. Glazing material was also applied and sintered in combination with ceramics; result after sintering

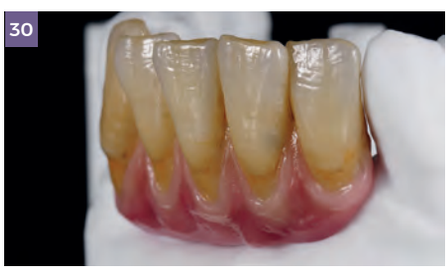



**FIGURE 30:** The final Prettau 2 Dispersive restoration on the printed model

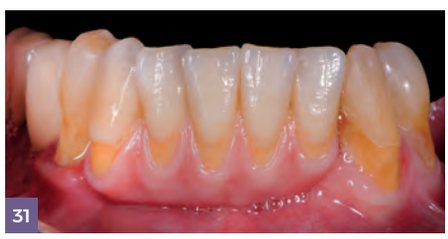



**FIGURE 31:** The final result in the patient's mouth

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VOCO THE DENTALISTS

# Restoring more than just a smile

Nina Frketin details the technical and emotional challenges of a complex BPS case, proving that the bond between clinician and technician is the key to restoring a patient's identity

**NINA FRKETIN**
Dental technician and founder of Nina's Dental Lab

'Hi, can you help me?'

Usually, I point the patient towards a dentist closer to their location and let the process unfold there. But this one felt different. This one stayed with me.

Perhaps it was because I recognised something familiar in her story.

She had moved here from my part of the world, worked relentlessly to support her family, and somewhere along the way, lost a part of herself.

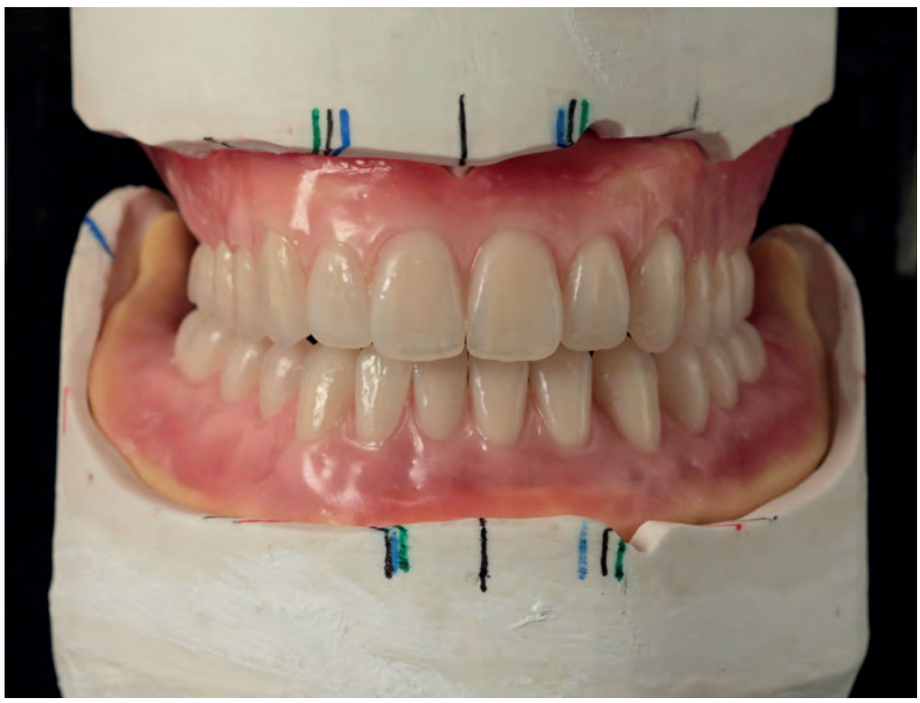
Her children were grown now, and after years of putting everyone else first, she had reached a moment of clarity – it was time to do something for herself.

She didn't simply want new dentures. She wanted her smile back. And with it, a sense of identity she felt she had misplaced over the years.

That was enough to make me pause – and then commit.

I referred her to Dr Dhiren Lad, a clinician I've worked closely with for the better part of eight years.

Together, we've restored many smiles, but this case felt like a true test of everything we had learned.



Dr Lad had just returned from Paul McNally's suction effective mandibular complete denture (SEMCD) training course, and I had spent the previous year under the mentorship of Richard Egan, immersing myself in the principles of the biofunctional prosthetic system (BPS).

We were eager to see where our combined experience could take us.

Then came the message every technician dreads.

## THE REALITY OF THE CASE

The patient's existing full-arch dentures were between 10 and 15 years old.

The upper denture was barely manageable; the lower was functionally unusable. It lacked retention, moved excessively, and prevented her from eating properly.

Aesthetically, she disliked them so much that she avoided smiling altogether.

Multiple previous attempts at replacement dentures had failed, offering no improvement.

Clinical examination revealed significant challenges. The upper denture lacked retention but the maxilla had sufficient anatomical height to support a new prosthesis.

The mandible, however, was severely atrophic, with a knife-edge ridge, poor-quality spongy tissue in the sublingual fold, a shallow retromylohyoid space, and unfavourable retromolar pads.

Years of resorption had taken their toll. Implant therapy was not an option due to the lack of bone.

To complicate matters further, the patient presented with a skeletal class III jaw relationship.

Her existing dentures reflected this, with a

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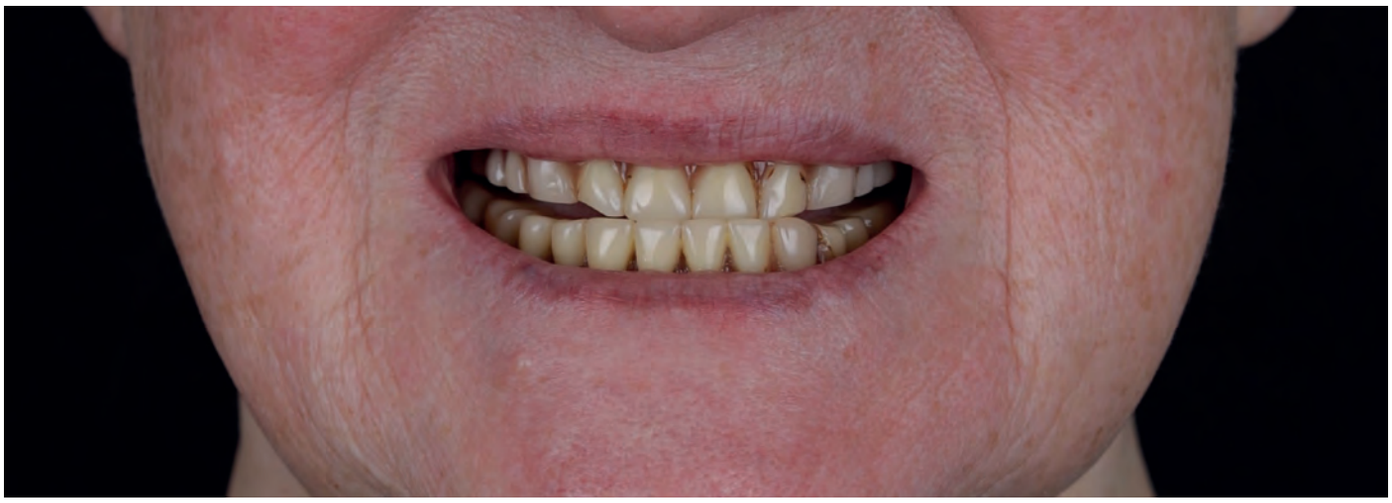
**CPD hours:** One

**Topic:** Complete dentures

**Educational aims and objectives:** To demonstrate the biofunctional prosthetic system.

This article qualifies for one hour of enhanced CPD. Turn to page 46 to answer the questions.

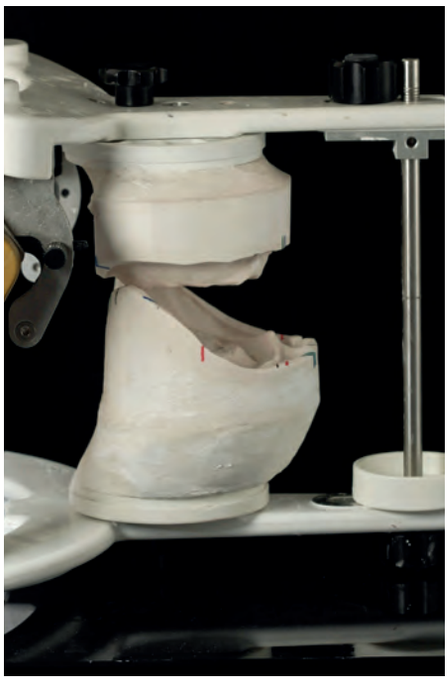


class III incisor relationship and a posterior open bite.

It was never going to be an easy case. But difficult cases are often the ones that matter most.

## CHOOSING THE BIOFUNCTIONAL PROSTHETIC SYSTEM APPROACH

From the outset, we agreed that if we were going to give this patient the best possible outcome, the BPS system was the appropriate choice.



USUALLY, I POINT THE PATIENT TOWARDS A DENTIST CLOSER TO THEIR LOCATION AND LET THE PROCESS UNFOLD THERE. BUT THIS ONE FELT DIFFERENT

BPS demands precision, collaboration, and discipline from both clinician and technician – and in return, it offers a pathway to results that conventional approaches often cannot deliver.

Dr Lad carried out the preliminary assessment and impressions, including a centric tray record.

I fabricated a lower frame cut-back (FCB) tray, allowing for a closed-mouth impression without exerting pressure on the retromolar pads.

Using the preliminary bite record, I mounted the maxillary and newly poured mandibular models and fabricated a gnathometer, which enabled accurate jaw relation recording and a final closed-mouth impression under stable occlusion.

At this stage, every millimetre mattered.

## TRAY DESIGN: WHERE OUTCOMES ARE WON OR LOST

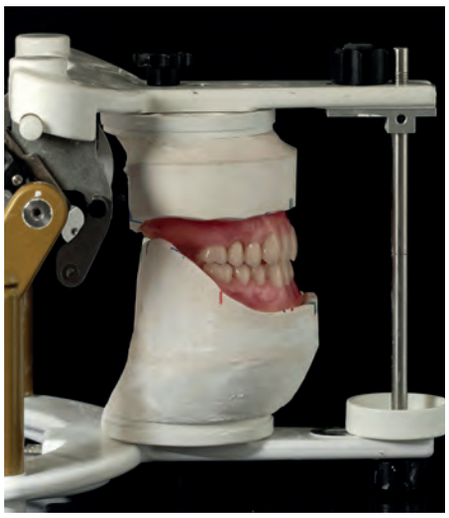
Special tray design is often underestimated, yet in cases like this, it is fundamental to success.

For the maxillary tray, the outline was marked 2mm above the mucobuccal fold, extending to 3mm in the labial region to accommodate increased soft-tissue mobility in the anterior zone.

For the mandibular tray, the retromolar pad was carefully followed while avoiding the Someya sinew string. The most inferior point of the mucobuccal fold was respected.

Lingually, the tray was extended 2-3mm beyond the mylohyoid ridge, while ensuring adequate tongue space.

The labial frenum was avoided, and the mentalis muscle was blocked out with wax to prevent displacement during function.



These details are not optional. Miss them, and even the most sophisticated system will fail.

## ARTICULATION AND TOOTH SETUP IN A CLASS III CASE

When articulating the models using the horizontal guide, the **mandibular model was articulated first.**

In a class III case, the wings of the horizontal guide – which define the occlusal plane – are positioned towards the **centre of the retromolar pads.**

By contrast, in class I cases the wings are placed at approximately one third of the retromolar pad, and in class II cases towards the superior border.

Once articulation was complete, a detailed **model analysis** was performed to determine the optimal tooth position, balancing aesthetics with functional stability.

Tooth setup in class III relationships comes with its own challenges.

Typically, the mandible is larger than the maxilla, and a crossbite arrangement is

often unavoidable.

In this case, however, we were able to avoid a crossbite altogether while still adhering strictly to the principles of class III occlusion.

The occlusal plane was carefully managed, acknowledging that in class III patients the mandibular closure path runs more anteriorly than in class I cases, often necessitating a posterior inclination of the plane to maintain balance and function.

## THE MOMENT OF TRUTH

At the try-in stage, the patient was already visibly emotional.

The fit, stability, and comfort were beyond anything she had previously experienced. For the first time in years, she felt hopeful.

With her approval, the dentures were processed using Ivobase, then finished with anaxgum pink composite to enhance gingival characterisation and create a natural, lifelike appearance.

At the fit appointment, we achieved suction on both the maxillary and mandibular dentures – a result that remains deeply satisfying, particularly in a case involving a severely atrophic mandible.

If I could include the video of that moment here, I would.

## WHY THIS CASE MATTERS

There are two immutable rules in complete denture prosthodontics:

1. The maxillary denture must never dislodge
2. The mandibular denture must achieve suction.


Achieving both requires precise determination of vertical dimension and suction-effective impressions taken under stable occlusion – something that can only be accomplished through close collaboration between an experienced clinician and a detail-driven technician.

The BPS system exemplifies this partnership.

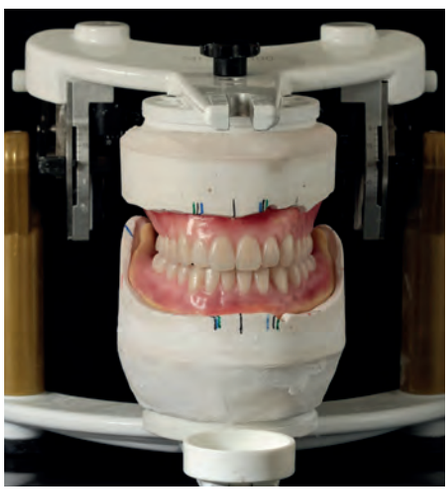
It is not a shortcut, and it does not forgive complacency. But when executed correctly, it has the power to transform lives.

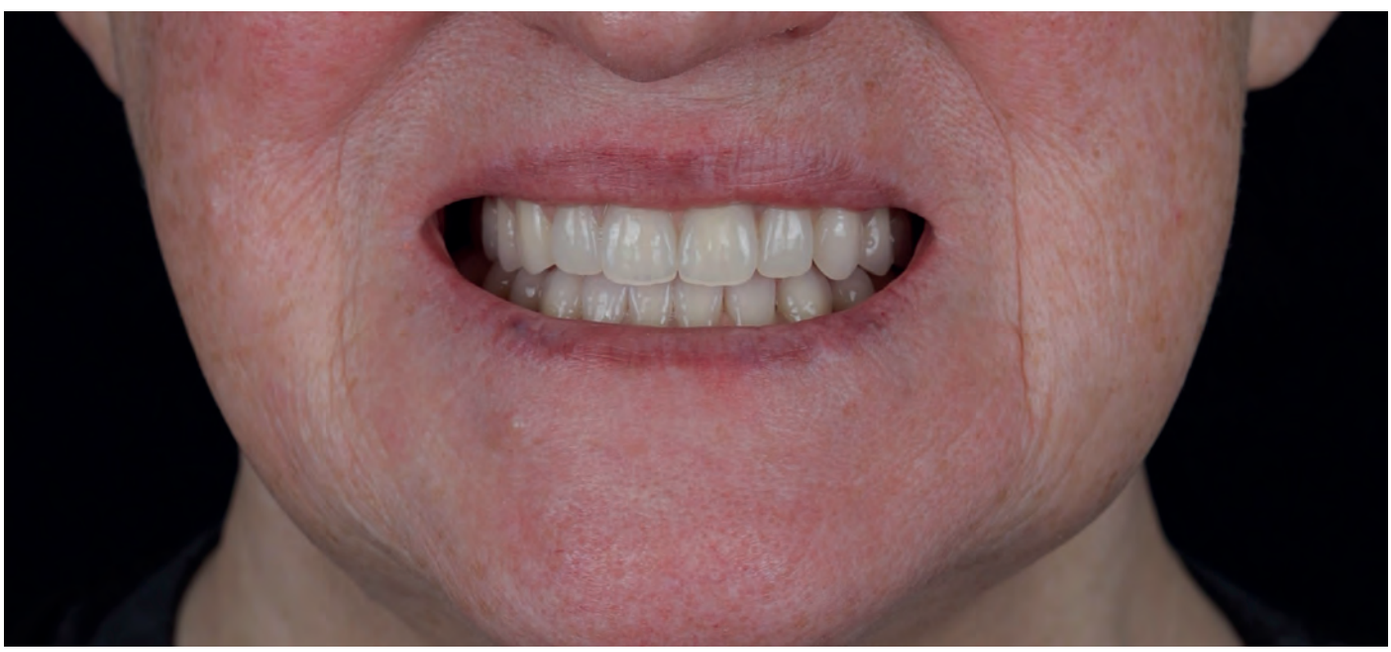
The patient was overjoyed with the final result, and years later, I still receive messages thanking us for what we did.

For me, this case represents everything I value in my work – technical excellence, teamwork and the privilege of restoring more than just a smile.

To this day, it remains one of my favourite patients and one of the most rewarding cases of my career.

> TO THIS DAY, IT REMAINS ONE OF MY FAVOURITE PATIENTS AND ONE OF THE MOST REWARDING CASES OF MY CAREER





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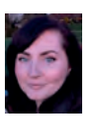
# Apprentices are the future

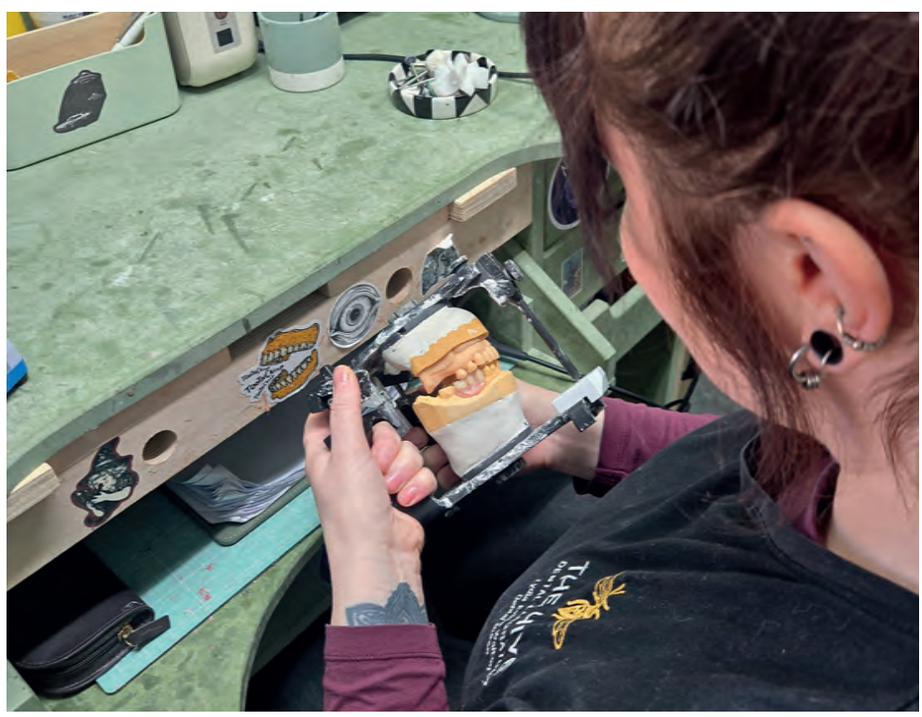
**Emily Pittard** examines the critical decline in registered dental technicians and speaks to two apprentices at The Hive Laboratory and Clinic to find out how deliberate mentorship can solve the UK's workforce crisis

**EMILY PITTARD**
Clinical dental technician, laboratory director at The Hive and an education associate for the GDC



**LYDIA EVLING WALTON**
Dental technician apprentice and treatment coordinator at The Hive

**ANNA-LOUISE GRAHAM**
Trainee dental technician at The Hive



The dental technician workforce is shrinking. According to the General Dental Council's (GDC) 2024 registration report, the number of registered dental technicians has fallen for the fifth consecutive year.

At the end of 2024, just over 5,000 technicians remained on the register, almost 10% fewer than in 2020.

Meanwhile, other dental professional groups including therapists, hygienists and nurses continue to grow.

Dental technicians are currently the only GDC registered group in consistent decline.

This is not simply a statistic. It is a pipeline issue. If fewer technicians are registering and more are retiring, the profession cannot rely on natural replacement.

The only sustainable solution is to grow the next generation deliberately.

And that starts with apprentices.

## MENTORSHIP IN THE LABORATORY

In our own laboratory, we are currently training two apprentices.

Given the decline in registered technicians, I felt it was important to ask them directly what makes entering this profession feel intimidating, and what support actually makes a difference.

Lydia Evling Walton (@theawkwarddentaltech) originally worked as my dental nurse and, during her time assisting as a CDT nurse, developed a genuine fascination with dentures.

Whether it was a growing love of prosthetics or simply a desire to escape being my nurse, she transitioned into the laboratory and has since begun the Dental Technology course in Yeovil.

## THE HURDLE OF EARLY APPREHENSION

Lydia explained: 'When I first started my journey into dental technology, I was constantly worried about making mistakes, trimming too much off a model or overextending a special tray.

The financial impact on the dentist or inconvenience to the patient felt overwhelming!

'Thankfully, I've had the most incredible mentor, Emily.

'I feel completely safe in her experienced (and weirdly strong!) hands.

'She's given me so much confidence in such a short time, and I'm so grateful for her support.

'Aside from the amazing support around me, what's helped me grow the most is simply putting in the hours.

'I've never felt this excited or passionate about my career before.

'I try to go beyond the nine to five while I'm learning. Whether that's staying late in the lab or studying at home.

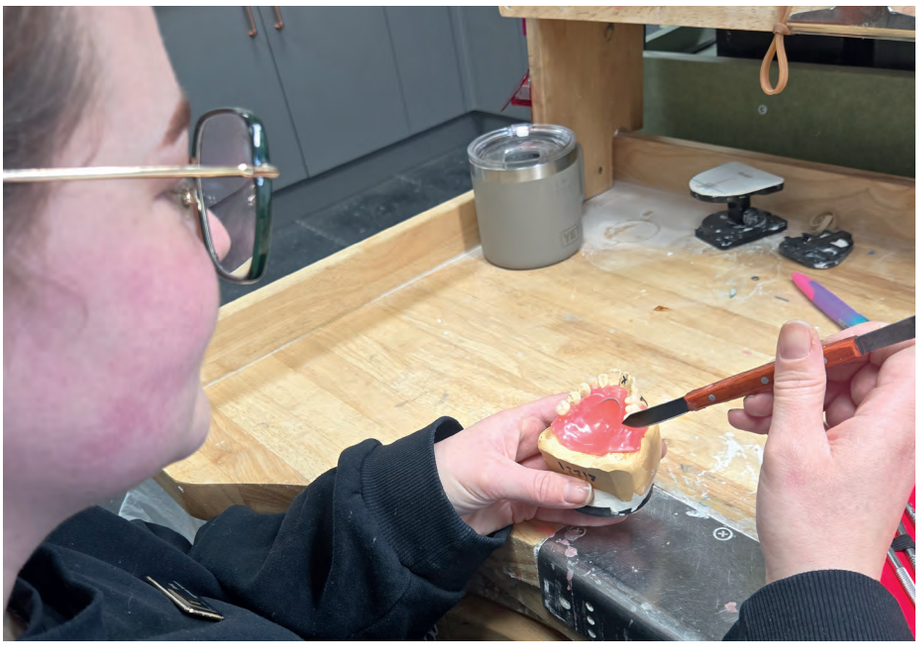
'That extra time has really accelerated my progress, and I genuinely love learning new things.

'However, I do make sure to balance it out with plenty of downtime too!'

Lydia's experience reinforced something important. The initial fear is real, but so is the growth that follows when the right support is in place.

Anna-Louise Graham (@traineetoothtech), who joined us more recently, described similar feelings: 'I was always passionate about my work as a dental nurse, but it didn't satisfy my creative drive.

'Throughout my career, I'd admired the high level of prosthetics and ceramic work I



saw and realised that was the path I wanted to pursue.

'So I began searching for a way into the industry.

'I quickly discovered that, although the profession needs new technicians, it felt almost impossible to break into.

'Some labs didn't have enough work to take on an apprentice, others were nearing retirement, and it was difficult to find a progressive lab embracing the digital direction the industry is moving in.

'Without a lab placement, I couldn't access formal education. It felt like a vicious cycle, and I began to think I'd have to give up on my dream.'

## THE HIVE LABORATORY AND CLINIC

'Then I found The Hive Laboratory and Clinic,' Anna-Louise continued.

'Meeting Ella and Emily was a breath of fresh air.

'They truly value learning and nurturing the next generation of dental technicians.

BEHIND EVERY FUTURE REGISTRANT IS AN APPRENTICE WHO ONCE FELT DAUNTED. THE QUESTION IS NOT WHETHER WE NEED MORE TECHNICIANS; IT IS WHETHER WE ARE PREPARED TO BUILD THEM

'They showed me that dental technology isn't an exclusive, unreachable club and reignited my passion and curiosity.

'Since joining The Hive, I've been fortunate to learn from technicians who actively share their knowledge and champion my growth.

'We've recently started a Saturday study club, like The Breakfast Club, but with dentures instead of detention.

'Emily, Ella and Beth give up their free time to invest in my future, and I'm incredibly grateful.'

## BUILDING CONFIDENCE THROUGH REPETITION

'The sessions focus on one topic at a time, combining teaching with hands-on practice,' Anna-Louise explains.

'After a study club on denture repairs, my apprehension disappeared.

'Dentures are someone's confidence, their reason to smile and laugh. And I was once afraid of altering that.

'Now I feel confident assessing and carrying out different types of repairs. A few months ago, I would have been petrified.

'Today, I take repairs head on, grateful that I can help restore someone's smile.

'Being in a supportive, judgement free environment where people genuinely want you to succeed has transformed my learning.

'I've only been on this journey for four months, but if I could tell my past self what I'm capable of now, I wouldn't have believed it.

'I'm proud to be an apprentice, and incredibly thankful for the technicians who have helped me grow.'

BEHIND EVERY FUTURE REGISTRANT IS AN APPRENTICE WHO ONCE FELT DAUNTED. THE QUESTION IS NOT WHETHER WE NEED MORE TECHNICIANS. IT IS WHETHER WE ARE PREPARED TO BUILD THEM

## A SHARED RESPONSIBILITY

I promise they were not under duress to write such nice things, and their words are generous but mentorship is never one sided.

Apprentices who progress quickly are the ones who show up, stay curious and commit to learning.

Confidence in dental technology does not appear overnight. It is built through repetition, responsibility and access to structured education.

Apprenticeships provide the entry point, but modern apprentices also benefit from accessible learning platforms alongside their formal education and day to day lab experience.

Initiatives such as 'Techtalk' by the party enamel (Beth Brown) offer structured continuing professional development (CPD) that supports what apprentices are learning at the bench, helping bridge the gap between theory and practice.

When supportive mentorship, consistent hands-on experience and structured learning come together, competence strengthens and confidence follows.

The decline in registered dental technicians will not reverse on its own.

If we want the profession to thrive, laboratories must see apprentices not as a short-term burden but as a long-term investment.

Education providers must continue expanding accessible training routes.

Experienced technicians must recognise the responsibility they carry in shaping those who follow them.

Behind every future registrant is an apprentice who once felt daunted.

The question is not whether we need more technicians.

It is whether we are prepared to build them.

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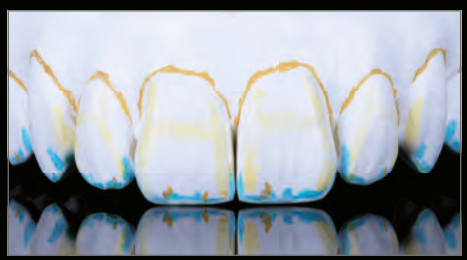

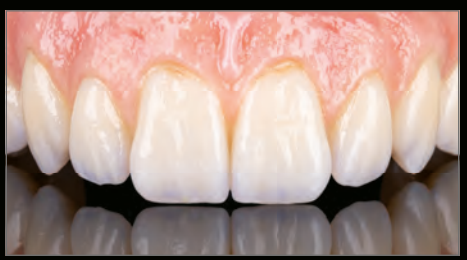

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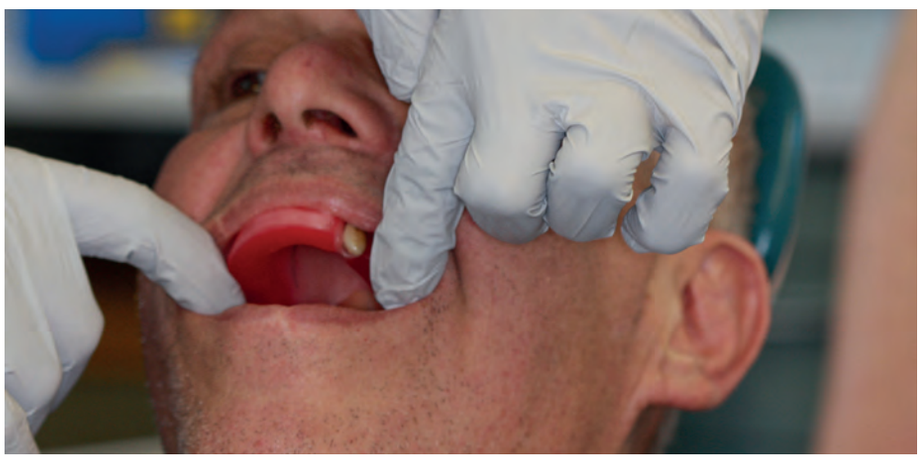
# When dental care becomes a luxury

**Andrea Johnson** discusses the broken link between dental labs and clinics, the trauma-informed care gap, and why the UK now relies on charities for basic healthcare

**ANDREA JOHNSON**
Chair, CEO and co-founder of dental charity Den-Tech



**Where are the biggest gaps in dental care access right now affected and who is most affected?**

Who is most affected – it is always those on the lowest income that suffer the most; the fact that people do not have a regular dentist with routine checkups as a normal healthcare provision anymore is huge.

I have had conversations with various different professionals over the years, and I have had quite a few conversations where I have had certain dentists say to me: 'If people are desperate enough, they will pay.' They clearly have no clue.

There are so many people out there for whom it does not matter how much pain they are in. They cannot magic up some money. They cannot magic up a few hundred or a few thousand pounds to have treatment.

So, at the moment, it just feels like dental treatment is a provision for those who have got money. And that is what needs to change.

I came into the NHS because I like the ethos of the NHS, regarding the fact that it does not matter how much money you have, what your means are, or what your status is.

Everyone deserves a certain level of care, regardless of what your means are.

If you want to pay extra for something a bit fancy, then that is fine. But everyone deserves a certain level of care.

That is why I came into this, but that seems to be missing at the moment. And that is really sad.

**Do you think NHS dentistry can handle the volume and complexity of cases**

No. I think there are a lot of challenges for those trying to provide NHS dentistry as well. They know for a fact they can get paid a lot more if they work privately, and their lives would be easier because they do not have to see as many patients.

Consequently, the volume of work that people are expected to do within NHS dentistry is significant for nowhere near as much money.

I have spoken to some dentists who attempt to provide almost entirely NHS dentistry because they have a similar outlook on life to me. They find it a real struggle. It is always a compromise.

Even those who want to be in NHS dentistry are having to move to private just because they cannot cope with it.

Some have businesses that are at risk because it is almost costing them money to do it, which is bonkers. It just does not make sense; it is crackers.

I think the situation with the labs also does not help because we cannot operate on race to the bottom prices all the time.

We have bills to pay. We have an expectation to earn a sensible wage and not be working 18 hours a day for less than a minimum wage, which I know quite a lot of technicians have done and still do because they are trying to secure work.

Those that stand their ground and say: 'Actually, I am going to charge this. If you are going to treat me like an outside supplier, I will behave like an outside supplier. This is the price for my work and this is how much it is worth,' often find it is a lot more than what the dentist is even getting paid for the whole treatment in that band.

So how do you resolve for the clinic, the lab, and the patient?

**What role should dental labs and technicians play in improving access, and are they supported to do that?**

I think creating a better awareness within the public of what labs and clinical dental technicians (CDTs) are able to provide is necessary.

People can go get a repair at their local lab; they do not need to see a dentist first.

The lab cannot take impressions of that patient or improve the fit as such, but they can repair it back to the condition it was in before it broke.

If more people knew that, they would go direct, which would ease the burden on clinics. That would be beneficial for the labs as well.

Regarding CDTs, if people realise that if they have no teeth they can go straight to a CDT instead, that helps.

I think some work has been done on this now to allow them to register as NHS

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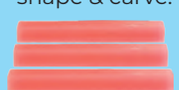

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practitioners so they can take on a little bit of NHS work.

Up until now, they have been 100% private and unable to access an NHS performer number; therefore, they cannot bid for contracts and do NHS work.

Opening the door on that and allowing them to do more NHS work would massively ease pressures.

Even just the culture – when patients do come in to see them, just referring the patient on to a clinical dental technician if it is appropriate, rather than thinking they have to do that all in-house, saying: 'I will charge you this consultation fee, and then refer you on to a CDT who will be able to do the work for you.' This is part of the culture change that dentistry needs to have.

**Through Den-Tech's work, you must see a side of dentistry that many in the industry don't. What have you learned about how the system works or doesn't work?**

We tend to see a lot of people who have very complicated needs.

It is not always just the dental side, because they have been through a significant trauma. We have to source people who can treat them, who are able to understand that and who have been trained to give treatment to people who have been through traumatic experiences.

Even knowing that if you have, say, a domestic abuse survivor in the chair, what might trigger them?

Even knowing how to speak to them about the dental condition, how it came about, or what their expectations are, is a whole different skill set to having your everyday patient coming in – even one with dental phobia. It is really not the same thing.

The feedback I have had from quite a few dentists is that they do not really feel like they have had a significant amount of training in dealing with patients who have been through trauma, including veterans and others with post traumatic stress disorder (PTSD).

That has always been a challenge. When we have tried to source dental clinicians to do work on them, some are weary and worried because they either do not feel confident in dealing with patients with such complex needs, or think they might end up with them on their books for a lot longer because there is going to be a lot more complications.

We need to make sure those patients are in a stable condition before they even start treatment, so that they are out of the dangerous situation and on the road to recovery.

The system itself as a whole is broken for everybody.

Around the country, there is no one set way of doing things; different ICBs and different regions seem to have different provisions in place. You cannot just say to a patient within the UK, or within England even, that these are the routes you go through; it is so different everywhere.

There is no standardised way of accessing dental care.

If we could level that out so we can give confident advice as to the different routes for people, it would be helpful.

I do not know why we do not work together, through all the different counties and ICBs and areas. We are supposed to be one big NHS or one big healthcare provider.

**Was there a moment or experience that made you realise that a charity like Den-Tech was necessary?**

I was invited to go abroad with another dental charity to Uganda.

At first I was very sceptical, but they were keen to see if they could do something with some lab work.

I went over and was basically having to be a very bad dental nurse, because I am really no good at dental nursing at all.

I did work alongside a lovely dentist who was incredibly patient, and we got on like a house on fire. I ended up being able to assist him throughout the week. It was a steep learning curve for me.

But the thing was, whilst I was there, it upset me quite a bit because I saw all these people who cannot normally access dentistry at all.

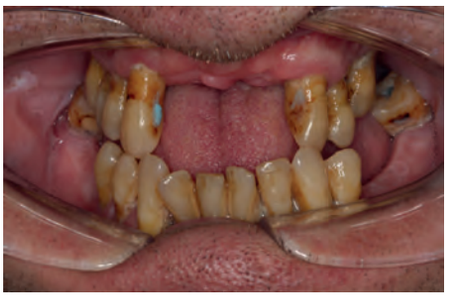
They were coming to these clinics, walking for hours or days, and sleeping under trees to stay in the queue to try and get some treatment.

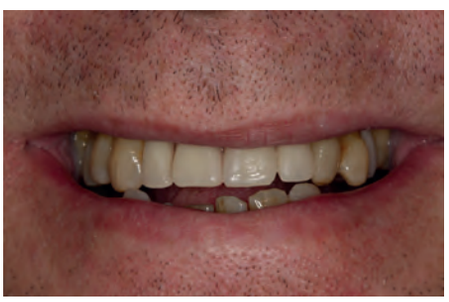
Because these clinics were basically pulling teeth, filling teeth and getting them out of immediate pain, there were one or two who said: 'I cannot let you take my teeth out, even though I am in absolute agony, because you are not putting anything back, and I will be considered ugly. I will be thrown out on the street.'

There is no welfare system in places like that.

And it struck me, because that is what I do: I make stuff to replace this.

That really had quite an impact on me; you see stuff on the TV or read stuff, but it does not really impact you properly until you are there.





It was with a colleague of mine that we went out, Andrew Sinclair, my co-founder, and it was him that said: 'Why don't we just set up a charity?' And me being naive said: 'Yeah, how hard could that be?'.

Since then the UK work has come on because of the state of dentistry in the UK, and it is so sad that we even need that in the UK.

**Is there anything else you would like to add?**

Dentistry is in a bit of a state. There is not going to be a quick fix for it.

As a result, dental charities are required in the UK, and I think they will be for quite some time.

There are quite a few different ones out there. I think it would be nice for people to support that where they can, helping out in some way, or doing a good deed. Maybe just pick one of the charities.

Ideally, I would suggest you pick Den-Tech, but even if you just pick one or two of them and help them, you are directly helping someone who is in a less fortunate position than you.

You could end up giving someone their teeth back, giving them their lives back, their dignity and helping them just feel like a normal human again.

I would like people to recognise that chucking a few quid at a dental charity every now and again will actually have a real impact on someone's life.

This is a healthcare need, not just vanity.

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# The quiet weight of ceramic work

**Jenna Ellis** reflects on the emotional toll of the 'perfectionist' mindset and explains why true clinical consistency only arrives when pressure is shared across a team

**JENNA ELLIS**
Dental technologist and ceramist at Godigital Dental Laboratory

As a ceramic team leader in a fully digital laboratory, I've learned that the most demanding part of ceramics isn't the material itself. It's the responsibility that comes with delivering consistent, high-quality results day after day while managing workflow, deadlines and a growing team.

For a long time, I believed pressure was simply part of the role. If I felt overwhelmed, it meant I cared. If I was constantly checking, correcting, and worrying, that meant standards were being protected.

What I didn't fully recognise at the time was how closely pressure and inconsistency were feeding into one another.

## WHEN EVERYTHING DEPENDS ON ONE PERSON

Earlier in my career, I worked largely on my own in ceramics.

With limited support, every case felt like it rested on my shoulders.

If something wasn't right whether it was shade, contour, or finish I didn't question the process. I questioned myself.

I've always been someone who strives for perfection, and when outcomes didn't meet that expectation, I took it personally.

I blamed myself for not being good enough, fast enough, or skilled enough.

While that mindset can drive high standards, it also creates a quiet, constant pressure that isn't sustainable.

As the ceramic department grew, my role evolved. I now work within a small team in the ceramic department and have trained two apprentice technicians, who are due to qualify this year.

Alongside producing my own work, I'm responsible for managing workflow, supporting their development, and ensuring we're all working to the same standards.

At times, that responsibility felt heavier not because standards had dropped, but because expectations had increased.

## PRESSURE DOESN'T ALWAYS LOOK LIKE BURNOUT

The pressure I experienced wasn't dramatic.

It showed up as constant mental noise, rechecking cases that were probably already acceptable, and struggling to switch off.

In ceramics, where judgement and detail play such a large role, inconsistency quickly becomes emotional.

When standards live only in one person's head, stress becomes personal rather than procedural.

## CONSISTENCY WAS THE TURNING POINT

Real consistency didn't come from tightening internal checks alone. It came when we raised our expectations of the information coming into the lab.

For a long time, we would simply get on

WHEN STANDARDS LIVE ONLY IN ONE PERSON'S HEAD, STRESS BECOMES PERSONAL RATHER THAN PROCEDURAL

with cases, even when scans or prescriptions weren't ideal.

We absorbed the stress, worked around the limitations, and often carried the cost of remakes without question.

That approach might keep work moving in the short term, but it isn't sustainable.

Poor input makes consistent, accurate outcomes almost impossible. Especially in a fully digital workflow where everything relies on the quality of the data provided.

As a team, we made a conscious decision to be more confident in saying no when a case wasn't suitable.

That meant questioning inadequate scans, asking for clearer information, and being honest with clinicians about what was achievable.

No one wants to turn work away, but we learned that accepting compromised cases created far more pressure than refusing them.

What made the difference was alignment within the team.

We communicate openly, share opinions, and support one another in those decisions, which has strengthened how we work together.

This confidence has also improved our communication with clients.

Instead of reacting to problems, we now help guide dentists on what we need from the lab side to achieve predictable results, satisfied clinicians and ultimately happier patients.

## A CALMER TEAM PRODUCES BETTER CERAMICS

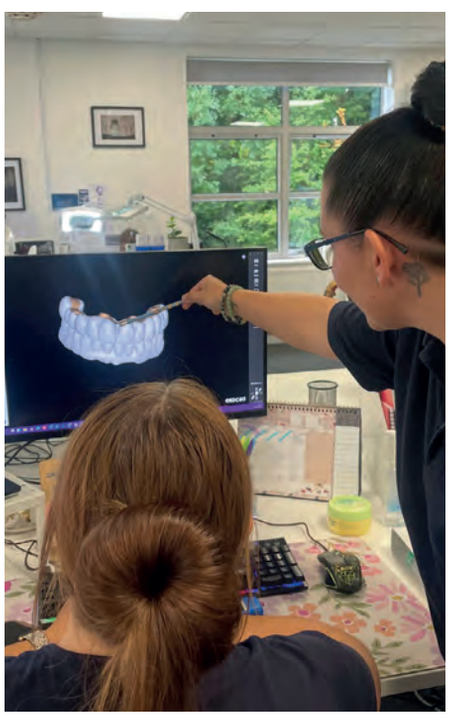
Today, the pressure hasn't disappeared, but it's shared.

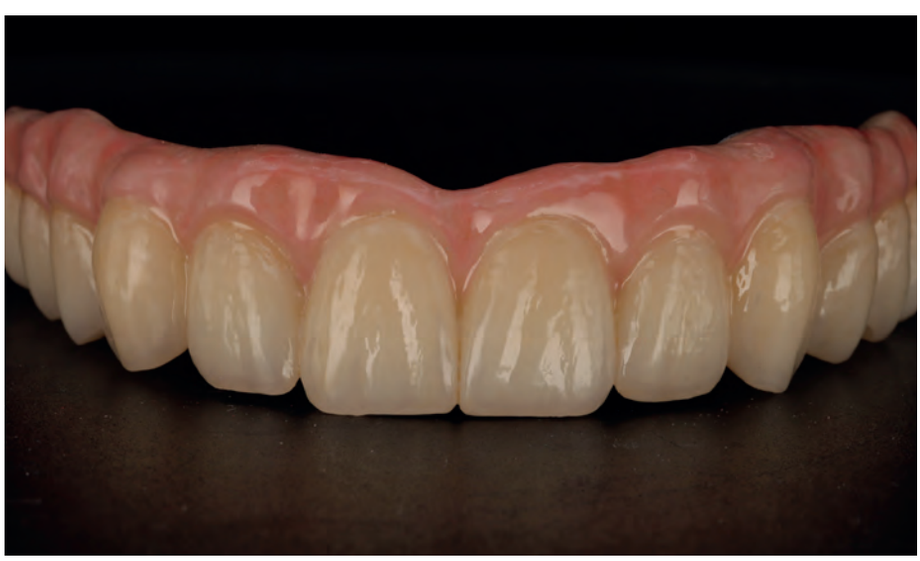
We work to common standards, with clearer boundaries and better communication.

When something doesn't go right, it becomes a discussion rather than a personal failure.

Consistency reduces pressure. Reduced pressure allows consistency to grow.

They aren't separate challenges; they're two sides of the same one. L





# Evolve or expire

## Are digital dentures the beginning of the end for clinical dental technicians? questions **Spencer Greening**

**SPENCER GREENING**
Clinical dental technician

For many years, the role of the clinical dental technician (CDT) has been vital in delivering high-quality removable prosthetics.

CDTs emerged not by chance, but by necessity.

As undergraduate dental training evolved, the depth and volume of denture construction education gradually reduced compared with 30 or 40 years ago.

The result was a generation of dentists less confident and less experienced in complex denture work, particularly full dentures.

In the analogue world, this model worked well. Dentists referred cases they either didn't enjoy or didn't feel confident managing, and CDTs stepped in to deliver excellent outcomes.

Using traditional impressions, wax rims, bite blocks, and try-ins, skilled CDTs produced life-changing dentures for patients.

Clinical artistry and technical craftsmanship were at the heart of this process.

However, digital dentures are fundamentally changing this landscape.

### MENTORSHIP IN THE LABORATORY

The biggest disruption is not the technology itself, but what it removes from the workflow.

Traditional denture construction is filled with opportunities for error – distorted impressions, unstable bite blocks, incorrect jaw relations and subjective records taken across multiple appointments.

Digital workflows replace much of this with intraoral scanning, objective data capture, and repeatable processes.

As scanning for dentures becomes more predictable and more widely taught, dentists are no longer required to master the 'art' of impressions and bite registration in the same way.

Instead, success is driven by understanding scanning principles, soft-tissue management, occlusal capture, and digital communication.

When done correctly, this leads to superior fit, improved occlusion, fewer adjustments and often delivery in just two appointments.

### MENTORSHIP IN THE LABORATORY

This is where the traditional CDT model begins to feel pressure.

In an analogue system, CDTs were essential because of the complexity and variability of clinical records. In a digital system, predictability increases.

Dentists who are confident in scanning can control the entire clinical workflow, while design and manufacturing can be outsourced or automated.

Global design centres now allow denture designs to be created anywhere in the world and returned instantly as digital files.

These files can then be printed or milled in-house, reducing laboratory costs and turnaround times significantly.

I believe this trend will continue to accelerate.

### A VISION OF THE NEXT DECADE

Looking ahead five to 10 years, it is entirely plausible that trained scanning nurses will routinely capture denture scans.

Dentists may oversee treatment planning, but no longer need to physically carry out the scans themselves.

In this scenario, referrals may shift away from CDTs and towards trained digital teams, both local and global.

The role of the CDT, as we know it today, could diminish if it does not evolve.

That said, this is not a prediction of extinction – it is a prediction of transformation.

### A VISION OF THE NEXT DECADE

Digital dentures still rely on deep clinical denture knowledge.

Tooth positioning, occlusal schemes, phonetics, aesthetics and patient-specific functional considerations cannot be replaced by software alone.

The danger is not digital dentures themselves, but CDTs failing to adapt to them.

The CDTs who will thrive are those who embrace digital workflows, lead on scanning education, influence design protocols and position themselves as clinical and technical authorities within digital systems.

Those who rely solely on analogue skills risk being left behind as workflows become faster, more scalable and more data-driven.

Digital dentures are not the enemy of CDTs, but they will expose complacency.

The future belongs to clinicians and technicians who combine digital efficiency with deep prosthetic understanding.

Digital is here, it is evolving daily, and its potential is vast.

The question is no longer if it will disrupt the profession, but who is prepared to evolve with it.

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# Why 90% of dental laboratories never reach £1 million

**Kash Qureshi** outlines an eight-step framework for dental laboratory owners to move beyond technical skill and build a scalable, systemised business with predictable growth

**KASH QURESHI**
Clinical dental technician

In the UK dental laboratory industry, most labs never reach £1million in annual turnover.

A small percentage build highly profitable, systemised businesses. A few are doing well and progressing.

The majority are covering wages, managing cash flow month to month, and feeling constant pressure. Some are simply surviving.

The difference is rarely technical skill. Dental technicians are highly trained, precise, and capable.

The difference is structure. The laboratories that scale build strong foundations, understand their numbers, execute with discipline and optimise continuously.

This framework is built specifically for dental technicians and dental laboratory owners who want predictable growth, strong margins and long-term stability.

## STEP ONE: FOUNDATIONS, YOUR LIFE PLAN AND TERMS

Before scaling your dental lab, you must define what you actually want your business to give you.

Your laboratory should support your life, not consume it.

Your life plan must be clear. How much do you want to earn each month? What does financial security look like for you as a clinical dental technician or lab owner? Do you want one high quality boutique lab or a multi site dental laboratory group? Do you want to remain at the bench or move fully into leadership? Do you want time freedom or aggressive growth?

Once your life plan is clear, you define your terms.

Time is how many hours you are prepared to commit to your dental lab each week.

Energy is deciding whether you focus on clinical work, complex prosthetics, sales visits to dental practices, or leadership and strategy.

Resources include your premises, digital scanners, 3D printers, CAD/CAM systems, staff structure and lab management software.

Money means understanding what you must pay yourself now and what you want to build for the future through retained profit and investments.

Sanity is critical. If payroll keeps you awake or cash flow stress dominates your thinking, your structure needs adjusting.

Most dental laboratory owners never define these terms. They simply react.

The labs that scale, design their model intentionally.

## STEP TWO: KNOW YOUR DENTAL LABORATORY NUMBERS

Technical excellence is not enough. You must understand your profit and loss statement.

There are seven key numbers every dental lab owner must know.

Net profit is what remains after materials, technician wages, overhead and tax. This is the real measure of success.

Operating expenses include rent, utilities, lab software, equipment finance, admin salaries and PAYE.

Cost of goods sold includes teeth, acrylic, zirconia discs, metal, implants components, and direct technician labour.

Revenue is the total income from crowns, dentures, implants, orthodontics, and other laboratory services.

Average order value is your total revenue divided by the number of cases.

Increasing case value through better treatment planning support or premium options can significantly improve profit.

The number of cases required tells you exactly how many units must move through your lab each month to hit your income target.

Gross margin is revenue minus direct costs expressed as a percentage.

If your gross margin is 40%, you are

generating 40 pence before overhead for every pound invoiced.

You do not need to double your dental laboratory turnover to change your life.

Often you simply need to improve your margins, tighten overheads and increase profit per case.

## STEP THREE: DEFINE YOUR PATH

On one clear page, define how your dental laboratory creates value.

How does a dental practice first hear about you? What happens when they send their first case? How do you manage shade communication? How do you handle quality control? Where do remakes occur? Where is profit created and where is it lost?

Your path must deliver the numbers you defined in step two so you can achieve the life plan from step one.

Every workflow from case intake to dispatch must be aligned with profitability and quality.

If your systems are inconsistent, your margins will be inconsistent.

## STEP FOUR: BUILD A TEAM THAT MOVES YOU FORWARD

A real dental laboratory becomes scalable when it no longer depends on the owner for every decision.

Your team must understand the mission. For example, providing a trusted dental laboratory service that delivers consistent quality, saves chairside time and supports predictable clinical outcomes. That clarity drives behaviour.

Technicians must know what excellence looks like.

Quality standards, turnaround times, communication protocols and accountability must be clear.

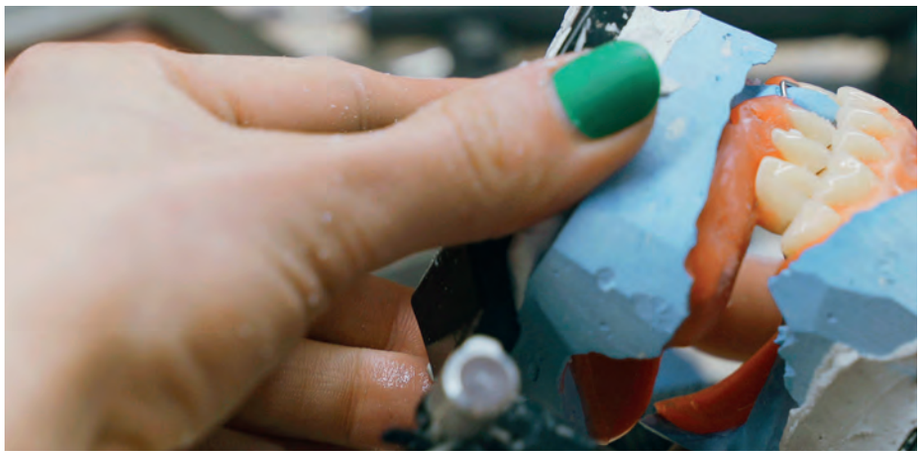
Fairness and transparency in pricing and internal culture build trust with both staff and dental practices.

Your goal is to create careers, not just jobs. Training in prosthetics, ceramics, digital design, and implant workflows strengthens the lab and reduces reliance on one person.

A structured team allows you to step away from day to day bench work and focus on growth.

## STEP FIVE: RHYTHMIC ACQUISITION OF THE RIGHT DENTAL PRACTICES

Growth should not be random. It should be consistent.



Define your ideal dental practice. It may be practices billing £1,000 to £3,000 per month with you, valuing quality over price, and respecting clinical protocols.

Not all clients are equal. Some strengthen your lab. Others drain margin and time.

Marketing generates leads. Leads become prospects. Prospects become active practices.

The gap between each stage is follow up. Many dental laboratories lose growth because they fail to follow up consistently.

Map the customer journey. An enquiry is received. A price list and welcome pack are sent. A follow up call is made. A meeting is arranged. The first case is handled carefully. Feedback is requested. Ongoing communication is maintained.

Most dental practices want one simple thing. They want to feel valued.

Remembering preferences, checking in after complex cases and acknowledging loyalty builds long-term relationships.

Consistent follow up turns interest into revenue.

## STEP SIX: OPTIMISE YOUR DAY TO DAY FOCUS

At the optimisation level, discipline becomes critical.

Spend at least 60 to 90 minutes each day working on the business rather than purely in it.

Review key metrics such as case numbers, gross margin, remake rates, average turnaround time and cash flow.

Use a weekly scorecard that shows targets, actual performance, and responsibility.

When performance is visible, improvement follows. Alerts and dashboards prevent surprises.

Clear expectations keep everyone aligned.

## STEP SEVEN: LEVERAGE AND FIX THE LEAKS

Every dental laboratory has leaks.

It may be excessive material waste, low productivity per technician, poor pricing on implant cases, or weak conversion of enquiries. It may be remakes reducing margin or slow payers affecting cash flow.

Your scorecard should reveal where profit is escaping.

Small improvements in gross margin, conversion rate, average case value, or repeat work from existing dental practices can create significant impact without increasing stress.

Optimisation is about refining systems, not simply increasing volume.

## STEP EIGHT: DESIGN THE FUTURE

True leverage comes when the business gives you options.

This might mean reducing your clinical days, focusing on strategy, or planning expansion into digital dentistry, additional departments, or acquisitions.

When your dental laboratory runs on clear foundations, strong numbers, structured teams, consistent acquisition and disciplined optimisation, you gain control of your time and future direction.

Most dental labs never reach seven figures because they rely solely on technical skill.

The laboratories that do scale combine technical excellence with financial discipline and strong leadership.

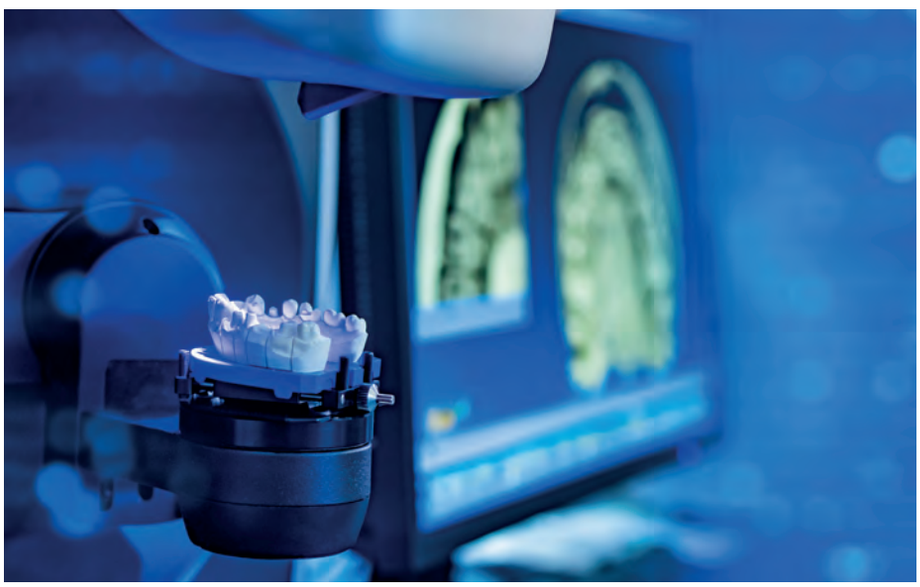
For dental technicians who want sustainable growth, improved profit margins, and long-term stability in the UK dental laboratory sector, the path is clear.

Define your life plan. Understand your numbers. Build the right team. Acquire the right practices. Optimise relentlessly.

Then design the future on your terms.

# Lab success in the age of digital growth

**Eleanor Pittard** looks at the real market forces hitting labs this year and explains why a simple, data-led strategy is actually the best way to stay ahead of the curve



LABS THAT THRIVE AREN'T ALWAYS THE QUICKEST ADOPTERS OF EVERY GADGET; THEY ARE THE ONES WHO FOCUS ON PEOPLE DEVELOPMENT, DATA-INFORMED OPERATIONS AND STRONG PRACTICE PARTNERSHIPS

**ELEANOR PITTARD**
Co-founder and director of The Hive Dental Clinic & Laboratory

The dental laboratory market continues to grow, with forecasts projecting steady expansion in both volume and technology adoption through the rest of the decade.

Yet this growth comes alongside consolidation, rising expectations and new operational dynamics that lab owners cannot ignore.

Here is a practical look at the forces shaping the industry and how labs, especially those without extensive customer relationship management (CRM) systems, can monitor performance and adapt strategically.

## MAJOR MARKET DYNAMICS

The dental lab market is expected to expand significantly through 2030, driven by digital dentistry adoption and advanced restorative materials.

Labs that embrace digital workflows position themselves for both capacity and quality gains.

As large dental service organisations (DSOs) and group practices grow, they increasingly demand reliable turnaround, digital compatibility and predictable pricing.

This shift is forcing labs to formalise processes and communication systems to meet higher client expectations.

## STRENGTHENING CLIENT RELATIONSHIPS WITH DATA

Many labs struggle to monitor performance metrics without a CRM. However, even a simple Google sheet system can act as a lightweight data hub.

To set up a core metrics dashboard, create a sheet with tabs for:

- Client orders: number received, due dates and status
- Turnaround times: planned versus actual
- Remake rates: by clinician or case type
- Revenue by client: monthly totals
- Material and labour costs.

Use filters and colour coding to highlight outliers, such as repeat remakes from one practice, and to identify clients where improved communication could reduce pain points.

## ACTIONABLE STEPS TO MONITOR AND IMPROVE

- Weekly review meeting with your team each week to identify who is ahead or behind and what trends are emerging
- Use data to inform conversations with dentists. Data helps you lead the conversation rather than reacting to it
- Standardise protocols including establishing minimum case requirements regarding file formats and scan quality standards.

## STRATEGY WINS OVER SPEED

Growth and digital technology are reshaping the dental lab economic landscape, but the labs that thrive are not always the quickest adopters of every gadget.

They are the ones who focus on people development, data-informed operations and strong practice partnerships.

With a simple tracking system and a culture of continuous learning, even small labs can navigate change confidently and profitably.

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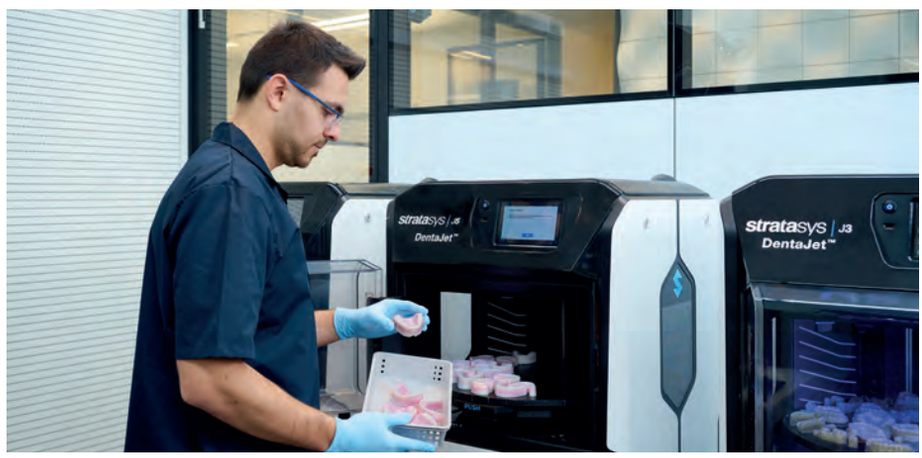
# The milestone of trust

Following the landmark news that Stratasys' Truedent has received CE-mark certification as a class IIa medical device, we sat down with **Shoshana Glickman** and **Negar Movahed** to discuss why this regulatory milestone is a game-changer for UK labs labs

**SHOSHANA GLICKMAN**
Dental marketing and content lead

**NEGAR MOVAHED**
Head of product for dental




***Laboratory* magazine (LM): Could you both briefly introduce yourselves and your roles at Stratasys, and for our readers who may be new to the brand, tell us a bit about the Stratasys mission?**

**Negar Movahed:** I am the head of product at Stratasys Dental.

My role sits at the intersection of customer needs, technology innovation, and long-term market direction.

Essentially, my goal is to bring valuable products to the market that solve real problems for lab technicians, clinicians and, ultimately, the patients.

**Shoshana Glickman:** I'm on the dental marketing team at Stratasys, where we focus on getting the word out to dental labs about what our 3D printing technology can do – from improving lab efficiency and reducing labour to enabling scalability and delivering consistent, reliable quality.

At Stratasys, we are global leaders in additive manufacturing.

While many know us from the industrial or aerospace sectors, our mission in dental is to deliver fully validated, end-to-end solutions, opening the door to scalable, high-quality production for dental labs.

**LM: We've just seen the news Truedent has received CE-mark certification as a class IIa medical device. For technicians, what does this actually mean?**

**Shoshana Glickman:** It's a major milestone.

It means we've been held to a much higher level of scrutiny regarding technical documentation, biocompatibility and mechanical properties.

For the lab, it provides peace of mind. They know the entire material lifecycle – from raw materials to the final product in the patient's mouth – is verified.

The class IIa certification also allows us to move into expanded indications like removable partial dentures (RPDs) with our new Truesnap workflow.

Truedent is an especially ideal material for RPDs as it enables close, highly customisable shade matching to existing dentition, a level of precision that is difficult to achieve with other three-dimensional printing solutions such as the single colour DLP printing.

**Negar Movahed:** It also gives labs the green light for long-term intraoral use with expanded indications.

When a lab fabricates these medical devices for the dentist, they can do so with absolute confidence that the clinical safety and performance have been verified by an independent body.

**LM: There are a lot of bargain resins or counterfeits on the market right now claiming to be compliant. How does this certification separate Truedent from the 'wild west' of unverified products?**

**Negar Movahed:** I love this question because it speaks to the heart of our discipline.

Stratasys is a conservative company in the best way possible.

As a large, public tech company with a dental vertical and relatively new to the medical device world – rather than a traditional dental medical device company – our approach is different, we make an intentional choice not to pursue risky loopholes.

Our leaders gave us a clear mandate to be conservative when it comes to safety, quality and patient safety.

Biocompatibility tests are incredibly expensive and they take time. That's why some companies choose to use literature references instead of testing new formulations.

We completed the full battery of tests defined by an independent toxicologist, based on the device type, contact type and exposure duration, in accordance with ISO 10993, rather than selecting only a subset.

Partial testing can introduce unnecessary risk to the patient. You rarely see that level of commitment from other resin manufacturers.

A lot of these bargain companies you mention market a resin and say: 'Put it in any printer, use any setting, the result is up to you'. That is a dangerous situation.

We take a different approach. We validate every single step of the workflow-material, printer, parameters and process – because patient safety and clinical reliability are non-negotiable.

**LM: Why is that trust factor so critical right now for a lab manager looking to scale their business?**

**Shoshana Glickman:** If you scale your production up to hundreds of units a month and then find out your material was non-compliant or has been pulled from the market, that can be a catastrophe for your business.

This certification gives labs the confidence to embark on scalable production of dentures and RPDs, knowing they have a recognised global standard behind them.

It reduces their legal liability and protects their reputation with the dentists they serve.

**LM: Can you pull back the curtain on the certification process? What hoops did you have to jump through to get the class IIa stamp?**

**Negar Movahed:** It's an exhaustive process.

Beyond the mechanical property testing (ISO 20795-1), we have to create a massive technical file. This includes an independent toxicologist – someone totally unaffiliated with Stratasys – reviewing our formulations and the size of the part going into the patient's mouth. They define the testing plan, not us.

Then there is the quality management system (QMS) scrutiny.

Everything from our manufacturing process to our marketing claims has to be reviewed and approved.

It's a level of oversight that ensures the product isn't just 'good' from the manufacturer's perspective, but consistently safe and effective with a stamp of approval from an independent third party.

**LM: Truedent is famous for its monolithic 3D printing – printing teeth and gingiva in one go. How does the technology itself help with the labour shortages in UK labs?**

**Shoshana Glickman:** Polyjet technology is essentially like inkjet style 3D printing.

We print tiny droplets of different resins simultaneously.

This allows us to combine five base-colour resins in various ratios to create incredible, multi-shade aesthetics in a single print run.

Because it's a monolithic print, there's no manual assembly of teeth into a base.

Any time you introduce a human into that assembly process, you inevitably get variations.

With Truedent, the accuracy is locked in digitally. Plus, our J5 Dentajet has a large print tray but a small footprint.

You can set an overnight print, the nesting is automated with one click, and you walk in in the morning to find finished dentures ready for a quick water-wash.

It's designed for labs that need to do more with fewer people.

**Negar Movahed:** It also fundamentally changes the try-in experience.

Historically, a try-in looked like a 'white block'. With Truedent, the patient sees a highly aesthetic, full colour preview of the final denture.


It builds immediate trust between the clinician and the patient and gives the patient an instant gratification which you don't get with other technologies.

Aside from eliminating the labour-intensive assembly of the denture teeth to the base, from a function perspective, monolithic printing addresses a known pain point: the risk of decoupling of the two during its useful life with the patient.

Because Truedent is printed as a single, integrated structure, patients do not have to worry about such failures during use. the monolithic printing, many dentures experience decoupling of the denture base, gum and the teeth.

With Truedent since it is printed all together, patients don't experience losing a tooth on their denture!

**LM: For the younger generation of technicians, how does this digital-first approach change the 'art' of the craft?**

**Shoshana Glickman:** For the digital natives, this is incredibly exciting.

We use software called Grabcad, which is much more than just a slicer.

Technicians can design in Exocad or 3shape, and then apply characterisations and aesthetics digitally in Grabcad.

We are constantly releasing new software updates – which are free, by the way – that add new shades and features.

The art is still there; it's just moved from the physical brush to the digital screen.

**Negar Movahed:** We have just launched our next-generation advanced aesthetics capability with Truevoxel, taking Truedent polychromatic printing to the next level.

With enhanced translucency and characterisation built directly into the digital workflow, technicians can design truly life-like aesthetics with the simplicity of a click.

This launch gets us even closer to mimicking the natural smile that every denture patient wants to achieve.

**LM: Finally, is there anything else you'd like to add for the UK lab community?**

**Negar Movahed:** We truly believe we've found the holy grail of dental 3D printing.

We're not just launching a product; we're launching a beautiful smile that gives patients the confidence to show it off.

With the launch of Truedent as a class IIa medical device, we have planned a dedicated roadshow for our European resellers and customers.

This means we are heavily investing in training the industry, from understanding the technology itself to mastering Truedent's digital design techniques and clinical requirements, so labs can integrate Truedent into their workflows with confidence.

Our goal is long-term success, not just adoption.

We have a strong roadmap of innovation ahead, and we are excited to continue sharing what is next with our industry partners.

**Shoshana Glickman:** Stratasys is fully committed to dentistry.

We are here to bring reliability, efficiency and trust to UK dental labs. Watch this space!

**FOR MORE INFORMATION**

contact Stratasys Dental at dental@stratasys.com **or** visit stratasys.com/dental.

# Stop calling it a business if it can't run without you

You did not build a business, you built yourself a job, **Matt Everatt** argues

**MATT EVERATT**
Owner and director at S4S Dental Laboratory and Smilelign Limited

In a previous article we talked about exit strategy, and one thing became very clear.

Many smaller labs and sole traders simply do not believe their business has any real value when the time comes to step away.

They assume exit planning is for the big corporate labs or the high turnover labs.

Not for a small team working hard to keep clients happy and cases moving out the door.

The most common response I hear is: 'My lab is not really worth anything. It is just me.' And that belief is where the real problem begins.

## THE BIGGEST MYTH IN SMALL LABS

Many owners do not realise they have spent years building something of genuine value.

They see long hours, constant pressure, staff who rely heavily on them, clients who call them directly often out of hours, and a business that feels tied entirely to them being present in the lab.

So, they feel they have not built a saleable asset. They have just created themselves a demanding job.

The reality is that value is not about size. It is about stability, trust and relationships.

A small lab with loyal clients, consistent workflows and a reliable team can be far more valuable than a larger operation that lacks structure or culture.

The problem is that most owners never step back far enough to see it.

## THE JOB VERSUS ASSET TRAP

This is where many individuals and smaller labs unintentionally end up. They generate good income, support families and build strong reputations. But they remain entirely dependent on the owner's daily involvement.

If the owner stops, everything stops.

At that point you do not truly own a business. You own a role that you cannot easily step away from.

And that is why an exit strategy often feels irrelevant. You cannot imagine exiting something that only functions when you are present.

THEY HAVE BUILT TRUST, CONSISTENCY AND LIVELIHOODS, NOT JUST THEIR OWN BUT FOR THEIR TEAMS. THAT HAS REAL VALUE, EVEN IF IT DOES NOT YET LOOK LIKE SOMETHING YOU COULD EASILY SELL

## WHY THIS MATTERS EVEN IF YOU NEVER PLAN TO SELL

It is about knowing you could step back if you needed to, that your income would not disappear overnight, that your team would not be left vulnerable and that your family would not inherit a problem instead of an asset.

Even small steps toward reducing owner dependency can dramatically change the quality of life for a lab owner.

This is not about building a corporate machine. It is about building options.

## THE HIDDEN VALUE MANY SMALL LABS ALREADY HAVE

Most small labs underestimate what they have created.

They overlook years of trusted relationships with clinicians, a reliable support network that includes accountants, IT support and long-term suppliers, a recognised reputation, efficient systems developed through years of experience, and a culture that clients genuinely value.

This isn't just 'pie in the sky', this is exactly what potential buyers or future successors would look for.

More importantly, they are what makes a business sustainable without constant owner strain.

## CHANGING THE WAY WE THINK ABOUT VALUE

Perhaps the biggest shift needed is psychological.

Many lab owners have spent decades seeing themselves as technicians first and business owners second. They take pride in their craftsmanship and their work ethic, but rarely pause to acknowledge that they have built something far more significant than a technical role.

They have built trust, consistency and livelihoods, not just their own but for their teams.

That has real value, even if it does not yet look like something you could easily sell.

## A DIFFERENT WAY TO THINK ABOUT EXIT STRATEGY

For small lab owners, exit strategy does not need to mean preparing for a sale tomorrow.

It simply means asking one honest question.

Could my lab survive without me for a period of time?

If the answer is no, then the opportunity is not about selling. It is about strengthening. Strengthening systems, strengthening leadership within the team and creating resilience.

Once a business can function without its owner at the centre of every decision, that's when the landscape changes from being just a job, it becomes an asset.

## THE REAL TAKEAWAY

Most small lab owners do not lack an exit strategy because they are careless or short sighted.

They lack one because they have never truly believed they have something worth exiting from.

The reality is that many of them do. They just have not considered it or have never been encouraged to see it that way.

Recognising that value is the first step, not toward leaving, but toward building a lab that supports you rather than one that cannot survive without you.

## NEW COLOUR LIQUID PRETTAU AQUARELL BOOST - FOR VIBRANT, NATURAL EFFECTS TO YOUR RESTORATIONS

Colour is the key for creating lifelike, aesthetically pleasing restorations.

With the new Colour Liquid Prettau Aquarell Boost, Zirkonzahn introduces a new generation of colouring liquids that set new standards in the colour design of zirconia restorations.

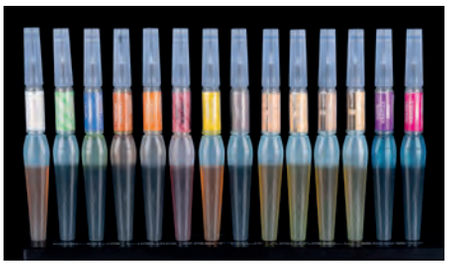
The highly intensive, water-based liquids are applied before sintering with nylon brushes specifically optimised for the watercolour technique.

This special application method ensures maximum precision, controlled integration of the colour pigments into the zirconia structure, and easy handling for both beginners and experienced technicians.

Additionally, the intensely pigmented formulas offer heightened colour visibility – and therefore easier application – allowing to carefully assess each brushstroke before sintering.

Then, the customised colouring of details, such as mamelons, cervical areas, and interdental spaces, is significantly enhanced and can be executed with extreme precision.

The set includes 14 colours precisely matched to the entire Prettau line.



Clear system enables seamless data flow across application guidelines and reliable colour accuracy simplify the effect individualisation.

Supplied exercise papers also help to master brush techniques and gain a deeper understanding of how colour flows from the brush.

Through continuous practise and skilful application, the potential of these new liquids can be further enhanced.

The result is restorations with depth, vibrancy, and unique personality. ensuring natural-looking.

## W&H UNVEILS THE NEXT CHAPTER IN ITS EVOLUTION

After more than 135 years of engineering excellence, W&H is entering a new phase focused on innovation, design and connected digital workflows.

The company's latest development, the Seethrough imaging portfolio, reflects a renewed commitment to supporting modern dentistry with intuitive technology and integrated clinical solutions.

Designed as a connected imaging ecosystem, Seethrough brings together extraoral and intraoral imaging within a single digital environment.

The range includes Seethrough Flex, a compact high-performance imaging system suited to contemporary practices, and Seethrough Max, which offers the same advanced capabilities with a larger field of view.

Integrated with Implantmed Plus II through W&H's cloud-based Iodent platform, the diagnostics, planning and treatment.


Jon Bryant, managing director of W&H UK, said the launch represents a 'confident and connected' future for the brand, combining clarity, usability and design to support clinicians and enhance patient care in an increasingly digital dental landscape.

**www.wh.com**


## *NAIL-IT LEADERSHIP: YOUR BLUEPRINT TO OPTIMAL PERFORMANCE* OFFICIALLY LAUNCHES

*NAIL-IT Leadership: Your Blueprint to Optimal Performance* by specialist periodontist, Dr Rana Al-Falaki is now on the shelves and already attracting national attention, having been featured in The Bookseller's recommended non-fiction preview for upcoming releases.

The feature recognises the book's unique ability to bridge science, mindset and practical leadership strategy – positioning it as essential reading for professionals seeking sustained success without sacrificing wellbeing.

The book was launched recently at an invitation-only event at an exclusive private members' club in the heart of London's West End.

Attended by a carefully curated group of leaders, professionals and change makers, it certainly wasn't a typical book launch.

The evening was high-energy and had a celebratory quality – the setting allowed connection, conversation and a great atmosphere – in true Rana Al-Falaki style!

There were signed copies and all book proceeds from the evening were donated to Bridge2aid.

Michael Levin, New York Times Bestselling author, describes the book: '*NAIL-IT Leadership* is a must-read. Dr Rana Al-Falaki delivers a timely and essential blueprint that fuses wellbeing with leadership.'

Years in the making, *NAIL-IT Leadership: Your Blueprint to Optimal Performance* brings together the complete NAIL-IT system in one powerful, practical guide.

It challenges the outdated belief that high achievement must come at the expense of energy, balance or fulfilment.

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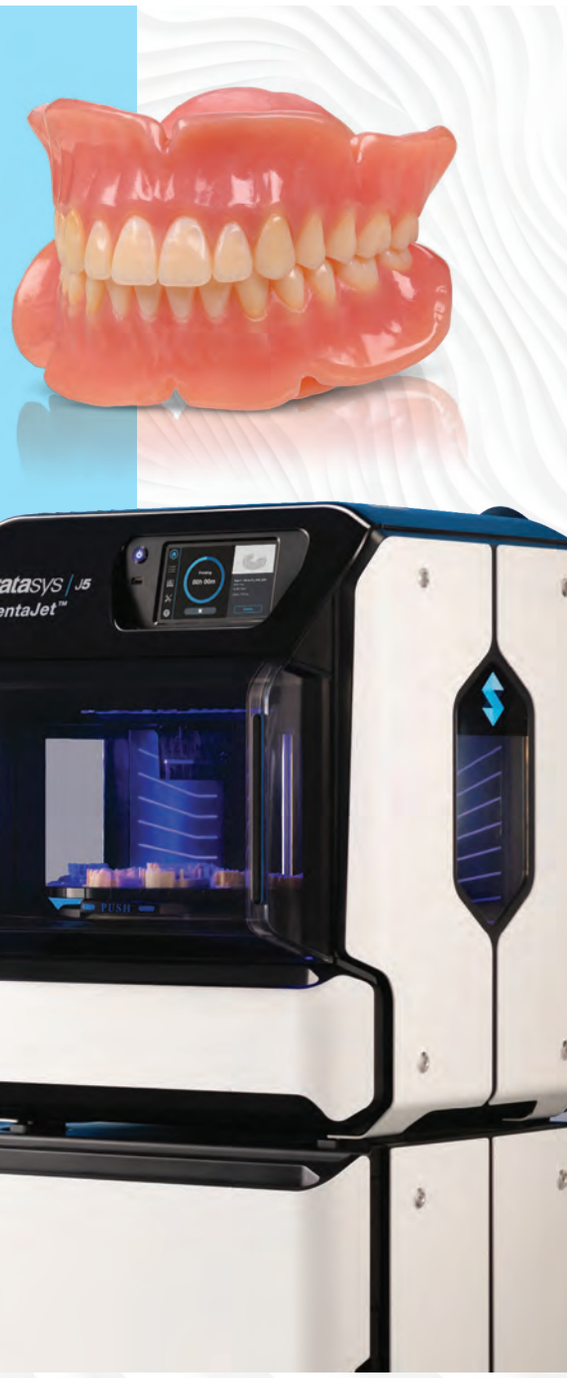


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# Fresco Ceramics course in London

Zirkonzahn's School of London: course on aesthetic characterisation on 1-2 June. The course is about the use of Fresco Ceramics, including an introduction to the new Colour Liquid Prettau Aquarell


**FIGURE 1:** The new Zirkonzahn School of London, in Canary Wharf

The School of London is Zirkonzahn's first facility in the United Kingdom. Located in Canary Wharf, not far from the city centre, it is designed to host a showroom as well as a variety of courses covering a wide range of topics – from material diversity and layering techniques to CAD/CAM systems. The trainings, open to both dentists and dental technicians, are held by qualified dental technicians. They include a practical session allowing participants to apply and consolidate their newly acquired skills and meet the criteria for the GDC's development outcome C.

**FIGURE 2:** Fresco Ceramics application

At present, the courses available focus on Zirkonzahn.Modifier design software, the digital design of full dentures and Fresco Ceramics application. Registrations are now open for the upcoming edition of the Fresco Ceramics course, which will take place on 1-2 June 2026. During the course, the instructor provides the participant with a theoretical and practical basis for the application of Fresco Ceramics on zirconia restorations, teaching how to achieve different results through the application of the pastes, also used in combination with stains.

**PROGRAMME DAY 1 from 09:00 am to 06:00 pm**

- Presentation of ethos behind Fresco Ceramics and Zirkonzahn Prettau Dispersive zirconia materials
- Application of Fresco Ceramics on two single units with cutbacks from the Heroes Collection virtual tooth library
- Stain, glaze and polish of two Fresco layered anteriors and a monolithic molar crown
- Bond layer application of 'implant style' bridge.

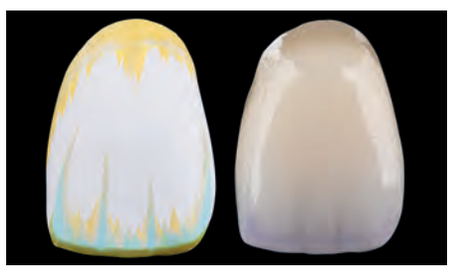

**FIGURE 3:** Colour Liquid Prettau® Aquarell Boost® application

**PROGRAMME DAY 2 from 09:00 am to 06:00 pm**

- Recap of steps performed on day 1
- Application of Fresco Enamel ceramics to the 'implant style' bridge with enhanced characteristics
- Application of Fresco Gingiva masses according to natural colour variations and anatomy
- Perform customisations with 3D stains and glazes
- Finalise and polish all units for maximum vitality of the Fresco Ceramics
- Joint assessment of final structures
- Discussion and clarification of any outstanding issues with the system as demonstrated.

The trainer will also introduce the new Colour Liquid Prettau Aquarell Boost, explaining the colour range, their characteristics and application on zirconia restorations.

Participation is limited to four participants.
For more info and application scan the code or contact: Martina Milani, T: **+39 0474 06 6653**, **martina.milani@zirkonzahn.com** | Jasmin Oberstaller, T: **+39 0474 06 6735**, **jasmin.oberstaller@zirkonzahn.com.**

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# Enhanced CPD

## LAB/SPRING/MANAZZA/PAGE 14

**1. What was the main reason for incorporating gingival reconstruction in this case?**

- ☐ a. To reduce laboratory costs
- ☐ b. To improve implant osseointegration
- ☐ c. To avoid disproportionately long teeth and create a natural effect
- ☐ d. To simplify the milling process

**2. Which software was initially used by the dental technician to design the prototype?**

- ☐ a. Zirkonzahn.modellier
- ☐ b. Zirkonzahn.modifier
- ☐ c. Exocad
- ☐ d. 3Shape Dental System

**3. What material was selected for the final restoration?**

- ☐ a. Lithium disilicate
- ☐ b. PMMA resin
- ☐ c. Prettau 2 Dispersive zirconia (A2)
- ☐ d. Titanium alloy

**4. How was the 4C shade of the canine reproduced?**

- ☐ a. 100% Colour Liquid A4
- ☐ b. 100% Colour Liquid C4
- ☐ c. 70% A3 with 30% C4
- ☐ d. 50% Colour Liquid A4 mixed with 50% Colour Liquid C4

## LAB/SPRING/FRKETIN/PAGE 18

**1. What was the primary issue with the patient's lower denture?**

- ☐ a. It was aesthetically unacceptable but functionally stable
- ☐ b. It lacked retention and prevented proper eating
- ☐ c. It caused excessive gum irritation only
- ☐ d. It was recently fitted and too tight

**2. Why was implant therapy not considered for this patient?**

- ☐ a. The patient declined treatment due to cost
- ☐ b. There was insufficient bone due to resorption
- ☐ c. The clinician lacked experience with implants
- ☐ d. The patient had a class I jaw relationship

**3. In a class III case, where are the wings of the horizontal guide positioned?**

- ☐ a. At one third of the retromolar pad
- ☐ b. At the superior border of the retromolar pad
- ☐ c. Towards the centre of the retromolar pads
- ☐ d. At the anterior border of the ridge

**4. According to the author, what are the two immutable rules in complete denture prosthodontics?**

- ☐ a. The dentures must be aesthetic and low cost
- ☐ b. The maxillary denture must never dislodge and the mandibular denture must achieve suction
- ☐ c. Both dentures must be implant-supported
- ☐ d. The mandibular denture must be rigid and the maxillary flexible

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