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October 2026
FMC CONNECTING DENTISTRY

Dentistry

Understanding menopause in dentistry

Discover how menopause can affect those working across dentistry – as well as its potential implications for oral health from **page 22.**

MENOPAUSE MATTERS IN DENTISTRY

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DHSC to consult on dental hygienist and therapist prescribing rights

The Department of Health and Social Care (DHSC) has opened discussions on prescribing rights for dental hygienists and therapists with the British Association of Cosmetic Dental Professionals (BACDP).

The BACDP said it had been 'invited to present the case for change', advocating for dental therapists and hygienists to be awarded powers to independently prescribe.

The lack of scope for dental care professionals to prescribe basic medications has often been questioned, with dental governance specialist Alicja Zajac criticising the extent to which they are 'restricted by rigid item lists and unable to exercise full diagnostic and prescribing autonomy'.

In 2024, dental hygienists and therapists were granted the power to supply and administer certain prescription-only medications.

While he considers this a 'welcome first step', dental therapist Robbie Stewart stressed that these exemptions were 'never meant to be the finish line'.

He said: 'Dental therapists and hygienists are already diagnosing, treatment planning and managing patients within their scope every day, yet we still have to stop and ask a dentist to sign off routine medicines. Nurses, pharmacists, physiotherapists and podiatrists all have a structured route to supplementary and then independent prescribing. Dental professionals deserve the same: an accredited qualification, within our existing scope, with proper governance.

'That isn't about stepping on dentists' toes. It's about getting patients treated without unnecessary delays, at a time when access to NHS dentistry is at crisis point.'

'An exciting step for dental therapists and hygienists'

The dental hygiene and therapy community has welcomed the news that the DHSC will hear evidence on expanding prescribing rights.

Dental therapist Freya Milnes said: 'I think this is such an exciting step for dental therapists and hygienists.

'More prescribing rights would be a huge development in terms of allowing dental therapists to work more autonomously within their scope of practice, remove some of the barriers we can face when managing patients, and ultimately provide a more seamless experience for patients.'



Dentist Ben Atkins on what an endurance challenge taught him about oral health risks in sport. p53



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Mission statement

Dentistry magazine's unparalleled coverage of current affairs, new developments and the latest thinking keeps the dental sector on top of the issues that matter. For further information and to get in touch, email siobhan.hiscott@fmc.co.uk.

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Are we asking the right questions?



Siobhan Hiscott
Editor's view

October is Menopause Awareness Month. And while awareness has undoubtedly improved in recent years, I wonder how many of us still instinctively reduce menopause to the same handful of symptoms: hot flushes, night sweats and perhaps disrupted sleep.

The reality is far broader. Menopause can affect concentration, confidence, mood, joints, energy and mental wellbeing. For some, those effects spill directly into working life. CIPD research found that 67% of working women who had experienced menopausal symptoms said they had had a mostly negative impact at work, while 27% reported a negative impact on their career progression.

For dentistry, that should matter enormously. We know that the profession is predominantly female (78% of registered dental professionals identify as female, including 54% of dentists and 92% of dental care professionals, according to the General Dental Council).

This is not a peripheral workforce issue. It is something likely to be affecting colleagues, practice owners, clinicians and team members.

But there is another reason we need to talk about menopause: patients.

Hormonal changes associated with menopause can influence the oral environment, with research linking the transition to xerostomia, burning mouth syndrome, periodontal problems and changes in bone health. A 2025 review highlighted that around half of postmenopausal women may experience xerostomia, while estimates for burning mouth syndrome range from 18% to 33%.

Yet awareness remains remarkably low. One survey found that 70% of women over the age of 50 had experienced at least one oral symptom since developing menopausal symptoms, but only 2% had discussed those concerns with their dentist.

That gap is exactly why we're running Menopause Matters in Dentistry, in partnership with Colosseum Dental. Turn to page 22 of this issue and keep your eye on dentistry.co.uk for more about this dedicated campaign running throughout October.

This is not about turning dental professionals into menopause specialists. It is about curiosity. Asking another question. Recognising that a dry mouth, burning sensation, change in periodontal health or struggling colleague may have a bigger story behind it.

Awareness begins when we stop assuming we already understand something.

Menopause is more than a hot flush. And for a profession built around prevention, diagnosis and listening carefully to patients, perhaps it is time we understood just how much more.

'Lack of political will' blamed as child tooth decay hospital admissions rise

The British Dental Association (BDA) has blamed a 'lack of political will to fix NHS dentistry' after tooth decay remains the leading cause of hospital admissions among children aged five to nine years.

New NHS England data recorded 21,787 finished consultant episodes with dental caries as the primary diagnosis in this age group during 2025/26, up 3% from 2024/25. Acute tonsillitis was the second most common primary diagnosis, with 11,511 episodes attributed.

BDA chair Eddie Crouch said: 'It shouldn't be inevitable that tooth decay sends more young kids to hospital than any other condition. Decay can and should be prevented, but instead of catching it early many thousands of children reach the point where they need extractions.'

The figures follow repeated warnings about children's access to NHS dentistry. NHS Business Services Authority data showed that 60% of children had seen an NHS dentist in the 12 months to 31 March 2026, leaving 40% without a recorded visit. The BDA welcomed government measures including supervised toothbrushing and the planned ban on sales of high-caffeine energy drinks to under-16s. However, it said these policies must be accompanied by better access to NHS care.

Disallowed dental prescriptions leave pharmacies £50,000 out of pocket

New figures show 5,274 items prescribed by NHS dentists were disallowed in one year, leaving pharmacies an estimated £50,000 out of pocket.

The unpaid dental items formed part of approximately 32,000 prescription items disallowed by the NHS Business Services Authority (NHSBSA) between July 2025 and June 2026. A disallowed item is one that a pharmacy may have already supplied but will not receive reimbursement for.

The Dental Practitioners' Formulary (DPF) determines exactly which items NHS dentists are permitted to prescribe. For example, it includes amoxicillin capsules but not tablets. Before prescribing, NHS dentists should check that the exact item and formulation appear in the prescriber's formulary.



However, Suraj Shah, drug tariff and reimbursement manager at Community Pharmacy England (CPE), told *Dentistry* that the formularies were overdue for review, as they included discontinued medications and product names that do not align with those displayed in current prescribing and pharmacy systems.

He said: 'The Department of Health and Social Care (DHSC) and NHS should tidy up the formularies to remove products that are no longer available, and reflect the names as they appear on NHS systems. In addition, both formularies should be updated to reflect latest prescribing guidelines.'

CPE, which estimated the £50,000 figure, said it had requested that DHSC review and update both the dentist and nurse prescribers' formularies.

How to prevent dental prescriptions from being disallowed

Suraj stressed that pharmacists were dispensing the disallowed items in 'good faith' as they have a seemingly valid prescription from a dental professional. He called for collaboration between dental and pharmacy professions to raise awareness of the exact products that dental professionals can prescribe and prevent invalid prescriptions.

He added: 'Pharmacies, similarly to NHS dentists, are going through a lot of financial pressure – money is tight. Anything we can do to help avoid such risks is always welcome.

'Raising awareness of the items not permitted for prescribing on FP10D forms will help NHS dentists and pharmacy teams reduce prescribing and dispensing errors, respectively.'

He also said moving NHS dentists towards electronic prescribing would be hugely beneficial, as it could restrict selection to items listed in the formulary. However, he acknowledged that this reform would take time to progress.

NHSBSA has been asked to provide details of the dental products most frequently disallowed on FP10D forms but has not yet provided them.

Dental nurse visa grants fall 95% after skilled worker visa change

Sponsored visa grants for overseas dental nurses fell by 95% after the government removed the role from the skilled worker route, new Home Office figures showed.

The latest immigration statistics recorded six grants for dental nurses in Q4 2025-Q2 2026, down from 122 in the previous three quarters.

Visa grants for medical and dental technicians also fell sharply, from 121 to three, while dental practitioner grants fell from 376 to 334.

The fall followed changes introduced on 22 July 2025, when several dental care professional roles became ineligible for new skilled worker sponsorship.

Dental nurses, dental technicians and dental hygienists were among the roles affected. The Home Office data covers sponsored work entry clearance visas for main applicants applying from outside the UK. It does not include in-country visa extensions or switches.

Dental nurse visa and sponsor licence changes

For dental practices, the figures raise two issues: which roles can be sponsored, and whether employers have the systems in place to stay compliant once they sponsor overseas workers.

Anushika Brogan, head of Damira Dental Group, told *Dentistry* that practices should not underestimate sponsor licence compliance after her group's licence was previously suspended following a Home Office visit.



'We had to unpick it all after the event'

She said: 'We went into it blind. We didn't know what was required of us, and we had to unpick it all after the event.'

Anushika's full interview can be found at bit.ly/4drcwnU.

Under Home Office rules, licensed sponsors must monitor workers' immigration status, keep relevant records, track attendance, maintain contact details and report certain changes to UK Visas and Immigration.

A sponsor licence can be downgraded, suspended or revoked if an employer fails to meet its duties.

Read *Dentistry*'s full explainer and download Dentistry HR's guide to employing overseas workers at bit.ly/4y4zuIY.

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Team PDM takes on Tough Mudder for Dental Wellness Trust

A team of dental professionals, mentors, former delegates, friends and family took on Tough Mudder London South to raise funds for the Dental Wellness Trust.

Team PDM, brought together by Private Dental Mentor (PDM), completed the challenge at Holmbury Estate on 20 September.

The event was organised to support the Dental Wellness Trust, a charity working to improve the oral health of children in the UK and internationally through education, prevention and outreach programmes.

Those taking part in the challenge included Ruben Douglas-Smith, Grace Douglas-Smith, Dr Floyd Lee-Briggs, Andrew Hewat, Dr Esme Court-Johnston, Ajsa Makó, János Makó, Daniel Mason, Neo Positivity, Dr Andrew Osafo, Christina Riley, Frances Riley, Dr Tristan Roberts, Emmanuel Santiago, Burhan Berke Tevetoğlu, Dr Merve Tevetoglu and Shane White.

The challenge was also supported by Dolfinpack, MudGear, Private Dental Mentor and Salomon.

Fundraising remains open, with donations continuing to support the Dental Wellness Trust's work.

Donations can be made via www.justgiving.com/page/pdmtoughmudder2026.



Get involved

The charity's next outreach initiative will take place in Luton on 6 November, when volunteers will visit schools to support children's oral health.

Dental professionals and other volunteers interested in taking part can get in touch via charity@dentalwellnesstrust.org.

Only 38% of registrants trust the fitness to practise process

Only 38% of registrants involved in concluded fitness-to-practise cases trusted the process to reach the correct outcome, according to a new General Dental Council (GDC) report.

Confidence was also low across other measures. Just 41% of registrants agreed that the process was fair and unbiased, while 39% felt their case had been treated appropriately and 36% said it had been handled proportionately.

'Just 41% of registrants agreed that the process was fair and unbiased'

The figures were even lower among informants, including patients and dental professionals who had raised concerns. Only 34% trusted the process to reach the correct outcome, 17% considered it fair and unbiased and 19% believed the case had been handled proportionately.

Theresa Thorp, executive director of regulation at the GDC, acknowledged the 'real fear and distress' caused by fitness to practise proceedings.

She said: 'Dental professionals tell us the wait is the hardest part, and people who raise concerns tell us they too often feel unheard. Our communications are now clearer than they were, and more people trust the process, but fewer than half believe it is fair and proportionate, and that is not where we want to be.'

What are the problems with the process?

Satisfaction with the fitness to practise process has trended upwards since 2023 – however, the report notes that this trend is 'not pronounced'.

Timeliness remained the most prominent concern, as 71% of registrants and 51% of informants said the time taken to resolve the case could be improved.

Overall support received was also a frequent complaint, along with certain aspects of the GDC's communication such as 'tone and respect'.

The findings follow a 26% rise in fitness-to-practise concerns during 2025.

The GDC pledged to keep making efforts to improve the process. Theresa added: 'Reducing the negative impact of regulation is central to our strategy, Trusted and Effective, and it matters beyond the individual cases: fear of regulation shapes how dental professionals practise, and that reaches patients.

'We are focused on moving cases faster, keeping people informed, and making sure nobody feels they are facing this alone, while protecting patients. We will use this research alongside other evidence to keep improving the process, so that participants feel properly supported, and feel confident that they will be treated fairly.'

The regulator also said it would continue to run surveys to understand the experience of fitness to practise proceedings.

The GDC commissioned researchers from Newcastle University, the University of Manchester, the University of Nottingham and Queen Mary University London to compile the *GDC Fitness to Practise experiences survey report 2026*. The survey received responses from 570 registrants and 645 informants, covering cases reaching a decision from April 2022 to September 2025.

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Dental school entry requirements 'out of kilter' with profession, says CDO for England

Chief dental officer (CDO) for England Jason Wong has questioned whether current dental school entry requirements reflect the practical and people-centred nature of the profession.

Speaking during a panel discussion hosted by mydentist at its Chesterfield practice, Jason said work was under way to widen participation in dental education.

He also called for dentistry to move away from what he described as a 'fear culture', arguing that mentoring and professional support should become routine throughout clinicians' careers. The discussion, which was shared exclusively with *Dentistry*, also included mydentist chief executive Nilesh Pandya, chief clinical officer Nyree Whitley and Dentaid head of clinical and policy Catherine Rutland.

Jason said: 'In terms of how we widen participation, we have got an incredibly academic entry requirement, with an incredibly academic course, with a job that if you learn in general practice, which most do, is really people centred. You know these relationships that you have or in practical skills can be out of kilter.

'I've made the point and there's some work going on and we've got meetings coming up with the Dental Schools Council about how we're going to address that.'

Competition for dental school places

Competition for UK dental school places remains intense. A recent *Dentistry* contributor article reported that more than 9,900 people applied for around 1,630 places in 2025. In the same article, Eshaa Hafeez described choosing to study dentistry in Bulgaria after missing the grades required for her UK offer by two marks.

Training capacity is expanding, though. The government has allocated 50 additional dental school places to the University of Portsmouth and the University of East Anglia from 2027. However, the profession continues to debate whether increasing places will widen participation or resolve the geographical distribution of the dental workforce. Nyree said mydentist planned to establish scholarships through its charitable foundation.

'These days it's really, really challenging,' she said. 'I don't want it to be a barrier for entry for people because there are loads of amazing people out there who will make great clinicians.'

'The increase of skill mix is on an upward trajectory, but I think we could speed that up'



Moving away from a 'fear culture'

Jason called for greater use of mentoring and continuing professional support.

'As far as the environment's concerned... maybe more use of mentoring and actually just general development. A learning culture rather than some parts of dentistry that have been stuck a bit in a fear culture,' he said. He argued that mentoring should become a routine part of professional development instead of something introduced only when a clinician encountered difficulties.

'We seem to be in a position where you need mentoring when you need help. But actually, the message I'm trying to communicate, we've been going around to all the students and saying it, you should be getting mentoring from the people surrounding you then and, actually, as you progress in your career.'

Nilesh said mydentist had invested in a large clinical development network. 'We've invested in well over 500 clinical development advisers and mentors to be working with our dentists to make sure that we are delivering on the ambitions that you have there, Jason,' he said.

Jason said observing colleagues and receiving career-long support were more established in other parts of healthcare. 'I think that's where we've got to catch up,' he said.

'We could speed up' skill mix

The CDO for England also called for faster progress in making use of the wider dental team.

'The increase of skill mix is on an upward trajectory, but I think we could speed that up,' Jason said. 'The other thing is to build on what the workforce actually wants.

'You've talked about upskilling. You've talked about the ability to work to the top of their scope. Actually, that's the other opportunity, which is, giving the simple things that you have for someone else to do, while actually being able to upskill and find different areas.'

From April this year, NHS dental contract reforms introduced a new course of treatment allowing suitably trained dental nurses to apply fluoride varnish to children without an accompanying examination.

Jason said policy changes could only go so far. 'It's actually individual practice leadership.

'I think it's a great opportunity that you've got the reach, whereas an individual practice owner may not have the reach to do that.'

Read the full article at bit.ly/4rO3IIf to find out more about NHS reform and workforce pressures, addressing access issues, support for internationally qualified dentists and the place of third-sector dentistry.

Orthodontic community takes the plunge for motor neurone disease

Around 150 members of the orthodontic community took to the sea in Brighton in support of retired specialist orthodontist Joff Machell, who is living with motor neurone disease (MND).

The fancy-dress 'Chilly Dip' took place during the British Orthodontic Conference, bringing together colleagues from across the UK to raise awareness of MND and funds for the MND Association.







Participants entered the water in an array of costumes, including a Tyrannosaurus rex, giant red chillies and a flamingo, before joining hands to form a large circle in the shallows. A similar number of colleagues and supporters gathered on Brighton Beach to cheer them on.

Joff was diagnosed with MND in October 2025. The progressive condition forced him to retire early and is increasingly affecting his speech, mobility and physical strength. Since his diagnosis, Joff has continued to organise a series of 'Chilly Dips' with family, friends and supporters, using the events to raise funds and awareness for the MND Association. His personal fundraising total has now passed £82,000. To donate, visit bit.ly/4jIcpbf.

Speaking before the Brighton dip, Joff said: 'I am incredibly grateful to my orthodontic colleagues for your love, kindness and generosity. MND is not incurable, it is under-funded.

'There is a powerful saying in the orthodontic community: "There will be no finish line, until there is a cure for MND."'

Further fundraising events are planned as Joff continues to support the MND Association and campaign for greater awareness and investment in research.





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Is NHS dentistry at a turning point?

Chief dental officer for England Jason Wong discusses the record numbers of children seen by a dentist in last year

Jason Wong
Chief dental officer for England

We are at what feels like a turning point in dentistry. The latest NHS dental figures show the hard work and huge efforts that the whole system has put in to improving access for patients.

More children than ever before were seen by a dentist in the last year, and we reached a five-year high in adults seen over the previous two years.

Treatments delivered by NHS dental teams were also significantly higher in 2025/26 – with 37.6 million courses of treatment delivered – up 2.2 million (6.2%) on the previous year.

Alongside this, the dental workforce is growing. We have hundreds more dentists working in the NHS now compared to last year. And this expansion and your hard work is delivering for patients.

The number of children being seen by an NHS dentist within the last year to June hit 7.18 million – up more than 200,000 on the same period last year, the highest since data has been collected.

It was also a five-year high of adults being seen by a dentist within the previous two years, standing at 18.82 million in June.

Supporting and sustaining

Supporting dental teams to work at their best within the NHS is key to sustaining this improvement and we have been taking steps to make it a better place to work.

In April we rolled out reforms to the dental contract with a focus on better remuneration and more support for the profession, which has led to better patient experience.

For the first time, appraisals for a range of NHS dental professionals will be supported through the contract.

Changes to urgent care and the introduction of new funded pathways for those with significant tooth decay or gum disease also mean we are diverting more resources to patients with the highest needs.

The golden thread running through these changes has been putting clinical best practice at the heart of everything we do, with a laser-like focus on treating patients who need us the most.

However, we are still at the early stages of implementing these changes, and we know there is more to do.

Gathering feedback from you and your teams is an important part of that, so we encourage you to work with your commissioners and NHS England to shares learnings and contribute to this process.

Fit for the future

Alongside the reforms to the contract, the recent publication of our guidance for concise record keeping should also support clinicians to reduce time and efforts spent on excessive recording and give them more time to focus on patients.

In addition, from last month with the start of a new academic year, I am delighted that our dental therapy and dental hygiene students (level 5 and 6 courses) will be able to start their courses without having to worry about paying for their placement costs upfront.

We know upfront costs for things like travel or accommodation can be a burden – so eligible dental hygiene and dental therapy students will be able to receive advance payments to cover these costs, to make sure they can focus all their efforts on training instead of worrying when their expenses will hit their bank accounts.

These changes, alongside supporting the government's work towards tackling the causes of dental problems – such as by promoting supervised toothbrushing and fluoridation – are helping us to build, maintain and deliver an NHS dentistry system that is fit for the future.

I would like to thank you for your hard work and commitment – and please look out for further announcements as we work to build on the progress already made and continue to expand the reach of NHS dentistry.

Read NHS England's guidance for concise record keeping via bit.ly/4AGg3bY.



What should another government deliver for dentists?

Simon Kidd is hopeful as he sets out his dental treatment plan for the health secretary and her team

Simon Kidd
Head of the DDU

It's frustrating for all of us who care about dentistry in the UK that the service is facing some of the greatest challenges at a time of maximum instability at the top.

Yvette Cooper is the 10th Secretary of State for Health and Social Care since 2016 and the fact that her predecessor, James Murray, was in post for just over two months exemplifies the constant ministerial churn.

As Andy Burnham recognised in one of his first speeches as Prime Minister, political turbulence has been damaging for the country.

Each new administration has promised to address the deep-rooted issues in dentistry but left office before they could make a difference.

As a result, there are many long-standing issues that need to be solved if the government is to win over practitioners and restore professional morale.

We are willing the government to succeed, but there's a lot to be done, including overhauling the UDA system, improving access and integrating internationally qualified dentists into the workforce.

However, from a DDU perspective, I want to focus on two urgent priorities.

Top of the list

The first priority is setting a clear and realistic timetable for reform of the General Dental Council's (GDC's) legislative framework. This is even more urgent following the GDC's 2025 annual report, which showed that fitness to practise (FTP) complaints had rocketed by 26% in 2025 and increased by 40% since 2022.

This higher caseload doesn't indicate a dramatic fall in standards – most cases still don't progress beyond the assessment stage and the proportion of erasures following a hearing has fallen slightly. But combined with an unwieldy FTP process they make it harder for the GDC to meet its performance target on timeliness, which has already been missed for several years.

The GDC is doing its bit through initiatives like the Initial Inquiries project and directing more resources to the assessment stage but without legislation, its hands are tied.

Meanwhile, the median time for initial hearings to start from a referral by case examiners increased to 11 months and 10 days in 2025. A process that is intended to protect the public has become a punishment in itself for dental professionals, regardless of the outcome.

Making the FTP procedures faster, fairer and less adversarial will help dispel the climate of fear that hangs over the profession and which contributes to more defensive practice. It's also in the interests of patients, as no one wants to be treated by a stressed and potentially distracted dental professional.

All this means that dentistry should be at the front of the queue of professional healthcare regulators awaiting reform, but the government hasn't yet made any announcement.

While we welcome elements of the government's draft framework for the General Medical Council, including retaining health as a category of impairment, we have concerns that some proposals create the conditions for more delays.

Giving the regulator the right of appeal against FTP decisions, for example, and scrapping the 'five-year rule', which currently means allegations over five years old can't be investigated unless it's in the public interest. We want the government to finally push the button on GDC reform but equally we need it to listen to the profession and those with day-to-day experience of the FTP process.

Priority number two

The second area where the government can deliver change is unsustainable clinical negligence costs, which divert money from patient care and are an inflationary pressure on professional indemnity.

According to the latest *NHS Resolution Annual Report*, clinical negligence costs for the financial year 2025/26 were up 4.8% to £3.2 billion. Claimant damages accounted for £2.4 billion, while claimant legal costs were £622.2 million and NHS legal costs £188 million.

It noted that for claims valued up to £25,000, average claimant legal costs paid per claim have increased by 11% from the previous year to £30,264 which meant they 'exceeded the highest damages paid for this cohort of claim'.

Dental claims tend to fall into this 'low value' bracket and we regularly encounter disproportionately high legal costs from claimants' solicitors that dwarf their clients' compensation awards. Of course, negligently harmed patients deserve compensation but the government must now expedite the introduction of fixed recoverable legal costs to address the issue of ballooning legal costs.

Positive signs

Action on these two issues would go some way to showing the government is listening to the concerns of dental professionals ahead of the necessary but complex reforms to the dental contract.

Despite previous disappointments, I think there are grounds for some optimism. Andy Burnham has already shown a willingness to grasp the nettle on social care, another intractable issue.

I also think it's a positive sign that the PM has previously served as health secretary.

In fact, he's the first occupant of 10 Downing Street to have overseen the nation's health since Neville Chamberlain back in 1937!

Of course, dentistry is facing serious challenges, but I hope that the government has the experience and resolve to see through the vital reforms we need.

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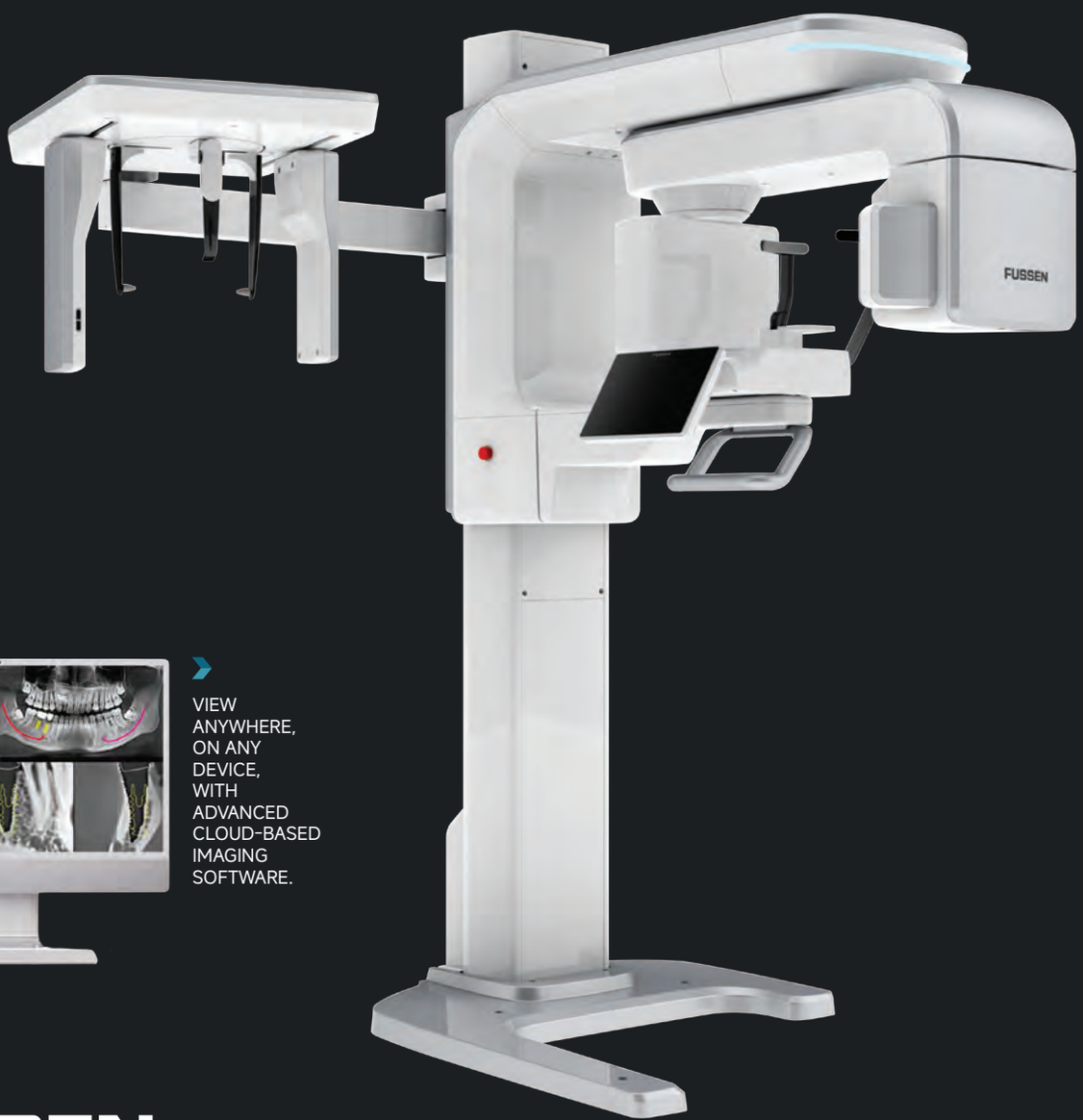
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Are they patients or consumers?

Nigel Jones considers the distinction between patients and consumers – and what it reveals about competition, trust and the changing private dentistry market

Nigel Jones
Director, Practice Plan

The debate about whether patients are consumers has been brought back into sharp focus by the Competition and Markets Authority (CMA) and its market study into private dentistry services in the UK. The update, published in July, refers to the CMA having heard from '1,825 consumers who had received private dental treatment in the UK in the last five years', so it's pretty clear where the CMA stands on the issue.

For many who consider the two terms interchangeable, it's a semantic argument about an inevitable byproduct of the language of markets in healthcare. For others, there's more to it than simply accepting that patient-centred care naturally leads to considering dental patients as customers.

I recently read *What Money Can't Buy: The Moral Limits of Markets* by Michael J Sandel. Although contentious, you can't help but come away from the book with misgivings about how market thinking can be misapplied in certain sectors. However, I can see how it can be helpful when trying to interpret some apparently contradictory observations on the state of the private dentistry market.

Take, for example, how the rule of supply and demand applies to private dentistry. On the one hand, some would say there is an imbalance due to widely acknowledged workforce shortages restricting supply while demand from an ageing and image-conscious public shows little sign of abating. 'Not enough dentists' is the refrain we've heard from organisations such as the BDA and ADG throughout the past few years.

On the other hand, we have this quote from one of the submissions to the CMA: 'Private dentistry is competitive especially as now more and more practices are leaving the NHS. This makes growth and patient retention more difficult as there is more choice for patients'.

At first glance, it might seem hard to reconcile the two views, but closer scrutiny is thought-provoking, particularly if one truly considers the differences between the market for general dentistry and that for cosmetic dentistry.

The new normal

In the wake of COVID-19 and the virtual world that emerged during lockdowns, we all became familiar with the term 'zoom boom' and how that drove demand for straighter, whiter teeth. The resulting commercial opportunities were embraced by many entrepreneurial dentists, and successful new business models emerged.

Roll on a few years, and we have a cosmetic dentistry market flooded with suppliers eager to replicate the success of the early adopters, but with patient demand that appears to be softening. In that context, the quote about a highly competitive market and lots of patient choice makes sense.

So, what of private general dentistry? I would suggest that in this market the supply and demand imbalance continues to favour the profession.

The supply of general dental services is under pressure from the trend towards part-time working, lower productivity prompted by the perceived risks of complaints and litigation, and the move towards private dentistry.

The latter is partly a reflection of clinical resources being diverted to focus on cosmetic dentistry and the desire to see fewer patients for longer appointment times. For many practitioners, it is simply a more sustainable, pleasant and rewarding way of earning a living.

Considered in this light, the two apparently opposing views on competition within dentistry start to make more sense. Different strategies are required to cultivate a thriving book of patients attending regularly for general dental care compared with generating a pipeline of people wanting to address a perceived aesthetic deficiency.

Clarity needed

So, are people visiting dental practices, patients or consumers? At least part of the answer lies within their motives for being there in the first place.

In other parts of healthcare, patients are often sick and vulnerable, so shopping around for the best deal may not be the priority. Dentistry differs because of its strong focus on prevention. Half the population attend a dental practice regularly for a health screening, for which most have to pay, and not because they feel ill.

However, the fact that an oral health screening may reveal a problem they were previously unaware of means the choice of clinician goes beyond normal consumer considerations. It's not about convenient parking, great marketing or even price; it's about trust, which is why recommendations from friends and family become so important.

Contrast that with someone seeking a cosmetic solution to a problem they've self-diagnosed and a result they can visualise. The difference in the sense of empowerment must be significant and lend itself to more consumer-like behaviour, including being influenced by marketing.

The differences between the general dentistry and cosmetic dentistry markets, both in terms of competition and patient behaviours, need to be reflected in business strategies. There are risks and benefits to having all your eggs in the cosmetic dentistry basket, while there can be missed opportunities within your cohort of regularly attending patients. Blending both together in a flexible way that can adapt to a constantly changing environment will be key.

Whether attendees at a dental practice are patients or consumers raises some interesting commercial considerations alongside very important ethical considerations. Perhaps the CMA will clarify matters.





What AI is doing to dentistry

Robert Donald on embracing innovation without losing the human touch

Robert Donald
Director, Independent Care Plans

Artificial intelligence (AI) is one of those subjects that seems to dominate every business conversation now, and dentistry is no exception.

Depending on who you listen to, AI is either about to revolutionise healthcare or replace half the jobs in it. The reality, as is often the case, lies somewhere in between.

From my perspective, AI isn't here to replace dentists – it's here to support them.

Across the profession we're already seeing AI helping clinicians analyse radiographs, support treatment planning, streamline administration and improve patient communication. Used well, these technologies can free up valuable time, improve consistency and allow dental teams to focus on what they do best – delivering excellent patient care.

At Independent Care Plans, we work with practices that are constantly adapting to new technologies, changing patient expectations and an increasingly demanding regulatory environment. AI is simply the latest development that practices need to understand and manage effectively.

An emerging issue

What strikes me, however, is that much of the conversation focuses on what AI can do for dentistry. Far less attention is being paid to what AI is already doing to dentistry.

One example is the growing number of patient complaints that are being drafted using artificial intelligence.

The medical defence organisation MDDUS has identified this as an emerging issue for the profession.

Helen Kaney, head of dental division at MDDUS, said: 'We are noting an increase in the use of AI by patients when making complaints or when trying to pursue a claim without formal legal advice.'

She added that many of these complaints were lengthy, repetitive and often included legal references that appeared convincing but were not always accurate.

'The AI generated patient complaint runs to multiple pages of repetitive material and often quotes incorrect legislation for the jurisdiction concerned.'

That doesn't mean the complaint itself lacks merit. Every concern deserves to be considered carefully and professionally, however it does illustrate how AI is changing the environment in which practices operate. Resolving complaints can become more time-consuming, more stressful and more costly for everyone involved.

Clinician considerations

The challenge works both ways. As dentists begin using AI to assist with administration or correspondence, they also need to think carefully about confidentiality and governance. Helen said: 'Members should be aware that AI tools commonly used may not be safe to input patient identifiable information. Such action puts the clinician at risk. Careful consideration of the use of AI from a risk management perspective is required.'

I think that is sound advice. Technology should always support professional judgement – not replace it.

No artificial intelligence system can replicate the trust between a patient and their dentist, the reassurance provided during a difficult appointment or the experience that comes from years of clinical practice. Nor should it.

The practices that will benefit most from AI won't necessarily be those using the greatest number of digital tools; they'll be the ones that introduce technology thoughtfully, establish clear policies, train their teams properly and continue to put patient care at the centre of everything they do.

That's where I believe organisations like Independent Care Plans can play an important role. Good practice management has always been about balancing innovation with responsibility. AI simply adds another dimension to that.

Solid foundation

There's little doubt that artificial intelligence will become an increasingly familiar part of modern dentistry. It has enormous potential to improve efficiency, support diagnosis and enhance the patient experience.

However, the future of dentistry won't be defined by AI alone. It will be defined by how successfully dentists combine new technology with the professionalism, empathy and clinical judgement that have always been the foundations of outstanding patient care.

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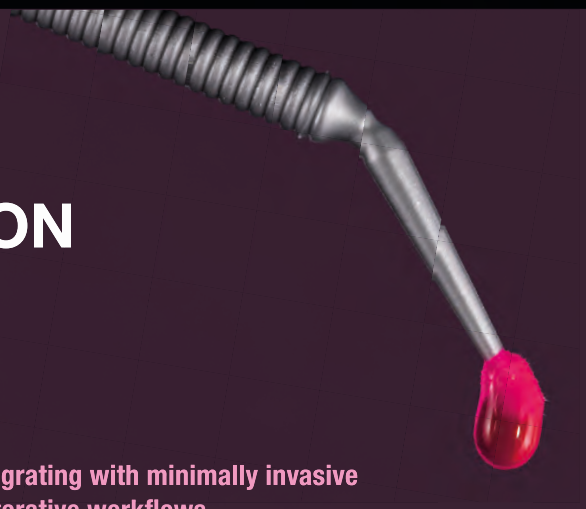
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Understanding the dentine layers

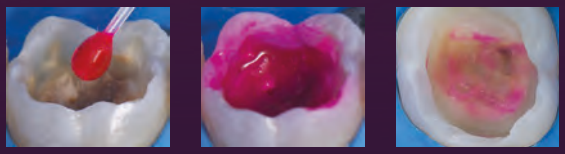
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Understanding menopause in dentistry

Menopause can affect everything from sleep and concentration to confidence and oral health. Siobhan Hiscott explores what dental professionals need to know – and how they can better support themselves, colleagues and patients

Siobhan Hiscott
Group managing editor, FMC

We're all familiar with the hot flush – the classic cliché used as shorthand to sum up menopause for generations of people. But while they're the symptom most readily associated with menopause, hot flushes are only a small part of the story – particularly when it comes to menopause in dentistry.

Menopause and perimenopause signal the onset of significant changes for people experiencing them. Disruptions to sleep, mood, memory and concentration, alongside headaches, joint pain, palpitations and genitourinary symptoms are among the many ways perimenopause and menopause can affect everyday life (NICE, 2024; NHS, 2025).

For some people, the impact is relatively mild; for others, symptoms can have a profound effect on their health, relationships and working lives (NICE, 2024).

In dentistry, menopause deserves particular attention.

Clinical practice requires concentration and precision, often while working in brightly lit environments, wearing personal protective equipment (PPE) and moving between patients with limited opportunities for a break. Understanding menopause in dentistry therefore matters – whether experiencing symptoms yourself, supporting a colleague or caring for patients navigating this stage of life.

The stages of menopause

Menopause describes the point when someone has not had a period for 12 months and is not using hormonal contraception that affects their menstrual cycle (NICE, 2024). After this point, someone is described as postmenopausal (NHS, 2025).

In everyday language, however, terms such as 'menopause', 'menopausal' and 'going through menopause' are often used interchangeably to describe the wider transition and the symptoms associated with it. Technically, these experiences can span both perimenopause and postmenopause.

Symptoms typically begin before menopause itself is reached: a stage called perimenopause.

Perimenopause is the transition leading up to menopause, as hormone levels fluctuate and symptoms begin.

While symptoms begin during perimenopause, reaching menopause doesn't necessarily mean symptoms stop. Guidance from the NHS last year states that symptoms typically last between seven and nine years and can persist for longer. Some, such as joint pain and vaginal dryness, may continue after other symptoms have subsided.

While menopause predominantly affects women, some transgender men and non-binary people registered female at birth can also experience it (NICE, 2024).

Symptoms of menopause and perimenopause

One of the first signs of menopause is often a change to periods, which may become more or less frequent, and heavier or lighter. However, symptoms can emerge while someone is still menstruating and may not immediately be recognised as being associated with menopause (NICE, 2024; NHS, 2025).

Common symptoms include:

- Hot flushes and night sweats
- Sleep difficulties
- Fatigue
- Low mood
- Anxiety
- Memory and concentration problems ('brain fog')
- Headaches and migraines
- Palpitations
- Muscle and joint pain
- Reduced libido
- Vaginal dryness
- Urinary symptoms.

Changes to skin, hair and body composition can also occur.

However, the experience is highly individual: symptoms can vary in type, severity and duration, and may change over time (NICE, 2024).

Not everyone's journey is the same

Menopause doesn't always happen gradually or at the expected age.

Surgical menopause occurs when both ovaries are removed before natural menopause. Because ovarian hormone production falls abruptly rather than gradually, symptoms can begin suddenly (British Menopause Society, 2024).

Medical or induced menopause, sometimes referred to as chemical menopause, can result from medical treatments that affect or suppress ovarian function. This can include some cancer treatments and medications used to manage conditions such as endometriosis. Depending on the treatment, the effects may be temporary or permanent (British Menopause Society, 2024).

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This October, to mark Menopause Awareness Month, *Dentistry* is launching Menopause Matters in Dentistry, in partnership with Colosseum Dental.

Through expert insight, evidence-based information and the real experiences of dental professionals, the month-long campaign will focus on education, visibility and practical support, exploring the different ways menopause can affect those working across dentistry – as well as its potential implications for oral health.

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Early menopause occurs between the ages of 40 and 44, while premature ovarian insufficiency (POI) involves loss of normal ovarian function before the age of 40 (NICE, 2024).

These distinctions are important – someone experiencing a gradual natural menopause in their early 50s may require very different support from somebody suddenly entering surgical or treatment-induced menopause at a much younger age.

Menopause and dentistry

For dental professionals, menopausal symptoms can intersect with the demands of the job.

A poor night's sleep followed by a full day in clinic can exacerbate fatigue. Hot flushes may feel harder to manage beneath PPE and surgery lights. Joint and muscle pain can add to the physical demands of dentistry, while anxiety, low mood or brain fog may affect someone's confidence at work.

Perimenopause may also arrive at an already demanding career stage. Some professionals will simultaneously be managing clinical responsibilities, practice ownership or leadership roles alongside commitments outside work. That doesn't mean someone experiencing menopause is less capable of doing their job.

It does mean that seemingly small workplace adjustments can sometimes make that job considerably easier.

These could include access to cool drinking water, temperature control or fans where appropriate, appropriate breaks, changes to uniforms or PPE arrangements where clinically permissible, and flexibility around working patterns or appointment schedules.

Most importantly, support should be individual. The National Institute for Health and Care Excellence (NICE) (2024) recommends an individualised approach to menopause because symptoms and circumstances vary between people and over time.

A simple conversation can be a better starting point: 'Is there anything about your working environment or schedule that we could adjust to support you?'

Listen, don't assume and respect the person's privacy.

What can I do?

If you're experiencing symptoms…

- Don't dismiss what you're experiencing. If symptoms are affecting your work, wellbeing, relationships or everyday life, consider speaking to a healthcare professional (NHS, 2025)
- Think about what would help at work. Identify practical changes that could make your working day easier and discuss these with an appropriate colleague or manager
- Use trusted information. The NHS, NICE, British Menopause Society and Women's Health Concern provide evidence-based information about menopause and treatment options.

If you're supporting a colleague…

- Listen rather than assume. Menopause experiences differ enormously, so allow your colleague to explain what they are experiencing and what they need
- Keep conversations confidential. Someone choosing to talk about their symptoms doesn't automatically mean they want the wider team to know
- Don't minimise symptoms. Their severity and duration can vary considerably between individuals (NICE, 2024).

If you lead or manage a dental team…

- Start the conversation. Make it clear that team members can raise menopause-related concerns without embarrassment or judgement
- Consider practical adjustments. Temperature, breaks, working patterns and appointment scheduling are all areas worth discussing – but ask the individual what would help rather than prescribing a solution
- Build understanding across the team. Greater awareness can help make menopause an ordinary workplace wellbeing conversation rather than a taboo subject.

The impact of menopause on oral health

For dental professionals, there is another important dimension to the conversation: patients.

Research into menopause and oral health is continuing to evolve. A scoping review of 30 studies identified xerostomia and altered taste among the most commonly reported oral manifestations, alongside research investigating periodontal health, alveolar bone, the oral microbiome and other oral changes (Labunet et al, 2025).

Civiletto-S Martín and colleagues' (2026) systematic review also found greater clinical attachment loss, increased probing depths and more pronounced signs of periodontal inflammation among postmenopausal women compared with premenopausal women.

However, importantly, the authors rated the certainty of the periodontal evidence as moderate to low because of methodological variability and concluded that higher-quality prospective research is needed before the findings can inform clinical guidelines.

Age, medication, systemic health and other factors can also influence oral symptoms such as xerostomia (Labunet et al, 2025). Menopause should therefore not automatically be assumed to be the cause of oral changes. For the dental team, this provides another reason to take a comprehensive history. When a patient presents with new dry mouth, burning sensations, altered taste or changing periodontal health, sensitively exploring their wider health, symptoms and medications may help build a fuller clinical picture.

Finding the right support

There is no need to wait until symptoms become unbearable before seeking advice. The NHS (2025) recommends seeking support when menopause or perimenopause symptoms are affecting everyday life and notes that getting advice early may help reduce their impact on health, relationships and work.

Treatment and management should be individualised. Options may include hormone replacement therapy (HRT), non-hormonal treatments and cognitive behavioural therapy (CBT), depending on symptoms, medical history, individual circumstances and preferences. Lifestyle measures around physical activity, sleep and general wellbeing may also form part of the conversation.

Reliable information and further support are available from the NHS, NICE, the British Menopause Society and Women's Health Concern.

Ultimately, better menopause awareness isn't about becoming an expert in somebody else's health. It is about understanding that experiences differ, recognising when someone may need support and creating an environment in which they feel able to ask for it. For dentistry, that means looking at menopause through more than one lens: as a health issue, an oral health consideration, a workplace issue and a conversation that all of us can become better equipped to have.

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Perimenopause and menopause: oral health considerations

For dental professionals, menopause should be a prompt to ask more questions rather than make assumptions, says Rafina O'Brien

Rafina O'Brien
Dental hygienist and therapist, Colosseum Dental

Perimenopause and menopause can bring a wide range of physical and psychological changes, but oral health is an area that can easily be overlooked.

For some women, the menopausal transition may coincide with symptoms such as dry mouth, altered taste, burning or oral discomfort, alongside changes in gingival and periodontal health. However, the evidence is complex, and these symptoms should not automatically be attributed to hormonal changes. Age, medication, systemic health, hydration, oral health behaviours and other factors can all contribute.

For dental professionals, menopause should therefore be a prompt to ask more questions, rather than make assumptions.

Start with a question

A simple conversation can uncover problems that might otherwise remain unreported.

Rather than waiting for a patient to volunteer information, dental professionals can ask whether they have noticed any changes in their mouth, particularly if they mention changes to their menstrual cycle or other symptoms associated with perimenopause or menopause.

A question such as: 'Have you noticed any changes in your mouth since your periods or other menopausal symptoms started changing?' can open the door to a much broader assessment.

This is relevant because an integrative review examining oral healthcare among women during perimenopause and menopause identified limited oral health knowledge and unmet oral health needs, alongside gaps in advice from healthcare professionals. The authors also highlighted the limitations of the existing evidence base, reinforcing the need for caution when interpreting associations between menopause and oral health (Thomas et al, 2025).

The conversation does not need to become another lengthy medical history. It is about creating an opportunity for the patient to tell us what has changed.

Look beyond the scale and polish

Menopause does not create a separate set of periodontal protocols. The fundamentals of prevention and periodontal care remain the same.

However, the menopausal transition can be a useful prompt to reassess the patient's individual risk. Plaque control, bleeding, periodontal probing findings, recession and attachment levels should be considered within the context of the patient's overall periodontal assessment and established risk factors.

A 2026 systematic review found associations between postmenopausal status and several periodontal clinical outcomes, including greater clinical attachment loss, probing depths and periodontal inflammation compared with premenopausal women. However, the certainty of the evidence ranged from moderate to low, and there was considerable variation between studies. The authors concluded that higher-quality prospective research is required (Civiletto-S Martín et al, 2026).

That distinction is important in practice.

We should be attentive to changes in periodontal health, but we should not tell a patient that menopause itself means they will develop periodontal disease.

Don't overlook dry mouth

Xerostomia is another symptom worth exploring.

Patients may describe waking with a dry mouth, needing to sip water frequently, difficulty eating dry foods, changes in taste or general oral discomfort. However, dry mouth has numerous potential causes, including medication,



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dehydration and mouth breathing. A careful medical and medication history is therefore essential.

Medication review is particularly important because xerostomia can be associated with a wide range of commonly prescribed medicines and should not automatically be attributed to hormonal change.

Saliva has an important protective role within the oral environment. Reduced salivary flow can increase susceptibility to caries and contribute to difficulties with eating, speaking and maintaining oral comfort.

Management should be individualised according to the patient's symptoms, clinical findings and underlying risk. Depending on the circumstances, this may include advice on hydration, reducing the frequency of free sugars, stimulating saliva, using saliva substitutes and optimising fluoride exposure.

Current UK prevention guidance recommends that adults brush twice daily with toothpaste containing 1,350 to 1,500ppm fluoride. Additional fluoride measures may be appropriate where an individual's caries risk indicates a need for them (Department of Health and Social Care, NHS England, Welsh Government, Department of Health Northern Ireland, 2025).

Burning, altered taste and oral discomfort

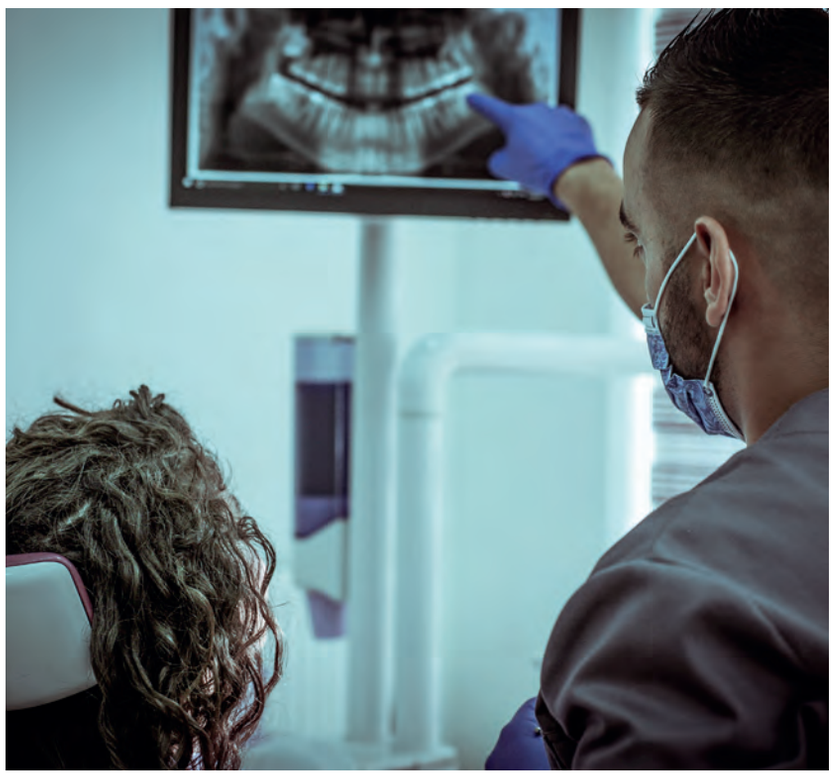
Burning oral symptoms can be particularly challenging for both patients and clinicians because significant symptoms may occur despite little or no obvious clinical abnormality.

A 2026 systematic review examining the relationship between menopause and burning mouth syndrome reported an association between the two, but also highlighted the multifactorial nature of the condition (Qaderi et al, 2026).

This means that persistent burning symptoms should not simply be explained away as 'hormones'.

A thorough history and appropriate examination remain important. Consider the timing and nature of symptoms, medications, oral habits, dietary factors and relevant systemic conditions, alongside the clinical examination. Where symptoms persist or the diagnosis is uncertain, further investigation or referral may be appropriate.

'Management should be individualised according to the patient's symptoms, clinical findings and underlying risk'



The patient's experience should be taken seriously even when the clinical examination appears relatively normal.

Don't miss what isn't menopause

Perhaps the most important clinical message is that menopause should never become a diagnostic shortcut.

A new ulcer, persistent red or red-and-white patch, unexplained lump or other concerning mucosal change should be assessed on its own clinical merits rather than attributed to perimenopause or menopause.

NICE recommends referral through a suspected cancer pathway for unexplained oral ulceration lasting more than three weeks. It also recommends urgent assessment of a lump on the lip or in the oral cavity and of a red or red-and-white patch consistent with erythroplakia or erythroleukoplakia.

This is not about alarming patients. It is about good clinical examination, appropriate documentation and recognising when a finding does not fit the expected clinical picture.

Make prevention personal

The menopause conversation does not need to become another lengthy checklist, instead:

- Ask what has changed
- Assess periodontal and caries risk
- Check saliva, medication and relevant medical history
- Reinforce fluoride and effective plaque removal
- Discuss interdental cleaning where appropriate
- Examine the oral mucosa carefully
- Investigate persistent or unexplained symptoms rather than automatically attributing them to menopause.

And where a patient is experiencing wider menopausal symptoms, dental professionals can signpost them towards an appropriate healthcare professional for further discussion.

Our role is not to diagnose or manage menopause treatment. It is to recognise potential oral health changes, assess what we can clinically assess, identify problems that require further investigation and support patients with appropriate prevention and signposting.

NICE recommends an individualised approach to identifying, discussing and managing perimenopause and menopause, with care adapted according to the person's symptoms and changing circumstances. The menopausal transition is not a dental diagnosis. It is a life stage that can intersect with oral health in several different ways.

As dental professionals, we do not need to label every symptom as hormonal. We need to notice, ask, assess and act appropriately. Sometimes, making oral health part of the perimenopause and menopause conversation is the most useful place to start.

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Midlife in dentistry

Makbule Sipahi lifts the lid on practising through perimenopause

Makbule Sipahi
General dentist with a PhD degree in paediatric dentistry

Life as a midlife female dentist can be challenging. While everyone discusses the impact of menopause on patients' oral health, it can be equally tough for professionals experiencing these changes. From hot flushes during procedures to brain fog mid-discussion, such moments are part of daily life for female practitioners.

Dentistry demands a kind of resilience that is quiet, steady, and often invisible. By midlife, many of us have honed not only our clinical skills but also our emotional endurance – handling anxious patients, leading teams and working precisely under pressure. However, I hadn't fully realised how perimenopause would affect that professional rhythm.

This lack of awareness is common. In 2026, US researchers published a collaborative study with Flo, the women's health app, to assess perimenopausal symptoms among 17,494 people from 158 countries (Hedges et al, 2026).

They found that fatigue, physical and mental exhaustion, mood changes, digestive issues, and sleep disturbances were all central to many people's perimenopause experiences, with hot flushes way down the list of reported symptoms.

The researchers recommend that future studies should focus on how demographic and lifestyle factors, social determinants of health, attitudes about perimenopause and menopause, and knowledge-seeking behaviours affect these differences.

'Midlife is a transition, not a decline'

Understanding these factors, they say, will help create targeted educational initiatives for patients and healthcare providers.

Commenting on the results, the study's first author, Mary Hedges, a community internal medicine physician at Mayo Clinic, said: 'This



study shines a light on how little we still understand about perimenopause and how much it affects people's daily lives.'

Increased demands

Perimenopause doesn't have a clear start or set rules. It can begin subtly with poor sleep, a shorter temper, and mental fog creeping in.

In dentistry, where focus and fine motor skills are critical, even small changes can feel magnified. A restless night can lead to a longer clinical day. Decisions that once felt instinctive may now require more conscious effort. It's not that competence vanishes; it's that it sometimes demands more of you.

Physical demands

Fatigue remains a major challenge. Dentistry is physically demanding, and hormonal shifts can make energy levels unpredictable. On some days, maintaining good posture, focus, and pace feels disproportionately difficult.

It's therefore important to plan carefully by spacing procedures, allowing breaks between patients, and knowing when to step back rather than push through.

Emotional demands

Emotional challenges are also significant. Perimenopause can heighten anxiety or reduce stress tolerance, which is hardly ideal for a profession that depends on calm reassurance. Most days, we stay steady, but maintaining that calm can take more effort internally. Difficult interactions or delays may linger longer than they used to.

Comfort levels

There are other unexpected issues, too. For example, dry eyes can affect daily work. Long sessions under loupes and bright lights can become uncomfortable. Anything tight-fitting can become unbearable. Scrubs are not always designed with women's needs in mind; white scrubs, in particular, can be problematic for menstrual hygiene.

'Menopause and other midlife changes should not be taboo'

In addition to fluctuating temperatures, skin sensitivity and bloating can occur. Choosing lightweight, stretchable, moisture-wicking fabrics and layering with a breathable undershirt can improve comfort, while seamless or tagless designs can prevent skin irritation. Incorporating adjustable features, such as drawstrings or Velcro, can also enhance fit and support.

The clinical setting can impact the ability to practise. It is essential to have well-ventilated treatment rooms, and women experiencing symptoms should feel at ease discussing any necessary workplace adjustments.

While not insurmountable, these issues can accumulate, highlighting the need to adapt rather than resist. Small changes – such as reviewing clinic templates, improving ergonomics, staying hydrated, and consulting healthcare providers – can make a significant difference.

Open conversations are vital. Although we discuss clinical complications readily, personal health topics such as menopause often remain unspoken.

Midlife offers a valuable perspective; experience brings confidence, and understanding of patient care deepens beyond technical skills.

Communication improves, empathy grows, and priorities are clarified. Perimenopause prompts a re-evaluation, not just of health but of our practice.

For those of us at this stage, the goal isn't to match the pace of youth but to sustain an effective and humane workstyle for ourselves and our patients.

Make some noise

Dentistry is a long career, and midlife is a transition, not a decline. With awareness and support, it can be navigated with the same professionalism and care we bring to our work every day.

But we do need a cultural shift within the profession, involving regulatory and representative bodies, to raise awareness of the challenges midlife women face in dentistry, including workforce design, care delivery patterns, and ergonomic issues.

Awareness is slowly improving, particularly in patient care. When discussing personal health topics such as menopause, we should approach these conversations openly yet professionally. Menopause and other midlife changes should not be taboo, especially in a predominantly female profession.

Honest conversations with colleagues help normalise experiences and foster support. With patients, I will always discuss relevant health topics sensitively and only when appropriate, as hormonal changes can affect oral health and wellbeing.

Long, healthy careers

However, the profession hasn't yet made sufficient progress in addressing the unique challenges midlife women face in dentistry. While menopause and wellbeing are discussed more openly, meaningful structural change remains slow.

As dentistry becomes more feminised, a major shift in how midlife professional women are understood is necessary.

There needs to be greater recognition of how workforce design, care-delivery patterns and ergonomic pressures affect women in midlife. Greater flexibility, stronger support, and sustainable working practices are essential to retain experienced clinicians and support long, healthy careers.

Given the feminisation of dentistry, the profession must recognise that a one-size-fits-all career model is unsustainable. Midlife women often face overlapping challenges, including menopause, caring responsibilities and physical demands.

Without evolving workforce planning, ergonomics and career flexibility, we risk losing highly experienced clinicians at a time when their expertise is most valuable.

Maintaining resilience has meant accepting that I cannot work as I did 20 years ago. Prioritising ergonomics, taking regular breaks, being selective about my workload, and focusing on wellbeing have helped. Most importantly, I am kinder to myself in recognising that adapting in midlife isn't a weakness but is vital for a long, healthy dental career.

Makbule is on Instagram as **@dr.mac_bule**.

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Through expert insight, evidence-based information and the real experiences of dental professionals, the month-long campaign will focus on education, visibility and practical support, exploring the different ways menopause can affect those working across dentistry – as well as its potential implications for oral health.

Find out more at dentistry.co.uk.

Menopause at work: what employers need to know

Lara Brewood-Green looks into the legal responsibilities dental practices have around menopause at work and how employers can support their teams

Lara Brewood-Green
Lead people consultant, Dentistry HR

What legal responsibilities do dental practices have around menopause at work?

Menopause itself isn't currently a protected characteristic under the Equality Act 2010, but employees experiencing menopausal or perimenopausal symptoms might be protected under existing characteristics, such as disability, sex and age.

If someone's symptoms have a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities, they could meet the legal definition of disability. If they do, the employer has a duty to consider what reasonable adjustments they can make to support that individual.

There was a useful case, Rooney v Leicester City Council, where the Employment Appeal Tribunal recognised that severe menopausal symptoms were capable of amounting to a disability.

Dental practices also have health and safety responsibilities, so they should consider whether the working environment is exacerbating someone's symptoms. For example, if somebody is working in a surgery without air conditioning or a fan and is really suffering with hot flushes, the practice should be mindful of what reasonable adjustments could be made.

Dental practices are often very female-centric workplaces, so this is likely to be particularly relevant.

What reasonable adjustments might a dental practice need to make?

There's no one-size-fits-all adjustment because everybody is individual and there are many recognised symptoms. The starting point should always be a conversation with the individual about what they're experiencing and what might help them.

Adjustments can be quite simple. They could include additional breaks between patients, better access to drinking water, a fan or cooler in the working area, flexible start and finish times or changes to uniform where possible.

Menopause and perimenopause can cause physical, psychological and cognitive symptoms. These can include:

- Fatigue and sleep problems
- Brain fog
- Difficulty concentrating
- Memory problems
- Anxiety
- Low mood
- Reduced confidence
- Headaches and migraines
- Joint pain and stiffness.

Symptoms and their severity vary considerably from person to person. However, if colleagues are experiencing fatigue, sleep disturbances, brain fog or having difficulty concentrating, practices could look at the length of clinical sessions or particularly demanding duties and whether things can temporarily be organised differently.

In a dental setting, you also need to think about personal protective equipment (PPE). Surgeries can be small and stuffy, and then you have masks and other PPE on top of that. Adjustments don't necessarily have to be expensive. It's about understanding what might work for that individual and agreeing a plan to support them.

How should managers handle menopause-related absence or performance concerns?

I think practices should exercise a level of discretion when applying absence trigger points where absence is related to perimenopause or menopause, rather than applying them automatically. Managers should consider the individual circumstances, whether the symptoms could amount to a disability and whether adjusting trigger points or treating some absence differently might be a reasonable adjustment.

'The starting point should always be a conversation with the individual about what they're experiencing and what might help them'

Menopause and the dental workforce

Research published in the *British Dental Journal* in 2022 reported that 76.9% of the dental team were women, including 92.6% of dental care professionals (DCPs) and 50.9% of dentists.

It also found that 35% of DCPs and 43% of dentists were within an age range potentially affected by menopause.

More recent GDC figures continue to show the female-heavy nature of the profession: of dental nurses joining the register during 2025, 96% were female.

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If someone has previously performed well and suddenly starts struggling with concentration, fatigue or absence, it is important to understand whether there is an underlying reason.

Return-to-work conversations are important so managers can understand and document the reason for an absence and whether the employee is struggling with anything.

If there has been a significant increase in absence related to perimenopausal or menopausal symptoms, it may also be helpful, with the employee's consent, to seek appropriate medical or occupational health advice.

This can give the practice manager or owner a better understanding of how the employee is being affected and what support or adjustments might help.

That doesn't mean employers can't manage genuine performance or attendance concerns, but they need to understand what is causing the problem and what support might be appropriate. Managers aren't there to diagnose menopause. It's important to take the time to have a good conversation with the individual and document what has been discussed, including any agreed actions.

What simple steps can practices take to support their teams and reduce legal risk?

Some of the most effective measures are quite straightforward. The first is creating an environment where people feel comfortable having a conversation. There used to be a lot of stigma and embarrassment around perimenopause and menopause. Although I don't think we're quite in the same place now, it can still be difficult for people to talk about.

If you create an open and supportive environment, employees are more likely to feel comfortable talking to their practice manager about what is happening.

Practices should also review their policies and make sure they are fit for purpose. It's worth considering a menopause policy or guidance, although having a policy isn't enough on its own. Managers need to understand how to apply it practically.

Training can also help managers feel comfortable dealing with these situations. Ultimately, it comes back to listening to the individual, agreeing adjustments, documenting them and reviewing them. Perimenopause and menopause can take place over many years, so somebody's needs may change over time.

What has changed under the Employment Rights Act 2025?

The Employment Rights Act 2025 introduces a specific requirement around menopause action plans for larger employers. From 6 April 2026, action plans around menopause and gender pay gaps were introduced on a voluntary basis. Subject to remaining secondary legislation, they are due to become mandatory from spring 2027 for employers with 250 or more employees.

Those plans will need to set out the steps the employer is taking to address the gender pay gap and support employees experiencing menopause.

Most individual dental practices won't meet the 250-employee threshold, although larger DSOs will. But that doesn't mean smaller employers should do nothing. They still need to recognise their existing Equality Act and health and safety responsibilities, have conversations with employees and make reasonable adjustments where needed.

What should a team member do if they feel unsupported at work?

I would encourage them to speak to their practice manager or practice owner in the first instance and explain how their symptoms are affecting them at work. It helps to be specific about the difficulties they are experiencing and what adjustments they think might help.

If they don't feel comfortable speaking to their immediate manager, they could consider whether there is somebody else within the practice they feel comfortable approaching

Employees don't necessarily need to disclose everything, particularly if something feels very personal. The important thing is that the employer understands how their symptoms are affecting them at work and what support they might need. If concerns cannot be resolved informally, the employee could consider raising the matter through the practice's formal grievance procedure or seeking independent advice, for example from Acas.

What is your main advice for dental practices?

Don't make assumptions – have the conversation. Menopause and perimenopause affect everybody differently. One person might experience hot flushes, while another might struggle predominantly with sleep, migraines or joint problems.

Ask what is affecting them at work, what would help them and what the practice can reasonably accommodate, and then review it.

For dentistry specifically, supporting employees through menopause isn't only about legal compliance. It's also about retaining experienced, skilled people. Menopause can have a significant impact on someone's confidence and wellbeing, and some people may find the changes they experience difficult or unsettling. Having empathy and taking the time to listen is a really good place to start.

The impact at work

CIPD research among UK working women aged 40-60 found:

- 73% had experienced symptoms relating to the menopause transition
- Of those experiencing symptoms, 67% said they had a mostly negative impact at work, while 53% recalled a time when symptoms had prevented them from going into work
- 67% had experienced psychological symptoms including mood disturbance, anxiety, depression, memory difficulties, loss of confidence or reduced concentration.

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Could you be a perimenopause detective?

In the latest Dentistry Talks podcast episode, Kate Muir discusses menopause and the role dental professionals play in joining the dots

'Dentists are the perimenopause detectives'. That is Kate Muir's pitch to the profession. A patient may still be having periods. She may not have spoken to her general practitioner. She may not even suspect perimenopause. But something in her mouth has changed.

A wobbly tooth. Dryness. Burning mouth. Changes to her gums or bone. Could her dentist be the person who joins the dots?

'Your mouth is a big oestrogen party, and when you know you take the fun out of the party, things start to crack up. Things start to dry up,' Kate says.

This is where the latest episode of Dentistry Talks, sponsored by Sensodyne, begins: with the mouth as an overlooked part of the menopause conversation.

Kate is a journalist, author and documentary maker who helped push menopause into public discussion through her Channel 4 films with Davina McCall.

Yet she admits that she only recently began investigating the connection between hormones and oral health.

'It's in your teeth. It's in your gums. And, it's in your saliva. It helps maintain your oral microbiome,' she says.

'I thought, oh my, I've got Alzheimer's – and I panicked'

For dental professionals, the opportunity is not to diagnose menopause. It is to notice, ask and signpost.

'Maybe they can make the connection between the teeth and the rest of the body in a kind of backwards way,' Kate says, 'and say maybe you should go see your doctor, maybe you should be paying more attention to this.'

Perimenopause and the oral health workforce

Her own perimenopause did not announce itself clearly.

While working as chief film critic at *The Times*, Kate developed heart palpitations and memory loss. One day, while writing a shopping list, she could not remember the word 'razor'.

'I thought, oh my, I've got Alzheimer's because my mum had died of Alzheimer's just before that, and I panicked and panicked,' she recalls.

The conversation moves from that frightening moment to the battle to get her first documentary commissioned, the phone call that brought Davina McCall on board and the hormone replacement therapy claims Kate believes are still frightening women away from treatment.

There is also a question for practice owners. General Dental Council data shows that 103,138 registered dental professionals are women. Kate says surveys found that one in 10 women were leaving their jobs because of menopause symptoms.

How much dental experience is being lost because somebody is struggling silently?

And how much could be retained if practices knew what to ask?



Topics explored in this Dentistry Talks episode include:

- Why dentists could be 'the perimenopause detectives'
- Menopause and its effects on oral health
- Recognising changes and beginning sensitive patient conversations
- Supporting dental professionals experiencing menopause symptoms
- Memory loss, heart palpitations and other overlooked symptoms
- Misinformation and continuing fears around hormone replacement therapy
- How Kate Muir and Davina McCall brought menopause to television
- Why menopause awareness must now lead to action.

To watch the full Dentistry Talks episode, scan the QR code.

Menopause at chairside

Menopause is in the chair, but are dental professionals trained to see it, asks Sarika Shah

Sarika Shah
Clinical director,
Platinum Dental Care

Seventy percent of women report at least one oral health symptom during menopause. Two percent have ever mentioned it to their dentist (Delta Dental of California, 2023).

Sit with that for a moment, because it is not a gap in patient awareness so much as a gap in what we, as a profession, have trained ourselves to ask. The scale of what we are missing is not small. Roughly 13 million women in the UK aged 45 and over are currently perimenopausal or menopausal, close to a third of the female population, and more than half of the patients sitting in our chairs will be affected by menopause at some point in their lives (Berry and Tighe, 2025). Yet around 90% of the public has no idea that menopause and oral health are connected at all.

We are not dealing with a rare presentation. We are dealing with an ordinary, universal life stage that dentistry as a profession has largely left unexamined.

Part of that silence starts in training. Practitioners surveyed on this exact question described leaving dental school with, in their words, zero knowledge of menopause's oral health effects, and that gap in awareness tracked directly with a lack of confidence raising it at chairside (Williamson and Reed, 2023).

Breaking barriers

There is also a quieter, two-way taboo at play. Patients are reluctant to mention something that can feel private or ageing. Clinicians, meanwhile, are more likely to attribute oral changes to hygiene than to hormones, particularly among male colleagues treating female patients on a subject neither party was ever taught to discuss (Williamson and Reed, 2023).

That matters clinically, not just culturally. Oral tissue and salivary glands carry oestrogen receptors in the same way bone and skin do, and declining oestrogen shows up in the mouth in ways that are fairly well documented but rarely connected back to menopause in a routine consultation: reduced salivary flow and dry mouth, burning mouth syndrome, altered taste, and periodontal disease accelerated by oestrogen-driven bone loss (Adam and Wooton, 2022).

A patient presenting with a burning tongue, a sudden change in denture fit, unexplained taste disturbance, or gum recession that will not respond to hygiene alone may be showing us a perimenopausal symptom, not a hygiene failure or an unrelated complaint.

Without that context, we tend to treat what is in front of us rather than the cause behind it: a mouthwash for the dryness, reinforced brushing for the bleeding, a new denture adhesive for the fit, each reasonable on its own, but each missing the thread that connects them.

A simple shift

None of this needs to wait for national curriculum reform, although I believe that reform is overdue. It starts with a simple shift at chairside, and it is the gap I set out to address when I launched Menopause Mouth Matters, a campaign built to put this conversation on the profession's radar.

Awareness alone will not change practice unless it comes with a standardised way of acting on it, which is what I have been developing through the Shah Menopause Oral Health Index (SMOHI), a chairside menopause screening index currently on the pathway to ethical approval for a pilot study.

The intention is a consistent structure across the whole pathway: prompting the conversation at chairside the same way we already ask about pregnancy or medication changes, assessing for the oral symptoms linked to the menopausal transition, managing what sits within our scope, and referring onward through a clear pathway, whether to a GP, a menopause specialist or another allied healthcare professional, when it does not.

Building that kind of connection between dentistry and the wider healthcare team is what patient-centred care in modern dentistry is supposed to look like.

'Around 90% of the public has no idea that menopause and oral health are connected at all'

Filling the gap

The wider fix is ours to build together as a profession: clinical training that treats menopause as core clinical knowledge rather than an optional extra, and a shift in mindset that treats a patient's silence on the subject as a sign of our own gap in asking, not theirs in telling. This sits in the ordinary, daily list of half our patients, whether we have been trained to see it or not.

Two per cent of women are currently raising this with us unprompted. That number will not move until asking first is backed by a standardised way of doing it, and until it becomes as unremarkable a part of dental training as asking about smoking or diet ever was.

For the references that accompany this article, email siobhan.hiscott@fmc.co.uk.

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Virtual patient-guided full-mouth rehabilitation

Yolanda Antuñano López discusses transferring functional adaptations from long-term temporalisation to definitive restorations through digital montioring

Dr Yolanda Antuñano López
Postgraduate in prosthodontics and implantology, Universidad La Salle Bajío, Mexico

Dr Eric Sánchez Alonso
Clinical professor in prosthodontics and implantology, Universidad La Salle Bajío, Mexico

This clinical report describes the use of the virtual patient as an integrative tool for the diagnosis, planning and execution of a full-mouth rehabilitation through a comprehensive digital workflow.

Particular emphasis is placed on the temporalisation phase as a period of functional validation, during which digital records were used to document wear patterns and occlusal adaptations developed by the patient. Incorporating this information into the design of the definitive restorations improved functional predictability, minimised intraoral adjustments, and contributed to the long-term stability of the final prostheses. This approach is particularly relevant for monolithic zirconia restorations.

Case presentation

A 67-year-old female patient, medically healthy, presented to the department of prosthodontics and implantology at Universidad La Salle Bajío (Mexico) requesting new, functional prostheses (Figure 1).



Figure 1: Initial situation, full face







Figures 2-4: Initial situation

She reported that a full-mouth rehabilitation treatment initiated approximately 18 months earlier was interrupted during temporalisation due to discontinued clinical follow-up during COVID-19. As a result, she had been wearing the same provisional restorations for more than one year without any maintenance or occlusal adjustments, which caused her severe facial myalgia, dental pain during mastication and recurrent debonding of the provisional restorations.

Clinical examination revealed inadequate function, compromised aesthetics, poor marginal integrity of all existing restorations and evident signs of bruxism.

Following removal of the worn temporaries, most teeth exhibited full-coverage preparations, recurrent caries, partial edentulism, defective restorations, maxillary asymmetry, and a reduced occlusal vertical dimension (Figures 2 to 4). In addition, several previously placed dental implants had not yet been restored, and a considerable loss of peri-implant soft tissue was observed.

Although peri-implant soft tissue augmentation was considered, it was not included in the treatment plan because the patient declined additional surgical procedures and wished to complete treatment without further delays. Consequently, the existing implants were restored prosthetically.

Radiographic examination revealed localised vertical bone loss, inadequate inter-implant proximity, endodontically treated teeth, and multiple post and core restorations (Figure 5).

Treatment plan

A fully individualised full-mouth rehabilitation was chosen as a treatment, combining a virtual patient workflow with a long-term PMMA biofunctional prototype, followed by a definitive restoration composed of zirconia single crowns and lithium disilicate veneers.

The decision to restore the patient with single crowns was primarily based on the existing dentition condition. Most teeth had already been prepared for full-coverage restorations, and the remaining tooth structure of each abutment was adequate, with no biological, periodontal or structural factors. Single crowns would also allow independent maintenance and facilitate future retreatment if required. Lithium disilicate veneers were indicated only for the mandibular anterior teeth, as these were the only teeth that had not previously

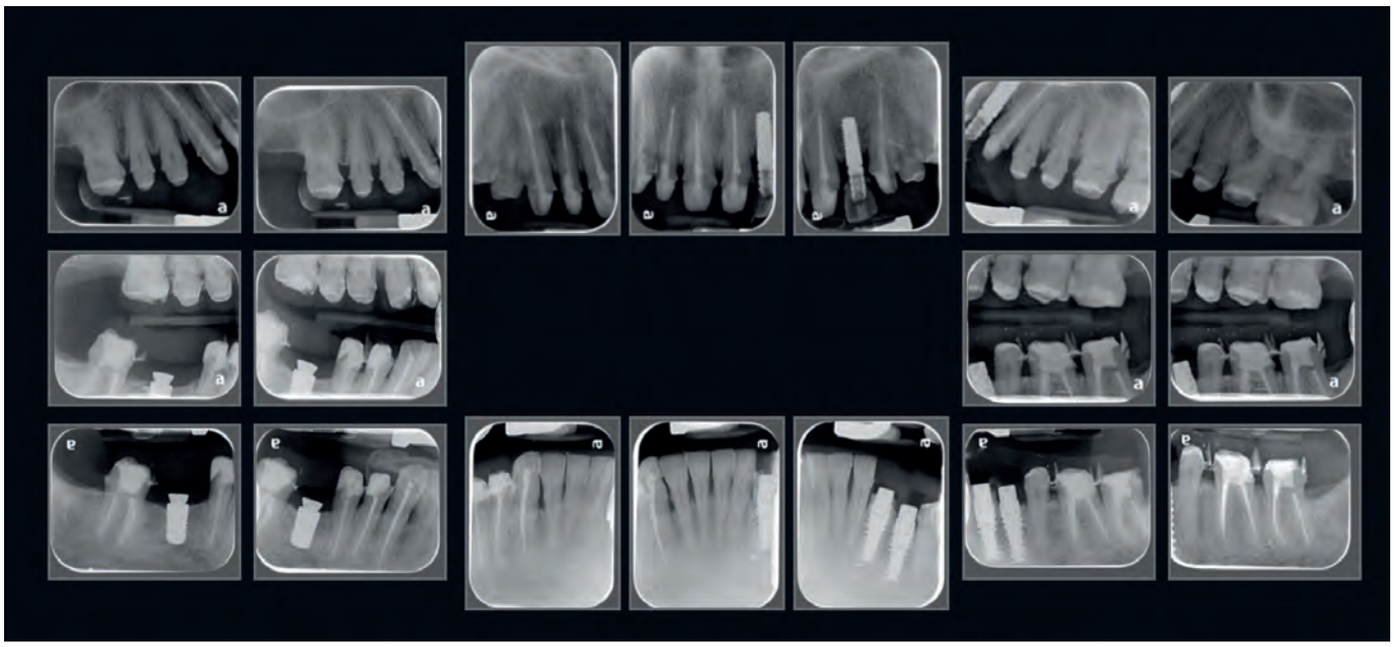


Figure 5: Initial radiographic examination

undergone full-coverage preparation. A minimally invasive approach was therefore adopted to preserve sound tooth structure while restoring the planned aesthetics and function.

OVD increase using a jig

An anatomical, multifunctional, aesthetic jig (Figure 6) was fabricated to reestablish the occlusal vertical dimension (OVD). The device was fabricated using Pattern Gel Red light-curing composite pattern resin (ID) and was used to evaluate phonetics, incisal edge display at rest, facial aesthetics and a tentative centric relation position.

In addition, it increased treatment predictability by allowing preliminary assessment of functional parameters associated with the proposed OVD as well as aesthetic parameters related to tooth proportions and morphology. Based on these findings, a preliminary conventional maxillary diagnostic wax-up was fabricated to further refine the aesthetic treatment objectives.Nevertheless, as the diagnostic phase progressed, the complexity of the rehabilitation exceeded the capabilities of a conventional workflow. Therefore, rather than continuing with the analogue wax-up, a completely new digital diagnostic wax-up was generated using a virtual patient workflow.



Figure 6: The anatomical, multifunctional, aesthetic jig

Intraoral scanning

A digital impression was obtained using an intraoral scanner.

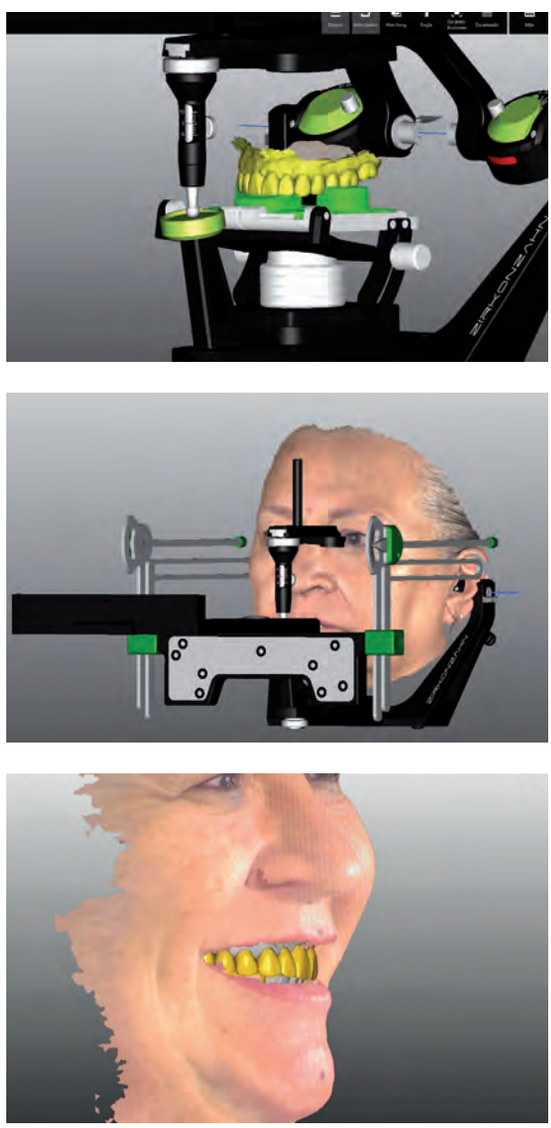
Two maxillary scans were performed: one of the prepared dentition, and one of the diagnostic prototype obtained from the conventional wax-up, to preserve the proposed aesthetic parameters and serve as a reference for the subsequent digital diagnostic wax-up.

Prior to scanning, a conditioning phase was performed, including dental prophylaxis and removal of defective restorations.

The existing implants were scanned using scanbodies without performing any soft tissue conditioning.

In addition, definitive biomechanical preparation of the abutment teeth was completed before fabrication of the provisional restorations.

This avoided further tooth reduction during the definitive phase and helped preserve the finish lines and the soft tissue architecture established during temporalisation.



Figures 7-9: 3D virtual reproduction of the patient for detailed analysis, treatment planning, and fabrication of highly individualised restorations

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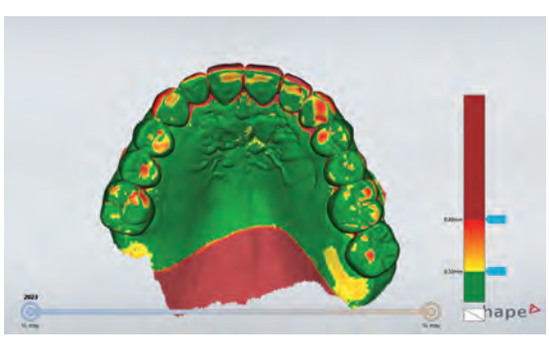
Virtual patient development

Because each patient presents unique skeletal growth patterns, facial asymmetries and soft tissue characteristics, the integration of digital tools such as the Face Hunter 3D facial scanner (Zirkonzahn) and the PlaneSystem (Zirkonzahn, in collaboration with MDT Udo Plaster) facilitated a more precise and individualised restorative planning process.





Figures 10 and 11: The long-term provisionals in Prime PMMA





Figures 12 and 13: Evaluation of wear facets from day one to four months, following the temporalisation period. Colour mapping shows the adjustments that were made, for example in the area of the palatal surface of UL3, where a significant amount of adjustment was made to prevent the provisional restoration from becoming dislodged

The PlaneSystem represents a digital alternative to conventional facebows. It enables accurate transfer of the maxillary spatial position, facial midline, and occlusal plane orientation into the virtual environment.

The Face Hunter, on the other hand, allows incorporation of 3D facial anatomy into the digital workflow, enabling simultaneous evaluation of facial midline, facial symmetry, interpupillary plane, occlusal plane orientation, tooth-lip relationships, buccal corridors, and lip support.

Once all digital records were obtained (3D facial scans, intraoral scans with and without the prototype, OVD records and PlaneSystem information) all data was integrated to create a 3D virtual reproduction of the patient that enabled detailed analysis, treatment planning, and fabrication of highly individualised restorations (Figures 7 to 9).

Digital wax-up and prototype verification

At this point, a fully customised digital diagnostic wax-up was developed. The efficiency of the digital workflow allowed rapid design of complete rehabilitation while enabling selection and modification of tooth morphologies according to the patient's specific anatomical characteristics and aesthetic requirements.

Before milling the definitive PMMA provisional restorations, a verification prototype was milled in order to evaluate marginal integrity, interproximal contact areas, aesthetics, occlusal vertical dimension and occlusion.

PMMA provisional and occlusal refinement

The long-term provisionals (Figures 10 and 11) were fabricated from Prime PMMA (Zirkonzahn). Injectable resin provisionals were produced for the lower incisors, to reduce the risk of debonding and to help preserve soft-tissue health during the several-month provisional phase.

A prolonged temporalisation phase was intentionally selected to capture and validate the patient's functional adaptation. The patient was monitored for four months, with follow-up appointments scheduled every seven to 10 days. During this period, occlusal wear patterns, functional contacts and mandibular movements were carefully evaluated as the occlusion gradually adapted to the patient's individual functional envelope. Several occlusal refinements were performed throughout this phase, including correction of a recurrent restoration dislodgement associated with occlusal interference involving UL3.







Figures 14-16: The definitive restoration

Digital analysis of functional adaptation

Following the temporalisation period, a new intraoral scan was obtained. In the lab, the Patient Monitoring tool (3Shape) was used to superimpose intraoral scans performed every month during this period, generating a 3D map of the changes in the provisional restorations (Figures 12 and 13). This analysis enabled identification and quantification of wear facets, providing objective information regarding effective occlusal contacts, functional pathways and biomechanical adaptations established by the patient's stomatognathic system. Incorporating this into the digital design of the definitive restorations allowed the transfer of a clinically validated occlusal anatomy rather than relying on theoretical parameters or adjustments performed in a virtual articulator.

Fabrication of the definitive restorations

Prettau zirconia (Zirkonzahn) was chosen as the material for the single crowns because of its long-lasting durability, high flexural strength and aesthetic qualities even when used in a monolithic design. Scientific evidence supports the combined use of zirconia and lithium disilicate according to the functional and aesthetic requirements of each clinical situation, while enabling a minimally invasive restorative approach when appropriate (Figures 14 to 16):

- Teeth UR6, UR5, UR4, UR3, UL3, UL4, UL5, UL6, LL4, LL5, LL6, LL7, LR4, LR6, LR5 and LR7 were fabricated monolithically. No glaze was applied to the functional occlusal surfaces. Instead, all functional areas were high gloss polished to obtain a smooth surface and minimise wear of the opposing dentition
- Teeth UL1, UL2, UR1 and UR2 were minimally reduced and slightly layered with Fresco Enamel Fluo
- Teeth LL3, LL2, LL1, LR1, LR2 and LR3 were restored with additive lithium disilicate veneers (IPS Emax).

Three-year follow-up

The three-year follow-up confirmed the successful integration of the virtual patient workflow and digital monitoring protocols, demonstrating sustained functional, aesthetic and biological outcomes with minimal maintenance requirements.

Clinical and radiographic examinations performed after three years demonstrated excellent long-term stability of the rehabilitation. Stable gingival margins, preservation of the occlusal scheme established during temporalisation, as well as maintenance of the aesthetic outcomes were observed.

Furthermore, radiographic comparison with the baseline records obtained immediately after definitive cementation revealed stable peri-implant bone levels, with no significant changes in the supporting bone structures. This long-term stability was likely influenced by the maintenance of a stable occlusal scheme, the use of a protective occlusal splint to manage parafunctional loading associated with bruxism, and the patient's compliance with a regular supportive maintenance programme. These findings suggest that the transfer of functional information acquired during the transitional phase to the design of the definitive restorations contributed to a biomechanically stable and clinically predictable rehabilitation over time.

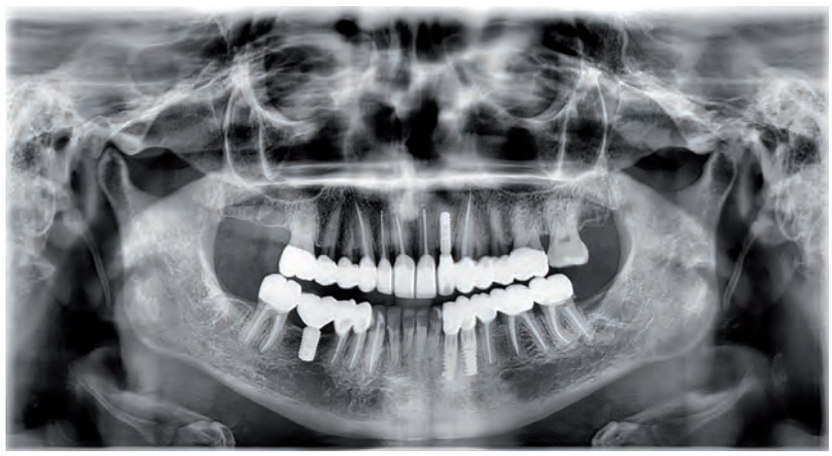


Figure 17: Panoramic radiograph at treatment completion

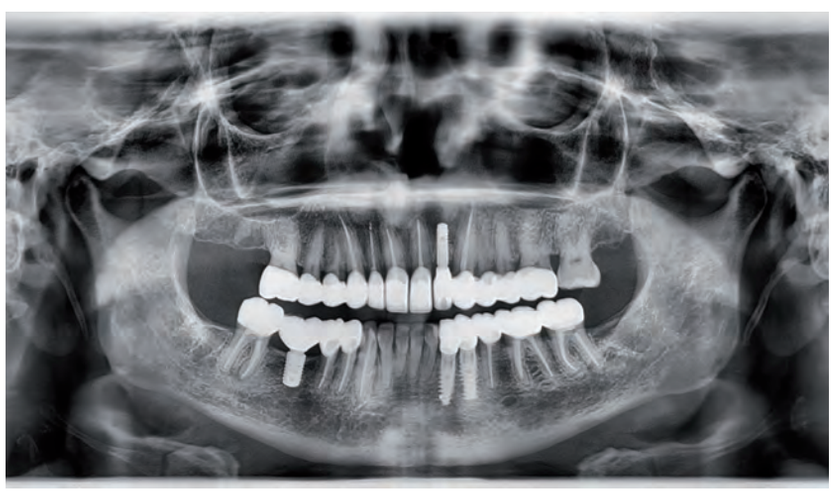


Figure 18: Panoramic radiograph at the three-year follow-up



Figure 19: Final restoration in situ

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The single central crown

Kostas Karagiannopoulos tackles one of the hardest aesthetic challenges: matching a single central crown

Kostas Karagiannopoulos
Specialist prosthodontist

Matching a single central crown is probably the hardest task aesthetically for a restorative dentist. If you throw in the enigma of that crown being a replacement one, the restorative challenge becomes even greater. This patient requested a crown replacement. Patients usually do not know about the complexities involved and why would they expect anything other than perfection? Opacity, form, line angles, value, restorability and incisal effects simply do not even cross the patient's mind. They want it to match the neighbouring tooth, which usually has its own eccentricities and defects.







Figures 1-3: Initial presentation

Assessment and consent

First things first: consent and restorability assessment. Key consent points include:

- 'I do not know what is under your crown'
- 'X-rays and CBCT may help but do not exclude cracks or caries'
- 'Nine out of 10 crowns I replace are fine for like for like renewal'
- 'You need to be prepared for additional work: endo, post or even losing the tooth'
- 'I will need to remove your crown merely for the purpose of assessing the condition of the supporting tooth'
- 'You will have an excellent temporary crown thereafter'
- 'I may need a few attempts until I can match the final crown to your natural teeth'
- 'If you want brighter teeth, we need to do whitening first and it will delay the outcome by six weeks.'



Figure 4: Coarse/medium diamond bur versus Jet tungsten carbide



Figure 5: With Vita shade tabs



Figure 6: Cross polarised photos with Vita shade tabs



Figure 7: Cross polarised photo with grey eLab card



Figure 8: The prep (ideally with shade tabs or natural die material shade guide)





Figures 9 and 10: The approved temp

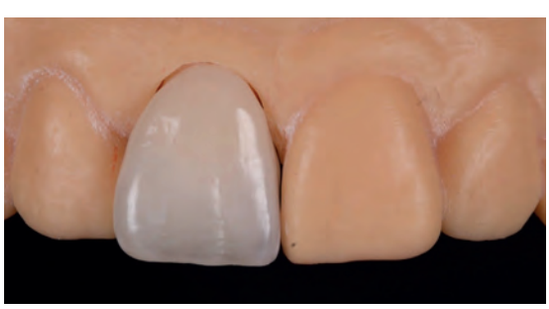


Figure 11: Crown made using LiSi PRESS (GC) with facial layering

Step one: restorability assessment

We start this by considering the shape of the provisional the patient will leave with. If we can control the tooth shape intraorally, we can take an index/stent of the existing/adjusted crown to use for the temp. Otherwise we may need a wax-up to mirror the contralateral crown tooth.

A coarse/medium diamond bur will cut through porcelain or zirconia. A Jet tungsten carbide may be needed if a metal coping is present. Crowns can be ranked by removal difficulty, from most to least complex, as follows:

1. Bonded lithium disilicate
2. Zirconia crowns
3. Metal ceramic crowns
4. Metal crowns.

An excellent provisional crown will aid with:

- Aesthetic planning
- Ability to mask prep
- Promoting tissue health in preparation for scan/impressions and cementation
- Patient reassurance
- Lab communication.

Step two: capture the data

This aims to gather all the information needed by the dental technician. We start with shade matching as dehydration affects value massively within a few minutes, hence it is best not to carry out this step during restorability assessment (Figures 5 to 7). Finally, intraoral scanning/impressions of the prep, opposing teeth, a bite record and a copy of the provisional (ideally superimposed over prep model) should be taken (Figure 8).







Figures 12-14: Final result

It is the clinician's responsibility to identify the base shade and give that to the technician. Other details the lab requires include:

- Zirconia or lithium based
- Degree of translucency (HT, MT, LT)
- Degree of texture (low, moderate, high)
- Degree of lustre (high or satin gloss)
- Incisal effects (mild, moderate, high)
- Tooth map drawing to describe specific things needed eg opacities, CEJ, line angles etc.

It is also an option to send the patient to the lab for a custom shade match and even a custom finish on the day of cementation.

Pricing for a single crown must allow for the above as well as multiple try-ins potentially. A single anterior crown should be priced at 50-100% more than the fee of a standard crown.

Step three: cement the crown

In this case, the crown was made using LiSi PRESS (GC) with facial layering (Figure 11).

A try-in paste is recommended to check colour match under different lights and allow adequate time for the patient to verify and approve. A few attempts/returns may be needed with the relevant photos to convey the message to the lab for changes needed.

Once all parties are satisfied, use resin cement and isolation as per clinician's choice.

In this case , G-CEM ONE (GC) A2 resin cement was used under rubber dam isolation (Figures 12 to 14).

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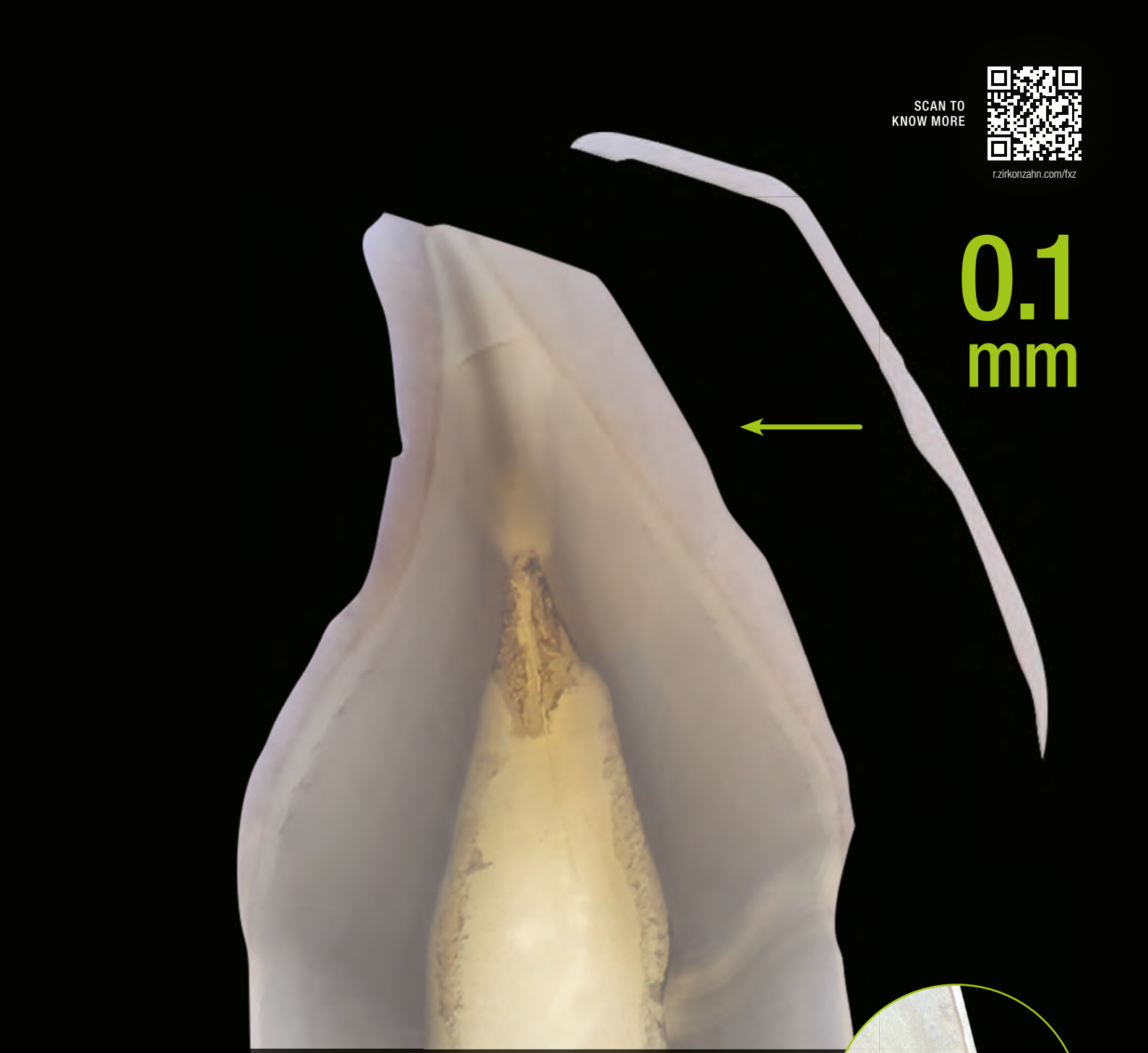
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Transcrestal nasal floor elevation

Eduardo Anitua presents a retrospective study with a six- to 16-year follow-up of patients with moderate to severe premaxillary atrophy treated using transcrestal nasal floor elevation with a frontal-cutting drill, autologous bone and PRGF-Endoret

Eduardo Anitua
DDS MD PhD
Dentist and clinical researcher

Bone resorption following tooth loss is a continuous physiological process that particularly affects the anterior maxilla. The premaxilla is characterised by a thin buccal cortical plate, buccal alveolar inclination, and the proximity of the nasal floor and nasopalatine canal, making prosthetically driven implant placement increasingly difficult as vertical and horizontal bone resorption progresses (Chappuis et al, 2013; Chappuis, Araújo and Buser, 2017; Etoz and Sisman, 2014; Demiralp et al, 2018).

Traditionally, rehabilitation of these patients has relied on reconstructive procedures such as guided bone regeneration, block grafting, or ridge expansion. Although predictable, these techniques increase surgical complexity, morbidity, treatment time, and costs (Sjöström et al, 2007; Torres et al, 2019).

The introduction of short and extra-short implants, narrow-diameter implants, and biologically oriented surgical protocols has shifted implant dentistry toward more conservative approaches that maximise residual bone and reduce the need for extensive augmentation, while meeting patients' preference for less invasive treatments (Gibney, 2001; Ramani et al, 2023; Becker et al, 2005; Tallarico et al, 2017).

Transcrestal nasal floor elevation, first described by Garg (1997), has become an alternative for vertically atrophic premaxillae. Progressive refinements have expanded its indications beyond cases with moderate residual bone height (Garg, 1997; Camargo et al, 2015; Calvo Guirado et al, 2006; Anitua et al, 2022; Mazor et al, 2012; Lorean et al, 2014; Garcia-Denche et al, 2015).

Our group developed a modification using a frontal-cutting drill within a low-speed biological drilling protocol, allowing

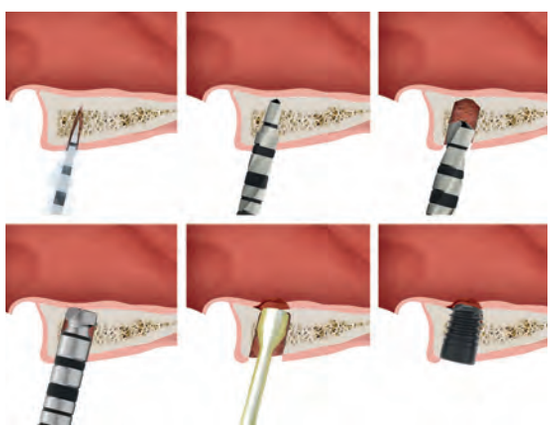


Figure 1: Drilling sequence for implant placement using the transcrestal nasal floor elevation technique. Initial marking with the starter drill. Progressive biological drilling of the implant bed, followed by the use of the frontal-cutting drill

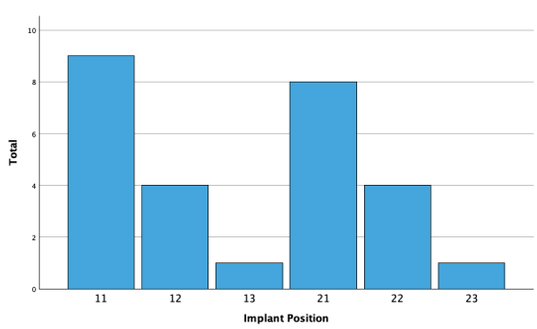


Figure 3: Implant positions included in the study

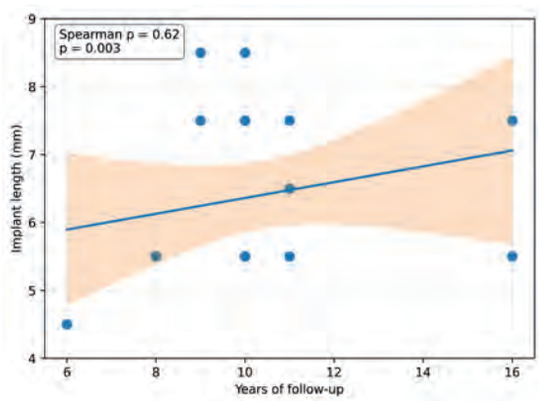


Figure 2: Relationship between implant length and follow-up duration. The graph shows a positive association between both variables,. Cases with longer follow-up generally corresponded to longer implants, reflecting the evolution of clinical practice toward the progressive use of shorter implants in situations of more severe bone atrophy and greater anatomical complexity

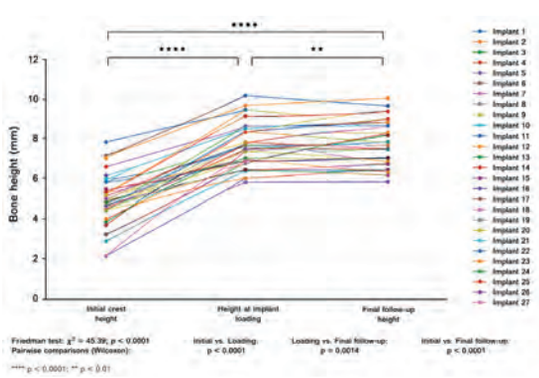


Figure 4: Individual changes in bone height (mm) at the three study time points: initial crestal bone height, bone height at prosthetic loading, and bone height at the final follow-up. Bone height increased between baseline and prosthetic loading ($p < 0.0001$), between prosthetic loading and the final follow-up ($p = 0.0014$), and between baseline and the final follow-up ($p < 0.0001$)

controlled elevation of the nasal floor, collection of autologous bone during osteotomy preparation, and its combination with PRGF-Endoret when required. This approach facilitates placement of short and extra-short implants with high primary stability through a minimally invasive procedure (Anitua et al, 2022; Anitua et al, 2021).

Despite growing interest, evidence on transcrestal nasal floor elevation remains limited, particularly regarding long-term implant survival, peri-implant crestal bone stability, and complications (Anitua et al, 2022; Mazor et al, 2012; Lorean et al, 2014; Garcia-Denche et al, 2015). Therefore, this study evaluated the long-term clinical and radiographic outcomes of patients with vertical premaxillary atrophy treated using this technique, analysing implant survival, peri-implant crestal bone loss, surgical and prosthetic complications, vertical bone gain, and maintenance of the regenerated bone after a mean follow-up of nine years.

Materials and methods

A retrospective study included patients with moderate to severe vertical premaxillary atrophy treated with short and extra-short implants combined with transcrestal nasal floor elevation between January 2010 and January 2019. Only patients with complete clinical and radiographic records and active follow-up until January 2026 were included.

Preoperative assessment comprised cone-beam computed tomography (CBCT), study casts, and a diagnostic wax-up, from which a customised surgical guide was fabricated. In selected cases, the guide was also used during preoperative CBCT. Patients received 2g amoxicillin and 1g paracetamol one hour before surgery.

All procedures were performed by a single surgeon under local anaesthesia using a biological drilling protocol with a frontal-cutting drill during the final osteotomy. This approach enabled controlled nasal floor elevation, harvesting of autologous bone during osteotomy preparation, and implant placement with high primary stability while minimizing the risk of nasal membrane perforation. Implants were inserted with a surgical motor (25Ncm) and final torque was applied manually using a torque wrench (Figure 1).

Flaps were closed with 5/0 non-resorbable monofilament sutures, removed after 10 to 15 days. Following a five-month healing period, Multi-im transmucosal abutments were connected and definitive prostheses were delivered. Patients were reviewed every six months with standardized panoramic radiographs obtained using a reproducible positioning protocol. Marginal bone loss was measured on the last panoramic radiograph after digital calibration with implant length as the reference, recording mesial and distal measurements for each implant.

CBCT was performed at definitive prosthesis delivery to confirm osseointegration and quantify the bone gain achieved through nasal floor elevation. A second CBCT at the final follow-up assessed maintenance of the regenerated bone volume.

The implant was considered the unit of analysis for implant-related variables, whereas the patient was the unit for demographic and clinical variables.

The primary outcome was bone height gained and maintained after nasal floor elevation. Secondary outcomes included implant survival and mesial and distal marginal bone loss. Implant survival was estimated using the Kaplan–Meier method. Statistical analyses were performed with SPSS 15.0. Normality was assessed using the Shapiro–Wilk test.

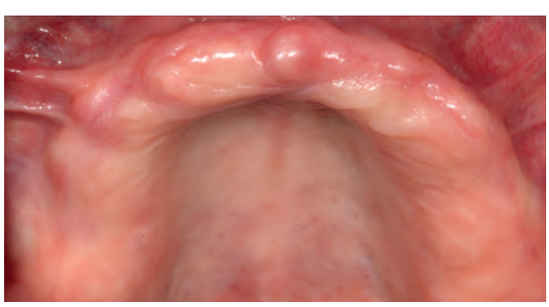


Figure 5: Initial panoramic radiograph of the case, showing marked vertical bone atrophy throughout the maxillary arch





Figures 6 and 7: Initial clinical photographs of the patient wearing her existing removable prosthesis









Figures 8-11: Relationship between the maxillary and mandibular arches after removal of the prostheses. As shown, particularly in the lateral views, the maxilla has undergone extensive resorption, resulting in a class III interarch relationship

Results

A total of 11 patients receiving 27 implants placed in conjunction with transcrestal nasal floor elevation using the previously described drilling protocol, autologous particulate bone harvested during osteotomy preparation, and PRGF-Endoret were included. Mean patient age at surgery was 65.66 ± 3.94 years, and two patients were male.

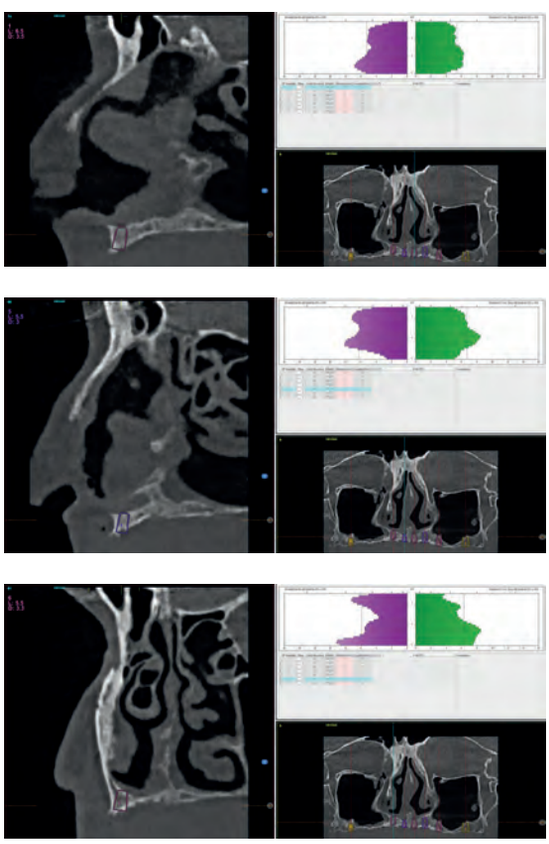
Implant length ranged from 4.5 to 8.5mm, with 5.5mm implants being the most frequently used (48.1%). Implant length was significantly associated with follow-up time (Spearman's $\rho = 0.421$; $p = 0.029$), reflecting the progressive adoption of shorter implants during the study period (Figure 1). Implant diameter ranged from 2.5 to 5.5mm, with 3.75mm (29.6%) and 3.5mm (25.9%) being the most frequent. No significant association was observed between implant diameter and follow-up time (Spearman's $\rho = 0.31$; $p = 0.115$).

Implants were distributed throughout the premaxillary region, most frequently at sites UR1 (33.3%) and UL1 (29.6%) (Figure 2).

Mean residual bone height increased from 4.96 ± 1.71mm at baseline to 7.24 ± 1.12mm at prosthetic loading and 7.58 ± 1.15mm at the final follow-up. Friedman analysis showed significant differences among the three time points ($p < 0.0001$). Pairwise Wilcoxon tests demonstrated significant increases between baseline and prosthetic loading ($p < 0.0001$), baseline and final follow-up ($p < 0.0001$), and prosthetic loading and final follow-up ($p = 0.0014$), indicating stable maintenance of the regenerated bone over time (Figure 3).

All implants supported splinted prostheses connected to additional implants; 59.3% restored full-arch prostheses and 40.7% fixed partial prostheses. Multi-im multi-unit abutments were used in all cases.

Mean mesial and distal marginal bone loss was 0.71 ± 0.22mm and 0.67 ± 0.21mm, respectively. Mean follow-up was 9.59 ± 2.48 years (range, six to 16 years). No implant failures occurred, resulting in a cumulative implant survival rate of 100%. Figures 4 to 25 illustrate one representative clinical case.



Figures 12-14: CBCT cross-sectional images showing the three implants planned for placement in the premaxilla using the transcrestal nasal floor elevation technique described

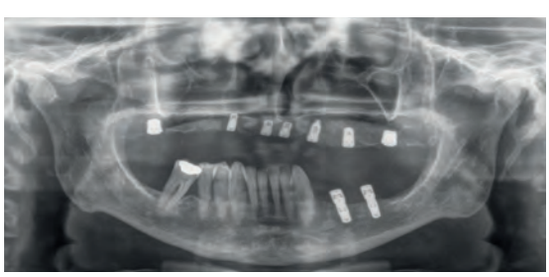


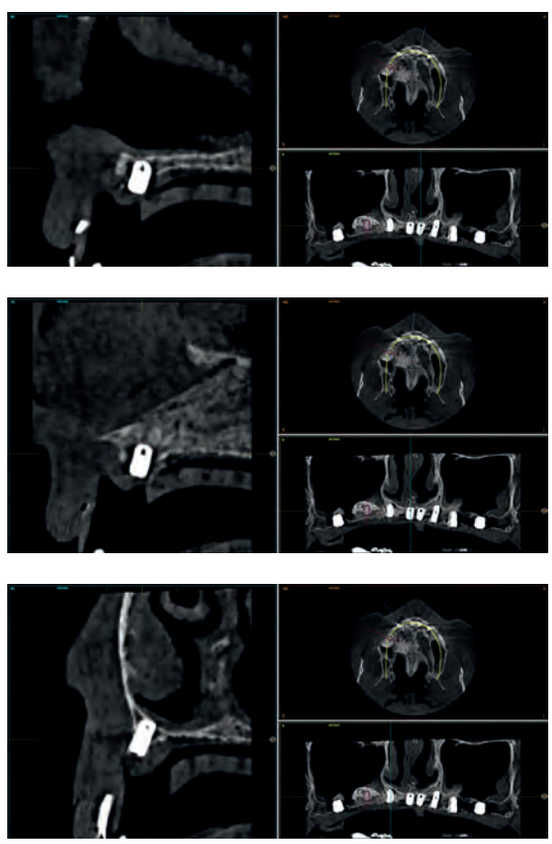
Figure 15: Postoperative panoramic radiograph after placement of all implants in the maxillary arch, which were left to heal following a two-stage surgical protocol. In the first quadrant, the posterior region corresponding to the maxillary sinus was grafted to allow implant placement during a second surgical stage

Discussion

Rehabilitation of the atrophic premaxilla remains challenging because of anatomical limitations, aesthetic demands, and the need to achieve adequate primary stability (Chappuis et al, 2013; Chappuis, Araújo and Buser, 2017; Andrés-Veiga et al, 2012).

Unlike the posterior maxilla, where bone loss is mainly related to sinus pneumatisation, anterior maxillary atrophy is largely determined by proximity to the nasal floor and post-extraction alveolar resorption (Demiralp et al, 2018; Andrés-Veiga et al, 2012).

Consequently, treatment has traditionally relied on reconstructive procedures, including block grafts, guided bone regeneration, and nasal floor elevation combined with conventional implants (Sjöström et al, 2007; Torres et al, 2019; Satpathy, 2025; Urban and Monje, 2019; Rocchietta et al, 2016; Jepsen et al, 2019).



Figures 16-18: CBCT cross-sectional images obtained at the time of prosthetic loading, corresponding to the end of the implant osseointegration period



Figure 19: Beginning of progressive loading after placement of all implants in the maxillary arch

Over the last decade, however, implant dentistry has shifted toward more conservative approaches. In sinus augmentation, systematic reviews have shown that short implants achieve survival rates comparable to longer implants placed after sinus floor elevation while reducing morbidity and complications (Yan et al, 2018; Del Fabbro, Wallace and Testori, 2012; Anitua and Piñas, 2020; Huang et al, 2020).

In contrast, evidence for transcrestal nasal floor elevation remains limited to small case series and case reports (Anitua et al, 2022).

Initially described by Garg (1997) and later modified by Mazor and colleagues (2010) nasal floor elevation was developed to facilitate placement of conventional implants. The introduction of short and extra-short implants has changed this concept, shifting the objective from creating large bone volumes to optimising residual bone through less invasive procedures (Camargo et al, 2015; Anitua et a;, 2022; Garcia-Denche et al, 2015; Anitua et al, 2021).

This evolution was objectively demonstrated in the present study by the significant association between implant length and follow-up time, reflecting the progressive incorporation of shorter implants as clinical evidence accumulated. To our knowledge, no previous study has statistically documented this temporal evolution of the technique.

Another distinctive feature of the present series is the severity of the treated atrophy. Whereas previous studies generally reported residual bone heights of 8-10mm, the mean baseline height in our patients was below 5mm, demonstrating that the technique can be successfully extended to more advanced defects (Anitua et al, 2021).



Figure 20: Progressive loading of all implants except the last implant placed in the first-quadrant nasal floor elevation site



Figure 21: Soft tissue condition at the time of the definitive prosthetic impression





Figures 22 and 23: Definitive ceramic prosthesis with Emax crowns cemented onto the CAD/CAM-manufactured framework

Most published studies have focused on surgical feasibility and implant survival, whereas long-term changes in regenerated bone have received less attention (Garg, 1997; Camargo et al, 2015; Calvo Guirado et al, 2006; Anitua et al, 2022; Mazor et al, 2012; Lorean et al, 2014; Garcia-Denche et al, 2015; Chen and Cha, 2020).

In the present series, bone height increased significantly after surgery and remained stable throughout follow-up. The regenerated compartment was filled exclusively with autologous bone harvested during biological drilling combined with PRGF-Endoret, a strategy that preserves the osteogenic, osteoinductive, and osteoconductive properties of autologous bone while enhancing healing through platelet-derived growth factors (Anitua et al, 2021; Anitua, Allende and Alkhraisat, 2022).

Marginal bone loss remained below 0.8mm after nearly 10 years of follow-up, values comparable with or lower than those reported for implants placed in native bone without regenerative procedures (Duyck and Vandamme, 2014; Podaropoulos et al, 2016; Berglundh, Abrahamsson and Lindhe, 2005; Felice et al, 2019).

This favourable response is likely related not only to implant length but also to factors such as primary stability, bone quality, prosthetic design, and splinting through multi-unit restorations.

The absence of implant failures after a mean follow-up of 9.6 years is particularly noteworthy considering the severity of the initial atrophy. Although the retrospective design and limited sample size preclude direct comparison with other reconstructive approaches, the prolonged follow-up, complete implant survival, and documentation of the evolution of the treatment protocol constitute important strengths of the present study.



Figure 24: Panoramic radiograph obtained after seven years of follow-up, demonstrating implant stability and preservation of the mandibular dentition following conservative periodontal treatment

Conclusion

Transcrestal nasal floor elevation using a frontal-cutting drill, autologous bone harvested during osteotomy preparation and PRGF-Endoret proved to be a predictable, minimally invasive technique for rehabilitating moderate to severe vertically atrophic premaxillae.

After a mean follow-up of almost 10 years, it achieved 100% implant survival, limited marginal bone loss, and stable maintenance of the regenerated bone.

The significant association between implant length and treatment year reflects the progressive incorporation of short and extra-short implants into clinical practice, extending the indications for this technique to increasingly severe defects while reducing the need for more invasive reconstructive procedures.

Although larger prospective studies are needed, these findings support transcrestal nasal floor elevation combined with short implants and a biological surgical protocol as a reliable long-term treatment option for the atrophic anterior maxilla.

For the references that accompany this article, email siobhan.hiscott@fmc.co.uk.



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Endurance sport's hidden oral health challenge

When athletes prepare for an extreme endurance challenge, training, nutrition, hydration, recovery and injury prevention tend to dominate the agenda, while oral health is rarely given the same attention. After crossing Iceland by bike, kayak and on foot, Ben Atkins discovered first-hand why that needs to change

Dr Ben Atkins
General dental practitioner and Oral Health Foundation trustee

When you think about the physical demands of endurance sport, teeth are unlikely to be high on the list. With months of training to complete, calories to replace, kit to test, hydration to manage and injuries to avoid, oral health can easily become an afterthought, and perhaps surprisingly, that proved true even for an experienced dentist.

Dr Ben Atkins, a Manchester-based general dental practitioner and former president and long-standing trustee of the Oral Health Foundation, recently completed the Rat Race Iceland Coast to Coast, involving around 110km a day of off-road mountain biking over five to six days, approximately two hours of kayaking and a 44km ultramarathon-style challenge to finish.

He had spent around two and a half years rebuilding his fitness after serious back problems affecting three discs had stopped him running and, for a period, left him without feeling in one foot.

His preparation was meticulous, covering training, nutrition, hydration and equipment, while his kit included the new Philips Sonicare DiamondClean 9900 Prestige sonic toothbrush, which he took with its rechargeable travel case, together with toothpaste and interdental cleaning aids. Despite all that planning, there was one risk he admits he had underestimated. 'I overlooked it,' he says. 'And this is my world.'

The endurance blind spot

For Ben, Iceland was always about the experience rather than chasing a finishing time. 'I wanted to absorb every detail and not hare through every stage,' he explains. 'It was much more about the journey.'

'Iceland was always about the experience rather than chasing a finishing time'

That journey took him through black volcanic landscapes, river crossings, snow and green valleys, often in complete isolation. He had relatively little experience of technical mountain biking beforehand and, by the end, his cycling shoes had deteriorated so badly that they had to be cable-tied to his feet.

For six days, he says, the group he was with saw nobody outside the expedition. Against this backdrop, he began to appreciate an aspect of endurance sport that research suggests deserves greater attention.



A study of 352 elite and professional UK athletes found untreated caries in 49.1%, erosive tooth wear in 41.4% and gingival bleeding or calculus in 77%, while 21.6% recorded probing depths of at least 4mm. Overall, 32% reported an oral health-related impact on sporting performance (Gallagher et al, 2018).

Importantly, this cannot simply be explained by athletes neglecting their teeth. A related study found that 94.2% brushed at least twice a day, yet only 40% had visited a dentist in the previous six months and 80% used sports drinks during training or competition (Gallagher et al, 2019).

A 2026 review by Needleman, Gallagher and Ashley in the *British Dental Journal* concluded that oral disease remains common among elite athletes and suggested that, because the carbohydrates required to fuel training and competition cannot simply be removed, oral health support is more realistically approached as risk mitigation.



Endurance athletes may consume 90g of carbohydrate an hour or more for sustained periods, potentially keeping plaque pH depressed while high airflow and possibly stress can reduce saliva availability.

When a healthy mouth becomes high risk

In Iceland, Ben experienced that combination himself. The food provided between stages was healthy and well planned, but once he was on the route he needed enough portable energy to sustain long days on the bike.

By his estimate, he was burning around 6,500 calories a day. 'You couldn't avoid it. You needed that volume of food,' he says. 'The only way to get it in is cake.'

What concerned him most was not simply the amount of sugar, but the frequency of exposure. 'A lot of people were on isotonic drinks, and they have sugar in them, so you have a sugar solution in your mouth for 12 hours, which is not something we do at home. I do worry about how that affected my mouth.'

The greater surprise was dry mouth. 'The dry mouth was a challenge, without question. I wasn't even thinking about it,' he says. 'I know about sugar, but it was the dehydration that caught me out.' His conclusion was simple: 'You suddenly become a high-risk patient.' Even a week and a half after returning home, Ben described his mouth as still feeling 'shot'.

Prevention before performance

The experience has changed the way he thinks about conversations with patients preparing for endurance events. One member of the Iceland group brought the issue sharply into focus when he needed root canal treatment only two days before travelling after developing a facial swelling.

Dentistry Top 50

Dentistry Top 50

Ben Atkins – one of dentistry's most engaged advocates for prevention and improving the nation's oral health – is on this year's Dentistry Top 50. A past president of the Oral Health Foundation, his current role as trustee and media ambassador sees him work with government, industry and healthcare organisations to tackle oral health inequalities. He is chairman of the Dental Industry Awards and Dentistry DSO Awards, where he spotlights innovation and excellence across the profession.



'The last thing you want is toothache in the middle of Iceland,' Ben says. 'You have spent a lot of money and a huge amount of time training, so get a good examination performed before you embark on a challenge and review anything that could go wrong.'

Rather than simply telling athletes to avoid gels or sports drinks that may be necessary for performance, he believes prevention needs to fit around how they actually train. That may mean checking oral health well before a major event, looking more closely at the timing and frequency of carbohydrate exposure, following sugary gels or drinks with water where practical and reviewing the patient again after an intensive period of training or competition (Needleman, Gallagher and Ashley, 2026).

'We often think prevention is what we do when we see bleeding gums, but that is treatment,' Ben explains. 'Even if you have perfect oral health, you are about to assault your mouth.'

Keeping prevention on track

Ben continued using his Philips Sonicare throughout the trip and, as far as he could tell, was the only participant using an electric toothbrush. His normal routine became more thorough rather than less, with brushing increasing to three times a day and often taking place as soon as he came off the bike.

The brush's AI-supported coverage map, displayed directly on the handle, showed which areas of his mouth he had covered and helped him identify places he had missed, prompting him to go back over them.

However, the benefit he remembers most was more personal than technological. 'It gave me five minutes away from everybody,' he says. 'Brushing your teeth, it's that two minutes away. Let's just reset.'

'By the end, his cycling shoes had deteriorated so badly that they had to be cable-tied to his feet'

At the end of long days on the bike, the familiar routine gave him a few minutes to switch off before eating, showering, repacking his kit and preparing for the following morning. 'By the time I'd brushed my teeth, I was like, okay, we're okay again now. Now I can go.'

A different question for active patients

For Ben, perhaps the most useful lesson from his Iceland challenge is that asking a patient what they eat may not reveal the whole picture. Someone may eat well, brush twice a day and appear highly motivated about their oral health, yet during training or competition spend hours repeatedly exposing their mouth to carbohydrates, while also experiencing dehydration.

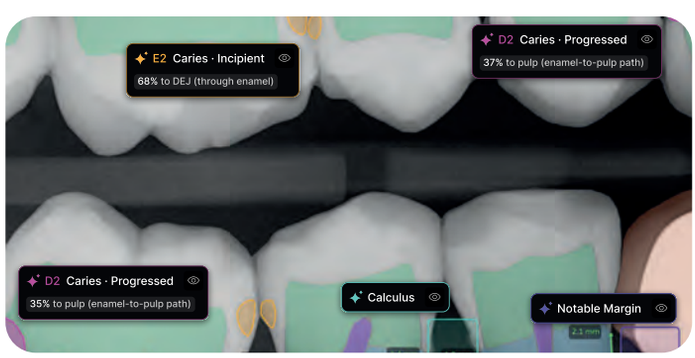
'We should speak to our patients about this,' says Ben. 'We should ask:

- "Are you training for something?"
- "What are you doing during a sporting challenge?"
- "What are your children drinking during a match?"

'For dental teams, asking how patients fuel their sport could uncover a very different pattern of oral health risk. Endurance sport has become increasingly sophisticated in the way athletes monitor training, nutrition, hydration, sleep and recovery, yet oral health can still fall between the gaps. Ben went to Iceland expecting to test his fitness, his back and his nerve, and returned thinking differently about his own profession. If a dentist can overlook that risk while preparing to cross Iceland, it is worth asking how many active patients may be overlooking it too.

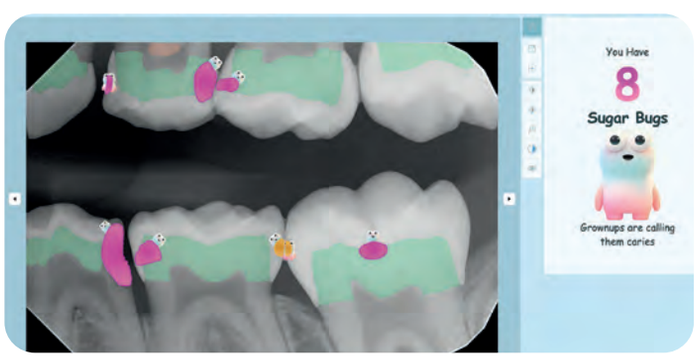
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Perfect harmony: an overseas dentist's journey

Sudheesh Kakkunath Mani reflects on the exams, moves and setbacks that shaped his career – and the parallel passion for music that took him to Wembley

Sudheesh Kakkunath Mani
BDS MDS(IND)OMFS, MFDS RCSEd
Associate dentist

The lights were down, but I could hear more than 12,000 people on the other side of the curtain. Standing backstage at OVO Arena Wembley, waiting for my cue, I could feel the energy of the crowd before I could see them. In a few moments, I would walk onto that stage to perform as an opening act for legendary Indian playback singer Sonu Nigam's London concert.

As I waited, all the people and events leading up to that moment flashed before me. One of them was my spouse, who has always had an extraordinary ability to see the bigger picture and work backwards to find a route to make it happen. It was her vision too, to see me perform on a huge stage in front of a massive audience.

As I walked onto the stage, I proudly introduced myself: 'I am a dentist whose passion for singing has landed me here today.'

This journey has been long, challenging and full of surprises, but it has been worth it. From my dental training in India to our first migration from India to Malaysia, preparing for and passing the qualifying examinations for the UK, arriving in the UK during COVID-19 with our four-month-old child, and starting my first job as a general dentist.

Where it all began

I trained in dentistry in India and developed a particular passion for oral and maxillofacial surgery, graduating with distinction and achieving second rank at university. Alongside this, I was also active in extracurricular activities and received the 'Famdent Indian Dental Talent Award', a national-level recognition for dentists across India.

I have carried music hand in hand with my dental career. Between and outside the long night shifts, I kept singing whenever I had the opportunity. This kept me rejuvenated and helped me tackle work-related stress.

With the immense love I received for my singing, I entered an online singing competition, which was the only way I could think of participating due to my full-time surgical training. I reached the top 500 across India. That was my first notable moment as a musician.

At the time, I had no idea that music would continue to accompany me across countries and through some of the most important years of my professional and personal life.

A year after my graduation, I married my wife, who is a dentist herself. After a few years of working in India, we decided to plan our move to the UK with a bigger professional goal. But getting ready for it required us to get our finances in place for registration examination fees, travel, accommodation, training courses and much more.

Gaining experience

This was when we applied for and got our first jobs abroad – lecturer posts at a Malaysian university in our respective departments. It gave us professional experience, financial stability and, importantly, the opportunity to prepare for the future we had imagined.

Again, among all this, there was music in the background. I carried on with my singing, even performing a famous Malaysian song. I still remember the surprise on people's faces when they realised that I was an Indian with no connection to the language.

Those moments stayed with me because they taught me something simple but powerful: music can transcend language, culture and background.

During this period, my wife and I strengthened our postgraduate experience by obtaining the MFDS qualification. This also helped us understand UK dentistry as well as prepare for the licensing examinations.

As with any other overseas dentist looking to sit these exams, it was a nightmare getting the exams booked. I did not get a booking on my first two attempts and only managed to secure one on the third. I sat the ORE, while my wife sat the LDS examination.













We both passed our respective UK dental licensing examinations on our first attempts. We were still cherishing the moment when COVID-19 struck. UK dentistry was hit as badly as many other industries. Recruitment stopped, flights were cancelled and redundancies were looming.

After around eight months, I was contacted by a recruiter for my first job in the UK. Though this was a happy moment, it turned out to be even more challenging, as we had to travel to the UK with our four-month-old daughter.

Starting again in the UK

An overseas dentist's journey contains many things that never appear on a CV: sleepless nights, childcare, financial pressures, homesickness, uncertainty and the responsibility of building security for a family while learning to navigate an unfamiliar professional system. Interestingly, I was still singing – this time, they were lullabies.

Over time, opportunities began to emerge. My spouse and I were appointed as clinical lecturers at King's College London. It was a major milestone in my oral surgery career. These roles recognised and valued our achievements, allowing us to contribute to the education of future UK dentists.

We had arrived as overseas-trained dentists learning how to navigate a new system. Now, we were trusted to contribute to the education of students within that same system.

Two years down the line, our own experiences eventually inspired us to establish NS2 Dental Academy, through which we now support other overseas dentists as they navigate their own journeys in UK dentistry.

Keep singing

Through every professional change, I kept singing.

I participated in regional competitions, performed at gala dinners, local community events and other small stages.

Music did not wait for life to become convenient. It simply found a place within the life I was building.

Again, it was one of the ways I could overcome the stress related to dentistry. Music and dentistry gave me two important identities.

Just as I improved my skills and understanding in dentistry through courses, I decided to enhance my singing skills. This led me to join Artium Academy, an online music academy.

I was selected from among the participants in the UK to represent the academy and was given the opportunity to perform on stage at the iconic OVO Arena Wembley – every musician's dream!

'Music can transcend language, culture and background'

As I was driving to the venue, I thought about examinations, migration, parenthood, community programmes, setbacks, brave decisions and all those small stages where I had sung without knowing where they might lead. It was like incremental composite layering in dentistry – each small layer contributing to the final result.

I remain grateful to India for giving us our foundation; to Malaysia for giving us the professional and financial strength and to the UK for welcoming us and giving us opportunities to learn, teach, contribute and build our future.

In the spotlight

Moving countries does not mean starting from zero. You carry your education, experience, resilience, relationships, culture and identity with you. You learn and adapt to a new professional environment, but every previous chapter travels with you.

Sometimes, years later, you look back and realise that every examination, every flight, every difficult goodbye, every setback, every brave decision and every small stage was quietly taking you towards your own Wembley moment.

Today, I work as a general and implant dentist during the week, and on weekends, you will often find me on a stage somewhere, continuing my passion for music.











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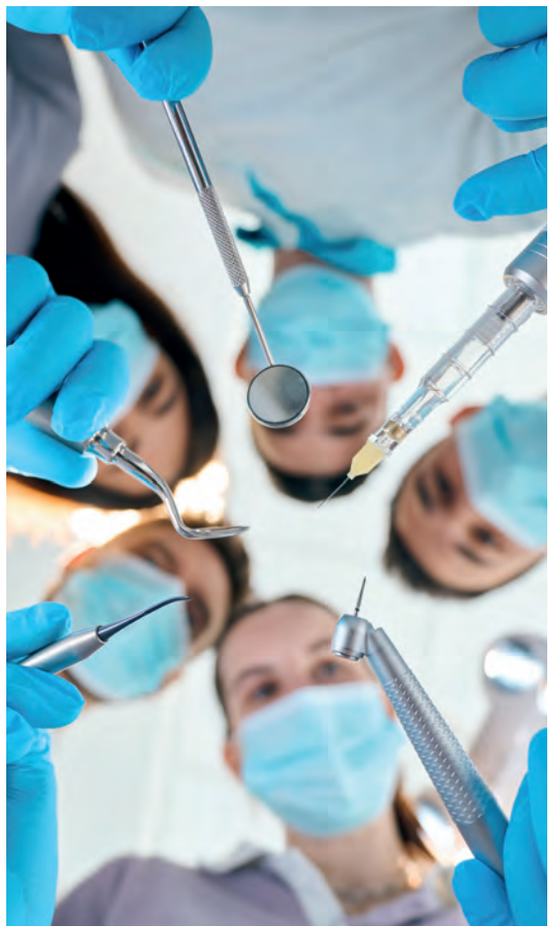
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The team dentistry needs

Jason Wong, chief dental officer for England, shares his thoughts with Rhiannon Jones on why making better use of the whole dental team is a 'no-brainer'



Jason Wong MBE
Chief dental officer for England

Rhiannon Jones
President, British Society of Dental Hygiene and Therapy

Rhiannon Jones: What are the biggest pressures facing NHS dentistry right now?

Jason Wong: The main pressure has really been access to NHS dentistry and, as we restore services, making sure they are aimed at those in greatest need. The inverse care law is alive and well in dentistry and oral health, so that has to be a real focus for us.

Rhiannon: Prevention is often talked about as a priority. How well is it being put into practice?

Jason: I do not think we have absolutely clarified what we all mean when we talk about prevention. Colleagues vary from thinking it is giving a bit of dietary advice about eating less sugar, through to prevention being about behaviour change, motivational interviewing and assessing that change.

There is a big difference between those approaches, and I think we need greater consistency in what we mean by prevention.

Rhiannon: What are the main barriers for dental hygienists and dental therapists trying to deliver that preventive care?

Jason: Most people would probably quote time. I actually think the clinician has to both understand and believe the information they are giving out. That is really important. It is also about having a consistent message, while being able to personalise it to the individual.

Rhiannon: Do you think contract reform is genuinely shifting the focus towards prevention?

Jason: It is definitely moving in the right direction. We have, for example, incentivised preventive care within the forthcoming contract changes. You can have a discussion about whether it is enough, but I think it is a significant step.

Once that beds in, there is also the issue of quality improvement within the contract, including peer review and building communities of practice within dentistry.

Rhiannon: Where do you see British Society of Dental Hygiene and Therapy (BSDHT) members having the greatest impact?

Jason: I think an organisation like BSDHT has a role in collaboration, both within its membership and in how its members collaborate with other associations, societies and other parts of the sector.

I would really like to see the profession working together collaboratively rather than within our own small silos. Overall, what I am also trying to do is bring dental and oral health into the wider healthcare system and make sure we are part of that.

Rhiannon: Are we making the most of dental hygienists and dental therapists?

Jason: Overall, it is not as good as we would like it to be, which is why we have started a workstream looking at the real barriers. It should be about the right person in the right place, making the best use of time and enabling every member of the team who wants to work to their full scope to do so.

Direct access is part of that, but I would put more emphasis on teamwork. Too often, direct access is spoken about in an almost adversarial way, as though dental therapists are replacing dentists. It should be about the whole team working together and everyone providing a service to patients.

We are also finding that dentists in particular do not always understand the full scope of practice of their colleagues. That is an education piece we are working on.

Rhiannon: What could an NHS career offer dental hygienists and dental therapists entering the profession now?

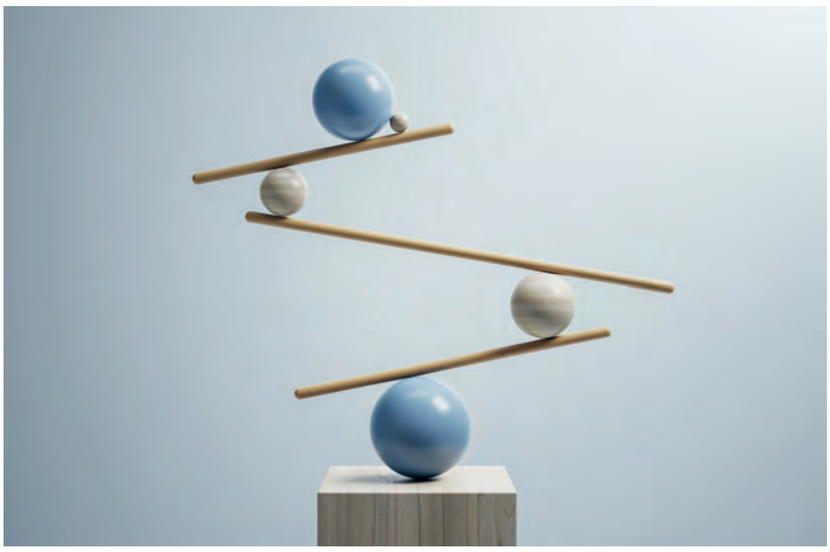
Jason: Firstly, I would hope it offers the opportunity to work to the top of your scope. For dental therapists in particular, children's dentistry fits really well within that.

I think you should take the role of prevention champions and be part of the workforce delivering essential healthcare for the nation.

I am making the call for dentists to see this as a positive move too, rather than any kind of threat. We have more work than we have workforce. Making better use of the team around us is a no-brainer.

'We need greater consistency in what we mean by prevention'

Hear more from Jason and Rhiannon in the 'Shifting the dial – prevention, access and the role of the dental team' episode of the BSDHT's Dental Health Matters podcast. Listen at bsdht.org.uk/podcast.



The real staffing challenge

Staffing pressures are not just about recruitment. For many practice managers, the bigger challenge is balancing empathy, accountability and the everyday reality of keeping the practice running, says Pat Langley

Pat Langley
Clinical director,
Dentistry Compliance

Staffing was one of the clearest themes to emerge from conversations with practice managers at a recent discussion hosted by the Association of Dental Administrators and Managers (ADAM) and Dentistry Practice Services.

Not in a broad, abstract sense. Not simply as a comment on recruitment being difficult or finding the right people taking longer than it used to. The challenge felt much more personal than that.

Practice managers were talking about the day-to-day reality of managing people. The calls that come in before the working day has started. The last-minute sickness. The rota gaps. The difficult conversations. The tension between wanting to be supportive and needing the practice to function.

Because in a dental practice, staffing issues are rarely contained.

If a dental nurse is off unexpectedly, it affects the clinician, the diary, the patient experience, the wider team and often the financial performance of the day.

Practice managers: in conversation

The Association of Dental Administrators and Managers (ADAM) and Dentistry Practice Services brought practice managers together at this year's British Dental Conference & Dentistry Show in Birmingham for a special breakfast meeting.
This series of articles presents some of the topics that were raised during the morning's discussions.

If there is no clear process in place, the practice manager is usually the person trying to hold all of that together.

There was also a strong sense that workplace expectations have shifted.

Some practice managers spoke about differences in attitude, communication and boundaries across teams. Others reflected on how difficult it can be to manage sickness, absence and performance without feeling as though they are being unfair or unsupportive.

The balance between care and consistency

This is where people management becomes complicated.

Most practice managers care deeply about their teams. They want to be flexible. They want to understand what is happening in people's lives. They want to create a supportive environment.

But care still needs structure.

Without clear expectations, consistent policies and good communication, even small issues can become emotionally draining. The same conversations happen again and again. Decisions feel personal. Managers start to carry the weight of problems that should be shared more clearly across the team.

This is where HR compliance becomes much more than a set of documents:

- Clear absence processes
- Consistent onboarding
- Documented expectations
- Fair performance conversations
- Defined escalation routes.

These are the things that help practice managers feel more confident handling people challenges consistently and professionally. It gives practice managers clearer structure to lean on and helps ensure conversations and decisions are handled consistently and fairly.

'They don't always understand the impact it has on the practice'

What practical support actually looks like

The strongest support for practice managers is not about making the role more formal or less human. It is about giving them the confidence to manage people well, without feeling they have to work everything out alone.

Through ADAM, practice managers can access peer connection and shared learning from others who understand the realities of the role.

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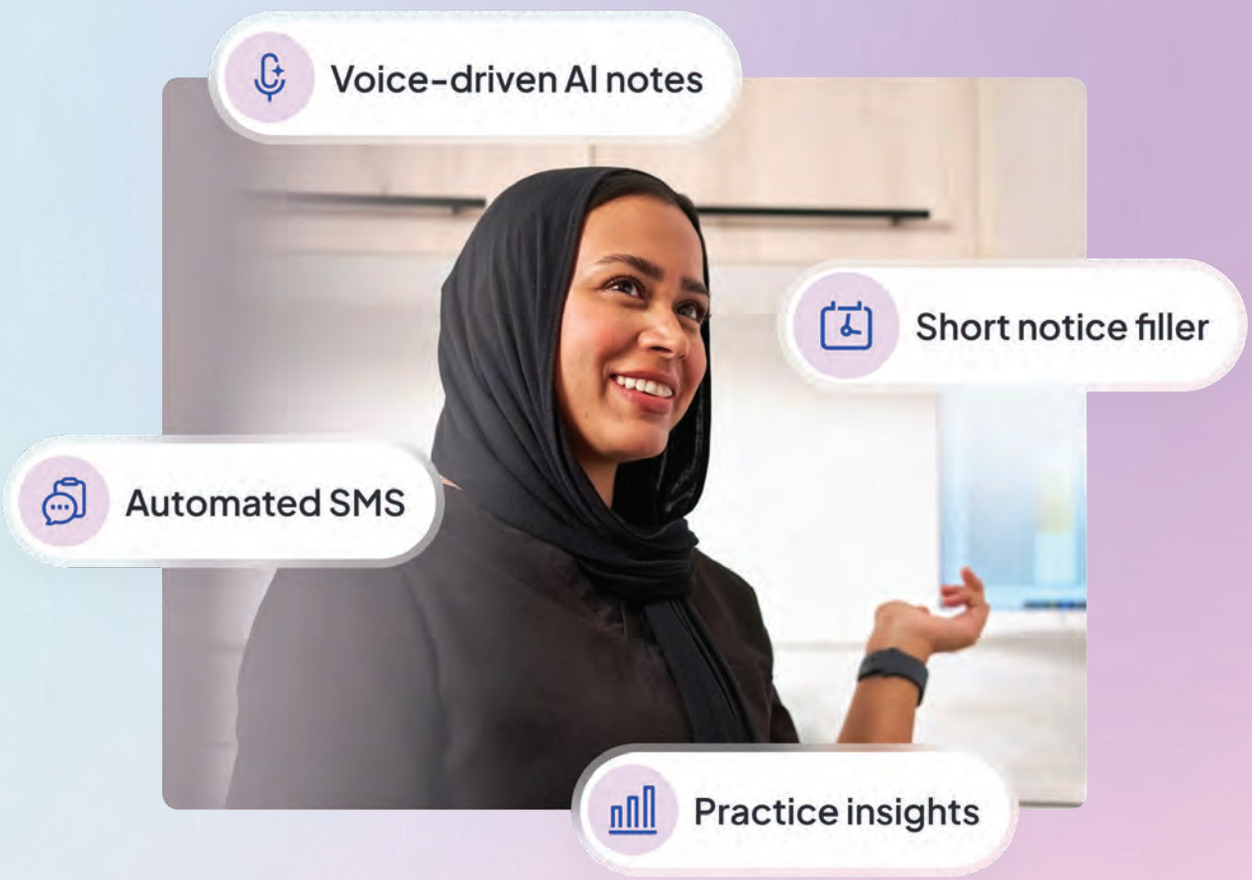
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Building systems in dental therapy

Despite policy changes slowly recognising the full potential of dental therapists, many practices continue to rely on outdated ways of working. Cat Edney and Bradley Wilson explain why meaningful change demands systems that allow dental therapy to thrive

Cat Edney
Dental therapist

Bradley Wilson
Dental therapist

One of my favourite things about writing for *Dentistry* is the conversations it starts. Every month I hear from dental therapists working in completely different environments, all experiencing the profession in slightly different ways. Sometimes those conversations reinforce something I've been thinking for a while, and sometimes they make me look at things from a completely different perspective.

Recently, I sat down with fellow dental therapist Bradley Wilson to talk about where we think our profession is heading. Bradley works in an NHS mixed corporate practice and is thriving as a direct access dental therapist. He has carved out a role for himself where there once was only dental hygiene work available. I was interested to hear his thoughts on how the profession could grow like he has.

We started by discussing the recent NHS changes affecting dental therapists, but very quickly found ourselves talking about something much bigger than policy. We found ourselves talking about systems.

The systems we inherit

Cat Edney: Bradley, one thing I've been speaking about for a while is how few therapists actually walk into a practice and build their own way of working. Most of us qualify, arrive in practice, and inherit whatever system already exists. The diary template is already there, the appointment lengths have already been decided, referral pathways already exist and everyone simply carries on doing what the previous clinician did. We accept those systems because we assume they're normal. Do you think that's part of the challenge?

Bradley Wilson: I do. I think most dental hygienists and therapists have spent years developing themselves inside a framework that somebody else created. Regardless of our individual skills, that framework inevitably shapes the contribution we're able to make. Over time that has pushed many therapists towards the edge of patient care rather than placing them where they could have much more influence.

The interesting thing is that therapists have become exceptionally good at working within those systems. We've adapted to them. We've mastered them. But that doesn't necessarily mean they're the best systems for either clinicians or patients.

Cat: I think that's an important distinction because these conversations sometimes become quite divisive. This isn't about suggesting every therapist should suddenly be carrying out every aspect of their scope every day. There are therapists who absolutely love providing prevention-focused care all day and they do it brilliantly.

Ambition beyond existing systems

Cat: The concern for me is the therapist who qualified wanting to use restorative skills, wanting to work collaboratively with dentists, wanting to practise through direct access, but never really finding an environment that allows those skills to develop. They haven't consciously chosen that path. They've simply adapted to the system they found themselves working within.



'Policy can open the door, but it's thoughtful leadership within practices that determines whether anyone walks through it'

Bradley: Exactly. I don't think the profession lacks ambition. I think opportunity has been inconsistent.

If somebody spends years carrying out the same appointment repeatedly, it's only natural that confidence in other areas starts to diminish. That doesn't mean the ability has disappeared. It simply means those skills haven't been exercised often enough.

Cat: That's something I hear all the time. Therapists often tell me they don't feel confident restoring teeth anymore, but when we explore that further, what they really mean is they haven't restored many teeth recently. Confidence isn't something you either have or don't have. It's usually the product of repetition, support and opportunity.

Progress driven by policy

Cat: What I also find fascinating is how much momentum there seems to have been over the last few years. For a long time progress felt slow, then suddenly we've seen direct access become established, provider numbers introduced, exemptions legislation passed and therapists increasingly opening NHS courses of treatment independently. What do you think has driven that change?

Bradley: Looking back over the last 20 years, representative organisations, educators and therapists have all worked incredibly hard to move the profession forwards. Sometimes it felt frustrating because slow progress happened one small step at a time.

Over the last few years though, we've seen several policy changes happen in relatively quick succession. Therapists can now hold NHS PIN numbers, open and manage their own courses of treatment within scope, and exemptions legislation has removed barriers that previously prevented therapists from providing complete care independently. More recently, we've also seen NHS contract reforms continue to recognise the wider dental team and encourage greater utilisation of skills mix.

When you stand back and look at those changes together, they represent a significant shift in how therapists can contribute within primary care.

Making full use of the workforce

Cat: What strikes me most is that therapists themselves didn't suddenly become different clinicians.

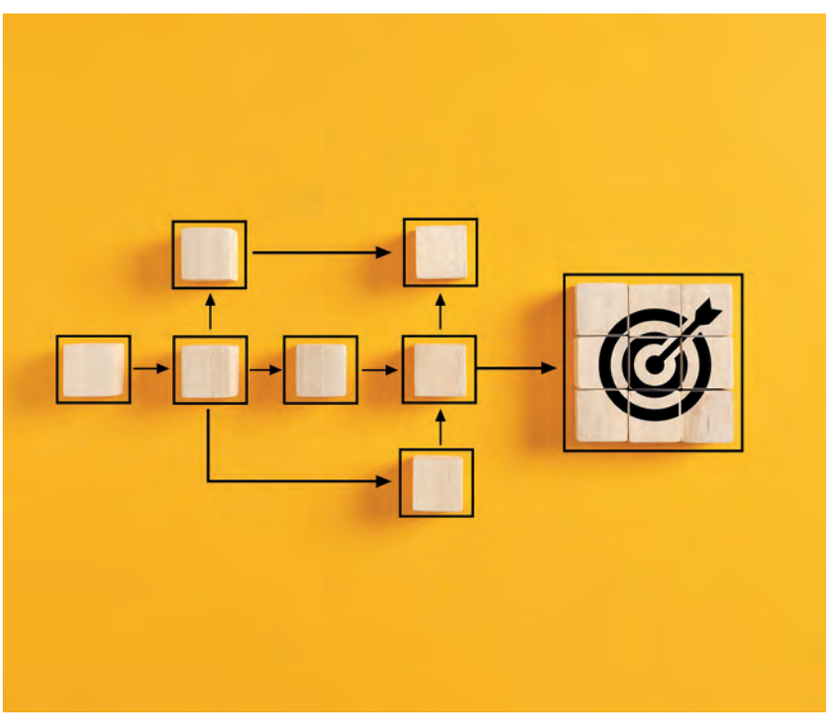
Bradley: I think that's probably the biggest lesson we've learned. The COVID-19 pandemic accelerated the dental access crisis and forced policymakers to think differently about how the workforce could be used. Therapists became part of that conversation because the skills were already there. Policy didn't create new clinicians. It simply removed some of the barriers that had prevented existing clinicians from contributing more fully.

Cat: That's where I think practice owners can learn something really valuable: if changing national policy unlocked the potential of therapists across the NHS, could changing practice policy achieve exactly the same thing inside an individual practice?

Bradley: We often think about policy as something that only happens nationally, but every practice has its own operating system. Because every practice already has its own policies. It decides appointment lengths. It decides referral pathways. It decides who sees which patients.

It decides how clinicians communicate and what information should accompany referrals. Those decisions shape the contribution every clinician can make.

Well-designed systems remove uncertainty. When uncertainty disappears, clinicians naturally become more confident because everybody understands where they fit within the patient journey.



Confidence follows systems

Cat: This is what I find when I'm working with practices. People often assume I'm there to teach composite techniques or discuss direct access legislation. In reality, much of my work happens before anyone even picks up a handpiece. We're discussing how examinations should be standardised, agreeing referral criteria. We're deciding what information should accompany every referral. We're creating communication pathways between therapists, dentists, reception teams and dental nurses so that everyone understands the patient journey.

What's interesting is that once those systems exist, the clinical confidence tends to follow surprisingly quickly. Dentists become more confident referring because they know exactly what information they're going to receive. Therapists become more confident because expectations are clear and support is visible. Patients simply experience one joined-up team rather than individual clinicians working independently.

Bradley: Which perhaps means we've been asking the wrong question all these years.

Rather than asking whether therapists are ready to work differently, perhaps we should be asking whether our practices are ready to support therapists differently.

Measuring the impact of dental therapists

Cat: That is a really interesting way of looking at it: because it also changes how we measure success. Historically we've spoken about the value therapists bring to patient care, but we've often struggled to demonstrate that contribution in a meaningful way. Do you think that's beginning to change?

Bradley: I do. The introduction of NHS PIN numbers gives us opportunities we've never really had before. Through General Provider Reports, Compass reporting and practice-level data, practices can begin understanding not only how active therapists are, but the type of care they're providing and the impact they're having on access, prevention and patient outcomes.

Rather than relying on assumptions, we can begin having conversations based on measurable data. That creates opportunities for identifying development needs, refining patient pathways and demonstrating the value therapists bring within the wider dental team.

Leadership unlocks potential

Cat: What really stands out for me is that this conversation has become much less about therapists themselves and much more about the environments we ask them to work within.

If we can create practices where referral pathways are clear, communication is consistent, education is valued and therapists are supported to grow gradually rather than expected to change overnight, then everyone benefits.

Dentists spend more time delivering the treatments they enjoy most. Therapists develop fulfilling and varied careers. Practices become more efficient. Most importantly, patients receive care from the right clinician at the right time.

Perhaps that's the real lesson from the last few years. Policy can open the door, but it's thoughtful leadership within practices that determines whether anyone walks through it.

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The £100,000 trap and the illusion of high income

In the second of his three-part series, Minesh Patel explores marginal tax rates, student loans, pensions and incorporation for self-employed dental professionals

Minesh Patel
Associate dental practitioner

In the first part of this series, published in the September issue of *Dentistry*, we examined the financial foundations of self-employment: tax reserves, compliance, and financial protection.

These form the baseline of sound financial management.

Now we will move into more nuanced territory – areas where even financially literate clinicians can unknowingly lose substantial sums each year. For many associates, practice owners and higher-earning DCPs, the monetary focus is naturally on increasing income. Yet increasing income is only half the story. The real measure of financial progress is how much of that income you retain and convert into long-term wealth.

Understanding profit: income is not wealth

Within dentistry, gross income figures dominate the conversation; associates compare UDA values, while practice owners discuss revenue growth. Yet tax is levied on taxable profit, not turnover, and far fewer discussions focus on net retained income.

Accurate identification of allowable business expenses is therefore essential. Common deductible expenses may include:

- GDC registration
- Professional indemnity
- Dental memberships
- Relevant dental and clinical equipment, such as loupes and instruments
- CPD and professional training (including qualifying travel and subsistence)
- Appropriate professional clothing and qualifying laundry costs
- Professional journals and subscriptions
- Proportionate home-working costs.

The key principle is that an expense must satisfy the relevant tax rules to be deductible, but spending money simply because it's tax deductible is rarely good financial planning.

Knowing which expenses you can claim is only part of the picture; accurate record keeping is equally important, as it reduces errors, supports legitimate claims, and helps clarify your true financial position.

The £100,000 threshold

Crossing £100,000 is commonly viewed as a milestone. In reality, it introduces one of the most punitive marginal tax rates in the UK.

For those whose net income exceeds £100,000, the tax-free personal allowance of £12,570 is withdrawn at £1 for every £2 of additional income. This taper continues until £125,140, at which point the allowance is lost entirely, creating an effective 60% marginal income tax rate.

The impact extends beyond tax alone. Earning above £100,000 can mean losing entitlement to:

- Tax-Free Childcare for children under 12 (worth up to £2,000 annually)
- 30 hours of funded childcare for eligible working parents in England (potentially worth more than £10,000 annually).



Once additional taxation and withdrawn benefits are factored in, the overall gain from extra earnings can be surprisingly small, or even negative. This catches many clinicians by surprise, and serves as a stark reminder that earning more and being financially better off are not the same thing.

This disproportionate tax erosion, however, should not prompt clinicians to work less, but to work more strategically.

A strategic lever

Pensions are frequently seen purely as retirement vehicles. They can be much more than that.

By making eligible pension contributions, particularly into a self-invested personal pension (SIPP), adjusted net income can be reduced for tax purposes, potentially bringing income back below £100,000 – instantly restoring your full personal allowance and childcare benefit eligibility.

This opportunity is widely missed. Many clinicians fail to adjust contributions proactively and consequently pay thousands more in tax while losing valuable benefits unnecessarily.

For those whose income falls in the £100,000-£125,140 range, pension contributions can be a shrewd, tactical planning tool.

NHS Pension Scheme

For dentists undertaking NHS work, contributions to the NHS Pension Scheme remain extremely valuable, providing:

- Inflation-linked retirement income
- Ill-health retirement protection
- Survivor/death-in-service benefits
- Substantial NHS contributions.

For dentists combining NHS and private work, pension planning becomes more complicated and should be reviewed as part of the wider financial strategy, rather than considered in isolation. The interaction between NHS benefits, private pension contributions, tax relief and annual allowance rules can make professional advice particularly valuable for higher earners.

Private practice and the SIPP

For those working predominantly in private practice, retirement provision becomes entirely self-directed. A SIPP offers significant flexibility over investment choice and withdrawal options, while providing tax relief on eligible contributions.

Pensions also compound quietly in the background for decades. While a lifestyle expense is immediately tangible, money directed into a pension remains invested and amplifies over time. Notably, because of tax relief, a £1,000 gross contribution may effectively only cost £600 for a higher-rate or £550 for an additional-rate taxpayer.

Tax should not only be reduced for its own sake; rather, the aim should be to redirect money that would otherwise be paid in tax into assets capable of growing over time and supporting long-term financial freedom. Pensions can therefore be one of the most effective wealth-building structures available to clinicians, not simply as retirement vehicles, but as important tools for tax-efficient wealth building.

> ‘One of the most common areas of financial leakage is unclaimed pension tax relief’

The overlooked claim

One of the most common areas of financial leakage is unclaimed pension tax relief.

Money paid into a pension from taxed income can qualify for tax relief. Personal pensions usually operate under a ‘relief at source’ scheme, meaning the pension provider automatically claims basic-rate relief of 20% on eligible contributions; an £8,000 net contribution becomes a £10,000 gross pension contribution.

For higher- and additional-rate taxpayers, however, the full relief is not applied automatically. The provider applies basic-rate relief only, and any further relief entitlement must be claimed through your Self Assessment return, which typically takes the form of a reduction in your tax liability.

On that same £8,000 eligible contribution, a higher-rate taxpayer is entitled to a further £2,000 totalling £4,000 of tax relief, while an additional-rate taxpayer is entitled to a further £2,500, totalling £4,500 relief.

Many professionals are unaware that the onus is on them to claim this additional relief; an oversight that can cost thousands of pounds annually.

Student loans: the hidden 9% marginal rate

Student loans further erode disposable income, and early- to mid-career dental professionals often underestimate their impact on true net income. Several undergraduate and postgraduate loan plans are in operation. Repayment rates and thresholds vary by plan, but are typically 9% above the relevant undergraduate threshold.

For higher-rate taxpayers, earnings between £50,270-£100,000 are subject to 40% income tax, 2% Class 4 National Insurance Contributions (NICs) and 9% student loan repayments; an effective 51% marginal deduction rate.

Within the £100,000-£125,140 band, where effective income tax rises to 60%, the true marginal deduction rate can approach 71% once loan repayments and NICs are factored in. For every extra £1 earned, you may only retain 29p.

Those with both an undergraduate and a postgraduate loan may face a combined 15% repayment rate.

These figures are often underappreciated because payslips are absent in self-employment; the deductions occur through Self Assessment, obscuring their impact. With such high deduction rates, every pound earned needs to work harder, with a clear purpose behind how it is ultimately deployed.

Incorporation: nuance over narrative

Incorporation has historically been promoted as a tax-efficient structure for higher-earning dentists and some DCPs, but changes to corporation tax rates, dividend taxation and allowances have since narrowed the differential.

Paying yourself a company salary generates corporation tax relief, but also triggers employer NICs (15% above £5,000) and employee NICs (8% between £12,570-£50,270 plus 2% above this range), whereas sole traders, pay 6% NICs over the same range, and 2% above it. This makes incorporation less efficient where most profits are withdrawn.

A limited company can, nevertheless, offer



opportunities unavailable to a sole trader, particularly where profits are retained rather than extracted immediately, but profit extraction requires consideration.

Dividends avoid NICs, but are paid from company profits already subject to corporation tax and are then subject to shareholder dividend tax. While dividend rates are lower than income tax, the combined effect often reduces incorporation advantage, especially for those withdrawing most of their profits. Yet it may be worth considering where:

- Earnings consistently exceed higher-rate thresholds
- Tax deductible pension contributions are being maximised via the company
- Limited liability protection is strategically desirable; recognising that a company structure does not shield against professional negligence or regulatory obligations
- Surplus profits are retained within the company
- Business continuity and succession planning are a priority.

There may also be scope for legitimate family tax planning by involving a spouse in the business or structuring share ownership appropriately, allowing income to be distributed more efficiently within the family.

Such arrangements, however, should reflect genuine commercial circumstances and comply with the relevant tax and company-law rules.

Incorporation also introduces greater administrative burden, accountancy fees and compliance responsibilities. For many clinicians, sole-trader simplicity will outweigh the advantages; for others, particularly practice owners able to retain and reinvest profits, a company structure may be preferable.

There is no universal answer; the right decision depends on income, expenditure, future earnings forecasts, profit extraction, pension planning, family circumstances and long-term objectives. The overall position is highly nuanced; incorporation should therefore be based on detailed financial modelling rather than anecdote or headline tax differentials alone.

Retention, not revenue

Practitioners assume financial security follows automatically from a high income. It does not. The UK tax system is layered and interconnected; marginal rates can increase, allowances can taper, benefits can be withdrawn, and student loans add further layers of deductions.

Financial decisions are rarely absolute and perfectly optimal; most involve trade-offs, and knowledge provides the foundation for informed decision-making. In this regard personal finance is not dissimilar to informed consent, which clinicians practise every day; presenting options, explaining benefits and risks, and enabling considered decisions based on a clear understanding of the consequences.

Over a 30- or 40-year career, the difference between informed and uninformed financial decisions can be profound.

The clinician who consistently retains an additional few thousand pounds each year, directs it into productive assets, and lets those assets compound will build substantially more wealth than the counterpart focused only on turnover and lifestyle spending.

Wealth management is not merely about accumulation; it is about structure and continual evaluation. Ultimately, it is about creating what every clinician values but cannot measure on a payslip: financial independence and greater choice.

In the next article, we'll move beyond tax mechanics to examine the risks many ignore; capacity, estate planning and lifestyle creep, and why an annual review is what protects long-term freedom.

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Budget: be prepared

Don't let the budget dictate your financial planning, argues Iain Stevenson

Iain Stevenson
Head of dental,
Wesleyan Financial Services

With the next UK budget confirmed for 28 October, it's understandable that many dentists will be wondering what the Chancellor might announce – and, more importantly, what it could mean for your personal and professional finances.

'My advice is simple: focus first on what you can control'

But before speculating about potential changes to tax, pensions or other areas, there's value in taking a step back and reviewing where you are today.

Having all the facts

The budget may change the financial landscape, but it can't tell you whether your existing plans are right for your circumstances. Having a clear picture of your current position means you can assess any announcements objectively, rather than making decisions based on headlines or assumptions.



For dentists, that could mean reviewing your pension arrangements, investments, protection, savings and borrowing, alongside the financial position of your practice.

It's also worth considering whether your plans still reflect your priorities and timescales. Your circumstances may have changed since you last reviewed them, regardless of what happens on budget day.

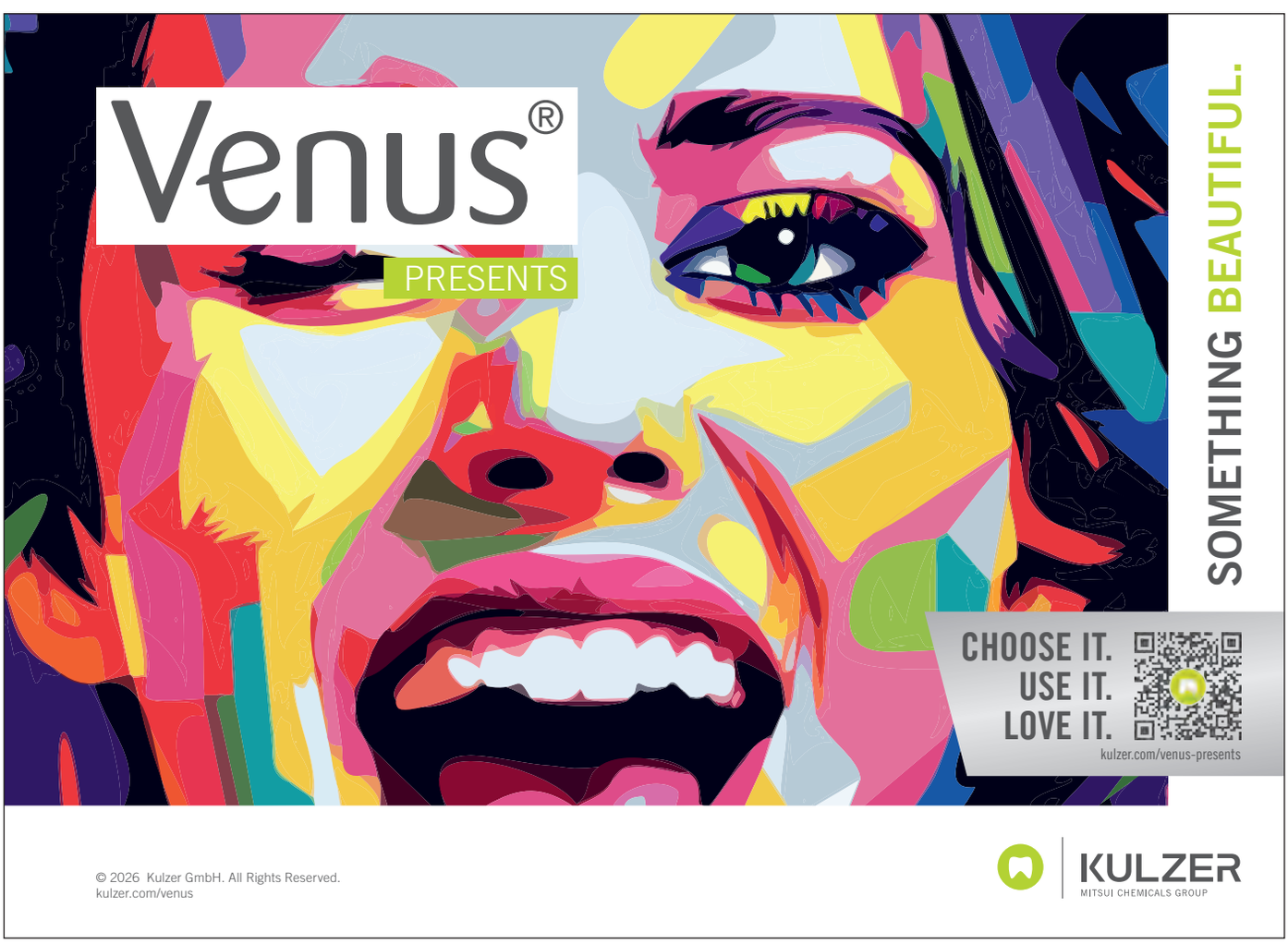
All change?

There can be a lot of noise in the run-up to a budget, and plenty of predictions about what might happen.

My advice is simple: focus first on what you can control.

Know your starting position. Then, once the Chancellor has spoken and the detail becomes clear, you will be in a much better position to decide whether you need to do anything differently.

Good financial planning isn't about trying to predict the budget. It's about being prepared for it.



“It’s mainly the commute, to be honest.”

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Six questions. Be honest.

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- [ ] The last person who resigned told you the real reason.
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- [ ] Your last three appraisals changed something.
- [ ] You’ve delegated authority to your manager, not just tasks.

Five or six ticks and your people aren’t going anywhere. Three or four and it’s the systems, not the market. Fewer than three and you already knew that.

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Mark Topley
Founder, Exceptional Team Performance



Leadership without the drama

Mark Topley explains how to stay calm, clear and kind when people are hard work

There's a particular kind of tiredness that doesn't just come from a busy diary. You can run a full list all week and go home perfectly fine. But one conversation you didn't have, or had badly, can follow you round for days.

In my experience, most leaders in dentistry aren't worn out by the work. They're worn out by a small number of people who take up a disproportionate amount of their headspace – the team member who sighs at every change, the one who's clinically excellent but culturally corrosive, the colleague who somehow makes a simple request feel like an imposition. Nineteen little irritations – and that's before lunch.

Something worth saying early: difficult behaviour is rarely about you. It's usually fear, fatigue or a genuine lack of clarity about what's expected. That doesn't make it acceptable, and it certainly doesn't mean you put up with it. But it changes the job in front of you, because you're not managing a difficult person, you're addressing a behaviour that's been allowed to carry on.

Start with what's been allowed

Most difficult behaviour in a practice has a history. Someone tried it once, nothing happened and over time it became normal. Everyone else adjusted around it, which is how you end up with a team that quietly organises itself to avoid one person's moods.

That's not a comfortable thing to look at, but it is good news, because it means the thing that changed it can also change it back. One of my core beliefs as a coach is that 'clarity is kindness'. People behave better when they know exactly what good looks like, and most of them are relieved when someone finally says it out loud.

Calm language does the heavy lifting

The words you choose matter more than the strength of feeling behind them. Two habits will carry you through nearly every difficult conversation you'll have.

The first is describing behaviour rather than character. Not 'you're being negative', which invites an argument about who they are, but 'you've pushed back on the last three changes we've made, and I'd like to understand what's going on'. One is a judgement. The other is an observation, and observations are much harder to fight.

The second is the pause. Say your sentence, then stop talking. Most of us undo a perfectly good piece of feedback by filling the silence that follows it – softening it, explaining it, adding a joke, offering an excuse on the other person's behalf. Let the silence sit there. It's doing work.

'People behave better when they know exactly what good looks like'

Holding the line isn't drama

Drama doesn't come from boundaries. It comes from boundaries that move. When a standard applies on Tuesday but not on Friday, or to one dental nurse but not another, people stop trusting the standard and start testing you instead. When you've decided something, say it plainly and stop hedging. 'That's not how we speak to each other here' doesn't need a preamble or an apology attached to it.

If you have to say it calmly for the third time, that's not a failure – that's just what bedding in a new standard looks like, and repetition without irritation is one of the most underrated leadership skills there is.

Getting your energy back

The bit people miss is what happens afterwards. Difficult conversations cost something, so don't stack four of them into one afternoon and then wonder why you're flat by 6pm. Take one at a time, protect a bit of headspace either side, and be honest about which parts of this are actually yours to carry.

You're responsible for being clear, fair and consistent. You are not responsible for managing another adult's feelings about a reasonable expectation.

This week, pick one person and one behaviour, and write down the single sentence you'd say. Just one. That's usually where it starts.

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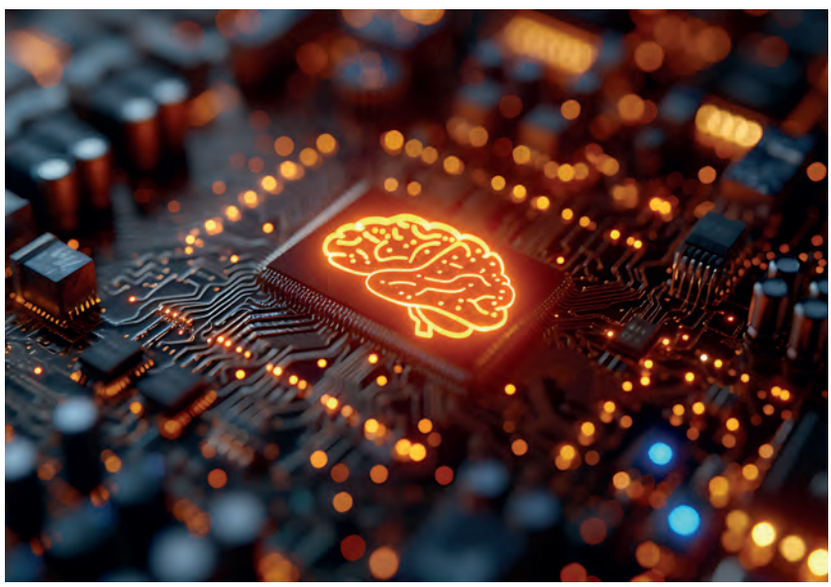
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SCAN TO LEARN MORE

Passing the AI detector test

Your AI content now carries a watermark but that is not what should worry you, argues David Nelkin

David Nelkin
CEO and founder of Xcelerator Dental



Since the beginning of August, text produced by Claude has carried an invisible watermark woven into the writing itself, one that travels with the text when it is copied and pasted. Google has been doing the same with Gemini since 2024, and OpenAI has said it intends to follow suit for ChatGPT.

EU rules that took effect on 2 August require the artificial intelligence (AI) companies to mark what their models produce, and they are applying it worldwide rather than building a separate European version. The obligation sits with them, not with you.

The reaction across the marketing world has been close to panic, and several practices have been asking whether content on their website is now going to be found out and punished for it. As of today, they are not. There is no data or info from Google which says you can't use AI to generate content. However, there is something you need to be looking at that does deserve that level of concern.

What the watermark actually does

The watermark doesn't do anything you can see. There are no hidden characters, and no label goes on the page.

The model nudges its own word choices in a pattern that a detector holding the right key can pick up, and the mark survives light editing. A full rewrite might remove it.

It also proves far less than people assume judging by the conversations I've had. A watermark indicates that an AI model was probably involved somewhere in the process. What it can't do is tell anyone whether that model wrote the piece, tightened it, or simply corrected the grammar in something a dentist wrote by hand.

Run your own writing through a model to fix the punctuation and it comes back marked.

Google doesn't penalise AI content

Google's published guidance says plainly that AI can be useful for researching topics and adding structure to original work. What it goes after is scaled content abuse, meaning pages churned out in volume to manipulate rankings with nothing useful in them. That policy predates AI by years. AI just made the churn cheaper.

Google has announced nothing that treats a text watermark as a ranking signal, and Google actually watermarks its own AI text using the same method. The provenance features it launched this year cover images, video and audio, and they exist to tell users where a file came from rather than to punish anybody.

So, using AI is fine, as of today. How you use it is what matters.

'If you ask it to write you content with no training and no input, you will get slop'

The thing that should worry you

Sit and read the content across 10 dental websites and you'll notice it has all started to sound the same. I expect that to continue.

The same phrasing, the same reassuring and slightly weightless tone, the same structure on every treatment page. That is what comes out when a model is handed a treatment name and asked for 800 words. And it is stripping practices of the one thing that made them competitive in the first place.

However, this isn't anything new – there are marketing companies out there who use the same content on multiple dental websites.

The output depends almost entirely on what goes into it. Feed a model your own consultation notes, the objections you hear every week, the way your team actually explains implants to a frightened patient, and you will sound like you have something to offer that nobody else does. That is the reason a patient picks you over the practice down the road.

If you ask it to write you content with no training and no input, you will get slop that reads exactly like your competitor's slop.

What cannot be generated

Patients do not choose a practice because of the copy on the treatment page. They choose because of the photograph of the actual dentist, the video of the actual team, the line in a real review describing precisely the fear they came in with and how it was handled. None of that comes out of a model, and all of it gets sacrificed quietly when a practice decides to move fast on AI content and AI imagery without thinking about what it is giving away.

The question I'd be asking before anything goes live is not whether a detector could tell that AI helped. It's whether the piece would still be worth publishing if it could.

AI is not the threat to your marketing. Generic marketing is the threat, as it always was. The watermark has just made it slightly harder to pretend otherwise.

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A sense of belonging

Zoe Close reflects on one of the essential ingredients for running a successful business

Zoe Close
Head of sales, Practice Plan

People often think that running a successful business is simply about getting the product or service right. While that's important, what creates a business that people want to continue to work with is less tangible than that. It's more to do with making your customers feel important and valued.

At Practice Plan we want our clients to feel as if they're an important part of something bigger. That they have joined a community of people all brought together by a common aim: to build businesses that thrive while providing great service to their customers.

We try to bring people together as often as possible, which is why we have an extensive events calendar supplemented by various breakfast clubs and meetings organised locally by Practice Plan regional support managers.

Our marquee event is the Practice Plan annual workshop tour held at different locations across the UK. This is a highlight for many of our practices, and we know our clients enjoy and value the experience because they tell us so. The feedback we receive is always fulsome in its praise.

However, nobody has been able to sum up what we're trying to achieve as a business better than dentist and practice owner, Manish Chitnis. He took the time to write a Facebook post about his experience with Practice Plan that truly encapsulates what makes a great business and what we try to do here at Practice Plan.

This is what he said: 'As I sat here reflecting, I realised just how much our relationship with Practice Plan has evolved over the years. It may have started as a business relationship. But somewhere along the journey, it became something much more.

'We became part of a tribe. A tribe where you are welcomed with genuine warmth. Where people remember you. Where conversations continue from one year to the next. Where success is celebrated together. Where there is laughter, friendship and a genuine desire to see each other grow.

'That is something incredibly rare in business. Because great businesses don't simply sell products or provide services. They create a feeling. A feeling that says: You belong here. We know you. We value you. And we are on this journey together.'

'Great businesses don't simply sell products or services – they create a feeling' – Manish Chitnis

Making people feel valued

It strikes me that Manish is making a valuable point about businesses in general. Creating that sense of belonging is what makes loyal customers. People want to feel that they matter, that they're not just another name in the diary.

They want to feel and believe that you have their best interests at heart and that they can trust you to act for their benefit and not your own.

A patient journey that makes your patients feel valued is essential. Small touches such as greeting them by name, finding out more about their family and their pets, talking about their holiday plans and so on go such a long way. These are things that show you are interested in them as a person, that you value their continued attendance at the practice and that you want them to be part of your tribe.



This is important as, although NHS patients may have few choices open to them, for those who pay privately there are plenty of options if they want to vote with their feet. And remember, loyal patients who are prepared to recommend you to their family and friends are worth a lot when it comes to marketing.

Manish's words remind me of the Maya Angelou quote: 'I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.'

If you can make your patients feel welcome and valued, they'll stay with you for life.

Practice Plan has been welcoming dental practices into the family since 1995, helping them to grow profitable businesses through the introduction of practice-branded membership plans. With more than 300 years' dental experience in its field team, if you're looking for a provider that has that family feel but knows a thing or two about dentistry, then you're in safe hands. Be Practice Plan and get in touch. Call **01691 684165** or visit **www.practiceplan.co.uk/be-practice-plan.**

UP, UP AND AWARD!

Dentistry DSO AWARDS 2026

FRIDAY
11 DECEMBER
2026
UNDERGLOBE
LONDON

SCAN TO SEE
THE FINALISTS

THE SHORTLIST

IS IN.

MEET THE INAUGURAL FINALISTS

Standard Table Package

- Arrival drinks reception with unlimited bubbles and cocktails
- Unlimited beer, wine and soft drinks on table for 4 hours
- 3 course meal and coffee

Premium Table Package

CIRCLE TWO

- Arrival drinks reception with unlimited bubbles and cocktails
- Premium positioning in circle two
- Unlimited beer, wine and soft drinks on table for 4 hours
- 3 course meal and coffee

VIP Table Package

CIRCLE ONE

- Arrival drinks reception with unlimited bubbles and cocktails
- Top tier premium table positioning in circle one
- Corporate branding in centre of table
- Unlimited beer, wine and soft drinks on table for 4 hours
- 3 course meal and coffee

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The Big Rethink 2026: making oral care more inclusive

Innovation is shaping the future of oral healthcare, but inclusivity lies at its heart. Oral-B's Paola Mulas explains why dentistry needs a fresh perspective

Paola Mulas
Senior communications director, P&G/Oral-B

The digital evolution has been a game-changer for dentistry, unlocking innovative solutions and opening the door to a wide range of minimally invasive treatments. This reimagining of the profession continues at pace.

Dentistry has evolved at a deeply human level, too. Optimal treatment is now patient-centred and empathetic, with clinicians using open, honest communication to educate, demonstrate skills, and empower every patient to manage their oral health at home. Inclusivity is fostered in a clinical environment where no one is left behind. Access for all is the shared vision. Yet for millions of people living with disabilities, this can feel out of reach. A Europe-wide study conducted by Oral-B in collaboration with the International Association for Disability & Oral Health (iADH) sought to better understand the hidden impact of disability on oral health. The findings reinforce the urgent need to make oral care more inclusive. Approximately 166 million people (one third) in the UK, France, Germany and Italy are affected by disability in some way. Of these, 37% of survey respondents felt anxious or frustrated about visiting the dentist.

Almost half of people with disabilities surveyed had never been taught how to brush their teeth properly.

The wider findings were striking, too, with the research showing that the impact can affect overall health, confidence and emotional wellbeing. While 27% of respondents felt demotivated about maintaining their oral health, oral care was twice as likely to be painful or uncomfortable for people with disabilities compared with those without.

The research also found that one in five (20%) of those with severe disabilities find brushing all their teeth physically challenging. As one respondent said: 'For care that's so simple for the majority, oral care can be so difficult for those with disability or illness.'

Truly inclusive care

This study underscores an important truth: improving oral health is about more than developing better products. It also means equipping dental professionals with the knowledge, confidence, and tools to deliver truly inclusive care.

This is why Oral-B is continuing its mission to ensure everyone has an equitable oral care experience – both in dental surgeries and at home. To better inform our approach, we are working with the iADH and have already co-created a 'Positive Practices' programme.

The iADH is focused on ensuring that the dental experiences of people with disabilities and their carers are more inclusive and positive.

As part of this ongoing oral health inclusion initiative, and in partnership with the iADH, Oral-B recommends that each practice designate a Disability Champion – someone who provides leadership and actively promotes accessibility and opportunities.



We have also co-created accessible, relevant and helpful content for people with disabilities, their carers and families, as well as for dental teams.

The Big Rethink 2026

Our latest initiative – The Big Rethink 2026 – marks a significant evolution of this programme, aiming to achieve a wider, transformative impact.

It starts with Project Steady, a six-month, multi-country study exploring how people with disabilities interact with oral care products. Through feedback gathered using the Oral-B iO2 and an innovative adaptive accessory designed to improve control, ergonomics, stability, and toothpaste application, we are deepening our understanding of the challenges and turning lived experience into practical solutions. Project Steady builds on lessons from earlier pilot phases and complements our long-term commitment to inclusion, including the aforementioned Disability Champions programme and professional education developed with iADH.

Oral-B is also expanding its educational support. The Big Rethink Lab will offer an accessible online hub for inclusive educational resources, including:

- Specialist dentist advice videos
- Frequently asked questions
- Tips and advice from people with disabilities
- Interactive Q&As.

We have also launched a new training programme to build dental teams' confidence in delivering inclusive care and in creating a more welcoming experience for every patient. This includes student training and accreditation programmes.

Reference

The Oral Health & Disability European Study, March 2022

For more, scan the QR code or visit **iadh.org/oral-b-iadh-disability-champions**.

Brighter restorations without the fake white look

XBL joins the COLTENE BRILLIANT shade range

COLTENE has extended the BRILLIANT shade range with XBL, a new Xtra Bleach shade designed to provide a brighter option than the existing Bleach (BL) shade – available for both BRILLIANT EverGlow universal composite and BRILLIANT Crios reinforced composite CAD/CAM blocks. As whitening has become more popular in general practice, the demand for restorations that match very bright dentitions has increased. XBL gives clinicians another shade option when restoring brighter smiles.

Bright, but not artificial

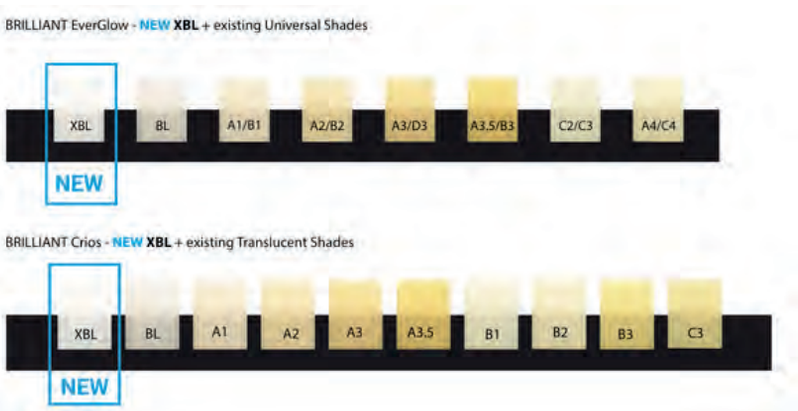
A common reservation for clinicians with very light composites is that they can look flat and opaque against natural enamel – precisely the effect that patients want to avoid too.

XBL has been developed within the existing submicron hybrid filler technology, so its optical behaviour is consistent with the rest of the BRILLIANT EverGlow range allowing it to be layered with the translucent and opaque shades where internal characterisation is required.

Without presenting as an overly opaque or artificial-looking result that many are now attempting to avoid in restorations, it produces the smooth and natural result that a whitened dentition should possess.

Material properties

XBL has also been introduced to BRILLIANT Crios, which means that treatment plans can combine a direct restoration on one tooth with another restoration on its neighbouring tooth – all with seamless integration. BRILLIANT Crios offers realistic elastic behaviour suited to biomimetic restorations, along with shock-absorbing properties that make it a dependably excellent choice for implant-supported work, veneers, and more.



As BRILLIANT Crios requires no firing or glazing, it also supports a same-day workflow that many practices are now building their restorative services around – improving patient satisfaction and profitability.

The properties behind the finish

Better yet, the monomer composition used in BRILLIANT EverGlow produces low water sorption, which supports colour stability over time, offering both patients and clinicians alike greater satisfaction. Handling remains consistent with existing BRILLIANT EverGlow shades, providing a smooth consistency that resists sticking to instruments while cusps and contact points hold their shape during placement. In an internal COLTENE survey of 39 dentists across Europe and the USA, all respondents rated polishability positively with 30 awarding it the highest available rating.

Trying it on a case

Dr Sylvia Rahm, who works extensively with minimally invasive adhesive techniques, describes BRILLIANT EverGlow as a material that is both enjoyable to use and reaps the best rewards. She explains: 'For me, the future of restorative dentistry lies in minimally invasive adhesive techniques, and this is where BRILLIANT EverGlow becomes the ideal filling and luting material for everyday use – it is simply fun to work with, and the enthusiasm of patients speaks for itself.'

COLTENE is currently running a buy two, get one free offer on the Xtra Bleach shade for BRILLIANT EverGlow and Crios, which offers practices the perfect way to bring XBL into stock and test it across anterior cases. For practices already using BRILLIANT EverGlow or Crios, it makes existing workflows easier than ever to adapt – ensuring a familiar shade system, extending what brightness is achievable without introducing an unfamiliar material.



COLTENE

For more information on BRILLIANT Xtra Bleach shade and the wider BRILLIANT range, email **info.uk@coltene.com**, call **0800 254 5115** or visit **www.coltene.com**.

Zirkonzahn's lecture tour: Manchester and Dublin

Free two-hour lecture exploring the digital design possibilities of Zirkonzahn.Modifier

Zirkonzahn®
Human Zirconium Technology

'The full power of Zirkonzahn.Modifier – digital design advantages', Zirkonzahn's lecture tour for 2026, continues with its last stop in Manchester and Dublin on 12 and 14 October.

Presented by dental technician Raquel Ferreira, the lecture explores Zirkonzahn.Modifier, the company's advanced design software, illustrating its latest features and seamless integration within the treatment workflows.

Zirkonzahn.Modifier was developed specifically for digital dental technology: by presenting two real patient cases, the lecturer will highlight how the software opens up entirely new pathways for digital designs, offering an intuitive and modular workflow that does not bind dental technicians to rigid project structures, but leaves them maximum flexibility.

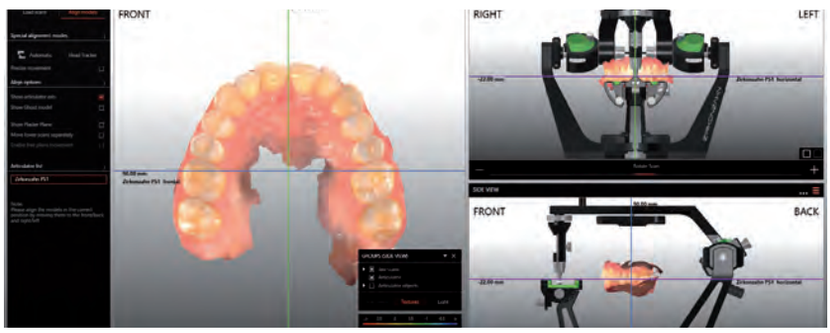
The first patient case focuses on a complete implant-supported restoration consisting of zirconia suprastructures and substructures. Participants will gain insight into the design process including the Die & Implant module, the passivity check step and final characterisation with the new Colour Liquids Prettau® Aquarell Boost®. The second case presents the digital workflow for creating ultra-thin Prettau® Skin® veneers. From the Mock-up module and Bone Doctor to the Veneer & Inlay module, the session will also cover the use of the Partial Planner module for designing gingivectomy guides.

Following the cases step-by-step, participants will be able to observe, amongst others, how the software's cutting-edge algorithms offer exceptionally natural and functional tooth setups that go far beyond standard solutions.

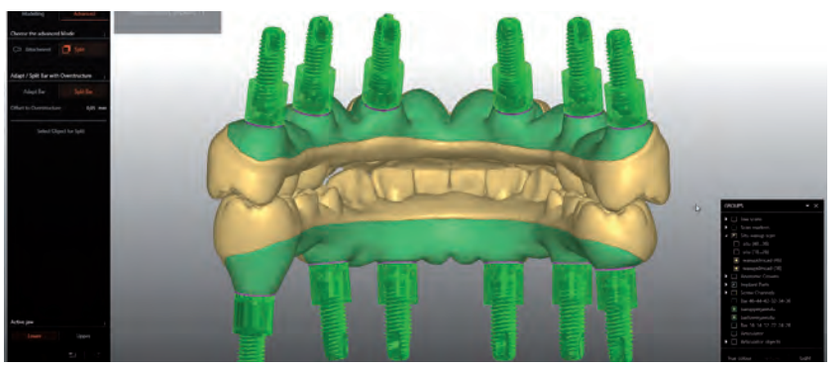
They will also gain insight into the high level of automation and flexibility in data processing and editing. The lecturer will explain, for example, how intraoral and laboratory scans can be automatically positioned in digital articulators, allowing occlusion and function to be evaluated directly during the design process.

DT Ferreira will also illustrate how changes can be applied immediately within the ongoing project, and how models, constructions and scan data can be edited and adjusted in real time.

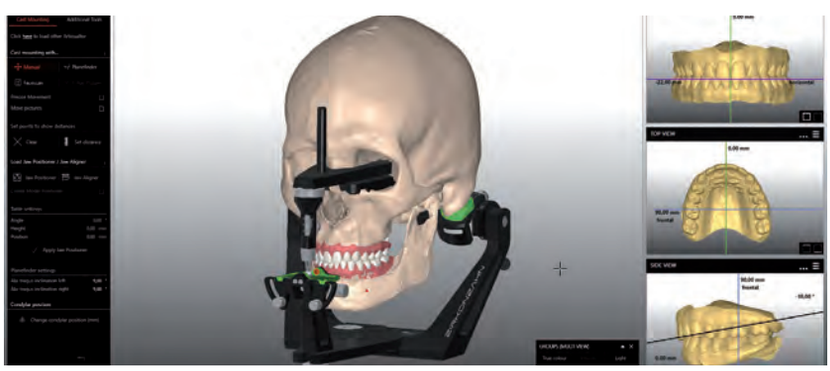
Part of the lecture will also be dedicated to the new Zirkonzahn.Archiv Plus software in combination with the Zirkonzahn.App, the Head Tracker digital facebow and the new Qlone Dental Pro 3D scanner app, for taking facial scans from smartphones.



Automatic digital scan alignment to articulator



Bar and superstructure created in a single step using the Split function



Mounting in the articulator using intraoral scans and segmented files generated from the 'Bone Doctor' software module

Additional information

The two-hour lecture is open to both dental technicians and dentists.

It meets the criteria for the General Dental Council's (GDC) development outcome C.

Lecture participation is free, but application is mandatory.

Places are limited.

For more details, scan the QR code or contact Carmen Ausserhofer (call **+39 0474 066 662** or email **carmen.ausserhofer@zirkonzahn.com**) or Jasmin Oberstaller (call **+39 0474 066 735** or email **jasmin.oberstaller@zirkonzahn.com**).

Free digital portal launched for waterline compliance

Aura Infection Control shares details of its new online portal, designed to simplify Compliance Club audits

Aura Infection Control has launched CC Digital, a free online portal designed to help dental practices manage their Compliance Club audits more easily, receive their certificates sooner and keep their records in one accessible place.

Included at no additional cost for Compliance Club members, the portal reduces certificate turnaround from the previous five to seven days to just one to three days. Members enter their audit results directly into the system, while Aura's team continues to check every submission against the Alpron protocol.

Quick and easy

For busy dental teams, keeping track of results and certificates can mean searching through emails, handling paperwork and waiting for documents to arrive. CC Digital brings these records together, giving practices a clearer view of their Compliance Club history and making evidence easier to find when it is needed.

Previously, members completed paper audit sheets and emailed them to Aura. The team then checked the results manually and entered the information into its system before generating and sending a certificate for audits that passed. Turnaround was typically five to seven days, particularly during busy periods.

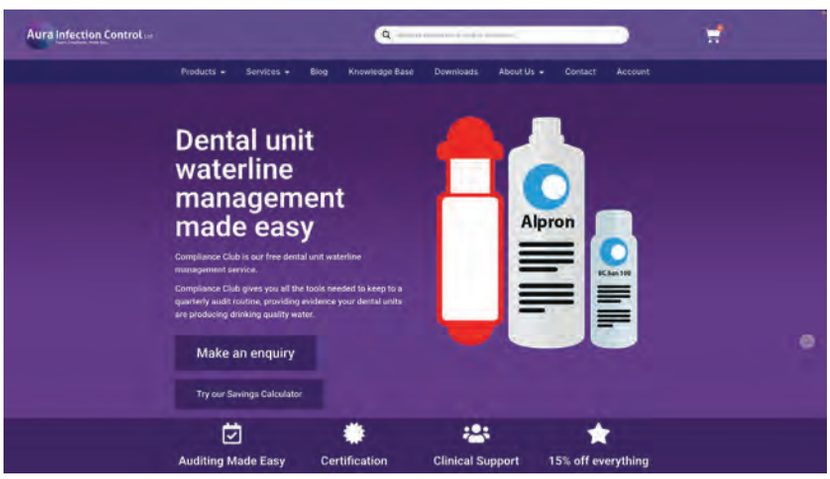
The new portal removes the need for Aura to re-enter information supplied by the practice. Members submit their audit data online, allowing the team to move directly to reviewing the results. Once a submission has been checked and approved, the certificate appears on the portal.

Crucially, the faster process retains the personal oversight that members receive from Aura. Every result is still reviewed manually to make sure it meets the Alpron protocol. The change is to how information reaches the team and how certificates are delivered, with expert checks remaining part of the process.

Explaining the approach in its launch announcement, Laura Edgar, managing director of Aura Infection Control, said: 'Our team still checks every result manually to make sure everything meets the Alpron protocol, but because the data's already in the system, that turnaround drops to just one to three days.'

All together

Alongside quicker certificates, CC Digital provides an accessible record of audits submitted through the portal. Every certificate generated through the system is stored in one place, allowing members to look back at previous results and retrieve the supporting documentation without working through separate email trails.



That visibility can be particularly useful when a practice is preparing for a CQC inspection or carrying out an internal audit. Having its Compliance Club records readily available helps the team locate relevant evidence and review its history as part of the practice's infection control compliance arrangements.

The portal also makes it easier for members to check where they stand with their records during routine practice administration. Rather than relying on a collection of paper sheets and messages, teams can access the information held in the system whenever they need to review it.

For Aura, reducing duplicated administration creates more capacity to help practices with questions and challenges that need individual attention. Time previously spent transferring information from emailed audit sheets can instead be directed towards advice, troubleshooting and practical infection prevention and control support.

Get started

Laura added: 'We are really proud of our investment in this technology. Moving data entry onto CC Digital frees up that capacity, and speeds things up for our clients at the same time.'

The launch reflects Aura's focus on making compliance easier to manage in everyday practice. By combining a simpler submission process with continued manual checks, CC Digital is designed to reduce administrative delays while keeping members connected to the team's expertise.

There are no additional portal fees, and access is included within existing Compliance Club membership. Practices can therefore benefit from the new system without adding another charge to their membership costs.

Existing members can get started by contacting their Aura account manager or completing the access request form at www.aiconline.co.uk/compliance-club.

Once access is arranged, they can begin submitting audits online and building an accessible digital history of their results and certificates, supported by the same team that reviews their submissions.

For more information, contact Aura on 01833 630393 or email orders@aiconline.co.uk.

Streamlined endodontics with COLTENE COLTENE



The HyFlex EDM OGSF Sequence from COLTENE brings simplicity and predictability to root canal preparation. Built around just four files, used in a defined order of opener, glider, shaper, and finisher, it takes the canal from initial negotiation through to a fully prepared shape, ready for disinfection and obturation.

Each file offers flexibility, pre-bendability, and high resistance to fracture. This allows the files to respect even the most challenging of anatomy, while ensuring the learning curve remains short and the workflow streamlined.

Available in 21mm and 25mm lengths, with a corresponding update for the CanalPro Jeni endomotor, the sequence is designed to reach working length with minimal pecking, supporting confident, efficient endodontics in everyday practice.

0800 254 5115
info.uk@coltene.com
products.coltene.com/en/gb/products/endodontics

An epic birthday bike ride
Association of Dental Implantology

The Association of Dental Implantology (ADI) celebrates its 40th birthday in 2027!

To mark the momentous event, four long-time ADI members will embark on an epic bike ride in the lead up to ADI Team Congress 2027, taking place on 15-17 April. Drs Andrew Little, Adam Bzeu, Amit Mistry and Kasia Gurzawska will take on the fundraising challenge of cycling 200 plus miles to the event – and doing so in two days!

From Banbridge in Northern Ireland to King's Dock in Liverpool, the four will take on '200 Miles to Congress' to raise money for two brilliant charities: Dentists' Health Support Trust and Young Lives vs Cancer. The congress theme of Health and Wellbeing is highlighted by the ADI's support of these two invaluable organisations.

Every donation made will be split and sent directly to the two charities. Donate today at www.adi.org.uk/about/200_miles_to_congress.

www.adi.org.uk/congress
claire@adi.org.uk | ania@adi.org.uk

A partnership that protects what you've built
DeNovo Dental Partners



When Katie and Malcolm Campbell were presented with the opportunity to sell one of their practices to DeNovo Dental Partners, it offered them the chance to reduce some of the day-to-day pressures of practice ownership while remaining closely involved in the business they had built. Katie shares their experience:

'We wanted to remain in control as much as possible because we are really proud of what we've built and the loyalty of our team. We knew we couldn't sell to a traditional corporate because it would never have aligned.

'We did loads of research, spoke to the right people, and decided that if we were going to sell, it had to be DeNovo – they aligned where no other corporates did. The people involved and their cultural values were the most important factor that led us to join DeNovo Dental Partners.'

www.denovo.partners

Taking your digital workflow to another level Planmeca



Planmeca offers a complete platform for CAD/CAM dentistry where all of the elements work together seamlessly. From scanning and designing to milling and printing, Planmeca provides a complete ecosystem that creates connectivity and removes compatibility issues.

PULSE brings together five core strengths – precision, usability, liberty, speed and ecosystem – to give you a smooth digital workflow and boost productivity in any surgery setup.

You can expect accurate and reliable results at every step, with easy to use hardware and software. Along with the freedom to collaborate with external partners or manage everything in-house, faster processes for a better patient experience and the possibility of offering same-day treatments.

All wrapped up on one complete ecosystem for CAD/CAM dentistry, which means support is simplified too.

enquiries@planmeca.com

Supporting your digital dentistry journey Dental Directory



Digital dentistry is no longer the future – it's the now. Intraoral scanners, 3D printers, milling machines, digital imaging, and integrated software are now part of everyday practice for a growing number of UK dental teams. For those still considering the move, the question is less whether to go digital, and more how best to do it.

Dental Directory supplies a comprehensive digital dentistry range, from intraoral scanning and 2D and 3D imaging to in-house milling and 3D printing, backed by a team that can advise, install and support throughout. Practices are not left to figure it out alone: the digital dentistry specialists at Dental Directory help match technology to clinical need, ensure teams are confident using it from day one, and provide ongoing engineering support to keep everything running smoothly.

Whether a practice is taking its first steps into digital dentistry or looking to build a fully integrated in-house workflow, Dental Directory offers the product range, the technical expertise, and the after-sales support to make the transition a smooth one.

For a reliable supplier relationship, consider Dental Directory.

0800 585 586
www.ddgroup.com

Equipping your practice for the long term Dental Directory



The equipment your practice invests in today shapes the quality of care it can deliver for years to come. Whether fitting out a new surgery, upgrading an existing one or replacing equipment that has reached the end of its service life, the decisions made at the purchasing stage – on specification, compatibility and supplier support – have a lasting impact on how efficiently and confidently a practice runs.

Dental Directory supplies a wide range of dental equipment to practices across the UK, from chairs, stools and cabinetry through to compressors, vacuum systems, decontamination units and imaging technology. The range spans both established brands and trusted own-label lines, with options available to suit single-surgery practices and multi-site groups alike.

Importantly, supply does not stop at the point of purchase. Dental Directory's engineering team provides installation, commissioning, ongoing servicing and repair across the equipment it supplies – meaning practices have a single point of contact for both procurement and long-term maintenance. That continuity of relationship, and the accountability it brings, makes a difference when something needs to be resolved quickly.

0800 585 586
www.ddgroup.com

Win a clinical photography kit DB Orthodontics



Laura Short and DB Orthodontics are offering the chance to win a clinical photography kit, including:

- Gold photo cheek retractors
- Palatal silicone contraster
- Adult intraoral mirror
- Large photo cassette.

To enter, post your best clinical image on Instagram, tag Laura Short (@la.ab_photography) and DB Orthodontics (@db.ortho), tag a friend or colleague and follow both accounts.

Laura will be announcing the winner during an Instagram Live 22 October at 7pm.

Get posting and give it your best shot!

Next-level chairside restorations with the SprintRay Midas and Crown HT SprintRay



Transform same-day dentistry with the SprintRay Midas 3D printer and its exclusive resin, Crown HT.

The Midas uses patented digital press stereolithography (DPS) to overcome the viscosity limitations of traditional 3D printing, enabling clinicians to use materials that are highly-filled and more fracture resistant, with remarkable accuracy.

As simple as scan, place, and press, the capsule workflow prints a crown in less than 10 minutes, all chairside.

Paired with the Midas, the next-generation Crown HT contains more than 60% ceramic for excellent strength and durability comparable to natural dentition, blending seamlessly into the smile. Aesthetics are also well-matched, with exceptional translucency, shade fidelity, and a smooth surface finish for definitive crowns, inlays, onlays, and veneers.

www.sprintray.com/en-uk

Outstanding translucency, comparable to glass-ceramic Zirkonzahn



With Prettau 5, Zirkonzahn has achieved a new level of translucency – comparable to glass-ceramic. Its natural light dynamics ensure particularly vibrant and aesthetic results while maintaining high flexural strength.

This new ceramic material with zirconia has been specifically developed for inlays, onlays, veneers, partial and single crowns, as well as three-unit bridges, and can be designed either monolithically or reduced for ceramic veneering.

For patient-specific aesthetics, Colour Liquid Prettau Aquarell Dip can be applied using the dipping technique, ensuring even and precise colouring. Further individualisation can be achieved with Colour Liquid Prettau Aquarell Boost, ceramics or stains.

www.zirkonzahn.com

Clear panoramic images – every time Carestream Dental

The CS 8200 3D Access from Carestream Dental is a compact four-in-one imaging system combining panoramic, CBCT, 3D model scanning, and optional cephalometric capability in a single unit – built for general dental practices looking to extend their imaging capability without the complexity of a large-scale system.

The system offers up to six selectable fields of view, ranging from 4×4cm to 10×10cm, covering clinical indications from endodontics and implant dentistry through to periodontics and oral surgery. High-resolution CBCT at 75 microns supports precise visualisation of fine anatomical detail, while CS MAR technology reduces metal artefacts for more accurate image interpretation. A low-dose mode is available for both 2D and 3D examinations.

Panoramic programmes include full panoramic, segmented bitewing, maxillary sinus, and TMJ views. The open platform integrates with leading intraoral scanners via CS Imaging software for a streamlined digital workflow, and the compact footprint suits practices of any size. Follow Carestream Dental for the latest news and updates @carestreamdental.uk

0800 169 9692
www.carestreamdental.co.uk



The future of intraoral digital imaging is here

Carestream Dental

Carestream Dental has launched the new CS 1300 intraoral camera, designed to support more effective patient communication through high-definition chairside imaging.

The CS 1300 delivers HD resolution in 1080p via a five-megapixel CMOS sensor, providing sharp, detailed images to maximise effective clinician-patient communication. Guide patients towards informed treatment decisions and bypass hesitation with clear visual information.

Its 280° rotating head and ergonomic handpiece allow for comfortable access to all areas of the mouth, while dual autofocus modes and a 10–100mm focus range support imaging from close macro detail through to full arch views.

Nine adjustable LEDs with selectable cool and warm colour temperature modes reduce glare and ensure consistent illumination. Driver-free USB plug-and-play connectivity enables fast setup and straightforward sharing between operatories, with images integrating directly into CS Imaging for a streamlined digital workflow.

Follow Carestream Dental for the latest news and updates @carestreamdental.uk.

0800 169 9692

www.carestreamdental.co.uk



Elite athletes' poor oral health highlights need for earlier intervention

vVARDIS

Research showing that 49% of elite athletes experience cavities is highlighting the need for earlier, less invasive approaches to oral healthcare, according to vVARDIS, the company behind drill-free early cavity treatment Curodont.

A recent peer-reviewed article in *Frontiers in Oral Health* argues that sports dental medicine could help pioneer a shift towards proactive and sustainable oral healthcare (Avgerinos et al, 2025). Despite decades of prevention, tooth decay remains the world's most common disease, affecting more than two billion people globally (World Health Organization, 2022).

Elite athletes face particular risks from sports drinks, carbohydrate consumption, dehydration and reduced salivary flow, while poor oral health may also affect wellbeing and performance (Gallagher et al, 2018).

These issues were explored at the fourth Global Oral Health & Climate Action Conference, held alongside COP30 in Brazil, where biomimetic technologies were highlighted as supporting earlier intervention and preservation of natural tooth structure.

vVARDIS' Curodont uses proprietary biomimetic peptide technology to treat early-stage cavities non-invasively, helping preserve natural enamel before drilling becomes necessary.

Dr Goly Abivardi, co-founder and co-CEO of vVARDIS, said: 'Sports dentistry has a solid incentive to change because athletes can't afford weeks of recovery from invasive treatment – biomimetic innovation is already helping make that a reality.'

References available upon request.

'COLTENE BRILLIANT Crios has revolutionised my clinical practice' COLTENE



Edward Bateman of Tain Dental Care has shared his experience using BRILLIANT Crios, highlighting its impact on efficiency and restorative outcomes: 'I've been using Crios for around four years now. I appreciate the fact that it is milled quickly with no additional furnace stage. As it is a void-free, industrially cured block of composite, it polishes beautifully and quickly. It bonds well, and is adjustable and repairable in the mouth. It is also kind to opposing teeth.'

With a strong background in CAD/CAM, Mr Bateman now relies heavily on the material in daily practice: 'I used to largely use lithium disilicate when making CAD/CAM restorations, but around 80% of what I do now is Crios since discovering it. I would say that it is critical to follow the bonding protocols with the material but when you do the bond is entirely predictable.

'Crios has revolutionised my clinical practice, and makes my life a lot easier.

Glenn Mason
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Sheena Tanna

Lessons in dentistry



Sheena is principal dentist and owner of Billericay Dental Care

Why did you decide to pursue a career in dentistry?
I come from a family of bankers, but work experience at HSBC convinced me I wanted a different path: more interaction with people and the opportunity to make a tangible difference.

During sixth form, I explored dentistry, pharmacy and medicine. Dentistry brought together everything I enjoyed: science, patient relationships and a close-knit team. Improving someone's teeth could change how they felt about themselves.

That curiosity started young. My mum took me to the library weekly, and while other children chose fiction, I picked books about the body – even the effects of smoking, alcohol and drugs! Dentistry connected that fascination with practical work that could help someone eat comfortably, speak confidently or smile freely.

'While other children chose fiction, I picked books about the body'

Tell us an interesting fact about yourself...
I attend an art class every Tuesday, and my work was exhibited at London's Oxo Tower a couple of years ago. Three detailed drawings hang in our practice hallway.

Someone visiting to train our team noticed them and said the patience and concentration needed to produce them suggested I brought the same attention to my practice. I'd never made that connection, but his observation has stayed with me.

What is your most recommended gadget?
My iTero Lumina scanner – I love it. It makes restorative work easier, supports my smile design work and adds detail to check-ups.

I've always enjoyed explaining things to patients. Exploring a 3D image together helps them understand their teeth, my recommendations and what we hope to achieve.

I've noticed greater treatment acceptance because patients understand why treatment is recommended. That also makes conversations easier for my treatment coordinator. Its greatest value is the trust it helps build: patients feel informed, involved and at the centre of their care.

What has been your most memorable experience within the profession?
Being named *Dentistry*'s Next Top Digital Dentist 2025. I'd already invested in a renovation centred on digital dentistry and better patient communication; the award accelerated that vision.

Access to treatment coordinator and social media courses allowed my team to develop several areas at once, rather than spread the investment over time.

It also gave me a platform beyond Essex. I've actively built on it through national television and radio opportunities, sharing my belief in prevention, particularly around children's oral health. Seeing both my team and my own voice grow made it especially meaningful.

What do you believe the future of dentistry holds?
AI and digital dentistry could help us explain potential outcomes before treatment, support informed consent and reduce administration, giving us more time with patients.

I'm hopeful prevention will gain greater emphasis. Social media, press interest and younger generations' engagement with health create opportunities to reach people earlier. Cosmetic dentistry will remain important alongside keeping teeth healthy.

Even as robotics develops, patients will value the personal touch. Technology's greatest promise is making care easier to deliver while giving us more time for human connection.

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