

CONNECTING DENTAL TECHNOLOGY Laboratory

FMC CONNECTING
DENTISTRY

Autumn 2026 / Volume 20 / No 4



BUILT ON CERTAINTY

Making photogrammetry the baseline
for predictable full-arch success [p.20](#)

The future of removable
prosthetics? [p.13](#)

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Season of change

MATT EVERATT

Editor-in-chief

Welcome back to our editor, Lucy Veal. She took a sabbatical over summer, and this edition shows exactly what her absence taught us: a mix of strong technical cases, industry insight, solid business thinking and stories from across the community is the kind of content that works for labs right now. We missed her.

Autumn always feels like a time of change. September seems to whizz by in a blink, and before you know it, it's Christmas. I think it is always a great time for reflection. You can assess what's been good in the first three quarters of the year, what's been lost, and what needs to change before the next season starts.

PRESSURE FROM EVERY DIRECTION

We've had a new Prime Minister since our last edition. Political uncertainty is very much a thing – fiscal pressure is another. HMRC is clearly looking at dentistry differently. The VAT on aligners made headlines – I don't think it is a random ruling. I think it's a snapshot of what is to come. I am sure dentistry is seen as the cash cow that is ready for milking.

MHRA seem to have played a blinder this year with the GMDN code burden. Labs were left thinking they owed thousands of pounds, and now there's a mention of further fee increases coming in 2027. For labs already operating on thin margins, it stacks up fast.

The DLA has done genuinely proactive work on the codes and MHRA clarity – read all about it on page 18.

STRONGER TOGETHER

This is the moment to invest in the relationships that matter: your team, your network, the labs and dentists you genuinely want to work with. The profession is under pressure, but the labs that thrive won't be the ones working in isolation. They'll be the ones connected to people who lift them up. This magazine remains committed to being honest about where we are, celebrating the work being done, and supporting the decisions that matter. Thank you to everyone who has contributed to this edition. And thank you to all of you holding this profession together, often invisibly, but always with impact. Enjoy the read.

GET IN TOUCH

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Laboratory

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Back in the thick of it

It's great to be back in the world of dentistry. After some time travelling, it is clear that plenty has been going on, from another fall in registered dental technicians and a significant VAT ruling for clear aligners to enamel regeneration edging closer to market. Dentistry never stands still! Turn to page 9 for these stories and more.

When we last spoke, Keir Starmer was Prime Minister. Since then, Andy Burnham has taken office and James Frith has been given responsibility for dentistry. However, many of the same questions around access, workforce pressures and reform of the NHS dental contract remain. It will be interesting to see what this new leadership means for the profession and whether dentistry receives the attention it needs.

There is plenty to explore in this issue. On page 32, Deepa Bharakhda – recognised in this year's *Dentistry* Top 50, which celebrates influential figures shaping the profession – reflects on finding her feet in dental technology. Her story of discovering her passion also demonstrates the value of a supportive network.

We also have two fantastic technical cases, both offering an hour of enhanced CPD. Turn to page 50 for the CPD questions. On page 16, Tony Atkins looks at common faults in the CAD/CAM workflow, what causes them and how they can be prevented. With digital workflows playing an increasing role in the industry, it is a really useful and practical read.

On page 13, Patryk Szablowski demonstrates a hybrid digital and conventional workflow for a denture case. The result highlights why the future of dental technology lies not in choosing between digital tools and human craftsmanship, but in understanding how the two can work together.

Elsewhere, Andrea Johnson explores the lab-clinic divide on page 30, Steve Campbell considers the impact of increased MHRA registration fees on page 22, and Anna Veli asks whether AI will help or hinder prosthetic care on page 44.

There is so much to get stuck into, and I hope you enjoy the issue. Thank you, as always, to everyone who contributed. If you would like to share an article, talk through an idea or offer feedback, please get in touch. I always want to hear what you think and make *Laboratory* the best it can be for its readers.

Until next time!

LUCY VEAL
Editor of *Laboratory*



ENHANCED CPD

Complete this issue's enhanced CPD online at cpd.dentistry.co.uk or scan the QR code. Email cpdsupport@fmc.co.uk if you're in need of guidance.

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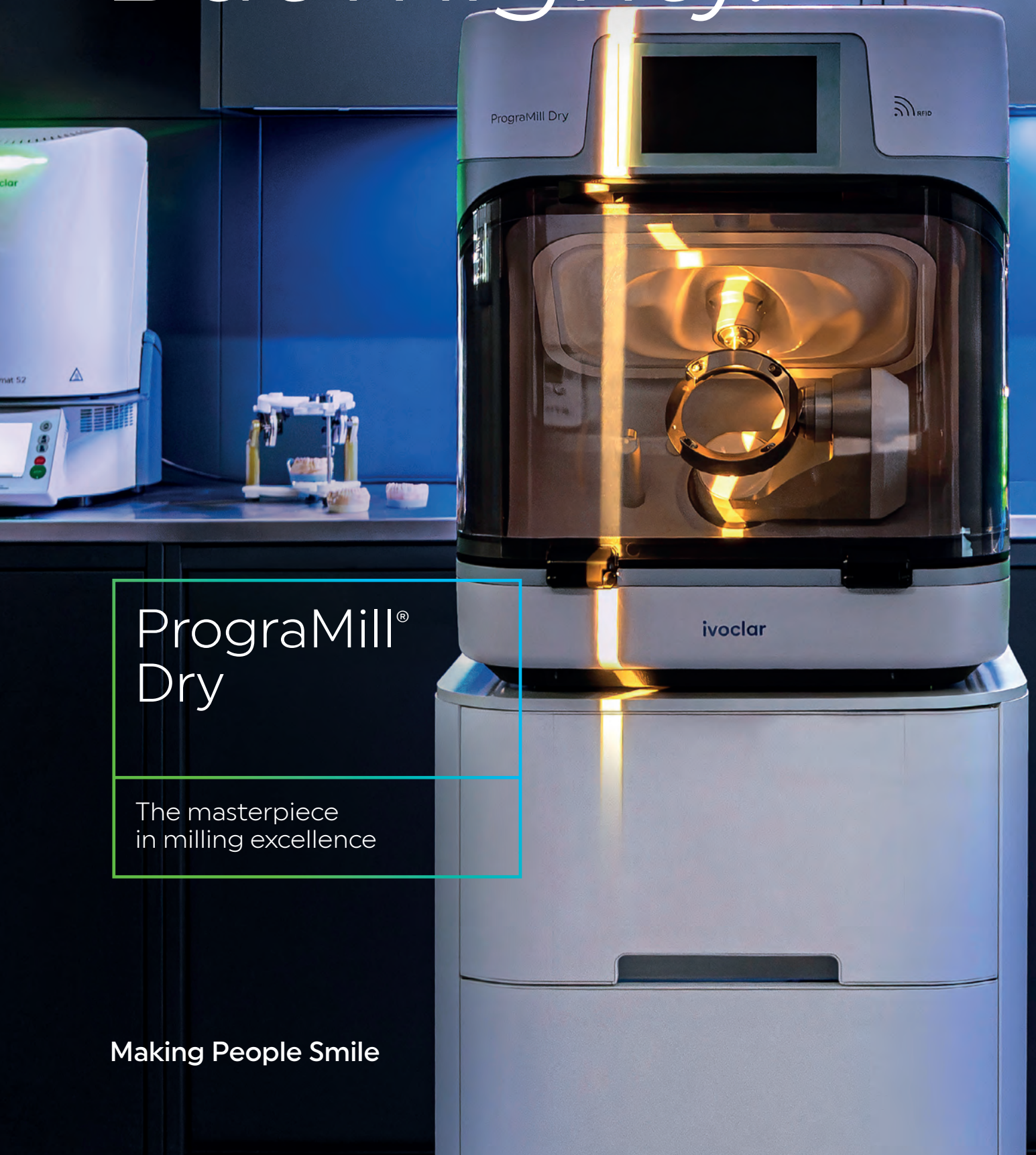


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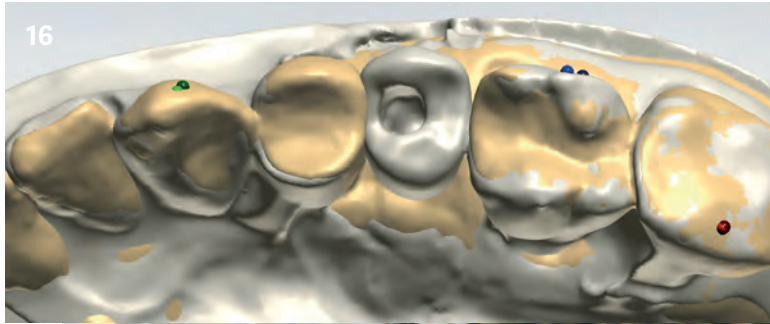
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Laboratory's Lab Experts panel

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



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Senior dental
technician and
surgical planner

Technician workforce still in decline

The number of dental technicians on the UK register has fallen for the sixth consecutive year, despite the overall dental care professional register growing by almost 5%.

Annual renewal statistics from the General Dental Council (GDC) showed that 84,746 dental care professionals (DCPs) were registered in 2026, an increase of 3,746 compared with the equivalent point last year.

However, dental technician numbers fell from 4,895 to 4,824, continuing a decline that has prompted concerns about training and the future capacity of UK dental laboratories. *Laboratory* editor-in-chief Matt Everatt has suggested that the decline in the dental technology workforce was due to a number of factors including training programmes under financial pressure, unregulated manufacturing, and the impact of new technology.

A total of 3,769 DCPs were removed from the register following the annual renewal period. Due to ongoing problems with the MyGDC portal during this renewal period, the GDC said that DCPs who were having technical issues would not be removed from the register provided they contacted the regulator before the deadline.

DENTAL WORKFORCE DEMOGRAPHICS

Dental nurses remain by far the largest DCP group, with 69,824 registered – up from 65,797 in 2025. Additionally, the number of dental hygienists increased to 11,407 from 11,065 in 2025.

The dental therapy profession has seen significant growth since 2023. In three years, the number of dental therapists has increased from 5,558 to 8,824. Many of these were from internationally qualified dentists who joined the register with DCP titles, a route that the GDC has now closed.

Since 2025, the government has called for a greater use of the wider team in NHS dentistry, particularly by helping dental therapists practise to the 'top of their clinical potential'.

Training capacity for dental therapists is also being significantly expanded through new courses and facilities.



Technician visa grants fall 98%

Sponsored visa grants for overseas medical and dental technicians fell by almost 98% following changes to the skilled worker route, new Home Office figures show.

The latest immigration statistics recorded three grants for medical and dental technicians in Q4 2025-Q2 2026, down from 121 in the previous three quarters. Visa grants for dental nurses also fell sharply, from 122 to six, 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.

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

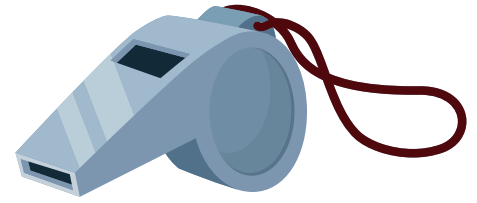
not underestimate sponsor licence compliance after her group's licence was previously suspended following a Home Office visit.

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.'

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.

Fitness to practise whistleblowing rises by 74%



The General Dental Council (GDC) has reported 138 whistleblowing disclosures relating to dentistry in the past year, a 74% increase on the previous reporting period, with every report resulting in a fitness to practise case being opened.

Between 1 April 2025 and 31 March 2026, most disclosures came from dental professionals, while anonymous reports more than tripled year-on-year, rising from six to 22.

The GDC said the increase in whistleblowing may partly reflect a wider rise in fitness to practise concerns overall. It also suggested changes to the reporting process may have made it easier for individuals to identify themselves as working within the dental profession when raising concerns.

REPORT FINDINGS

The Whistleblowing Disclosures Report 2026 found:

- 267% increase in anonymous whistleblowing
- 74% increase in whistleblowing from within the profession
- 16% of all disclosures were anonymous
- 67% of disclosures related to conduct
- 26% increase in all fitness to practise disclosures.

Conduct was by far the most prevalent fitness to practise concern raised. Two thirds of the whistleblowing disclosures (92) related to conduct, up from 54 the previous year. This represents around a 70% year-on-year increase.

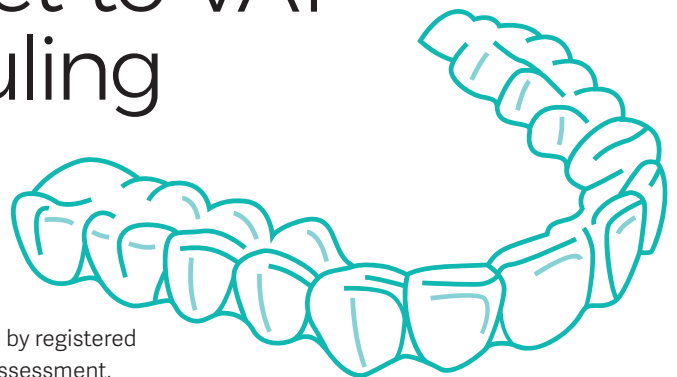
Of the 138 fitness to practise investigations that opened as a result of whistleblowing, 99 cases proceeded to

regulatory action with 39 closed at the assessment stage due to a lack of information. At the time of reporting, 82 cases remain at the assessment stage and 17 have been referred to case examiners – of which, seven have gone to a practice committee.

The report was produced by the GDC alongside regulators for chiropractics, medicine, osteopathy, pharmacy, health and care professions, nursing and midwifery, and social work.

The GDC said it 'highlights the regulators' coordinated efforts to address the serious issues raised by whistleblowers'.

Clear aligners subject to VAT following tribunal ruling



Clear aligners are subject to standard-rate VAT after the Upper Tribunal ruled that they do not qualify as exempt dental prostheses.

The decision in HMRC versus Align Technology was handed down on 7 July 2026. It overturned a 2025 First-tier Tribunal ruling that had supported Align's treatment of Invisalign supplies as exempt dental prostheses under Schedule 9 of the VAT Act.

The case centred on the legal definition of a dental prosthesis. The Upper Tribunal concluded that a prosthesis replaces a missing or damaged part of the body and performs its function.

It accepted HMRC's position that clear aligners do not replace missing or damaged teeth but instead move existing teeth into a different position. As a result, the appliances fall outside the VAT exemption for dental prostheses.

Align had argued that its aligners were bespoke medical devices used within

clinical treatment plans to correct malocclusion, restore bite function and support oral health.

The ruling does not alter the VAT exemption applying to clinical treatment provided by registered dentists and orthodontists. Assessment, treatment planning, fitting and adjustment remain exempt as medical care. The change concerns the supply of the appliance itself.

WHAT DOES THE RULING MEAN FOR LABORATORIES?

The decision may also have implications for other laboratory-made appliances that move, hold or protect teeth rather than replace missing or damaged tooth structure. These could include retainers, occlusal splints, functional appliances and mouthguards.

However, laboratories should seek specialist advice before changing the VAT treatment of individual products.

The ruling could also affect whether some laboratories need to register for VAT. The registration threshold is £90,000 of taxable turnover within a rolling 12-month period. Supplies previously treated as exempt would not have counted towards this figure, whereas standard-rated supplies do.

The British Orthodontic Society has warned that applying VAT to orthodontic appliances could increase treatment costs and place further financial pressure on NHS orthodontic services.

The Upper Tribunal's decision is binding, although Align may seek to appeal to the Court of Appeal.

Investment moves enamel regeneration tech closer to market

After a reported £3 million investment round, a new keratin-based enamel regeneration technology developed by King's College London (KCL) researchers is moving towards commercial market launch next year. Hoxton Ventures, a London-based venture capital firm which was an early backer of tech firms such as Deliveroo, is leading the funding round for Eterna Regeneratives.

Founded by Sherif Elsharkawy, clinical lecturer in prosthodontics at KCL, and PhD candidate and CEO Khaled Eissa, start-up Eterna Regeneratives develops regenerative biomaterials using naturally derived molecules to help the body rebuild tissues.

Existing approaches to enamel loss largely focus on managing associated symptoms or replacing damaged tissue with synthetic materials. Eterna says its approach uses keratin to form a layer similar to the original enamel directly on the tooth surface

through a biomimetic mineralisation process.

Sherif Elsharkawy and PhD student Sara Gamea conducted laboratory experiments on extracted teeth, finding that the layer formed on the tooth surface by the keratin was almost as hard and mechanically strong as healthy enamel.

Khaled Eissa said: 'Enamel is one of the only things the human body can't regenerate. We wanted to create a product that is readily available, scalable and has the potential to deliver long-term results.'

COMMERCIAL APPLICATIONS OF ENAMEL REGENERATION

The research has now been developed into a patented technology, which Eterna hopes will be accelerated towards the market by early 2027. The technology is being developed in

a mouthwash and professional products for use in dental care, researchers say, though development, testing and regulatory work is required before launch.

Dr Elsharkawy said: 'Solving enamel loss, which frequently leads to even worse conditions and diseases, is a major step forward to better oral health care. It is a validation of years of research, and a step change in how quickly we can bring this technology to patients.'

Hoxton Ventures and The Venture Collective are co-leading the investment, which Sky News reported as being £3 million.

Hussein Kanji, partner at Hoxton Ventures, said: '(This) technology has the potential to transform oral care from managing enamel loss to actually repairing it, while opening the door to broader applications in tissue and bone regeneration.'



Could a tiny robot transform crown preparation?

A miniature intraoral robot could allow dentists to complete crown preparations in a single visit, potentially eliminating the need for additional appointments.

Developed by researchers at the Department of Biomedical Engineering at the University of Basel, the robot is roughly the size of a cork and designed to fit comfortably inside the patient's mouth. Its controls are located outside of the robot and connected with flexible cables.

The device is able to carry out precise crown preparation according to a digital plan. After a diagnostic scan, clinicians can

plan exactly how the robot should remove the tooth material and order the crown immediately. Developers say that this means a second appointment is not needed. In addition to planning the crown, the scan produces a custom-fitted dental splint which the mini robot is attached to. If the patient moves their head during the treatment, the splint allows the device to move with them.

HOW DOES IT WORK?

First, the intraoral robot uses a wide drill to reduce the tooth surface by removing material from above. It then uses a finer drill to work on the sides of the tooth.

This process was tested on tooth models made of synthetic resin and on a ceramic material with a hardness similar to that of tooth enamel. The margin of positional error was less than 0.2mm, which will be reduced

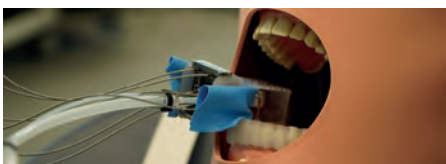
further once positional sensors are integrated into the design.

The force generated during drilling was also tested and found to be less than five newtons – comparable to the weight of a 500ml bottle of water. The robot's noise levels are being assessed further to determine its suitability for use in practice.

Once further testing has been completed and sensors have been added, the researchers hope it could be implemented into dental workflows.

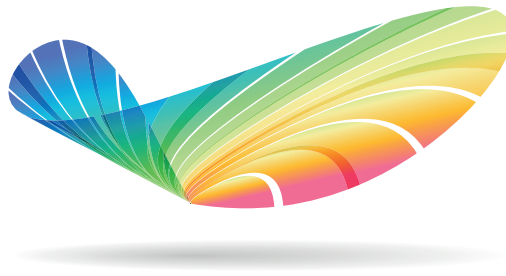
Yukiko Tomooka, first author of the paper, said: 'Even after a power outage, [the miniature intraoral robot] would know where it is and where it needs to continue based on the sensor data.'

Dental robotics remains largely experimental in UK clinical dentistry, though robot-assisted implant systems are already being used overseas.



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Image courtesy of Spencer Greening, CDT.



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The future of removable prosthetics?

Patryk Szablowinski demonstrates a case in which digital precision and handcrafted artistry combine to achieve an accurate, functional and natural-looking result



PATRYK SZABLOWINSKI
Dental technician

CASE OVERVIEW

A 58-year-old edentulous patient presented dissatisfied with their existing complete dentures, reporting instability, poor aesthetics and difficulty chewing. The clinician discussed treatment options including conventional acrylic dentures, implant-retained overdentures, and digitally designed and manufactured prostheses. Due to financial considerations and anatomical limitations, the agreed treatment was a new set of complete removable dentures.

From a technical perspective, however, this case represented more than a routine remake. It highlighted a pivotal moment in modern dental technology: the transition period where digital denture workflows coexist with traditional handcrafted methods. The technician's task was not only to fabricate a functional prosthesis but also to determine which workflow – digital or conventional – would best meet the patient's expectations for fit, aesthetics and longevity.



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GDC anticipated outcome: C

CPD hours: One

Topic: Removable prosthetic workflows

Educational aims and objectives: To examine how hybrid workflows can improve fit and predictability.

This article qualifies for one hour of enhanced CPD. Turn to page 50 to answer the questions.

CHALLENGES

Several challenges defined this case:

- High aesthetic demand: the patient requested a natural appearance with individualised tooth characterisation rather than a standard 'denture look'
- Functional expectations: previous dentures lacked retention and caused sore spots, so precision fit was critical
- Material considerations: the patient was interested in newer materials but uncertain about durability and repairability
- Technological decision-making: choosing between digital and conventional workflows reflects a wider challenge facing the profession globally. As digital dentistry expands, technicians must decide when automation enhances outcomes and when craftsmanship remains irreplaceable.

TECHNICAL WORK

After consultation with the clinician, a hybrid workflow was selected. Primary impressions and jaw relations were taken conventionally to capture functional anatomy accurately.

These records were digitised using a laboratory scanner to create a virtual model. From this point, two parallel design paths were evaluated...

1. Digital workflow assessment

Using CAD software, a virtual denture was designed with automated tooth arrangement algorithms. The software produced an occlusal scheme based on anatomical landmarks and generated a printable baseplate. The advantages were immediately clear:

- Rapid design iterations
- Predictable occlusion
- Digital storage for remakes
- Reduced manual labour.

However, the technician noted limitations. The software's tooth arrangement lacked subtle asymmetries and natural irregularities that contribute to realism. Gingival contours appeared uniform, and surface texture required manual refinement after printing.

2. Conventional workflow assessment

A wax setup was also produced by hand. This allowed artistic positioning of teeth according to facial features, lip dynamics and phonetics. Custom characterisation – rotations, translucency layering and gingival staining – was easily incorporated. The disadvantages were time and technique sensitivity. Achieving precise occlusion required multiple adjustments, and remakes would necessitate repeating the process from the beginning.

FINAL TECHNICAL DECISION

The technician combined both approaches. The denture base was digitally designed and milled from a high-density pre-polymerised PMMA puck to ensure optimal fit and strength.

Teeth were selected conventionally and individually set in wax, allowing aesthetic customisation. After try-in approval, the prosthesis was processed using a traditional injection technique.

This blended method demonstrated a key principle for the future of the industry: digital technology excels in precision engineering, while human craftsmanship excels in aesthetic nuance.

Communication between technician and clinician remained central throughout. Digital previews were shared instantly for approval, while physical try-ins allowed the evaluation of phonetics and smile dynamics. This collaborative workflow reduced chair time and improved predictability.

FINAL PRODUCT

The completed dentures displayed excellent retention, balanced occlusion, and a natural appearance.

The patient reported immediate comfort and improved confidence in speech and eating. Clinician feedback highlighted the accuracy of the milled base and the lifelike arrangement of teeth. Photographs taken before insertion and in situ confirmed significant improvement in facial support and smile aesthetics (Figures 1 and 2).

The combination of digital precision and handcrafted detailing achieved a result neither method could have produced alone.

REFLECTIONS

This case illustrates a broader trend shaping the future of removable prosthetics. The profession appears to be moving toward a dual-path model:

1. Mass-produced digital prosthetics

Fully digital dentures – scanned, designed, and printed – will likely dominate high-volume workflows. They offer speed, reproducibility, and cost efficiency.

For many patients, especially those prioritising affordability and function over fine aesthetics, these prostheses will be entirely satisfactory.

2. Handcrafted premium prosthetics

At the same time, there will remain strong demand for traditionally fabricated dentures made with premium materials and artistic techniques.

Just as collectors value handcrafted porcelain over factory-produced ceramics, some patients will continue to appreciate the individuality, detail and craftsmanship of conventional work.

The combination of digital precision and handcrafted detailing achieved a result neither method could have produced alone



FIGURES 1 and 2: Photographs taken before insertion and in situ confirmed significant improvement in facial support and smile aesthetics

Rather than one replacing the other, these approaches will coexist. Laboratories may evolve into two parallel production streams: digital manufacturing units focused on efficiency, and artisan departments dedicated to high-end bespoke prosthetics.

For technicians, this shift will redefine skill requirements. Digital literacy, software proficiency and equipment management will become as essential as waxing and finishing skills. The most successful professionals will be those who master both domains and understand when to apply each. Another important implication is professional identity. As automation increases, technicians risk being perceived as machine operators rather than skilled clinicians. Maintaining handcrafted techniques preserves not only aesthetic quality but also the professional artistry that distinguishes dental technology from industrial manufacturing.

Finally, patient perception will shape the future. Some patients will value speed and convenience, happily accepting a printed denture produced in a single visit. Others will seek individuality, willing to invest time

and cost for a prosthesis crafted with traditional artistry. Understanding these preferences will be key to treatment planning and case acceptance.

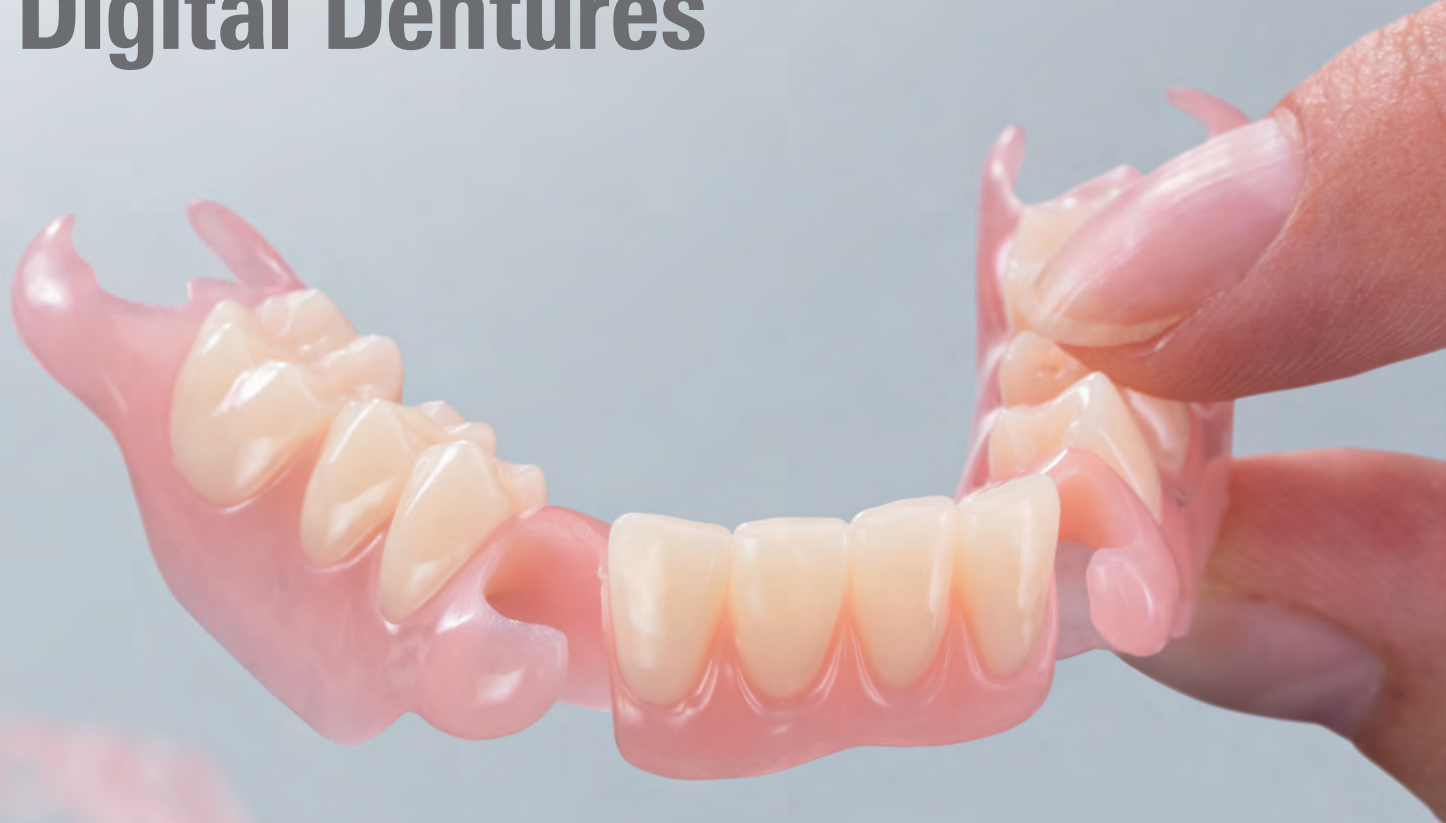
CONCLUSION

The future of removable prosthetics is not a competition between digital and conventional methods but a convergence of both. Digital systems provide unmatched precision, efficiency and reproducibility, while traditional techniques deliver artistry, characterisation and material nuance. Together they form a complementary partnership.

As technology advances, the technician's role will evolve from fabricator to decision-maker – selecting the appropriate workflow for each patient's clinical, functional and aesthetic needs. The laboratories that thrive will be those that embrace innovation without abandoning craftsmanship.

In essence, the dentures of tomorrow may be printed, milled, layered or hand-set – but the best results will always come from the informed judgment of a skilled dental laboratory. [L](#)

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Common faults in CAD/CAM

Tony Atkins explores some of the most common faults encountered in CAD/CAM, their causes, and strategies to prevent them



TONY ATKINS

Senior technician and ceramics lead,
Ceramic Designs Laboratory

Digital workflows in dental technology have transformed how restorations and appliances are designed and manufactured. Computer-aided design (CAD) and computer-aided manufacturing (CAM) systems enabled laboratories and clinics to produce restorations with greater precision, and improved efficiency.

However, despite these advantages, faults and complications are not uncommon. Errors within CAD/CAM can arise at any point from digital impressions, software processing, or during milling and printing stages. In many cases, these errors aren't obvious from the outset and often lead to costly remakes, reduced trust in digital solutions and, worse still, the laboratory fabricating the restoration.

COMMON CAD-RELATED FAULTS

1. Inaccurate digital impressions

Digital impressions form the foundation of CAD workflows. Any inaccuracies at this stage are carried through the entire process (Figures 1 and 2).

Causes:

- Poor intraoral scanning technique (eg skipping surfaces, improper angulation)
- Presence of saliva, blood, or reflective surfaces during scanning
- Limited access in posterior regions.

Consequences:

- Poorly fitting restorations, open margins or poor occlusion
- Increased adjustments or remakes.

Prevention:

- Use of retraction techniques and moisture control
- Adhering to scanning protocols with proper angulation and overlap
- Verification scans before finalising.

2. Software design errors

CAD software provides powerful tools for designing restorations, but incorrect use or limitations can result in suboptimal designs.

Causes:

- Inadequate knowledge of software settings
- Over-reliance on default parameters (eg spacer thickness, occlusal clearance)
- Lack of anatomical understanding by the designer.

Consequences:

- Weak restorations due to thin walls or inadequate connector size
- Poor aesthetics due to incorrect contouring or emergence profiles.

Prevention:

- Training and continuous professional development
- Customising parameters for each material and indication
- Using built-in verification tools to check thickness, contacts, and occlusion.

3. Marginal fit discrepancies

Even small errors in margin tracing or interpretation can compromise fit (Figures 3 and 4).

Causes:

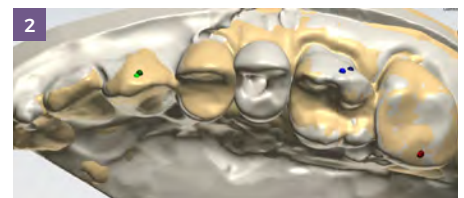
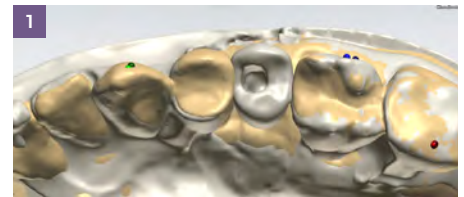
- Poor visibility of preparation margins in the scan
- Inaccurate margin marking within the CAD software
- Operator misjudgement in subgingival areas.

Consequences:

- Microleakage and secondary caries
- Gingival irritation and long-term biological complications.

Prevention:

- Use high-resolution scans and multiple angles
- Careful manual verification of automatically detected margins
- Collaboration between dentist and technician when margins are unclear.



FIGURES 1 and 2: Same case, two different scans. Can you spot the error?



FIGURES 3 and 4: Visual comparison of well-defined versus poorly defined margins

By identifying and addressing these common faults, dental professionals can harness the full potential of digital workflows



FIGURE 5: Common milling faults from left to right: chipped screw hole channel caused by fractured burr, complete failure of molar restoration caused by fractured disc, holes within the occlusal surface, restoration designed to minimum thickness followed by inaccurate CNC calculation

COMMON CAM-RELATED FAULTS

1. Milling defects

Milling machines translate CAD designs into physical restorations. Errors in this process often relate to calibration, tool wear, or machine limitations (Figure 5).

Causes:

- Worn milling burs leading to rough surfaces or inaccurate fit
- Machine calibration errors
- Incorrect nesting of restorations within the block or disc.

Consequences:

- Surface irregularities requiring excessive manual adjustment
- Poor internal fit due to over- or under-milling
- Fracture during milling of thin restorations.

Prevention:

- Regular maintenance and calibration of milling units
- Scheduled replacement of milling tools
- Appropriate nesting strategies to reduce material stress.



FIGURE 6: Failed 3D-printed bridge

2. 3D Printing errors

As additive manufacturing grows in dental applications (models, surgical guides, temporary restorations), printing errors are increasingly reported (Figure 6).

Causes:

- Incorrect orientation of the restoration during printing
- Insufficient support structures
- Resin contamination or expired materials.

Consequences:

- Warping, delamination, or inaccurate dimensions
- Fragile or incomplete structures.

Prevention:

- Follow manufacturer's recommendations for orientation and supports
- Ensure proper cleaning and post-curing protocols
- Regularly check resin quality and storage conditions.

3. Sintering and post-processing issues

For materials such as zirconia, the post-processing stage is critical (Figure 7).

Causes:

- Incorrect sintering temperature or cycle
- Contamination during handling
- Insufficient polishing or glazing.

Consequences:

- Altered shade or translucency
- Warping or shrinkage errors
- Reduced strength and long-term durability.

Prevention:

- Strict adherence to manufacturer's sintering protocols
- Proper handling to avoid contamination
- Quality control checks after post-processing.

WORKFLOW-RELATED CHALLENGES

1. Data transfer errors

Since CAD/CAM workflows rely on digital communication, file conversion or transfer issues can compromise accuracy.



FIGURE 7: Zirconia crown with incorrect shade due to sintering error

Examples:

- STL file corruption during transfer
- Loss of detail due to excessive file compression.

Solution:

- Secure, cloud-based transfer platforms with version tracking
- Verification of files before manufacturing begins.

2. Human factors

Despite digital automation, human input remains essential.

Errors often arise from insufficient training or miscommunication.

Examples:

- Incorrect material selection in CAD software
- Misinterpretation of clinical instructions.

Solution:

- Continuous training for both clinicians and technicians
- Clear communication protocols between surgery and laboratory.

CONCLUSION

CAD/CAM technology in dentistry has redefined the standards of precision and efficiency, yet it is not free from errors. Faults can occur at any stage – from scanning to design, milling, or post-processing. The key to minimising these issues lies in a combination of:

- Proper training and adherence to protocols
- Routine maintenance of hardware and software
- Effective collaboration between clinicians, technicians, and manufacturers.

By identifying and addressing these common faults, dental professionals can harness the full potential of digital workflows, ensuring restorations that meet both functional and aesthetic expectations for patients. 



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Authors must also submit four to 15 images alongside the article. These should be clearly identified with a number or letter in the file name. Please provide captions with corresponding numbers/letters for all images and, if there is any doubt about which way up it goes, or from which side a picture should be viewed, please mark it accordingly.

Authors are also encouraged to make reference to the images within the article text, eg 'The casts were mounted on the articulator (Figure 3).'

The images should be supplied separately as jpegs at original size or at the highest available resolution (300dpi, at least 4cm x 4cm). Digital workflow screenshots are acceptable, but images of the physical/final restoration are important.

STRUCTURE

Address the following key points when putting together your article. The headings do not have to be replicated or followed precisely/in order:

- **Case overview:** what were the patient's problems at presentation? What treatment was needed/agreed upon? What solution did the technician need to supply?

- **Challenges:** outline briefly the key difficulties specific to this case – high aesthetic need, difficult shade matching, remote communication etc
- **Technical work:** describe the solution in more detail, mentioning why this decision was made. Detail the steps taken and the process of the case. Discuss how patient/dentist communication was prioritised
- **Final product:** briefly outline the final restoration and describe the patient/technician/dentist reaction to it. Ideally, include pictures of it before fit and in situ
- **Reflections:** a short review of the case from the technician's perspective – explain what went well, what could be changed and what lessons have been learned for the future.

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Making photogrammetry the full-arch standard

Joe Ganderton explores how photogrammetry can remove uncertainty from full-arch cases, improving fit, efficiency and confidence across the team



JOE GANDERTON

Associate director,
Corus Remo Dental Laboratory

When I first started working on full-arch implant cases, photogrammetry was viewed as disruptive. It was something innovative clinicians were beginning to explore, but it was far from routine. Most cases relied on high-quality intraoral scans of scan bodies and, although we all understood the potential for distortion across long spans, that risk was largely accepted.

Full-arch dentistry has always been described as complex, and rightly so. It demands careful planning, close collaboration between clinician and laboratory, and a sound understanding of biomechanics and aesthetics. Over time, however, I began to question whether some of the complexity we were managing was not purely clinical, but digital.

In single-unit cases, small discrepancies in data capture may never become visible. In a full arch, they rarely remain insignificant. When restoring multiple implants across an edentulous span, minor positional inaccuracies can compound and only reveal themselves at the point of fit.

LIMITS OF 'GOOD ENOUGH' DATA

Long-span intraoral scans are susceptible to stitching distortion.

Small discrepancies between scan bodies, soft tissue interference and cumulative tolerance stacking may each appear manageable in isolation, yet together they introduce uncertainty that affects every stage of design.

That uncertainty shapes behaviour in the laboratory. Technicians begin compensating for possible distortion, often subconsciously. Frameworks may be designed cautiously, occlusion approached defensively, and when a bridge does not



seat as expected, the team is left questioning whether the issue lies in surgery, mechanics or data capture.

Those recurring moments of doubt led us to a simple question at Corus Remo Dental Lab: if technology exists that can provide verified spatial accuracy of implant positions, why continue relying on relative positioning alone?

A discussion surrounding the straw technique with a clinician highlighted to me a contradiction: if the promise of digital dentistry is precision, why are we attempting to fine-tune digital workflows through analogue verification?

**IF THE PROMISE OF
DIGITAL DENTISTRY IS
PRECISION, WHY ARE
WE ATTEMPTING TO
FINE-TUNE DIGITAL
WORKFLOWS THROUGH
ANALOGUE VERIFICATION?**

MAKING PHOTOGRAMMETRY THE BASELINE

Photogrammetry systems capture implant positions using multi-angle optical triangulation, producing a precise three-dimensional coordinate map that is independent of soft tissue and free from stitching distortion. In practical terms, we are no longer estimating where implants sit in relation to one another; we are working from confirmed spatial data.

When we made photogrammetry our standard input for full-arch cases, the impact was immediate.

Passive fit became more predictable because frameworks were designed around verified implant positions. Chairside adjustments reduced, and fit appointments shifted away from troubleshooting seating issues towards refining aesthetics and occlusion. Digital verification also became more meaningful, as we could confidently overlay photogrammetry data with intraoral scans of healed soft tissue, CBCT records and provisional designs.



WE ARE NO LONGER
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TO ONE ANOTHER; WE
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Over the past year we have completed more than 400 full-arch cases, and that volume has reinforced how much difference reliable input data makes to downstream efficiency. With appointments reduced from six to as few as three and fewer phone calls with clinicians regarding patient issues and troubleshooting.

THE EFFECT ON DESIGN AND TEAM CONFIDENCE

One of the more significant changes has been in mindset. When the starting point is stable, design decisions become more deliberate. There is less need to build in tolerance to guard against potential inaccuracies. Framework thickness, material choice and occlusal planning can

be approached with intention rather than caution. Within the laboratory, this has had a noticeable cultural effect. Technicians are more confident in their work because they trust the data they are building from. Reducing avoidable remakes improves not only efficiency but morale and accountability. Accuracy, in that sense, extends beyond microns. It influences how teams think and collaborate.

CONSISTENCY OVER OPTIONAL UPGRADES

We did consider offering photogrammetry as a premium option.

Commercially, that would have been straightforward. In practice, it would have introduced inconsistency.

Different data capture methods demand different expectations, which creates friction within a workflow. We therefore took the view that for full-arch cases, photogrammetry should not be an enhancement but the baseline.

To support that approach, we introduced a dedicated booking system through our app, allowing clinicians to reserve scanners alongside patient appointments and specify when scans will be ready for technician review. Removing logistical uncertainty is just as important as improving technical accuracy in complex cases.

Our protocol now reflects this emphasis on verified implant positioning. Planning remains prosthetically driven. Following surgery or osseointegration, implant positions are captured using photogrammetry, with healed soft tissue recorded via intraoral scan. Trial stages and final restorations are then designed on the basis of confirmed coordinates.

Photogrammetry does require investment and clinician engagement, and it does not eliminate the need for judgement.

However, in high-value full-arch cases where chair time and reputational considerations are significant, the cost of working from uncertain implant positioning can be far greater. For us, what was once considered disruptive has become responsible practice. Full-arch implant dentistry will always demand skill and experience. Photogrammetry does not replace those qualities.

It provides a more predictable digital foundation on which they can operate, allowing the focus to return to function, aesthetics and long-term success. [L](#)

A mounting burden for dental labs

Steve Campbell explains why the proposed rise in MHRA registration fees could disproportionately affect dental laboratories – and what is being done to challenge it



STEVE CAMPBELL

Director for policy, Dental Laboratories Association (DLA)

From April 2026, the MHRA introduced a new annual charging structure for medical device registration.

Manufacturers are now charged £300 each year for every chargeable GMDN Level 2 category, or Level 1 where no Level 2 exists.

During the introduction of the system, there was considerable uncertainty over how dental devices should be categorised and very little dental-specific guidance available to laboratories. The DLA, worked with the MHRA, obtained clarification and helped members understand which categories applied to their products, reducing the potential financial exposure for many.

ANOTHER SUBSTANTIAL INCREASE

You might reasonably have expected everyone to be given time to see how that new system operated. Instead, only months after its introduction, the MHRA launched another consultation proposing to increase the annual charge from £300 to £511 from 1 April 2027. That is an increase of more than 70% in twelve months.

I make no apology for saying that the DLA considers an increase of that magnitude extraordinary. Government talks about

supporting small businesses, reducing regulatory burdens and providing businesses with greater certainty.

Those commitments have to mean something in practice.

Reducing the cost of government cannot simply mean transferring more of that cost onto small businesses through higher compulsory fees. We believe there is a fundamental question about whether the existing charging structure is sufficiently proportionate.

IS THE SYSTEM PROPORTIONATE?

Medical devices encompass an enormous range of risk. Some devices understandably require significant post-market surveillance, investigation, safety action and regulatory resources.

But dental laboratories predominantly manufacture individually prescribed custom-made medical devices. Yet a micro dental laboratory can face the same unit charge for a GMDN category as a vastly larger medical device manufacturer.

We believe risk, scale and actual regulatory workload should matter.

QUESTIONS THAT NEED ANSWERS

How many dental laboratories have been inspected? What non-compliance has been identified? What does regulating our sector actually cost?

If dental laboratories are being asked to pay considerably more, those are entirely reasonable questions. In response, we prepared a formal challenge calling for the proposed increase to be paused and the underlying charging structure reviewed. We sent it to the MHRA, relevant government ministers and parliamentary select committees.

We also mobilised our membership, we provided members with guidance for responding to the consultation and a separate template letter that could be sent

to their constituency MPs. The objective was to ensure that Government heard both the collective voice of the DLA and the voices of the individual businesses that will actually have to pay these fees.

On 10 September, we received a formal letter from Lawrence Tallon, chief executive of the MHRA. The MHRA has acknowledged the DLA's concerns and confirmed that our representations will be considered alongside the other consultation responses. Most importantly, the chief executive has confirmed that the MHRA will contact the DLA directly to arrange a meeting to discuss our concerns in greater detail.

We welcome that meeting, but our position has not changed.

WHAT HAPPENS NEXT?

We will be asking the MHRA to justify the proposed 70% increase. We will ask for evidence about the actual cost and level of post market surveillance associated with dental technology. We will challenge whether a charging system that does not adequately recognise differences in manufacturer size, device risk and regulatory workload is genuinely proportionate and we will continue to make the point that cost recovery cannot become a blank cheque handed to a regulator and ultimately paid for by compliant small businesses.

The DLA supports strong regulation. We support effective post market surveillance. We support patient safety without reservation, but good regulation must also be proportionate, transparent, accountable and evidence-based.

The job is not finished.

Our objective now is to use that engagement to secure a fairer outcome for DLA members and to ensure that the voice of UK dental laboratories is heard clearly when decisions affecting their businesses are made. [L](#)

We believe there is a fundamental question about whether the existing charging structure is sufficiently proportionate

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Dental technology's biggest threats – and why it always survives

Ashley Byrne reflects on 20 years of surviving the threats that were supposed to kill dental technology



ASHLEY BYRNE

Associate director,
Byrnes Dental Laboratory

Twenty years. Two decades of early mornings, late nights, difficult conversations, and genuinely incredible moments. It's a milestone I'm proud of – but more than anything, it's made me reflect on just how many times someone told me we were finished. And I mean that quite literally.

THE THREATS THAT NEVER CAME

Cast your mind back. Overseas laboratories were going to wipe us out. Why would any dentist pay UK prices when they could send work abroad for a fraction of the cost? I heard it constantly. It kept a lot of lab owners awake at night, myself included.

Then came digital dentistry. Intraoral scanners, CAD/CAM, milling machines – the narrative shifted. Why would labs survive when dentists could design and mill restorations chairside? The technology was supposed to make us redundant overnight.

But here we are. Still going. Not just surviving, either – genuinely thriving.

WHY THE THREATS NEVER MATERIALISED

Overseas labs took some work. I won't pretend they didn't. But the quality issues, the communication barriers, the turnaround times and the increasing demand from patients for British-made, high-quality restorations brought a lot of that work back. Patients started asking questions. Dentists started caring about the answers. Digital dentistry didn't kill labs – it transformed them. Yes, some of the simpler, more commoditised work moved elsewhere. But labs that evolved with the technology found themselves doing more complex, more interesting, and frankly more rewarding work than ever before. Today, 90% of the work coming into my lab arrives as an IOS file. That's not a threat. That's an opportunity I'm grateful for every single day.

Digital dentistry
didn't kill labs –
it transformed
them

Chairside milling? It has its place. Single-unit same-day restorations in certain clinical situations – absolutely. But there is a ceiling to what chairside can achieve, and above that ceiling is where skilled technicians live. Complex full-mouth rehabilitations, implant-supported restorations, high-end aesthetics – no milling unit in a practice corridor is replacing that.

SO, WHY DO WE KEEP PANICKING?

Honestly? Because fear sells. A headline that says 'dental labs are evolving and adapting well' doesn't get clicks. 'AI will replace dental technicians' absolutely does.



I understand the anxiety. I've felt it myself. When you've invested years into learning a craft, built a team, a client base, a reputation – the idea that it could all be disrupted is genuinely frightening. That fear is human and it's valid. But it becomes dangerous when it stops you from moving.

The labs that struggled through those so-called existential threats weren't the ones who faced the most disruption. They were the ones who stood still waiting for the worst to happen.

WHAT'S COMING NEXT?

I'm not going to pretend the landscape isn't changing again – because it is, faster than ever.

The newest shift is a genuinely impressive one. Tech-driven lab models are emerging that offer slick digital interfaces, free scanner placements, automated crown production, and yes – technical advice and clinical support too. These aren't corner-cutting operations. Some of them are very good at what they do, and they're making it easier than ever for a dentist to access consistent, efficient restorative work. I say that with no sarcasm. We should respect what these companies have built.

But here's the question it forces every traditional lab to ask: if someone else is offering all of that, what are you offering?

It kept a lot
of lab owners
awake at night,
myself included

THINK OUTSIDE THE BOX

This is where I think the real opportunity lies – and it requires us to be honest about whether we're genuinely adding value, or just assuming our relationships will carry us through. The labs that will thrive aren't the ones who simply match what these new models offer. They're the ones who go further. The ones who embed themselves so deeply into a practice's clinical workflow that the relationship becomes genuinely irreplaceable.

What does that look like in practice? It means understanding a dentist's patient base well enough to anticipate problems before they arise. It means being proactive about scan quality, not just reactive to a bad impression. It means helping to reduce chair time – fewer adjustments, fewer second appointments, better-fitting restorations first time. It means being a clinical partner, not just a manufacturing service. It might also mean offering things that fall completely outside the traditional lab model. Training days. Workflow consultations. Being present in the practice, not just at the end of a courier run.

AI-assisted design, automation, advanced materials – we should be embracing all of it too. The best version of our industry isn't us versus the new models. It's us using the same tools, while offering a depth of partnership that a standardised platform simply isn't designed to provide.

I've heard the 'this will finish us' story before, and I know how it ends.

The labs that invest in thinking creatively, that build genuine clinical

I'm not going
to pretend the
landscape isn't
changing again –
because it is, faster
than ever

partnerships, that ask 'what else can we do for this practice?' – those are the ones that will look back at this moment the way I look back at the 'overseas labs will kill you' era. With a quiet smile.

WHAT I'D SAY TO ANY TECHNICIAN READING THIS

Your skills matter enormously. But in the current climate, technical skill alone isn't enough. You need to be curious, creative, and genuinely invested in the success of the practices you work with.

Get closer to your clients. Understand their challenges. Don't wait for the phone to ring – pick it up first. Find out where they're losing time, where cases are going wrong, and work out how you can help fix that.

Go to shows. Try new things. Talk to people who are doing it differently. The best ideas often come from outside your comfort zone. And stop waiting for the industry to collapse. It won't.

Twenty years in, I'm more optimistic about the future of dental technology than I have ever been. The work is better, the science is better, and the people coming through are extraordinary. Change isn't the enemy. Staying still is. 

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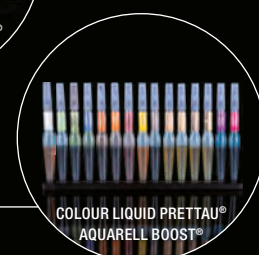


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The technician decline is not what it seems

The register is shrinking, but **Matt Everatt** explains why the figures do not tell the whole story and where the true danger lies



MATT EVERATT

Editor-in-chief, *Laboratory*

In August 2021, I wrote about the declining numbers of dental technicians. The article headline was intentionally blunt: 'By 2040, dental technicians will be extinct.' Although it is very unlikely to go that far, it was based on the trajectory of the numbers, and I wrote it to sensationalise the message.

The figures were stark. In 2018, 6,163 dental technicians were registered with the General Dental Council (GDC). By 2021, that had fallen to 5,535. By 2026, we are now below 5,000 for the first time. There were just 143 new registrations last year in the entire UK.

The decline is real, but the story behind those numbers is more complicated and perhaps not as grim as they may first seem.

WHAT THE TECHNOLOGY ACTUALLY CHANGED

CAD/CAM, 3D printing, digital design, and automation have fundamentally changed what technicians can produce. An experienced technician using modern workflows can deliver work that once required several varied skills often from different technicians. Accuracy is better,

reproducibility is reliable and the quality has arguably risen.

This is progress, not a problem. It means the profession genuinely does not need as many registered technicians as it did in 2018. Some decline is inevitable. Some is healthy, but not all of what we are seeing is inevitable.

INEVITABLE VERSUS CHOSEN DECLINE

If technology efficiency was the only factor, the register would fall to a lower sustainable level. Fewer technicians, more highly skilled, paid better, using advanced technology for premium work. That is a viable profession.

That is not happening. Technology-driven efficiency is colliding with structural choices that are unsustainable. We use efficiency gains to cut prices instead of improving margins. Unregulated manufacturers are still going unchecked, along with chairside manufacturing, distorting the market. We also do a pretty good job of making the profession unattractive to youngers or newcomers, so fewer people join. These are choices and they compound the inevitable decline into something far worse.

TWO PATHS FORWARD

We can continue as we are, compete on price, accept unregulated competition, pay people as little as possible, watch training institutions close. In ten years, 3,000 technicians, most over 50, many exhausted. The profession continues its demise towards obsolescence.

Or we accept technology-driven efficiency as the new way and make different structural choices. Stop undercutting. Price on value and expertise. Address unregulated manufacturing. Use margins to pay technicians better and create real development pathways. Run labs as proper

businesses. In ten years, 3,500 registered technicians, well-paid, highly skilled, specialised in complex work. A smaller profession that is thriving.

Both futures are possible. Neither is inevitable. The choice is mostly ours.

IF WE WANT A PROFESSION TO EXIST

If we choose to be the thriving profession rather than the diminished one, we need to stop competing on price. Not because it feels good, but because it is the only way margins improve enough to pay people well and invest in quality. Some clients will leave. Let them. The ones attracted by price are the ones most likely to be demanding, slow to pay, and quick to complain. They are not worth keeping.

We need to invest those margins in people. Pay laboratory technicians what they are worth, salaries that reflect their expertise and regulated status. Invest in development and specialisation. When you do this, good technicians stay.

Quality improves, reputation compounds and the phone rings more often than you could imagine.

We need to collectively address unregulated manufacturing. The GDC and MHRA have regulations. They need to be enforced. As a collective, we can do more to make our voices heard. Dental practices need to understand that work produced outside regulatory frameworks carries real liability. This is not negotiable if we want standards to mean anything.

We need training institutions properly resourced. You cannot sustain viable programmes on cohorts of a dozen students with shoestring budgets. If the profession wants technicians capable of advanced work, education has to be funded accordingly. There are good moves towards supporting apprenticeships. Labs need to be onboard to support these institutions. **L**

These are choices and they compound the inevitable decline into something far worse

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Breaking down the lab-clinic divide

Andrea Johnson explores why laboratories are still treated as outsiders – and what it will take to build a genuinely united dental team



ANDREA JOHNSON
Chair, CEO and co-founder,
Den-Tech

DESCRIBE THE RELATIONSHIP BETWEEN DENTAL LABS AND THE REST OF THE TEAM TODAY

There is a significant separation between the two. While it's potentially better than it was, there's still a long way to go. There's still very much a 'them and us' dynamic, and the blame can be attributed to both clinics and technicians. Communication needs vastly improving – we need to work on that to eliminate the divide.

WHAT WOULD YOU SAY THE MAIN DRIVERS OF THAT DIVISION ARE?

I think it's a mixture of structure, communication and economics.

There isn't one single cause. Quite often – or in the majority of cases now – the lab isn't on site, so we don't have that same collaborative relationship.

I work in a hospital, so I'm based at the end of the clinic and people are in and out of here all the time.

If they've got a tricky case, they'll come and consult me. Labs that aren't attached to a clinic are treated almost as outside suppliers, rather than as an integral part of the team.

I worked in a private lab for my first couple of years and didn't speak to a dentist once during that entire time. There's a massive disconnect for the lab in that situation because you're not connecting the work to a patient as easily.

A lot of technicians don't feel confident enough to offer an alternative solution, even if they have contact with the dentist, because they don't always get a good response. The attitude can be: 'Well, I'm the dentist; you do as you're told.' So, there's an element of feeling inferior.

WHAT IMPACT DO YOU THINK THIS DIVIDE HAS ON THE LAB COMMUNITY?

It makes some people quite bitter, disillusioned and angry. They feel they're treated unfairly. There are always going to be differing perspectives on either side, but some do treat technicians as though they're inferior. I've had young trainees come through the hospital system and say, 'I wish things were back to the way they used to be historically, when the dentist was in charge.'

It really affects morale and makes a lot of people feel they aren't treated well. If people don't feel valued, they become disenchanted. They don't do their best work because they feel unappreciated, and it becomes a downward spiral. It's difficult to recover once they get into that mindset.

There is definitely a lab-clinic divide, where the clinical side is considered to be dentistry – the important stuff – and the lab is seen merely as something that supplies it. You see it in the way regulators and insurers treat people, as well as across the wider support network and regulatory framework. The clinic and the lab are treated differently.

HOW DID COVID-19 AMPLIFY THE DIVIDE?

During COVID-19, labs were disproportionately neglected, and this deepened the lab-clinic divide.

All we kept hearing about was the financial support clinics were getting. They were getting paid even though they were unable to practise because they had been told they couldn't work. They also received substantial PPE provisions.

There was so much support for clinics, yet many of them hadn't even paid their lab bills, so a lot of technicians were struggling.

Labs received only the standard help available to general businesses on the high street. They were treated as a generic commercial entity and didn't receive any support from the dental sector because they weren't considered clinical.

The phrase 'dental family' was used frequently during that time, but little action followed. If you weren't clinical, you were effectively left behind. It didn't matter what we said or how we put it; there was no compromise.

Quite a lot of labs went under as a result, fostering significant anger and resentment. It also undermined all those years of trying to bring people together as a team.

IN AN IDEAL WORLD, WHAT WOULD GREAT COLLABORATION LOOK LIKE, DAY TO DAY?

Regular communication. That could mean giving us better information on prescriptions, sending a photo or having more calls. A dentist, or someone suitable to represent them, could ring and say, 'I'm just going to talk this case through with you,' or, 'Can you pop in? I've got this really awkward case coming up.'

That's one of the best things about my job here: they involve me. Not only can I discuss the case and the different treatment

COMMUNICATION
NEEDS VASTLY
IMPROVING – WE
NEED TO WORK ON
THAT TO ELIMINATE
THE DIVIDE

IT DIDN'T MATTER
WHAT WE SAID
OR HOW WE PUT
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COMPROMISE

options with the dentist, but I also learn what the patient's expectations are. I can explain to the patient what is and isn't possible.

Patients are often much more responsive because they can discuss the design, feel that they've had some input and know that I'm taking their wishes into account when I construct their appliance.

WHAT WOULD MOVE THE NEEDLE TO IMPROVE THIS RELATIONSHIP, AND WHO NEEDS TO LEAD IT?

I don't think I could name one specific person or group. We need a cultural change within the dental industry, with numerous different parts coming together with a more team-orientated mindset.

If we automatically treated everyone as part of the team, rather than thinking of the clinical team and then everyone else, I think that would really help. It doesn't help that we aren't on site, but we need to make sure it isn't a case of out of sight, out of mind.

I think we need more non-dentists in senior leadership positions – within the regulators, the CDO's office, insurance companies and other organisations involved in administration, management and policy.

If we had a genuine mix of people, we would have ideas coming from all the different areas of dentistry and could build a much bigger picture of what's happening across the whole dental field. Once we start doing that, I think we'll see much more progress.

IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD?

Ultimately, I just want the dental team to come together and integrate for the benefit of the patient. The better we work together, the better the results will be for patients and for us as a profession. It makes our lives easier, more enjoyable and much smoother.

If people were simply a bit nicer to each other, the world would be a better place. 

Crafting a career with purpose

Deepa Bharakhda reflects on finding her place in dental technology and the people who supported her along the way



DEEPA BHARAKHDA

Dental technician,
J Vara Dental

Growing up in an Indian heritage household, there was almost an unspoken expectation that my career choices would be medicine, dentistry or law! For a while, I considered all three, but it wasn't until secondary school that I became particularly interested in dentistry. I arranged work experience at dental surgeries to see what the profession was really like.

After narrowly missing the grades for dentistry, I decided to study dental technology at Manchester Metropolitan University, initially planning to apply for dentistry afterwards.

During my final year, everything changed. Working alongside dental students and fabricating dentures for patients, I discovered how much impact a technician could have on someone's smile, confidence and wellbeing. I found a career that combined creativity, craftsmanship and purpose and I haven't looked back since.

NAVIGATING CHALLENGES

After graduating, one of my biggest challenges was simply getting my foot in the door.

Finding a lab willing to take on a graduate was incredibly difficult. I remember calling labs and even offering to work voluntarily, just to gain some experience, but for a while, nothing came through.

I never considered giving up or changing career paths. I was determined to find somewhere that would give me the opportunity to learn and grow. Eventually, I found that opportunity at a private laboratory in Bolton, where I started my career as an apprentice and learnt the foundations of dental technology.

FINDING MY FEET

When I was starting out as a young dental technician, I worked in several laboratories and even relocated to gain more hands-on experience.

I worked in commercial labs and as a process technician, but at one point I stopped and questioned whether this was really what I wanted. I wanted to be a technician who took pride in her work and created smiles that genuinely made a difference to patients.

Eventually, I found a laboratory in Leicester where I finally found my feet. I was given the opportunity to learn, develop and be supported in my growth. It was there that I truly found my passion and bloomed. And yes I have learnt a lot about myself through the process.

LEARNING AND GROWING

Working closely with clinicians has shaped me hugely as a technician. Building strong working relationships and earning their trust gave me a solid foundation, and with that came knowledge, confidence and the courage to step outside my comfort zone.

As opportunities came my way, I embraced them – from writing for magazines and collaborating with dental companies to speaking at conferences and sharing my experiences with others.

One of the biggest things I've learnt is the importance of supporting and sharing knowledge with other technicians. I remember what it felt like when I was struggling to find that support, and it's something I never want others to feel.



FINDING PASSION

I love creating smiles! Whether it's an implant-retained denture, chrome denture or a crown, knowing that something I've created can make a difference to a patient's smile, confidence and quality of life is what fuels me.

I also love the collaboration.

One of the most recognisable champions of modern dental technology, Deepa Bharadka's work combines technical excellence with a passion for education, mentorship and raising the profile of the profession. An award-winning dental technician, she is a regular speaker, writer and educator who actively supports the next generation of technicians. Through her work with Den-Tech, Nightshift and the wider laboratory community, she promotes greater collaboration, diversity and recognition while encouraging others to embrace innovation and lifelong learning.

Dentistry *Top*
50



Working closely with dentists, discussing cases and problem-solving together reminds me that we're one team, all working towards the same goal – a successful restoration and happy patient. There's nothing more rewarding than receiving positive feedback from a patient or clinician.

I also love sharing knowledge with fellow technicians, whether through social media, demonstrations, lectures or community platforms. If I can help someone in our profession, that means everything to me.

MY SUPPORT NETWORK

My family has been my biggest support through every up and down, always standing beside me and encouraging me to keep going. My best friend Nina has also been a huge part of my journey. She has always believed in me, pushed me to do well and encouraged me to step outside my comfort zone.

I am also incredibly grateful for my current laboratory J Vara Dental, who have become like my work family, supporting my teaching, demonstrations and opportunities alongside my day-to-day work. My dental friends and the Nightshift community have also played such an important role.

Having a community that encourages, celebrates and supports one another has been invaluable.

MAKING AN IMPACT

If I could change one thing, it would be to create more opportunities for dental technicians to be recognised and celebrated for the important work they do. We play such a vital role in patient care, however our contribution can sometimes go unseen.

I'd love to see more platforms, opportunities and recognition for technicians at every stage of their careers – not just those who are already established. I believe celebrating the talent within our profession can inspire the next generation, build confidence and remind technicians just how valuable their skills and contribution are.

I FOUND A CAREER
THAT COMBINED
CREATIVITY,
CRAFTSMANSHIP
AND PURPOSE AND
I HAVEN'T LOOKED
BACK SINCE

ADVICE FOR STUDENTS

My biggest advice would be to find a laboratory that genuinely wants to support you. Look for somewhere that will give you hands-on training, constructive criticism and the opportunity to learn from your mistakes – these are all part of becoming a good technician.

For young technicians starting out, have that passion and fire in your belly! Be curious, ask questions and never stop wanting to learn and improve. Dental technology is constantly evolving, so stay open-minded and embrace every opportunity that comes your way. Most importantly, believe in yourself, be patient with your progress and remember that becoming a great technician takes time.

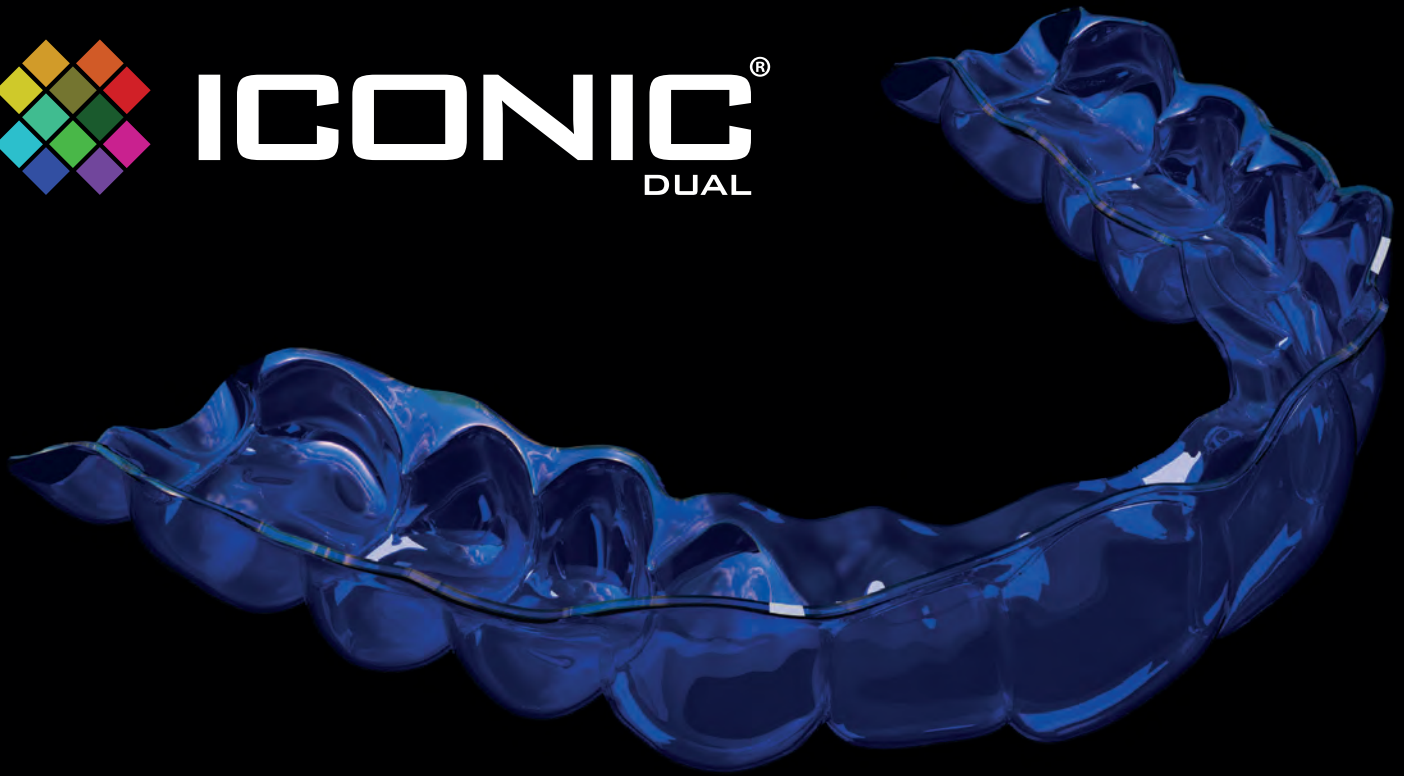
You're not alone. There is an amazing community around us, and Nightshift is a space for everyone – especially young technicians looking to learn, find opportunities and connect with others in the profession.

Yes, we shine a spotlight on female technicians and give them a platform to grow, educate and become the best versions of themselves, but at its heart, Nightshift is an educational and supportive community for everyone. Don't be afraid to reach out, ask questions, make connections and put yourself out there. Sometimes, finding the right people around you can make all the difference. [L](#)

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The cost of undervaluing your business

Matt Everatt explores why dental technicians undervalue their work, and what they can do about it



MATT EVERATT
Editor-in-chief, *Laboratory*

Dental technicians are among the most skilled professionals in healthcare. They are also among the most undervalued. That is not a coincidence.

Every day across the United Kingdom, extraordinarily talented techs create dental devices that change lives. They restore confidence, rebuild smiles, correct function. The patient wearing the device has no idea who made it. That invisibility has a price.

A beautifully handcrafted crown leaves a laboratory for £95. By the time it reaches the patient it has been marked up as much as ten times over. The technician who brought thirty years of knowledge to that single case takes home a fraction of the final value. And the person whose mouth it ends up in never once asked who made it.

This is the reality of being at the thin end of the wedge in a business-to-business profession. For too long it has been accepted as simply the way things are.

THE COST OF UNDERVALUING YOURSELF

Yes, there is the direct cost. Margins squeezed to the point where labs cannot invest in equipment, training, and people. In a year when MHRA fees are proposed to increase by nearly 40% and VAT has been enforced on aligners, that pressure is existential.

But the deeper cost is harder to quantify. When a professional chronically undervalues their work, they send a signal. That signal says: this is what I am worth. Over time that signal becomes a belief and that belief becomes a ceiling.

The technician who drops their price to win a case sets up a precedent. They invite every future conversation to start from that lower point. The clients attracted by the lowest price tend to be the most demanding, quickest to complain, and slowest to pay. The race to the bottom costs more than money. It costs time, energy, reputation, and ultimately the joy of doing work you are proud of.

WHAT KNOWING YOUR WORTH ACTUALLY LOOKS LIKE

Knowing your worth is not about arrogance. It is about having a clear and justified sense of the value you bring and being willing to articulate it.

In practice, it begins with a shift in how you talk about your work. A pricing conversation that starts not with an apology but with an explanation: here is what this case involves. Here is the expertise required. Here is why this is the price. Most dental professionals, when presented with a clear and confident rationale, do not push back. They respect it.

Once you have had that conversation, you begin to see which clients are genuinely worth your time and which ones are costing you more than they are paying. The client who always queries the invoice, demands discounts, sends unclear prescriptions, that client is not an asset. Walking away from them is often the best financial decision you will make.

This clarity naturally leads you to the next step: investing in your own development. Not to chase work, but to become irreplaceable rather than interchangeable.

From there, your relationships transform. You stand alongside the dental team not as a supplier but as a technical partner. You

contribute to decisions about materials and design where your expertise adds genuine value. You are present in discussions about patient outcomes, not waiting passively for the next prescription to land.

Finally, something compounds. Your reputation is built case by case, relationship by relationship, over years of consistent excellent work becomes your most valuable asset. Your reputation is what makes the phone ring when competitors are struggling. It is what clients talk about when they recommend you to a colleague.

WHERE TO START

It starts with a decision that the way things have always been done is not the way they have to continue.

I made that decision early in my career. I lost clients because of it. Almost every time it was more beneficial to the business than detrimental – the clients who left over price were almost always the ones who never truly valued the work in the first place.

The ones who stayed became partners. They trusted my technical judgement. They sent their complex cases. They paid on time and they recommended me to others.

If this resonates, if you recognise yourself in the habit of undervaluing, you are not stuck with that story. You can write a different one, starting today. [L](#)

Matt is also the author of *The Invisible Professional: Know Your Worth. Own Your Value*

Common pitfalls in team appreciation

Faye Mear shares why celebrating your dental technicians matters more than ever, and how to avoid underappreciation



FAYE MEAR

Client liaison, Corona Marketing

A successful dental laboratory relies on precision, craftsmanship and expertise. But in today's climate – with UK labs facing a shrinking workforce, increased outsourcing to overseas manufacturers and rising operational pressures – your most valuable asset isn't your equipment or software, it's your technicians.

These are skilled artisans whose attention to detail keeps clinicians loyal and your output consistent. In a sector fighting hard to protect British-made quality, celebrating and supporting your team isn't optional – it's essential!

THE PROBLEM: TECHNICIAN RETENTION IS BECOMING CRITICAL

The UK dental technology workforce is shrinking. Fewer new technicians enter the profession, and experienced technicians are retiring, so labs are competing for the same limited talent. Losing even one person can cause operational delays, increase stress and damage client relationships.

The solution

Consistent, genuine appreciation is one of the strongest tools for retention. When people feel valued, trusted and connected to the lab's future, they are far more likely to stay. Recognition doesn't need to be expensive, but it does need to be regular, specific and sincere.

Top tips

- Make micro-recognition a habit – notice and compliment the skill
- Include quick weekly shout-outs in meetings
- Be honest about industry pressures and acknowledge how essential every technician is to your lab's stability.

THE PROBLEM: UK CRAFTSMANSHIP RISKS BEING OVERSHADOWED

One of the biggest threats to UK labs is the growing volume of work being outsourced overseas, making technicians feel their skills are undervalued. Competing on price alone is impossible, but precision, quality and consistency is where UK labs can shine.

The solution

Your technicians' craftsmanship is your competitive edge and strongest defence against commoditised, low-cost work. Publicly celebrate their craftsmanship and highlight the detail, precision and consistency of their work that sets your lab apart.

Top tips

- Showcase standout cases on social media, customer communications and in the lab
- Create a 'case of the month' to honour exceptional work
- Acknowledge complex cases or creative problem-solving in team meetings.

THE PROBLEM: PERSONAL MILESTONES GET LOST IN THE WORKLOAD

Fast-paced production means birthdays, work anniversaries or other milestones can be forgotten. When personal moments pass unnoticed, technicians can feel like their worth begins and ends at the workbench.

The solution

Marking occasions helps individuals to feel valued and having the team share in these moments builds loyalty and a stronger team culture.

Top tips

- Use a shared calendar for birthdays and anniversaries
- Mark occasions with small gestures – a card, a cake etc
- Recognise professional milestones too.





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THE PROBLEM: LIMITED DEVELOPMENT OPPORTUNITIES

For trained technicians, growth opportunities are often limited, but investing in training and development is both motivating for the individual and essential for your lab to stay competitive and maintain high standards.

The solution

Invest in training that strengthens both the individual and the lab. Development motivates technicians, supports innovation and protects the lab's future skill base.

Top tips

- Ask each technician about their development goals
- Offer training in digital workflows, implant work or advanced CAD/CAM
- Create in-house mentoring or cross-training to build flexibility and confidence.

THE PROBLEM: HIGH PRESSURE CAN LEAD TO BURNOUT

Their job is not an easy one, and tight deadlines, remakes and complex cases can put technicians under even more pressure. Without a supportive workplace culture, this can lead to fatigue, mistakes and burnout – especially in understaffed labs.

The solution

Support wellbeing through practical adjustments. When technicians feel cared for, productivity improves and errors decrease.

Top tips

- Keep workloads realistic and ensure breaks are taken – not skipped
- Provide ergonomic equipment and updated tools to reduce strain
- Personally check in regularly with technicians to see how they're coping.

THE PROBLEM: TECHNICIANS OFTEN FEEL EXCLUDED FROM DECISIONS

Operational decisions about equipment, materials, workflow are sometimes made without consulting the team. They often understand the day-to-day realities best and will feel undervalued if not asked for their input.

The solution

Involving technicians in decisions builds ownership, boosts morale and often results in finding more efficient solutions.

Top tips

- Ask for feedback before purchasing new equipment or materials
- Hold improvement discussions to gather ideas
- Acknowledge when technician suggestions lead to real changes.

Your technicians are your greatest strength, and they need your support and care. Their craftsmanship is your reputation, your product and your competitive edge. By appreciating their work, supporting their development and involving them in decisions, you will retain the best people and create a workplace where technicians feel proud to stay. This is now more important than ever before, and it's essential for your laboratory's future. [L](#)

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LEARN MORE



How to stand out in an interview

Eleanor Pittard shares what employers really want to hear – and how honest, thoughtful preparation can help dental technicians make the right impression



ELEANOR PITTARD

Managing director and co-owner,
Hive Dental Laboratory

A good interview is not about pretending you can do everything. It is about showing that you understand your current ability, can speak honestly about your development and know how your work contributes to the wider laboratory.

KNOW WHAT YOU CAN ACTUALLY DO

One of the first things I want to understand is whether a technician knows themselves. If I ask how long it takes you to complete a bite block, I am not looking for the fastest possible answer. I am looking for an accurate one.

If it usually takes you 45 minutes, say 45 minutes. Do not say 20 because you think that is what an employer wants to hear. Once you start working, your real timings will become obvious very quickly, especially during a three-month probation. An inflated answer does not make you look more capable. It

makes it harder for the laboratory to plan work properly and can damage trust before you have had the chance to build it.

Before the interview, write down the main stages you can complete and give yourself an honest rating. What can you do independently? What can you do with a final check? What are you still learning? Knowing this does not make you weak. It gives an employer something realistic to work with.

Your qualification matters, but I also want to know what you have done beyond it



BRING EVIDENCE THAT YOU ARE PROACTIVE

Your qualification matters, but I also want to know what you have done beyond it. That does not mean you need a long list of expensive courses. It could be attending study clubs, completing relevant CPD, practising a digital workflow, following the work of experienced technicians, asking to observe another department or keeping photographs of cases that show your progress.

The important part is being specific. Instead of saying, 'I am always trying to improve', explain what you have actually done. For example: 'I realised my tooth setups lacked consistency, so I studied natural tooth position, asked for feedback on each case and photographed the changes over three months.' That answer shows awareness, action and improvement.

BE ABLE TO EXPLAIN WHAT INTERESTS YOU

Passion can sound like an overused interview word, but it is still important. I want to know who inspires you, which part of dental technology you enjoy and where you would like to be in a few years. You do not need a perfect ten-year plan, but you should be able to show some direction.

AREA	QUESTION TO ANSWER HONESTLY
Current ability	What can I do well today, and what still needs checking or support?
Timing	How long do my common stages genuinely take at a consistent standard?
Development	What have I done to improve beyond my qualification?
Direction	Which area interests me, who inspires me and what would I like to learn next?
Value	What would I bring to this laboratory in quality, output, communication and attitude?
Examples	When have I adapted, owned a mistake, helped someone or responded well to feedback?

TABLE 1: Questions to prepare before the interview

Maybe you want to become excellent at removable prosthetics, build confidence with implant work, develop your digital skills or eventually work more closely with patients. Tell the interviewer what interests you and why. If you are unsure, be honest about that too, but show that you are open to finding your strengths. A good laboratory can help develop you, but it needs to see that you are engaged in your own progression.

UNDERSTAND THAT A LABORATORY IS ALSO A BUSINESS

Technical skill is only one part of working in a laboratory. Every remake, missed deadline, wasted material and poorly communicated change has a cost. You do not need to arrive with a business degree, but you should understand that your role has to create value.

If you are asking for a particular salary, be prepared to explain what you can reliably contribute at that level. Think about your quality, output, independence, range of skills and ability to help the wider team. Salary should not be discussed as though the employer is simply buying your time. They are paying for the standard, consistency and value you can bring during that time.

SHOW THAT PEOPLE CAN TRUST YOU

Some of the strongest technicians are more than good with their hands. They can communicate with dentists, support colleagues, speak appropriately with patients and build reliable relationships with suppliers. That combination is incredibly valuable.

Prepare examples of how you have handled a mistake, received difficult

feedback, helped a colleague or explained a technical issue clearly. Do not tell the interviewer that you have never made a mistake. Explain how you responded, what you learnt and what you changed afterwards. Trust is built through ownership, not perfection.

PREPARE FOR CHANGE

Laboratory days change. A repair arrives, a case needs to be prioritised, a clinician calls with new information or equipment causes a delay. An employer needs to know that you can adapt without becoming defensive or losing control of the rest of your work.

Think of a real example where your task list changed unexpectedly. Explain how you reprioritised, who you communicated with and how you protected the quality of the work. Saying that you work well under pressure is easy. A specific example makes it believable.

THE FINAL POINT

You do not need to walk into an interview as the finished article. Most good employers understand that technicians need development, especially early in their careers. What matters is whether you are honest, self-aware, interested in learning and able to work as part of a business as well as at the bench.

Go in ready to answer three questions clearly: What can you do well today? What are you working on? What would you bring to this laboratory? If you can answer those with real examples, you will already be far more memorable than someone relying on rehearsed interview phrases. 

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Everything from a single source' is the principle that has always guided the Zirkonzahn dental company (South Tyrol, Italy).

This work philosophy dictates that all hardware, software, tools and materials provided by the firm are conceived and manufactured in-house, with full control over the entire production process, to guarantee the highest standards of quality and a reliable workflow.

However, 'in-house' philosophy for Zirkonzahn also means that all working teams, from research & development to customer care, all the way through production, sales, technical support and education, are gathered under the same roof. This ensures easy communication and knowledge transfer from team to team.

This is one of the core aspects of the company, which allows them to provide clients with quick problem solving and a 360° support that covers all technical, dental technology and methodological assistance, with extremely short response times.

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- Modular products to facilitate maintenance work – clients can repair their machines autonomously under the guidance of a Zirkonzahn technician via remote and live assistance
- A multilingual, in-house support team with many years of experience in the sector of informatics and dental technology, composed also of dental technicians. Each team member is trained internally to become specialised in a specific sector (machines, software, PC, materials, case design, nesting – such as calculation/positioning etc)
- An efficient ticket system with high priority for software and hardware issues.

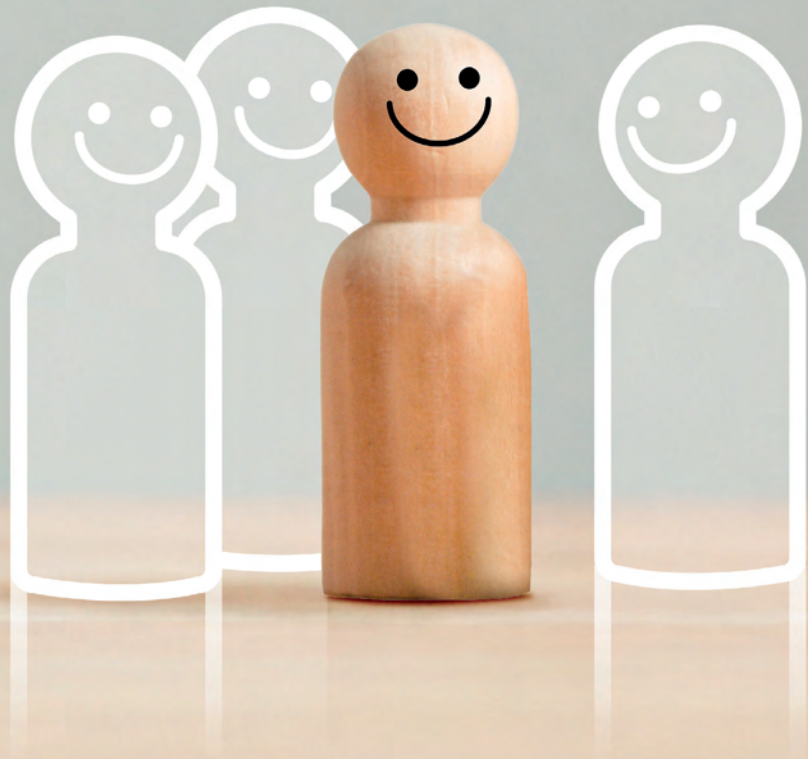
EDUCATIONAL SUPPORT

Alongside the technical and technological support, Zirkonzahn also offers educational assistance through the 'Zirkonzahn School', an extensive training programme for dental technicians and dentists to help them get the most efficient use out of their equipment. From Zirkonzahn, clients don't just buy 'a product'. They buy a whole work philosophy that includes the conception of a seamless dental workflow, a complete package of services, and reliable technical and educational support.

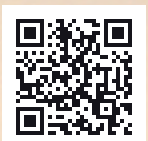
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AI in prosthetic care

Is AI helping dental professionals personalise care or just producing generic advice in a more convincing font, asks **Anna Veli**



ANNA VELI

Consultant maxillofacial prosthetist,
Engreco Healthcare

Artificial intelligence (AI) has quietly become part of clinical life, from drafting emails and tidying spreadsheets, to sitting somewhere in a patient's own research before they reach us. In maxillofacial prosthetics, that raises an interesting question: is AI helping us personalise care, or producing generic advice in a more convincing font?

INFORMATION IS NOT JUDGEMENT

Patients researching a silicone ear, nose, eye or nipple prosthesis can arrive already familiar with retention magnets, adhesives, silicone grades or digital scanning. That's not necessarily a bad thing. After all, an informed patient makes for a better conversation. The difficulty starts when general information is mistaken for personalised advice.

The real clinical question is rarely: 'can this be made?' It's whether it will work for this patient's anatomy, lifestyle and expectations; weighing tissue condition, colour, function, retention, maintenance and priorities together, and occasionally concluding a prosthesis isn't the right answer at all.

No AI does that weighing up. A trained and certified prosthetist does.

USING AI IN A PROSTHETICS CLINIC AND LAB

At Engreco Healthcare, a maxillofacial prosthetics clinic and dental laboratory, AI is a tool, not a decision-maker. The team uses it to draft and refine website content, review on page SEO and structured data, audit our website for usability gaps, and refine social media posts.

Behind the scenes, we've built our own repeatable skills within AI tools such as Claude, saved instructions and house style



that let recurring jobs (including correspondence, spreadsheets, and report formatting) run automatically to a consistent standard, not reinvented each time. That frees a small team for work that needs a human.

We also use AI to spot patterns in patient questions when searching for our services, and shaping educational content based on that. Most interestingly, we're exploring AI-assisted analysis of anatomy, colour and skin-tone against digital models, flagging areas needing closer attention or a more natural look.

Similar clinics and labs are likely to see AI move into digital shade matching, CAD design assistance, automated quality checks between scan and print, business inventory forecasting, and clinician-reviewed transcription.

Patient-facing chatbots for booking are plausible too, provided they're clearly signposted as non-clinical and never used to triage symptoms unsupervised.

THE LEGAL BOUNDARY MATTERS

Of course, none of this sits outside regulation. Where AI software is used for a medical purpose, it may fall within the UK's medical device framework overseen by the Medicines and Healthcare products Regulatory Agency (MHRA), depending on intended use.

Where patient images or health data are processed, that's special category data under UK GDPR, and the Data Protection Act 2018 requires meaningful human involvement in decisions with significant effects on a patient.

For us, AI supports the workflow; it never replaces clinical judgement or accountability.

HUMAN EXPERTISE, AMPLIFIED

The most exciting future for this profession isn't AI versus the prosthetist. It's the prosthetist with better tools.

AI can search faster, spot patterns and flag things worth a second look. It cannot examine a patient, sense what a facial difference means to them, or carry responsibility for the final decision.

AI can make information look personal; the clinician's job is to make the care personal.

WHAT'S NEXT FOR US?

Right now, all of the above lives across separate AI systems. One system for the website, one for admin, one for social media, one for image analysis. The logical next step is bringing it together: a single AI app of our own, built specifically around prosthetic patients and the prosthetic workflow we use in-house, not a generic assistant adapted to fit.

Less time stitched between tools, more precision in the prosthesis itself, and subsequently better outcomes for the patients we treat. **L**

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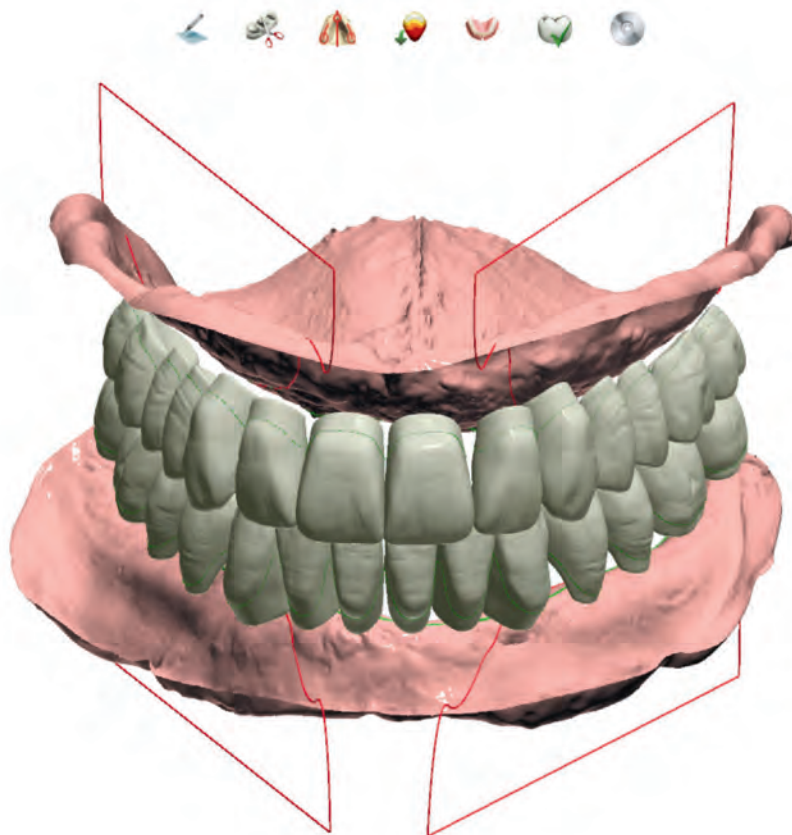
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Transforming sports mouthguards

Dr Theodoros Tasopoulos demonstrates a digital workflow for creating a precisely fitting, comfortable and protective 3D-printed sports mouthguard



THEODOROS TASOPOULOS

Prosthodontist and
practice owner

Sports mouthguards can play a crucial role in preventive dentistry by dispersing and absorbing impact forces, thereby protecting dentofacial and craniofacial structures. Studies indicate that up to one-third of oral and craniofacial trauma is associated with athletic activity.

In general, sports mouthguards are classified into three main types: stock, mouth-formed (boil-and-bite), and custom-made. Custom-made mouthguards are preferred among these categories due to their superior fit, enhanced comfort, and greater protective capabilities, especially in high-impact sports.

The efficacy of a mouthguard largely depends on its material composition, thickness, and the manufacturing process employed. Ethylene-vinyl acetate (EVA) has long been the preferred material due to its remarkable impact resistance and inherent flexibility.

However, EVA mouthguards fabricated by thermoforming frequently exhibit thickness inconsistencies, primarily due to material sagging and model cast distortion during pressure or vacuum forming, particularly in the occlusal areas.

In response to the constraints posed by conventional manufacturing methodologies, digital technologies are emerging as an alternative.

No modifications were necessary, demonstrating the precision of the digital design and fabrication workflow



FIGURE 1: The occlusal plane was first defined digitally using the software's mean-value virtual articulator

CAD/CAM workflows, particularly those incorporating additive manufacturing, provide enhanced control over mouthguard thickness and occlusal relationships. These advanced methodologies effectively mitigate the dimensional inaccuracies commonly observed with thermoforming, thereby improving the final product's accuracy and reproducibility.

THE CASE

A 25-year-old patient with a full set of teeth, actively participating in a high-impact contact sport, presented to our clinic. Examination showed a stable occlusion, with no evidence of parafunctional behaviour and no clinical signs or symptoms indicative of temporomandibular disorders.

TREATMENT PLAN

A new case was initiated in the TRIOS order form, and the 'Appliance' option was chosen within 3Shape Splint Studio using 3Shape Unite CAD software. Full-arch intraoral digital impressions of both the maxilla and mandible were captured with a TRIOS 5 scanner. To create adequate restorative space for the sports mouthguard, the occlusal vertical dimension (OVD) was increased by 2 mm using a 3D-printed anterior deprogrammer.

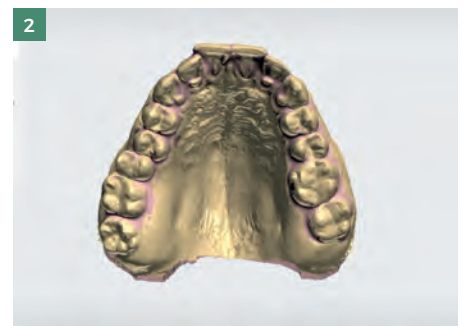


FIGURE 2: Key interdental areas were selectively blocked out and retentive undercuts were optimised

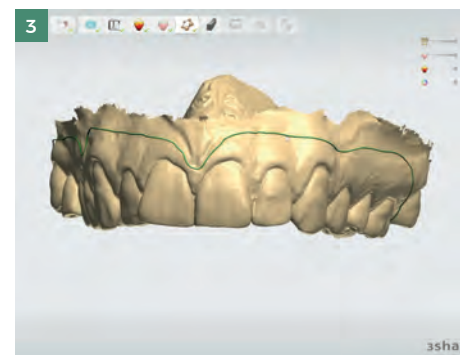


FIGURE 3: The outline of the mouthguard was delineated, and thickness was identified based on the preferred protection level

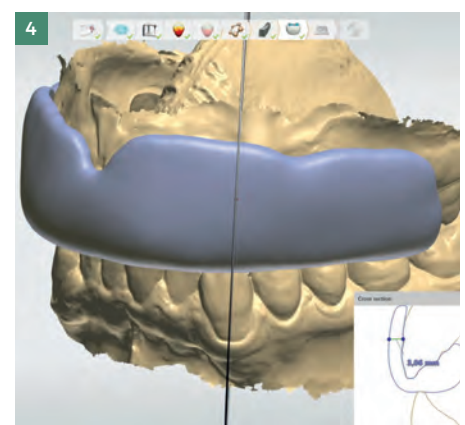
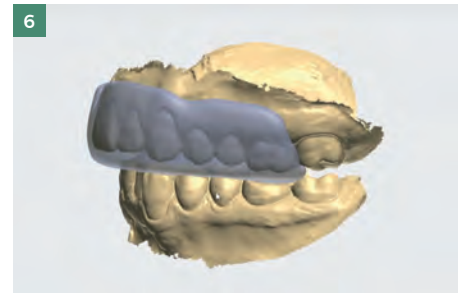
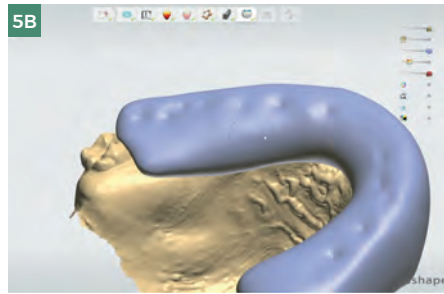
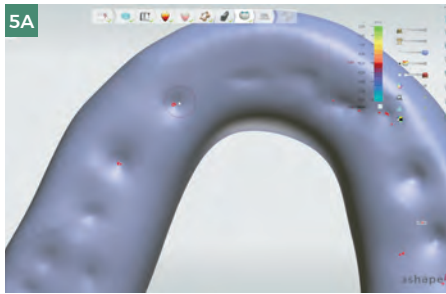


FIGURE 4: The mouthguard was digitally extended to include the distal surfaces of the first molars, while maintaining a 2 mm clearance from the vestibular sulcus to prevent contact with the mobile soft tissues



FIGURES 5A and 5B: Furthermore, the palatal flanges were gradually tapered toward the gingival margins to reduce soft tissue irritation and increase patient comfort

FIGURE 6: The antagonistic dentition was protected during occlusal loading with a buccal barrier

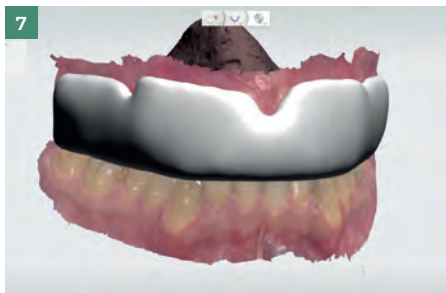


FIGURE 7: Upon design verification, the digital mouthguard file was finalised and sent for production



FIGURE 8: The custom-designed, 3D printed sports mouthguard was delivered after a comprehensive evaluation of its fit, occlusal performance, and overall comfort for the athlete

build orientation with a layer thickness of 100 μm . Post-processing included immersion in 99% isopropyl alcohol for 5 minutes, followed by air drying at room temperature and ultraviolet curing for 20 minutes as recommended by the manufacturer protocol.

After printing, all support structures were carefully detached. The appliance was then finished and polished using a Scotch-Brite Medium wheel and a Fine Blue Abrasion Disc to achieve a smooth surface.

At this elevated OVD, a new maxillomandibular relationship in centric relation (CR) was digitally recorded. This was achieved using a 3D-printed anterior deprogrammer designed to engage at least two maxillary teeth and one mandibular tooth. A bilateral vertical occlusal record was then obtained, including no fewer than four maxillary and four mandibular teeth. The scans were subsequently articulated automatically within the software.

The occlusal plane was first defined digitally using the software's mean-value virtual articulator, allowing the maxillary and mandibular models to be aligned in centric relation at the increased OVD (Figure 1).

The path of insertion was established to promote adequate retention while limiting engagement with undercuts during placement and removal. Key interdental areas were selectively blocked out, and retentive undercuts were optimised to improve stability and avoid weak or thin areas within the appliance (Figure 2).

The outline of the mouthguard was delineated, and thickness was identified based on the preferred protection level (Figure 3). A retention zone was designed along the labial aspect of the anterior teeth to enhance mechanical stability during function. The mouthguard was digitally extended to include the distal surfaces of the first molars, while maintaining a 2 mm clearance from the vestibular sulcus to

prevent contact with the mobile soft tissues (Figure 4).

Labial, occlusal, and palatal thicknesses were established at 3–5 mm, 2 mm, and 1 mm, respectively, following current guidelines. This design improves shock absorption on the labial and occlusal surfaces while maintaining a thinner palatal region to enhance comfort and support speech. The appliance thickness was subsequently refined to ensure proper occlusal contact with the opposing dentition for optimal functional performance.

Furthermore, the palatal flanges were gradually tapered toward the gingival margins to reduce soft tissue irritation and increase patient comfort. Targeted reduction of material in areas corresponding to the palatal cusps of the premolars and molars prevented controlled intrusion of the mandibular teeth into the appliance, thereby establishing a protective interface for the lower dentition (Figure 5a, 5b). The antagonistic dentition was protected during occlusal loading with a buccal barrier (Figure 6). Upon design verification, the digital mouthguard file was finalised and sent for production (Figure 7).

The mouthguard was fabricated using a 3D printer (Asiga Max 2) with a biocompatible resin specifically developed for this application (Keyguard, Keystone Industries). Printing was carried out at a 45°

FINAL RESULT

The custom-designed, 3D printed sports mouthguard was delivered after a comprehensive evaluation of its fit, occlusal performance, and overall comfort for the athlete (Figure 8). No modifications were necessary, demonstrating the precision of the digital design and fabrication workflow. Fit was verified through visual assessment of marginal adaptation, stability during insertion and removal, and the absence of pressure points or soft tissue impingement. Occlusal performance was assessed by confirming even, stable contacts with the opposing dentition at the increased occlusal vertical dimension, while identifying and eliminating any premature contacts or interferences.

CONCLUSION

The use of splint design software enabled precise control over thickness, occlusal relationships, and overall fit, overcoming several limitations associated with traditional thermoforming techniques. This digital workflow ensures consistent, efficient, and cost-effective fabrication, benefiting athletes through improved comfort, protection and wear compliance, while also supporting clinicians by minimising the need for adjustments and facilitating quick reproduction when required. [L](#)

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Enhanced CPD

LAB/AUTUMN/SZABLOWINSKI/PAGE 13

1. Why were the primary impressions and jaw relations recorded conventionally?

- ☐ a. To avoid creating a virtual model
- ☐ b. To capture the patient's functional anatomy accurately
- ☐ c. To eliminate the need for a physical try-in
- ☐ d. To enable the denture base to be printed immediately

2. What material was used for the digitally manufactured denture base?

- ☐ a. Heat-cured acrylic resin
- ☐ b. Zirconia
- ☐ c. High-density pre-polymerised PMMA
- ☐ d. Light-cured composite resin

3. What was the principal advantage of setting the teeth conventionally?

- ☐ a. It enabled individual positioning and aesthetic characterisation
- ☐ b. It removed the need for technician input
- ☐ c. It guaranteed that no adjustments would be required
- ☐ d. It allowed the complete denture to be produced in a single visit

4. According to the article, what is most likely to define the future of removable prosthetics?

- ☐ a. Digital methods completely replacing conventional techniques
- ☐ b. A return to wholly handcrafted production
- ☐ c. Standardised production regardless of patient preference
- ☐ d. The convergence of digital precision and traditional craftsmanship

LAB/AUTUMN/ATKINS/PAGE 16

1. Why is accuracy at the digital impression stage particularly important in a CAD workflow?

- ☐ a. It determines the selected milling material
- ☐ b. Any inaccuracies are carried through the entire process
- ☐ c. It eliminates the need for margin verification
- ☐ d. It prevents all post-processing faults

2. Which approach helps prevent software design errors?

- ☐ a. Using default parameters for every restoration
- ☐ b. Increasing spacer thickness in every case
- ☐ c. Customising parameters for the material and indication
- ☐ d. Allowing the software to determine margins without verification

3. What can worn milling burs cause?

- ☐ a. Rough surfaces and an inaccurate fit
- ☐ b. Resin contamination during printing
- ☐ c. Loss of detail during file transfer
- ☐ d. Incorrect sintering temperatures

4. How can data-transfer errors be reduced?

- ☐ a. By compressing files as much as possible
- ☐ b. By converting every design into several file formats
- ☐ c. By beginning manufacture immediately after receiving the file
- ☐ d. By using secure transfer platforms and verifying files before manufacture



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