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PROFESSIONAL
ORAL HEALTH

November/December 2026
FMC CONNECTING DENTISTRY

Dentistry

An essential guide to mouth cancer

A routine appointment could save a life. Explore the dental team's vital role in spotting mouth cancer and taking action – from **page 20.**

DENTISTRY IN FOCUS
MOUTH CANCER



Cosmetic dentist Sam Saleh speaks to Alan Clarke about life practising between Los Angeles and London. p50

GDC proposes tighter English-language rules

Overseas-qualified dentists could face English-language test costs of £200-£300 under General Dental Council (GDC) proposals to restrict the evidence accepted for registration.

GDC modelling suggests approximately 90% of dentist applicants currently using qualifications taught and examined in English would lose access to that evidence route.

The proposals would limit qualification and clinical-experience evidence to countries on the UK government's English-speaking list, while recognising more language tests. Affected applicants would need another accepted form of evidence to demonstrate their English-language competence.

The GDC has launched a consultation, closing on 6 January 2027.

Stefan Czerniawski, GDC executive director of strategy, said: 'We particularly want to hear from internationally qualified dental professionals and those planning to apply, so that the final guidance works well for them.'

Additional costs for overseas dentists

Council papers presented on 30 October reported a five-year average of 480 dentist applications annually using qualification-based English-language evidence. Applicants needing a language test could pay £200-£300, depending on provider and country.

The potential expense follows a 65% increase in the Overseas Registration Examination (ORE) Part 2 fee, from £4,235 to £6,967.

In September, the GDC reported an ORE waiting list exceeding 8,000. India, Pakistan, Egypt, Sudan and Nigeria were the five leading countries represented. None appears on the government list referenced in the proposals.

Qualifications from these countries would no longer qualify for the proposed evidence route simply because they were taught and examined in English. Recent clinical experience in a listed country could provide an alternative where it meets GDC criteria. A route for other suitable evidence would remain. The changes concern where qualifications or clinical experience were obtained, rather than nationality.

The regulator proposes accepting OET Dentistry, IELTS Academic, Cambridge C1 Advanced in digital format, TOEFL iBT and PTE Academic. These options remain subject to consultation outcomes.

Candidates whose English-language evidence expired while awaiting the ORE could use a Part 2 pass as evidence, provided they applied for registration within two years of passing.

Final guidance is due to return to council for approval in March 2027, with transitional arrangements proposed for applicants already preparing applications.

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Mission statement

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

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What will you do differently tomorrow?



Siobhan Hiscott
Editor's view

As the year draws to a close, attention naturally turns to deadlines – and for dentists, the CPD deadline looms among the largest. CPD records need updating, certificates need finding and – occasionally – outstanding learning needs completing. For dentists, the CPD year ends on 31 December, of course, with statements for 2026 due by 28 January 2027. Those deadlines deserve attention, particularly for anyone nearing the end of a five-year cycle.

But when reviewing your development, there is perhaps a more pointed question worth asking: what has it changed for the patient in the chair?

Mouth cancer in particular can bring that question into sharp focus, which is why this issue carries a spotlight on the subject for Mouth Cancer Action Month. The aim is for these pages to prompt reflection, conversation and, where needed, a change in practice.

Familiarity with the subject should never be mistaken for current knowledge. You may have covered it before... but can you confidently recognise a suspicious change or explain what happens next should you need to refer it?

The case for checking every patient at every appointment is pretty unequivocal. A familiar face, a busy diary or a visit booked for something else aren't reasons to be any less vigilant – because early detection saves lives.

The Mouth Cancer Foundation advocates systematic checks at every routine examination and describes a comprehensive check taking less than two minutes. In the calm away from clinic, few people would argue they don't have two minutes. But in the midst of a busy day, it can feel like a different story. Keeping that attention consistent does take conscious commitment – which is why remembering why you're doing it is so important.

Staying informed also means being prepared to act. Are findings recorded clearly? Does everyone understand local referral arrangements? Can concerns be explained sensitively?

Patients should understand what is being done, too. Explaining the check makes this part of their care visible and opens a conversation about changes to report between visits.

November's Mouth Cancer Action Month brings welcome attention to the disease, but mouth cancer isn't just for the month before Christmas. It matters just as much on every day of the year, and the focus must outlast the month-long campaign.

So, as you review and reflect upon your CPD, try asking yourself what you're going to do differently tomorrow. The patient whose life might depend on your vigilance doesn't care how many hours you've logged. But they might care a lot about what you spot.

AI model predicts patients at high risk of caries

Researchers have developed an artificial intelligence (AI) model to predict which patients are at high risk of developing caries.

A collaboration between New York University (NYU) and Brazil's Federal University of Santa Maria used data from almost 24,000 patients to predict caries risk and severity across age groups. The data came from Brazil's 2023 national oral health survey. Machine learning enabled researchers to identify patterns within complex datasets. The strongest risk signals were wealth and household density.

Non-white groups had higher caries risk across ages, while private dental insurance and a recent dental visit were protective factors. Water fluoridation was also a strong predictor: 62.5% of 12-year-olds without fluoridated water had cavities, versus 35.5% with fluoridated systems.

'The emergence of AI offers a transformative opportunity for public health surveillance and risk stratification, including addressing the global burden of cavities,' said Fernando Neves Hugo, chair of the Department of Epidemiology and Health Promotion at NYU College of Dentistry. 'These are powerful tools that could be helpful for targeting resources and delivering preventive care to specific groups that will benefit the most.'

Published in *Caries Research* in October, the study found AI could accurately predict cavity risk and severity by age group. The researchers suggested the same models might apply in other middle-income countries, although differences in local access could change the factors associated with caries development.

Could DNA cages assist with oral tissue regeneration?

Programmable DNA cages are being explored for their potential to promote oral tissue regeneration by breaking the cycle of oxidative stress and inflammation in oral diseases.

Researchers at Sichuan University set out to find a solution to the harmful cycle of oral tissue damage whereby inflammation generates excessive reactive oxygen species (ROS), which further intensify inflammation and tissue destruction. They described this as a 'vicious cycle of sustained immunological activation and severe oxidative stress'.

One potential solution investigated by the team is a 'promising nanotechnology-based strategy' that uses pyramid-shaped DNA structures to absorb the damaging ROS molecules and deliver repair-promoting medicines to a precise location. Allowing delivery of molecules such as RNAs, antioxidants and bioactive peptides moves the treatment beyond symptom control and towards active regeneration.



The programmable shape of the DNA cages also allows them to be adapted to a range of therapeutic applications including recovery from periodontal disease, oral submucous fibrosis and some forms of jaw osteonecrosis.

DNA cages and dental treatment

The findings were published in a review in *Oral Science and Homeostatic Medicine*, considering previous studies that have employed DNA cages. In some animal models, the structures have reduced inflammatory or oxidative markers and improved measures of wound healing or bone repair.

The authors note that translating their findings into patient care presents questions around long-term safety, how and when the nanostructures are cleared from the body, and whether they can be produced consistently for clinical use.

The review calls for more detailed studies of how the DNA cages behave inside living tissues, alongside disease-specific designs, reliable manufacturing and safety investigations.

The researchers concluded: 'If these hurdles can be overcome, programmable DNA nanostructures may eventually provide a new way to treat inflammatory damage while helping oral tissues regenerate.'

General Dental Council opens annual renewal for dentists

The General Dental Council (GDC) has opened the annual renewal period for dentists.

To maintain their registration, dentists must pay their annual retention fee (ARF) of £720 and declare that they have appropriate indemnity or insurance cover in place by 31 December 2026. Dentists must also submit their continuing professional development (CPD) statement by 28 January 2027.

Renewal must be completed through MyGDC via www.gdc-uk.org, which replaced eGDC in March 2026. Dentists accessing the platform for the first time should use the email address linked to their former eGDC account and reset their password using the 'Forgot your password?' option. The regulator warned against creating a new account, as duplicate records could affect renewal.

Dentists must complete at least 10 hours of verifiable CPD in every two-year period and submit an annual statement, even if they completed no hours that year.

Those in the final year of their five-year cycle can apply for an eight-week grace period before 31 December if they need more time.

Dentists registered within the past 12 months will begin their first CPD cycle on 1 January 2027.

The GDC warned that missing renewal deadlines could result in removal from the register, leaving dentists unable to practise legally in the UK. A non-compliant CPD statement could also put their registration at risk.



Entry opens for NASDAL Dental Check by One award 2027

Entry has opened for the 2027 NASDAL Dental Check by One Practice of the Year award, recognising dental practices helping young children access preventive dental care.

Now in its ninth year, the award celebrates teams implementing the British Society of Paediatric Dentistry's (BSPD) Dental Check by One initiative, which aims to increase the number of children aged zero to two years accessing dental care. The winning practice will receive £1,000, a trophy and the right to use the title 'NASDAL Dental Check by One Practice of the Year 2027'.

Entries must be submitted before 5pm on Friday 5 February 2027 via nasdal.org.uk/awards.

Chief dental officer for England Jason Wong will present the award at BDIA Dental Showcase at London's ExCeL on Friday 5 March 2027.

Judges will consider creative approaches supported by qualitative or quantitative results, with particular credit given to applications from dental practices with evidence supporting their contribution to the overall health of their community.

NASDAL chair Heidi Marshall said: 'This award shines a light on something truly special: the difference dental practices can make to the lives of children and families in their communities. Every year, we are moved by the passion, imagination and sheer dedication of our entrants, who go above and beyond to give children the healthiest possible start in life.'

She added: 'But we also want to show that prevention and commercial success are not competing priorities.'

BSPD president Dr Rachael Nichol highlighted the importance of introducing children to dental care when their first tooth appears.

'Prevention is at the heart of everything we do, and the habits formed in those early years can shape a child's oral health for life,' she said.

She encouraged dental teams across the UK to enter and gain recognition for their work with young patients nationwide.



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ChloroStay 7-Day Mouthwash is a unique mouthwash, developed by a multi-disciplinary team at Queen Mary University of London. Unlike traditional mouthwashes that have a high initial chlorhexidine concentration but are quickly washed away in the mouth, ChloroStay provides low and sustained chlorhexidine release for up to a week.

When should patients use ChloroStay 7-Day Mouthwash?

To provide added protection in difficult to clean areas such as between teeth and around orthodontic appliances. Whenever compliance with a once-a-week regime is easier to achieve or supervise than a regime carried out daily, and for patients who have difficulty in effectively brushing their teeth.

For further information or to request a sample* of ChloroStay 7-Day Mouthwash, please call Schottlander on freephone 0800 97 000 79, email chlorostay@schottlander.co.uk, visit schottlander.com or chlorostay.com.

QUOTE **DENT26** TO REQUEST A SAMPLE

*Free samples are limited to 1 per practice. A GDC number is required before the sample will be sent. Subject to availability.

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Mouth cancer rise prompts calls for action on tobacco, alcohol and HPV

The Oral Health Foundation has called for stronger action on tobacco, alcohol and HPV vaccination after mouth cancer diagnoses in England rose by 40% in a decade.

Its new report, *Tobacco, Alcohol, HPV: Closing the Risk Factor Gap*, sets out 11 priorities covering prevention, earlier diagnosis and support after treatment. It also demands better access to NHS dentistry so patients at higher risk can receive advice and have concerning changes checked promptly.

NHS England figures cited in the report show 9,673 cases were diagnosed in 2024, up from 6,908 in 2014. Across the UK, 3,650 people died from mouth cancer in 2024, equivalent to 10 deaths a day. Dr Rachael England, head of policy and advocacy at the Oral Health Foundation, said: 'Rising mouth cancer cases demand stronger action on tobacco, alcohol and HPV. Telling people about the risks is not enough if they cannot get the support they need.

'People need practical help to stop using tobacco, stronger alcohol policies and accessible HPV vaccination. They also need timely access to a dentist or doctor when they notice a worrying change in their mouth.'

Tackling risk factors

The report recommends sustained funding for stop-smoking services, clearer referral routes and stronger tobacco controls, alongside support developed with South Asian communities for people using smokeless tobacco.

It also calls for a new alcohol strategy in England, minimum unit pricing and a timetable for labels carrying cancer warnings and drinking guidelines. England's alcohol strategy has not been updated since 2012, the report says.

Dr Giota Mitrou, executive director of research and policy at World Cancer Research Fund International, said: 'Whilst welcome progress has been made on smoking, action on alcohol continues to lag far behind. With alcohol linked to over a third of mouth cancer cases in the UK, this is unacceptable.'

On HPV, the report says more than a quarter of year eight girls and a third of boys in England were not vaccinated in 2024/25. It also recommends catch-up vaccination and targeted action in areas with the lowest uptake.

Supporting earlier diagnosis

For dental teams, the findings underline the importance of routine dental examinations: fewer than half of adults knew their dentist checks for mouth cancer during an appointment. The Oral Health Foundation is working with the Faculty of Dental Surgery, British Dental Association and British Association of Oral and Maxillofacial Surgeons to improve referral routes and coordination for patients with suspected mouth cancer.

Further recommendations include routine mouth checks for higher-risk adults, greater transparency on referral delays and a named government lead for mouth cancer prevention. The report was funded by Bupa Dental Care and endorsed by Oracle Head & Neck Cancer UK, the Mouth Cancer Foundation and The Swallows.

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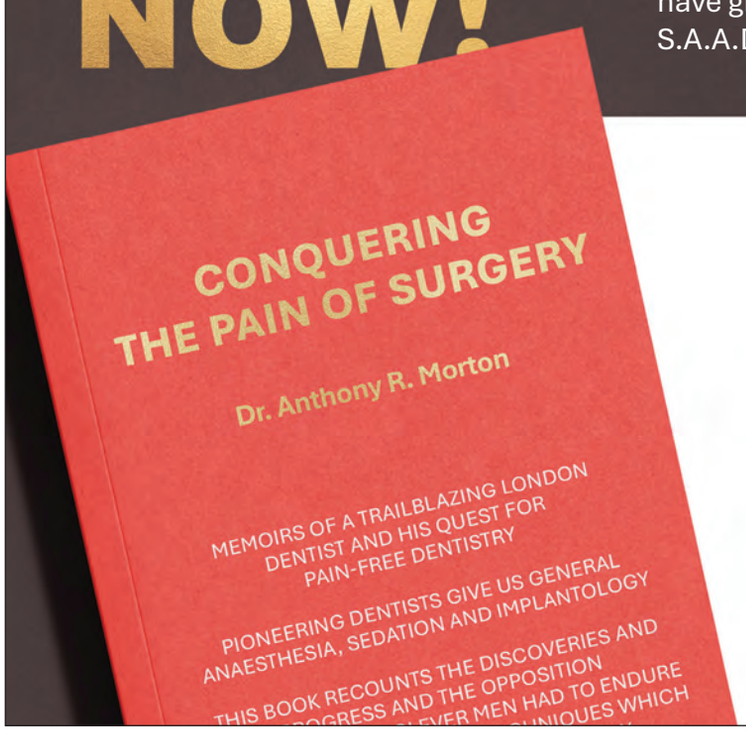

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Dentists struck off for falsifying documents

Two dentists have been erased from the General Dental Council (GDC) register after falsifying documents, including fabricated employment references and fake indemnity certificates.

In a hearing concluding on 29 September, the Professional Conduct Committee (PCC) said the first dentist had knowingly supplied fake Medical and Dental Defence Union of Scotland (MDDUS) indemnity certificates to the GDC. Proper indemnity cover was not in place for a period of approximately 15.5 months, with the dentist continuing to treat patients throughout.

Clinical failings were also



reported, such as inadequate assessment and treatment, not taking a necessary radiograph, insufficient discussion of treatment risks and benefits, and failure to obtain valid consent.

The committee also found that they failed to treat a patient with 'dignity and respect', with the patient describing the dentist as 'dismissive and belittling'.

Evidence of patient harm was given, as an open contact point left between teeth had caused 'inflammation, discomfort and pain from food packing'.

The committee determined that erasure with immediate suspension was the only appropriate sanction. It concluded that the dentist's 'dishonest behaviour towards his regulator, (their) blatant disregard of the GDC's rules and regulations as well as (their) lack of insight is incompatible with being a registered dentist'.

Falsified employment references

In a separate hearing earlier in September, the GDC also ordered the erasure of another dentist after they admitted falsifying employment references.

In 2023, a witness reported hiring the dentist after reaching out to two email addresses they provided as referees, receiving positive feedback on the candidate from both.

However, the PCC found that the email addresses were fake and, along with the responses, had been created by the dentist themself.

After the dentist had stopped working at the practice, the practice owner discovered that one referee's email address was incorrect. Both supposed referees then confirmed they had not supplied references.

The dentist admitted that this conduct was misleading, dishonest and lacked integrity. While the PCC acknowledged this remorse and some 'very difficult personal circumstances' when the misconduct occurred, it remained concerned that the clinician had not explained why they falsified the references.

Ultimately, the committee found that a lesser sanction than erasure with immediate suspension would not maintain public confidence or uphold professional standards.



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1. Schmidlin PR, et al. J Appl Oral Sci. 2016;24(1):31–36. **2.** Welk A, et al. Sci Rep. 2020;10(1):6819. **3.** Alkilzy M, et al. J Dent Res. 2018;97(2):148–154. **4.** Godenzi D, et al. J Am Dent Assoc. 2023;154(10):885–896.e9.

Nearly two thirds of whitening products tested exceeded peroxide limit

Almost two thirds of tooth whitening products in a targeted safety assessment exceeded the hydrogen peroxide limit for products sold directly to consumers, the UK product safety regulator has revealed.

The Office for Product Safety and Standards (OPSS) tested 70 products during 2025/26 and found that 45 contained more than the permitted consumer limit of 0.1% hydrogen peroxide. Its annual delivery report also revealed that imported tooth whitening goods valued at more than £1 million had been seized during the year.

Legal peroxide limits

When it comes to the legal limits:

- Products containing or releasing no more than 0.1% hydrogen peroxide can be sold directly to consumers
- Products containing more than 0.1% and up to 6% can only be sold to dental practitioners
- Whitening products containing or releasing more than 6% hydrogen peroxide are prohibited for cosmetic use.

OPSS said its online enforcement work had included engagement with major marketplaces such as Amazon, eBay, TikTok Shop, AliExpress, Meta and Fruugo.

It also worked with HM Revenue and Customs (HMRC), Border Force and fulfilment houses to identify non-compliant imported products.

It stressed that the assessment was deliberately targeted at products of concern.

Whitening products linked to £8.5 million fraud

The findings followed the imprisonment of two men who sold whitening products containing dangerously high concentrations of hydrogen peroxide while stealing value added tax (VAT) charged to customers. Ian Barnes and Alastair Ramage were jailed for a combined eight years and 10 months after an £8.5 million tax fraud.

Messages disclosed during the investigation showed that the pair knew customers had reported dental damage. The case was separate from the OPSS testing and seizures.

The British Dental Association said the prosecution demonstrated the need for regulators to act against illegal whitening products before patients were harmed, rather than relying on tax investigations to secure convictions.

Jonathan Meadows, managing director of Regulation Resolution Solicitors, said: 'What stays with me is that these men went to prison for unpaid tax, not for the harm. The damage only surfaced because a patient sat in a dental chair.

'That's where you come in. You are often the first to see the burns, the sensitivity, the lost enamel. Record it carefully. Ask where the treatment came from. Report it to the General Dental Council (GDC). Illegal whitening thrives because no single agency sees the whole picture. Your chairside notes might be the piece that's missing.'

Unsafe whitening products: what should be recorded?

- The product and brand name
- The batch or lot number, where available
- The ingredients and peroxide concentration shown on the packaging
- Where, when and from whom it was obtained
- How frequently and for how long it was used
- When the symptoms began
- Clinical findings, photographs and the treatment provided
- Advice given to the patient and any referral or follow-up arranged.

Advice and information for dental teams

Dental professionals may be among the first people to identify injuries caused by products bought online or supplied by an unregistered whitening provider.

The GDC requires dental professionals to maintain complete, accurate and contemporaneous patient records.

If a potentially unsafe whitening product has been used, dental teams should make a record and patients should be encouraged to retain the product, packaging, receipt and screenshots of the online listing.

Suspected unsafe consumer products can be reported through the Citizens Advice consumer service in England and Wales, Advice Direct Scotland in Scotland or the relevant district council in Northern Ireland. Reports can be referred to Trading Standards and escalated to OPSS.

Ectopic tooth found in upper eye socket thought to be world first

Doctors removed a mature canine tooth from the eye socket of a 16-year-old boy in an ectopic tooth case thought to be the first of its kind.

The patient presented at the Aravind Eye Hospital in Madurai, India, having first noticed a painless swelling in the upper left eyelid one month prior.

Examination revealed two hard, white projections that computed tomography scanning identified as a complete canine tooth. The crown-root structure was arising directly from the bone of the orbital eye socket.

'This is the first and only ectopic tooth reported in the superior orbit'

Surgeons removed the tooth, which did not show any signs of being part of a teratoma – a rare type of tumour that can contain complete tissues such as teeth, hair and bone.

It was therefore diagnosed as an ectopic tooth, whereby an otherwise normal tooth structure grows in the wrong location.

First reported case in the superior orbit

Dr Meghana Tanwar, co-author of the case, told *Live Science*: 'To the best of our knowledge this is the first and only ectopic tooth reported in the superior orbit.'

Ectopic teeth most commonly occur the maxillary sinus behind the cheekbone. However, developmental problems or genetic conditions can cause tooth tissue to grow anywhere – even outside of the mouth.

Once removed, an ectopic tooth generally does not grow back, though rare cases have been reported.

The case was published in *Opthalmology* in June 2026.

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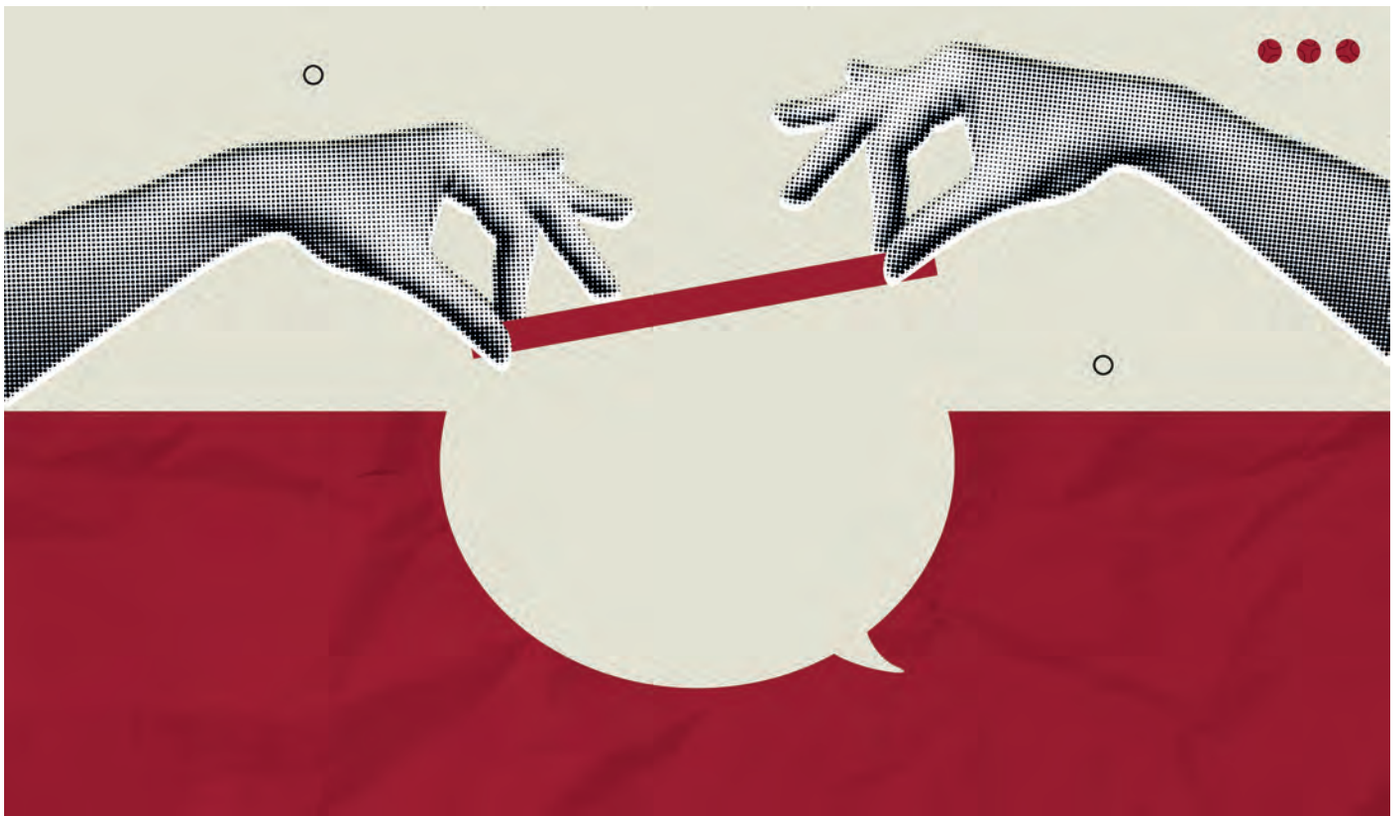


Whole-person care: where do we draw the line?

Debates about floss, interdental brushes and mouthwash risk overshadowing the person using them. Hafeez Ahmed makes the case for a broader approach to prevention, supported by meaningful dialogue, appropriate referrals and a clear understanding of professional boundaries

Hafeez Ahmed
BDS FDS MRD MSc MClinDent DGDP, periodontist

I think nowadays too much emphasis is placed on cleaning aids and mouthwashes when in essence the paradigm has shifted from treating the mouth to treating the person.

Part of the message in my recent article 'The therapy is in the flossing – not the floss', published in *Dental Health*, was about 'the person' over 'the aid'.

The article was also about the confusion around what is best for prevention against what is best for treatment. Worryingly, something changed about three years ago. I started getting the occasional phone call from a dental hygienist I share patient care with, who would say: 'Please can you stop telling my patients to floss'. It came as a shock.

The conversation would typically continue: 'Don't you know what the evidence says? It says interdental brushes are better than floss, so we must recommend these over floss'.

It transpired that most of the confusion was based around the S3-level clinical practice guideline 4.7 (Sanz et al, 2020) which did not suggest flossing. However, the context is missed by some professionals, as this guidance is for periodontal maintenance, not prevention. It is a treatment guideline for periodontitis.

That literature is about the role of flossing in Step 1-4 of periodontal therapy, not about its use in health for primary prevention, or in gingivitis management. That said, in respect to health and prevention, there is no good evidence to support the benefits of flossing, this does not mean flossing has no benefits – it means funds have not been available to produce the evidence.

This needs to change, for the sake of prevention, the evidence needs to be created.

Rethinking prevention

During my undergraduate training the emphasis of the preventive enterprise was to reduce the number of bacteria on the tooth surface and especially the dento-gingival crevice – it wasn't to reduce the overall number of bacteria in the mouth. These days, the talk isn't about reducing bacteria at all, but about shifting the balance towards health promoting bugs from pathogenic ones with increasing emphasis on mouthwash. It helps to

remember that mouthwash is an adjunct to mechanical disturbance, not an alternative. Over-reliance on it can potentially result in a range of iatrogenic ailments including digestive disturbance (Dagher and Hannan, 2019).

One of my preferences for offsetting the undesirable effects of having a 'sweet tooth' and a habit for sugary snacking is a piece of cheese (Herod, 1991; Kashket and Depaola, 2002). It also helps to remember that we are all technically born with 'soft teeth' – in that the enamel is hypomineralised when they erupt and it undergoes post-eruptive maturation upon exposure to the saliva (Crabb, 1976; Woltgens et al, 1981).

The shift from treating the mouth to treating the person is indeed a good one, however, it is adding to tensions that already exist in the profession, mainly over time constraints, professional competence, emotional exhaustion and feeling bullied (Malcom et al, 2020; Geisinger and Dershewitz, 2022).

When conversations get personal

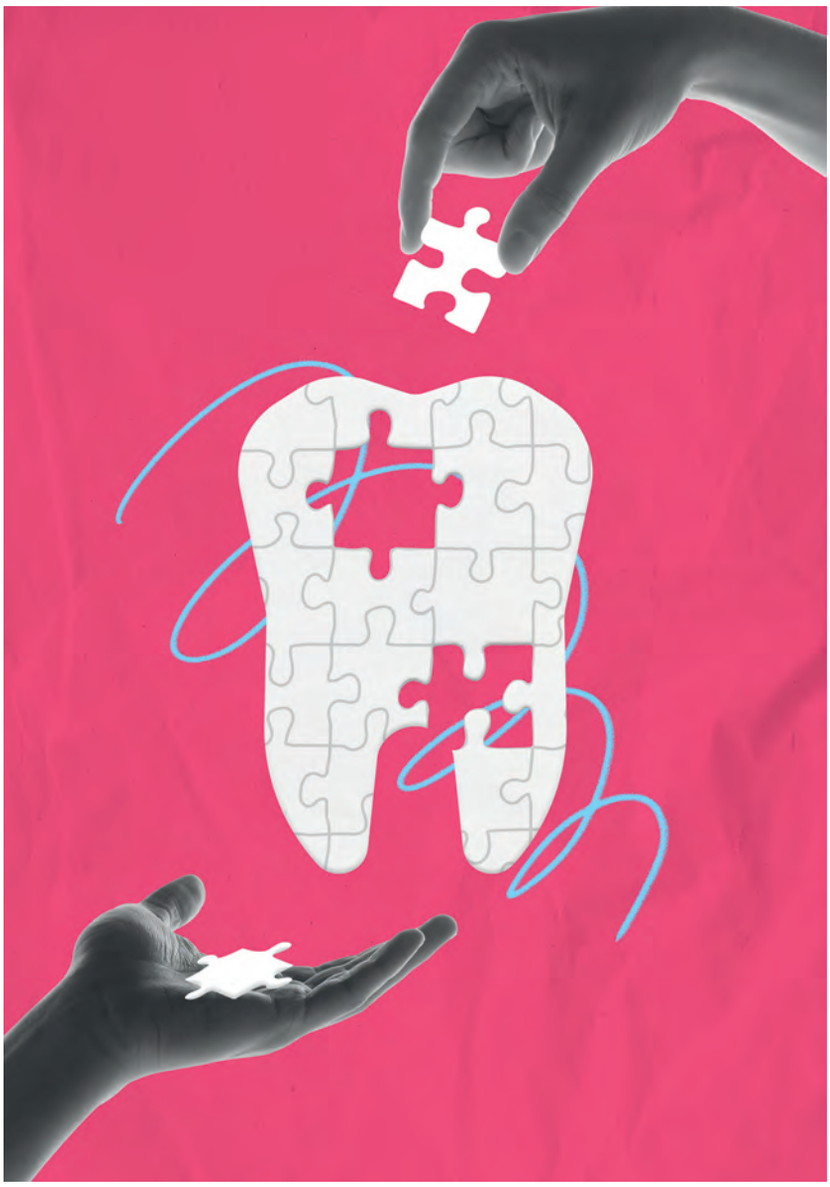
Often, discussions about poor oral hygiene drift into the topics of cigarette use, alcohol consumption and disruption to eating habits with a progressive move to emotional, mental, behavioural and psychological issues. Distress, anxiety, depression, irritable bowel, and chronic fatigue being relatively popular. Some patients believe these to be personal matters and don't appreciate the connections between dental health, mental health and general health.

The environment can quickly become uncomfortable with patients reluctant to continue discussing matters they perceive as unrelated to dental health – they find it intrusive and can become increasingly defensive and upset. If, and when, they do engage in a meaningful way it becomes significantly more time-consuming than simple conversations about the teeth, gums and the mouth.

As oral health professionals we are expected to work within our professional training and competence. In this respect, my formal training was largely limited to the teeth, the gums and the mouth. If a patient was ever to make a complaint about intrusive questioning, I would struggle to prove my competence in psychological, psychiatric or even general medical matters.

Classically, as primary care providers, we are required to identify potential causes and make appropriate referrals to discipline specific professionals. One obstacle is information on the ideology or experience of the individuals available for us to refer to isn't clearly stated. Additionally, professionals from other disciplines may be unaware of the links between their discipline and oral health (Bissett et al, 2013). This attracts further complaints from patients about mixed messages and inconsistent advice amongst professionals.

To add to this, it's worrying that one of the few things mental health professionals have agreed on is that they cannot agree on anything. Diagnosable mental health disorders have steadily increased from 106 in 1952 to 541 in 2022. This has prompted some mental health researchers to question if instead of continuing to fragment disorders there's more value in looking at the common dysfunctions shared across them (Foulkes, 2022). The most common dysfunction across disorders is anxiety and it helps to adopt a positive perspective on it.



Finding the right balance

The holy grail is in getting the balance right and, to this end, I've always remembered what one of my teachers said: 'It helps to pretend you know nothing about anything beyond the tooth'.

Another teacher told me: 'The easiest way to run a dental practice is by keeping patients in the dark'.

In essence, dentistry involves dispensing bad news – and this can be exhausting. My teachers had devised their own method of avoiding exhaustion, my preference is a 'shared dialogue' based on the patients' level of engagement; I make clear entries in the clinical record about what the patient has instructed me to avoid talking about.

In addition to this, I only ever make one recommendation and that is for the patient to see their medical doctor. With the recommendation I also advice patients that their doctor may make further referrals. In most cases, I highlight that other professionals may lack an awareness of the oral-systemic link.

In summary, the shift from treating the mouth to treating the person is a positive and important step forward. Although questions remain about roles, responsibilities, and interprofessional coordination, the direction is clear: oral health cannot be separated from overall health and wellbeing.

As oral health professionals, our challenge is to balance holistic care with professional competence, supporting patients through meaningful dialogue, appropriate referrals and evidence-informed practice. Done well, this approach can improve not only oral health outcomes but also the overall patient experience.

For the accompanying article references, email siobhan.hiscott@fmc.co.uk.

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Is NHS dentistry running out of road?

As political caution continues to shape NHS dentistry's future, Nigel Jones questions whether meaningful reform will arrive before the profession's patience runs out

Nigel Jones
Director, Practice Plan

Since 1990, I've been paying careful attention to the politics of UK dentistry and watched successive governments of all colours kick the NHS dentistry can down the road.

As frustrating as it has been to watch that continued failure to grasp the nettle, I have a degree of sympathy for any government trying to tackle deeply rooted problems that need long term solutions within the framework of an electoral system that encourages short termism.

'The clock is ticking and the ramifications of those contractual changes that will emerge in the new year may not make for comfortable reading'

This summer's Nuffield Trust report *The Great Extraction* spoke about the demise of NHS dentistry in England and how those that cannot afford to pay privately lose out most. I would hesitantly suggest that it is often those same people who find it hardest to access what NHS dental provision still exists locally as they get squeezed out by savvy patients who can afford to pay privately but wish to exert their 'right' to state subsidised dentistry.

The fear that such attitudes among motivated voters would manifest themselves at the ballot box must act as a deterrent to substantive action for any politician however much they understand what's needed.

Besides which, procrastinating has its advantages when it allows the service to be gradually privatised without an official policy announcement to that effect.

During one of the first conversations I ever had with a dentist, he put forward his view that what was happening to NHS dentistry amounted to constructive dismissal from the health service. For many, such thoughts still hold water today, 36 years later.

High risk, high reward?

There are signs that our new(ish) prime minister is, for now at least, willing to take the kind of difficult decisions that have scared off many of his predecessors. Even when linked to the funding of a national care service, announcing changes to the state pension triple lock is a bold move. Publicly floating the possibility of rejoining the EU is also politically high risk for obvious reasons.

The economic context in which such announcements have been made, including, for example, the probable need to provide targeted support for the looming exacerbation of the energy crisis, means we all know the answer to one of the questions posed by the Nuffield Trust about whether NHS dentistry will truly return to being a universal service.

The willingness of those savvy voters to, albeit often reluctantly, be maneuvered into paying privately for their oral care suggests that the Nuffield Trust's reference to a service stripped back to act as a safety net for the poorest and for groups like children and pregnant women is far more likely to be the ultimate destination.

The obvious challenge is how to navigate a way there that is quick enough and politically safe enough. The constructive dismissal route is arguably proving too slow and quietly damaging but working out how to accelerate the journey while minimising the political pain is not straightforward.

Buying time

Perversely, the wave of optimism that accompanied the election of Labour and the promise of the cavalry coming to save the day will have persuaded many in the profession to hang fire on plans to leave the NHS, temporarily slowing the drift to private.

That, at least, allowed the new administration to take stock of the situation and the government then bought itself more time with the contractual tweaks introduced in April and the promise of a consultation.

Furthermore, any significant announcements about the changes to NHS dentistry seem highly unlikely given the launch by the CMA of the market study into the provision of private dental services in the UK. It would be unwise to make public any meaningful reform intentions that could lead to a rapid expansion of the private dental market until it has been established it is working appropriately for consumers.

The statutory deadline by which the CMA must publish its final report, along with any remedies, is 4 March 2027.

That edges perilously close to the next general election so – at that late stage in the electoral cycle – the Association of Dental Groups (ADG) is likely to get its wish for incremental rather than fundamental contractual change.

However, the clock is ticking and the ramifications of those contractual changes that will emerge in the new year may not make for comfortable reading. The patience of NHS dentists, who have seen their health and wealth suffer trying to make NHS contractual arrangements work, is running out if September's survey by the BDA is anything to go by. There is only so much road left down which to kick that can.



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We frequently receive questions about the intraoral repair of porcelain chippings. To achieve success in repairs, it is essential to consider several important issues. Perhaps the single most crucial issue to recognise is why the chipping occurred in the first place.

Fundamentals of adhesion

Adhesive procedures can only be successful by using the proper substances and methods. Different kinds of surfaces often need different treatments for success. However, the three basic fundamentals of adhesion must be respected to achieve the best results.

1. Mechanical retention through a roughened surface.
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3. High energetic bonding surface allowing for optimal interaction (wetting capacity) between the surface and the applied medium. Contamination will lower the bonding capacities and must be avoided or removed in any case.



Types of fracture

The most frequent fractures are porcelain only and those that include exposure of the substructure in PFZ or PFM prosthesis.

When repairing porcelain chippings where the substructure is exposed, it is essential to be aware that multiple substrates are dealt with, indicating a need to adjust the repair protocol accordingly.

How should each surface be treated?

Clean the roughened fractured surface thoroughly. KATANA™ Cleaner is the product of choice. It is a safe and easy-to-use product with high cleaning power. It can be used both intra and extra orally on all kinds of dental substrates. After rinsing and thorough drying, the surface is ready for the next step, chemical activation.

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Every appointment counts

When it comes to mouth cancer, a routine appointment could save a life. Jocelyn Harding explores the dental team's vital role in mouth cancer detection and awareness

Jocelyn Harding
Dental hygienist and Mouth Cancer Foundation president

Dental professionals are often the first, and sometimes the only, healthcare workers to see inside a patient's mouth in any given year. That makes every appointment, whether a routine check-up, a hygiene visit or a quick review, a chance to detect changes or mouth cancer early, when survival chances are at their best.

The scale of the problem

The Oral Health Foundation's *State of Mouth Cancer UK Report 2024* shows a disease still on the rise.

A record 10,825 people were diagnosed in the UK last year, passing 10,000 for the first time. That compares with 8,864 the year before, and a 133% increase over 20 years.

Sadly, 3,637 people lost their lives to mouth cancer in the most recent figures – equating to around 10 people every day. In the previous report, the figure was 3,034 deaths, so the toll is climbing.

Mouth cancer resources

Further information about mouth cancer can be found at:

mouthcancerfoundation.org
dentalhealth.org/mouthcancer
dentistry.co.uk/tag/oral-cancer

Late diagnosis is a major reason survival has improved so little. The Oral Health Foundation has previously reported that just over half of cases are diagnosed at stage four, the most advanced stage.

Around 80% of the public cannot recall seeing any public messaging about mouth cancer, so people rarely know what to look for. That is where the dental team comes in.

Staying vigilant at every visit

Often, patients will not mention any symptoms or realise they matter. Asking directly – and documenting what you find – can make the difference.

Smoking and alcohol remain the biggest risk factors. Around two thirds of mouth cancer cases are linked to smoking, and people who both smoke and drink heavily face a risk around 30 times higher. Smokeless tobacco, betel quid, and vaping are also worth discussing. Every appointment is a chance to raise lifestyle habits sensitively and without judgement.

Human papillomavirus (HPV) is also a growing cause, particularly of cancers at the back of the throat, including the tonsils and base of the tongue. HPV-related cancers affect people who may never have smoked or drunk heavily, so they can be unexpected.

DENTISTRY IN FOCUS
MOUTH CANCER

Mention the HPV vaccine as part of prevention conversations with patients, and do not assume a 'low risk' patient has nothing to worry about.

Patients are your messengers

Patients talk. What you say in the surgery travels home to partners, parents, friends, and colleagues. When you explain why an ulcer that lasts more than three weeks needs checking, or recommend a particular toothbrush or interdental cleaning routine, those messages get passed on.

A patient who leaves understanding the warning signs may be the person who tells a neighbour to book an appointment about a lump they have been ignoring.

Make that easy. Offer leaflets, point patients to trusted resources, and encourage them to share what they have learned. The Mouth Cancer Foundation website is one such resource, with more than a million people helped by its information each year.

Mouth cancer can affect anyone, and the numbers show it is no longer a rare disease. Staying alert at every appointment could save a life. Check thoroughly, ask the right questions, talk openly about risk factors, and encourage patients to spread the word.



Mouth cancer screening: 10 easy steps

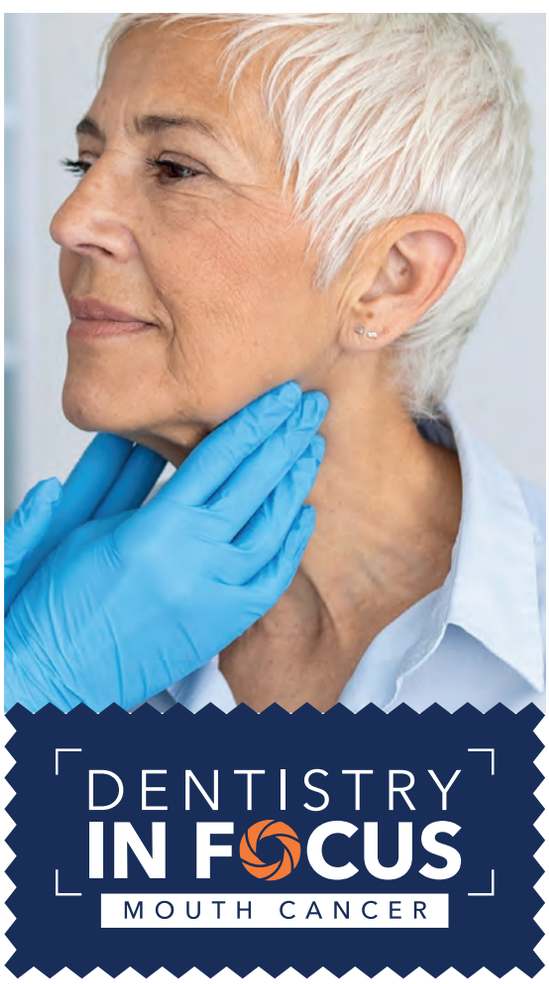
The Mouth Cancer Foundation shares its simple mouth cancer check

To help dental professionals standardise mouth cancer checks for all patients aged over 16 years, the Mouth Cancer Foundation has developed a simple checking protocol.

This comprehensive mouth cancer screening can be carried out in the dental chair using gloved hands, a mirror and good lighting. It takes less than two minutes to carry out a full head and neck cancer check.

Before the examination, communicate to your patient what you are doing and looking for. The time after the examination is ideal for giving appropriate advice to those at risk.

Importantly, confirm the test was performed in the clinical notes.



Download the Mouth Cancer Foundation's mouth cancer check in 10 easy steps at **mouthcancerfoundation.org/screening-by-a-dentist.**

1

Start of the mouth cancer check

- Inform the patient that you are going to do a mouth cancer check and that this will involve examination of their neck
- Gain informed consent
- Record notes if the patient declines to have the check.

2

Extraoral examination – step one

- Check for obvious swelling of the lips, face and neck.

3

Extraoral examination – step two

- Look for visible skin abnormalities on the lips, face and neck.

4

Extraoral examination – step three

- Palpate the lymph nodes in the neck for abnormal swelling.

5

Intraoral examination – step one

- Examine the right and left buccal mucosae and sulci.

6

Intraoral examination – step two

- Ask the patient to protrude their tongue to note any changes of the surface papillae or altered movement.

7

Intraoral examination – step three

- Using gauze, examine the lateral border of the tongue.

8

Intraoral examination – step four

- Assess the floor of the mouth and hard/soft palate. Ask the patient to say 'ah' to visualise the uvula, oropharynx, tonsils and pillars of fauces.

9

Palpation of tissues

- Palpate any visual tissue abnormality for presence of firmness.

10

Recording the findings

- Be descriptive to record any abnormality found (ie white patch, red patch, ulcer or swelling). If all tissues are normal, state 'no abnormality detected'.

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The golden ticket

For Ben Atkins, a tragic patient story became the catalyst for a safer, team-led approach to uncertainty, referral and follow-up. Here, he explains why every dental practice needs a system for the unexpected

Dr Ben Atkins
Dentist and Oral Health Foundation ambassador

Most dentists can remember a patient they will never forget. Not because of the dentistry they provided, but because of what the patient taught them. For me, that patient was John.

He was only 25 years old. Fit, healthy and with no obvious risk factors. He presented with what appeared to be a straightforward toothache. The radiographs were clear, the clinical findings did not quite fit the symptoms, and like many clinicians facing uncertainty, I hesitated to intervene. Eventually, after multiple visits, treatment was carried out and his symptoms initially settled. Then the pain returned.

A few months later, John died from cancer.

The tumour responsible for his symptoms had not originated in the mouth. His toothache was referred pain from a secondary tumour affecting the nerve supply to the tooth. By the time the diagnosis was made, the disease had already progressed beyond treatment.

For years, I carried that story with me. Eventually, I realised something important – medicine had not failed John. Cancer had beaten medicine.

But my business systems had failed to recognise and manage uncertainty. That distinction changed the way I lead teams forever.

From individual responsibility to team responsibility

Many practices have referral pathways. Most have protocols. Yet when something unusual presents itself, we often rely entirely on the individual clinician's judgement.

The problem is that people are fallible.

Systems are what protect patients when our instincts are challenged.

Following John's death, I developed what became known in our practices as the 'golden ticket' pathway. It was not a complex document. It was a practical process designed to identify patients who did not fit the normal pattern and ensure nobody was overlooked.

The pathway was built around four simple principles:

- The 21-day rule for ulcers, patches and swellings
- A nominated 'care captain' within every practice to monitor high-risk patients and ensure follow-up
- A five-minute pause that allows clinicians time to reflect when something does not feel right
- A team feedback process where every member of staff can raise concerns and contribute to patient safety.

None of these steps are revolutionary. What matters is that they happen consistently.

Saving a patient's life

One of the biggest leadership mistakes we make in dentistry is assuming that safeguarding health is purely a clinical responsibility. It is not.

Reception teams notice weight loss. Dental nurses spot changes in behaviour. Hygienists often spend more preventive time with patients than anybody else.

When practices create an environment where everyone has permission to speak up, remarkable things happen. One of the oral cancer diagnoses identified through our pathway originated from concerns raised during routine preventive care. The system worked because the whole team was involved, not because any one individual was exceptional.

Leadership is creating space

As clinical director, one lesson became increasingly clear. Patient safety is rarely improved by working harder. It is improved by creating space to think.

In a busy surgery, reflection is often the first casualty. Yet the most important decisions are frequently made when we stop, pause and ask ourselves one simple question: 'What if this is not what I think it is?'

Good leadership creates permission for that pause. Great leadership builds it into the system.

What is your golden ticket?

Your practice may already have excellent cancer referral protocols. That is not the challenge. The challenge is identifying the patient who does not fit the protocol. The patient whose symptoms seem odd. The patient who keeps returning. The patient everyone reassures because they do not fit the expected profile. Every practice has them. The real question is whether your team has a process to recognise them.

John's story was tragic. But his legacy lives on through every patient who is identified earlier, referred sooner and cared for more effectively.

As leaders, our job is not to create perfection. Our job is to build systems that catch what individuals might miss. That is the real golden ticket. And somewhere out there, it may save the life of somebody else's John.

The impact of mouth cancer at a glance

- 11,140 new cases are diagnosed in the UK each year
- The number of new cases has doubled over the past 20 years
- 66% of cases occur in men
- 67% of cases are diagnosed in people aged over 60
- The tongue is the most common site, accounting for 30% of cases, followed by the tonsils at 23%
- More than half of cases (55%) are diagnosed at stage 3 or 4
- In 2024, 3,650 people in the UK died from mouth cancer
- Deaths from mouth cancer in the UK have increased by 30% over the past 10 years.

Source: Oral Health Foundation

Mouth cancer resources

Further information about mouth cancer can be found at:

mouthcancerfoundation.org
dentalhealth.org/mouthcancer
dentistry.co.uk/tag/oral-cancer

Referral of urgent suspected cancer – getting it right!

Mike Lewis explores the dental team's role in recognising mouth cancer through systematic checks, clear records and timely referrals

Professor Mike Lewis
Emeritus Professor of oral medicine and Mouth Cancer Foundation chief clinical ambassador

The incidence of mouth cancer in the UK is progressively increasing each year and has risen from approximately 3,000 cases in 1984 to more than 10,000 cases last year. Unfortunately, despite advances in treatment that have improved the quality of life of sufferers, the overall five-year survival rate has remained the same at around 50%.

The size of the cancer at the time of initial diagnosis is the single most important factor that can improve the five-year survival. Tumours under 2cm in diameter with no spread to the neck (stage one) (Figure 1) can be treated relatively easily and are associated with an 80% five-year survival rate.

In contrast, larger tumours that are more than 4cm in diameter and have spread to the lymph nodes in the neck (stage four) (Figure 2) have a five-year survival of only 10%. Therefore, it is obvious that detection of a tumour when small in primary dental care combined with appropriate urgent referral to secondary care can save lives.

Every patient, every visit

All members of the dental team are trained to recognise soft tissue abnormalities in the head and neck. It's crucial to perform a mouth cancer check on every patient at every visit.

This can be completed in less than two minutes using the Mouth Cancer Foundation's 10 easy steps guide (a version of this can be found on page 21), which ensures a systematic assessment of the neck, face and mouth.

For the vast majority of patients, the check will reveal normal, healthy tissues, and this observation should be recorded in their notes. However, if an abnormality is detected then descriptive terms, such as ulcer, white patch, red patch or swelling, should be used to record the findings.

The term 'lesion' comes from the Latin word for 'injury' and as such should not be used in the notes since it has no descriptive benefit.

Any soft tissue change detected should be palpated to determine consistency.

As a generalisation, firmness reflects the presence of a tumour while softness to palpation represents a benign inflammatory condition.

'The term "lesion" should not be used in the notes since it has no descriptive benefit'



Figure 1: An ulcer 2cm in diameter affecting the tongue



Figure 2: Swelling 7cm in diameter with red/white surface mucosa

DENTISTRY IN FOCUS MOUTH CANCER



Figure 3: Ulcerated mucosa in lower third molar region



Figure 4: Unilateral swelling under right chin



Figure 5: Ulcerated swelling of the lip



Figure 6: Erythroleukoplakia affecting the tongue

Finally, it is best practice to take a clinical photograph of the affected mucosa. A decision then has to be made as to whether the patient needs to be either reassured of the absence of any sinister condition and simply kept under review or referred to a specialist on an urgent suspected cancer (USC) pathway.

Urgent suspected cancer guidance

Guidance on the clinical features that fulfil the criteria for a USC referral are freely available online as part of the Head and Neck Cancer toolkit (bda.org).

The National Institute for Health and Care Excellence (NICE) cancer guideline for use in England and Wales includes the following:

- Unexplained ulceration in the oral cavity lasting more than three weeks (Figure 3)
- A persistent and unexplained lump in the neck (Figure 4)
- A lump on the lip or in the oral cavity consistent with oral cancer (Figure 5)
- A 'red' or 'red and white' patch in the oral cavity consistent with erythroplakia or erythroleukoplakia (Figure 6).

In the guidelines for Northern Ireland and Scotland, there are additional 'red flag' factors, including a persistent hoarse voice, pain on swallowing and unexplained tooth mobility.

If the mouth cancer check indicates that a USC pathway is required then the patient should be informed that the examination has revealed a tissue change that is unlikely to be cancer, but it is advisable to get a specialist opinion. Therefore, an urgent referral needs to be made to the local oral and maxillofacial surgery or oral medicine service, who will arrange an assessment within two weeks.

It is important to reassure the patient that, overall, nine out of 10 USC referrals are found to be benign conditions.

The exact form for a USC referral and the process for its submission will depend on the geographical location of the patient and local regional NHS service. There are wide variations in the USC referral form and amount of information required, including the need for a photograph, within different areas of the UK.

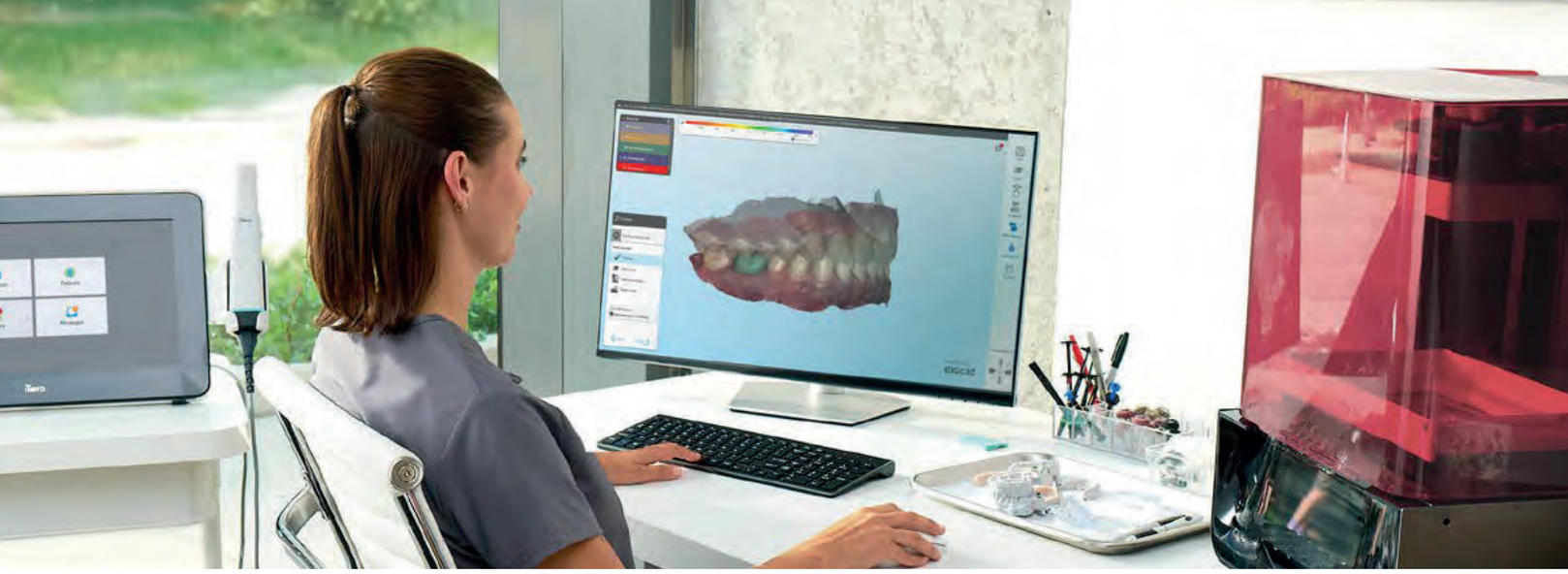
The staff within a dental practice should be aware of the local arrangements for USC referral for their patients.

Improving knowledge

The confidence to differentiate a tissue change that suggests malignancy or alternatively represents a benign condition comes with clinical experience. Misinterpretation of a benign condition and an inappropriate USC referral causes unnecessary anxiety for the patient and increases pressure on secondary care clinics.

All dental professionals should undertake continuing professional development on the subject of mouth cancer. The Mouth Cancer Foundation provides a comprehensive resource of information to help dental professionals recognise mouth cancer. The charity is also a source of educational material for use by patients, particularly in November, which is Mouth Cancer Action Month in the UK.

Dental professionals should feel at ease discussing cancer with patients and routinely perform the check for mouth cancer. Any patient found to have an abnormality that fulfils the criteria for USC should be referred appropriately.



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How to screen for mouth cancer

DENTISTRY IN FOCUS MOUTH CANCER

Ciro Gilvetti and Andrew Osafo review the signs and symptoms of mouth cancer and explain how to perform a mouth, head and neck cancer examination

Dr Ciro Gilvetti
Specialist oral surgeon

Dr Andrew Osafo
General dentist

November is Mouth Cancer Action Month – a campaign that aims to raise awareness of mouth cancer to enable people to become 'mouthaware' and save lives through prevention and early detection. Are you planning to take part in this year's Mouth Cancer Action Month?

Although November is Mouth Cancer Action Month, as dental professionals we should be continually raising awareness of mouth cancer. We are in a prime position to educate the public about this devastating condition.

Mouth cancer is a serious and debilitating disease that can devastate – and prematurely end – lives. Our actions can, therefore, help save lives.

Consequently, the aim of this article is to review the signs and symptoms of mouth cancer and discuss how to perform a mouth cancer examination.

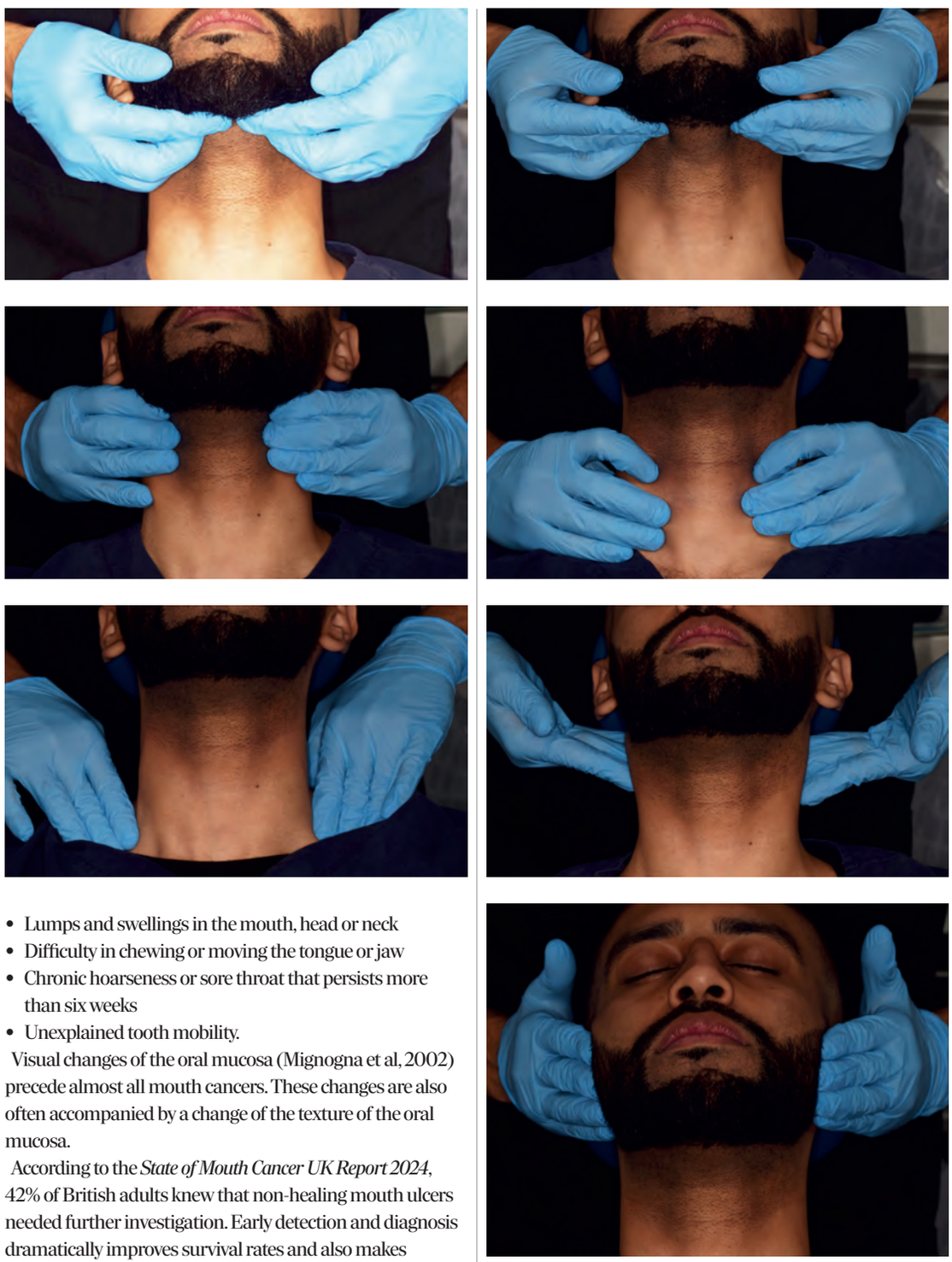
Sign and symptoms

The signs and symptoms of mouth cancer include:

- Persistent pain in the mouth
- White or red patches in the mouth
- A sore or ulcer in the mouth that does not heal within three weeks
- Lumps and swellings in the mouth, head or neck
- Difficulty in chewing or moving the tongue or jaw
- Chronic hoarseness or sore throat that persists more than six weeks
- Unexplained tooth mobility.

Visual changes of the oral mucosa (Mignogna et al, 2002) precede almost all mouth cancers. These changes are also often accompanied by a change of the texture of the oral mucosa.

According to the *State of Mouth Cancer UK Report 2024*, 42% of British adults knew that non-healing mouth ulcers needed further investigation. Early detection and diagnosis dramatically improves survival rates and also makes treatment and rehabilitation easier.



Figures 1-7: Head and neck examination

Mouth, head and neck cancer screening

The Mouth Cancer Foundation recommends dental professionals carry out a mouth, head and neck screening on every patient over the age of 16 at least once a year.

For a thorough, systematic mouth cancer examination, dentists require a pair of gloves, good lighting and gauze. The screening is divided into two components: extraoral and intraoral.

Extraoral examination

During the extraoral exam, the head and neck are visually inspected for any signs of asymmetry, scars or lumps or skin abnormalities (Figures 1 to 7).

It is important to look, listen and feel every area examined.

Examine the neck one side at a time or both sides contemporary. Apply gentle pressure with two fingertips to identify any asymmetry or indurated lump.

It is generally started at the level of the submental nodes, moving to the submandibular then upper middle and lower cervical area.

Supra clavicular, posterior cervical and the parotid glands are also inspected and palpated. These areas are also referred as levels I to VI.

Intraoral examination

Before starting the intraoral examination, remove all dentures.

Conduct the oral cavity examination with mirrors or the clinicians' fingers as retractors. Fingers allow the clinician to not only visualise the oral mucosa but also feel if there are any area of induration within the soft tissue or changes of texture of the mucosa.

Pull the lower lip downward and the upper lip upward and manipulate with the thumb and index finger (Figures 8 to 10).

Pull the right and left buccal mucosa away one side at a time to allow the inspection of the retromolar area and the upper and lower vestibule (Figures 11 and 12).

The tongue is thoroughly inspected, as it is the most common area of mouth cancer presentation. The use of a white gauze is extremely helpful as it allows clinicians to stretch the tongue to both sides to inspect lateral borders and ventral area of the tongue (Figures 13 to 17).

'For a thorough, systematic mouth cancer examination, dentists require a pair of gloves, good lighting and gauze'

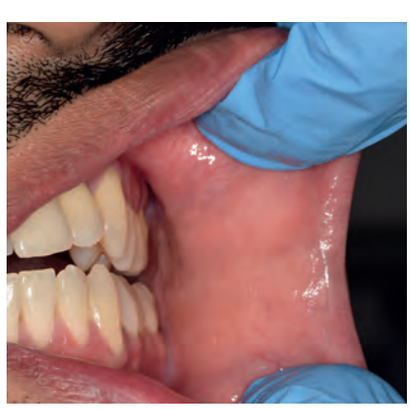






Figures 8-10: Lip examination





Figures 11 and 12: Buccal mucosa, retromolar area and upper and lower vestibule

Mouth Cancer Action Month: ways to get involved

- Brief staff. Hold a short team meeting on warning signs, patient concerns and local referral and cessation pathways
- Explain examinations. Tell patients when you are checking for mouth cancer and discuss key symptoms and risks
- Share campaign resources. Use posters, self-check sheets, waiting room screens, newsletters and social media to reinforce the message
- Wear a blue ribbon. Give team members a Blue Ribbon Appeal badge to show support and encourage conversations
- Reach beyond the practice. Run an awareness session with a care home, homeless shelter or community group, or share a short video using #MouthCancerAction
- Plan for Blue Wednesday. On 18 November, wear blue, share self-check advice or light up the practice. Encourage local landmarks and public buildings to join in and explain the campaign.



Figures 13-18: Tongue examination – dorsum, lateral borders, ventral, tip of tongue

Floor of the mouth

The floor of the mouth is another area of the oral cavity at high risk of cancer presentation. Use the index finger to lift the side of the tongue and explore the mucolingual fold and floor of the mouth.

Use one or two fingers of each hand for the bimanual palpation of the floor of the mouth, also trying to gently compress between them the floor of the mouth and the neck to look for lumps and fixed lesions.

Gingival tissues are generally inspected visually during the manipulation of the lips and inspection of the buccal mucosa. Ask the patient to lift the tip of the tongue to allow visual inspection of the ventral area of the tongue and the roof of the mouth (Figure 18).

With a gentle yet firm pressure of one finger to the dorsum of the tongue, also ask the patient to say 'ahhh' to expose the posterior wall of the oropharynx and the tonsillar area for inspection (Figure 19).

Ask the patient to lift their chin to inspect the roof of the mouth (Figure 20).

You can also use dental mirrors to inspect areas of the oral cavity that are difficult to examine directly like the lingual and the maxillary tuberosity.

Suspicious areas

If any unusual findings are discovered during the examination, a review appointment should be made two weeks after the initial examination.

Record the size, shape, colour, texture and the position of the suspicious areas. It is also a good idea to take clinical photographs of the area of concern.

The oral mucosa generally

Mouth cancer: signs and symptoms

- Persistent pain in the mouth
- White or red patches in the mouth
- A sore or ulcer in the mouth that does not heal within three weeks
- Lumps and swellings in the mouth, head or neck
- Difficulty in chewing or moving the tongue or jaw
- Chronic hoarseness or sore throat that persists more than six weeks
- Unexplained tooth mobility.



Figure 19: Oropharynx and the tonsillar area

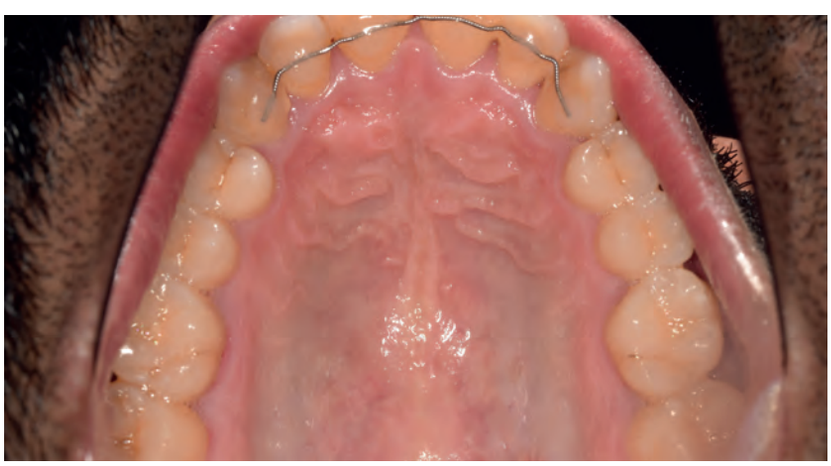


Figure 20: Roof of the mouth

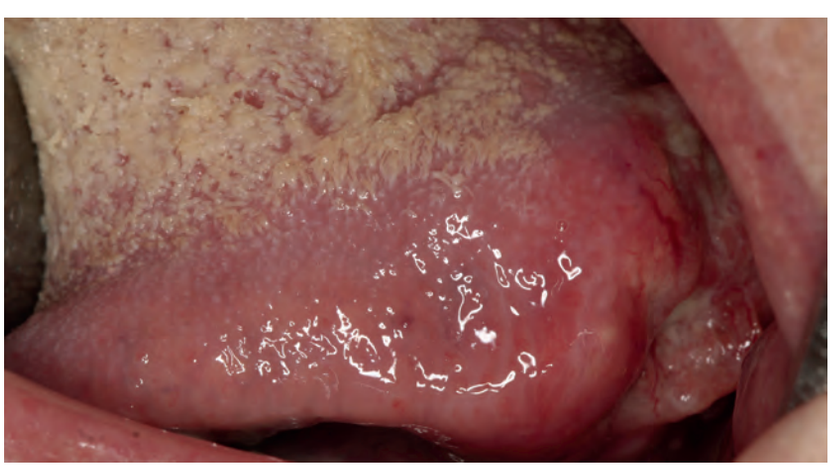


Figure 21: Ulceration of tongue (left side) with raised and rolled borders

heals itself in two weeks. Refer the patient for further investigation if the suspicious areas are still present at the review appointment.

Refer highly suspicious lesions (Figure 21) urgently under the two weeks wait referral pathway.

A thorough systematic mouth, head and neck examination can be completed in less than two minutes. The Oral Health Foundation and Mouth Cancer Foundation have produced videos that show a mouth, head and neck examination taking place. We encourage you to watch these videos, which can be found on their websites.

It is also vital that we inform our patients of the risk factors of mouth cancer, which include tobacco use, heavy alcohol use, excessive sun exposure to lips, human papillomavirus, a history of cancer and a weakened immune system.

Self-examination

A number of organisations recommend self-examination for mouth cancer. The Mouth Cancer Foundation launched Bite Back at Mouth Cancer, providing a head and neck cancer check that can be carried out by anyone, at any time.

The self-examination should be carried out ideally once a month.

The *State of Mouth Cancer UK Report 2024* revealed that 71% of British adults have never checked their mouth for signs of cancer. The report also showed that only 9% of adults conduct a check once a month.

‘Early detection results in a 90% survival rate, compared to 50% in late detection of mouth cancer’

Conclusion

Our goal should be to detect mouth cancers before our patients present with symptoms.

Early detection and diagnosis of mouth cancer dramatically improves survival rates and also makes treatment and rehabilitation easier. It is well documented that early detection results in a 90% survival rate, compared to 50% in late detection of mouth cancer.

Systematic and regular screenings therefore save lives.

Taking part in Mouth Cancer Action Month is an excellent way to help raise awareness of this devastating condition. To find out more, visit dentalhealth.org/mouthcancer and mouthcancerfoundation.org.

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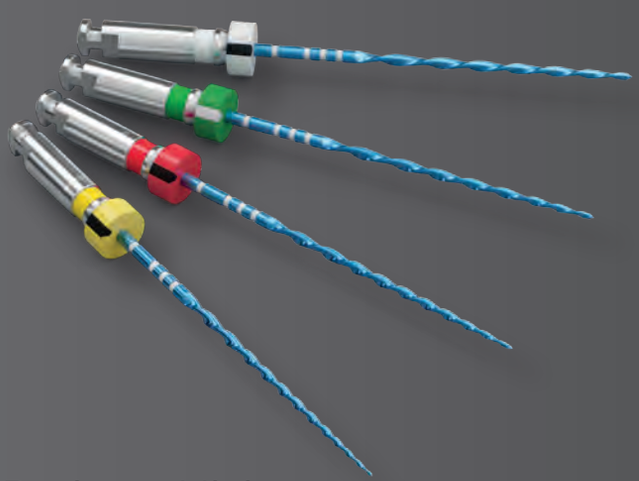

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Early class III correction

Maï-Linh Tran presents a case report detailing class III correction using early orthopaedics

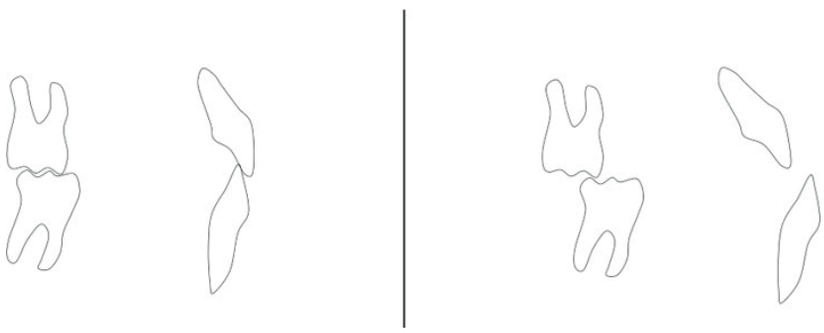


Figure 1: Class I occlusion (left) and class III malocclusion (right) as described by Angle. An anterior crossbite is often reported in class III cases



Figure 2a: Initial pre-treatment photo, side view

Maï-Linh Tran
Specialist orthodontist,
Happy Kids Dental

Skeletal class III is a rare skeletal discrepancy consisting in a retrusive maxilla relative to the mandible. Its prevalence is estimated between 1 and 6% of the population, and it is most often associated with an anterior crossbite and a family history (Figure 1).

Early class III correction in the mixed dentition aims at improving jaw growth, restoring facial harmony, simplifying treatments and decreasing the need for maxillary surgery. It also has psychosocial benefits and helps boost patient confidence during school years.

Case report

A seven-year-old female patient presented with a hereditary skeletal class III, a moderate class III malocclusion, and an anterior crossbite. Her initial overjet was reversed (-2mm) and her overbite was reduced (-1mm) (Figures 2a and 2b). The Index of Orthodontic Treatment Need (IOTN) in her case was initially 3b.

The goals of the interceptive treatment were:

- To stimulate the growth of the upper jaw
- To limit the growth of the lower jaw
- To correct the overjet and the overbite.

Treatment options

Orthopaedic correction of the skeletal discrepancy can be undertaken between the ages of six and 11 years.

The appliance of choice is an extraoral Delaire protraction facemask with a forehead rest and a chin pad (Figure 3a).

Heavy orthopaedic forces (400g) are applied to the maxilla thanks to extraoral elastics anchored to a rapid maxillary expander (RME) (Figure 3b). The elastics should be worn 14 hours a day (at home and at night) for up to 12 months. Other functional appliances have been described with various degrees of success.

Bone anchored maxillary protraction has been proposed as an alternative for patients aged 11 to 14 years old. Skeletally anchored miniplates are fitted in the infrazygomatic region in the maxilla and in the canine region in the mandible and support intraoral class III elastics (Figure 4). This alternative has shown results comparable to the facemask as it reduces the need for orthognathic surgery by approximately 30%.

In the permanent dentition, the therapeutic options are limited and include conventional orthodontic treatment with or without extractions, orthognathic surgery, or a combination of both.



Figure 2b: Initial pre-treatment scan. The initial overjet was -2mm and the initial overbite was -1mm

In the absence of treatment, unfavourable jaw growth is to be expected; functional, soft and hard tissue concerns could arise, and psychosocial risks should be taken into account.

Treatment plan and chronology

Treatment was planned as follows:

1. Fit of the RME and facemask
2. Maxillary protraction with elastics (400g/side, 14 hours a day)
3. (Over-)correction of the overjet and overbite
4. Retention and monitoring of growth
5. Phase II in the permanent dentition.

Results

After 12 months of treatment, the skeletal pattern evolved from a class III (ANB=-2°) to a class I (ANB=2°). The mandibular growth was redirected downward and backward (initial FMA=22.6°, final FMA=24°) (Figure 5).

A positive overjet of 3.7mm was achieved (versus -2mm initially).

Occlusion wise, the patient now has a near Angle class I molar relationship (Figure 6). Her IOTN is 2e.

A functional removable retainer was given to her to maintain the results. The retainer is designed to maintain the posterior position of the lower jaw relative to the upper. It should be worn at night until the full permanent dentition.

Close monitoring of her lower jaw growth is planned, with follow-up appointments to be scheduled every six months, as some overjet relapse can usually be anticipated in such cases.

A second phase of orthodontic treatment will be considered after all permanent teeth have erupted.



Figure 4: Bone anchored maxillary protraction (source: Nguyen, 2011)

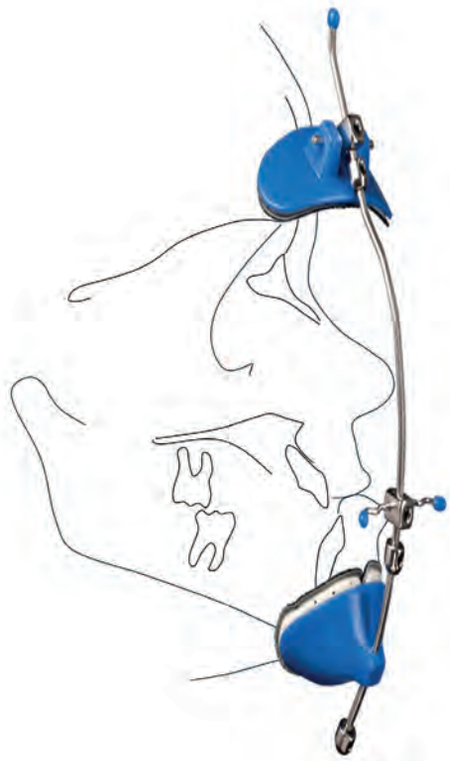


Figure 3a: Delaire protraction facemask

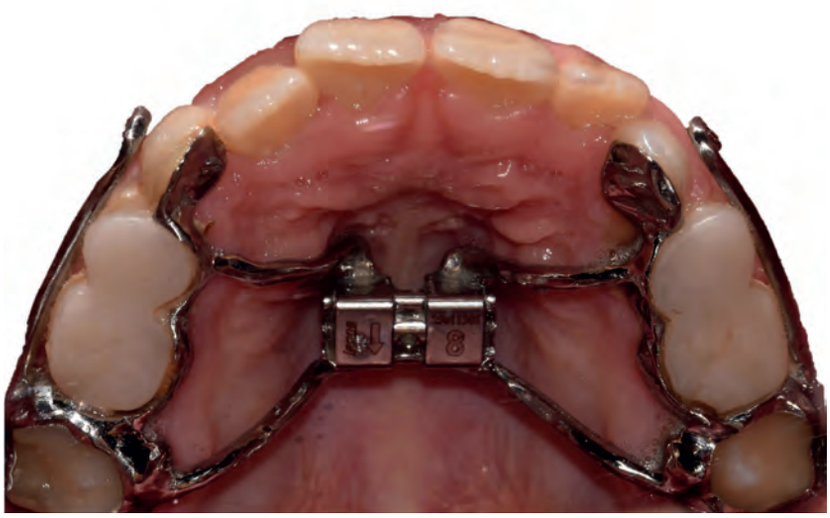
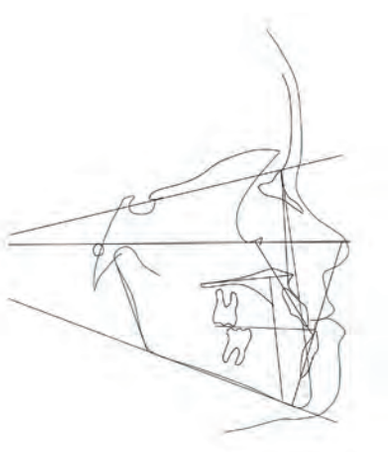


Figure 3b: Rapid maxillary expander





Figures 5a and **5b:** Initial cephalometric X-rays and analyses

Conclusion

This young patient's case is an example of what can be obtained in class III cases with interceptive orthopaedics and optimal patient compliance.

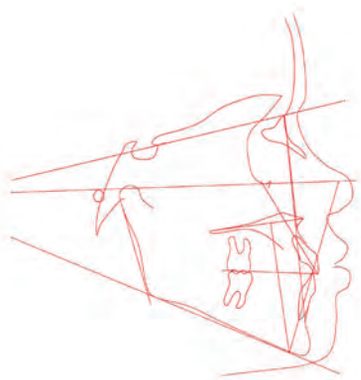
Patient compliance is often excellent in the mixed dentition. Within 12 months, skeletal growth modification and dental correction were achieved (Figure 7).

Early treatment reduces the need for complex orthodontic and/or orthognathic treatment in the future.

In case of unfavourable mandibular growth, surgery remains an option at the end of growth, but studies have shown that this outcome will be considered in only a third to a quarter of the patients who benefited from facemask therapy.

In any case, visible changes in the soft tissue and facial aesthetics can have a very positive psychosocial impact both for the child and the parents during preadolescent and adolescent years.





Figures 5c and **5d:** Final cephalometric X-rays and analyses. The ANB angle and overjet are now positive



Figure 6a: Final post-treatment photo, side view



Figure 6b: Final post-treatment records. The final overjet was 3.7mm and the final overbite was 2mm

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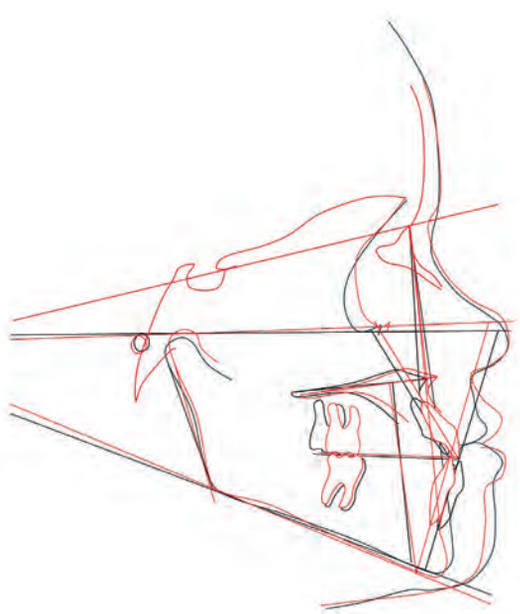

Figure 7: Superimposition of the initial and final records. Note the harmonious profile with better upper lip support


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Rebuilding a smile and restoring confidence

Hussain Rashid takes a patient from failing crowns and active disease to a confident, natural smile, using composite restorations to restore function, aesthetics and long-term stability

Dr Hussain Rashid
Restorative dentist,
Crescent Lodge Dental Practice

Comprehensive rehabilitation of a compromised dentition calls for careful sequencing, disease control before any definitive work, and restorative materials that combine aesthetics with longevity.

Where a patient presents with active periodontal disease, caries and failing restorations, the temptation to move quickly to the cosmetic result must be resisted in favour of a staged and biologically sound approach.

The following case shows how a structured treatment plan, stabilisation of the periodontal tissues, and the use of BRILLIANT EverGlow (COLTENE) delivered a result that transformed the patient's confidence.

Patient background

A 57-year-old man attended the practice having been self-conscious about his smile for many years.

Over the previous two years, he had explored several treatment options, including a consultation abroad where full-coverage crowns were recommended across the arch. He was eventually referred to me by a patient who had seen the results achieved for another individual with similar concerns. Clinical examination revealed poor oral health, with widespread inflammation, generalised plaque accumulation and multiple active carious lesions. There was significant periodontal involvement with bone loss, alongside several failing crowns. Establishing health, rather than simply replacing the existing restorations, was the priority from the outset.



Figure 1: Before and after: smile view



Figure 2: Before and after: retracted anterior view



Figure 3: Before and after: right lateral view



Figure 4: Before and after: lateral view following alignment and restoration

Assessment

Full-mouth radiographs were taken to assess the extent of decay and the periodontal bone levels.

Two failing root canal treatments were identified at the UR4 and UL4, both requiring retreatment, and the UL4 was found to have internal root resorption.

The diagnosis was periodontal disease with associated bone loss, and the patient was referred to the hygienist.

The mild to moderate gum disease was stabilised over a six-month period before any restorative work began. Spacing on the lower anterior teeth was also noted and incorporated into the planning stage.

Treatment planning

A detailed, staged treatment plan was prepared, setting out each phase of work alongside the associated costs and clinical photographs. The patient referred back to this plan throughout treatment, and it played a central role in building his confidence in the process.

The plan prioritised periodontal stabilisation, followed by endodontic retreatment and caries management, before progressing to alignment and the final restorative phase.

Crucially, spaces on the lower anterior teeth were to be managed orthodontically and then closed with composite rather than crowns, keeping the approach minimally invasive.

Treatment

The functional phase began with periodontal stabilisation, supported by interdental brushing and a thorough oral hygiene regime. Endodontic retreatment was carried out on the UR4 and UL4, with caries removal and management across the UR4, UR5, UL4, UL6, LR6 and LR7.



Figure 5: Lower anterior composite build using a greater curve band

On dismantling previous restorative work, interproximal caries was found that had not been fully apparent radiographically.

Once the carious lesions were stabilised and the periodontal condition was settled, the patient progressed to 14 months of clear aligner therapy. This was used deliberately to create controlled spaces on the lower anterior teeth, which were then closed with direct composite to achieve an even, natural result.

BRILLIANT EverGlow was used for the lower anterior composite work from the LR3 to the LL3, and on the upper centrals to mask exposed dentine, with the upper lateral spaces also shaped using the material. Emax crowns were placed on the UL4, UR4, UR5 and UR6, and an Emax veneer on UR2.

For the lower composite veneers, BRILLIANT EverGlow Bleach (BL) shade was selected for its exceptional and long-lasting lustre, its broad and natural shade range, and its ability to retain a high shine without the need for repolishing.

Retainers were provided at the end of treatment and the patient continues to wear these.



Figure 6: Before and after: full face portrait

Outcome

The patient was delighted with the outcome, becoming emotional on the day the lower restorations were completed. He described the result as life-changing.

His own words, recorded after treatment, capture the difference it made: 'For years I was conscious of my smile and never showed my teeth in photographs.

'From the moment I walked into the practice in Clapham it felt different. Hussain spent a full hour with me and produced a treatment plan that set out every stage with the costs and photographs, and I glanced back at it throughout for reassurance. He is extremely conscientious, and his assistant Cinthia made the whole process a joy.

'I cannot stop smiling or showing off my new teeth, and I am absolutely over the moon with the results.'

The case demonstrates how a disciplined, health-first sequence combined with a high-performance composite can deliver an aesthetic result that genuinely changes a patient's quality of life.

The long-term gloss retention of BRILLIANT EverGlow means the lower anterior restorations should maintain their appearance without repeated polishing, supporting both the aesthetic outcome and the longevity of the work.

This universal submicron hybrid composite is engineered for highly aesthetic, long-lasting restorations. Its filler composition produces a smooth surface with a satin shine straight after placement, reducing the polishing burden, and it is noted for excellent gloss retention over time.

The Duo Shade system allows a single shade to cover two VITA shades, supporting both single-shade and layered restorations, while its sculptability and form stability make it convenient to handle in both anterior and posterior work.

Case appraisal and learning points

This case reinforced the value of investing time at the planning and stabilisation stages before any definitive restorative work.

Controlling the periodontal disease and managing caries first created a stable foundation, and using aligner therapy to engineer spaces for composite closure allowed a minimally invasive result where crowns might otherwise have been used.

For colleagues approaching similar comprehensive cases, my advice is to prioritise health, communicate the plan clearly and visually, and select restorative materials that combine handling, aesthetics and durability.

Hussain runs hands-on courses for general dentists focused on predictable direct composite work, from anterior bonding and diastema closure to posterior restorations. Combining clinical reasoning with practical workshops, delegates leave with the confidence to apply the same staged, health-first approach to their own patients.



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Made in Sweden

Restoring harmony

Javier Bobes Bascarán, Clare Perrell-Jones and Mark Sinclair detail a digital-analogue workflow for a peg lateral restoration

Dr Javier Bobes Bascarán
Multidisciplinary clinician

Dr Clare Perrell-Jones
Private dentist

Mark Sinclair
Ceramist, Nexus Dental

The patient arrived at the clinic with a primary aesthetic complaint regarding the UL2. The tooth was a 'peg lateral' – conically shaped and undersized – which created disharmony in the smile due to both its form and shade mismatch with the adjacent dentition. The patient was also concerned about the tooth showing signs of getting discoloured.

After a comprehensive clinical assessment, various treatment options were evaluated and discussed with the patient, including:

1. Immediate post extraction with ridge preservation and immediate restoration
2. Bonded bridge, mechanical risk increases as per tooth wear. Could be used as temporary solution if not enough primary stability or if fail to integrate at some point.



Figure 1: Initial situation, smile view



Figure 2: Initial situation, side view

The patient desired a fixed, long-term solution that would correct the architecture of the smile. Following the patient's approval, an intraoral scan was taken and sent to the laboratory to begin the digital planning phase.

Challenges

Treating a peg lateral in the aesthetic zone presents a set of clinical and technical difficulties that require a meticulous multidisciplinary approach. The primary challenge in this case involved managing the limited mesiodistal space while attempting to create an ideal emergence profile that mimics the morphology of a natural tooth.

Furthermore, the patient presented with an enlarged gingival contour with zenith very distal and an awkward tooth shape that complicated the transition between the restoration and the surrounding soft tissue.

Achieving a predictable outcome was further hindered by limited bone availability, requiring precise 3D positioning during immediate implant placement to preserve the buccal bone plate and ensure screw-retained restorability. This precise positioning was made more difficult by a complex insertion path necessitated by the proximity of adjacent teeth. Ultimately, seamless coordination between the clinical workflow and the laboratory's digital design was essential to ensure that both the surgical guide and the provisional restoration were prepared and verified for use on the day of surgery.

Technical work and planning

The digital workflow began with the virtual extraction of the peg lateral on the Exocad software. Dental technician Andy Rippon performed a digital diagnostic wax-up to define the ideal shape and volume of the future crown.

Once the design was finalised, the laboratory printed the model. A vacuum-formed retainer was fabricated over this printed model (covering the adjacent teeth for stability). On the physical model, the peg tooth was removed.

A temporary crown was 3D printed using SprintRay Resin based on the digital design and positioned into the vacuum-formed retainer. This provisional was designed to be picked up intraorally on a standard stock abutment.

The palatal aspect of this setup (temporary crown and vacuum retainer) was opened. This modification transformed the appliance into a dual-purpose device: a positioning matrix for the temporary and a visual surgical guide for the dentist.

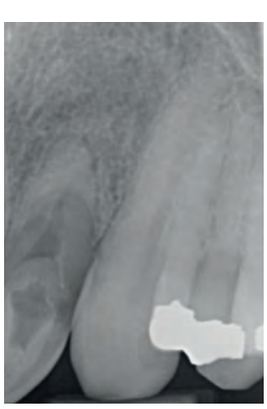

Figure 3: Initial X-ray

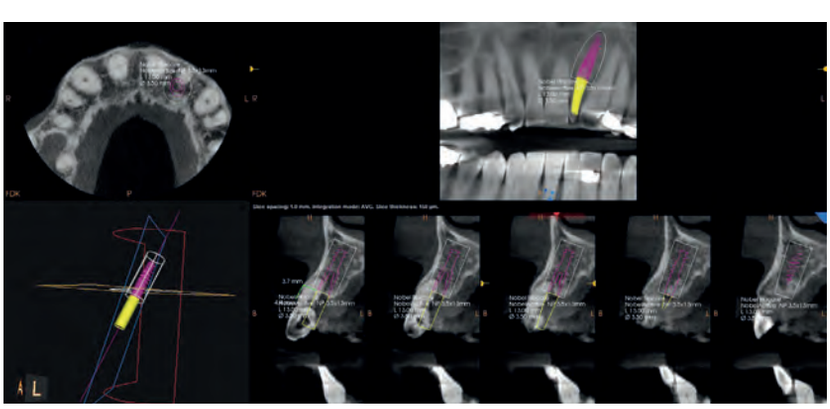

Figure 4: Initial situation, CBCT

Surgical phase and immediate loading

On the day of surgery, the patient's peg lateral (UL2) was a traumatically extracted to preserve the buccal bone plate.

On the day of surgery, the peg lateral (UL2) was extracted atraumatically to preserve the buccal bone plate and integrity of the soft tissues.

The custom transparent vacuum guide was initially seated without the temporary crown to facilitate the preparation of the osteotomy. The transparency of this appliance was invaluable, as it allowed for direct visualisation to ensure the implant was placed in the correct, prosthetically driven position.

A Nobel Biocare N1 TiUltra TCC NP (3.5 x 13mm) implant was placed using a biologic osteotomy preparation (low RPM and no irrigation), achieving primary stability with an insertion torque exceeding 35N/cm using both the motor and a manual wrench.

Upon final seating, the implant was in a satisfactory position.

Following the 'one time, one abutment' concept to promote stable healing, a Nobel Biocare N1 Base Xeal TCC NP (1.75mm) intermediate abutment was seated and torqued to 20Ncm as per manufacturer instructions.

This grade IV anodic titanium surface treatment is designed to enable 'mucointegration', which helps the soft tissue bond to the abutment and minimises biological disruption to the site.

The emergency contour of the base, slim, flat and perfectly sealed connnection, allowed to achieve an ideal emergence profile following the 'EBC zone concept'.

For the immediate loading phase, a temporary abutment Nobel Biocare N1 Base NP was secured. The laboratory-fabricated temporary shell was then 'picked up' intraorally using flowable composite to bond it to the temporary cylinder.

A 15N/cm was applied with the Angle Screw Channel system with the Omnigrip M driver. The screw access hole was protected with Teflon and flowable composite. To manage the jumping gap and support long-term bone stability, the buccal void was carefully filled with a xenograft with 10% of collagen (Nobel Creos Xenogain, 250mg).

Once the position was captured, the screw was loosened and the entire complex was removed. The

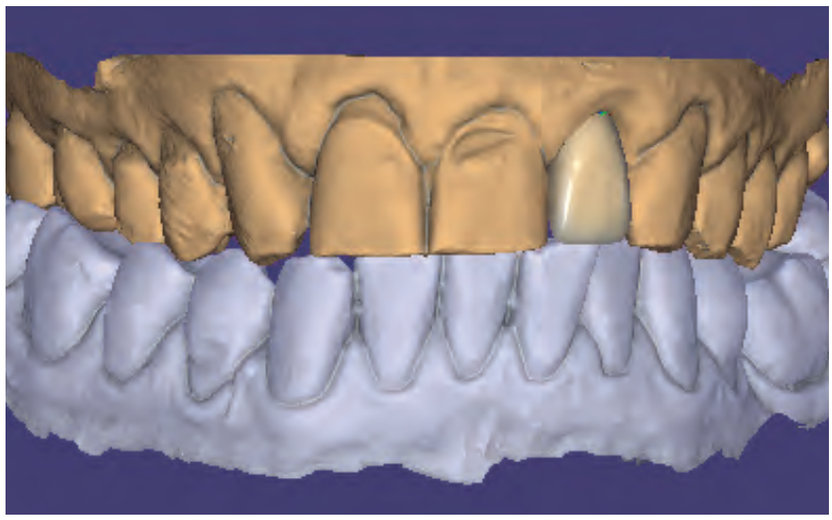

Figure 5: Digital wax-up/design



Figure 6: Vacuum-formed retainer and 3D printed crown in place



Figure 7: Vacuum form retainer/crown with access hole

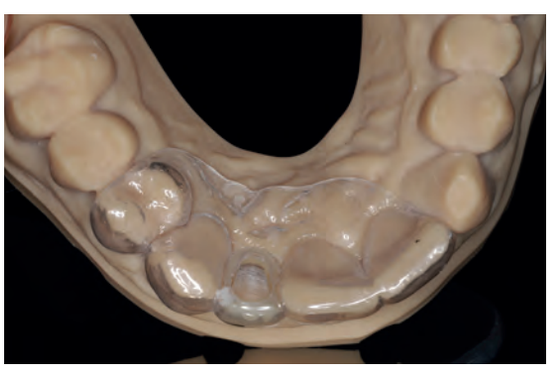

Figure 8: Vacuum form retainer without crown on the model



Figure 9: Extracted tooth (UL2)



Figure 10: Tooth socket

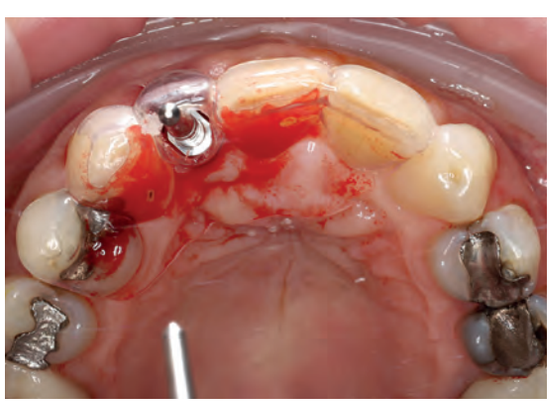

Figure 11: Implant position in line with retainer hole – incisal view



Figure 12: Implant position in line with retainer hole – side view. Implant driver indicates the direction, note the vertical line indicating an implant wall facing towards the buccal. Horizontal lines indicating depth

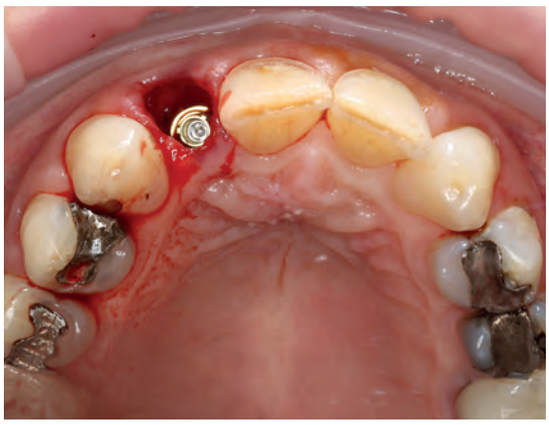

Figure 13: Implant position towards the palatal side, maintaining a jumping gap of at least 2mm to accommodate the bone graft



Figure 14: Temporary cylinder



Figure 15: Temporary cylinder with retainer/3D printed crown in place to initiate bonding



Figure 16: Occlusal image with visible bone graft on the buccal side

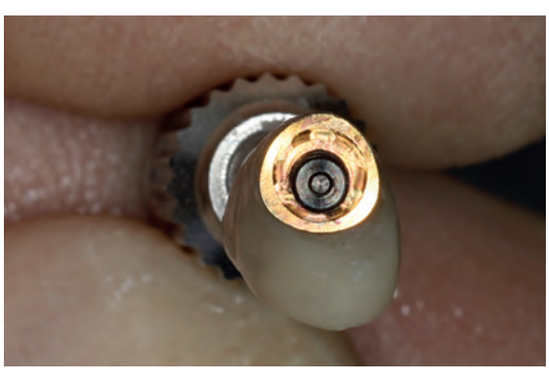

Figure 17: Temporary abutment connection and 3D printed crown fully bonded with initial emergence profile



Figure 18: Temporary crown in place



Figure 19: 17-day control appointment

critical step of contouring the emergence profile was performed extraorally to ensure an ideal biological transition. Following the EBC (straight, concave, convex) principles described by Ramon Gomez Meda and colleagues (2021) composite was added to fill the gap and smooth the transition between the cylinder and the crown.

This specific contouring ensures a profile that supports the soft tissue while protecting the graft and surgical site. At this stage, it was agreed with the patient that the gingival margin would be kept slightly higher to remain in line with the neighbouring teeth.

Significant space was intentionally left for soft tissue recontouring, allowing the final architecture to be entirely prosthetically driven.

‘The result was aesthetically pleasing and functionally sound’

The final restoration

The patient returned for a follow-up 17 days after surgery.

Ten weeks post-surgery, following successful soft tissue maturation, where zenith and tooth axis showed some improvement already.

During this 10-week appointment, a comprehensive radiographic review was conducted to verify the clinical success of the treatment. These radiographs confirmed the stable osseointegration and the maintenance of the

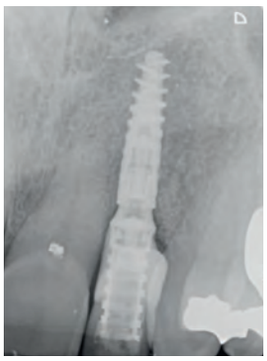

Figure 20: 10-week X-ray for bone density evaluation

buccal bone plate during the healing phase, providing the necessary clinical clearance to proceed with the final crown fitting. Back at the laboratory, the final restoration was designed using Exocad (Figure 17).

For this case, a Universal Abutment Nobel Biocare N1 was selected to support a zirconia crown with a cervical collar highly polished for optimal gingival response allowing adhesion of the soft tissue and buccal cutback to allow dental technician Mark Sinclair room for aesthetic depth and correct translucency.

Final product and reflections

The zirconia crown was seated, achieving a seamless integration with the natural dentition (Figures 21 and 22). The patient was delighted with the transformation, particularly the correction of the tooth shape and the natural appearance.

From a technical and clinical perspective, this case highlights the efficiency of combining digital planning with analogue surgical support, specifically the modified vacuum-formed guide. The result was aesthetically pleasing and functionally sound.

There is a slight loss of volume on the distal papilla

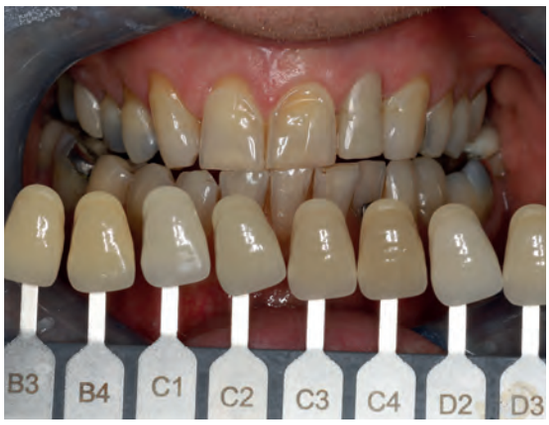

Figure 21: Shade taking



Figure 23: Final crown in place, smile view



Figure 25: Layered zirconia implant crown (18-month follow-up)

in line with the initial situation. A connective tissue graft would help to increase the volume available for a more ideal recontouring of the gingival margin and profile. In this particular case, considering the patient expectations, we do not deem necessary.

Every case should begin with a thorough assessment of both the hard and soft tissues, alongside careful evaluation of dental morphology, including tooth size, shape, shade and position. A multidisciplinary approach is therefore central to modern implant dentistry. This includes appropriate implant selection, biologically driven materials and designs, a stable implant-abutment connection and respect for the tissues when developing the ideal emergence profile.

Close collaboration and direct communication between the surgeon, restorative dentist and dental technician remain the gold standard for achieving the most natural result possible. This is particularly important – and often more challenging – in the anterior region, especially when restoring a single tooth.

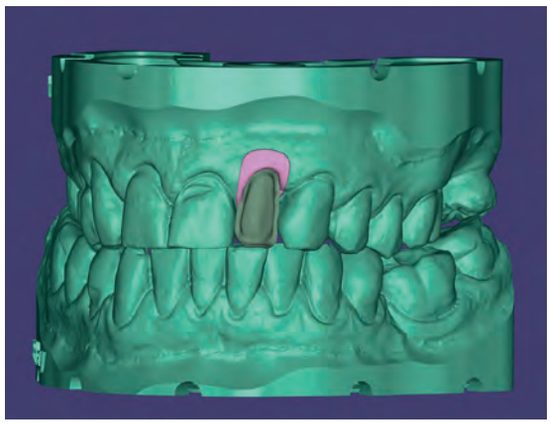

Figure 22: Digital design of crown with buccal cutback



Figure 24: Side view



Figure 26: Crown in situ (18-month follow-up)



Figure 27: Soft tissue after crown removed (18-month follow-up)

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Opening doors to oral health research: one year on

From mentoring to training and networking, the NIHR-supported incubator in oral health research is helping more dental professionals get involved in research. One year after its launch, Zoe Marshman, Chris Vernazza and Clare Bartlett explore its progress, the barriers clinicians face and what comes next

Professor Zoe Marshman
Incubator co-lead, NIHR senior investigator and professor of dental public health, University of Sheffield

Professor Chris Vernazza
Incubator co-lead, head of school of dental sciences and professor of oral health services, Newcastle University

Dr Clare Bartlett
Incubator project manager, University of Sheffield

What is the incubator in oral health research?
The incubator for oral health research is supported by the National Institute of Health and Care Research (NIHR) to build capacity in policy-relevant oral health research across the UK.

The incubator was launched in July 2025 and is supported by a broad steering group of members, including primary dental care dentists, dental care professionals, clinical academics, consultants, specialist societies, plus representatives from industry, policy and patient groups.

The incubator aims to identify barriers to oral health research, and develop and support an inclusive and diverse oral health research community with the right skills to address key unanswered research questions for the future.



Figure 1: Advanced specialist dental technician Becki Van Der Land (North Cumbria Integrated Care Trust) is an early career researcher. She was awarded a bursary from the incubator to attend the BSODR conference in Manchester in September 2026, where her abstract won a poster prize

What key achievements have the incubator made in the first year and what are its upcoming plans?
Since the incubator's launch last year, it has a growing mailing list of more than 300 people, with workshops and training events, a webinar series for academic foundation trainees and support for those early in their research careers to present at the British Society of Oral and Dental Research (BSODR) conferences and interact with policymakers at the Office of the Chief Dental Officers' Scientific Conference.

Additionally, the incubator has raised the profile of research within Dental Schools Council and influenced NIHR to fund more oral health research projects.

What have you learned during the first year that has surprised you most about the barriers dental professionals face when trying to get involved in research?
Jennie Ross, who is a general dental practitioner from Sheffield, has analysed information from more than 40 dental professionals.

Some of the barriers were as expected, including lack of opportunity, time and funding. It was often chance encounters that opened peoples' eyes to what research roles existed, the opportunities available to diversify their careers and impact patient care on a wider scale.

We are hoping the incubator will raise the awareness of research so that many more dental professionals recognise its benefits and have the chance to be involved.

'There is good evidence that patients have better outcomes when they have care from providers who are research active'

Why does increasing research participation among clinicians working in primary dental care matter, and what could their involvement add to the evidence base?
As most dentistry takes place in primary care, taking part in research in primary care means clinicians can contribute to the evidence-base where the findings are going to be more relevant for more patients.

They can help investigate which treatments work best and thereby improve outcomes for patients. Indeed, there is good evidence that patients have better outcomes when they have care from providers who are research active.

Dental professionals have told us how rewarding it can be to feel to be advancing knowledge more widely beyond their daily roles providing care for individual patients.



Figure 2: Incubator co-leads Professor Zoe Marshman and Professor Chris Vernazza and project manager Dr Clare Bartlett at the BSODR Conference

Can you share an example of how the incubator has already helped an individual, team or research idea progress?
Already, the incubator has provided advice and informal mentorship, it has supported more than 20 individuals to attend their first dental conferences and has helped link individuals with research ideas with teams who have the expertise to conduct the projects.

We have also worked with funders of research to increase the priority given to funding oral health research.

What are the biggest unanswered questions in oral health that you believe research should be prioritising over the next few years?
In 2018, an exercise was run by a patient organisation called the James Lind Alliance to prioritise the top 10 research areas.

The top priority areas then were:

- How best to prevent dental diseases such as dental caries and periodontal disease
- To promote early detection of oral cancer
- How to improve dental access, communication and interprofessional working.

The incubator has plans to run a new prioritisation exercise so we have agreement of where researchers should be directing their efforts in future.

For a dental professional interested in research but has no academic background or does not know where to start, what would you encourage them to do first?
We would recommend anyone who is interested to sign up for the mailing list and put themselves on the oral health research map.

By joining the mailing list, they will receive an introductory pack that details where to begin. It includes information on getting involved with oral health research, training and networking events, funding opportunities, organisational updates and exciting oral health news.

It is also a good idea to make links with experienced researchers and discuss with them where you might like to start – the incubator can help put people in touch with colleagues working nearby or in a similar field.

As part of the incubator, interviews have been conducted with dental professionals and academics to determine barriers to research and potential solutions to overcome these. As a result of these interviews, over the next year, the incubator plans to develop a series of 'How to...' guides, training workshops and work closely with other organisations including policymakers to make a list of priority research areas.

Put yourself on the oral health research map!
A new oral health research directory has been launched, which aims to build collaborations across the UK. It maps individuals involved in oral health research to allow those with shared research interests, geographical locations and experience to connect plus it will form the foundation of a mentoring scheme.

To add your profile to the directory and search for others that you would like to connect with, visit oralhealthdirectory.sheffield.ac.uk.

To find out more about the incubator, visit **sheffield.ac.uk/dentalschool/research/themes/transforming-oral-health/incubator** or email **oralhealthincubator@sheffield.ac.uk**.

Dentistry Top 50

Dentistry Top 50
Professor Zoe Marshman – one of the UK's leading researchers in children's oral health, whose work has shaped national policy and prevention programmes – is on this year's Dentistry Top 50.

Contributing to landmark National Institute for Health and Care Research-funded studies, including the BRUSH programme, she has provided the evidence underpinning the expansion of supervised toothbrushing initiatives across England, influencing policy makers to turn research into preventive reality.

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‘You have to believe in yourself’

In the latest Stateside Session, Sam Saleh reflects on opening his Rodeo Drive practice with no patients and no reputation in Los Angeles

Sam Saleh
Cosmetic dentist

I was in my 20s. I had no patients. I had no history. And I came and took on probably the most expensive real-estate rental you could take on as a doctor.

I was always curious about the idea of living in LA and practising dentistry in LA. We’d been coming out to LA ever since I was a child, so when I got the call saying there was a space available on Rodeo Drive, it was a full circle moment.

But it was a huge risk. All the doctors in the neighbourhood were saying: ‘It’s going to fail any minute now.’ They were almost waiting for it not to work. Everyone close to me told me: ‘You’re crazy. This is a big mistake.’

But I believed in myself. I believed in my passion. I believed in my vision.

Were there times when I felt like we weren’t going to be able to make it? Yes, 100%.

But we just worked through it and, 25 years later, I’m still here. I’m still enjoying what I’m doing. I have a pretty good reputation. So, I think it’s testament to the fact that ultimately you have to believe in yourself.

I was expecting this ‘wow’ moment. I was expecting a little bit more than what I saw.

When I first came out here, I was a little underwhelmed by what I was seeing in other offices. I did a lot of work experience and tagged along in a lot of places.

I had this vision in my mind of how it should be, and I thought that was what was already there. When I noticed it wasn’t, I trusted my own intuition and my own inner voice.

You have to be 400% passionate about it to get someone to buy into it. You’ve got to bring the energy at such a high level that other people then feed into your enthusiasm.

Honestly, I think we’re getting to a place where having an in-house lab is going to be the standard of care for aesthetic dentistry.

If you want to practise aesthetic dentistry and you want to be consistent with it, having that direct relationship with your ceramist is a must. It’s a necessity: it’s such an integral part of what we do on a daily basis.

I’ve been working with my ceramist in the office for coming up to a decade now. I can’t imagine working in an environment where I wouldn’t be able to directly refer back to the ceramist working on the case and give feedback in real time. I just can’t fathom how you would do it.

We really have an international patient base now.

A lot of our patients don’t live in London, so they travel to come and see us. One patient came from Jakarta, another was travelling from Monaco. Each patient has their own specific aesthetic – their own nuances that you have to cater to. I think that’s what keeps it exciting for me as a clinician.

A lot of our patients have multiple residences, so they’re based in lots of locations.

One patient was travelling with his fiancée and came for a consultation while they were in LA. He decided to proceed with treatment, but after LA he was going to Europe.

It just so happened that it worked with my schedule.

I was able to start the first stage of treatment here in LA, then we created the final porcelain and delivered it in Europe. So we were able to stay on the same path around the world.

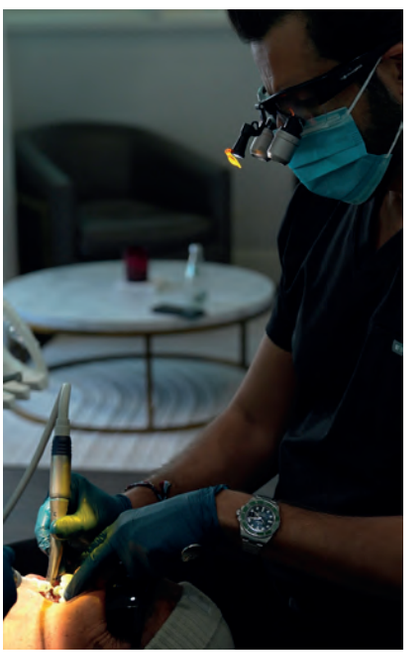


‘Be authentic. If you’re good at something, work harder at becoming better at it’









The exciting part of practising in London and LA is that I get to experience life in both places.

I'm a proud King's graduate and London will always be home for me. I typically travel out there about once a month, so I touch base with London often.

Travel can be tiring, so if you don't do a lot of the self-care, look after yourself, eat right, sleep and recuperate, then it can be really tiring. But I've put myself into a strict regimen where I focus on getting to bed on time and sticking to a routine that travels with me. That way, my body kind of stays within the same circadian rhythm.

When you practise in different countries, there are always slight nuances between the two settings. It keeps you on your toes, keeps you fresh and, most of all, keeps the profession exciting.

Once you have a voice and you have a platform, the onus is on you to provide the work.

I think today it's easier for young dentists than it was when I started, and that should give them some peace of mind.

Social media was not a viable option for expanding a practice back then. It was through hard work, and there were a lot of barriers. If you wanted media coverage, that wasn't the way it is today.

But today, you can do good work and post it on your social media for free, and you can attract a group of people who will follow you. Your following can grow. So I strongly urge all the young guys to embrace that. I feel that it's such an integral part of having a voice.

Once you have that platform, the onus is on you to provide what it is that you're telling people you can do for them.

Be authentic. If you're good at something, work harder at becoming better at it. That will become your natural edge because people will then be drawn to whatever it is that you do better than the average person.

Dentistry x Pasted

To watch the full Stateside Session with Sam Saleh and Alan Clarke, scan the QR code or visit **bit.ly/4ipybQf**.

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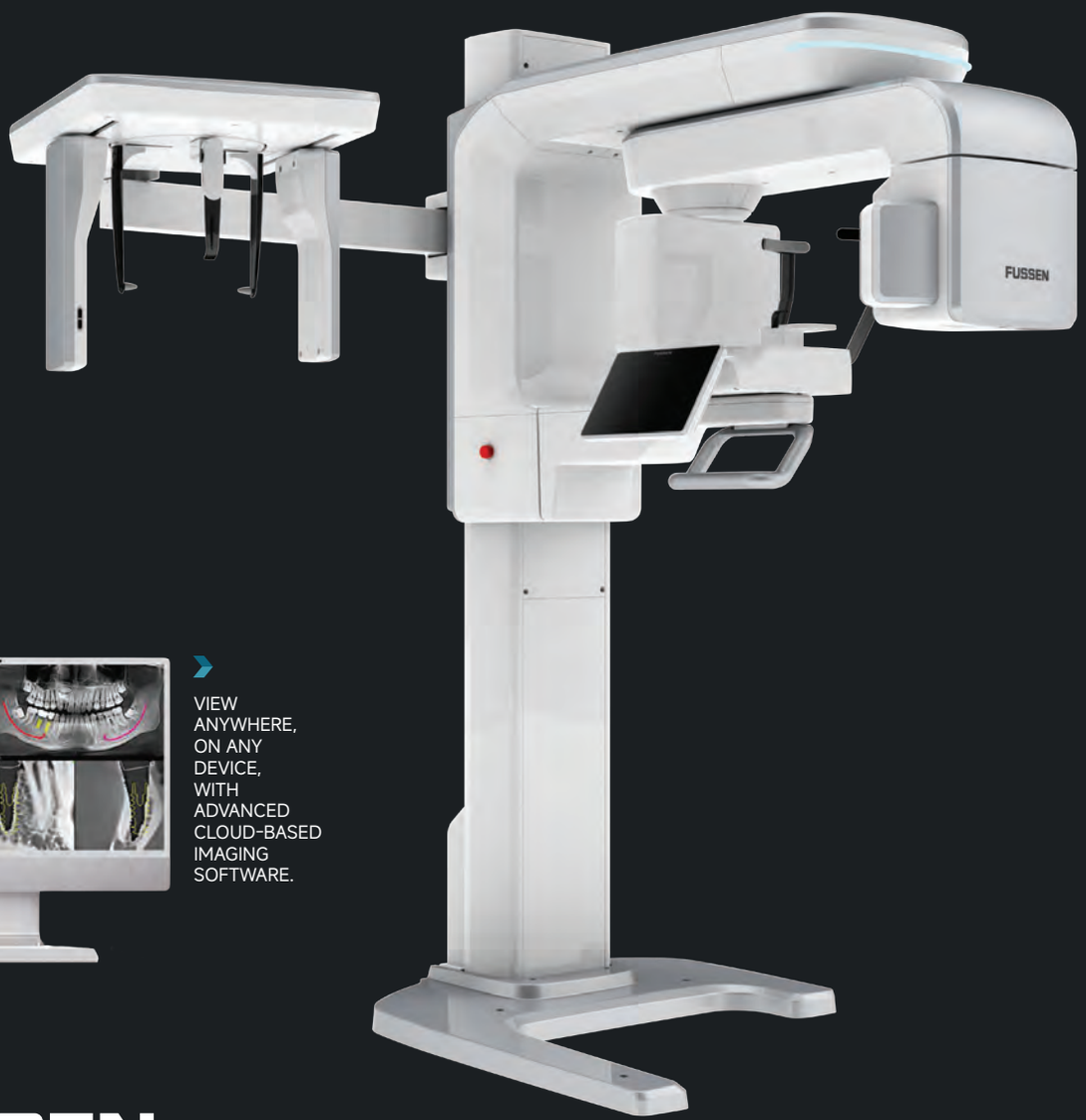



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The next chapter for dental hygiene and dental therapy

Iain Chapple and Rhiannon Jones reflect on how far dental hygiene and dental therapy have come, where their potential remains untapped and what needs to happen next

Professor Iain Chapple
Consultant in restorative dentistry, periodontologist, clinical academic, researcher, educator and BSDHT honorary vice president

Rhiannon Jones
Dental therapist and outgoing BSDHT president

As you both come to the end of your current positions within the British Society of Dental Hygiene & Therapy (BSDHT), how have you seen the roles of dental hygienists and dental therapists change?

Iain: Slowly but surely, during my time serving the BSDHT I have seen a cementation of the respect held for hygienists and therapists by dental surgeons, patients and the public, and the culture change within UK dentistry that now recognises the critically important role that dental hygienists and dental therapists can play in oral healthcare provision.

Direct access and extending scope of practice are two examples, but perhaps the most important change has been the trailblazers like Jeanie Suvan and Dagmar Else Slot, dental hygienists with PhDs who lead at European workshops and command respect and collaboration from periodontal specialists across the world. Dental hygienists and dental therapists leading scientific discovery and endeavour is critical to the future of their respective professions.

Rhiannon: I think there has been an increased understanding that, to solve some of the problems we face in providing dental care to the public, we need a whole-team approach.

What I have particularly noticed during my BSDHT presidency is greater respect for dental hygienists and dental therapists within the discussions that affect us. It feels as though we are now being invited to the table and genuinely listened to, rather than having to battle to be included.

Where do you believe there is still untapped potential within the profession?

Iain: In improving the oral health literacy of non-dental professionals, schools, midwives, pharmacies and medical practices, where the oral-systemic connection is not known or appreciated.

Engagement in early case detection of chronic systemic diseases is another key area, such as pre-diabetes, chronic respiratory diseases and cardiovascular diseases. These are key roles that leverage the educational skills and knowledge of the profession to broaden understanding of the importance of oral health to general health and wellbeing.

Rhiannon: There are so many areas where we could be used more effectively as healthcare professionals. During the pandemic, I worked on a dementia ward and realised how many transferable skills we have. So much can be seen in the mouth, and there is a huge opportunity for us to become more involved in patients' wider health.

There is also untapped potential in how patients access our care. There should not be only one route into oral healthcare. I would love to see dental hygienists and dental therapists playing a greater role in caring for children and the frail, and reaching people who may not otherwise access care.

'Funding of education needs to be looked at, alongside career opportunities'

What needs to happen next to make fuller use of the skills of dental hygienists and dental therapists?

Iain: We need to train more dental hygienists and dental therapists but, to ensure NHS Trusts and Higher Education Institutions engage with this, the placement tariff needs to increase from £5k per year to more than £20/25k per year. No financial director of a trust or university will take a dental hygiene or dental therapy student over a dental student when the discrepancy in funding is so large. We need the government to start walking the walk and finally rebalance the training tariffs for dental hygienists and dental therapists to ones that do not require subsidisation by BDS tariff.

We also need higher numbers in training, more working within the NHS sector and real career progression that generates self-respect and self-esteem, as has been achieved in medical nursing with nurse consultants and nurse specialists.

Rhiannon: I agree that the funding of education needs to be looked at, alongside career opportunities. There is not a clear career pathway for dental hygienists and dental therapists, particularly in primary care, and even advanced academic and clinical development does not always translate into progression.

I would also like to see a rethink of how people access care, starting with what serves the patient best. We should be reaching people where they are, rather than simply waiting for them to enter a dental practice.

Research is important too. If we are advocating for change and the removal of barriers, we should be helping to generate the evidence that supports it.

Ultimately, this comes back to the patient. We have to keep asking whether the systems in place are in the best interests of the public, and whether unnecessary barriers are preventing people from accessing care from professionals who are trained to provide it.

The BSDHT represents and supports dental hygienists and dental therapists while advocating for the profession and its contribution to patient care. Visit **bsdht.org.uk** to find out more.

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A decade defending dentistry

As he steps down after 10 years at the helm of the Dental Defence Union, John Makin reflects on a changing profession, the pressures facing dental teams and why protecting professional reputations still matters

John Makin
Former head of the DDU

Looking back at your tenure as head of the Dental Defence Union (DDU), what do you consider your most significant contribution to the protection of the dental profession?

I don't think I can claim sole credit because I had fantastic colleagues around me at the DDU. Together we've worked hard to be a voice for the profession through initiatives like the All-Party Parliamentary Group for healthcare workers and responding to consultations.

Most importantly, we've been there for professionals during the darkest time in their careers, be that a fitness to practise case, claim or another investigation.

When a DDU member notifies us of a General Dental Council (GDC) investigation, they can now expect a virtual meeting with their assigned adviser who will explain what to expect and will be by their side throughout, along with an instructed lawyer. And they can trust us to robustly defend their reputation.

Looking back, I'm most proud of the heartfelt letters of thanks from members for the fantastic support they've had from the DDU over the years. And I've always found it hugely satisfying to conclude an advice line call with a member who says they feel much better than they did at the start.

How has the landscape of dental litigation changed from the day you started, and do you feel the profession is safer now than it was then?

I think the skills, knowledge and dedication of dental professionals are as impressive as ever, but the service has been under intolerable pressure because of a toxic combination of the pandemic, NHS access problems, greater and more complex levels of dental need, alongside the difficulties caused by the contract. Sadly, all this is outside the control of the average dental professional, but it's had a demoralising effect because many feel they can no longer meet patients' expectations.

At the same time, I think a climate of fear has developed around dentistry with professionals feeling under siege from negative headlines, a growing number of patient complaints, costly negligence claims and, of course, a surge in protracted and stressful GDC cases.

To give the GDC credit, it has made steps to improve the fitness to practise process, but the climate of fear will only dissipate when the profession receives better support from policymakers. In particular, we desperately need the government to bring forward regulatory reform so the system can be made more proportionate, faster and fairer to all involved.



'The skills, knowledge and dedication of dental professionals are as impressive as ever'

With the rise of fixed-benefit, contract-based insurance, do you still fundamentally believe that discretionary indemnity is superior, or has the market outgrown it?

I firmly believe in the power of a not-for-profit mutual organisation, staffed by dental professionals and owned by our members. We exist to represent the interests of ordinary dental professionals, not a group of shareholders and that ethos shapes everything we do, from our support for individual members to our campaigning work in areas like regulatory reform.

This approach is a far cry from insurance companies where every decision must have a commercial justification.

As dental professionals ourselves, we understand the fundamental importance of our members' professional



reputations and how upsetting it can be when their clinical care is called in to question. We never settle cases for financial expediency. If a case is defensible, we aim to win it.

Finally, the benefits of membership go beyond professional indemnity. As a discretionary organisation, we offer a wealth of services to help dental professionals handle the day-to-day dilemmas of dental practice, including our 24-hour advice line, which members can call as often as they need, guidance, learning and development resources and help with contracts.

In a crowded market, do you feel you have enhanced the DDU's reputation, or has the DDU become more reactive?

I think we continue to stand out from the crowd but, of course, we can't be complacent. We have to stay relevant for members in a time of constant change in dental practice, which means looking for more ways to support members throughout their professional careers.

That includes keeping members up to date with the latest developments, from AI to the new CQC inspection framework. We've started our peer support network that puts members who are going through a complaint or claim in touch with a fellow member who has been in their shoes.

We've joined forces with other organisations to help members with other aspects of their professional lives, including Peninsula for employment law advice and Armstrong Watson for tax and accountancy.

Most recently, we launched a new dental education programme for DDU members, in collaboration with Red Whale (part of the MDU group). We continue to seek out new ways to support our members, and we're always pleased to hear from members about what they want. After all, we are a mutual and they are our owners.

Between the ORE overhaul, the crisis in NHS funding and the rise of corporate dentistry, where do you see the 'average' high-street dentist in five to 10 years' time?

Probably the biggest change in UK dentistry over the course of my career has been the rise of corporate dentistry.

When I first qualified, there were only 27 corporate bodies allowed on the dentistry register but, since then, the corporate sector has grown very rapidly.

'We desperately need the government to bring forward regulatory reform so the system can be made more proportionate, faster and fairer to all involved'

Looking ahead to the next five to 10 years, I think there'll be further corporatisation with many more colleagues choosing to work as associates or employees in corporate practices, rather than establishing their own practice with all the financial risk that entails.

And it remains to be seen how the government's plans for Neighbourhood Health Service offering oral health services will impact the high street dentistry model.

Finally, I think dental professionals have always been forward-thinking so it's inevitable that more high street practices will expand into growth areas like cosmetic dentistry and facial aesthetics.

While this is financially lucrative and professionally satisfying, it also marks a shift from a practitioner-patient relationship to a practitioner-consumer one with higher expectations and a higher risk of complaints.

If you could leave one piece of advice for the person taking over your office, what would it be?

Simon Kidd, my successor, is very capable of leading the DDU without a backseat driver! As a registered dentist, he's well aware of the challenges of everyday practice and the pressures our members are under and he shares my determination to campaign for a fairer deal for our dental professionals.

I'm sure the DDU will go from strength to strength under his leadership, but if I was to give him one piece of advice it would be to make the most of it.

Being head of the DDU is a great privilege and a wonderful experience but my 10 years at the helm passed in the blink of an eye.

After years of defending the profession, what does life after the DDU look like for you?

Retirement is a change of pace for me having lived and breathed the DDU for so long, but I still enjoy doing some consultancy work and there are lots of exciting projects where I hope I can make a useful contribution.

Outside the DDU, I've been blessed with four beautiful grandchildren, so I'm relishing the chance to spend more time with them.

And if I do get a spare moment, you'll probably find me working on my golf swing.

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It's good to talk

Iain Stevenson on why talking about money with your family matters

Iain Stevenson
Head of dental,
Wesleyan Finance Services

For dentists, years of hard work can build up more than a successful career. A practice, a property, pensions and investments can all form part of the financial legacy you eventually leave behind.

Yet while many dentists plan carefully for retirement and later life, talking to family about those plans can be much harder.

Money remains an uncomfortable subject in many households. But avoiding the conversation can leave loved ones feeling uncertain about your intentions or facing important decisions without the context they need. This can be particularly relevant when approaching retirement or considering the sale of a dental practice. It's a natural opportunity to talk to adult children and other family members about what you want your wealth to achieve, whether that means providing financial security, helping younger generations or supporting causes that matter to you.



Make time to chat

You don't necessarily need to disclose every financial detail. Starting with your intentions and values can make the conversation easier. It's also worth ensuring those closest to you know where important documents are held, who your professional advisers are and whether they've been appointed as an executor or attorney.

These conversations shouldn't be a one-off event. Circumstances, relationships and financial plans change, so revisiting them regularly can help ensure everyone remains clear about your wishes.

Ultimately, financial planning isn't only about building and protecting wealth. Good communication can be just as important. A conversation today could spare your family uncertainty and difficult decisions tomorrow.

Focused on the future

Christopher Leech shares his plans for growing the British Academy of Cosmetic Dentistry for the next generation

Christopher Leech
BACD president

It is a great honour to take on the role of British Academy of Cosmetic Dentistry (BACD) president and build on 23 years of hard work and achievement. I'm reminded of a quote often attributed to Warren Buffett: 'Someone's sitting in the shade today because someone planted a tree a long time ago.'

The BACD began as a seed of an idea: to bring together British clinicians with an interest in cosmetic dentistry.

Today, I am one of many people who have benefited from its education, support and community.

To me, legacy means leaving something better than you found it. As president, I want to build on the work of my predecessors and deliver even greater value to our members. This is also an opportunity to ask where we are, where we want to go and what we can do for those who come next.

'Legacy means leaving something better than you found it'

That requires a balance between consistency and change. We must protect what works while adapting to the changing needs of our profession.

A successful restaurant keeps the dishes people return for, but makes room for new ideas on its specials menu. An association should have the same confidence: know what it does well, then be willing to try something new.

The balance will be different for every organisation. Some change their identity to signal a new direction; others keep a familiar identity and evolve in other ways. Twinings, for example, has retained its historic logo while developing new products for changing tastes.

The lesson for the BACD is to be deliberate about what we preserve and where we innovate.

Leading by example

We have always listened to our members, and we have an opportunity to lead in both dental education and the way it is delivered. I want the BACD to keep pace with a changing profession while strengthening the qualities that make it special. One of those qualities is our commitment as a non-profit organisation to reinvest in affordable education for our members. Affordability should never mean compromising on quality. Our ambition is to lead by example. I want to continue the outstanding work of previous presidents, strengthen our community and reach clinicians who have yet to discover what the BACD can offer. I'm excited to share changes as we enter 2027. Throughout, our priorities will remain clear: excellent education, meaningful mentoring, strong professional connections and support for our members. The people who founded the BACD planted something that has benefited us all. Our responsibility now is to help it grow for the next generation.

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Improving practice culture

Having a positive culture in practice is a business asset, not just a nice-to-have. Katrina James shares six tips that will support your practice culture

Katrina James
Area manager, Practice Plan

When I visit a practice and ask them about their culture, while they might say that they're 'patient-centred' or 'supportive', often they haven't thought about the behaviours that would underpin and demonstrate those types of culture.

That's why it's important first to think about the behaviours that define the sort of culture you want to foster in your practice and agree them as a team. Culture is what you see every day, not a list of things written on a wall. It's what your dental practice lives and breathes.

Once you have defined your culture, it's important to think about how you will support it.

Something that is essential to the success of every human relationship and endeavour is clear communication. People function best when they understand what's expected of them.

Regular huddles help clarify what's happening in practice as well as who's expected to do what. These, alongside a policy of encouraging staff to speak up when they don't understand or see that something needs to change, can help a practice develop a climate of continual improvement and build psychological safety. This is especially true if blame is also kept at bay.

Sitting alongside open communication is recognition. Celebrating wins and good work in a timely way encourages more of the same. It doesn't always have to be in the form of a big award or with great ceremony. Letting your staff members know that their hard work or achievement has been noticed and appreciated can sometimes be all that's needed. It's amazing how motivating a bit of praise can be!

A wise investment

Investing in your whole team will pay dividends through staff satisfaction and retention. There may be some team members who are happy to just come in and do the same job every day and then go home. However, they are more likely to be the exception rather than the rule.

Most people want to be able to develop new skills and make progress in their career. Helping them do that means that you end up with a team that's happier at work and with a broader skill base.

Some owners fear that encouraging their staff to improve their skills will lead to them leaving the practice for bigger things. However, by supporting your employees' development you're likely to enhance the practice's reputation as a great place to work. So, when someone leaves, you'll have potential replacements queueing up to come and work for you.

Prioritising wellbeing offers a benefit to the patient experience as well as the team. A team that's allowed to get on with the job in a stress-free and safe environment is likely to be happier, make fewer mistakes and deliver a better service to patients.

Working with poorly maintained or out of date equipment makes life harder for the team. If they're also being asked to use systems that are inefficient and time-consuming then this is a recipe for stress and burnout. Make sure your systems work for the team, not against them.

Breaks and leaving on time should be the norm rather than the exception. People need time to rest and recuperate to be able to give of their best. Without proper breaks people start to run on empty leaving them prey to illness, burnout and being unable to come to work or even leaving their job.

Having to cover for staff absence just heaps more stress on the team members left behind, which perpetuates the cycle.

Set the tone

For all these things to work you need to lead by example. You need to buy into the behaviours that define the culture you want for the dental practice.

If you, as practice owner or manager, don't prioritise your work/life balance then it becomes harder for that to become part of your culture. If you don't communicate clearly then that hinders communication throughout the team, and so on.

Remember, culture is what happens in practice every day. Having identified the behaviours that define your culture, then it's up to you to demonstrate them.



Six tips in a nutshell

1. Define your values
2. Communicate openly
3. Build trust and psychological safety
4. Recognise and reward contributions
5. Invest in development
6. Lead consistently.

Get in touch with Practice Plan at **01691 684165** or **practiceplan.co.uk/be-practice-plan.**

MTD... what have we learned?

Seb Stracey explores Making Tax Digital for Income Tax Self-Assessment and what dental professionals need to know

Seb Stracey
Partner, Humphrey & Co

After many years of waiting and wondering whether Making Tax Digital for Income Tax Self-Assessment ('MTD ITSA' or simply 'MTD') would ever actually be implemented, we have now completed and filed the first quarter under the new regime and are currently about to complete quarter two.

Originally intended to be rolled out from April 2018, after government delays, tweaks to the criteria and timelines, we finally had to deal with the fact MTD is here on 6 April 2026.

As a reminder, Making Tax Digital is the biggest shake up to the UK tax system since Self Assessment was first introduced.

What's changed?

Previously, income was only reported to HMRC once a year through a taxpayer's Self Assessment tax return. Income for the 12 months up to 5 April each year would be declared on a Tax Return and submitted by the following 31 January, with payments due in January and July. From 6 April 2026, for many self-employed dentists this has changed in a lot of ways – while still keeping some familiar aspects.

From April 2026, if your total business and/or property income exceeds £50,000, you needed to comply with MTD, which means:

- Keep digital records of all income and expenses
- Use HMRC-compliant, cloud-based accounting software
- Submit quarterly updates to HMRC (rather than just one annual tax return form).

If your income is between £30,000 and £50,000, these requirements will come into effect from April 2027.

However, it isn't all change, as the quarterly updates are in addition to the regular annual filing, so for the first year 2025/26 tax returns will be due alongside the quarterly filings for 2026/27. At this stage, HMRC has stressed that there are no changes to the tax payment dates and these will remain in January and July.

What has happened so far?

The first quarter filing under MTD was due for the quarter ended 30 June 2026 (or 5 July if elected) and due to be filed by 7 August 2026.

According to HMRC data, around 436,000 filed their first return on time. On the surface, this sounds impressive, but more than 570,000 taxpayers had signed up, which means more than 130,000 failed to get their first return in on time.

Furthermore, HMRC estimates more than 864,000 taxpayers are within the scope of MTD for the first year but nearly 300,000 have failed to sign up in time to submit their first quarter.

From September 2026, HMRC will be signing up any taxpayers who are yet to do so, so if you are affected but



have yet to take action, you should receive correspondence from HMRC shortly. Penalties will start from April 2027 so it important that returns are filed before the deadline each quarter. 31 January is now not the only important date in the tax calendar for filing!

What lessons have been learned?

At Humphrey & Co, we act for around 2,000 dentists, many of whom are affected by MTD. We took pre-emptive steps and signed up a large number of clients for the pilot scheme last year to test the systems, overcome any teething issues and formulate a complete solution for dentists that ensures compliance and efficiency.

With close to 1,000 MTD returns filed as a firm, we have noticed a few things and noted some lessons for taxpayers to take onboard as MTD looks set to become a big part of self-employed life going forwards:

- Knowing deadlines. Knowing when returns are due and for what period they include is important to ensure you can gather all of the correct information on a timely basis and make the deadline
- Understanding the requirements. MTD is only for self-employed and rental income. It does not extend to dividends, interest or other sources of income. These remain part of the end of year submission only. For this reason, the tax estimates generated are very unlikely to be accurate and should not be relied upon
- If you miss something, don't panic. Each return period is cumulative meaning you can simply update prior periods on the next submission if you miss an invoice for example. While it is important to get the returns as accurate as possible, you may not have all the paperwork to hand at the time, so it is fine to add this in later
- Be organised. This is especially important as it underpins everything else. Having a clear system for recording and capturing the information required for the submission will ensure you do not waste time through inefficiency and also makes things as easy as possible. A good example of this is using a dedicated bank account for all of your dental and rental income and expenses – it should reduce the potential for including personal transactions by mistake or missing things
- Don't rely on HMRC to send reminders. In an ideal world, HMRC would prompt you when something is needed, however under a Self Assessment system it is down to the taxpayer to ensure these things are done on time to avoid penalties
- Communication. If you are working with an accountant, communicating with them about what they expect you to do and what they will be doing to assist will ensure everyone knows how to get MTD over the line each quarter, in the most pain-free way.

The above is just a selection of some the things we think people should know, but we are firm believers that as dentists your time can be better spent earning money through dentistry rather than coping with the peculiarities of the tax system.

'31 January is now not the only important date in the tax calendar for filing'

It isn't too late to engage with this in a meaningful way and set things up to try and help make MTD second nature and reduce tax related stress.

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Pause or press on?

Peter McKenzie explains how to make the right move in today's dental market

Peter McKenzie
Specialist financial adviser,
Wesleyan Financial Services



For dental practice owners considering a sale, acquisition or eventual exit, the current market can present a difficult choice. Should you move forward now, or take time to prepare for what comes next?

While economic uncertainty continues to influence decision-making, dentistry remains a resilient and attractive sector.

Buyer demand continues, but the market has become more selective.

For practice owners, this means that preparation, realistic expectations and a clear understanding of both business and personal financial goals are more important than ever.

Preparation can make the difference

Buyers and lenders are increasingly looking beyond historical performance when assessing a dental practice. The sustainability and quality of earnings are becoming just as important as the headline figures.

Factors such as staffing stability, income mix, compliance, operational resilience and exposure to rising costs can all influence how a practice is perceived and, ultimately, valued.

For owners considering a sale, this makes preparation particularly important. Practices with consistent profitability, robust governance and compliance, a healthy balance of income and a clear demonstration of future sustainability are likely to be better positioned when they come to market.

It's also important to be realistic about current market conditions. A strong practice can still command significant interest, but buyers may take longer to make decisions and scrutinise opportunities more closely than they have in the past.

Valuation is only part of the picture

Achieving a strong sale price is understandably a priority for many practice owners. However, the valuation figure alone does not determine the financial outcome.

Tax planning, pension arrangements, personal wealth and future lifestyle requirements can all have a significant bearing on what a practice sale ultimately means for an owner.

Two practice owners could achieve the same sale price yet have very different financial outcomes, depending on their individual circumstances.

Considering practice valuation alongside personal financial planning can therefore help owners make decisions that support their wider objectives, rather than focusing solely on the transaction itself.

A strategic pause can still be progress

For some dentists, the right decision may be to proceed with a sale while buyer demand remains healthy. For others, delaying an exit could provide an opportunity to strengthen the practice, improve profitability or address operational weaknesses.

A strategic pause can also provide valuable time to review pension arrangements, consider potential tax liabilities, improve cash flow forecasting and model different financial scenarios.

The key is to make the pause purposeful. Waiting without a plan can create uncertainty, whereas using additional time to prepare can put a practice owner in a stronger position when they are ready to act.

Prepare early, whatever your plans

There is no single answer to whether practice owners should pause or press on.

The right approach will depend on the individual practice, the owner's objectives and their wider financial position.

What matters is avoiding the temptation to simply wait and see.

Understanding the practice's true market position can help owners make more informed decisions about tomorrow.

Whether the goal is to buy, sell, expand or eventually retire, seeking specialist advice early can provide something that is often in short supply – time.

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Protecting a future you cannot see

In the final of a three-part series, Minesh Patel explains why true financial freedom in dentistry is about control and confronts the risks that most dental professionals do not see coming

Minesh Patel
Associate dental practitioner

When dental professionals consider financial risk, they often focus on investments and diversification. However, some of the biggest risks arise elsewhere: unplanned incapacity, premature death, gradual lifestyle inflation, and inadequate legal and estate planning.

The costliest mistake is often not planning for these risks at all.

The legal blind spot: capacity and control

Financial safeguarding extends beyond income and taxation. If you lose mental capacity due to illness, stroke, accident or a progressive condition such as dementia:

- Spouses, partners and family cannot automatically make financial decisions on your behalf
- Access to bank accounts and investments may be legally blocked unless appropriate authority is in place
- For practice owners, business continuity and practice finances can be disrupted.

Many professionals either do not consider this, or assume family can act on their behalf; a common, dangerously optimistic, and legally incorrect assumption.

In England and Wales, the solution is both simple and crucial – a lasting power of attorney (LPA). Of note, Scotland and Northern Ireland have different legal arrangements for powers of attorney.

An LPA allows you to appoint one or more trusted people as attorneys to make decisions on your behalf if capacity is lost. There are two types:

1. Property and financial affairs LPA, covering bank accounts, investments, bills, property and business interests
2. Health and welfare LPA, covering decisions relating to medical treatment and care.

Without an LPA, family members do not automatically acquire authority to manage your financial affairs. In England and Wales, an application must be made to the Court of Protection to appoint a deputy; a slow, administratively demanding and costly process, leading to family members unable to access funds or pay bills; precisely when simplicity and swift decision-making are needed most.

Medical decisions are different. If someone lacks capacity and has no health and welfare LPA, the responsible healthcare professional decides based on the person's best interests while consulting those close to them, which can occasionally lead to disagreement about appropriate treatment. A health and welfare LPA gives a chosen attorney legal authority to make those healthcare decisions instead.

For practice owners, the absence of appropriate authority can have immediate operational consequences, affecting staff payments, stock purchasing, cash flow and patient care. Even a well-run practice becomes vulnerable when its leadership cannot act; like a ship without a captain, capable people may be aboard, but with no one at the helm, direction is lost and problems can escalate.

Having power of attorney is, therefore, part of sound business continuity planning.

Wills: who decides – control versus assumption

A will determines how your assets are distributed after death, appoints executors, and can appoint guardians for children under the age of 18.

Dying intestate (without leaving a valid will) triggers statutory distribution rules, and assets may not be distributed as you'd expect:

- Executors are appointed by the courts
- Unmarried partners, or those not in a civil partnership, receive nothing
- Stepchildren are excluded by default
- Marriage or remarriage can revoke a previous will in England, Wales and Northern Ireland, potentially leaving an estate distributed under intestacy rules
- Blended families require particular care, as assets passing to a surviving spouse may ultimately move outside the deceased's intended family line (Scotland succession rules differ, including statutory rights for spouses, civil partners and children over certain parts of the estate).

Many people assume family members can simply 'sort things out' and that common sense will prevail; a supposition that is inaccurate, financially costly, emotionally draining for those left behind, and one that can leave lasting family disputes as an unintended legacy.

Even with a will, administering an estate is a significant undertaking. Dying intestate, however, makes matters more complex and protracted, requiring an application to the HM



Courts & Tribunals Service for a Grant of Letters of Administration to administer the estate.

Intestacy rules are rigid; they cannot account for the personal circumstances, relationships or intentions that make every family different. A clear will ensures:

- Asset distribution rights
- Appointment of trusted executors and guardians
- Avoidance of prolonged legal processes.

For practice principals, the absence of a will introduces further complexity. Business interests may pass in ways that do not reflect the owner's intentions, creating difficulties for continuity and succession. A well-structured will preserves stability for a practice and everyone with a vested interest in it.

Shareholder/partnership agreements should also be considered alongside estate planning to ensure no stone is left unturned.

Planning ahead

In an era of rising life expectancy, dementia prevalence, complex family structures and significant personal and business assets, estate planning can no longer be left to chance.

The greatest risk is often inaction. Without formal legal arrangements, decisions may ultimately be determined by the state and the courts:

- The court decides who manages your affairs
- The state decides who inherits
- Your family carries the prolonged stress, delays and financial burden that follow.

Despite this, a substantial proportion of UK adults have not put these safeguards in place. Research from the Money and Pensions Service indicates that 56% of UK adults do not have a will, and other research shows almost four in five UK adults over the age of 40 have no power of attorney in place.

Proactive individuals anticipate risk and act early. Reactive counterparts respond only once events have occurred, thrusting them into a firefight to manage the resulting chaos with already depleted reserves. Legal safeguards are not expressions of pessimism; they are instruments that provide clarity, protection and control.

'Much like periodontal disease, without monitoring and intervention, financial inefficiencies can progress silently, becoming increasingly burdensome and difficult to correct'



Lifestyle inflation

Financial risk does not arise solely from catastrophic events. More often, it develops in a far less obvious way – through the gradual expansion of fixed costs and lifestyle inflation.

As income increases, expectations naturally adjust; larger mortgages, higher rent, premium vehicles, private schooling and frequent travel begin to feel justified. Each step seems reasonable in isolation, but collectively these commitments reduce flexibility; a clinician may wish to reduce sessions only to discover that fixed costs anchor them to workloads they no longer enjoy. This phenomenon, called lifestyle creep, can lead to the dreaded 'golden handcuffs' – the inability to reduce clinical hours without financial strain.

The paradox is striking; income intended to provide freedom, may ultimately restrict it.

The annual financial examination

Modern dental careers are rarely linear. NHS commitments may reduce while private income increases; associates may become equity holders, and DCPs may progress into lead clinical or managerial roles.

Each transition alters cash flow, tax exposure and lifestyle dynamics.

Dentistry is grounded in prevention; most patients are advised to attend recall appointments every six to 12 months to identify problems before they become complications. The same discipline should apply to personal finance.

At regular intervals, dental professionals should conduct a structured financial review, examining:

- Emergency fund reserves
- Tax reserves and projected liabilities
- Cash flow and expenditure patterns
- Investments and performance
- Pension contribution levels and tax efficiency
- Protection policies (income protection, critical illness, life insurance)
- Estate planning documents, including wills and lasting powers of attorney
- Signs of emerging lifestyle creep.

Financial oversight should be planned and scheduled; setting aside one dedicated review day each year, and treating it as non-negotiable, creates a simple but powerful discipline that pays dividends.

This annual review should be far more than simply a meeting with your accountant.

It should be a structured assessment of your entire financial system.

It may not feel urgent early in a career, but much like periodontal disease, without monitoring and intervention, financial inefficiencies can progress silently, becoming increasingly burdensome and difficult to correct.

Across this three-part series a common pattern emerges; when problems arose, assumptions had replaced verification, paperwork and advice were deferred, financial structures went unreviewed, and the rigidity of UK law was underestimated. The warning signs were present but overlooked.

Several practical lessons follow:

- The systems governing finance are rule-based; brute-force income expansion alone does not create wealth, but also structure, investing, and maximising income retention are what convert earnings into lasting security
- Responsibility for financial accuracy and efficiency rests with the individual, not the accountant or the practice; fee protection insurance should also be considered to mitigate accountancy fees incurred in connection with HMRC investigations
- Protecting income, family and business interests through insurance, pensions or company structure is foundational, not an optional extra
- Legal safeguards preserve your intentions when you can no longer act; assuming family will 'sort it out' is not a plan; the legal system operates on documentation, not assumption
- Financial structures left unchecked can quietly erode flexibility; disciplined spending is rarely glamorous, but frequently transformative; depreciating assets satisfy present consumption, while appreciating assets create future opportunity, ultimately leading to greater choice
- A scheduled, non-negotiable annual review is what catches these issues before they become crises.

Financial structure enables professional freedom

Dentistry offers exceptional earning potential and a high degree of professional autonomy. Yet autonomy within dental practice means little without financial independence beyond it, and crisis-driven decision-making, whether in patients or portfolios, almost never yields good outcomes.

Effective financial management is not merely about accumulating wealth. It is about preserving the ability to choose your clinical hours, your working environment, and when you step away from the chair, on your terms. That is the essence of genuine financial freedom. Income is the tool, not the goal.

Mark Topley
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Uniting teams on what matters most

Mark Topley reflects on a year of columns about leading a dental team – and the one question that underpins them all

Mark Topley
Dental leadership and team performance coach



Here's a small experiment to run before the festive do. Ask five people in your practice, separately, what the practice is for. Not what it does, because they all know that, but what it's for.

I'd be surprised if you got fewer than four answers, and at least one of them will be 'teeth'.

Most practices do have a purpose written down somewhere. It's on the website, or in the induction folder, or in a picture frame near the staff room kettle where it has been politely ignored for years. And that's the trouble with most purpose statements, because culture shows up in behaviour, not posters – and a sentence that nobody uses isn't doing any work.

What this year was really about

Over the past year, I've taken to *Dentistry* to write about setting standards, being clear, building a rhythm into the week, giving feedback without fear, handing over authority rather than tasks, closing the gap between knowing and doing, and staying calm with the people who are hard work.

All of that is the how. And every bit of it works better when the team knows the why, because a standard without a reason is just a rule, and people follow rules when someone's watching. A standard with a reason behind it is something they'll hold when you're not in the building, which is the only time it really counts.

I believe purpose is less of a nice extra than it sounds. It's the thing that holds the other systems together.

A purpose is for making decisions

The test I use is a simple one: can someone on your team use it to make a decision when you're not there to ask?

Imagine it's late afternoon on a Friday. The diary is full, you're mid-treatment, and a nervous patient who hasn't been in for six years is on the phone, half hoping to be told there's nothing available. If your purpose is 'delivering excellence in patient care', your receptionist is on their own, because that sentence could mean anything.

If it's 'we're the practice people stop being frightened of', they know exactly what to do, and they'll do it without coming to find you.

That's what a good purpose sounds like. Plain enough to say out loud without anyone wincing, and specific enough to settle an argument.

Find it, don't write it

The good news is that you don't need an away day and a flipchart. Your purpose is almost certainly in the building already, and the job is to find it rather than invent it.

At your next team meeting, ask everyone to describe a day they went home proud of the place. Then listen for what the stories have in common, because they will have something in common, and it won't be the wording on the website. Write that down in the team's own words.

Then use it, in three places:

1. In the huddle, with one example a week of someone doing it
2. In recruitment, where you describe it at interview and watch who lights up
3. In decisions, where 'which of these is more us?' becomes a perfectly reasonable question.

You'll feel like you're repeating yourself, and that's normal. It's about the time you're bored of saying that the team starts believing you mean it.

One thing before January

December is when most practice owners start a list for the new year, and by February most of those lists have gone the way of every list before them. So don't write 10 resolutions.

Ask the question at one team meeting before Christmas, write down what you hear, and bring one sentence back in January. One thing, maybe two, and that's it.

Consistency beats intensity, and a team that knows what it's for will carry next year's work a good deal further than you can carry it on your own.

If you'd like a straight read on where to point that effort first, the implementation gap scorecard asks 10 questions about what holds in your practice when you're not there, and it only takes a few minutes. Check it out at scorecard.marktopley.co.uk.

That's the last article of the year from me, so have a good break when it comes, switch off properly, and I'll see you in January!

For more information, visit **marktopley.co.uk**.

Leadership is not about having all the answers

Lisa Bainham's message to practice managers is a reassuring one: leadership is not about doing everything yourself. It is about building confidence, trust and responsibility across the team, says Pat Langley

Pat Langley
Clinical director,
Dentistry Compliance



One of the most useful leadership messages for practice managers is also one of the hardest to accept: you cannot do everything.

For many practice managers, that is easier to say than to live by. The role often attracts people who are capable, reliable and used to being the person others turn to. When something needs doing, they do it. When someone needs help, they step in. When something goes wrong, they absorb it.

But over time, that can become unsustainable.

Lisa Bainham, chairperson of the Association of Dental Administrators and Managers (ADAM), has spoken often about the importance of delegation, communication and helping teams take ownership.

Practice manager conversations

The Association of Dental Administrators and Managers (ADAM) and Dentistry Practice Services brought practice managers together at this year's British Dental Conference & Dentistry Show in Birmingham for a special breakfast meeting.

This series of articles presents some of the topics that were raised during the morning's discussions.

Not as leadership theory, but as practical day-to-day behaviours that help practices run more confidently, consistently and sustainably.

Delegation is not letting go of standards or accountability

For some managers, delegation can feel uncomfortable.

It can feel quicker to do the task yourself. Safer to keep control. Easier than risking a mistake.

But genuine delegation is not about lowering standards. It is about helping the right people take responsibility for the right things, with the right support around them.

That might mean giving a team member ownership of a process. It might mean creating clearer communication routes. It might mean helping people understand when something should be escalated and when they are empowered to manage it themselves.

> **'You can't do everything'**

Done well, delegation does not reduce accountability. It spreads it more fairly.

Confidence grows through support

Leadership in practice management is rarely neat.

There will be difficult conversations, competing pressures and moments where the answer is not immediately clear. That does not mean someone is not leading well. It means they are leading in a real practice, with real people and real pressures.

This is why support networks matter.

Through ADAM, practice managers can connect with others who understand the role and can share experience, reassurance and practical ideas. Through Dentistry Practice Services, practices can access HR compliance, dental compliance and operational support that helps create clearer frameworks for teams to work within.

That includes support around onboarding, policies, HR documentation, accountability structures, compliance visibility and the day-to-day operational processes that help practices run more smoothly.

Leadership is not about knowing everything.

It is about building a practice environment where responsibility, communication and support are shared.

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Dentistry Practice Services can help your practice strengthen its processes and reduce pressure on the people managing them. Visit **dentistry.co.uk/practice-services** and **adam-aspire.co.uk** for more information.

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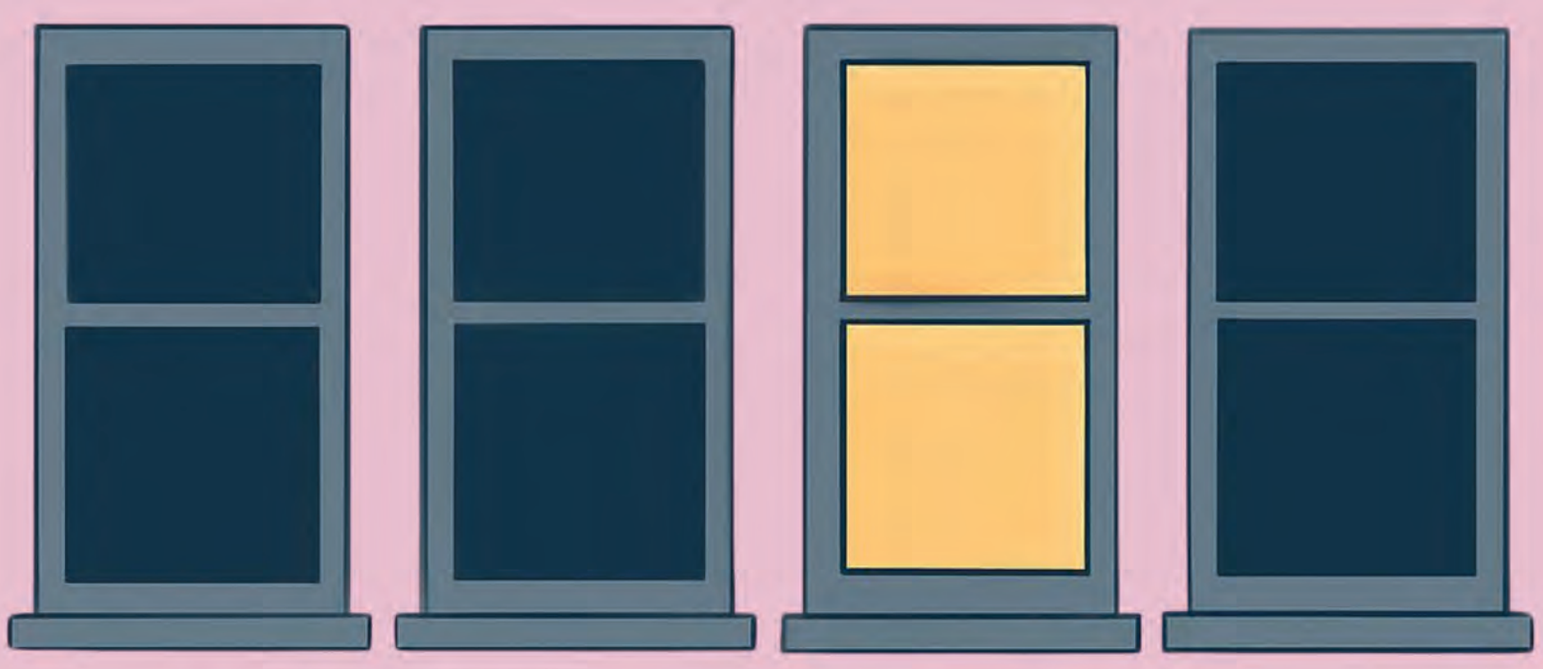

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Modern implant dentistry

A clinician's guide to treatment planning with the Straumann iExcel modular implant system

From the moment that Per-Ingvar Brånemark ushered osseointegration into the surgery, dental implant case planning has demanded an ability to balance anatomy, biology, biomechanics and restoration – typically simultaneously, and rarely under ideal conditions.

Today's implant surgeon operates in a landscape defined by breadth: broader indications, broader patient expectations, and a far broader array of tools with which to respond.

Single tooth replacements and full-arch rehabilitation sit alongside immediate placement protocols, delayed loading, compromised sites, peri-implant tissue challenges and aesthetic demands.

We now understand that bone is far from the only variable: ridge morphology, biotype, restorative space and occlusal risk (to name but a few) all exert pressure on treatment planning long before the torque wrench ever comes to hand.

Add to this an ageing population, greater patient awareness and a profession more comfortable interrogating outcomes – and variability has become the norm rather than the exception.

Implant selection is a layered choice, coloured by implant-abutment connection, restorative platform compatibility, emergence profile management and long-term prosthetic flexibility.

The risk for clinicians is therefore not a lack of options, but the opposite: navigating a complex ecosystem of components, protocols and platforms while still delivering treatment that is repeatable, understandable and defensible – both clinically and ethically.



What does modularity bring to this challenge?

Modular implant systems adapt to diverse anatomies and indications while retaining familiarity in handling, restorative logic and component integration.

When done well, modularity allows clinicians to 'mix and match' within a coherent system, aligning implant design, connection geometry and prosthetic workflow to patient needs, without relearning the system each time. The question is whether these systems help clinicians navigate complexity – and keep decision-making focused where it belongs: on the patient in front of them, not the catalogue behind them.

Key considerations of implant selection

Contemporary implant selection should be guided by an integrated assessment of biological, prosthetic and patient-specific factors rather than by familiarity with a particular system. Bone quality and morphology remain fundamental determinants. Sites with reduced density or limited volume require careful consideration of implant macro-design, surface characteristics, and insertion protocols to achieve predictable primary stability and long-term integration.

From a restorative perspective, implant positioning must support a physiologically appropriate emergence profile and prosthetic envelope. Three-dimensional misalignment between implant position and restorative contours may compromise soft tissue health, plaque control, and long-term maintainability, particularly in aesthetic areas.

Soft tissue behaviour is closely related to peri-implant mucosal thickness, implant–abutment configuration, and restorative margin position. Systematic reviews and clinical studies suggest that increased soft tissue thickness and platform switching may contribute to reduced early marginal bone loss. This is particularly relevant in patients with thin tissue phenotypes.

Workflow integration is increasingly important in digitally driven practices.

The availability of validated scan bodies and CAD/CAM libraries supports prosthetic accuracy from planning to restoration.

Systems such as Straumann iEXCEL provide integrated digital resources that can facilitate structured workflows without altering the biological principles guiding treatment planning.

Patient-related factors including occlusal loading, parafunctional habits, medical history and aesthetic expectations must inform implant selection.

Predictable outcomes are achieved when biological, prosthetic and patient-centred considerations are synthesised.

Why 'one-size-fits-all' systems are losing relevance

Historically, many implant systems were developed around limited component ranges intended to address most clinical scenarios. While operationally convenient, this approach often required clinicians to adapt treatment strategies to system constraints.

Modern implant dentistry increasingly recognises that anatomical variability, tissue dynamics, and prosthetic demands cannot be reliably addressed through uniform designs. Restricted options in diameter, connection type, or prosthetic components may necessitate biological

With thanks to Dr Jose Cordero Bayo for his contribution to this article

compromise, particularly in narrow ridges or thin phenotypes. The widespread adoption of three-dimensional planning and digital workflows has further highlighted the need for adaptable systems. Accurate transfer of virtual plans into clinical reality depends on compatible surgical and restorative components, supported by validated digital libraries.

In addition, evidence supporting immediate placement and immediate loading in selected cases has increased expectations for structured provisionalisation pathways. These protocols require systems capable of supporting staged tissue conditioning and prosthetic refinement. As implant dentistry evolves towards personalised, evidence-informed care, clinicians increasingly favour systems that support flexible clinical decision-making rather than rigid standardisation.

Effective modularity

Modularity uses interchangeable surgical and prosthetic components within a unified system, adapting treatment protocols to clinical requirements.

A modular framework typically includes multiple implant geometries and dimensions, combined with a comprehensive range of abutments, prosthetic interfaces, and restorative accessories designed to function cohesively.

Effective modularity is characterised by consistency in manufacturing tolerances, connection stability, and biological performance.

Flexibility is introduced through validated component options rather than uncontrolled variability. From a clinical perspective, modular systems support restorative-driven planning, facilitate digital integration, and allow staged adaptation throughout treatment. Provisional and definitive components may differ, reflecting changes in tissue maturation and functional demands.

Straumann iEXCEL

The iEXCEL system is Straumann's next-generation implant platform, designed to simplify implant dentistry while providing clinicians with the flexibility to treat a broad spectrum of clinical indications.

iEXCEL combines Straumann's proven implant designs into a single, integrated platform with a unified restorative workflow. It aims to improve efficiency, predictability and inventory management without compromising treatment options.

At the core of the iEXCEL system are four implant designs – TLX, BLX, BLC and TLC – which allow clinicians to select the most appropriate implant for each clinical situation while maintaining a consistent prosthetic and surgical workflow.

This modular approach enables clinicians to treat everything from straightforward single-tooth restorations to immediate implant placement, full-arch rehabilitation, soft bone, dense bone and complex aesthetic cases using a common restorative platform with the Torque fit connection.

The system prioritises simplicity. The implants share a unified prosthetic connection across compatible diameters, reducing the number of restorative components required and simplifying treatment planning, ordering and inventory management.

Advanced design features

The iEXCEL system incorporates several advanced design features to optimise primary stability and long-term success. Depending on the implant selected, features include:

- Aggressive thread designs for enhanced initial stability
- Tapered implant bodies for predictable placement in a variety of bone qualities
- Optimised cutting geometry to support immediate protocols where appropriate.

The platform is also fully compatible with Straumann's digital ecosystem, allowing integration with guided surgery, intraoral scanning, digital treatment planning and CAD/CAM restorative workflows.

An important component of the platform is Roxolid, Straumann's proprietary titanium-zirconium alloy. Roxolid provides higher mechanical strength than conventional commercially pure titanium while maintaining excellent biocompatibility.

This enables clinicians to consider reduced-diameter implants in suitable cases without compromising mechanical performance, helping preserve surrounding bone and soft tissue where space is limited.

iEXCEL implants are also available with SLActive, Straumann's hydrophilic implant surface technology. SLActive enhances early blood wetting and promotes faster osseointegration compared with conventional implant surfaces.

This supports shorter healing protocols and can provide greater confidence when treating challenging patients or cases where accelerated healing is desirable.



Scan the QR code to explore a clinical case using Straumann iEXCEL and read the full article.

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The Implant Centre: two decades of success

Celebrating 20 years of implant dedication at The Implant Centre

When The Implant Centre opened its doors 20 years ago, the goal was straightforward: create a dedicated implant hub that delivered exceptional outcomes for patients while making implant restoration in practice easy for referring dentists. Two decades later, that vision has evolved into one of the UK's most respected implant referral centres, built on innovation, collaboration and a relentless commitment to patient care.

Looking back, founder Bill Schaeffer recalls how the journey began: 'I left a hospital surgical career to start a mobile implant service. At the time, we were travelling between practices, treating patients wherever we were needed. It worked, but we realised there were limitations. We were dependent on other practices' facilities, and patients were given little flexibility. We wanted to create somewhere patients and dentists could come to us and receive the best possible experience.'

Together with co-founder Guy Barwell, they transformed that idea into reality, opening the first Implant Centre in 2006.

'We were visiting dozens of practices between us,' Guy explains. 'Once we opened our own centre, everything changed. We had control over the environment, the equipment, the team and ultimately the quality of care we could deliver.'

Growth came quickly. What started as a small practice with three surgeries rapidly expanded, leading to the opening of a much larger site in Hove just a few years later. The founders realised they had created something that resonated strongly with both patients and referring dentists.

The secret sauce of success

'Our aim has always been to make things simple,' Bill explains. 'We wanted implant treatment to be straightforward for referring dentists and stress-free for patients. When you simplify the process, everyone benefits.'

That philosophy has shaped many of the practice's innovations, from early adoption of screw-retained restorations to today's highly digital treatment pathways.

Bill and Guy point out that implant dentistry itself has changed beyond recognition during the past two decades but along the way, they embraced opportunities that others might have considered risky.

The practice invested in one of the first CT scanners in the region at a time when the technology was still relatively uncommon. They developed educational evenings for local dentists and later made another bold decision by creating an on-site dental laboratory.

'Setting up Ceramic Designs Laboratory was a huge step,' says Bill. 'It gave us complete integration between surgery, restoration and laboratory work – it made us better clinicians and allowed us to continuously improve the quality of treatment we provide.'



Patient impact

Both founders speak passionately about cases they've treated over the years. Guy remembers a young woman in her 30s whose severe dental problems had destroyed her confidence.

'Her treatment was challenging, but the transformation was incredible. Seeing someone regain their confidence and quality of life is what makes this work so rewarding.'

Bill tells a story about a jazz saxophonist who had stopped performing because of deteriorating teeth.

'After treatment, he returned to the stage and started performing again. That's when you realise implants aren't really about teeth. They're about giving people their lives back.'

The team behind the success

Ask either founder what has contributed most to The Implant Centre's success and their answer is immediate: the team.

'The team is everything,' says Bill. 'We've always believed that attitude and culture matter just as much as technical skills. When you have people who genuinely care about patients and each other, amazing things happen.'

That culture extends throughout the organisation, and patients frequently comment on the warmth, kindness and professionalism they experience at every stage of their journey with every member of staff.

Looking ahead

With new digital innovations continuing to reshape the dental profession, Bill and Guy remain enthusiastic about what lies ahead.

After nearly 30,000 implants placed, the story of The Implant Centre is ultimately a story of people: patients whose confidence is restored, teams that grow together, and two clinicians whose passion for improvement remains as strong as ever. Their secret to success is surprisingly simple: embrace change, support one another and never stop putting patients first.

THE Implant CENTRE

For more information, visit **www.theimplantcentre.com**.

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New solutions, same proven quality

With new additions and reinventions added to the Waterpik water flosser range, there truly is a solution for every patient

It's around this time of year that many patients are looking to make an effective upgrade to their oral hygiene routines – whether looking to make the most of seasonal sales, picking a new adjunct ahead of a new year's resolution, or opting to purchase an item as a gift this holiday season.

When choosing an item, being able to trust that it will make a meaningful difference to their routine is key. This is especially important when patients have extra oral hygiene needs, for example restorations that must be cared for diligently.

Waterpik has long been a key proponent of effective oral hygiene routines backed by science, supporting patients across the world with the maintenance of a brilliant smile every day. With new additions and reinventions added to the Waterpik water flosser range, there truly is a solution for every patient.

Improved implant care

Dental implants are supporting more patients year-on-year, now aiding approximately 2% of the UK adult population (Office for Health Improvement & Disparities, 2025). They are a really important restoration for patients, reviving aesthetics and function that may have been affected by edentulism. As a significant investment of both time and money, and a potential risk for increased anxiety, the successful outcome of a natural-looking restoration should be protected for many years to come.

The Implant Denture Tip from Waterpik, now included with the Ultra Professional water flosser, is engineered to effectively clean around fixed implant retained dentures, full-mouth implant systems and full-arch dental implants.

Its curved design helps patients reach underneath and around implant supported dentures, where access to the build-up of plaque bacteria is notoriously difficult with just a standard toothbrush and traditional flossing.

Patients can add it to their oral hygiene routine and immediately feel more confident in predictable long-term health. When used with the Waterpik Ultra Professional water flosser, patients can remove up to 99.9% of bacterial plaque from treated areas for a thorough clean (Gorur et al, 2009). The tip can then be easily swapped to target the rest of the dentition, whether patients have their natural teeth, single unit restorations, or bridges.

A new-look cordless solution

For patients looking for a cordless water flosser, the upgraded Cordless Pearl water flosser from Waterpik provides 60 seconds of thorough floss time, with the ability to be up to two times as effective as traditional brushing and flossing for removing bacterial plaque and reducing bleeding (Mancinelli-Lyle et al, 2023).

The Cordless Pearl has a new premium design, including an electronic push button and LED modes, with a recharge indicator light making it easier for patients to manage their items. A cordless solution can be preferred by many, with improved portability enabling simple use at home (including in the shower, due to a waterproof design) and on their travels.

The water flosser tip options include the Precision tip, which ensures a powerful, targeted clean along the gingival margin and in the interdental spaces, as well as the Plaque Seeker tip, which is optimised with bristles to remove plaque from hard-to-reach areas including around implants, crowns, bridges and other restorations. In addition, patients receive the Orthodontic tip, which improves plaque removal around braces, retainers and wires.

In fact, when used with a Waterpik water flosser, such as the upgraded Cordless Pearl, the Waterpik Orthodontic tip is clinically proven to remove up to three times more plaque than string floss around braces (Sharma et al, 2008) – an ideal choice for those opting for such care.





Why Waterpik?

Patients are choosing to invest in their oral health care, as awareness around its impact on general health grows. Waterpik offers reliability and confidence, with clinical findings backing each new solution, and the effectiveness of long-standing items in the catalogue. When patients choose alternatives, they are often gambling on items without such credibility.

Recommend a brilliant smile for your patients. Recommend with confidence. Recommend Waterpik.

References available on request.

Discover the Waterpik range and explore the clinical research supporting Waterpik water flossers at **www.waterpik.co.uk**.

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Supported by over 80+ clinical research studies. Clinically proven to remove up to 99.9% of plaque bacteria in treated areas* and be 2X as effective as string floss for improving gum health.

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†Based on 2025 independent survey of Dental Professionals; among those who recommended branded water flossers

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waterpik™ waterflosser



Unlock enhanced diagnostics with AI Insights

Carestream Dental introduces its robust AI diagnostics tool, AI Insights

In the modern dental practice, many clinicians have now adopted digital solutions to improve their workflows and treatment processes. With its ability to drive efficiency, aid in communication, and provide a second opinion, artificial intelligence (AI) has become a far more prevalent tool than in previous years. However, not all systems are built equally, and it's important to implement these tools with intention, focusing on the areas which truly bolster practice growth, patient care, and clinical accuracy. AI Insights, the robust AI diagnostics tool from Carestream Dental, enables clinicians to unlock the power of AI in their practice. By automatically analysing your panoramic X-ray images and reporting its findings, AI Insights saves you time and improves case acceptance simultaneously. The tool is intuitive, and integrates seamlessly with CS Imaging 8 software, enabling it to deliver consistent results and automate reporting.

Reliable results made simple

When working in a busy dental practice, there's no space for overcomplicated systems. That's why AI Insights makes achieving reliable results easy – providing the information you need to make a confident and accurate diagnosis at the push of a button. Simply, carry out a panoramic exam as usual, upload the image to the cloud in an instant, and AI Insights does the rest. The tool automatically analyses the image and displays its findings within a few seconds.

The software detects a broad range of pathological and non-pathological conditions – from caries to implants and fillings – and highlights them in colour layered directly over the image and within an interactive chart.

With high-quality reports generated in seconds, clinicians have the ability to review the image and add to or reject the results with ease, ensuring full control over the diagnosis and treatment planning process.

The effects on the practice and your patients

Not only does this offer clinicians an intuitive diagnostic tool, but it acts as a highly effective device for patient communication. Dr Kunal Shah shares his experience using the system: 'AI Insights is an effective tool for patient communication and a valuable conversation starter. It enhances comprehension and rationale behind dental procedures.'

Improve clinical outcomes

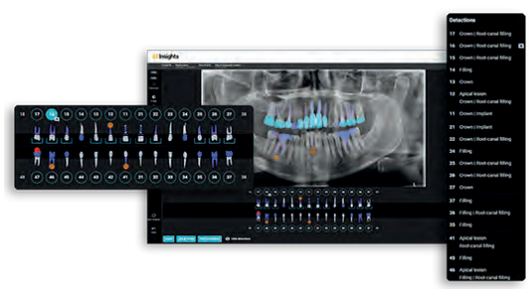
When you use AI Insights, you achieve the consistent X-ray results you need to improve clinical decision-making. The automated reports it produces can be used for enhanced patient communication and record keeping.

Increase case acceptance

Share findings with patients more effectively with consistent, objective, and clear visual information displayed in the reports. This helps to improve patients' trust in your treatment recommendations and therefore drive case acceptance.

Grow your practice

The efficiency offered by artificial intelligence ensures AI Insights gives



clinicians the ability to identify, diagnose, and treat more pathologies than ever. This means a reduction in undiagnosed and untreated cases, providing increased opportunities for revenue generation and a boost to practice performance.

Pair with your imaging equipment today

AI Insights is compatible with Carestream Dental's digital panoramic X-ray systems, included in both its traditional 2D equipment and 3D/CBCT systems.

Cutting-edge CBCT imaging systems from Carestream Dental provide practices with the power to obtain 3D views of the dental and facial structures not possible with 2D imaging. With a range of options to choose from, Carestream Dental offers imaging solutions for practically every budget and clinical need.

Digital panoramic imaging solutions provided by Carestream Dental feature Tomosharp technology to automate image reconstruction – delivering crystal-clear, high-quality images. The experienced team at Carestream Dental is able to assist practices in selecting the most appropriate imaging solutions for their unique needs.

With the possibilities offered by AI diagnostics practically endless, consider implementing AI Insights and revolutionise your processes today.

Carestream DENTAL

For more information on Carestream Dental, visit **www.carestreamdental.co.uk** and follow **@carestreamdental.uk** on Facebook and Instagram.

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Boosting children's oral health

Six million toothbrushes and toothpastes delivered as Joe Wicks MBE joins campaign to boost children's oral health

Celebrating one year of the national supervised toothbrushing programme, government and Colgate-Palmolive have announced six million toothbrushes and toothpastes have been delivered directly to nurseries and schools in a bid to help children look after their teeth.

As the programme enters its second year, fitness coach, author and founder of The Body Coach Joe Wicks MBE has joined the initiative to help parents, teachers, and children build better brushing habits. His role will be focused on sharing practical tips for busy families to help make brushing for two minutes, twice a day second nature.

The five-year collaboration aims to boost oral health among children across the country, supported by Colgate-Palmolive's commitment to donate more than 23 million toothbrushes and toothpastes. It is also providing educational materials through its Colgate Bright Smiles, Bright Futures initiative, and a public-facing children's oral health campaign supporting the NHS, developed with its experience of global oral health education.

Tackling the children's oral health crisis

The government introduced the supervised toothbrushing programme to tackle a longstanding children's oral health crisis. The most common reason children aged five to nine years are admitted to hospital is to have treatment for decayed teeth. One in five children aged five years have experienced tooth decay in England, with higher rates of up to one in three in more deprived areas.

The programme is tackling these levels of poor health by ensuring children get the support they need to learn positive habits and prevent tooth decay, in turn helping to avoid related illness, poor oral health later in life and safeguarding their healthier futures.

Health Minister James Frith said: 'One year into our national supervised toothbrushing programme, we are already seeing incredible progress in tackling the children's oral health crisis. Delivering six million toothbrushes and toothpastes so far shows the power of focusing on prevention to give every child the best start in life.

'We're working hard to improve the oral health of the nation and our partnership with Colgate-Palmolive and the support of Joe Wicks MBE are so vital to achieving that goal.'

Joe Wicks said: 'As a parent I know how busy family routines can be, but brushing for two minutes, twice a day is one small habit that can make a real difference to children's health and confidence.

'Children's oral health is part of their wider wellbeing and building good habits early can help set children up for healthier futures.

'I'm proud to support Colgate-Palmolive and the government for the second year of the supervised brushing scheme to help parents, teachers and kids feel confident building healthy habits that last a lifetime.'

Ricardo Cardenas, senior marketing director at Colgate-Palmolive, said: 'Colgate-Palmolive is a caring, innovative growth company that is reimagining a healthier future for all. As part of our purpose, we believe every child deserves the chance to have a healthier smile. We are thrilled with the milestones achieved in the first year of our partnership with the UK government, and are proud of our impact through Colgate Bright Smiles, Bright Futures (BSBF).

'Globally, BSBF has reached over two billion children and their families since 1991 with free oral health education and dental screenings. Since expanding to the UK in 2014, the program has reached over 18 million children across the nation with oral health education and donations of essential health and hygiene products.

'The supervised brushing scheme is making a real impact in preventing tooth decay and ensuring brighter futures for new generations. We want all children, regardless of needs or circumstances, to be fully equipped with the education and tools they need to keep improving their oral health every day.'

Further measures

To ensure habits continue outside the classroom, the partnership provides children with brushing kits to take home, alongside educational materials for families and support over school holidays.

The scheme works alongside wider public health measures announced by the government, including £21.5 million in government funding for supervised toothbrushing so far, water fluoridation and the biggest overhaul of school food standards in a generation.

Targets to reduce sugar and salt, and guidelines to improve labelling in baby food and drink, were also published in 2025 with industry given until February 2027 to make these changes.

Three million more courses of NHS dental treatment have been delivered compared to the year leading up to the general election and 7.2 million children (60%) accessed dental care – which is higher than before the pandemic.

The government is also bolstering the workforce through the biggest sustained expansion of dental school places in 20 years and getting overseas qualified dentists living in the country into work.

For more information, visit **colgate.co.uk** or follow #brushwithus on social media.

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Four decades of implant excellence
Association for Dental Implantology



What better way to celebrate a 40th anniversary year than ADI Team Congress 2027!

Marking four decades of continual excellence in the field of dental implantology, ADI Team Congress 2027 will be a calendar high point, delivering an unmissable, in-depth educational programme for all members of the dental implant team. Taking place on 15-17 April and themed 'The future in focus. Four decades of implant excellence', the event will reflect on the progress made by the ADI community over the years while looking ahead to see what the next era of implant dentistry will bring.

Held at the LEX, Liverpool, Team Congress 2027 is a must-attend for all those with an interest in dental implants, from students at the start of their journey to seasoned professionals. Between the lectures, hands-on workshops, international speakers and trade exhibition, there is a rich variety of ways to enhance your knowledge and skills. When adding the exciting social events and networking opportunities, attending is a no-brainer! Save the date and book your ticket to ADI Team Congress 2027.

www.adi.org.uk/congress

Precision and excellence
Carestream Dental



The CS 8200 3D Advance Edition from Carestream Dental facilitates the profession-wide need for adaptable, precise diagnostics.

The four-in-one compact unit blends high-quality panoramic technology, CBCT imaging, 3D model scanning and optimal cephalometric imaging. It allows clinicians to select the appropriate field of view for the task at hand – capturing the necessary detail without unnecessary exposure.

Intuitive software, straightforward workflows and AI-powered processes help integrate advanced imaging into daily practice without adding complexity. The CS 8200 3D Advance Edition is also scalable, so it can grow as your business does for optimal convenience and support.

For the latest news and updates, follow Carestream Dental on Facebook and Instagram @carestreamdental.uk.

www.carestreamdental.co.uk

The missing link in your workflow Carestream Dental



Open the door to seamless scanner integration across your practice with the IO Scanner Link from Carestream Dental.

The innovative software provides a direct link between CS Imaging software and leading intraoral scanners, achieving a new level of clinical and operational freedom.

Compatible with a number of leading brands of intraoral scanner, the programme facilitates communication between your technologies of choice, elevating integration and workflow efficiency.

The Carestream Dental team is readily available to answer any questions you may have or to help you build an interconnected system within your practice. Get in touch today to find out more!

For the latest news and updates, follow Carestream Dental on Facebook and Instagram @carestreamdental.uk.

www.carestreamdental.co.uk

OHC 2026 tackles today's oral health challenges British Society of Dental Hygiene and Therapy

The British Society of Dental Hygiene and Therapy's (BSDHT) Oral Health Conference (OHC) 2026 will bring two days of relevant CPD, clinical updates and professional connection to ICC Wales on 27 and 28 November.

Under the theme 'Illuminating smiles, inspiring change, impacting communities', the programme will explore issues including health inequalities, neurodivergent care, oral nicotine pouches, peri-implant disease, local anaesthesia, minimally invasive dentistry, the oral microbiome and patient communication.

Simone Ruzario, BSDHT president elect, said: 'We have focused on creating two days that feel genuinely relevant to our members and the patients they care for, while giving delegates plenty to think about, discuss and explore.'

Alongside the education programme, delegates can enjoy dedicated exhibition and networking time, the annual poster competition and Friday evening conference party.

OHC 2026 takes place at ICC Wales, Newport. Registration is now open.

www.bsdht.org.uk/ohc-2026

A stocking-filler that guarantees smiles Waterpik



Your patients are already looking ahead to Christmas, with Black Friday sales around the corner. Help them give the gift of a fresh, healthy smile, and recommend the Cordless Advanced water flosser from Waterpik.

An oral hygiene addition that helps to prevent gingival inflammation and caries by removing 99.9% of plaque bacteria from treated areas in as little as a three second application (Gorur et al, 2009), the Cordless Advanced water flosser enables access to all interdental spaces with a 360° rotating tip.

With three pressure settings, patients can choose an approach that is most comfortable for them, with the ability to also lightly massage the gingival tissue.

A range of flossing tips also help patients adjust their approach dependent on a variety of dental needs, including braces and dental implants, for complete confidence.

Help your patients give friends and family a smile for Christmas. Recommend Waterpik.

Find out more today.

www.waterpik.co.uk

Introducing 3D Fusion Ultra Adaptive Wedge

Garrison Dental Solutions



The 3D Fusion Ultra Adaptive Wedge fuses two materials together to produce the perfect combination of adaptability and retention.

The wedge has a patent pending design that combines a Soft Face Versmold with a firm inner core and advanced mechanical features to produce a wedge with improved adaptation to interproximal irregularities. Further, while insertion and separation are significantly improved with this design, supple retentive fins help to prevent back-out, even when wet.

Providing enhanced adaptation and separation, the 3D Fusion Ultra Adaptive Wedge works in concert with the 3D Fusion rings and bands. It effectively enables the practitioner to complete their restorative procedure, resulting in an improved clinical outcome.

The wedges are available in an assortment kit as well as a range of sizes (extra-small, small, medium, and large).

Dental Directory has you covered on consumables

Dental Directory



Dental Directory's consumables range covers the everyday essentials every practice gets through. The range spans from gloves, masks and infection control to cups, needles, bibs and saliva ejectors – including the extensive own-brand Unodent line.

Reliability and value are key factors to consider when ordering items used so frequently within the practice – availability across the whole basket matters as much as the price of any one item.

As such, Dental Directory's vast, consistently in-stock range and dependable delivery mean a practice can order everything it needs in one place, delivered at one time.

Browse the full consumables range at ddgroup.com.

0800 585 586
www.ddgroup.com

Delivering uniform smiles with Dental Directory Dental Directory



The vast orthodontic range from Dental Directory includes everything from brackets, band, wires, elastomerics, instruments, and everyday field-specific consumables. This also includes the comprehensive own-brand Unodent orthodontics line alongside other well-established specialist names.

Orthodontic practices get through a wide spread of items, so consistent availability across the whole basket matters as much as the price of any single line. Dental Directory's broad, in-stock range means a practice can source what it needs in one place, delivered reliably, rather than splitting orders across several suppliers.

Explore the full orthodontics range at ddgroup.com.

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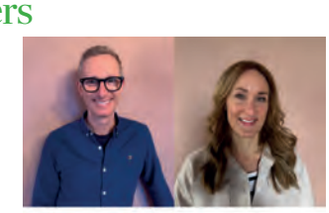
Ease the pressure with DeNovo Dental Partners

DeNovo Dental Partners



Owning a successful dental practice should not have to mean straining under the pressure of running a business. DeNovo Dental Partners supports clinicians across the UK with its shared ownership model.

For Dr Ben Goode and Dr Ursula Mulholland, selling their practice was never about retirement: 'We loved dentistry,' Ursula explains.

'What we didn't love was the constant pressure of running every aspect of the business. We were proud of what we'd built and didn't want to hand it over to someone who wouldn't value it in the same way.'

'We were told this wasn't a typical sale,' Ben says. 'It was a shared ownership approach where we would remain involved, still have skin in the game, and help shape not only our practice's future but the wider company too. That was exciting.'

Contact the DeNovo Dental Partners team today for a no-obligation chat.

kristen.pope@denovo.partners
www.denovo.partners

Mectron dental joins HuFriedyGroup Mectron

Mectron has signed a framework agreement to sell its dental business to HuFriedyGroup.

The transaction covers dental operations in Italy, Germany and the US, alongside dedicated commercial and research and development teams.

Manufacturing will remain at Mectron's Carasco plant in Italy under a multi-year supply agreement.

The deal will expand access to Mectron's piezoelectric and air polishing technologies through HuFriedyGroup's global network. Mectron will focus on its medical business while remaining a dental manufacturing and technology partner.

Completion is expected by the end of 2026, subject to legal procedures and customary conditions, with no immediate changes for customers, distributors or suppliers.

www.mectron.com

Become a member of the British Endodontic Society!

British Endodontic Society



Don't miss out on the plentiful benefits on offer when you become a member of the British Endodontic Society (BES). Join today! In addition to three key annual meetings – the Spring Scientific Meeting, Early Career Group Study Day, and Regional Meeting – the BES provides a wide range of benefits to its membership. These include:

- Access to the *International Endodontic Journal*
- Opportunities to enter BES Prizes and Research Awards
- Discounted access to the digital note taking platform Kiroku and bespoke endodontic templates developed by the BES
- Reduced rates at partner society congresses
- A monthly newsletter straight to your inbox.

Get in touch with the BES team today to find out more and become a member.

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www.britishendodonticsociety.org.uk

SprintRay MIDAS creates a new route to same-day restorations SprintRay



Restorative dentistry has often felt binary: place a direct restoration chairside or prescribe an indirect restoration from a laboratory or mill.

SprintRay MIDAS introduces a third option. The compact chairside 3D printer produces digitally designed indirect restorations in the practice, without the investment, space, and maintenance of a conventional milling unit. MIDAS uses SprintRay's patented digital press stereolithography technology. Instead of drawing resin from an open tank, it presses material into the build area from a single-use capsule. This enables highly ceramic-filled formulations (>60%) for definitive restorations to be printed while simplifying material handling. Cloud-based SprintRay Studio uses AI to generate a restoration proposal from intraoral scans. The clinician retains control and can adjust the margin, contacts, occlusion, and anatomy before printing. Up to three capsules can be loaded simultaneously, with printing typically completed in seven to 10 minutes. Restorations are then cleaned, post-cured using SprintRay NanoCure and finished for clinical use.

Discover an option for single-visit indirect dentistry with MIDAS.

www.sprintray.com/en-uk

Easier than ever to say 'yes!' Solventum



Optimised for increased patient acceptance, Clinpro Clear fluoride treatment from Solventum features an improved taste, smell and mouthfeel with enhanced fluoride delivery.

Available in watermelon, mint and flavourless, the Clinpro solutions have a rosin-free, water-based formula.

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The solution can glide smoothly onto teeth, requiring a minimum contact time of only 15 minutes. This means appointments can fit seamlessly into your patient's day. 96% of patients also report that they can't feel or taste Clinpro Clear fluoride treatment just one hour after treatment, meaning the benefits can be gained with minimal disruption.

www.solventum.com/en-gb/home/oral-care

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VIP Table Package

CIRCLE ONE

- Arrival drinks reception with unlimited bubbles and cocktails
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Alif Moosajee

Lessons in dentistry

Why did you decide to pursue a career in dentistry?
As a child, I was a good boy so when my parents said that I should either be a doctor or a lawyer, I agreed. When the time came to do work experience at school, they couldn't find me a doctor to visit, so I went to a dental practice instead. I absolutely loved it. I loved the idea of being able to fix people with my hands, so I was very motivated to work towards becoming a dentist. I've never looked back.

Tell us an interesting fact about yourself...
I used to work in a chocolate factory. I feel that my career saving teeth is penance for the damage I caused.

My daughter is a budding actress and will soon be performing in *Charlie and the Chocolate Factory*. It's all about chocolate factories in our family!

What has been your most memorable professional experience?
There have been so many, but I distinctly remember when I won the Dentistry Award for Best Young Dentist. It was 10 years ago! I was happy about being called 'best', but I was secretly overjoyed about being called 'young'!

What's your approach to behavioural change?
I'm sure Dr Wilbur Wonka, Willy Wonka's dentist father, meant well when he said:

- 'Lollipops – what we call "cavities on a stick"'
- 'You know, just last week, I read in a very important medical journal that some children are allergic to chocolate. It makes their noses itch'
- 'All these years... and you haven't flossed?'

Behavioural change is an abiding interest and my mantra is to guide rather than instruct.

Dental professionals would never promote sweets or chocolate, but lecturing patients or taking Dr Wilbur Wonka's strict approach is also unlikely to help. A more effective approach is collaborative behavioural coaching that addresses the psychological and practical causes of compliance fatigue.

Communicate openly, lead with empathy, and remind patients that every small step is a step in the right direction.

Which dental technologies have the potential to encourage a change in patient behaviour?
I love empowering patients so they can see what we, as dental professionals, see.

I particularly love the iTero intraoral scanner; it enables us to communicate with patients in a way that allows them to really understand the problem, and ask us for a solution, rather than us telling them about a problem they cannot see, cannot relate to, and about the need for a treatment they would rather not have.

I am also very impressed with the latest Sonicare DiamondClean toothbrush, which uses AI technology to help patients to see and understand where they have brushed well and areas that have been brushed less effectively.

I genuinely believe it is such a great use of technology and a great advance that will help so many patients.

'It's all about chocolate factories in our family'



Alif is principal dentist at Oakdale Dental

What makes smile design so rewarding for you, and how did 'The Smiling Dentist' name come about?
For me, smile design isn't just about making teeth look beautiful. It's about understanding the person behind the smile, what makes them happy, what gives them confidence and what they would love to change. I love combining the art and science of dentistry to create something truly personal.

As for being called 'The Smiling Dentist', I suppose it's rather fitting! I believe if you smile you engage far more effectively and make patients feel relaxed, I love making people smile, and I'm lucky enough to have a job where I can help create smiles every single day.

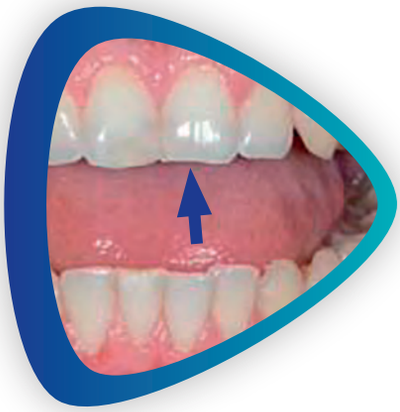
People sometimes call it smile magic, but the real magic isn't just what happens to the teeth. It's what happens to the person when they finally feel confident enough to smile without holding back. That's the bit I love most!

What do you believe the future of dentistry holds?
I really think this is the most exciting time to be a dentist. So many more people than ever are engaging with the benefits a dentist can give them – people want to have nice smiles, and it gives us an incredible opportunity.

My philosophy is that if we give patients what they want, we earn their trust to give them what they need.

SENSODYNE PRONAMEL

YOU WILL FIND SIGNS OF EROSIVE TOOTH WEAR IN ALMOST EVERY PATIENT



97% of adults

have evidence of erosive tooth wear (BEWE score ≥ 1)

72% of adults

show signs of **significant erosive tooth wear** (BEWE score ≥ 2)*

40% of young adults

have evidence of significant erosive tooth wear†

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*At least one tooth with a BEWE score of at least 2

†Age 18-27

1. Recession, dentine hypersensitivity, tooth wear periodontal health and associated risk factors: an observational, cross sectional multi-centre epidemiological study in 7 European countries, December 2023

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