

BDJ Team

NOVEMBER 2014



Managing caries in primary teeth

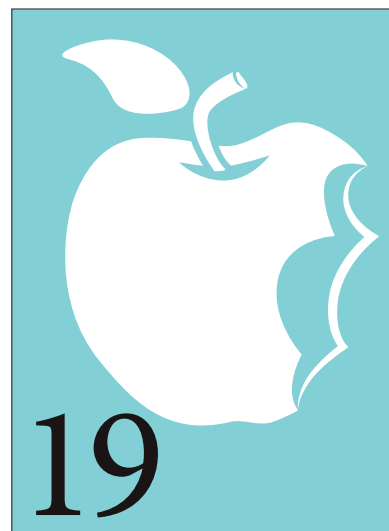
BDA
British Dental Association

November 2014

CPD:
ONE HOUR

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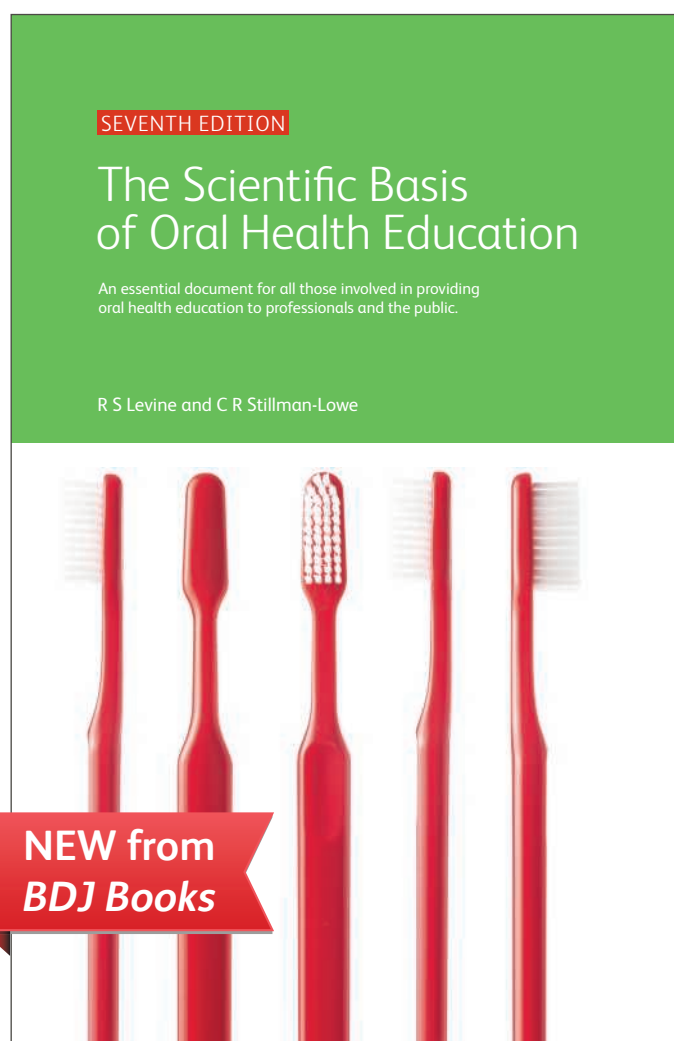
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DENTAL THERAPISTS HAMPERED BY UNFAIR PRESCRIBING RIGHTS

New president of the British Association of Therapists (BADT), Fiona Sandom, is pledging to work towards changing the 'unfair' status quo on prescribing rights for dental therapists.

It comes as physiotherapists were granted powers to prescribe (a restricted list of) medicines under new laws coming into force in Wales, Fiona's home country.

The change – also applying to chiroprpodists and podiatrists – is aimed at easing the pressure on these areas of the NHS.

Nurses, pharmacists and optometrists can already prescribe certain medicines, with powers now extended to additional groups of health professionals, subject to training.

Fiona explained: 'It's unfair and hampers our work greatly, since we are unable to carry out the full scope of our practice and whilst some of our places of work have Patient Group Directions (PGDs) in place, they are still extremely limiting.'

Fiona is already in negotiations with the chief dental officers in the BADT's bid towards changing prescription rights for therapists.

Fiona said that as president she wants to make a difference to the way dental therapists care for patients and increase their access to dental care. 'We are aware of the discrepancy over the access to dental care, especially in rural and deprived areas. As dental therapists, we are able to help the profession deliver preventative – as well as restorative – care and with prescribing

rights, we can contribute to improving the oral health in Britain while working to our full scope of practice.'

A PGD is a written instruction allowing listed healthcare professionals to sell, supply or administer named medicines in an identified clinical situation without the need for a written, patient-specific prescription from an approved prescriber.

The Human Medicines Regulations 2012 require that both a dentist and a pharmacist must sign a PGD. For practices providing NHS primary dental services, the PGD must also be signed on behalf of the commissioning body.

For private dental practices in England and registered with the CQC, the PGD must be signed by a dentist and a pharmacist and by or on behalf of the registered provider and, if there is a relevant manager for the practice or clinic, by that manager.

For private practices in Wales, the PGD must be signed by the private dentist who is treating the person, a pharmacist and, if there is a manager for the practice or clinic, by that manager.

An interview with Fiona Sandom, new BADT President, appears in BDJ Team this November (zmag pages 5-6).



Fiona Sandom,
BADT president

TIPS AND ADVICE FOR PARENTS AND CARERS

Public Health England recommends the following tips and advice for parents and carers of young children for good oral health:

- Reduce amount and frequency of sugary foods and drinks given to young children
- Don't add sugar to weaning foods or drinks
- Aim to introduce drinking from a free-flow cup from six months old and stop feeding from a bottle at 12 months
- Start brushing children's teeth as soon as the first tooth appears and supervise brushing until age seven or eight. Brush kids' teeth twice daily, including just before bed, using fluoride toothpaste
- From age three, use a pea-sized amount of fluoride toothpaste; for younger children a smear
- Use only sugar-free medicines.



GENERAL CPD ANSWERS, DENTAL EROSION, OCTOBER ISSUE

Managing dental erosion, by Carolyn Renton, <http://www.nature.com/articles/bdjteam2014109>.

Question	Answer
1	C
2	B
3	A
4	D
5	C
6	B
7	B
8	A

Do you have a news story that you would like included in BDJ Team? Send your press release or a summary of your story to the Editor at bdjteam@nature.com.



HIGH CARIES LEVELS AMONG 3-YEAR-OLDS

Twelve percent of three-year-olds in England suffer from visible tooth decay, according to a survey conducted by Public Health England (PHE).

This is the first national survey of the oral health of three-year-old children in England and was carried out at nurseries, children's centres and playgroups in 2013. Over 53,000 children were examined, representing 8% of the total age three population across England.

The results show that those affected by tooth decay had an average of three decayed teeth. There was a dramatic variation in tooth decay prevalence across the county, ranging from 2% to 34%. However, the large majority of children in this age group - 88% - have no decay at all. This reflects trends of significant improvements in dental health since the introduction of fluoride toothpaste in 1976. In some cases Early Childhood Caries was found: decay affecting the upper front teeth spreading rapidly to other teeth and related to the consumption of sugary drinks in baby bottles or sipping cups.

Dr Sandra White, Director of Dental Public Health at PHE, said: 'While there have been significant improvements to the nation's oral health, some areas still experience problems with tooth decay among young children. Thankfully [this] can be prevented by following a healthy lifestyle, by parents and carers reducing the amount of sugary foods and drinks they give their children and supporting them to brush their teeth twice a day with a fluoride toothpaste, especially just before bedtime.'

‘I am passionate about dental therapy’



Introducing the British Association of Dental Therapists' new president, **Fiona Sandom.**

Fiona Sandom became President of the British Association of Dental Therapists (BADT) during BADT's annual conference in Manchester in September this year, taking over from Baldeesh Chana, who was President from 2010-2014.

Fiona is a dental therapist with North Wales Community Dental Services, a postgraduate tutor at Cardiff University, and a GDC Quality Assurance Inspector.

At Fiona's PDS NHS practice in Bethesda she works in a team with two dentists, two dental nurses and a healthcare support worker. For her tutor role, she is based at Ysbyty Glan Clwyd in Bodelwyddan.

Fiona's hometown is Newborough on Anglesey, Wales; she has a partner called Paul and a 19-year-old son called John; she loves to run, swim and cycle, has just started to compete in triathlons and would like to complete an Ironman.

Fiona:

My first job in dentistry was as a trainee dental nurse. I needed a job as my parents were living and working in America and I didn't want to return after a holiday at home. I was lucky to get a place at a great training practice, 'The Old Lookout', in Cemaes Bay on Anglesey.

As a dental nurse, I loved working as a team to improve patients' oral health, comfort and appearance.

I completed my National Certificate in September 1992. In January 1993 I started

my dental hygiene training. I was very lucky and got a place at Manchester dental hospital quite quickly.

After completing my CEB Diploma in Dental Hygiene in 1993, I returned to The Old Lookout and found work quite easily in a couple of other practices. It was quite difficult working as a dental hygienist to begin with; we only had an 11-month course and were then thrown out into the big bad world. I would realistically say it took me a good six months to find my feet.

As a dental hygienist, I enjoyed the responsibility of seeing my own patients and promoting dental health to them.

In 1997 I heard about the conversion course for dental therapy and felt that this was an area I would like to explore. My son was two and I was only working part time. After some preliminary research there were murmurs that dental therapists would be able to work in practice in the near future. Anglesey at that time had a shortage of dentists, especially in the NHS, and I felt that if I could take some of the workload from the dentists this would increase patient access to care, as well as increase the variety of treatments that I was able to deliver.

It wasn't until 2002 that the restrictions were lifted and dental therapists were allowed to work in all areas of dentistry. I received my Diploma in

Dental Therapy from Liverpool in 1999. I was fortunate to secure a therapy post in the North Wales Community Dental Service, for one day a week. This helped me greatly as I was supported by a dental officer and an experienced dental nurse and ensured that I didn't deskill until therapists were able to work in all areas of dentistry.

I now work clinically exclusively as a dental therapist and use my full scope of practice. I am very lucky, but it is important to remember that dental hygiene duties are part of dental therapists' scope of practice and a vital part of caring for our patients' dental health.

I have also trained to treat patients under inhalation sedation and enjoy this very much.

It is difficult for me to comment on whether more dental practice principals are employing a dental therapist these days. I live and work in an area that has always been short of dental manpower, so I have never had any trouble finding work as a therapist and with good conditions. I am aware that this is not the case everywhere, especially in areas close to dental hospitals. I understand that the new NHS contracts in England and Wales promise to involve a greater use of skill mix and an increased advantage to employing dental therapists.

I have taught dental nurses in North Wales since 1994 and still do as part of my CDS role. I enjoy it a great deal. Once I qualified as a dental therapist from Liverpool I was offered a tutor post. I commuted for two years until the journey became too much for me. A few years later, in 2004, the Wales Deanery (Cardiff University) created the DCP postgraduate education department, which at the time was very forward thinking and in anticipation of the registration of dental nurses and the GDC introducing CPD for DCPs. I enjoy the variety and opportunities that my tutor's role brings me and last year I gained my MSc in Medical Education from Cardiff University.

I have been a member of BADT since 1997, first as a student member and then as a full member. I first became a council member when I was North West regional representative with Keddie Kelsall, then more recently as training and education officer.

It was a huge honour to become BADT president. I can't quite believe it,

but I am passionate about dental therapy and want to promote the value of working within a team that has a dental therapist.

As BADT president, I like to help address the issues around direct access. The GDC has lifted the restrictions and allows us to see and treat a patient without first seeing a dentist. However, there are legislative issues that are beyond the GDC, for example NHS regulations and prescribing rights [see news pages]. I am aware that the time frames to resolving these issues are long; I want to work with all four chief dental officers (CDOs) to



'I THINK THAT DENTAL THERAPISTS SHOULD JOIN BADT BECAUSE WE ARE ACTIVELY TRYING TO ADDRESS MEMBERS' ISSUES. WE HAVE A RELATIVELY NEW COUNCIL THAT IS ENTHUSIASTIC AND READY TO WORK WITH OUR PARTNERS TO DELIVER QUALITY EDUCATION.'

understand these issues and work at resolving them.

As president I am looking forward to understanding the barriers that we have to overcome in order to use our full scope of practice directly with patients and increasing their access to dental care. I hope to represent the BADT's members as well as possible.

I think that dental therapists should join BADT because we are actively trying to address members' issues. We have discussion boards and offer help and advice from experienced therapists working in all areas of dentistry. We have a relatively new council that is enthusiastic and ready to work with our partners to deliver quality education.

There are lots of newly qualified dental therapists joining the profession these days. I personally love being a dental therapist and I am very proud of the work we carry out. I would certainly encourage others, including dental nurses, to choose dental therapy as a career.

Interview by Kate Quinlan

The British Association of Dental Therapists (BADT)

The BADT was founded in 1962 with the first AGM taking place on 2 March 1963 at New Cross School for Dental Auxiliaries. The BADT works for all dental therapists working in all areas of the profession, improving working conditions and pay and fighting for recognition within the profession.

www.badt.org.uk

Read more about the history of the dental therapist in the UK in the Vital archive: 'But for New Cross, dentistry would be the poorer'; <http://www.nature.com/vital/journal/v6/n1/pdf/vital888.pdf> (free).

bdjteam2014117



Managing caries in primary teeth

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N. P. T. Innes¹ and **D. J. P. Evans¹** compare the different modern approaches to managing dental caries in primary teeth to those used for the carious permanent dentition.

When prevention of dental caries fails, and a child is exposed to the risk of pain and infection, the disease must be managed to reduce this risk. There is growing evidence supporting more 'biological' and fewer 'surgical' approaches to managing dental caries in primary teeth. These biological methods include partial and stepwise caries removal procedures, as well as techniques where no caries is removed. An overview of clinical trials comparing these biological methods to complete caries removal shows that they perform as well as traditional methods and have the advantage of reducing the incidence of iatrogenic pulpal exposures. The Hall Technique

is one biological approach to managing caries in primary molars which involves sealing caries beneath preformed metal (stainless steel) crowns. The crown is cemented over the tooth without caries removal, tooth preparation or use of local anaesthesia. The clinical steps for the Hall Technique are straightforward but, as with all dental care provision, appropriate treatment planning for the procedure requires skill. The Hall Technique offers another method of managing early to moderately advanced, active carious lesions in primary molars, with good evidence of effectiveness and acceptability. This evidence aligns with the positive findings of other studies on biological strategies for managing caries in primary teeth.

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Primary vs. permanent

Dentistry for children is not the same as dentistry for adults. The effective prevention and management of dental caries in children presents the oral healthcare team with a different set of challenges (and opportunities), compared with providing care for adults. Although evidence-based techniques for preventing dental caries are available, and the delivery of these interventions might seem at first glance to be similar for children and adults, the reduced autonomy of children means there are important differences, and this article explores these. Similarly, the limited lifespan of the primary dentition before it is naturally shed presents the opportunity for a different approach to managing dental caries from that used for the carious permanent dentition. A more 'biological', less 'surgical' approach can be used to slow or arrest caries progression in primary teeth such that the tooth exfoliates before causing the child pain or infection. This article gives an overview of the evidence on biological approaches to caries management in the primary dentition, demonstrating that they perform as well as traditional methods with the advantage of reducing the incidence of iatrogenic pulpal exposures. One particular biological caries management method, the Hall Technique, is described, along with an overview of the current place of the technique in the UK.

Caries prevention and children's oral healthcare

With regard to their oral health, children are extremely vulnerable, being entirely dependent on their parents/carers, who must take full responsibility for the child's oral health until the child is old enough to accept this responsibility for themselves. This involves the parents/carers in more than simply bringing children for appointments with the oral healthcare team. It includes the wider aspects of oral healthcare, such as providing the fundamental home-based caries preventive programmes of best toothbrushing practice and a healthy diet, as well as being role models for children in establishing good habits and attitudes. Children also depend on the oral healthcare team to deliver the four principal evidence-based preventive interventions of toothbrushing (toothpaste) advice, dietary advice, fluoride varnish and fissure sealants, in line with national guidance,¹⁻³ as well as providing caries management when prevention has failed and, of course, all of this to a high standard. Children and their parents/carers are rarely sufficiently informed to ask for these

interventions, neither are they in a position to make any assessment of the quality of the intervention provided; the oral healthcare team looking after the child must shoulder this responsibility.

The imperative for effective caries prevention for children is that adult dental disease begins in childhood.⁴ This means that prevention not only ensures children avoid the consequences of unmanaged dental caries (pain and infection), but that in addition, they can progress to adulthood with a healthy dentition (Fig. 1), a positive attitude to taking on the responsibility for maintaining their dentition for themselves, and the ability to accept any necessary dental treatment without anxiety. This is the goal of all members of the oral healthcare team who provide care for children, be they dental hygienists, dental nurses, dental therapists, general practitioners, oral health educators or specialist dentists.

Unfortunately, despite dental caries being a preventable disease, many children in the UK will experience caries in their primary dentition. Recent surveys show 31% of 5-year-olds in England having obvious caries⁵ and in Scotland, despite a dramatic reduction from 57.2% in 1998, 33% of 5-year-olds had evidence of the disease in 2012.⁶ Dental caries continues to be far too prevalent and, like other diseases associated with social inequality, is heavily skewed towards lower socio-economic groups. Management of the disease is further complicated by the fact that children who have dental caries tend to have several teeth affected. In England, the 31% of 5-year-old children with the disease had, on average, 3.45 teeth affected,⁵ and in Scotland, the 33% of children with obvious dental caries had, on average, 4.1 teeth affected.⁶ This poses particular challenges for the oral healthcare team; when a child presents with dental caries, it is rarely only a single tooth that needs to be managed.

Managing dental caries in the primary dentition

Caries management for children differs from that for adults. For adults, the management of an active dentinal lesion is generally straightforward. The consequences of leaving the lesion unmanaged can be explained to the patient, who will then usually accept the necessary inconvenience of a restorative intervention for the expected benefit of improved function, aesthetics, and freedom from pain and infection in the future. However, children (enviously), generally live in the present, and can have difficulty accepting the concept of 'let's sort it now, for benefit



Fig. 1 The healthy, caries-free and unrestored dentition of a 16-year-old girl

later'. For the younger child, freedom from pain and infection is their priority, and if they are not currently in pain, then they do not see there is a problem to be managed. This compounds the difficulties faced by the oral healthcare team when providing conventional restorative care for the child. For adult patients, it is accepted that best practice is to manage active dentinal caries lesions with some form of restoration. However, for 5-year-old children the Care Index (the proportion of carious teeth which have been restored) is 14% in England⁵ and 13% in Scotland,⁶ meaning that only around one out of eight carious primary teeth are restored. For 12-year-old children, with their permanent dentitions, the figures are more positive: in England the Care Index is 47%⁷ and in Scotland 53.8%.⁸ How much this difference in the proportion of teeth being restored is attributable to the relative importance attached to permanent teeth over primary teeth, and how much is related to the difficulties in providing restorative care for children in primary care, or other factors, is debatable and contentious.

Teaching in UK dental and dental therapy schools on the restorative management of the primary dentition is generally based on the British Society of Paediatric Dentistry guidance, which includes the recommendation that the optimum treatment of caries in primary teeth should be its removal, followed by the placement of a conventional filling to replace lost tooth tissue.^{9,10} However, these recommendations are largely based on evidence obtained from studies conducted with selected populations,

Table 1 Details of the seven randomised or controlled clinical trials where there has been stepwise, partial or no caries removal in primary teeth compared with conventional restorations (search strategy available on request)

Author and study design	Participants and teeth	Details of intervention and control	Follow up	Outcome measures and results	Author's conclusions
Magnusson³⁹ (1977) Randomised parallel group study set in one secondary care site with four operators (Sweden)	62 children (510 years) 110 primary molars. Seem to be occlusal lesions only	Intervention Stepwise (partial caries removal – with re-entry after 46 weeks); temporary – calcium hydroxide, intermediate layer of ‘Dropsin’ and zinc oxide eugenol cement. Control Complete caries removal (restorative material not stated)	100% follow up at 1 year	Pulp exposure during treatment Intervention: First stage: 0/55 (0%) Second stage: 8/55 (14.5%) Control: 29/55 (52.7%)	‘Consequently, judged by the clinical criteria used [stepwise caries removal] with a calcium hydroxide inlay may obviate a considerable number of pulp treatments in primary molars.’
Ribeiro⁴⁰ (1991) Randomised parallel group study (Brazil)	38 children (711 years) 48 primary molars. Equal Class I and Class II restorations carried out. Caries into dentine ‘at least 2 mm wide’	Intervention Partial caries removal: removal of carious dentine from enamel-dentine junction (EDJ) but visible, moist, soft dentine not removed from floor or axial walls & immediate placement of definitive composite restoration. Control Complete caries removal and placement of composite restoration	100% follow up at 1 year	Signs/symptoms pulpal pathology Intervention: 0/24 (0%) Control: 1/24 (4.2%) Longevity of restoration Intervention & control: 100% both arms	‘Application of an adhesive restorative system to irreversibly infected dentin did not affect the clinical performance of the restoration.’
Innes^{13,26} (2007 and 2011) Pragmatic, multi-centre split mouth, RCT set in primary care with 17 operators – general dentists (Scotland)	132 children (310 years) 264 primary molars. Class I (33%) and Class II lesions/ restorations (67%)	Intervention Hall Technique with 42% of teeth caries radiographically >half way through dentine. Control Dentists usual treatment including caries removal 69% GI; 11% composite; 8% amalgam; 5% compomer; 1% PMC; 2% fissure sealant	94% (124/132) at 2 years and 69% (91/132) at 5 years	Signs/symptoms pulpal pathology At 5 years: $p = 0.000488$; NNT 8 in favour of intervention. Intervention: 2 yrs: 3/128 (2%) 5 yrs: 3/91 (3%) Control: 2 yrs: 19/128 (15%) 5 yrs: 15/91 (16.5%) Longevity of restoration At 5 years: $p < 0.000001$; NNT 3 in favour of intervention. Intervention: 2 yrs: 6/128 (5%); 5 yrs: 4/91 (5%) Control: 2 yrs: 57/128 (46%); 5 yrs: 38/91 (42%)	‘...sealing-in caries by the Hall Technique statistically, and clinically, significantly outperformed the GDPs’ standard restorations. Hall technique outcomes were comparable with those of standard restorations in studies in secondary care. These results strongly support the Hall technique as a predictable restorative option, with low failure and, therefore, re-treatment, rates for managing carious primary molars in a primary care environment.’
Lula⁴¹ (2009) Parallel group randomised control trial. Secondary care with multiple operators (Brazil)	30 children (58 years); convenience sample. 36 primary molars. Caries extending into inner half of dentine on radiograph; occlusal and occluso-proximal. Sometimes more than one tooth per child included	Intervention Partial caries removal; microbiological samples taken; calcium hydroxide base; restored with composite. Control Complete caries removal; microbiological samples taken; calcium hydroxide base; restored with composite	1 year follow up. Children; 87% (26/30) Teeth; 89% (32/36) Four children and four teeth were lost to follow up, two from each arm	Bacterial growth from dentine samples ‘No difference in microbial growth between groups was observed after 36 months for any of the microorganisms studied.’ Pulp exposure during treatment Intervention & control: 0% both arms Longevity of restoration Intervention: 16/16 (100%) Control: 15/16 (94%)	‘The results suggest that persistence of bacteria does not seem to be a reason for reopening of cavities in deciduous teeth after partial caries removal.’
Orhan⁴² (2010) Parallel group randomised control trial (Turkey)	123 children (415 years) 94 mandibular second primary molars with caries extending >three-quarters through dentine radiographically. (Also included 60 mandibular permanent first molars)	Intervention Group 1: Partial caries removal and compomer restoration. Group 2: Stepwise caries removal if pulp exposure suspected – calcium hydroxide base, ZOE; re-entry after 3 months; restoration with glass-ionomer base and compomer. Control Complete caries removal and compomer restoration	1 year follow up Teeth; 78% (73/94)	Pulp exposure no statistically significant difference between partial and stepwise caries removal or between stepwise and complete caries removal. Intervention: Group 1: 2/31 (6.5%) Group 2: 3/32 (9.4%) Control: 6/31 (19%) Signs/ symptoms pulpal pathology (NB unexposed teeth only) Intervention: Group 1: 0/29 (0%) Group 2: 1/29 (3%) (lost temporary then abscess 1/29) Control: 2/25 (8%) (Internal resorption 2/25)	‘Indirect pulp therapy in both primary and young permanent teeth can be used successfully with a 1 or 2 visit approach.’

Continued on page 10

Table 1 Details of the seven randomised or controlled clinical trials where there has been stepwise, partial or no caries removal in primary teeth compared with conventional restorations (search strategy available on request)

Continued from page 9

Borges⁴³ (2012) Single centre randomised trial set in University Dental Centre (Brazil)	30 children (59 years) Two unrestored, non-cavitated teeth with occlusal caries into dentine per child	Two arm RCT; each child had two teeth entered to the trial but not clear if one assigned to each arm Intervention Rubber dam isolation, cleaned and fissure sealant placed. Control Local anaesthesia, rubber dam isolation, high speed access to caries, 'cariious tissue' removed and tooth restored with composite	1 year follow up. Children 87% (26/30) Clinical caries progression or cavitation in sealant group and radiographic progression	Radiographic lesion progression not statistically significant $p = 0.12$ Intervention: 3/26 Control: 0/26 Longevity of restoration not statistically significant $p = 0.12$ Intervention: Complete retention 23/26 (88.5%) Partial retention 3/26 (11.5%) Complete sealant loss 0/26 Control: Complete retention 26/26 (100%)	'Fissure sealing and tooth restoration were equally effective in the management of non-cavitated dentine occlusal caries in primary teeth. Invasive procedures can be replaced with the non-drilling approach with no adverse consequences for paediatric patients.'
Phonghanyud⁴⁴ (2012) 'Two standard dental clinics in two hospitals'. Single operator. (Thailand)	276 children (611 years) Occlusal and/or proximal surface caries extending >one-third through dentine without signs/symptoms of irreversible pulpitis	Three arm RCT Intervention Group 1: Partial caries removal at EDJ - spoon excavation Group 2: Complete caries removal - spoon excavation. Control Group 3: Complete caries removal - rotary instruments (LA used for five children). All cavities accessed with high speed round bur & teeth restored with glass-ionomer cement (GIC)	1 year follow up. Children 96% (266/276) clinical and radiographic	Cumulative survival rates of restorations not statistically significant for any groups Group 1 83%, Group 2 83% Group 3 (Control) 89% Pulp survival not statistically significant for any group Group 1 99%, Group 2 100%, Group 3 (Control) 98% However teeth excluded prior to analysis: Group 2 - 1 pulp exposure Group 3 - 2 pulp exposures	'The clinical and radiographic evaluations after 12 months indicated that partial soft caries removal at EDJ followed by GIC restoration was comparable to that of ART and conventional approaches.'

either in a secondary care or specialist paediatric dental practice setting.¹¹ The evidence supporting the effectiveness of such care when provided by general dental practitioners (GDPs) in primary care in the UK is less convincing.^{12,13}

There are many reasons why the provision of conventional restorative care for the primary dentition in primary care might be problematic. Although development of child dental anxiety is not attributable to a single factor and there is a link between child and maternal anxiety,¹⁴ experiences of dental treatment have been shown to play a significant role.¹⁵⁻¹⁷ Despite very little investigation into children's perceptions of dental treatment, what evidence there is indicates that they can find a conventional approach (that is complete removal of caries and placement of a restoration) more difficult to accept than less invasive procedures.¹⁸⁻²⁰ The low levels of provision of these restorations may be compounded by dentists' perception that conventional approaches are ineffective in managing caries in young children.²¹

A biological approach to caries management in the primary dentition

Recently, biologically-orientated strategies

for managing dental caries have come back into focus. A number of clinical trials have been carried out looking at incomplete or no caries removal in primary teeth and how the outcomes for these techniques compare to complete caries removal. These 'minimal intervention' approaches reduce some of the adverse consequences associated with carrying out restorative treatment, with the advantages of conservation of tooth structure and integrity, maintenance of maximum pulpal floor dentinal thickness (which can reduce the impact on pulpal health²²), and reduced pulp exposure. In addition, if no vital dentine is being removed, there can be less need for local anaesthesia, which has been shown to reduce children's reported discomfort.^{18,19} A recently updated Cochrane systematic review has compared biologically-orientated strategies (stepwise, partial and no-caries removal), with complete caries removal for managing caries in both primary and permanent teeth. Eight trials of 934 patients (1,372 teeth) with outcomes reported for 1,191 teeth were included in the analyses. The conclusion of the review was that for symptomless and vital teeth, biologically-orientated strategies had clinical advantages over complete caries removal in the management of dentinal caries. Not only were there no differences in restoration longevity

or in the numbers of teeth (or patients) experiencing pulpal pathology (pain or infection), but there were significantly fewer pulp exposures. For partial caries removal in primary teeth, this gave a relative risk of 0.24 [95% CI 0.06 to 0.90], when caries was not completely removed: a 76% reduction in the risk of pulp exposure compared to complete caries removal. In other words, the risk of pulp exposure was reduced by around three quarters when partial caries removal was performed, and there were no additional pain or infection events over the following year.

Table 1 presents an updated, comprehensive overview of randomised control trials (RCT) and controlled trials of primary teeth alone where stepwise, partial and no caries removal has been compared to complete caries removal. This was constructed following an electronic database search up to 15 January 2013 (of MEDLINE via OVID, EMBASE, the Cochrane Oral Health Group's Trials Register and CENTRAL), based on the Cochrane review search strategy, built around key words (including dental caries, dental restoration, ultraconservative, minimal invasion, atraumatic, fissure seal, randomised trial, controlled clinical trial) but limited to primary teeth. References of all included studies were checked for further studies and systematic reviews, and the references of



Fig. 2a Four-year-old child with caries on occlusal surface of tooth 84 extending distally

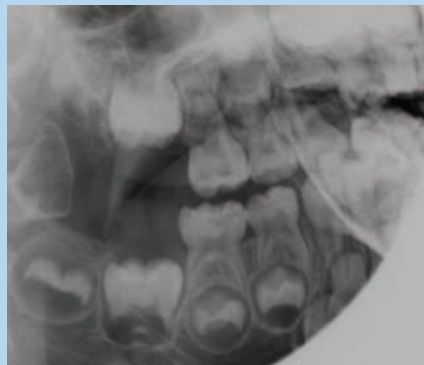


Fig. 2b Lateral oblique radiograph of 84. The lesion is limited to the outer half of the dentine



Fig. 2c Orthodontic separator placed distally to tooth 84



Fig. 2d Tooth 84 following removal of separator



Fig. 2e 'Trying in' to determine correct size of PMC for tooth 84



Fig. 2f Initial seating of PMC on tooth 84



Fig. 2g Child completes seating of PMC by biting down on a cotton wool roll



Fig. 2h Removal of excess cement



Fig. 2i Hall crown fitting completed. Slight changes in occlusion are acceptable at this stage

removal techniques over complete caries removal and this was true for all of the different outcomes measured (pulp exposure during treatment; signs/symptoms of pulp pathology; longevity of restoration; bacterial growth from dentine samples; radiographic lesion progression). However, these techniques all depend on a high quality seal for their effectiveness; even the most perfect Class II cavity preparation will fail if the tooth is restored with a glass-ionomer cement²³ or an inadequately bonded composite. This is demonstrated clearly in Borges' study in Table 1, where fissure sealants were used to seal over non-cavitated dentinal caries and there was radiographic evidence of lesion progression in the three teeth where the sealant had been partially lost.

Biological approaches have advantages for child patients receiving dental care. They are less destructive and potentially less damaging for primary teeth, and offer clinicians more scope for treating their patients with less invasive techniques. The Hall Technique is one of these approaches and background evidence to support its use together with an update on the professions' perception of the technique, and a brief clinical 'how-to' will be presented here.

THE HALL TECHNIQUE

Background

The Hall Technique is named after Norna Hall, a GDP, who had initially been routinely using preformed metal crowns (PMCs), also known as stainless steel crowns, using conventional techniques. She developed a simplified technique where the PMC was cemented over a carious primary molar, with no local anaesthesia, caries removal, or tooth preparation of any kind (see Innes and Evans, 2009²⁴ for further background). An audit of her records²⁵ together with an RCT based in primary care,¹³ supported her findings, and found the technique to be acceptable to the children, their parents and the GDPs. At five-year follow up,²⁶ only three (3%) of the primary molars managed with the Hall technique had experienced a major failure (irreversible pulpitis, loss of vitality, abscess or unrestorable tooth), compared with 15 (16.5%) of the matched control teeth, managed according to the GDPs' usual practice. The GDPs' conventional restorations did show high failure rates. However, not only were the Hall crowns more effective than these conventional fillings ($p < 0.001$), the low failure rates of the Hall crowns were comparable with those of standard restorations carried out in studies in secondary care.¹¹

these also scrutinised. There are seven studies which all compare complete caries removal in some teeth to incomplete (stepwise or partial) or no caries removal in other teeth using randomised or controlled trial designs. There

is considerable variation in the interventions, the techniques used, the restorative materials and the outcomes measured in these studies. However, the findings are consistently positive or equivalent for the various minimal caries

Placing a PMC using the Hall Technique

The following is a brief outline of the method for placing a Hall crown. Full information, including an explanation of indications and contra-indications for placing a Hall crown and with hints and tips, is included in a short illustrated manual, freely available online.²⁷ Case selection is extremely important; an ideal indication for the Hall Technique would be a primary molar with early to moderately advanced active dentinal caries affecting the proximal surface, and no signs or symptoms (clinically or radiographically), of irreversible pulpal involvement. The child, and their parent, will have given fully informed consent. In the example shown, a 4-year-old girl had a right mandibular first primary molar (84) with caries affecting the occlusal and distal proximal surface (Fig. 2a). Clinical and radiographic examination (Fig. 2b) indicated there was a low risk of irreversible pulpal disease. An orthodontic separator was fitted to the distal part of the tooth (Fig. 2c) to create interproximal space and aid placement of the PMC at the child's next appointment, three days later. After measurement of the occlusal vertical dimension (OVD) at the canines, and removal of the separator (Fig. 2d), different sizes of PMCs were tried until one was found which could be fitted over all the cusps, with a feeling of 'spring back' when pushed as far (but not beyond), the contact points (Fig. 2e). The PMC was then filled with a glass-ionomer luting cement and seated over 84 (Figs 2f) to engage the contact points, following which the child was asked to bite down (Fig. 2g). Excess cement was removed, the child asked to bite down a second time (which pushed the crown further into place) and then pressure kept on the tooth until the cement set. Excess cement was removed and the contact points flossed (Fig. 2h). The OVD was remeasured to exclude excessive increase, displacing contacts were checked for, and the child discharged to be reviewed at her next treatment appointment (Fig. 2i).

Limitations of the Hall Technique

The Hall Technique will not suit every child with carious primary molars. The very anxious, or the very young child, might find placement of a Hall crown more than they can cope with. Others might object to the aesthetics, particularly when placed on maxillary first primary molars. Finally, Hall crowns are not restorations to be used on primary molars as a last resort when all else has failed. For primary molars with signs and/or symptoms of irreversible pulpal involvement, conventional pulp therapy

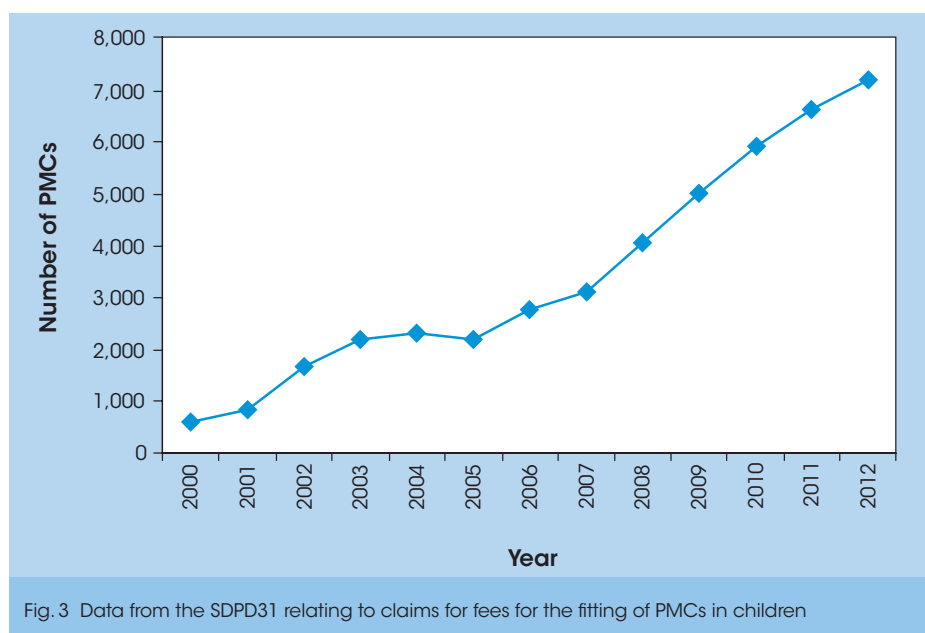


Fig. 3 Data from the SDPD31 relating to claims for fees for the fitting of PMCs in children

and PMC placement, or extraction, remain the treatment options. Hall crowns should only be fitted after clinical examination *and* radiographic investigation have indicated there is only a very low risk of irreversible pulpal pathology. Hall crowns, like all restorations, require careful follow up after fitting, with prompt management of pulpal pathology if this does develop. Most clinicians will have witnessed the unfortunate situation where a carious primary tooth that has not been treated eventually disintegrates (usually as a result of both the caries continuing and the body responding to the associated dento-alveolar infection with inflammatory processes). The tooth crumbling away at least limits, to some extent, the duration of chronic infection experienced by the child. However, this already far from ideal situation could be worsened by placement of a PMC over a primary molar with associated sepsis. With the molar protected from breaking up by the PMC, it could, without appropriate management, become a source of chronic infection for an extended period of time. As such, Hall crowns are not the answer to providing oral healthcare for disadvantaged or underserved populations; instead, resource should be invested in oral health improvement programmes.

The Hall Technique will not suit every clinician. Clinicians tend to use restorative techniques they feel comfortable with. For some, using a glass-ionomer material to manage proximal lesions in primary molars will remain their treatment of choice, despite overwhelming evidence as to its ineffectiveness for this application.²³ Some will question whether any restorative approach for carious primary molars is effective.²⁸ Other

clinicians may state they are uncomfortable sealing in dental caries, despite high quality evidence that provided the seal is maintained, this is an effective management method.²⁹ However, these same clinicians will often use indirect pulp caps as part of their regular clinical practice: an effective, evidence-based technique for managing the deep carious lesion where caries is sealed in over the most vulnerable part of the tooth, directly over the dental pulp.

Current position of the Hall Technique

Since 2000, the use of PMCs by GDPs in Scotland has been rising steadily. Figures from the Scottish Dental Practice Board, who process all claims for dental procedures carried out under the NHS in Scotland,³⁰ show the number of claims for placement of PMCs on primary teeth has risen from 599 in 2000 to 7,183 in 2012 (Fig. 3). To determine the extent of the teaching and use on clinics of the Hall Technique, all 16 UK undergraduate dental schools and 18 dental therapy schools were contacted. Information from course leaders in all 34 schools was obtained. Fifteen out of 16 dental schools stated that they taught the Hall Technique as a standard part of their undergraduate curriculum. The single dental school where the Hall Technique is not formally taught, 'mention it' within a lecture on conventional PMCs. Similarly, in the same 15 out of 16 of the dental schools, the Hall Technique forms an accepted part of the caries management strategies within the clinic and is used to treat patients. Out of the 18 dental therapy schools, all teach the technique as a standard part of the curriculum and use it with patients. The Hall technique has only had evidence supporting its use for the last

five years and it is surprising for a technology to be adopted so widely in teaching in such a short period of time. Despite the integration of the technique by teaching establishments in the UK, the place of the Hall technique in child oral healthcare remains controversial, particularly amongst the wider field of specialists in paediatric dentistry, although there is evidence of its growing acceptance in Europe.³²

The Hall Technique has attracted interest, and a number of commentaries have been published on the RCT that was carried out in Tayside with GDPs between 2001 and 2009, with two-year¹³ and five-year²⁶ results published. In 2008, the *Evidence Based Dentistry* commentary³¹ concluded, for the two-year results, that 'The Hall Technique seems to offer an effective, non-invasive treatment option for carious primary molar teeth involving two or more surfaces. Sealing in caries in primary molars using Hall PMC seems to improve pulpal health and patient benefit from the smaller cavity size, no need for local anaesthesia and a less traumatic

failed to note that despite PMCs being used by the paediatric dental community for over 60 years,^{35,36} there are no good quality RCTs of conventional crowns *versus* any restorative treatment.³⁷ In the Hall technique split mouth RCT (see Table 1 for further detail), for the teeth treated, almost half (42%) of the 86% of teeth where radiographs were available had caries lesions extending over half way through dentine and over two thirds (68%) resulted in a Class II restoration - that is the cohort of teeth were significantly affected by caries.¹³ Nevertheless, after five years following treatment with a Hall Crown, the success rate was 97% of the teeth followed up (n = 91 patients; 69%) being free from pain, and infection and 95% not requiring any further treatment. It is difficult to see these results, compared with other studies of restorative treatment¹¹ and obtained by GDPs without recourse to general anaesthesia or sedation, as indicating anything other than success for the restorations provided.

It is interesting to note the different interpretations and recommendations have

access to dental services for children.³⁸

The programme is centred on nursery and primary school preventive programmes (brushing and fluoride varnishing) and universally-accessible, child-centred NHS dental practices (<http://www.child-smile.org.uk>). For improving children's oral health, what happens at home, and in the community, is at least as important as what happens in the dental surgery. The Hall Technique is not the answer to the problem of childhood dental caries. Dental cavities are the *consequence* of the disease of dental caries, and should not be confused with the disease itself. Fitting a Hall crown to a child may well manage the problem of the cavity, but it will do nothing to sort the problem of the disease; the child will develop further cavities in other teeth if nothing else changes. However, the Technique does offer another method of managing the early to moderately advanced active dentinal lesion in primary molars, with good evidence of effectiveness, and acceptability to children and parents. This evidence aligns with the positive findings of other studies of biological strategies for managing caries in primary teeth.

'WHAT HAPPENS AT HOME, AND IN THE COMMUNITY, IS AT LEAST AS IMPORTANT AS WHAT HAPPENS IN THE DENTAL SURGERY.'

procedure from the point of view of child behaviour management.' The *Journal of Evidence Based Dental Practice's* 2012 review, which included analysis and evaluation of a systematic review of caries removal in primary teeth,³³ suggested that 'the five-year data should not be seen as evidence that the Hall Technique is superior to other not yet measured interventions, such as the traditional crown preparation'. However, the conclusion of the review itself, where the Hall Technique was one of three studies included, was that 'this systematic review suggests that minimally invasive techniques ... are the procedures of choice in the arrest of dental caries in the primary dentition'. Also in 2012, the *Pediatric Dentistry* five-year results commentary³⁴ stated: 'Based on the available inconclusive evidence, provision of preformed metal crowns for primary molars using the Hall Technique cannot be recommended in clinical practice.' Unfortunately, the author of the article did not interpret the findings in reference to outcomes of other restorative studies, the extent of caries involvement for teeth and likely outcomes, or even the general field of restorative paediatric dentistry, and

been based on the evidence from a single retrospective study and single RCT of the Hall technique, which seems to be a focus for the controversy that still surrounds biological management strategies for caries. Further investigations into the Hall Technique are currently being carried out which will support or otherwise the evidence from the Scottish work. One international study between Germany and Lithuania is well underway, and in Australia, additional funding has just been granted to continue a community based trial of pre-school children for three years. In New Zealand, a successful government funded pilot trial has been completed in one region, with a larger trial investigating generalisability and longer term outcomes planned.

Conclusion

Caries prevention can be extremely effective; many ascribe the dramatic improvement in the oral health of Scottish 5-year-olds over the last eight years (the proportion free from visible caries rising from 44.6% in 2003 to 67% in 2012), as largely due to Childsmile, a preventive programme aimed at reducing inequalities in oral health and supporting

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FLASH INTERVIEWS

with a DCP near you

Kasbir Kaur

Kasbir Kaur is a 28-year-old dental nurse/receptionist from Blackpool who works at St Annes Dental Clinic. Her partner Richard is a senior support worker.

How long have you worked in dentistry?
Ten years.

Why did you choose dentistry for your career? I wanted to work in a clinical environment and have always been fascinated with dentistry so I enrolled onto an apprenticeship after studying A levels at college.

Do you have any special responsibilities within your dental practice? Yes. I'm an orthodontic nurse and I can take dental impressions. I also take dental radiographs and I trace cephalometric radiographs. I update the emergency drugs kit every three months. I also carry out administrative duties for the orthodontist such as placing patients on the waiting list for ortho treatment, typing letters that she reads to the dictaphone, uploading patient photographs to the patient files on the computer,

scanning all paperwork, and checking the orthodontic email account for any enquiries from dental companies and patients etc.

What do you like best about your job? Assisting the orthodontist whilst she carries out orthodontic treatment on patients. It's great to see their teeth improving during the treatment and it's nice to see the patients regularly over the course of their treatment.

What is the most challenging part of your job? Keeping up with my workload but I always manage to in the end and I ask for help from others when needed.

What are you most proud of? Passing my courses in dental nursing, orthodontic nursing, dental impression taking and dental radiography.



What do you like to do outside work? I go walking with my local walking group (Wyre Ramblers) every two weeks around the UK. My favourite places to walk are the Lake District and Wales.

What do you like about BDJ Team? I like reading the articles to help me continue my professional development.

What three things could you not live without (besides people)? My three-legged rescue cat Timmy, my phone and my car.

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- You would like to appear in a mini 'FLASH INTERVIEW'
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All ideas and suggestions are welcome!



Sheena McCormick

Sheena McCormick is a 50-year-old practice manager at Newport Pagnell Dental & Teethinline Orthodontics in Milton Keynes. Sheena is married to Paul, a police officer; they have three children called Aaron, Joel and Lewis and two grandchildren, Halle and Landon.

How long have you worked in dentistry?

Four-and-a-half years.

Why did you choose dentistry for your career? I didn't! Fell into it through a mystery job advert for a business manager and absolutely love it!

Do you have any special responsibilities within your dental practice? Depends what you mean. To me the whole thing is special and quite unique - managing three practices, juggling so many different roles and responsibilities, people and their varied roles/professions and getting a balance between private and NHS work. I previously worked as an HR Manager and Business Consultant but never got the sense of fulfilment that I get in this job.

What do you like best about your job? The variety! I love my office admin days, managing projects and balancing the books but I relish the opportunity to get behind our reception and meet/greet and chat with our patients.

What is the most challenging part of your job? Every day brings a different challenge but the most challenging is keeping everything going every day - people, equipment, finances...

Do you have any outstanding ambitions? Work-wise I would like to develop and enhance our practices so that they are regularly seen as outstanding practices with fab service for every patient and a great place to work for the whole team - we're not far off! On a personal level, I want to visit as many places as possible before I'm too old to do it.

What do you like to do outside work?

Holiday! Paul and I have very busy weeks so obtaining a good balance of work/life is very important to us. Love a lush little weekend break (the team are always asking where you off to now) and I read books by the dozen (no preference for authors but love a good read).

Tell us a secret. My husband is so proud that I now visit the gym three times a week - what he doesn't know is that I spend a fraction of that in the gym and the rest chilling by the pool or having a latte in the coffee lounge!

What do you like about BDJ Team? It keeps me up to date and abreast of what's happening in the wider arena and covers a multitude of topics, news and views. It's like a useful networking buddy outside your practice!

What three things could you not live without (besides people)? My iPad, a good book and my latte!

Becky Hudson

Becky Hudson is a 25-year-old dental nurse from Corby who works at Smiles Ahead (Corby) Ltd. Becky is married to Daniel, a warehouse supervisor, and they have two children, Alfie and Oscar.

How long have you worked in dentistry? I started as a dental receptionist in March 2008 and qualified as a dental nurse in April 2014.

Why did you choose dentistry for your career? If I am completely honest this is a career that I fell into. My first full time job after finishing college was as a dental receptionist. This was only meant to be temporary but I thoroughly enjoyed my time within this job role along with the responsibilities I was given. Due to family commitments, I left this job in 2012 after having my second child as I needed to try and balance work with child care while they were both young. However, when they got a bit older I decided to go back to work and back into dentistry. Nursing was just the next logical step in my career progression and I haven't looked back since!

Do you have any special responsibilities within your dental practice? At my current practice we are all equal and form a great team. We all share the daily, weekly and monthly responsibilities that come with the job. We all help each other out instead of everyone having set tasks.

What do you like best about your job?

Helping people overcome their fears of the dentist, making sure they have a positive experience and I love seeing how much dentistry can change a person, making them more confident and happier in themselves.

What is the most challenging part of your job?

Being a dental nurse is so much more challenging than just sitting chairside. There is so much more to the job role: admin duties, covering reception, managing the de-con room, following policies and protocols, documenting everything, keeping on top of stock levels, CPD requirements ... and much more! The challenge is keeping on top of everything and prioritising your work, ensuring the patients always come first. But if you are a committed dental nurse and love your job then it shouldn't be challenging at all!

What are your outstanding ambitions?

My next step is to complete an impressions taking course which I am already enrolled on. Then I am aiming to do advanced impression taking, fluoride application and OH educator along with radiography. Other interests I

have are sedation/implant nursing and minor oral surgery.

What do you like to do outside work?

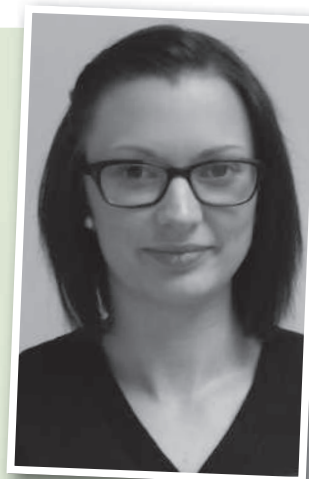
I love spending time with family and friends! We are always out and about doing something, seeing the family and keeping the boys and our two pooches entertained and out of mischief! In all fairness being a married, full time working mum of two young boys doesn't leave much time for anything else.

Tell us a secret. I originally wanted to be a veterinary nurse but ended up qualifying as a dental nurse!

What do you like about BDJ Team? It's helpful, provides great CPD and is always there if you need any advice.

What three things could you not live without (besides people)? Dogs (pets), shoes, and of course a toothbrush!

bdjteam2014120





A comparison of oral health knowledge

This research summary compares oral health knowledge between dental professionals, other healthcare professionals and the public.

ABSTRACT

Title of original research: Mind the gap! A comparison of oral health knowledge between dental, healthcare professionals and the public

Authors: W. Richards, T. Filipponi and V. Roberts-Burt, Faculty of Health Sport and Science, University of South Wales

Publication details: *British Dental Journal* 2014; **216**: E7. Published online on 21 February 2014.

Introduction: The importance of consistent, accurate and unambiguous messages is well documented in oral health promotion literature. Whether the reality of delivering messages in the field fulfils these principles is questionable.

Objective: This paper explores the perceptions of dental professionals, healthcare professionals and lay community members with regard to key oral health messages in order to highlight any inconsistencies and knowledge gaps between and within groups for disease risk factors.

Method: A questionnaire was administered to individuals who belonged to three groups: dental professionals, healthcare professionals and lay community members. The questionnaire established knowledge regarding risk factors for caries, periodontal disease and erosion (Fig. 1). The professional disciplines included dentists, orthodontists, hygienists, dental nurses, public health dietitians, general medical practitioners, pharmacists, health visitors and specialist and general nurses.

Results: The questionnaire returned 315 completed questionnaires with a response rate of 100%. The participants consisted of four orthodontists, 38 dental practitioners, six hygienists, 13 dental nurses, 11 public health dietitians, eight general medical practitioners, 51 specialist and general nurses, nine pharmacists and 175 lay community members. Thirty-five (57.4%) of the dental group answered the whole questionnaire correctly, identifying that all nine statements in Figure 1 were false. Twenty-two (27.8%)

and nine (5.1%) of the healthcare and lay community group answered the whole questionnaire correctly, respectively. The question of fluoride levels in children's toothpaste was the main reason for incorrect answers in the dental group. This can be explained by the fact that fluorosis as a result of excess fluoride use in infancy is a contentious issue. From a public health point of view, the risk of tooth decay and its consequences such as pain and extractions is greater than the small risk of fluorosis.

Conclusions: The results of this survey demonstrate a knowledge gradient from dental professionals through to healthcare professionals and then to lay members of the community. The knowledge base observed in the dental group is reflected in the other two groups as would be expected albeit with a significant gap between each group. As expected the dental professionals are generally well informed, but not as well informed as could be expected.

Please answer all questions

1. If I want to stop my teeth decaying, it is more important to cut down how much sugar I eat/drink, than to cut down how often I have it.

True/False/Don't know

2. If a drink says 'no added sugar' on the packaging, this means that it has no sugar in it, and that it is safe for my teeth.

True/False/Don't know

3. I should rinse out my mouth after brushing to remove all the toothpaste.

True/False/Don't know

4. All children should use a children's toothpaste with less fluoride in it than in an adult toothpaste.

True/False/Don't know

5. Mouthwashes are just as effective as flossing at preventing gum disease.

True/False/Don't know

6. If I brush my teeth for 3-5 minutes twice a day, I won't get any tooth decay.

True/False/Don't know

7. If my gums bleed, I should avoid brushing and flossing in these areas.

True/False/Don't know

8. Brushing my teeth straight after drinking a fizzy drink will protect them.

True/False/Don't know

9. When brushing my teeth, it is more important to brush the teeth themselves than around the gums.

True/False/Don't know

Fig. 1 Risk factor questions for the prevention of dental disease

AUTHOR Q&A

Q. Why did you undertake this research?

A. The Faculty of Health Sport and Science of the University of South Wales is primarily involved in training healthcare professionals, eg nurses, health visitors and midwives. With increasing emphasis on using healthcare teams to deliver preventive care we were ideally positioned to investigate the perceptions of healthcare professionals with regard to key oral health messages. To add another dimension to the study we thought it would be interesting to establish the perceptions of dental professionals and lay community members, thereby establishing patterns of knowledge between 'givers' and 'receivers' of messages.

Q. What would you like to do next to follow on from this work?

We would like to undertake qualitative investigations with healthcare professionals. Qualitative group studies could highlight practical obstacles to implementing recommendations to enhance oral health in the community. Take for example the recommendations to not rinse following toothbrushing with a fluoride toothpaste; would this be an acceptable behaviour in the eyes of the healthcare provider? Exploring the feelings/beliefs of healthcare professionals towards issues surrounding oral health behaviours could enlighten researchers so as to understand and/or resolve barriers.

EDITOR'S SUMMARY

A little knowledge is a dangerous thing, is, I believe, how the expression goes. Perhaps a rider to this could be that a confusion of knowledge is an even more dangerous thing. At the basic level the results of this piece of research are hardly surprising: that the more professional and educated one is the more likely one is to give the correct answers. However, by collating these predictable outcomes it does confront us with a host of questions about the state of our knowledge and crucially the status of our scientific or

evidence-based knowledge on various aspects of oral health and preventive advice.

The well respected and frequently updated text published by the BDJ, *The scientific basis of oral health education* is an attempt to clarify many of the preventive messages that benefit our patients. It may be that this concise book should have a greater prominence in all areas of dental professional, health professional and lay education in order to provide coherent messages and collaborative understanding. If this provides a route to solving one of the problems raised by this paper there are others which might not be so easily resolved.

Confusion over the correct, or currently thought to be correct, messages is common to all areas of health, diet being a glaringly obvious example in which what is good, bad or indifferent seems to vary on a daily or sometimes apparently hourly basis. How one 'de-clutters' not just the past messages learnt at dental school, postgraduate meetings or through other sources but the individual beliefs in these mantras is quite another matter and one that needs addressing if we are to move forwards effectively in terms of the promotion and improvement of oral health.

'Mind the gap' is famously used as an announcement on the London Underground warning passengers to step over the space at older stations caused by straight carriages when stopped against curved platforms. Modern stations are constructed to avoid this situation and we should perhaps heed this advance in the design of our messages thereby leaving no apertures for our advice to fall through.

Stephen Hancocks OBE,
Editor-in-Chief, BDJ portfolio



'FROM A PUBLIC HEALTH POINT OF VIEW, THE RISK OF TOOTH DECAY AND ITS CONSEQUENCES IS GREATER THAN THE SMALL RISK OF FLUOROSIS.'

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INDEPENDENT COMMENTARY

This paper reports on a simple study to compare the oral health knowledge of three groups: dental professionals, other healthcare professionals and a lay public group, using a questionnaire consisting of nine basic oral health statements requiring either a true or false response. Not surprisingly a knowledge gradient was found between the three groups. While the authors commented that the dental professional group appeared to have a good knowledge of oral health education issues, surprisingly only 35 of the 61 members gave correct answers to all nine questions. Only 22% of the healthcare group and 9% of the lay public group gave fully correct responses. While the response of the dental professional group - which included dentists and dental hygienists - appears surprisingly poor, the question that caused the greatest difficulty was should all children use a children's toothpaste with less fluoride in it than an adult toothpaste? The current advice from the UK Department of Health is that children under three years of age should use a toothpaste containing at least 1000 ppm F and children and adults over that age should use a toothpaste containing between 1,350 and 1,500 ppm. Indeed most toothpastes marketed for the three to five year age group contain 1,450 ppm. Consequently there is no simple true or false answer to the question as posed. The dental professional group should have been aware of this recommendation and consequently may have

been unsure of the appropriate response to the question. Two of the questions relating to periodontal disease may also

have caused confusion. The first asked if mouthwashes were just as effective as flossing for the prevention of gum disease. However, the type of mouthwash was not specified and there is little evidence to show whether mouthwashes or flossing are more effective for plaque removal. The second question asked if it is more important to brush the teeth themselves rather than around the gums. The generally accepted advice is to brush both the teeth and gums to remove plaque deposits building up around the gum margin; again, however, there is little evidence on this issue.

The authors conclude that their survey demonstrated a knowledge gradient between the three groups, which they correctly state is not surprising. Their final statement is that the reduction of dental disease requires consistent, accurate and unambiguous key messages. This is certainly true.

R. S. Levine OBE, Hon. Senior Research Fellow in Child Health, Academic Unit of Obstetrics and Senior Clinical Tutor, Department of Oral Surgery

HOW DID THE BDJ TEAM READER PANEL DO?

I sent the questionnaire on oral health knowledge to *BDJ Team's* reader panel (<http://tinyurl.com/kmvtuca>). The correct answer to all nine of the questions was **false**. Seven panel members responded to the questionnaire; of these, one correctly identified that all answers were **false** but, as in the real survey's results, three thought that the answer to question 4 was **true** - that children should use a children's toothpaste with less fluoride in it than in an adult toothpaste. One of the respondees, a dental nurse, also thought that questions 1 and 9 were **true**.

One of the panel members commented: "Question 5 should be reworded "interdental cleaning" rather than "flossing". In the latest Cochrane review, flossing has been shown to have little evidence to support it as an effective way of helping with gum disease.^{1,2}

1. Sambunjak D, Nickerson J W, Poklepovic T *et al*. Flossing for the management of periodontal diseases and dental caries in adults. *Cochrane Database Syst Rev* 2011; CD008829. doi: 10.1002/14651858.CD008829.pub2.
2. Poklepovic T, Worthington H V, Johnson T M *et al*. Interdental brushing for the prevention and control of periodontal diseases and dental caries in adults. *Cochrane Database Syst Rev* 2013; CD009857. doi: 10.1002/14651858.CD009857.pub2.

BY KATE QUINLAN

bdjteam2014121

Products & services

Product news is provided as a service to readers using text and images from the manufacturer, supplier or distributor and does not imply endorsement by *BDJ Team*. Normal and prudent research should be exercised before purchase or use of any product mentioned.

DENTURE WEARERS USE ALL SORTS TO CLEAN THEIR TEETH



A new study of more than 2,800 denture and partial denture wearers in six countries has found that more than ten different types of cleaning methods are used instead of specialist denture cleansers - including toothpaste, household bleach, dishwashing detergent and vinegar¹ - even though they often don't kill key bacterial and fungal microorganisms and some can damage denture materials. The findings were announced at a symposium at the IADR General Session in Cape Town, sponsored by GSK Consumer Healthcare.

The researchers found that most denture wearers use regular toothpaste to clean their dentures, followed by water, mouthwash and denture tablet cleansers either alone or in combination. More than 70% said they had received or followed a recommendation from a dental health professional, while 30% had not.¹

However, in another study, the majority of dentists and dental hygienists said they most often recommend specialist denture cleansers to their patients.

While regular toothpaste is used by large numbers of denture wearers, research shows that it fails to effectively kill *Candida albicans*,² a fungus which can cause denture stomatitis (thrush), as well as other bacteria that are associated with malodour and gum infections in denture wearers.

Toothpaste does not completely kill *Candida*, even after five minutes of treatment. Other methods, including

soap, many mouthwashes and water also perform inadequately in these tests.²

Until recently, denture care hygiene has not been a research focus so there is a lack of evidence-based recommendations. Consensus is limited; sharp differences exist between developed and emerging markets;⁴ and patient compliance is inconsistent.¹

Globally, 810 million people are aged 60 years or over; by 2050 they will number 2 billion.⁵ The incidence of denture wearing is high in this age group and the percentage of denture wearers is expected to rise.⁶ Research has shown that specialist denture cleansers are the optimal method for denture care hygiene - killing harmful oral microorganisms,² while being gentle on denture material.³ Denture wearers who use specialist cleansers also report greater satisfaction with their cleaning regimen than other denture wearers.¹

Poligrip Denture Cleansers from GSK have proven antibacterial and antifungal activity against a wide range of microorganisms, including *Candida albicans*.² Poligrip also significantly reduces depth of abrasion on the denture compared with a regular toothpaste. Unlike toothpaste, Poligrip Denture Cleanser is gentle on denture materials.³

1. GSK data on file 2014, Multinational Diary study - denture cleaning.
2. GSK data on file 2014, Antimicrobial testing denture cleanser vs household methods.
3. GSK data on file 2014, Compatibility of different methods on denture materials.
4. GSK data on file 2014, Multinational dental recommendation study.
5. UNFPA and HelpAge International.
6. Steele J G, Treasure E, Pitts N B, Morris J, Bradnock G. Total tooth loss in the United Kingdom in 1998 and implications for the future. *Br Dent J* 2000; **189**: 598-603.

DESIGNED TO PREVENT CARIES IN CHILDREN



Infant dental care designer and manufacturer Brush-Baby has a range of innovative products for babies, toddlers and children which will help parents protect their children's dentition from the tooth decay seen in Public Health England's recent survey [12% of three-year-olds in England suffer from visible tooth decay].

Brush-Baby's Chewable Teether/ Toothbrush forms the basis of a three-step easy to follow oral care regime: step 1, 0-16 months, cleaning baby gums; step 2, 10 months - 3 years, teething and brushing; step 3, from 3 years, brushing and flossing.

Brush-Baby has ten products for babies, toddlers and infants from newborn to six years of age that are sold across 22 countries and stocked by UK retailers including Boots, Tesco, Sainsbury's, John Lewis, Waitrose and Mothercare.

Brush-Baby was started by a mum, Dominique Tillen who, frustrated at the lack of dental care products available for her daughter, decided to design her own.

For more information call 0845 5202229 or visit www.brushbaby.co.uk.

If you would like to promote your products or services direct to the dental industry in *BDJ Team*, just give Andy May a call on 020 7843 4785 or drop an email to a.may@nature.com.

Save money on the event of the year

The excitement is building for the British Dental Association's (BDA's) flagship event, the British Dental Conference and Exhibition, which takes place on 7-9 May 2015 in Manchester. It promises to be the largest ever conference and exhibition in UK dentistry: an event not to be missed.

Thursday 7 May 2015

Special care dentistry: two sides of a coin

Speakers:

Richard Valle-Jones, Clinical Director for Dentistry and Specialist in Special Care Dentistry, Pennine Care NHS Foundation Trust, Manchester

Debbie Chandler, Lead Dental Nurse, Special Care Dentistry, Dorset County Hospital NHS Foundation Trust, Dorchester, Dorset

Summary:

This session on special care dentistry will consider firstly the patient's point of view in order for you to gain a good understanding of their varying needs and anxieties when planning care. It will then look at the clinician's perspective, offering top tips to consider when planning and delivering special care dentistry - from assessment to completion - that leads to a successful outcome for all involved.

The presentation will also examine the importance of all dental professionals working together to provide high quality care to patients with challenging needs; what support and advice is available when the need to refer to a specialist service arises; and what training is available for if you want to enhance your skills in special care dentistry.

To expose or not to expose, that is the question? The role of the IR(ME)R practitioner in dose reduction

Speaker:

Jane Luker, Senior Clinical Lecturer, Oral and Dental Sciences, University of Bristol and Dental Postgraduate Dean for Health Education South West

Summary:

Patients often ask dental practitioners why they require dental radiographs and what the risks of having radiographs are. This session will provide you with an overview of the dose patients will receive from dental radiographs and how you can communicate the risks to patients. The role of the IR(ME)R practitioner in justification of the exposure will be covered together with issues raised about direct access and if dental hygienists and therapists are able to clinically justify radiographs.

Foundations for the future: periodontal issues affecting children and young adults

Speaker:

Wendy Turner, Head of Centre for Adult Oral Health, Clinical Senior Lecturer and Consultant in Restorative Dentistry, Barts and The London School of Medicine and Dentistry

Summary:

This session will explore the prevalence and clinical management of the different periodontal issues affecting this young age group so you can be confident with early recognition, diagnosis and treatment. It will help you to understand the importance of making a correct diagnosis as well as assist you when assessing the impact of risk factors on children's periodontal health as well as the periodontal implications of orthodontic treatment.

'THIS PRESENTATION WILL EXAMINE

THE IMPORTANCE OF ALL DENTAL

PROFESSIONALS WORKING TOGETHER...'

New challenges

Are you clear about the changing needs of the patients you see in practice? From young children to the elderly, in order to provide the best patient care, make sure you take the time to hear from others who specialise in these areas and learn from their experience.

With over 100 sessions taking place over the three days of the conference, the hardest thing can be to choose which sessions to attend as you are truly spoilt for choice. Here are just a few which may be of interest as they all focus on getting to grips with the ever-changing dental needs of the population.

See the website for the full listing www.bda.org/conference.

EARLY BIRD PRICE

These sessions form part of the Conference Programme and you will need to register for a Conference Pass to gain access. A one day Conference Pass for DCPs costs just £85* or choose from the whole Conference programme by registering for a full three day Conference Pass which costs just £145*.

*Early bird prices end Monday 9 February 2015 after which time the one day Conference Pass costs £95 and the three day Conference Pass costs £155

Friday 8 May 2015

Engaging and managing dentally anxious children and adolescents in primary care



Speaker:
Carrie Campbell,
Consultant in
Paediatric Dentistry,
Department of
Paediatric Dentistry,
University of Glasgow

Summary:

The *Engaging and managing dental anxious children and adolescents in primary care* session on the Friday at Conference will include a discussion on how you can assess child and adolescent dental anxiety easily in a timely manner and how this links with subsequent treatment success. Speaker Carrie Campbell will cover a number of practical techniques which can be implemented by the busy primary care practitioner to help dentally anxious/phobic children and adolescents cope. This session will also help dental professionals to understand when it is appropriate to refer dentally phobic children and to whom for improved treatment success.

Dementia: Understanding how it affects us and the impact it has on our patients and their care



Speaker:
Joanna Millwood,
Specialist in Special
Care Dentistry,
Senior Community
Dentist, Derbyshire
Community Health
Service

Summary:

This session aims to enable all members of the dental team to better consider the impact of dementia. By 2015, the Alzheimer's Society reports that there will be 850,000 people with dementia in the UK. The session will consider treatment planning and provision of dental care at different stages of dementia. Provision of domiciliary care, which is included within the Care Quality Commission's definition of primary care dental services provided by dentists on the 'high street', will be addressed. The session will include advice on care plans and referral pathways. It will consider issues and challenges of oral and dental aspects of residential and nursing care including palliative care.

Saturday 9 May 2015

Evidenced based periodontal treatment: protocols for everyday practice



Speaker:
Ian Dunn, Specialist
Periodontist,
Liverpool

Summary:
This session will
look at how patient-
centred treatment

can lead to simpler, less aggressive treatment of periodontal patients. It will look at the evidence for shorter

protocols than previously taught in many dental schools and how you can apply this in practice. Ian will also look at the role of adjunctive treatments in the management of the periodontal patient.

Early detection of oral cancer - how the dental team can make the difference and save lives

Speaker:
Simon Whitley, Consultant in Oral
and Maxillofacial Surgery, Barts and
the Royal London Hospitals; Lead

Clinician and Chair, Head and Neck Multidisciplinary Team, North East London NHS

Summary:

This essential session for all dental team members will help you to spot potential dangerous lesions, identify patients at risk and provide preventative education and support. In addition, speaker Simon Whitley will explore cancer pathways and help you to ensure patients receive specialist care as quickly as possible.

bdjteam2014124

Regular events for the whole dental team

Did you know that the BDA specialises in a range of events from small interactive workshops to seminars and conferences? Each year the BDA holds an impressive 75 events covering all CORE CPD topics as recommended by the General Dental Council (GDC), as well as business and personal development topics. There really is something for everyone, whatever stage you're at in your dental career.

Core CPD courses

For most dental nurses keeping on top of core CPD learning can be a challenge! The BDA offers cost effective one day courses with dental experts helping you meet your CPD requirements - with DCP places starting at just £135.

An IRMER course in dental radiography and radiation protection

This one day course will be of interest to general dental practitioners as well as IRMER operators: hygienists, therapists and dental nurses who have already obtained their dental radiography certificate.

LONDON – 16 January 2015

MANCHESTER – 13 March 2015

Achieving high standards in infection control

This one day course suitable for all members of the dental team will update your knowledge and ensure your team carries out best practice in managing infection control and how to maintain high standards of decontamination and comply with HTM 01-05.

LONDON – 22 January 2015

Law, ethics and record keeping

Get up to date with the current legal and ethical issues facing dentistry and where we are now with the Care Quality Commission (CQC). Learn how to keep quality records in order to protect your practice and the team and support the welfare of your patients.

LONDON – 5 February 2015

Want to learn something new?

The New Year is fast approaching so make your mind up about learning a new skill in 2015 with these interactive workshops in January.

Online marketing and social networking

Confused about Twitter, Facebook and hashtags? **Mark Oborn**, one of the UK's top dental marketing professionals, will show you how to use these social tools to grow your practice, engage patients and boost your career.

LONDON – 23 January 2015

An introduction to dental hypnosis for the whole dental team

Anthony Asquith, qualified psychotherapist and hypnotherapist, will help you understand what hypnosis is and how it can be used in a dental setting. He will also teach you how to calm highly anxious and phobic patients and how to induce trance states using simple techniques to help patients during treatment.

LONDON – 30 January 2015

Are you a new dental practice manager?

This packed two day workshop is suitable for DCPs who are new practice managers or existing managers.

It will help all attendees gain a whole suite of updated management tools and techniques that can be implemented immediately to help you improve the performance of your practice – from management of staff performance and development to selection and recruitment of new staff.

Alison Miles-Jenkins has over 30 years' experience in management development and has trained over 36,000 professionals in increasing performance at work and she can help you reach your potential too.

The essentials of staff management: a two day intensive course

LONDON – 15-16 January 2015

iLearn webcasts – watch and learn when it suits you

If time is of the essence, then why don't you try one of the BDA's online webcasts? These handy bite-sized online lectures can be viewed on a desktop computer or tablet at a time and place that suits you with a downloadable CPD certificate. Recommended core CPD, clinical and business topics are all covered by these webcasts.

Visit www.bda.org/ilearn for a list of iLearn webcasts and further details.



For the complete list of BDA courses with information about learning objectives, speakers and dates just visit www.bda.org/training. Not too sure which course is right for you? Then just call the Events team who will be happy to help on 020 7563 4590.

Have you seen the BDJ Team course directory? If you are looking for a course - be it a diploma, a higher education course, CPD training or your next postgraduate certificate - just go to the BDJ Team website and search on 'course directory' for listings by region. www.bdjteam.co.uk

BDJ Team continuing professional development



CPD questions – November 2014

CPD ARTICLE: Managing caries in primary teeth

- Which of the following is **not** one of the four main evidence-based preventive interventions for caries management?
 - fissure sealants
 - composite fillings
 - toothbrushing (toothpaste) advice
 - dietary advice
- Select the **correct** statistic.
 - 31% of 5-year-olds in England had obvious caries according to a survey published in 2009
 - 33% of 5-year-olds in Scotland had evidence of caries in 1998
 - 57.2% of 5-year-olds in Scotland had evidence of caries in 2012
 - the 33% of children with caries in Scotland in 2012 had on average 3.45 teeth affected

- Which of the following statements is made in this article?
 - Hall crowns can be used on primary molars as a last resort
 - Hall crowns could be used to serve disadvantaged populations
 - all 18 dental therapy schools contacted teach the Hall Technique as part of the curriculum
 - the Hall technique has no evidence of effectiveness



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BDJ Team is offering all readers **TEN hours of free CPD** in 2014 through our website and a further TEN free hours in 2015.

Just go to www.nature.com/bdjteam/cpd to take part!

- Which of the following is **false** regarding the Hall Technique?
 - it involves no local anaesthesia
 - caries is removed from the tooth first
 - a PMC is cemented over a carious primary molar
 - the technique proved acceptable to children in the first RCT

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You can complete *BDJ Team* CPD through our website, any time in 2014 and 2015.

Just go to www.nature.com/bdjteam/cpd to find out how!

Topics covered so far

► March 2014: **The use of radiographs in clinical dentistry**



► April 2014: **Disposing of clinical and dental waste**



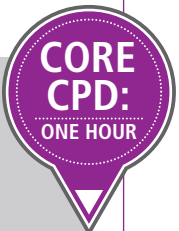
► May 2014: **Emergency oxygen therapy in the dental practice**



► July 2014: **Needlestick and occupational exposure to infections**



► August 2014: **Medical emergencies: the drug box, equipment and basic principles**





BDJ Team CPD – through the post

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YES! Just print off this page, complete the form and send it with your payment of £6, to cover administrative costs. **Send to: BDJ Team CPD, Nature Publishing Group, 4-6 Crinan Street, London, N1 9XW.** We will check your answers to the CPD questions, process your payment and send you a certificate through the post.

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Job title: _____

GDC registration no.: _____

2. Payment details – SUBMISSIONS SENT IN WITHOUT PAYMENT WILL NOT BE PROCESSED

I enclose a cheque for £6 made payable to Nature Publishing Group for **ONE** hour of CPD

I would like to pay for more than one person and enclose a cheque for £_____ made payable to Nature Publishing Group (£6 per person for an hour of verifiable CPD).

Or

Please debit the sum of £6 or £_____ from the following credit/debit card (tick box):

Visa
 Mastercard
 Switch/Maestro
 Visa Debit

Card number: _____

Expiry date: _____ Issue no. (Switch/Maestro): _____

Name of cardholder: _____

Address of cardholder (if different to above): _____

3. I am answering the CPD questions in the _____ issue (PLEASE ENTER MONTH):

	A	B	C	D
Q1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Please add any comments or feedback that you might have below or email bdjteam@nature.com.

