BDJ Team
OCTOBER 2015

ORAL CANCER

improving early detection

BDA
British Dental Association

October 2015

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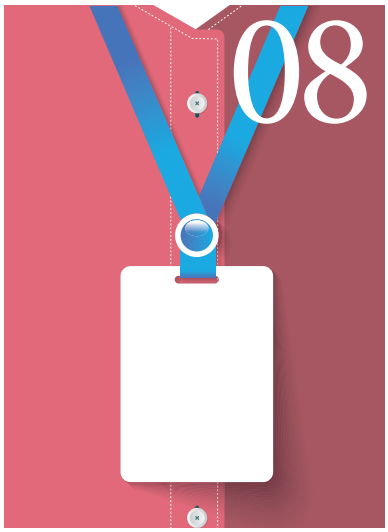
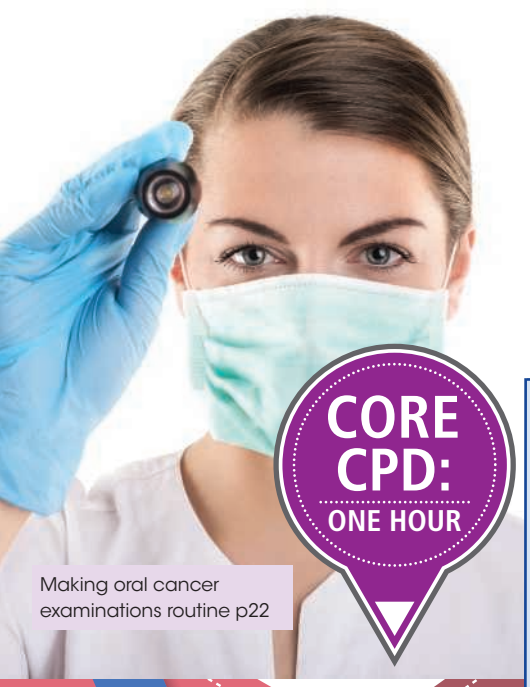




CORE CPD: ONE HOUR

Making oral cancer examinations routine p22

Ed's letter

Another Dental Showcase is in the bag, and – from what I could see – so are a plethora of leaflets, goody bags, toothpastes and freebies.

I do hope one of those is from *BDJ Team*. So many people pick up leaflets as they meander through the aisles without really paying attention to what it says. If you picked up one from *BDJ Team*, then chances are you'd like to know what it says.

That's because we're giving away (yes, GIVING AWAY) an Apple Watch®. All we ask in return is that you complete our short survey on your CPD habits. I've completed it, and it takes less than two minutes. Good luck!

The end of Dental Showcase also means Mouth Cancer Action Month is almost upon us. The annual campaign, which takes place every November, needs your support to mobilise friends, colleagues and patients to get checked out. You can read about how to get involved and show your support in this month's edition.

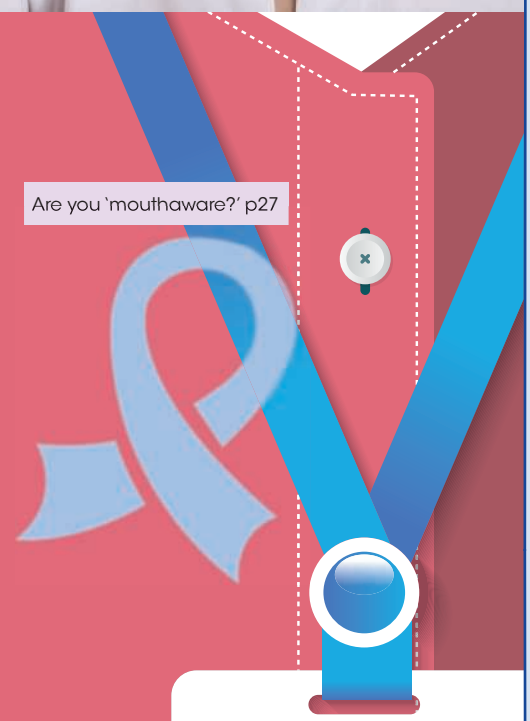
With the onus on the profession to identify cases of oral cancer early, oral cancer is also the topic of this month's core CPD. That means one more free, verifiable hour's CPD to add to your portfolio.

This month we're also calling people names. Not the sticks and stones variety, but the British Association of Dental Therapists, about what they think a dental therapist should be named, and consider how the very simple act of what you call yourself may, in fact, change not only the mind set of our patients but could shape the future of the delivery of dentistry.

President's column p12

Ahead of the British Association for the Study of Community Dentistry (BASCD) November scientific conference, President Jenny Godson gives us her insight into what attendees can expect. This year the focus is on '*Action to reduce the consumption of free sugars – What is BASCD's view?*', and in this month's President's Column, Jenny tells us that this Joint BASCD Autumn Scientific Meeting and BASCD Consultant Group Meeting will concentrate on what BASCD's position will be.

Enjoy the issue and we'll see you in November for the last issue of 2015!



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THE TEAM

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'CONSIDER YOURSELF AS ONE' CHIEF DENTAL OFFICER TELLS DENTISTRY'S WORKFORCE

The distinctive roles within a dental team need to be overlooked if dentistry's workforce is to successfully meet the oral health needs of a future population.

That was the message from the new Chief Dental Officer (CDO) for England, Sara Hurley, when she addressed delegates at the British Association of Dental Therapists (BADT) national conference last month (25-26 September).

Joining her predecessor, Barry Cockcroft, in delivering the event's keynote speech, she advocated the policy of dental teams considering themselves as 'one entity' when tackling dental health care.

She also promised to act on any ideas put forward by DCPs in order to successfully facilitate the necessary changes for future care.

Speaking after the conference, she said: 'The conference was an outstanding success, testament to the talent and energy of an exceptional group of health care professionals. I was honoured to be present and to initiate a dialogue, which I am confident will endure and produce high value health dividends for our patients.'

BADT president, Fiona Sandom, said: 'The fact the CDO Sara Hurley chose to address dental therapists in her first 100 days in post signifies how much she values DCPs and views us an integral part of delivering dental treatment. She spoke of the dental profession – and not of dentists and DCPs – which I thought interesting and demonstrated a mind-set.'

Amanda Gallie, BADT president elect, also welcomed her address. She said: 'It's heartening to hear Sara Hurley acknowledge the value of DCPs and to hear that she wishes to keep in touch with us, offering to be a sounding board and conduit for our ideas and suggestions.'

In his contribution to the opening presentation of the conference, Barry Cockcroft, past CDO for England and now non-executive director of Mydentist, said the profession must 'learn from the past in order to predict the future'.

He argued that data – and accurate interpretation of that data – was key to developing services for the future and, whilst acknowledging the current inequalities in child dental health, maintained that these could not be tackled by improvement of dental services alone.

The joint presentation concluded that segmentation of the workforce was not a 'sensible way' to plan and deliver the best outcomes.

GROWING NUMBER OF DENTISTS **WOULDN'T** RECOMMEND THEIR PROFESSION

Half of dentists would not recommend their profession to friends and family members, according to new research by Wesleyan, the specialist financial services provider for dentists.

In sharp contrast to findings a year ago, 50% of dentists said they would not recommend the profession, compared with 31% in 2014.

More than eight out of 10 (81%) dentists also say the increasing cost of education and training, along with changes to pay and conditions, will deter future generations from choosing the profession, up from 74% a year ago.

Despite their concerns for the future, just under three quarters (71%) of those already working in the profession say they would choose the same profession if they could start again, compared with 60% in 2014. However, 94% admit increased pressure caused by recent changes in the profession is a major issue.

When asked what they were most concerned about over the next five years, the introduction of the new NHS dental contract (in England and Wales) emerged as the biggest worry for 60% of dentists followed by rising costs in the profession (58%).

JUNIOR DENTISTS BALLOTED ON INDUSTRIAL ACTION

Junior hospital dentists in England will be balloted on industrial action as the government prepares to impose a flawed contract.

This is the first time members of the dental profession have been asked to consider industrial action, their trade union the British Dental Association (BDA) announced on 9 October.

These NHS dentists are employed on the same terms of service as junior doctors, who are set to be balloted by the British Medical Association (BMA).

Peter Dyer, Chair of the BDA's Central Committee for Hospital Dental Staff, said: 'From the start doctors and dentists have asked for a fair contract, one that works for patients and practitioners. We are taking this step because the government is now set to impose a contract that fails both tests.

'Our profession has never gone down the road of industrial action before. We have not taken this decision lightly, but an unprecedented attack on our members' interests requires an unprecedented response. It is now vital that all the NHS dentists affected by this contract have their say.'

Mick Armstrong, Chair of the BDA, said: 'These professionals form a small, but vital part of our NHS. This contract is bad for them, their families and their patients. It's bad for the oral health of Britain.

'Hospitals are at crisis point dealing with record numbers of children requiring oral surgery. This contract represents a frontal assault on an already overstretched workforce. These dentists don't expect special treatment, just a fair deal, and industrial action may now be necessary in order to achieve it.

'All healthcare professionals have a stake in this. We are determined to stand up for the next generation, and secure a contract that won't put their futures or patient care in jeopardy.'

Further information is available on the BDA website.

DENTAL VOLUNTEERING WITH CRISIS AT CHRISTMAS

There are many things people want for Christmas. Some gifts that are sent are thoughtful and meaningful. Some are merely by request. For **Janine Doughty**, Senior Volunteer and member of Crisis at Christmas Dental Service steering group, her gift was one of necessity.

Here she tells us what it's like to be a volunteer at Christmas.

'Hundreds of volunteers descended upon London over last year's Christmas period, generously donating both their time and skills to people experiencing homelessness in the capital city. The Crisis at Christmas charity provides a range of volunteer-led services to the homeless, offering support and companionship throughout the festive season; the dental service is just one of the many teams providing care for guests during this time.

'Last year, the Crisis at Christmas dental team operated out of four fully equipped dental vans stationed across two sites in North and South East London. The vans were generously donated to the charity for two weeks by the Community Dental Services in East and Coastal Kent, Newport and Bedford.

'Each year, the triage team are tasked with seeking out guests who would benefit most from a visit to the dental service. The guests are subsequently transported them from their original centres to the dental vans for afternoon treatment sessions. Here, fillings, extractions, scale and polishes, and oral hygiene instruction are delivered by our dental volunteers.

'Between the 23 and 29 of December 2014, the Crisis at Christmas dental team examined 393 patients. The treatments performed included 218 permanent fillings, 213 scale and polishes, and 109 extractions.

This year the team plans to increase the number of dental vans involved with the service from four to six units; these additional vans will enable 200 more guests to receive much-needed treatment over the Christmas period this year. If you are, or know of, a dental van owner who would be willing to let Crisis use their facility for the Christmas period then do get in touch.

'Our volunteers allow the dental service to help hundreds of guests year after year, and their contribution is truly appreciated. This year the dental service is in need of full-qualified dental nurses, if you are a registered dental nurse and are keen to make a difference by volunteering for Crisis at Christmas in 2015 your help would be invaluable. The application for Crisis at Christmas volunteers is now open, so please do take a look and support what we do.'

Further information about the dental service and other ways to get involved with Crisis throughout the year can be found at www.crisis.org.uk.

A thank you from us...

Thank you to everyone who visited our stand at BDIA Dental Showcase and took part in the CPD survey. The survey will be open until Friday 20 November 2015 with the winners announced in November's issue of Team. So to be in with the chance of winning an Apple Watch® please click here.

NEWS FROM THE GDC

It appears the GDC have been extremely busy this month clamping down on illegal tooth whiteners. In the space of five weeks, five different individuals were successfully prosecuted for unlawfully practising dentistry – namely tooth whitening.

Natalie Kowalczyk from Jo and Cass Beauty Salon in Lancaster, Victoria Reeve from The Nail Bar in Halstead, Jade Hayes from LA Hair Extensions, Nottingham, Julie Marino, Director of The Teeth Whitening Company and Sam Wellman in Leeds were all prosecuted.

And they say the ARF is too expensive…!

Speaking of ARF, The GDC has launched a consultation on the level of its ARF for dentists and dental care professionals in 2016. While proposing that the ARF levels remain the same as in 2015, the GDC is taking this opportunity to conduct an exceptional consultation to:

- Set out the financial and other information on which the proposal is based
- Seek views on the proposed level of the fees.

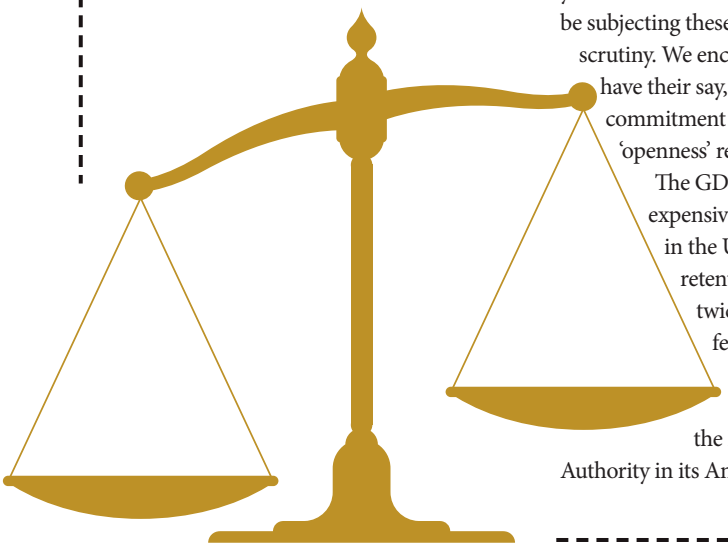
Based on 'projections of the levels of complaints' – which they believe will remain at recent peak levels - and sound financial modelling covering the work of the GDC, they are proposing that the ARF for 2016 remains the same as in 2015: £890 for dentists and £116 for dental care professionals.

Mick Armstrong, Chair of the British Dental Association responded by saying: 'The General Dental Council has announced a consultation on not changing their fees. We hope they aren't expecting us to take any comfort from this, as for 40,000 dentists 'business as usual' means another year shackled to the most expensive, and least effective health regulator in Britain.

'This latest announcement shows nothing has changed. Dentists are still paying double the average for UK health professionals. Registrants are still on the receiving end of the same one-sided conversation from a cavalier regulator, which continues to ignore its own failings.

'What we've not seen is any real willingness from a failed regulator to get on top of its day job, and to finally draw a line under years of mission creep. For our part we will be subjecting these numbers to forensic scrutiny. We encourage all colleagues to have their say, so we can see what GDC's commitment to 'transparency' and 'openness' really means.'

The GDC remains the most expensive healthcare regulator in the UK – at £890 its annual retention fee is more than twice the average professional fee – and it was recently identified as the worst performing regulator by the Professional Standards Authority in its Annual Performance Review.



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CQC: DENTAL SERVICES REMAIN LOW RISK

The British Dental Association (BDA) has welcomed the latest Care Quality Commission (CQC) State of Care report, which has again revealed the low risk, good quality care delivered in English dental practices.

The CQC carried out 714 inspections of primary dental care services in 2014/15. It concluded that, compared to other sectors dental services present a lower risk to patients' safety, that the majority of dental services are safe and that the quality of care is good.

The low risk has prompted the CQC to move to a model of inspecting just 10 per cent of all practices each year.

Mick Armstrong, Chair of the BDA, said: 'In recent years we've seen a clear and consistent picture emerge from inspections by the CQC. The care provided by dental services combines low risk and good quality – which is something our profession has always known. It's also a reminder why the new approach to dental inspections was the right choice.'

Global oral health burden amounts to $442 billion

Improvement in oral health alone can offer the world substantial economic benefit as researchers have estimated that the yearly global economic impact of dental diseases amount to $442 billion.

The research by Stefan Listl from Heidelberg University in Germany, and colleagues estimated that the direct treatment costs due to dental diseases worldwide were at $298 billion yearly, corresponding to an average of 4.6% of global health expenditure.

In addition to treatment costs, there are indirect costs to consider, mainly in terms of productivity losses due to absenteeism from work.

Indirect costs due to dental diseases worldwide amounted to $144 billion yearly, corresponding to economic losses within the range of the 10 most frequent global causes of death.

While estimation of direct treatment costs was based on a systematic approach, for estimation of indirect costs, an approach suggested by the World Health Organisation's commission on macroeconomics and health was employed.

This approach factored in 2010 values of gross domestic product per capita as provided by the International Monetary Fund and oral burden of disease estimates from the US Global Burden of Disease Study.

'Through this study, the authors have amplified the message that we need to increase the availability of internationally comparable data on dental treatment costs, disease-specific absenteeism from work and school, as well as intangible costs of oral diseases in terms of quality of life,' said Timothy DeRouen, former president of American Associations for Dental Research (AADR).

The research, published by AADR and International Associations for Dental Research (IADR), appeared online in the *Journal of Dental Research*.

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What's in a name?

Passions run high when it comes to job titles. So, what should dually qualified dental hygienists and dental therapists call themselves – and why? Here, we poll the BADT council

Name-calling – it's a tricky one, isn't it? Many may argue that a name is an arbitrary label – surely, all we need to know is what something *is*, not necessarily what it is *called*. And, why must we assign so much importance to a simple job title? As a dually qualified dental hygienist and dental therapist, you know what you are and what you do, you are fully aware what you qualified as and understand what treatments you are entitled to carry out within your Scope of Practice on qualifying. But, how many patients appreciate the role? Come to think of it, how many other members of the dental team are fully up to speed with what dentistry a dental therapist may deliver within the workplace? Additionally, does every dental therapist carry out his or her full Scope of Practice on a day-to-day basis? And, if not – and a lot of the work is hygiene based – then is it sometimes far simpler to stick with the 'hygienist' handle than call yourself a 'therapist'? Interestingly, the General Dental Council (GDC) does not recognise the term 'hygienist/therapist' – if a patient wishes to search its registers, the options are in the singular: you are either a dental hygienist or a dental therapist. But the debate over job title continues to rage – a look at any of the social media dental forums bear testimony to this, with dental therapists (and other members of the dental team) debating it *ad infinitum*; strong views aired on either side of the fence with heartfelt passion and reasoned argument well matched.

Simple act

Here, we hear from British Association of Dental Therapists about what they think a dental therapist should be named, and consider how the very simple act of what you call yourself may, in fact, change not only the mind set of our patients but could shape the future of the delivery of dentistry.

Q&A

The full Scope of Practice for a dental therapist can be found here – https://www.gdc-uk.org/Newsandpublications/Publications/Publications/Scope%20of%20Practice%20September%202013.pdf.

We asked dental therapists the following three questions and their answers follow…

1. If you have dual qualification, what do you refer to yourself as and why?
2. Do you think it matters to a patient what you are?
3. Do you think the title, 'dental therapist' could supersede 'dental hygiene/therapist' if you have dual qualification or does this remain an acceptable title?

President Fiona Sandom – *'It is important to have clarity'*

I initially trained as a dental nurse, then a dental hygienist and then a dental therapist. I call myself a dental therapist because that describes what I can do. I don't need to call myself a hygienist and a therapist because, as a therapist, my Scope of Practice includes the skills of a hygienist. A dentist would not call him- or herself a dental hygienist/therapist/technician/dentist, would they?

I believe this term 'hygienist/therapist' stems from the dental schools and is incorrect; the GDC does not recognise this term. It is also confusing for patients to have this inconsistency. If you refer to the medical model, there are practice nurses and nurse practitioners and patients have come to recognise and accept the difference. Why has this not transferred to dentistry? It is important for there to be clarity, so that patients are aware about who they are seeing and are able to determine the dental hygienist's or dental therapist's Scope of Practice – especially in light of direct access. It is really important for patients to be able to make an informed choice about the DCP they are seeing. How can they find out from the GDC about a hygienist/therapist when, in reality, one doesn't exist?

Jacky Hart – *'Promote the name'*

I refer to myself as a dental therapist and, where patients are concerned, I usually briefly explain the remit of a dental therapist, including being able to do all aspects of hygiene work. I strongly feel the job title of dental therapist needs to be promoted at every opportunity – both to the general public and the dental profession.

Katrina Matthews – *'The title "therapist" suggests empathy'*

I have a single qualification as a therapist and always explain to my patients and to the general public what I am trained to do and promote my profession.

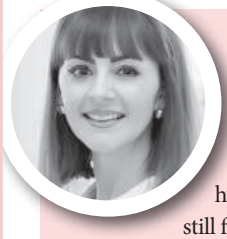
People like the title 'therapist' as it suggests the empathetic skills we have. Therapist/hygienist is not a registered professional name by the GDC and so I understand the confusion by the public. With dual qualification, I think therapist is the best title for the future.

'I AM A THERAPIST, I CALL MYSELF A THERAPIST AND I EXPECT OTHERS TO CALL ME A THERAPIST, TOO'

Secretary Mel Prebble – *'The profession overestimates what patients might think'*

From a marketing point of view, I use the term 'hygienist' in my title to attract patients but, although I tell patients I'm a hygienist, I occasionally try to explain what a therapist is, too. Professionally, I refer to myself as a therapist. I don't think patients care what we are so long as we are professional and communicate well and I think the profession overestimates what patients might think. It would make life simpler if the term 'therapist' was all encompassing of our skills and we didn't have to try to use both all of the time.

That said I'm not a fan of the word 'therapist' as, for some patients, it implies something else. I once treated an elderly patient who thought she had been sent to a beauty therapist for a filling! I also think people think we fix scared people's heads so they can visit a dentist.



Victoria Wilson – '*Enlighten the general public'*

I call myself a dental hygiene therapist, as I still feel the public are not fully aware of the role of the therapist. I'm often asked the question: 'What is a therapist?' and I guess this is a call to action to raise awareness and fully educate patients of our role. I think it is extremely important for our future that the title of 'dental therapist' supersedes 'dental hygiene therapist'. But we need to enlighten the general public first.

Amanda Gallie – *'Too confusing'*

I call myself a dental therapist now as it's less of a mouthful and as it's my latest qualification. Perhaps we need a fresh, new title such as 'oral health therapist' – or something of the ilk. A hygienist/therapist just sounds too confusing. Patients continue not to be aware of dental therapists and that's what we need to change.

'I'M OFTEN ASKED THE QUESTION: 'WHAT IS A THERAPIST?'

Debbie McGovern – *'Reminds our employers we have additional skills'*

If therapists call themselves hygienists they will only be treated as so and only get hygienist-related patients. If we use the title 'dental therapist', it reminds our employers we have additional skills. I intend to drill this into all final-year students!

'IT ALL DEPENDS WHO I AM TALKING TO!'

'WE NEED TO USE THE TITLE OF 'THERAPIST' AS MUCH AS POSSIBLE'

Julie Ellis – *'Actively discourage the use of this title'*

My qualification is as a dental therapist and I think it does matter that the patients know us by our correct title. We need to do away with this notion of being 'dually qualified' All recent graduates are dental therapists whose training has covered the full remit. The only way you can get the title of hygienist now is if you fail final therapy exams and exit early, which I believe happens in a few universities. Or train specifically for that role, which I think is only available in one training school now. The title hygiene/therapist does not officially exist and I think we need to actively discourage the use of this title. We need to use the title of 'therapist' as much as possible and, if more people referred to themselves as therapists, even if they are employed carrying out hygiene duties only, they are more likely to be referred therapy work.

Debbie Hemington – *'We need to target the profession so they gain an understanding of what therapists can do'*

I qualified as a therapist first in 1983 at New Cross, which as you will know was the only training school in the UK from 1960-83. We did not qualify as hygienists, as they were two completely separate qualifications at that time. Therapists were restricted to working in community or hospitals at that time and treating mainly children and we were not trained in periodontal disease or treatment to the same level as a hygienist. We could not work in practice as a hygienist unless we had done a separate hygiene qualification. It is here where the distinction and separation between 'hygienist' and 'therapist' originated.

After having worked for several years in community, I trained as a hygienist (a full course, not a shortened course) in order to open up my employment opportunities. Dually qualified practitioners were rare in those days and we had to call ourselves 'hygienist and therapist' as they were different jobs in those days, and had separate GDC registers, too. I could not work in practice at that time if I used the title 'therapist', even if I was providing hygiene treatments, and I could not do any restorative treatment in community or hospital if I used the title 'hygienist'. This changed when the restriction on therapists' employment was lifted. There are still many singly qualified therapists still working and, although many have brushed up on their perio knowledge by way of CPD courses etc, they do not have a formal hygiene qualification.

This is the true origin of the double-barrelled title, along with the term 'dually qualified'. The dental schools often had – and, indeed, still do have – schools of dental hygiene and dental therapy, as students sat both exams and both qualifications were awarded. The term 'hygiene therapist' doesn't exist as a title, and has been an attempt by the profession to show there is a difference in some therapist qualifications. So, what do I call myself? It all depends who I am talking to! Socially, I will say I am a dental hygienist and therapist, as Joe Public only really understands the term 'hygienist', although I will always explain what a therapist does. If I am in professional company, I will say I am a hygienist and therapist. Many fellow dental professionals still separate the two skills, and there are still singly qualified hygienists being trained, although they are in a minority.

But there is a need to target the profession so they gain an understanding of what therapists can do, that their training includes perio and, just as important, they should be aware of the level to which we study. There is no difference in the curriculum if it is a BSc course or Diploma course, but dentists often think it is a very basic education. This is illustrated in some of the editorials that have appeared over recent years, especially when discussing direct access.

Anne Marie Yarwood – *'Dual name is misleading'*

I qualified at New Cross in 1979 and then had a 21-year gap, only to return to dental therapy in 2005, working in a general dental practice for 10 years. Dental therapists were trained by the NHS and fully funded and were intended to work for the NHS in a community or hospital setting. Telling therapists they could not be employed as hygienists may have been a ploy to prevent trained therapists draining away for more lucrative work. I for one had a lot of dental hygiene work, with patients who had a wide variety of needs, referred to me in community. Having done the three months of additional training required to gain a hygienist title, some therapists believed they had not gained any more knowledge. When jobs were scarce in the 1980s, it made sense to attend a hygiene short course to obtain a 'licence', allowing therapists to widen their scope for employment. The dual name is misleading. If the therapist job role were more widely understood by the public (and other members of the dental team) there would be no need to expand the title into sections in an effort to explain what we do. Dental therapy is a professional qualification just as dentist is a dentist and not a dentist-therapist-hygienist. Orthodontists don't call themselves orthodontist-dentist-therapist-hygienist, do they? In fact I would take it one step further and make it a rule that those therapists who are employed in a hygienist job should actually still call themselves a dental therapist. The general public, I believe, may be better pleased to learn that a more qualified member of the dental profession is attending to their oral hygiene needs. In my workplace, I always insist the dentist refers patients to the therapists and does not call us hygienists. It is inaccurate and also only perpetuates the confusion when patients are unable to find their DCP on the GDC registered 'hygienist' list.

Diane Lockhart – *'Caution must be taken to ensure others do not feel less valued'*

When working as a hygienist (as required by my contract), I call myself a hygienist. When utilising both roles, I call myself a hygienist therapist and this is more for ease. On occasions, when I have called myself a therapist, patients have been known to question why they were not seeing a hygienist. This usually takes up valuable appointment time to explain that I am qualified in both roles. I really do think it matters to most patients and always introduce myself. Technically, with the current training, 'therapist' does need to supersede 'hygienist' as our job title (or therapist only with no hygiene qualification) but this may be a very emotive issue to all those with one qualification. It is very important to raise awareness of dental therapists, but caution must be taken to ensure others do not feel less valued within the team.

'THERAPISTS WHO ARE EMPLOYED IN A HYGIENIST JOB SHOULD ACTUALLY STILL CALL THEMSELVES A DENTAL THERAPIST'

'THE DUAL NAME IS MISLEADING'

Madalyne Tucker – *'So long as my patients are happy'*

This is an interesting question which causes lots of discussion especially between the dually and singular qualified. As a dually qualified I used to call myself 'hygienist/therapist' or 'DHT' for short as this is what we were referred to as at dental school. I have two separate qualifications so never had a problem using both in my title and I still don't! I have had many discussions with other therapists, some quite heated. The argument that we should call ourselves 'therapists' is a valid one, as we need to promote ourselves as part of the dental team; we are still an 'unknown' as far as the general public is concerned.

I work with practice owner and dental hygienist, Christina Chatfield, who still refers to me as a hygienist/therapist on her website and when talking to her patients. I asked to be called a therapist and we had quite a debate. Her answer was purely from both a marketing and business perspective because patients do not know what a therapist is but they all know a hygienist and feel comfortable with that. I also understand this viewpoint. I personally do not like the term 'therapist ' it's a very misleading title as is DCP.

To be honest, I am not really too concerned what I'm called – 'therapist', 'hygienist', 'DHT' – so long as my patients are happy!

Can you handle it?

Seemingly, views are varied but what do you think? The BADT would love to hear the thoughts of other members of the dental profession on the importance of a professional name. Email secretary.badt@gmail.com or post on the BADT's Facebook page or tweet @BADT1963.

bdjteam2015149

Addressing a burning issue

In this month's *President's Column*, **Jenny Godson**, President of the British Association for the Study of Community Dentistry (BASCD) gives us her views on the latest in dentistry.

One of the burning issues in dentistry and of course in general healthcare is the widespread consumption of free sugars especially in sugar-sweetened beverages. This contributes not only to dental decay but also the increased risk of weight gain and obesity.

In July 2015, the Scientific Advisory Committee on Nutrition (SACN) published a comprehensive review of the scientific evidence concerning carbohydrates and health. They advised the government to halve the recommended intake of free sugars. The World Health Organisation (WHO) also recommended a reduction in free sugars intake.

What is the issue?

The latest National Diet and Nutrition Survey (2014) showed that in the UK we are consuming too much sugar with;

- 12% of adults' daily energy coming from sugar
- Teenagers (11 to 18 years) consuming three times the recommended sugar intake with the biggest source being sugary drinks
- 25% of the sugar in children's (4 to 10 years) diet coming from sugary drinks.

Sugar sweetened beverages have a direct effect on glycaemia and insulin resistance. A recent systematic review (Imamura *et al*, 2015) concluded that habitual consumption of sugar sweetened beverages is associated with a greater incidence of type 2 diabetes and that this appears to be independent of obesity.

The impact of dental caries and excess body weight and their disproportionate effect on those who are living in social deprivation are reasons why we should be concerned about excess intake of sugar. Despite being preventable, dental caries is the most common oral disease affecting children and young people in the UK, once it develops it is irreversible and the affected teeth may require long term maintenance following initial treatment. In addition dental decay in young children is a leading cause of childhood admission to hospital. A recent HSCIC report for the year 2013-14 highlighted that just under 26,000 five to nine year olds were admitted to hospital for the surgical removal of teeth due to tooth decay.

There is also a significant financial impact; in England the cost to the NHS for dental care is estimated to be £3.4 billion annually. In addition an estimated £2.3 billion is spent on private dental care. In Wales the net dental spend in 2013-14 was £140.7 million, plus £30.3 million in patient charges whilst in Scotland in 2013/14 the cost of NHS Dental Services was estimated at £500 million.

'DESPITE BEING PREVENTABLE, DENTAL CARIES IS THE MOST COMMON ORAL DISEASE AFFECTING CHILDREN AND YOUNG PEOPLE IN THE UK'

Action to reduce the consumption of free sugars

BASCD have decided to make free sugars central to our November scientific conference this year focusing on '*Action to reduce the consumption of free sugars- What is BASCD's view?*' The BASCD autumn scientific meeting will be held on Thursday 19th November 2015 at Cavendish House in London. The one day meeting will develop a position statement to identify key evidence based actions that together will reduce the consumption of free sugars.

The morning session will include eminent speakers such as Prof Paula Moynihan, who authored the systematic review which informed the recent WHO guidelines and will be discussing what the halving of the consumption of free sugars will mean to everyday public health practice. Modi Mwatsama, Registered Nutritionist (public health) and Director - Global Health, UK Health Forum will examine evidence from around the world on what actions work to reduce the intake of free sugars. Prof Richard Watt will consider the consumption of sugar sweetened beverages, the biggest source of sugars for children, and what actions work to reduce their consumption, including fiscal measures such as a sugar tax. This should be a very interesting morning with plenty of chance for discussion and debate.

The afternoon session will take the form of workshops allowing members and delegates, having heard from our speakers, to contribute to the development of a BASCD position statement on action to reduce the consumption of free sugars. I would be delighted to welcome you to the conference.

Rates are as follows *(includes lunch and refreshments):*

- Member £130
- Non-member £150
- Student/DCP£100

For more information please call Jaki Walker on 01424 316062 or 07830 527409 or visit our website **http://www.bascd.org**

bdjteam2015150

The oral health benefits of sugarfree gum

It has long been accepted that sugarfree chewing gum is linked to fresh breath, yet few patients are aware of the clinical benefits. As this article will illustrate, chewing sugarfree gum enhances production of saliva and its oral health benefits, namely: clearing the mouth of food debris and sugars, neutralising acids, and supporting remineralisation – all of which can help reduce the incidence of caries.

Debris removal and plaque neutralisation

When gum is chewed by healthy subjects, the flow of saliva increases from a resting value of 0.4–0.5 mL/ minute, to approximately 5–6 mL/ minute, and gives a 10–12 fold production increase over unstimulated saliva.[1] The flow of saliva falls after about 5 minutes to around 2 mL/ minute, and slowly thereafter to 1.2–1.5 mL/minute at 20 minutes.[1]

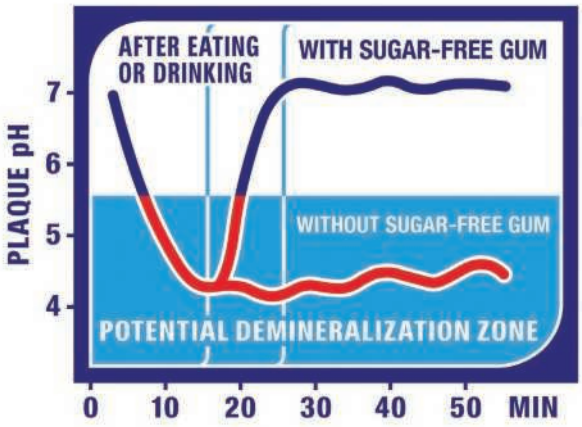
The effect of stimulation is to increase the concentration of bicarbonate in the saliva entering the mouth. This bicarbonate raises the pH of the saliva and greatly increases its buffering power; the saliva is, therefore, much more effective in neutralising and buffering food acids and acids arising in plaque from the fermentation of carbohydrate.[2] At the same time, the phosphate of saliva changes as a result of the rise in pH, so that a higher proportion of it is in the form of PO_4^{3-}.[2] The calcium content of saliva rises as well.[2]

The observation by Hein *et al.* of a 'large and sustained rise in plaque pH' when gum was chewed after sugar intake[3] has been confirmed by many studies conducted around the world as reviewed by Imfeld (1999).[4] These changes in the composition of stimulated saliva lead to a greater ability to prevent a fall in pH and a greater tendency to favour hydroxyapatite crystal growth.[5] In addition, the greater volume and rate of flow of stimulated saliva results in an increased ability to clear sugars and acids from around the teeth.[5] These three properties of saliva are correlated to the caries susceptibility of the individual and are all enhanced by salivary stimulation.

The action of stimulated saliva is most important during the plaque acid threat during the 20–30 minutes after a cariogenic food intake.[6] However, with most foods, salivary stimulation ceases shortly after the final swallow and salivary composition returns to normal in less than 5 minutes, so the protective effects are not mobilised when most needed.

In order to enhance salivary protection during the acid exposure, a stimulant is needed which is not itself cariogenic and the effects of which last as long as possible.[7] Sugarfree chewing gum is a very practical and acceptable stimulus that can be chewed after the intake of fermentable carbohydrates, and brings no undue calories. Research has shown that chewing sugarfree gum stimulates saliva production which can last up to two hours.[8]

Figure 1: Chewing sugarfree gum for 20 minutes after meals and snacks has been proven to keep teeth healthy



'THE USE OF SUGARFREE GUM HAS BEEN ASSOCIATED WITH A REDUCTION IN THE QUANITITY AND DEVELOPMENT OF PLAQUE'

Enhancing remineralisation

The concentrations of ions which make up the lattice structure of hydroxyapatite (Ca^{2+}, PO_4^{3-}, OH^-) are higher in stimulated than in unstimulated saliva. Therefore, stimulated saliva is a more effective medium for remineralising enamel crystals damaged by initial acid exposure. In an *in situ* caries study by Leach *et al.*[9] subjects chewed sorbitol gum for 20 minutes after meals and snacks (five times daily). The gain or loss of mineral content of human enamel slabs, bearing artificial lesions and mounted intra-orally for 3 weeks, was then measured and compared with results after similar periods without gum chewing. Remineralisation of the enamel lesions occurred both with and without gum, but with gum the remineralisation was approximately doubled.

This effect was broadly confirmed by Creanor *et al.*[10] and was consistent with a reduction in enamel demineralisation (measured as iodide penetration) by chewing sorbitol gum, as found by Kashket *et al.*[11] The findings of Steinberg *et al.*[12] further confirmed these results. In this study the use of sugarfree gum (sweetened with either xylitol or sorbitol) for six weeks resulted in an increase in plaque calcium and a significant reduction in plaque index, compared with no gum. Remineralisation *in vivo* is generally considered to be a slow process[13] and thus it was noteworthy that significant remineralisation occurred within 3 weeks. These model experiments suggest that sugarfree gum use can help prevent decay by tilting the equilibrium towards remineralisation and away from demineralisation.

Furthermore, the use of sugarfree gum has been associated with a reduction in the quantity and development of plaque,[14-17] and a reduction in the acid-forming ability of plaque.[18]

The potential outcome from these effects of stimulated saliva is a reduction in the incidence of caries. Multiple clinical trials have observed a reduction in the incidence of caries in response to the regular chewing of sugar-free gum, which has been confirmed by two systematic reviews.[19,20] The reduced incidence has subsequently been reviewed and confirmed in the form of several approved health claims.[21-23]

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bdjteam2015151

10 top tips for special care dental nursing

Patients with additional needs may require you to give additional thought into how they access your service. All patients have individual needs specific only to them so care must be tailored to each patient. Dental Nurse **Nicola Sherlock** thinks the following ten top tips may help the dental team when treating some of the many patients with more complex needs.

1 Get information

Garner as much information about the patient and their social/medical history as possible prior to their first appointment Asking some of the following questions will really help you gain a better understanding of the patient:

- Do they have speech, sight or hearing difficulties?
- Do they usually consent for treatment themselves?
- Who will they attend with or will they attend alone?
- Do they use a wheelchair or another mobility aid?
- Does the patient become agitated in unfamiliar surroundings?
- Are they known to lash out or bite when feeling threatened or anxious?
- Do they demonstrate Pica (eating non-food items such as stones, paperclips)? If so, all reception and surgery surface areas must be clear of any small objects prior to the patient's visit.

All information gathered can help to tailor the environment and make their first visit as smooth as possible as this first trip is crucial, particularly for patients with learning disabilities or dental anxieties.

2 Give Information

Fore-warned is fore-armed. Patients worry about coming to the dentist. Patients with additional needs and their family are no different, throw into the mix a genuine dental phobia and we're guaranteed a failed appointment.

Give directions to the clinic; tell them the best place to park if extra space is required to unpack a wheelchair.

Tell them what to expect on the first visit. Often it is just a chat about medical history and treatment plans but the patient may be envisaging extractions under general anaesthetic (GA).

Inform the patient's parents or care team that they should bring along their medical

history information, a list of medication, rescue medications if needed, funds for payment or proof of exemptions. If the patient has a personal information booklet or folder (a 'Traffic Light Passport') which details all of the above, ask them to bring it.

It will always help if you tell them a little about your practice. Simply having the name of the dental nurse who will be at their first visit can be a comfort as they have a point of contact.

3 Identify barriers to care

In an ideal world we would all have purpose-built, ground floor facilities with wheelchair access, dropped kerbs and car parking in close proximity to the building for ease of access but if you don't have that clinic you need to work as a team to answer questions such as:

- How can you facilitate the patient's visit?
- Could one of the team meet the patient outside and help to guide them into the clinic?
- Can you offer a domiciliary (home) visit or refer them to another service provider who can?
- Can the appointment be made when a family member/support worker can attend with the patient to help with communication for valid consent?
- Can a family member be contacted to bring the patient to appointments or offer support and remind the patient of appointment times?
- Is it feasible to invest in a wheelchair recliner, or hoist? Can the patient transfer using boards or mobility aids?

'SUPPORT CUSHIONS CAN HELP IN MAKING SOME PATIENTS WITH SCLEROSIS OF THE SPINE OR CEREBRAL PALSY MORE COMFORTABLE'

In some cases, the perception for need of treatment may be altered by psychosis, drug and alcohol use or learning and developmental delay. Prejudices, attitudes and discrimination by staff or even family members can result in poor attendance.

Support cushions can help in making some patients with sclerosis of the spine or cerebral palsy more comfortable to endure the length of time some treatments can take.

An increasing number of patients exceed the upper weight limits of the dental chair and must be treated on a Bariatric chair or plinth. It would be important to obtain details of the patient's weight and when they were last weighed prior to their appointment or when referring said patients to a hospital or community dental service.

4 Be flexible

To a certain extent, be flexible with appointment times. I would recommend offering an afternoon appointment if the patient has mobility difficulties such as Multiple Sclerosis and requires time in the morning to wait for carers to help them dress, wash, or take their medication. A patient with a neurological disease such as Parkinson's which requires them to wait a certain amount of time after taking their medications in order to function without severe symptoms may also need an afternoon appointment.

Some medications may affect the patient's ability to co-operate with dental treatment. Similarly, if a patient is an alcoholic or drug abuser they may require a morning appointment before they are too self-medicated to co-operate with care.

Some patients get anxious or agitated if they have to hang around in the waiting room (notably those with autistic spectrum); the first appointment of the session is advisable in these instances as there (in theory) will not be a back-log of patients before them.

Be aware that a patient's health may dictate their ability to attend appointments and may affect their overall attendance; some leniency in rescheduling must be afforded.

5 Consent

A person's ability to make an informed decision resulting in 'valid consent' can be affected for many different reasons such as dementia, learning difficulties, brain injury or mental illness.

As it states in the GDC Standards for the Dental Team:

You must always consider whether patients are able to make decisions about their care themselves, and avoid making assumptions about a patient's ability to give consent. This is a complex area and you should refer to the appropriate legislation.

If an adult patient is assessed as lacking the capacity to give valid consent a 'Best Interest Decision' may be required at some point whereby the patient, staff, care managers and an Independent Mental Capacity Advocate (IMCA) meet to establish a treatment plan (or not) which is in the patient's best interest. This is a legal right for people over 16 who lack mental capacity and do not have an appropriate family member or friend to represent their views.

© Photo courtesy of Design Specific

'COMMUNICATION AMONGST THE DENTAL TEAM IS VITAL'

6 Distraction

Shifting the patient's attention to something less unpleasant than the procedure being carried out can help with most patients, for example, asking the patient having a local anaesthetic to wriggle their toes or talking to them about a favourite past-time or cartoon character.

This is something that the clinician and nurse can do together but is more commonly done by the dental nurse. Relatives or staff can help too by holding hands, chatting and comforting throughout. Some surgeries may have posters or coloured lighting on the ceiling which the patient can be asked to focus on.

7 Anxious patients

Many patients are not keen on a trip to the dentist but it can often be easy to spot the terror a true dental-phobe experiences. Acknowledge their anxiety. Show empathy in all forms of communication including body language. I would recommend you think SOFTEN: Smile, Open posture, Forward lean, Touch, Eye contact, Nod.

Give the patient control techniques such as phrases or actions. Raising their hand if they want to stop or keep the surgery door ajar have worked in the past. Offer reminders prior to appointments to ensure attendance.

8 Oral hygiene advice

This is often a big struggle for carers and patients alike and the main thing that can really make a difference when done properly.

You will need to demonstrate to carers and parents the correct techniques. Encourage having two to brush, one who actually brushes and one who distracts the patient, holds hands and encourages them. Show them how to use an additional brush as a prop if the patient tends to clamp down.

If carers are struggling with compliance, brushing in a different room could help.

Be aware of products available such as grips for toothbrushes, Barman's 3 headed toothbrush and bite supports which could be suggested as brushing aids.

9 Cancer patients

All of the above still applies to this patient group but these patients must have additional support both pre- and post-treatment with oral hygiene, they must be monitored for signs and symptoms of oral mucositis to reduce the risk of aspiration pneumonia (see the WHO Oral Mucositis Scale), they may consider dental treatment and oral hygiene as their last priority so give as much information as possible as to reasons to keep up with mouth care plus lots of support and empathy.

There are products to assist with dry mouth, sore mouth and the inability to eat as a consequence of both, for example, a non-foaming (SLS free) and non-flavoured toothpaste or a mouthwash which acts as a 'liquid plaster' and enables the patient to eat in relative comfort.

10 Communication is key

Where possible, have a 'named nurse'. Someone the patient and their support network can ask to speak to who is familiar with their specific needs is important for continuity of care and can avoid repeat explanations on both sides.

Bear in mind it is good to be in contact with other disciplines when required, such as the GP for medications and medical history or health visitors and school nurses (especially if there are safe-guarding issues). If a patient fails their appointment do your best to find out why. Make phone calls to family members, where applicable to keep them informed of treatment and care.

Communication amongst the dental team is vital; it ensures all the valuable information gleaned previously as to how to assist the patient in accessing dental care and advice is utilised and available to all staff involved.

Further reading

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bdjteam2015152

Don’t risk handling counterfeit goods.

Using counterfeit and non-compliant devices not only puts your registration at risk, it places your patients, colleagues and practice at risk too.

Counterfeit and substandard dental devices are a growing problem within the UK dental sector. As part of an industry-wide response the BDIA operates a Counterfeit and Substandard Instruments and Devices Initiative (CSIDI).

CSIDI facilitates the reporting of those selling counterfeit and non-compliant products and promotes responsible purchasing throughout the dental supply chain.

Every BDIA member adheres to a strict code of practice which means that in choosing to do business with any of them you can have confidence that everything you buy is of guaranteed quality and provenance.

To find out which suppliers are members of the BDIA and how they can help to protect your practice by providing the genuine, quality products and services that you need, visit: **www.bdia.org.uk**

Report anything suspect now to www.bdia.org.uk/device-reporting

BDIA CSIDI
COUNTERFEIT AND SUBSTANDARD
INSTRUMENTS AND DEVICES INITIATIVE

British Dental Industry Association, Mineral Lane, Chesham, Bucks HP5 1NL
T: 01494 782873 **E:** admin@bdia.org.uk **W:** www.bdia.org.uk

Image of counterfeit products confiscated by the MHRA.

Guidance on handling the *touchy* subject of ***sexual harassment*** at work

By **Fiona McLellan**, Partner, Hempsons

Dental practices are often relatively small businesses, which involve close working relationships between staff, as well as close contact with patients and consequently face an increased risk of having to handle difficult allegations of sexual harassment.

This article sets out the statutory framework for sexual harassment in the workplace and provides practical guidance for dealing with these often sensitive, complex and costly cases.

The Equality Act 2010

The Equality Action 2010 ('EqA') prohibits discrimination in the workplace. Specifically, under the EqA workers are protected against discrimination, including harassment and victimisation related to any of nine prescribed protected characteristics, which include sex and sexual orientation.

The EqA provides protection against discrimination to those in employment which is widely defined and includes individuals working under:

- A contract of employment;
- A contract of apprenticeship; and
- A contract to do work personally.

This means individuals who would ordinarily be classed as self-employed, for example dental associates, are likely to be afforded protection against discrimination if the contract under which they work obliges them to perform the work personally (i.e. they cannot substitute or sub-contract the work to someone else).

Sex/Sexual Harassment

The EqA provides protection against three different forms of harassment, specifically:

- ***Unwanted conduct related to sex*** that has the purpose or effect of either violating a person's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that person;
- ***Unwanted conduct of a sexual nature*** that has the purpose or effect of either violating a person's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that person; and
- ***Less favourable treatment*** of a person on account of ***rejecting or submitting to unwanted conduct of a sexual nature***.

What constitutes sexual harassment?

Sexual harassment can take many forms. It can be verbal, non-verbal and/or physical and take the form of: unwelcome advances, touching, sexual jokes, displaying pornographic images or sending material of a sexual nature.

'ISSUES CAN ARISE FOR PRACTICES AND INDIVIDUAL EMPLOYEES WHETHER INTENTIONAL OR NOT FROM CONDUCT THAT CAN CAUSE OFFENCE.'

When assessing the effect of alleged unwanted conduct the following factors must be considered:

- The perception of the complainant;
- The other circumstances of the case; and
- Whether it is reasonable for the conduct to have that effect.

This is a subjective assessment balanced by other relevant factors such as the nature of the relationship between the parties (i.e. status/seniority) and the sensitivity of the complainant. If a complainant is overly sensitive it is unlikely the conduct complained of would constitute harassment.

What is Unwanted Conduct?

Unwanted conduct is not defined in the EqA but over the years case law has developed helpful clarification on how this is assessed, for example:

- It is well-established law that there is no need for a worker to have stated conduct is unwanted before it can constitute harassment;
- A one-off incident can constitute sexual harassment;
- The fact that a worker might have suffered in silence for some time (even years) does not mean that conduct cannot constitute harassment. This is likely to be relevant in cases involving junior/younger workers being harassed by senior/older staff; and
- A worker's participation in sexual banter would not preclude conduct being unwanted and harassment. The participation could be a coping mechanism and/or because the worker did not wish to show discontent for fear of reprisals.

Some behaviour is easily categorised as sexual harassment, for example, the Employment Tribunal (ET) found no difficulty in determining that a male colleague commenting on a female colleague's breasts was sexual harassment. In a less clear cut case the ET determined that a female worker, who was aware her male colleagues were downloading pornographic images onto their computer screens but was not shown the images and didn't complain at the time, had not been subjected to sexual harassment. However, the Employment Appeal Tribunal (EAT) overturned this decision and determined that there had been sexual harassment as the conduct obviously undermined the claimant's dignity.

Particular issues for dental practices

In the dental practice environment where staff such as dentists and dental nurses (in relation to whom there is a difference in status and often age) work in consistent, close and often isolated proximity to each other care needs to be taken to avoid the usual professional barriers in the workplace from being breached. Issues can arise for practices and individual employees whether intentional or not from conduct (including between colleagues of the same sex) that can cause offence, for example:

- A male dental associate seeking to build a rapport with a new young female dental nurse by asking inappropriately personal questions about the dental nurses' relationship with her partner and making comments about the dental nurses' appearance/physique;
- An informal environment in which professional boundaries are crossed daily due to banter involving jokes of a sexual nature and sexual innuendo without any action being taken to set appropriate standards;
- A failure to notify new staff (including locums) about unacceptable standards of behaviour including intentional physical contact being a summary dismissal matter; and
- Inadequate social media policies prohibiting staff from making offensive comments of a sexual nature about colleagues/patients.

Action practices could face

Internal action

Workers who believe that they have been sexually harassed may in the first instance raise internal complaints (grievances) about their treatment, which would usually involve an investigation followed by a formal meeting at which a decision would be made and the right of appeal against that decision offered. If the complaint was up-held it would most likely necessitate disciplinary action being taken against the harasser.

Such processes can be time-consuming and create difficult practical issues from the outset for small employers with limited resources. For example,

- If the complainant raises a serious harassment issue but states that s/he does not wish it to be addressed formally. Ordinarily if an issue is sufficiently serious it would be imprudent for the practice not to take steps to investigate notwithstanding the complainant's position;
- Consideration will have to be given to whether or not to suspend the worker accused of sexual harassment which could impact on the running of the practice;
- The issue will be sensitive and the confidentiality of those involved will require careful consideration. In small practices maintaining confidentiality is likely to be impossible thereby creating staff morale problems and potentially resulting in limited options being available to resolve the issue; and
- The need to notify relevant regulatory bodies and when this should be done.

It is important to ensure an even handed and sensitive approach to such complaints and that they are managed by trained impartial senior members of staff who understand the organisation's policies and the potential implications of the internal complaint process.

Litigation

A worker who has been harassed can also raise proceedings in the ET (a public forum thereby creating significant reputational risks for a practice/practitioners).

ET litigation can be a complex and protracted process in relation to which legal advice will ordinarily need to be taken. Further, the award (compensation) that could be made by the ET if a claim of sexual harassment succeeded is uncapped and could, depending on the nature and impact of the harassment, be significant.

In successful claims, in addition to awarding compensation for loss flowing from the harassment, which could include lost salary if the worker resigned as a result of the harassment or missed a promotion opportunity, an ET will also make an injury to feeling award to compensate for the distress caused by the discrimination. The average award for sex discrimination in the ET is currently £23,478 and injury to feeling awards span a range from £600 to £30,000 depending on the extent/severity of the discrimination.

In a recent case the ET awarded a 22 year old zero-hours worker £19,500 injury to feelings in relation to an eight month period of sexual harassment by the worker's manager, which involved asking her about her sex life and on occasion touching her, kissing her neck and simulating sexual intercourse with her. Despite complaining to another manager nothing was done and when subsequently a formal complaint was raised the actions of the employer in investigating the complaint were cursory and no action was taken against the manager.

Liability for harassment

Sexual harassment claims can be brought against both the alleged perpetrator of the harassment and the employer. Employers are vicariously liable for the actions of their staff in the course of employment whether or not the employer knew about/approved of the conduct. Conduct carried out in the course of employment would be likely to include not only acts committed in work premises during working hours but also at staff events (whether or not organised by the employer) such as parties and after work drinks, as well as work-related social media postings.

Employers can defend sexual harassment claims by demonstrating that they have taken reasonable steps to prevent discrimination from happening. The most common examples of steps an employer will seek to rely on if using this defence are that is has:

- Implemented relevant policies and procedures (i.e. a bullying and harassment policy);
- Issued the procedures to all staff;
- Trained staff responsible for managing the policy on its application and on equality and diversity matters more generally; and
- Taken appropriate action in response to allegations of discrimination.

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'CONDUCT CARRIED OUT IN THE COURSE OF EMPLOYMENT WOULD BE LIKELY TO INCLUDE NOT ONLY ACTS COMMITTED IN WORK PREMISES DURING WORKING HOURS BUT ALSO AT STAFF EVENTS'

Practical steps to reduce risk

Allegations of sexual harassment can be complex and require careful and sensitive handling to avoid an adverse effect on the operation of a practice and a detrimental impact on staff morale, as well as reducing the risk of ET litigation, which is often protracted, creates the potential for adverse publicity, incurs significant legal costs and can result in substantial awards of compensation being made against practices and practitioners.

Dental practice principals should therefore consider the points below as a means of reducing the risk of harassment issues arising and to better equip the practice to manage harassment issues robustly and utilise the reasonable steps defence:

- Introduce/review policies on equality/harassment, which set out in clear terms what constitutes acceptable/unacceptable behaviour and the consequences of acting in breach of the policies;
- Ensure that the practice balances a friendly and open working environment with appropriate professional standards. Regular staff feedback sessions/surveys could provide a means of identifying inappropriate conduct allowing this to be nipped in the bud informally;
- Ensure policies on equality/harassment are regularly reviewed and are highlighted to all new staff including locums at the induction stage;
- Train managers responsible for handling allegations of harassment on the practice's relevant policies and provide refresher training from time to time;
- Ensure staff understand that they should raise concerns about harassment (discrimination) and that the practice has a zero tolerance policy to harassment meaning that allegations will be taken seriously and investigated; and
- Take legal advice at an early stage to ensure that matters are handled appropriately from the start and a lack of action/the wrong action does not create intractable issues for the practice.

bdjteam2015153

CORE CPD: ONE HOUR

Making oral cancer screening a routine part of your patient care

PART 2

By Linda Douglas RDH

Fig. 1 Vizilite pre-rinse solution and light stick/mirror

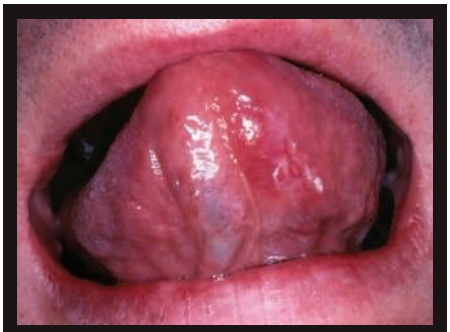
Fig. 2 Squamous cell carcinoma viewed under normal light

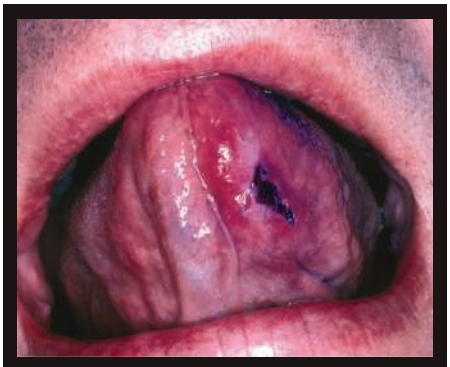
Fig. 3 Squamous cell carcinoma viewed with *ViziLite® Plus* and T-Blue

On completion of this CPD paper, the participant will be able to:

- List examples of screening techniques which have improved survival rates for other cancers
- Define screening and discuss the criteria for evaluating screening techniques
- Describe adjunctive technologies for oral cancer screening
- Discuss some of the current research on oral cancer, including aetiology, prevention, diagnosis and treatment.

Introduction

Oral cancer is the world's sixth most common malignancy and has one of the lowest survival rates, often due to late diagnosis. Most oral cancers are preceded by precancerous lesions and early cancers that can be identified by visual inspection of the oral cavity. Oral cancer is therefore potentially amenable to primary and secondary prevention.[1] A cluster randomised controlled trial in India found that oral visual screening can reduce mortality in high-risk individuals.[2] However, while conventional oral examination is useful in the discovery of some oral lesions, it does not identify all potentially premalignant lesions, as some are not readily apparent to visual inspection alone.[3] Adjunctive techniques have emerged that may facilitate early detection of oral premalignant and malignant lesions.[4]

Screening techniques which have improved survival rates for other cancers[5]

Screening involves checking for the presence of disease in an asymptomatic individual.

Screening for breast, cervical, and colorectal cancers saves lives through early detection; it is often the first step in preventing colorectal and cervical cancers from developing. Routine screening can reduce deaths from colorectal cancer by at least 60%. Mammograms performed every one or two years for women aged 40 years and over can reduce mortality by approximately 20% to 25% during a ten-year period. Rates of cervical cancer death dropped by 20% to 60% after screening programmes began.

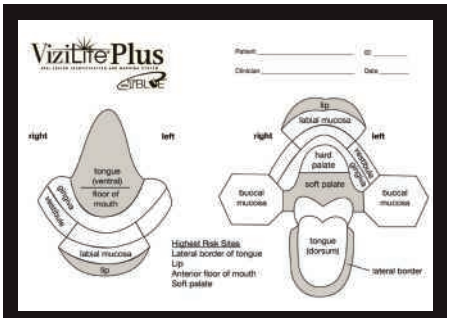

Fig. 4 Mouth map. Reproduced with permission from ViziLite® Plus from Zila, a TOLMAR Company

Criteria for assessing the results of screening tests[4]

- Sensitivity refers to how accurately a test identifies people who have the disease
- Specificity refers to how accurately a test identifies people who do not have the disease
- The best tests demonstrate high sensitivity and high specificity
- The predictive value of a test reflects the probability that the test result is correct or incorrect.

Characteristics of a good screening test[3]

- Simple, safe and acceptable to the public
- Detects disease early
- Detects lesions which are likely to progress
- Detects lesions which are treatable, or where intervention will prevent progression
- High positive predictive value and low false positives.

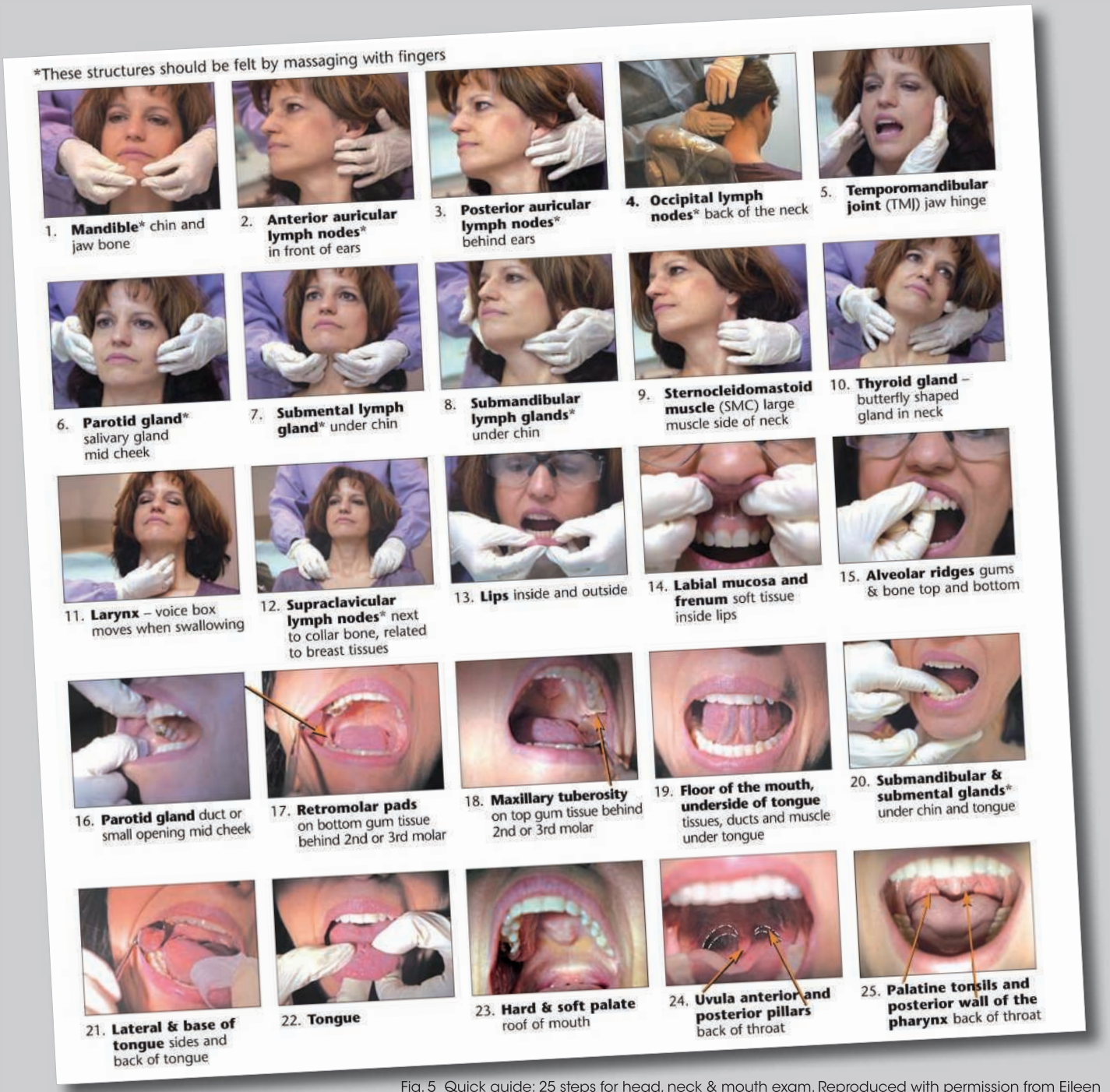

Fig. 5 Quick guide: 25 steps for head, neck & mouth exam. Reproduced with permission from Eileen McQuade RDH BS, and GoToDDS.com

Adjunctive techniques for oral cancer screening

These adjuncts may be used in conjunction with oral cancer screening, to aid in the detection of oral precancers and cancers (Figs 1-4).

Visualisation adjuncts

When using adjunctive visual screening technologies, the same sequence of assessment applies as for the conventional intra-oral examination, so that all areas of the mouth are methodically and thoroughly inspected (Fig. 5).

Chemiluminescent illumination

Chemiluminescent light is used to visualise the oral cavity after rinsing the mouth with 1% acetic acid. Acetic acid dessicates the cells slightly, to enhance visibility of abnormalities. Chemiluminescent light is reflected by leukoplakias, highlighting them as acetowhite regions; red lesions reportedly appear darker than normal tissue. Vizilite Plus utilises this technique together with Toluidine blue (T-Blue) staining, to enhance sensitivity and specificity.

Toluidine blue staining

This has been shown to identify lesions with molecular changes associated with increased risk of progression to oral cancer. Toluidine blue staining demarcates malignant/dysplastic areas, to identify sites for biopsy.

Autofluorescence

Autofluorescence of tissues is produced by fluorophores that naturally occur in living cells after excitation with a suitable light wavelength. Healthy tissue emits fluorescence, while abnormal tissue exhibits loss of fluorescence, and appears dark. Autofluorescence may be useful in detecting lesions that are not easily noticed by visual inspection, and to distinguish the margins of lesions for biopsy. Images of the fluorescence produced can be recorded using a camera. VELscope (Visually Enhanced Lesion Scope) and Identafi® (Fig. 6) utilise this technology.

Identafi® uses fluorescence and reflectance to enhance visualisation of mucosal abnormalities.

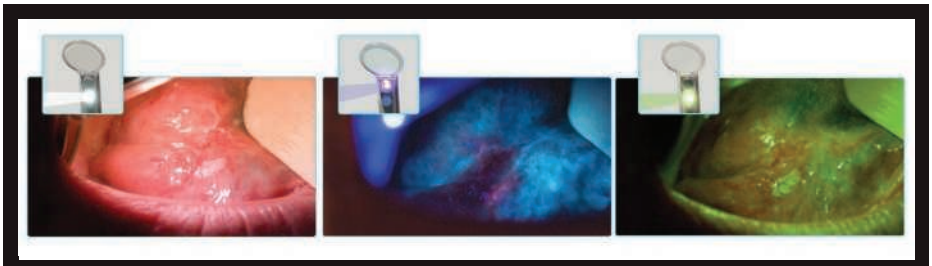

Fig. 6 *Identafi*® clinical images reproduced with permission from: *Identafi*® and DentalEZ® Group. These images are for illustrative purposes only and are not meant for clinical diagnosis or definitive treatment planning

Fig. 7 Brush test of a lesion

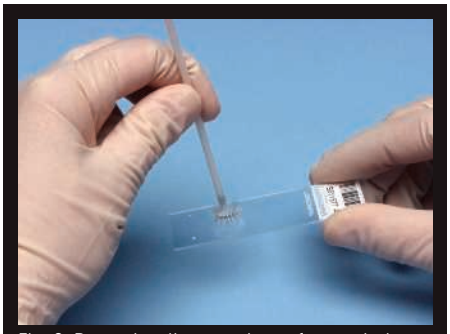

Fig. 8 Preparing the specimen for analysis. Copyright CDx Diagnostics™/OralCDx®

Intra-oral visual examination is first done with a white light, then with a fluorescent violet light, followed by the amber reflectance light wavelength, which is absorbed by haemoglobin to highlight the vasculature around lesions. Abnormal tissue exhibits loss of fluorescence, and disorganised vasculature.

Adjunctive screening technologies which involve laboratory analysis

Oral exfoliative cytology

With this adjunct, the lesion must be visually identified before taking the specimen. A cytobrush is used to obtain a sample of the full thickness of stratified squamous epithelium for interpretation. The cells can be evaluated using the following methods: computer-assisted image analysis, DNA cytometry, immuno histochemistry, monolayer cytology and molecular biological analysis. OralCDx is one such brush test, recording 72.7% sensitivity and 92.3% specificity in diagnosing and monitoring oral leukoplakia[7] (Figs 7 and 8).

The OraRisk HPV salivary test

Oral Human Papilloma Virus (HPV) is primarily found in the oropharyngeal complex: it is an *oncovirus*, meaning that it could potentially lead to cancer. Incidence of HPV-related oropharyngeal cancers is increasing: particularly from HPV types 16 and 18; approximately 74% of HPV-positive cancers are found on the tonsils. The OraRisk® HPV test identifies the type(s) of oral HPV, and could facilitate risk assessment for oropharyngeal cancer. An example of a squamous cell carcinoma of the posterior pharyngeal wall is shown in Figure 9 and a tonsillar carcinoma in Figure 10.

Current research on oral cancer

Aetiology and prevention

Recent research finds that the human cytomegalovirus (HCMV), a herpes virus found in the mouth, could have a role in the development of oral cancer.[8]

Researchers at Columbia University Medical Centre and Harvard School of Public Health found that women with high folic acid intake are at lower risk from oral cancer.[9] Recent research has also shown that an increase in foods with omega 3 and foods high in fibre can help decrease the risks.

> 'Wide variations are seen in the research findings for each adjunctive screening technology...'

Xylitol inhibits carcinogenic acetaldehyde production by Candida species[10]

Acetaldehyde is a highly toxic and mutagenic product of alcohol fermentation and metabolism, which has been classified as a Class I carcinogen for humans.[11] Many oral Candida species are capable of acetaldehyde production from ethanol.[12] Xylitol was found to reduce acetaldehyde production by Candida to below mutagenic levels.

Screening and diagnosis

Salivary analysis to enhance oral cancer screening

Researchers at UCLA have developed the Oral Fluidic Nanosensor Test: saliva from individuals with head and neck cancer was profiled and analysed. Salivary mRNA and proteomic biomarkers were able to predict if a sample was from someone with oral cancer, or from a healthy subject, with 82% accuracy.[13]

Salivary metabolomes can also aid in the detection of oral squamous cell carcinoma. Subjects with oral squamous cell carcinoma, oral leukoplakia, and those in healthy control groups demonstrated characteristic salivary metabolic signatures.[14]

Enhanced imaging

PET/CT (Positron Emission Tomography with Computed Axial Tomography)[15-17] involves intravenous injection of Fludeoxyglucose (FDG), a radioactive glucose analogue; several tumours show increased FDG uptake. FDG is taken up by high-glucose-using cells, and the CT scanner forms images of its distribution. The PET gives the metabolic information, while the CT is higher resolution and gives the anatomic location. These are overlayed to produce a CT scan with areas that 'light up' to coincide with the higher metabolic uptake.

Innovative therapy[18] – chemoprevention

Researchers have developed a mucoadhesive oral patch that releases Fenretinide, a chemoprevention drug, directly into oral precancerous lesions over an extended time.[19] Fenretinide is a synthetic derivative of vitamin A with anticancer properties. Scientists had previously failed to achieve a therapeutic systemic dose of Fenretinide because of drug toxicity and rapid release from the body.

Conclusion

Wide variations are seen in the research findings regarding sensitivity, specificity and predictive values for each adjunctive screening technology: this appears to be partially related to differences in study design. A 2005 Cochrane

systematic review by Kujan *et al.*[20] and 2007 research by Lingen *et al.*[3] found that 'the implication that adjunctive screening technologies may improve detection of oral cancers and precancers beyond conventional oral examination alone has yet to be rigorously confirmed'.

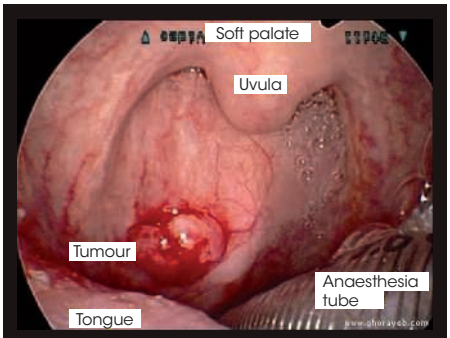

Fig. 9 Squamous cell carcinoma of the posterior pharyngeal wall. Reproduced with permission from Otolaryngology Houston www.houstonoto.com

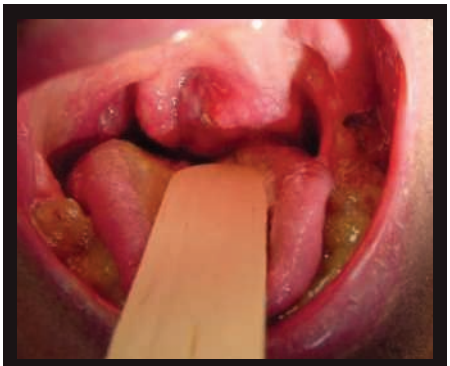

Fig. 10 Tonsillar carcinoma. Reproduced with permission from Otolaryngology Houston www.houstonoto.com

Patton, Epstein and Kerr's 2008 research[4] found evidence that Toluidine blue is effective as a diagnostic adjunct for use in high-risk populations and suspicious mucosal lesions, and OralCDx is useful in assessment of dysplastic changes in clinically suspicious lesions. However, they concluded that 'overall, there is insufficient evidence to support or refute the use of visually based examination adjuncts in general dental practice settings; therefore clinicians must rely on thorough oral mucosal examination, supported by specialty referral and/or tissue biopsy for diagnosis of oral premalignant and malignant lesions'.

Conversely, since there is no compelling evidence against utilisation of adjunctive technologies for oral cancer screening, their application is not precluded: they might potentially enhance early detection of oral cancers and precancers. Nevertheless, re-evaluation of lesions in 14 days to confirm persistence reduces potential errors in diagnosis,[21] and regardless of which screening technique is used, the most reliable method to confirm exact diagnosis is still scalpel biopsy and histopathological examination.

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Useful resources

Short tutorials on adjunctive screening technologies
http://vivalearning.com/tutorials.asp?x_action=search&x_type=category&x_catID=95&1324672852869#results

A digital manual for early diagnosis of oral neoplasia (WHO International Agency for Research on Cancer)
http://screening.iarc.fr/atlasoral_detail.php?flag=0&lang=1&ld=A4000034&cat=A4

Mouth Cancer Action Month website:
www.mouthcancer.org

The Risk of Omission: Performance of Screening Exams
http://www.dentistrytoday.com/oral-cancer-screening/4814-the-risk-of-omission-performance-of-screening-exams

Oral cancer e-supplement
http://www.dentistryiq.com/etc/medialib/new-lib/dentstryiq2/online-articles/documents/2011/04.Par.73665.File

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http://services.aamc.org/30/mededportal/servlet/s/segment/mededportal/?subid=7768

Oral Cancer Screening Video
http://www.dentalce.umn.edu/OralCancerVideo/home.html

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Show your support for Mouth Cancer Action Month November 2015

This Sunday (1 November) sees the start of an annual campaign to help saves lives. Interested? Read on…

Mouth Cancer Action Month is taking place during November and the UK's leading oral health charity want to ensure that each and every member of the dental team is 'mouthaware'. But what does that mean?

It means being able to recognise the early signs and symptoms of mouth cancer. It means being extra vigilant with potentially high-risk patients. It means educating patients on the risk factors associated with mouth cancer and being vigilant about recognising changes in their mouth.

Organised by the British Dental Health Foundation, Mouth Cancer Action Month aims to save lives through early detection and increase education and knowledge about a disease about which awareness of still remains worryingly low.

Mouth cancer is one of the UK's fastest increasing cancers, with cases up by almost 40 per cent in the last decade alone. Dental professionals are on the frontline in the fight against mouth cancer and their support and participation remains instrumental in helping to combat a disease which kills more people every year than testicular and cervical cancer combined.

Unfortunately survival rates for those with mouth cancer have not improved in the last 20 years and it is one of the few cancers which has seen an increase in the past decade. By being 'mouthaware' and spotting mouth cancer early enough, patients are given the best possible chance to be successfully treated and have a good quality of life.

As part of every check-up dentists are required to carry out a visual examination on their patients for the early signs of mouth cancer. It is important that you know how to carry out an effective examination and also communicate with your patient what you are doing and what you are looking out for.

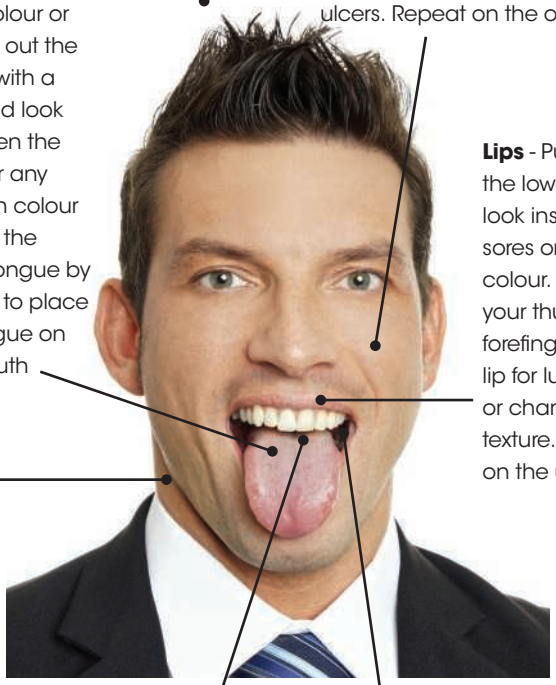
FOLLOW THESE SEVEN SIMPLE STEPS WHEN CARRYING OUT A MOUTH CANCER CHECK:

Head and neck - Look at the face and neck. Do both sides look the same? Look for any lumps, bumps or swellings that are only on one side of the face

Tongue - Get your patient to stick out their tongue and look at the surface for any changes in colour or texture. Gently pull out the tongue holding it with a piece of gauze and look at one side first, then the other side. Look for any swelling, change in colour or ulcers. Examine the underside of the tongue by asking the patient to place the tip of their tongue on the roof of the mouth

Neck - Feel and press along the sides and front of the patient's neck. Can you feel any tenderness or lumps?

Cheek - Use your finger to pull out the cheek so that you can see inside. Look for red, white or dark patches. Put your index finger inside the cheek and your thumb on the outside. Gently squeeze and roll the cheek to check for any lumps, tenderness or ulcers. Repeat on the other cheek



Lips - Pull down the lower lip and look inside for any sores or change in colour. Next, use your thumb and forefinger to feel the lip for lumps, bumps or changes in texture. Repeat this on the upper lip

Roof of the mouth - Tilt back the patient's head and open their mouth wide to see if there are any lumps or if there is any change in colour. Run your finger on the roof of the mouth to feel for any lumps

Floor of the mouth - Look at the floor of the mouth for changes in colour that are different from normal. Gently press your finger along the floor of the mouth and underside of the tongue to feel for any lumps, swellings or ulcers.

THREE TIMES AS MANY PEOPLE SUPPORT THE HPV JABS FOR BOYS THAN ARE OPPOSED TO IT

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter OBE, highlighted the importance of DCPs being 'mouthaware.' Dr Carter said: 'Survival rates from mouth cancer, based on an early diagnosis, are 90% compared to 50% if caught late. This is why it is so important that all dental professionals are aware of the signs, symptoms and contributing factors of mouth cancer and relay them onto patients during the visual examination part of their check-ups.

'SIGNS OF MOUTH CANCERS INCLUDE; NON-HEALING MOUTH ULCERS, RED OR WHITE PATCHES IN THE MOUTH AND ANY UNUSUAL LUMPS OR SWELLINGS IN THE LIPS, TONGUE, CHEEKS OR THROAT'

'Around 90% of mouth cancers are linked to lifestyle factors and certain risk factors increase chances of developing the disease. These include smoking, alcohol and the human papillomavirus (HPV).

'Through dental professionals recognising these contributing factors in their patients they will be able to identify those most at risk and make them aware of how their lifestyle choices could be putting their health at risk.'

One of the risk factors – the human papillomavirus (HPV), is forecast to overtake smoking as the leading cause of mouth cancer within the decade. The Joint Committee on Vaccination and Immunisation (JCVI) have been considering whether to offer the HPV vaccination to boys for some time, with no significant progress made.

Keynote speaker at the launch event at the House of Commons, Peter Baker, HPV Action Campaign Director, told those gathered that there is more than enough information out there to make a decision about the vaccination and urged the JCVI to get a move on.

In the time since the JCVI began discussions on whether to vaccination boys, it could be too late for as many as 1.6m boys. Peter highlighted how the JCVI's handling of the consultation is becoming 'almost Chilcot Inquiry-esq', after their decision this year to put the consultation back until 2017. Even last year when the JCVI recommended the vaccination be offered to men who have sex with men (MSM), it went to consultation. Peter reiterated the call to go ahead and implement this immediately.

During his speech Peter also spoke about the importance of making the right decision – not just a decision. With more than 100 senior and highly influential names supporting the decision to give the vaccination to boys, Peter said 'it is more difficult to find someone not in support of it than someone who does support it'. The level of support at a public health level is significant, yet the only people who oppose it are the bean counters.

The cost of extending the vaccination programme to boys in the UK would be relatively modest, especially now that two doses of the vaccine are required instead of three. HPV Action estimates the additional cost as being in the region of £20-22m a year. In reality, Peter thinks it could bc roughly half of this. And, to put it into context, that's half of Cristiano Ronaldo's salary.


Peter Baker, HPV Action Campaign Director

The cost of treating each case of invasive anal cancer – also caused by HPV – from referral through to either completion of follow-up or death has been estimated at £16,473 in England; the total cost of treating just the 414 men diagnosed with anal cancer in 2011 will therefore be in the region of £6.8 million. The cost of treating RRP has been estimated at £4 million a year in the UK.

A study of the cost of treating nine major HPV-related diseases (the different cancers, anogenital warts and RRP) in Italy produced an estimate of almost €530 (£455) million a year; a study of the economic burden of HPV-related cancers in France estimated the cost to be about €240 (£161) million.

To register your support for the campaign, please visit www.mouthcancer.org/register

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BDJ Team continuing professional development

CORE CPD: ONE HOUR

CPD questions – October 2015

CPD ARTICLE: Oral cancer screening – Part 2

1. How common is oral cancer worldwide?

a) fourth most common
b) fifth most common
c) sixth most common
d) seventh most common

2. How much did cervical cancer deaths drop by after screening programmes began?

a) 20%
b) 40%
c) 60%
d) 80%

3. Which of these is a toxic and mutagenic product of alcohol fermentation?

a) Formaldehyde
b) Acetaldehyde
c) Glutaraldehyde
d) Valeraldehyde

4. According to the author, how many characteristics are there of a good screening test?

a) Two
b) Three
c) Four
d) Five

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