PATHWAY

NORTH WEST

OCTOBER 2006 · ISSUE NO 10

THE NEWSLETTER OF THE NORTH WESTERN DIVISION OF THE FACULTY OF GENERAL DENTAL PRACTICE (UK)

FACULTY OF GENERAL DENTAL PRACTICE (UK)
THE ROYAL COLLEGE OF SURGEONS OF ENGLAND

"Pathway" Goes Digital!

Adrian Bennett
Editor

Welcome to the Autumn edition of Pathway. Following the online availability of the Faculty's "Primary Care" publication, Pathway has now moved into digital format too. (Please note that it is obviously important that we have an up-to-date email address for you!) The new format will no longer restrict us to six pages, meaning that case studies etc can be better presented, almost in-full, and will also allow the use of full colour.

In this issue you'll find two articles very relevant to those undertaking (or planning to) the MFGDP(UK) or the Faculty Diploma in Implant Dentistry.

The first article is an audit cycle showing how useful this simple procedure can be in an area that often receives less attention than it should: Oral disease. The second article is an implant case and has been donated by John Moorhouse, North-West Division Director.

Both of these reports give valuable information on the type and quality of reports required for these qualifications.

Andrew Shelley gets back to basics and refreshes his anatomy with the amazing Apollonius Allen as part of his own implant training. And Sunil Panchmatia reports the latest goings-on with the MFGDP(UK) study group.

Back in May, the Faculty and Denplan ran the second of their "Keep Smiling - Contemporary Techniques in Care and Restoration for Anterior Teeth" study days at the Manchester Conference centre. Speakers Professor Callum Youngson, Professor Paul Brunton, Mr Martin Kelleher, Mr Naresh Sharma and Dr Thomas Kaus provided a very entertaining and educational day. It was interesting to hear the different approaches from both academics and practitioners; their conclusions not always agreeing! However, some of the methods of improving anterior aesthetics that were agreed on were of the more minimally invasive approach e.g. space closing with composites, bleaching for tetracycline staining/ fluorosis, implants as opposed to bridgework etc, thus thinking ahead for the future and stopping the patient sliding down the "Restorative staircase".

In June, the Faculty gave the go-ahead for a route to a "Clinical Dental Technician" qualification; a great step forwards for the dental care team, finally providing a much needed UK qualification for technicians. It will allow edentulous patients to be treated by a technician for the provision of complete dentures, without prior consultation with a dentist. The qualification, "Faculty Diploma in Clinical Dental Technology" became registerable with the GDC at the end of July.

It is the NW-Division's AGM time of year again; this year's is on Wednesday 18th October at the MANDEC. The meeting kicks-off at 6:30pm and will be followed by a presentation by the new Faculty Dean Richard Hayward on "The Faculty now and the future". Richard took over from Mike Mulcahy in July this year and I'm sure the Division will want to give him a warm welcome. Please note that there will be no parking available in the quadrangle, however the multi-storey will be open as usual.

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INSIDE THIS ISSUE

FACULTY AGM

18th October at 6.30pm

at the MANDEC

DID YOU KNOW?

Info about upcoming national events is available at http://www.rcseng.ac.uk/fgdp

Many thanks to Jim Darcy for donating this issue's MFGDP(UK) article.

Audit of Record Keeping: Assessment of Oral Disease Risk and Justification of Dental Recall Intervals

What was formally the Dental Practice Board, now the Business Services Authority, visited our practice in March 2006. The objective was to assess the standards of clinical and non-clinical activity in the practice for all three dentists. To do this, for each dentist they:

- Assessed four sets of notes.
- Reviewed four patients and their notes immediately after treatment by the dentist

A maximum result from the inspection was a pass and we achieved this easily. The inspector had one criticism namely the lack of written justification within the notes for the annotated recall interval. He felt this should be addressed. It was decided I should audit our notes and examine them for this justification. I felt it necessary in doing so to also assess whether risk of disease was being recorded and if indeed the recall interval was clearly demonstrated.

Sources and Reference Texts

NICE Guidelines:

"Aim to help clinicians assess the most appropriate recall interval for individual patients taking into account the patient's: "General well-being, health and preventive habits, caries incidence and avoiding restorations, periodontal health, avoiding tooth loss and avoiding pain and anxiety." - NICE discuss risk factors for the onset of oral disease. It focuses on three aspects namely caries, periodontal disease and oral cancer:

- CARIES: Caries risk can be predicted most consistently by assessment of previous carious experience. There are many other factors also implicated in caries risk/development. Caries risk can be readily ascertained at regular check-ups.
- PERIODONTAL DISEASE: The main risk factors for the development/advancement of periodontal disease include the presence of plaque, smoking and diabetes. The evidence is scarce concerning the correlation of gingival disease and periodontal disease. Untreated periodontal disease progresses much faster than treated periodontal disease.
- ORAL CANCER: Survival rates from oral cancer are low when diagnosed late. The incidence increases with age, in males and with alcohol and tobacco use. Clinicians should be vigilant for and mucosal changes or lesions that appear abnormal. The lateral and ventral surface of the tongue and floor of mouth are the high-risk areas of the mouth.

Standards in Dentistry, 30th Jan 2006, FGDP (UK) Website

This is a regularly updated document of standards for general practitioners to follow. On the subject of the audit the following information is present:

All practices should have a policy on recall interval guidelines.

Others:

Davenport C *et al*, "The effectiveness of routine dental checks : a systematic review of the evidence base". Br Dent J 2003; 195:87-98 and **Brunton P.** "Six-month dental examinations: what's the evidence base?" Surgeons News 2004; 3:18

They concluded that recall interval should be determined by the risk of disease.

The Benefits:

Patients:

- Allows care to be provided on a more individual basis.
- Improves the consent process.
- Prevents unnecessary check-ups and thus saves time and money for the patient.
- Supports a minimally interventive policy by promoting prevention and encouraging patients to attend before disease requires treatment.
- Aids patients to understand their oral health through discussion of risk of oral disease and risk management of oral disease. Increases the likelihood of recognising, diagnosing and treating disease at and earlier stage and thus hopefully more successfully.

The Practice:

- Medico legally necessary.
- Places responsibility on patient by addressing risk factors and prevention.
- Prevents unnecessary check-ups and thus saves time and money for the practice.
- Follows the principles of best practice by following evidence based practice
- Promotes better practice philosophy by supporting the practice mission statement.
- Improves standards of clinical record keeping and thus improves communication
- Improves patient confidence in clinicians through appropriateness of treatment.
- Through increasing recall intervals it frees up more clinical time for new and existing patients.

Audit Design

Data To Be Recorded

- The presence/absence of a caries risk assessment.
- The presence/absence of Basic Periodontal Examination.
- The presence/absence of an oral cancer risk.
- Recall interval.
- Justification of this recall interval.

The Sample

- Patients over 18 years.
- Dentate or partially dentate.
- The treatment must include a full examination thus excluding occasional pain treatments.
- These patients were sampled from those who were had just completed courses of treatment under all three dentists.

The process

I undertook a training session with two nurses. I explained our aims and objectives. With their help I then compiled the notes and began the task of assessing each set.

We searched the notes for the following:

- For caries risk a CR is our abbreviation, preceded by either a high/low or ↑/↓arrow.
- The BPE. For oral cancer risk an OC is our abbreviation, preceded by either a high/low or ↑/↓arrow.
- The recall interval is expressed as x/12months depending on perceived need.
- For justification I was simply seeking a post-script to the re-call interval such as HIGH CR.

Re-Audit

The results of the audit would be discussed and changes to our current practice be considered and implemented. Another audit would be undertaken one month after the meeting. Given the high patient turnover of the practice, one month was though to be sufficient time for the changes to be implemented and observable.

Standards

The First Cycle

I discussed the standards with the other dentists at the practice and at a peer review opportunity during an MFGDP meeting. Given we do not have a protocol for this combination of information a 100% standard for any was unrealistic BUT following the NICE guidelines I concluded the following:

Caries Risk recorded?	**90%**
BPE recorded?	**90%**
Cancer Risk recorded?	**50%**
Recall interval recorded	**90%**
Justification of recall interval recorded?	**50%**

Results - 1

The first audit on March 13th 2006 revealed the following results:

Caries Risk Recorded?	Basic periodontal examination recorded?	Oral cancer risk recorded?	Recall interval recorded?	Recall interval justified?
47%	91%	20%	69%	22%

These results show that all aspects of the audit are being poorly recorded. The lowest to be recorded was the oral cancer risk at only 20%. As expected, the recall interval justification was also poorly recording. Recording of BPE was above standard at 91%.

Discussion - 1

I discussed the results with the other dentists at the practice. We felt that although risk assessments were being made mentally and leading to a recall interval being decided, these risks were not being written in the clinical notes. As discussed, we expected there to be little justification of the recall interval in the notes, so 22% was surprisingly good (yet obviously way below the standard). We were happy the BPE was being recorded in most instances and confident we can improve this. Ibelieve the poor oral cancer risk recording was due to the lack of record ing of low risk patients. Currently we are only highlighting the high-risk patients. The caries risk assessment was very low at 47%

Action Plan

We formulated a protocol which covers the assessment of risk factors for disease, the appropriate recall intervals for monitoring these diseases and the importance of the justification of this. There are also recommended abbreviations to ensure the information can be easily incorporated into the notes. Each of the dentists has a laminated copy of this protocol.

To re-audit in one month to ensure the changes implemented have worked and to continue the audit cycle every 6 months. For this second audit the standards should be raised given the retraining:

Caries Risk	**100%**
BPE	**100%**
Oral Cancer Risk	**90%**
Recall Interval	**100%**
Justification	**90%**

Summary

This audit was very useful in assessing the accuracy of our note keeping at the practice. The information being audited is essential for the reasons described above (Section 2.4) yet we are failing as a practice to maintain good standards. It will be interesting to see how the new protocol and retraining affects the audit results.

Re-Audit

After further staff training through the introduction of a protocol I re-audited the notes. Again I used a sample of 200 notes of patients finishing treatment from the 25/3/6 onwards. The sample was taken one month later on the 14/4/6 from those completed patients seen since the implementation of the protocol.

Results - 2

Caries Risk Recorded?	Basic periodontal examination recorded?	Oral cancer risk recorded?	Recall interval recorded?	Recall interval justified?
97%	98%	83%	97%	89%

Discussion - 2

There has been a great improvement in the record keeping at the practice. Although not quite meeting the standards set for the second cycle the improvement is huge and the standards only nearly missed. Only 6 of those sampled failed to have a caries risk assessment and only 4 failed to have a BPE at routine recall examination.
Of the two hundred notes sampled, 34 patients did not have an oral cancer risk recorded. On discussion with my colleagues this was again thought to be due to not recording low risk patients on every recall. We agreed we must be more careful of this in the future as failure to document it could be interpreted as a failure to make a oral cancer risk assessment. None the less this still represents a 63% increase in this aspect of record keeping. This is excellent. 22 of the 200 patients had no overt justification for the recall interval suggested BUT 194 patients did have a recall interval recorded in the notes. Once again we discussed the 67% increase in recording to be an excellent achievement but must strive to improve further.
Re-audit in three months time will reveal how well these standards are being maintained and hopefully demonstrate a further improvement.

An Afternoon with the Amazing Apollonius Allen

Taking a Faculty Diploma such as the MFGDP(UK) means revisiting your anatomy. However, anatomy doesn't have to be hard slog, it can be fun !

Andrew Shelley reports on his amazing afternoon with anatomist Apollonius Allen.

"When you know your anatomy it gives you confidence!" proclaims Apollonius. He's right of course and I was really looking forward to the anatomy module of my implant course with Perio-Implant Europe. Unfortunately I had a long standing prior commitment. "But you're missing the best bit !" cried my colleagues from the previous year's intake. I was gutted, as they say around here in Manchester. Then a chink of light, Apollonius had found a

"When you know your anatomy it gives you confidence!"

free afternoon in his hectic schedule and invited me for a one to one tutorial at his dental practice in London. In one astonishing afternoon Apollonius covered all the relevant anatomy for dental implantology and much more as well. His knowledge of anatomy never stops, he just knows everything. "People get confused" he confides, "They think that because I am a dentist I only know the head and neck but I know full body anatomy".

Educated at the University of Lagos, Apollonius emerged in 1983 with his BDS, MSc and PhD in anatomy. By 1986 he was the first dental anatomist in the whole of Africa. Having won a scholarship to continue his studies at the University of London he then moved to England and picked up his FDS RCS Eng. Apollonius now combines his London dental practice with a heavy teaching schedule. This includes not only dental students at Guy's hospital but also gynaecologists, physiotherapists and anyone else who can make use of his encyclopaedic brain. As if this wasn't enough to keep him busy he is also a church minister. This is important because when you know about this you can see where his approach comes from. It's as if he is marvelling at God's work.

By 1986 Apollonius was the first dental anatomist in the whole of Africa.

Apollonius's teaching methods are engaging. For example did you know what a nervous plexus really is ? Like me you probably thought it was a little knot of nerves. "It's a party!" says Apollonius. "The nerves all get together to have fun but one of them has too much to drink and leaves worse for wear!" He's talking about the lesser petrosal nerve leaving the tympanic plexus and weaving a tortuous drunken course on his way. With Apollonius every anatomical situation has a story to help memory and keep you interested. His enthusiasm for his subject never lets up. He demonstrates with a comprehensive collection of specimens including every separate bone of the skull, even the tiny ossicles. If he can't illustrate his point with these he also has a slide for every eventuality.

With Apollonius every anatomical situation has a story to help memory and keep you interested

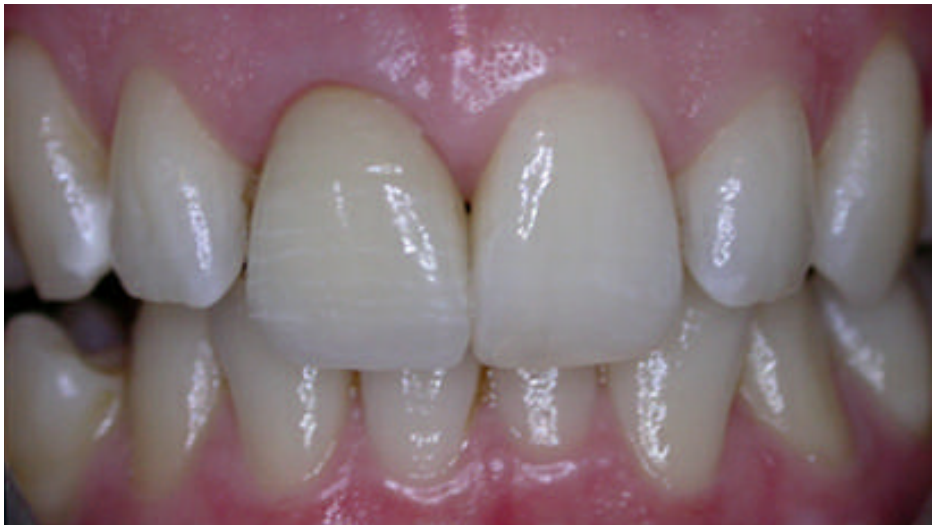
If you get the chance to hear Apollonius on anatomy it will change the way you think about dentistry. After all it's the basis for everything we do, that's why they teach us anatomy first when we get to University. It is also a vital part of the Faculty diplomas such as MFGDP(UK). You can find Apollonius on the courses run by Perio-Implant Europe but he hopes that he will be able to spread his knowledge more widely to the profession in the future.

After an afternoon of his boundless enthusiasm for anatomy I confessed, "I'm beginning to feel a lot better about carrying out implant surgery". "Ah hah !", replied Apollonius, "He who has knowledge has power !"

For more information about Perio-Implant Europe see HYPERLINK:

"http://www.implantsuccess.com"

Many thanks to John Moorhouse for his contribution this issue. This implant case details the replacement of an upper central incisor in a patient with a high lip-line.



General Medical History:

A questionnaire was completed and this was verified verbally in the surgery. No relevant findings were recorded apart from taking contraceptive pill.

General Dental History:

Regular attender 6 monthly check ups. Not under active course of treatment.

Present complaint:

Vertical fracture UR1 diagnosed by GDP 10 days ago. He advised cheaper to fly to Sweden to get implant but patient then found our practice via the internet.

Crown of tooth in situ but mobile.

UR1 history of trauma age 18. Root treated 5 yrs ago and bleached last year.

Examination

A thorough clinical examination was undertaken.

Only observations relevant to implant provision are recorded below.

Extra-oral

- TMJ - both grate on opening but patient unaware and asymptomatic.
- Lip line at rest – gingival 1/3. On smiling reveals gingivae U4-4.
- Skeletal relation mild class II div 2

Intra-oral

Soft tissue

- Slight erythema to gingival labial to UR1.
- Papillae present between UR12 and U11.

Hard tissue

Occlusion

- Overbite = 7mm, overjet = 3mm,
- LR12 labially placed. Incisor relation Class 2 div 2.
- Right group function on UR37: Left canine guidance with NWSI on UR7
- Protrusive on UR1 and UL12 LR4 in cross bite.
- RCP first contact Right 4s Vh slide 2mm.

Periodontal condition

- No significant findings, good plaque control.
- No recession, no pocketing, no bleeding on probing except labially UR1.
- Attached gingivae UR1 area 6mm+

Current status and diagnosis.

Transverse / oblique fracture of UR1 requiring immediate treatment.

Dental charting at date of examination

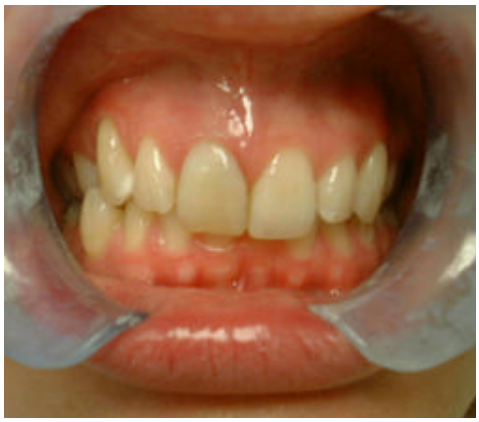
Fully dentate except UR5 and UL4 missing.

Investigations

Radiographs: A periapical of the UR1 shows a root filled tooth with a transverse/oblique fracture running just below gum level. The root is mesially inclined and close to the UR2 root.

Mounted study casts: These were not considered necessary although impressions were taken to make a temporary adhesive bridge.

Images: A Pre-operative photograph was taken.



Pre op

Examination outcome, treatment options and treatment plan:

The patient did not want other treatment options as discussed and listed in the treatment plan. The mode of treatment then rested on the aesthetic demands of her high lip line. She declined a staged approach with grafting in preference for an immediate placement on the understanding that if the bone loss was found to be excessive at the time of extraction then placement would be aborted and we would review in 4-6 months. Immediate restoration was contra-indicated because of the deep overbite and risk of further bone loss. The risk to the UR2 root was discussed and accepted. It was deemed critical to limit the spread of the mild infection around the fracture line to prevent further bone loss and to book the patient for surgery as soon as possible.

The consent form was discussed and signed by the patient after it was fully understood and agreed.

Treatment plan

Preparatory stage

- Oral hygiene instruction. – reinforcement only
- Check consent forms signed

Surgical stage

- Careful removal of the root UR1
- Placement of implant UR1
- Monitoring healing and oral hygiene

Restorative stage

- Construction of temporary crown
- Modification of the cervical contour of the temporary crown if necessary
- Restoration of UR1 with single abutment and crown

Monitoring stage

- Monitoring at 6 monthly intervals.

Details of treatment and sequence of surgical treatment

14 March 2003.
Implant assessment

19 March 2003.
Implant placement

Straumann TE 4.1/4.8 L14mm lot 1003 ref 043.764S placed with 2mm gingival former to support papillae

Post-operative instructions discussed and given to patient

Post-operative radiograph taken

26 March 2003.
Review. C/o nil

24 April 2003.
Monthly review

23 May 2003.
2 monthly review

Abutment trimmed and temp crown fashioned out of luxatemp

16 June 2003.
Co nil. Healing satis.

Temp removed, impregum impression taken with synocta imp transfers, lower alginate, to lab for shading.

14 July 2003
Temp removed, photos taken of gingivae and abutment and uncemented crown.

Abutment 048.605 lot 1030 torqued to 35Ncm- Pa to check fit.

Crown cemented & occlusion adjusted.

14 July.
Abutment torqued into place.

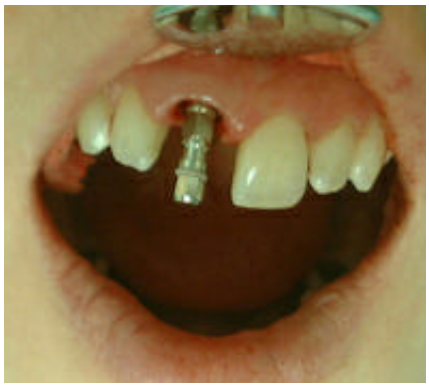
13 August 2003
co nil. OH is good

Occlusion checked RV 6/12

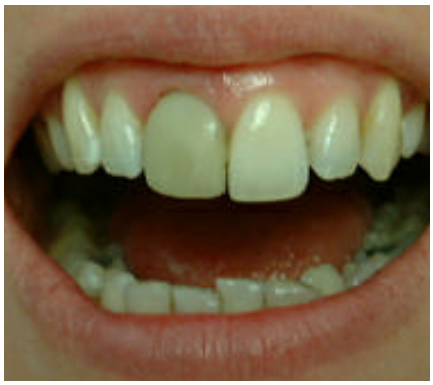
22 December 2003
RV: Co Nil, OH is very good

Photo taken

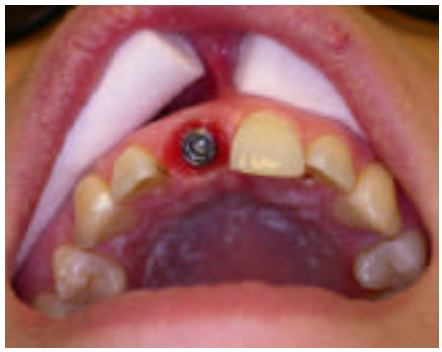
Review 1 year



Implant and carrying attachment

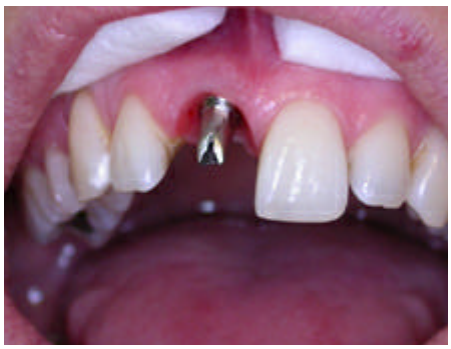


Temp crown

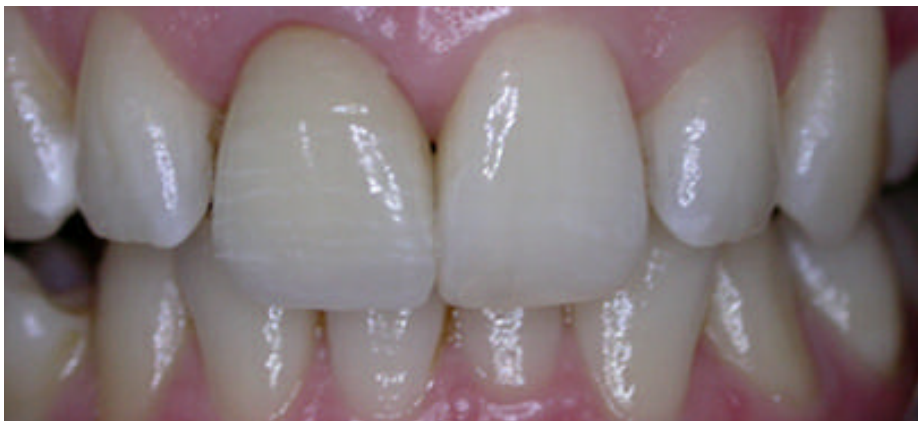


Occlusal view

Treatment complete



Abutment torqued



MFGDP tutor's report

The popularity of this essential qualification grows year on year nationally. This year's MFGDP Study Course has just kicked off at MANDEC on 11th September 2006 with over 20 dentists having enrolled. Our previous study groups continue to produce some great results with well over 95% success rates for those candidates that have taken the examinations!

Candidates for this year will be presenting a new Key Skill on Risk Management & Communication as part of the Coursework. The new development is that the MFGDP and MFDS are to merge to form the MCD qualification - details are still emerging. However, we anticipate that the MFGDP in its current form can be still taken for the next 5 years - please note that this is yet to be confirmed!

This years regular tutors also include Andrew Shelley and Ian Hunt, with help from Ian Wood. I would like to take this opportunity to extend our deep gratitude to Ian Wood for his huge contribution to the MFGDP Study Groups - after nearly ten years of involvement, Ian is taking a back seat this year to concentrate on his work as course director for the Diploma in Restorative Dentistry.

If you have any friends and colleagues that may be interested in taking the qualification please ask them to contact me.

Sunil Panchmatia

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The Faculty of General Dental Practice(UK)

What the Faculty Can Offer:

The FGDP(UK) provides the means by which GDPs can:
◆ Develop their knowledge of dentistry
◆ Enhance their clinical skills
◆ Prove to their patients, their colleagues and more importantly, themselves, that they provide the highest standards of patient care
◆ Find a sense of achievement in general dental practice

Benefits of membership:

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◆ Reduced fees at local and national study days
◆ A network of local study groups around the UK, to help with preparation for the examinations
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◆ Free Faculty newsletter, First-hand, published quarterly
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◆ 15% discount at Swallow Hotels
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Special offer for Faculty Members from the Dental Directory.

Please don't forget that the Dental Directory have generously offered a special deal to faculty members. North Western Division members are eligible for a preferred Faculty member discount of 10% off all catalogue prices (excluding mini-catalogue and promo offers) plus 1.5% for all orders placed via the computer ordering system, Desktop. In addition if you hold MFGDP/MGDS or fellowship there will be a further 1%. This could amount to a significant discount of 12.5% off already low master catalogue prices. Should you become a new member of the Faculty the Dental Directory will credit your account with £50 which you can spend on the house-preferred range (Unodent, Degussa, Perfection Plus)

We are most grateful to the Dental Directory for their generous support of the faculty division and sponsorship of this newsletter. Northern Sales Manger Steve Brown may be contacted on e-mail - swbrown@dentaldirectory.co.uk.
Also see web site:
http://www.dental directory.co.uk

How to join The Faculty of General Dental Practice (UK)

Memberships packs are available from the College, from Jean Cook at the MANDEC office or at the fortnightly Advanced Refresher courses at MANDEC on Tuesday nights.

Costs

Full membership - £175
Available to registered dentists who have been awarded a relevant postgraduate diploma by any of the four Royal Colleges.

Affiliate membership - £140
Available to registered dentists, qualified for more than three years, who do not hold an appropriate postgraduate diploma.

Associate membership - £40
Available to registered dentists within three years of their graduation.

Retired membership - £68
Available to dentists who support the aims and objectives of the FGDP(UK) but who have retired from all forms of general dental practice.

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FACULTY OF GENERAL DENTAL PRACTICE (UK)
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You can download previous issues of Pathway from www.fgdp-nw.com - very handy for reviewing previous MFGDP case studies.