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# DENTAL HEALTH

The Journal of the British Society of Dental Hygiene and Therapy



## OIL PULLING

IS THERE A CLINICAL  
BENEFIT TO ORAL  
HEALTH?

## THE EARLY YEARS

OF A DUALY QUALIFIED  
DENTAL HYGIENIST THERAPIST

## THE MANAGEMENT OF A PATIENT

WITH SPECIAL NEEDS: A  
CASE STUDY



The mission of BSDHT is to represent the interests of members and to provide a consultative body for public and private organisations on all matters relating to dental hygiene and therapy. We aim to work with other professional and regulatory groups to provide the highest level of information to our members as well as to the general public.

The Society seeks to increase the range of benefits offered to members and to support this with a clear business and financial strategy. The Society will continue to work to increase membership for the benefit of the profession.

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The early years of a dually qualified  
Dental Hygienist Therapist

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# GUEST EDITORIAL

## Show up, sit back and enjoy!



Have you ever wondered how a conference is organised or what goes on behind the scenes? Let me give you a little taste of what is involved.

Firstly a date is decided, this will very much depend on what other conferences or events are being held around the chosen date. All organisations will be contacted in advance to avoid a potential clash of dates. Just like wearing white when you are a guest at a wedding, it is simply rude to clash dates with other sister organisations! Once the date is settled, the choice of venue is next. A city will be chosen then hotels are booked for viewings. Hotels will do their best to please but sometimes the conference room is too big or too small for your conference needs or the trade areas are not within proximity of the main room. These key considerations will determine which hotel you choose. Price is a major factor too, value for money for the delegates, and the host association, is extremely important.

### Ok so we have our date and our venue what next?

A theme is decided upon, which will determine the lecture content. A list of potential speakers and workshops will be put together; speakers will be contacted to check their availability and the content of the required lecture is discussed. The speakers will be given a continuous professional development (CPD) form to fill in and return by a certain date. This form is then sent to Council for approval of points and verifiable hours. The timetable for the conference can now be drawn up.

In parallel (we are excellent multi-taskers!) the conference registration will be set up online and the conference brochure will be worked on. Notice will be given to all members and non-members of the open registration and the early bird offers.

Once the brochure is ready, which may take several edits, it is then sent to the printers. Here in Ireland, the printer will send it to a designated person from the committee usually the Continuous Education Office (Cont. Ed.) who will package and post them out to both members and non-members. The Cont. Ed. and the Membership Officer then work closely putting together a list of those registered for printing of delegate

badges and CPD forms to have ready for the day of the conference.

Throughout the conference process the committee will work together on the various tasks required of them in their respective roles. On the day of the conference each committee member will have a specific role to play, everyone is vital for the smooth running of the meeting. Organising a conference is a huge task to undertake especially for a committee who are voluntary and who will usually not have any, or little, prior experience of organising a conference, but we are a resourceful bunch and always pull it together.

### So why do we do it?

Because we know how important continuing professional development is in order to stay up to date with best practice and provide the best care possible for our patients.

Why not join us for a conference and maybe even join the committee! It's the perfect place to: update your skills, learn something new, network with your peers, meet industry experts, catch up with your colleagues, share ideas, and meet the organising committee, just to mention a few.

Working with other dental and non-dental professionals in this capacity is great for networking and expanding the reach of organisations, therefore always aiming to improve the delegate experience. Working with our partners in the trade allows us to gain sponsorship which helps towards education of all dental hygienists, wherever you work.

So why not pick up that registration form today and join the IDHA in Dublin October 14th & 15th and 'Innovate, Integrate, Motivate'.

The following month BSDHT will hold the OHC 2016 in Belfast on November 18th & 19th. Both organisations are supportive of each other and work closely together for a collaborative approach to education of the profession.

### *Louise Fleming*

President, Irish Dental Hygienists' Association

# FROM THE PRESIDENT

Having to write this article several weeks in advance of its publication means that many of the exciting events I want to mention will have come and gone before you get to read this: the outcome of the EU referendum will be known (I have my postal vote!), the ISDH will have taken place in Switzerland and First Smiles will have been even more successful than last year. I will miss my opportunity to share my views on the EU vote and how it might affect us as a profession. It has been quite a thought-provoking debate and I will be interested to see the result. Hopefully, regardless of the outcome, we will still work closely with our European colleagues.

## International

I will be representing the UK accompanied by your President elect, Helen Minnery, at the International Federation of Dental Hygiene House of Delegates meeting, which takes place before the International Symposium on Dental Hygiene. Here we meet with dental hygiene representation from all over the world and discuss issues, both global and local, which affect our profession. I know it will be over by the time you read this but we are looking forward to hearing two of our members present their papers on this international platform - Mike Wheeler (past president- proving there is life after this role) and Claire McCarthy.

## Domestic matters

As for First Smiles, it is very important to BSDHT that we showcase what our profession does. Regardless of being trained in the UK for 73 years, there is still a lack of understanding about our role in prevention and treatment of dental disease. Demonstrating that what we do can positively impact on children's oral health will hopefully result in driving a powerful message home to the public, as well as the profession.

Thank you all for taking part in the initial part of our joint venture with BSP to promote Gum Health Day 12th May. There were some beautiful photos gracing Facebook! Using the phrase "Don't let gum disease wipe the smile off your face" Gum Health Day's aim was to raise awareness of gum health and achieve behavioural change by encouraging people to visit their dental professional. This is just the start of a public campaign to promote awareness of gum disease.

I recently filmed a sequence for Oral-B on how to brush with an electric toothbrush in order to address our concerns that the brush is being used incorrectly by some patients. This will be available on the website's public facing page. BSDHT have accredited the education programme on how to brush your teeth with an electric toothbrush.



I recently presented to the Health Education England Advisory Group (HEEAG) on future dental need of the people who will be 65 years and older by 2039. The HEEAG is trying to decide on the shape the future workforce and this age group is a demographic that is growing much more than the others. This would mean the demand for maintenance and prevention would be much higher than before, a demand that could be met by our profession. Being able to chair this group and present to it means that we can keep dental hygiene and therapy at the forefront of any changes to the workforce to deal with these future needs.

Thanks to all of you who took the time to come see us at the dentistry show and BDA conference. We hope to see some of you at ISDH in Switzerland and then our own flagship conference in Belfast this year. Don't forget to nominate for the Dr. Leatherman award and to enter the poster competition. Applications are available on the website.

We will need nominees for the positions of President Elect, and also the positions of Honorary Secretary and Honorary Treasurer which are relinquished each year after the initial two year tenure, but can be re-elected. This year only Helen Westley, Hon.Treasurer will be standing again so the position of Hon. Secretary is open to anyone who would like to apply. The application forms are not live yet but this may give you time to consider who would be an appropriate candidate for a position such as this.

Although it will have been completed by now, I would like to draw attention to Christina Chatfield and Gillian Fenwick who have both been undertaking amazing feats of endurance in support of Move it 4 Smiles, raising awareness of mouth cancer and HPV vaccination equality. Christina has been walking the pilgrim route along the Camino Way in Spain and Gillian climbed Ben Nevis in Scotland. If you have taken part please let us know.

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## DIPLOMAS IN DENTAL HYGIENE AND DENTAL THERAPY

The Royal College of Surgeons of Edinburgh is pleased to announce that it is reinstating the examination for the Diplomas in Dental Hygiene and Dental Therapy. This examination has been designed to indicate that the candidate has demonstrated that he/she has achieved the required specific learning outcomes of their Dental Care Professional (DCP) category as specified by the General Dental Council's publication Preparing for Practice – Dental Team Learning Outcomes for Registration [www.gdc-uk.org](http://www.gdc-uk.org).

### EXAMINER VACANCIES

The College is now recruiting examiners for these Diplomas and applications are invited from both Dental Hygienists and Dental Therapists.

Examiners must be in good standing with the General Dental Council, should hold current registration with the GDC and have been registered for a period of not less than four years.

Training for all examiners will be provided by the College and all appointed examiners will be expected to contribute to the question bank and attend appropriate further training.

The application form, referee form and the criteria for applicants can be found on the College website: [www.rcsed.ac.uk](http://www.rcsed.ac.uk) under Examiner Vacancies.

For further details visit  
[www.rcsed.ac.uk](http://www.rcsed.ac.uk) or contact:

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# THE EARLY YEARS

## OF A DUALY QUALIFIED DENTAL HYGIENIST THERAPIST *by Iona Carter*

Three years at university will pass faster than any first year student can imagine! Before I knew, it was May 2014, we were facing finals and trying to make a decision regarding the best move to make after graduation. I had two choices: do I make that intimidating leap straight into the world of work? Or should I take the route most of us at The University of Manchester chose, which was to apply for one of the vocational training schemes offered to qualified hygiene therapists?

Jumping straight into work within a general dental practice (GDP) after the luxury of hour-long appointments at The Manchester Dental Hospital was far too daunting a prospect for so many of us. To bridge the gap between the two, I decided that one of the VT schemes on offer would be the preferred alternative for me.

### Training in South Wales

After researching, I applied for the Introduction to Practice (ITP) Scheme run by Cardiff University. The 222 miles between my home in Derbyshire and South Wales did not matter to me at the time; I decided the inconvenient travelling would be worth it in order to receive the training that would improve my skills as a hygiene therapist, in the long run.

The ITP Scheme in Wales involved working in GDP for two days a week with one study day a month. Normally held at the Prince Charles Hospital in Merthyr Tydfil, these study days were excellent. The days varied from completing core CPD topics such as Child Protection, to being given half a pig's head to revise the use elevators and luxators in paediatric extractions.

My two working days were spent in a NHS practice in Swansea with the Principle Dentist as my trainer. The experience I gained here was invaluable. The practice had not had a hygienist on site before, which meant there was a lot of periodontal treatment at first! However I still found I was getting far more therapy experience than colleagues from university who had bypassed the scheme and gone straight into work.

Having a trainer by your side at times of uncertainty was extremely helpful. I was mentored in several areas. For example, during our session on local anaesthesia, my trainer insisted on jumping into the dental chair and letting me practice an ID block on her, as I had admitted it was a procedure where my confidence was lacking.

### Looking back

The confidence I gained on the ITP scheme helped me gain two further hygiene therapy jobs at two NHS practices in the Derbyshire/South Yorkshire area. This meant I was working pretty much a normal Monday to Friday, however travelling just under 500 miles to and from during the week.

Despite numerous comments advising against the travelling, the skills I learnt from this experience were worth not just the tedious motorway travelling, but also having my suitcase stolen on the train when the weather was too poor to drive! I feel I have gained so much not only from treating patients from different parts of the UK, but from the wide variety of practical and theoretical skills I learnt from both the study days and my trainer during the 12 month ITP scheme.



### What next?

After completing the ITP scheme I decided it was time to move out of the family home in Derbyshire and find my feet somewhere new. My advice to any new dental hygienist therapist looking for a job is that it is not easy, but do not feel its necessary to accept the first job offered if it does not sound like it would suit you.

After months of CV and cover letter writing, I was offered a position at an NHS practice in the South East of England, which I started in Autumn 2015. This practice is not only larger than those I have worked in previously, but the general patient base has much lower treatment need. I have therefore found that due to the treatment need, and the majority of my referrals originating from associates, I am lacking in therapy work. It is interesting to learn how your role as a dental hygienist therapist fits differently into practices of different sizes, with patients of varying treatment need. Despite this I greatly enjoy working here, I have gained a great deal from treating patients from an entirely different socio-economic background and I have expanded my periodontal treatment knowledge dramatically.

I am looking forward to continuing my career and gaining further experience and knowledge about patients and working in GDP. I hope this article has been encouraging to recently graduated Oral Health Science students unsure as to what the next step for them is. The main lesson I have learnt over the last 18 months is to utilise any opportunity you are offered to increase your knowledge, skills and experience. Do not let geographical distance be a barrier!

#### ABOUT THE AUTHOR:

Iona graduated with BSc (Hons) Oral Health Science from the University of Manchester in 2014. Since then she has completed the Cardiff Introduction into Practice Scheme and now works full time as a Hygienist (offering a very small amount of therapy treatment!) in a GDP in Oxfordshire.

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## INVITATION TO BECOME BSDHT COUNCIL OBSERVERS

BSDHT Council would like to invite any interested BSDHT members to apply for the role of Council Observer.

Council agreed that it would make the work of the BSDHT Council more transparent to members if Council meetings were to be opened to invited observers.

A number of members of the Society may attend full Council meetings purely as observers, although numbers will be limited due to space. Applicants will be accepted on a first come basis and no expenses will be paid. Meetings are held twice a year in Birmingham.

**THE NEXT MEETING WILL  
BE HELD ON TUESDAY  
13TH SEPTEMBER 2016.**

**To register your interest please  
contact the President,  
Michaela O'Neill on 01788 575050 or  
email [enquiries@bsdht.org.uk](mailto:enquiries@bsdht.org.uk)**

# Making a difference, my way!

by Joanne Kennedy

I qualified as a dental hygienist more than 14 years ago and I love my career: I have more passion for dentistry now than when I first qualified. I love being able to help my patients maintain a healthy mouth and take pride in them leaving our appointments feeling fresh, clean and healthy.

The idea of The Sparkle Fairy was brought to life through my passion for our chosen profession of dental hygiene and care for my patients. Over the years I have met so many wonderful patients who have often expressed to me the difficulty that some of their loved ones have attending dental appointments, for a number of reasons. This started me thinking. Surely everyone deserves to have good quality dental hygiene care and, furthermore, why not provide that to the patient on their terms rather than ours?

I knew that I wanted to provide a more flexible way of delivering dental hygiene care to suit my patient needs, and at a time and place that suits them.

## A new concept

I had been considering this concept for a very long time, well before the implementation of Direct Access. I was, of course, very happy when Direct Access became a reality because it provided me with an opportunity to explore my goal - the provision of a new style of service to so many patients who could not easily access high quality primary dental care, for varying reasons.

It took a long time to set everything up, almost two years in fact, from start to finish, and all of my savings were ploughed into starting up this new style of dental service. Domiciliary services are scarce and those that are available do not involve many dental hygienists. Most domiciliary services are run by dentists, and hygiene appointments are carried out by dentists. I fully respect dentists, and have worked with some extremely talented individuals during the last fourteen years, who equally fully respect the work that I do. They appreciate that dental hygienists are integral to the practice environment, and vital in educating and motivating our patients to achieve and maintain their oral health.

I have always loved the relationship building element of our profession. I like to try and discover as much as I can about my patient, but The Sparkle Fairy has elevated this to a different level. The way in which I get to know my patients is a lot more intimate. Seeing people's family photos, meeting the grumpy teenager, normally a hermit in the house, and even playing with the family pets are all part of working within someone's home environment. The patient - client relationship is a lot more relaxed, which is one of the reasons I wanted to set up this type of practice. Patients are a lot more compliant which makes treating them so much easier.

I love working on my own terms, these patients are my patients and I can see them in ways that suit us both. I can set up treatment plans and treat the patients as I always wanted to, as I would want to be treated myself. It is lovely not to have a queue of patients waiting at the surgery door, which means as a clinician I am a lot more relaxed and find I can deliver the best possible care. Not having to work with one eye on the clock is absolutely fantastic, not only for me but also for the patient, and I believe my patients feels more relaxed under these circumstances too.



One of my favourite aspects of this practice is to treat patients in the care home, hospital and hospice environment - it is so rewarding. A lot of the time we are called in by family members as they have identified that their loved one has a very uncomfortable mouth. Our nurses and carers do an amazing job at looking after patients but do not have time to always care for their mouths the way the mouth needs caring for, so being able to go in and make these patients feel more comfortable is so rewarding. It is also nice for the patient as they can remain in their beds which makes the experience a lot more comfortable for them.

To start up our practice has been a very long road, filled with lots of paperwork, red tape, trouble shooting and learning as we go. But it is also one of the most rewarding and wonderful things I have ever done. I love my job more now than I have ever done. Yes, we are still learning. I think we always will be and at the moment we are still trying to get to grips with marketing, as no-one knows this service exists, and marketing is not something we learn at hygiene school. But despite every adversity and every challenging twist and turn I would not change a thing. Starting our practice is the best thing I have ever done, and we at The Sparkle Fairy are so proud to be able to say we are the first private mobile hygienist practice in the UK.



# UP TO DATE: A SEMINAR REPORT

## ALLOWE

This year's Up to Date forum was held at the Copthorne Hotel, not the usual venue for the Welsh seminar but an excellent location to host the final of eight events. There was delicious food prior to the lectures and the evening was hosted by Dr Stephen Hancock's, who was both informative and entertaining as ever.

The first speaker was Professor Avijit Banerjee from King's College London who focused on the "baby boomer" generation (born between 1946-64), minimum intervention dentistry and the use of modern restorative materials.

### Baby boomers

Avijit discussed this group of 'baby boomer' patients; an important and ever increasing demographic with particular financial, medical and social statuses that affect their oral health, and whom most of us encounter daily. He explained how they are the 'heavy metal generation' as they often have wall to wall amalgam MOD restorations which are now beginning to fail and need treatment! Such patients present with various challenges including caries, periodontal disease, tooth wear, dry mouth, and reducing levels of edentulousness as revealed by the last ADHS which showed that disease is still very much present and needs to be managed. Avijit demonstrated this with a series of clinical scenarios.

The importance of saliva was discussed and Avijit explained that 20-25% of patients have altered saliva flow (ASF) from the relatively young age of 30. This percentage increases as patients age, often as a result of polypharmacy to treat various medical issues that are prevalent in this population.

It is essential that we establish whether our patient's salivary glands are functioning; is saliva flow just reduced or are their salivary glands irreversibly damaged as a result of radiotherapy, for example? It is important that we are aware of the signs and symptoms associated with a dry mouth and record any findings in the patients' notes. Also, if patients are suffering from erosion or caries we need to question whether they have ASF. Enamel wears as we age so it is often dentine that is exposed to the oral cavity; this is of significance as the critical pH of dentine is 6.2. However, the solution is not as simple as cutting out carbonated drinks since the critical pH of each patient's mouth varies and if a patient has good salivary flow they may well be more tolerant to acidic challenges. This is where remineralising solutions score as they contain a similar formula to the calcium and phosphate ions found in saliva which plays a protective role. Products such as Recaldent & Tooth Mousse from GC, among others, are designed to keep calcium phosphate concentrated at the tooth surface and may help some patients.

### Minimal intervention

We all need to be aware of the minimum Intervention (MI) approach; finding and arresting problems early in order to optimise primary and secondary prevention of disease. This is one of the most critical aspects of successful long term oral health management.

Avijit discussed the MI management of the tooth-restoration complex using the 5'R's' concept and provided a detailed resume of contemporary restorative materials, adhesives, bonding systems and the clinical handling techniques needed to optimise their properties. He stressed that it is essential for clinicians to understand the chemistry behind the materials they use, reinforced the importance of photography and recommended we wear loupes to maximise our vision. If there was a take home message it was definitely that 'less is more'.

### The good, the bad and the elderly

Iain Chapple who is professor of periodontology at Birmingham University delivered the closing talk on the topic of "The Good, the Bad and the Elderly". He explained that chronic non-communicable diseases (CNCD) are increasing in prevalence globally, partly as a result of an ageing population, but also due to an increase in sedentary lifestyles and refined diets. He provided an alarming array of statistics; 92% of older adults have at least one CNCD and many have two or more. Periodontitis is a highly prevalent CNCD; 60% of people over the age of 60 have some form of periodontal disease and severe periodontitis is the 6th most common disease and is independently associated with several systemic conditions including chronic kidney disease (CKD), diabetes, pneumonia, male infertility, obesity and cognitive impairment. Indeed, there are at least four studies which prove that there is a co-morbidity risk associated with periodontal disease and some CNCD's particularly diabetes and chronic kidney disease. Our kidneys start failing from the age of 40 at different rates, and this may be exacerbated by periodontal problems.

Worryingly, atheromatous plaques are now detectable in patients as young as 12-13yrs of age. Two million people a year die from cardiovascular disease (ACVD) and there are several studies which indicate an increased risk of ACVD in patients with periodontal disease; this is highest in males and younger people.

There is also a bi-directional relationship between diabetes and periodontitis. Diabetes has become a pandemic affecting 380 million people worldwide. Therefore, if a patient presents with multiple periodontal abscesses they should be referred for a diabetic screening, particularly as pre-diabetes is reversible through exercise and diet.

Systemic inflammatory responses are initiated as a result of a build-up of pathogens in plaque biofilm. If a patient has gingival bleeding this is due to micro ulcers in the epithelium lining the pocket, whilst blood will seep out each time they brush, bacteria get into the blood each time they eat or brush, resulting in bacteraemia. The bacteraemia triggers an "acute-phase" response in the liver that generates C-reactive protein (CRP) and the latter causes a systemic inflammation.

Iain's presentation was interspersed with four stunning video sequences which demonstrated key findings together with the biological plausibility associated with periodontal disease and CNCD's. He also touched on the findings of the EFP manifesto on periodontitis and general health and the need for all health professionals to combat CNCD's as recommended by the National Association of Primary Care Medicine (NAPCM).

The speakers oozed enthusiasm about their respective subjects and injected humour into their presentations through the use of amusing videos and images. They were also united in stressing the need for good oral hygiene in order to prevent disease and both provided practical advice for us to offer to our patients.

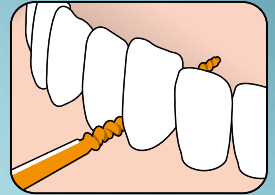
As with all Oral-B events, the evening was the perfect mix of education and pleasure. Oral-B will be publishing details of their next seminar series in the autumn so look out for this in the dental press or visit [www.dentalcare.com](http://www.dentalcare.com).

#### ABOUT THE AUTHOR:

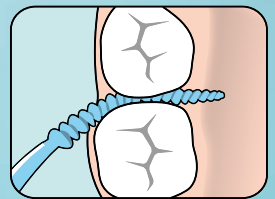
Alison is a member of the Publications Team. She divides her working week between two dental practices in Cardiff and the Orthodontic Department in Cardiff Dental Hospital.

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# Hooked on Oral Hygiene

Michelle Coles

I would like to share with you my experience and pride at winning the inaugural Oral Hygiene by Design award 2015.

I remember one very hot day last June, on a day trip to Brighton on the train, reading the latest edition of Dental Health. As I flicked through the pages a large colourful notice caught my eye. It was about a new competition being launched by BSDHT in partnership with WOHP (Wrigley Oral Healthcare Programme) inviting us to unleash our creative talents and submit ideas for a patient oral hygiene education tool.

Interesting! - I thought. So I read on. It said that 'Prospective designs should take an innovative approach to oral hygiene education and must be portable, intended either for chair-side use or for patients to take away to encourage good oral hygiene behaviours at home'. And that's the line that got me thinking further, about how this was the problem we face - we've spent time with the patient explaining things and giving advice and motivating our patients, but how do we know they will remember this accurately and continue to be motivated once they've left the practice and gone home? If I could think of a way to achieve this then this would be my ideal oral hygiene tool.

## Inspiration

While working I often use models and pictures to explain things to patients and then I write down the key points on the back of a leaflet or an appointment card. But once the patient has left the surgery these often get lost or forgotten about. Everybody has busy life. So I thought I want something beautiful or funky that patients would want to hang on to, and take home. And I wanted a way that the patients would be constantly reminded of their tailored advice. So I needed to think of something that patients would be happy to have on display in their homes. I wanted the patients to hang on to their advice, hang it some where in their bathroom and therefore hang on to their oral health. So that's where the idea for the Hooked on Oral Hygiene tool came from.

I was delighted when I found out that I was the Gold winner of the award. BSDHT President Michaela O'Neill and Global WOHP Senior Manager, Matthew Kent, presented the award to me at the AGM, in Birmingham last October. As a winner I received a year's supply of sugar-free gum for my clinic and £750 financial grant towards my education. I have decided to

spend my grant by using it to attend the International Symposium on Dental Hygiene 2016, which is being held this June in Basel, Switzerland.

## Bringing my design to life

The most exciting part of my prize has been the opportunity to work with WOHP and BSDHT, along with a professional designer and production team and to see my idea come to life. It is made of steam proof paper and is designed to be hung in the patient's bathroom on the door handle or a hook. On the front there are three boxes where you can write advice or motivational tips for your patients, like 'Spit, don't rinse', 'Eat, drink chew', 'Brush for 2 minutes' or 'Floss in the bath'. On the reverse there is an illustration of a mouth where areas that need special attention can be circled and discussed. Therefore keeping the chair-side advice close at hand and a visible reminder for your patient when they get back home.

The power of the tool is that you control what is written on it. So you can personalise the care you give to each of your individual patients. And now at least you can hope that your advice is being continued and delivered correctly once the patient has left the practice and gone home.

I hope you will find it useful and I am proud to say it was launched on 20th March 2016 to coincide with World Oral Health Day. A sample is attached to the front cover of this issue of Dental Health

To order the new Hooked on Oral Hygiene tool for your practice, visit the Wrigley Oral Healthcare Programme's website at [www.wrigleyoralhealthcare.co.uk](http://www.wrigleyoralhealthcare.co.uk) to request your tools.

- See more at: <http://www.bsdht.org.uk/dhcontact/hooked-on-oral-hygiene-michelle-coles#sthash.mhf0zsr2.dpuf>



Caption: From left to right: Matthew Kent (WOHP Senior Global Manager), Michelle Coles (Gold Award winner), Jack Waddington (Silver Award winner), Jennifer Huntley (Bronze Award winner) and Michaela O'Neill (BSDHT President).

## COPY DATES FOR DENTAL HEALTH

### 1ST AUGUST FOR THE SEPTEMBER ISSUE

The Editor would appreciate items sent ahead of these dates when possible.

Send your contributions to: The Editor, Heather Lewis,  
19 Cwrt-y-Vil Road, Penarth, Cardiff CF64 3HN  
or Email: [editor@bsdht.org.uk](mailto:editor@bsdht.org.uk)

# REGIONAL GROUP NEWS

## BSDHT EASTERN GROUP SPRING MEETING

**DATE:** Saturday 12th March 2016

**VENUE:** Hallmark Hotel Bar Hill Cambridge

**SPEAKERS:** Lesley Benson, Monica Lee, Rosalyn Clarkson, Imogen Wood

**SPONSORS:** Thanks to CTS, Dentsply, 3M Espe, GSK, J+S Davis, Lloyd and Whyte, Optident, P+G, Swallow TSI and TePe.

**Lesley Benson** opened the meeting with a presentation focusing on **the emotional brain**. The objective of the presentation was to help understand how to take better control of both one's personal and professional life by appreciating our needs and how they impact on behaviour, emotional state, physical condition and thinking, ultimately creating stress.

The presentation discussed how to control/manage our inner "chimpanzee" and to recognize it in others around us, both at home and at work, enabling us to manage challenging behavioural situations and thus reducing stress.

**Monica Lee** provided an interesting presentation on **implant maintenance** highlighting the differences between periodontal tissues and those surrounding implant supported restorations. Monica discussed the various instruments and equipment available for treating and maintaining implants, looking at the advantages and disadvantages of each system.

Monica outlined the differences between tooth and implant tissue anatomy and how this impacts on maintenance techniques and also how to recognise and evaluate the health and deterioration of the supporting tissues. A number of interesting case histories were presented which demonstrated the difference between health and disease, aiding the awareness of the clinical manifestation of peri-implant diseases and the subsequent diagnosis and treatment modalities.

**Rosalyn Clarkson** delivered an update of **radiation protection and quality assurance**, highlighting the need for radiation protection in dental practice. She provided an overview of legislation and guidelines relevant to the use of ionising radiation. Quality assurance recommendations for both film and digital systems were discussed along with a number of examples of various image faults and how to improve image quality.

**Imogen Wood** was our final speaker of the day with a thought provoking and highly insightful presentation on **dental care for head and neck cancer patients**. As a Macmillan Dental Therapist working at the John Radcliffe and Churchill hospitals for the last four years, she was able to give an understanding of what the patients are going through along with the effects of radio/chemo therapy on the mouth and teeth. Imogen outlined the treatment and patient management pathways.

**Sarah Dennison** presented the Council Representative report incorporating the President's report discussing the ongoing developments concerning prescribing rights. She informed Society members of discussion and meetings with Dental Corporate Bodies over current working practices. Development of the BSDHT website was presented along with plans for a public facing page and "find a hygienist" section for patients to access. A reminder that booking for the Oral Health Conference in Belfast is now open was given along with advice on discount packages on flights and accommodation.

The meeting closed at 5.30pm with great feedback from the delegates and the announcement of the Autumn Meeting date of Saturday October 1st 2016 and Spring Meeting as Saturday 18th March 2017.

**Juliette Reeves**

## BSDHT SCOTTISH GROUP SPRING SCIENTIFIC MEETING

**DATE:** Saturday 19th March 2016

**VENUE:** Radisson Blu Hotel, Argyle St, Glasgow

**SPEAKERS:** Oral-B, Avijit Banerjee, Diane Rochford and Morag Powell

**SPONSORS:** Thanks to Colgate, CTS, Dentsply, GSK, J&S Davis, Lloyd & White, Oral-B and Tepe.

There were 74 delegates in attendance, comprising 41 members 12 non-members and 21 students.

The Trade Show opened the day for one hour during registration, and another hour was allocated mid-morning.

The raffle raised £200 and was donated to The Ben Walton Trust. Prizes were donated by: Colgate, CTS, J&S Davis, Oral B, Tepe and The Radisson Blu Hotel. The committee would like to extend their thanks to all the trade companies who supported this meeting and donated a raffle prize.

Hazel Cameron was Chair and welcomed delegates, both old and new.

**Oral-B** then provided the first presentation, in the form of a "**Small Bite**". Delegates were asked to consider our role as dental hygienists or as dually qualified in "selling" products to patients. Louise discussed our role as oral health providers by means of introducing correct products to patients. She highlighted the benefits of the Oral-B Test Drive as a means of improving a patient's oral health, within a practice setting.

**Professor Avijit Banerjee** then took to the stage and delivered the first part of his lecture on contemporary patient-focussed **MI (Minimal Invasive) caries management strategies**. The main concept of this lecture was the practical application that can be employed by the oral healthcare team, ranging from non-invasive preventive measures through to minimally invasive operative interventions.

The hour trade slot mid-morning allowed delegates quality time with our trade colleagues to catch up on new innovations and developments. Once again, Scottish BSDHT would like to extend their gratitude for the continued support the trade companies offer.

Professor Banerjee's second input of the morning gave delegates the opportunity to consider the range of adhesive restorative materials currently available. The rationale behind selective partial caries removal was also discussed.

**Sarah Walker**, our Regional Group Representative, updated delegates on Council news. The main issues discussed were:

- BSDHT new website. Should anyone experience problems logging in please remove your middle name, if you have one, and try again.
- Michaela O'Neill, BSDHT president, continues to move forward the issues of prescribing rights for dental hygienists and those dually qualified with the relevant government bodies.
- BSDHT OHC at the Waterfront Hall, Belfast on 18th -19th November 2016
- Next Council Meeting scheduled for 13th September 2016.

The afternoon session was opened by **Diane Rochford**, who gave delegates an **update on tooth whitening**, with particular reference to EU legislation. Diane provided an overview of the types of tooth whitening treatment available to patients, and their merits. Discussion was also focused on the

process of supporting patients in their decision to undertake appropriate tooth whitening treatment.

**Morag Powell** was the last speaker of the day. Her lecture gave delegates an opportunity to revise tooth structure and dental caries process. Delegates were then guided through caries recognition and accepted recognition techniques. Morag then provided current “best practice” in **treatment planning for caries** which was supported by a selection of slides.

Delegates are now able to apply the theory of caries diagnosis in a clinical setting, by completing a record of evidence (under supervision) for five cases.

Delegates gained 5 hours verifiable CPD from this Scientific Meeting. A further 2 hours non-verifiable CPD were available when attending the Trade Fair.

The Autumn Scientific Meeting will be held on Saturday 1st October 2016 at the Hilton Doubletree Hotel, 34 Bread St, Edinburgh, EH3 9AF. Again, 5 hours of quality, verifiable CPD will be offered to delegates. The finalised programme and booking form is on the BSDHT website. We currently have the following topics confirmed by excellent lecturers: Oral medicine, cross infection and decontamination, medical Emergencies and local anaesthesia. On-line bookings will open during the summer. Please remember that an on-line booking is the most efficient way to secure your place at this meeting.

**Jane MacConell**

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# Book Review by Ali Lowe

Periodontal problems are prevalent but many clinicians underestimate their complexity, which ultimately can prove challenging. This book aims to address these concerns and is for clinicians at all stages in their professional career – students, newly qualified or experienced practitioners.

The book has contributions from various renowned clinicians. It draws upon the experience of not only leading periodontal specialists, but also experts in microbiology, immunology and restorative dentistry. Both of the authors have great experience in education and teaching and this is reflected in the compilation of the book.

It consists of seven sections further divided into chapters, and each chapter commences with an overview of the content. All sections follow a clear logical pattern and are beautifully illustrated with relevant clinical photographs. Also included is a concise 'key point summary' which fits perfectly with the text.

The first section addresses the aetiology of periodontal diseases and explains how we are where we are today with our understanding. It succinctly discusses topics, such as the macro and micro-anatomy of periodontal tissues, and the pathogenesis of periodontal disease.

The second section focuses on 'Periodontal Diagnosis and Prognosis' including 'Classification of Periodontal Diseases' and is written in a very easy-to-read format, drawing upon examples from World Workshop in Periodontics Classification Systems. The following chapter focuses on treatment planning but with a strong emphasis towards periodontal therapy. In the fourth section the emphasis is on 'The Role of Self Care and Oral Hygiene Methods' and it is full of useful tips that we can implement into our everyday practice.

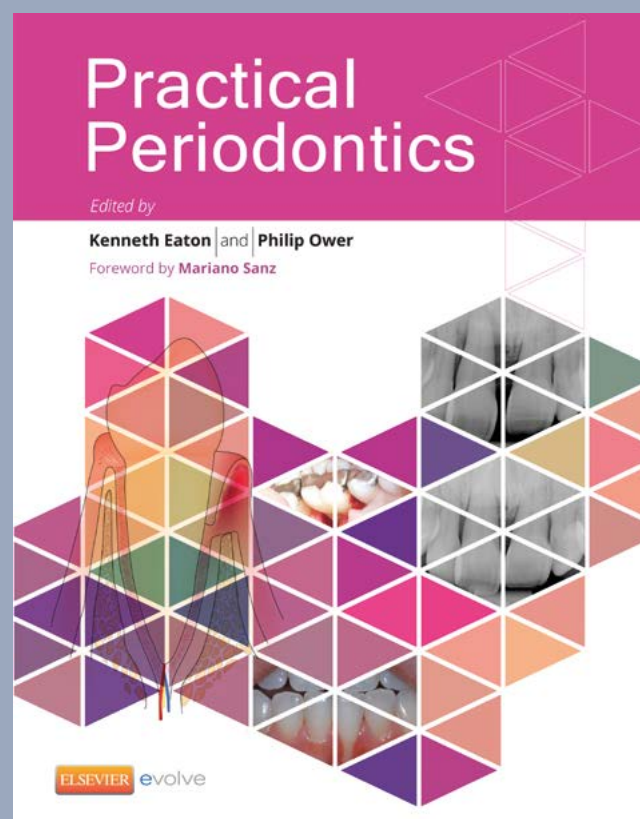
Section five focuses on 'non-surgical periodontal management' including clinical techniques. It is extremely well illustrated with very useful pre and post oral hygiene measure photographs.

Section six focuses on topics such as the 'Rationale for Periodontal Surgery', the text is concise and reinforces our understanding of surgical procedures.

The final section addresses the importance of interaction with other disciplines and has some good examples of aesthetic considerations. The last chapter is related to the periodontal-orthodontic interface. It talks about how the role of periodontics in orthodontic therapy and how to prepare periodontal patients for orthodontic treatment.

In summary, this is an excellent, relevant, easy to follow book that is clear, concise, contemporary and evidence based. It is informative, easy to use and, enjoyable to read! I would highly recommend this as a valuable tool for any student or qualified dental hygienist/ therapist looking to update their knowledge.

## Practical Periodontics



**Edited by:** Ken Eaton and Philip Ower

**Cost:** GBP 49.99 EUR 59.99.

**ISBN:** 978-0-7020-4357-4

Use	DCP Category		
	Dental Hygienist	Dental Therapist	Student
CPD	★★★★	★★★★	★★★★
Usefulness in practice	★★★★	★★★★	★★★★
Revision Tool	★★★★	★★★★	★★★★

KEY: ★Average ★★Good ★★★Excellent ★★★★Absolute must!

## GUIDELINES FOR AUTHORS

Log on to the BSDHT website for full guidelines on how to publish your work in the journal.

Alternatively contact the Editor. Email: [editor@bsdht.org.uk](mailto:editor@bsdht.org.uk)

# OBITUARY MAUREEN E GINGELL

(NEE MILNE) 1966 - 2016

Our colleague Maureen very sadly passed away peacefully, and with dignity, at her home in April 2016 after losing her battle with cancer.

A dedicated dental hygienist, held in high regard by her colleagues and loyal patients, she will be greatly missed.

Maureen's career in the dental profession began at Dundee Dental Hospital in 1985, where she gained not only the Certificate of Proficiency in Dental Nursing but also the James Bruce Prize. She then moved west and qualified from Glasgow School of Dental Hygiene in 1986. With a brief period of time spent in general practice in Ayr, Maureen then decided to take the plunge (not literally!) into the ocean by joining the Royal Navy, where she held the rank of Petty Officer Dental Hygienist for five years.

Once back on dry land Maureen settled to work in a specialist referral practice in Plymouth. During her time there she was awarded the national accolade, "Hygienist of the Year 2004" for her significant contribution to the practice. Maureen then took on a secondary role of practice and marketing management, gaining further qualifications to add to the endless list she already held.

With a pending move to London (to be with her future husband) Maureen found work in two practices, which is when I had the pleasure of meeting her: my new colleague quickly became a very dear friend.

Laterally Maureen lived and worked in the SW of England, where once again she increased her role to become the Treasurer for the SW Peninsula group of BSDHT.

Maureen was a very highly skilled, motivated and gentle dental hygienist with the most amazing interpersonal skills, extending her kindness to everyone she met.

Socially Maureen had a great passion for horse riding, she not only enjoyed the sport most weekends locally on Dartmoor but on wonderful holidays abroad, including the USA, and latterly with her husband in Spain. Here she is seen pictured with her favourite horse PIENADO in happier days riding in Spain.

Sleep well Maureen.

*Emma MacDonald*

Penny Williams, Council representative SW Peninsula Group adds:

*Mo was a dedicated member of the South West Peninsula Group BSDHT, and served in a number of roles on the committee over the years.*

*She will be greatly missed by her patients, our group and the practices where she worked.*

*Mo will be remembered for her warmth, her sagacity, her calm efficiency and her support to us all in the profession.*



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# Oil pulling

## is there a clinical benefit to oral health?

Katie Lee

### Introduction

Oil pulling is fast becoming fashionable in the developed world based on such assertions that it can improve the immune system, bad breath and gingivitis as well as whiten teeth and reduce the risk of dental caries.<sup>1</sup> Although oil pulling is a relatively new technique to the modern world, it originates as a traditional Indian folk remedy that has been used for thousands of years. It is considered a form of ayurvedic medicine which takes a holistic approach to health and disease and mainly involves herbal medicine.<sup>2</sup>

The action of oil pulling involves the swishing of a tablespoon of edible oil in the mouth for 15-20 minutes and then spitting out. This needs to be carried out in the morning before eating, followed by brushing with toothpaste for two minutes. Any household oil can be used but most recently the trend has been to use coconut oil.

With an increasing interest in oil pulling, and more patients looking for a quick fix to improve their smile, dental professionals need to be able to answer their queries, based on a sound knowledge of the current evidence.

The purpose of this short review is to investigate whether the action of oil pulling does have any clinical benefit to oral health and, if so, what benefits can we expect?

### Current literature

Although oil pulling dates back thousands of years the current published evidence is limited. To date, no Cochrane systematic reviews have been undertaken on this subject. A search for papers was undertaken using online search engines: Pubmed, ResearchGate, Google Scholar and the University of the Highlands and Islands Multisearch. Fifteen studies are included in this review with a mix of randomized controlled trials (RCT), *in vitro* studies and trials without control groups. Because the evidence is scant, the limiting criteria were that the author required free access to published papers written in the English language. Currently research is too limited to be able to conduct a literature review specific to one aspect of oral health and so Table 1 depicts the topics that have been included and Table 2 portrays the inclusion and exclusion criteria set by each paper. Because not all of the studies have the same aim and objectives this makes comparisons between each paper's results slightly more difficult.

Study Focus	Authors	Study Type	Sample	Length
Addition of oil to dentifrice	<sup>8</sup> Pretty <i>et al.</i> 2003	RCT & <i>In vitro</i>	20 (mean age – 35)	5 days
Oil pulling and plaque induced gingivitis	<sup>3</sup> Amith, Ankola and Nagesh 2007	Trial without control	10 (age 19-21)	45 days
Oil pulling and plaque induced gingivitis	<sup>4</sup> Asokan, Emmadi and Chamundeswari 2009	RCT	20 (age 16-18)	10 days
Halitosis	<sup>15</sup> Asokan <i>et al.</i> 2011	RCT	20 (age 17-19)	14
Addition of oil to dentifrice	<sup>9</sup> Filogonio <i>et al.</i> 2011	RCT	30 (age 18-21)	90 days
Oil pulling and dental biofilm	<sup>13</sup> Thaweboon, Nakaparksin and Thaweboon 2011	<i>In vitro</i> (controlled)	N/A	24 hours
Fatty acids effects on oral microorganisms	<sup>18</sup> Haung <i>et al.</i> 2013	<i>In vitro</i>	N/A	48 hours
Vegetable oils effect on Streptococcus mutans	<sup>11</sup> Hughes <i>et al.</i> 2013	<i>In vitro</i>	N/A	12 hours
Candida albicans	<sup>14</sup> Ogawa, Nishio and Okada 2013	<i>In vitro</i>	N/A	24 hours
Dentine sensitivity	<sup>17</sup> Cheema <i>et al.</i> 2014	RCT	30 (age 18-40)	8 weeks
Massaging oil onto gingiva and effect on microorganisms	<sup>12</sup> Singla <i>et al.</i> 2014	RCT	40 (age 18-55)	3 weeks
Halitosis	<sup>16</sup> Sood <i>et al.</i> 2014	RCT	60 (age 17-23)	3 weeks
Adjunct to periodontal treatment	<sup>7</sup> Dani <i>et al.</i> 2015	RCT	40 (age 16+)	14 days
Comparing fluoride and herbal mouth rinses to oil pulling	<sup>10</sup> Jauhari <i>et al.</i> 2015	RCT	52 (age 6-12)	14 days
Oil pulling and plaque induced gingivitis	<sup>5</sup> Peedikayil, Sreenivasan and Narayanan 2015	Trial without control	60 (age 16-18)	30 days

Table 1 – The studies

Study Focus	Authors	Inclusion Criteria	Exclusion Criteria
Addition of oil to dentifrice	<sup>8</sup> Pretty <i>et al.</i> 2003	Good tooth brushing	Fixed/removable prosthesis Pregnancy Use of chlorhexidine products Antibiotic use in past 6 months
Oil pulling and plaque induced gingivitis	<sup>3</sup> Amith, Ankola and Nagesh 2007	20 permanent teeth Gingivitis Willingness to refrain from dental treatment during experiment	Allergy to oil Systemic disease and use of antibiotics Orthodontic treatment/artificial prosthesis Use of mouthwash
Oil pulling and plaque induced gingivitis	<sup>4</sup> Asokan, Emmadi and Chamundeswari 2009	16-18 years Plaque induced gingivitis	Antibiotic use in past month Use of mouthwash History of dental treatment
Halitosis	<sup>15</sup> Asokan <i>et al.</i> 2011	17-19 years old 24 permanent teeth with probing depth <3mm Gingival and Plaque index = 1 in more than 10% sites	Antibiotic use in past month Orthodontic appliance or any prosthesis Smokers Participants with deep fissured tongues
Addition of oil to dentifrice	<sup>9</sup> Filogonio <i>et al.</i> 2011	Good General Health	Antibiotic use in past 3 months Pregnancy/lactating Orthodontic appliance
Oil pulling and dental biofilm	<sup>13</sup> Thaweboon, Nakaparsin and Thaweboon 2011	60ml unstimulated saliva from three individuals 2 hours after eating/drinking/carrying out oral hygiene	N/A
Dentine Sensitivity	<sup>17</sup> Cheema <i>et al.</i> 2014	18-40 years old At least 2 sensitive teeth Good general health	Antibiotic use in past month Fractured restoration Gingivitis Allergy to drugs Pregnancy/lactating
Massaging oil onto gingiva and effect on microorganism	<sup>12</sup> Singla <i>et al.</i> 2014	At least one carious tooth Gingivitis	Antibiotic use in past month Undergoing orthodontic treatment Using prosthesis Use of mouth rinse Any medical conditions compromising oral examination
Halitosis	<sup>16</sup> Sood <i>et al.</i> 2014	18 years+ 24 permanent teeth with <3mm probing depth Intrinsic malodour two hours after any oral activity e.g. brushing Gingival & plaque scores =>1 in 10% of sites	Systemic cause of malodour Medications such as antihypertensives & oral hypoglycaemics Antibiotic use in past month Dental treatment in past week
Adjunct to periodontal treatment	<sup>7</sup> Dani <i>et al.</i> 2015	Plaque induced gingivitis 20 permanent teeth	Antibiotics use in past 3 months Mouthwash use in past 3 months Pregnancy/lactating Smokers (including previous smokers) Anyone younger than 15 years
Comparing fluoride and herbal mouth rinses to oil pulling	<sup>10</sup> Jauhari <i>et al.</i> 2015	Good general health	Antibiotic use in past 3 months Fluoride treatment in past 2 weeks
Oil pulling and plaque induced gingivitis	<sup>5</sup> Peedikayil, Sreenivasan and Narayanan 2015	16-18 years Plaque induced gingivitis	Antibiotic use in past month Dental treatment in past month

Table 2 - Set inclusion and exclusion criteria of *in vivo* studies

## Gingivitis

Three of the papers reviewed considered the effect of oil pulling on gingivitis, using sunflower, sesame and coconut oil respectively. After assessing modified plaque and gingival indices, all three studies showed significant positive results in which oil pulling improved the gingival health of the participants involved, by the reduction in these scores.<sup>3-5</sup> However, a control group was included in only one of these studies<sup>4</sup> and participants were requested to rinse with 0.12% chlorhexidine mouthwash, regarded as 'gold standard'<sup>6</sup> in terms of chemical plaque control, as well as 0.2% chlorhexidine mouthwashes. There was no significant difference (defined as 5%) between the results of the study group and the control group at day 10 (the final day). However, when comparing the mean plaque and gingival index scores at baseline and day 10 there were significant differences in both groups.

Microorganism colony count from baseline to day 10 was also measured in one of these studies but the reduction in both groups was not enough to be described as statistically significant.<sup>4</sup>

Looking at the effect of oil pulling as an adjunct to dental treatment, namely scaling and root planing, only one group also measured microbial colony counts. This study found a reduction of almost half for their test (scaling, root planing, oral hygiene instruction and sesame oil pulling) and control (scaling, root planing, oral hygiene instruction and CHX mouthwash) groups. The researchers also found no significant difference in results between their control group and their test group after 14 days, again suggesting that oil pulling is as effective as the gold standard mouthwash.<sup>7</sup>

The efficacy of dentifrices with the addition of oils to them had positive outcomes in two studies.<sup>8-9</sup> Researchers found that the use of olive oil resulted in a 22% reduction in plaque scores. However part of this work was also conducted *in vitro* when it was found that olive oil affected the adhesion as well as the growth of *Streptococcus mutans*.<sup>8</sup> The other study considered biofilm control and the difference between the use of a standard toothpaste, a toothpaste with the addition of mineral oil and a toothpaste with the addition of a vegetable oil. Results revealed a statistically significant difference between both oil groups and the control group after the 90 day test period, indicating the benefits of adding oil to a toothpaste for plaque control.<sup>9</sup>

Only one study included children, evenly split into four groups and asked to rinse twice daily for two weeks with either 200ppm fluoride mouthwash, a herbal mouthwash (active ingredient – *Salvadora Persica*), sesame oil or distilled water (control group). Measurements were taken at baseline and at 14 days to assess the *S. mutans* counts using oratest and dentocult SM strip mutans kit. There was no significant difference between participants at baseline with regards to *S. mutans* counts but at day 14 there was a significant reduction in the fluoride group and the herbal group.<sup>10</sup> Similarly to other researchers, the oil pulling group showed no significant reduction in *S. mutans* counts.<sup>4</sup> An *in vitro* study, complimented these results and found that

the growth of *S. mutans* was not affected by sunflower seed, palm, olive or coconut oils.<sup>11</sup>

One study included four groups of eight adults massaging their gums with either sesame oil, coconut oil, olive oil or chlorhexidine gel (positive control) every day for three weeks. Saliva samples were obtained at baseline and after three weeks and counts were taken for *S. mutans* and *Lactobacilli*, implicated in dental caries. Gingival and plaque indices were measured at these times also. This is the only study that advises massaging of the products and the only one that instructs participants to use the products after brushing, and not before. Again, there was no significant difference between the four groups' results, however there was significant reduction in all four measurements in each group, thus concluding that oil massaging with sesame oil, olive oil or coconut oil can be equally as effective as massaging with chlorhexidine. Participants were advised to massage for ten minutes after brushing, which is about half the recommended time when compared with oil pulling. This may allow for better compliance as it takes less time.<sup>12</sup>

One *in vitro* study assessed the effects of coconut, sesame, sunflower, corn, palm, rice bran and soy bean oils on strains of *S. mutans*, *Candida albicans* and *Lactobacillus casei* and compared this to chlorhexidine (positive control) and a saline solution (negative control). Results showed that the corn, palm, rice bran and soy bean oils had no antimicrobial effect on *S. mutans*, *C. albicans* or *L. casei* but statistically significant results were depicted by coconut oil on *S. mutans* and *C. albicans*; sesame oil on *S. mutans* and sunflower oil on *C. albicans*.<sup>13</sup> Other researchers also found that in their *in vitro* study, sesame oil inhibited the growth of strains of *C. albicans*, commonly found in oral thrush.<sup>14</sup>

## Halitosis

Investigating the effects of sesame oil pulling on halitosis, it has been concluded that oil pulling can be just as effective as chlorhexidine mouthwashes when it comes to improving halitosis and reducing the organisms causing halitosis.<sup>15-16</sup>

One team of researchers included a sesame oil pulling group and a chlorhexidine mouth rinse group and after assessing sixty 17-19 year olds with a questionnaire, and once inclusion and exclusion criteria had been taken into account, only twenty participants were selected for the trial. These participants had their modified gingival index, plaque index and probing depths measured a week prior to the experiment beginning and were also given a dental scaling. This was to ensure participants did not have periodontitis and met the study's inclusion criteria. The night prior to assessment, participants were asked to refrain from eating certain foods that would cause bad breath as well as alcoholic drinks. They had to brush before 12pm and the next morning were not allowed to eat or brush. They were asked not to wear any scented cosmetics. All this criteria helped control variables.<sup>15</sup>

At baseline and day 14 plaque and modified gingival indices were measured along with organoleptic breath assessment (by a blinded examiner and the participant) and a tongue coating sample was taken by

another examiner to identify if halitosis causing microorganisms were present or not. At the pre and post-assessments the results showed no significant difference between the two groups.

When comparing plaque index at baseline and 14 days as well as modified gingival index there was a significant difference (defined as 5%) in both groups. The self-assessment of organoleptic breath assessment showed a significant difference in both groups also. The other two measurements showed a difference, however this was not of significance.

## Hypersensitivity

Investigating whether oil pulling has any clinical benefit on reduction in tooth sensitivity one team of researchers split participants into three groups to either rinse with sunflower oil, topically apply sensitive toothpaste or rinse with saline solution (placebo). Measurements were taken at baseline and eight weeks where the clinician scratched participants' dentine with a sharp probe and then cold air was applied for ten minutes using a dental air syringe. Participants used a visual analogue scale to convey their level of sensitivity afterwards. The placebo group showed little to no improvement in sensitivity to the air jet and to the tactile test. The oil pulling group showed significant improvement when tested with the air jet and the sharp probe – with 70% and 60% of participants respectively claiming improvement. In the positive control group (sensitive toothpaste application), 60% and 40% of participants claimed to have improvement in sensitivity towards the air jet and tactile test respectively. The results of this study show that the action of oil pulling can be an effective aid to dentine sensitivity and could even work better than dentifrices aimed specifically at improving sensitivity.<sup>17</sup>

## Discussion

Overall none of the current studies are of a long enough time period or on a large enough scale with a varied enough sample to be able to extrapolate the results to a whole population.

Four of the studies were carried out *in vitro* and as the conditions are not exactly as they would be found in the normal setting, are considered to be of lesser quality than *in vivo* experiments. However, they do offer evidence to take into account when conducting future *in vivo* research. Two of the studies reviewed were not randomised controlled studies and sit fairly low on the hierarchy of evidence in comparison. Although these types of studies do not provide results of high validity they do provide a good source of information for future researchers to consider. The other nine studies (randomised controlled trials) included are of improved reliability and sit highly on the hierarchy of evidence. They provide valid results due to the use of control groups and reduce any study bias by conducting blind trials.

Only one study did not report statistically significant results with oil pulling. This could be due to participants not complying fully with instructions as they were only 6-12 years old, despite parents reporting back that they did.<sup>10</sup> Further research, on a larger scale and over a longer time frame, would need to be carried out involving children, however

it is uncertain whether or not the results would be reliable enough and perhaps oil pulling should be advised for adults, or adolescents only. Future studies concerned with paediatrics could involve the addition of oil to dentifrices or the massaging of oils onto the gingiva rather than the action of oil pulling.

Results from one study show that the addition of oil to a dentifrice did not provide significant results until the 90th day (compared with day 45) and so consideration should be taken as to whether the results would further improve if the study was carried out over a longer period of time.<sup>9</sup>

One group of researchers' results could be a basis for others to begin research in the same area. These results are promising and so future studies could use this work as a basis for their methodology but increase sample size, use a more generalised population i.e. individuals other than dental students, and continue the study for a longer period of time. The results show oil pulling can improve dentine sensitivity after eight weeks but future studies could question whether sensitivity could be improved long term.<sup>17</sup>

## Participant acceptance of oil pulling

One group of participants was asked to complete a post experiment questionnaire in which 60% stated that they would be willing to continue oil pulling as part of a regular oral hygiene regime. A total of 80% of participants reported a burning sensation after using chlorhexidine as well as taste alteration (60%) whereas no oil pulling participants complained of burning and only 20% reported an oily taste rather than any actual taste disturbance.<sup>7</sup>

Other researchers similarly conducted a questionnaire in which 80% of participants said they would be happy to continue oil pulling as part of their daily oral hygiene regime.<sup>3</sup> Other study participants felt the oil pulling procedure was lengthy but became accustomed to the taste and texture after a couple uses.<sup>16</sup> In one study a sixth of participants reported initial discomfort when using a toothpaste containing oil.<sup>9</sup> One participant reported sensitivity after application of the chlorhexidine gel but no other participants stated any undesirable side effects.<sup>12</sup>

## Conclusion

Future longitudinal studies must be carried out with a larger sample size to enable clinicians to provide patients with evidence based, non-biased advice when it comes to oil pulling and its effects on oral health. Many studies showed significant positive results after around 30 days of using oil in their daily oral hygiene routine and thus suggests that more studies should be carried out for longer than 30 days.

The current research is not reliable enough and does not provide us with enough evidence as to whether or not we as dental care professionals can advise our patients to begin, or to continue with oil pulling, as part of their oral hygiene routine to benefit their oral health.

This treatment regime has been in use in developing countries such

as India for thousands of years and from the results of this short review it seems reasonable to suggest that further research should be undertaken, particularly into any impact on the oral flora and any potential benefits of adding oil to dentifrices. If longitudinal studies mirrored the results of the current evidence, then oil pulling could be an extremely cost effective and important aid to oral hygiene for all our patients, particularly those at high risk of caries and periodontitis, or who have manual dexterity problems.

With these small scale studies suggesting oil pulling is just as effective as chlorhexidine, could oil pulling become the new 'gold standard'?

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Katie Lee has very recently qualified from the University of The Highlands and Islands, in June 2016. Excited to get out into the 'real world' of dentistry Katie will be starting out on her career as a Dental Hygiene-Therapy Vocational Trainee later this year, in August. Her paper is based upon the work she undertook as a third year student.

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# THE MANAGEMENT OF A PATIENT WITH SPECIAL NEEDS:

## A CASE STUDY

KATIE ROWLAND

The British Society for Disability and Oral Health define special needs patients as individuals who have disabilities or impairments, which may be social, emotional, mental, intellectual, sensory, physical or medical.<sup>1</sup>

The following case study is centred around the management of a patient with a previous addiction to alcohol and drugs. The forty one year old Caucasian male gave his consent for the case study and was made aware that his anonymity and confidentiality would be protected throughout the study. Management included exploring how his conditions had an effect on potential treatment, and his home self-care, and was undertaken by a student dental hygienist in a general practice.

### Social history

The patient lives alone and up until 18 months ago he had been a drug addict and diagnosed alcoholic for 20 years. The patient previously worked as a labourer and described himself as a functioning alcoholic for several years before losing his job. He became unemployed because he was unable to make it into work after evenings of drinking alcohol and taking drugs. Loss of job is a common result of addiction, which consequently drives the victim further into their substance abuse.<sup>2</sup>

During his years of substance misuse the patient used two psychoactive drugs, cannabis and cocaine. Psychoactive drugs have the ability to alter one's consciousness, and can have many detrimental effects on health, including increasing the risk of oral cancer.<sup>3</sup> Studies show that chronic abuse of cannabis can lead to issues with the respiratory, cardiovascular and reproductive systems, whilst also having adverse effects on a person's mental wellbeing, such as schizophrenia and psychosis.<sup>4,5</sup> Cocaine stimulates the central nervous system by increasing the levels of dopamine, thus giving the user a feeling of euphoria. The drug has strong addictive potential, which increases in those who have obsessive psychological traits.<sup>6</sup>

### Medical history

#### *Alcoholism*

From the age of 20 the patient started drinking approximately two litres of 5% cider every day, equating to 70 units a week, for 20 years. This is over three times the recommended maximum weekly unit consumption in the UK, with national guidelines advising two alcohol free days throughout the week.<sup>7</sup> Over the past five years he had tried professional and home detox programmes, however these were unsuccessful. The patient suffered a major seizure due to sudden withdrawal from alcohol during one detox and was hospitalised. Statistics show that 5% of alcoholics who drink heavily and then suddenly stop experience alcohol-withdrawal seizures.<sup>8</sup>

Eighteen months previously, the patient suffered from alcohol poisoning and was hospitalised. It is estimated that 2% of the English population are hospitalised each year due to an alcohol-related illness.<sup>9</sup> At this point the doctors told the patient he had a year to live if he carried on with his current lifestyle. The medical staff aided him in finding appropriate networks and service providers to support him throughout recovery. These services included support from local drug and alcohol related facilities.

#### *Alcoholic cirrhosis*

Alcohol-induced liver disease is a progressive disease which has three stages: fatty liver, alcoholic hepatitis and alcoholic cirrhosis.<sup>10</sup> Necrosis and inflammation of hepatocytes caused by the continual metabolism of alcohol leads to the eventual cirrhosis.<sup>11</sup> The patient was diagnosed with the condition five years previously, and the importance of ceasing his alcohol intake was stressed by doctors.

#### *Reactive gastropathy*

Reactive gastropathy is another condition that is often noted alongside prolonged alcohol consumption.<sup>12</sup> It presents when the gastric mucosa is damaged by chemicals such as ethanol or nonsteroidal anti-inflammatory drugs (NSAIDs).<sup>13</sup> Proliferation of the smooth muscle fibres, oedema of the mucous membrane, and minimal inflammation of the gastric mucosa are evident with reactive gastropathy.<sup>14</sup> Gastropathy can be attributed to gastric reflux, a condition treated with proton-pump inhibitors, such as Lansoprazole.<sup>15</sup>

#### *Lansoprazole*

Presently the patient takes 15 milligrams of Lansoprazole daily to reduce gastric acid that may exacerbate his reactive gastropathy. Lansoprazole is part of a family of drugs called proton pump inhibitors, which reduce the secretion of gastric acid by entering the parietal cells of the stomach and blocking the hydrogen potassium adenosine triphosphate enzyme system, therefore interrupting the final stage in acid production.<sup>16</sup> The suggested dosage of Lansoprazole is 30 milligrams daily, however in patients with moderate to severe liver conditions, a half dose is recommended due to hepatitis being a rare side effect, hence the patient's prescription of 15 milligrams. Oral side effects of the drug can include taste disturbances, glossitis, stomatitis, and dry mouth.<sup>15</sup>

### Dental history

The patient first attended in December 2014 for an examination with a General Dental Practitioner (GDP). It had been 10 years since he had last visited a dentist. The patient had never been treated by a dental hygienist. At the patient's first appointment, a Basic Periodontal Examination (BPE) was taken (Fig 1.) recording scores of three and four, demonstrating

3	4	4
4	4	4

FIG. 1

pocket depths over 3.5 millimetres in all sextants. The British Society of Periodontology (BSP)<sup>17</sup> advise hygienists to record a 6PPC and deliver oral hygiene advice and root surface debridement when these measurements are recorded, as they are considered too deep to be improved with plaque control measures alone. Furthermore, horizontal bitewing radiographs are recommended if a patient presents with BPE codes of three or above.<sup>18</sup> These were taken by the GDP, and after further examination a diagnosis of generalised chronic periodontitis was made. Due to the side effects of the patient's medication, and his previous association with alcohol and drugs, he is at a higher risk of periodontal diseases.<sup>19</sup> The patient was referred to the student hygienist (SH) for a six point pocket chart (6PPC), two appointments for non-surgical periodontal therapy under local anaesthetic, and a review appointment six to eight weeks after treatment.

### First appointment

The patient attended the SH in January 2015. He arrived late due to traffic issues enroute, limiting the amount of treatment that could be completed in this appointment. On arrival, it was noted that he had a yellow colouring to his complexion and whites of his eyes. Yellow discoloration of skin or mucous membranes, jaundice, can be caused by a patient's inability to excrete bilirubin due to cirrhosis of the liver.<sup>20</sup>

Medical, social and dental histories were taken to assess whether there were any changes: a fundamental aspect of health care, giving clinicians an opportunity to educate patients on factors of their lifestyle that may have a detrimental impact on their health.<sup>21</sup> Although the patient had already discussed his alcohol addiction, he had not disclosed to either clinician that he was a previous user of recreational drugs.

The patient's oral hygiene regime consisted of brushing twice a day for two minutes with a manual toothbrush and a toothpaste with 1450 parts per million of fluoride. He did not use any interdental cleaning aids, and did not use mouthwash due to his belief that they all contained alcohol. The student hygienist performed an extraoral and intraoral examination. This analysis revealed no abnormalities to the soft tissues and no evidence of the previously mentioned side effects associated with Lansoprazole. There was however pathological attrition of the patient's dentition (Fig. 2) Attrition can be associated with the involuntary bruxism that is caused by the over production of dopamine, as a result of cocaine abuse.<sup>22</sup>

The patient's oral health was suboptimal. There was mature generalised plaque and substantial supra gingival calculus associated with the upper



FIG. 2

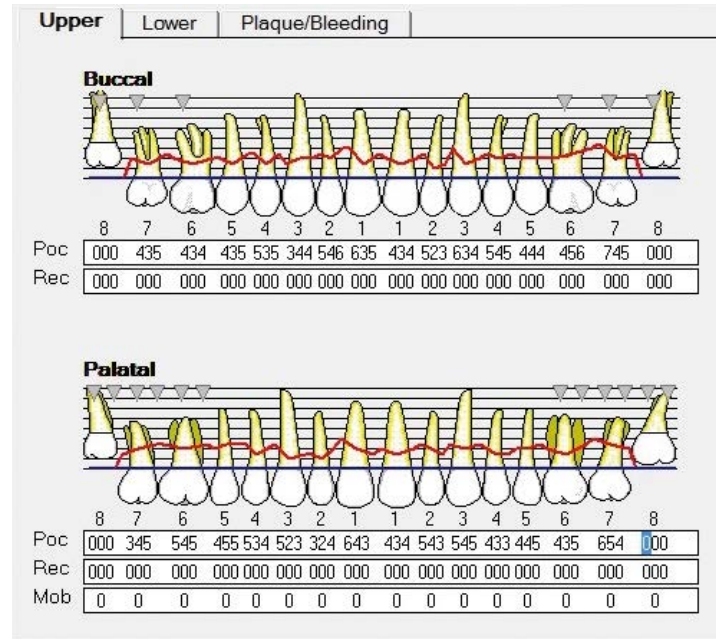


FIG. 3a

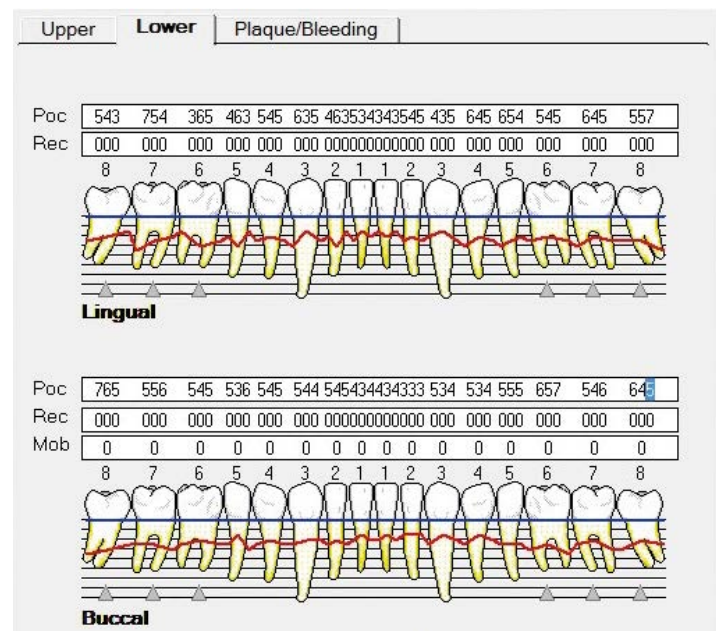


FIG. 3b

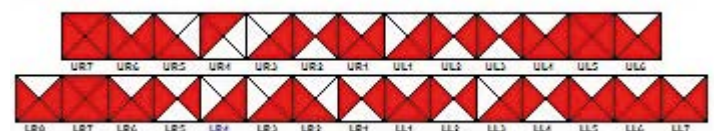


FIG. 4

molar teeth buccally, and lower anterior teeth lingually and interdentally. There were also sub gingival calculus deposits associated with the upper and lower molars, mainly interdentally.

As the BPE revealed codes of four, a full mouth six point pocket chart (6PPC) was taken (Fig.3) so that the student hygienist could evaluate the extent of the periodontal disease and to provide data that can be reviewed at future appointments<sup>23</sup> - a vital component of a periodontal assessment.<sup>21</sup> A bleeding on probing index was taken (Fig.4), and the patient was also disclosed as a visual aid to the plaque score as a means of motivating him

and provide information to which he can relate.<sup>24</sup> These procedures indicated a 64% bleeding and a 74% plaque score.

As time was limited, the patient wanted to commence treatment at the next session. The rest of the appointment was spent informing and educating the patient on the aetiology of periodontitis and discussing his 6PPC, plaque and bleeding scores and stressing the need for improvement in his oral hygiene. He was shown how to use interdental brushes and the Modified Bass Technique.<sup>25</sup> It was stressed that good oral hygiene is imperative to improve his periodontal disease.<sup>26</sup> The patient was also advised to be aware of how much sugar and salt he adds to his food, as taste disturbance can be a side effect of lansoprazole.<sup>15</sup> The aetiology of caries was explained and the effect that fermentable carbohydrates and the plaque biofilm can have on the dentition.<sup>27</sup>

## Second appointment

Before the patient returned, the student hygienist discussed with the GDP which LA would be prescribed for the treatment. LA such as articaine hydrochloride, lidocaine hydrochloride and mepivacaine hydrochloride, can have increased side effects in patients with hepatic impairment.<sup>15</sup> Furthermore, research indicates a higher risk of prolonged paraesthesia and anaesthesia when using adrenaline hydrochloride for an inferior dental (ID) block.<sup>28</sup> For these reasons, the dentist prescribed 2% lignocaine hydrochloride with 1:80,000 epinephrine, 2.2 millimetres, but with a reduced maximum dose of 4 cartridges to avoid the complications mentioned above. As LA is a prescription-only medicine, the SH required the dentist to provide a patient specific prescription.<sup>29</sup>

When the patient returned for this appointment the student hygienist reviewed his histories. There were no changes to his medical history; however the patient had been making a conscious effort to improve his oral hygiene. He had been using the modified bass technique and using interdental brushes every other day.

The patient then informed the student hygienist that in the past he had misused drugs, however he had been too embarrassed to admit this before. In order to build trust and ensure patients feel comfortable disclosing certain information, clinicians must exhibit excellent communication skills such as active listening and recognising needs.<sup>30</sup> Furthermore, the dental team should not discriminate on the basis of lifestyle, and all patients must be treated in a non-judgemental manner.<sup>31</sup> The patient explained that he had been placed in foster homes throughout his childhood and suffered physical abuse during his time in care. He described drugs and alcohol as an escape from his memories from his youth. Since achieving abstinence the patient attends weekly meetings and professional counselling sessions with Open Road, a support group that teaches past addicts new skills, such as gardening, to increase their self-esteem and employability in the future.<sup>32</sup>

The student hygienist used a systematic approach to treatment and administered the prescribed LA on the right hand side. A plaque score of 39% (Fig.5) was recorded, a 35% decrease since the first appointment. The patient was praised for this improvement and encouraged to aim for a further reduction by his next appointment. The SH completed half mouth sub and supra gingival debridement with an ultrasonic and hand instrumentation. A mixed method approach was chosen as although ultrasonic instrumentation allows effective irrigation and removal of the biofilm, studies have shown that they can reduce the tactile sensitivity of clinicians with prolonged use.<sup>33</sup>

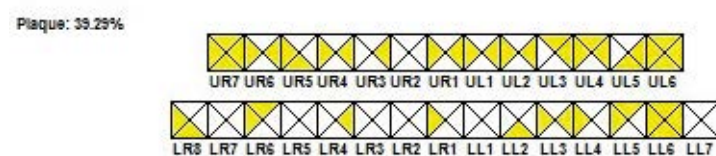


FIG. 5

After treatment, the student hygienist offered the patient post treatment instructions. The use of NSAIDs in patients with hepatic or gastro-intestinal impairment should be avoided; therefore the patient was advised to take paracetamol if he experienced any discomfort after treatment.<sup>15</sup> The importance of using interdental brushes everyday was also highlighted as a vital part of successful non-surgical periodontal therapy.<sup>24</sup>

## Third appointment

When the patient returned the same treatment was carried out on the left hand side, along with previous precautions. The student hygienist re-evaluated the patient's plaque score, which had reduced to 34%. The patient was praised for this, and the improvement he had made since his first appointment was highlighted to encourage and motivate.<sup>28</sup> The student hygienist also made him aware that he could purchase an alcohol free, 0.2% chlorhexidine digluconate mouthwash and recommended using it at a different time to brushing over two weeks. Public Health England (PHE) advise the short term use of a mouthwash such as this in those patients taking medications that cause dry mouth.<sup>19</sup> It is vital that recovering alcoholics avoid products containing alcohol as this could trigger a relapse.<sup>34</sup>

## Fourth appointment

The patient was due to return for his review appointment six weeks later to allow time to see a true response to treatment.<sup>33</sup> The student hygienist planned to re-record the patient's 6PPC and plaque and bleeding scores and assess whether there had been a response to treatment and the oral health advice given. However, the patient cancelled as he had to attend an urgent appointment at the hospital regarding his liver. A subsequent visit to the student hygienist was booked at a more suitable time for the patient, ensuring that he still had adequate access to the dental surgery and appointments, regardless of his medical or social difficulties.<sup>1</sup> He failed to return for completion of treatment.

## Role of the hygienist

Clinicians must work as part of a team and use effective communication with other dental and healthcare professionals to ensure well maintained standards in both oral and general health.<sup>35</sup> Dental Hygienists have the responsibility to consider the broad scope of patient management and education, rather than just carrying out treatment in the dental chair.<sup>35</sup> The demand for this holistic care is greater in patients who fall into a special needs category due to their increased vulnerability.<sup>1</sup>

The management delivered throughout this case study has considered the specific needs of a patient recovering from substance abuse. This included taking into account his lifestyle choices, medical conditions and medications that may impact dental treatment or that have a detrimental effect on his general and oral health.

## Reflection

The SH believes that due to the improvement in his oral hygiene that the patient achieved the motivational approach taken in this case was correct. As this patient started with a 74% plaque score, it was unreasonable to expect him to achieve a flawless brushing regime and daily interdental cleaning in one appointment. Behaviour change is an extensive process, which may require numerous attempts from the clinician before a goal is met. In future, should he return, the student hygienist would aim to make continual improvements with the patient's oral hygiene by increasing the days that he uses the interdental brushes and using SMART goals to further improve his plaque scores.<sup>19</sup>



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Individuals who partake in particular behaviours, such as drug and alcohol misuse, can be more likely to display other negative behaviours such as poor diet, smoking, or poor oral hygiene. Therefore, patients who display clustering of these behaviours are less likely to succeed in improving any one of these areas as they are still being affected by similar influences.<sup>19</sup> With this in mind, the SH believes that as the patient has reasonable control regarding his addictions at present, he is in a more beneficial position to make continual improvements to his oral health.

The student hygienist considers that three monthly appointments would be appropriate in light of the patient's risk assessment in regards to periodontal disease and cancer. As highlighted previously, both cannabis and cocaine can have associations with oral cancer. Furthermore, alcohol is an aetiological factor of erythroplasia which has a malignant potential greater than 85%. Regular oral cancer screening is imperative for this patient as he at greater risk of a malignant neoplasm in the region of the head or neck.<sup>22</sup>

This patient is vulnerable to relapse even after achieving abstinence; however the chances of this are reduced in patients who receive sufficient social support.<sup>36</sup> The SH would encourage all clinicians to review whether patients are receiving the support they need and refer to an appropriate service provider if they are concerned.

## Conclusion

This patient presented with some challenges and reinforced the importance of a holistic approach to dental management that takes into consideration the patient's social and medical histories, as well as treating the patient's

oral needs in the surgery. The patient's on going care will include support, reinforcement and praise from the dental team, along with other service providers to facilitate a continuing healthy trajectory.

This case study was undertaken in 2015 and the author is aware that guidelines and procedures may have been updated or changed since then.

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Thanks to my lecturers Emma Pacey and Kirstie Thwaites for their guidance and support.

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Katie graduated from the University of Essex with a FdSc in Oral Health Science in 2015. She currently works as a dental hygienist in the South Essex area, taking a special interest in prevention and the care of nervous patients. In 2016 she decided to return to education and study for a BSc which will allow her to register as a dental therapist.

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# DENTAL ANXIETY IN PATIENTS ATTENDING FOR TREATMENT BY A DENTAL HYGIENIST (STUDY 1)

Ellie Kani

Two studies (Study 1 and Study 2) have been undertaken to identify the characteristics of dentally anxious patients attending a primary dental care practice, using different measures. The purpose of this work is to help dental hygienists and therapists recognise dentally anxious patients and adapt their treatment to suit. Both studies are based on the outcome of an IADR poster presentation “*Dental anxiety of patients attending for treatment by dental care professional*” Boston, 2015.

## Introduction

The mouth is a physiologically and psychologically a highly sensual area of the body. Dental treatment and the surrounding dental environment may elicit negative cognitions and behaviours among some patients, leading to anxiety and long term negative implications and avoidance for these individuals. To treat or prevent dental disease successfully we require the development of special communication skills and an ability to provide reassurance, personal care and comfort. Honing these skills will improve an anxious patient’s satisfaction with treatment as well as provide them with high quality dental care.

## Aim

The aim of this study is to characterise the levels of dental anxiety in new and existing patients in relation to their attendance for treatment by a single dental hygienist in a primary dental care practice.

## Setting

A survey of a consecutive series of 100 patients (50 new patients (NP) and 50 existing patients (EP)) took place in a primary dental care setting in London. The study was conducted between July 2014 and January 2015. The study was reviewed and approved by the Research Ethics Committee of Kings College university of London. The survey was confidential and the informed consent of each participant was obtained.

## Subjects and methods

To assess the level of dental anxiety in new and existing patients two separate sets of questionnaires were used. The questions were based on demographics, self-reported oral health, dental attendance and dental fear. Patients were approached and questioned by a member of staff while waiting to be seen by the dental hygienist. All 100 participants then received their dental hygiene treatment from a single dental care professional.

For both groups of patients (new and existing) they were informed: “We hope that by finding out why people are anxious about coming to the dental surgery we will be able to improve our service.” Or, if the patient advised that they felt no anxiety about attending for treatment, they were told: “You might not be very anxious yourself but we plan to compare results with people who are dentally anxious.”

This work (Study 1) is based on the responses of the new and existing patients to the following questionnaires:

- Demographic information (gender, age)
- Self-reported dental attendance, visiting the dental hygienist (5 point Likert-like scale ranging from every “3-6 months” to “Never”)
- Self-reported dental attendance visiting the dentist (5 point Likert-like scale ranging from every “3-6 months” to “Never”)
- Self-reported Modified Dental Anxiety Scale, MDAS.<sup>1</sup>

The dental anxiety and avoidance of dental care was then assessed accordingly. The data was edited and analysed using SPSS (Statistical package for the social sciences, version 21).

## Main outcome measures

The effects of dental anxiety described in this study use the theoretical model of participants with high dental anxiety levels evaluating less regular dental care or even avoidance of dental treatment.<sup>2-3</sup>

The study, reviewed the most commonly used assessment instrument for dental anxiety and phobia known as the Modified Dental Anxiety Scale (MDAS).<sup>1</sup>

MDAS is a modified version of Corah’s Dental Anxiety Scales.<sup>4</sup> The MDAS is a five-item measure assessing anticipatory anxiety associated with an imminent dental appointment, fear of dental cleaning and drilling and fear of dental anaesthetic injection. The original DAS scale was modified by the addition of the dental injection item and the response format for each item was modified to comprise a five point response from “not anxious=1”, “slightly anxious=2”, “fairly anxious=3”, “very anxious=4” and “extremely anxious=5”. The total scores on the MDAS range from 5 to 25. Previous research<sup>5</sup> has established a cut-off of 19 or higher as indicative of a phobic level of dental anxiety. The MDAS has good psychometric properties – correlating well with other self-reported measures of dental anxiety and demonstrating high levels of internal consistency.<sup>6</sup> In addition, the inclusion of the MDAS in the most recent Adult Dental Health Survey (2009)<sup>7</sup> means those population norms for the scales are now available.<sup>8</sup> The scale has been recommended as a model of the assessment of dental anxiety in clinical settings.<sup>9</sup> The scale was significantly correlated with avoidance of dental procedures in an internationally diverse sample.

## Results

Fifty consecutive new patients visited the dental hygienist for the first time, and 50 existing patients, who had visited the dental hygienist for at least two or more visits, participated in the study. The participants’ demographics are shown in table 1. The mean age of new patients was 42 years (SD 12.6, range 17 to 80 years) and the mean age of existing patients was 54 years (SD 14.5, range 22-82 years).

50 New Patients		50 Existing Patients	
Gender	Number of participants/%	Gender	Number of participants/%
Male	18 (36%)	Male	17 (34%)
Female	32 (64%)	Female	33 (66%)

Table 1 represents the demographics of participants

In response to self-reported attendance, there was a difference in the two groups. Almost 14 percent of new patients only attended the dental surgery in an emergency and 7 percent of the patients had never been to dental hygienist before, whereas on average, 79 percent of existing patients regularly attended two or more visits to the dentist or hygienist in a year (Table2).

Attendance schedules		3-6 months	6-12 months	2-5 years	Emergency only	Never
New patients % of attendance	Dentist	4.5	61.4	20.5	13.6	0
	Hygienist	4.5	48.8	27.9	11.6	7
Existing patients % of attendance	Dentist	12.5	87.5	0	0	0
	Hygienist	27.5	70	2.5	0	0

Table 2, represents the percentage of dental attendances to dentist and dental hygienist among new and existing participants.

According to the result (table 3), the total mean score on the MDAS was calculated: the new patients 12.76 (SD: 5.78) and existing patients 10.96 (SD: 3.71). A large proportion of the new participants (14.2 percent) scored 19 or above for dental phobia, being extremely anxious, in comparison to no respondents in the existing patients group scoring above the cut-off point.

In both groups, patients represented greater anxiety related to two major dental treatments: having a tooth drilled (NP 44 percent and EP 29 percent), having local anaesthetic (NP 36 percent and EP 20 percent). In both dental treatments pain and discomfort is inevitable. Pain related to these treatments is a subjective personal experience which cannot be measured accurately. Importantly, 24 percent of NP were extremely anxious, if they had to visit the dentist the following day which clearly explains more about anticipation and avoidance behaviour of the patients towards dental treatment. Feelings of shame and embarrassment of their teeth would lead to anxiety and reinforced avoidance. They often avoid dental care thereby compounding the problem and increasing the likelihood that subsequent dental visits will be for emergency reasons. In contrast none of the existing patients were anxious about attending the dental surgery the next day.

Modified Dental Anxiety Scale	Proportion of individuals reporting being extremely anxious about the item (%)	
	New patients	Existing patients
1. If you went to your Dentist for treatment tomorrow, how would you feel?	12 (24%)	0
2. If you were sitting in the waiting room (waiting for treatment), how would you feel?	10 (20%)	0
3. If you were about to have a tooth drilled, how would you feel?	22 (44%)	14.6 (29%)
4. If you were about to have your teeth scaled and polished, how would you feel?	8 (16%)	2 (4%)
5. If you were about to have a local anaesthetic injection in your gum, above an upper back tooth, how would you feel?	18 (36%)	10 (20%)
<b>Total Mean (SD)</b>	<b>12.76 (SD:5.78)</b>	<b>10.96 (SD:3.71)</b>

Table 3: Responses to the Modified Dental Anxiety Scale by New and Existing patients.

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The responses to the MDAS are summarised in figure 1. In the current sample, the existing patients who regularly attend exhibit no anxiety about coming to the dental surgery or waiting for the treatment.

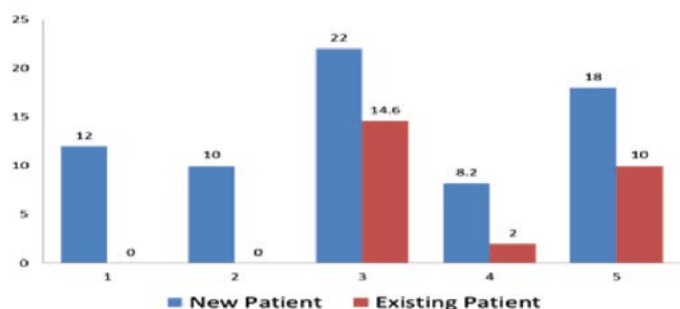


Figure 1: Represents the comparison of MDAS for New and Existing Patients

## Discussion

There are several studies which indicate that for some individuals various environmental, procedures and treatments in the dental setting are relatively more stressful and anxiety provoking, resulting in the establishment of a vicious circle: an individual's initial fear and anxiety may lead to an avoidance of, or sporadic attendance for, dental care and the subsequent development of dental disease. If oral health examinations and maintenance are not carried out regularly, and there is a delay in carrying out necessary dental treatment, over time this will result in deterioration of their oral status.<sup>3,10</sup>

In this study, for new dentally phobic patients who have overcome some degree of dental anxiety and managed to attend for treatment, the effective use of MDAS and dental history attendance via questionnaire has helped to identify the patient's behaviour. According to MDAS findings, the anxiety in the dental setting may be linked to pain from drilling and injection as well as anticipation of discomfort which may have led to avoidance behaviour. In this study, on average, over 24 percent of the new participants would seek dental help every two to five years while, on average, 13 percent would only attend in a dental emergency.

In contrast, the existing patients' attendance behaviours were clearly shaped and maintained as regular attendees of six to 12 months.

Dental anxiety is still a barrier to many patients.<sup>8,11</sup> Therefore motivating

these patients throughout the dental anxiety reduction journey and a good partnership with a dental hygienist can instigate behavioural changes and result in an increased dental attendance.<sup>2</sup> The experience of pain with repetition and anticipation could be an example of negative behaviour reinforcement.<sup>9,12</sup> Encouraging and increasing desire in patients to take control of their treatment and care is a great tool to provoke positive reinforcement towards better oral health and prevention of dental diseases.

## Conclusions

This small study confirms the findings of previous studies<sup>10</sup> that phobic behaviour leads to irregular dental attendance habits and for some patients, only attending for emergency dental treatments, will result in deterioration of their dental health. Attendance for maintenance of oral health and preventative treatment has a potentially therapeutic effect in terms of reducing dental anxiety. Mechanisms for such an effect include systematic desensitisation through repeated exposure to the feared object or situation<sup>13,14</sup> to prevent negative anticipations, thoughts or beliefs.<sup>15</sup>

## Acknowledgements

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### ABOUT THE AUTHOR:

Ellie qualified as dental hygienist in June 2005 from Kings College University. She has worked in various areas: general practice, holistic practice, periodontal practice, practice consulting, hospital, teaching and research.

Ellie also has an BSc (Hons) in analytical chemistry from University of London. She is currently doing research in Guy's, King's and St Thomas's Dental institute on dental public health. Her goal is to achieve better oral health and prevention in oral diseases.

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# CLINICAL QUIZ



**In recent years there has been increasing evidence to support a role for human papilloma virus (HPV) in oropharyngeal cancer.**

1. Name two other forms of cancer that are caused by HPV.
2. Which two types of HPV are associated with oropharyngeal cancer?
3. In the UK, a HPV vaccination programme has been introduced for which population group? Boys only, girls only or boys and girls?
4. In Australia, a HPV vaccination programme has been introduced for which population group? Boys only, girls only or boys and girls?

SEND YOUR ANSWERS TO THE EDITOR BY 31<sup>ST</sup> AUGUST. THE FIRST CORRECT ANSWER OUT OF THE BAG WINS A TOP OF THE RANGE TRIUMPH ORAL B TOOTHBRUSH (RETAILING AT £150) COURTESY OF BRAUN ORAL B.



## ANSWERS TO CLINICAL QUIZ MAY 2016

Q1. What is your diagnosis?

A1. Localised gingival recession

Q2. What is the primary aetiological factor in a case like this?

A2. Bone dehiscence.

Q3. How do we classify these defects and what type of defect is this?

A3. Miller Classification: this is a Miller class II defect.

Q4. What are her basic treatment options?

A4. 1. Do nothing and monitor

2. Correct any dysfunctional habits

3. Soft tissue graft to correct the defect.

# CPD PROGRAMME

*Dental Health is pleased to include a Continuing Professional Development (CPD) Programme for its members who are required to show evidence of CPD hours spent.*

The Programme is formulated in accordance with the guidance of the UK General Dental Council's regulations which now require all registered UK hygienists and therapists to undertake CPD and provide evidence of the equivalent of 10 hours per annum of verifiable CPD. The questions in this issue will provide 1 verifiable hour for those entering the CPD programme.

#### Aims and outcomes

The aim of the July 2016 Dental Health Continuing Professional Development Programme is to provide the opportunity for dental hygienists and dental hygiene therapists to learn about aspects of the following subjects: Oil pulling and its potential clinical benefits to oral health and Dental anxiety in patients attending for treatment by a dental hygienist.

The anticipated outcomes are that dental care professionals will be better informed about methods, techniques and procedures of these subjects and that they might apply their learning to their practices and the care of their patients

Members wishing to enter the Programme need to log on to [www.bsdht.org.uk](http://www.bsdht.org.uk) and select CPD. Register if you have not yet done so, or Login if you have already Registered, and go to the Take CPD section. Certificates can be printed for the Programme in each issue, or stored in a personal 'Global' account and printed at any time. There is no charge for this service.

Alternatively, members may complete the answer sheet overleaf (or a photocopy). Return it with a cheque for £11.75 (£10 +VAT) made payable to BSDHT, to: BSDHT, Smile House, 2 East Union Street, Rugby, Warwickshire, UK CV22 6AJ. Responses must be received before 31st August 2016 as the answers will be given in the September 2016 issue (Volume 55 No 5).

Members from whom fully completed forms and appropriate cheques are received will receive a certificate for 1 hour of verifiable CPD with the answers to the questions.

**Pass rate is 85%**

## PAPER 1: OIL PULLING – IS THERE A CLINICAL BENEFIT TO ORAL HEALTH? PP18-22

### 1. Which form of medicine best describes oil pulling?

- A. Ayurvedic medicine
- B. Traditional Chinese medicine
- C. Moxibustion
- D. Sa-Rigpa

### 2. Which of these does oil pulling not claim to improve?

- A. Halitosis
- B. Plaque induced gingivitis
- C. Dentine sensitivity
- D. Gingival recession

### 3. What undesirable side effects of oil pulling were reported?

- A. Burning sensation
- B. Taste disturbance
- C. Oily taste
- D. Increased gingival bleeding

### 4. After how many weeks did oil pulling begin to aid dentine sensitivity?

- A. 1 week
- B. 8 weeks
- C. 12 weeks
- D. 52 weeks

### 5. Which oil should be used for oil pulling?

- A. Sunflower
- B. Sesame
- C. Coconut
- D. All of the above

### 6. What conclusion can we come to about the efficacy of oil pulling?

- A. It should be advised in preference to chlorhexidine based mouth rinses
- B. There is not yet enough evidence to be able to recommend its use to our patients
- C. It is inferior to all other mouth rinses
- D. Rinsing with a herbal mouthwash is more effective than oil pulling

## PAPER 2: DENTAL ANXIETY IN PATIENTS ATTENDING FOR TREATMENT BY A DENTAL HYGIENIST (STUDY 1) PP28-31

### 1. Which of the following was not found to be a cause for avoidance of regular dental visits by individuals?

- A. Dental treatments
- B. Dental environments
- C. Dental anxiety
- D. Cost

### 2. Which of the following statements is incorrect?

- A. MDAS stands for modified version of dental anxiety scale
- B. The total scores on MDAS range from 5 to 25
- C. Individuals with a score above 19 are dental phobic
- D. MDAS has poor psychometric properties

### 3. Which of the following statements is correct?

- A. A dental injection and the use of the dental drill are key aspects of dental fear
- B. In this survey the MDAS score of existing patients is higher than new patients
- C. In this survey existing patients are very anxious when they have a tooth drilled
- D. In this survey new patients exhibit an extreme level of dental phobia towards local anaesthetics

### 4. Which of the following statements is incorrect?

- A. The function of anxiety in dental settings is linked to pain or discomfort
- B. Over 60 percent of new patients were found to only attend the dental surgery in an emergency
- C. The anxious patients are scored high on levels of anticipation to dental treatment
- D. Seven percent of new patients were identified as attending for hygiene treatment for first time

### 5. According to a 'vicious circle', an individual's initial fear and anxiety may lead to...?

- A. An avoidance or irregular dental care
- B. Development of dental disease
- C. Delay necessary dental treatment over time
- D. All of the above

### 6. Which of the following statements is incorrect?

- A. On average, over 24 percent of the new participants would seek dental help every two to five years
- B. On average, 13 percent of new patients only attend for dental emergency situations
- C. The existing patients' behaviours regarding attendance were clearly shaped and maintained, as being regular attendees of six to 12 months to dentist and hygienist respectively
- D. None of the above

# DENTAL HEALTH

VOLUME 55 - NUMBER 4 JULY 2016

## ANSWERS TO THE CPD QUESTIONS IN DENTAL HEALTH - VOLUME 55 NO 3 OF 6 MAY 2016

### Paper 1: Xylitol chewing gum - does it reduce saliva levels of Streptococcus mutans in children? pp20-24

1. C. Sugar alcohol
2. B. 125
3. C. 8
4. D. 6-17 years
5. B. Cytoplasm
6. A. 900 and 586  
respectively

### Paper 2: Is Chlorhexidine an effective adjunct alongside treatment for peri-implant mucositis? pp25-33

1. B. Gingivitis
2. B. Sodium laurel  
sulphate
3. B. 3mm
4. C. Parvimonas micra
5. A. Type of implant
6. D. CHX offered  
minimal benefits

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2. **TICK** the answer to each question for each article you select. You may complete one or two articles.

	CPD article 1				CPD article 2				
	a	b	c	d		a	b	c	d
Q1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Q1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Q2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Q3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Q4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Q5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Q6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Answer sheets must be received no later than 31st August 2016. Answer sheets received after this date will be discarded as the answers will be published in the September issue of Dental Health.

### Feedback

We wish to monitor the quality and value to readers of the BSDHT CPD Programme so as to be able to continually improve it. Please use this space to provide any feedback that you would like us to consider.

# DIARY DATES



## BSDHT OHC 2016

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### AUTUMN 2016 BSDHT REGIONAL GROUP MEETING DATES

Regional Group	Date	Venue	Contact the Secretary	Contact Details
Eastern	1st October 2016	Hallmark Hotel, Cambridge, CB23 8EU	Juliette Reeves	<a href="mailto:bsdht.east@gmail.com">bsdht.east@gmail.com</a>
Jersey	TBC	TBC	Tammy McArdle	<a href="mailto:jerseysecretary@bsdht.org.uk">jerseysecretary@bsdht.org.uk</a>
London	17th September 2016	Holiday Inn, Coram Street, Bloomsbury, WC1	Mala Kanan	<a href="mailto:londonsecretary@bsdht.org.uk">londonsecretary@bsdht.org.uk</a>
Midlands	24th September 2016	Ramada Hotel, Solihull, W.Mids	Joanna Ericson	<a href="mailto:midlandssecretary@bsdht.org.uk">midlandssecretary@bsdht.org.uk</a>
North East	17th September 2016	Holiday Inn, Garforth, Leeds	Sharron Parr	<a href="mailto:nergsecretary@gmail.com">nergsecretary@gmail.com</a>
Northern Ireland	NO MEETING (AGM 17th Sept)	OHC IN BELFAST NOV 2016	Bridie Sergeant	<a href="mailto:northernirelandsecretary@bsdht.org.uk">northernirelandsecretary@bsdht.org.uk</a>
North West	24th September 2016	TBC	Karen McBarrons	<a href="mailto:northwestsecretary@bsdht.org.uk">northwestsecretary@bsdht.org.uk</a>
Scottish	1st October 2016	TBC but in Edinburgh...	Jane MacConnell	<a href="mailto:scottishsecretary@bsdht.org.uk">scottishsecretary@bsdht.org.uk</a>
South East	22nd October 2016	David Saloman's Centre, Tunbridge Wells	Kate Fry	<a href="mailto:kate.fry@mac.com">kate.fry@mac.com</a>
Southern	1st October 2016	Salisbury District Hospitals	Donna Brien	<a href="mailto:secsouthern@gmail.com">secsouthern@gmail.com</a>
S West & South Wales	24th September 2016	Hilton Hotel, Bradley Stoke, Bristol	Stephanie Sherwood	<a href="mailto:swwsecretary@bsdht.org.uk">swwsecretary@bsdht.org.uk</a>
South West Peninsula	1st October 2016	China Fleet Country, Cornwall	Sarah Hopkin	<a href="mailto:secretarybsdhtswpen@gmail.com">secretarybsdhtswpen@gmail.com</a>
Thames Valley	24th September 2016	The Jury's Inn, Godstow Road, OX2 8AL	Karrie Archer	<a href="mailto:thamesvalleysecretary@bsdht.org.uk">thamesvalleysecretary@bsdht.org.uk</a>



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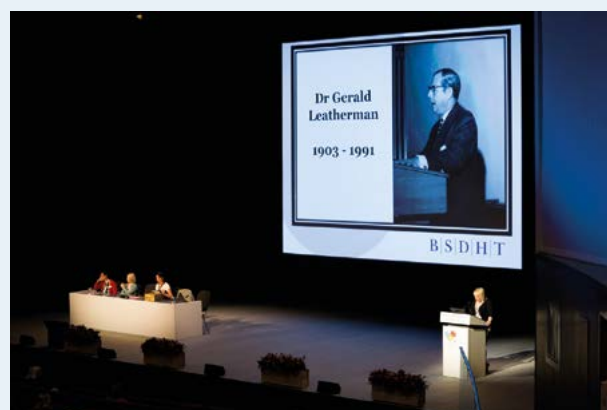
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## Do you have a nominee for the Dr. Leatherman Award?

The late Dr Gerald Leatherman played a very important part in promoting the role of the dental hygienist as one of the pioneers of preventive dentistry in the UK. Described as 'The Father of World Dentistry' by Dame Margaret Seward he dedicated his professional life to raising the profile of both the dental hygienist and dental health promotion. He was actively involved with the British Dental Hygienists' Association (now BSDHT) from the start and played a leading role in the establishment of the first dental hygiene training school in England. Following his retirement from the office of President of the BDHA in 1957 he was appointed Honorary Vice President until his death in 1991.

The Dr. Leatherman award is held in the highest regard by this profession. It is the only award nominated and agreed upon by your peers. It reflects true dedication, professionalism and determination for the greater good of all the profession. Nominees do not have to be high profile, in fact past winners have ranged from those who worked tirelessly behind the scenes to those who laid the foundations for the society we know today.

If you know of a worthy candidate please contact **enquiries@bsdht.org.uk** for terms and conditions and a nomination form. Please note we do not accept self-nominations; you must be nominated by your colleagues. All completed forms must be with us by **July 31st 2016** and the successful applicant will be notified in October.



# Oracle



## *So Smart, it's GENIUS*

Oral-B GENIUS is the first of its kind and Oral-B's most intelligent brushing system to-date. Featuring groundbreaking Position Detection Technology that combines cutting-edge motion sensor technology located in the brush, and video recognition using the smartphone's camera, it tracks to ensure that no zone is missed. Patients receive instant feedback via the Oral-B App 4.1, including guidance on pressure applied and brushing duration. These features, combined with the Oral-B Oscillating-Rotating-Pulsating Technology help patients improve their oral health.

The Oral-B GENIUS will be available in select markets starting in July 2016. The Oral-B App 4.1 will be available in July 2016 on iTunes and Google Play.

Visit [oralb.com/genius](http://oralb.com/genius).

## *Poligrip® fixatives help your patients eat, speak and smile with confidence*

Up to 86% of patients are affected by food becoming trapped under their dentures.<sup>1</sup> This can lead to discomfort and can cause bad breath.

Results have shown that Poligrip® denture fixatives have the ability to seal out food particles helping to reduce gum irritation<sup>2</sup> and lead to increased levels of confidence, comfort and chewing efficiency.<sup>3</sup>

### **The Poligrip® range of fixatives include:**

- Poligrip® Flavour Free Fixative Cream
- Poligrip® Ultra Denture Cream

For further information on Poligrip® and dentures, why not complete the Poligrip® distance learner module and earn up to 1.5 hours of CPD. visit [www.gsk-dentalprofessionals.co.uk](http://www.gsk-dentalprofessionals.co.uk) today!

References on request



## *Patient protection*

Toothbrushes are exposed to a multitude of environmental contaminants every day, with an estimated 10 million bacteria alone living in the bristles. The innovative new Steripod toothbrush protector safeguards toothbrushes by simply clipping onto the head of any manual or electric. The encircling 'pod' physically surrounds the head and shields it from both airborne and cross contamination, protecting it from contagion and damage. The pod exudes a laboratory formulated thymol compound (also used in mouthwashes and oral antiseptics) to ward off contaminants for three months.

Family friendly, easy to use and particularly suitable for patients who are health compromised, having orthodontic treatment or about to travel. Low cost RRP for a pack of two is £4.99 for six months of protection. Visit [www.steripod.co.uk](http://www.steripod.co.uk)

**steripod**  
get your pod on

## *Free Corsodyl® verifiable CPD opportunity*

GSK has launched a new distance learner on the topic of gum disease.

The 2009 Adult Dental Health Survey found that only 17% of dentate adults in England, Wales and Northern Ireland had very healthy periodontal tissue and no periodontal disease.<sup>2</sup>

# CORSODYL®

The Corsodyl® distance learner module provides training on periodontal disease, the BPE, and patient management to treat and prevent the condition. It is suitable for the whole dental team to use and is available 24 hours a day. On top of this, there is no time limit to complete this module and completion of the module can contribute up to 1.5 hours towards your verifiable CPD.

**Visit [www.gsk-dentalprofessionals.co.uk](http://www.gsk-dentalprofessionals.co.uk) to complete the module now!**

References on request

## *Free online tooth wear CPD module from Pronamel®*

ESCARCEL, a recent pan-European study, amongst 3,187 subjects aged 18-35, concluded that 1 in 3 young adults suffer from tooth wear.<sup>1</sup> In a survey of 200 dental professionals completed in 2013, 84% said they see signs of erosive tooth wear on a weekly basis and 86% felt the condition is on the rise.<sup>2</sup> This emphasises how common erosive tooth wear is throughout the population.

To help raise awareness of the risk factors for tooth wear associated with eating and drinking acidic foods and drinks found in today's diet, Pronamel® are offering dental professionals access to a specially developed online module. Topics include identifying signs of tooth wear, condition management advice, the use of the Basic Erosive Wear Examination tool (BEWE) and the role of Pronamel® in protection from the effects of acidic diets.

The Pronamel® online CPD module is available in an easy to use format which is free of charge. Available 24 hours a day, you can access this module whenever is convenient. Completion of the module can contribute up to 1.5 hours towards your verifiable CPD.

In addition, it provides information on the Pronamel® range and how it can help protect patients from the effects of erosive tooth wear.

**Visit [www.gsk-dentalprofessionals.co.uk/pronamelcpd1](http://www.gsk-dentalprofessionals.co.uk/pronamelcpd1) to complete the module now!**

References:

1. Bartlett DW et al. *J Dent* 2013; **41**: 1007-1013
2. GSK Data on File, 2013



# Oracle

## Dentistry Show success for GSK

Another Dentistry Show has come to an end and it was an outstanding exhibition for GSK. This year GSK showcased two leading oral care brands, Sensodyne® and Pronamel®, where delegates were able to sample both toothpastes for themselves at the GSK tasting station and participate in interactive lectures, revealing insights from patients suffering from dentine hypersensitivity and erosive tooth wear.

The on-stand lecture revealed that as many as 70% of sufferers consider that the sensations associated with dentine hypersensitivity took the pleasure out of eating and drinking.\* Furthermore, 33% of sufferers believe that dentine hypersensitivity makes them feel old.\*

### Were you unable to attend this year?

Visit [www.gsk-dentalprofessionals.co.uk](http://www.gsk-dentalprofessionals.co.uk) to complete the Sensodyne® and Pronamel® distance learners. Completion of the module will help increase your awareness of dentine hypersensitivity and erosive tooth wear, including how to help patients prevent and manage the conditions. Not only will the distance learners provide you with advice on how to support your patients but it will also enhance product awareness across both oral care brands. What's more each module can contribute up to 1.5 hours towards your CPD.

Support your patients further and order samples for your dental practice from the Sensodyne® and Pronamel® range. Simply visit [www.gsk-dentalprofessionals.co.uk](http://www.gsk-dentalprofessionals.co.uk).

\*Pooled analysis of 7 clinical studies involving 905 participants aged 18-65 (mean 39.7 years) in Canada, Europe and USA before treatment. All participants who gave ratings of 5, 6 or 7 (agree a little, agree, strongly agree) on a 7-point scale were considered to have the impact in question.

## Another successful DTS for GSK

This year GSK exhibited at DTS, showcasing leading denture care brand, Poligrip®. The GSK Consumer Healthcare team were on stand offering out valuable information on how to support your patients in adapting to life with their new dentures as well as providing an insight into the Poligrip® range.

Away from the stand, GSK were pleased to be sponsoring Tim Friel's lecture "Implants are great, but we still need dentures". Tim Friel has a keen clinical interest in all aspects of removable and fixed

prosthodontics and dental care of older people which was evident in his presentation. The lecture attracted many delegates to the theatre who gained knowledge and CPD.

### Were you unable to attend DTS this year?

If you could not make DTS this year there are still other opportunities to help support your patients with dentures and boost your CPD.

Visit [www.gsk-dentalprofessionals.co.uk](http://www.gsk-dentalprofessionals.co.uk) to complete the Poligrip® distance learner module. Completion of the module will enhance your knowledge on how to support your patients with dentures as well as having a better understanding on the Poligrip® range.

To order Poligrip® samples for your practice simply visit [www.gsk-dentalprofessionals.co.uk](http://www.gsk-dentalprofessionals.co.uk).



VISIT  
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ONLINE



Logging on to the members' area, you will see the box below on the screen

Complete the boxes using the following information:

User name: your full name, no abbreviations, no spaces, all in lower case eg. dianamarysmith. Password: your BSDHT membership number.

If you need clarification of the details we have on file – first name, middle name (if provided) and membership number – please contact BSDHT on 01788 575050.

Let us know what you think about the new site by clicking the 'contact us' button in the top right hand corner.

# RECRUITMENT

## BERKSHIRE

**Kingsclere.** Great opportunity for a Hygienist / Therapist to join a BDA accredited practice to work Mondays, Tuesdays and 2 Saturdays per month. Fully computerised. SOE. Competitive hourly rate based on experience. Please send covering letter and CV to [neelbdc@yahoo.co.uk](mailto:neelbdc@yahoo.co.uk)

## EAST SUSSEX

**St Leonards on Sea.** Sessions available for an experienced and enthusiastic hygienist in the Hastings area. Modern contemporary practice using SOE software. Supportive and friendly staff. Please email [brdp-admin@btconnect.com](mailto:brdp-admin@btconnect.com)

## JERSEY

**Jersey.** Dental hygienist required for maternity cover in our fully private practice on the lovely island of Jersey. Temporary full time position required to cover maternity leave from September 2016 with the possibility of a subsequent permanent part time position. Excellent remuneration and benefits package. Minimum 30 minute appointments. Please email Katie Park - [katie@cosmeticdentalgroup.je](mailto:katie@cosmeticdentalgroup.je) with CV and covering letter.

## KENT

**Maidstone.** Part time hygienist required from July 2016. 3 days plus 1 Saturday per month. Pay 35% of gross. Contact Matthew Wall manager@roseacredental.com / 01622 730548.

**Deal.** Come Join us in Kent!! An exciting opportunity has come up for a Part Time Dental Hygienist in our surgery due to the retirement of one of our long standing Hygienists.

Your chance to work within a busy NHS/Private surgery with a long established, helpful, friendly, professional team in a picturesque Kent Coastal town. To apply please contact Lynne Frackleton at [browneandlaurens@btconnect.com](mailto:browneandlaurens@btconnect.com)

## NORFOLK

**North Walsham.** Experienced hygienist required for friendly dental practice in North Walsham, Norfolk. Currently one full day a week with a view to increasing to 2-3 days. Please send CV in first instance to Sheila at [treetopsdental11@gmail.com](mailto:treetopsdental11@gmail.com)

## OXFORD

**Oxford.** Hygienist overload! Enthusiastic hygienist required in long established private Oxford Dental Practice for two days per week. Good communicative skills and team approach essential. Please send CV to [oxforddental@btconnect.com](mailto:oxforddental@btconnect.com)

## SHROPSHIRE

**Nr Kidderminster.** Private Dental Hygienist required for NHS/Private Practice Shropshire/Worcestershire border. Friendly experienced team, BDA Good Practice member, computerised, nurse to assist. To work a day per week 9am-6pm. Fee per item and Plan patients. Please contact by sending your CV to partners. [cleoburydental@telitmail.co.uk](mailto:cleoburydental@telitmail.co.uk)

## SOMERSET

**Burnham-On-Sea.** Parkfield Dental has an exciting opportunity for a Dental Hygienist to join our friendly team in Burnham-On-Sea and Bridgwater to take over an existing list of well-established patients. Both surgeries are modern, computerised and well equipped. Hours are 8.30am- 5.15pm. Thursdays in Burnham-On-Sea and alternate Fridays in Bridgwater. We are looking for applicants with the following attributes:

- GDC Registered with a minimum of 1 year UK work experience as a hygienist.
- Articulate with a warm personality.
- Well presented.
- Excellent oral and written communication skills.
- Organised and able to prioritise and manage their time well.
- Computer savvy and preferably familiar with Software of Excellence.
- Familiar with infection control protocol.
- Able to treat Periodontal disease alongside our dentists daily tasks including oral hygiene education.
- Recommending hygiene recalls to fit patient needs.
- Scaling, root planing, polish and fluoride treatment if needed.

If you are interested, please forward your CV for consideration to: [natashaw@parkfielddental.co.uk](mailto:natashaw@parkfielddental.co.uk)

## SURREY

**Richmond.** Upmarket fully private dental practice has a vacancy for a dental hygienist. Please send your CV to [michael@roseneath.co.uk](mailto:michael@roseneath.co.uk) or call 0208 940 9955

## WEST SUSSEX

**Haywards Heath.** Hygienist required for friendly, four dentist, mixed practice. Dedicated, computerised hygienist surgery, established book, off-street parking. Please email CV and any questions to [newlandsdental@gmail.com](mailto:newlandsdental@gmail.com)

**Littlehampton.** Part time hygienist needed for family owned practice. Established Denplan. Private & NHS patient list. Immediate start. Attractive rates of pay available. CV to [lhamptondental@gmail.com](mailto:lhamptondental@gmail.com)/Call 07515118432.

# BSDHT Admin

## ADMINISTRATION

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# PLAQUE CONTROL: 'GOOD' CAN BE BETTER



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A combined analysis of 29 clinical studies on essential oils has been published in the *Journal of the American Dental Association*.

This showed that after 6 months of using **LISTERINE®**, after brushing and inter-dental cleaning, **37%** of patients had at least half their mouth free from plaque, compared with only **5.5%** of those who just brushed and used inter-dental cleaning.<sup>1</sup>

**LISTERINE®** contains a unique anti-plaque agent, 4 powerful essential oils. These penetrate the plaque biofilm to kill **97%** of bacteria left behind after brushing.<sup>2</sup> For some patients 'good' can be better.

To see the full study visit [http://jada.ada.org/article/S0002-8177\(15\)00336-0/abstract](http://jada.ada.org/article/S0002-8177(15)00336-0/abstract)

Johnson & Johnson  
FAMILY OF CONSUMER COMPANIES

[www.listerineprofessional.co.uk](http://www.listerineprofessional.co.uk)

#### References

1. Araujo MW, et al. *J Am Dent Assoc* 2015;146:610-622.
2. Johnson & Johnson. Data on file.

Date of preparation: April 2016 Job code: UK/LI/16-6530

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