DENTAL HEALTH

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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.

BRITISH SOCIETY OF DENTAL HYGIENE AND THERAPY
Promoting health, preventing disease, providing skills

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GUEST EDITORIAL

Transforming Higher Education
The Rise of AI in Academia

Cassandra Lewis

Clinical Senior Lecturer in Paediatric Dentistry
Centre for Dental Public Health and Primary Care
Queen Mary University of London, Institute of Dentistry.
Member BSDHT Editorial Board

Novel digital systems and intelligent technologies have offered immense challenges and benefits to higher education in recent years; from the rapid transition to online education over COVID-19, to the 'AI Boom' and use of large language models like ChatGPT, Google Gemini and Microsoft Copilot. These bring far-reaching ethical and legal matters to the fore, not least relating to data security, privacy, plagiarism, intellectual theft, medical misinformation, transparency, accessibility and inequity.

Within the United Kingdom, a pro-innovation approach is advocated by key authorities such as the Department for Education[1], Joint Information Systems Committee (JISC)[2], The Quality Assurance Agency (QAA)[3], and The Russell Group of Universities[4]. All of whom call upon higher education institutions to work with and integrate AI; to provide training to students and staff in AI literacy and academic integrity/misconduct, and rapidly review current assessment processes to ensure they are fit for purpose. Interestingly however, generative AI (GenAI) as applied to higher education lacks a universally-accepted definition. In keeping with a pro-innovation approach, below is a third iteration output from Google Gemini:

"In higher education, generative AI leverages intelligent technologies like machine learning, natural language processing, and data analysis to personalize learning, augment teaching, and enhance student success. This encompasses tailored experiences, adaptive assessments, automated support, and streamlined administration, ultimately aiming to improve educational outcomes within universities and colleges" (Google Gemini, 2024)

Over the last year, education conferences and journals abound with academic papers, policies and case studies in response to the emergence of GenAI, with divergent viewpoints and perspectives on the effect this will have on higher education. A recent systematic review by Bearman et al[5] highlighted the contrasting discourses of AI as a constructive, generative "utopian" asset which personalises learning and revolutionises education; versus an existential or "dystopian" threat on technological, intellectual and social fronts. Potential cognitive and/or psychological effects for both students and staff are raised, with terms such as 'technostress'[6] and 'productivity panic' referred to when confronted with the impossible challenge of keeping abreast of an ever-expanding universe of AI Apps and tools. Recommendations suggest educators remain cognisant of our relationship with these new technologies, and address the potential impact on student motivation, energy and potentially even their identities[7]. Indeed, Kramm and McKenna[8] address the question of what is "higher education really for?", specifically encouraging educators to instil feelings of belonging and trust which embolden and nurture transformative relationships with knowledge. Unsurprisingly, student responses to GenAI in higher education are similarly varied, but there is universal feeling that it is inappropriate to ban GenAI use.[9]

Regardless of one's personal viewpoints, GenAI is clearly here to stay and an immediate, ethical, strategic, sustainable and effective institutional plan is needed, with the student voice at its heart. There is an overwhelming call from students and staff for guidance and direction from their institutions, to facilitate accountable and responsible GenAI usage.[10] Co-creation with our students is essential to any educational GenAI approach, not only because these budding soon-to-be colleagues will be graduating into a new AI-enhanced world, but critically because many are often more versed with GenAI use than their educators.[11]

The impact of GenAI will be felt across teaching, learning and assessment, and is already one of the largest disruptors to higher education. Higher education institutions need to be resilient and innovative when adopting institutional policies and codes of practice which emphasise the need to balance these technologies with human guidance.[12] A refocus on the intrinsic value of education, on the learning process rather than the outcome, is critical to develop in our students an awareness, curiosity and criticality towards knowledge which future-proofs them to this ever-changing world.

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DÜRR DENTAL

THE BEST, BY DESIGN

FROM THE PRESIDENT

BY **MIRANDA STEEPLES**

May is here and the buds on the blossom trees are bursting into bloom, a certain sign of spring. Conference season is also underway and the BSDHT is engaging with members and colleagues within dentistry at these events. Following successful sessions at the BDIA Dental Showcase in London, I was invited to present at the British Association for the Study of Community Dentistry annual conference in April, where I detailed how skill-mix and team working can help improve population health. I am delighted that our members are invited to speak at different conferences on topics that are close to their hearts, and Ben Marriott, Gulab Singh and Diane Rochford will all present at the forthcoming Dentistry Show, Birmingham.

Stakeholder news

We continue to nurture our relationships with other stakeholder groups, and enjoyed a productive meeting with Lord Toby Harris, GDC Chair, where we discussed topics such as proposed Provisional Registration, and the data collection that they will undertake when we make our annual declarations and renew the Annual Retention Fee. BSDHT encourages members to engage with this when the time comes. We also met with the team at the GDC who are developing the new Scope of Practice guidance document and helped to steer this in the right direction. Following the GDC Council team's approval, we hope this will be published later this year.

Alongside other stakeholders, we were invited to the Department for Health and Social Care for a round table with the Minister Andrea Leadsom, where we talked about the Dental Recovery Plan. The most important development to come out of this plan is that the government has agreed with the outcome of the consultations for the Exemptions Legislation, which had 97% support! This project has been 10 years in the making and it is wonderful to see this through and to have the authority to work with full autonomy. We thank Michaela ONeill and Fiona Sandom for their work on this project. Michaela has represented BSDHT members' interests from the start, and says: *"We are delighted to have finally achieved this and are now working on implementing the education as efficiently as possible in order to prevent further delays in progress".*

Community projects

Every year the Women's Institute chooses a project to support. This year they have voted for *'Dental Health Matters'* and indicated that they would like to work with organisations within dentistry to guide any work they do. The WI is a powerful organisation with many members and the Executive has agreed that we would reach out to our local groups to see if we can engage with them. I urge you all to do the same. Local groups can usually be found via Google, and Emma Bingham formulated a fabulous letter template that you might use if you are stuck for words, so do get in touch and request that if you wish.

BSDHT continues the work to reach out to patients, and to those who are not yet patients. We are collecting member stories to support *'75 hours for 75 years'* and it is heartening to see what our members are doing in their communities. The *'First Smiles'* initiative is back this year during National Smile Month, and I'd love it if we could make it to visit 75 schools this year to help mark our 75th anniversary.

Conference tickets will be on sale from 13th May so do take advantage of the Early Bird ticket price. Rhiannon and the team have worked hard to curate an excellent programme packed with a variety of topics and speakers to fulfil all of your CPD needs. The countdown is on, just 6 months to go. We hope to see you all there!

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DR LEATHERMAN AWARD WINNER 2023

Elaine Tilling is the current recipient of the Dr Gerald Leatherman Award. A worthy winner, Elaine epitomises the spirit of this prestigious award, which she received at the OHC in Bournemouth.

Consistent support to BSDHT

Elaine has been an active member of the Society since graduation and has held many roles over her 40 years, including: Chair of the Thames Valley Regional Group; Elected Council Member to the BSDHT Executive Team; and has served over 20-years on the Publications team. Over this time the publication portfolio has grown to include the *Annual Clinical Journal*, alongside the bi-monthly *Dental Health* journal.

When on Executive, she was co-opted onto a guideline development group for NICE in 2002-2004: 'Dental recall: recall interval between routine dental examinations'. National guidance subsequently changed from the traditional six-monthly recall interval approach, to a more risk-based approach.

Elaine was part of the core group of dental hygienists and dental therapists who championed the BSDHT proposal for Direct Access, as she fundamentally believed this could change and widen public access to oral healthcare in general dental practice. She has the ability to take what others are trying to say and enhance their written words to make the piece more polished and professional, whilst not losing the essence of the original meaning and intention.

Elaine has been a sought-after speaker for her highly entertaining and informative presentations, particularly for the annual OHC but also local BSDHT regional group study days. She gives her time freely to speak on core CPD subjects.

Consistent support to the profession

There is so much that could be written about Elaine. Confined by space, here is a short summary:

Qualifying in 1982 in the Royal Air Force (RAF) Elaine was responsible for training dental hygienists for the three-armed services. Since leaving the RAF in 2002, she has worked for TePe as Clinical Education and Project Manager; her role has provided her with the opportunity to design and implement a range of verifiable continuing professional development programmes. She was the clinical expert for the professional and consumer markets.

Elaine has written for many dental publications including *Dental Health, Dental Nursing,* the *Daily Mail* and *The Guardian*. In 2020 Elaine was a contributor to *Public Health England Developing Better Oral Health* review for the dental erosion group. She has written book chapters in 'Practical Periodontics' and more recently, on 'Smoking and Vaping' for the book 'Care of Head and Neck Cancer Patients for Dental Hygienists and Dental Therapists'.

Altruistic traits in achieving goals

Elaine has a talent for empowerment and inspiring professionals (often women) to reach their potential. She is inspirational and is a trusted advisor who gives her time freely with no interest in being recognised for her contributions.

The '500Miles4Smiles' (latterly Moveit4Smiles) walks raise funds and promote awareness of mouth cancer. Her nature and military background has led to a significant role in the logistics and ensuring that the walk was effectively promoted was paramount to its success. Elaine galvanised members of the professions, by promoting the walk with banners and flyers at national and regional study days, signing up individuals and groups to walk on specific days, in addition to sourcing opportunities that individuals could access mouth cancer screening training for their own continuing professional development.

With a strong sense of community, Elaine is a Guide Leader; she is a role model and an inspiration for these young women in reaching their potential, and her military background will ensure they all become valuable members of society in whatever they do. She also regularly batch cooks Sunday lunches for older folk who enjoy a roast dinner. She is a selfless individual who does not seek attention and prefers to quietly make the world a better place.

Working tirelessly behind the scenes to help others succeed, Elaine is altruistic, approachable, dedicated, knowledgeable and a highly professional individual who is a true ambassador for the dental profession, and a credit to her Society.

Throughout her career Elaine has clearly demonstrated all of the attributes for which Gerald Leatherman stood.

BSDHT STRATEGY SURVEY

YOU SPOKE, WE RESPONDED

BY SARAH MURRAY, MIRANDA STEEPLES

In December 2023, a short anonymous questionnaire was sent to members to hear their views on the direction of the BSDHT Strategy; there was no distinction between members who are dental hygienists, dental therapists or students, as this was irrelevant to the planned outcome.

Key statements were selected that reflected the existing Strategy, and additional statements were developed that also considered the current landscape of dentistry. Members were asked to select six statements from a list of 14 and rank them in order of priority. The statements were listed in alphabetical order to reduce bias. There was also an opportunity for free text comments.

Responses

Eighty-nine BSDHT members completed the survey (via Survey Monkey), representing approximately 3% of the current membership. Although the top 6 priorities were

asked for, numbers 6 and 7 in the list (below) were ranked equally.

Respondent members top 7 priorities:

1. Enhance the professionalisation of dental hygienists and dental therapists, within the profession but also more broadly to the wider public (in the top 3 for 58 respondents).
2. Continue to actively promote and support regional group study days through provision of eCPD (in the top 3 for 43 respondents).
3. Continue to increase BSDHT visibility within dentistry (in the top 3 for 42 respondents).
4. Raise awareness of working conditions of dental hygienists and dental therapists (in the top 3 for 35 respondents).
5. Enhance BSDHT involvement in additional skills, that include facial aesthetics (in the top 3 for 12 respondents).
6. Develop a patient/public facing webpage (in the top 3 for 10 respondents).
7. Develop a communications panel for writing for dental journals etc. (in the top 3 for 7 respondents).

At the lower end the statements were (in order):

8. Increase membership numbers to assist with greater membership benefits.
9. Provide or support training around the use of exemptions.
10. Explore research grants for members.
11. Develop a patient and public involvement (PPI) group to inform the Society and our research agenda.
12. Raising greater awareness of careers in dental hygiene and dental therapy.
13. Support members with research opportunities.
14. To be part of the conversation regarding developing dental hygiene apprenticeships.

There were 16 free text comments that were submitted: these were categorised into the following domains; professionalisation; CPD; BSDHT visibility; working conditions; additional skills; and becoming a Trade Union.

Next Steps

The findings and free text comments which provide rich data will now be considered by the Executive team and Council.

It is proposed that that this survey is repeated on a yearly basis so all members have the opportunity to share their views.

Further to Sarah's analysis, qualitative submissions were considered and Miranda shares some comments and her responses below:

- *"Remind ourselves the key role of DH and DTh within prevention and non-communicable diseases. This needs consistency with a national approach and accuracy in all oral health promotion services."*

  This is a public oral health messaging issue, which we will aim to address with the patient facing page.

- *"Continued collaboration with the wider dental world."*

  We already do this and will continue to do so.

- *"We need to increase membership"* and *"I think it is good to support membership growth in any way for the Society, because without members the Society will not be in a position to do the important and necessary work it does to raise the profile of the profession, and to work towards a better future for the profession and ultimately patients."*

  I absolutely agree, this is to ensure longevity of the Society. Membership is a source of funding

for the Society and is how we ensure succession for leadership roles, and continuity for BSDHT. It is also important for our colleagues in industry to see we are visible, so they continue to work with us and expand their reach, while supporting us. Increased membership also helps to give us credibility and to be able to say with confidence that we are representative of the professions.

- *"Visibility to the public."*

  This will help members as individuals perhaps more than the Society, because it will normalise us in common language, and increase public awareness of us in the same way as dentists. It is also a consideration for future work forces, if children don't know we exist then how can they dream of joining our professions? Reaching out to the younger generations and ensuring they know there are more opportunities within dentistry than only being a dentist, will be a way of growing and future-proofing the Society. This point was the main reason I agreed to engage with the reporters for the Sunday newspaper article, to try and reach the wider general public audience.

- *"Research has been shown to be of advantage for the Society and should be encouraged."*

  We are exploring how we could facilitate a research support grant to be available for members to apply for if they wish to pursue a piece of research, or to present some work they have completed.

- *"Pursue as many exemptions as possible, get exemptions for facial aesthetics."*

  Having the Exemptions Legislation passed by government is not the same as becoming Prescribers. While this has been given parliamentary approval, there is still work to do. Training in how to use the mechanism will be required for those who choose to work in this way in order to support the government's aspiration for dental hygienists and therapists to undertake more NHS dental work. The current list for exemptions cannot be amended in any way, it is a fixed piece of legislation for a specific list of medicines to facilitate patient dental care. Additionally, it will not work in the case of facial aesthetics, it is a totally separate mechanism.

- *"I believe it is worth changing the status of BSDHT to become a union; with regard to bullying in the workplace and withholding payments. If the BSDHT was a union, it would carry more influence, such as the nurse's unions, and doctor's unions."*

  We explored this, and sought legal advice about this idea in 2023. The advice given was to not do this because it would lead to an increase in costs to the BSDHT, and an increased administrative load, with little benefit in return. A big barrier, and difference between us and medical doctors and nurses, is that we don't have one single employer,

therefore, we cannot unionise. What we can do is continue our work with other organisations, especially dentist organisations, and continue to share with them best practice and how to treat their teams fairly. Even if we were a union, we could not change how someone is treated in the workplace with regards to bullying or withholding of payments. BSDHT cannot dictate to a business owner how much they should pay their team members, even a union would be unable to do that. There is a guidance document on how to negotiate terms and conditions and one can refer to the survey undertaken for typical rates of pay in your area. We already support members by giving advice, and can direct members to the legal helpline if this is needed.

- *"Continue to promote the scope of a dental therapist", "Continue raising professional and public awareness of our highly trained skills", "Improve both the standing of, and the understanding of, the role of the profession which will be crucial to our ability to influence policy in oral health - we need to keep the bigger picture at front of mind."*

  We will. This also motivated the newspaper article. This is what underpins most of the presentations I have delivered this last year. This is part of the 75 hours for 75 years initiative, to get us out into our communities and engaging with those who are not yet our patients. To help normalise 'going to see the dental therapist' in conversation, just as much as 'going to see the dentist'.

- *"Increase discounts with affiliates with other dental courses."*

  We do have some affiliate offers on our website. We also run our own courses and can develop courses on other topics if you would like to send in your suggestions for what you would like to see from us.

- *"Number one wish is for all dental hygienists to have chairside nursing support."*

  BSDHT continues to make the case that it is best practice, that it is the gold-standard approach, and is the right thing to do. We continue to work with other organisations to reinforce this approach. However, we are mindful that we also have members that do not wish to work with chairside support, and who fear losing income if it were to be mandated. This must also be taken into consideration. BSDHT has an article pending publication which will help to strengthen this stance.

- *"Number two wish is for cheaper hygienist conferences for all BSDHT members, not just the students and newly qualified."*

  We keep costs as low as possible, and obtain as much financial support from trade as we can, but a typical conference centre that we tend to use may cost £85,000 before you've even gone through the door. There are regional group study days and other opportunities for CPD that are offered, and some of those are free for members to access.

- *"Number three wish is we need add on courses for dental therapist qualification and sponsorship."*

  There are dental therapy courses available. Unfortunately, there are no sponsorship opportunities for this. This is not the remit of the Society, and is for the universities and the bodies that fund the courses to make decisions upon.

- *"We need more contact and updates via the Regional Group Facebook page and promoting study days. It is hard to find information about study days. We need good speakers about interesting topics and trade to be there as well."*

  Study days are currently promoted via direct email to the membership, they are listed in BSDHT Bites each month, they are published in Dental Health, and they are promoted on our social media channels. I would be grateful to receive further ideas about how we can make information easier to find. The Regional Groups always request ideas for speakers, so if there is someone you would like to see then do let us know. The same goes for trade, they will happily attend the study days, they love to meet our members, but the membership need to support the study days as well.

- *"Start a development programme to progress to GDP."*

  One can go to university to study to be a dentist, and some universities offer courses where, if you have graduated in recent years, you do not have to do the full five years. This idea is outside the remit of the Society and so is not something that will be explored further.

- *"More public awareness is fundamental to raise the profile of the profession and drive demand for direct access, exemptions and more emphasis on prevention of oral diseases. Our over-arching goal or mission should be to represent the entire profession, not just members, with a shared vision to improve the oral health of the nation and strive to improve access to preventive oral care to underserved communities. The Society should consider investing in more outreach programmes that get dental hygienists and therapists out into the community to deliver oral health messages and fundamental oral health training."*

  Public awareness is definitely on the agenda, as noted above, and the way I work when presenting or writing is to always consider the whole profession. If we invest in an outreach programme, we will have to ensure it can be sustained. BSDHT facilitates the schools programme Frist Smiles every year and this year have launched 75 Hours for 75 Years as another vehicle through which this kind of work could be explored.

- *"A strategy to implement direct immediate communication between the medical profession and dentistry in general would be a massive plus."*

  We do try to engage with other professions so they are aware of our professions and what we can do, and we will continue to do so.

I hope that this goes some way to explaining what we are trying to do for the Society, in a 'you said, we answered' kind of way. Thank you to all those who submitted responses, we will continue to do our best to represent our professions within and outside of dentistry, especially to patients we know, and even more so to those who don't yet know us.

Development and analysis:
Sarah Murray MBE, past Honorary Secretary BSDHT

Further explanation:
Miranda Steeples President BSDHT

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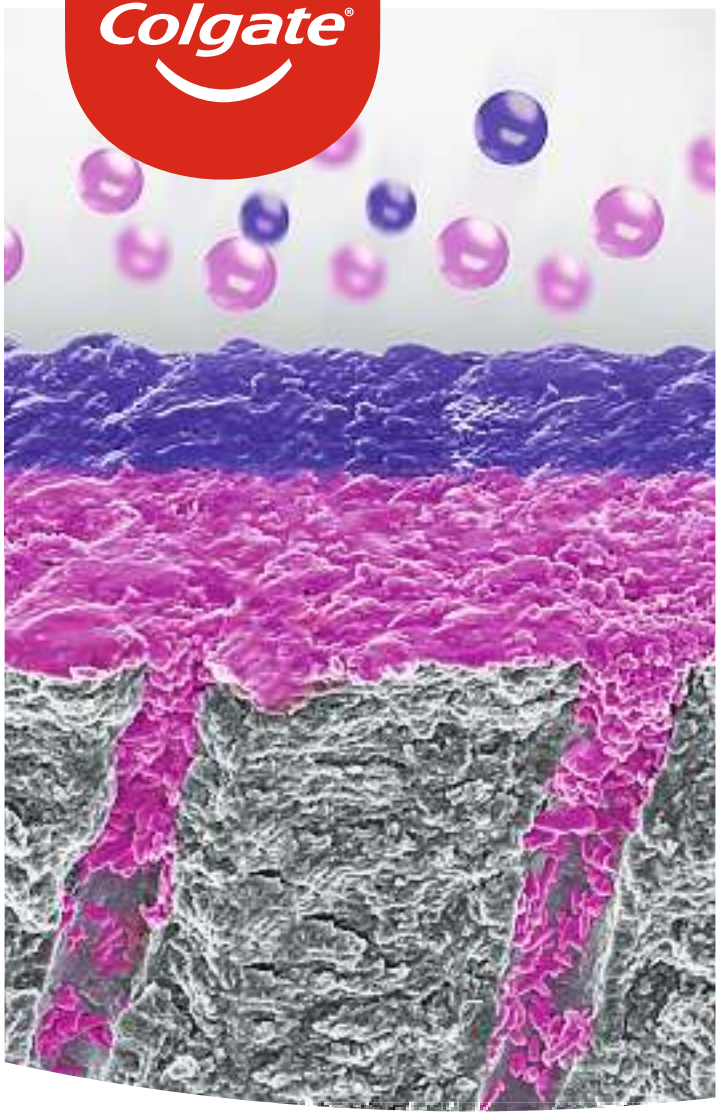
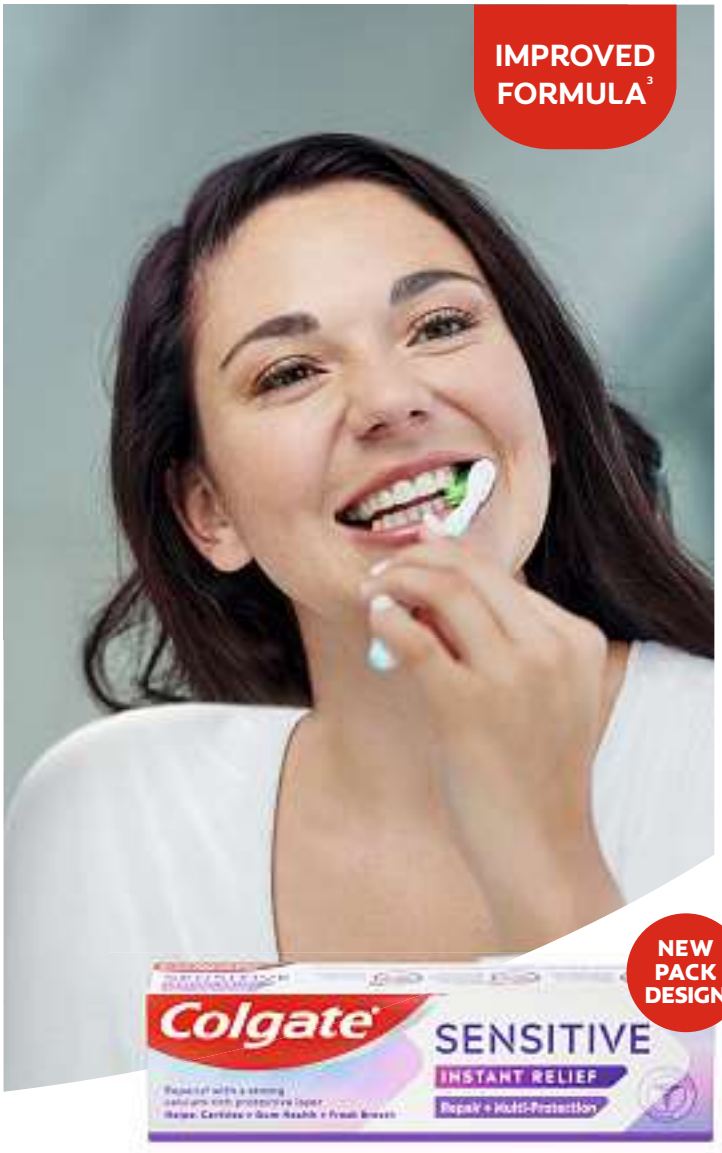


Creative representation of the mode of action



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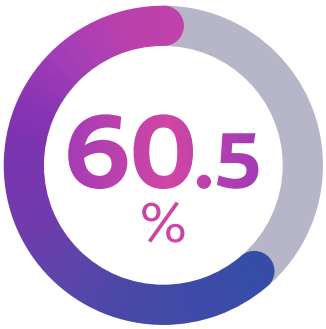
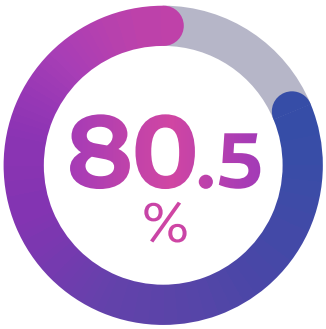
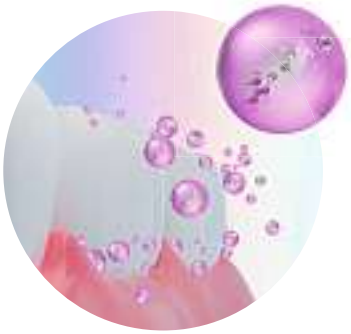


Reduction in sensitivity pain from the first use[1]



Long-lasting reduction in sensitivity pain[2]



And **superior dental tubule occlusion**[4] with PRO-ARGIN + Zinc Phosphate

References: **1.** Vs baseline, Nathoo et al. J Clin Dent. 2009;20 (Spec Iss):123 -130 (when toothpaste is applied directly with a finger tip to each sensitive tooth for one minute.) **2.** With continued use, Docimo et al. J Clin Dent. 2009;20 (Spec Iss):17- 22. **3.** Vs previous formula, in vitro acid resistance after 5 brushings, report by Hines 2021, Data on File, Colgate-Palmolive Technology Center (2021). **4.** Pro-Argin technology vs Stannous fluoride / sodium fluoride technology. Liu et al. J Dent Res. 2022;101(Spec Iss B):80.

Scan the QR code to learn more or visit www.colgateprofessional.co.uk/products/sensitive-instant-relief

PROFESSIONAL
ORAL HEALTH

PHOTO BY **JIM DIVINE** ON **UNSPLASH**

BY **MIRANDA STEEPLES**

BSDHT HOSTS THE EDHF AGM

It is 75 years since the inception of BDHA, now BSDHT, and, second only to the USA, we are the oldest organisation for dental hygienists in the world. BSDHT is an organisational member of the European Dental Hygienists Federation (EDHF), a group of European dental hygienist country organisations.

Dental hygienists can be found in 34 different countries and the EDHF represents 24 member countries. Four dental hygienists sit on the Board: Gitana Rederiene (Lithuania); Ellen van Bol (The Netherlands); Veronica Montebello (Malta); and Anne-Claire van der Lans (Austria). Every member country sends two delegates to the AGM each year and in 2023 this was held in Malaga hosted by the Spanish organisation, HIDES.

As 2024 is our 75th anniversary, the UK submitted a bid to host the AGM, which President, Miranda Steeples, presented to the assembled delegates. We had decided that we would bid to host the AGM in Edinburgh, Scotland, because we represent members in all four nations, and wanted to give EDHF delegates an opportunity to see another part of the UK that they may not have visited before. Our competition was Belgium, who celebrate their fifth anniversary in 2024. We are delighted to report that the UK won by 13 votes to 8.

The BSDHT formed an organising committee with the EDHF and this comprises Miranda Steeples, Rhiannon Jones, and Immediate Past President, Diane Rochford, with the EDHF Board members. We meet online once a month to discuss progress.

The AGM will be held at the Village hotel, Edinburgh 20-21 September 2024. It is anticipated that member delegates will arrive on Thursday evening prior to the AGM on Friday. Day two will involve further discussions, reports from the Board and the various working groups within the EDHF. Member countries also submit reports. The intention is to finish this meeting at lunchtime on Saturday and then we will take the delegates on a tour of Edinburgh, either a walking tour or a bus tour, but this will be weather dependent! The social aspect will take place on Saturday, for which the EDHF have put aside funds to cover the costs. This will mark the end of the annual meeting. During this meeting member countries will be invited to submit a bid to host the AGM for 2025.

Being a member of EDHF is about being part of something bigger. Initially, I struggled to understand why we are a member of these organisations, and then I realised what a privilege it is. As one of the oldest member organisations, we are in a position to offer organisational mentorship. For example, the Belgian organisation was created with help from both the International Federation of Dental Hygiene, and the EDHF, and when you talk to delegates from other member organisations, it quickly becomes clear that dental hygienists all over the world face the same problems that we do.

We are all on the same path for professional fulfilment and development, just some of us are further along the path than others. Having the privilege to represent not only the BSDHT, but UK dental hygienists as well, at these larger events, are experiences that I will treasure forever as the President of BSDHT. Thank you for allowing me to do this, and bringing the EDHF to our United Kingdom.

BSDHT FIRST SMILES CAMPAIGN IS BACK FOR 2024!

In our 75th year, we would love First Smiles to be bigger and better than ever, and reach 75 schools to match our 75 years!

The campaign aims to:

- Build essential relationships between nurseries, schools and their local dental practices
- Educate children and those who care for them about the fundamental aspects of good oral health
- Improve the oral hygiene habits of children across the UK
- Make children feel more comfortable about visiting a dental practice
- Integrate oral hygiene within health education in schools
- Tackle the worrying rise in tooth decay and extractions among children in the UK

Would you be willing to volunteer some time to arrange a First Smiles visit to your local primary school / nursery / community group? If so, why not contact your local schools or nurseries to see if they would be interested in you visiting the children to educate them on the importance of good oral hygiene.

There's more information on our website. If you are interested in getting involved, complete the participation form in the link below, and we'll be in touch with more information in due course.

Ideally, we would like visits to fall on/around Fri 14th June 2024, but there is some flexibility if necessary (although unfortunately we cannot guarantee supply of resources should visits be arranged more than 2 weeks before or 2 weeks after the 14th June).

We have a limited stock of resources which will be allocated on a first-come first-served basis.

Deadline for submission of participation form is Friday, 31st May 2024 @ 5pm.

GET INVOLVED HERE:

https://www.surveymonkey.com/r/FirstSmiles2024

NEW FELLOWSHIP OPPORTUNITIES FOR DENTAL THERAPISTS AND DENTAL HYGIENISTS IN THE MIDLANDS

Applications for the September 2024 cohort of Leadership Fellows opened in April 2024. This year there will be three leadership positions for Dental Care Professionals (DCPs). NHS England Workforce, Training & Education (WT&E) hope that these will be filled by professionals from across the registrant groups.

Increasing talk about skill mix and need for registrants to work to their full scope of practice means we need more opportunities for dental therapists and dental hygienists to undertake leadership training. Thereby, enabling them to take the lead in empowering others within dentistry and raising the profile of the profession.

This 12-month fellowship is open to any dental therapists and dental hygienists working within, or supporting NHS dentistry, in the Midlands. It will give the successful applicant the opportunity to spend two days a week working on developing their leadership skills and undertaking projects working with Local Dental Network Chairs, Associate Dean for Dental Workforce Development, ICBs, Consultants in Dental Public Health and the healthcare workforce beyond dentistry.

Our current DCP fellow, Sophie Fletcher (dental nurse), has recently had the opportunity to present at a national conference, BDIA, on the projects she has worked on and how she has developed during the fellowship. She has also embarked on a MSc in Healthcare Education through Anglian Ruskin University, despite not having an undergraduate degree she has been supported to collate evidence providing experiential equivalence allowing her onto the masters programme.

The successful postholders will take part in the monthly dental Leadership Development Programme. The posts come with significant NHSE funding (up to £4000) towards registration fees for an academic qualification, short course or other development activity which has been agreed by the Associate Dean for Dental Leadership Fellows.

The posts are suitable for:

- DCPs at various stages of their clinical career
- DCPs looking for non-clinical professional experience
- DCPs looking to enhance their professional portfolio and CVs
- DCPs starting out in their leadership journey.

You will be seconded from your substantive (clinical) employer for two days a week and it is expected you would continue in your current clinical role for the remainder of your working week. For DCPs working on a self-employed basis there will be the option to retain this working arrangement and be employed 0.4WTE on a Thursday and Friday for the Leadership aspect of the role.

If you do not have a substantive (clinical) employer for the clinical component NHSE can look to place you with a host organisation, these are available across the Midlands region.

WT&E are mindful of the impact seconding dental therapists or dental hygienists to this programme will have on the clinical team and can work with employers to ensure that equitable remuneration is in place. This funding can then be used to ensure stability of the clinical team.

To learn more about the upcoming positions and how to apply visit the Midlands website or scan the QR Code

https://eastmidlandsdeanery.nhs.uk/dental/leadership-fellow

Please direct any questions to **england.dentalfellow.midlands@nhs.net**

The deadline to apply is 3 May 2024.

DENTAL CARE MANAGEMENT OF A PATIENT WITH PERIODONTITIS AND AN INCREASED RISK OF INFECTIVE ENDOCARDITIS

BY ALEX IGNACZ

Treating patients with an increased risk of infective endocarditis (IE) can be daunting for students. It is important to carefully consider the patient's medical history and risk factors before proceeding with any invasive dental procedure. In such cases, it is always recommended to consult with a specialist and to follow guidelines and protocols to ensure the safety and well-being of the patient.

Infective endocarditis (IE) is described as inflammation of the endocardium, particularly affecting the heart valves.[1,2] This is caused by bacteria that enter the bloodstream and travel to the heart. Two main types of bacteria responsible for a large percentage of cases of IE are staphylococci and streptococci species, also found in dental plaque.

Although IE is rare, it has a 30% mortality rate and 50% of affected patients require corrective heart surgery. Additional considerations should be taken when providing treatment for these patients based on the increased risk of IE, which involves conversations with both the patient and their specialist cardiac consultant or surgeon.

When treating a patient with an increased risk of IE, it is crucial to find out whether they have had any previous episodes which would move them into the 'special sub-group' category. In this sub-group, the patient is more likely to be considered for non-routine management which may involve antibiotic prophylaxis.[2]

Historically, the recommendations relating to the treatment for prevention of IE in 'at-risk' patients, was more straight forward. Prior to 2008, recommended practice in the United Kingdom was that all 'at risk' patient groups for IE were given antibiotic prophylaxis before any invasive dental procedures.[2] In 2008 the National Institute for Health and Care Excellence (NICE) issued clinical guidance (Clinical Guideline 64) regarding antibiotic prophylaxis for IE: *"antibiotic prophylaxis against infective endocarditis is not recommended for people undergoing dental procedures".* Following on from this, the guidance was amended again in 2016: *"antibiotic prophylaxis against infective endocarditis is not recommended* ***routinely*** *for people undergoing invasive dental procedures."*[2,3]

Various factors were considered regarding amendments of the guidelines. The use of antibiotics had been questioned due to lack of evidence that their prophylactic use is effective in preventing IE following invasive procedures. As well as this, the risk of adverse reactions to antibiotics were thought to outweigh the benefits.[2,4] Furthermore, various arguments regarding over-prescription of antibiotics and the rise in antibiotic resistance were of increasing concern.[4]

An in-depth review was carried out in 2015 by NICE in response to much of the dental profession expressing concern that no consideration has been given to the views of the patient regarding their own personal risk of IE, and that it would be inappropriate to withhold the use of antibiotics in those who were at increased risk.[5] This was particularly important regarding the issue of informed consent that had been highlighted in Scotland in the legal case of 'Montgomery V Lanarkshire Health Board'.[6]

Currently, it is now the responsibility of the clinician to inform the patient of the risks and how they can be reduced, in order to allow them to consider what the best treatment is.

The clinician should make use of the available guidance, preferences of the patient and their own clinical judgement as well as a discussion with the patient's cardiac consultant, to consider the most appropriate treatment plan.[2]

Treatment planning

Patients with an increased risk of IE, will require modifications to the way in which their treatment should be carried out. A detailed history must be undertaken to ensure all aspects are considered.

In line with the British Society of Periodontology guidelines on periodontal diseases, the treatment plan for all patients with a diagnosis of periodontitis should begin with patient engagement. To achieve this, the following needs to be carried out: explanation of the disease; risks and benefits of treatment (including no treatment); the importance of good oral hygiene; encouragement of behaviour and/or lifestyle changes; and tailored oral hygiene to the individual patient. These essential pre-treatment steps are necessary for optimal outcomes and to ensure progression to the next step of treatment which includes sub-gingival professional mechanical plaque removal (PMPR).[7]

The first step when treating a patient with increased risk of IE, is to establish awareness with an explanation of the condition's risks of development. In addition, the patient should be made aware of symptoms, so that they are able to recognise it, should it occur. The patient should be informed to contact their doctor immediately if they become aware of any symptoms.[2]

The importance of maintaining good oral hygiene should be discussed with every patient, however, in a patient with increased risk of IE this requires further reinforcement.[2] As part of the discussion with the patient, it should be explained that the cardiovascular system in health is sterile, however that some bacteria may enter the bloodstream during everyday activities such as flossing, toothbrushing and chewing, particularly if the patient has periodontitis.[2,8] It should also be highlighted that invasive dental procedures such as those involved in sub-gingival PMPR can also cause this.[2] It should be explained that although the bacteria usually have a transient existence (known as transient bacteraemia), it can sometimes lead to IE.[8] Crucially, the patient needs to know that by maintaining good oral hygiene and reducing the level of bacteria present in their mouth, the chances of infection are also reduced.[9]

It is appropriate to mention the effects stress can have on maintaining good periodontal health. In addition, although evidence for alcohol abuse is not certain, this should also be identified as an important factor and included in the periodontal health advice.[10] Moreover, the patient's cardiac specialist should be contacted to advise on antibiotic prophylaxis for treatment in the dental practice. If they recommend antibiotic prophylaxis is required for you to carry out your treatment plan, then a conversation can begin with the patient to discuss the risks and benefits involved in this and whether they wish to proceed with the proposed treatment. An information leaflet may also be given that covers the main points discussed, to aid the patient's understanding.

If antibiotic prophylaxis is not recommended, routine management should be followed. All conversations regarding the provision of information to the patient (during appointments) for antibiotic prophylaxis as well as discussions with the specialist cardiologist should be recorded and documented in their notes.[2] **https://www.sdcep.org.uk/media/joskqfcw/sdcep-antibiotic-prophylaxis-patient-information.pdf**

Summary

IE is a rare but potentially fatal disease. It is important that clinicians treating patients who are at increased risk, follow the most up to date clinical guidance available and provide the appropriate information so that the patient can make an informed decision about their health. Careful considerations should be made to assess the best course of treatment with clinicians using their own judgement and advice of the patient's cardiologist, whilst always considering the best interests of the patient. With the rise of antibiotic resistance and lack of strong evidence to support the effective use of antibiotic prophylaxis, further studies would be beneficial to provide more clarity where possible.

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DENTISTRY AND THE PLANET: A STUDENT'S PERSPECTIVE

BY MIA HARRISON

Sustainability and climate change have been part of the public discourse for many years. Despite this, many of us wonder what we can do to make a real and lasting difference. How do we make the changes that will positively impact our world?

Now, more than ever, it is so important for the next generation in dentistry to stand together and make dental clinics 'greener' with small changes that make big impacts.

Dental guidelines and sustainability

The importance of improving dental clinics to make them more sustainable is vital to counter the devastating carbon footprints in the healthcare world. The NHS identified the need to 'lead by example in sustainable development', highlighting in its long-term plan that only 23% of waste was recycled during 2016/17, a figure that needs major improvement.[1]

Although the plan considers the whole of the NHS healthcare, the Royal College of Surgeons further back up the need in dentistry with new clinical guidelines set out for dental care professionals.[2] The main aspects of these guidelines include waste management and the selection of greener products in clinics. Education also has a major role to play in sustainability. Training new dental care professionals to practise dentistry both safely, always with a greener mindset, could really help create a sustainable dental profession.

Ways to make a change

Small changes in clinical waste and non-clinical waste segregation, as well as recycling paper and cardboard, can significantly reduce the dental carbon footprint. A thorough and easy to follow recycling system for all the dental team can easily be implemented and make a great difference.

Where possible, reducing the number of single-use plastics is a greener change that is vital in all aspects of healthcare - especially dentistry. It has been found that a mean mass of 354g of plastic waste was produced per dental procedure, an amount that involves not only the instruments and materials used, but also personal protective equipment.[3]

The scale of which single-use plastics are used in dentistry is enormous but a reduction in this is possible. It is suggested that using recyclable or biodegradable materials for plastic cups and tray liners could be beneficial, as well as investing in autoclavable plastics or metals that can be reused once sufficiently disinfected.[4]

Similarly, offering environmentally friendly products as an alternative would benefit the planet greatly: limiting the number of plastic toothbrushes, interdental brushes and packaged toothpaste. There is a range of new and upcoming sustainable brands which offer products made of greener materials, such as bamboo, and are fully plastic free. These are worth researching when recommending products to patients.

An update in toothpaste packaging is a step in the right direction with some companies selling toothpaste tablets that have reusable packaging and no plastic. If they include the recommended 1450ppm fluoride, these may be a suitable swap for many patients and clinicians alike.

As a student dental hygienist, I have been testing out some of the products myself before recommending to patients and have thoroughly enjoyed the process. For me, this is the start of a more sustainable pathway in dentistry and I aim to continue in my attempts to reduce my carbon footprint throughout my career.

Keeping in mind the need for change to make dentistry greener, and implementing the new clinical guidelines, is

vital moving forward. In addition, educating and training both students and current dental team members in the best up-to-date sustainable practise from an evidence-based perspective will provide planetary benefit for all.

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REFLECTIONS 30 YEARS ON

BY SABINA CAMBER

Sabina Camber, Southwest Regional Group representative and mental health first aider, reflects on her career and some changes in the profession over three decades.

I started as a dental nurse in 1986 when we did not wear gloves except for extractions; used hot air ovens for instrument sterilisation; and the glass beaker for the patient's mouth rinse was just swished in some pink solution between appointments.

When I became a dental hygienist, from The Eastman Dental Hospital in 1993, dental therapy was only carried out in the dental hospitals or community clinics. Dental hygienists were legally allowed to work in a practice with a dentist on site. We were trained to administer infiltration only anaesthetic and our Scope of Practice did not include: impressions; photography; radiography; temporary dressings for fractured teeth or lost fillings; or recementing crowns - this was all to come later with extended duties training. There was no provision for direct access, owning a practice or being an autonomous clinician!

I have worked full time since qualifying, whilst raising a family and moving from the Southeast to the Southwest of England. I have always attended courses and kept my skills up to date but I have often felt isolated and occasionally bored with general practice.

When Covid caused a halt to the daily working life we knew, webinars became a connection to the dental world. Chatter started on social media, and we supported each other through the uncertain times. I realised this enforced stop allowed me to appreciate what else was out there – I had a chance to look up from the mouths of my patients and see a bigger picture.

Once back to work, I was asked if I would stand for a position on the Southwest regional group committee. Me ? No way! I definitely could not do that, what did I have to offer? However, ignoring my imposter syndrome, I stepped up. Four years later I am still Regional Group Representative for the Southwest Peninsula Group. I have also spent a year on the BSDHT Executive and am in awe at the volume of work and commitment that goes on behind the scenes of BSDHT.

This opportunity has been almost a springboard, as my professional life continues to expand:

I worked with my dental practice to become an early adopter of the Mental Health Wellness in Dentistry Programme. Framework – MHWD (that's a whole article in itself); I have become a mental health first aider – and have taken part in a webinar about mental health in dentistry; I have been part of the SDCEP Guidance development programme - updating guidelines for Prevention and Treatment of Periodontal Diseases in Primary Care: Periodontal care | Scottish Dental Clinical Effectiveness Pr (sdcep.org.uk); the Office of the Chief Dental Officer (England) has a working group called Project Sphere and in April I attended my first meeting, representing BSDHT .

These opportunities have arisen from my active involvement with BSDHT, starting at local level then building connections within the profession and outside. I have learnt so much about the enormous work that goes into driving our profession forward; how the society works, its structure, the working groups within it.

Forums are great for a chat and sharing our positive news, but they cannot offer professional advice only personal anecdotes, often anonymous.

The conclusion to my reflection would be that we all have something to give: we all have ideas, plans, projects. We are stronger together at moving our profession forward. Do not be me, previously intimidated by the success of others to the detriment of your own self-worth. Dip your toes into BSDHT: volunteer at a regional study day; stand for a role on a regional group committee. The opportunities for personal growth are amazing!

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REFLECTIONS 70 YEARS ON

BY **FREDA RIMINI BEM**

In addition to being Services Representative on BDHA Council, for many years Freda Rimini, BEM, Sqn. Ldr. (ret), successfully organised advertising for Dental Health and trade sponsorship for the Association's meetings, building it up from virtually nothing.

Leaving school in 1951, unless going to university, a girl had little chance of an interesting career. However, I saw an advertisement for a dental assistant in the local paper, applied and was accepted. Apart from the children's dreadful extraction sessions under gas on a Saturday morning, I thoroughly enjoyed the work.

The Royal Air Force had trained a few dental hygienists during the war, to alleviate the burden of work experienced by the dentists. I heard that the Eastman Dental Hospital had retrained these WAAF hygienists to permit them to work in clinics, but not private practice. I immediately wrote to the Eastman, only to be told that training had ceased, although it continued in the RAF Dental Branch. Thus began a career in dentistry which proved to be the happiest days of my life.

Joining the RAF in1953, I was accepted as a dental hygienist student and posted to RAF Halton. Here I had to first pass the dental assistant course and then wait for the next dental hygienist training course to commence. During this period, I was employed on secondary duties which seemed to mainly involve the cleaning of toilets and drains - possibly the dental administrator had a sense of humour!

My training course lasted nine months. We began by scraping paint from door handles and carving teeth in wax and then came the phantom head stage where we stood to work. Left-handed students had to work with their right hand! A period of practising on each other followed and then, at last, we treated patients. These were mostly young males and gross calculus was not uncommon. Drury instruments were used, which were very thin, with no decent grip, and turned black when first dropped into the hot water steriliser!

We instructed patients in the use of a toothbrush and taught the Roll Brush method - brushing upwards on the lowers and downwards on the uppers. The emphasis was on cleaning not prevention. Polishing was completed with the Porte Polisher whose tip consisted of a piece of wood cut at an angle and was used from gum to tooth tip. Patients were told to come back in six months-time when we would repeat the treatment.

I qualified the following year, 1954, and my examiner was William Fry, later Sir William Kelsey Fry, who had been instrumental in the introduction of the dental hygienist into wartime RAF. The General Dental Council at this time was not involved in the training or examination of the dental hygienist.

After my initial posting to RAF Boscombe Down, in December 1956 I was sent to Rheindalen, the HQ of RAF Germany. Here I worked part-time in a static mobile unit parked outside the dental centre and part time at Wegburg hospital, where I first encountered black copper cement. Instruments were no better and possibly the removal was more painful for the operator than for the patient!

Back in the UK, in 1960 after an instructor's course (tutoring came later), I was posted to the Dental Training Establishment (DTE), where students now had to sit the General Dental Council examination.

In 1970 the wooden hutted DTE closed and training moved to the newly built Institute of Dental Health and Training.

The 1970s heralded an increasing momentum for change. Boiling water sterilisation had long given way to the autoclave, and dental hygienists worked seated and could undertake scaling with their left hand, if preferred! The RAF Dental Branch began to train male hygienists. Furthermore, training was no longer confined to the military as Manchester Dental School introduced training in 1959, following the closure of the Eastman Dental Clinic. The emphasis was now on prevention and the importance of good oral health and its influence on general and systemic disease was acknowledged.

Today, training is a three-year degree course, carried out only in civilian schools - a far cry from my nine months training seventy years ago. The pioneers who began their training so many years ago, during a war, would be amazed, and I think proud, to see how far we have come.

DENTAL HEALTH ON TOUR

Representatives of the Publications Team, Heather Lewis and Fay Higgin, accompanied by President Miranda Steeples, were pleased to join a UK dental press trip, organised by Barker PR, to visit EMS head office in Nyon, Switzerland.

First impressions

We were all very pleasantly surprised when we arrived at the EMS factory. In contrast to what you might imagine a factory floor to look like is a large laboratory-like room where 10,000 devices are made every year. There are no robots here! Each device is assembled by hand by just 60 people. Each individual is trained in every part of the process and rotates through the different work areas to not only ensure attention to detail but also their investment in the end product. Detailed records are kept of every device, and every component part within it, and EMS is proud to report that they record only a 1% fault rate with their machines.

We also learned that EMS is the only company with a 'Professor of Powders' whose role is to develop and continue to innovate powders. EMS dates back to 1981 when Piezon was brought to the market, Airflow followed in 1982. By 2016, the Guided Biofilm Therapy (GBT) protocol had evolved.

Education is key

Not only for the patient, but for the clinicians who employ it in their daily practice the company's focus is firmly on training and maintaining high levels of skills. Currently, more than 1,000 clinicians in the UK are now trained in how to utilise the protocol, (more than 100,000 globally). Education is ongoing and mandatory retraining takes place every two years. Dental hygienists (and in the UK, dental therapists as well) are the primary focus of the company, and you will not be surprised to hear that one of the Directors is a dental hygienist! His journey was interesting: his belief in the system was such that he had introduced GBT into a corporate group for whom he was working. EMS subsequently recruited him to work for them.

Education and motivation of the patient are essential and disclosing fluid is fundamental in the process

(even clinicians miss three times more supragingival biofilm than with the use of disclosing solution). Patients are fully involved in their care and discussions ensue as to their home care regime and how that can be improved, forever building rapport and engaging them in their own self-care.

At the EMS Swiss Training Academy, we were all given the chance to trial the Airflow Prophylaxis Master. For the two clinicians in the room (Heather and Miranda), this was a surprising learning curve! The technology is certainly impressive and it was clear to see how this would be a very pleasant patient experience.

Ethos

The business is currently 75% dental, with the rest medical. The medical side focusses on pain control (shockwave) treatment and urology (kidney stone treatment).

The business' ethos extends to staff; twice every week each member is offered GBT in the on-site clinic. Shockwave (pain control) treatment is also offered and Celso da Costa, the Director and dental hygienist we met, told us how effective he found this for treating an injury sustained while running. This particular form of treatment is becoming increasingly popular with physiotherapists and, as you would expect from the company, is backed up with plenty of research data.

With the focus on education, it was obvious that research data would be needed to confirm any claims of efficacy. Each clinician delivering GBT gives a patient a survey to fill in, the same survey is used all over the world. To date, data are available from more than 220,000 patient surveys; 76,000 alone were issued in 2022. The findings show that 92% of patients prefer GBT to 'standard treatment' (also confirmed by the University of Zurich).

Hygiene – led practices

Many practice owners, as we know, focus financial resources on the dentist as bringing in the most revenue in the practice. It was encouraging to hear EMS argue that this model is upside-down! They advocate that dental practices should be 'hygiene-led', rather than focusing on lengthy expensive treatments that a patient may or may not take up. GBT can be incorporated into all the S3 treatment and management guidelines. The hygiene-led system also ensures greater patient retention as the patient is reassured that the team is invested in maintaining their oral health. If everything is focused on the patient's health, if they are happy and feel cared for by the dental hygienist or therapist, they may then feel more comfortable and reassured to be guided on to needs/wants-type dentistry. This may seem obvious to our members, as typically you are very patient-centric, but it may well challenge the conventional hierarchy in a dental practice!

While in the UK the airflow system has been largely based in private practices, presumably due to the cost of the equipment, it is not insurmountable for use in the NHS.

Within the overall dental hygiene market of the UK, GBT has about 8% share. There are other competitors in the sector and with conventional oral hygiene treatment actually being the biggest 'competitor', there is certainly room for growth.

Barriers remain, however, for dental hygienists and therapists to establish this treatment modality as part of their repertoire, not least the cost of the equipment for resistant practice owners. However, it is possible to build a business plan to make a case for how this can feed in to the turnover of the practice, whilst enhancing patient retention and their experience. It is worth bearing in mind that some clinicians will never be able to utilise such equipment, and thus marketing, including social media, should not be exclusionary or make people feel they are providing an 'inferior' patient experience, because this is not the case. Obviously, a skilled dental hygienist or therapist maintains patient comfort and loyalty. We all have those patients who have followed us when we change practice because of the skill and care they receive.

Nevertheless, it was an interesting opportunity for representatives of the *Dental Health* team to immerse ourselves into the culture and processes of a company who figure quite largely in the UK dental sector. We would encourage our members to check this out for themselves and see how you can make this work for you and your patients.

FROM STUDENT TO PROFESSOR

THE JOURNEY OF A DETERMINED DENTAL HYGIENIST

BY SOFIA DRIVAS

I am 31 years old and I would like to share my journey because it's a living testimony to the passion, commitment and constant thirst for knowledge that characterise, not just my career, but that of so many dental hygienists and therapists. I hope it will inspire readers to focus on their own aspirations and take that leap to make them reality.

I have always had a passion for continuous learning and immediately after graduating as a dental hygienist I embarked on a two-year MSc programme in public health; in Italy, my home, this is essential if you want to pursue a university career.

Having successfully obtained my MSc, I then moved to London where I completed a second Master's degree at the Eastman Dental Institute, University College London. This experience expanded my skills set beyond my expectations! The courage to embrace the unknown and learn from different perspectives proved to be a strategic move. I felt I was at the top of my game!

My studies highlighted the importance of overall holistic care of our patients, in addition to their oral health. Classes and residential workshops, combined with motivational interviewing, focussed on managing periodontitis and perio-medicine. The third year was completely dedicated to my personal research project - investigating the association between hypertension and periodontitis. Some of my patients in practice were recruited as participants: they never failed to be shocked to hear of the many potential links between periodontitis and systemic diseases. There were also many patients that were unaware of their risk of hypertension, which was identified by in-practice screening. This project prompted me to re-consider our role as dental hygienists in practice. There is great potential for it to expand: the professional hygiene session could include all-round screening of our patient's health.

Home to Italy

Returning home offered me the chance to emerge as a leading figure in our profession of dental hygiene. My passion for the profession has spilled over into personal projects and initiatives that have further evolved my career. With the creation of a dedicated website (www.sofiadrivas.it) and the effective use of social media (@sofia.drivas), I have found being online is a powerful asset in today's digital world. My Instagram profile, specifically targeted at dental hygienists, has gained a large following and created a virtual community in which to share knowledge, experiences and explore new developments in the field. The newsletter, followed by over 1400 Italian dental hygienists, has become a point of reference for professional updating and sharing best practices. Every month I create new content for my newsletter on a specific topic. For example, when new guidelines are published, I translate them into Italian, and create an outline that can be easily used by Italian dental hygienists in their clinical practice.

Industry

I have forged significant partnerships with leading companies such as Procter & Gamble and EMS. I have used my acquired skills and put them into practice, contributing to the development of other dental hygienists by conducting training courses on new technologies

and new protocols related to home care and professional care. Thanks to these collaborations I have travelled extensively - Barcelona, Switzerland, Berlin, Copenhagen, different areas of Italy, Amsterdam, Vienna - and have been fortunate to meet so many fellow dental hygienists and learn about their different backgrounds along the way. The opportunity to exchange ideas has also helped me to stay motivated in all my professional activities.

Teaching

At 27 years old, I found myself teaching at the University of Verona.

For me, this was the icing on the cake of, I hope, an ever-growing career! Initially mistaken for a student, I have proven over time that age is just a number when it comes to dedication and competence. My passion for teaching and sharing my experiences has helped my students, hopefully inspiring them to pursue excellence and cultivate a mindset of continuous learning. I teach: patient education; innovative technologies and new protocols in the field of oral prevention, such as the use of ozone, laser, air-polishing with low abrasive powders; the use of strategies to remove white spots; and dental bleaching. All my favourite topics!

My working week currently

Today I work in clinical practice three days per week with another dedicated to university teaching.

Having embraced the importance of sharing all the experiences and skills gained through these intense years with other professionals in the field, I was inspired to develop an area of my website dedicated to continuing education through online courses.

This new section will be a valuable resource for dental hygienists eager to grow professionally. One of the courses I have planned concerns the importance of photographic documentation. Photography is not only a way to immortalise our work, but also an essential tool for analysis and communication with patients and the dental team. I plan to share practical tips and tricks on how to capture high-quality images that can enrich clinicians' portfolios and document the progress of treatments.

I have also created my personal portfolio, a crucial element to ensure we can stand out in the competitive world of dental hygiene. I share how I have created mine and how to present clinical cases clearly and persuasively, highlighting your skills so that you stand out as an outstanding professional.

In conclusion, like many BSDHT members, my story is one of perseverance, passion and the constant pursuit of knowledge. Through our commitment, we demonstrate to colleagues and patients that dental hygiene goes far beyond cleaning teeth! I would urge everyone to embrace a path of personal and professional growth. I hope that by sharing my personal experience readers are inspired to also share their knowledge and embrace every opportunity that professional life offers.

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DG MUTUAL – ALWAYS THERE FOR ME

I am a 30 year-old self-employed, married dental hygienist with a lively 2 year-old Golden Retriever. When my husband and I were walking Max on a lead through a wood, a car backfired on a nearby road, which startled us all. My dog pulled sharply on the lead, causing me to trip over a tree root and land heavily on my left arm. Emergency Services attended and in hospital I was told I had fractured my wrist and would have my arm in plaster and a sling for 6 weeks. However, due to the nature of the injury and physiotherapy, I was unable to return to work for 10 weeks.

As a member of **dg mutual** since qualification, this is the second time that I have made a claim. Staff in the **dg mutual** office, as before, were very sympathetic and helpful, making the claims procedure really straightforward and everything was settled quickly.

You think you are never going to be ill or have an accident, however, my recent experience has shown that in an instant you may find yourself unable to treat patients due to an injury. Being self-employed, I am not entitled to statutory sick pay and rely on my income to help pay the mortgage and other expenses. Fortunately, the income protection policy I have with **dg mutual** means that it commenced payments promptly. My monthly premium is £62.65 and I was in receipt of sickness benefit of £700 per week, so I could pay my bills until I was fit enough to go back to work, which gave my husband peace of mind. It definitely helped my recovery knowing that my financial commitments would be met during this difficult period.

Please contact the friendly team at **dg mutual** today so they can create a bespoke policy for you – peace of mind may cost less than you think.

dg mutual – supporting professionals from all walks of life.

dg mutual is offering BSDHT members an exclusive 50% discount on their premiums for the first 24 months for all new policies, making it even more affordable (**Subject to Terms and Conditions*).

Please quote BSDHT24 when you ask for your quotation

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info@dgmutual.co.uk

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SPOTLIGHT ON...

BSDHT COACHING AND MENTORING VOLUNTEERS

The BSDHT Coaching and Mentoring programme is a member benefit, offering up to six sessions of coaching or mentoring. The scheme has received over 50 applications so far and our volunteers have never been busier providing support to our members. Over the coming months we will be introducing you to our amazing volunteers on the coaching and mentoring team.

In this issue, we meet Alison Brown from the southwest peninsula regional group. Alison is a dental hygienist and is passionate for all things dental hygiene, undergraduates, perio and career pathways.

DH: Can you tell us about your C&M practice, including your specialty or areas of interest?

AB: I am currently a clinical supervisor and understand only too well the problems that newly qualified graduates may be experiencing in the workplace. Having completed my MSc, I can help members with their dissertations, researching a topic, time management as well as how to negotiate a change in career. I can also help members navigate any big decisions they may be contemplating as well as working through any dissatisfaction they may be feeling. The latter is a common problem for some who have worked in dentistry for a long time. Let's reignite your enthusiasm together!

DH: Can you share some of the common concerns with which members approach you or help?

AB: Those members who are starting out on their career pathway, as well as those who are dissatisfied with their careers, often find it useful to talk through their thought processes and potential future decisions regarding career change or any problematic issues in the workplace.

DH: What is your background and experience and how it will help members meet their goals in their area of interest?

AB: I have been a dental hygienist for 30 years and a clinical supervisor for 10 years and have witnessed so many changes in dentistry. On a personal note, I have made several changes of direction in my career, moving from clinical to post graduate education. I have experience and knowledge of challenging situations and problems that arise in practice as well as career dissatisfaction.

DH: What credentials, qualifications or certifications do you have, or are working towards?

AB: I have a Diploma in Dental Hygiene, an MSc in dental hygiene, a Certificate in Mentoring and Coaching, a BSc in health promotion and the AFHEA Teaching Certificate.

DH: What other activities are you involved in with your work as a coach and mentor?

AB: I use my coaching and mentoring not only with the BSDHT, but in my full-time role with undergraduates.

DH: Do you mentor members on personal issues, professional issues, or both?

AB: Mostly professional but sometimes professional and personal overlap.

DH: How would you describe your mentoring style?

AB: Democratic and mindful.

DH: What is your expectation of your clients?

AB: Honesty, and an understanding that I am not providing answers but facilitating their ideas.

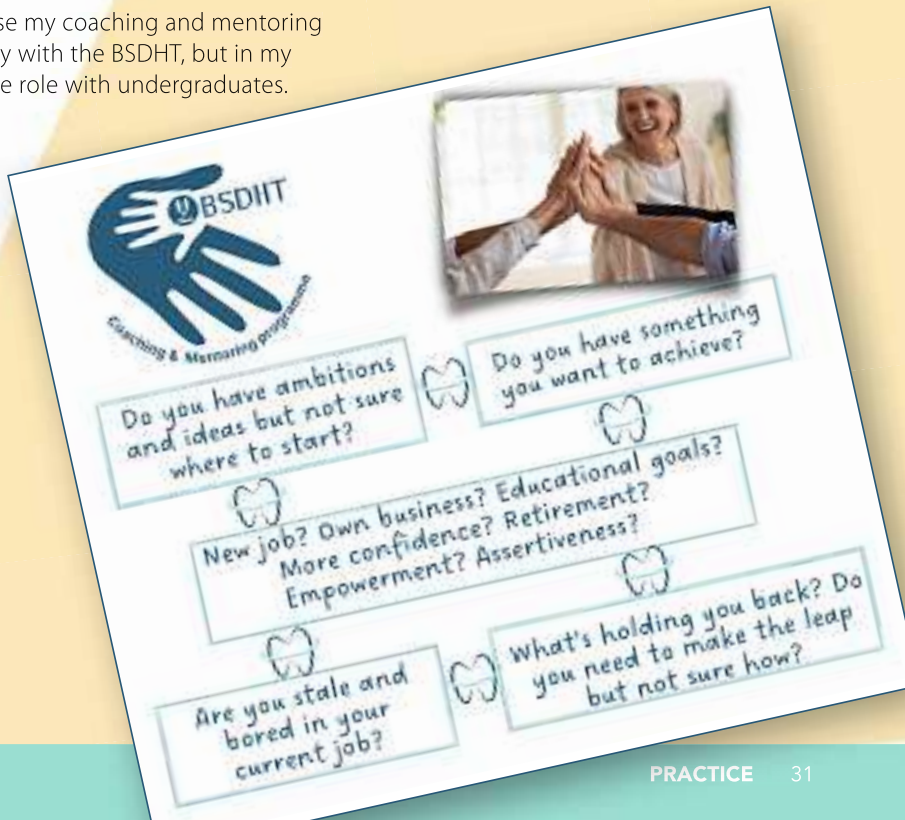
DH: What could members expect from you as their mentor?

AB: Kindness and commitment.

DH: How would you describe your approach to C&M sessions?

AB: Calm and open.

To find out more, visit our website: **https://www.bsdht.org.uk/mentoring/**



LET'S TALK ABOUT STRESS

BY RAFINA O'BRIEN

In our fast-paced professional world, dental hygienists (DH) and dental therapists (DT) play crucial roles in patients' oral health. However, our bright smiles and compassionate care often belies a profession fraught with unique stressors. From demanding schedules to intricate patient care, there are myriad challenges that can take a toll on our mental and physical well-being.

Demanding work environment

Our workplaces are often high-pressure environments, where we are expected to balance multiple responsibilities simultaneously. The demands of the job require precision and efficiency. Tight schedules and back-to-back appointments leave little room for breaks, leading to physical strain and mental exhaustion. Furthermore, we spend more time at work than we do at home with our families and therefore any challenging relationships with our colleagues can negatively impact on us.

Emotional labour

Beyond having excellent manual dexterity and technical skills, DH and DT must also possess strong interpersonal skills to navigate and deal sensitively with all types of patient interactions: dental anxiety; fear; or complex oral and medical health issues. Empathy and patience are required to provide tailored compassionate care. Constantly managing patients' emotions and concerns can be draining.

IMAGE BY **GERD ALTMANN** FROM PIXABAY

Occupational hazards

Daily exposure to various occupational hazards, including sharp instruments, hazardous chemicals, and infectious diseases are part of the job and require strict adherence to safety protocols and infection control measures. Ongoing training and education is essential and is often only practicable at the end of a demanding day.

Perfectionism

The pursuit of perfection is inherent in dental care, with an emphasis on precision and attention to detail. DH and DT often feel pressure to deliver flawless results while meeting productivity targets and maintaining high patient satisfaction levels. The fear of making mistakes or falling short of expectations can lead to anxiety and self-doubt.

Social media is populated by colleagues' impressive success stories. Although this can be a real positive for the profession's growth and recognition, it can sometimes leave us wondering if we are doing enough, or why something may not be working.

It is important to focus on the reality: success is built on experience, hard work, dedication and many (mistakes) learning opportunities. Everyone has a different approach and that's what makes us unique.

Work life balance

Achieving a work-life balance can be challenging especially if working long hours or employed in multiple jobs to make ends meet. Balancing professional responsibilities with personal commitments and self-care can sometimes feel like an uphill battle, leading to feelings of overwhelm, exhaustion and potential burn out.

Individuals have different coping mechanisms and passions. It is important to reflect on what is important to you and set small achievable goals or changes where feasible. For example, delaying an 08:30 am start to a 09:00 am can help reduce the morning rush and allow a more relaxed setting up time. It is also helpful to set aside one day in the week for 'me time': whatever your interests - reading, exercising, catching up with friends - it does not have to be anything too demanding as long as it gives you balance.

Impact on well being

The cumulative effects of stress can have a profound impact on a clinician's well-being, both physically and emotionally. Chronic stress has been linked to a range of health issues, including fatigue, musculoskeletal disorders, anxiety, depression and even cardiovascular disease. Left unaddressed, prolonged stress can diminish job satisfaction, decrease productivity and increase the risk of burnout.

We are often well meaning and quick to caution our patients and friends when we perceive them to be stressed but often forget to see the impact on ourselves!

Coping strategies

Despite the challenges we face, there are proactive steps that can be taken towards mitigating stress and prioritising one's well-being. Establishing healthy boundaries, practising self-care activities such as mindfulness, regular exercise, seeking support from colleagues or professional networks, and pursuing continuing education opportunities can help build resilience and promote work-life balance.

Support

It is essential that dental practices and healthcare organisations recognise the unique stressors faced by DH and DT and implement strategies to support their mental health and well-being. This includes fostering a positive work culture, providing access to resources for stress management and mental health support, and promoting open communication channels to address concerns and provide feedback.

Being a part of an organisation such as BSDHT also provides the support of like-minded people who empathise and understand the impact of this profession. Sharing ideas and experiences is a good way to recognise that what we are doing is ok and that we can thrive in our professional and personal well-being.

These daily stressors are significant, impacting physical health, emotional well-being and job satisfaction. By raising awareness of these challenges and implementing supportive measures, we can empower our colleagues to thrive and continue providing exceptional care to patients. After all, a healthy and happy dental workforce is essential for maintaining overall oral health and well-being in our communities.

Author: Rafina qualified as a dental hygienist and therapist in 2012. She is dedicated to improving oral health in the community, private practice and military settings. She had the honour of being the first dental hygienist aboard the HMS Queen Elizabeth during its inaugural world tour. She currently works with Dentaid on the Bright Bites programme. In her free time, she runs ultra-marathons to raise money for the charity.

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For dry mouth – when just water is not enough

New

1 in 5 suffer from dry mouth, and water is usually the standard remedy. But for many people, water only provides brief relief. TePe's new hydrating mouthwash and mouth gel ease the feeling of dry mouth, provides comfort, and protects teeth. We recommend the gentle, unflavoured products for those with a very dry mouth and mildly flavoured products for those with moderate problems.

TePe® Hydrating Mouthwash - TePe's mouthwash moistens the mucosa and leaves a pleasant feeling in the mouth. Not only does it help with dry mouth, but the added 0.2 % fluoride also gives that extra protection against caries.

TePe® Hydrating Mouth Gel - TePe mouth gel gives immediate and long-lasting comfort*, moistens and soothes the oral mucosa and is convenient and easy to use whenever needed – great for on-the-go.

Available from dental wholesalers. Find out more at tepe.com.

*The duration of the comfort is individual; people with no or very little saliva usually experience a more prolonged effect.

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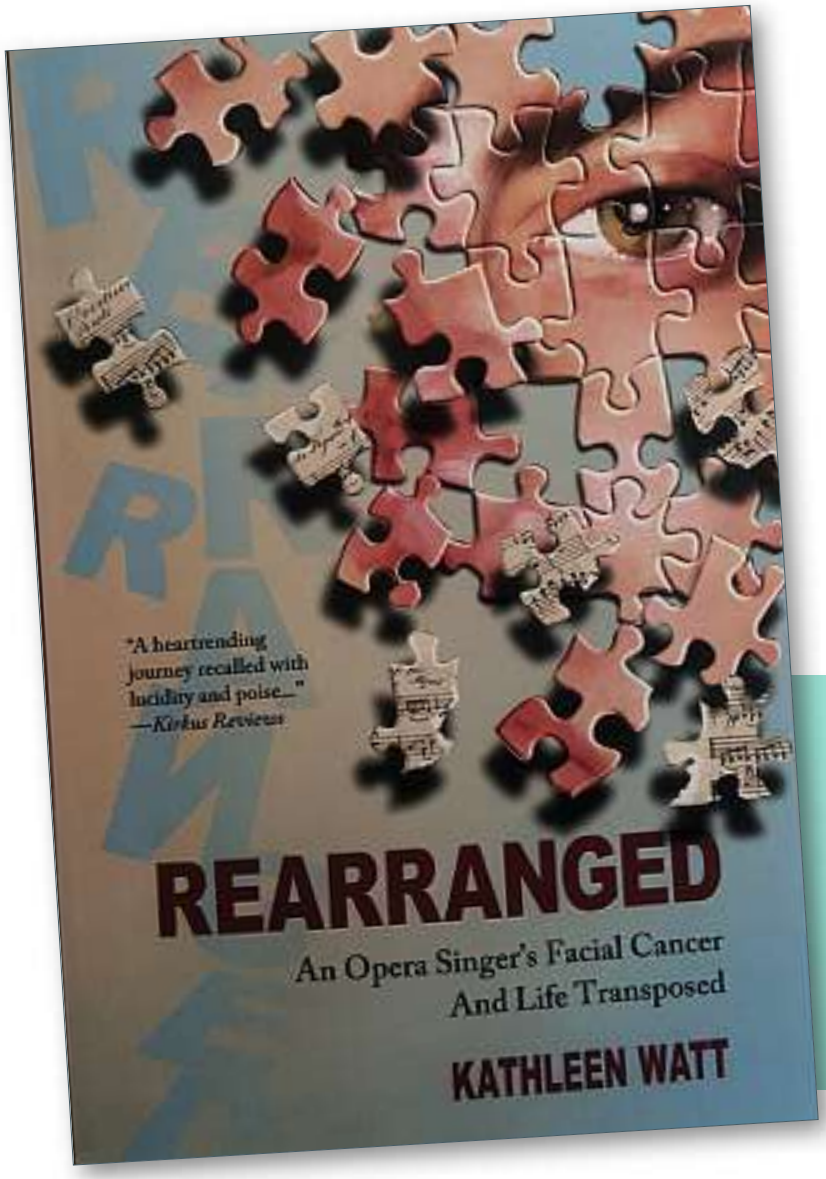

BOOK REVIEW

REARRANGED: AN OPERA SINGER'S FACIAL CANCER AND LIFE TRANSPOSED.

Kathleen Watt
Heliotrope Books; 2023
ISBN: 978-1-956-47434-3

Reviewed by Professor Mike Lewis
Emeritus Professor
Cardiff University

This book has been published at a time when the subject of cancer is increasingly being raised in the media, both on television and in the general press. In the past few years, sufferers have openly discussed the diagnosis and management of their type of cancer in detail to encourage public awareness of the disease. Most recently, two senior members of the Royal Family have revealed a diagnosis of cancer. There is no doubt that seeking advice and achieving an early diagnosis are the most important factors that will improve outcome.

Rearranged, an opera singer's facial cancer and life transposed is a book written by Kathleen Watt who, as the title indicates, was an opera singer diagnosed with cancer in her maxilla. I have previously read short personal articles written by sufferers of mouth cancer and been deeply moved by the candid descriptions of their experiences of diagnosis and management. However, this book takes things to a higher level and is outstanding in the depth and breadth of information presented. The text is well written and the author cleverly mixes the harsh reality of the medical details with the huge human emotional impact of cancer on not only herself but also her loved ones.

This was not an easy journey for Ms. Watt. There are many times when things went wrong and the delivery of her care was less than ideal. Whilst starting to read the book from a knowledge that a cancer diagnosis was coming, I became increasingly frustrated by the delays and the prolonged time that this took to achieve. When eventually pathology revealed the presence of an osteogenic sarcoma, Ms. Watt was informed of the diagnosis by telephone. Such a diagnosis must always be given within the clinic with appropriate support. The treatment provided was at a time where surgical techniques were developing, particularly the introduction of free flaps. The description of the multiple investigations and numerous episodes of surgery is informative and it is inspirational in the way she managed to deal with the frequent failures.

There are many professional things to be learnt from reading this book and as such it is of direct interest to anyone involved with the care of patients with head and neck cancer, either in secondary or primary care. It would be especially helpful for dental hygienists or dental therapists working in multidisciplinary teams.

I thoroughly enjoyed reading this book, which provides an interesting blend of medical facts with the important emotional aspects of cancer. Kathleen Watt deserves our gratitude and congratulations in putting forward a unique and extraordinarily detailed account of the way in which cancer transposed her life.

BY ANNA MOLLY CHARTERS

SUPPORTING PEOPLE WITH AUTISM

I am ashamed to admit that I did not know much about autism until I had a child who I suspected had autism at 14 months old. At that time, I felt that I was failing my child, and I found myself avoiding people with children of a similar age. We could not access the support we needed without a diagnosis, and the waiting list for a diagnosis was 18 months, causing further anxiety; we did not have the tools to support our child's development! Following a diagnosis, we were relieved to receive the professional support that we so desperately needed.

We have since met some incredible healthcare professionals. However, sadly, negative healthcare experiences still occur. Although autism awareness and understanding are improving, as a healthcare profession we still need to push forward with inclusion.

As a spectrum condition, autism is lifelong and affects how an individual communicates and how they experience the world. More than 700,000 people in the UK are diagnosed with autism, but there are many more people living with undiagnosed autism. Studies have shown that without support, an autistic person is likely to experience anxiety, depression and loneliness living in a world where they feel they do not belong.[1]

Autism and communication

All people with autism experience differences in communication. It is important to realise that just because someone has difficulty communicating does not mean they have nothing to say, or lacks awareness of what is being said to them. Many tools are used to support communication, such as Augmentative and Alternative Communication (AAC) - a range of methods to aid communication instead of speech. This can include Picture Exchange Communication (PECS), talk pads, writing, drawing, and Makaton. Research shows these methods increase language development, making communication a positive experience[2,3]

Experiencing the world

Individuals with autism can be oversensitive to sensory stimuli (hypersensitive) and therefore try to avoid it or under-sensitive (hypo sensitive) and will try to seek more significant sensory input. For some, it can be a combination of both. Within the special educational needs (SEN) community, this is referred to as 'sensory seekers' or 'sensory avoiders'. It is essential that we as professionals have a good understanding of our patients' sensory profile as this information can improve or hinder the experiences, we offer them within the dental practice. The world can be difficult to understand, resulting in a desire for sameness, structured routines can provide security.

Danger awareness

Many autistic people have no danger awareness; they may need 24/7 supervision or 1:2 carers as they may exhibit dangerous, unpredictable behaviour from becoming overstimulated, such as laying down in dangerous places. They may have no awareness that dental instruments could cause them harm.

When my son becomes overstimulated, he will have an absence and collapse, lying down no matter where we are; these episodes can be unpredictable and dangerous. As he becomes older, it is difficult to lift him, so he now has to be restricted to a special needs buggy for safety.
SEN Parent

Restricted diets

Many people with ASD have extreme diet restrictions, only eating certain foods. Those foods can also be limited to a brand or shop, and any changes to packaging or ingredients

Figure 1

can mean this food is no longer accepted. Others may have food fixations, only eating a particular food for prolonged periods deemed familiar and safe. These restrictions can put immense pressure on the carer/parent, who fears that restrictions in nutrition will impact their child's health, growth and development.

My son became very lethargic and agitated and had lost a lot of weight. We had numerous doctor appointments and he was referred for blood tests. Then he started limping. We again visited the GP multiple times, and eventually, he was referred to the hospital; however, before the appointment arrived, he became weaker and stopped walking. We took him to A&E, where he had blood tests and x-rays, which showed anaemia and was under investigation for arthritis or a fracture. An MRI was carried out, and it came back clear for fractures. Then we had another visit with my son's paediatrician, who thought all symptoms were linked to something bigger; after hearing all the symptoms and examination, including looking at my son's gums, which were swollen and red, he suspected scurvy and prescribed high doses of vitamin C. My son has now fully recovered.
SEN parent

Techniques to support understanding

Visual timetables: These are helpful for an individual to understand what will be expected during their day. Each stage of the day will be listed with a picture and words, and after completion of each stage, the image will be removed and placed in the finished bag. Visuals can be used for big or small tasks, such as a bedtime routine, including pictures of a bath, putting on pyjamas, brushing teeth, getting into bed, a story, and sleeping.

Now and Next: This Is used as a motivational tool to help keep an individual focused on the task. Once completed, they will be rewarded with an activity or something they enjoy, for example: NOW– toothbrushing NEXT – play on the trampoline.

Social Stories: These are short descriptions of a particular situation, event or activity. They include specific information and can be personalised to use the individual's name so that they can understand what to expect in a situation and why. For support on writing a social story, visit CarolGraySocialStories.com.

What if cards: Sometimes, plans or the routine need to change, which can cause an autistic person to become overwhelmed or anxious as they no longer know what to expect or what is expected of them. 'What if?' cards will help the patient feel in control in unpredictable situations? For example:

What can I do if my appointment is running late?

I can ask to reschedule.

I can ask to wait outside or somewhere quiet.

I can ask how much longer I will need to wait.

In the dental setting

The dental practice is an overwhelming environment, with smells and sounds, constantly changing faces in the waiting

Cathedral
DENTAL

When you attend the practice for your appointment, you can park in one of the below car parks.

Angel Hill Car Park (IP331UZ)

Ram Meadow Car Park (IP331XT)

This is a picture of the practice (across from the One Bull pub) - come in through the front door.

Once through the front door, go to the reception, where you will be met by Adam.

Adam will ask you to take a seat in our waiting room.

Hannah, the nurse will call you into the surgery, where her and Indy, the dentist will ask you to take a seat

You can visit our toilets on the ground floor down the corridor. If you need the toilet during your appointment.

Once you have finished your appointment, you can go back to the front desk to see Adam.

We can't wait to see you!

Cathedral
DENTAL

Figures 2

room, unknown expectations, close contact and physical touching by the clinician. We can take simple steps to limit the impact of these potential barriers.[4]

Reassurance

We need to get to know our patients and their individual needs; you could do this by sending a form in advance to the patient or via a phone call to the patient/caregiver. The parents/ caregiver will often be anxious about visiting somewhere new: will the place they visit be understanding and patient if their child cannot cope in the new environment? Receiving a call or a questionnaire will reassure them they will be visiting an inclusive setting.

Finding out about their needs will enable us to tailor their visit and prevent any unnecessary barriers.

Language

Difficulties in understanding dental terminology can make instructions hard to follow; the patient may not understand your expectations (why would a stranger want to look in their mouth!). Use simple, literal language and allow time for the information to be processed. Some patients may prefer you to talk to the parent or carer as constant talking may increase anxiety. Use visual support during explanations and send the patient a social story before their visit covering the procedure that will be carried out (Fig.1).

Some health professionals do not understand my child's communication difficulties and continue to speak without appropriate language or any visual support, which causes anxiety.
SEN parent

With the desire for sameness and fear of the unknown, try to ensure the patient consistently sees the same clinician and nurse, and room. Visuals of the surgery waiting room, toilets and clinicians will help support the patient (Fig. 2).

Sensory input

Finding out if your patient is a sensory 'avoider or seeker' will reap benefits, and making minor adjustments to how you provide treatment will also be beneficial.

Limit wait times: where possible book patients at quieter times in your clinic, and, if possible, allow the patient to wait in a calm space.

Limit noise: Hypersensitive (avoiders) may struggle with noise. Try to limit common sounds: turn the radio off; ensure suction does not go off if it isn't needed; maybe have some ear defenders, or suggest patient brings their own.

Reduce the smells: Remove air fresheners and chemicals to cupboards.

Touch: Consider if they can cope with being touched and have the mirror and instruments move around their mouth. What level of pressure can they cope with? Sensory seekers require a firmer retraction, but avoiders may require very minimal retraction when it can be done safely. The taste of the instruments and gloves may be challenging to tolerate, and breaks and mouth rinsing may be required.

The overhead light: This may be too bright; dimming the light, using alternatives such as loupe lights, providing dark safety glasses, or asking the patient to attend with some sunglasses may be helpful.

Vestibular (balance) and proception (body awareness): Lying prone may cause dizziness and a feeling of falling. Would the patient prefer to sit semi-reclined? There may be difficulties with awareness of the pressure needed to complete tasks, and some potential over- and under brushing may occur.

Further considerations

Tooth brushing may be a challenging daily task. They may need help understanding why this is necessary; a social story could support this. They may find the bristles too overwhelming and underbrush or alternatively, seek deep pressure, and apply too much force when brushing. Think about the patient's sensory needs and tailor OHI. Toothpaste may cause sensory challenges. Different flavours with reduced foaming may be beneficial e.g. Buddies Mild Mint, Oronurse or the Zing range.

One size does not fit all so be adaptable and give the SEN patient some control; they may like to hold a mirror or toothbrush in their mouth or film themselves having their teeth examined. Taking photos of their teeth at home may assist if the patient is uncooperative. The desire for sameness may lead to a struggle with new things in their mouth. A new toothbrush will have a different texture and smell. Check if the individual has an occupational therapist with whom you can develop a plan to increase toothbrushing acceptance?

Extreme diet restrictions are one of the most challenging aspects of Autism; we must support parents and carers with this very stressful area. Check the mouth for signs of malnutrition, red swollen gingivae, decay, erosion and hypomineralisation. Try to engage a multi practitioner approach; gain consent to discuss your findings with other professionals involved in the patient care. These professionals may include: GP; dietitian; paediatrician; specialist health visitor; special needs nurse; and disability social worker.

Check-in with the parent/caregiver to see how they are. Are they getting support? Have a suggestion for local support. Being a parent/ carer of an SEN child brings challenges. Fighting for services their children need and deserve is one the most difficult parts of being a parent of a child with a disability. Be supportive, focus on the positives, and show you are championing their child.

When my child was going through diagnosis, we met many different health professionals who always seemed to focus on what our son couldn't do, and it saddened us that they couldn't see what an incredible little boy he was. Then we met a specialist health visitor who spoke about all the great things our son could do; this was such a wonderful moment for us; we felt that finally, we had someone who understood and was on our side. SEN parent

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CASE STUDY

BY HAFEEZ AHMED

TREATING CHRONIC ADULT PERIODONTITIS AND MANAGING THE LEGACY OF EXTENSIVE BONE LOSS

This case offers a great opportunity to look at multi-disciplinary treatment from start to finish and then to follow the supportive periodontal therapy for a further 15 years. Readers can appreciate the treatment in its entirety whilst reflecting on individual elements which they might want to deliver themselves if and when they are given the opportunity to work in a multi-disciplinary team.

This patient was referred to the author, a Specialist Periodontist in 2007. She was 54 years old. Her main concerns were bleeding gums, mobile teeth, drifting of teeth and a dark appearance to her smile (Fig.1).

Examination

The patient reported that she was medically fit and healthy, had no allergies and not taking any medications. She had smoked between 10—15 cigarettes every day of her adult life and more recently had taken to going outside to be able to smoke in the car park at her workplace.

The oral examination revealed generally plaque free teeth however the plaque score at the dento-gingival margin was closer to 70%. Bleeding on probing was almost 80%

Figure 1

with periodontal pockets generally >3mm and between 5-9mm at mesial and distal sites with buccal recession between 2-5mm. All teeth demonstrated mobility between grades 1-2 and were vital when tested with an electronic pulp tester. The upper anterior teeth had over-erupted and rotated creating an increased overbite. Full mouth long-cone periapical radiographs were performed.

Diagnosis

A diagnosis of advanced active chronic generalised adult periodontitis with bone loss of 80-90% around most teeth was made. The risk of disease progression and potential tooth loss was high. [1,2]

Consultation

The consultation, as is typical of a case like this with extensive bone loss and drifted teeth, was awkward, challenging and difficult. The patient countered practically every explanatory statement with: *"Why haven't I been told this before?"*; or *"I've never been told this before!"; or "I'm definitely going to sue my dentist!"; or "I've never missed an appointment with the hygienist!"*

Explanations of the disease process included the familiar following statements: *"…gum disease is a genetic predisposition to the potential loss of the bone which supports*

your teeth;" and "…the process is usually triggered when your oral hygiene falls below a threshold for your particular level of genetic susceptibility;" and "…back when your teeth started to feel loose, significant bone had already been lost;" and "…back when your teeth started to drift there was already insufficient bone remaining to hold them in their original position;" and "…smoking does not cause bone loss but it can increase your susceptibility;"[3] and "…the response to periodontal treatment is generally less in current and former smokers;"[4] and "…the bone loss is irreversible".

Her dismay was clearly evident at this news and throughout the discussion the patient was emotional and repeatedly swung back and forth between angry and tearful.

Treatment plan

Broadly speaking it was aimed to divide the treatment into the following stages:

- Cause related therapy
- Review and revise
- Corrective therapy
- Review and revise
- Restorative therapy
- Review and revise
- Maintenance therapy

Treatment

Treatment commenced with oral hygiene instructions and smoking cessation advice. It was made clear that the success of any professional treatment was wholly dependent on her compliance and that if she did not it would fail miserably.[5] The patient promised to perform the homecare exactly as demonstrated and she also agreed to quit smoking.[6]

A period of three months was agreed for the patient to get used to her new homecare regime and for the gingival tissues to respond to her new no smoking status.

February 2008

A course of non-surgical therapy was undertaken using local anaesthetic. The patient accepted the strong recommendation to have this done as 'full mouth disinfection' as it offers time efficiency for the patient and places their entire mouth into the healing period simultaneously. The patient was then provided with supportive periodontal therapy and, specifically, disturbance of the biofilm at four weekly intervals for a period of three months.

May 2008

At review (Figs. 2, 3, 4), examination revealed plaque free teeth and a plaque score at the dento-gingival margin < 20%. The gingivae did not bleed when they were gently stimulated with a probe and bleeding on probing was reduced to approximately 35%. Periodontal pockets had reduced significantly however multiple pockets > 4mm persisted in all sextants. All teeth demonstrated mobility

Figure 2

Figure 3

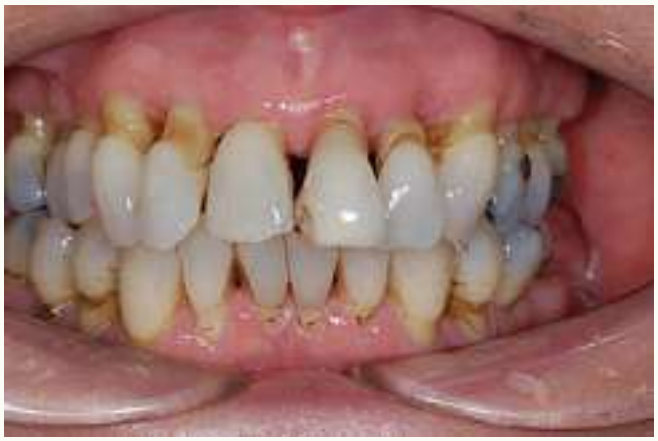

Figure 4

between grades 1-2 and were vital when tested with an electronic pulp tester. The number of residual periodontal pockets > 4mm coupled with the bleeding on probing indicated a high risk of disease recurrence so a course of corrective pocket reduction therapy was agreed.[8,9]

June 2008

A course of corrective pocket reduction therapy using local anaesthetic was undertaken, performed as a full mouth approach in a single treatment session. This revealed that the actual amount of bone loss was far more severe than the radiographs had originally indicated.[10] Whilst sutures were being placed, it was impossible to ignore the fact that

Figure 5

Figure 6

the teeth were significantly more mobile than at the first appointment. Sutures were removed after 10 days and the patient was provided with supportive periodontal therapy, and specifically biofilm disruption at four weekly intervals for three months.

September 2008

At further review, examination revealed plaque free teeth and a plaque score at the dento-gingival margin < 20%. The gingivae did not bleed when they were gently stimulated with a probe and bleeding on probing was reduced to < 20%. Periodontal pockets were < 2mm and elevated pockets had been completely eliminated. All teeth demonstrated mobility between grades 1-2, they were vital when tested with an electronic pulp tester and overall temperature sensitivity had increased.

At this point it was decided to postpone further treatment and to attempt to maintain what had been achieved. Supportive periodontal therapy continued at three monthly intervals for a period of one year to allow for the periodontal tissues to stabilise, which they did.

September 2009

Options for smile correction were discussed at this point: Plan A was based around some tooth removal; and Plan B was based around the retention of her natural teeth.

Plan A involved the removal of three upper teeth; the upper right lateral incisor (11), the upper left central incisor (21) and the upper left lateral incisor (22). Subsequent to the tooth removal the spaces would be restored using three individual dental implant retained crowns or a six-unit fixed bridge using the two upper canine teeth and the upper right central incisor as the bridge retainers.

Plan B was to 'cross our fingers' and reposition the natural teeth utilising fixed braces, to which the patient agreed.

October 2009 - September 2011

A course of fixed brace therapy was provided by a specialist orthodontist. The patient continued to attend for supportive periodontal therapy at intervals of three months (Fig.5).

November 2011

Pocket reduction therapy was repeated on the distal surface of the upper left lateral incisor (22). In 2012 the upper first molar teeth were restored with porcelain bonded crowns, during which the upper left first molar became pulpitic and required root canal treatment, which was provided by a specialist endodontist.

Two years later, the diligent application of homecare devices had hastened the root surface damage which had been evident six years earlier in 2007 (Fig.6). Due to the extent of root surface damage a decision was taken to restore the lost root surface tissues in an attempt to prevent further loss (Fig.7)

In 2014, during a supportive periodontal therapy session the patient produced an advert for a flexible gum veneer. I made

Figure 7

Figure 8

a valid attempt to talk her out of it, but eventually conceded and agreed to having one fabricated and fitted it: it was not easy! (Fig.8)

January 2024

The most recent supportive periodontal therapy session continued the uninterrupted treatment plan since she first presented in 2007, apart from the period March 2020 to March 2022 when she went into an extended period of Covid related self-isolation.

At this most recent review appointment, her gingival health was stable. The staining at the cervical margins of the top right restorations had become increasingly unsightly. The upper left second premolar unexpectedly displayed grade 3 mobility, and yet it had remained symptom-free. We have discussed the removal of this tooth followed by restoring the site using an implant retained crown. The patient is yet to decide.

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For any reader who is interested, visit YouTube: Oral Hygiene Instructions with Gum Specialist Dr Ahmed.

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BY CHRISTOPHER BYRNE

TONGUE CANCER WHAT HAPPENS NEXT?

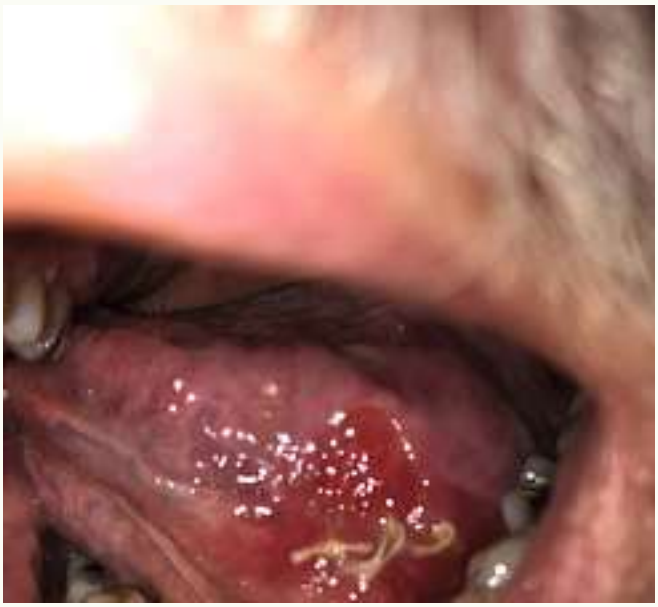

Figure 1: **Biopsy**

I have recently learnt that no matter your background, or station in life (recent royal events back this up), half of us will get a cancer diagnosis[1], whether or not we are intellectually prepared! When I heard those life changing words: '...your results have come back with cancer cells present...' I was intellectually prepared. My background in pharma sales and marketing, including a stint as an oncology product manager, meant this was a familiar area; adverse events, survivorship curves and treatment regimes, were all part of daily discussions. However, when it happens to you...!

A biopsy (Fig. 1), results and my treatment options quickly followed. However, what was never discussed, or if it was, I missed it, was living with and beyond cancer after all this specialist activity finished.

I was so grateful that my odd mouth ulcer had been caught early – thanks to my dentist who had fast tracked me into the head and neck cancer team. My larger than usual mouth ulcer turned out to be squamous cell carcinoma. A biopsy and the consultant treatment plan preceded a ten-and-a-half-hour operation for a partial glossectomy and left neck dissection. The whole experience was completely horrible - necessary and I thanked them for it, and meant it - but horrible!

Having spoken to many head and neck cancer patients through my association with The Swallows Head & Neck Cancer Charity[2] it turns out that, for obvious reasons, there is a huge focus on treatment and immediate recovery. Was there any discussion about living with the aftermath of all this specialised treatment? Not really. I was just happy that my tongue cancer had been caught early, I was in the system and they would look after me. They did. My cancerous cells had been cut out and I now had become accustomed to this new normal: a piece of my wrist grafted onto my tongue (Fig. 2), a scar on my neck and railroad track scar on my left arm from the forearm flap procedure (Fig. 3). My taste buds were all over the place and I could not feel the left side of my face. Over time this turned into odd tingling sensations which only now, six years on, are disappearing.

Why did no one tell me about this stuff?

I would have liked to have been put in touch with a past patient who had been through a similar journey. I understand not everyone wants this, one of my mates who had prostate cancer did not want to know anything – "…just do it!" was his coping strategy. With my background I needed to know everything and fix it. This is why, along with another past patient we set up a local branch of The Swallows Head & Neck Cancer Charity where new and existing head and neck cancer patients, and their carers can talk to each other, share their journeys and learn how to cope.

The Swallows charity supply sample boxes, free of charge, to local head and neck cancer teams. Patients can try products

Figure 2: **Skin graft**

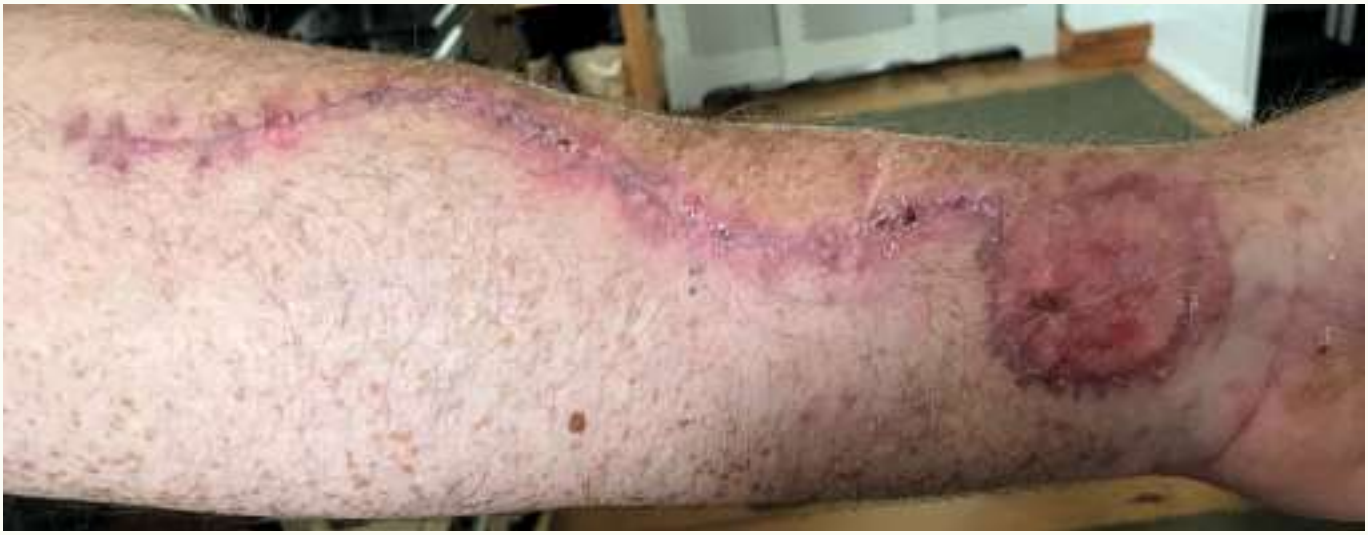

Figure 3: **Forearm flap dissection**

to help them with such problems as dry mouth and the after effects of radiotherapy. It will come as no surprise that mental health is a real problem for some patients, as the surgery and radiotherapy can be visibly disfiguring and impact badly on speech.

A main role in my work required me to give presentations so I was terrified when I heard myself talking differently as a result of my tongue reconstruction. I got through this, more in my head than anything, but real nonetheless, and I now give talks on the head and neck cancer patient's journey. For those who need to talk to someone who 'gets it', and when they want to talk, The Swallows has a 24/7 helpline[3] for anyone impacted by head and neck cancer, especially for those moments when it all gets too much and they need someone to talk to who has been on this journey.

Dry mouth

Up to 78% of H&N patients who have had radiation therapy suffer from xerostomia.[4]

When a patient is telling you about their dry mouth as a result of surgery, radiotherapy or chemotherapy, it is important to remember it is the journey they have been on that has led to this discussion with you, their clinician. Be mindful when you are looking after our mouths and ask us about dry mouth. Some of us might need coaxing to open up about our issues. Patients with radiotherapy induced hyposalivation should be referred to nutritionists and dental clinicians should monitor them for mouth infections.[5]

In the UK rates of head and neck cancer are on the rise. Since 1990, Cancer Research UK has reported[6] incidence rates have increased by around a third overall, with rates in women increasing by almost half again and in men by a fifth. While head and neck cancer is the 8th most common cancer overall it is 4th most common in men. Us men are not generally that good at spotting these things, odd lumps, changes in taste, so when we do see you bear this in mind. Talk to us about smoking, drinking and the other things on the list below.

A big advance in head and neck cancer prevention occurred when the UK Government recommended HPV vaccination for boys. Human papilloma virus vaccines[7] are now available for boys as well as girls of school age with the aim of reducing this risk factor. Vaccinating boys and girls at school against HPV aims to significantly reduce the incidence of ovarian and head and neck cancers.

Be vigilant

Symptoms of dry mouth in head and neck cancer patients[8] include:

- Constant dryness and a feeling of stickiness in the mouth
- Difficulty swallowing or speaking
- Sore throat and hoarseness
- Increased thirst
- Bad breath
- Altered taste sensation
- Difficulty wearing dentures
- Oral infections such as thrush or yeast infections

On a recent Swallows virtual support group meeting I asked attendees how they cope with a dry mouth and, the other common condition, oral mucositis, where the mouth is sore and inflamed from chemo/radiotherapy. As radiation burns its way through tissue it can damage that tissue resulting in inflammation, soreness, loss of taste and cause dry mouth symptoms like thick sticky saliva and also a lack of saliva. Teeth may have been removed, jaw lines remodelled and tongues grafted or even removed. It is no surprise that the incidence of dry mouth is common and maybe the result of a number of underlying causes.

Xerostomia for head and neck patients is often permanent - try eating a dozen dry crackers with only sips of water to wash them down to get some insight into what permanent dry mouth feels like! A healthy mouth has active saliva, with a pH of between 6.7 and 7.4 and a normal production of saliva around 1-2ml/min when eating and talking, and around 0.3-0.4ml/min at rest. Without an adequate saliva flow to wash away food particles and neutralise acids produced by bacteria

patients can find it challenging to chew, swallow and digest food properly which could lead to malnutrition and weight loss. Hyposalivation[9], when stimulated salivary flow is less than 0.5ml/min (dry mouth), can lead to dental caries, acid erosion, oral candidiasis, halitosis and altered taste.

My tastes changed: hot spicy foods gave way to more umami flavoured foods (Indian to Chinese); red wine became dry rose - there's now always a Pinot Grigio box to hand in my fridge – small win!

Sjögren's syndrome

As clinicians, you are familiar with this autoimmune disease which may be linked to genetics and/or hormones, of which dry mouth is a common symptom.[10] People with Sjögren's syndrome may also have additional autoimmune conditions, such as rheumatoid arthritis or lupus. Other symptoms include dry eyes, dry skin, vaginal dryness, rashes and swelling between the jaw and ears (swollen salivary glands). Recommendations for patients to minimise the dry mouth element of Sjögren's syndrome are the same for dry mouth resulting from head and neck cancer treatments (surgery/ chemotherapy and radiotherapy)[11]:

- Cut down alcohol
- Stop smoking
- Practice good oral hygiene including brushing teeth with a fluoride toothpaste twice a day
- Avoid sugary food and drinks
- Try sugar free gum or suck on ice cubes
- Use lip balm if prone to cracked lips
- Have a regular dental check up – at least every six months
- Check your other medications, the patient information leaflet, to see if dry mouth is listed as a known side-effect

Practical advice

On a more practical note, the meeting attendees had a range of strategies, some idiosyncratic, to handle their dry mouth issues. Many have water bottles to sip from, crushed ice was often recommended by head and neck cancer teams but clearly this is not a practical long-term solution. Another patient had taken the time to create and mix his own solution based on xylitol as lack of sufficient teeth meant xylitol chewing gum was not an option. Water flossers were used by some as a gentler way to clean sensitive mouths, as were humidifiers. De-caffeinated tea was preferred as it appears to be less harsh. A dry mouth at night was commonly considered agreed as more bothersome.

It was clear from this discussion that one size does not fit all. Dry mouth also has a psychological component and in my opinion should be seen as a holistic problem rather than a mouth problem. For example, a common observation was, 'I don't go out to eat anymore.' What does that do for socialisation? One lady had complained to her doctor that she suffered from pain at the first bite of a meal and was offered paracetamol! In your roles as clinicians, even a small win can have huge benefits for your patients.

On the Swallows virtual meeting another patient told us about First Bite Syndrome[12] (FBS). New to me, I've since 'Googled FBS' and it is a thing. For that patient, on that Wednesday night, you should have heard the relief in her voice - just hearing that these symptoms were a recognised problem and had a known medical term made all the difference. It wasn't all 'in her head'! We helped provide that patient with the tools to go back to her GP and be taken seriously.

The prevalence of FBS is about 9.6% and usually considered as a post operative complication in head and neck cancer. I also heard about prescription treatments like Pilocarpine[13] which works on muscarinic receptors to stimulate salivary gland function. There was a discussion around the side effects of Pilocarpine, some based on the known adverse events such as sweating and flushing and one which I have researched that had no basis on known facts – no data (so not reported here). This flags up a warning to all health care professionals: help educate your patients to distinguish between fact and fiction, between useful researched products and anecdotal stories which do not stand up to scrutiny. Your role as a HCP is crucial to help patients navigate the AI and fake news world we all inhabit.

Patients spend a lot of time talking about how to deal with dry mouth. There is no one size fits all solution. Why not just recommend water? Water is a temporary answer, it could wash away any saliva leaving the mouth vulnerable to oral disease. Dry mouth patients are not dehydrated (not withstanding other conditions) and water can of course increase the frequency of toilet visits. Sipping water can help, but is not a solution (pun intended!), gels, creams, rinses and sprays are often better suited as they are formulated specifically for dry mouth, especially where they contain matching enzymes. Your patients may not be aware what is available to help them. Oralieve[14] have a useful range of moisturising mouth sprays and mouth gels replicating the same natural enzyme system found in saliva; Xerostom[15] mouth spray, the Biotene[16] range, Xylimelts17 and Dr Heffs[18] Remarkable mints (containing Xylitol) are all available to name a few, so one or a combination should be able to provide some dry mouth relief for your patients.

When you are seeing patients who are living with and beyond head and neck cancer please understand that the journey they have been on is often long, complicated and can have had a severe impact not only on their physical appearance but also their psychological well being. There are four questions to ask:

- Does your mouth usually feel dry?
- Do you regularly do things to keep your mouth moist?
- Does your mouth usually become dry when you speak?
- Do you get out of bed at night to drink fluids?

These four questions have been clinically validated to identify 75% of all dry mouth suffers[19]. Please use them - we need your expertise.

As a head and neck cancer family of patients, we have learned to live with some frankly nasty side effects from our treatments, so as dental hygienists and therapists, when you are looking into our mouths ask us about common conditions

like dry mouth, we may need a prompt to talk about this stuff. Research the products available and talk to us about them, we will listen.

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Reluctant tongue cancer patient

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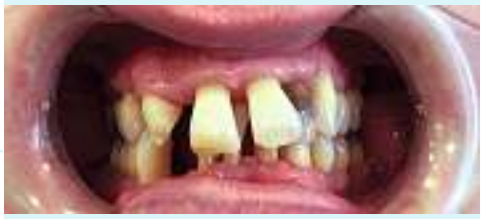

Recall at 12 months

Case study and photographs courtesy of **Pat Popat**
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CLINICAL QUIZ

This 60-year-old edentulous gentleman complains of an "electric shock" like pain that last a few seconds in his right cheek. The pain, which is the worst pain that he has ever experienced, occurs five or six times a day but does not disturb sleep.

Q1. What is the diagnosis?

Q2. What is a likely trigger factor in this patient?

Q3. What is the drug of choice for management of the pain?

SEND YOUR ANSWERS TO THE EDITOR BY 31ST MAY. PLEASE INCLUDE YOUR ADDRESS.

Email: editor@bsdht.org.uk **Postal:** The Editor, Dental Health, BSDHT, Bragborough Hall Business Centre, Welton Road, Braunston NN11 7JG.

ANSWERS TO CLINICAL QUIZ MARCH 2024

The winner is: **Emma Slater**

Atrial fibrillation is not a life-threatening heart rhythm problem, but it can be troublesome and often requires treatment.

Q1. List four risk factors for AF.

A1.
- *Older age*
- *Family history of AF*
- *Having heart failure, high blood pressure, or other cardiovascular disease*
- *Having diabetes*
- *Thyroid disorders*
- *Excessive alcohol intake*

Q2. List four symptoms for AF.

A2.
- *AF Related Stroke*
- *Breathlessness*
- *Chest Pain*
- *Dizziness*
- *Fainting*
- *Fatigue*
- *Irregular Pulse*
- *Palpitations*

Q3. List four treatments for AF.

A3.
- *Heart Monitor*
- *Insertable Cardiac Monitor (ICM)*
- *Medication*
- *Pacemaker*
- *Pill in the Pocket*
- *Remote Monitoring*

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