DENTAL HEALTH

VOLUME 63 | NO 4 OF 6 JULY 2024

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THE JOURNAL OF THE BRITISH SOCIETY OF DENTAL HYGIENE AND THERAPY

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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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DENTAL HEALTH – ISSN 0011-8605

EDITOR
Heather L Lewis,
Bragborough Hall Business Centre, Welton Road,
Braunston NN11 7JG
Email: editor@bsdht.org.uk

BSDHT NATIONAL ENQUIRY LINE
Tel: 01788 575050
Email: enquiries@bsdht.org.uk

ADVERTISING SALES
Fay Higgin
Email: sales@bsdht.org.uk

CLASSIFIEDS & JOBLINE
Tel: 01788 575050
Email: enquiries@bsdht.org.uk

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Annual Subscriptions for non-members: £128.00 per annum
UK 6 issues including postage and packing. Air and Surface Mail upon request.

Warners Midlands plc
The Maltings, Manor Lane, Bourne,
Lincolnshire PE10 9PH
Telephone: 01778 391000
Email: helpdesk@warners.co.uk
Web: www.warners.co.uk

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DENTAL HEALTH

08 ON THE COVER
75 + 75:
Two diamonds still going strong!

75 YEARS AT THE HEART OF PREVENTION

BSDHT
The British Society of Dental Hygiene & Therapy
PRESENTS

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The guidelines and submission forms are now on the **website:https://www.bsdht.org.uk/ohc-2024/**

GUEST EDITORIAL

Protecting adults at risk

Stacey Clough

Consultant in Special Care Dentistry
The Royal London Dental Hospital
Barts Health

BSDHT Editorial Board member

High profile cases in the media continue to emphasise that abuse is still happening all around us. We wonder how these things could happen, apparently without anyone noticing? Surely someone must have known about it, or noticed something?

It is a sad fact that one day, we may find ourselves or a loved one at risk of abuse or neglect. This can happen anywhere, often to the most vulnerable members of our communities - in your own home or a public area, attending a day centre, while in hospital or perhaps in residential care. The person, or people, causing harm is often someone who is well known to the victim and in a position of trust or power. This often includes: a family member(s); professional staff; paid care workers; other adults at risk; volunteers; other service users; neighbours; friends and associates; people who deliberately take advantage of vulnerable people; strangers; and people who see an opportunity to abuse.[1]

Public Health England (PHE) defines an adult at risk as: 'A person aged 18 years or over with a need for care and support, as a result of which they are unable to protect themselves from either the risk of, or the experience of, abuse or neglect.'[2] This has replaced the previous term 'vulnerable adult' as it may wrongly imply that some of the fault of the abuse lies with the victim. Experiences of vulnerability in childhood can negatively impact adults in later life, especially if they do not have many protective factors in place such as a stable income or a supportive family.[3]

There are many factors which can influence an adult's risk of abuse and neglect[4]:

- Aged over 75 and female
- Organic brain injury (lower mental function due to illness)
- Cognitive impairment (someone having trouble with memory, thinking skills or making decisions)
- Physical, mental or emotional dysfunction, especially depression, recently losing a partner, not having friends or a social network, living alone, or not having contact with their children
- Records of the person being abused before, or suspected abuse
- Other members of the family being abused
- Family tensions and conflicts

In 2019, PHE published *'Safeguarding in general dental practice – A tool kit for dental teams'*[2] which highlighted different types of abuse and the importance of recognising neglect. Parallel to this, initiatives such as 'Mouth Care Matters' have finally put the spotlight onto oral health care among adults at risk, having been largely de-medicalised for decades. Although significant progress has been achieved at an organisational level, self-neglect in the context of oral health, remains a continued area of concern.

Self-neglect can be challenging to define, but includes a wide range of behaviours which result in neglecting to care for one's own personal hygiene, health or surrounding.[2] Oral health may be a component within this. From a professional perspective, self-neglect can be difficult to identify and address, because of the need to achieve a balance between respecting a person's autonomy and wishes, while protecting their health and wellbeing. Importantly, an assessment should be carried out to determine if the person has capacity to make decisions around aspects of their personal care.[5] When assessing capacity, it is important to be aware of the five key principles of the Mental Capacity Act:

1. Assume that a person has capacity to make decisions, unless there is evidence otherwise
2. Do all you can to maximise a person's capacity
3. Unwise decisions do not in themselves prove lack of capacity
4. If you are making a decision for or about a person who lacks capacity, act in their best interests
5. Look for the least restrictive option that will meet the need.

Dental professionals have an ethical and legal duty to act if they believe an adult at risk is experiencing any form of abuse or neglect[2], whether due to the omissions of others or indeed themselves. Sometimes a 'feeling' or noticing something that 'just doesn't seem right' can play a vital part in the protection of someone in a vulnerable position. Where there is a risk to the health and wellbeing of a person, safeguarding concerns should be raised. After all…

'If we fail to look after others when they need help, who will look after us?' (Buddha)

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FROM THE PRESIDENT

BY MIRANDA STEEPLES

Community… Connection… Communication!

It is July 2024, and 75 years ago twelve dental hygienists came together and set about forming the British Dental Hygienists Association. These innovative individuals recognised the need for a community that we could all belong to: a safe space for dental hygienists to come together to share knowledge and to support each other. They arranged regular meetings and produced a News sheet to share information with the membership. Could those forward-thinking individuals ever have foreseen how BDHA would grow and develop?

Today, 75 years on, BSDHT continues to welcome dental hygienists and dental therapists to our family. There are regular meetings of the BSDHT Council and Executive teams, the 12 regional groups meet each year, and the working groups meet as needed. The membership is kept informed of our activities via *Dental Health*, DH Contact, our website, regular emails, BSDHT Bites, and our social media platforms.

Digital media enables us to share our activities with those within dentistry and beyond, and helps us to extend and develop our connections even further. This is an important means of communication which must remain engaging and informative in order to capture the attention of those who access their knowledge and updates in this way. It enables us to deliver information contemporaneously and this stream must be maintained in order that we remain relevant.

However, print media is as important as ever, and Heather Lewis has been working alongside Fay Higgin, the Publications Team, and Editorial Board to develop an anniversary issue of the *Annual Clinical Journal of Dental Health* in collaboration with the *International Journal of Dental Hygiene*. This is a fantastic opportunity to share with our colleagues, all around the world, the research that dental hygienists in the UK are undertaking. I am grateful to Heather for taking on this additional layer of work in order to make this special edition come to fruition.

Face to face connections continue to be invaluable. BSDHT starts this with nurturing strong links with the dental schools and Claire Bennett has worked hard to ensure we have a student representative in each one. We are regularly invited to present to the students, and that is something that those of us who have done it really enjoy.

More recently, BSDHT has been engaging with the Women's Institute regarding their annual resolution, 'Dental Health Matters,' and I was delighted to have the opportunity present to a couple of groups about this. We will continue to work with the WI and help them shape the work they want to do around this subject.

The Dentistry Show in Birmingham was another successful weekend where we met with members, student members and welcomed new members. BSDHT was also represented in the Dental Hygienist and Therapist Symposium, and it was a great opportunity for Fay Higgin and I to catch up with some of our industry colleagues.

BSDHT partnered with the Oral Health Foundation for National Smile Month (NSM) for a radio broadcast day, where I reminded everyone that they can come to see dental hygienists and therapists directly, as well as delivering key messages for oral and general health. This scenario was similarly replicated on the final day of NSM with an Instagram live, where Karen Coates and I answered oral health questions from viewers; another way of delivering advice to those in need.

Simone Ruzario and I were invited to attend the Association of Dental Groups evening event where we listened to England CDO Jason Wong talk about skill mix across dentistry. We were also able to network and nurture BSDHT's relationships with other groups. Similarly, Rhiannon Jones and I represented BSDHT at the most recent GDC Dental Leadership Network event, where we listened to people's lived experiences, learned about compassionate leadership, how work is moving on with fostering diversity and inclusion in dentistry and how we can encourage each other to be our best authentic selves. I was also honoured to have been invited, as the first non-dentist, to deliver The Wood Memorial Lecture for the Royal Navy Dental Specialism Study Day. It was wonderful to see Lynn Harris play her part in this day.

BSDHT continues to thrive thanks to hard work from those many individuals who go 'over and above' to serve the membership and ensure the Society continues to stand the test of time, growing and evolving to serve the profession's needs.

Here's to the next 75 years!

BY PHILIP PRESHAW

75 + 75:

TWO DIAMONDS STILL GOING STRONG!

It is a remarkable coincidence that two major UK dental societies that focus on the clinical discipline of periodontology are both celebrating their 75-year (Diamond) anniversary this year. Both the British Society of Dental Hygiene and Therapy (BSDHT) and the British Society of Periodontology and Implant Dentistry (BSP) were founded in 1949. This must have been a very exciting moment in oral and dental healthcare, given that the NHS had only just been established in the summer of 1948. At that point in time, dental treatment was free of charge. Not surprisingly, demand for treatment was very high (particularly after the hardships of the Second World War), and it was only a short time until charges were introduced for dental treatments. First, dentures became chargeable to patients in 1951 (at that time a majority of adults in the UK were edentulous), followed by other treatments in 1952.[1] The rest, as they say, is history!

At the close of World War II, discussions were initiated between Gerald Leatherman, George Cross, Sam Cripps and Cyril de Vere Green, to consider establishing a national periodontal society.[2] The BSP was duly formed, and the first President was Sir Wilfred Fish, who was Winston Churchill's dentist. Churchill had lost several teeth in his younger years and was particularly worried that missing teeth and problems with dentures might affect his public speaking (surely one of his greatest assets). Accordingly, he formed a close relationship with Wilfred Fish, and nominated him for a Knighthood in 1954. He sent a letter to Fish to inform him of the nomination, and also took the opportunity to enclose with the letter his dentures for repair! Churchill had several sets of dentures, and carried two of them with him at all times.

The objectives of the BSP are to promote *"…for the general health, wellbeing and knowledge of the public, the art and science of dentistry and in particular the art and science of periodontology and dental implantology…"*. (The text referring to dental implantology was added when the name of the Society changed to the British Society of Periodontology and Implant Dentistry in 2019). The BSP's founding President, Sir Wilfred Fish, was again appointed as BSP President for a second time in 1974 (on the occasion of the BSP's 25-year anniversary), and the BSP still awards an annual research prize in his name to this day. The Society membership is a rich mix of dental hygienists, dental therapists, general dentists, researchers, postgraduate students, restorative consultants and specialist periodontists. We also offer Associate Membership to other members of the dental team, practitioners retired from practice, and UK undergraduate dental, dental hygiene and dental therapy students.

The mission of the 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…"*. It is noteworthy that the same Dr Gerald Leatherman, who was so influential in the founding of the BSP, was also very actively involved in the British Dental Hygienists' Association (BDHA, now BSDHT) from the outset. The first President (Chair) of the BDHA was Vera Creaton MBE who held this office from 1949-1957. Dr Leatherman himself was Honorary President from 1957 until 1991, and the highly prestigious Dr Gerald Leatherman Award (introduced in 1994) continues to be awarded by the BSDHT to individuals in recognition of their significant commitment and dedication to the Society and the profession.

At the date of the founding of both of our Societies, there were very few dental hygienists in the UK. Whereas dental hygienists had existed in the USA for many years (and these had such a profound influence on Dr Leatherman when he was working there) and had been introduced by the RAF during World War II to combat the huge amount of oral disease then present, the dental profession in the UK (i.e., dentists) at that time were very much against their introduction. However, and very importantly, the GDC licensed their practice in the 1957 Dentists Act. A little later, dental auxiliaries began working in community clinics in the early 1960s, becoming dental therapists in 1979. In 2006, the BDHA was renamed the BSDHT, and in 2013 Direct Access was introduced. It is certainly clear that it has taken huge efforts, commitment, and dedication over the years to overcome very significant challenges, and to develop and consolidate the professional standing of dental hygienists and dental therapists to their current role and importance in the dental profession. And yet, there is still much more to be done.

Broadly speaking, the BSDHT and the BSP have the same general aims – to serve patients by providing treatment in the clinical discipline of periodontology, to provide education and training for clinicians, and to develop the profession to meet these aims. Teamworking is an essential component of dentistry in general and periodontology in particular, and dentists, dental hygienists and dental therapists working together provides the best opportunities for successful treatment outcomes. There are huge problems of access to NHS dental services in the UK at the present time, and dental hygienists and dental therapists will (and should) have a significant role to play in addressing these challenges. Support will be needed from all stakeholders, including the dental schools and education providers, the NHS and GDC, and of course government to address the funding issues and anomalies such as current lack of access to the NHS pension scheme for dental hygienists and dental therapists. All of these elements need to be brought together to create a truly cohesive dental workforce made up of a range of valued team-members who work collaboratively to deliver best care for patients.

Reflecting again on the history of our two Societies, it is interesting that the BSP (under the Presidency of Professor Francis Hughes) and the BSDHT (under the Presidency of Dr Marina Harris) both celebrated Diamond Anniversaries in 2009. Some online research reveals that two Diamond Anniversaries are celebrated: one at 60 and one at 75 years. Apparently, the original Diamond Anniversary is 75 years, but the 60-year version was added for the 60th anniversary of Queen Victoria's accession to the throne in 1897 (she reigned from 1837-1901). 2024 is therefore the second occasion on which the BSP and BSDHT have celebrated their Diamond Anniversaries. Many congratulations to our two wonderful Societies, whose histories are so closely intertwined and whose members work so closely together in the betterment of oral health. Here's to the next 75 years!

Author: Prof Philip M. Preshaw is President of the British Society of Periodontology and Implant Dentistry and Dean at the School of Dentistry, University of Dundee.

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BSDHT NORTH EAST REGIONAL STUDY DAY

Date: Saturday 20th April

Venue: The Crown Plaza Hotel Harrogate

Speakers: Michael Goodman; Elaine Tilling

Hands on: Julie Rosse; Caroline Smith; Elaine Tilling

Sponsors: thanks to: Acteon; CTS; J&S Davis; Optim; Oral B; Oralieve; RIS Healthcare; Swallow Dental; TePe; Trycare; Waterpik; Wyvern Medical

The new North East Team organised an action-packed day in Harrogate, in record time, including a celebration of our group's 50th Birthday!

The committee (and a few helpers) were up at the crack of dawn to be ready for 12 trade stands and almost 80 members! It was lovely to see some students mixing with our colleagues who have been practising for 30+ years.

The format was slightly different to usual, as we included three hands on sessions in the afternoon, to complement our two fabulous morning speakers. Our trade colleagues joined us from 8am – 9am, and again during our morning break.

The morning speakers were Michael Goodman, a dentist with special interest in periodontology, and Elaine Tilling, who has been an extremely active member of our society for more than 40 years and is the current recipient of the Dr Gerald Leatherman Award.

Caroline Smith – The Functional Hygienist – joined us for our afternoon hands on session.

The subject of our first speaker's interactive presentation was **Periodontitis: new and practical ways to manage the oral - systemic link.** Michael delivered a fascinating insight into the emerging links between periodontal diseases and obesity, and a reminder of the well-researched links of periodontitis and diabetes. This prompted a number of discussions on how to best manage and screen for diabetes and obesity within the dental setting, the referral pathways to use in suspected cases, and how to discuss this sympathetically with our patients. It was fascinating to hear how Michael has on site blood testing facilities within his practice and how cost effective these can be, reducing the potential for delays in assessing a patient's blood sugar levels.

Elaine's 90-minute session was entitled: **Smoking cessation and myth busting vaping – what we need to know and what we need to unknow.** This was a great refresher for everyone, as she guided us through the dangers of tobacco and nicotine addiction, and discussed the problems with unlicensed products.

It was encouraging to learn that the number of smokers has reduced greatly since 1974 and the strict measures that are now in place to hopefully stop it from ever rising again. It is lovely to think that England will be smoke free by 2030.

The second part of Elaine's presentation, guided us through the minefield of nicotine replacement products. Although they are also being greatly restricted, they are an important device in smoking cessation. It certainly opened up a good discussion! Unfortunately, we are now all aware that these products are no longer just being used for smoking cessation and are becoming an issue in their own right. I think everyone was shocked by the fact that although it is illegal for anyone under 18 to buy a nicotine replacement product, it is not illegal to use them, as they are not under the same legislation as tobacco.

Before we stopped for lunch we had a presentation from Oral B – thanks go to Mr Phil Boxell for staying behind after the trade show.

For the afternoon sessions we divided delegates into three groups for 30 minutes with each speaker:

Elaine's head & neck workshop, was a great anatomy refresher.

Julie's sharpening workshop reminded delegates to keep our instruments in top condition.

Caroline's self-care myofascial techniques and breathing exercises provided techniques for releasing tension and pain relating to clenching and grinding.

Our raffle was in aid of Alzheimer's Research. We had a huge number of prizes donated and raised an amazing £252.00.

Apart from a few AV hiccups, this was a very successful day, even with the early start!

Our committee, who were voted in during the day are already organising the Autumn 2024 & Spring 2025 meetings! If you would like to suggest content or a particular subject, please contact BSDHT NORTHEAST.

Sarah Warwick

OBITUARY

DIANA MACDONALD
(NEE WOODWARD/HARWOOD)

21.7.1951 – 28.4.2024

It is with immense sadness that we announce the death of our dear friend and colleague, Diana.

Diana trained as a dental hygienist in the WRNS at HMS Victory, Portsmouth, qualified in 1970 and served in Malta prior to living in Tewkesbury and working in NHS dental practices in Cheltenham and Evesham. After moving to the Nottingham area, she subsequently settled in Frome, practising in mainly private practices in the towns Devizes, Westbury and Cirencester.

Diana was an active member of the South West and South Wales Regional Group for many years, holding the post of Treasurer in 1981/1982 and Regional Group Representative on BDHA Council for several years in the mid-1980s. She was an enthusiastic educator and passionate about improving the dental health of her patients.

Although small in stature, Diana was truly a giant amongst her many friends. Those that knew her will never forget her stunning blue eyes and her laughter that would brighten up any room. Lynne Cooper, past BDHA Honorary Treasurer, remembers her as "wacky, intense, sincere and a friend for life". This sentiment is echoed by Patricia Macpherson, past BDHA Honorary Secretary, who also recalls arriving at the Heathrow Penta Hotel for a BDHA Annual Meeting in the early 1990s to find the hotel being evacuated due to a fire: "When I arrived for the meeting, I met Diana in the car park swathed in a white sheet with the end of it carried like a bridal train by our mutual friend Julia Page with whom she had shared a room. Diana explained she had been in the bath when the fire alarm went off and had not had time to pick up anything other than the sheet. We all congregated in the hotel opposite, with Diana ending up wearing clothes donated by some delegates who had just arrived from Cardiff, until the all-clear was given and we could return to the Penta for the meeting. As with all things, she coped admirably and with humour".

Sue Adams, former BSDHT Membership and PR, a friend for 50 years, reflects: "Diana was always kind and understanding. Her faith was an important part of her life and she was guided by it, her whole lifetime. She was given a second chance of joy when she met Malcolm. They married in 2009 and relocated to Weymouth in 2017".

Former BDHA /BSDHT Administrator, Ann Craddock recalls: "Diana always had a smile on her face which lit up her eyes, was very positive, loyal and never had a bad word for anyone".

Diana was also a keen creative writer. Her aforementioned faith helped her through difficult times. In her forties she overcame bowel cancer and was able to carry on working in practice. However, in recent years she developed endometrial cancer. Despite this, Diana remained cheerful and positive to the end. She will be remembered for her passion for life, her faith, friends, and dental hygiene – she was warm, full of fun and a joy to know. We will miss her hugs.

Patricia Macpherson
BSDHT Publications Team

READERS FORUM

I was astonished to read in the last issue of Dental Health (2024;63(3):10-13)that so few members (3%) had responded to the online survey!

Within the same issue there was a stark reminder of just how far the profession has come in 70 years in the article by Freda Rimini.

Do the current members think that the improvement in working practice happened by chance, or perhaps they think it was by the benevolence of the dental community? Well, I hate to disabuse them of those reasons and say it was, and indeed is, down to the combined efforts of our professional organisation, BSDHT, and those members who are prepared to take up the challenge!

Members need to be made aware that if they don't contribute, either by spending a few minutes to complete an online survey, actively supporting regional groups, and their national organisation, they put in jeopardy any progress that might be made in the next 70 years.

Yours sincerely

Jacqui Smith
BDHA Past president 1992-1994

THE DR GERALD LEATHERMAN AWARD 2024

This year we not only celebrate the 75th anniversary since the formation of BDHA but it is also the 30th anniversary of the Dr Gerald Leatherman Award - the first one was presented to Jean Bailey in 1994. Jean had been President BDHA for the period 1980-1982. Last year it was awarded to Elaine Tilling.

Nominations need to be received no later than 13th September 2024 **Email: enquiries@bsdht.org.uk**

Background

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

It was during his early professional years, whilst working in the United States, that he first experienced the 'new profession' of the dental hygienist and oral health clinics. Being the visionary that he was, Dr Leatherman could see the potential benefits of such a group of dental auxiliaries. He brought his ideas back to the UK and began the crusade with like-minded colleagues which led to the recognition of the dental hygienist as an integral member of the dental team.

To recognise the work and support of Dr Leatherman, the 'Dr Gerald Leatherman Award' was established in 1994 to perpetuate and honour his name.

The Dr Leatherman Award is held in the highest regard by the profession, with past recipients having demonstrated dedication, professionalism, and consistent support of the profession and the BSDHT (formerly BDHA).

The Award is in the form of a lapel pin bearing the words: 'Dr Leatherman Award' and a certificate to commemorate the date that the presentation was made.

Nomination Criteria

Nominations must demonstrate how the nominee has shown:

- Consistent support to our profession
- Consistent support to BSDHT
- Altruistic traits in achieving their goals

Self-nominations will not be considered.

The nominee does not need to be a dental hygienist or dental therapist

Submission Documentation

To remain open to the various ways in which the qualities of a nominee may be conveyed, the Dr Gerald Leatherman Committee recommend the nomination should include:

- The name, address, and a contact telephone number of the nominee.
- A citation demonstrating why the nominee should be considered as a worthy recipient of the Dr Gerald Leatherman award, including:
- How the nominee fulfils the criteria
- A brief CV of the nominee.
- The name, title and academic or professional affiliation of the **proposer**, their contact details, BSDHT number (if applicable) and length of time the individual is known to them.
- The name, title and academic or professional affiliation of the **seconder**, their contact details, BSDHT number (if applicable) and length of time the individual is known to them.

Eligible Nominators

All BSDHT members can propose or second a nomination.

Nominations by a non-BSDHT member must be seconded by a **full BSDHT** member.

The nomination form must be signed by the proposer and seconder and accompanied by synopsis and brief CV.

If nominations are found not to meet the exacting standards, then the Dr Gerald Leatherman Award Committee will not present the award.

Submission Date

Nominations are requested on an annual basis.

Nominations can be emailed or posted to BSDHT and must be received **no later than 5.00pm on Friday 13th September 2024**

Nomination papers must be forwarded to:

POST: BSDHT, 'Swallow', Bragborough Hall Business Centre, Welton Road, Braunston, Daventry, Northamptonshire, NN11 7JG.

OR

EMAIL: enquiries@bsdht.org.uk

Nominations received after the closing date will not be accepted but can be resubmitted the following year.

Presentation

The award will be announced and presented at the annual Oral Health Conference in November.

OHC 2024

75 YEARS AT THE HEART OF PREVENTION

22-23 NOVEMBER 2024, HARROGATE CONVENTION CENTRE

We were delighted that, 85% of you who joined us in Bournemouth for OHC 2023 told us you would be back in 2024! We can't wait to welcome you to the beautiful town of Harrogate at a particularly special OHC celebrating 75 years since the creation of the BDHA, now the BSDHT.

The full conference programme is available at bsdht.org.uk/ohc-2024, and as an insert to this copy of the journal – take a look to see how you could benefit from a programme that's packed with sessions designed to enhance and elevate your clinical practice, whilst providing two days of quality CPD.

A member-focused programme

The conference programme has been developed by

Rhiannon Jones, the BSDHT's President Elect, and is built from past delegate feedback, ensuring content that's current and relevant for our members and their day-to-day work:

It has been an honour to once again design a programme for the Oral Health Conference. In my opinion, this is one of the best OHC venues I have visited in the 20+ years I have been attending!

The programme is varied and aims to offer content and interest for both dental hygienists and dental therapists. Catering for the different settings we all work in can be challenging but we use previous feedback to build the future conference and I hope that those who fed back suggestions can see that we have acted on them where possible.

Once again, our trade partners have generously offered to support some of the speakers on the programme. We are very grateful as without this support we would not be able to host such an excellent event. Please take a look at the list of trade exhibitors and be sure to plan your time in the hall wisely.

I am delighted to announce that the Friday evening's celebrations will be a sit-down dinner followed by socialising and dancing (depending on your 'social batteries' after a full day at conference!). I will be taking the reins from Miranda on the Friday so this will be my first time to meet you all as the newly installed President. Please come and say hello and introduce yourself if we have not met. Everyone is welcome and I recommend booking early if you can.

So, block your diaries for the 22/23 November! I look forward to seeing you in Harrogate.

Rhiannon Jones, President Elect, BSDHT

11 CPD hours and an expert panel of speakers

Offering better value than ever, and delivered by some of the best speakers in the field, the full programme is in this issue's insert or take a look at just a few of the highlights here:

- Intervention for prevention – Ms. Jocelyn Harding, dental hygienist, and Dr. Mohsan Ahmad, dentist
- The next 75 years in periodontology – Dr. Paul Renton Harper, periodontist
- Child protection in dentistry – Mr. Gulab Singh, dental therapist
- Into the Abyss. Advanced instrumentation techniques for furcation areas – Dr. Jeanie Suvan, clinical lecturer, and Dr. Claire McCarthy, clinical research fellow
- New advances in caries prevention - Professor Nicola Innes, professor of paediatric dentistry
- Mandibular reconstruction planning and surgery using fibula free flap - the role of the dental hygienist and dental therapist in major head and neck cancer surgery - Mr Steven Hutchison, consultant maxillofacial prosthetist, and Ms. Yasmin Sutherland, dental therapist
- Trauma informed ergonomics - supporting wellness for the dental hygienist and dental therapist – Ms. Clare Kelly, physiotherapist

Submit your work to the annual poster competition

The BSDHT will be accepting submissions of abstracts to be considered for the annual poster competition. Prizes for best posters will be awarded at the conference and successful abstracts will be presented in a poster display onsite. Look out for details at bsdht.org.uk/ohc-2024. The poster competition is kindly sponsored by Colgate.

Come together as a profession

"BSDHT has always been about community and connections, and this is never truer than when we celebrate 75 years of our BSDHT family by learning and socialising together. There are so many chances to broaden your knowledge alongside friends, old and new, in Harrogate. New for 2024, is an afternoon of presentations led by the Oral and Dental Research Trust (ODRT) introduced to BSDHT by Honorary Vice President, Professor Iain Chapple. This is especially for DCPs who have an interest in research and how we can use these skills in our daily practice. It will be accessible to all, and we encourage you to bring colleagues along for this free-to-attend event, and then to book a place to stay on for Saturday's OHC programme. In between conference days, we want you to join us in letting your hair down, so do be sure to purchase a ticket for the Friday night party – this promises to be a night to remember!"

BSDHT President, Miranda Steeples

Save more than 20% until 16 September and pay in instalments

Registration is open and early-bird fees are available until 16 September 2024. **Book your place online at bsdht.org.uk/ohc-2024**. Once again, we're pleased to offer payment by instalments to make the cost easier to manage.

The special rates for newly-qualified and student members will also run again. BSDHT student members and members who qualified in 2022, 2023 and 2024 are eligible to register at less than 40% of the standard member rate – prices start from just £55.

We can't wait to see you in Harrogate!

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SWALLOW

BRIGHT BEGINNINGS
NURTURING HEALTHY SMILES IN KIDS

BY ALISHA HUSSAIN

Paediatric dentistry embodies an approach where each smile is testament to the clinician's thoughtful care and skilful behaviour management. As a student dental therapist, my mission is to foster bright, healthy smiles that last through childhood and into adolescence. This is my approach.

The first dental visit

An early encounter during my training was with a 4-year-old little girl, her first ever dental visit. Expecting the treatment process to be challenging, I drew on my own positive dental experiences as a child when I had regular check-ups and orthodontic care.

In preparation for this important appointment, I strived to create a welcoming and comforting environment. When she entered the clinic, with a mixture of curiosity and obvious anxiety, I greeted my young patient with a warm smile and seated myself at her level. Standing over a patient can be intimidating, so I aimed to reduce any feelings of unease by appearing less 'scary'. My goal is always to create an atmosphere as far removed from any negative perceptions as possible.

I have learnt that through gentle guidance and behaviour management techniques, such as allowing children to have 'enhanced control' in the dental chair and asking them to place their hands on their tummy during the appointment, they gain a sense of control and feel safe, which increases their level of trust. Having implemented these techniques, our appointment progressed smoothly. Witnessing her relax reaffirmed the significance of patient-centred care and behaviour management in paediatric dentistry.

Teaching Independence

As toddlers grow, they are eager to assert their autonomy. I have tackled toothbrushing battles with determined two-year-olds by using patience and creativity to transform brushing into a fun activity. Even actions like singing 'baby shark' or offering colourful toothbrushes can turn dentistry into an enjoyable experience.

Young children eagerly absorb information, so this is an excellent time to reinforce the importance of healthy eating and routine dental check-ups. Gentle guidance and effective behaviour management strategies can also impact on parents so that they too have a positive experience. It is also important to offer sound advice to parents. The Delivering Better Oral Health toolkit suggests parents should assist with brushing until the child is at least seven, using fluoride toothpaste appropriate for the child's age to effectively prevent decay.

Teenagers — we've all been there!

For many teenagers, dental care often includes orthodontic treatments which not only enhance their smile but also boost their confidence. As a student dental therapist I aim to support patients through these changes, using behaviour guidance strategies to ease anxieties and promote cooperation during treatments.

However, our role goes beyond aesthetics; it is about empowering teens to take charge of their dental health. Discussions on smoking risks and the importance of regular dental visits help educate adolescents about the broader aspects of health, focusing not just on the mouth but on overall well-being.

Our role is an important one in the prevention of disease and it can be challenging at times to successfully treat young children. However, with some thought, and the right approach, we can ensure every child feels comfortable and empowered when they come to visit us.

Volunteering with the Dentaid 'Bright Bites' programme has allowed me to enhance my skills of raising oral health awareness to children and I would urge my fellow students to consider it.

Author: Alisha is in her final year at the University of Leeds Dental Institute. Her favourite part of the course is learning how to create a positive impact on patients' oral health and wellbeing.

Contact: alishahussaindcp@gmail.comk

Instagram: @alisha.dental

REFLECTIONS 30 YEARS ON

BY AMANDA ZOE GALLIE

Firstly, it's an honour to be asked to write about my career in this important anniversary issue. I qualified with a Dip Dental Hygiene Manchester 1996; Dip Dental Therapy RCS KCL 2012 and obtained my MSc AMID in 2020.

I thrived at dental school. I loved it, and had a great education from some of the trailblazers of the time. I found purpose, and quickly realised that I wanted to teach and give back to that environment when I had more experience under my belt. I set myself an objective: to gain experience in every single sphere of dentistry that I could. I wanted to create a solid educational base for teaching students and provide good care for my patients. In my first five years I had two hospital jobs in periodontics, restorative and orthodontics, and maxillofacial surgery departments at Leicester, in conjunction with an NHS practice job in Nottingham. I started to assemble a teaching qualification at night school and started some voluntary observing and teaching at Sheffield dental school. I was in my early 20's and I had a lot of energy - I was busy but I loved it - and I learnt so much. I became a fully-fledged tutor at Sheffield in 2001. I adored that job, and I can remember making up acetates for the overhead projector, teaching anatomy and thinking I was in heaven! I did explore escalating to dentistry as I wanted to study periodontal surgery, as I found it fascinating. But the top grades in chemistry A level eluded me twice, so I decided to stop and focus on what I could do - and do it well. I'm so glad I did.

Career direction

I then worked for Philips Oral Healthcare, part time in a professional relations role for six years. I helped launch two toothbrushes and had the privilege of going to America and observing in a Seattle clinic for several days. I was co-creator of a biofilm learning package that went into schools of hygiene and therapy. I also volunteered as secretary for BDHA, and got a job in a specialist periodontal practice - I was on it! In my second half of my career dental therapy became the goal. I moved to London to study and was seconded to teach a group of students from Brunei. I taught them and got to train as a therapist on the job. The Brunei cohort were wonderful women, and it was an honour to teach them the dental hygiene syllabus, we all had a great learning experience together. I worked on the clinics at Kings with the hygiene and therapy students, wonderful students including a certain Nick Coller no less! I also practised in Wimpole Street with a great team, treating the great and the good. Obtaining my therapy qualification was difficult, it was a hard point in my life both personally and professionally and I am proud that I got that piece of paper. Good people held me up and we got through that time: hard work and perseverance does help move you forward. I worked on the direct access project, I started working for EMS and Dentocare, running courses in London and became president elect of the BADT and then president. I moved to Rutland, got a job with Oasis, now Bupa, met my husband and built a happy life around my work. Would I change it? No! I attest to being a lifelong learner. I now have an MSc in minimal intervention dentistry, a field I love, and I carry out some board work – which is a great skill to hone and develop.

I am currently working as a doctoral researcher full time in the Rural Institute for Health at Lincoln University, researching oral health integration into medicine and social care. It's nice to be in a non-dental environment, and the medical school, staff and university campus are inspiring. A PhD was the logical next step for me. I would like to be involved in research and travel full circle to teaching my specialism for the last 10-15 years of my career and hopefully see some patients if my body stays strong.

The biggest change in the profession?

Combining dental hygiene and therapy was a step-change, and diploma to degree has boosted our educational and professional position. Direct access and nursing assistance has given us a huge opportunity to practise our craft, build our profession and show our worth. We are mentioned in UK government documents and conversations in Whitehall - this demonstrates our good standing with the public and ministers. Dental hygienists and therapists are needed more than ever, and we have a huge opportunity to develop even further. I feel research will be crucial to document and test that development.

Lessons for life: Always have good people around you. Have fun with your career, try things!

REFLECTIONS 50 YEARS ON

BY ROSEMARIE KHAN OBE

BDHA PRESIDENT 1984-1986, DR LEATHERMAN AWARD RECIPIENT 1995

I qualified as a dental hygienist at Manchester University Dental Hospital in December 1970 and joined the GDC register on 4th January 1971.

When I was a student, I had been introduced by my tutor to the British Dental Hygienists' Association (BDHA) (as BSDHT was called in those days). As students we had the benefit of receiving the BDHA *Newsletter* which was organised and printed by volunteers. *Dental Health* was not published as frequently as it is now and so the *Newsletter* was a good way of keeping members in touch.

At that time, most of the work and organisation of the Association was carried out by willing volunteers. I feel grateful to those pioneers who had the foresight and enthusiasm to establish the Association that has gone on to become the BSDHT, the recognised professional organisation that we have today.

The first meeting of the BDHA that I attended was a Spring meeting and this was held in London at the Eastman Dental Hospital. I really enjoyed meeting other dental hygienists from around the UK and hearing their views and experiences.

In the 53 years that I have been a member, I have attended every national annual general meeting (AGM) with the exception of a one day AGM held in London in 2010. This was only a short meeting as we had hosted the International Federation of Dental Hygienists' meeting in Glasgow that year. I also went to the BDHA Spring meetings. Although we no longer have national Spring meetings, BSDHT Regional Groups usually hold spring and autumn meetings that are very well presented and so convenient for those who are not able to travel to national meetings.

I can honestly say that every time I attend a meeting, I come back having learned something new – sometimes this is from the lectures and presentations and often it is from talking to other dental hygienists and therapists.

I have been to several international meetings in the UK and abroad and found it interesting talking to dental hygienists and therapists from around the world. Although many of them have a slightly different scope of practice to the UK, they appear to face many of the same challenges that we do.

Over the years the Officers, Council Members, Publications Team and the Administrators have served us well and the current incumbents of these positions are no exception.

The Administration Team keep us well informed in a very timely manner as the recent prompt distribution to members of information regarding the new powers granted to dental hygienists and therapists illustrated. This was sent on the very day the embargo was lifted, even though it was very close to the Easter holidays. The Administration Staff and Miranda, the current President, keep us all updated in respect of information relevant to members.

It can be quite a lonely life for dental hygienists and therapists working in general dental practice as often we may be the only dental hygienist/therapist. Although there may be another colleague working in the same practice, it may not be on the same day. Staying in touch via BSDHT membership is therefore important and rewarding.

As we celebrate the 75th anniversary of the formation of BDHA, I feel very proud of the achievements that so many people have worked hard to bring about over many years. We have grown from a small beginning of just a few members and developed into a professional organisation that commands recognition and respect nationally and internationally.

I believe that with the continuing support of its members, BSDHT will continue to develop and progress. I hope that many of you will be able to join in with some of the celebrations being held to mark this special year. If you are attending the OHC 2024 in Harrogate, I look forward to meeting you and catching up with members, ex-colleagues and former students.

WHAT IS THE WHO GLOBAL ORAL HEALTH ACTION PLAN 2023-2030 AND IS IT RELEVANT TO DENTAL HYGIENISTS AND THERAPISTS?

BY KENNETH EATON

It has been estimated that 3.5 billion people suffer from an oral disease, which may be dental caries, a periodontal disease, such as periodontitis, mouth cancer or other diseases of the oral mucosa. Dental caries is the most prevalent Non-Communicable Disease (NCD) in the world and in 2017 it was estimated the 2.3 billion adults and 0.53 billion children had untreated caries.[1] Furthermore, the estimate for the prevalence of severe periodontitis was 0.796 billion, about 10% of the global population.[1]

Because oral diseases have generally been perceived by policy makers and national governments as not life threatening, their prevention and treatment has been either ignored or given a low priority. It is therefore most encouraging that the World Health Organization (WHO) has recognised the need to address this problem and highlight the need to improve oral health globally. It has produced the Global Oral Health Action Plan (OHAP) 2023-2030 following a public consultation which took place during August and September 2022.[2] As oral diseases are the most prevalent diseases, it is good to see that the OHAP will co-exist alongside the Global Action Plan for the Prevention and Control of Non-communicable Diseases (NCDs) 2013–2030.

The OHAP has six strategic objectives, which relate to:

- Governance: to improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside the health sector.
- Oral health promotion and prevention: to enable all people to achieve the best possible oral health and address the social and commercial determinants and risk factors of oral diseases and conditions.
- Health workforce: to develop innovative workforce models and revise and expand competency-based education to respond to population oral health needs.
- Oral health care: to integrate essential oral health care and ensure related financial protection and essential supplies in primary health care.
- Information systems: to enhance surveillance and health information systems to provide timely and relevant feedback on oral health to decision-makers for evidence-based policy-making.
- Research: to create and continuously update context and needs-specific research that is focused on the public health aspects of oral health.[2]

The Action Plan includes 94 specific actions for Member States to help them achieve the objectives and two overarching and ambitious global targets, which are that by 2030:

- 75% of the global population will be covered by essential oral health care to ensure progress towards Universal Health Coverage (UHC) for oral health.
- The global prevalence of the main oral diseases and conditions, over the life course, will show a relative reduction of 10%

It includes 11 core indicators to monitor progress and there are a further 40 additional indicators. They include essential care, some clinical measures and public health measures, such as implementation of a sugar tax.

Obstacles

There are many obstacles which will have to be overcome if the OHAP is to succeed.

The first is how influence policymakers and governments to raise the profile of oral health when planning health services. Pressure to achieve this must come from the public, informed by the media and professional organisations such as the BSDHT, stakeholders who may have the power to influence public health policy.

The second is how to fund the provision of oral healthcare. In developing countries there is little or no public funding for oral health care. In Europe, one third of spending on oral health care is funded by public sources and the remainder is paid by voluntary health insurance or out of packet payments.[3] In England, since the introduction of the NHS New Contract in 2006, most care and treatment provided by dental hygienists, is paid for privately by patients, rather than from NHS contracts. The most vulnerable in the population and those on low income, who it has been found generally have worse health and oral health, are therefore adversely affected. Currently, in the United Kingdom lack of workforce as well as lack of finance has created "dental deserts", which will need to bloom again if the WHO targets for access to care and diseases reduction are to be achieved by 2030.

The third problem is how to assess whether or not the WHO targets have been achieved. This requires reliable and up to date epidemiological data to demonstrate the true prevalence of oral diseases in 2023 and then again in 2030. In England, Wales and Northern Ireland an Adult Dental Health Survey is currently taking place and there have been regular surveys of child dental health in these countries and in Scotland. However, such national surveys often do not take place in many European countries and, when they do, the data for some countries may have been collected over 20 years ago, from nationally unrepresentative samples they cannot be compared with those from other countries.[4]

Thus, the WHO Oral Health Action Plan puts oral health on the global health agenda providing an opportunity to gain momentum and improve oral health outcomes for the population. Collaboration with the wider public health agenda and inter-sectoral working will be instrumental in achieving OHAP and its targets. Dental hygienists and therapists need to be aware of the OHAP and support efforts to meet its targets by 2030. As Sir Richard Horton, editor of The Lancet has stated: 'Everyone who cares about global health should advocate to end the neglect of oral health.'

Author: Ken is a Visiting Professor at the University of Portsmouth, Honorary Professor at the University of Kent and a member of BSDHT Editorial Board.

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SPOTLIGHT ON...

BSDHT COACHING AND MENTORING VOLUNTEERS

BSDHT's coaching and mentoring coordinator Emma Slade-Jones sat down with volunteer Mireille Jackman to find out a bit more about her approach and involvement with the coaching and mentoring programme:

Emma Slade-Jones: In which areas are you most keen to support members?

Mireille Jackman: I'm a huge perio geek! I love anything to do with perio, maintenance and prevention. I seem to have collected a vast knowledge of products over the years - everything and anything that can be used by patients and clinicians alike. Also, I love supporting people with confidence building, assertiveness, and setting healthy boundaries.

ESJ: Please describe your coaching and mentoring practice including your speciality or areas of interest.

MJ: At the moment I'm really enjoying mentoring newly qualified clinicians in practice, or those who are about to qualify. To me that's a huge buzz - I love watching people grow.

In my everyday practice, I am currently mentoring a student dental hygienist who is due to graduate in the summer. She has a clinic that runs alongside mine. I discuss the patients with her before they arrive. I provide supervision, we discuss the clinical case, I provide honest feedback and advice as and when needed, and after she has treated the patient we talk about what she did well, and what could have improved any outcomes. I encourage her to identify areas in which she feels she did well. We cover critical appraisal and reflective practise as each patient goes through.

ESJ: Can you describe the characteristics of those clients with whom you work well?

MJ: I like working with individuals who are motivated to achieve goals. Someone who is proactive and willing to put the work in, and who is willing to accept and action the work that needs to be done to achieve their goals.

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

MJ: I'm ex-military. I served for 12 years. I feel I have a lot of self-discipline and a strong work ethic. I'm very much goal focused and driven. I'm a good team player and have a wealth of experience in the world of dentistry, both NHS and the private care system. I can't take that knowledge with me, so I'm happy to share it.

For seven years I taught clinical skills to students on the BSc Hygiene and Therapy course at Teesside University. I understand the apprehension of newly qualified clinicians when they leave that safe environment and venture out to work in the real world.

Oh, and I've made mistakes, and learned a lot from doing so. I'm in a good position to guide you and to prevent you from making the same ones!

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

MJ: I'm a dental hygienist with over 30 years of experience. During the pandemic I qualified as a coach and mentor with City & Guilds and ILM. I also coach and mentor for DM UK.

Currently I'm teaching Level 4 oral health practitioners at a local college. The students are already qualified dental nurses, who have extended their scope of practice to include specialist training alongside health care. It's a new qualification, a pilot scheme being funded by NHS England, and it puts prevention first.

ESJ: What other activities are you involved in within being a coach or mentor?

MJ: I currently mentor a third-year dental hygiene student in practice, which I love. And of course, the BSDHT C&M programme. I have provided some short webinars on behalf of Health Education England on subjects such as assertiveness and setting boundaries and building credibility and trust.

ESJ: Do you coach or mentor clients on personal matters, professional matters, or both?

MJ: I tend to do both because I have a holistic approach to my coaching practice.

ESJ: How would you describe your coaching or mentoring style?

MJ: Curious and compassionate. And very much holistic. I believe that if one area of your life is off kilter then it is likely that it is impacting on other areas. I tend to look at the whole picture.

ESJ: What do you expect from your coaching and mentoring clients?

MJ: Commitment! Honesty with oneself and a willingness to see things from a different perspective.

ESJ: What can clients expect from you as their mentor or coach?

MJ: I will encourage you to reach the goals you set. I have relevant knowledge and lots of enthusiasm for the profession. I'd like to think I can inspire you. I'm a good listener and compassionate. I will encourage you and applaud you.

ESJ: How would you describe your approach to coaching and mentoring sessions?

MJ: I want the client to tell me what they want or where they want to be. It is easier for us both if there is a goal in mind. I think that is where honesty comes in. As a coach, I can help you to break up your goal into smaller, achievable chunks in a strategic way.

In coaching and mentoring, I see myself as a teacher, your advocate and your ally.

BY SABINA CAMBER

MENTAL HEALTH WELLNESS IN DENTISTRY

Many of us feel challenged in finding a work-life balance: a rewarding and enjoyable career; meeting financial commitments; spending quality time with family and friends; allowing time for hobbies; developing new interests; networking with our peers; and continuing our professional development. At times this can lead to feelings of stress and anxiety. In order that we avoid feeling overwhelmed, it is key to recognise these feelings and then change behaviours accordingly, before we burnout!

As part of my clinical role in practice, I am the 'mental health first aider'. Following my training, our team started asking questions of ourselves, initially to raise awareness of daily stresses, but then considering what we could change or implement within our working environment to reduce or manage these stresses. All members of the team undertook a stress awareness course which revealed, unsurprisingly, that we all felt a level of frustration or anxiety within a working day.

Quick wins and easy fixes

Initially, we asked ourselves if we could try to be more considerate in our actions, thinking about the language used and tone of voice, and asking for help when needed. We quickly agreed that it is important to offer help to one another, before being asked, and to appreciate that sometimes a colleague will have other factors in their life that may affect their attitude to work. Although you may not be able to change these factors, we all can certainly ask: "are you alright"?

It is important to actively listen to the answer without distractions and be non-judgemental in your own attitude. It is helpful to perhaps: be available for a lunchtime walk; offer to make a cup of tea; or just sit quietly with someone. As a mental health lead, you are taught to 'Ask, Listen, Give Support' and to signpost to appropriate and safe professional organisations when needed.

Our practice signed up to an Employee Assistance Programme which offers confidential professional advice to all employees, initially via an app but then a telephone conversation if you choose.

Introduction of team days … learning about our posture and daily nutrition

Our team went paddle boarding, had lessons in volleyball and building rafts at the beach. As a team we did a community litter pick then played

rounders at the beach. We have BBQs after work. We have orienteered over Exmoor and rewarded ourselves with a cream tea. We had a staff pumpkin carving competition.

We have introduced an evening in the working week, at the practice, to have a Pilates class - funded by the practice.

The practice now has a comfortable outside seating area for the team to use and provides a daily fruit bowl to encourage positive nutrition. We have a wellness board that encourages the whole team to share positive experiences e.g. sharing details of a pottery class, feedback on a great restaurant meal, a novel that was enjoyed and a location for wild swimming.

Working in a large practice with a huge team can still be isolating whatever your role. It is easy to spend a day treating patients and then leave without really having any connection with your peers. Having a variety of activities at various times of the day and week means that members of our team attend what fits with their lifestyle. The activities over the last couple of years have helped us to grow professional relationships along with new friendships within our team, promoting better understanding of individual strengths whilst increasing empathy, when needed.

It does not have to be a business owner or a manager who brings mental wellness conversations to the practice. Are you willing to take that lead in your workplace?

Top tips

- Introduce a framework to improve mental health and start the conversations around mental wellness.
- Discuss the demands of work and the practice working pattens, listening to team members' input to improve and change systems in the practice.
- Give individual team members space to grow in confidence and self-worth.
- Define team members' roles and responsibilities whilst building respect for each other and stronger relationships.
- Look at overall communications and the language used.
- Support the team in prevention and provide mechanisms for detection and early intervention with safe sign posting.

Life will continue to challenge us all but learning habits and having a personal toolkit to recognise how we feel every day can lead us into positive emotions, stronger relationships, living in the moment, feelings of accomplishment, meaning and fulfilment.

Resources

Mental Health Wellness in Dentistry: dedicated to supporting and driving the need to look differently at mental health in the workplace. Its guiding philosophy is to ensure that there is a whole team approach to mental health wellness in the workplace and that 'early intervention and safe signposting' is a given. MHWD – Mental Health Wellness in Dentistry

The FDI toolkit: aims to improve mental health and well-being by providing guidance on actions that can be taken to improve the well-being of dental team members at three levels of intervention: individual (oral health professional), organisational and system (national) levels.

FDI World Dental Federation - Mental health and well-being in the dental workplace (fdimentalhealthtoolkit.org)

ConfiDental: a confidential listening ear and signposting helpline available 24/7, 365 days a year.

Confidental | Emotional First Aid for Dentists (confidental-helpline.org)

Human Factor in Dentistry: Aims to empower dental teams to create safer systems and supportive open cultures through an awareness and understanding of Human Factors principles and theories and a systems approach to the safety of dental care delivery. www.HFiD.uk

BSDHT - Coaching and Mentoring programme for members, receive up to six sessions of coaching / mentoring, where you will explore your motivations and goals, and how to achieve them.

enquiries@bsdht.org.uk

The NSK Ikigai Oral Hygiene Community: Teaches dental hygienists and therapists to fully embrace their vocation.

www.nsk-ikigai.co.uk

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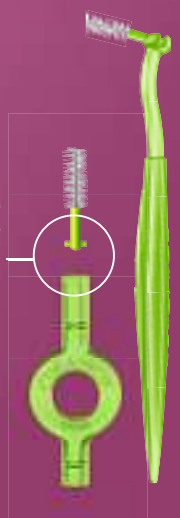

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SWISS PREMIUM ORAL CARE

WHY DOES IT HURT BEING A CLINICIAN

BY ANITA HOSTY

A record 185.6 million working days were lost because of sickness or injury in 2022 and just over ten percent of the absences were related to musculoskeletal problems.[1]

Furthermore, musculoskeletal disorders in dental professionals are the most common cause of ill health retirement (IHR).[2]

Are you heading into an early retirement?

Many of us are accustomed to aching after a long day treating patients. But we should question ourselves: are we just expecting, and accepting, a musculoskeletal pain as part of our work? Despite the fact that we know that prevention is always easier, and less costly, why are so many dental professionals suffering from musculoskeletal pain?

Consider what is happening to our bodies while we work:

- Our mind is focussed mostly on our work not on our body
- Our shoulders tend to creep up
- Our upper body is hunched over

- Our head is usually forward and down
- Sometimes our chin moves forward
- We often experience stress or multiple micro stresses
- During stress our muscles tense up
- Our body twists awkwardly
- Our posture is out of neutral alignment
- Our body may start aching, distracting us from our work

Why are we experiencing pain?

- Static and awkward posture
- Our muscles are inactive for prolong period
- Weak core
- Weak pelvic floor
- Weak back and stomach muscles
- Poor balance
- Poor posture
- Stress
- Repetitive strain
- Holding our breath
- Inactive lifestyle
- Sedentary job
- No work / life balance

To compensate, we should all follow the government recommendations for exercise[3]:

Adults should aim to:

- Carry out strengthening activities that work all the major muscle groups (legs, hips, back, abdomen, chest, shoulders, and arms) on at least two days a week
- Undertake at least 150 minutes of moderate intensity activity a week, or 75 minutes of vigorous intensity activity a week
- Spread exercise evenly over 4 to 5 days, or every day
- Reduce time spent sitting or lying down
- Break up long periods of not moving with some activity

Have you done 150 minutes of moderate intensity activity or 75 minutes of vigorous intensity activity this week? If not, you are just like so many other busy dental professionals.

How can you implement gentle exercise into your practice when working?

- Start stretching even before you get up from bed
- Perform a few stretches when your get up from your bed

- Park your car further from your workplace and implement daily walking to and from work
- Perform a few stretches before you see your first patient and also between patients
- Walk out to the reception area to call your patient
- Perform a few stretches after your work or when you get home from work
- Be always aware of your posture
- Park your car further from supermarket when you do your weekly shopping

Find what you love!

It is much easier to do something you love instead of forcing yourself to something you do not like. Do you love swimming but somehow life got busy, and stopped? Do you love a Pilates class? However, you stopped going because work has been so busy lately. Do you love spending time talking to other people?

Start something new!

Science shows that if we learn a new skill, it is good for us. So go ahead and sign up for that rowing or Tai chi class. Join a walking or running group. Maybe it is time to give LOOSE HANDS a go with a mini session?

Lunch & stretch

The session is designed to help you with core, posture, correct breathing technique and balance. We will focus on your shoulders and back. Upper and lower back discomfort will be eased with dynamic stretching and balance infused exercises with a mini meditation.

You will also be helping charity. Profits will be donated to dental charity supporting dental professionals.

WHEN: Most Mondays 1.15 - 1.25 pm & most Thursdays 1.15 - 1.25 pm

WHERE: online - zoom

REGISTER:

COST: pay what you want!

FREE CPD WEBINAR – TEA with LOOSE HANDs:

"Why does it hurt being a dental professional?"

WHEN: Thursday 29 August 2024 6pm

Register zoom - online:

You or your practice receive tea and a sheet with stretching exercises for dental professionals to help you stretch between patients.

Author: Anita is a dental hygienist and a fitness instructor who is passionate about helping fellow dental professionals remain pain free while they are working.

She is the creator of LOOSE HANDs – an ergonomic and fitness programme for dental professionals. No dental professional should be in pain

Contact her for a free assessment if you suffer musculoskeletal issues.

Contact: anita_zazy@yahoo.com

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HAPPY 75TH BIRTHDAY BSDHT

BY NICK COLLER

As part of the 75th anniversary celebrations of the BDHA (now BSDHT), Nick Coller spoke to some dental hygienists and therapists about the changing nature of their work and aspirations both inside and outside of dentistry. Many thanks to all those who took the time to share their experiences. Their responses make for interesting reading with clear themes often emerging.

Nick Coller: What were your career aspirations when you first qualified?

Teaching, academia and research

- To be a tutor - Michelle Williams, Linzy Baker, Daniela Schadler, Harjot Bhogal and Maree Thomas
- To go into academia, research or teaching - Laura King
- To do a PhD - Ryan O'Donnell

Focus on dental therapy

- To work in community dental services (it was the only place dental therapists could work then) - Debbie Hemington
- To work as a paediatric dental therapist - Charlotte Eastwood-Bloom
- To do direct access dental therapy - Edith Gwatsvaira

A good work / life balance

- To have a career that would be compatible with being a mother one day - Maggie Jackson

To focus on excellence and serving the community

- To raise the profile of dental hygienists in my local area - Sarah Thorne
- To be the best DHT I could possibly be - Lisa Stone
- To work within remote and rural practice in Scotland - Lizzie Aucott-Hall
- To own my own dental hygiene practice - Siobhan Kelleher
- To gain experience in every single sphere of dentistry that I could - Amanda Gallie

NC: Where has your career taken you?

Further education and research

- I am a clinical lecturer, part of the mentoring team and involved in published research at the University of Liverpool - Michelle Williams.
- I went into research and then studied for my master's degree. Now I lecture at Newcastle University, and have an NIHR fellowship - Ryan O'Donnell
- I am currently studying the final module in the PGCert in teaching and learning in the clinical context - Julia Hollywood
- I was part of the Clinical Entrepreneur Programme (CEP) under NHS England and I did a Master's in Global Public Health - Maria Martinez
- I completed a Masters of Education and now I teach the Masters of Education students at UHI -Lizzie Aucott- Hall
- I am working as a doctoral researcher full time in the Rural Insitute for Health at Lincoln University - Amanda Gallie

Dental voluntary work

- I volunteered as a hygienist in Kenya in the Maasai Mara - Rachael England
- I volunteered in Israel, working in a clinic set up for families unable to access dental treatment - Erica Leslie
- I undertook dental charity work with Dentaid in Uganda - Harjot Bhogal

Practice ownership

- I own my own practice - Pat Popat
- I am the clinical director of Dental Health and Aesthetics Dental Clinic - Luke Snelling

Working for dental companies

- I became a key opinion leader for Johnson and Johnson and clinical educator for NSK Ikigai Oral Hygiene Community - Gulab Singh
- I was a rep for for Dentocare , doing school visits - Charlotte Eastwood-Bloom

- I am a clinical educator for the NSK Ikigai oral hygiene programme and part of the clinical education team for TePe - Nina Farmer
- I work for Knowledge Oral Healthcare where I deliver mouthcare training to care home staff - Emma Clayton
- I film content for Dentsply Sirona and Colosseum Dental - Cherise Gould

Ownership of dental related businesses

- I launched DentalDirectives, which helps dental practices with Patient Group Directions. We also provide consultancy services to dental compliance services such as Agilio - Benji Blum
- I recently became a postgraduate course provider with Edqual - The PgDiploma in Oral and Positive Health. It is the first course of its kind globally. I also run my own conference yearly, The Magic of Education - Siobhan Kelleher
- I worked with manufacturers and developed VisionPerio brushes - Maggie Jackson

Working for BSDHT and other societies and associations

- I served as BSDHT President Elect (2018-2020) and then as President (2020-2022) - Diane Rochford
- I joined the board of the Association of Dental Implantology. I am also on the board for Barts and the London Dental Club - Linzy Baker

Further training in other dental fields

- I qualified as an orthodontic therapist - Amanda Borthwick, Benji Blum

No longer in clinical dentistry

- I am Education and Public Health Manager at FDI World Dental Federation in Geneva - Rachael England
- I have now left clinical dentistry and run my own aesthetics clinic and training academy - Lisa Moore
- I am a compliance analyst, which involves using a wide range of skills from data analysis, policy writing and understanding dentistry as a business - Daniela Fowler

NC: Have you embarked on any work outside the profession of dental hygiene and therapy?

Sports and wellness

- I have undertaken seven teaching qualifications in ballroom, latin and classical sequence dancing including two fellowship qualifications - Michelle Williams
- I am a reflexology practitioner, reiki master and therapeutic facial therapist. I have worked backstage at music festivals treating various performers from the Kaiser Chiefs to Dizzee Rascal - Erica Leslie
- I am a nutritional therapist - Nina Farmer
- I was the Wales Masters Hockey Manager and was an international player all over the world - Maree Thomas
- I provide wellbeing training for companies and universities - Siobhan Kelleher
- I got into bodybuilding and competed from 2016-2019. This led me to buying a gym - Pat Popat
- I have become a yoga teacher - Amanda Borthwick
- I became an infant massage instructor - Shaheena Valimahomed

Healthcare

- I am a facial aesthetics trainer - Linzy Baker
- I studied to become a physician associate. I now work as a research officer for the British Skin Foundation and in scientific communications for the Skin Health Alliance - Sarah Thorne

Small business

- I currently have a 'side hustle' making cupcakes (Gouldylocks Bakes) - Cherise Gould
- I make and sell jewellery on Etsy - Harjot Bhogal

Community spirit

- I am a community leader helping to build healthy communities for women abroad - Vincenza Sgura
- I am secretary and treasurer for a UK-wide Land Rover club - Daniela Schadler

NC: What has been the biggest change in the profession since you qualified?

Aesthetic focus

- People are becoming more focused on their appearance and wanting to achieve the perfect smile - Amanda Jordan

Scope of practice and working practice

- Extending scope of practice for dental therapists - Michelle Williams, Ryan O'Donnell, Diane Rochford, Julia Hollywood
- Direct access - Kevin Oates
- More male DHTs - Gulab Singh
- Regulations. I qualified the same year CQC came into being - Amy O'Brien

Professional importance and gravitas

- Respect for hygienists (and therapists) in and outside of our profession and the possibility to continue to post graduate qualifications - Maggie Jackson

- Patients are more aware of the link between oral health and their general health - Cherise Gould, Amanda Jordan
- The number of DCPs being trained each year (and the entry qualifications required) - Lisa Moore

NC: What changes do you see ahead in the profession of dental hygiene and therapy?

Influence of technology

- Increased use of digital technology - Asia Begum
- Artificial intelligence will eventually provide individual patient care plans by identifying patients at high risk of oral disease - Rachael England
- Robots…Gulp! - Charlotte Eastwood-Bloom

Working Practice

- Therapy led practice model - Ryan O'Donnell, Erica Leslie
- A 'refer up' model with the DHT being the first contact who then refers on any treatment out with their remit to a dentist - Lizzie Aucott-Hall
- Mandatory nursing support - Erica Leslie, Diane Rochford, Shaheena Valimahomed, Asia Begum
- More environmentally focussed dentistry - Linzy Baker
- Importance and focus in good clinical note taking - Amanda Jordan

The impact of the WHO's Global Health Action Plan

- The WHO is calling on the government to consult with mid-level professionals in the workforce to support prevention.
  I feel this could be our golden ticket - Siobhan Kelleher
- Dental hygienists and therapists within primary healthcare working closely with medical colleagues - Rachael England
- Increased recognition and involvement in oral health promotion programmes and international collaboration - Vincenza Sgura

Scope of practice

- The right to prescribe not just exemptions– Lisa Moore, Luke Snelling, Alisa Yalcin
- Conversion courses for hygienists and therapists to complete a BDS/BChD - Pat Popat, Linzy Baker, Rachel England
- Top up modules for therapists to be able to provide more treatment options, eventually leading to be able to sit BDS exams - Benji Blum
- Beyond receiving our own performer number…fairer remuneration including pensions - Ryan O'Donnell, Maggie Jackson, Sarah Thorne

When the BDHA was founded who would have thought that as a profession we would have come so far. It is clear that we are a motivated and exceptionally talented workforce who relish every opportunity. Here's to the next 75 years with the BSDHT continuing to ensure we are able to help our patients and society to our maximum capacity and reach our full potential.

RESPONDENTS (YEAR QUALIFIED)

Maggie Jackson	1961
Debbie Hemington	1983 Therapist, 1987 Hygienist
Erica Leslie	1986
Amanda Jordan	1988
Diane Rochford	1996
Maree Thomas	1996
Amanda Gallie	1996
Kevin Oates	2001
Sarah Thorne	2002
Siobhan Kelleher	2002
Lisa Moore.	2003
Rachael England	2006
Michelle Williams	2008
Benji Blum	2008
Amanda Borthwick	2009
Gulab Singh	2009
Luke Snelling	2009
Amy O'Brien	2010
Lizzie Aucott-Hall	2010
Shaheena Valimahomed	2011
Maria Martinez	2012
Pat Popat	2012 Therapist, 2014 Hygienist
Nina Farmer	2013
Vincenza Sgura	2013
Emma Clayton	2013
Lisa Stone	2013
Charlotte Eastwood-Bloom	2014
Cherise Gould	2014
Harriet Elsworthy	2014
Asia Begum	2015
Linzy Baker	2017
Julia Hollywood	2017
Daniela Schadler	2019
Harjot Bhogal	2019
Ryan O'Donnell	2020
Alisa Yalcin	2021
Edith Gwatsvaira	2022

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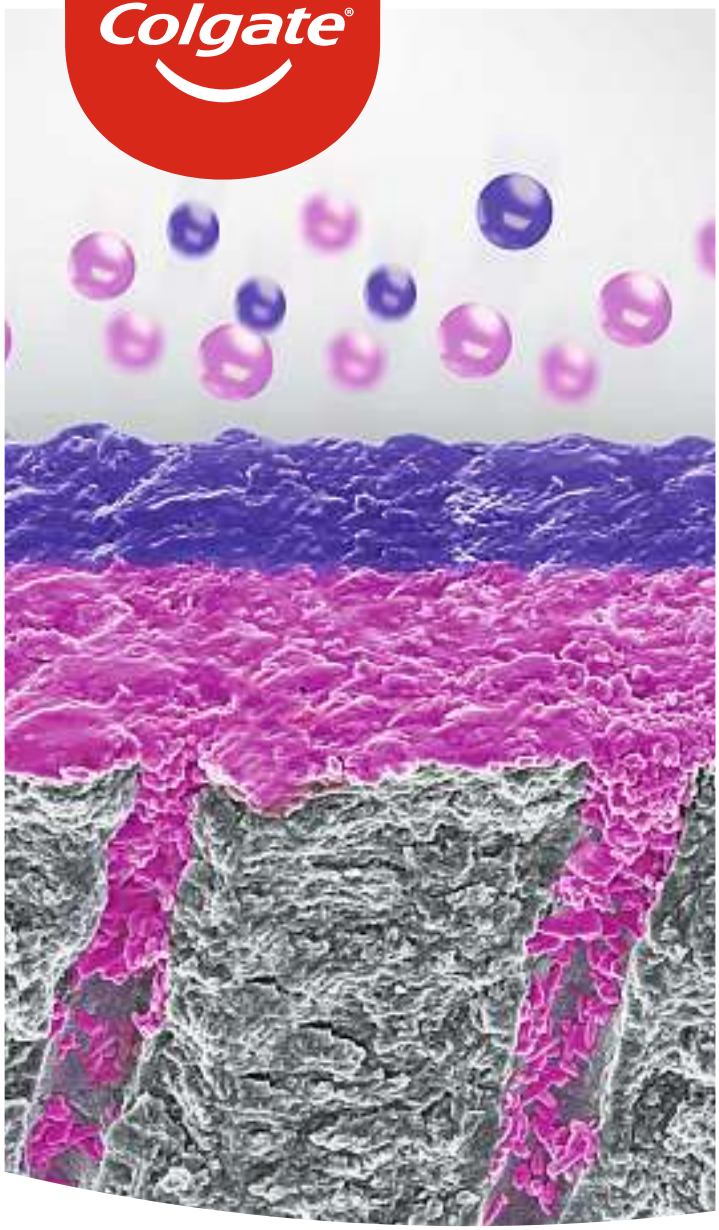
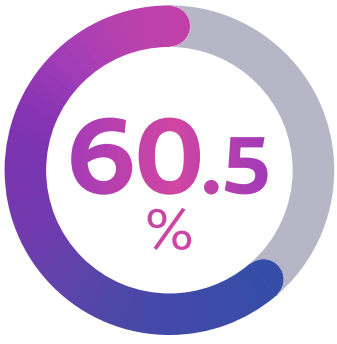
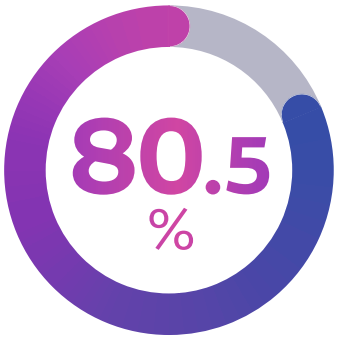


Creative representation of the mode of action

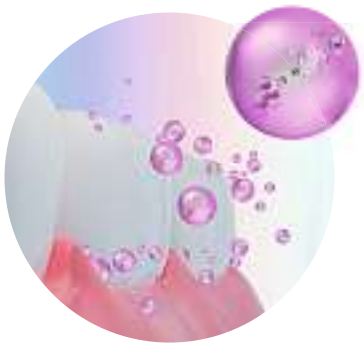
Instant[1] and **long-lasting pain relief**[2]
Now with **enhanced acid resistance**[3]



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

1.5x

more **occlusion**
vs **competitive technology**[4]

IMPROVED FORMULA[3]

NEW PACK DESIGN

Now with enhanced acid resistance[3]

PRO-ARGIN technology now with **Zinc Phosphate**

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PROFESSIONAL
ORAL HEALTH

INTERDENTAL ORAL HYGIENE AIDS – IS IT A SIMPLE MATTER OF PREFERENCE?

BY HAFEEZ AHMED

The regular toothbrush is the most effective and important oral hygiene aid for overall prevention. Unfortunately, it is relatively ineffective at removing interdental plaque, and therefore patients need to resort to additional techniques. Interdental cleaning by whatever method is an adjunct to brushing and not an alternative. In this article I'll be sharing my personal preferences on interdental cleaning aids, specifically: string-floss, brushes, picks, prongs and sticks.

I did not think there was such a thing as a bad oral hygiene aid, that is until the disposable single-use tooth pick came along. What a waste, and, then, there is the environmental damage, you can literally fill football stadiums with them – weekly.[1] And, yet, ironically, in my experience, string floss still provides the best properties for true prevention interdentally.

Introduction

Interdental regions present more plaque and gingivitis[2,3] and are most affected by periodontal attachment loss.[4] And, in my experience, more tooth decay which is typically found adjacent to the contact point in younger individuals and immediately below the cement-enamel junction in older ones.

The quality of evidence to recommend one product over another is poor[5] however one thing is for sure, the product is only as good as the person holding it. This means that if someone is good at using one device, they'll be good at using another, and vice- versa, if they are bad at using one device, they'll be bad with another. Often the common feature that is lacking is time. Obviously, for individual patient oral health, it is best to form a tailored solution based on their oral health status and risk profile.[6]

The eruption years

As the teeth are erupting, whether it is the deciduous ones or the permanent ones, it is a major achievement to get a child to brush them. (I rely on the science of having three children for this wisdom.) It is just as difficult to get them to reduce the frequency of sugary snacks, for which I can add my experience of having patients' mothers tell me, "I'm not going to be the only parent who doesn't put a treat in my child's lunchbox!"

Interdental cleaning, at this age, if it happens, is a bonus. And, if it happens, string-floss, in my experience, which has changed over my career, is the best performing oral hygiene aid for it and some of the research matches my experience[7]. I believe this is largely because the exposed part of the tooth surface is convex and ideally contoured for flossing.

The gingivitis years

This is the reversible period prior to any attachment loss. The age range is dependent on individual susceptibility and usually the effectiveness of plaque control. Once again, during this period, in my experience, string-floss is best at reducing interdental plaque and some of the research supports my experience.[8]

There are many options and gadgets available for patients to floss (Fig. 1). Sadly, not all the research supports that flossing

Figure 1

is beneficial, some of it has found that flossing can be of no benefit at all.[9] This does not surprise me, as earlier in my career I failed to see the benefits of flossing. The barriers are many: most people find floss difficult to use; it requires a high degree of dexterous skill; flossing gadgets are notoriously fiddly or flimsy. My experience of flossing has improved steadily over my career and I believe this is largely because the type of patients I care for has also steadily changed. Early in my career I generally saw patients who were not that invested in homecare or in turning up for a professional clean and polish with any regularity. Flossing is impossible when the calculus has already formed, or when it has been partially removed. Now, the patients I care for attend regularly for supportive professional cleaning although their homecare usually remains as it was when I first met them – inconsistent. They usually confess towards the end of an appointment, after I have gently raised my suspicions for the third or fourth time.

Nowadays, my favourite flossing gadget by far is the sturdy looking red handle in the centre of figure 1. I have to declare my bias because this the one I use myself. I have been slowly developing it over many years by sticking bits of plastic together with superglue! Recently, I used my fast handpiece skills to engrave 'Floss&Co' on it and am hoping to finish tinkering with it and start finding a manufacturer. I have fashioned it into a robust rigid handle onto which I can load a prefabricated continuous loop of floss. The arms have just enough flexibility to be squeezed together as the loop is clicked into place. Releasing the arms stretches the floss creating the perfect tension for it to pass easily between my teeth and yet loose enough to hug them as I floss. I have calculated that this plastic handle with its continuous loop of floss generates 1/48th of the waste created by disposable single-use flossettes - so that's progress!

Whatever therapy I am providing, whether it is active treatment or supportive, its aim is to create a smooth tooth surface from which the patient can then easily remove newly formed plaque bacteria. As part of the therapy, I always check my debridement by flossing the interdental surfaces. The floss allows me to check the smoothness of the surface and to identify residual calculus. I finish off by burnishing any sharp edges or potential plaque traps without unnecessarily using my instruments on areas that do not require it.

The early bone-loss years

Once disease progression becomes irreversible, with attachment and bone loss the teeth start to look longer. The tooth surfaces that were previously concealed under the gums become exposed. These newly exposed surfaces are typically more complex with concavities which floss cannot access. This is when I ask patients to add the use of interdental brushes to their homecare regime.[10] My preference is the Curaprox UHS

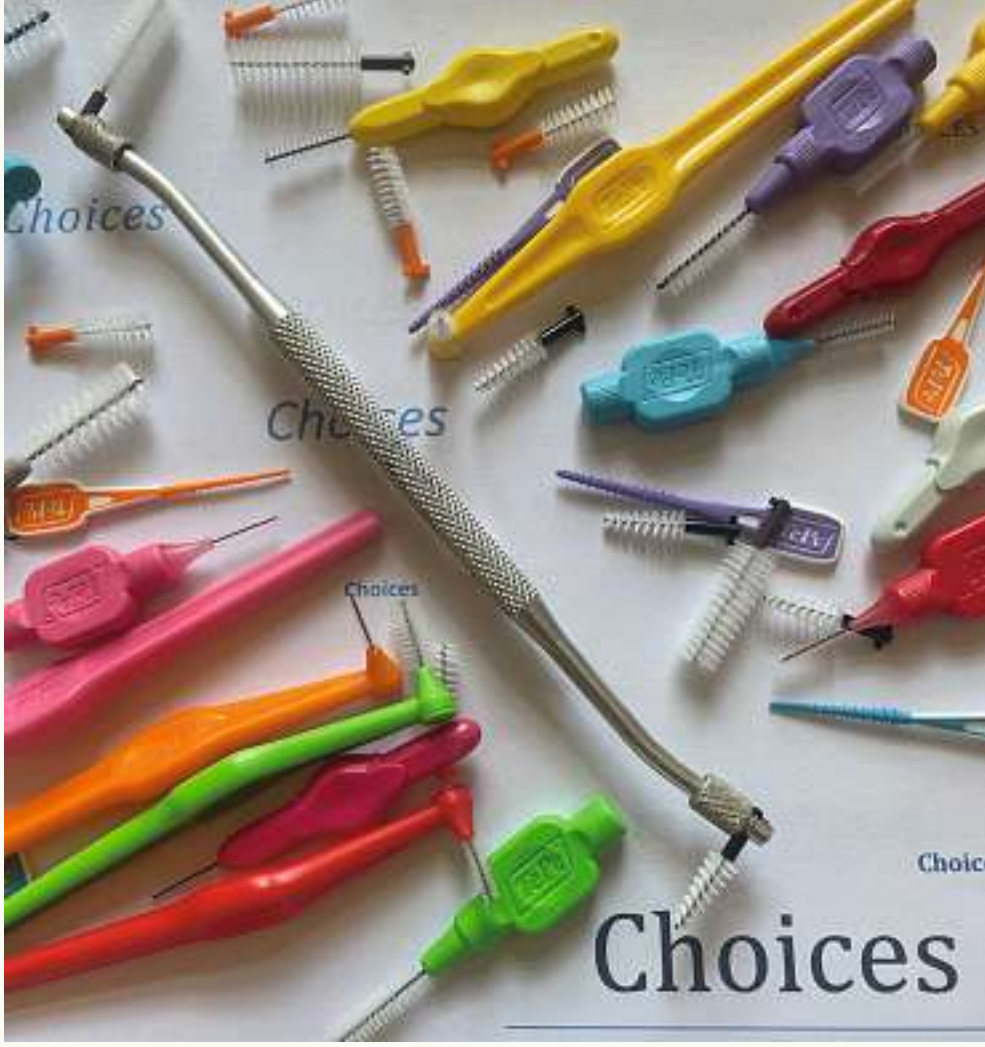

Figure 2

420 duo handle for which I select two appropriate sized brush heads (Fig. 2). This system also minimises plastic waste – so once again, that's progress!

Patients often report that the bristles separate from the spine and get trapped in the gingival crevice or the brush head got partially trapped under a papilla, traumatising it. To this I can add my personal experience: when a patient selects the correct sized brush and uses it adequately, with the frequency required to eliminate the inflammation, abrasion of the root surface is consequential and, rather sad.

The exposed furcation years

Over time, and if bone continues to be lost, furcations on multi-rooted teeth become exposed. At this point I ask patients to add daily use of wood sticks to their homecare regime. My preference is for round wood sticks over square or rectangular ones.[11] Wood sticks come top of the list for green credentials!

In summary

To me, general brushing and flossing have the potential to be truly preventive, the trick is to encourage planned interventions.[2] Beyond that, by the time interdental brushes and tooth picks are indicated, irreversible breakdown has occurred.

About 10 years into my career, it was obvious that the science around interdental oral hygiene aids was consistently erratic

Figure 3

with some of it proving a particular technique to be of great benefit, and some of it proving the same technique to be of no benefit at all. One reason for this, in my experience, is the vast majority of patients rarely comply with the advice I give them. Those who said they would – generally did not; and, those who said they had – usually confessed that they had not.[13] For me, repeatedly giving advice to patients who did not follow it, or lied about it, became tiresome. In response, I made my own oral hygiene video and uploaded it to YouTube. Now, once I've demonstrated a particular technique to a patient I direct them to YouTube for the repeats – this has made our relationships much happier!

A work in progress...

The Floss&Co handle and floss loop assembly has been a work in progress for the last six years (Fig. 3). Patients, hygienists and therapists have been involved from the beginning and we are currently testing what I hope is the last of the trial samples. There may be two versions, a string one and a tape one - let's see!

We are very close to perfecting it and I now invite BSDHT members to trial it. You can request a free sample by emailing me.

Author: Dr Hafeez Ahmed, Specialist Periodontist BDS (Wales)1991, FDS, MRD, MSc, MClinDent, DGDP. Binswood House Dental Practice, Royal Leamington Spa, Warwickshire CV32 5SE.

Contact: binswoodhousedentalpractice@btinternet.com

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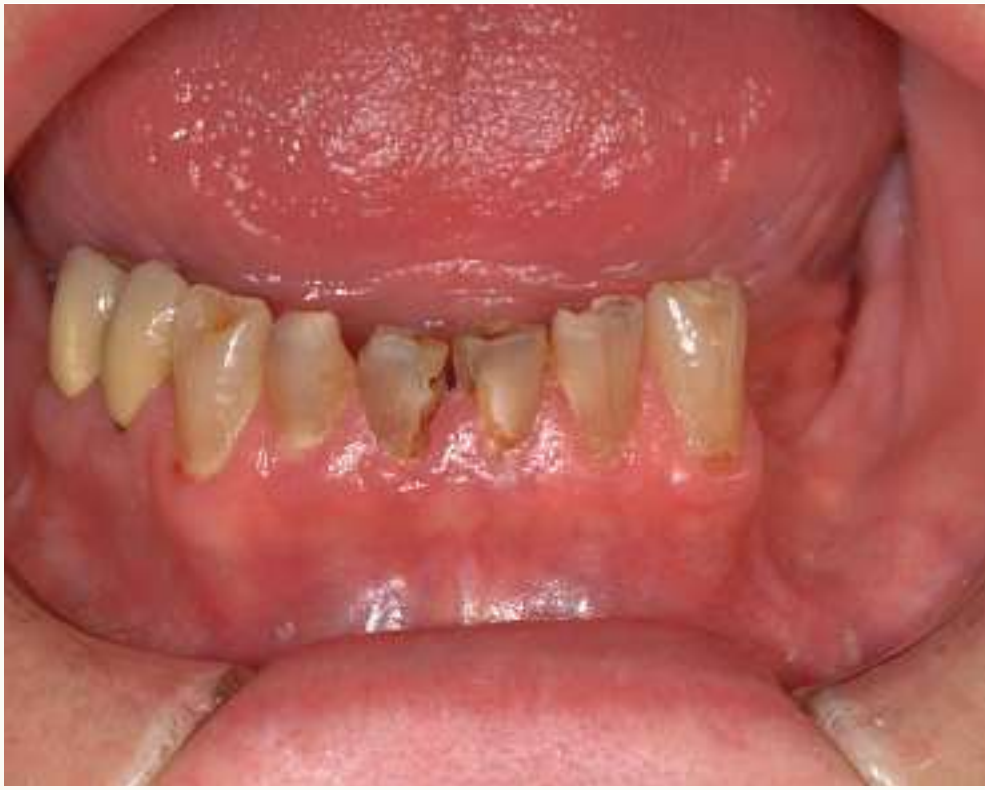
Cite this article:

Ahmed H. Interdental oral hygiene aids – is it a simple matter of preference? *Dental Health* 2024;**63(4)**: 36-38
https://doi.org/10.59489/bsdht144

NAVIGATING DRY MOUTH XEROSTOMIA VS HYPOSALIVATION

BY ANASTASIA MALOVE



IMAGES COURTESY OF MIKE LEWIS, EMERITUS PROFESSOR CARDIFF UNIVERSITY

Dry mouth, whether termed xerostomia or hyposalivation, poses a significant challenge to oral and general health and negatively impacts quality of life. Research carried out in Sweden in 1996 found that around 21% of men and 27% of women were affected by dry mouth.[1] A study carried out a decade later in Scandinavia identified that the prevalence of dry mouth ranged between 0.9% and nearly 65%.[2] Distinguishing between xerostomia and hyposalivation is crucial for effective patient management. This article explores the differences between the two conditions and outlines clinical strategies for dental hygienists and therapists.

Xerostomia is a term that reflects an individual's perception of dryness in their mouth.[1,3,4] Interestingly, examination often reveals that salivary flow is within normal range. However, patients may complain about the sensation of dry mouth, an altered sensation of taste, difficulty in swallowing and a burning sensation in the oral cavity.[3] Potential causes include modern life's stresses, severe nervous tension and modern ecology.[5]

In contrast, hyposalivation represents an insufficiency of salivary secretion resulting in a reduction of saliva pooling in the mouth.[1] Patients will complain of similar intra-oral symptoms as xerostomia. There are several causes of hyposalivation, such as poorly controlled diabetes mellitus, Sjögren's syndrome, hepatitis C infection, radiotherapy, chemotherapy or, most frequently, a side effect drug therapy.[4]

Although patients may encounter either condition separately or simultaneously, the presentation can exhibit considerable diversity.[3]

Research suggests that when patients seek treatment for dry mouth symptoms, salivary flow may already be significantly reduced, increasing the risk of oral diseases and diminishing overall quality of life.[1] As frontline healthcare providers, dental hygienists and therapists are ideally positioned to conduct hyposalivation screening and clinical assessment during routine dental appointments.

A thorough clinical history is essential, focusing on medical conditions, lifestyle factors and medication usage. Detailed examination techniques, including soft and hard tissue assessment, aid in identifying oral dryness manifestations and guiding treatment decisions.[4]

The Challacombe Scale developed to quantify the severity of hyposalivation by producing a Clinical Oral Dryness Score, offers a tool for visual identification and monitoring of dry mouth symptoms over time.[6]

Quantitative evaluation of salivary flow, pH, and buffering capacity informs tailored intervention strategies. Simple tests, such as unstimulated and stimulated saliva collection, provide

valuable insights into salivary gland function and oral health status. The overall time required is 5-15 minutes depending on whether it is stimulated or unstimulated flow that is assessed.[7]

Homecare recommendations should include preventative advice to minimise the risk of dental caries associated with dry mouth. Tailored oral hygiene should involve the use of an effective toothbrush, fluoridated toothpaste and interdental cleaning aids. Dietary advice should include increasing water intake and minimising the frequency of sugar consumption. Additionally, fluoride varnish application and daily use of a fluoride mouthwash monitored during dental examinations are essential components of comprehensive care provided by the dental team.[4]

Pharmaceutical approaches should include recommendations for over-the-counter salivary stimulants or substitutes available in a variety of delivery forms from different brands.[4,7] It may be trial and error before the patient finds what suits them and their lifestyle most at the same time having the least side-effects. If that fails to deliver the desired result, consider discussing with the dentist or general practitioner prescription alternatives.

Distinguishing between xerostomia and hyposalivation is pivotal for the effective prevention and management of oral, general and mental health. Through proactive screening, personalised interventions, and ongoing monitoring, dental hygienists and therapists can help alleviate dry mouth symptoms and improve patient quality of life outcomes.

Author: Anastasia was a dental therapy lecturer for several years. She is currently developing a health coaching project to raise awareness about the links between oral, general and mental health.

Contact: wholehealthoasis@gmail.com

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Cite this article:

Malove A. Navigating Dry Mouth: Xerostomia vs Hyposalivation. *Dental Health* 2024;**63(4)**:39-40 https://doi.org/10.59489/bsdht145

COMMON ORAL MANIFESTATIONS OF MULTIPLE MYELOMA

BY LAURA BOSAH-REECE

AIM

The aim of this paper is to provide a contemporary review of the orofacial manifestations of multiple myeloma. Recognition of hard tissue and mucosal abnormalities should be followed up by investigation of underlying systemic disease.

LEARNING OBJECTIVES

- To provide readers with a comprehensive and contemporary description of the orofacial manifestations of multiple myeloma.
- To explain the importance of determining the potential presence of underlying systemic disease when hard or soft tissue abnormalities are observed during routine examination.
- To be aware that systemic disorders may initially present as manifestations in the orofacial tissues.

LEARNING OUTCOMES

By the end of this article, readers will be able to:

- Demonstrate an enhanced understanding of multiple myeloma.
- Understand the need to investigate the possible presence of underlying disease when abnormalities are detected in the orofacial tissues.
- Be aware that systemic disease may initially present in the orofacial tissues.

Aligned to GDC development outcomes: C

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DEADLINE FOR SUBMISSIONS 31 AUGUST 2024

This article aims to identify some common oral signs and symptoms of Multiple Myeloma, (MM) a cancer of the plasma cells. Plasma cells develop from B-lymphocytes (B-cells) found in the bone marrow; their function is to produce antibodies, also known as immunoglobulins (Ig).[1]

Aetiology

The cause of MM is yet to be identified, although associations with monoclonal gammopathy (MGUS) of undetermined significance have been made.[2] A contributing factor to the development of MM is the presence of one or more plasmacytomas, an accumulation of malignant plasma cells: Solitary Extramedullary Plasmacytomas (SEP) are usually found in the soft tissues; and Solitary Bone Plasmacytomas (SBP) are located in the bones.[1]

The type of multiple myeloma depends on the immunoglobulins present. Immunoglobulins consist of two types of chains; short protein (light) chains and long protein (heavy) chains. Light chains are often split into two categories; kappa and lambda, and heavy chains are split into five categories; A, D, E, G and M. Other types of myeloma include, 'Bence Jones Myeloma' where an excess number of light chains are produced, and 'Non-secretory Myeloma' where no light chains are produced.[3]

Risk factors

The most common risk factors for MM are[4]:

- Age – occurrence of MM increases in people around the ages 50-54 and peaks around ages 85-89 years
- Gender – the ratio of males to females with MM in a 2020 Cancer Research UK study was 57:43 respectively
- Family history – having a close relative with MM or MGUS was found to place an individual at a higher risk of developing MM
- Ethnicity – Multiple myeloma has been found to be more common amongst the black community compared to other ethnicities

Systemic manifestations

Characteristically, patients do not experience any signs or symptoms of MM during the early stages however, if symptoms do occur, they include pain in the bones affected, fractures and compression of the spinal cord, which commonly presents as numbness in the lower body, or 'pins and needles.[2]

Figures 1 & 2: **This patient presented with discomfort and multiple swellings on his tongue. An incisional biopsy demonstrated the presence of amyloid after staining with Congo Red.**

IMAGE COURTESY OF MIKE LEWIS, EMERITUS PROFESSOR, CARDIFF UNIVERSITY

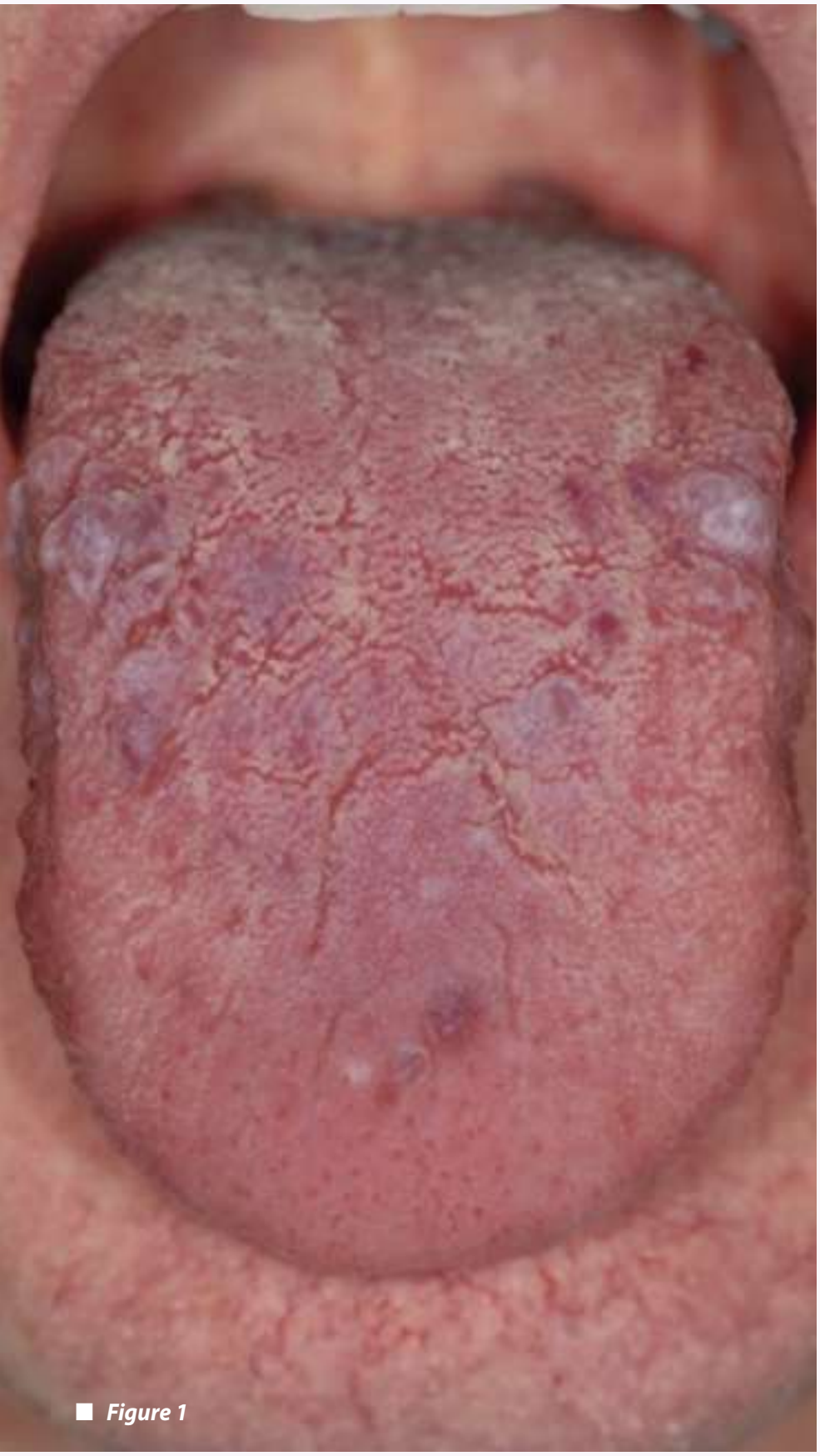


Figure 1

Patients with multiple myeloma often become anaemic due a decreased number of red blood cells in the body. As the white blood cells are also compromised by the disease, patients can be subject to repeated infections which can last for a prolonged period of time.

The primary investigations for multiple myeloma involve blood tests and diagnostic imaging techniques. Further testing can involve urinalysis, incisional or excisional biopsies and advanced digital imaging techniques, such as CBCT and MRI, to identify the antibodies and proteins present in the body, malignant plasma cells, and any areas affected by the disease.[2]

Treatment

The appropriate treatment option for MM is decided on a case-by-case basis by a multidisciplinary team (MDT). The least invasive treatment procedure for MM is active monitoring, suitable if the patient is asymptomatic. If the patient is symptomatic, the intensity of the treatment is heavily dependent on how fit and well the patient is.[3] Chemotherapy is common for patients with multiple myeloma, and involves taking medication in the form of a tablet to destroy myeloma cells in the body. Corticosteroids, such as dexamethasone, can supplement chemotherapy by helping target myeloma cells.[2]

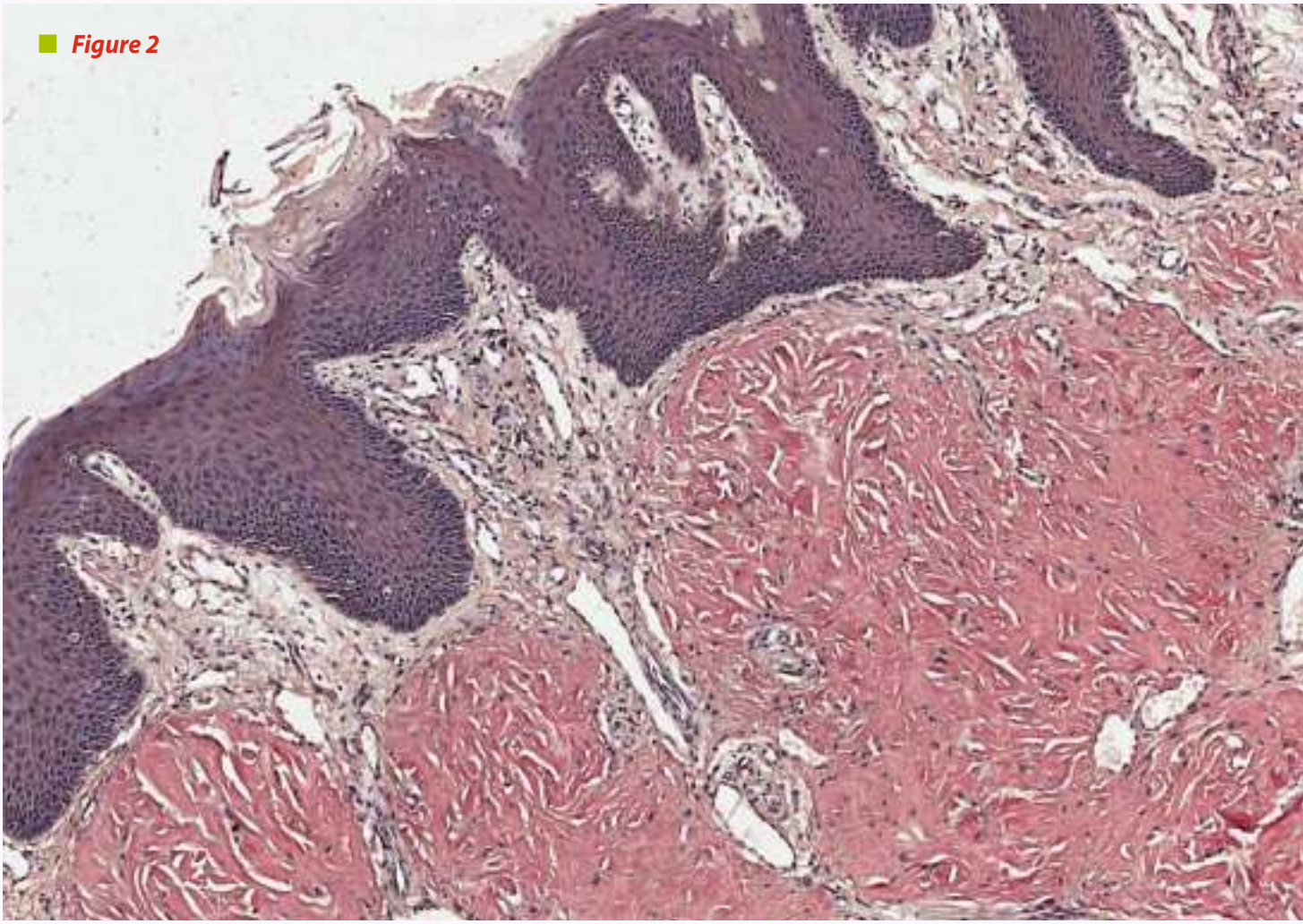
Prognosis

The prognosis for MM is poor; it can be managed with various treatment options however, it is considered to be a terminal non-curable form of cancer.[1] Even when it is managed effectively, it is common for patients to experience relapses. A study by Cancer Research UK (2014)[5] revealed that the 5-year survival rate for a MM patient is 52.3%, with management of the condition playing a significant role.

Manifestations of oral hard tissues

A frequently reported manifestation of MM is the presence of osteolytic changes in the mandible and maxilla. Osteolytic changes in bone are characteristic signs of malignancy; they

Figure 2



identify areas of the bone which have been damaged and are therefore less dense than normal cortical bone.[6] They present visually as 'punched-out lesions' on radiographs.[7] Patients often present with a painful mandibular swelling or 'toothache', alongside these hard tissue changes.[8,9,10]

Thomas et al. (2015)[11] described a mandibular swelling which was previously interpreted as an infection and treated unsuccessfully with antibiotics. On further examination, the firm swelling was initially suspected to be a parotid gland tumour. Radiographs of the area revealed an osteolytic lesion, later confirmed with CBCT. A differential diagnosis of MM was made, and later confirmed by a bone marrow biopsy.

Shimada et al. (2022)[12] undertook a cross-sectional study investigating 98 patients (55 male, 43 female) ages 43-91, suffering from different stages of MM. Their medical records were assessed prior to undergoing radiographs and CBCT. They revealed that 42.9% of 'punched out lesions' (POLs) were found in the skull, and 18.4% were found in the mandible. As the stages of MM progressed, so did the tumour involvement. It was found that the ramus and the angle of the mandible were the most common areas affected in these patients.

Teeth can also be affected by MM; the presence of plasmacytomas can lead to root resorption and tooth mobility.[13]

Periodontal diseases

Periodontal diseases affect around 743 million people globally.[14] However, bleeding gums can be due to a reduced number of platelets in some forms of cancers.[15] Beaumont et al. (2021a)[10] reported a case of a 57-year-old male with IgA kappa MM, who presented with swelling and pain around his UL56. A radiolucency around a 9-millimetre periodontal pocket was evident on a radiograph. CBCT identified an additional radiolucency palatal to the UL56 and a differential diagnosis of medication related osteonecrosis of the jaw was subsequently made. However, following a biopsy of the area, a plasmacytoma was subsequently diagnosed.

Oral soft tissues

A frequently reported manifestation is the presence of swellings and soft tissue masses and discolouration in the oral tissues.[10,16,17]

A case report described a 72-year-old male who presented complaining of pain in his mandible on chewing, caused by a soft tissue overgrowth. There had been no evidence of such an abnormality when, previously, he had an extraction in the same area. Intraoral examination revealed an ulcerated pink mass with poorly defined margins. An excisional biopsy detected abnormal plasma cells and bone imaging techniques were used to identify osteolytic lesions, which did not present until three months later. A bone marrow biopsy

identified abnormal plasma cells and aided the diagnosis of stage II MM.[18]

The tongue

The tongue has been a key area regarding research; studies based on the tongue have investigated the presence of amyloid, a protein that can build up in the body's tissues and impair function (amyloidosis).[10,19] It is closely linked to MM but can also lead to problems such as heart failure and kidney failure.[2] Some symptoms experienced by patients with amyloidosis included pain and stiffness in the tongue (with associated dysphagia), and the presence of yellow or white papules and ulcers. These symptoms can present in immunocompromised[20] or anaemic[21] patients which are both common occurrences in MM.

Oral candidosis

Candidosis has been observed in patients suffering from burning mouth syndrome (BMS).[22] Some suspected causes for this are psychological factors such as stress and anxiety[23] which should be considered when looking to identify symptoms which are sole manifestations of MM.

Pérusse et al. (1994)[22] described a case of a 63-year-old female with a burning sensation in her mouth. Her hard palate, soft palate and tongue were erythematous on examination and the diagnosis of chronic candidosis was duly made. Due to the unknown cause of the candidal infection, a bone marrow aspirate was subsequently undertaken and a diagnosis of MM was made.

Vučićević-Boras et al. (2004)[24] investigated the case of a 79-year-old female with burning mouth symptoms. Her oral tissues appeared healthy however, radiographs revealed a radiolucency at the apex of the UL2. A microbial swab was positive for candida and, despite the patient being treated with antifungals, the burning sensation remained. Subsequent blood tests revealed an abnormal red blood count. A bone marrow biopsy identified a plasmacytoma, which progressed into MM one year later.

Altered nerve function

The presence of a plasmacytomas can cause nerve compression, leading to neurological problems.[25] Patients may present complaining of a numb sensation in the lower lip.[26,27] In one such case, a malignant mass in the maxillary premolar region has been found. In another case,[26] the causative malignancy was in the parotid gland, involving the mandibular ramus. Pati et al. (2022)[28] identified a causative mass to be in the patient's parotid gland, which had presented as facial palsy.

Cardoso et al. (2014)[27] described a case where the patient experienced numbness in the mandible with the malignant mass in the gingivobuccal sulcus. The patient had been diagnosed with MM years prior to the diagnosis of this plasmacytoma.

Diagnostic techniques

Oral manifestations of MM can include pain, swelling and the presence of candida. Some common digital imaging techniques include radiographs, CT scans, MRI and PET scans. A CT scan is a more detailed version of a traditional radiograph, and allows medical professionals to view an area from an alternative angle – they are best used for detecting cancer.[29] MRIs are predominantly used for diagnosing injuries; however, they have an advantage over other methods as they do not involve the use of radiation. A PET scan is the most current digital imaging technique and tends to focus on organs rather than bones.

Other techniques used to aid the diagnosis of MM include urinalysis, haematological investigations and incisional and excisional biopsies – the use of these techniques will depend on the availability of services at the time of diagnosis.

In summary

There are a number of oral manifestations associated with MM that commonly present in patients and generally affect the mandible, maxilla, teeth, soft tissues and tongue. Diagnostic imaging techniques and incisional biopsies are vital in the diagnosis of oral pathology, and are often supplemented with haematological testing and urinalysis.

Dental hygienists and dental therapists routinely undertake careful examination of their patients' mouths. It is essential that we are vigilant to any abnormality and take a patient's concerns seriously. It is also important that as clinicians we feel confident to refer on appropriately. It is therefore important that the referral pathway is clear and easily accessible.

Author
Laura graduated from Cardiff University with a BSc in Dental Hygiene and Dental Therapy in July 2023. She currently practises in North Wales.

Contact
lauradentaltherapist@gmail.com

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Cite this article:

Bosah-Reece L. Common oral manifestations of Multiple Myeloma *Dental Health* 2024;**63(4)**:41-45 https://doi.org/10.59489/bsdht146

General Dental Council (GDC) publishes new stats reports and EDI strategy

The General Dental Council (GDC) has published its annual Registration and Fitness to Practise statistical reports for 2023.

The **Registration Statistical Report 2023** showed that the GDC processed 11,476 registration applications from the UK and overseas in 2023, marking a significant increase from the previous peak of 8,979 applications in 2015.

The **Fitness to Practise Statistical Report** revealed a 15% drop in the number of cases referred to a Practice Committee for hearings – 132 in 2023 compared to 156 in 2022.

COPY DATES FOR

DENTAL HEALTH

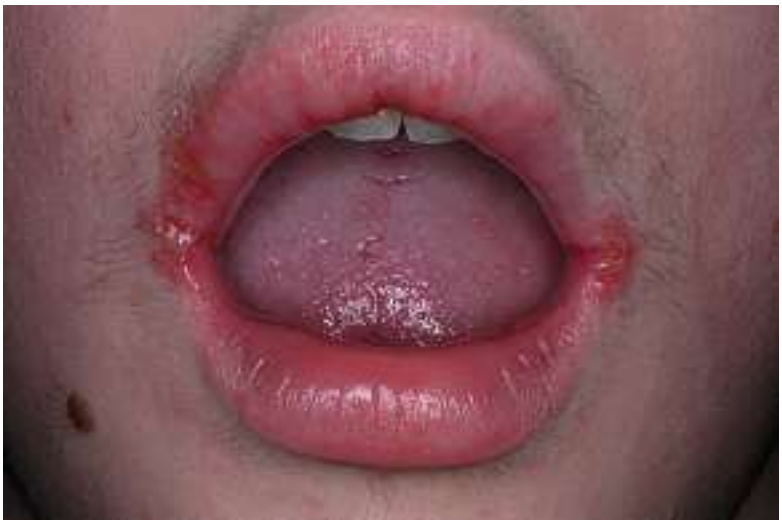
1ST AUGUST FOR SEPTEMBER ISSUE

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

Email: editor@bsdht.org.uk

CLINICAL QUIZ

These painful erythematous changes have been present for three months. You diagnose angular cheilitis..



Q1. What two types of micro-organism are most frequently recovered in microbiological swabs of angular cheilitis?

Q2. Give two types of anaemia that may be an underlying predisposing factor.

Q3. What common underlying endocrine disorder should be excluded?

Q3. What topical antimicrobial agent has been found to be helpful?

SEND YOUR ANSWERS TO THE EDITOR BY 31ST JULY. 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 MAY 2024

The winner is: **Amy Smith**

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 his sleep.

Q1. What is the diagnosis?

A1. *Trigeminal neuralgia*

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

A2. *Shaving.*

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

A3. *Carbamazepine (Tegretol).*

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DIARY DATES

AUTUMN 2024 BSDHT REGIONAL GROUP STUDY DAYS

Contact: enquiries@bsdht.org.uk

Regional Group	Date	Details	Contact (Group Secretary)	Contact Details
Eastern	12th October 2024	Delta Hotel, Huntingdon	Amanda Kestell	easternsecretary@bsdht.org.uk
London	Thurs, 26th September 2024	BDA, Wimpole Street, London	Theai San	londonsecretary@bsdht.org.uk
Midlands	12th October 2024	Bragborough Hall, Braunston, Daventry	Joanna Ericson	midlandssecretary@bsdht.org.uk
North East	Thurs, 26th September 2024	**AGM Online only**, 7pm - 9pm	Sarah Hunter (Acting)	northeastsecretary@bsdht.org.uk
North West	TBC	TBC	VACANT	northwestsecretary@bsdht.org.uk
Northern Ireland	23rd September 2024/ 8th October 2024	Malborough Clinic, Belfast/Online	Gill Lemon	northernirelandsecretary@bsdht.org.uk
Scottish	Thurs, 3rd October 2024	**Online** - AGM combined (7pm - 9pm)	Emma Hutichison	scottishsecretary@bsdht.org.uk
South East	Sat, 28th September 2024	Canterbury Cathedral Lodge, The Precincts, Canterbury, CT1 2EH	Sam Davidson	southeastsecretary@bsdht.org.uk
Southern	Sat, 14th September 2024	The Mercure White Hart Hotel, Salisbury	VACANT	southernsecretary@bsdht.org.uk
South West & South Wales	N/A	N/A	Harriet Elseworthy	swswsecretary@bsdht.org.uk
South West Peninsula	Weds, 2nd October 2024	AGM online only	Lynn Chalinder	southwestsecretary@bsdht.org.uk
Thames Valley	Sat, 28th September 2024	Stoke Mandeville Hospital	Keileigh Ierston (Acting)	thamesvalleysecretary@bsdht.org.uk

THE MOUTH CANCER FOUNDATION

10 KM AWARENESS WALK

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Saturday 21st September 2024

Join thousands of supporters completing their 10Ks to raise money to help support all head and neck cancer patients and their families. The Mouth Cancer Foundation makes a huge impact and exists to help and support anyone affected by head and neck cancer as well as educating the medical, dental and pharmacy professions and raise awareness among the general public.

Sign up to the challenge and secure your place at the Hyde Park event. Survivors of mouth, head and neck cancer and support groups assisting patients and their families are invited to attend the Mouth Cancer 10 KM Awareness Walk in Hyde Park for **FREE**.

Raise over £50 we will send out one of our mouth cancer charity T shirts for free. All walkers receive a medal and goodie bag at the end of the event.

We look forward to seeing you there.

For more information visit
www.mouthcancerwalk.org

Register Today - https://register.mouthcancerwalk.org/

BSDHT ADMIN

'Swallow' Bragborough Hall Business Centre, Welton Road, Braunston NN11 7JG. **Tel: 01788 575050** **Email: enquiries@bsdht.org.uk**

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Rhiannon Jones - presidentelect@bsdht.org.uk

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Elected Council Members:
Kirsty Chappell - ecm1@bsdht.org.uk

Elected Council Members to Executive Team:
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Tracy Doole - ecm2@bsdht.org.uk

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Rhiannon Jones, Miranda Steeples

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Institute of Health Promotion and Education:
Elaine Tilling

BSDHT representative Health Education England Advisory Group (HEEAG): **Diane Hunter**

Student representative to council:
Billie Dunn - studentrep1@bsdht.org.uk
Lauren Chipman - studentrep2@bsdht.org.uk

Student Representative Coordinator:
Claire Bennett - studentrep@bsdht.org.uk

Coaching and Mentoring Representative:
Emma Slade-Jones - MC1@bsdht.org.uk

Diversity, Inclusion and Belonging representative:
DIB2@bsdht.org.uk

REGIONAL GROUP REPRESENTATIVES ON COUNCIL

Eastern: **Andrea Hammond** easternregionalrep@bsdht.org.uk

London: **Nancy Bentley** (Acting) londonregionalrep@bsdht.org.uk

Midlands: **Nina Farmer** midlandsregionalrep@bsdht.org.uk

North East: **Suzanne Ellis** northeastregionalrep@bsdht.org.uk

North West: **Victoria Griffiths** northwestregionalrep@bsdht.org.uk

Northern Ireland: **Tracy Doole** northernirelandregionalrep@bsdht.org.uk

Scotland: **Lynn Harris** scottishregionalrep@bsdht.org.uk

South East: **Jo Downs** southeastregionalrep@bsdht.org.uk

Southern: **Anna Wahlberg** southernregionalrep@bsdht.org.uk

South West and South Wales: **Adam Taylor** swswregionalrep@bsdht.org.uk

South West Peninsula: **Sabina Camber** southwestregionalrep@bsdht.org.uk

Thames Valley: **Fiona Stovold** thamesvalleyregionalrep@bsdht.org.uk

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Treasurer: **Pelagia Kaplanidou** easterntreasurer@bsdht.org.uk

Trade Liaison: **Anna Charters** Email: easterntlo@bsdht.org.uk

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Trade Liaison: **(Mary) Annastasia Kellett-Wright** londontlo@bsdht.org.uk

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Secretary: **Joanna Ericson** midlandssecretary@bsdht.org.uk

Treasurer: **Stephanie Leyland** midlandstreasurer@bsdht.org.uk

Trade Liaison: **Jenny Whittaker** midlandstlo@bsdht.org.uk

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Treasurer: **Sarah Warwick** northeasttreasurer@bsdht.org.uk

Trade Liaison: **Liz Powell** northeasttlo@bsdht.org.uk

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Secretary: **VACANT** northwestsecretary@bsdht.org.uk

Treasurer: **Poppy Urvine** northwesttreasurer@bsdht.org.uk

Trade Liaison: **Kathryn Mayo** northwesttlo@bsdht.org.uk

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Treasurer: **Chloe Hutchinson** northernirelandtreasurer@bsdht.org.uk

Trade Liaison: **Niamh Adair** northernirelandtlo@bsdht.org.uk

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Secretary: **Emma Hutchison** scottishsecretary@bsdht.org.uk

Treasurer: **Yasmin Sutherland** scottishtreasurer@bsdht.org.uk

Trade Liaison: **Yasmin Sutherland** scottishtlo@bsdht.org.uk

SOUTH EAST

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Secretary: **Sam Davidson** southeastsecretary@bsdht.org.uk

Treasurer: **Adelle Cager** southeasttreasurer@bsdht.org.uk

Trade Liaison: **Sarah Breslin** southeasttlo@bsdht.org.uk

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Secretary: **VACANT** swswsecretary@bsdht.org.uk

Treasurer: **Rachael Redstone** swswtreasurer@bsdht.org.uk

Trade Liaison: **VACANT** swswtlo@bsdht.org.uk

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Secretary: **VACANT** southwestsecretary@bsdht.org.uk

Treasurer: **Lauren Binns** southwesttreasurer@bsdht.org.uk

Trade Liaison: **Alison Brown** southwesttlo@bsdht.org.uk

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Secretary: **VACANT** southernsecretary@bsdht.org.uk

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Trade Liaison: **Jessica Davies** southerntlo@bsdht.org.uk

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Secretary: **(Acting) Keileigh Ierston** thamesvalleysecretary@bsdht.org.uk

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BSDHT
The British Society of Dental Hygiene & Therapy
PRESENTS

ORAL HEALTH CONFERENCE 2024

Harrogate Convention Centre
22 - 23 November
#OHC2024

It's BSDHT Annual Poster Competition time

Not only is this a chance to win a prestigious accolade
there are some great prizes on offer too!

Free 2-day delegate pass to BSDHT Oral Health Conference 2024 incl. travel expenses & 1 night's accommodation.

Free attendance at a BSDHT Regional Group CPD event in 2025.

PLUS ... free BSDHT membership for a whole year.

... and that's just 1st prize!

The guidelines and submission forms are now on the **website:https://www.bsdht.org.uk/ohc-2024/**