Our ref: DentalBoard2011-098

Document 11

From: Greg Cocks [mailto:gcocks@thedentalcentre.com.au]
Sent: Tuesday, 17 August 2010 6:26 PM
To: [redacted]
Cc: [redacted]
Subject: Request for Information

Hi John,
Congratulations on your appointment as Chair of The Dental Board of Australia.
This is an extremely important position and is obviously an acknowledgement of your previous good work with the NSW Dental Board and your unique standing in our profession.

The reason for this correspondence is to seek clarification from your board regarding the use of botulinum toxin and dermal fillers in the dental surgery setting.
The background to this request is that I have a number of patients who are receiving treatment with butulinum toxin (Dysport), for acute trismus or chronic spasm of the facial and /or masticatory musculature.
This is a well documented treatment modality and is used with great success in patients who suffer from these debilitating conditions. There is a need for retreatment every 3 or 4 months in some cases, and these visits are generally short – 10 to 15 minutes, and cost effective. Some of these patients are medically compromised and this treatment can occur in conjunction with an overall medical care plan.
The other group are those who suffer from angular chelitis and its associated complication of recurrent candidial infection. These patients are generally treated by improving lower face height with an increase in the occlusal vertical dimension, followed by use of dermal fillers (Restylane) to remove residual clefting. This treatment can last up to 18 months and there is an extensive body of research to support this efficacious treatment modality.
I recently travelled to the UK to undertake some more extensive training and accreditation in the use of Botox and dermal fillers and also, over a 3 week period, visited a number of dental and medical practices who provide theses functional and cosmetic procedures.
You may be aware that there has been an expansion in the use of these techniques and materials into the more general area of non surgical facial aesthetics and there is an increasing demand from patients for us to provide these services in conjunction with contemporary dental services. Whilst it is not yet common in Australia, research shows that more than 10 % of private dental practices are providing these services in the United Kingdom and almost 20% of private practices in some states in the United States, most notably Florida, California, Nevada and New York.
In Australia, these services are generally provided in medical practices and 'beauty therapy' clinics and day spas by trained registered nurses and occasionally medical practitioners.
Anecdotal evidence, in conjunction with an extensive web search, indicates a small but slowly increasing number of dental practices offering theses services.

I have kept abreast of developments in AHPRA via your website and the most recent documentation – Statement from The Dental Board of Australia, 12th August 2010, says
a) We 'can only perform procedures ...and which have been approved by the board' and
b) 'In which they are competent'.
In view of this statement, does the board have a position on the use of botulinum and dermal fillers by trained and accredited practitioners in the dental setting?

I have the training and associated accreditation and have demonstrated competency in this area.
I have the appropriate medico-legal indemnity cover for these procedures.
My practice was recently accredited by the infection control assessor form ADA SA branch and we demonstrated we comply with all the necessary areas under AS4817.
All team members are fully trained and accreditated holders of cert 3, cert 4, radiography and extra-oral imaging, and current infection control accreditation and first aid certification.

It is interesting to note that as I sit at this workstation, I have just come from a patient who presented with pain necessitating the difficult surgical removal of tooth 46 which had a vertical root fracture.
An implant was placed into the distal root socket and bone augmentation and resorbable guided tissue membrane placed prior to closing the wound with rotated flap procedure. The whole procedure, including cone beam imaging, diagnostics and gaining written informed consent, took less than 1 hour and was indicative of what is possible in a contemporary private dental practice with the appropriate training and equipment, sound workplace protocols and a good team.

This would have been unthinkable in our industry 10 years ago and is a demonstration of how dynamic our profession has become.

I understand that you and the board are very busy with the development and implementation of new systems and protocols but I would be appreciative of your timely and considered response.
Kind regards,
Greg Cocks
www.thedentalcentre.com.au