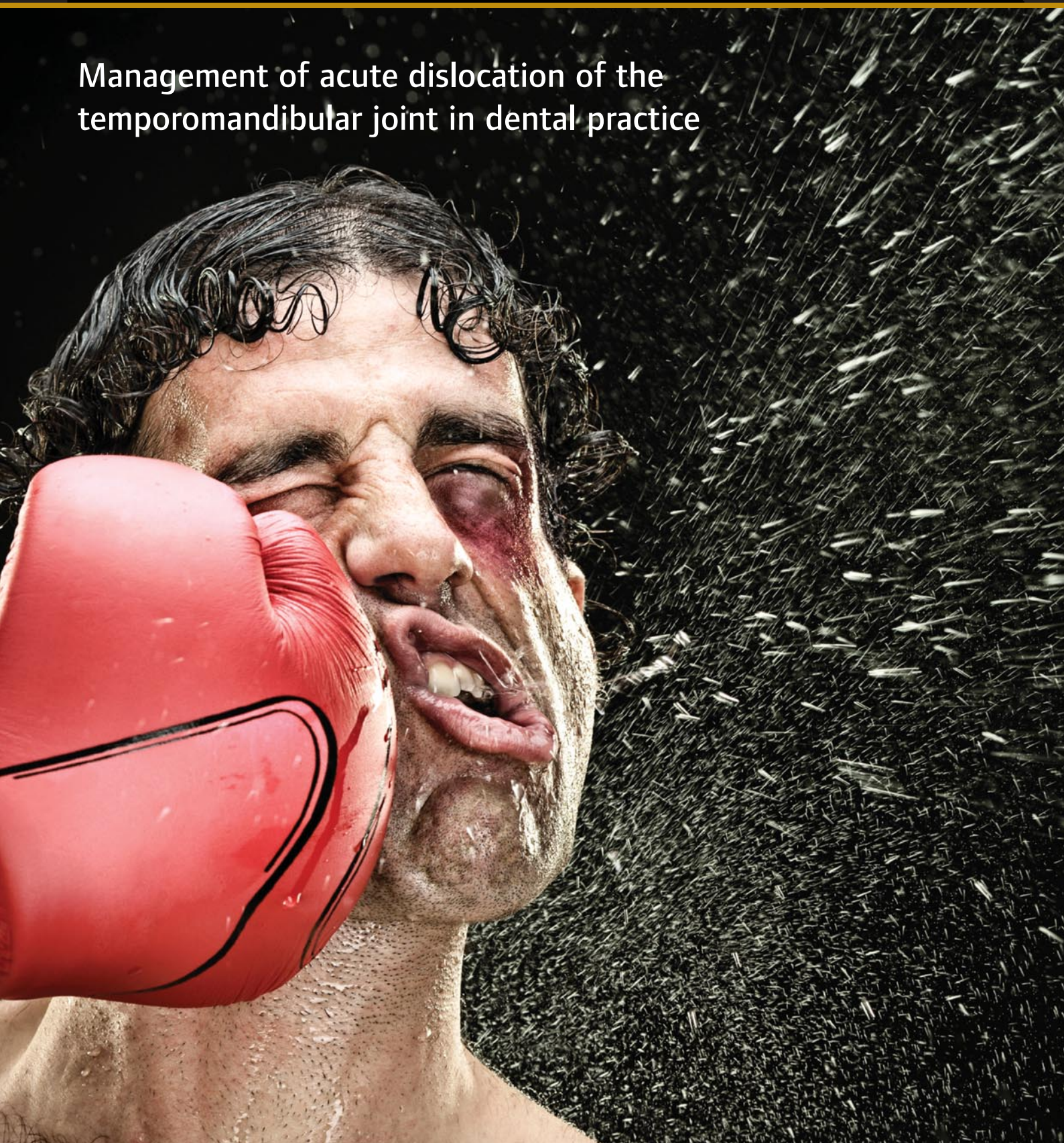


Journal of the Irish Dental Association

Iris Cumainn Déadach na hÉireann

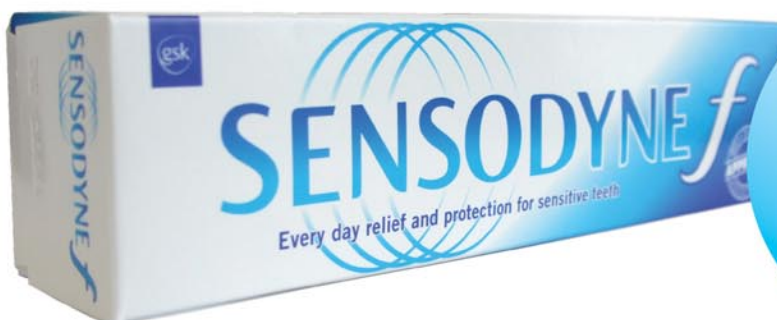
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temporomandibular joint in dental practice



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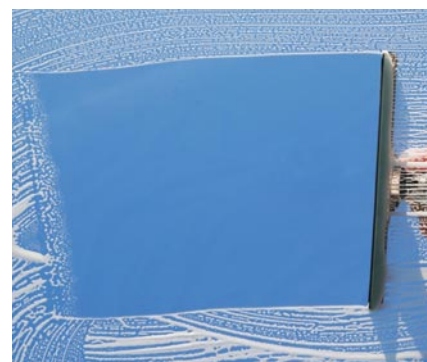
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Does it matter what it looks like - as long as it works?

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There is only one right direction for Ireland

When it comes to dental plans, there is only one right direction for Ireland. The Dental Plan was created by, and is owned and run by, dentists. We understand that there are other plan companies, however The Dental Plan is unique in the expertise, experience and size of the Irish based team we have.

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Change is the theme

Editor Leo Stassen makes an appeal on behalf of common sense, and outlines some changes already made to the *Journal* and some that are coming.

Budget day will be tough and we all are patiently waiting for the next bombshell to hit. Dentistry, hopefully, will be spared a rough time in 2011. Our Association continues to fight for what is required but it needs to have the power and it can only do this if it represents us all (p251). Please encourage your colleagues to become members.

Sometimes the truth hurts but what has happened to Ireland is more painful than that, with most people suffering for the 'folly and greed of many others'. It really is time that the Irish people stand up and say we have had enough and insist on the electoral changes required to bring about 'good governance and Government', 'change in how we, and whatever Government we elect, do things', 'transparency and probity in all areas' and develop a 'streamlined healthy Government electoral scheme'. The lack of clear leadership from our elected representatives in these times has been exasperating. The bank bail out on behalf of Europe may have seemed necessary, but look at what it has cost. Is it right to pay senior public servants, directors and executives of our banks exorbitant bonuses? It may be legally right but is it morally right to allow those who plundered our resources to simply move on with no apology or hide behind bankruptcy? I do not think so. There is an alternative to all of this and we need to demand it from our elected representatives.

A packed *Journal*

This *Journal* is full of exciting events that are coming up with courses and CPD points available on many aspects of dentistry: Cavan (p252), sedation (p251), endodontics (p255) and diary events (p282). Thanks to Elaine Hughes for the quiz (p272 and p278), which challenges our understanding of CPD guidelines – I got four right!

The role of the Dental Council is highlighted in our interview with David O'Flynn (pp260-262), who gives an excellent overview of the regulatory authority and governance for the dental team, where we are and where we are going. Thanks to all those who voted for the new Dental Council (p260) and it is a great privilege for anybody to be elected and to represent your views.

Our peer-reviewed articles highlight the amazing tooth movements possible with orthodontics (pp264-267) and what to do if a patient presents with or develops a dislocation in your surgery (pp268-270) but watch yourself or you might get more than you bargained for – bitten! Our abstracts highlight an important statement by the AADR (p271) on TMJ and advocate a trial of conservative treatment and to avoid surgery if possible. The fact file continues to develop the theme of metal-ceramic vs all-ceramic restorations and our thanks to Seamus Sharkey for this – it is easy to read and understand, and gives a very succinct assessment of our needs.

In this edition, consent for adult patients is discussed in the practice management section (pp275-276) and really is a very good guideline, which we need to keep in our CPD portfolio. Our thanks to Dental Protection for another informative article.

Changes to the *Journal*

Dr John Barry tells us it does matter what it looks like (pp277-278) and how we might easily improve the state of our practices at little cost. This allows me to explain the change in your *Journal*. We felt that it was time to update the look and feel of the *Journal*. The members of the Editorial Board hope that you like it.

Thank you all for your help, hard work and support in 2010. Thanks to all the referees, who do a huge job and a particular thanks to our authors, advertisers, and readers because without you all, our *Journal* would not succeed.

In 2011 there will be a rotation in the Editorial Board. Dr Aislinn Machesney steps down as our GP representative and fact file co-ordinator. I hope that you can join me in expressing our thanks. She did an amazing job in difficult times. Thank you, Aislinn.

In the summer of 2011, Dermot Canavan and I need to move on and let new blood take the reins. These posts will be advertised (no financial reward) and applications of those interested will be considered and greatly appreciated. It is a great job and anybody who would like some background, please contact me through our most efficient and competent *Journal* co-ordinator, Fionnuala O'Brien. These are posts we both give up reluctantly.

Happy Christmas and a great and more relaxing 2011.



Leo F. A. Stassen

Prof. Leo F. A. Stassen
Honorary Editor

Reaching out to the population

The IDA's stand at the National Ploughing Championships was a great success, says DR BILLY DAVIS.

As I write my last President's News of 2010 the country is awaiting a very tough budget. We all hope that dentistry will not be subjected to a further reduction in Government spending. From our pre-budget meetings with the politicians they all accepted that dentistry had received a greater reduction than other professions and we hope that this message will be borne in mind in the formulation of the Budget.

IDA at the Ploughing

In September I was part of the team of volunteers who helped out at the IDA's stand at the Ploughing Championships in Athy. This was a very successful initiative with an estimated visitor count to our stand of well over 2,000. The smile photo competition proved to be a very successful way of interacting with the public. It was great that a number of dentists helped out over the three days. Dr Gillian Smith's demonstration model of teeth allowed us to see how children brush their teeth and how interested they were to hear about the best way to do it. Many parents with young children also came up to us looking for advice. The older generations were not quite as comfortable about asking questions but many did approach with their own individual queries. One appeared with what he thought was his implant in hand; thankfully, it was only the crown! I think this was a very successful exercise as it allowed many people who don't meet dentists outside of a dental surgery to do so.

It provided a snapshot of the difference in experience of oral healthcare between the generations. I sincerely hope that the retrograde effects of the decisions taken in oral healthcare in Ireland in the past few Budgets do not bring us back to the days where the general population does not hold out much hope of keeping their teeth past the age of 50.

Meetings continue

In October I attended meetings in the Dáil where we met with Mary Harney TD, the Minister for Health. The Minister had attended the oral cancer screening initiative in the Dublin Dental Hospital. She was touched by the patients' stories and accepted the importance of screening for oral disease. Unfortunately, there is no extra money available, but we did impress on her the dire effects of leaving oral disease untreated, both for the patient and for the State.

Also in October I had a very worthwhile visit to the IDA Public Dental Surgeons' Seminar in Sligo. It was an excellent meeting and well attended. Congratulations to the new President of the PDS Group, Dr Andrew Bolas. I wish him every success in his year of office and assure him of my support. Recently we had a get-together of the branches of the Association and it is clear that there is a great need for more people to become more involved. Do not be shy, do not wait to be asked, you have a lot to contribute: volunteer, your Association and your profession needs your input. It is a busy time for the Association with a number of negotiations to be concluded. Let's look forward to successful outcomes.

At the time of going to press, it seems likely that the case brought by Drs Martin Reid and James Turner will be heard by the High Court commencing December 7. It is only fitting that we commend James and Martin for their commitment and unstinting efforts, along with the secretariat and the legal team.

A time to support each other

With Ireland going through a very difficult time at the moment and the future looking uncertain, dentistry has been severely affected by cutbacks and the current economic crisis.

At times like this it is a natural response to focus more on oneself, but it is also a time that can define us as a profession if we step up to the mark and cope with the demands that are placed upon us. We are by definition a caring profession and as such we also need to look out for each other, particularly at the present time. We need to foster a strong sense of collegiality by being there for each other, by making contact with the colleague that we have not seen in a while. By simply listening and empathising we can help each other through whatever challenges come our way.

To any colleague who finds it too great a struggle at present, I want to emphasise that we are here for you and I strongly urge you to reach out and realise that all problems can be managed with a little help. So talk to a friend or contact Aware (phone 1890 303 302) or the Samaritans (1850 609 090). Whomever you call, please be assured you will receive comfort and good advice.

Finally, I take this opportunity to wish you all a happy Christmas and New Year!

Billy Davis

Dr Billy Davis
IDA President



Problems with staff issues?

Members are reminded that the IDA offers an employment relations service. So if you are looking for advice or information on redundancies, pay cuts, staff absences, etc., please contact Clare Dowling in IDA House.

IDA membership for 2011

The new IDA membership subscription rates for 2011 will be posted to you shortly. There are new concessionary rates available for a number of new categories (e.g., members with incomes below €50,000/€25,000, members in their first and second years in practice and unemployed dentists).

Please remember that subscriptions may be paid on a monthly or quarterly basis by direct debit.

IDA obtains trade union status

Over 1,000 dentists will shortly receive formal confirmation of their admission to membership of the trade union being established for IDA members. This momentous step follows the policy agreed at the AGM in Kilkenny last year to secure trade union status as a matter of urgency. Securing trade union status will significantly enhance the representation of dentists and afford greater protections to all members.

The rules of the trade union have been formally adopted by seven signatories. An application is to be made to the Registrar of Friendly Societies and thereafter an application will be made to secure a trade union licence. It is important to reiterate that securing trade union status does not oblige the IDA to affiliate to any outside bodies. The Association will continue as a fully independent professional representative body and we will continue to offer the same scientific and educational services to members.

Letter to the Editor

Postgraduate Diploma in Conscious Sedation in Dentistry

Dear Editor,

The Dublin Dental School and Hospital (DDUH) is inviting applications to the Postgraduate Diploma in Conscious Sedation in Dentistry to commence in July 2011. This is an 18-month course.

The aim of the Postgraduate Diploma in Conscious Sedation in Dentistry is to provide a recognised education and training programme that will equip dentists with the knowledge, skills and experience to safely and independently use conscious sedation techniques in their own clinics. The objectives of the course are to provide:

1. A comprehensive education in the theoretical principles and clinical practice of conscious sedation, anxiety and pain control for patients.
2. Development of an ability to critically analyse professional literature.

The Postgraduate Diploma is awarded by the University of Dublin, Trinity College, and is a fully registerable qualification with the Dental Council. The course will involve attendance for 11 didactic days and a minimum of 20 clinical, hands-on sessions in the DDUH or an associated hospital over an 18-month period.

Applicants must have a dental qualification and be registered by the Dental Council, and must have evidence of satisfactory seroconversion for protection against hepatitis B and hepatitis C. Garda (police) vetting will also be a prerequisite for acceptance onto the course.

Entry to the Diploma in Conscious Sedation in Dentistry would normally follow at least a two-year period of dental training, preferably with exposure to/experience of sedation.

Postgraduate students will be assessed throughout the course by:

- written examinations;
- course work and essays;
- oral presentations;
- literature review project; and,
- professional practice placement/logbook.

Further details may be may be obtained via our website – www.dentalhospital.ie – or www.tcd.ie/graduatestudies. Applications to the course can only be made online by logging on to www.pac.ie/tcd from November 2010 with a closing date of March 31, 2011. Interviews will be held in the DDUH in early May. Please address any enquiries to Catherine Creagh, Course Administrator, Tel: 612 7354, between 9.30am and 1.30pm, or Email: catherine.creagh@dental.tcd.ie.

Yours sincerely

Dr Mary Clarke

Course Organiser, Postgraduate Diploma in Conscious Sedation,
Specialist in Oral Surgery/Lecturer in Conscious Sedation

Professor June Nunn

Course Director,
Professor/Consultant in Special Care Dentistry

Professor Leo Stassen

Course Director
Professor/Consultant in Oral and Maxillofacial Surgery

Dublin Dental School and Hospital
Lincoln Place, Dublin 2,
Ireland.

Learning by the Lakes – Annual Scientific Conference, Cavan, May 2011



The Annual Conference 2011 will move to a new location in the beautiful county of Cavan. The Slieve Russell Hotel and Country Club will be the venue for next year's conference from May 12-15, 2011. The hotel has a state-of-the-art conference centre, excellent accommodation and leisure facilities, and a championship golf course on the doorstep. The emphasis will be on learning and fun in a wonderful tranquil setting.

Our visiting speakers include:

Dr Harald Heymann – Professor and Director of Graduate Operative Dentistry at the UNC School of Dentistry, North Carolina. Professor Richard Ibbetson, Chair of Primary Dental Care at the University of Edinburgh and Director of the Edinburgh Postgraduate Dental Institute.

Dr Fred Barnett – Program Director of Postdoctoral Endodontics at Albert Einstein Medical Centre in Philadelphia. He also runs a private practice in endodontics.

Dr Esmond Corbett – a Trinity College graduate, Esmond is Professor of Periodontics at the University of Hong Kong.

Other speakers include: Drs Barry Dace, John Seward, Brid Hendron, John O'Brien, Paul Cashman, Frank Burke, Simon Wolstencroft, Mark Kelly, Claire Healy and Andrew Norris. A full trade show will take place on Friday and Saturday, May 13 and 14.

Attendance at the entire conference guarantees all dental practitioners their full annual CPD requirements for 2011. There will also be presentations in all three core CPD subject areas of infection control, oral radiology and medical emergencies.

The conference will include a varied social programme, including cultural events, golf and our annual dinner on Saturday May 14, along with some special guest appearances. Be sure to include 'Cavan – Learning by the Lakes' in your 2011 diary for you and your dental team members today!

Dental Conference at the Aviva

A one-day conference for IDA members will take place on Saturday January 15, 2011, at the Aviva Stadium in Dublin. The conference, open only to IDA members, will include presentations from leading national and some UK-based experts in the area of practice management and business skills.

Speakers include:

Dr John Tiernan, Dental Protection, who will present on how he sees dentistry on a world-wide basis and where he sees dentistry in Ireland;

Ray Gordon, MRM Public Relations, whose presentation will focus on how dentists can deal with the media;

Leanne Papaioannou, Chilli Pepper Marketing, who will show dentists how they can market their practice with minimal budgets;

Kevin Rose and Dr Simon Thackeray. Dr Thackeray is a UK-based dentist who converted his NHS practice to a fully private practice. He did so with the guidance and assistance of business consultant Kevin Rose;

David McCaffrey, MedAccount, will present on managing costs and dealing with specific tax issues;

Sheila Scott will give her thoughts a year on after the dramatic PRSI cuts and give advice on selling skills and how to maintain patient loyalty.

There will also be a speaker on dealing with stress in the current difficult economic climate. Admission is €50 and will include lunch. Further details will be sent to members before the event or contact Elaine in IDA House.

Irish Division of the European Academy of Paediatric Dentistry – first meeting



Pictured back row (from left): Dr Mike Brosnan; Dr Paddy Fleming; Prof. June Nunn; Dr Eimear Norton; Dr Rona Leith; Dr Abby Moore; Dr Margaret Tuite; and, Dr Rosemary Daly. Front row (from left): Dr Evelyn Connolly; Dr Billy Fenlon; Dr Anne O'Connell; and, Dr Eleanor McGovern.

The European Academy of Paediatric Dentistry (EAPD) was formed in 1990 to advance the specialty for the benefit of the oral health of children. Irish paediatric dentists were among the founding members, and hosted the 6th Congress of the EAPD in TCD in June 2002. At present, Dr Paddy Fleming is on the Board, serving as Secretary, and Dr Billy Fenlon is the Irish Councillor to the Academy. With over 20 Irish graduates having completed masters degrees in paediatric dentistry currently resident and working in Ireland, the Irish Division of the EAPD had its first meeting in September.

'In Practice' at the RCSI

It was standing room only for many of the presentations at the Faculty of Dentistry of the Royal College of Surgeons in Ireland Annual Scientific Meeting on October 28 and 29 last. The theme of the meeting was 'In Practice', and an impressive line-up of clinicians and academics from at home and abroad made presentations.

Eminent maxillo-facial surgeon Mr David Ryan offered a light-hearted and thought-provoking overview of 40 years in practice. Faculty Dean Dr PJ Byrne introduced the 12th Edward Leo Sheridan Memorial Lecture, which was delivered by Professor Jan Wennstrom of the Department of Periodontology, University of Gothenburg, Sweden. Prof. Wennstrom described the rigorous work involved in Sweden's new National Guidelines in Dentistry. On Friday, Dr Alison Dougall offered her top ten tips on the treatment of medically compromised patients, pointing out that such patients are becoming more common in dental surgeries. Dr Andrew Toy used his own experiences to argue for an ethical business model in dentistry, where "profit with integrity" can be achieved. Dr Garry Heavey gave some valuable advice on the use of intra-oral cameras



Speakers at the RCSI Faculty of Dentistry Annual Scientific Meeting (from left): Dr Garry Heavey; Dr Sue Greening; Dr Andrew Toy; and, Dr Paul McEvoy.

in practice. Dr Ed Cotter offered practical and valuable advice on how to carry out urgent denture repairs, listing the materials and equipment required, and emphasising that much of these can be purchased at relatively low cost but can still offer an excellent result for the patient. Dr Paul McEvoy wound up proceedings with a fascinating description of his experiences using Cerec in general practice.

Vhi DeCare Dental Making Oral Healthcare a Regular Habit...

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Media analysis shows success of IDA campaigns

A media analysis commissioned by the Irish Dental Association (IDA) has confirmed that the Association achieved a high level of positive coverage of its campaigns relating to dentistry and oral health during 2009 and 2010. The report, which was carried out by newsaccess, shows that the 224 pieces of print and media coverage reached a total audience of over 43m persons and the worth of this coverage was equivalent to over €850,000 in advertising value. The report reveals that the three most successful IDA stories of the year were the 'Stop the Rot' and 'Bite Back' campaigns against cuts to the DTBS (PRSI) scheme, and stories relating to the IDA's denunciation of the Government's decision to effectively dismantle the medical card scheme. These stories were covered on over 160 occasions in the Irish media, demonstrating their importance to the public, and also the IDA's commitment to keeping these issues in the public eye despite difficult economic circumstances.

Analysis

The newsaccess analysis measures coverage according to three key markers:

- **quantitative** – how much media coverage a campaign has received;
- **qualitative** – the impact of this coverage, and whether it is positive or negative; and,
- **reach** – the maximum possible audience for each piece (calculated according to measures of 'opportunity to see' [OTS] and readership/viewer figures).

The analysis then attributes a value to each piece of coverage that is based on the equivalent cost of placing an advertisement in the relevant media. It also measures the favourability of coverage according to a number of criteria, such as:

- **use of photographs;**
- **presence of logos or other branding; and,**
- **interviews with key personnel in an organisation.**

The newsaccess analysis shows that coverage of the IDA achieved a total value of €859,768.95, including:

- **€858,532.71 of positive coverage; and,**
- **€1,236.24 of negative coverage.**

OTS/audience/readership figures reached a total of 43,502,237, including:

- **43,185,537 for positive coverage; and,**
- **317,000 for negative coverage.**

IDA bites back

A breakdown of the figures shows that there were peaks in coverage in August and December 2009, and in May 2010. These periods correspond with the IDA's 'Stop the Rot' and 'Bite Back' campaigns against cuts to the PRSI scheme, and with the Association's campaign to reinstate the medical card scheme.

According to the media analysis, these were also among the most valuable items of coverage in terms of their quality and audience reach:

- **the 'Bite Back' campaign had a value of €186,354.60 and potential reach of 10,634,505;**
- **'Stop the Rot' had a value of €53,888.14 and a potential reach of 4,145,593; and**
- **the campaign to reinstate the medical card had a value of €108,481.09 and a potential reach of 6,150,646.**

Other stories that received extensive coverage included the IDA's AGM in Galway in May 2010, issues around dentists' fees, the reductions in patient numbers and dental income, and the decrease in treatments carried out under the PRSI scheme in the first nine months of 2010.

Only one piece of negative coverage was noted in the study: an item in the *Evening Herald* in December 2009 under the headline 'Dentists accused of making claims for dead patients'. This item had a value of €1,236.24 and a potential reach of 317,000; however, this represents a tiny percentage of the overall coverage.

Coverage across Ireland

The media analysis also broke down the different media where coverage of the IDA's campaigns featured, and showed that the majority of coverage was in print media (169 items), compared to 45 items on radio and 10 on television. However, analysis shows that, perhaps unsurprisingly, coverage on radio and television had a higher relative value in terms of audience reached.

Further analysis reveals the role of IDA representatives all over the country, with coverage in national and local newspapers and on national and local radio. This shows both the commitment of the IDA to putting its message across, and the value of such coverage, which contributed hugely to the success of the IDA's campaigns on behalf of dentists and patients.

Value to Association

IDA Chief Executive Fintan Hourihan paid tribute to the dentists who had volunteered to act as spokespersons for the Association in the media. "This analysis quantifies the noticeable increase in media coverage of dentistry in the last 18 months and is testimony to the large group of dentists who spoke out publicly on behalf of their colleagues and the profession. We provided media training programmes for these dentists and would welcome further volunteers for whom we would run the programmes again. It's evident from the figures that the return that we get for our investment in public relations is excellent and warrants continuing time and effort."

IDA keeping members informed

The distribution of Circulars to IDA members by email is an important IDA service. In addition to the Circulars we issue on contractual and service matters, we also circulate our popular Dáil Digest, which offers information on parliamentary questions on dental matters.

Below is a list of the latest Circulars and Dáil Digests: if you are a member and are not in receipt of our publications by email please contact IDA House and we will arrange to send you copies immediately.

IDA Circulars

Date	Subject
Nov. 2	Circular to GDPs re DTSS
Nov. 17	Circular to GDPs re DTSS
Nov. 22	Circular to HSE dental surgeons re PA Report/HSE dental reforms
Nov. 23	Circular to HSE dental surgeons re reconfiguration
Nov. 24	Circular re reconfiguration of acute hospital services in Cork/Kerry
Nov. 25	Circular to GDPs re DTSS, DTBS, Ombudsman's report re nursing homes/DTSS and miscellaneous other matters

Dáil Digests

Date	Subject
Oct. 5	DTSS, DTBS, professional fees, tax relief on dental expenditure
Oct. 11	HSE policy on deciduous teeth, DTSS
Oct. 22	Numbers of dentists participating in dental schemes, DTSS, HSE public dental services, Competition Authority recommendations, HSE orthodontic services
Nov. 18	DTSS, administration of medical cards, HSE public dental services, credit availability for SMEs



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Details from Sandra Duffy at above address.

Irish dentist addresses European conference on healthcare fraud

The 7th Annual Conference of the European Healthcare Fraud and Corruption Network (EHFCN) took place recently in Brussels. The title of the conference was 'The real cost of fraud and corruption in healthcare – how to reduce it'. More than 150 participants from 20 countries took part in the event. Brussels was chosen in order to tie in with the Belgian Presidency of the Council of the European Union. Over 20 scientific papers were delivered, which sought to measure the problem of fraud in healthcare and suggest solutions. Professor Omre (Norway) described international risk research indicating a level of healthcare fraud of 5-8%. Dr Button (UK) found the percentage loss rate in healthcare to average 5.59%. He felt that it would be reasonable to assume that in most large healthcare delivery organisations fraud costs will be at least 3%, probably more than 5% and possibly more than 9% of budget. He also believes that the introduction of an appropriate strategy can produce a 12-1 return on investment. Publicly funded oral healthcare delivery systems were frequently referred to in the papers delivered at the two-day

conference. The participants were interested therefore in the paper delivered by Dr Liam Lynch (Ireland), the only speaker with experience as a dentist. Dr Lynch emphasised the pivotal role of peer review in probity assurance in dentistry. Peer review was defined as "a process by which a dentist examines the clinical work of a colleague and determines whether the dentist under review has met accepted standards of care in rendering dental services". He believes that each micro-sector of healthcare must develop specific counter-fraud systems utilising components suitable for the profession. Peer review is an essential such component for dentistry. The EHFCN is a not-for-profit organisation and is the only European organisation dedicated to combating fraud and corruption in the healthcare sector across Europe. The EHFCN was formally established in 2005 as a result of the first pan-European conference held in London in October 2004. Its foundations lie in the European Healthcare Fraud and Corruption Declaration agreed upon by delegates. Today the network represents 23 member associations in 10 countries.

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New facilities at Dublin Dental Hospital



Tánaiste and Minister for Education and Skills, Ms Mary Coughlan, recently opened new facilities at the Dublin Dental Hospital. New space for the library, additional seminar rooms, a new laboratory and new offices were all part of the development. The Minister is pictured (second right) unveiling the plaque with (from left): Brian Murray, CEO; Dr Michael O'Sullivan, Clinical Director; Professor June Nunn, Dean; and, Ms Emer Daly, Chairperson, Dublin Dental Hospital Board.

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Strong turnout at PDS Seminar

Despite the downturn and the challenging times, there was a strong turnout for the Public Dental Surgeons Seminar in Sligo in October. President of the Public Dental Surgeons Group, Dr Andrew Bolas, and his team put on a superb programme of speakers, combined with an excellent social programme.

While it was a strong programme throughout the three days, highlights of the presentations included David Ryan’s valedictory address in which he reviewed the progress of dentistry and oral surgery over his lifetime; Brid Hendron’s marvellously entertaining – and very pointed – journey through the world of neuro-linguistic programming, during which she pointed out the danger of certain modes of thinking; and, Professor Monty Duggal’s presentation on molar incisor hypomineralisation.



Professor Monty Duggal presenting in Sligo.



Dr Andrew Bolas, President of the Public Dental Surgeons Group, welcomes the President of the Association, Dr Billy Davis, to the PDS Seminar in Sligo.



At the dinner were (from left): Drs Marie Tuohy, Jane Renehan, Coleen O’Neill and Michael Mulcahy.

Omega offers free pension review for IDA members



John O’Connor of Omega Financial Management has announced that for the first quarter of 2011, Omega will be providing a new, free Pension Review Programme for IDA members over the age of 50. Omega’s experience is that dentists have tended to write once-off cheques to their pensions at tax time and place them with a different fund and provider each year. As a result dentists tend to have a considerable number of pension policies built up without any focus or direction. Most times dentists are confused

about the asset content of each fund, the overall value of the funds, and the amount of risk in their portfolios, and often times are uncertain and unhappy about why their funds have performed poorly.

The idea of the Pension Review Programme is to assess the funds that people have invested in to-date and give them an idea of:

- when they will be able to retire;
- how they can secure their current position;
- how much they will have in their fund at retirement;
- how much of a pension that will give them; and,
- if they need to move the funds to more conservative investments.

Omega will be providing an appointment service for dentists but if you would like to arrange your review you can do so by calling John immediately at Omega.

Dental recruitment service now a year in business

"If I had a mantra for recruitment, it would be that 'people matter'," says Marguerite Morgan, Principal of Irish Dental Jobs. "Recruitment is all about finding the right people for the right jobs and I always focus on a person's personality and ability as well as their experience." Marguerite established Irish Dental Jobs almost a year ago after identifying the need for a specialist dental recruitment business to service the needs of the Irish dental profession. Marguerite has 11 years' experience in the recruitment business. She started out in commercial recruitment before setting up legal recruitment divisions in companies here in Ireland and in Melbourne, Australia. Back in Ireland, Marguerite was one of the founders of Lex Consultancy and while specialising in legal recruitment, quickly identified a niche in the Irish dental recruitment market. Thus, Irish Dental Jobs was born. While Marguerite agrees that 2010 has been a challenging year she believes that recruiting the right dental professional is even more important in this economic climate. Irish Dental Jobs has



Marguerite Morgan of Irish Dental Jobs says that people matter and that she will find the right people for your practice.

been successful in placing a significant number of dental professionals in its first year and is busy expanding its ever-growing dental database. The new service of placing experienced temporary nurses and hygienists nationwide at short notice is growing rapidly.

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An eye for the big picture

New Dental Registrar David O’Flynn deals with a complex set of duties but demonstrates an easy authority, combined with an eye for the big picture, when interviewed for the *Journal*. PAUL O’GRADY reports.



The Dental Council is the regulatory authority for dentistry in the Republic of Ireland. It was set up under the terms of the 1985 Dentists Act and is a statutory body. Its main functions are to maintain the Register of Dentists; to set the standards for dentistry; to assess and review education of dentists; to regulate and enforce fitness to practice; to provide for the regulation of auxiliary dental workers; and, to provide guidance to the profession, the public, and the Minister for Health. The Dental Council, which is made up of 19 members, has the ultimate responsibility for the carrying out of its functions.

Some functions are delegated to the Registrar, and additionally the Registrar advises the Council on the provisions of the Act, and attends all meetings, although he does not have a vote.

David O’Flynn was appointed as the Registrar in January 2010. He had served a period as the acting Registrar, and his appointment followed the retirement of the long-serving Tom Farren. The

Council’s 19 members also serve across a variety of committees. These include: the Finance and General Purposes Committee; the Fitness to Practice Committee; the Auxiliary Dental Workers Committee; and, the Specialist Training and Registration Committee.

Specialist registration

The area of specialist registration has been held up to scrutiny in recent times. The scrutiny is of areas which are specialties in other European countries but not in Ireland. O’Flynn essentially makes two points on the issue. In relation to the number of specialties, he states that as long as 13 years ago the Dental Council recommended a list of 10 specialties (see list in panel) to the Minister for approval. The Minister chose only to recognise two (oral surgery and orthodontics). The Dental Council also recommended in 2005 that special needs dentistry be recognised as a specialty.

Again this was not approved. The Registrar feels that the recently elected Council (see panel) is likely to make a new submission to the Minister on the topic. This position, of course, throws the situation of those dentists with specialist training in areas that are not recognised as specialties into sharp relief. How does the Dental Council monitor and regulate these dentists (typically operating with limited practices)? “Any dentist may decide to limit their practice completely to one area, but they will still be held accountable to the Dental Council for any treatment provided,” says O’Flynn. In reality, he says, Ireland is such a small market that general dental practitioners (GDPs) will not send their patients to any dentist with a limited practice unless they are certain their patients will get the best treatment. The qualifications of those dentists with limited practices are also registered with the Council. “And any complaint received would be measured against the Expected Standards test,” says the Registrar.

New Dental Council

The following dentists were recently elected for the new five-year term of the Dental Council: Dr Eamon Croke; Dr Terry Farrelly; Dr Gerard McCarthy; Dr Barney Murphy; Dr Paul O’Reilly; Dr Roger Ryan; and, Professor Leo Stassen.

Auxiliary Committee Elections

The following professionals were deemed elected: Clinical Dental Technicians – Mr Maurice Petherick; Dental Hygienists – Ms Rhona Butterfield; Dental Nurses – Ms Carmen Sheridan.

The new President of the Council is:

Dr Eamon Croke.

“Any dentist may decide to limit their practice completely to one area, but they will still be held accountable to the Dental Council for any treatment provided.”



Advertising issues

O’Flynn says that patients only rarely make contact with the Council about advertising, but when they do it is typically where a GDP advertises that they have a special knowledge of orthodontistry. In those instances, the Council contacts the dentist in question and advises that they alter their advertising. So far, this instruction has been followed in all cases. The Council has also dealt with a number of instances of dentists registered overseas who have been advertising their services to patients in Ireland via websites. In those instances, the Council has required the dentist to state where their qualification is registered. In relation to websites, David said that the same rules that apply to claims and statements in advertising and brochures apply to websites. One area that has been brought to his attention is the use of ‘before’ and ‘after’ photographs. These can only be used if they are photographs of patients who received that treatment at the surgery or clinic that is being promoted by the website.

“There are 2,700 dentists on our Register and the number of complaints we have to deal with is relatively small – and the number that need to progress to hearings is much smaller again.”

General complaints

In 2009 the Dental Council dealt with 69 complaints against dentists, and in 2010 to-date, there have been 91 complaints. Of these, only a very small number progress to Fitness to Practice hearings (currently, there are four complaints going before a hearing). While David O’Flynn is prohibited from commenting on

FEDCAR

The Dental Council of Ireland is a member of FEDCAR which is the European Federation of Dental Regulators. Dr Martin Holohan who recently completed his term as President of the Dental Council, was also Chairman of FEDCAR. Through that body, the Council has good relationships with fellow regulators. In particular, there is a good relationship with our nearest neighbour, the UK’s Dental Council.

Recommended specialties

The following list of specialties were recommended to the Government for recognition in 1995. Of these, only oral surgery and orthodontics were actually recognised.

- Oral Surgery,
- Oral Medicine,
- Oral Pathology,
- Dental Radiology,
- Orthodontics,
- Paediatric Dentistry,
- Dental Public Health,
- Periodontics,
- Endodontics
- Prosthodontics
- Special Needs Dentistry

In 2005, the Council also recommended special needs dentistry as a specialty. It has not, yet, been recognised.



the details of any case, he has a strong piece of advice for dentists: "Based on our experience at the Council, a large number of complaints relate to issues of communication rather than the quality of the treatment itself. And given that we get very few spurious complaints, it means a patient that goes to the trouble of writing to us is really seriously aggrieved. Therefore, I would urge dentists to pay particular attention to listening to their patients' complaints. It is much better to deal with the complaint at the time, even if it seems minor, than to have to end up dealing with correspondence from the Dental Council." Having given that advice, David O'Flynn reiterates his confidence in the profession. "There are 2,700 dentists on our Register and the number of complaints we have to deal with is relatively small – and the number that need to progress to hearings is much smaller again."

Based on our experience at the Council, a large number of complaints relate to issues of communication rather than the quality of the treatment itself.

CPD

Continuing professional development is an obligation as a matter of dental ethics. "It is not" says David, "a condition of being on the Register of Dentists. However, a dentist's participation in CPD will be considered if there is a Fitness to Practice hearing against him or her." Until a new Dentists Act comes into law, CPD will remain an obligation but not mandatory. Since the demise of the Post Graduate Medical and Dental Board (PGMDB), the Dental Council has put a voluntary scheme in place. Under the terms of that scheme, dentists are required to do 250 hours of CPD over a five-year term. One hundred hours must be verifiable and the balance is general CPD. "The voluntary scheme is an encouragement to start, so that it will be a seamless transition to the new system."

The future

Mandatory CPD is likely to arrive with a new Dentists Act. The draft Heads of Bill are expected in 2012 and the Registrar observes: "The Department of Health has to carry out a regulatory impact analysis. This is a rigorous process which will involve consultation with all interested parties." The Dental Council has already made a submission on the Bill. The new Dentists Act is expected to mirror existing legislation and result in a minority of dentists on the Dental Council. David O'Flynn comments: "The reality is self-regulation is being replaced as a concept by co-regulation."

It is certainly likely to change the operation of the Dental Council and of Fitness to Practice procedures. Interestingly O'Flynn comments that there is an argument that dentists have a deep understanding of their own professional expertise and are likely to be harder on any dentist guilty of malpractice than perhaps a lay person would be. Regardless, that's for the future and is in the realm of a new regulatory framework. In the short term, the Registrar has a first year under his belt and is fully engaged by his current work with the Council.

Regulator, Accountant, Photographer

David O'Flynn is a professional man with many talents. He trained as a management accountant while working with the ESB and after 15 years left for what turned out to be a brief sojourn in the technology sector. Joining An Bord Altranais in 2002 as Director of Operations, he learnt the details of the Nurses Act, which, as it turns out, is very similar to the Dentists Act. Joining the Dental Council in 2009, he became the Dental Registrar in January 2010. Married to Helen, they have two daughters – Aoife who is 14, and Maeve who is 11. Much of what spare time he has is devoted to photography. He has already had a book of photographs *Images of Fingal* published, and a second one – dealing with Irish people and their relationships with horses – is with the publishers. To stay fit, David enjoys a regular game of five-a-side football.

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Maxillary canine–first premolar transposition in the permanent dentition: treatment considerations and a case report

Abstract

Transposition is defined as the interchange of position between two adjacent teeth within the same quadrant of the dental arch. Permanent maxillary canine–premolar transposition is the most commonly observed transposition in the human dentition. Its prevalence is relatively low and its aetiology remains unclear, although it has been associated with genetic factors. It may also be related to a combination of localised factors such as malformation of adjacent teeth, tooth agenesis, retention of the deciduous canine and a history of local trauma. Treatment is selected on an individual case basis after thoroughly considering the overall facial and dental characteristics, duration of treatment, cost, patient preference and the orthodontist's experience. This article provides a case report of maxillary canine transposition in the permanent dentition, successfully managed with orthodontic treatment.

Key words: tooth transposition, ectopic eruption, maxillary canine, orthodontic treatment.

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Introduction

Tooth transposition is defined as a type of eruption anomaly where there is either an exchange of position between two adjacent teeth, or the development and eruption of a tooth in a position normally occupied by another non-adjacent tooth.¹ Transposition is classified as complete, where it involves both the crown and the root (with the roots of the transposed teeth parallel to each other), or incomplete, where the crown alone is involved.¹⁻⁴ Transposition of teeth should not be confused with ectopic eruption. By definition, all transpositions are ectopic eruptions but not all ectopic eruptions result in transposition.⁵ It is a rare condition with a reported prevalence of 0.13-0.4% in the general population.^{1,4,6-9} Patients with tooth transposition may present with concomitant dental anomalies including hypodontia (most often missing the permanent upper lateral incisor), dilacerations, and abnormalities of tooth

size/shape (such as peg-shaped teeth).^{1,10} In addition, retention of deciduous teeth (especially the primary canine) is often observed, along with the presence of malaligned adjacent teeth.^{1,10,11} Transposition affects teeth of either the maxillary or the mandibular arch, and only rarely occurs simultaneously in both arches. Overall, it is more frequently observed in the maxilla than in the mandible.^{1-4,10,11} **Table 1** shows the types of transpositions most frequently seen in the maxillary arch.

Table 1: Classification of transposition of permanent maxillary teeth in decreasing order of frequency.⁴

1. Canine–first premolar.
2. Canine–lateral incisor.
3. Canine on the site of first molar.
4. Lateral incisor–central incisor.
5. Canine on the site of central incisor.

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Transposition of teeth affects males more frequently than females at a ratio of 3:2.¹¹ In most cases transposition of teeth is observed unilaterally,¹⁻³ especially in male patients.^{10,11} Unilateral transposition appears to be more likely to occur on the left side.^{1,7,8,17} Nevertheless, bilateral cases have also been reported.^{5,12-16}

The exact aetiology of tooth transposition remains unclear but several explanations have been postulated (Table 2).^{1,4,7,8,10,14,15,18,19}

This article reviews the aetiology, diagnosis and treatment options for patients presenting with transpositions of the maxillary canine. Additionally, a case report is presented of the management of a maxillary canine–first premolar transposition.

Maxillary canine transposition

The fact that the maxillary permanent canine transposition is the most commonly seen transposition is attributed to the long eruption path of the maxillary canine, which makes it more vulnerable to deflective movement. The bud of the permanent maxillary canine initially develops at the boundary between the developmental fields of the lateral incisor and the first premolar, located superiorly and palatally, just under the orbital ridge. Following its eruption pathway, the maxillary canine gradually moves more buccally and mesially, where it usually becomes progressively palpable in the labial sulcus. Transposition occurs in cases where the eruption pathway of the upper canine is disturbed under the influence of genetic and/or environmental factors. In such circumstances, the erupting maxillary canine follows a path located more mesially to the lateral incisor or distal to the first premolar. Similar anomalies have also been described in ancient skeletal samples and transposition cannot therefore be regarded as an anomaly of modern times.^{5,20-22} It has been suggested that transposition of the maxillary canine is genetically determined.¹ Findings such as a moderate rate of bilateral occurrence, sex-related differences,^{1,3,11,18} unilateral left-sided prevalence,^{1,3} increased prevalence of additional dental anomalies,^{1,3,11,18} hereditary pattern of occurrence,^{12,23,24} increased prevalence in patients with Down syndrome²⁵ and varying incidence among populations, support a genetic aetiology. In many instances of maxillary canine transposition, the deciduous canine is retained. The result is lack of space in the upper arch for the ectopically erupting permanent canine. In situations of canine–first premolar transposition, the permanent canine is usually rotated mesio-buccally. The first premolar is tipped distally and rotated mesio-palatally. In most cases the transposed canine is buccally positioned and only rarely palatally positioned.⁵

According to data from epidemiological studies, the prevalence of maxillary canine–first premolar transposition ranges from 0.03-0.51% (Table 3).^{6,26,27}

Table 2: Proposed aetiology of tooth transposition.

- Genetic factors
- Exchange of position between developing tooth buds
- Retention of deciduous teeth, especially the deciduous canines
- Intra-osseous migration of the developing permanent canine
- Trauma to the deciduous teeth
- Cysts or other localised pathology

Maxillary canine transposition is usually associated with aesthetic and functional problems that need to be addressed at an early stage. Timely diagnosis of a developing transposition is the most important factor favouring preventive intervention aiming to restore the normal tooth order. Early intervention greatly improves the prognosis of treatment while minimising the risk of damage to teeth and their supporting tissues.²⁸ Early diagnosis is facilitated by timely clinical and radiographic examination at the beginning of the late mixed dentition stage of dental development.

Orthodontic treatment considerations in cases presenting with maxillary canine–first premolar transposition

Optimal treatment of maxillary canine–first premolar transposition should be determined after thorough clinical examination, as well as radiographic and dental cast analyses. In general, the available treatment options are:²⁹

- orthodontic treatment, including extraction of the upper first premolars. This is particularly indicated where arch length–tooth size discrepancy exists prohibiting the accommodation of all maxillary teeth to their alveolar base; and,
- non-extraction orthodontic treatment, where either the transposed teeth are moved to their normal positions,^{5,30-32} or their positions are accepted and the teeth are aligned to their transposed sites.^{14,33-35}

In maxillary canine transposition, treatment planning should consider treatment duration, difficulty, risks of side effects, dental and facial aesthetics, occlusal function, stability, professional experience and patient preferences.⁵ The principal aim of treatment is to orthodontically move the transposed teeth to their normal positions, since this benefits dental and occlusal aesthetics, function and stability.^{5,28,30,32,36} This option will, however, prolong the duration and increase the difficulty of the treatment. In incomplete transposition, where only the coronal part of the canine is affected, canine uprighting is usually the primary objective of orthodontic treatment, provided that adequate space for tooth alignment is available. This facilitates natural tooth order. In more severe cases the position of both the crown and the root of the transposed teeth needs to be corrected. In such situations, treatment is prolonged and more complicated. There is an increased risk of incurring damage to the teeth and their supporting tissues by occlusal interferences, and of developing gingival recession, root resorption and supporting bone loss. Bone loss is most commonly from the buccal alveolar plate.^{5,28,32}

In patients where orthodontic tooth movement to correct intra-arch position is indicated, treatment should initially provide a pathway for the canine movement from its transposed position to its normal site. In

Table 3: Prevalence of maxillary canine–first premolar transposition.

Study	Population	Prevalence (%)
Thilander and Jakobsson (1968) ⁶	Swedish schoolchildren	0.03
Ruprecht <i>et al</i> , (1985) ²⁶	Arabian dental patients	0.13
Burnett (1999) ²⁷	Composite African sample	0.51



FIGURE 1: Intra-oral occlusal view of the upper and lower dental arch.



FIGURE 2: The initial panoramic radiograph of the patient.



FIGURE 3: A peri-apical radiograph of the transposed teeth.

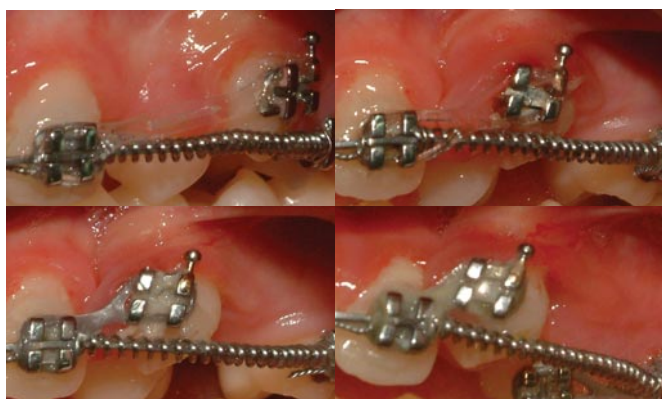


FIGURE 4: Labial view of the maxillary left canine–first premolar transposition area at successive stages of orthodontic treatment.



FIGURE 5: Intra-oral occlusal view of the upper dental arch after the completion of orthodontic treatment.

maxillary canine–first premolar transposition, this is facilitated by pure palatally directed bodily movement of the premolar. This minimises the risk of canine to premolar root interference since the labio-lingual width of the maxillary first premolar is much greater than that of the canine.³² If orthodontically induced mesial movement of the canine is performed too labially, there is an increased risk of gingival recession and buccal bone loss. Therefore, fixed orthodontic appliances with good anchorage and maximum torque control should always be applied to prevent forcing of the canine root against the first premolar. After the canine is moved to its normal position the alignment of the premolar in the arch should follow.³⁶

Case report: a maxillary canine–first premolar transposition

A healthy nine-year-old female patient was referred for orthodontic consultation. Her extra-oral examination showed symmetrical craniofacial features with average facial proportions. Nothing abnormal was detected during a functional evaluation of the stomatognathic system and the temporomandibular joint (TMJ). Intra-oral examination revealed a Class I malocclusion with an almost complete permanent dentition. The upper left canine was palpable in the buccal sulcus located between the two premolars, and its cusp was emerging at the gingival level. The upper left primary canine had exfoliated, leaving its space vacant. The upper left first

premolar showed a mesio-palatal rotation. No other dental pathology was observed with the exception of the transposition and some plaque-induced gingival inflammation restricted mostly to the crowded areas (Figure 1).

A panoramic and a peri-apical radiograph revealed the ectopically erupting maxillary left canine in the site between the ipsilateral premolars. Its long axis was parallel to the premolars, thereby determining a complete transposition anomaly of the canine. The lower second molars were partially erupted, while the upper second molars were unerupted. The germs of all four third molars were present in the initial stage of their crown development (Figures 2 and 3). It was decided to commence orthodontic treatment straight away in order to prevent further eruption of the canine at its transposed site. The latter would complicate the orthodontic mechanics and would increase the risk of side effects. The primary treatment aim was to reposition the transposed canine to its normal site and align the labial segment of both arches. A non-extraction orthodontic treatment was chosen and fixed appliances were used on all upper teeth (Figure 4). Upon the restoration of the natural order of the maxillary teeth another stage of teeth levelling was performed. The duration of active orthodontic treatment was 23 months. Following completion, a Hawley-type retainer was used to retain the upper arch (Figure 5).

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Management of acute dislocation of the temporomandibular joint in dental practice

Précis

Temporomandibular joint dislocation may present acutely to the dentist. This article discusses its presentation and management.

Abstract

Acute dislocation of the temporomandibular joint is a situation that, although rare, may present to the dentist in practice at any time. A number of activities, such as removal of a tooth, may cause dislocation. The event is painful and distressing for the patient, their family and the dental team. Prompt management minimises discomfort, distress and long-term morbidity to the patient. We describe the aetiology of acute dislocation and outline a number of techniques that will aid the clinician in dealing with this event.

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Introduction

The temporomandibular joint or TMJ is a ginglymo-arthrodial joint whose articulation involves both sliding and hinge type movements. In the closed position, the condyle of the mandible lies in the glenoid fossa of the temporal bone. A fibro-cartilagenous disc lies between these bones. The joint is encapsulated by fibrous tissue. A number of weak ligaments, as well as the four muscles of mastication (masseter, temporalis, medial and lateral pterygoid) aid in the movement of the joint.¹ The ligaments of the joint (lateral, sphenomandibular and stylo-mandibular) are only condensations of fascia and are not true ligaments (**Figure 1**). Dislocation of the joint may be uni- or

bilateral. It may also be anterior, posterior, superior or lateral. Anterior dislocations are by far the most common. The other dislocation types are commonly associated with trauma and concurrent fractures.

Anterior dislocations occur when the condyle leaves the glenoid fossa and moves to lie anterior to the articular eminence of the temporal bone (**Figure 2**). In normal closing a complex series of muscle activities occur whereby the mandibular condyle is moved posterior to the articular eminence before being translated superiorly into the glenoid fossa. In dislocation this sequence is broken and the condyle instead moves superiorly first prior to retraction. A variety of activities

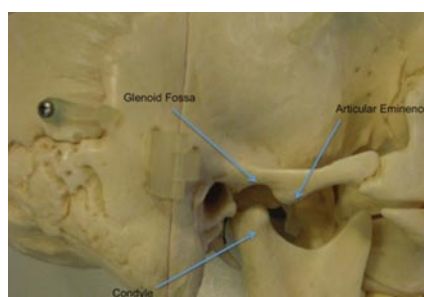


FIGURE 1: Bony anatomy of the TMJ.

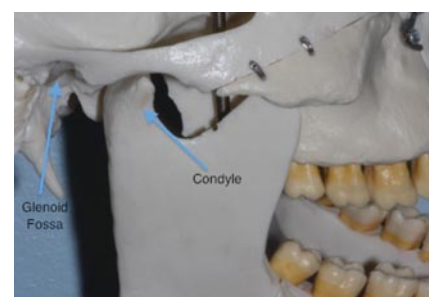


FIGURE 2: Anterior dislocation.



FIGURE 3: Acute presentation.



FIGURE 4: Unilateral dislocation.



FIGURE 5: Pre-auricular depression.



FIGURE 6: Radiographic appearance.

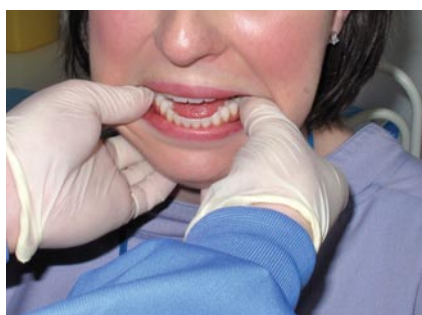


FIGURE 7: Classic technique.



FIGURE 8: Ipsilateral technique.

may lead to acute anterior dislocation. These generally involve maximal opening of the mandible and can include yawning, mastication, laughing, dental treatment, procedures involving general anaesthesia and even sedation. The potential for dislocation exists in practice with wide or repeated opening of the TMJ.

Presentation

A patient who dislocates within the dental practice or who arrives as an emergency will generally exhibit a number of signs and symptoms. The patient will be locked open and unable to bring their teeth together (Figures 3 and 4). This will be associated with pain and spasm, as the muscles of mastication attempt to correct the alteration. The patient will be unable to speak clearly. A depression in the pre-auricular area may also be seen (Figure 5). Radiographic examination (e.g., OPG) would confirm the anterior position of the condyle but should not be needed for diagnosis (Figure 6).

Management

A number of techniques exist to aid in the management and reduction of the dislocation. Central to all techniques is reassurance and explanation to the patient. The patient should be calmed and the procedure and good prognosis explained. Once reassurance is achieved, the clinician should attempt manual reduction as soon as possible. A delay in reduction will cause increased muscle spasm and associated pain. A delay often inhibits simple reduction and necessitates referral for reduction under sedation or general anaesthesia.

Classic technique

The clinician aims to direct a downwards and backwards force to the mandible. This is achieved by placing the clinician's thumbs on the outer aspect of the occlusal surface of the mandibular molars bilaterally, and then pushing gently, with increasing pressure downwards. At the same time, with the fingers, gentle upwards pressure is placed on the chin (Figure 7). The patient's mandible should be at the level of, or below the clinician's elbow to allow for adequate but gentle pressure. The effort required is such as to overcome the muscular spasm and guide the condyle down along the front of the articular eminence and back into the glenoid fossa. The patient needs to work with you and follow your movements. The patient may also experience a brief increase in pain during the procedure but immediate relief upon the reduction. The dentist should avoid placing their fingers on the occlusal surface of the teeth as the reduction may cause the patient to snap shut and inadvertently bite the dentist's thumbs.

Alternative techniques

Although the classic technique is generally successful and most commonly used, a number of alternative techniques have been described. In the ipsilateral approach, both thumbs are placed on one posterior side and then the force is applied in the same way as before. This allows for unilateral reduction and is repeated on the opposite side to allow for complete bilateral reduction.² Another ipsilateral approach has been described, which comprises an extra-oral component. In this approach, the displaced condyle is located extra-

orally and a downward force is placed on this using the clinician's thumb to direct the condyle inferiorly along the articular eminence. This may also be combined with the other thumb exerting a posterior force introrally similar to the classic technique (Figure 8). Once again this allows for unilateral before bilateral reduction.³ An interesting and completely different technique that has been described is the wrist pivot reduction. In this technique the clinician grasps the mandible bilaterally by placing his/her thumbs in the menton region of the mandible and resting the other fingers of both hands on the occlusal surfaces of the mandibular teeth. Then with an upward force directed at menton and a downward force on the teeth, the clinician's wrist will pivot towards the patient and allow the condyles to reduce.⁴

If the reduction has been successful, any planned treatment should be cancelled and the patient sent home following reassurance and advice on analgesia. The patient should be advised to eat a soft diet for two to three days and to avoid activity involving maximal opening. Dental treatment may recommence in two weeks. If the dislocation occurs again, the patient should be referred to an oral and maxillofacial surgeon for a surgical opinion.

Advanced management

If the above techniques are applied swiftly and carefully, an uncomplicated and speedy reduction should be possible. Unfortunately this is not always the case. The muscle spasm or pain or both encountered by the patient may be too great for them to undergo a simple reduction. In a similar fashion, a patient may present to the clinician with an open lock that has occurred some time previously. This delay may also limit the use of the above techniques due to prolonged muscle spasm, although an attempt should still be made.

If the clinician is unable to reduce the dislocation, referral to the local maxillofacial surgeon, dental hospital, or accident and emergency department is generally required. In this setting, conscious sedation will be used in combination with the aforementioned techniques to overcome the difficulties in reduction. Local anaesthetic techniques in the hospital setting have also been described, which involve neural blocks of the involved muscles to allow for reduction.⁵ Rarely, a surgical approach involving general anaesthetic may be required if the management proves problematic.⁶ Chronic dislocation can occur in some patients and is managed surgically in a variety of ways that aim to improve the stability of the joint, induce local muscle scarring or allow unrestricted reduction, e.g., eminectomy. Alterations are generally made to either the ligaments, musculature or bony anatomy of the joint.⁷

Summary

Although a rare occurrence, acute dislocation of the TMJ is a painful and distressing event that can arise in dental practice. The clinician should be familiar with and confident in attempting reduction so as to minimise patient distress and reduce the need for referral. A number of techniques may be performed, which have been shown to be successful in achieving this aim.

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AADR Temporomandibular Disorders (TMD) Policy Statement Revision Approved by AADR Council 3/3/2010

The AADR recognises that temporomandibular disorders (TMDs) encompass a group of musculoskeletal and neuromuscular conditions that involve the temporomandibular joints (TMJs), the masticatory muscles and all associated tissues. The signs and symptoms associated with these disorders are diverse, and may include difficulties with chewing, speaking and other orofacial functions. They are also frequently associated with acute or persistent pain, and patients often suffer from other painful disorders (comorbidities). The chronic forms of TMD pain may lead to absence from or impairment of work or social interactions, resulting in an overall reduction in quality of life.

Based on the evidence from clinical trials, as well as experimental and epidemiologic studies:

1. It is recommended that the differential diagnosis of TMDs or related orofacial pain conditions should be based primarily on information obtained from the patient's history, clinical examination and, when indicated, TMJ radiology or other imaging procedures. The choice of adjunctive diagnostic procedures should be based upon published, peer-reviewed data showing diagnostic efficacy and safety. However, the consensus of recent scientific literature about currently available technological diagnostic devices for TMDs is that, except for various imaging modalities, none of them shows the sensitivity and specificity required to separate normal subjects from TMD patients or to distinguish among TMD sub-groups. Currently, standard medical diagnostic or laboratory tests that are used for evaluating similar orthopaedic, rheumatological and neurological disorders may also be utilised when indicated with TMD patients. In addition, various standardised and validated psychometric tests may be used to assess the psychosocial dimensions of each patient's TMD problem.
2. It is strongly recommended that, unless there are specific and justifiable indications to the contrary, treatment of TMD patients should initially be based on the use of conservative, reversible and evidence-based therapeutic modalities. Studies of the natural history of many TMDs suggest that they tend to improve or resolve over time. While no specific therapies have been proven to be uniformly effective, many of the conservative modalities have proven to be at least as effective in providing symptomatic relief as most forms of invasive treatment. Because those modalities do not produce irreversible changes, they present much less risk of producing harm. Professional treatment should be augmented with a home care programme, in which patients are taught about their disorder and how to manage their symptoms.

<http://www.aadronline.org/i4a/pages/index.cfm?pageid=3465>

Risk management in clinical practice. Part 6b. Identifying and avoiding medico-legal risks in removable dentures

Stilwell, C.

The most likely cause of complaint with prosthodontics is a denture that in some way fails to be accepted. A denture that does not perform as the patient expects can give rise to great disappointment and anger. The problem is that acceptance of a denture is not just a technical issue. Success depends on the individual's ability to tolerate and adapt to the denture. It is therefore essential to make the right assessment for the patient from the outset. This includes discovering the patient's priorities and establishing realistic expectations. With the aim of assisting the dental profession in identifying and avoiding medico-legal risks in removable dentures, this article sets out a systematic, diagnostic and collaborative approach to complete and partial denture assessment and treatment.

British Dental Journal 2010; 209: 339-350.

Volumetric determination of the amount of misfit in CAD/CAM and cast implant frameworks: a multicenter laboratory study

Drago, C., Saldarriaga, R.L., Domagala, D., Almasri, R.

Purpose: The purposes of this study were:

1. To evaluate the fit between implant frameworks and implants fabricated with two types of implant framework fabrication techniques: computer-aided design/computer-assisted machining (CAD/CAM) and conventional casting with the lost wax technique; and,
2. To describe a digital measurement system consisting of tactile scanning and computer software programs that measured the volumetric differences between implant-supported frameworks and implant restorative platforms fabricated with these technologies.

Materials and methods: This laboratory study used acrylic resin models with five interforaminal implants. The models were scanned; implant-level impressions and verification indexes were then made to construct master casts. First, a cast gold alloy framework and a titanium milled bar fabricated with CAD/CAM technology were made to clarify the construction processes of each. After this pilot study was completed, five cast and five CAD/CAM frameworks were made at each of three dental schools (15 milled and 15 cast bars). Each framework was made on a master cast from individual impressions. The implant restorative interfaces of the frameworks were scanned, and the data were entered into a computer software program. The virtual representations of the frameworks were fitted onto digitised scans of the implant restorative platforms and used for virtual one-screw tests on both sides of the arch. Volumetric differences between

the implant restorative platforms of the implant-supported frameworks and the model implants were measured to determine the amount of misfit between the frameworks and the model implants.

Results: Implant-supported frameworks made with the CAD/CAM technology fit significantly better onto the implants than the cast implant frameworks. There was a significant difference between the right and left one-screw tests; there were no significant differences among the three university sites.

Conclusions: The CAD/CAM frameworks featured in this study were significantly more accurate than cast frameworks made with the lost wax technique.

Int J Oral Maxillofac Implants 2010; 25: 920-929.

Mandibular implant-supported overdentures and oral function

Van Der Bilt, A., Burgers, M., Van Kampen, F.M.C., Cune, M.S.

Objectives: Oral rehabilitation by means of implant-retained mandibular overdentures is known to improve oral function. The aim of this study was to evaluate the long-term effects of mandibular implant treatment on oral function. We quantified maximum bite force and masticatory performance 10 years after implant treatment. It was hypothesised that these outcome measures would not change in this period.

Materials and methods: Eighteen edentulous patients were scheduled for re-evaluation of their oral function 10 years after they had participated in a randomised cross-over clinical trial. In that trial, they had received two mandibular implants and a new denture with successively magnet, ball-socket, and bar-clip attachments.

Results: At the 10-year follow-up, 14 of the initial 18 patients participated in the evaluation. As a result of the implant treatment, the average maximum bite force more than doubled, from 162 to 341N, whereas the average number of chewing cycles to halve the initial particle size decreased from 55 to 27 cycles. No significant changes in maximum bite force and masticatory performance were observed after 10 years. However, the average maximum bite force obtained with implant-retained overdentures is still significantly lower than that of dentate subjects (569N).

Conclusion: Maximum bite force and masticatory performance significantly increased after implant treatment and remained unaltered during the following 10-year period. Thus, implant treatment greatly improves oral function for a long period of time.

Clin Oral Impl Res 2010; 21: 1209-1213.

QUIZ

Submitted by Elaine Hughes, Assistant Chief Executive Officer, Irish Dental Association.

1. What body/organisation is responsible for approving and accrediting CPD courses in Ireland?
2. What three areas are regarded as core subjects?
3. Whose responsibility is it to record CPD activities?
4. According to Dental Council guidelines, how many hours per year CPD should a dentist complete?
5. Are non-clinical subjects regarded for CPD purposes?

Answers on page 278

Don't have the **answers** for all those **questions** in your head?

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Metal-ceramic versus all-ceramic restorations: part 2

The second part of this series by DR SEAMUS SHARKEY looks at some of the evidence behind both types of restorations and some of the indications for use, as well as methods of maximising the outcomes for both types.

Review of available evidence

The best available evidence to date is a series of systematic reviews by Pjetursson¹ and Sailer² in 2007. They compared studies on metal-ceramic and all-ceramic restorations with a minimum of three years follow-up.

Crowns

Pjetursson's¹ findings for single crowns are summarised below and in **Table 1**:

- more data is available on all-ceramic crowns;
- metal-ceramic studies have longer follow-up times; and,
- five-year survival rates were similar (survival is defined as the restoration remaining in situ; survival rates are chosen as they are more readily standardised than success rates).

The survival rates imply that overall single-unit restorations have a broadly similar survival rate. But this includes restorations in all areas of the mouth. Is there a difference between anterior and posterior survival rates?

Table 2 shows that the survival rates for all-ceramic crowns depend very much on the material (no data was available at the time of writing for single-unit zirconia restorations that fit the inclusion

criteria). There is a definite trend towards improved five-year survival rates in the anterior portion of the mouth for all-ceramic restorations. Metal-ceramic crowns, however, have very little evidence available to distinguish a trend between anterior and posterior. DeBacker³ reported a 76% anterior and 80% posterior survival rate at 18 years, and Walton's study⁴ confirmed this trend of higher retreatment in the anterior area.

Table 3 shows that the five-year complication rates are broadly similar for both types of restoration. There are some differences, such as caries rate and porcelain chipping rates, but these are probably representative of the longer time frame over which metal-ceramic crowns have been functioning and their use in almost every clinical situation.

Fixed partial dentures

Pjetursson and Sailer² also produced a systematic review of metal-ceramic versus all-ceramic fixed partial dentures (FPDs) using the same inclusion and exclusion criteria. The results are outlined in **Table 4**.

This survival rate can be translated into an annual failure rate for all-ceramics of 2.11 times that of metal-ceramics. The complication rates were largely similar to the rates for crowns and no information on position (anterior versus posterior) was given. One

Table 1: Comparison of the literature on metal-ceramic and all-ceramic crowns.

Metal-ceramic	Comparison	All-ceramic
6	Total number of studies	18
1765	Combined number of crowns	6006
9.2 years	Average follow-up time	4.9 years
95.6%	Combined survival rate @ 5yrs	93.3%

Table 2: Comparison of the anterior and posterior five-year survival of the various all-ceramic crowns.

Type of ceramic	Anterior 5yr survival	Posterior 5yr survival
Dicor	91%	84%
Empress	96%	93.7%
Procera	96.7%	94.9%
In-Ceram	96.7%	90.4%

very noteworthy point was the technical complication of porcelain chipping. For metal-ceramic FPDs the cumulative five-year rate was 2.9%. For all-ceramic FPDs the rate was 13.6%. This emphasises the point in the previous section about the veneering porcelain being the weak point. The authors also pointed out that framework fracture of the particle-filled glass ceramics did occur up to a five-year cumulative survival rate of 6.5%. Zirconia frameworks almost never fractured but were prone to veneer chipping.

Indications

From the available evidence it would appear that a number of conclusions can be made:

- metal-ceramic crowns have better survival rates posteriorly and have the longest track record;¹
- all-ceramic crowns perform better in the anterior region of the dentition;¹
- metal-ceramic FPDs have better survival rates than all-ceramic FPDs;²
- if an all-ceramic posterior crown is necessary then a high strength core such as alumina or zirconia is best;⁵ and,
- if an anterior all-ceramic crown is indicated then other factors (outlined in the next series) will dictate choice of material.⁶

Table 3: Comparison of the five-year rates of major complications that affect metal-ceramic and all-ceramic crowns.

Metal-ceramic	Complication	All-ceramic
2.1%	Loss of vitality	2.1%
3.2%	Caries	1.8%
0.9%	Tooth fracture	0.4%
0%	Core fracture	5.7%
5.7%	Chipping	3.7%

Please refer to part 1 of this series, 'Metal ceramic versus all ceramic restorations: part 1' (Journal of the Irish Dental Association 2010; 56 (4): 196-199).

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Table 4: Comparison of the literature on metal-ceramic and all-ceramic fixed partial dentures.

Metal-ceramic	Comparison	All-ceramic
5	Total number of studies	9
1,163	Combined number of FPDs	343
8yrs	Average follow up time	3.8yrs
94.4%	Combined survival rate @ 5yrs	88.6%

Consent for adult patients

In the latest article from Dental Protection, SUSAN WILLATT looks at the issues around patient consent.

Consent is a complex topic and its importance should never be underestimated. Failing to obtain valid consent could leave the practitioner open to criminal proceedings for battery, and could also become the subject of civil proceedings for negligence. The Irish Dental Council provides guidance for dentists on the issue of consent, which should be followed. It highlights (among other things) that consent can be implied, oral or written, and that the latter is recommended when extensive treatment is being undertaken and is essential when general anaesthesia or sedation is to be administered. Consequently, any failure to obtain valid consent from a patient could well compromise the dentist's professional position. From a different but equally important viewpoint, failure to obtain valid consent could encroach upon a patient's autonomy and right to determine what treatments can be performed on their body.

Significant factors

For a dentist to ensure that consent is legally valid, several factors need to be taken into consideration.

- Firstly, it should be established that the patient has given (or withheld) consent voluntarily and has not been influenced unduly by a third party, including the dentist.
- A second factor is whether the patient has sufficient capacity to consent. A patient aged 16 or over is deemed in law to be able to consent to medical, dental and surgical procedures, and for children below the age of 16, the decision to consent is deferred to the parent or legal guardian. However, where the actions of the parent could potentially endanger the child, the medical profession has the option of seeking the assistance of the court to override the parent's wishes.

The practitioner also has to make a judgment as to whether the patient has sufficient mental capacity to provide consent. In Ireland, the courts have favoured the 'best interests' test when treating patients in circumstances where they are unable to consent for themselves. In such a situation, a practitioner's defence (if challenged) would be that they were acting in the 'best interests' of the patient. In such circumstances it would be important for the practitioner to keep comprehensive records of the decision to proceed with treatment and, where possible, to seek a second opinion from a colleague confirming their clinical opinion. In any event, it should be presumed



that a patient has capacity unless it is proven otherwise. Further, it should be borne in mind that competent adults are entitled to refuse treatment even if, in the opinion of the healthcare professional, their decision is not rational.

- A third factor to be considered when obtaining consent is that of providing a patient with sufficient information upon which to base their decision. There are two approaches to this, one of which is the application of the 'reasonable doctor' test, and the other involves the application of the 'reasonable patient' test.

In terms of disclosure of information, it was initially established in Irish law that if a doctor provided information that a 'reasonable doctor' would have done, then there would be no negligence unless the court felt that the standard of disclosure employed by the 'reasonable doctor' was insufficient. However, this approach has been criticised as being paternalistic.

The Irish Dental Council provides guidance for dentists on the issue of consent, which should be followed.

This approach was steered towards that of the 'reasonable patient' test in the pivotal case of *Geoghegan v Harris* (2000). In this case, Mr Geoghegan claimed that he had not been warned by Dr Harris that there was a remote and rare risk that he could suffer chronic neuropathic pain as a result of having implants/a bone graft (an elective procedure). In concluding that there was an obligation to warn of this risk, the judge gave the view that a dentist is required to warn of material risks that the 'reasonable patient' would wish to know and indeed that the 'particular patient' would wish to know. Although the view of the medical experts in this case was that no warning was necessary, the judge concluded that nerve damage had to be considered a 'known complication' of the procedure and that neuropathic pain was therefore foreseeable and there followed an obligation to warn the patient of this risk. In the cases of *Walsh v The Family Planning Limited* (1992) and *Bolton v Black Rock Clinic*, the Courts laid down the principle that the duty on the dentist to disclose information increased in correlation to the degree of choice the patient had in relation to undergoing a procedure. It is evident, therefore, that the standard of disclosure of information for elective treatment is very high.

Not set in stone

It should be borne in mind that consent is an ongoing process. Asking a patient to sign a consent form at the start of treatment does not necessarily confirm that valid consent has been obtained. If the clinical situation changes the issue of consent may need to be revisited. Any changes in the treatment plan and the associated costs, risks and benefits should be discussed with the patient in order that they can consent to the agreed modification.

Practitioners need to communicate effectively with patients and set out the risks, benefits, complications, costs and options available. Where treatment is expected to be complex or expensive, it is also helpful to allow the patient time to reflect upon the proposals, rather than embarking upon treatment at the initial consultation. Crucially, a full record of discussions held with the patient should be maintained in the clinical records and this should be contemporaneous. Just as negative clinical findings should always be recorded, it is also important to record a decision by a patient to decline treatment that is recommended.

Susan Willatt BDS MBA LLM

Susan has worked in general practice and in the Community Dental Service, as well as working as a clinical adviser for a corporate dental body. She is now a Senior Dento-legal Adviser at Dental Protection, where she also acts as Secretary to the Board. In addition to handling cases for members in Ireland, Sue is Deputy Lead for members in New Zealand.

Further reading

D’Cruz, L. Risk management in clinical practice. Part 2. Getting to ‘yes’ – the matter of consent. *British Dental Journal* 2010; 209: 69-72.

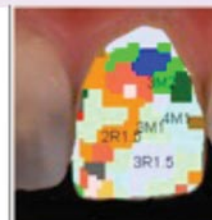
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Does it matter what it looks like – as long as it works?

The Dental Plan's DR JOHN BARRY advises never to underestimate the power of appearances.

It was a Sunday night, November 12, 2006, pretty much four years ago to the day of sitting down to write this article. I will never ever forget the date or the day. It was one of the most brutal nights that I can remember in terms of weather. There was torrential rain and it was dark and miserable, and my mood was pretty desperate too. I was being admitted to ward 62 in the Southern General in Glasgow for my full neck dissection the following morning.

Quite a few of you will have heard part of my story about that episode in my life – having a malignant tonsillar squamous cell carcinoma removed using the forearm free-flap operation. I knew that I was in great hands; I had all the tests, all the reassurance and I knew that the team led by John Devine and Andrew Carton were world leaders.

What has this got to do with the title and what does it have to do with you as dentists in Ireland in the middle of this recession when State funding has been ripped out from beneath you?

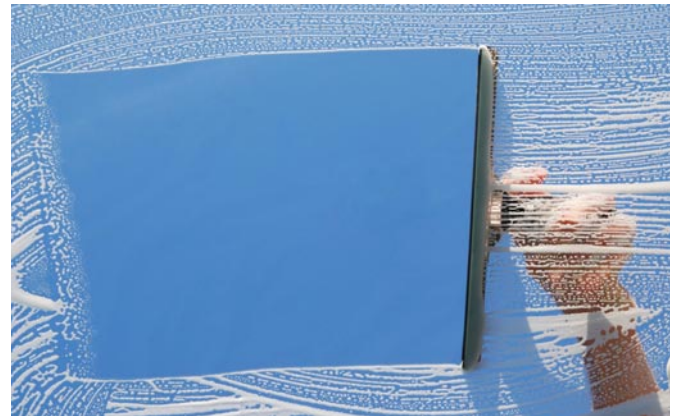
What does it have to do with your positioning in the dental marketplace, where you are competing with everyone else and every other struggling business for the Euro in the patient's pocket?

What am I doing here in this dump?

It really does matter what it looks like and let me tell you why. When the young attending doctor finished her admission process and when John Devine (who had come in on a Sunday evening to reassure me) had left and I was left all alone in that one-bed unit with nothing but my thoughts of what was before me, I went to the window and pulled

back the blinds to look out. It all sounds very melodramatic but it was lashing down rain and I was pretty low despite the outward signs of bravado. The sight that greeted me is one I will never forget as long as I live and it has had a profound effect on me and my attitude and beliefs. The outside of the window was absolutely filthy and caked with streaky dirt. In that moment a feeling of terror gripped me like I have never experienced before and I imagine will never again! The inescapable, possibly irrational, fear that possessed me at that moment was: "What am I doing here in this dump? This place is filthy and I'm having a neck dissection done here!" I recoiled from the window and spent quite a long time, it seemed, debating with myself, trying to beat back an almost overwhelming urge to get dressed and literally run away. My logical side finally won through by convincing me that I knew that John Devine and his team, who had been brilliant up till then, were not going to let me down. I still struggled very hard not to feel that the whole place was a dump!

I struggled through the night and the rest, as they say, is history. The results were delivered and my life and features were saved despite the filthy windows.



All surfaces in your practice - including windows! - should be kept clean.

*Give yourself every chance!
Look very critically at the fabric of
your business. Make sure you do
not have shabby looking areas.*

Lessons to learn

I have in the past 20 years been in hundreds of practices all over the UK from Cornwall to John O'Groats and now in Ireland from Cork to Donegal. I have seen the good, the bad and the ugly. I have seen the most beautiful practices in both countries and I have seen practices that really should be an embarrassment to the individuals concerned. Mind you, I can honestly say that I have had similar experiences in restaurants all over the UK and Ireland. I have had similar experiences in hotels up and down both countries. I suppose it boils down to the reality that there are those who run all types of businesses well and those who run them less well. There are business owners who look critically at their businesses from the perspective of the customer and those who do not, as the case may be. I have seldom had the feeling of enjoying great service and great customer experience in a place or business that was run down and grimy. I started off my practice career in a practice in the extreme north of Scotland, which I chose because of the people and their warm friendly attitude. I did see that the place was a bit shabby but I had just qualified and it was one of the first practices I had ever been in. It did not, however, take long for me to look objectively at my environment and compare it with the clinic that I had qualified from, where hygiene and cleanliness and patient care and record keeping were of the utmost priority. I began to have feelings that now that I was actually taking money off people

for dentistry, and quite good money at that (that was back in 1987 when you could still make some money on the NHS in the UK), it really would be nice to make sure that the lino wasn't ripped coming in the door or that the chair where they were sitting didn't have a rip in the arm taped with brown duct tape. I kind of felt that it looked a bit of a poor show really for a dental surgeon to be working in that sort of environment. I also felt that the weeds growing outside the side of the practice and the brown discarded cardboard boxes and broken equipment in full view gave an impression of clutter and disorder. I began to notice the ingrained dirt on the carpet in the waiting room and the cracked mirror in the toilet and the notices on the wall that were simple paper stuck up that were curling at the edges. I saw the scuffed wallpaper from the constant banging of the plastic chairs in the waiting room and the three-year-old ripped and torn magazines on the chipped coffee table in the waiting room and it occurred to me that it was not of a quality I really could be proud of. I then had this horrible realisation come over me that maybe, just maybe, some of these patients that I was trying to connect with discussing all of the fantastic highly technical stuff I could do for them like bridges and

crowns and life-like dentures, were sitting there thinking: "How does this guy think he can provide real quality when the environment in which he is working does not reflect quality but shoddiness?"

Wake-up call

It was a wake-up moment. I do not dare tell you, my fellow Irish dentists, to try to become boutique practices with all fancy dancy stuff! What I am telling you, however, is that in this day and age in Ireland, you are competing hard for the Euro in their pocket. Give yourself every chance! Look very critically at the fabric of your business. Make sure you do not have shabby looking areas. Spend the time and a little money to ensure that your practices are spotless, with no cracked lino or ripped carpets, no dog-eared and out-of-date magazines, no broken mirrors or door handles, with spotless loos and, finally, clean windows. I really could not have escaped ward 62 that night as my life literally depended on it but I promise you I will not eat in a shabby restaurant or stay in a shabby hotel and I, like countless others, would not decide to spend my time or money in a shabby dental practice. The advice I have given above is based on experiences that are real in the Irish and UK market and the changes to ensure a clean, pleasant, basic standard are not expensive and in most cases can be sorted out for very small money over a weekend or two.

John Barry is Operations Director with The Dental Plan Ltd.

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Quiz answers (questions on page 272)

1. The Dental Council of Ireland
2. a) Medical emergencies; b) infection control; and, c) radiation protection
3. It is the dentist's own responsibility to record CPD activities.
4. A dentist should complete at least 50 hours of CPD per year.
5. Yes – all aspects of a dental practice are covered for CPD purposes.

There is **always** hope!

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Classified advert procedure

Please read these instructions prior to sending an advertisement. On the right are the charges for placing an advertisement for both members and non-members. Advertisements will only be accepted in writing via fax, letter or email (fionnuala@irishdentalassoc.ie). Non-members must pre-pay for advertisements, which must arrive no later than January 10, 2011, by cheque made payable to the Irish Dental Association. If a box number is required, please indicate this at the end of the ad (replies to box number X). Classified ads placed in the Journal are also published on our website www.dentist.ie for 12 weeks.

Advert size	Members	Non-members
up to 25 words	€75	€150
26 to 40 words	€90	€180

Non-members must send in a cheque in advance with their advert. The maximum number of words for classified ads is 40.

**Only if the advert is in excess of 40 words, then please contact:
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Tel: 01-856 1166 Fax: 01-856 1169 Email: paul@thinkmedia.ie

Please note that all classified adverts MUST come under one of the following headings:

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Practices Wanted

Unwanted/Second Hand Equipment for Sale

Classified adverts must not be of a commercial nature. All commercial adverts must be display advertisements, and these can arranged by contacting Paul O'Grady at Think Media, Tel: 01 856 1166.

POSITIONS WANTED

Experienced dentist seeks two or three sessions per week in the Wexford/Wicklow area, and in Carlow town. Tel: 087-972 9379, or Email: judit.jaczko@freemail.hu.

Male Irish Trinity graduate with five years' experience seeks locum position two days a week immediate start. Tel: 087-233 2308, or Email: bid_dee@hotmail.com.

Endodontist seeking a part-time position to provide high quality endodontic care. Enthusiastic, friendly and ready to start immediately. Tel: 087-980 7006, or Email jtb.endodont@gmail.com.

AAAAARRRRGHHH! My excellent dental nurse wants to leave me, move cross-country, and be with her husband in Meath. She's cheerful, kind, capable, honest, hardworking, enthusiastic, responsible, experienced, fully qualified and now looking for work, commutable from Navan. Tel: 087-9054645, or Email: orthodontics@ireland.com.

POSITIONS VACANT

Associate dentist required to join busy family practice in South East County Galway. Modern surgeries, full chair-side and clerical support, OPG, etc. Please Tel: 086-809 5809, or Email: rothwellauct@eircom.net.

Dental associate required for Saturday session in a busy modern Dublin city centre practice. Must be experienced in high level of cosmetic dentistry. Excellent conditions and support team. Immediate start. Please Email CV to sinead@portobellodental.com.

Full-time dental associate required to work between two established practices. Modern facilities and excellent support team available. Practices situated in Swords and Tyrrelstown areas. Tel: 01-610 5022, lo call 1890 703 703, or Email: maria.d.kavanagh@primacare.ie.



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Associate wanted to join our team in Wexford town. Busy practice with superb conditions. Immediate start possible. Email: emmet@smiles.ie.

Associate dentist required for three and a half days a week. Private practice in County Galway. Tel: 086-837 5759.

Sandymount Dental Clinic. Associate required for long established, stable family practice. Superb location. Modern, well-equipped surgery. Highly trained and friendly support staff. A great opportunity to join an excellent team. Contact Paula, Tel: 01-668 9921, or Email CV to info@sandymountclinic.com.

Full-time associate required for busy, modern Belfast practice. Great facilities and support team. Ideal for young graduate. Tel: 0044-780-246-7250, or Email: info@beechviewdental.co.uk.

Experienced dental associate required for a busy modern dental practice in Galway City. Fully equipped and computerised (digital x-ray, OPG, hygienist). Please Email: dental.practice1@yahoo.ie.

Experienced dentist required to cover maternity leave starting December 3. Full five days required. Busy practice with all modern equipment, etc. Practice situated in Bray, Co. Wicklow. Replies to info@avondaledentalclinic.com.

Dentist required for Saturday session in busy practice with all modern equipment, digital radiographs, hygienist, etc. Practice situated in Bray, Co. Wicklow. Starting immediately. Replies to Info@avondaledentalclinic.com.

Locum required for maternity cover Abbeyleix, Co. Laois for six months from Oct/Nov 2010. Experience essential. Please email CV to abbeyleixdental@ireland.com.

South East. Locum required January 2011 leading to long-term view as associate. Friendly, patient-oriented, progressive dentist required. City centre/excellent equipment/great staff/bright premises. Very busy – scope for expansion. Tel: 086-807 5273, or Email: niall@innovatedental.com.

Locum dentist required in the North East, one month, immediate start with prospect to becoming full-time associate. Fully computerised, digital x-ray, etc. Enquiries to eldibany113@hotmail.com.

Locum required for South Dublin starting first week in December. Will possibly consider two dentists on a two- and three-day week. Tel: 01-849 4070, or Email: marguerite@irishdentaljobs.ie.

Orthodontist required part-time in busy thriving multi-disciplinary practices in Dublin. They are modern, fully equipped surgeries, OPG, hygienist and excellent support teams. Please send CV to reception@rfdentalclinic.com.

Orthodontist wanted for specialist multidisciplinary practice located in Dublin 2. Please send CV to perioprosortho@gmail.com or post to IDA, Box No. J610.01.

South Down Dental Clinic, Newry. Full-time/part-time position for specialist oral surgeon in referral clinic. IDC registration. Registered on specialist oral surgery list or equivalent. SOE computerised system. Digital x-ray/CT scanner. Email CV with references to southdowndental@btconnect.com.

Required dental hygienist. Salary over \$2,500 PM. Tax free. Plus accommodation. Plus annual vacation. Plus annual flight ticket. Plus commission. Interested? Please contact info@draliconsultgrp.com.

Dental nurse required (part-time) immediately for busy practice in Killaloe, Co. Clare, to cover maternity leave. Three days per week. Please email CV to brendaodowd@eircom.net.

Dental nurse required for friendly modern surgery in Ranelagh. Excellent organisational skills and warm caring personality essential. Chairside assistance with some admin work included. Tel: 01-497 5804, or Email: info@smilemakers.ie.

DSA/practice manager required for Clontarf Orthodontics. Experience essential. The successful candidate will have excellent organisational skills and a warm caring personality. Generous package available. Join our team today and help us create beautiful smiles. Reply to shona@clontarfbraces.ie.

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Practice for sale – Dublin South East. Thriving, very busy single-person practice. Well equipped. Room to expand. High-visibility location. Low overheads. Great staff. Hygienist. Fully computerised. Excellent figures – nil medical card. Strong profits. A must see. Tel: 086-807 5273, or Email: niall@innovatedental.com.

For sale – South Dublin. City centre four miles. Top class location with high passing trade. Two surgeries, excellent equipment. Ripe for expansion, extra room available. Low medical card. Walkable. Good figures. Competitively priced. Immediate sale. Tel: 086-807 5273, or Email: niall@innovatedental.com.

Southern provincial town. Unit to let between two specialist dental practices. Suit periodontist, prosthodontist, endodontist. Tel: 087-902 0486.

South County Dublin. Fully operating practice available to lease with option to purchase. Excellent location. Current owner emigrating. Great opportunity with flexible terms. Contact 01-280 6414, or Email: steven@medaccount.ie.

Practice for sale – Donegal. Busy practice. Superbly equipped. OPG, computerised, no medical card. Large new patient numbers. Excellent staff. Low overheads – high profits. Long lease/freehold property. Principal can stay on. Area wide open. Excellent expansion possible. Tel: 086-807 5273, or Email: niall@innovatedental.com.

Dentist retiring soon wishes to dispose of well-established practice with potential to expand. Located in South Dublin. Enquiries, principals only, to Aidan McCarthy, Ormsby & Rhodes, 11 Clare Street, Dublin 2, Tel: 01-676 7244.

For sale – Cork. Busy, patient-friendly practice. Excellent equipment. Room to expand. Large footfall. Low overheads. Good figures. Computerised. Large potential to grow. Part of medical complex. Contact Niall, Tel: 086-807 5273, Email: niall@innovativedental.com, or Liam, Tel: 087-232 7557, Email: liamtuohy46@eircom.net.

For sale – Dublin City Centre. High-class busy practice. Excellent visibility – large footfall. Three well equipped surgeries. Fully computerised. High new patient numbers. Long lease. Medical card – nil. Knowledgeable staff/hygienist. Figures excellent. Realistically priced. Tel: 086-807 5273, or Email: niall@innovativedental.com.

Limerick City Centre – dentist retiring – good will and client base for sale. Reasonable offers. Tel: 061-227852 (evenings).

Drogheda! Exciting opportunity to develop new practice in purpose-built medical centre, in suburban South Drogheda. Tel: 087-253 0345, or Email: ollielynn@gmail.com.

For sale – South Dublin. Very long-established, busy two-surgery practice for sale. Large unopposed catchment area. Excellent location adjoining shopping centre and petrol station. High turnover from PRSI and private. Freehold. Replies to Box No. J610.02.

For sale – practice in prime location in centre of busy south east town. Worked part-time at present with great potential for growth. Computerised. Tel: 087-688 9394, or Email: clonmeldental@eircom.net.

Team needed. Two to three fully equipped, good size dental surgeries to let. Can suit general dentists or specialists. Superb location. Email: newsurgery12@gmail.com.

Established leasehold dental practice for sale, North County Dublin. For further information contact John McCarthy, Liston & Company Solicitors, Donnybrook, Dublin 4. Tel: 01-668 5557, or Email: john@wtliston.ie.

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DECEMBER 2010

South Eastern Branch, IDA – Scientific Meeting – ‘Oral Radiology – Bits and Pieces’

December 2 Ramada Hotel, Waterford
Speaker is Dr Donal McDonnell.

Munster Branch, IDA – Scientific Meeting

December 7 Maryborough House Hotel
Speaker is Dr Ray Dookun, President, British Academy of Dental Sleep Medicine, on ‘Snoring and sleep apnoea’.

2011

JANUARY 2011

IDA – National Meeting

January 15 Aviva Stadium, Dublin
Various speakers will address means of maintaining and developing business in 2011.

Munster Branch, IDA – Scientific Meeting

January 17 Maryborough House Hotel
Speaker is Dr Tim Newton on ‘Psychology and dentistry’.

Metropolitan Branch, IDA – Scientific Meeting

January 20 Hilton Hotel, Dublin 2
Speakers are Professor Stephan Renvert on ‘Peri implantitis – the new dilemma’, and Dr Pat Cleary on ‘Endodontics saves teeth’.

South Eastern Branch, IDA – Scientific Meeting – ‘Medical Emergencies’

January 26 Ramada Hotel, Waterford
Speaker is Dr Mairead Cashman.

Irish Endodontic Society – Annual Scientific Meeting 2011

January 27 (evening) and 28 (all day) Hilton Hotel, Charlemont Place, Dublin 2

FEBRUARY 2011

AEEDC Dubai 2011

February 1-3 Dubai International Convention & Exhibition Centre
For further information contact aeedc@index.ae.

Metropolitan Branch, IDA – Annual Scientific Day

February 18 Hilton Hotel, Dublin 2
Speakers are Professor Robin Seymour on ‘Oral health and systemic diseases, where are we now?’, Professor St John Crean on ‘Recognising medical conditions in the dental patient’, Dr Garry Heavey on ‘Marketing – the most effective bang for your buck’, and Dr Ashley Latter on ‘Ethical sales and communication’.

Munster Branch, IDA – Scientific Meeting

February 22 Maryborough House Hotel
Speaker is Prof. John Whitworth on ‘The wise man built his house ... concrete foundations and soggy bottoms in endodontics’.

MARCH 2011

South Eastern Branch, IDA – Annual Scientific Meeting

March 4 Ormonde Hotel, Kilkenny
For more information, please contact Annemarie,
Tel: 056-777 5337, or Naomi, Tel: 087-298 9200,
Email: naomi@kilkennyendodontics.com.

Metropolitan Branch, IDA – Scientific Meeting

March 24 Hilton Hotel, Dublin 2
Speakers are Dr Jason Owens on ‘Location, location location – site consideration in implant placement’, and Dr Raphael Bellamy on ‘100% – X the challenge of endodontic success’.

The International Dental Show (IDS) 2011

March 22-26 Cologne, Germany
For further information see www.ids-cologne.de.

APRIL 2011

Orthodontic Society of Ireland – Meeting

April 15-16 Aviva Stadium, Lansdowne Road
Speaker is Dr Hugo De Clerck. See www.orthodontics.ie for more details.

MAY 2011

IDA Annual Conference 2011

May 11-14 Slieve Russell Hotel and Country Club, Ballyconnell, Co. Cavan. For further information contact IDA House, Tel: 01-295 0072.

Irish Society of Dentistry for Children – Annual Scientific Meeting

May 19-20 Limerick

OCTOBER 2012

21st Congress of the International Association for Disability and Oral Health

October 17-20 Sydney, Australia
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1 Loesche WJ. Dental Caries: A Treatable Infection. Springfield, Illinois: Charles Thomas; 1982:64-66. 2 Amornchat C, Kraivaphan P, Triratana T. Mahidol Dent J. 2004;24:103-111. 3 Kruger IJ, Murphy CM, Sullivan RJ. Demonstration of the sustained effect of Colgate Total by confocal microscopy. Poster presented at: American Association for Dental Research; March 7-10, 2001; Chicago, IL. Abstract 1031.

Trade name of medicinal product: Colgate Total Toothpaste. **Active ingredients:** Triclosan 0.3% w/w, Sodium Fluoride 0.32% w/w (1450ppm F) **Indications:** To reduce dental caries, improve gingival health and reduce the progression of periodontitis. **Dosage and administration:** Brush the teeth for one minute twice daily. Children under 7, use a pea-sized amount. If using fluoride supplements, consult your Dentist. **Contraindications:** None Known. Individuals with known sensitivities should consult with their dentist before using. **Special warnings and special precautions for use:** Children under 7, use a pea-sized amount. If using fluoride supplements, consult your Dentist. **Interactions with other medicines:** None known. It is important to note that as for any fluoride containing toothpaste in children under systemic fluoride therapy, it is important to evaluate the total exposure to fluoride (fluorosis). **Undesirable effects:** None known. **Legal classification:** GSL. **Product authorisation number:** PA320/5/1. **Product authorisation holder:** Colgate-Palmolive (U.K.) Ltd, Guildford Business Park, Middleton Road, Guildford, Surrey GU2 8JZ. **Recommended retail price:** €1.59 (50ml tube), €2.59 (100ml tube). **Date of revision of text:** August 2009.

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Maximum bone-to-implant contact and
preservation of vital structures.

All-on-4 was developed to provide clinicians with an efficient and effective restoration using only four implants to support an immediately loaded full-arch prosthesis.* Final solutions include both fixed and removable prostheses such as NobelProcera Implant Bridge Titanium or Implant Bar Overdenture. The tilted posterior implants help avoid relevant anatomical structures, can be anchored

in better quality anterior bone and offer maximum support of the prosthesis by reducing cantilevers. They also help eliminate the need for bone grafting by increasing bone-to-implant contact. All-on-4 can be planned and performed using the NobelGuide treatment concept, ensuring accurate diagnostics, planning and implant placement.

Nobel Biocare is the world leader in innovative and evidence-based dental solutions. For more information, call + 44 (0) 208756 3300 (UK), 1800 677306 (Ireland) or visit our website.

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