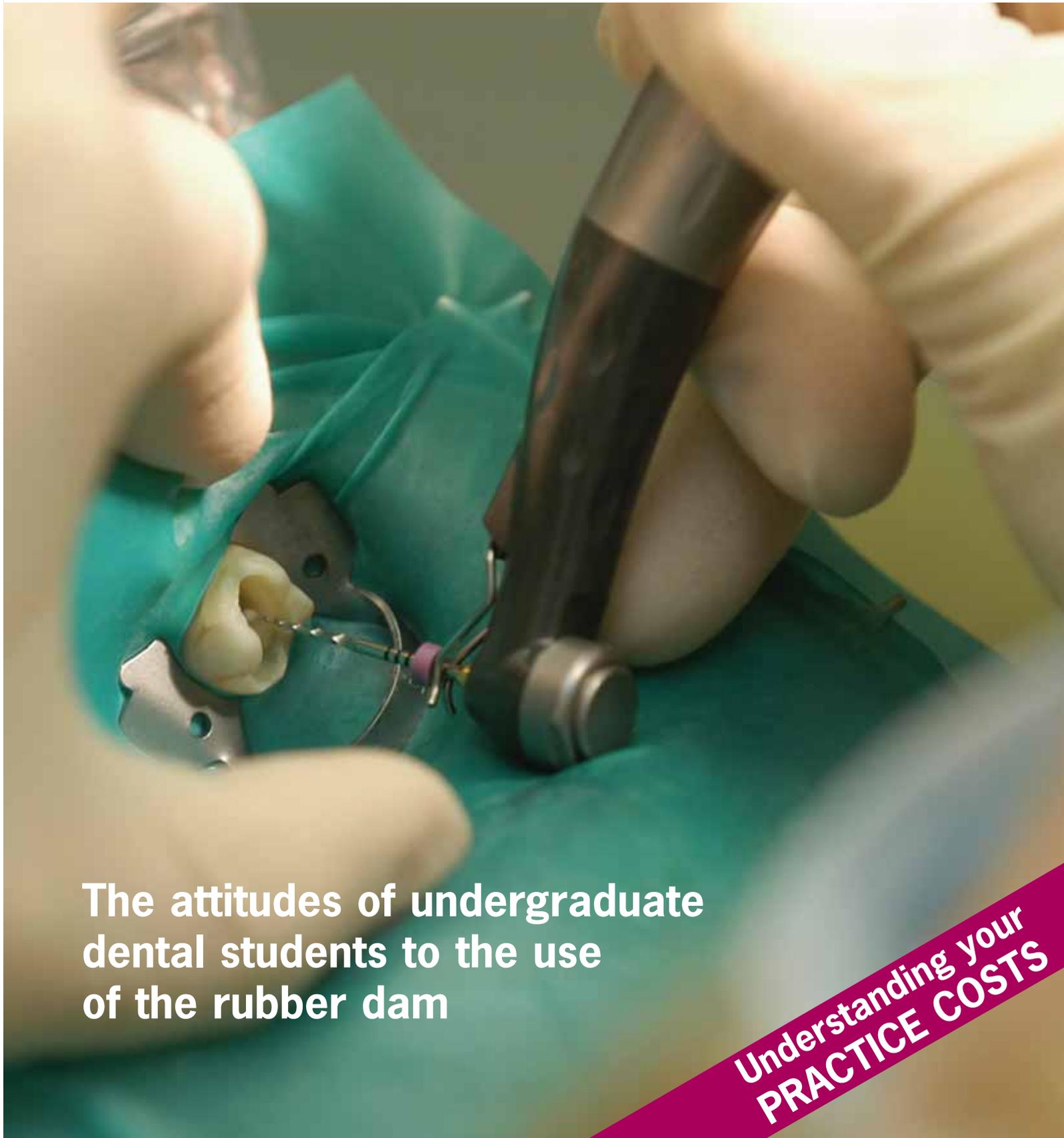


Journal of the Irish Dental Association

Iris Cumainn Déadach na hÉireann



The attitudes of undergraduate dental students to the use of the rubber dam

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1. Davies RM, Eilwood RP, Davies GM. *Journal of Clinical Periodontology* 2004; 31: 1029-1033. 2. Data on file, Colgate-Palmolive.

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Packed issue

Election over

The General Election is over. We wait for a Government to be formed and expect that the promises made to us on what they will do for dentistry and medicine will be honoured. Candidates called to my door and asked me to vote for them. Deep discussions followed and I managed to vote for what I believe in. Woody Allen said: "Everybody knows the same truth, our lives merely consist of how we choose to distort it".

Lesson of the week

There are a number of studies highlighting problems with the use of articaine 4% with 1:200,000 or 1:100,000 adrenaline leading to permanent numbness of the lingual nerve or inferior alveolar nerve following a dental block for routine dentistry and dentoalveolar surgery. Why is not understood, but articaine probably should be avoided as a dental block. It works well as an infiltration anaesthetic. It is advisable to warn patients of the potential risk of nerve damage (Hillerup, S., Jensen, R. Nerve injury caused by mandibular block analgesia. *IJOMS* 2006; 35 (5): 437-443, and Hillerup, S.J. Iatrogenic injury to oral branches of the trigeminal nerve, records of 449 cases. *Clin Oral Investigations* 2007; 11 (2) 133-142 (in press)).

ASC success

Our President is to be congratulated on an excellent meeting in Cork. All reports indicate that it was thoroughly enjoyed. Your pictures in the Journal show that it was a good educational and fun meeting. The IDA's work on the DTSS review needs to be progressed by everybody to ensure this impasse is navigated urgently for the sake of our patients.

Europe

This report, by Tom Feeney, needs to be read, in particular the sections on 'medical tourism', 'professional qualification directive' and 'amalgam'. Communication is an essential part of patient care and unless we stress the need for good communications (written and verbal) in a multilingual Europe with no professional borders, our patients will suffer. Tooth whitening is very advantageous to our patients and must remain under the direction of a competent practitioner.

Alcohol and the dental profession

An exciting new Irish dentists' health programme will help us deal with this dependence/addiction difficulty for both our patients' and our own protection. In my work with patients with oral cancer, alcohol and smoking are major aetiological factors. Working with smoking cessation counsellors and this programme may help alleviate the problems. The smoking ban in Ireland was a great breakthrough. The IDA is planning a National Oral Cancer Campaign and it is hoped these two areas of support for patients can be highlighted.

Rubber dam

The attitudes of undergraduate dental students to the use of the rubber dam surprised me. As a practitioner who spent three years in an advanced restorative practice with the late Colm O'Sullivan, rubber dam was my

saviour many times and helped me to undertake advanced treatments in a dry, safe, timely and effective manner. Dr. Ryan and Dr. O'Connell are to be congratulated on this article.

Bitewing radiographs

The article on the role of bitewing radiographs highlights the need for common sense but stresses the importance of assessing, clinically and radiographically, caries risks. Most orthodontic patients and patients prior to fissure sealants warrant these radiographs. Again when I worked in practice, bitewings had an important part to play in developing the initial treatment plans. Opgs are excellent but still do not have the accuracy for caries detection in those most at risk.

Thanks

Our thanks must go to Dr. Therese Garvey, who has for a number of years provided us with excellent abstracts, easily accessed, across the breadth of dentistry. She will be sorely missed but hopefully when her plate becomes less full in the future, she will rejoin the Editorial Board. The abstracts for this Journal have been chosen by Dr. Ioannis Polyzois, Lecturer in Periodontology.

Business practice

The business section highlights two essential areas: 'Understanding practice costs' by David McCaffrey; and a summary of the 'Safety, Health and Welfare at Work Act, 2005' by Shirley Coulter from the IDA. Both of these are easy to read and understand, and give us 'food for thought'.

DentEd Advisory Meeting

Dr. McLoughlin discusses the meeting in April 2007 in Trinity to consider the 'Competencies of an EU Dentist' and our Association has been asked to offer its advice. The well-attended meeting was constructive with a very strategic long-term view and I hope that the IDA, particularly the Council, is willing to look at the European document. We need to determine how the new European general dental practitioner should be educated and what they should be competent in, on qualification, taking into consideration the resources to train. There was some strategic vision that the training of the general practitioner needs to change from the rigorous laboratory-based, restorative emphasis to the more clinical stomatology in those schools that are very technique-orientated, and from the very stomatological non-technique orientated to more technique-orientation in those schools that are more medically orientated. Balance is required.



Leo F. A. Stassen

Prof. Leo F. A. Stassen
Honorary Editor

PRESIDENTIAL NEWS

Representing members and forging new alliances

The Association has certainly been kept very busy during the months of springtime; most especially with the Annual Scientific Conference, the ongoing DTSS impasse and meeting with the British Dental Association. Furthermore, the IDA undertook extensive political lobbying in the run-up to the General Election and I hope that the IDA Update 'Election Special' was helpful to all members in deciding who to elect to the next government.

Annual Scientific Conference

I am delighted to report that almost 600 delegates attended our very successful Annual Scientific Conference in Cork from April 18 to 21. The scientific lectures, trade show and social programme all complemented each other greatly to ensure the education and enjoyment of all the dental team. We were joined at our annual dinner by Minister for Health and Children, Mary Harney, who assured all those present of her belief in the importance of oral health and its vital role in guaranteeing a person's overall wellbeing. Minister Harney also made a public commitment to meet with the IDA to discuss the current impasse in the DTSS Review. We were also honoured by the presence of many other distinguished guests during the conference including Dr Sue Greening, President of the British Dental Association, Mr Gerry Cowan, President of the Northern Ireland Branch of the BDA, Dr Mary McCaffrey, President of the IHCA and Dr Marie Cassidy, State Pathologist. My sincere thanks again to all those involved in the conference including the many speakers, trade representatives, the organising committee and the IDA team. I would like to wish President Elect Dr Ena Brennan every success for ASC 2008 and I look forward to seeing you all in Wexford!

DTSS update

I am disappointed to report that there has been little movement in the current impasse in the DTSS Review since my last President's News. Despite repeated requests by IDA for clarification from the HSE on their assertion that negotiation of professional fees with representative bodies such as the IDA may not be permissible under the Competition Act, 2002, no such clarification has been forthcoming. Frequent correspondence has been exchanged between the IDA, the HSE, Professor Brendan Drumm and the Department of Health and Children, but as yet there is no resolution in sight.

The IDA remains extremely concerned that access to dental services for medical card holders is continuing to be negatively affected, especially in light of the recent ballot of IDA members, where over 92% voted in favour of the IDA, as a representative body, withdrawing its support for the DTSS in general practice pending a satisfactory resolution to the DTSS Review.

Much media attention has been given to this issue across local and national newspapers, radio and television, and the IDA will do all it can to ensure that accurate information is being relayed to the general

public. Please rest assured that the IDA is continuing to actively pursue this issue as a matter of urgency and members will be kept informed of any progress.

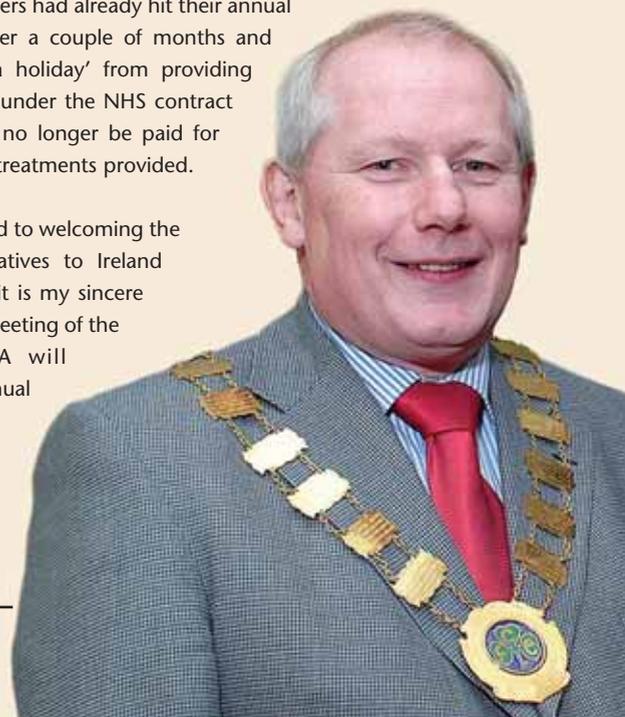
IDA meeting with BDA

In early April, I travelled to London with the IDA CEO, Ciara Murphy, for our first official engagement with the British Dental Association. Dr Peter Ward, the newly appointed CEO of the BDA, and Dr Susie Sanderson, Chairperson of the BDA, spent the day with us addressing issues of mutual concern. The meeting was very productive with matters such as the new NHS dental contract, continuing professional development, corporate governance and teeth whitening, among many others, being the focus of our exchange.

In recalling my own time spent practicing in the UK, I was saddened to learn of a further deterioration in the NHS dental system. Many dentists in the UK are having great difficulty reconciling the requirements of the new contract with the clinical needs of their patients. The new contract is primarily based on units of dental activity (UDAs), with each contractor being assigned a target level of UDAs for any given year. Already, up to 2,000 dentists have decided to cease providing dental services under the NHS contract, while many others had already hit their annual UDA target after a couple of months and had to 'take a holiday' from providing dental services under the NHS contract as they would no longer be paid for any additional treatments provided.

We look forward to welcoming the BDA representatives to Ireland next year and it is my sincere wish that the meeting of the IDA and BDA will become an annual event.

John Barry
President



Letter to the Editor

Dear Editor,

I opened my spring number of the JIDA and to my astonishment I was confronted by a large cover picture of a plaster model of (horror or horrors) a male sexual organ – in sickly green!

Oh Editor, how could you?

Yours sincerely,

Walter C Allwright

93 Ardoyne House, Pembroke Park, Dublin 4

(or should it be in traditional style "Disgusted Father of Four"?)

Public Dental Surgeons Seminar

The Annual Public Dental Surgeons Seminar goes west this year to the magnificent surroundings of Knockranny House Hotel, overlooking Croagh Patrick in the picturesque Co. Mayo town of Westport.

The Seminar takes place from Wednesday 10 to Friday 12 October, 2007. We are delighted to continue with a team-based approach to the seminar and have included, for the first time, a dedicated half-day session for dental nurses and dental hygienists.

We are particularly delighted to welcome Dr Peter Cooney, a Cork graduate and the current Chief Dental Officer for Canada, who will address the seminar on Thursday October 11, and will be the guest of honour at the gala dinner on Thursday evening. Other speakers will include Dr Christine McCreary, Dr Frank Burke, Dr John Walsh, Prof. Dennis O'Mullane, Dr Marielle Blake, Dr David Hegarty and Dr Anne O'Connell.

Suspension of nimesulide

The Irish Medicines Board (IMB) has announced the suspension of the marketing and sale of nimesulide-containing medicinal products for oral use available in Ireland, with immediate effect.

The products concerned are:

Aulin 100mg Tablets	PA 294/18/1
Aulin 100mg Granules	PA 294/18/2
Mesulid 100mg Granules	PA 915/1/1
Mesulid 100mg Tablets	PA 915/1/2
Mesine 100mg Tablets	PA 281/111/1
Aulin 100mg Tablets	PPA 465/110/1
Aulin 100mg Granules	PPA 1328/51/1
Aulin 100mg Tablets	PPA 1328/51/2

Nimesulide is a non-steroidal anti-inflammatory medicine that has been authorised in Ireland since 1995 for the treatment of acute pain. It is available only on prescription. Liver damage is a rare but serious adverse effect known to occur with nimesulide and the IMB has previously issued advice to healthcare professionals regarding this risk. The IMB has now been provided with information from the National Liver Transplant Unit at St Vincent's University Hospital on six patients who required liver transplant following treatment with nimesulide. Since nimesulide was first licensed in Ireland in 1995, a total of 53 liver-related adverse reaction reports have been received. The IMB is working to inform all patients and health professionals of this issue and has instructed the relevant companies to recall their products immediately.

BRANCH NEWS**Munster ASC**

An impressive group of speakers will address the Munster Branch Annual Scientific Meeting on Friday September 28 at the Clarion Hotel, Cork. Speakers will include: Prof. Duncan Sleeman, Head of Dept. of Dental Surgery, Oral & Maxillofacial Surgeon, University Dental School & Hospital, Wilton, Cork; Dr Barbara Coyne, Past Clinical Lecturer/teacher, University of Manchester, and specialist paediatric dental practice in Dublin and Limerick; and Dr Jonathan Lack, Clinical Lecturer, Eastman Dental Institute, London, and Specialist Periodontist, Harley Street, London. A large trade show exhibiting the most up-to-date products and services for the dental profession will also take place throughout the day.

Branch Officers

Dr Niall O'Connor was inaugurated at the recent AGM of the Metro Branch. Niall takes over from Dr Alva Hope-Ross as President. Dr Dermot Canavan is the President-Elect. Dr John Fearon is the new President of the South Eastern Branch for the next year.

Retirement dinner

An evening to celebrate the career of Dr John Browne was held recently at Marfield House Hotel by the Eastern Branch. John Browne has been a lifetime supporter of the IDA and was Branch Secretary for many years. John received the Roll of Honour from the IDA in 2001 for his lifetime dedication to the Association. Dr John Barry, IDA President, attended the dinner.

IDA golfers win Lyttle Cup

Dr John McDonagh of the Northern Ireland branch of the BDA and Dr Ciaran Allen of the IDA with the Lyttle Cup.

The annual golf match between the IDA and the Northern Ireland branch of the BDA for the Lyttle Cup was held recently at Co. Louth Golf Club, in Baltray. Fifty golfers from both associations played in what were very trying conditions with near gale force winds whistling around the famous links. The IDA narrowly emerged victorious. The Midland Branch's outing is on June 15 at Glasson GC, while the IDA Society Captain's Prize is at Carlow GC on September 8.

IDA NEWS

Metropolitan Branch Acknowledgement Award

On February 15, 2007, at the non-scientific meeting of the Metropolitan Branch of the Irish Dental Association, Vincent Browne was awarded the Acknowledgement Award of the Metropolitan Branch. This award is presented to a branch member who has brought credit to the profession.

At the presentation, Branch President Alva Hope-Ross said: "Vincent Browne graduated in 1951 from NUI; he worked in London for one year and returned to Ireland where he set up practice in Finglas in 1952. He worked and taught in the DDH from 1956-1992, a period of 36 years (a feat well deserving of an award in its own right!). He was founder Secretary of the Metropolitan Branch of the IDA in 1957 and served as President in 1975. He was an avid sportsman, playing both tennis and golf, and served as secretary of the IDA Golf Society for 20 years.

Vincent retired from practice in 1997 but continues to be active in the profession. He contacted me only last September to enquire about the possible celebrations for the 50th year of the Branch. He was also the instigator of our dinner for retired dentists

Vincent has not only been active in dental circles but our paths have also crossed in the world of rotary. Vincent has a deep sense of



Dr Vincent Browne receives the Acknowledgement Award from Metro Branch President Alva Hope-Ross.

commitment to rotary, being a founder member of Dublin North Rotary Club in 1969. He served as President of the Club and has been honoured with a Paul Harris fellowship."



Dr Vincent Browne with the fractured incisor team – Vienna 1965

In the foreground is Dr Browne. Standing at the back are some of the leading lights in Irish dentistry at that time and for decades to come. Left to right: Dr Leo Heslin, who practised as a periodontist at 91 Leeson Street, Dublin 4, and who tragically died in a road traffic accident some years ago; Dr Gerry Meehan, who practised as a prosthodontist in Galway and who is recently deceased; Dr Gerry Leatherman, who was a high ranking officer in FDI, and was based in London; Dr Tom O'Grady, who practised at Fitzwilliam Square, Dublin 2, and was also a visiting dental surgeon at the Dublin Dental Hospital. He is now deceased; Dr Frank Allen, who practised as an oral surgeon at Fitzwilliam Square, Dublin 2, and also worked at the Dublin Dental Hospital and St Mary's Hospital in the Phoenix Park. He is now retired and living in London; and Dr Colm O'Sullivan, who practised first at Fitzwilliam Square with Dr Tom O'Grady, then at Fitzwilliam Place with Dr Leo Heslin and finally, for many years, at 91 Leeson Street, also with Dr Leo Heslin. Dr O'Sullivan passed away before his time some years ago.

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BUSINESS NEWS

Appointments

Bailey at GSK



Sinéad Bailey, Medical Marketing Manager, GlaxoSmithKline Consumer Healthcare Ireland, has recently gained medical marketing responsibility for the company's specialist oral care portfolio, which comprises Sensodyne, Corsodyl and Polident. A biochemistry graduate of the University of Limerick, Sinead has worked in GlaxoSmithKline for the past four years.

Keating at Johnson & Johnson



Carol Keating is the new Brand Manager for Listerine Mouthwash, Rembrandt Toothpaste and Reach Toothbrushes and Floss. Johnson & Johnson now covers the complete oral healthcare portfolio with toothbrushes, floss, toothpaste and mouthwash – the complete three-step oral health routine.

Melvin at McCormackHorner



Rita Melvin has been appointed as Area Sales Manager for McCormackHorner with responsibility for Munster. Rita joins McCormackHorner from Promed and is working on both the consumables and the equipment sides of the business.

Murphy at Bicon



Bicon Europe Ltd. has announced the appointment of Elaine Murphy as Marketing and Education Manager for Ireland. Elaine joined Bicon in 2005, working at the company's headquarters in Boston for two years. Elaine will have primary responsibility for marketing Bicon's dental implant system in Ireland.

Spillane at NobelBiocare



NobelBiocare has announced that Lorna Spillane has joined the Ireland team as part of its continued expansion. Lorna joins NobelBiocare after four years with GSK and will look after the east coast of Ireland.

Way at Schein



Henry Schein Ireland has appointed Jim Way as its new equipment sales representative for Leinster and Connaught. Jim brings with him a wealth of knowledge and a reputation as one of the most experienced dental professionals in Ireland.

New dental implant



As treatment protocols become more advanced and dental implants are placed in more challenging clinical scenarios, a surface that potentially provides a greater rate and extent of osseointegration on a more predictable basis could be a benefit. According to Biomet 3i, the NanoTite implant starts with the industry-proven osseotite surface at the core. Next, discrete nanometer scale crystals of calcium phosphate (CaP) are deposited onto the osseotite surface substrate. These crystals are bonded to the substrate, occupying approximately 50% of the surface, which differentiates them from the traditional plasma-sprayed CaP coatings that have been in commercial use for more than 20 years.

The NanoTite implant.

China-bound to help



Elspeth Ohle will join Special Olympics Ireland as a volunteer at this year's World Summer Games in China.

Henry Schein Ireland has made a donation to Elspeth Ohle from Dr Garry McMahon's surgery in Blackrock, Co Dublin. This is to aid her fundraising to be part of the team of Special Olympics Ireland volunteers who will travel to China for the 2007 Special Olympics World Summer Games in September/October. Each member of the team has to raise €7,000.

Introduction to implant treatment for GDPs

General dental practitioners who wish to take the first steps into implant dentistry may be interested in a new two-day course which has been added to Dentsply Friadent's Implantology Skills Development Programme from June 2007. Presented by Dr Jonathan Ziff, the Introduction to Implant Treatment course provides participants with valuable first-hand implant training, with a presenter who has been placing implants for 15 years and delivering implant training for more than six years. 2007 dates are June 20-21 and September 13-14 while 2008 dates are February 28-29 and September 11-12. The venue is in Leicestershire, England.

Sirona scanner

Henry Schein has just installed the first Sirona Gallileus CT Scanner in the Republic of Ireland into a GDP's surgery in Limerick. According to Craig Evans of Henry Schein, this unit is a low-dose, high-resolution scanner designed specifically for dental use. The first of its kind in the UK and Ireland was installed in Belfast in April, and another one is going into a Wexford surgery in July.

Karma's seminar

Dr Jeffrey Hoos will present a seminar on 'The Dental Revolution: Balancing the art, science and business of dentistry' at the Grand Hotel, Malahide, Co. Dublin on Friday September 7. Further information is available from Paddy O'Sullivan of Karma Dental.

Real world dentistry – any time

DMP Flexi Learn Ltd has launched a new educational DVD – 'Introduction to Implantology'. According to the company, 'Introduction to Implantology' is non-product specific so is appropriate for all implant systems, and its approach embraces all the potential pre-clinical situations through to implant placement and restoration.

The course is designed to take about six hours to complete and part of the package is a certificate for six hours of verifiable CPD. DMP's first DVD has an introductory launch offer of Stg£295 (plus VAT).

Paracetamol guidance

Health professionals have confirmed paracetamol as the first-line treatment of choice for all types of pain in an 'Expert guidance on the appropriate use of OTC analgesia' launched recently. The document has been developed by the Pain Relief Academy, an advisory board established to develop a series of recommendations for healthcare professionals and consumers on pain management.

The guidelines have been developed to address the need for up-to-date best-practice advice on pain management. They have been drafted following the assessment of medical evidence, existing guidelines and healthcare professionals' experience to determine the appropriate use of OTC medicines in treating pain effectively.

In addition to an algorithm that encapsulates the fundamental recommendations, the guidelines also detail key points in relation to the common analgesics paracetamol and NSAIDs, and provides a step-by-step process for recommending OTC medicines for common pain conditions such as osteoarthritis, acute muscular pain and dental pain.

'Expert guidance on the appropriate use of OTC analgesia' was developed with an educational grant from GlaxoSmithKline.

Old friends meet



Minister for Health and Children, Mary Harney, met a contemporary from her time at TCD, James Holohan, General Manager, Colgate Palmolive Ireland at this year's IDA ASC in Cork. Colgate was a partner with the IDA in the ASC, while Minister Harney was the Guest of Honour at the ASC Dinner.

AIDI Cup



At the presentation of prizes at the AIDI outing were (from left): Paul O'Grady, Journal of the IDA, main sponsor; winner Peter Morris of Morris Dental; Ann O'Neill, winner of the guest's prize; and Seamus O'Neill, President of the AIDI.

Peter Morris ensured that Morris Dental is the first company to register both a father and son as winners of the AIDI Golf Cup when he overcame severe winds on the Bundoran links at the AIDI outing in mid-May. Ann O'Neill, wife of the Irish Dental Equipment Company director Pearse O'Neill, took the guest's prize.

The AIDI AGM took place the next morning and plans are advanced for IDENTEX which takes place in The Pavilion at Leopardstown Racecourse, Foxrock, Co. Dublin, on November 9 and 10 next.

BIOMET 3i

ONE YEAR IMPLANT COURSE

3i is fortunate to be able to run a year-long implant course under the tutorage of Dr Spencer Neville Woolfe.

This course will provide hands-on experience for General Practioners who wish to get involved with the clinical practice of implant dentistry.

Participants will surgically place and restore using their own patients under the supervision of Dr Woolfe.

Apart from gaining the invaluable clinical experience in a group of small numbers, each part of the individual session will have a didactic session which will consist of case presentations and mini lectures, with appropriate discussion.

Guest speakers will be invited during the duration of the course, to address the participants.

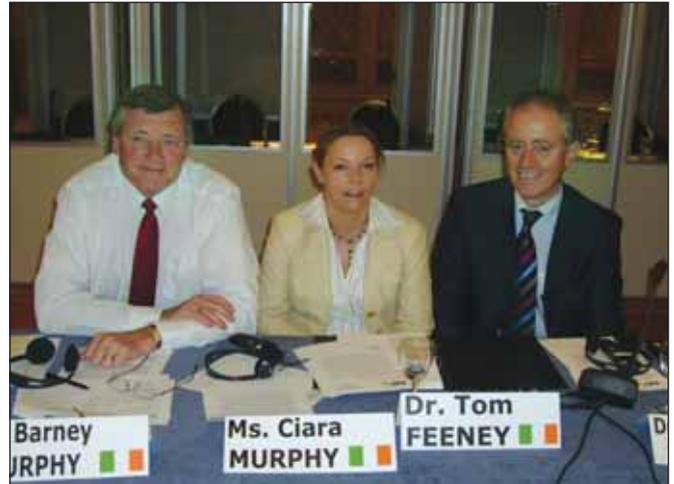
This course has been successfully run by Dr Woolfe over the past 20 years.

As numbers are limited early reservation is required so as not to be disappointed!

For further information please contact Olivia Kirwan on 086-8291440 or by email at okirwan@3implant.com.

European dental agenda

DR TOM FEENEY, Treasurer of the Council of European Dentists (CED), summarises the outcome of the recent CED Board and General Meetings.



Dr Barney Murphy, Ms Ciara Murphy and Dr Tom Feeney were part of the Irish delegation to the recent CED Board and General Meetings.

The Council of European Dentists (CED) held its Board and General Meetings on May 10, 11 and 12, 2007. Dr Robin Foyle joined the existing IDA team of Dr Tom Feeney, Dr Barney Murphy and Ms Ciara Murphy. Dr Foyle replaced Dr Tom Houlihan who unfortunately, due to work commitments, was no longer in a position to be part of the team. Many topics were discussed and decisions made over the three days, and below is a summary of the current position on the main issues.

CED accepted as member of patient safety group

The CED has been accepted as a member of the EU patient safety working group, a group consisting mainly of experts from every national health ministry plus a limited number of stakeholders, which seeks to improve patient safety across the EU. The working group has two main objectives:

- to improve patient safety by focussing on setting up reporting and learning systems on education and training, medication safety and the safe use of medical devices; and
- to discuss the creation of a comprehensive European framework for patient safety.

One key achievement of the project so far is the Luxembourg Declaration on Patient Safety, adopted in April 2005.

The CED has been accepted as a member because the working group recognises that patient safety incidents also happen in the dental profession, and that the profession's commitment to and experience of patient safety can help to make healthcare safer across the EU.

At the CED General Meeting on May 11 and 12, 2007, a CED patient safety working group was set up. Dr Barney Murphy of the Irish Dental Association has been selected to be a member of this group.

EU action on health services

The Commission has produced a summary report of the 276 contributions to the health services consultation. The CED consulted widely among its members before the January 31 deadline and made a comprehensive submission to the Commission. The Commission itself does not take a position on the various contributions, but states that it will present concrete proposals for EU action on health services later in 2007.

Member State health ministers had their first official exchange of views on the health services consultation on April 19-20 in Aachen, Germany. In the European Parliament, MEPs of the IMCO (Internal Market and Consumer Protection) Committee voted on Bernadette Vergnaud's draft report on patient and professional mobility on May 8.

Two amendments were tabled by Othmar Karas (EPP-ED, Austria), in collaboration with the CED, one of which stresses that medical tourism must not be actively promoted (amendment 76), and the other of which, in relation to professional mobility, emphasises the importance of health providers having adequate knowledge of the language of the country they are working in (amendment 114). Both amendments were adopted.

CED presentation on patient mobility at high-profile Brussels conference

At a recent high profile Brussels conference hosted by the European Health Management Association (EHMA), entitled 'Shaping the future for Community action on health services', Gordan Cok from the Slovenian Medical Chamber made a presentation on behalf of the CED.

This conference also had presentations from Robert Madelin, the Director General of the Commission's Health Department, and Nick Fahy, the Commission official responsible for the health services.

Dr Cok explained the specificities of patient mobility in the area of dental treatment: that most mobility is self-managed and treatment paid out of pocket by the patient; and that the most significant motive for mobility seemed to be the search for less expensive treatment. In line with the CED position paper from January 2007, he pointed out both the advantages and disadvantages: patients' expectations of extensive treatment in a short time; the difficulty of providing adequate aftercare; the risk of over-treatment; lack of medical records; and language barriers. He concluded that it was important that patients realise that dental treatment can often be complex and should not be seen simply as a commercial product. He made clear that patient mobility should not be actively promoted and that it was beneficial for patients to seek regular treatment from a local dentist.

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President, Dr Orlando Monteiro da Silva (centre), addressing the Meeting.

CED ethical code

A Board task force (BTF) to revise the CED's ethical code was established in May 2005.

The major changes to be incorporated in the revised ethical code were discussed and agreed at the CED General Meeting in May 2006 in Porto. They were based on the results of a questionnaire circulated to CED members prior to the General Meeting.

It is important for an organisation such as the CED to have its own ethical code. While it is not legally binding, it is nevertheless a powerful statement to the EU institutions of the professional standing of the organisation. The second version of the revised Ethical Code was sent to CED members in April 2007 alongside a template form for the submission of amendments. All proposals for amendments received by the given deadline were examined by the BTF "Ethical Code" at its third meeting on May 9 in London. The results of the BTF meeting were then presented and discussed at the recent General Meeting. Further amendments to fine tune the document will be accepted over the coming months before it is finalised, probably in November 2007. The document will then be available as a resource to member associations.

Professional Qualifications Directive

On October 20, 2007, at the end of the transposition period, the Professional Qualifications Directive (PQD) will replace 15 existing Directives in the field of the recognition of professional qualifications. It constitutes the first comprehensive modernisation of the Community system since it was conceived 40 years ago and, in short, sets the rules for the movement of professionals from one country to another. The Commission is producing a guide for national authorities to help them in their work on transposing Directive 2005/36/EC on the recognition of professional qualifications into national law. The most recent interim version of this document is from November 2006.

The CED welcomed the adoption of the PQD and stated in its responses to the Commission's consultation on health services that the Directive comprehensively regulates professional mobility for dentists.



Attendees at the CED General Meeting.

However, there are two issues linked to the PQD that the CED finds unsatisfactory: the minimum training requirements in the annex, which date from 1978; and the Commission's interpretation of the law on language testing.

A meeting will be set up with the Commission to seek clarification and guidance in the area of language testing. There are clear areas of concern for patient safety if a dentist and patient cannot communicate effectively. The Commission is so far firm in its position that no systematic language testing can be undertaken. So what type of language testing will be allowed? Member associations will be informed of the outcome in due course.

Amalgam

The Commission published a mercury strategy in January 2005. The objectives of the strategy were: to reduce mercury emissions; cut supply and demand; find solutions for dealing with mercury surpluses; protect people against mercury exposure; and promote international action on mercury. The strategy included action to be taken on amalgam – investigating the implementation of waste laws and requesting scientific opinions on the health and environmental risks of amalgam.

In March 2006 the European Parliament called for the Commission to propose, by the end of 2007, restrictions on the use of amalgam for health and environmental reasons. In October 2006 the Commission published a draft Regulation on the banning of exports and the safe storage of metallic mercury. This does not target amalgam directly, but amendments proposed by the Parliament may change this.

In February 2007, the Commission submitted requests for opinions from two scientific committees as follows:

- request for an opinion on the safety of dental amalgam and alternative dental restoration materials for patients and users; and
- request for an opinion on the environmental risks and indirect health effects of mercury in dental amalgam.

The CED Resolution on amalgam, adopted in May 2006, was updated at the recent General Meeting and is as follows:

- The safety and importance of the continued use of amalgam is supported by the World Health Organisation (WHO) and the World Dental Federation (FDI) (Consensus Statement, 1997). The effectiveness and safety of dental amalgam in the restoration of decayed teeth has been demonstrated through long usage. Research over many decades has failed to show any significant health risk posed by dental amalgam;
- the CED regrets the European Parliament's call in March 2006 for restrictions on the use of amalgam despite the lack of any scientific justification for this action (P6_TA(2006)0078). It is important that political decisions of the EU institutions take into account up-to-date scientific evidence;
- research into the potential health risks posed by dental amalgam should continue. However, this must go hand in hand with research into existing alternative materials, since far too little is known about their risk of toxicity, safety to both patients and dental staff and about their other properties. In this respect, the CED welcomes the Commission's request for a scientific opinion on the safety of both amalgam and alternatives for both patients and users;
- the dental profession takes seriously the environmental impact of its members' activities. The CED calls on Member States to ensure the full implementation and enforcement of EU waste laws, and fully supports examination into whether this is happening. In most Member States amalgam separators are used and in many they are obligatory. Amalgam separators are an effective way of reducing harmful waste – preventing 92-98% of waste amalgam entering the waste stream – and their use should be encouraged;
- the CED also encourages national dental associations to share best practice on waste management and to support their members regarding compliance with waste management obligations;
- dental amalgam continues to be the most appropriate filling material for many restorations, due to its ease of use, durability and cost-effectiveness. Dentists are best placed to identify patients' oral health needs;
- the worldwide consensus of the dental profession is that amalgam should remain part of the dentist's armoury in order to best meet the needs of patients. It is important that patients must not be denied freedom of choice in respect of how to be treated;
- restrictions on the use of amalgam would damage the financial stability of health systems as well as impact on individual patients' ability to afford dental care; and

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- all healthcare interventions carry with them some risk. The CED stresses the importance of promoting national and targeted prevention programmes for oral health in order to reduce the need for such interventions”.

Tooth whitening

The Commission has now decided not to go ahead with its plan to make tooth-whitening products (TWPs) with up to 6% H₂O₂ available over the counter. The Commission is expected very soon to request a new opinion from the Scientific Committee on Consumer Products (SCCP) on what strength of products could be safely sold over the counter.

Over the last six months, the CED working group has looked into the broader question of how best to regulate TWPs at EU level, and considers that the medical devices regime is the best option. The CED agreed the following Resolution at its recent General Meeting:

“Tooth whitening is one of an expanding range of minimally invasive techniques of dentistry and not just a simple cosmetic procedure. It is important that a dentist diagnoses the cause of the discolouration, predicts whether the stains can be removed or not, checks whether the patient has any other oral health problems and counsels the patient about the best way of dealing with this aesthetic problem. If problems do arise – such as increased tooth sensitivity or mouth irritation – patients will require additional advice and care.

It is for this reason that most national dental regulatory bodies in the EU regard the process of tooth whitening as the practice of dentistry. The CED supports the opinion of the Scientific Committee on Consumer Products (SCCP) that tooth-whitening products containing between 0.1 and 6% hydrogen peroxide (H₂O₂) are not safe to be sold over the counter and used freely, but are safe to be used after the approval and under the supervision of a dentist.

The CED welcomes the European Commission’s decision not to make tooth-whitening products with between 0.1 and 6% H₂O₂ available over the counter, but to uphold the SCCP opinion. Any decision to raise the maximum strength of tooth-whitening products for over-the-counter sale is for the SCCP to take, on the basis of up-to-date safety data.

The CED finds the present situation at EU level of all tooth-whitening products being considered as “cosmetic products” unacceptable.

Tooth-whitening products must be regulated under a regime that:

- takes proper account of the nature of tooth whitening as a clinical procedure;
- protects consumers from the direct availability of products which, if used without a dentist’s prescription, could be harmful;
- ensures controlled distribution of tooth-whitening products that are not available over the counter only to dental professionals; and
- enables the full range of tooth-whitening products to be available under the care of a dentist according to up-to-date evidence-based dentistry.

The CED believes that these criteria are met by the Medical Devices Directive. Tooth-whitening products of a strength higher than that considered safe by the SCCP for over-the-counter availability should be regulated under that Directive”.

Medical Devices Directive update

On March 29, the European Parliament adopted by a large majority a report on the proposed amendment to the Medical Devices Directive, which, among other things, contains new regulations on the safety of surgical instruments, custom-made devices and other medical products. The new Directive is due to come into force next year.

The new Medical Devices Directive covers a wide range of medical products, ranging from dressing materials and spectacles, via implantable devices, to ultrasound equipment and stomach probes. For the first time it also covers software for medical equipment.

Since the start of the legislative process, CED members and the head of the Brussels office have had individual discussions with MEPs from all major parliamentary groups and formulated proposed amendments to the draft directive.

One amendment introduced by the CED and tabled by the rapporteur has not been retained. This amendment concerned the validation of medical software. The CED considered that the concept of validation should not necessarily be applicable for medical software, so as to avoid excessive data collection, or should at least always be based on the relevant risk classification of the medical device concerned. Parliament has not voted for this amendment.

Those of the CED’s proposed amendments that were adopted in the plenary session of the Parliament concern the following regulations:

1. No naming of patients in conformity declarations for data protection reasons (amendment Proposal 31)

The Parliament was of the opinion that for data protection reasons the identity of the patient could be protected by being encoded (acronym or numeric code). Also, Parliament has proposed that the conformity declaration should be made “available” to the patient. This means that the patient could access it by asking his dentist, who will keep it in his files, but there would be no obligation on the dentist to give a copy to each patient. This represents a considerable softening of the original position where it was being proposed that the declaration must be given to the patient.

2. Post-marketing surveillance of custom-made devices: no introduction of systematic procedures to avoid additional costs (amendment Proposal 73)

With its proposed legislation the Commission intended to introduce a surveillance system for custom-made devices (ISO 13485) such as already existed for other medical products.

The CED proposed that post-marketing surveillance should be left up to the manufacturer and this was adopted by the plenary session of Parliament on March 29.

Getting these amendments taken on board represents a significant success for CED lobbying.

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Leading Light for Life

Alcoholism and other drug problems in the dental profession

A new support programme aims to assist dentists who are struggling with addiction.



Alcohol is a mood-altering substance that is widely used as part of a variety of social occasions – weddings, christenings, formal functions, casual gatherings and as ‘a drink with friends’. It is legally and widely available from multiple outlets. One of its main qualities is that of a disinhibitor and, as such, it assuages feelings of shyness and embarrassment, making conversation flow freely. It is one of the great social lubricants.

Alcohol, used in reasonable moderation, is a very safe and desirable substance. However, any mood altering substance used excessively over a period of time has the potential to produce changes in brain chemistry and function. The progression in vulnerable individuals who have a predisposition to addiction is:

normal use → heavy use → abuse → dependence = addiction.

Addiction is irreversible because, unlike other cells in the body, brain cells do not change throughout the life of the individual. The addictive condition is imprinted on the individual cells so that, even after a long period of abstinence, a return to the drug of choice will inevitably restart the state of addiction.

It is reliably estimated in the USA and the UK that some 10-15% of health professionals suffer the consequences of untreated dependence on alcohol and other drugs. There is no reason to suppose that this estimate should not apply equally in Ireland, particularly in the light of the results of Mori polls carried out in the US to assess the ethnicity factor relative to addiction among doctors – English/Irish topped the poll.

In the UK, a Dental Health Support Programme has been in existence since 1986 and more than 1,000 cases have presented in that time. Most cases concern alcohol and other substances. Similar programmes have operated in the pharmacy and veterinary professions since 1991 and 1999, respectively. A programme following the original model used in these countries is now being established in Ireland to help health professionals with problems that might endanger their professional lives and their personal wellness before trouble strikes.

The Programme

The Programme is confidential and based on the principle of early intervention. The objective of early intervention is to help the affected dentist to a state of recovery before there are adverse consequences such as patient complaint, loss of driving licence, health issues, major marital problems or a report to the Dental Council (DC). Where a complaint has already been referred to the DC, it is envisaged that the Programme can still be of help in a supportive role.

Not all cases of addiction reach the Programme early enough to avoid report to the licensing body. However, in the UK, some 85% of cases that have reached the Health Committee of the General Dental Council in the past five years have concerned alcohol and/or other substance abuse. The number of dentists that have achieved satisfactory recovery through the Programme in the UK in that time is far in excess of the number that reached the Health Committee.

Addiction causes impaired judgement, which leads to unacceptable adverse effects on the quality of care delivered by addicted practitioners. Recently, situations have arisen in the UK and in Ireland that have focused Government attention on the urgent need to address the quality of healthcare within all the health professions.

A health professional whose judgement is impaired cannot effectively assess his/her own impairment. When the Programme receives a request for help from someone who considers that a dentist may have a problem, the case will be assessed and verified, ideally by a number of concerned sources. In due course, after thorough investigation, the dentist will be approached in an empathetic manner that will penetrate their inevitable denial of the problem. After successful intervention, an appropriate solution, which may include treatment and rehabilitation, will be followed by an ongoing monitoring and support system, resulting in a safe and satisfactory return to work. In addressing addictive disease, it is helpful to examine the ASAM (American Society of Addictive Medicine) definition, which states:

- Alcoholism is a primary, chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations.

FEATURE

- The disease is often progressive and fatal.
- It is characterised by continuous or periodic: impaired control over drinking; preoccupation with the drug alcohol; use of alcohol despite adverse consequences; and distortions in thinking, most notably denial.

(This definition can be applied to any substance or process, such as gambling.)

“Addictive disease causes the sufferer to return to the substance or process of addiction, despite previous disturbances of function and despite previous negative consequences. Addiction is in the person, not in the substance.” (Lefevre)

Denial is a defence mechanism that the addict uses to neutralise the emotional pain induced by any revelation of the reality of his/her problem. It is an outer brain response to an inner brain trauma. It includes:

- rationalisation;
- minimisation;
- dishonesty;
- isolation;
- the chameleon effect – drinking only with heavy drinkers;
- withdrawal, e.g., from colleague situations; and
- projection.

Solution

Because of the mental impairment caused by the disease, addicts rarely recognise their own problem and when they do, their denial system kicks in to account for the consequences. Programmes are being established in the professions in Ireland that have the potential to deal with the problem. They have a proven track record over some 20 years both in the USA and the UK.

These programmes have in common trained, committed, clinically responsible personnel, capable of identifying, verifying, intervening, assessing and developing an individual package of care for each health professional referred to the programmes.

Each programme will be under the direction of a co-ordinator who will control its day-to-day functioning together with its overall management, including the maintenance of an effective, empathetic and confidential telephone service.

All first-time calls will be taken by a health professional who is him/herself in recovery from some form of addiction, so that there is no possibility of anyone sitting in judgement. Calls will be dealt with in an atmosphere of empathy and confidentiality.

The caller may be the affected professional, a family member, a colleague, or a friend, in fact anyone who knows of the problem and wishes to access help for someone in need.

A straw poll carried out among a large group of recovered addicted health professionals revealed that the average interval between the onset of impairment and commencement of recovery was some seven years. As a result of a process of early intervention, problems can be identified at an earlier stage in the disease process. This results in reduced morbidity in the health professional, significantly less danger to patients and considerable raising of the standards of clinical governance.

The corporate denial of the problem in the professions and the stigma attached to it will be lessened and a clearly perceived programme of confidential, effective and empathetic help will be demonstrated within the health workplace.

Contact will be maintained with reporting persons. In cases where no action is possible, due for example to a total denial or intransigence on the part of the health professional, the co-ordinator will contact the person who first reported within four weeks. After discussion, the person who originally made the report may initiate other action on an official level.

The co-ordinator will stay in contact with, and be available to the reporting person on an ongoing basis for as long as is reasonably necessary. The duration of the monitoring function lasts for at least two years. After that time relapse is rare and the individual will have established contact with health support groups. These will have been established throughout the State as part of an ongoing recovery network.

Education for prevention

The most basic principle in dealing with any disease process is, of course, prevention. In the case of addictive disease, which has such potentially disastrous consequences affecting every aspect of the sufferer's life, the need for prevention is obvious.

We must look to the education of the undergraduate section of the health professions so that our future graduates have a thorough knowledge of the dangers of legal, prescribed, over the counter and street-sourced substances.

In recent brain imaging research carried out in the USA several important factors have emerged. It has been shown that brain development is ongoing during adolescence and continues through the early twenties, contrary to what was previously thought. Sub-cortical areas develop first and dominate over the judgment areas, giving less planned thinking, more impulsive action, less self-control and higher risk taking. Frontal cortex areas involved in cognitive processes, inhibitory control, executive function, etc., develop later. It is at this stage, up to the age of 24 years, that the younger individual is most susceptible to the development of addiction, with or without pre-disposing factors.

Because of this situation, it is essential that a programme of education is included in all health professional education curricula as a method of primary prevention. There has always been a culture of heavy drinking among health professional students. The development of responsibility at a significant age is a powerful preventive tool.

The writer of this article has worked in this field for more than 20 years and has been in personal recovery from alcohol addiction for considerably longer than this. He would welcome telephone contact from any Irish dentist in recovery from any addiction on: 01 283 7409, which is the completely confidential number for the Irish Dentists' Health Programme.

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00.02 Thank you for your time.



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FEATURE

DentEd III advisory meeting

DR JACINTA MCLOUGHLIN explains the background to the DentEd project, and describes a recent DentEd meeting in the Dublin Dental School and Hospital.

Background

Since 1997 the European Union's Directorate for Education and Culture has funded three DentEd thematic network projects (TNPs): DentEd from 1998 to 2000; DentEd Evolves from 2000 to 2003; and, currently, DentEd III from 2004 to September 2007.

The first project was initiated by a group of dental educators, mainly from the Association of Dental Education in Europe (ADEE). DentEd was designed to facilitate EU convergence towards higher standards in dental education and professional training using a self-assessment process. Although DentEd has been initiated and driven by dental educators, the process of convergence is of vital importance to the regulatory bodies and dental associations.

The second project, DentEd Evolves (2000-2003), produced the document 'Development of Professional Competences'.¹ DentEd and DentEd Evolves paved the way for expanding the network and making an inventory on the existing curricula for dental education in Europe.

In 1999 the Ministers for Education from 29 EU countries signed the Bologna Declaration with the aim of establishing a European Higher Education Area by 2010 in which staff and students can move with ease and have recognition of their qualifications. One of the objectives is to 'tune' the curricula in terms of structures and actual teaching in order to make the programmes more comparable.

It was within this context of the free movement of dental graduates within the EU, the Bologna Agreement and 'tuning' that DentEd III commenced in 2004. DentEd III draws participants from a total of 182 partner institutions across Europe, within the EU and EEA countries and beyond. The work of DentEd III has been divided between six taskforces: Taskforce I is working on the 'Profile and Competences of an EU Dentist'; Taskforce II is working on curriculum model & ECTS; Taskforce III is working on benchmarking & quality assurance; Taskforce IV has organised a global



Attendees at the DentEd III conference.

congress for September 6-8, 2007, with the aim of launching a global network in dental education; Taskforce V is concerned with the creation of a permanent office for ADEE in Dublin (which has occurred); and Taskforce VI relates to the student input from the European Dental Student Association (EDSA). All the above documents are available on the ADEE website – <http://adee.org>.

On April 13 and 14, 2007, a DentEd III meeting was held in the Dublin Dental School and Hospital, Trinity College Dublin to obtain input on the Profile and Competences of an EU Dentist from ministries for health, competent authorities, and European and national dental associations, including specialist associations. JIDA editor, Professor Leo Stassen, represented the Irish Dental Association at this meeting. Some 55 delegates from 22 countries in Europe met for two half days and had intense discussions. Five chief dental officers from the European Chief Dental Officers Association, 14 representatives of national dental associations, five representatives of European specialist associations and seven representatives of regulatory authorities were in attendance.

A number of valuable suggestions were received on how to revise the present document. The revision process will be continued by asking all dental schools for more feedback and through working group discussions on the draft revised document at the annual ADEE meeting in 2008. The ADEE General Assembly will then decide on the revised version in September 2009.

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Dr Jacinta McLoughlin is Project Co-ordinator of DentEd III.



At the recent DentEd III meeting in Dublin:

far left: speaker Heikki Murtomaa;

middle: speaker Alphons Plasschaert; and,

left: speaker Alan Hegarty.

Briefing paper on proposals for the new MFD RCSI

SEAN M. SHERIDAN introduces the changes to the MFD examination.

From October 2007 the Faculty of Dentistry of the Royal College of Surgeons in Ireland will replace the current three-part MFD Examination with a new two-part examination.

Candidates will be eligible for the award of the MFD Diploma provided they; possess a primary dental qualification that is acceptable to the Councils of the Royal Colleges of Surgeons in Ireland and the UK; have completed a minimum of 24 months satisfactory whole time equivalent postgraduate experience at least 12 months of which has been gained in clinical posts in vocational training, hospital or institutions either in Ireland or overseas, which have been approved for training by the Faculty of Dentistry of the Royal College of Surgeons in Ireland; have passed both sections of the MFD Diploma examination; and complied with all the regulations.

Part 1

To be eligible to sit Part 1 of the examination candidates are required to provide evidence of completion of a minimum of six months satisfactory full-time experience, or part-time equivalent, in any field of dentistry obtained after gaining their primary dental qualification. The Part 1 examination will consist of two written papers:

- (a) multiple choice questions (two-and-a-half hours); and
- (b) objective short answers (two hours).

Part 1 will stand alone, candidates being awarded either a pass or fail. Part 1 will be held at least twice a year. There is full reciprocity of recognition of a pass in Part 1 between the MFD RCSI and the MFDS RCSEdin and RCPSGlas. Details of other reciprocal qualifications will be posted on the College website when available.

Part 2

Part 2 of the examination will be conducted at least twice a year in Ireland and once a year in approved overseas centres. The Part 2

examination will consist of an objective structured clinical examination with a minimum of 16 stations over a 90-minute period, and two 15-minute oral examinations assessing both applied basic sciences and clinical skills appropriate to 24 months postgraduate experience.

Information on transitional arrangements

The Colleges have put in place transitional arrangements with respect to the current MFD/MFDS examinations and these are described below.

The final diet of Part A was held in April 2007. This allowed candidates who failed Part A in April 2006 two further chances to pass. Candidates who proceed to sit the new Part 1 MFD, having previously failed the current Part A MFDS/MFD, will be allowed the full five years in which to complete both parts of the new examination.

The final diet of Part B will be held in April 2009. This will allow candidates who hold Part A at least three chances to pass Part B. Candidates who have not passed Part B by April 2009 will thereafter be required to enter the new MFD examination at Part 1.

The final diet of Part C will be held in May 2007.

Any holders of Parts A and B who have not yet passed Part C, will be able to enter Part 2 of the new MFD examination when it is introduced in November 2007. Thus, holders of Parts A and B of the current MFDS/MFD examination will be exempt from the requirement to pass Part 1 of the new MFD examination. After passing Part B they will normally be allowed two years in which to pass Part 2 of the new MFD examination.

The detailed regulations for the new MFD examination are available on the Faculty of Dentistry website – <http://dentistry.rcsi.ie>.

Mr Sean M. Sheridan, Dean, Faculty of Dentistry, RCSI.

FEATURE

At the ASC

There was a strong turnout at the Annual Scientific Conference in Cork in April. Superb presentations were accompanied by a first-class trade show and the social highlight of the week was the Gala Dinner. The Journal's camera was there.



Gala Dinner: Dignitaries attending the Gala Dinner at the ASC were (front row, from left): Dr Mary McCaffrey, President Irish Hospital Consultants Association; Minister for Health and Children, Mary Harney, TD; President of the IDA, John Barry; and President of the British Dental Association, Sue Greening. Back row: Dr Gerry Cowan, President, Northern Ireland Branch of the British Dental Association; and Martin Holohan, President of the Irish Dental Council.



Out of a sow's ear... Professor Duncan Sleeman provided instruction at the pre-Conference course on basic surgical techniques.



EXPERTS MEET: Professor David Whittaker, the world-renowned expert in forensic dentistry chats with the State Pathologist, Dr Maire Cassidy, prior to his address to the ASC.



IDA CEO Ciara Murphy introduced the guests at the Gala Dinner.



BIG TURNOUT: Close attention was paid to the detailed presentations.



WINNER: The winner of the Costello Medal was Barbara Carey of UCC for her presentation on 'Recent replacement techniques for lost alveolar bone'. She received her prize from IDA President, John Barry.

PARTNERS: IDA President John Barry and Vice-President, Ena Brennan, called to each of the Conference Partners' stands. They are pictured (all captions read from left to right) -



with Alan McCartney and Jim Geraghty on the GSK stand...



with Aoife Moran, Professional Relations Manager on the Colgate stand...



with Andreas Tishkewitz of Meisinger and Kevin Stump and Basil Mais on the Planmeca/Claudius Ash/J&S Davis stand...



with Eamonn Farrell on the Nobel Biocare stand...



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FEATURE



with Denis Kelly of Dentsply Friadent and George Fleeton of Dentsply UK on the Dentsply stand...



with Nicole Parkinson, David Burnard and Kirsten Hamilton on the Wrigley's stand...



with David Harper of Kerr and Keith Morgan of SybronEndo on the KerrHawe/SybronEndo stand and...



with Jim Way, Zita Buckley, Padraig Riordan, Siobhan Cleary, Craig Evans, Darrin Lynn, and Wayne Curtis on the Henry Schein stand.



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The attitudes of undergraduate dental students to the use of the rubber dam

Abstract: The majority of dental schools teach that use of the rubber dam is mandatory for certain procedures, e.g., endodontic therapy and adhesive dentistry. Despite this, many dentists perceive use of the rubber dam as a hindrance to dental treatment in adults and children.

Purpose: This study sought to evaluate the attitude of undergraduate students towards the use of the rubber dam and elucidate if the negativity towards its use is evident in undergraduate clinics.

Methods: A structured questionnaire was developed, which sought to establish current perceptions of the use of the rubber dam in adults and children, and circulated to the current fourth and final year clinical undergraduate class in the Dublin Dental Hospital.

Results: Isolation was identified as the main advantage of using a rubber dam and difficulty to place the main disadvantage. Some 98.5% of students believed they had received adequate training in rubber dam use for adults. While 72% of students were confident in placing a rubber dam for children, 38% felt that more training was necessary. The most commonly cited difficulty in placing a rubber dam was tight contacts. Most students are confident regarding which clamps to use. The majority of students (61%) believe that patients, especially children, prefer treatment without rubber dam isolation and that adequate isolation can be achieved without using a rubber dam. The average time spent placing the rubber dam was eight minutes for children and five minutes for adults. The students are more predisposed to using the rubber dam on adults than children for the same procedure.

Conclusions: Undergraduate students are not convinced that the use of a rubber dam is effective and efficient except for endodontic therapy. Students already believe that patients, both adults and children, would prefer their treatment to be conducted without a rubber dam. Teaching efficient methods of placing the rubber dam may improve students' confidence and reduce placement time so that the students will be more likely to use the rubber dam after graduation.

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Introduction

The rubber dam was introduced in 1864 by Barnum. Since then, the technique has been perfected, taught, used and rejected by many in the profession.¹ Use of the rubber dam is encouraged in undergraduate dental education and is mandatory for most restorative treatment in children and adults. There is a lack of evidence in the literature to prove that using a rubber dam improves the outcome of restorative dentistry, and further research is needed. There may be some difficulty in obtaining approval from ethics committees for research where the control is the same treatment, but without the intervention of the rubber dam. The European Society of Endodontology advises

the use of the rubber dam in its quality guidelines.² Irrigant choice is strongly linked to rubber dam use when endodontic treatment is performed, with 71% of rubber dam users using the recommended sodium hypochlorite, compared to only 38% for non rubber dam users.³ Use of the rubber dam has been shown to significantly reduce airborne bacterial contamination of the working environment during conservative procedures.⁴ There is ample research to show that oral micro-organisms compromise endodontic treatment.⁵

The British Society of Paediatric Dentistry recommends the use of the rubber dam, where practical, when placing or removing amalgam restorations, in order to reduce any

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potential risk of mercury toxicity to a minimum.⁶ However, despite the scarcity of scientific evidence to prove that the rubber dam improves the quality of care, it is obvious that it improves safety by protecting the patient’s airway from inhalation of foreign objects. Indeed, our dental protection societies prefer that the rubber dam be used for this reason.

It is our perception that undergraduate students perceive the use of the rubber dam to be a hindrance rather than an adjunct to dental treatment in adults and children. The highest use of the rubber dam is reported in the United States Air Force Dental Service (98% of dentists).¹ However, the literature suggests that the use of the rubber dam is not widespread in general dental practice. In a survey of general practice in the UK, 61% of respondents did not use the rubber dam for endodontics, let alone any other procedure.⁷ A considerable number of graduates in the UK reported a reduction in rubber dam use for endodontics, in contrast to their undergraduate training.⁸ Another recent survey of alumni of one UK dental school reported that only 19% of dentists used the rubber dam routinely and 44.5% never used it.⁹

Use of the rubber dam has many advantages beyond moisture control (Table 1). The perception that patients do not like rubber dam has been disproved in both adult and child patients.¹⁰

The practice of dentistry in Ireland differs from that in the UK, where it has been reported that remuneration in the NHS was a barrier to good practice and quality of endodontic care.¹¹ To date, there has been no data on the use of the rubber dam in general practice in Ireland. However, we suspect that many procedures are performed in general dental practice without the rubber dam. Students who acquire competence and efficiency in certain skills during their undergraduate training are more likely to continue to use those skills following graduation. We expect that students completing undergraduate training are competent in the placement of the rubber dam. Despite this, we suspect there is a fall off in the use of the rubber dam following graduation, and also that the rubber dam is not routinely used in general dental practice.

The aim of this study was to determine the perceptions of students towards the use of the rubber dam and to identify where problems exist with its use. We also wanted to ascertain if any negative attitude to the use of the rubber dam originates in the undergraduate setting.

Methods

A survey questionnaire was designed containing 13 questions (sample survey form in Appendix). The questions explored the didactic and clinical experience of rubber dam placement in adults and children. The survey questions were structured to prevent leading to an ideal answer and to avoid appearing judgemental. The fourth and final year undergraduate class were identified as having maximum clinical exposure during these years. The questionnaire was distributed to and collected from the undergraduate students on a single day. The survey was estimated to take no more than five minutes to complete. A response rate of 70% is considered adequate for limiting non-response bias for questionnaire-based studies.

TABLE 1: Advantages of the rubber dam.

Improved visibility
Reduction of microbial contamination of the environment and root canal
Protecting the aerodigestive tract from foreign materials
Moisture control
Retraction of soft tissues
Behaviour modification
Time efficiency

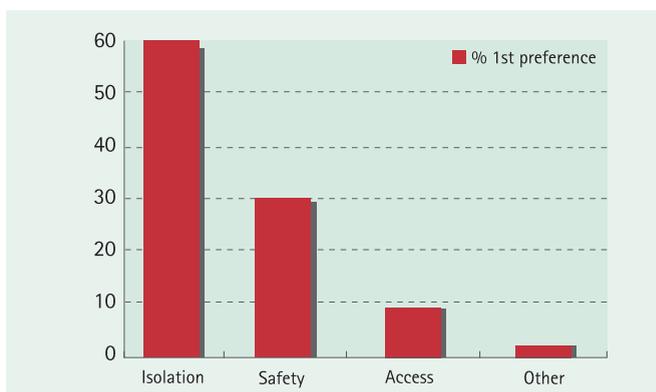


FIGURE 1: The advantages of the rubber dam, chosen by respondents as their first choice, as a percentage of total respondents.

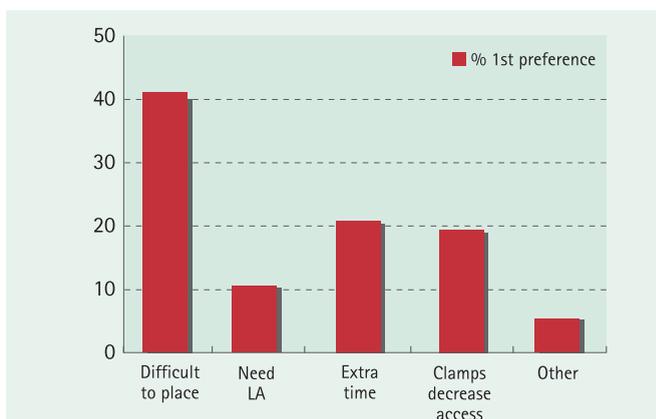


FIGURE 2: The main disadvantages chosen by respondents as their first choice, as a percentage of total respondents.

Results

Combined class size was 79 students, and 10 students were absent on the day (Erasmus programmes). Of the 69 questionnaires distributed, 65 were returned, resulting in a response rate of 94%. The average time spent completing the survey was three minutes. The main advantage of the rubber dam was correctly identified by the students as isolation (59%) (Figure 1). Safety against inhalation and soft tissue protection were also reported as very important issues. Students listed difficulty fitting a rubber dam as the main disadvantage (41%), with the additional clinical extra time required to

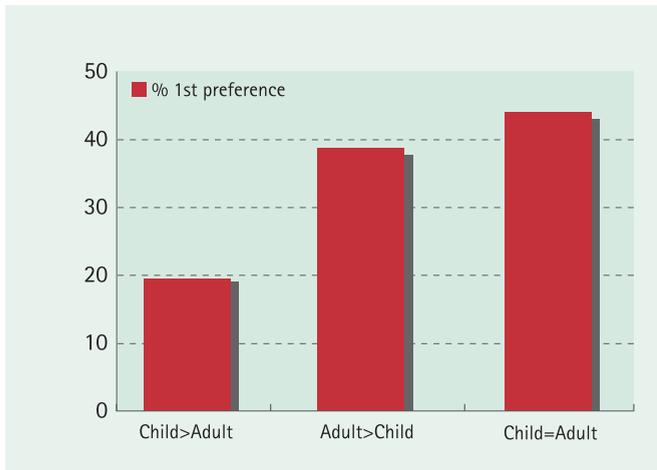


FIGURE 3: Response when asked how likely it was that the rubber dam would be used for similar procedures in adults and children.

TABLE 2: Clinical situations where difficulty was encountered, as a percentage of total responses.

Difficulty encountered	Number of reports
Tight contacts	15%
Child management	11%
Partially erupted teeth	9%
Posterior teeth, e.g., wisdoms	7%
Loss of tooth structure	6%
Spaced deciduous teeth	4%
Others	48%

TABLE 3: Predicted use of the rubber dam post qualification for certain procedures in both adults and children.

Procedure	Adults	Children
Amalgam restorations	34.5%	39%
Anterior composite restorations	61%	67.5%
Posterior composite restorations	90.5%	90.5%
Endodontics	100%	98.5%
Indirect restoration, prep or fit	6.5%	14%

fit also featuring as a major disadvantage (22%). Almost 19% of students reported that the clamp decreased access to the operative field (Figure 2). The students also suggested that when LA was required for placement of a clamp, it was less likely to be used. Most students (71%) thought that children did not like the rubber dam, which was significantly more than those who felt that adults did not like it (60%). Students also felt more confident using the rubber dam with adults (100%) compared to children (72%). Almost all the students reported having adequate training for use of the rubber dam in adults (98%) compared to children (62%), and 38% would like

more training in the use of the rubber dam with children. This is reflected in the increased time taken to place a rubber dam in children (eight minutes) versus adults (five minutes).

Approximately 56% of students believed they could achieve adequate moisture control without a rubber dam. The majority of students (86%) were sure about which type of clamp to use. The most common problem cited by the students in placing the rubber dam was tight contacts. The second most common clinical difficulty encountered was child management. The other common difficulties encountered were clamping partially erupted teeth in the posterior of the mouth, e.g., wisdom teeth, and where there was loss of tooth structure (Table 2).

A range of responses was reported when students were asked about use of the rubber dam for similar procedures in adults and children. It appears the students have a slight preference towards adults with regard to the use of the rubber dam, as 44% would use the rubber dam more often with adults than with children for the same procedure. A total of 37% of students would use the rubber dam equally in treating an adult or child patient, and only 18% of students would use the rubber dam more often in children than in adults for the same procedure (Figure 3).

When the students were asked to predict their use of the rubber dam in general dental practice, all students would use the rubber dam when performing endodontic therapy for an adult and all except one student would use it for pulp therapy on a child. The majority of students would use the rubber dam for posterior composite restorations on adults and children (both 90%). Use of the rubber dam for anterior composites was reduced to 61% in adults and 67% in children. Similarly, use of the rubber dam to place amalgam restorations was reduced to 65% in adults and 61% in children. The majority of students would not use the rubber dam when fitting an indirect restoration such as a crown, bridge, veneer or inlay (Table 3).

Discussion

The majority of dental schools worldwide teach the use of the rubber dam as an important adjunct to restorative dentistry in both adult and child patients.¹ Many procedures are technique sensitive and use of the rubber dam can facilitate successful restorations. In the Dublin Dental Hospital, the use of the rubber dam is mandatory for all paediatric restorative procedures, and in adults for endodontic therapy and adhesive procedures. The positive benefits to the operator and patient of using the rubber dam, particularly for endodontic treatment, are well recognised² but its use tends to fall off in practice.⁸ The rubber dam is an excellent behaviour management tool in paediatric dentistry, allowing efficient restorative care in a dry environment.

This survey highlighted that the undergraduate students had sufficient confidence and training to reliably place a rubber dam for adult patients. This ability was substantially lower when treating the child patient. The reason may be related to the students' clinical experience in paediatric dentistry within the undergraduate programme, where students see adult patients four times more often than children. Comments suggested that the problems encountered in use of the

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rubber dam in children may relate more to behaviour management of the child patient than to specific problems with the rubber dam. However, hands-on training and practice in placing the rubber dam in children needs to be provided to encourage efficiency with the procedure.

Many students reported that they felt that patients, particularly children, did not like treatment using the rubber dam. This is in direct contrast to the recent survey of patients' attitudes to the rubber dam for endodontic procedures, where the authors concluded that patients generally are not averse to the rubber dam and that operator experience improves patient compliance.¹⁰ Some of the reluctance to place the rubber dam may relate to the time taken to successfully place it. The average time our students estimated that it would take to successfully place a rubber dam on an adult was five minutes and eight minutes for children. This is similar to that reported by Stewardson and McHugh, where the mean time taken by students to apply the rubber dam for all procedures was 4.65 minutes.¹⁰ The reluctance of some students to place the rubber dam appeared to be because the time taken was perceived as wasted time rather than an adjunct to completing treatment. The ability to successfully and efficiently place a rubber dam in a variety of clinical situations comes with clinical experience and can be taught. It is evident that more practical experience is required by the students to incorporate efficiency into this technique, particularly with the paediatric patient. In almost all dental schools worldwide, the use of the rubber dam for endodontic therapy is compulsory. This survey showed that all students would reliably use the rubber dam for endodontic procedures and expect to continue to use this following graduation. This teaching is in line with ESE guidelines,² and all students have learned the accepted materials and methods within the undergraduate experience.

Many students reported that isolation can be adequately achieved without a rubber dam in a number of clinical situations. This was surprising, since dental students rarely have one-to-one nursing support. Use of other methods of moisture control is rarely as successful as the rubber dam is for many procedures, particularly when no assistant is available. None of the students suggested that use of rubber dam isolation increased the efficiency and quality of the restorative work completed. Over 90% of the students would use rubber dam isolation for posterior composites, however only 60-70% of students would use rubber dam isolation for anterior composite or amalgam restorations. Ideally, the emphasis should shift from the frequency of rubber dam use to the quality and effectiveness of the isolation achieved by using it.¹ The appropriateness of rubber dam isolation will depend on the clinical situation, including the procedure to be accomplished. The advantages of the rubber dam are emphasised in the curricula of dental schools. Much of the data relating to the UK seems to suggest that remuneration within the NHS system is a barrier to quality care.¹¹ In a recent study of undergraduate dental schools in the UK and Ireland, the authors found that all schools taught their students to use the rubber dam in 'most' cases where posterior cavities were to be restored with composite resin.¹² In the North West of England, only 1% of general dental practitioners used the rubber dam

routinely for operative procedures, this figure rising to 4% in Scotland.⁷ Worldwide, the literature suggests that there is a disconnect between what students are taught and how they practice in other disciplines, e.g., face-bow registration and special trays are often abandoned in the practice of prosthodontics following graduation.¹³

It would be interesting to report on the use of the rubber dam in dentistry in Ireland as it has never been examined. The results of this survey of students would suggest that the importance of the rubber dam has been learned, and that all students will use the rubber dam for endodontic therapy. However, some negativity is already associated with its use, particularly in children where it is already believed that patients prefer treatment without the rubber dam. The benefit of the rubber dam in completing the procedures in a more timely and controlled fashion, and as a behavioural tool, was not recognised by any of the students. A negative perception may therefore be related more strongly to operator attitude and time required for placement than to patient preference.

The educational process should place a greater emphasis on the reasons for rubber dam use, while ensuring efficiency in its placement. Rubber dam isolation is not the most technically demanding procedure in clinical practice, and it may be that convincing dentists of its value is the major issue in increasing its use in general practice.³ Improving skills using continuing professional education is considered to be the means of improving the quality of care.¹

Any apparent gulf that exists between procedures taught in dental schools and what is practiced in the 'real world' will challenge the dentist in making the successful transition from undergraduate practice to general practice. In Ireland, a comparison between general practitioners (private/GMS/PRSI patients) and the School Dental Service may highlight that regulations for remuneration are also a barrier to the routine use of the rubber dam. The results reported here will be used in the future to highlight any gap between teaching in the undergraduate curriculum and the use of the rubber dam in dentistry in Ireland.

Conclusions

This survey has highlighted some shortfalls in the teaching of the use of the rubber dam in the undergraduate curriculum. The students subjectively believe that patients, especially children, do not like the rubber dam, which is contrary to the evidence. While adequate isolation without using the rubber dam can be achieved, it is almost impossible in the undergraduate situation where one-to-one assistance is not available. Despite this, many students did not perceive this as a problem, and already demonstrate a reduced use of rubber dam isolation for certain procedures. Students need to believe in all aspects of rubber dam use to appropriately select it for the correct clinical situation. This survey would suggest that increased preclinical training on phantom heads and increased hands-on training in clinics would be advisable, particularly in paediatric patients. Students must be convinced of and confident in rubber dam isolation prior to graduation to increase the likelihood of its use being continued in practice.

The author would like to thank all the students who took part for their time and co-operation.

The role of bitewing radiographs – a review of current guidelines

Abstract: This article sets out guidelines on the use of bitewing radiographs for the detection of dental caries, with suggested risk factors and recall intervals. It describes a case in which extensive carious lesions were not detected clinically, but were revealed when radiographs were taken during an orthodontic assessment.

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Introduction

Over recent years, there has been a steady increase in dental awareness in the Irish population, which has led to a falling caries rate.¹ Fuelled by an image conscious media, the general population is demanding high standards of dental care and expertise, with an increased desire for cosmetic dental treatment. It is vital that prior to any of these procedures, including orthodontics, a thorough examination takes place. This article focuses on the guidelines for the use of bitewing radiographs in dental examinations for the detection of dental caries.

Guidelines

Dental radiography is an important diagnostic aid in the detection of dental caries. However, there are risks associated with any form of radiography, and in view of this, guidelines have been produced by the European Association of Paediatric Dentists (EAPD),² the American Dental Association (ADA),³ the Faculty of General Dental Practitioners (UK)⁴ and the European Commission.⁵ These are designed to avoid unnecessary exposure to x-radiation by helping to identify when a radiographic examination is required. Informed consent must be obtained before taking a radiograph, with the patient and parent being made aware of the risks versus the benefits. Radiographs should not be taken until a thorough clinical examination has taken place, along with a dental history.

The bitewing radiograph is defined as a form of dental radiograph that may be taken with the long axis of the film orientated either horizontally or vertically, which reveals approximately the coronal halves of the

maxillary and mandibular teeth and portions of the interdental alveolar septa on the same film.³ The role of the bitewing radiograph is to detect caries that cannot be otherwise visualised, to estimate the extent of carious lesions and to monitor enamel lesions.⁴ Studies have shown that bitewing radiographs are the most efficient method for the detection of approximal caries^{6,7,8} and caries under existing restorations.⁹

Llena Puy et al⁸ carried out a study in 2005 in which 162 children aged 14 years were examined. All molar and premolar surfaces were dried thoroughly and examined using a light, plane mouth mirror and blunt probe, and caries recorded. Bitewing radiographs were then taken of each patient using a paralleling technique. It was found that clinical examination diagnosed all occlusal caries but underestimated approximal lesions by 86.84%. Of the total caries detected, only three (6.97%) of the lesions detected in premolars and 12 (17.64%) of those in molars were visible in the clinical examination. Other studies have had similar results.^{9,10,11} The authors concluded that, in the context of public oral health programmes, bitewing x-rays are an important adjunct to clinical examination in order to avoid underdiagnosis of approximal caries.

In children and adolescents, the common reasons for taking a radiograph are for the detection of caries, monitoring dental development, investigating disturbances of tooth eruption and after dental trauma.³ Guidelines produced by the EAPD, the ADA, the Faculty of General Dental Practitioners (UK) and the European Commission all stress that when deciding on whether to take bitewing radiographs, the caries risk should

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first be assessed, and the patient assigned to a high or low risk category. The risk assessment relates to the caries experience of the local population, the individual's caries experience, oral hygiene, dietary habits and exposure to fluorides. While exposure to fluorides has increased, so has the exposure to sugar-laden carbonated drinks. A diet survey in the orthodontic unit in Letterkenny discovered that 82% of adolescents admitted to having at least one carbonated drink in the three-day period, with 4% of those having more than one a day.

Clinically detectable occlusal caries in an individual may suggest the presence of approximal carious lesions that can only be detected by radiographic examination. In addition, patients with existing carious lesions are at high risk of developing further carious lesions, as they are more likely to have poor oral hygiene and an increased exposure to sucrose-containing foods. Children who are caries free in the deciduous dentition are likely to remain so up to the age of 12 years.¹² Those who already have caries at this stage require careful monitoring. In adolescents, increasing independence, changing dietary patterns and decreased attention to oral hygiene may also increase the risk of dental caries. Other factors placing an individual in a high risk group are: existing restorations of poor quality; multi-surface restorations; a history of recurrent caries; and developmental or acquired enamel defects (Table 1).³ It should be noted that an individual's risk status can change. A child who attends a national school with a healthy eating policy can change from a low to a high risk upon entering a secondary school with a fizzy drink vending machine.

The EAPD's guidelines for bitewing radiographs state that due to the benefit of detecting caries at an early stage, radiographic examinations should still be conducted without any clinical evidence of disease. Open contacts in the primary dentition allow the dentist to visually inspect the approximal surfaces of posterior teeth. With eruption of permanent teeth, closure of these proximal contacts means that visual inspection is not possible, and therefore a radiographic assessment is required. With closure of proximal contact points, there is also an increased risk of approximal caries.¹³ The EAPD therefore recommends bitewings at age eight years, this being after the eruption of the first permanent molar teeth. Both the EAPD and the ADA also recommend considering bitewing radiographs in the primary dentition at age five years, when the approximal surfaces cannot be visualised, although this examination at such a young age may not be practical in the primary care setting. The EAPD suggest that bitewings should also be taken at the age of 12-14 years, including those with low caries rates, as at this time the premolars and second molars have erupted and once again the approximal surfaces cannot be visualised.

Intervals between bitewing radiographs depend on the caries risk. The EAPD guidelines state that those with low caries risk require bitewing radiographs at two- to three-year intervals, while those at higher risk require bitewing radiographs annually. The European Commission guidelines state that when children are designated as high caries risk they should have six-monthly posterior bitewings taken, those at a moderate caries risk should have annual posterior bitewing radiographs, and those at a low caries risk should have bitewing radiographs at intervals of two years, although longer intervals may be appropriate where there is continuing low risk.

TABLE 1: Assessment of caries risk.

High risk	Low risk
Caries in primary dentition	No caries in primary dentition
Clinically detectable caries present	No clinical caries detected
Poor oral hygiene	Good oral hygiene
High sugar diet	Low sugar diet
Heavily restored dentition	No restorations
Non-fluoridated area	Fluoridated area
Irregular attender	Regular attender
Recent detrimental change in diet	
History of recurrent caries	
Developmental/acquired enamel defects	

Moberg Skold *et al*¹⁴ carried out a three-year randomised controlled study into the effect of a school-based fluoride varnish programme on approximal caries incidence and progression in 13-16-year-olds in high, medium and low caries risk areas. They monitored the caries radiographically and showed that early caries can remain in the enamel for up to 12 months, and if discovered at this stage, can be arrested and then monitored with preventive intervention. With the use of the paralleling technique using x-ray holders, high quality, reproducible radiographs can be taken, allowing monitoring of carious lesions confined to the enamel.

Bitewing radiographs should also be taken prior to the placement of fissure sealants or restorations. Caries progression can be fast, especially in first permanent molars, once caries is into dentine. Without radiographs, there is the risk of missing decay.¹⁵ Weerheijm described "hidden caries" as a carious lesion seen in dentine on a bitewing radiograph where clinically the occlusal enamel appears sound.¹⁶ He also suggested that the increase in the use of fluoride may be responsible for this phenomenon by encouraging surface enamel remineralisation, and by slowing down the lesion progression.

Ten Cate has written extensively on the effects of fluoride on tooth structures. Fluoride can substitute for hydroxyl ions, forming a partially fluoridated hydroxyapatite, a form less susceptible to acid attack. Fluoride is gradually accumulated in the outside layer of enamel, resulting in a lower solubility than that of the underlying enamel.¹⁷ Ten Cate and Arends showed that with topical application of high concentration fluorides to white spot lesions, there were initial high rates of mineral deposition.¹⁸ They postulated that fluoride-enhanced deposition occurred primarily in the surface layer, leading to a blocking of the surface layer pores. During demineralisation, the organic acids then bypass the less soluble surface layer, removing mineral from the deeper layers.¹⁹ It is hypothesised that calcium and phosphate ions from the hydroxyapatite diffusing to the surface, in the presence of severe demineralisation, may precipitate with the fluoride, leading to supersaturation of the surface layer.²⁰ If there is alternating fluoride supply and cariogenic attack, laminations can develop in white spot lesions.

Once bacteria have invaded the dentine, the acid produced continues to dissolve the hydroxyapatite of deeper dentine, and this can be extensive before collapse of unsupported enamel occurs. Yanagisawa *et al*²¹ studied molars extracted due to small but deep occlusal carious lesions from adults in regions with a high fluoride level in the water supplies (3.5ppm). They used a scanning electron microscope to study the highly

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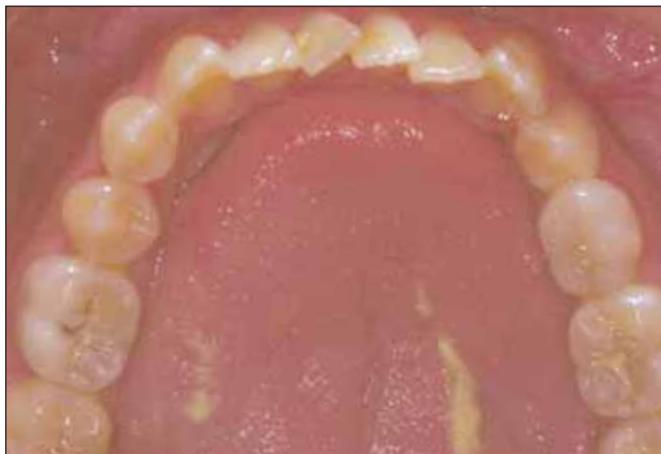


FIGURE 1: Lower arch.



FIGURE 2: Upper arch.



FIGURE 3: Dental pantomogram.



FIGURE 4: Right bitewing radiograph.

mineralised enamel surface found above the deep dentine lesions, and found it to be composed of many large, flattened, hexagonal crystals and extremely small, irregularly shaped crystals. This layer was found to be more opaque than enamel, with a lower fluoride content, and this opacity may mask the demineralisation occurring beneath.

Although all the guidelines recommend bitewing radiographs for new dentate adult patients, it is important to establish when previous radiographs have been taken as the European Communities (Medical Ionising Radiation Regulations)²² state: "The prescriber and the practitioner shall seek, where practicable, to obtain previous diagnostic information or medical records relevant to the planned exposure and consider these data to avoid unnecessary exposure". If the patient is to be referred for a radiographic examination, sufficient clinical information should be supplied to allow the practitioner taking the clinical responsibility for the radiographic exposure to perform the justification process. Often dental pantomograms (DPTs) are used as a general examination. However, a panoramic survey alone is not sufficient for the diagnosis of approximal caries for the entire dentition. Bitewing radiographs are still required as they are more efficient in the detection of approximal caries and for monitoring enamel caries.²³ A summary of the EAPD guidelines can be found in **Table 2**.

Case report

A 16-year-old girl attended the orthodontic department on referral from primary care. She regularly attended dental appointments, and had recently undergone a dental examination in which no clinical caries was detected (**Figures 1 and 2**). Fissure sealants had been placed on first permanent molars at a previous appointment, which were not fully intact. A DPT, taken in the orthodontic department, revealed extensive caries in a number of teeth (**Figure 3**). Bitewing radiographs were taken by the general practitioner, which confirmed multiple carious lesions (**Figures 4 and 5**). The caries on the lower left first molar extended subgingivally. This tooth was asymptomatic.

Conclusions

Within the primary care service, there are time and financial constraints, which have meant that sometimes radiographs have not been taken. There have also been general concerns regarding overuse of dental radiography. However, there are serious medico-legal implications when large carious lesions are missed. A thorough dental examination should be undertaken prior to a secondary referral such as orthodontics, and this should include bitewing radiographs for the detection of caries if the approximal surfaces cannot be visualised. The importance of taking bitewing radiographs prior



FIGURE 5: Left bitewing radiograph.

TABLE 2: Summary of EAPD guidelines for the taking of bitewing radiographs.

Baseline bitewing examination	Interval to next bitewing examination	
At age:	Low risk	High risk
5 years	3 years	1 year
8 or 9 years	3 years	1 year
12 to 16 years	2 years	1 year
16 years	3 years	1 year

to fissure sealants must also be emphasised. Both clear and opaque fissure sealants, if they remain intact, can make it difficult for the dentist to clinically diagnose caries until it becomes extensive.

In summary, the current guidelines for the use of bitewing radiographs in dentistry state that their use is important in the detection of caries, and should be based on a caries risk assessment. Intervals between subsequent bitewing radiographic examinations must be reassessed for each new period, as individuals can move in and out of caries risk categories with time. Useful guidelines have been produced, but each case needs to be taken individually and full justification for radiographic exposure given.

Full guidelines for taking radiographs can be found on:

- the EAPD website (www.eapd.gr/links.htm);
- the American Dental Association website (www.fda.gov/cdrh/radhlth/adaxray/);
- the European Communities (Medical Ionising Radiation) Regulations, PN:12216, Stationery Office, Dublin 2002; or
- by contacting the Faculty of General Dental Practitioners (UK) (www.fgdp.org.uk).

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ABSTRACTS

Bleeding disorders and periodontology

Vassilopoulos, P., Palcanis, K.

Delivery of patient care encompasses a wide range and variety of challenges, one of which is unexpected clinical bleeding. Clinical bleeding can be presented in two forms: the first can occur during surgery; and the second can manifest several days after the procedure. In both situations, the clinician will need to take immediate action to control the haemorrhage and stabilise the patient. The present article will review bleeding disorders and their management. The discussion will address the following issues:

- significance of bleeding disorders in the treatment of periodontal disease;
- prevalence of bleeding disorders;
- basic physiology of haemostasis;
- classification and definition;
- medical diagnosis;
- management of periodontal patients with bleeding disorders; and
- current concepts and new approaches in treating periodontal patients with bleeding disorders.

Periodontology 2000 2007; 44 (1): 211.

Success rate of mini- and micro-implants used for orthodontic anchorage: a prospective clinical study

Wiechmann, D., Meyer, U., Büchter, D.

Objectives

Whereas micro-implants have become a useful alternative as orthodontic anchorage elements in orthodontics, less is known about the clinical effectiveness of micro-implants. The aim of this prospective clinical study was to evaluate the success rate of micro-implants used for orthodontic anchorage.

Material and methods

A total of 133 mini-implants (79 Abso Anchor, 54 Dual Top implants), placed in 49 patients to support orthodontic tooth movements, were examined in the study. The majority of the implants were placed in the maxilla (82), followed by the vestibular (42) and lingual (nine) aspect of the mandible.

Results

An overall cumulative survival rate of 86.8% (102/133) was found by Kaplan-Meier analysis. The failure rate between Dual Top implants (13%) and Abso Anchor implants (30.4%) differed significantly ($P=0.0196$; log-rank test). The cumulative failure rate of implants was found to be significantly higher when implants were placed in the lingual aspect of the mandible compared with the other localisations ($P=0.0011$; log-rank test). Clinical evaluation revealed successful dental movements when implants remained stable during the orthodontic therapy.

Conclusions

The present results confirm the effectiveness of orthodontic micro-implants used as anchorage elements.

Clin Oral Impl Res 2007; 18: 263-267.

Does prophylactic administration of systemic antibiotics prevent postoperative inflammatory complications after third molar surgery?

Halpern, L.R., Dodson, T.B.

Purpose

To estimate and compare the frequencies of inflammatory complications after third molar (M3) surgery in subjects receiving intravenous prophylactic antibiotics or saline placebo.

Materials and methods

Using a placebo-controlled, double-blind, randomised clinical trial, the investigators enrolled a sample composed of subjects who required extraction of at least one impacted M3 and requested intravenous sedation or general anaesthesia. The predictor variable was treatment group classified as active treatment (penicillin or clindamycin for penicillin-allergic subjects) or placebo (0.9% saline). Study medications were randomly assigned. Both surgeon and subject were blinded to treatment assignment. The medication was administered intravenously prior to any incision. The outcome variable was postoperative inflammatory complication, classified as present or absent, and included alveolar osteitis (AO) or surgical site infection (SSI). Other variables were demographic, anatomic or operative. Descriptive and bivariate statistics were computed. Statistical significance was set at $P \leq 0.05$, single-tailed test of hypothesis.

Results

The sample was composed of 118 subjects ($n=59$ per study group). In the active treatment group, there were no postoperative inflammatory complications. In the placebo group, five subjects (8.5%) were diagnosed with SSI ($P=0.03$). No subject met the case definition for AO. All SSIs were associated with the removal of partial bony or full bony impacted mandibular M3s.

Conclusion

In the setting of third molar removal, these results suggest that the use of intravenous antibiotics administered prophylactically decreases the frequency of SSIs. The authors cannot comment on the efficacy of intravenous antibiotics in comparison to other antibacterial treatment regimens, e.g., chlorhexidine mouth rinse or intrasocket antibiotics.

Journal of Oral and Maxillofacial Surgery 2007; 65 (2): 177-185.

'Inadequate' dietary habits and mastication in elderly men

Liedberg, B., Stoltze, K., Norlén, P., Öwall, B.

Objective

The aim of this study was to re-evaluate data about oral status, mastication and nutrition in elderly men in Malmö, Sweden, recorded in 1985-1987, to assess associations between inadequate dietary habits, oral conditions and masticatory function.

Materials and methods

A total of 481 men, aged 67-68, participated in a comprehensive health examination, including tooth and denture status and masticatory tests. A separate study of dietary habits and nutritional status was made. A total of 95 men had inadequate dietary habits. The databases of dental/denture status, mastication, nutritional status and social network factors were re-evaluated for assessment of associations.

Results

No significant differences between those with adequate or inadequate nutrition were found with regard to the number of teeth, occlusal contacts or removable dentures. Also, self-assessed chewing did not show any differences.

Conclusion

Inadequate dietary habits were independent of teeth and denture status. Some correlations to social network conditions could be identified. Overweight, obesity, low physical activity and high alcohol intake were more common among those with inadequate nutritional intake.

Gerodontology 2007; 24; 41-46.

Answers to Summer Quiz on page 106.

1. The clinical photograph shows a palatal swelling with non-healing extraction sockets with an associated palatal swelling. The radiolucency which is ill-defined uncorticated and has greatly increased in size.
 2. Giant cell lesion. Langerhans cell disease (Histiocytosis X).
 3. The diagnosis is of a well-differentiated squamous cell carcinoma. Ameloblastoma. Squamous cell carcinoma.
- Treatment would likely require local resection, radiotherapy and reconstruction with bone grafting and implants placement.

Understanding your practice costs

DAVID MCCAFFREY looks at how overhead costs impact dental practice income.



Do you know the real cost of offering treatment to your patients? Are you unsure as to how your practice is performing in relation to your peers? With inflation at its highest level in six years, approaching 5% for the first few months of 2007, and property lease costs increasing, dental practices should pay attention to their overhead costs and attempt to understand the cost of treatments offered to patients.

As there are several methods of establishing a practice's overhead rate per hour or per patient, many dentists often ask where do they start in trying to review the cost of their practice, and how do they know if the costs look typical for the type of practice they operate? A dental accountant who has numerous dental practices as clients will be able to compare costs as a percentage of turnover to the industry standard and review the type, cost and number of treatments being offered. This will allow you to focus your attention on specific areas of overhead in order to improve your practice's profitability. The simplest approach to analysing the cost of treatments is to establish the overhead rate per hour through a three-stage process:

1. gather the practice costs;
2. gather an estimate of the hours to be worked; and
3. divide costs by hours to get overhead rate per hour.

Gather practice costs

By reviewing a practice's accounts, the overheads of a dental practice can be broken down into what are termed variable and fixed costs. Variable costs are those that change with the number of patients seen by a dentist,

whereas fixed costs tend to be more structural and usually change when there is a step change in the activity of the practice.

Variable costs:

- dental consumables;
- dental laboratory;
- staff wages (if paid by the hour);
- office expenses; and
- cross-infection costs.

Fixed costs:

- staff wages (fixed amount per week);
- insurance;
- energy;
- mortgage or lease costs;
- rates;
- loan interest;
- promotional costs;
- small equipment; and
- depreciation of practice assets.

The mix of costs will depend on the age of the practice, the number of dentists and whether there is a hygienist working in the practice.

Number of hours to be worked

Once the costs have been collected, the next step is to calculate the number of hours a dentist will practice in a year. In this example the dentist has decided that for an optimum work/life balance the practice will work 32 hours a week seeing patients for 47 weeks in the year. This will give 1,504 practice hours a year.

Practice costs excluding lab.	€	Hours	€ per hour
Dental consumables	34,000	1,303	27.11
Staff wages (inc PAYE/PRSI)	75,000	1,303	59.81
Energy costs	3,000	1,303	2.39
Property lease/insurance/rates	30,000	1,303	23.92
Promotional costs	3,000	1,303	2.39
Equipment lease	13,000	1,303	10.37
Office expenses	12,000	1,303	9.57
Waste disposal	2,000	1,303	1.59
Small equipment	6,000	1,303	4.78
Depreciation	13,000	1,303	10.37
Total costs	191,000	1,303	152.31

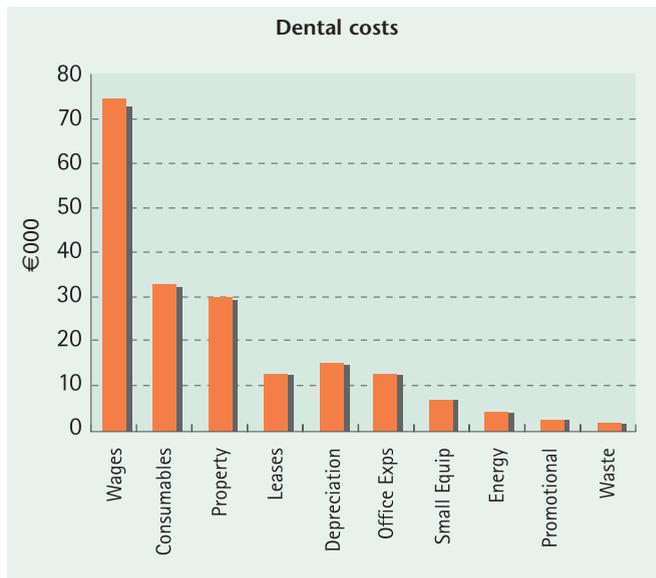


FIGURE 1: Graphic representation of practice costs.

The oral hours worked then need to be reduced for the change-over time for cleaning and sterilisation of equipment between patients. In this example we will estimate eight minutes per oral hour worked, and this reduces the number of treatment hours to 1,303 a year.

Overhead rate per hour

The next step is to calculate the average overhead rate per hour. **Table 1** shows a simple example of a sole practitioner who works with a full-time receptionist and two part-time dental nurses. The total costs of €191,000 are divided by 1,303 hours to give an overhead rate per hour of €152.31. This means that the dentist must earn €152.31 per hour before taking home any income. As laboratory costs relate uniquely to the treatment being offered, they can therefore be excluded from the general overhead rate calculation and added in at a later stage when calculating the specific cost of treatments. When viewing the practice costs graphically, it is readily apparent that wages, consumables and property-related costs make up over 70% of the practice costs (**Figure 1**).

An overhead template is included at the end of the article for those dentists that wish to calculate their practice overhead rate per hour.

Now that we have established the basic practice overhead costs we can look at building up the cost of various treatments and how much the dentist will earn for private, PRSI and GMS patients. Where a number of single treatments are bundled into a treatment plan the overhead cost is shared, for example:

A1 examination/A2 prophylaxis and A3A amalgam restoration:	
Fee income	110.46
Overhead cost (30 min)	76.16
Income to dentist	34.30

An analysis of the more routine single treatments offered is set out in **Figure 2**. A useful comparison can be made when the fee income is presented graphically (**Figure 3**).

Maximising income

Once the cost of treatments has been established the dentist is now in a position to try to maximise hourly income. This can be done in several ways.

a) Review overheads

By putting overheads into buckets that can be readily compared to other dental practices, your accountant will be able to indicate areas that may be higher or lower than expected given the type and size of practice. Consumables and laboratory costs should be reviewed to ensure that costs are competitive and that consumable stocks are not too high.

b) Review treatment times

Can the throughput of patients per hour be increased? If the dentist were to carry out an examination on a GMS patient, for which the payment due under the DTSS is €29.91, then in order to break even, the maximum time that could be spent with the patient is 14 minutes. This may not be feasible without impacting patient care.

c) Review treatment types and internal marketing

The type of treatments offered can be reviewed and existing treatments promoted or new treatments offered in order to maximise income per hour and gain greater acceptance of treatment plans. The practice literature and presentation skills of employees could be reviewed to ensure that patients are made aware of available treatments. Are intra-oral cameras used to highlight areas of the mouth for which treatment could be offered? It should be remembered that fees paid for dental courses are an allowable tax expense. If the dentist is to concentrate on treatments that are more complex and offer a greater income potential per hour, then consideration should be given to having a hygienist perform scale and polish treatments. This is particularly attractive where there is a spare chair in the practice as the practice overheads will be covered by the dentist's activities.

Income earned from treatments by type of patient									
	Treatment fee income			Average treatment time minutes	Overhead cost of treatment	Laboratory cost & extras	Dentist earnings per treatment		
	Private	PRSI *	GMS **				Private	PRSI Inc <55k p.a	GMS
Examination	60	32	32	20	51		9	(19)	(19)
Prophylaxis	80	30	30	30	76		4	(46)	(46)
Amalgam restoration	110	94	48	25	63		47	30	(15)
Composite restoration	140	119	50	25	63		77	56	(13)
Extraction	130	38	38	30	76		54	(38)	(38)
Surgical extraction	200	102	102	45	114		86	(13)	(12)
Endodontic treatment	450	450	175	120	305		145	145	(130)
Prosthetics									
Partial	600	220	220	80	203	110	287	(93)	(93)
Full upper or lower	650	300	300	100	254	150	246	(104)	(104)
Full upper and lower	1,000	440	441	100	254	200	546	(13)	(13)
Chrome cobalt	1,250	1,250		100	254	180	816	816	
Reline	180	120	120	45	114	40	26	(34)	(34)
Denture repair	80	56	58	20	51	40	(11)	(33)	(33)

* PRSI fee scale used. No upgrading of PRSI prosthetic service offered
 ** GMS treatment includes 2.9% fee increase for 2006 and 4% for 2007

FIGURE 2: Analysis of routine single treatments.

PRACTICE MANAGEMENT

Overhead template			
Practice costs excluding lab.	€	Oral hours	€ per hour
Dental consumables			
Staff wages (inc. PAYE/PRSI)			
Energy costs			
Property lease/insurance/rates			
Promotional costs			
Equipment lease			
Office expenses			
Waste disposal			
Small equipment			
Depreciation			
Total costs			

d) Increase prices

With a large fixed overhead base a percentage increase in treatment prices can lead to a disproportionate increase in the practice's percentage profit. See the example below where the sales prices were increased by 10%, which led to a 29% increase in practice income.

	€'000	€'000	% Increase
Sales	320	352	10%
Lab	30	33	
Fixed	191	191	
Income	99	128	29%

Where the prices charged are particularly low for high end treatments, an increase in prices can lead to an increase in the acceptance of treatment plans; this is due to some patients' perception that a low price reflects low quality. For those practices with a high proportion of patients under the DTSS, prices cannot be increased. This places an additional burden on dental practices, as DTSS fee income has not kept up with medical inflation over the last number of years. There is also an additional impact of a year on year reduction in the number of treatments per patient, which has led to the average GMS fee income per patient falling.

Withholding tax

There is often confusion about tax withheld through GMS and PRSI schemes. Some dentists see this as a cost to their practice and treat it as a deductible expense when trying to calculate profit for treatments.

Professional Services Withholding Tax is not an additional tax but a deduction at source by the Government of tax at the standard rate of 20%. It applies to payments made by all the public bodies in respect of professional services on account of a taxpayer's final liability.

As one F45 withholding tax certificate is issued in respect of every relevant payment made, these forms need to be kept in a safe place for six years as F45 forms are very difficult to replace.

In conclusion

Dentists have a difficult dynamic to manage between the duty of care to patients and maximising practice income. Once the cost of treatment has been established the dentist can set the price that will be charged to the patient. Various pricing models can be used, from a simple cost plus profit required model, to more complex activity- and value-based methods. If dentists are to maximise their revenue per hour it is essential that they understand the cost of the treatments that they are offering. By carrying out a benchmarking exercise a dentist can gain a lot of information in relation to fees charged and the cost of the underlying practice. It is only by gaining a deeper knowledge of their practices that dentists can manage the impact of inflation and income from government dental schemes.

The author

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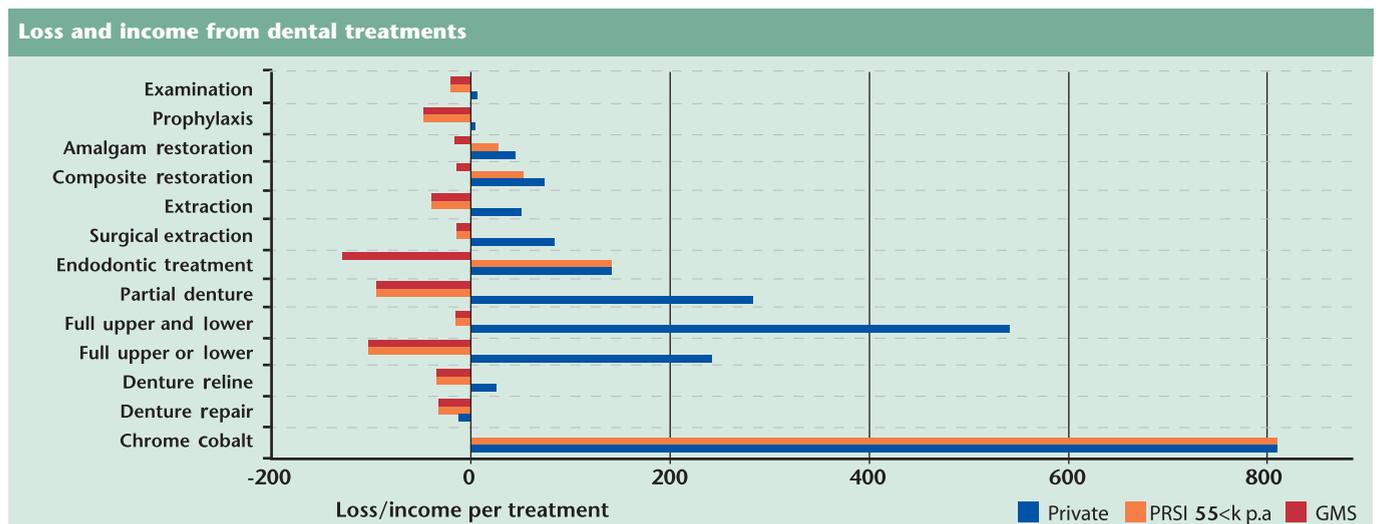


FIGURE 3: Graphic representation of fee income.

The Safety, Health and Welfare at Work Act, 2005

SHIRLEY COULTER explains what dentists need to know about health and safety legislation.

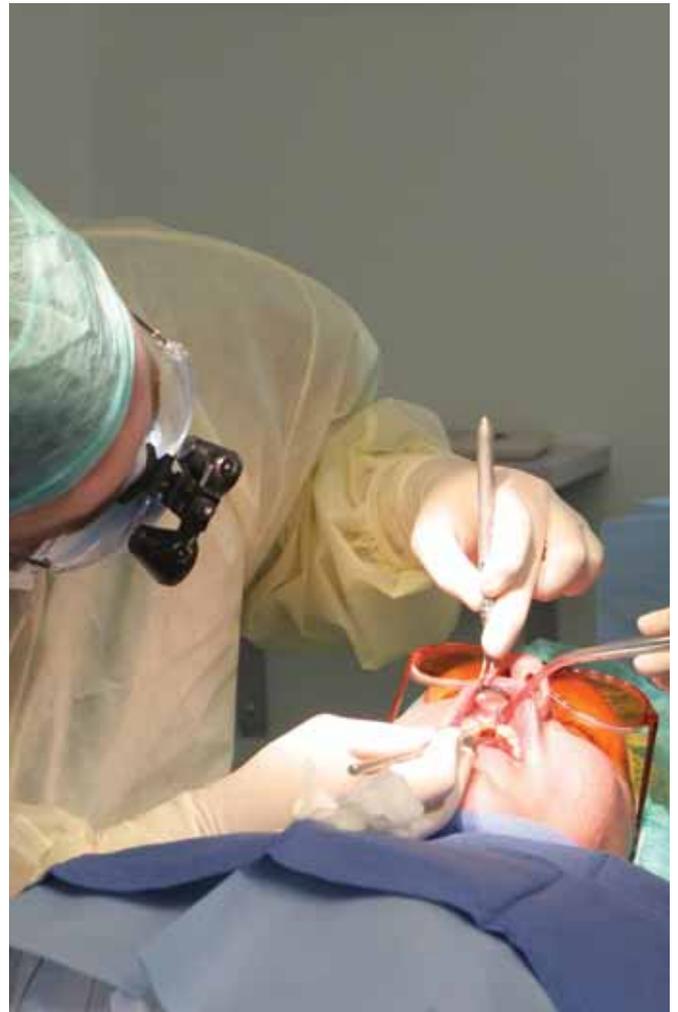


Most dentists will be aware of the Safety, Health and Welfare at Work Act, 2005, but awareness alone is not sufficient to meet the Act's requirement that "every employer shall ensure, so far as is reasonably practicable, the safety, health and welfare at work of his or her employees". Indeed the 2005 Act talks of the employer "managing and conducting" all aspects of health and safety in the workplace, which is

reflective of a very much hands-on approach expected of dentists as employers under the law when it comes to workplace health and safety.

Furthermore, under the Occupiers Liability Act, 1995, dentists will be held under the law to be the "occupier" of their practice surgery premises. In addition, the 1995 Act places a duty of care on the dentist as the occupier of the practice surgery premises to his patients as well as members of the general public who would come under the definition of "invitees/entrants/visitors" under the 1995 Act.

It is worth reminding all dentists that breaches of health and safety



legislation can result in fines of up to €1,900 or unlimited fines on indictment to a higher court and/or imprisonment for up to two years. As champions of good oral hygiene and the corresponding adage that 'prevention is better than cure', dentists must apply the same philosophy to ensuring compliance with all health and safety legislation.

Employer obligations

Section 8 of the 2005 Act sets out that the employer is to provide the following in order to meet their health and safety obligations:

- a safe place of work;
- safe means of entry and exit;
- safe equipment and machinery;
- safe systems of work and operating procedures;
- provision of appropriate information, instruction, training and supervision;
- provision of suitable protective clothing and equipment;
- preparation and revision of emergency plans, e.g., in the event of fire;
- designation of staff having emergency duties, e.g., fire warden;

PRACTICE MANAGEMENT

- prevention of risk from any article or substance;
- provision and maintenance of welfare facilities, e.g., eating and drinking facilities;
- provision, where necessary, of a competent person to advise and assist in risk and hazard identification, and drafting the safety statement; and
- reporting of accidents/dangerous incidents to the Health and Safety Authority.

Employee obligations

Section 13 of the Act stipulates that employees have to take reasonable care for their own safety and the safety of their fellow employees as follows:

- employees must take reasonable care to protect their safety, health and welfare at work as well as that of any other person who may be affected by the employee's act or omissions;
- employees must co-operate with the employer in order to comply with any statutory provision/requirement;
- employees must not act in any way that will endanger the safety, health and welfare of themselves or any other person;
- employees must not be under the influence of any intoxicant while at the workplace and must agree to any appropriate and reasonable medical examinations if their employer so reasonably requires;
- employees must attend any health and safety training as requested by their employer;
- employees must make appropriate use of any item provided for their protection at work including protective equipment, having regard to any relevant training and/or instructions; and
- employees must report any defect in the place or system of work, including defective equipment or the infringement of any statutory provisions, to the safety officer.

The safety statement

Section 20 of the Act sets out that every employer must have a written safety statement, which: represents their commitment to health and safety; identifies the hazards and risks in the place of work; and outlines the arrangements to safeguard health and safety, as well as the co-operation required from employees to ensure a safe place of work. The safety statement must at a minimum:

- identify the hazards in the workplace and the risks arising from these hazards;
- outline the protective and preventive measures and resources in place to secure the safety, health and welfare of employees;
- detail both the employer and employees' obligations;
- outline the plans and procedures to be followed and the measures to be taken in the event of an emergency, and the names and job titles of those staff with responsibilities for health and safety, e.g., safety officer, safety manager; and
- specify the provisions for consultation on health and safety issues with employees.

The employer is responsible for drafting the safety statement. It is recommended that a 'competent person', e.g., a risk auditing company/safety consultancy be employed to ensure that all risks and hazards are identified and all health and safety requirements are met. The safety statement should then be compiled on the basis of their findings. All employees must be made aware of the safety statement and must have access to it. Furthermore, the safety statement must be brought to the attention of other persons in the workplace who may be affected by risks to their health and safety, including temporary, service and maintenance staff. The safety statement should be reviewed at least annually and revised as appropriate.

The Health and Safety Authority

The Health and Safety Authority (HSA) has overall responsibility for the administration and enforcement of health and safety at work in Ireland. The HSA monitors compliance with legislation at the workplace including inspections of places of work and investigations of serious accidents. They also act as an information point for employers, employees and the self-employed on all aspects of health and safety in the workplace.

In order to be fully prepared in the event of a visit from a Health and Safety Authority inspector employers should ensure that at a minimum they have complied with the following actions:

- familiarisation with all health and safety regulations and in particular with those that specifically apply to their workplace;
- Employment of a 'competent person', e.g., a risk auditing company/health and safety consultancy to assess the risks and hazards in the workplace;
- Compilation of a safety statement to incorporate all the recommendations of the 'competent person' and to include all essential elements as outlined above;
- ensuring that all staff have a copy of and understand the safety statement, and their obligations as outlined above;
- provision of all necessary training to staff;
- designation of staff to act in a health and safety capacity (e.g., a safety officer to represent employees and safety manager to represent the employer) and to implement the safety statement, ensuring that it is integrated into the daily work practices and policies; and
- contact the Health and Safety Authority with any queries as necessary.

Implementation of these recommended actions should ensure both compliance with health and safety legislation, and most importantly, should ensure the health, safety and welfare of all staff. IDA, in association with its regional branches, will undertake to provide a series of lectures later this year on various employment relations topics including health and safety. Dates for these worthwhile events will be communicated to all members in due course.

The author

*Shirley Coulter, Employment Relations Officer,
Irish Dental Association.*

JUNE 2007**Midland Branch, Irish Dental Association
– Golf Outing**

Date: June 15, 2007
 Venue: Glasson Golf Club, Athlone, Co. Westmeath
 Tee-time is 12.30pm. The fee for golf and dinner is €100 – please forward cheque to Dr Clem Sullivan, 2 Church Street, Longford.

**Irish Society for Disability and Oral Health
– Sixth Annual Conference**

Date: June 22, 2007
 Venue: Tullamore Court Hotel, Tullamore, Co. Offaly
 For further information contact Dr Mark Henry, Dental Dept, Health Centre, Tullamore, Co. Offaly, Email: mark.henry@mailq.hse.ie.

JULY 2007**International Federation of Dental Hygienists (IFDH)
– International Symposium on Dental Hygiene**

Date: July 19-21, 2007
 Venue: Toronto, Canada
 The Canadian Dental Hygienists Association under the auspices of the International Federation of Dental Hygienists (IFDH) is hosting the International Symposium on Dental Hygiene from July 19 to 21, 2007, in Toronto, Canada. Further information is available from <http://www.cdha.ca/ifdh.asp>.

AUGUST 2007**2007 Conference on Dentist Health and Wellness:
Thriving Dentists, Healthy Practices**

Date: August 16-18, 2007
 Venue: ADA Headquarters, Chicago
 Featuring three programme tracks: 'Ergonomics in dental practices'; 'Personal growth'; and 'Professional impairment'. Further information is available at www.ada.org.

SEPTEMBER 2007**35th Indian Prosthodontic Society Conference**

Date: September 6-11, 2007
 Venue: New Delhi, India
 All relevant information and downloads are available at the official website for the conference – www.35sipsconference.com.

Irish Dental Association – Golf Outing: Captains' Day

Date: September 8, 2007
 Venue: Carlow Golf Club
 For further information contact Ciaran Allen, Tel: 047 71400.

**The European Society of Cosmetic Dentistry (ESCD)
– 4th Annual Scientific Meeting**

Date: September 21-23, 2007
 Venue: Marriott Hotel, Vienna, Austria
 New challenges in update dentistry. For further information or to register, Tel: 0043 1 536 6337, or Email: iris.bobal@media.co.at.

Irish Dental Association – Annual General Meeting

Date: September 22, 2007
 Venue: Hilton Hotel, Charlemont Place, Dublin 2
 The AGM will commence at 11am.

**The 148th American Dental Association Annual Session
and Marketplace Exhibition**

Date: September 27-30, 2007
 Venue: The Moscone Center, San Francisco
 Pre-session activities for ADA '07 take place on September 26, with scientific sessions from September 27-30. House of Delegates takes place from September 28 to October 2, and this year's session introduces the all-new World Marketplace Exhibition from September 27-29. For further information, or to download a copy of the programme, contact www.ada.org.

**Munster Branch, Irish Dental Association
– Annual Scientific Meeting 2007**

Date: September 28, 2007
 Venue: Clarion Hotel, Lapps Quay, Cork
 For further information contact Dr Kieran O'Connor, Tel: 024 92338, Email: klocdent@eircom.net.

OCTOBER 2007**Public Dental Surgeons Seminar,
Irish Dental Association**

Date: October 10-12, 2007
 Venue: Knockranny House Hotel, Westport, Co. Mayo
 Further information will follow when available.

FDI World Dental Congress

Date: October 24-27, 2007
 Venue: Dubai, United Arab Emirates
 For further information contact www.fdiworldental.org or congress@fdiworldental.org. Details of the scientific programme and very favourable accommodation rates in Dubai are available on the FDI website – <http://www.fdiworldental.org/microsites/dubai/congress4.html>. Direct flights are available from Dublin to Dubai.

NOVEMBER 2007**IDENTEX dental exhibition**

Date: November 9-10, 2007
 Venue: The Pavilion, Leopardstown Racecourse, Foxrock, Dublin 18

**Orthodontic Society of Ireland
– Autumn Meeting**

Date: November 9-10, 2007
 Venue: Druids Glen
 The Orthodontic Society of Ireland will hold their Autumn meeting in Druids Glen on November 9 and 10, 2007. Speaker is Dr Bill Clark. Subject is 'New horizons in orthodontics and dentofacial orthopaedics'.

**Irish Dental Association
– Golf Outing: Christmas Hamper**

Date: November 30, 2007
 Venue: Portmarnock Links Hotel and Country Club
 For further information contact Ciaran Allen, Tel: 047 71400.

APRIL 2008**IDA Annual Scientific Conference 2008
– Operation Wexford**

Date: April 23-26, 2008
 Venue: New White's Hotel, Wexford Town

CLASSIFIEDS

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 July 24, 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 within 48 hours, for 12 weeks.

POSITIONS REQUIRED

- German dentist, specialised, places implants in your clinic and provides prosthetic follow-up.** Single tooth replacement and edentulous jaws. Dublin preferred. Please contact: implantdentist@web.de.
- Motivated Italian dentist, already working in Ireland, is seeking a part-time position in Dublin** area two to four days every fortnight. Available Sun, Mon, Tues, Wed on alternate weeks. CV available on request. Email: volpatoale@yahoo.it or Tel: 086 845 7957 or 0039 349 743 7536 after 8pm.
- Female dentist relocating to Cork. Six years PQE.** Seeking Associate position, ideally with a view to partnership or purchase in Cork City or suburbs. Tel: 086 840 5431 after 8pm.
- Experienced UCC graduate relocating to Dublin.** Part- or full-time Associate position starting September 2007 sought. South Dublin preferred. Tel: 087 990 9470.
- Experienced TCD Graduate (1998) available for Associate position on Fridays only.** Dublin based. Tel: 087 745 4389.
- Dutch orthodontist (registered in Ireland) wants to Associate with Irish orthodontist to work 25-50% starting August.** Preferably Cork or Dublin area. Email: rg.potgieser@hccnet.nl.

**Looking to employ a dental hygienist?
Please contact Dara Jennings, Employment Officer,
at 086 0574469. The Irish Dental Hygienists Association.**

POSITIONS VACANT

- Position vacant. Four days available in dental surgery in Midleton.** Would suit Associate or Specialist (Oral Surgeon/Endodontist/Periodontist). Immediate start. Please Tel: 021 461 3976.
- Associate sought for busy modern three-surgery practice in Co. Galway. 20 mins to Galway City Centre.** Fully computerised, OPG, hygienist and orthodontist. PRSI and private fees only with full book. Send CV and references. Tel: 093 24452 or Email: tuamdental@hotmail.com.
- Dental Associate required for part-time locum position with immediate effect until August 2007.** Half-hour from Limerick. Three-quarters of an hour from Cork. Tel: 087 767 1515 or 063 81088.
- Enthusiastic dentist/Associate wanted for young Galway digital general practice – excellent conditions.** Tel: 086 818 7373.
- Keen Associate required for busy Dublin 15 practice.** Experience preferable. Hours and pay negotiable. Tel: 086 858 3855 after 6pm.
- Associate dentist required for Limerick City practice.** Immediate start. Computerised, digital radiography, OPG and hygienist. Tel: 087 853 7313.
- South Dublin.** Seeking Associates for permanent part-time orthodontist and oral surgeon. Modern computerised practice. Tel: 087 621 9891.
- Full-time Dental Associate required for busy dental practice, Clonee, Dublin 15.** Contact Maria at maria.kavanagh@yahoo.co.uk or Tel: 01 463 0962.
- Advert size** **Members** **Non-members**
up to 25 words €75 €95
26 to 40 words €90 €110
- 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:
Think Media
 The Malthouse, 537 North Circular Road, Dublin 1.
 Tel: 01-856 1166 Fax: 01-856 1169 Email: paul@thinkmedia.ie
- Digital Dublin City Centre general practice seeks an enthusiastic full-time Associate to join our team.** Excellent conditions. Tel: 086 818 7373 during office hours.
- Full-/part-time Associate required to replace departing colleague in busy Carlow practice.** Fully computerised, digital radiography, hygienist. Contact jsel@eircom.net or Tel: 087 299 8930.
- Associate required to join a number of colleagues in a busy multiple practice in Ballinasloe, Co. Galway.** Many friendly patients. Excellent staff. Modern equipment, OPG, Ozon, etc. Full- or part-time considered. Email: rothwellaut@eircom.net.
- Associate required to replace departing colleague.** Full-time, immediate start, full book. North Dublin, 10 minutes from airport. Excellent opportunity for enthusiastic dentist in a modern surgery with Healozone RVG Digital shading. Excellent staff support and hygienist. Tel: 087 997 3132.
- Dental Associate required, Wicklow/Carlow border, 45 mins Dublin, 20 mins Carlow.** Modern dental practice with good support staff, seeks friendly committed dentist for busy general practice. Long-term view required to replace departing colleague. Please Tel: 087 685 1568.
- Part-time Associate wanted for busy, friendly two-person practice in Clonmel, Co. Tipperary** (40 mins Kilkenny, Waterford, and 70 mins Cork, Limerick). Hygienist on site and excellent terms and conditions for a suitable candidate. Email: jpdheaney@eircom.net.
- Portmarnock, Co. Dublin.** Dental Associate required for busy, modern, friendly practice with private and PRSI patients. Part-time position available immediately. Tel: 01 816 9474.
- Associate Dentist required for practice in South Kerry** to replace departing colleague. Tel: 087 983 1290.
- Dental Associate required for modern well-equipped practice in Galway.** Starting June '07. Tel: 087 997 2877.
- Co. Kerry.** Sessions available/Associate required, view to buy. Busy but friendly practice. Replies to Box No. J207.002.
- Experienced, conscientious Dental Associate required for two days per week in Dublin City Centre practice.** GMS and private mix. Immediate start. Please contact the practice between 8.30am and 4.30pm on 01 878 3181.
- Dental Associate required 10 minutes from Cork City Centre (West side).** Start May/June 2007. Tel: 086 608 6196 after 6.30pm Monday to Friday or Email: whiteiem@gmail.com.
- Dental Associate required, Naas, Co Kildare.** Full- or part-time considered. Busy practice, 90% private. Tel: 086 389 3232.
- Dental Associate required.** Rapidly expanding, progressive, computerised dental practice, very modern working environment, OPG. Tel: 044 966 1777 for details or Email: drmulrooney@yahoo.com.
- Experienced, conscientious Associate required for full-time position in beautiful, bright, modern three-surgery practice six miles from Galway City.** Full book and excellent support staff assured. Immediate start available. Tel: 00 353 86 820 5838 after 7pm or Email: phewatal@eircom.net.
- Dental Associate required immediately full-time for very busy Dublin practice.** Tel: 01 451 2194 or 087 907 5573.

Associate wanted. Co. Meath practice seeks full-time Associate with long-term view to partnership. Extremely busy with no medical card work. Fully computerised with top spec equipment including RVG, digital panoral, microscope, etc. Two hygienists. Experience essential. Tel: 046 907 1961 (evenings) or 086 815 7705.

Position available for Associate Dentist in Galway City Centre digital general practice. Excellent conditions. Tel: Frank on 086 231 9994.

Full-time Associate wanted. Very busy Navan practice. Private and PRSI. Hygienist. Great potential. Tel: 087 629 3496, Email: jghonan@eircom.net.

Full-/part-time Associate wanted for progressive seven-surgery practice in the Midlands. Visiting implantologist/periodontist. 40 mins from M50. Excellent support staff. Fully computerised with digital intra oral and extra oral radiography/intra oral cameras. Tel: 087 687 4234 or 087 851 8489.

Locum dentist required to cover maternity leave in the South East. To start late July 2007. Tel: 087 226 2570 or 053 923 9283 after 6pm.

Locum dentist required for busy Dunderum practice for June 2007. Please Tel: 01 298 6029 between 9am and 5pm.

Locum dentist required for July to mid-September in Co. Meath. Full-time/part-time. Tel: Alison on 087 673 7429.

Locum required full-time in Dublin 6 for maternity cover. Start September. Tel: 086 602 4243.

Locum required for busy North Cork practice from mid August to the end of December. Maternity leave. Four-day week. Tel: 063 81088 (daytime) and 087 767 1515 (evenings).

Dental surgeon locum required urgently for month of March in modern medical centre in North Dublin. Email: info@touchstone.ie or Tel: 01 646 7830 to apply.

Dental surgeon required one to two days per week for busy practice in the North East. Tel: 087 934 0841.

Health Service Executive in Dublin North West requires two general dental surgeons – part-time and full-time – immediately. Contact Dr Jane Renehan, Tel: 01 646 4550, Email: jane.renehan@mailc.hse.ie. Send CV to Roselawn Road, Blanchardstown, Dublin 15.

Health Service Executive Dental Section has a vacancy for a general dental surgeon in the Kildare/West Wicklow Local Health Office. Contact Dr Siobhan Doherty, Email: siobhan.doherty1@mailm.hse.ie.

Kilkenny City. Departing colleague leaves an opportunity for holistic-minded dentist, full- or part-time. Newly equipped, RVG, 1/0 cameras, Ozone. Great staff. Contact Bill at billymccollam@yahoo.co.uk.

Part-time dentist required for sessions in Dublin West HSE area. Please contact Dr Nick Armstrong at nick.armstrong@maild.hse.ie.

Full-time and part-time posts available in County Wicklow with the HSE-Wicklow, providing dental care to children and eligible adults. Registration with Dental Council of Ireland required. Please email CV to Catriona Roe, Principal Dental Surgeon, Email: catriona.roe@maild.hse.ie or Tel: 086 380 5367.

Busy group practice in the Midlands requires dentist urgently due to illness of colleague. Tel: 086 853 6342 or Email: lboland@iol.ie.

Dentist required for busy modern practice in west Dublin area. Experienced friendly staff, new surgery, mostly private. Parking space. Part-time initially, working up to full-time. Long-term position a possibility. Contact Paul, Tel: 01 6102222 or Email: poboyliverivside@hotmail.com.

Full/part-time dentist required for general dental duties in HSE dental services Dublin West area. Please contact Dr Nick Armstrong, Tel: 087 210 8754 or Email: nick.armstrong@maild.hse.ie.

Dublin City Centre ultra modern practice seeks a dentist to join the team. A great opportunity not to be missed. Tel: 086 231 9994.

Endodontist required for Dublin 4 dental practice. Please Tel: 086 171 5441.

Dental specialists. Practice 90 minutes from Central Dublin invites a periodontist, endodontist and paedodontist to join it on a full-/part-time basis. Extremely busy practice. Fully computerised with digital panoral, RVG, microscope. Two hygienists. Full admin support. Tel: 046 907 1961 (evenings) or 086 815 7705.

Orthodontist required for a busy private multi-disciplined dental practice in Limerick City. For further information please contact Cormac on 087 906 5705.

Laboratory technician required for rapidly expanding, progressive, modern, computerised dental practice. Contact Coole Dental Clinic, Coole, Co. Westmeath, Tel: 044 966 1777.

Dublin 9. Full-time dental nurse required. Experience not essential. Please call 087 934 8007 or Email: eimear2t@yahoo.com.

Dental nurse required for Dublin 4 dental practice (experience not essential). Part-time/Full-time. Tel: 086 331 9950 for more details.

Dental nurse required full time, Naas, Co. Kildare. Tel: 087 947 1088.

Dental hygienist required for Co. Waterford practice. Part-time initially. Call 087 678 9642 after 5pm.

Hygienist required for busy Dublin 15 practice. Experience required. Hours and pay negotiable. Tel: 086 858 3855 after 6pm.

Full-time hygienist required in Sligo Town from July 2007 to join our existing full-time hygienist in our newly built expanded practice. Email: prdp@eircom.net.

Hygienist required for busy four-surgery practice in South East three days a week. Start June '07. Tel: 087 250 7830, Email: rogersdental@eircom.net.

Part-time assistant required for new practice in Sandyford, no experience required. Please call 086 835 5140 or Email: vsisodiya@hotmail.com.

Dental surgery assistant required. Part-time hours to cover maternity leave for minimum of seven months. Start May/June. Please send CV and cover letter to Dr Rory Dwyer, 1 Dempsey's Terrace, Peter's Square, Wexford, Tel: 053 912 1733.

PRACTICES FOR LET/SALE

For Sale, Dublin 6. Busy, modern, well-equipped two-surgery practice annexed to substantial period house. Established over 30 years. House offers obvious development potential or comfortable family home. Extensive off-street parking for 8-10 cars. Tel: 086 853 9966, Email: darareynolds@mail2ireland.com.

For Sale, Dublin 8. Dental practice in landmark period residence (recently refurbished). 9K+ clients, contents of surgery included. One-bed apartment, roof garden and secure parking. Extension potential. Ideal start-up for recently qualified dentist. Tel: 087 753 3416.

For sale. Long-established dental surgery, Dublin 12. Free hold house. Room for expansion. Tel: 085 736 0882.

130 square metres space in Capel Street (river end), Dublin City Centre, suitable for dental surgery. For viewing, please contact Kevin Daly, Tel: 087 251 8484, Email: kdalyaspire@eircom.net.

For sale, Dublin South. Superb location. Centre – two miles. Single-handed. Plans for expansion. Modern equipment. No MC. Almost fully private. Leasehold. Superb growth. Excellent profits. Tel: 086 807 5273.

Busy practice for sale in thriving West Cork town. 70% private. Tel: 086 404 2705 after 7pm.

To Let, Kinnegad, adjacent to Main Street. New single storey building, approximately 60 square metres. Suit dental surgery. Tel: 087 418 0235.

Dublin City Centre (10 minutes) practice for sale. Three surgeries, digital and computerised, hygienist, OPG. Thriving practice with large turnover, big list and huge potential for expansion with three essential ingredients – position, position and position. Tel: 086 387 7201 or Email: drmulrooney@yahoo.com.

Cork City Centre practice for sale. Tel: 00 353 87 257 7502, or Email: practiceforsale1@gmail.com.

For sale. Established Cork City Centre dental practice. Replies to Box No. J207.001.

For sale, Co. Galway. Two surgeries. Well established. Idyllic set-up. Great equipment. Huge growth. Expansion needed. Booked three months ahead. Hygienist. Competitively priced. High profits. Tel: 086 807 5273.

For sale, Dublin South. Superb location. City Centre – two miles. Long established. Single-handed two-surgery. Laboratory. 1,500 square feet. Freehold/leasehold option. Hygienist. Full book. Tel: 087 807 5273.

For sale, Galway City. Superb location. Enthusiastic Associate for med term buy-out. Top-class figures. Great growth. Loyal patient base. Very busy. Good will opportunity. Tel: 087 807 5273.

For sale, Cork City. Top-class, very busy single-handed. Two surgeries. Superb location, good equipment. OPG, hygienist. Reasonable rent. Expansion possible. Excellent figures. Realistic price. Tel: 087 232 7557.

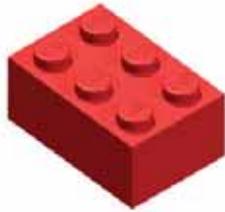
For sale, Ennis Co. Clare. Two surgeries. Superb location, good equipment. Long established leasehold. Huge growth possible. Full book. Low medical card. Realistic price. Immediate sale. Tel: 086 807 5273.

EQUIPMENT FOR SALE

Kavo Healozone machine for sale. Three years old in immaculate condition.

€10,000. Email: ada@smileclinic.ie or Tel: 01 451 3453/087 972 7091.

Contents of dental surgery for sale. Tel: 021 429 1828 or 086 845 9830.



**We know
you're perfect
as you are**



**But together
we can build
something better**



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for dentists today.*

*For details on becoming a member of the Irish Dental Association
contact Elaine on (01) 295 0072 or elaine@irishdentalassoc.ie
and she will forward the necessary application forms.*

QUIZ



Figure 1.



Figure 2.

Figure 3.

A 41-year-old lady was referred to the Department of Oral and Maxillofacial Surgery at the Dublin Dental School and Hospital by her general dental practitioner. She gave a history of a right-sided palatal swelling, associated with a canine tooth, of 16 months duration. A radiolucent area on a radiograph at the time of presentation to the GDP was associated with the canine tooth which was mobile (Figure 1). The canine had been extracted four months after presentation. The first premolar was extracted six months later on. At presentation to the DDSH, the incisor teeth were mobile. A clinical photograph (Figure 2) and a periapical radiograph (Figure 3) taken when the patient attended the DDSH are shown. The radiograph (Figure 3) is 16 months after the original radiograph (Figure 1).

Questions

1. Describe what you see in the photos/radiographs.

2. What is the differential diagnosis?

3. What treatment may be required?

Answers can be found on page 97.

Submitted by Mary Clarke, Specialist Oral Surgeon/Lecturer in Conscious Sedation, Dublin Dental School and Hospital.

**Oi, plaque.
Consider
yourself
warned.**



Join our campaign against plaque.
To register, visit www.BetterOralHealth.info
*Orbit Complete with Xylitol helps reduce the build up of plaque between brushing.**

*The Wrigley Company. Data on file (2006).

***Helps fight
the plaque
you can't see***



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