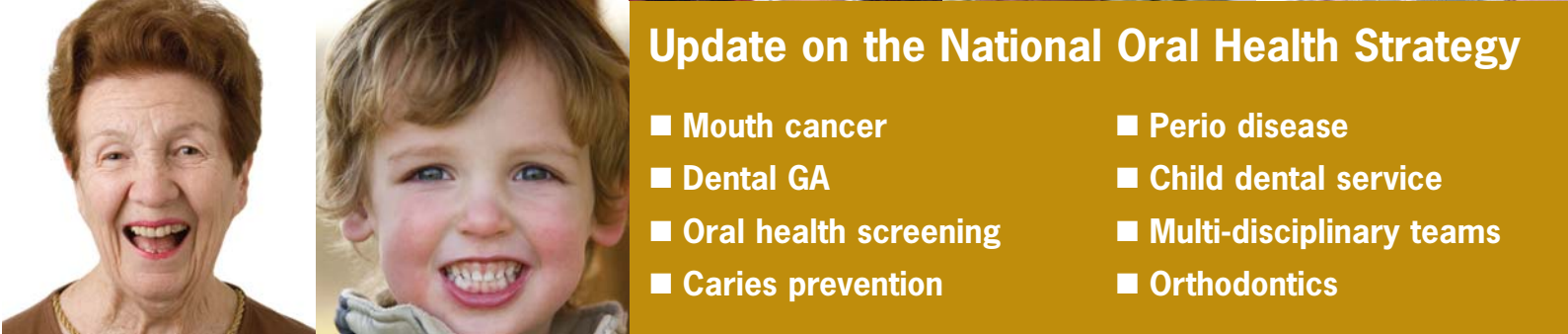


Journal of the Irish Dental Association

Iris Cumainn Déadach na hÉireann



Update on the National Oral Health Strategy

- Mouth cancer
- Dental GA
- Oral health screening
- Caries prevention
- Perio disease
- Child dental service
- Multi-disciplinary teams
- Orthodontics





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journal of the irish dental association
Iris Cumainn Déadach na hÉireann



The Journal of the Irish Dental Association

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1. Charles CH et al. J Am Dent Assoc. 2001; 132: 94-98
2. Morris AJ et al. British Dental Journal 2001; 231-237

Specialists play down risk of jaw condition

A recent editorial in the *Irish Medical Journal* (IMJ) was commented on in the 'Health' supplement of the *Irish Times* on Tuesday July 8, 2008, highlighting: 'Specialists play down risk of jaw condition'. There is no disagreement as to the value of bisphosphonates (oral and IV) for our patients, but as the burden for treating the patients who develop bisphosphonate-induced osteonecrosis (BONJ) falls on oral and oral/maxillofacial medicine to manage, it is sensible to offer a response to the *IMJ*, and hopefully develop a considered, balanced view. All patients on oral and IV bisphosphonates should be screened regularly by their dentists as indicated in 'Oral bisphosphonate-induced osteonecrosis: risk factors, prediction of risk using serum CTX testing, prevention and treatment' (Marx, R.E., Cillo, J.E. Jr., Ulloa, J.J. *JOMS* 2007; 65 (12): 2397-2410) and 'AAOMS Position Paper' (*JOMS* 2007; 65: 369-376).

These are the guidelines we use in the Dublin Dental School, and they can be used in dental practice. Not all patients need referral to the hospital service (Rogers, S., Ryan, D., Stassen, L.F.A. 'Guidelines for treating patients taking oral bisphosphonates for elective extractions', based on the present literature and clinical experience).

Patients taking oral bisphosphonates carry a small risk of developing BONJ following dental surgery. The risk is small if the drug has been taken for less than three years and without steroid therapy. The vast majority of these patients can be treated in the general dental surgery. For elective or non-essential treatment, the following guidelines may be used to treat these patients. If more speedy intervention is necessary, a first stage endodontic treatment may be considered in the interim. In some cases, an immediate extraction may be unavoidable.

It is essential that all patients with compromised immune systems or healing have impeccable oral hygiene. Therefore all such patients must be given oral hygiene instructions, use chlorhexidene 0.2% mouthwash daily (non-alcoholic) and see the hygienist if necessary before any surgery is performed. There is evidence to suggest that stopping oral bisphosphonates for three months before and after treatment allows bone turnover to recover somewhat and facilitates healing. Oral bisphosphonates must only be stopped with the consent of the prescribing doctor.

It is prudent to prescribe a loading dose of amoxicillin 3g orally pre-operatively and to continue the antibiotic 500mg tds for five days (if no allergy).

Since BONJ results from devascularised bone, any agent that reduces vascularity must be avoided; therefore, local anaesthetic agents without a vasoconstrictor should be used for infiltration, or preferably use a dental block. This is especially important when giving local infiltrations in the mandible, as the periosteum constitutes the majority of the blood supply to this area. Atraumatic surgery must be performed to reduce crushing of bone and further delayed healing. If necessary, sutures should be placed carefully and not too tight so that they do not cause further ischaemia to the area. Post-operatively, the patient must keep to a soft diet, and daily rinses with chlorhexidene and warm salt mouthwashes are advisable. A soft blow-down splint may be used to prevent food collecting in the socket but this is probably not necessary in most cases. The patient should be followed up to ensure closure of the socket.

National Oral Health Strategy

This report is awaited and I am pleased to see that Dr John Barry highlighted with Dr Chris Fitzgerald, Principle Officer, Department of Health and Children, the issues of hospital services and a lack of consultant/specialist staff to deliver a true primary, secondary and tertiary service. It is important that the IDA and others involved highlight the need to develop a multidisciplinary service, looking at all the issues of oral health. This service needs to be properly resourced and founded on good educational and training principles, delivering high-level oral/dental services for all patients (infant to old age). The National Oral Health Core Group is to be complimented on their consultation to date. It is hoped that the recent downturn in the economy will not detract from their ability to produce a visionary strategy.

It is advisable in this context to read a letter to the editor from Niall O'Neill (p. 155), which highlights the problems facing all of us in the near future.

Have a great summer.



A handwritten signature in blue ink that reads "Leo F. A. Stassen".

Prof. Leo F. A. Stassen
Honorary Editor

PRESIDENT'S NEWS

New IDA CEO and student awards

IDA President Ena Brennan updates members on developments in the Association.

Welcome to new IDA CEO

On behalf of all IDA members, I would like to welcome our new CEO, Mr Fintan Hourihan, to the Association. Fintan took up his post in mid June and brings with him a wealth of knowledge and skills. We are delighted to have such an experienced CEO on board to lead the Association into the future.

Meeting with the Department of Health and Children

I headed up the delegation of IDA representatives who recently met with representatives from the Department of Health and Children to discuss many of the current issues of relevance to the dental profession included in the National Oral Health Policy. The IDA was advised that an interim report on this Policy would be published in July of this year. The IDA will keep members updated on its publication.

Colgate Oral Health Month

Now in its sixth year, Colgate Oral Health Month, in partnership with the Irish Dental Association, will continue to promote good oral hygiene in Ireland among the general public during September. Increasingly, the general public is recognising the importance of healthy teeth and gums and, during September, Colgate and the Irish Dental Association will work together to highlight the long-term benefits of good dental practice with the message 'A healthy lifestyle includes looking after your mouth'. Following on from the success of last year's nationwide shopping centre activities, Colgate and the IDA aim to bring this out-reach programme to even more locations this year, including a well-known Dublin national school. These events will include free oral healthcare advice, a toothbrush amnesty and product sampling, as well as some fun for kids. Colgate and the IDA will also be taking the message of Colgate Oral Health Month into dental surgeries nationwide. Blitz teams will call to over 500 dentists across the country to bring the 'Share a Smile' theme and 'A healthy lifestyle includes looking after your mouth' message to dental surgeries. I encourage all members to actively engage with this very worthwhile endeavour.

Nobel Biocare World Tour

Nobel Biocare included Dublin as a stop on its fantastic World Tour programme and it was with delight that I accepted their invitation to attend. The event featured a host of interesting speakers, including many of our own IDA members. I congratulate Nobel Biocare on this very worthwhile event.

Dublin Dental Hospital student awards

I had great pleasure in attending the recent dinner to celebrate the graduation of this year's final year dental students. Once again, the IDA presented awards to the students who achieved highest results over the five years of the dental course and best academic presentation in the bachelor course in dental technology. I congratulate all graduates and wish them every success in their dental careers.

Summer 2008

Finally, I would like to take this opportunity to wish all our members a wonderful summer and to encourage you all to take your well-deserved holidays in the coming months in order that you are well rested and prepared to face the many challenges awaiting the dental profession over the next 12 months!



Dr Ena Brennan
IDA President



Dear Editor,

I noted your editorial in the April\May edition of the *Journal of the Irish Dental Association* encouraging CPD. You refer to a quiz on page 59, with the answers on page 65:

- 1) Temporomandibular joint disorders occur most commonly in:
 - a) Elderly males
 - b) Very young children
 - c) Female patients between the ages of 15-30 years

- 2) Which of the following items can result in limited mouth opening?
 - a) Ankylosis of the joint
 - b) Joint infection
 - c) Disc displacement without reduction
 - d) Muscle trismus
 - e) Neoplastic disease

- 3) Bruxism is commonly associated with:
 - a) Congenital factors
 - b) Side effects from certain drugs
 - c) Malocclusion
 - d) Parasites
 - e) Anxiety/depression

Answers

- 1) c (although this could be extended to later years).
- 2) All of the above.
- 3) a, b, e.

The answers offered to question 3 prompt this letter.

Perhaps these answers are a 'typo', or indeed a calculated error to prompt discussion. I accept answer e, although for teaching purposes I believe 'stress' might be the more appropriate wording. You might be kind enough to forward references to support answers a and b. I am an active CPD student of TMJ since 1982 (26 years) with Guichet, Neff, Dawson, Mike Wise, Mew, Truitt, Stack, Lotzof, and more ... Almost every educator in my 26 years of CPD has accredited malocclusion as a substantial factor. There may even be some truth to the more recent statement: "All bruxists are off the disc, but not all people off the disc brux", and it may well be that the future will identify the most common association for bruxism as 'disc displacement', but not to list malocclusion as one of the factors is incompatible with that 26 years of CPD, and it makes one acutely aware that, as we are to embrace CPD, the information should not be incorrect.

You might be kind enough to advise and refer me to the TMJ lecturer in the Dublin Dental Hospital & Dental School.

Yours Sincerely,
John TAIT BDS
Douglas Clinic
6 St Patrick's Terrace,
Douglas Village, Cork.

Response

Dear Dr Tait,

Thank you for taking the time to comment on the 'quiz' in the IDA Journal, which highlighted the multifactorial nature of bruxism. I believe the points raised in your letter are important and probably reflect the views of many practising dentists. Without doubt the traditional view has been that peripheral factors like occlusal discrepancies or skeletal misalignment play a major role in the aetiology of bruxism. However, more recent evidence points to the role of central factors, including stress, personality, genetics, medication usage, smoking and systemic illness. With bruxism now being considered a 'sleep disorder' based on its physiological characteristics, the influence of occlusal factors in bruxism has been downgraded to a more minor role. In fact, some would argue that occlusion has no role in bruxism. An article that reviews the pathophysiology and management of bruxism is planned for one of the future editions of the Journal.

Yours Sincerely,

Dermot Canavan

69 Eglington Road, Donnybrook, Dublin 4.

Reference

Lobbezoo, F., *et al.* Principles for the management of bruxism. *Journal of Oral Rehabilitation* 2008; 35: 509-523.

Dear Editor,

During the week starting Monday June 16, in an effort to reduce costs, the HSE issued a directive to all staff in the PCCC that all travel for purposes other than clinical necessity and essential maintenance of services is prohibited forthwith. While dental services are in the main clinical, and might not appear to be unduly affected, the profession is in fact deeply affected by the ruling. For example, health promotional activity carried out by staff, including dental hygienists and senior dental nurses employed specifically for this purpose, would appear to be covered by the embargo. Furthermore, included among non-clinical activities were "training" and "conferences". This of course must give rise to grave disquiet for all dentists employed by the HSE. Currently, verifiable CPD in Ireland is delivered only through the medium of courses and conferences. It is the stated intention of the Dental Council that mandatory CPD will be introduced in 2010 and will become a prerequisite for continuing registration. There will be a five-year CPD cycle of 250 hours, 75 verifiable. The Council recommends recording of CPD from 2008, i.e., this year. The HSE's directive is clearly in conflict with this recommendation. It begs the question as to the suitability of the HSE to assume the role and function of the Post Graduate Medical and Dental Board.

Yours sincerely,

Niall O'Neill BDS MDS HDip
Knocknahorgan, Glanmire, Cork.

IDA NEWS

New CEO welcomed to IDA



Mr Fintan Hourihan has recently commenced employment as Chief Executive Officer with the IDA. Fintan was previously Director of Industrial Relations with the Irish Medical Organisation. Prior to joining the IMO in 1999, he worked with the Association of Secondary Teachers in Ireland (ASTI).

We extend a warm welcome to Fintan and wish him well in his new position as CEO.

Increases in professional fees

The IDA has received confirmation of two fee increases for dentists. An increase of 3.5% is to be applied to fees payable under the DTBS scheme. This level of fee increase has been decided on the basis of a long-standing formula agreed as part of the contractual terms for the scheme, reflecting increases in inflation and wage rounds. In addition, an increase of 5% is to be applied to fees payable under the DTSS scheme. This increase is to be applied with retrospection to January 1, 2008.

These increases do not represent any change to official policy of non-engagement on fees with the IDA and other representative bodies. Members will be aware that the HSE is refusing to engage with representatives of the dental, medical and pharmaceutical professions because of its belief that such discussions would be anti-competitive and illegal. The IDA has obtained legal advice that we are perfectly entitled to continue to represent our members in fee negotiations and is committed to discharging our responsibility to serve our members in this regard, with legal guidance as appropriate.

Members will be aware that a number of legal challenges are being mounted by pharmacists who have seen their income cut by the HSE, and a significant High Court ruling is awaited later this month, which should be instructive for all professions in this regard.

The Association will continue to liaise closely with other bodies affected by this wholly nonsensical and unworkable approach by the HSE, and further updates on this matter will issue as appropriate.



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Tooth sensitivity increasing from brushing too hard

Figures released recently by the Irish Dental Association (IDA) reveal that one in five adults suffer from tooth sensitivity, with 70% of dentists warning that the number of patients suffering from the condition is increasing. The IDA found that 65% of dentists surveyed highlight tooth sensitivity as a serious oral health problem among Irish adults, which is often caused by heavy-handed brushing.

The survey of 150 Irish dentists found a rise in the number of people attending dental surgeries with varying degrees of tooth sensitivity, and that over half of dentists surveyed (53%) now treat patients with sensitive teeth on a daily basis, a 7% increase since 2002.

Dr Garry Heavey, IDA, said: "The figures show that tooth sensitivity is becoming more prevalent among Irish adults, and this trend looks set to continue. The most common cause of tooth sensitivity is gum recession, often due to vigorous or heavy-handed brushing. Many people don't realise that brushing with too much pressure can result in receding gums, and eventually lead to sensitive teeth".

Dr Heavey added: "In order to stop the gums from receding, patients should reduce the pressure on the tooth while brushing, use a soft bristled toothbrush, and set aside two to three minutes twice a day to properly brush and floss all tooth surfaces. Treatment of sensitive teeth is a must and we recommend that anyone experiencing sensitivity consult their dentist. The IDA recommends that people experiencing pain use a special toothpaste, such as Sensodyne, which desensitises the tooth nerve directly. In addition, sufferers should use a fluoride mouthwash and avoid acidic foods. Sensitivity should fade away in a matter of weeks".

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IDA NEWS

Dublin Dental School Alumni Association celebrating dentists with 40 years of service

Since the Alumni Association was formed, it has presented certificates to dentists who undertook clinical training in the Dublin Dental Hospital and qualified over 50 years ago. In the past, there were three dental schools (UCD, TCD and RCSI), but only one dental hospital.

Recently, the Association has reduced the original 50-year criteria, and is working towards presenting certificates at 40 years after qualification. It is hoped that by reducing the number of years qualified, more dentists will be able to attend.

This is a celebration for dentists, and a chance to renew acquaintance with colleagues from college, after devoting most of their working lives to delivering a service to the community.

This year, the celebrations will be on Saturday November 8, 2008, in the Dublin Dental School & Hospital, when those who qualified from all three colleges during the years 1964, 1965 and 1966 are invited to attend.

The Alumni Association is aware that a number of those who qualify to be present at this ceremony may have retired from practice. If you have a new address, please contact Ms Agnes Hagan in the Dental School, Tel: 612 7214, or Email: agnes.hagan@dental.tcd.ie.

Dr Barry Harrington
President Alumni Association
Dublin Dental School & Hospital

IDA meets HSE on behalf of public dental surgeon members

IDA CEO Fintan Hourihan recently attended a meeting with Professor Brendan Drumm and other senior HSE officials, where unions and representative bodies were briefed on new management structures to be introduced in the HSE.

Mr Hourihan spoke on behalf of the Association, emphasising that public dental surgeons were wary of even more re-organisation, and highlighting the serious lack of trust among clinicians who have effectively been left outside the door in managing the direction and delivery of services. The poor industrial relations climate, and the unilateral nature of cuts and savings being imposed, has also contributed to the poor state of industrial relations, he stated.

Two new internal circulars have issued recently directing that other value for money savings be achieved and yet again staff were given no prior notice of these – in fact, the ICTU unions are referring the HSE's latest directives to the trouble-shooting National Implementation Body alleging breach of procedures yet again by the HSE. In addition, Mr Hourihan also took the opportunity to highlight the great difficulties caused by vacancies among public dental surgeons, and is to follow up on this with the HSE.

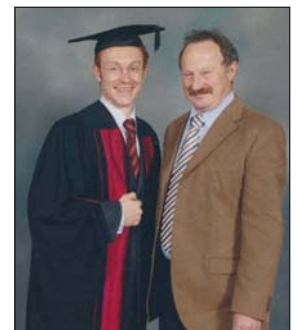
The HSE is moving to integrate PCC and the Hospital's Directorate, and is proposing to appoint four National Directors in the following areas: Integrated Care (effectively a chief operations officer), Clinical Care and Quality, Communications, and Planning. This will also be replicated at regional level, and there is to be decentralisation of decision-making generally.

Of specific relevance for dentistry, and in direct response to IDA representations, Professor Drumm confirmed that a senior dental adviser/leader is to be appointed to work with a proposed new National Director of Clinical Care and Quality (a clinician to be appointed by open competition). Similarly, senior roles are envisaged for medicine and nursing. He agreed to confirm the detail of the proposed arrangements in greater detail in the coming weeks.

Young Irish dentist wins prestigious award



Dr Stephen Cotter receiving the J.K. Williams Gold Medal from Professor Brian Avery, Dean of the Faculty of Dental Surgery, Royal College of Surgeons of England.



Dr Stephen Cotter, recipient of the J.K. Williams Gold Medal at the diplomats ceremony at the Royal College of Surgeons of England with his father and IDA member Dr Dermot Cotter (a dentist in Youghal).

Dr Stephen Cotter BDS NUI MFGDP(UK) MFDRCsIrel M Dent Sci(Orth) mOrth RCSEng, was awarded the J.K. Williams Gold Medal at the recent Membership of Orthodontics examination (mOrth RCSEng). The J.K. Williams gold medal is a prestigious prize awarded to the individual achieving the most outstanding examination performance (i.e., first place) at the Intercollegiate Membership in Orthodontics examination of the Royal College of Surgeons of England and Glasgow. Only one per year is awarded. Stephen qualified with honours from UCC in 1998 and worked in a number of general practice and hospital appointments in England before taking up a specialist registrar post in orthodontics in Leeds. He is currently in orthodontic specialist practice in Kilkenny and Carlow.



Promoting oral health



Now in its sixth year, Colgate Oral Health Month, in partnership with the Irish Dental Association, will continue to promote good oral hygiene in Ireland among the general public during the month of September. Increasingly, the general public is recognising the importance of healthy teeth and gums and, during September, Colgate and the Irish Dental Association will work together to highlight the long-term benefits of good oral hygiene with the message, 'A healthy lifestyle includes looking after your mouth'.

Following on from the success of last year's nationwide shopping centre activities, Colgate and the IDA aim to bring this out-reach programme to even more locations this year, including a well-known Dublin national school.

These events will include free oral healthcare advice, a toothbrush amnesty and product sampling, as well as some fun for kids.

Colgate and the IDA will also be taking the messages of Colgate Oral Health Month into dental surgeries nationwide. Blitz teams will call to over 500 dentists across the country to bring the 'Share a Smile' theme and 'A healthy lifestyle includes looking after your mouth' message to dental surgeries.

I encourage all members to actively engage with this very worthwhile endeavour.

Ena Brennan

Ena Brennan,
President,
Irish Dental Association.

Professional relations activities

Colgate-Palmolive and the Irish Dental Association invite you to take part in Colgate Oral Health Month 2008. Since 2003, Colgate Oral Health Month has become the leading Irish oral health campaign and is designed to inform and educate the general public on the importance of good oral health.

As part of Colgate and the Irish Dental Association's continued support for dental professionals, together we have implemented various initiatives involving the dental profession this September to ensure that we are all 'Working towards better oral health in Ireland'.

Aoife Moran, Professional Relations Manager.



*Dental Detailer,
David Kiernan.*

During Colgate Oral Health Month, Colgate endeavours to increase its support to the dental profession. 2007 saw a substantial increase in interest from the profession, with a staggering 70% registering with us. A further 240 dentists are getting involved this year, in activities that will include:

- our Blitz Team, comprising both dental and hygienist students, from Dublin and Cork, will be calling to dental surgeries throughout the country. They will distribute our special surgery packs, dress the surgery with bunting and posters, and distribute samples to the profession;
- we will be sending Colgate Oral Health Month packs to all who have registered with us. These packs include:
 - product samples for distribution to patients;
 - patient information leaflets;
 - CPE materials; and,
 - surgery posters.
- with members of the Irish Dental Association as spokespeople, we will be running various public relations activities, including national and regional radio slots and print media. This is with the view to increasing public awareness on the importance of good oral health.

Colgate has developed a Professional Relations Team headed by Aoife Moran. Colgate recognises the importance of working with and supporting the dental profession in the continuing pursuit of better oral health for Ireland.

Colgate activities include:

- visiting as many professionals as possible to keep them informed of our product development;
- developing and distributing clinical product evidence for the dental profession;
- supplying patient information leaflets to surgeries throughout the country;
- developing and distributing patient information posters relating to general oral care to surgeries;
- provision of both personal and patient product samples of key products;
- supplying continuing professional education (CPE) materials to the dental profession;
- development of strong academic relations within the dental hospitals; and,
- continued support of key Irish Dental Association activities.

For further information please contact:



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Email: aoife_moran@colpal.com
Mobile: 087 268 7591
Web: www.colgate.ie

Consumer drive

To complement Colgate Oral Health Month activities with dentists and the Irish Dental Association, Colgate is also undertaking a comprehensive consumer promotion campaign.



Advertising

A major advertising campaign will run throughout September, including television, radio and print. The 20-second TV advert encourages the public to 'give a thumbs up for their oral health'. There will also be a two-week promotion running in conjunction with TV3, whereby two lucky viewers can win fantastic prizes.

The 20-second national radio creative will run on all major national and regional stations during the first three weeks of September. In addition, there will also be promotional programmes with RTE 2FM, Dublin's 98FM and Cork's 96FM. New to this year's media programme is a full newspaper supplement dedicated to all things relating to oral care. The supplement will be published in the *Irish Independent* on September 1.

Public relations

A national public relations campaign will endeavour to place a series of oral care-related stories across a very wide range of media. This will assist in the process of building awareness of the need for improved oral care. While this process commenced in July, the major timing focus is for mid-August through September. News hooks for this year will include oral care myths, and a consumer survey. In addition to this, numerous national and regional consumer competitions will be placed through the public relations team.

The launch of Colgate Oral Health Month will also be supported with a media photocall.

On-line

From August 1, anyone logging onto www.Colgate.ie will be able to access all details related to the Colgate Oral Health Month campaign. This will include information regarding the partnership between the Irish Dental Association and Colgate for Oral Health Month, event listings, product information, oral care information leaflets and interactive tools.



Oral Care Nationwide Roadshow

Throughout the month of September, Colgate's Oral Care Roadshow will visit 12 major locations, encouraging the public to 'Share a smile'.

This year the roadshow will consist of three zones. In the Toothbrush Amnesty zone, participants who bring along their old toothbrushes will get a brand new one free. The Dental zone will have a professional dental hygienist and nurse offering free dental advice, with free product samples and information leaflets. Lastly, the fun zone will have lots of fun things for kids, including photos with the Colgate Toothfairy, hats, stickers and goodie bags to take away.

Five of the events will also be supported with national or regional live radio broadcasting.



Think all toothpastes work the same?

Take a deeper look.

Gingivitis, if left unchecked, may lead to periodontitis. Emerging scientific research is associating periodontitis with other diseases, such as cardiovascular disease, diabetes and stroke^{1,2}

"Over the last decade, mounting evidence from epidemiologic studies suggests that periodontitis... may be an independent risk factor for atherosclerosis and CVD."

Dye BA et al. *J Clin Periodontol.* 2005; 32: 1189–1199.

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Colgate Total: Clinically Proven 12-Hour Antibacterial Protection, *plus* Anti-Inflammatory Action



Better Oral Health as part of Better Overall Health

References: 1. Scannapieco FA. *Compendium.* 2004; 7(Suppl 1): 16–25. 2. Dave S et al. *Compend Contin Educ Dent.* 2004; 25(7 Suppl 1): 26–37. 3. Amornchat C et al. *Dent J.* 2004; 24: 103–111. 4. Lindhe J et al. *J Clin Periodontol.* 1993; 20: 327–334, supplemental report on file. 5. Garcia-Godoy F et al. *Am J Dent.* 1990; 3 Spec No: S15–26. Erratum in: *Am J Dent.* 1991; 4: 102.

*vs ordinary fluoride toothpaste.

The therapeutic indications set out in the Summary of Product Characteristics for Colgate Total include the reduction of dental caries, improvement of gingival health and reduction of periodontitis – it does not include the treatment or prevention of other diseases, such as cardiovascular disease, diabetes or stroke

For further information please call us on 01 403 9800 or visit www.colgate.ie

PRODUCT INFORMATION. Product Summary. Trade Name of the Medicinal Product: Colgate Total Toothpaste. Active Ingredients: Triclosan 0.3% w/w, Sodium Fluoride 0.32% w/w (1450ppm F). Indications: To reduce dental caries, improve gingival health and reduce the progression of periodontitis. Dosage and administration: Brush the teeth for one minute twice daily. Children under 7, use a pea-sized amount. If using fluoride supplements, consult your dentist. Contraindications: None known. Individuals with known sensitivities should consult with their dentist before using. Special Warnings and Special Precautions for Use: Children under 7, use a pea-sized amount.

If using fluoride supplements, consult your dentist. Interactions with Other Medicines: Not known. It is important to note that as for any fluoride containing toothpaste in children under systemic fluoride therapy, it is important to evaluate the total exposure to fluoride (fluorosis). Undesirable Effects: None known. Legal Class: GSL. Product Authorisation Number: PA320/5/1. Product Authorisation Holder: Colgate-Palmolive (UK) Ltd., Guildford Business Park, Middleton Road, Guildford, Surrey GU2 8JZ. Recommended Retail Price: €2.19 (50ml tube), €3.79 (100ml tube). Date of Revision of Text: October 2005.

TCD class of 2008



Back row (from left): Gilbert Lysaght; Julie Wheeler; Yvonne Rooney; Niamh Roe; Ali Bani Hamour; Amy O'Neill; Joseph Hennessey; Walhid El Kininy; Peter MacKessey; Teresa McGinty; and, David O'Malley. Middle row (from left): Jamie Cummins; Matthew Borland; Cathy Clyne; Gregory McGovern; Rachel O'Brien; Siobhán Mc Morrow; Aoife Kearney; Sharifa Al Rushaid; Peter Gallagher; and, Clodna Ashe. Front row (from left): Aine McGovern; Katie Wilson; Jess Kearon; Andrew Garry; Claire Burns; Kate Farrell; Paddy Barlow; Eimear McHugh; Laura Loughan; Jolene Molloy; Eimear Flemming; Lisa Walshe; Danielle McGeown; and, Gillian Smith.



IDA President Dr Ena Brennan with Margaret O'Keeffe, winner of Best Academic Presentation in the Bachelor in Dental Technology from Dublin Dental School & Hospital, Trinity College Dublin.



IDA President Dr Ena Brennan with Gilbert Lysaght, who achieved the highest result over five years of the dental course.

Introducing the TePe Oral Hygiene Range

available from Promed



Promed is pleased to present a new line of products from TePe, a leading brand of Swedish oral hygiene products.

The extensive range covers a wide spectrum, from manual toothbrushes and interdental brushes, through to specialist marketing products such as "TePe TV", a display stand with a television screen, which demonstrates tooth brushing, interdental brushing, flossing and many more oral hygiene products and techniques.

"Interdental brushes (IDB's) have become mainstream oral hygiene aids, and unlike flosses and tapes, patients can and DO use them. High quality plastic coating, a wide range of sizes and consistency within the sizing are key to the effectiveness and durability of an IDB"

Elaine Tilling, MSc RDH DMS MIHPE

TePe products are all designed to help the user achieve an exceptional standard of oral hygiene. All of these products are recommended by dental professionals and are designed to meet very specific requirements.

Promed supplies TePe patient information leaflets and posters, for the dental surgery reception and waiting area, showing how to use interdental brushes correctly, reinforcing the advice given in surgery.

For further information on the TePe range and promotions contact Promed on **freephone 1800 619 619** or log on to the new Promed website **www.promed.ie**

PROMED
A PARTNERSHIP IN PRACTICE

BUSINESS NEWS

New Oralmedic for mouth ulcer pain

Pharmed's Oralmedic is a new product that takes mouth ulcer treatment to a new level. According to the company, just one application eliminates mouth ulcer pain in seconds. Simply snap one end of the stick to allow Oralmedic to permeate the cotton bud before applying to the affected area for 5-10 seconds and then rinsing thoroughly. As well as pain relief within seconds, Oralmedic seals the infected area and so promotes natural healing.

As many as 22% of the population suffer from mouth ulcers from time to time. It tends to be a younger person's problem and more women than men get mouth ulcers. Possible causes include stress, fatigue, physical trauma, hormonal changes, menstruation, sudden weight loss, food allergies, and deficiencies in vitamin B12, iron and folic acid. Mouth ulcers can also occur as a complication of some medical conditions and side effect of certain medications. Oralmedic is a Class I Medical Device and is available through pharmacies nationwide, RRP €7.69.

Nobel Biocare World Tour 2008 comes to Dublin

The Nobel Biocare World Tour, 'Sharing evidence-based solutions', made its first visit to Ireland on June 13 and 14 last. Over the course of the two-day conference in the Burlington Hotel, Dublin, delegates from the whole dental team had the opportunity to consult with experts in the field of implant surgery, prosthodontics, and many other disciplines to learn the latest techniques. Nobel staff were on hand to provide assistance and information in what was a very well organised and interesting conference. At the opening ceremony on June 13, Dr Robert Gottlander, Executive Vice President Marketing and Products, welcomed delegates and provided some background to the decision to bring the World Tour to Ireland. He pointed out that Ireland has a higher ratio of dentists to patients than the UK, but that implant penetration is low at 2%, despite a high edentulous population. He argued that education is key to changing this situation, and said that Nobel Biocare prides itself on the quality of training offered to the whole dental team. He said that Nobel's training employs the latest in digital media, singling out key messages and key information. Having first introduced implants in 1982, Nobel has the scientific background and products that offer "a complete solution from root to tooth, using innovation based on scientific evidence". They can now also offer a sound evidence base, drawing on results from 20-year follow-up on crowns done in Sweden. Dr Gottlander said that the future for Nobel, and for the dental team, will involve state-of-the-art digital technology enabling better treatment planning.

Following Dr Gottlander's speech, Global Scientific Committee Chairman Prof. Brien Leng reiterated that Nobel's products, and the World Tour itself, are about "solution-based therapy and the science behind it".

The programme consisted of a main scientific programme, workshops, hands-on sessions and one-to-one sessions. The Nobel Biocare World Tour goes to London on October 24 and 25 this year, so Irish dentists can travel for another opportunity to benefit from the experience and expertise of the Nobel team. See www.nobelbiocare.com for further details.

Free downloadable patient resources from Wrigley

The Wrigley Oral Healthcare Programme has developed a website specifically dedicated to Ireland, which is IDA approved. This offers free downloadable resources for oral healthcare professionals and can be visited at: <http://www.betteroralhealth.info>.

More and more dental professionals are now accessing information and resources online due to the ease and convenience of the internet. The new Irish website offers quick and easy access to free online resources in the form of fact sheets and handouts, which dental professionals can download for their patients. Further



information for themselves, together with patient leaflets and samples, can also all be ordered conveniently online.

The Wrigley Oral Healthcare Programme by ORBIT Complete is specifically designed to support oral health professionals by offering a complete range of information and resources, free of charge. This year the programme also received IDA accreditation and this has now been reflected on all our resources. If you are not a member of the programme already, please visit the website and start benefiting from the information available.

Clearstep boosts fanbase at World Aesthetic Congress



The Clearstep stand.

Visitors to the 2008 World Aesthetic Congress were introduced to the Clearstep orthodontic system. According to the manufacturers, Clearstep is built around a set of clear, medical-grade polymer positioners, and can be combined with traditional orthodontic methods to treat any mild to severe malocclusion, not just in adult patients, but also in children over seven.

At the Congress, the Clearstep team discussed the benefits of the system, which uses positioners to move teeth in the required direction using gentle force. With the full support of readily contactable technical and orthodontic specialists, general dental practitioners can use Clearstep to treat their patients and, if they choose, can attend seminars to increase their treatment lists even more.

Diagnostic Computerised Technology Training for the General Dental Practitioner (GDP)



Morning seminar sessions will be provided for GDPs to enable them to comprehensively understand and utilise 3D technology for dental implant diagnosis. Individual hands-on tuition will be provided to a select group of practitioners. At the end of each session, participants will have a comprehensive understanding from a diagnostic viewpoint of what 3D imaging can provide for them and their patients.

Sessions will be held at the Northbrook Clinic in Dublin 6 on Saturday mornings with light refreshments provided. Limited places are available on a first come/first serve basis. The first five respondents will be invited to bring a patient for 3D radiological evaluation free of charge.

For information, please contact: (01) 4967111 ext 239/240

BUSINESS NEWS

Largest ever attendance at Implantology World Symposium

More than 100 dental professionals from the UK and Ireland attended the 13th Dentsply Friadent World Symposium in Berlin in April. The event attracted around 2,300 delegates from more than 60 countries, including some of the world's leading implant practitioners, technologists and system experts.

The UK and Ireland contingent was more than double that of the previous event, among them podium speakers Dr Koray Feran, Dr Nigel Saynor, Dr Ashok Sethi, Tony Sheppard and Peter Sochor. A diverse programme of topical presentations, a wealth of experienced international lecturers and spectacular evening entertainment made this symposium one to remember.

The major focus of the World Symposium was on the options for successful establishment of delegates' own implantology practices.



Some of the more than 100 UK and Ireland delegates enjoying the DENTSPLY Friadent International Symposium.

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Oraqix: not a drug in reserve

Dentsply has said that their non-injectable dental local anaesthetic Oraqix (25/25mg per g periodontal gel, lidocaine, prilocaine) assists hygienists and therapists in scaling and root planing procedures.

Oraqix is indicated in adults for localised anaesthesia in periodontal pockets for diagnostic and treatment procedures such as probing, scaling and/or root planing.

Oraqix is a liquid that turns to gel at body temperature, keeping it in place to help induce anaesthesia in just 30 seconds. In addition, there is minimal post-procedural numbness as the duration is about 20 minutes. Applied to the treatment area with a specially designed Oraqix dispenser, the gel can be site-specific and placed in a number of areas within the mouth in the same session, allowing greater clinical flexibility.

Changes at Dentists' Provident

2008 is a significant year for Dentists' Provident, leading provider of income protection to dentists in the UK and Ireland. The mutual organisation is celebrating its centenary year, and in January the company launched the most radical change to its income protection offering since its foundation in 1908. The new product offers dramatically increased flexibility, ensuring that every dentist can fully customise their contract.

May saw the retirement of Ian Passey, CEO, with Farrukh Mirza stepping into the role. The same month saw Sarah Martin appointed Head of Compliance and Risk while Christina Brock was appointed Head of Marketing and Communications.



From left: Simon Elliott, Head of Actuarial Services; Sarah Martin, Head of Compliance and Risk; Farrukh Mirza, Chief Executive Officer; and, Christina Brock, Head of Marketing and Communications.

Techceram's ACE group in Ireland

Techceram Ltd has announced that two laboratories based in Ireland are among the expanded membership of 38 members of their ACE group of laboratories, each dedicated to delivering ultimate aesthetic restorations to dentists and patients through their commitment to Techceram's ACE "All-Ceramic Excellence" concept. They are:

- Totten & Connolly Dental Laboratory, Bangor;
- and,
- Gordon Watters Dental Laboratory Ltd, Belfast.

Student winner battles with impact of oral care on systemic health



Wrigley Student Award winner Elizabeth Conner (left) was presented with her award by Gordon Watkins MBE, President of the BDA.

The winner of the 2008 Wrigley Student Award, in association with the British Dental Association (BDA), British Society of Dental Hygiene and Therapy (BSDHT) and the Irish Dental Hygienists' Association (IDHA), presented the findings of her winning entry at a seminar at the BDA Conference and Exhibition in Manchester last month.

Student hygienist/therapist Elizabeth Conner, from Dundee Dental School, accepted the challenge to create a research poster on how preventive dentistry impacts on systemic health and to present her findings to specialists in the field.

Elizabeth's research highlighted the importance of maintaining a healthy balanced diet. The importance of maintaining a good oral healthcare routine was also stressed, including chewing sugar-free gum after meals.

As well as the opportunity to present her findings, Elizabeth was presented with her certificate at the BDA Presidential Meeting, and received a cheque for £1,000 for herself and a further £1,000 for her school. Elizabeth thanked The Wrigley Company for this great initiative and its support of dental and therapy students.

Since being presented with her award at the BDA Conference, Elizabeth has passed her exams and accepted a position as a full-time dental therapist with Drs Stuart and Pauline Farmer at St Andrews Dental Care and Implant Clinic, Fife.

BUSINESS NEWS

NobelActive – a new direction for implants

NobelActive is Nobel Biocare's latest implant design with extended functionality and a unique dual-function prosthetic connection. According to Nobel, the expanding tapered body of NobelActive, with its double variable threads and apical drilling blades, was designed to condense bone gradually and deliver high initial stability, as well as allowing directional changes for optimal restorative positioning, even in compromised bone situations.

The dual-function prosthetic connection, with built-in Platform Shifting, was designed to provide maximum mechanical strength, create a sealed connection, and support a wide range of standard and individualised prosthetics, including Procera Implant Bridges. NobelActive is available in a variety of lengths and diameters, all featuring Nobel Biocare's well proven TiUnite biomaterial and grooves on threads.



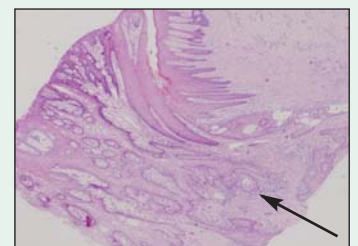
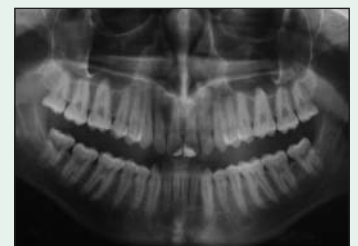
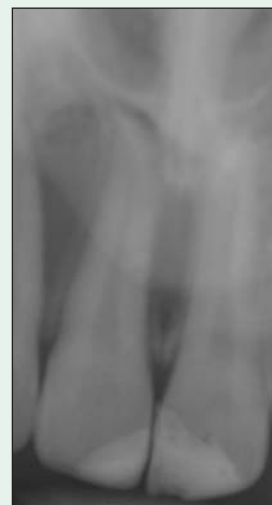
The role of pure water in infection control

Contamination control in dental surgeries is becoming increasingly regulated by industry guidelines and international standards. Many dentists and opinion leaders feel that Ireland is set to follow Scotland and Northern Ireland in moving towards applying similar standards for decontamination in primary care as those currently applicable to secondary care. ELGA Process Water has been operating within the secondary care market for many years and is now applying that knowledge and experience to primary care, introducing the Biopure 7/15, a water purification unit designed for all sizes of dental practice. According to the company, the Biopure 7/15, which is connected directly to mains water supply, incorporates a high efficiency reverse osmosis membrane that removes a broad range of organic and inorganic contaminants, a de-ionisation cartridge to remove dissolved contaminants including endotoxins, and an integral treated water reservoir with a bacterial vent filter to maintain microbiological integrity. With 80 years of experience in healthcare, ELGA claims to deliver solutions that:

- improve patient care;
- protect specialist areas or equipment;
- guarantee uninterrupted service;
- reduce operating cost and cancelled patient procedures; and,
- safeguard the safety and comfort of patients, visitors and staff.

QUIZ

A 22-year-old healthy man presented with a slowly growing palatal lesion reportedly present for two years. He complained of no pain, discharge or bad taste. Extra-oral examination was normal. Intra-orally, the lesion was palatal to the incisors, measured 15mm in diameter, was purple in colour, non-ulcerated, soft, and endophytic with a raised edge. The 1.2, 1.1 and 2.1 were grade one mobile but not tender to percussion. He had a history of trauma to this area a number of years ago; however, all teeth tested vital. OPG and peri-apical radiographs demonstrated a well circumscribed radiolucency related to the 1.2 and 1.1. An incisional biopsy was taken for histological analyses.



Questions

1. What is the likely diagnosis?
2. What does the histological picture show?
3. What further investigations would be indicated?
4. What treatment is required?

Answers on page 185

20 years at Septodont

Gerry Lavery of Septodont recently completed his twentieth year with the company, for which he received a special long service award from General Manager Mike Cann. Gerry is well known in the profession and has covered Ireland single-handed since he returned home in 1993.

Throughout his time with Septodont, Gerry has seen many developments and remains a central element of the team. Widely respected for his product knowledge and calmness under pressure, Gerry enjoyed celebrating his achievement at a special dinner together with the whole Septodont sales team.

Based in France, Septodont is known for dental pain relief and, in addition, supplies a range of well-known products to dentists in over 150 countries worldwide.

Gerry Lavery receives his long service award from Mike Cann of Septodont.



Captains Prize

The Captains Prize golf competition will take place in Carlow Golf Club on Saturday September 6, 2008. Please contact Ciaran Allen, Tel: 047 71400, for further details.

Munster Branch ASM

The Munster Branch Annual Scientific Meeting will take place on Friday September 26 next at the Clarion Hotel, Cork.

An interesting line-up of speakers has been announced, and a full trade show will take place on the day. Further information is available on our website – www.dentist.ie.

Public Dental Surgeons Seminar 2008

The annual Public Dental Surgeons Seminar will take place at the Knightsbrook Hotel, Trim, Co. Meath, from October 1-3 next.

An interesting line-up of national and international speakers has been organised, which includes Dr Trevor Burke, Birmingham School of Dentistry, Dr Monty Duggal, Consultant and Head of Paediatric Dentistry, Leeds Dental Institute, Dr Pat McSharry, Orthodontist, HSE, Dr Richard Watt, University of Edinburgh, and Dr Dan Ericson, Malmo University, Sweden.

Dublin graduate Professor Colman McGrath, Professor of Dental Public Health from the University of Hong Kong, will be the guest of honour and keynote speaker at the event.

We are delighted to continue with the team-based approach to the event again this year and we look forward to welcoming our dental nurse and hygienist colleagues to the event.

The seminar will also include a full trade show, which



will include the leading products and services on the dental market. Our ever popular annual dinner will be the social highlight of the seminar and will take place on Thursday evening, October 2.

BUSINESS NEWS

Heka Dental launches new UNIC Treatment Centre

Heka Dental's new UNIC Treatment Centre has been designed by David Lewis, the internationally renowned designer responsible for the beautiful and functional designs associated with Bang & Olufsen, etc. According to Heka, it has been designed to create a pleasant and relaxed environment for patient, dentist and dental assistant.

In addition to ensuring that everything – instrument table, trays, light, x-ray unit, etc. – is within easy reach, David's more humanised concept can be seen reflected in the sweeping, organic shapes, curved surface, s-shaped top and furnishing of the unit. Utilising feedback from patients, dentists, dental technicians and service engineers, UNIC combines aesthetics with functionality. Because of its inviting appearance and carefully thought through functionality, it creates the perfect environment for a pleasant visit to the dentist.



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New CED EU Affairs Officer, cross-border healthcare, and an end in sight for toothwhitening controversy

DR TOM FEENEY, Honorary Treasurer of the Council of European Dentists, summarises important European issues.

CED appoints new EU Affairs Officer



Mark Beamish, who has served as a most successful EU Affairs Officer for the CED, moved to a new job in the European Parliament earlier this month. He will be sadly missed. His place is being taken by Nina Bernot from Slovenia (left), who will begin her new post in September. Nina was one of 50 applicants for the job, and was chosen from a very impressive shortlist of four.

Nina studied for five years in the US and has a major in economics, a major in international relations, and has also studied in Buenos Aires, Argentina, and Antwerp, Belgium. Her previous posts were as political adviser at the permanent mission of the Republic of Slovenia to NATO, Brussels, and as adviser to the State Secretary for Multilateral Affairs in the Republic of Slovenia.

New directive on cross-border healthcare

The EU Commission proposal for a directive on the application of patients' rights in cross-border healthcare was launched on July 2, 2008.

Background and preparatory work

In 2003, health ministers and other stakeholders invited the Commission to explore how legal certainty in the field of cross-border care could be improved following the Court of Justice jurisprudence concerning the right of patients to benefit from medical treatment in another Member State. The Court's rulings on the individual cases are clear in themselves; however, it is necessary to improve clarity to ensure a more general and effective application of freedoms to receive and provide health services. The Commission's proposal for a directive on services in the internal market at the start of 2004 therefore included applying free movement principles to health services. This approach, however, was not accepted by the European Parliament and Council. It was felt that the specificities of health services were not sufficiently taken into account, in particular their technical complexities, sensitivity to public opinion and major support from public funds. The Commission therefore developed a policy initiative specifically targeting healthcare services as a separate issue.

Proposed directive

The Commission proposes the establishment of a Community framework for cross-border healthcare. As well as setting out relevant legal definitions and general provisions, this is structured around three main areas:

- common principles in all EU health systems;
- a specific framework for cross-border healthcare; and,
- European co-operation on healthcare.

Based on the case law, this initiative aims at ensuring a clear and transparent framework for the provision of cross-border healthcare within the EU, for those occasions where the care patients seek is provided in another Member State other than in their home country. When this happens, there should be no unjustified obstacles. The care should be safe and of good quality. The procedures for reimbursement of costs should be clear and transparent.

Scope of the directive

The proposed directive applies to all healthcare provision, regardless of how it is organised, delivered or financed.

CED response

The CED body dealing with this topic is the Internal Market Task Force. It is closely monitoring developments and is organising a meeting and comments further to the publication of the new document. The Task Force will analyse both the opportunities for the dental profession and potential risks to healthcare systems and to patient safety of the directive, as a first step to a CED position paper, and will also have a joint political meeting with the Standing Committee of European Doctors (CPME) under the patronage of Othmar Karas, MEP, in Brussels in the European Parliament on September 11, 2008.

Antibiotic prophylaxis in 'at risk' patients

There appears to be a wide variation in the recommendations across Europe regarding antibiotic prophylaxis in 'at risk' patients. In this country, many dentists are unsure as to what regime they should be following. For example, should they follow the American recommendations and use a slimmed down version of the 'at risk' category, should they follow the British recommendations and use

no prophylaxis in any case, or should they maintain the status quo? The Irish delegation on the CED decided that it would be helpful to find out what recommendations obtain in other European countries, who is the body responsible, what dosage is given, etc., and has circulated a questionnaire to all CED member organisations. The results will be published in the next *JIDA*.

EU NEWS

Tooth-whitening products – end in sight

The Commission has proposed a strategy to implement the opinion of the Scientific Committee on Consumer Products (SCCP), which will mean that tooth-whitening products (TWPs) containing more than 0.1% H₂O₂ will fall within the control of dentists. The SCCP's opinion, published in January, identified risks connected with the use of TWPs with more than 0.1% H₂O₂, and indicated that direct consumer access to these products should be limited. The Commission presented a strategy to implement this opinion to Member State representatives and stakeholders, including the CED, on June 9. CED representative and WG TWP chair, Stuart Johnston, broadly supported the strategy, which proposed amendments to the Cosmetics Directive to ensure that all TWPs with more than 6% H₂O₂ be used only by dentists and that TWPs with 0.1-6% H₂O₂ be available only through dentists, with the option of the dentist supplying the patient with material for use at home.

This is a very positive step in the CED's campaign to ensure the dentist's supervision of products, which, if used without proper clinical examination and precautions, could be dangerous. If the proposals become law, Member States would be obliged to prevent other people, such as hairdressers, from using TWPs.



At the meeting of Member State representatives, a number of countries foresaw implementation difficulties relating to the "1st use by a dentist" proposal. The representatives of France, Ireland, Portugal and Spain believed that dentists in their countries would be prevented from providing patients with tooth-whitening products by laws or rules prohibiting commercial activity.

The CED does not believe that dentists are engaging in commercial activity when they provide a patient with tooth-whitening material. Nor are they even 'selling' the product. They 'deliver' the product as part of a course of tooth-whitening 'treatment'. Legally speaking, they charge a fee for the dental service and not separately for the product delivered.

The CED is clear that some higher-strength tooth whiteners have as their principal purpose the correction of pathological tooth discolouration, and has therefore felt that regulating them under the Medical Devices Directive might be more appropriate than under the Cosmetics Directive. However, the CED is prepared to accept the proposal to regulate them as cosmetics, as long as it really can be ensured that in order to comply with the Cosmetics Directive, Member States will have to guarantee distribution only to dentists and make it impossible for consumers to have direct access to these products. In connection with this, the CED would support the calls of Belgium, Sweden and Norway to make it clear in a recital that products with more than 0.1% H₂O₂ should be made available "only to dentists" and not simply "not be freely and directly available to the consumer". The CED would also support the same countries' calls to add in the annex of the Directive (in the column "other limitations and requirements") a clarification that the 0.1-6% products for patient use at home "must be" supplied by the dentist.

We also consider it important, in the interests of legal clarity, to make a cross-reference in the Cosmetics Directive to Directive 2005/36, where the tasks and necessary training of a "dental practitioner" are set out. This should avoid doubt as to what exactly a "dentist" is.

Finally, the CED can accept in general terms the application of the precautionary principle to treatment of children under 18 years of age. This should not, however, prevent treatment where there is a clear clinical justification for a tooth-whitening procedure that is in the patient's best interest.

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Report on the First World Health Professions Conference on Regulation

Liam Lynch BDS MDPH

The first ever inter-professional and international conference on the regulation of health professionals was held recently in Geneva. Health professionals, government officials and academics debated the importance of professional regulation for safe, quality patient care. The conference was convened by the World Health Professions Alliance, which speaks for 23 million healthcare professionals worldwide. Discussion focused on the impact of international trade in services agreements and increasing cross-border movement of patients and health professionals. The opening keynote speaker was Dr Carissa Etienne, Assistant Director-General Health Systems and Services, WHO, who discussed the capacity and capability required to deliver services. Dr Peter Swiss, former president of the British Dental Association, and known in Ireland for his work with the Medical Defence Union, described the multiple jeopardies that a healthcare professional may face, and the different responsibilities of the various bodies involved. Professor Konstany Radziwill, President of the Polish Chamber of Physicians and Dentists, and Vice President of the Standing Committee of European Doctors, explored the issue of who



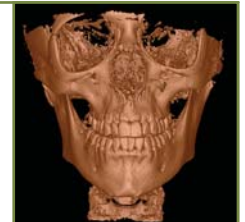
Dr Peter Swiss, Chairman of the Ethics & Dental Legislation Working Group of the World Dental Federation, with Liam Lynch.

should set standards and codes of conduct. He stated that it is both the responsibility and obligation of professional organisations to set standards and delineate the ethos and ethical principles of their profession with, of course, final appeal to the country's legal system. Dr Burton Conrod, President of the FDI World Dental Federation, said that he expected health professions and the public to play a major role where professional regulation was under discussion, and that self-regulation offered the most effective way to protect the public. Finally, Kamal Midha, President of the International Pharmaceutical Federation, in his closing remarks, said that the WHPA would consider holding another similar conference to follow up on the issues discussed in Geneva. "The public needs to be aware that self-regulation is an effective way of stimulating good practice and preventing poor practice in the interests of the patient", he said.



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Update on the National Oral Health Strategy

Association CEO FINTAN HOURIHAN summarises the current situation with regard to the National Oral Health Strategy, and the IDA's involvement.



The National Oral Health Strategy was announced by the Minister for Health and Children in October 2007, with the aim of facilitating the planning and re-orientation of oral health services in Ireland over the next five to 10 years. In order to develop the Policy, a Core Group was set up including representatives of the Department and the HSE, and a Consultative Panel was also established, including representatives from the Competition Authority, the Dental Council, the dental schools and the National Consumer Agency, among others. The IDA is represented on the Consultative Panel.

Further to a request from the Department of Health and Children for submissions on the scope and content of the strategy, the IDA produced a submission (along with some 75 other submissions). The submission can be summarised as follows:

- dentist of the future;
- integration of oral health in the wider healthcare delivery system;
- Competition Authority report on the dental profession;
- manpower planning; and,
- service delivery issues.

Meeting

On June 16, a delegation from the IDA met with representatives from the Department to discuss the Association's position on the Strategy. In response to the IDA's statement that members were unhappy that exclusion from the Core Group meant the Association was unable to contribute in an informed way to developing oral health policy, Mr Chris Fitzgerald, Principal Officer, Department of Health and Children, agreed that the IDA should be given more information on the rationale that has informed thinking behind the proposed changes. In particular, this will apply to the DTSS/DTBS and public dental services, and Mr Fitzgerald will liaise directly with IDA House in providing further documentation.

Consensus

Mr Fitzgerald stated that a consensus has emerged within the Core Group in regard to all of the matters under consideration with the exception of two key headings: 1. the possible alignment of the DTSS/DTBS; and, 2. the role of the public dental service.

DTSS/DTBS

The Department is reviewing all possibilities in terms of the administration of the DTSS and DTBS following the decision to transfer the DTBS into the health services, and while no firm direction is apparent for now, it seems that changes in administrative arrangements are the immediate priority. As regards possible merging of dental contracts, the IDA is firm in its view that it cannot see how dentists could contemplate a single contract for all services based on the approach of the HSE in administering the DTSS scheme. The Department does accept that contract negotiations will be an entirely separate exercise to follow the publication of the Strategy, with Mr Fitzgerald acknowledging: "Full and frank negotiations [with IDA] are inevitable". The Association continues to emphasise that change can only succeed if the profession has confidence in and support for reforms, while contractual change can only occur with the agreement of the IDA.

Public dental services

Mr Fitzgerald stated that the greatest disagreement within the Core Group relates to this issue. While the Group is obliged to consider options such as contracting out the children's service, it is recognised that difficulties would arise in regard to quality assurance.

Dr Bridget Harrington-Barry and Dr Rosarii McCaffrey asked for an indication of public dental surgeons' place in any new service and sought assurances as regards training, up-skilling and career pathways, and the possibility of designation/payment as specialists. Mr Fitzgerald emphasised that no final decision had been made in regard to public dental services, while also denying that there are plans to reduce or diminish public dental services.

Chief Dental Officer

The IDA emphasised the lack of follow through on Ministerial commitment to fill this post. Mr Fitzgerald stated that he had been asked by the Minister to ascertain whether the dental schools could

support this role being developed jointly between the Department and the schools. He has met with the RCSI, DDH and CDH, and will report with options to the Minister in the next week. The new role will also have to reflect changes in the administration and establishment of the HSE, claimed Mr Fitzgerald.

Hospital services

Dr John Barry enquired whether policy would promote development of a primary/secondary/tertiary care model. Mr Fitzgerald stated that he recognised the need to formalise arrangements with the acute hospital sector within a regional hub and spoke model. While he said that the Core Group had met representatives of oral surgery and maxillofacial surgery, the question of recommending expansion in consultant numbers had not featured on the agenda. He stated that the Core Group would welcome IDA submissions on this issue.

Oral health promotion

A presentation was made by Dr McCaffrey highlighting the need for two designated oral health promotion officers per community care area, and a ring-fenced budget. Mr Fitzgerald acknowledged this and also saw a role for GDPs in oral health promotion.

Education

Dr Gerry McCarthy sought information on the future of the PGMDB, including regional structures, undergraduate curriculum reforms and career pathways. The IDA highlighted cutbacks in vocational trainee funding and stated that the HSE approach to clinical audit could not be replicated in terms of education changes.

Mr Fitzgerald explained that the Core Group's intention is to produce an interim report by the end of July 2008 and to circulate this to parties, including the IDA, for comment. The deadline for publication of the final Oral Health Policy report is late autumn. IDA House will inform all members of the findings of the interim report once it is issued.

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Epilepsy in dental practice

Abstract

Epilepsy is a neurological condition characterised by seizure activity. It has an approximate incidence of 1%. General dental practitioners will encounter these patients in practice. This article discusses the types of epilepsy, the medical management and considerations in dental management of epileptic patients. General recommendations are made, based on current evidence, with respect to prescribing of medications. The management of an epileptic seizure is discussed. Status epilepticus is a rare but serious complication of epileptic seizures. An easy-to-follow algorithm is provided to assist the practitioner in managing seizures.

Journal of the Irish Dental Association 2008; 54 (4): 176-178.

Introduction

Epilepsy is a recurrent tendency to spontaneous, intermittent abnormal electrical activity in part of the brain, which manifest as seizures in sufferers. The incidence of epilepsy is approximately 1%.¹ Contrary to popular belief, several types of epilepsy exist and these are classified according to the types of seizures.

Types of epilepsy¹

1. Generalised seizures – affect the majority of the brain. Two types exist:

- tonic-clonic: characterised by loss of consciousness and fitting; and,
- absence seizures: brief period of unresponsiveness lasting <30 seconds.

2. Partial seizures – localised to part of the brain. Three types exist:

- simple: affects specific area, e.g., twitching of the thumb;
- complex: impaired consciousness; and,
- partial type progressing to generalised tonic-clonic seizure.

3. Others:

- myoclonic: patient suddenly throws themselves on the ground (salaam attacks); and,
- atonic: patient suddenly falls flaccid on the ground.

Medical management^{1,2}

These patients are managed with anti-epileptic drugs, which enhance the effects of GABA (gamma aminobutyric acid). GABA is an inhibitory neurotransmitter. These drugs reduce the incidence of the abnormal electrical activity that causes seizures. Examples of commonly used drugs are:

- carbamazepine;
- sodium valproate;
- phenytoin;
- phenobarbitone;
- lamotrigine; and,
- ethosuximide.

Dental considerations³

The major oral findings include:

1. Trauma to teeth due to falling at the time of a seizure. If an avulsed tooth cannot be found, a chest x-ray is indicated to rule out aspiration into the lungs.
2. Soft tissue lacerations, including bite injuries to the tongue, are common.
3. Gingival hyperplasia is a common side effect of phenytoin.
4. Vitamin B12 deficiency can occur as a result of drug therapy and may cause oral ulceration and/or glossitis.
5. Dislocation of the TMJ may occur, requiring repositioning. This must be carried out in a hospital setting due to the need for sedation and/or opioid analgesia.

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Principles of management

While it is recognised that stress can induce seizures, well-controlled epileptic patients can be managed in the general practice setting without concern.

It is important to check seizure patterns prior to commencing treatment. As always, the history should record types of seizures, degree of control, any possible precipitating factors, and times of the day when fits are more likely to occur. Patients with poor seizure control can be identified at this stage and referred for specialist hospital treatment. The patient should be advised to have a meal before treatment and to take medications as normal, as patients may not do this due to stress associated with the procedure. It is best to liaise with the patient's general medical practitioner to gain a full understanding of the severity of the condition.

General considerations

Appointments should be scheduled at a time when the patient is least likely to suffer a seizure, as established by the history. As little apparatus as possible should be in the oral cavity at any one time. Rapid removal of debris with suction is also important to limit the risk of airway obstruction if a seizure should occur.

Local anaesthetics

Local anaesthetics, such as lignocaine with 1:80,000 adrenaline, are safe to use. Dose reduction is recommended, as large doses of lignocaine have, on very rare occasions, been linked to seizures.³

Sedation

Intravenous sedation is safe to carry out in the general dental practice by dentists with the appropriate postgraduate training, as it helps to reduce the frequency of seizures. It is used in the management of status epilepticus. Caution should be taken not to over-sedate patients, as flumazenil (antagonist) can precipitate seizures.³

Treatment considerations

1. Caution is advised in procedures requiring multiple instruments in the mouth in case of seizure.
2. Fixed prostheses are preferable to removable prostheses. These should have metal reinforcement. Removable prostheses have a higher risk of causing airway obstruction. Removable prostheses can only be considered in well-controlled patients. The use of metal framework and radio-opaque materials is advantageous, as they have increased strength and are also visible on x-ray. Incisal restorations and removable prostheses should not be used in poorly controlled patients.²
3. Excellent oral hygiene is important in these patients to reduce the risk of gingival hyperplasia. Management of gingival hyperplasia often requires surgical excision.

Prescribing

Patients on antiepileptic drugs are sensitive to changes in the plasma concentrations of anti-epileptics, which can cause increased seizure activity. Medications that interfere with antiepileptic drugs should be prescribed with care. Any concerns regarding prescribing should be discussed with the patient's general practitioner or neurologist.

Medications that interfere with antiepileptic drugs

Antibiotics and antifungals:^{2,3,5}

- metronidazole (Flagyl) is known to cause seizures and should not be prescribed;
- clarithromycin (Klacid) can reduce phenytoin metabolism, giving increased plasma phenytoin levels;
- erythromycin may interfere with valproate; and,
- phenytoin will decrease the effectiveness of antifungals such as ketoconazole and miconazole, while also increasing phenytoin plasma concentrations.

Analgesics:^{2,5}

- tramadol (Zydol) enhances the effect of carbamazepine and should be avoided; and,
- non-steroidal anti-inflammatory drugs (NSAIDs: diclofenac, ibuprofen, etc.) can increase the plasma concentrations of valproate and phenytoin.

Management of seizure⁶

A generalised tonic-clonic convulsion may occur in the dental chair. The patient may or may not warn of an impending seizure. Consciousness is lost before the seizure begins. In this situation, the principal aim is to prevent injury to the patient:

- check that the patient's airway is clear;
- check the patient's breathing;
- check the circulation at the radial pulse (at the wrist) or, alternatively, the carotid pulse (in the neck);
- place the chair in the supine position;
- clear the area of equipment if an epileptic fit is suspected;
- turn the patient, if possible, to the side (recovery position). This reduces the risk of aspiration of secretions. If the patient is becoming cyanosed, gently extend the neck. Do not attempt to place anything in the mouth;
- use passive restraint only to prevent injury from hitting nearby objects or from falling out of the chair;
- make an attempt to identify the cause of the fit, such as a missed medication dose or anxiety; and,
- reassure the patient after they regain consciousness. Ensure that the patient is fully recovered before discharge home with a responsible adult.

Status epilepticus

Traditionally, status epilepticus was characterised by 30 minutes of continuous seizure activity or by multiple consecutive seizures without return to full consciousness between the seizures. It is now thought that a shorter period of seizure activity causes neuronal injury and that seizure self-termination is unlikely after five minutes. As a result, some specialists suggest times as brief as five minutes to define status epilepticus.⁷

The Resuscitation Council (UK) guidelines from 2006 recommend that medications should only be administered if convulsive movements occur for greater than five minutes or recur in quick succession.⁸

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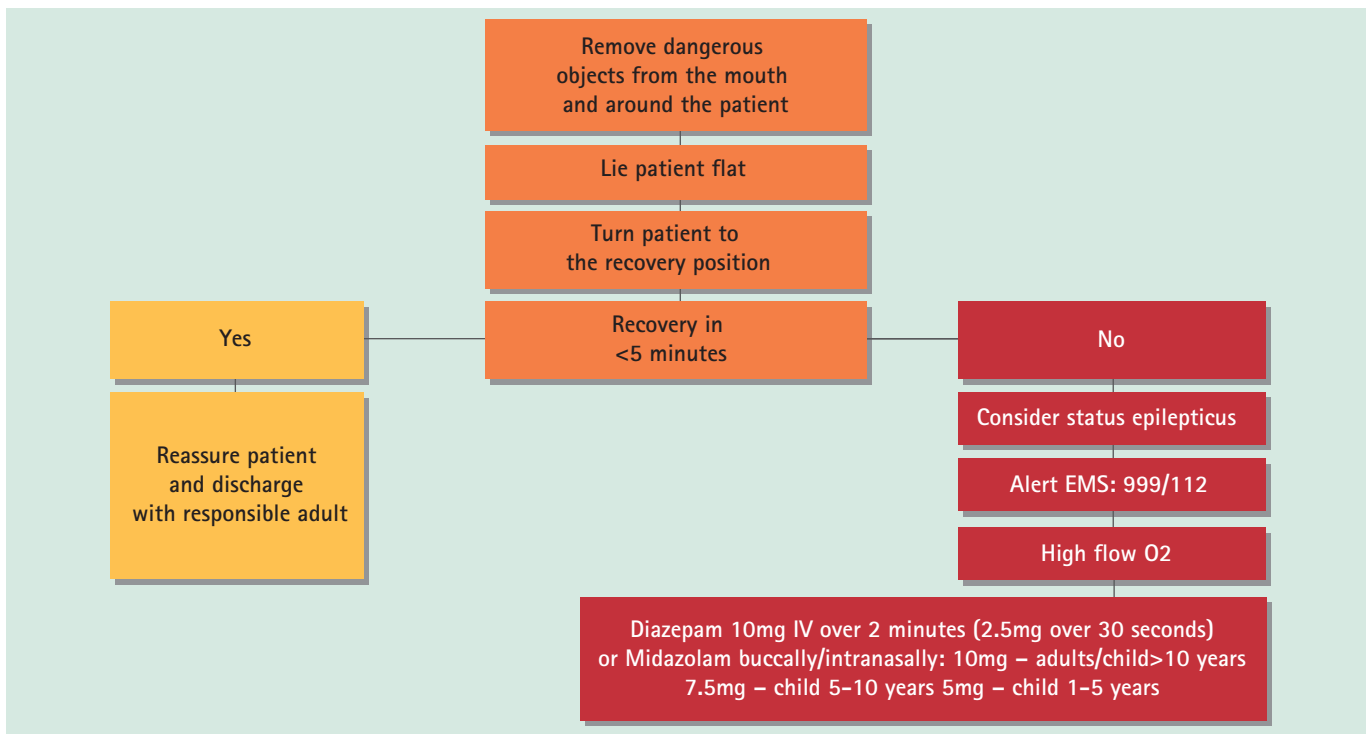


FIGURE 1: Algorithm for management of epilepsy.

Intravenous diazepam is considered first-line treatment for control of prolonged seizures; however, it may be more appropriate to administer a single dose of midazolam via the buccal or intranasal route in a dental practice setting, depending on the experience of the dental clinician in gaining IV access.

Status epilepticus management

1. ABCDE.
2. Alert emergency medical services (EMS).
3. Give oxygen – 10l/min.
4. Obtain IV access and give 10mg diazepam (or 5mg midazolam, if diazepam is unavailable) slowly over two minutes. Otherwise, administer 10mg midazolam buccally or intranasally for adults or children aged ten years and older.
5. Monitor vital signs until emergency services arrive.

Specialist hospital management⁹

1. IV phenytoin 15-18mg/kg administered at 25-50mg/minute. This must be carried out with ECG monitoring, as arrhythmia is a serious complication of IV phenytoin.
2. If the seizure continues, the patient requires ICU admission for intubation and cardiorespiratory support, which requires the use of IV thiopentone 100-250mg bolus followed by 50mg bolus every two to three minutes until the seizure is controlled.

Conclusion

Dental practitioners may feel some anxiety in managing patients who suffer from epilepsy. With careful assessment and planning, most epileptic patients can be managed quite safely in practice. Patients who have poorly

controlled seizure patterns require treatment in a specialist setting. It is very important that the practitioner is familiar with the management of acute epileptic seizures and status epilepticus, and that the appropriate medications and medical emergency equipment are available.

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Orthognathic surgery demands of a regional orthodontic unit

Journal of the Irish Dental Association 2008; 54 (4): 179-180.

Introduction

Prior to its abolition in 2005, the Southern Health Board provided dental care to eligible patients from the counties of Cork and Kerry. In 1992 a consultant orthodontist was appointed as the first stage in the development of a comprehensive orthodontic service for patients in these two counties. However, it was not until 1995 that the regional orthodontic unit, based at St Finbarr's Hospital in Cork, was officially opened. Orthodontic needs within the Southern Health Board were examined in 1995.¹ The oral surgery demands of a regional orthodontic unit were investigated in 1998.² This paper investigates the final aspect of our service in relation to the provision of orthognathic surgery. The Southern Health Board did not employ a permanent full-time consultant in maxillofacial surgery. Nevertheless, following the appointment of a professor of dental surgery to the University Dental School and Hospital, the orthodontic service has been fortunate to have access to this service. This article relates to the provision of orthognathic surgery to patients from the Southern Health Board Orthodontic Service between 1995 and 2005.

Material and methods

The parameters of all patients referred to the orthodontic/orthognathic surgery joint clinic at the University Dental School and Hospital between 1995 and 2005 from the Southern Health Board orthodontic services were examined. The criteria used for referral to the joint clinic were:

1. Patients presented with an orthodontic problem that required a combination of orthodontics and orthognathic surgery to complete their treatment. All patients had lateral cephalometric radiographs traced, which displayed a skeletal discrepancy outside the accepted range of normality. The Eastman standard means were used in the cephalometric analysis.³

2. Patients expressed a willingness to proceed with a combination of orthodontics and orthognathic surgery to correct their underlying skeletal problem.

The records examined were:

- A. The number of patients referred to the orthodontic/orthognathic surgery joint clinic between 1995 and 2005.
- B. The current treatment status of each patient.

Results

Table 1 indicates the number of male and female new patients who attended the joint clinics over the study period. Records show that almost twice as many patients were female (216 female versus 139 male patients).

Table 2 shows a breakdown of patients who attended a joint clinic appointment between 1995 and 2005. This table reflects the number of patients who have completed treatment, the number of patients currently undergoing orthodontic treatment prior to surgery, those who are now ready for surgery, having completed the orthodontic phase of their treatment and, finally, the number of patients who refused surgery. A total of 355 new patients attended the joint clinic. At the time of the investigation 143 patients (40%) had completed treatment, 103 (29%) were under treatment prior to surgery, and 23 (6%) were awaiting surgery. The number of patients who refused surgery was 86, almost 25% of the total number of new patients attending the joint clinics.

Discussion

The orthognathic surgery services in the Republic of Ireland are still in a disorganised state. Some areas, such as the Mid Western Health Board area (i.e., the counties of Limerick, Clare and North Tipperary) have two maxillofacial surgeons available to them.

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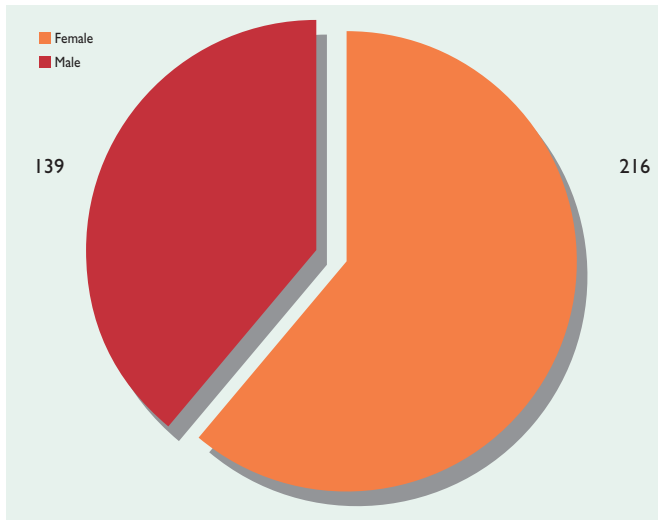


TABLE 1: The number of female and male patients who attended the joint clinics.

However, the Southern Health Board area, i.e., the counties of Cork and Kerry, does not have access to the services of a full-time public health maxillofacial surgeon. Since 1995 we have been extremely fortunate in and grateful for the assistance of the consultant maxillofacial surgeon to the University Dental School and Hospital in Cork. Without his continued support and assistance, the orthognathic surgery service would not have developed to its current level.

To date, there has been no study in the Republic of Ireland examining the need or demand for maxillofacial or orthognathic jaw surgery services in the public service. The demand within the private orthodontic service is not examined in this study. The recommendation of the Joint Oireachtas Committee on Health and Children 2005,⁴ that five maxillofacial surgeons be appointed, has still not been implemented. This study gives an indication of the need and demand for the service in order to allow the regional orthodontic service in the counties of Cork and Kerry to develop to its full potential. The total population of Cork and Kerry in 2006 was 621,130.⁵ The cost implications of providing this type of service have not been considered in this paper.

Almost twice as many female as male patients attended the joint clinics. All of the patients in the study were referred through the primary or national school service. Therefore this is a study of children attending a public health orthodontic service rather than a reflection of the need for orthognathic surgery among adult orthodontic patients.⁶ It is difficult to look for international comparisons between this study and other international studies.⁷ However Tornes and Lyberg⁸ found that the surgical correction of mandibular prognathism in Norway between 1975 and 1984 was 1,169 patients for the population of Norway. Proffit and White⁹ found that 0.0055% of patients required orthognathic surgery in the USA.

The study shows that, over a 10-year period, approximately 143 patients from the public health orthodontic service in the counties of Cork and Kerry received orthognathic surgery. The number of patients currently undergoing orthodontic treatment prior to surgery, and those ready and waiting for surgery, indicates that we have a developing service where the demand is increasing. The normal timeframe for pre-surgical orthodontic

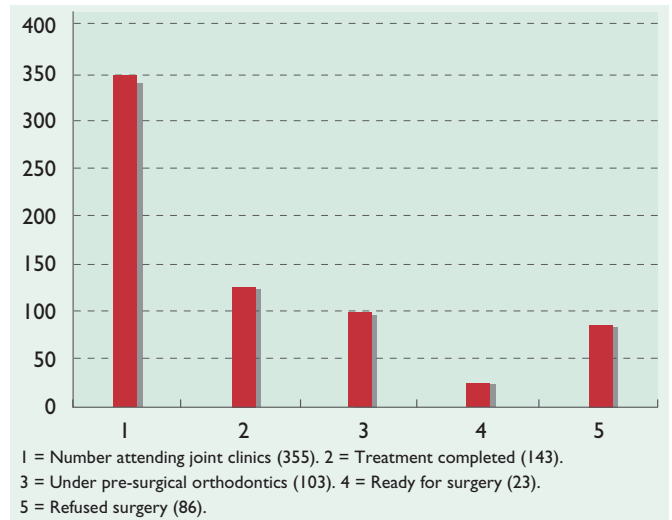


TABLE 2: The breakdown of patients attending joint clinics over a 10-year period (1995-2005).

treatment is between 18 months and two years. At the time of the investigation, 126 patients were either ready for surgery or undergoing pre-surgical orthodontic treatment. Preparation of patients for this type of surgery is time consuming, involving joint orthodontic and maxillofacial care. The increasing demand for these services needs to be taken into consideration in the planning of future service delivery.

Conclusion

Orthognathic surgery is an important aspect of treatment within the public health orthodontic service in the counties of Cork and Kerry. From 1995 to 2005, 355 patients were referred to orthodontic/orthognathic surgery joint clinics. At the time of the investigation 126 patients were being prepared for surgery, indicating that there is an increasing demand for this type of service.

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The establishment of a diagnostic reference level for intra-oral dental radiography in Co. Wicklow.

Abstract

The use of diagnostic reference levels (DRLs) is part of the optimisation process of radiation protection, in that it identifies practices that are in need of corrective action, resulting in dose reduction. Their use is provided for in Irish and European legislation. In this project, measurements were carried out at 42 of the 46 licensed intra-oral x-ray machines in Co. Wicklow using an Unfors Mult-0-Meter. The third quartile patient entrance dose for a maxillary molar was calculated at 2.31mGy, and all the measurements were below the European DRL of 4mGy. The effect of digital radiography was analysed. There is always scope for the optimisation of patient dose. To facilitate this, a DRL of 2.5mGy (patient entrance dose) is suggested for Ireland.

Journal of the Irish Dental Association 2008; 54 (4): 181-183.

Introduction

Radiation protection is based on the principles of justification, optimisation and dose limitation. A radiographic examination is justified if the benefit of the exposure is assessed to outweigh the risk. Optimisation is the process of keeping the radiation dose as low as is reasonably practicable, taking economic and social factors into account.¹

Setting up a diagnostic reference level (DRL) is the first step in the optimisation process, in that it identifies practitioners that use higher doses than may be necessary. The concept was refined by the International Commission on Radiological Protection (ICRP) in ICRP 73 in 1996, when the term 'diagnostic reference level' was introduced.¹ The report also described and quantified the risks from the use of ionising radiation. Radiation-induced malignancies are stochastic effects that have a random occurrence, and where the probability of the occurrence increases with an increased dose, but there is no threshold dose. Taking into account the varying risk factors within the entire population, the ICRP have issued a probability coefficient of 7.3% per Sievert (Sv) for serious stochastic effects.¹

This document recommended that the DRL use the third quartile of the distribution of doses for a particular examination as an indicator of high doses. The third quartile, or the 75th percentile, indicates the level that 75% of those examined will be under and 25% will be over. It also

recommended that DRL values should be selected by professional medical bodies, be reviewed at appropriate intervals and be specific to a country or region.¹ The DRL should use clearly defined dose measurements that are easily measured or calculated, and these measurements should relate to the radiation risk inherent to the examination. DRLs are a guide to good practice and their use should be advisory and not regulatory.² A local DRL is recommended due to the great socio-economic disparities within large political entities, e.g., the European Community. It must be noted that optimisation can be expensive and the cost is borne by the x-ray license holder. Past measures involved the removal of 50kV x-ray machines. Present measures include the hiring of a radiation protection advisor (RPA) and the putting in place of a quality assurance (QA) programme.

European legislation specific to medical exposures was updated in Directive 97/43/Euratom, which was implemented in Ireland by European Communities (Medical Ionising Radiation Protection) Regulations, 2000, S.I. No. 478 of 2002. Item 11. (1) of this statutory instrument provides for DRLs. As of yet, we do not have a DRL for intra-oral radiography in Ireland. However, Recommendation 5F of The European Commission's Guidelines in Dental Radiology recommends a DRL of 4mGy (milliGray) absorbed dose in air at the end of the spacer

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FIGURE 1: Unfors Mult-O-Meter.

cone for a standard maxillary molar projection.³ This figure is derived from a UK survey carried out in 1999 by Napier.⁴ The dose measurement used in this survey is called the patient entrance dose; it is quite simple to measure and bears a rough relationship with radiation risk. This measurement is used in all the national studies quoted in the European guidelines.³ Recent German studies have used dose area product measurements, which have a closer relationship to radiation risks.⁵

X-ray film speed and kV of the set were shown to have a great effect on the patient entrance dose. Johnson *et al* quoted a 75% dose reduction between the 1960s and the late 1980s because of improvements in these factors.⁶ In Ireland, older intra-oral x-ray machines operating at below 50kV were removed from service, as recommended in RPII guidelines.⁷ The use of the fastest appropriate speed films is also recommended.⁷

The main disadvantage of using patient entrance dose for DRL studies is that it is not influenced by which collimator type is being used. The use of a circular collimator will give a much higher effective dose, and therefore risk, than the use of a rectangular collimator.³ Thus, major risk reduction goes unobserved in studies using patient entrance dose.

Materials and methods

A list of dental practices was drawn up using the commercial telephone directories (*The Golden Pages*) that covered Co. Wicklow. A total of 28 private dental practices were identified, of which 25 agreed to take part. Some practices had more than one machine, giving 32 measurements. All 10 machines in the community dental service are included in the study, resulting in a total of 42 measurements. The RPII confirmed that at the time there were 46 licensed intra-oral machines in the county.

The survey was carried out in May 2007 using an Unfors Mult-O-Meter (Unfors, Sweden). This calibrated measurement device was supplied by Professor Wil van der Putten of University College Hospital, Galway and Bio-Physica, an RPA service to Irish dentists. The machine is a sealed silicon electronic dosimeter (Figure 1). The reading taken was the patient entrance dose for a maxillary molar, measured in mGy. The practitioner chose the appropriate setting used for this examination. It was noted

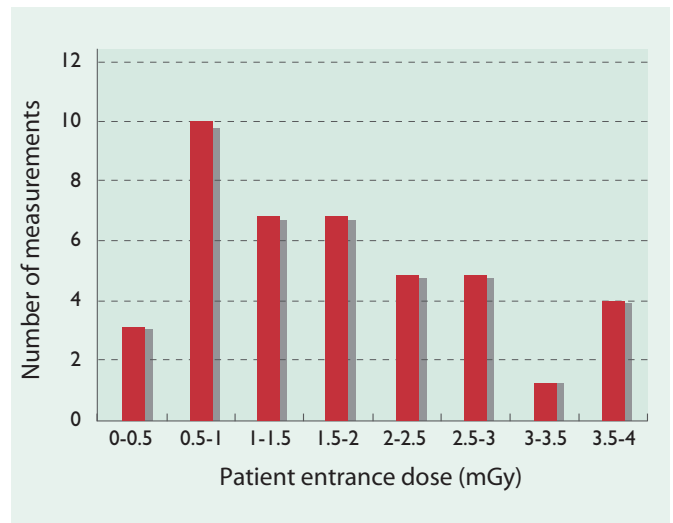


FIGURE 2: The distribution of patient entrance dose.

whether the practitioner was using digital technology or film to capture the image. Neither the film speed nor the type of digital imaging modality was noted. All statistical analysis was carried out using the statistics function of the spreadsheet of www.openoffice.org calc.

Results

The diagnostic reference level

The patient entrance dose distribution for the 42 measurements is illustrated in Figure 2.

All the measurements are below the 4mGy reference level of the European Guidelines.³ There is a factor of approximately 16 between the lowest dose of 0.22mGy and the highest dose of 3.99mGy. The third quartile patient entrance dose for a maxillary molar intra-oral radiographic image is 2.3mGy; this figure is the DRL for Co. Wicklow.

A total of 12 of the 42 (29%) recordings were set for use with a digital sensor. The range of measurements in the digital group was from 0.22mGy to 1.21mGy. The distribution of the digital group within the overall group is illustrated below in Figure 3. The DRL for this subset is 0.95mGy. The DRL for the group using film was 2.54.

The data of the recordings of the digital group and the film group were submitted to a 't' test using software from www.openoffice.org. A p value of less than 0.01 was calculated, indicating that there is a statistical difference between the patient entrance doses of those machines that use digital sensors and those using film. This is quite obvious from their respective distributions in Figure 3.

Discussion

A wide range of doses is seen in this survey, and there is therefore room for optimisation of dose. The establishment of a DRL is seen as the first step in dose optimisation. The 25% of machines over the reference dose can be identified; however, as stated, the DRL exercise is purely advisory. Participants who are over the new DRL should be helped to investigate the reasons for the higher dose and they should follow up with appropriate corrective action. A higher dose is often due to inappropriate equipment

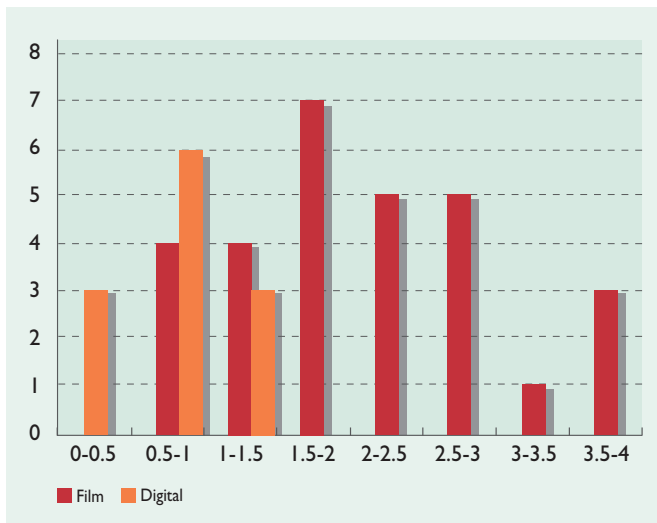


FIGURE 3: Comparison of digital and film doses.

settings.² Closer attention to quality assurance, as described in the European Guidelines, should also result in dose reduction. A change to a faster film will also reduce the dose substantially. This part of the optimisation process was not carried out here, as this was purely an academic exercise. Fortunately, all the results were compliant with European guidelines. It is sufficient to make a proposal for a lower DRL for Wicklow from this study. In the absence of a national study, this figure could be considered relevant for Ireland; at present, the only relevant DRL is 4mGy in the European Guidelines.³

In the UK, the latest five-yearly review of the National Patient Dose Database has issued recommended national reference doses for dental radiography.⁸ Their DRL for an adult intra-oral radiograph is a patient entrance dose of 2.3mGy. It was noted that the new adult DRL is approximately 40% lower than the 1999 value. The report said that the reduction was probably due to the use of faster films and digital systems.⁸ Due to the similarity of the result of this Wicklow study and the new recommended DRL in the UK, perhaps a more appropriate DRL for intra-oral radiography in Ireland would be rounded up to 2.5mGy for a maxillary molar. This figure would allow for a higher dose for a maxillary molar, as the UK measures the Patient Entrance Dose for a mandibular molar. The 75th percentile for the film group in the Wicklow study was 2.54, making 2.5mGy a reasonable DRL.

A total of 12 of the 42 measurements (29%) used digital radiography. Interestingly, this is similar to a Belgian study, where Gijbels *et al* found that 30% of the x-ray sets used digital radiography.⁹ The distribution of the digital group within the overall is illustrated in Figure 3. It is obvious that they had much lower doses than those using film. Within the digital group, there is approximately a factor of 6 between the lowest dose of 0.22mGy and the highest of 1.21mGy. This indicates that there is again room for optimisation. It is traditional to use only one DRL for a particular examination.⁴ In dental radiography, this will allow poor optimisation within the digital group to pass undetected. Perhaps this could be dealt with by using a DRL specific to digital radiography.

While digital sensors are faster than film, it is possible to get low doses using

film. It is noteworthy that eight (27%) of those using film registered measurements of under 1.5mGy. This type of dose is achievable as part of a good quality assurance (QA) programme.

Conclusion

This study was carried out to establish a DRL for intra-oral radiography in Co. Wicklow. A randomised study of all the dental x-ray machines in Ireland would give a statistically representative national picture but was beyond the remit of this project. It was reassuring that all the machines tested were below the DRL of 4mGy set in the European Guidelines. Hopefully, this study is representative of the national picture.

At present, there is a great opportunity to provide national figures for the Republic of Ireland. If the statutory authority were to collate all the information from the recently appointed radiation protection advisors' fieldwork, national DRLs for intra-oral, panoramic and cephalometric radiography could be produced. It is important to get this framework right to continue the optimisation process.

Acknowledgements

I would like to thank my colleagues in Co. Wicklow for their assistance and hospitality. This project is part of the postgraduate degree course of the MSc in Dental and Maxillofacial Radiology through Kings' College London. I would like to acknowledge the comments of my supervisor, Mr Alistair Mackenzie. Professor Wil van der Putten very generously loaned me the dosimetry machine and Mr Achim Treuman of RCSI gave advice on statistical programmes. I also wish to acknowledge the insightful comments and useful suggestions made by the reviewers of this journal.

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ABSTRACTS

The effectiveness of sealants in managing caries lesions

Griffin, S.O., Oong, E., Kohn, W., Vidakovic, B., Gooch, B.F., et al (CDC Dental Sealant Systematic Review Work Group).

A barrier to providing sealants is concern about inadvertently sealing over caries. This meta-analysis examined the effectiveness of sealants in preventing caries progression. We searched electronic databases for comparative studies examining caries progression in sealed permanent teeth. We used a random-effects model to estimate percentage reduction in the probability of caries progression in sealed versus unsealed carious teeth. Six studies, including four randomised controlled trials (RCTs) judged to be of fair quality, were included in the analysis (384 persons, 840 teeth and 1,090 surfaces). The median annual percentage of non-cavitated lesions progressing was 2.6% for sealed and 12.6% for unsealed carious teeth. The summary prevented fraction for RCT was 71.3% (95% CI: 52.8%-82.5, no heterogeneity) up to five years after placement. Despite variation in design and conduct among studies, sensitivity analysis found the effect to be consistent in size and direction. Sealing non-cavitated caries in permanent teeth is effective in reducing caries progression.

J Dent Res 2008; 87 (2): 169-174.

Non-vital tooth bleaching: a review of the literature and clinical procedures

Plotino, G., Buono, L., Grande, N.M., Pameijer, C.H., Somma, F.

Tooth discolouration varies in aetiology, appearance, localisation, severity, and adhesion to tooth structure. It can be defined as being extrinsic or intrinsic on the basis of localisation and aetiology. In this review of the literature, various causes of tooth discolouration, different bleaching materials, and their applications to endodontically treated teeth, are described. In the walking bleach technique the root filling should be completed first, and a cervical seal must be established. The bleaching agent should be changed every three to seven days. The thermocatalytic technique involves placement of a bleaching agent in the pulp chamber followed by heat application. At the end of each visit the bleaching agent is left in the tooth so that it can function as a walking bleach until the next visit. External bleaching of endodontically treated teeth with an in-office technique requires a high concentration gel. It might be a supplement to the walking bleach technique, if the results are not satisfactory after three to four visits. These treatments require a bonded temporary filling or a bonded resin composite to seal the access cavity. There is a deficiency of evidence-based science in the literature that addresses the prognosis of bleached non-vital teeth. Therefore, it is important to always be aware of the possible complications and risks that are associated with the different bleaching techniques

Journal of Endodontics 2008; 34 (4): 394-407.

The potential impact of periodontal disease on general health: a consensus view

Williams, R.C., Barnett, A.H., Claffey, N., Davis, M., Gadsby, R., Kellett, M., et al.

Background

Evidence for a link between periodontal disease and several systemic diseases is growing rapidly. The infectious and inflammatory burden of chronic periodontitis is thought to have an important systemic impact. Current evidence suggests that periodontitis is associated with an increased likelihood of coronary heart disease and may influence the severity of diabetes.

Scope

This paper represents a UK and Ireland cross-specialty consensus review, undertaken by a group of physicians and dentists. The consensus group reviewed published evidence (PubMed search for review and original articles), focusing on the past five years, on the contributory role of periodontal disease to overall health. In particular, evidence relating to a role for periodontal disease in cardiovascular disease and in diabetes was considered.

Findings

Initial studies of large epidemiological data sets have sought to find links between periodontitis and systemic disease outcomes, but a causal relationship still needs to be demonstrated between periodontal disease, cardiovascular disease and diabetes through prospective studies. There is a need for prospective studies assessing the association between periodontal disease and patients at particular risk of cardiovascular events, which will allow assessment of both cardiovascular disease clinical endpoints and surrogate markers of cardiovascular risk. Of note, periodontal disease is also often more severe in subjects with diabetes mellitus, a group at already increased risk for cardiovascular events.

Conclusions

While further research is needed to define the population-attributable risk of periodontal disease to both cardiovascular diseases and to diabetes control and progression, health education to encourage better oral health should be considered as part of current healthy lifestyle messages designed to reduce the increasing health burden of obesity, cardiovascular disease and diabetes.

Current Medical Research and Opinions 2008; 24 (6): 1635-1643.

ABSTRACTS

Periodontal parameters and cervical root resorption during orthodontic tooth movement

Giannopoulou, C., Dudic, A., Montet, X., Kiliaridis, S., Mombelli, A.

Objectives

To assess the relationship between periodontal parameters and cervical root resorption in orthodontically moved teeth.

Material and methods

In a standardised experimental tooth movement in 16 periodontally healthy subjects, 29 pre-molars were tipped buccally for eight weeks. A total of 18 contralateral pre-molars not subjected to orthodontic movement served as controls. Plaque index (PI), gingival index (GI), probing depth and bleeding on probing were assessed three times before and six times during the experimental phase. Teeth were extracted and scanned in a micro-computed tomography scanner. The presence or absence, and the severity, of cervical root resorption were evaluated on the three-dimensional reconstruction of the scans by two calibrated examiners.

Results

Overall, periodontal parameters were not different between the test and the control teeth. Clear signs of buccal cervical resorption were detected on 27 of 29 orthodontically moved teeth and on one control tooth. Ten subjects had perfect oral hygiene and no gingivitis, whereas six subjects showed a moderate level of plaque and gingivitis (>20% occurrences of PI or GI with >0). No relationship could be demonstrated between resorption and periodontal parameters.

Conclusions

Nearly all orthodontically moved teeth showed signs of cervical resorption. Periodontal parameters were unrelated to this important side effect of orthodontic treatment.

Journal of Clinical Periodontology 2008; 35 (6): 501-506.

Answers to quiz (from page 168)

1. Biopsy confirmed well differentiated squamous carcinoma.
2. The histology shows islands of well differentiated squamous carcinoma pushing downwards into the underlying connective tissue (see arrow).
3. Second confirmatory biopsy because of unusual presentation, CT, MRI and PET scans, haematological investigations and discussion in a multidisciplinary forum.
4. Surgical resection with a 1cm margin or more, with/without post-operative radiotherapy. Soft/hard tissue and prosthetic reconstruction.

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TCD graduate seeking locum position in Galway and surrounding area. Available end July to end September. F/T or P/T considered. Tel: 085 157 3626 anytime, or Email: ooshaugh1@hotmail.com.

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Excellent opportunity for associate to join busy, modern, family-based, multi-surgery practice 20 minutes from Galway City. Excellent support staff, OPG, hygienist, great patient base. New graduates also welcome to apply. Contact with CV please to phewatal@eircom.net.

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- Experienced associate required for modern city practice. Part-time position – Mondays and Wednesdays. Must be available to work evenings. Tel: 087 903 5461.
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- Associate required to join long-established Glasnevin Dublin 9 practice. Private/public. Modern surgery, computerised, OPG, hygienist. Efficient good-natured staff. Tel: 01 857 2120, or Email: rcahill@cahilldental.net.
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- Associate required for practice in Wexford. Excellent facilities and good support offered. For details please Tel: 086 259 2798.
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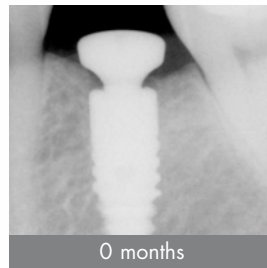
EQUIPMENT FOR SALE

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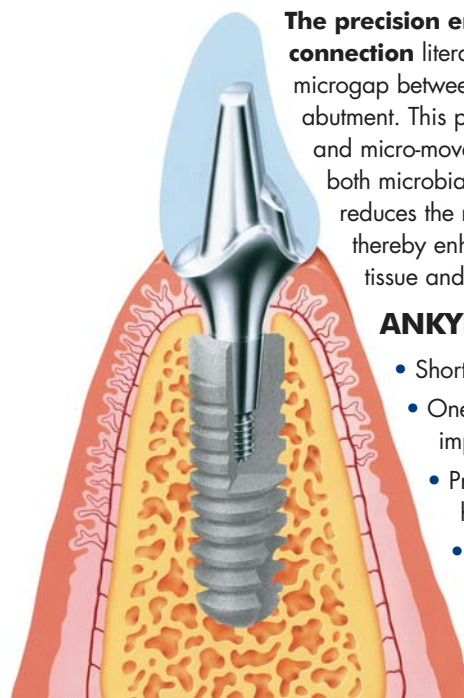
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DAIRY OF EVENTS

September 2008

Irish Dental Association Golf Society – The IDA Captains Prize
September 6 Carlow Golf Club

Metropolitan Branch IDA – Scientific Meeting

September 18 Hilton Hotel, Charlemont Place, Dublin 2
Speakers are Dr Mary Freda Howley on 'The traumatised tooth', and Dr John Lordan on 'Single visit molar endo – when, why, how?' Mr Fintan Hourihan, CEO, Irish Dental Association, will address the meeting.

Irish Dental Association – Council Meeting

September 20 IDA House, Leopardstown, Dublin

The European Society of Microscope Dentistry (ESMD) Conference

September 18-20 NH-Grand Hotel Krasnapolsky, Amsterdam

The ESMD will hold their first conference – 'To see or not to see' – in Amsterdam. Programme includes: hands-on workshops (restorative, perio, endo) at all levels; plenary sessions; masterclasses; social programme: Magical dinner; and, tours. For further information, visit www.ESMD2008.org.

FDI Annual World Dental Congress

September 24-27 Stockholm, Sweden
The FDI Annual World Dental Congress, including the World Dental Parliament, the Scientific Programme and the World Dental Exhibition, will be held in Stockholm. For further information visit <http://www.fdiworldental.org/microsites/Stockholm/congress1.html>.

Irish Academy of American Graduate Dental Specialists (IAAGDS) – Annual Scientific Meeting

September 27 Conrad Hotel, Earlsfort Terrace, Dublin 2
Time: 9.00am-1.00pm (registration from 8.30am). For further information, contact Dr Barry Dace, Email: barrydace@ireland.com.

October 2008

Irish Dental Association – Public Dental Surgeons Seminar

October 1-3 Knightsbrook Hotel, Trim, Co. Meath
For further information, contact the IDA on 01 2950072.

Irish Dental Nurses Association (IDNA) Meeting – 'The Way Forward'

October 4 Clontarf Castle Hotel, Castle Avenue, Clontarf, Dublin 3
For further information, visit www.idna-ireland.com.

Prague Dental Days

October 15-17 Prague
Since 1993, the Czech Dental Chamber has been organising Prague Dental Days (PDD), an international congress focused on dental issues. For further information, visit www.dent.cz.

Metropolitan Branch IDA – Scientific Meeting

October 16 Hilton Hotel, Charlemont Place, Dublin 2
Speakers are Dr Spencer Woolfe on 'Implant problems/solutions', and Dr Stuart Jacobsen on 'Restorative solutions'.

Irish Dental Hygienists Association (IDHA) Meeting

October 17-18 Cavan Crystal Hotel, Dublin Road, Cavan
For further information, visit www.irishdentalhygienists.com.

November 2008

Irish Dental Association – Council Meeting

November 15 IDA House, Leopardstown, Dublin

Metropolitan Branch IDA – Scientific Meeting

November 20 Hilton Hotel, Charlemont Place, Dublin 2
Speakers are Dr Sabine Maguire on 'Non accidental injury', and Dr Billy Fenlon on 'What's new in paediatric dentistry?'

Inaugural Trans-Tasman Endodontic Conference

November 20-22 Hotel Grand Chancellor, Hobart, Tasmania, Australia
Inaugural Trans-Tasman Endodontic Conference – 'Endodontics into the next decade'. Get on top of your endodontics at the bottom of the world with key speakers Professors Markus Haapasalo and Ove Peters, plus local Australian and New Zealand presenters. For further information and to register your interest, visit www.ase2008.com.

Metropolitan Branch IDA – Christmas Party

November 29 RDS, Ballsbridge, Dublin 4

December 2008

Irish Dental Association Golf Society – The Christmas Hamper

December 5 Royal Dublin Golf Club

2009

January 2009

Irish Dental Association – Council Meeting

January 24 IDA House, Leopardstown, Dublin

March 2009

Irish Dental Association – Council Meeting

March 7 IDA House, Leopardstown, Dublin

The Dental Nursing and Dental Hygienists Seminar

March 21 Cork University Dental School and Hospital
Further details available nearer the time.

April 2009

Irish Dental Association Annual Conference – 'Skilkenny 2009'

April 22-26 Hotel Kilkenny
Further details will follow when available.



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