

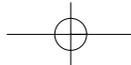


# Journal of the Irish Dental Association

Iris Cumainn Déadach na hÉireann



**Should parents  
accompany their  
children into the dental  
surgery?**



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**The Journal of the Irish Dental Association**

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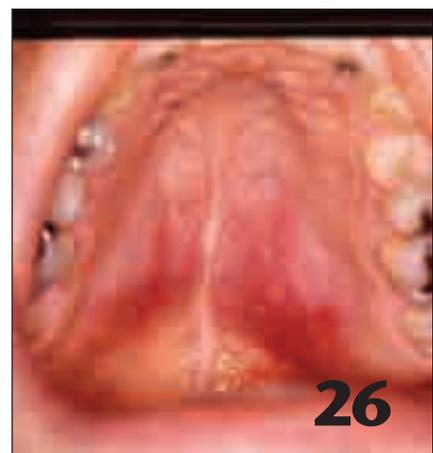
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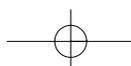
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## Promoting the positive aspects of dentistry

When are we ever going to hear anything good again about dentistry in the Irish media?

Bad press about dentistry in Ireland is frequent, unrelenting and it is time to speak up! The main cause of complaints appears to be based on the perception that the dental profession is some sort of cosy cartel that overcharges patients. While I look forward to the profession being formally vindicated by the Competition Authority on the allegation, I think we are equally innocent as a profession on the overcharging allegation.

Like every other business in Ireland, we continue to experience the massive increase in costs synonymous with our glorious Celtic Tiger. Irish businesses are now subject to some of the most expensive rents, insurance costs and labour costs in the entire EU. These high costs affect all aspects of a practitioner's business - the cost of materials has increased dramatically, staff costs are high, as are laboratory costs, electricity, etc. On top of that, we also incur various dental-specific costs such as the spiralling cost of cross-infection control procedures and adhering to EU directives in relation to the disposal of contaminated waste.

Not only is the dental profession subject to healthy competition from our colleagues in the north and in the rest of Europe, but, as a profession, we also facilitate foreign trained dentists practicing in Ireland. There are no restrictions or unwieldy processes in the way of dental graduates from other EU countries seeking to work as associates or setting up practice here. Non-EU trained dentists can also qualify for registration by passing an examination held annually by the Dental Council - a relatively simple process compared to, for example, the difficult process of gaining a US licence to practice.

We also hear calls for the training of more dentists - the reason that we do not train more dentists is because we do not have the facilities. In fact, it is not so long ago that the dental profession lobbied long and hard to keep the Dublin Dental Hospital open when it was severely at risk of closure.

For some reason, our message never gets across. I think it is time we got back to basics and promoted the decency in our profession the most of us have encountered during our student and professional days. We should promote our long-standing tradition for promoting health and providing world-class care for patients. We need to remind

people that we are an integral part of a team of healthcare promoters and providers and that we do not deliver a product but a valuable service where the patient's interest is paramount. We are part of a profession that campaigned for the fluoridation of water and one that continues to campaign to maintain fluoridated water because we know it reduces the incidence of caries dramatically and improves the quality of life of our patients and the general public. We need to let people know that many of our members are involved in developing and providing services in the third world and to the disadvantaged at home.

I was particularly pleased that the members of the Irish Dental Association passed a motion at the recent AGM stating that: "The IDA should undertake a proactive public relations campaign on an on-going basis to highlight the positive aspects of the care we provide." It is encouraging to hear that work has already commenced in this regard and I hope we will all participate in any campaigns that may be undertaken.

Despite the media, each of us everyday experiences the gratitude of our patients. We do make a difference and I think we can make an even bigger difference by giving a little back such as getting involved in pro bono work.

In my own experience, I have seen pro bono dentistry work. Both as a student and later as a member of faculty at a US dental school, I participated in compulsory student outreach programmes that provided dental care to poor rural communities for a week at a time, and to community centres in cities where free dental care was provided. The school also provided regular free care to disadvantaged people. It was voluntary, enjoyable and rewarding.

So let's get our act together and let's be proactive in promoting the many positive aspects of our profession.



Aisling O'Mahony  
Editor

## Consultation on reforms needed

Following the establishment of the Health Service Executive (HSE) on January 1, 2005, the country's health boards have now been abolished and the workings of the Department of Health and Children is also undergoing radical change.

Dr Maeve O'Connor, President of the Public Dental Surgeons Group of the Irish Dental Association (IDA), has expressed the group's concern over the lack of consultation between the HSE and the IDA. "It is paramount to all concerned that the reforms optimise the provision of dental care to the public. In order for this to happen, we believe that the representative body of the profession, the IDA, needs to be consulted. We are acutely aware of the strengths and shortcomings of the dental services to date," she said.

Dental public health measures have had a tremendous impact on dental decay in the Republic; in the past 40 years dental decay has been reduced by 70 per cent. The emphasis presently put on preventing dental disease has similar potential. This potential however needs developing. The preliminary results of the North/South Survey of Children's Oral Health 2002 are encouraging but at the same time challenging in respect of under five-year-olds whose level of decay has increased; 15-year-olds, two-thirds of whom continue to have decay, and the less well off, who suffer greater decay than the general population. We await the final report of this survey, the adult oral health survey and the survey of children and adults with special needs. "More has to be done for children and adults. Special needs children and adults in particular desperately need a better service," said Dr O'Connor. "We need to provide greater access to dental disease prevention and treatment for all. By providing a well planned comprehensive primary care service, we would be able to reduce the demands we presently place on orthodontics and on hospital services, both of which are stretched to capacity.

"While recognising and applauding the efforts of the Minister for Health and Children, Mary Harney, to revamp the health service, we now find



*Dr Maeve O'Connor, President of the IDA's Public Dental Surgeons Group, has voiced the profession's concerns over the lack of consultation between the recently established Health Service Executive and the IDA.*

ourselves with no direction. The post of Chief Dental Officer, the primary advisor to government in relation to dental matters, continues to remain vacant with no indication that a replacement is being sought. The post of Assistant Chief Dental Officer is also unfilled. No blueprint appears to exist for the organisation of Public Dental Services into the future. With no agreed structures to manage and organise the Irish Health Service, with the demands of headline issues such as the A&E crisis, and in particular in the absence of any strategic focus on dentistry at this time of change, our profession is justifiably concerned.

"We need to insure that the dental health of the nation gets the attention it deserves. We are proud of the results we have achieved in the past despite the chronic difficulties with resources, most notably with staff recruitment and retention. We need to be sure that in the future dental health gets the funding it needs and that the structures are in place to ensure appropriate use of this funding to maximise the benefits to the public."

## Major issues addressed at meeting

Following a meeting between the IDA and the Dental Council, the Council has advised the Association that the level of complaints in relation to the lack of emergency services after hours was continuing to increase and that this was an unacceptable situation.

This matter related primarily to post-treatment services.

The Ethics Committee of the Dental Council was particularly concerned about the matter, which reflected badly on the profession. The Dental Council emphasised dentists' ethical obligations in this regard.

The Dental Council has also said that it would like to see the Association establish an expert panel of general dental practitioners, specialists, public dental surgeons and hospital dentists to act as expert witnesses in legal cases involving dentistry. It was felt that it is more desirable to have local experts deal with cases rather than have experts brought in from abroad. The Association undertook to have this matter discussed with the Council of the Irish Dental Association. The Association has advised the Dental Council that its GP Group is examining the issue of displaying professional fees and would bring forward a recommendation in due course. The ethical guidelines, which require dentists to discuss and agree the treatment plan

and related fees with the patient in advance of the commencement of treatment, were also noted. The Association also expressed its concerns in relation to the new dental nurse training programme being run by both the Cork and Dublin Dental Schools. It was noted that some local training schemes, which were run with participants being prepared for the British Dental Nursing Examination, had ceased because there were no longer any exam centres in Ireland.

The schools have advised that the new course would be rolled out to a further eight locations throughout the country in due course. The Association will liaise with the schools to see if local courses can link in with the new national programme and participants sit for the national examination.

Finally, the Dental Council has advised that revised guidelines in respect of cross infection control would be issued early in 2005, along with revised guidelines in relation to the administration of general anaesthesia and sedation. New advertising guidelines for the profession will also be produced in 2005, following criticism of current restrictions from the Competition Authority.

Aidan Browne, HSE National Director of Primary, Continuing and Community Care, is the person with overall responsibility for the public health dental service.

Mr Browne told the Journal of the Irish Dental Association that, for the short term, all current arrangements and reporting relationships in relation to public dental services will remain unchanged.

The HSE has also confirmed that dental services will be delivered in the context of primary care, and that "all future structures will be developed in consultation with relevant stakeholders".

"It is somewhat of a relief to hear that we will be consulted," said Dr O'Connor. "However, we would be more assured if planning was beyond the short-term and if it already involved the relevant stakeholders. The administrative structure being developed must be designed to meet the needs of effective clinical service delivery rather than trying to reshape a clinical service to meet the needs of an administrative structure. We are concerned that, as a result of our effective management of resources to date, due consideration may not be given to long-term goals we can and must achieve for the betterment of dental health in Ireland in the decades to come. Dental health is important."



*Kevin Kelly took on the role as the Interim Chief Executive of the new Health Service Executive in January.*



*Aidan Browne has been appointed HSE National Director of Primary, Continuing and Community Care.*

## Abolished and streamlined agencies

The Health Service Executive has confirmed that it has commenced a communications process with trade unions to "provide ongoing information in relation to general developments arising from the establishment of the HSE". In addition, as provided for in The Health Act, 2004, the abolishment and streamlining of certain specialist agencies into the HSE has begun. The agencies involved have now been integrated within the Executive's organisational structure. These include:

- The General Medical Service (Payments) Board has been abolished as a separate statutory body. Services provided by the GMS (P) Board are now delivered as part of the Shared Services Directorate. The services involved have been re-designated as the Primary Care re-imburement Service, Shared Services Directorate, HSE.
- The Health Service Employers Agency has been abolished as a separate statutory body. Services provided are now delivered as part of the Human Resource Directorate. The services involved have been re-designated as the Employers Representative Division, Human Resource Directorate, HSE.
- Comhairle na nOspideal has been abolished as a separate statutory body. The existing Comhairle members have agreed to a request from the HSE to continue, on a non-statutory basis, to provide expert advice to the HSE until December 2005.
- The Hospital Bodies Administrative Bureau has been abolished as a separate statutory body. The services provided by Comhairle na nOspideal and the HBAB now form part of the National Hospitals Office.
- The National Disease Surveillance Centre has been streamlined. Services provided are now delivered as part of the Population Health Directorate. The services involved have been re-designated as the Health Protection Surveillance Centre, Population Health Directorate, HSE.
- The Health Boards Executive (HeBE) has been abolished.
- The Office for Health Management has been streamlined. Services provided are now delivered as part of the HR Directorate or the Change Management/Organisational Development Directorate, as appropriate.

## Cork graduate takes top Canadian job

Dr Peter Cooney, a Cork dental graduate, was recently appointed as Chief Dental Officer for Health Canada.

Dr Cooney's primary responsibilities will be to increase awareness about preventing oral diseases and to improve the oral health status of Canadians, according to Health Canada online.

Health Canada's goal in creating this new position is to increase awareness of good oral habits. This will be achieved by providing evidence-based advice on oral health policy and programme development; working to ensure oral health is included in the wider health agenda; and recommending that partners in oral health work together to prevent and control oral and associated diseases.

Dr Cooney's office will also assist in gathering epidemiological information to help establish priorities for research, and will work with expert bodies at all levels of government to move these objectives forward.



*Dr Peter Cooney, a Cork dental graduate, was recently appointed as Chief Dental Officer for Health Canada.*

## The Dental Council

The Dental Council is updating its guidelines on "the administration of general anaesthesia and sedation in the practice of dentistry".

Draft new guidelines have been drawn up and these are available from the Council in hard copy or may be accessed on our website: [www.dentalcouncil.ie](http://www.dentalcouncil.ie).

Interested parties are invited to make submissions in relation to the new guidelines and such submission can be made electronically to [info@dentalcouncil.ie](mailto:info@dentalcouncil.ie) or by post to:

The Registrar, Dental Council, 57 Merrion Square, Dublin 2

The latest date for receipt of submissions is February 18, 2005.

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### GP Group Rep

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### Elected Member

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Dublin 15

## IDA Annual General Meeting

Debates on the motions tabled at the well-attended Annual General Meeting of the Irish Dental Association were of a high standard with many delegates participating and doing so in a positive fashion.

One motion proposed calling on the Minister for Health and Children to fill "as a matter of urgency, the vacancies at the office of the Chief Dental Officer" was amended to add that the reporting relationships to the Assistant Secretary General be reinstated. The proposer, Dr Jack Galvin (Kerry) reminded delegates that not only is the Chief Dental Officer post vacant but so also is the post of Deputy Chief Dental Officer. The current stance of the Department of Health and Children is that it is considering the position in the context of the restructuring of health services and the recent establishment of the Health Services Executive. Delegates agreed that it is essential that these posts are filled immediately, precisely because of the need for professional dental expertise at a time of restructuring.

Drs Edward Cotter and Frank Ormsby proposed and seconded a motion expressing concern about the "precarious situation" of the vocational training programme in dentistry. Pointing out that he is unable to tell aspiring vocational trainees whether or not places will be available, Dr Ormsby said that the uncertainty surrounding the availability of training places is unfair to new graduates. Dr Cotter warned there is a danger of the whole vocational training scheme being disbanded, despite the excellence of the training and the success it has enjoyed since its introduction only five years ago. Dr Barry Harrington, supporting the motion, noted that vocational training is obligatory in the UK. During the ensuing debate many delegates complimented Dr Ormsby for his untiring work on this training scheme. The motion was passed unanimously.

Chairman of the GP Group Committee, Dr Tom Houlihan, and Dr Padraig O'Reachtagain combined forces to propose and second two motions which will change the existing rules governing the admission of members to the Association. These will have the effect of requiring a two-third majority of Council "present and voting" to secure admission and a similar majority to refuse an application for membership.

An interesting and very positive debate followed on the proposal that the Association should "undertake a pro-active public relations campaign on an on-going basis to highlight the positive aspects of the care we provide". Expressing the opinion that care provided by members of the Association "is of the highest standard", Dr Cotter said that nevertheless, the portrayal of the profession in the media is not good. Currently, the Association's public relations tended to be reactive while the need now was for a pro-active approach planned with a strategic, steady "slow burn" approach. Continuing, Dr Cotter said the Association's greatest weapons were its members who have direct access to the public on a daily basis and that this should be harnessed as part of a strategic plan with specific goals. Warning that public relations was not to be seen as a "bottomless financial pit", he called for a two-to-five-year plan with specific goals and a review mechanism. Supporting the motion, Dr Padraig O'Reachtagain said that each member of the profession needed to become involved in this and he cited the example of the Chicago Dental Association, which organised special dental clinics that were free of charge to the less well off. Following further contributions from Drs



*Dr Michael Galvin, IDA Vice-President, greets Dr Gerry McCarthy, President of the IDA.*

Bernard Murphy, Eamon Croke, Pat Cleary, Jack Galvin and Tom Houlihan, the motion was put to the floor and carried unanimously.

### New President inaugurated

Dr Gerry McCarthy, Kenmare, was elected President of the Irish Dental Association at the Association's Annual General Meeting held recently in Jury's Hotel, Dublin.

A native of Mitchelstown, Co Cork, Dr McCarthy qualified from UCC in 1982. He joined a general practice in England before returning to work in Public Health in Clare and Mayo and subsequently set up his own family practice in Kenmare during 1990.

A former member and Chairman of the South and Midwest Region Committee of the Postgraduate Medical and Dental Board, Dr McCarthy is a past President of the Kerry Branch of the IDA and was National Honorary Secretary before being elected President.

In his inaugural address, Dr McCarthy described the Association as: "An integral part of the community, depending on the voluntary contributions of its members and organising scientific meetings and courses to continue improving standards." Continuing, Dr McCarthy said that: "Ultimately it is our patients - the community - who benefit." Paying tribute to the Postgraduate Medical and Dental Board he said that he hoped that the reorganisation of health services would result in the Board being able to continue "complimenting and facilitating the educational activities of the Association and the two dental schools". Dr McCarthy went on to call for a "modern set of guidelines" for dentists advertising.

### Other officers elected at the AGM were:

President Elect	Dr R G Cleary, Dublin
Vice President	Dr Michael Galvin, Limerick
Honorary Secretary	Dr Roger Grufferty, Dublin
Honorary Treasurer	Dr Gary Boyle, Dublin
Honorary Secretary Designate	Dr Bernard Murphy, Carlow

**Staff exemplary and professional: Atkins**

In his report to the AGM, IDA Secretary General, Donal Atkins, referred to a raid on the IDA offices by a large team of investigators and Gardaí attached to the Competition Authority in October, 2004, and paid tribute to the staff who, he said, "although somewhat traumatised by the nature of the raid" and in some shock, "behaved in an exemplary and professional manner throughout".

The raid was authorised by a search warrant and, Mr Atkins was informed, "focused on matters related to VHI DeCare". After a number of hours' searching through filing cabinets, desks, etc., a number of notebooks, files, diaries and computer records were taken away.

Pointing out that the Authority officials were merely doing their job, Mr Atkins felt that "the confident belief that no deliberate breach of legislation" had occurred allowed him to facilitate the officials as requested.

Continuing, Mr Atkins said that he was not in a position to confirm who lodged the complaint but he found it "ironic" given that the dental profession is more competitive than any other profession in Ireland. There are, he said, no restrictions on entry to the profession (other than those imposed by educational authorities), no restrictions on practising dentistry or on participating in any state scheme and there is no price setting – not even fee guidelines. Also, there has been considerable growth in the numbers practising in Ireland over the past decade and there is freedom of movement for dentists from EU Member States.

Earlier, Mr Atkins had referred to the independent chairman's report on the review of the Department of Social and Family Affairs Dental Scheme. The chairman had observed that: "The review, while useful in identifying issues which the parties wished to progress took place too soon after difficult negotiations to result in many additional changes being mutually accepted." However, the chairman had highlighted both sides' agreement and commitment to the introduction of a new formula for annual fee increases, which would take account of increased costs specific to the practice of dentistry as well as consumer price indices, etc. Mr Atkins told the AGM that the GP Group's Negotiating Team is currently working on this issue.

**Dental treatment services**

Commenting on the Dental Treatment Services Scheme, Mr Atkins pointed out that "Ten years on, the scheme remains without adequate controls and without adequate probity measures." Approximately €50m of taxpayers money is being spent without anything more than minimal probity assurance arrangements in place. "Any further delay in appointing examining dentists and commencing a review of the scheme will lead to the very integrity of the scheme collapsing," Mr Atkins predicted. However, he pointed out that a few weeks previously, much progress had been made with the remuneration for examining dentists now agreed and only some relatively minor points in the documentation requiring finalisation. Once this is completed, it was agreed that the review would commence on January 18, 2005.

**Health service reforms**

Complimenting the Health Board Dental Surgeons Group Committee on its activities throughout the year, the Secretary General noted that the

Group is monitoring developments in the major re-structuring of the health services. He expressed concern at the absence of detailed information about alternative arrangements and said that this did not convey "a sense of duty of care to thousands of hard-pressed committed healthcare workers."



*Dr Roger Grufferty, Honorary Secretary; and Dr Paul O'Reilly, outgoing Honorary Treasurer.*

**Putting patients' welfare first**

Reminding delegates at the AGM that they must never forget that the appropriate professional relationship with patients is that "they are involved in treatment planning with you and neither party can delegate this right to a third party", Mr Atkins said: "Nothing excuses a professional dental surgeon from the ethical duty to put patients' welfare first." Finally, Mr Atkins predicted that the availability of disposable income combined with the general public's ever increasing awareness of the importance of good health "will ensure that the business element of your professional work will remain strong and you may look forward to a good 2005".

**Dr Michael Galvin's valedictory address**

Addressing delegates attending the AGM, outgoing President, Dr Michael Galvin, said that, as he travelled the country meeting members and listening to their "traumas in life, trouble with children, serious illness, battles with cancer and even death in their families", he was learning to prioritise what was truly important.

Noting that what had happened throughout the year was well recorded in the Annual Report, Dr Galvin highlighted the exceptionally busy year experienced by the GP Committee under the chairmanship of Dr Tom Houlihan; the success of the HBDS Seminar organised by the President of the Group, Dr Maeve O'Connor; the growth in membership; the revamped Journal; and the roles played by each individual officer.

Dr Galvin went on to record his appreciation of the Secretariat before noting the "dignity in which the office of President is held, throughout the profession" and thanking members for making him "feel at home" when he felt he "should be at home!"



*Dr Bernard Murphy, Honorary Secretary Designate, addresses attendees at the Irish Dental Association AGM.*

## EU Directive challenged

The EU Commission has proposed a draft Directive on Services in the Internal Market, which it feels would tackle obstacles hindering the freedom to provide services and freedom of establishment.

However, the EU Dental Liaison Committee (DLC) is concerned about the directive's impact on health professions. As a result, the DLC has adopted a resolution to lobby to have either health professions excluded from the directive or to try to obtain an exemption from the country of origin principle.

It appears that the European Parliament would be favourable towards an exemption from the country of origin principle and that many of DLC's suggestions would be taken into account.

These suggestions include:

1. harmonisation of legal provisions;
2. clear definitions, e.g., temporary cross-border activity or permanent cross-border activity in another country;
3. strengthening of professional surveillance;
4. cancellation of the country of origin principle;
5. a normal way of functioning with a harmonisation of the standards throughout the community; and,
6. a clear definition of the single contact point. It must be an organism enabling the person who exercises a liberal profession to get all the information required on one place in an intelligent manner and in a way enabling him/her to avoid unnecessary paperwork.

### Could the dental profession be affected by EU competition rules?

Secretariat lawyer, Mark Beamish, made a presentation on European competition policy recently to the DLC.

In his address, he mentioned the significance of the Heads of Government's declaration of their goal "to make the EU the most competitive and dynamic knowledge-based economy in the world by 2010".

In its report on competition in professional services (known as 'the Monti Report') the EU Commission was seeking to encourage reform and modernisation of restrictive professional rules, focussing on such things as fixed and recommended prices, advertising restrictions and exclusive rights. Furthermore, the European Court of Justice (ECJ) has delivered a number of judgments in this area that show a readiness to apply competition law to the liberal professions just as they would be applied to commercial enterprises.

It has been said that Article 81 of the EC Treaty is the means whereby rules of the dental profession could be attacked as anti-competitive.

The Monti report calls on national bodies to examine their own regulations to see if they are anti-competitive. If they are, they have either to justify their rightfulness or amend them. In short, five main practices are questioned by the Commission in the case of dentistry:

- 1) fixed and recommended prices;
- 2) advertisement restrictions;
- 3) restrictions to the practice dentistry;
- 4) reserved tasks; and,
- 5) business structure regulations.



## White Paper on services

Two sections of the EU White Paper on Services are of particular interest to the medical professions.

Section 3.7 recognises the specificities of healthcare professions and admits that the social and cultural diversities must be acknowledged.

Section 4.4 recognises that a special class should be created for healthcare services and announces that a Communication on services should be published in 2005, which would be followed either by a Green Paper or by a Directive.

The DLC President said that the Committee's work on the White Paper should, among other things, aim to avoid the limitation of dentists' scope of activity by emerging auxiliary professionals.

## Migration fears unfounded

A workshop was held in Prague late last year involving dental professionals from several EU countries, including the newly acceded states. Some delegates had observed that, six months after the EU enlargement, the concerns about migration of dentists to old EU countries had not materialised and that no dramatic changes had taken place in the economic situation of dental offices in the new member countries.

## Recognition of professional qualifications

The DLC will continue to exert lobbying pressure in the run up to the second reading of the EU Commission's proposed draft Directive on the Recognition of Professional Qualifications.

## Infection control and waste management

The results of a questionnaire dealing with major developments in the field of infection control and waste management reveal that, across the EU, there was already a certain harmonisation in some fields such as the sterilisation methods or waste storage and treatment, but that harmonisation was lacking in some others such as liquid wastes.

## Around the EU



### Germany

A revised professional code of conduct is expected to be introduced shortly. Several national health reforms are underway, including false teeth being covered again by public insurance; patients paying €10 for a first visit to the dentist every quarter to avoid "doctor-hopping"; and that continuing education will become legally required of dentists.



### Estonian

The Estonian Dental Association and Estonian Society of Stomatology have merged. In relation to EU enlargement, concern that many dentists would emigrate proved unfounded. Of those who have left, most have gone to the UK.



### Greece

There is concern over the granting of licences to holders (mostly Greek citizens) of dental qualifications from new member states. On the issue of competition in the dental profession, the Hellenic Dental Association explained its opposition to the suggestion that minimum recommended fees hinder free competition.



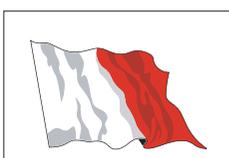
### Hungary

The Hungarian Dental Association reports that the CE programme for dentists is now fully operational. The HDA also reports that dental hygienists' training, which is a two-year, post-secondary training programme, is progressing successfully.



### Malta

The Maltese Dental Association has been lobbying against the severity of the Health Professions Act, which prevents general dental practitioners from doing specialist work and prevents specialists practising another branch of dentistry. Life-long education is being encouraged by the association through its continuing education programme. Dentists are also being encouraged to obtain professional indemnity insurance.



### Holland

On January 1, 2006, a new Health Care Insurance Act will come into force in Holland. It provides for compulsory basic insurance for all citizens. Additional insurance will be available from private insurance companies who will enter into contracts with dentists. It is hoped that this will introduce an effective system of 'regulated competition'. Also there are moves towards re-allocating certain tasks currently reserved to dentists to dental hygienists.



### Sweden

Prices for patients have increased by up to 125 per cent. However, the Swedish Dental Association asserts that these statistics ignore the fact that price increases were necessary as a result of under-financing of dental care. In education there is an interesting project underway: "the Tree of Knowledge" is a CE course for the entire dental care team. A quality register on dental implants is also being compiled.



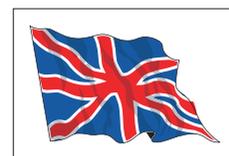
### Slovakia

A three-year Bachelor's course has been introduced, with a further two years being necessary at an "institute study school". The laws on healthcare providers and on medical insurance have been updated. The law has also changed so that membership of the Chamber of Dentists is now voluntary, whereas it was previously mandatory. A reversal of this decision is being sought.



### UK

In England and Wales, agreement is expected on proposals to make changes to how primary dental care is delivered. These changes will affect how dentists are paid, how their activity is measured and will change dentists' contractual relationship with the NHS. The Government has announced new funding for dentistry and increases in university places, given that the UK has a shortfall of full-time dentists. Primary care trusts are looking to continental Europe and beyond to entice dentists to practice in the UK. The BDA has also launched a new website incorporating a 3D mouth, specifically aimed at schools as well as dental practices for patient education purposes. [www.3dmouth.org](http://www.3dmouth.org).



business news

### Reducing plaque and gingivitis

A recent clinical study has shown that rinsing with Listerine antiseptic mouthwash as an adjunct provides an incremental 52 per cent greater plaque and 21 per cent greater gingivitis reduction over brushing alone. The study, 'Efficacy of a Brush, Floss, Listerine Antiseptic Regimen Compared With Brushing and Flossing Alone', compared the efficacy of a brush, floss, rinse regimen with that of brushing and flossing alone in reducing interproximal and whole mouth plaque and gingivitis.

"The results of this study demonstrate that the level of efficacy for the control of gingivitis that is produced by brushing and rinsing with Listerine mouthrinse is at least as good as that provided by brushing and flossing", says Dr Anne O'Donoghue of the Beacon Dental Clinic. "For several reasons, many people have difficulty with the mechanical removal of plaque, so dental professionals should consider recommending a brush, floss and rinse regimen to their patients, especially when their patients demonstrate that brushing and flossing alone are not enough to maintain gingival health."

### Techceram promotes Cojet

Techceram now promotes Cojet, which is designed to help create stronger, longer lasting bonds between all-ceramic restorations and composite luting cements. Distribution of Cojet further extends Techceram's portfolio of non-metallic restorative expertise and the company hopes it will play a key role in the development of all-ceramic restorations, particularly veneers.



### Orbit receives FDI World Dental Federation recognition

Wrigley Oral Healthcare in Action has announced that its range of Orbit sugarfree chewing gum has been recognised by the FDI World Dental Federation (Fédération Dentaire Internationale).

As a result, the FDI logo will now appear on packs of Orbit. As the independent, worldwide voice of dentistry, the FDI exists to contribute to the development and dissemination of policies, standards and information related to all aspects of oral care around the world.

Jo Hartop, Head of Communications at The Wrigley Company said: "The Wrigley Company is delighted that the chewing of sugarfree gum such as Orbit has been recognised by the FDI World Dental Federation, confirming the fact that Orbit sugarfree chewing gum can benefit patients around the world. Orbit sugarfree gum has been proven to help reduce tooth decay by up to 40 per cent and now the FDI recognition should give dental professionals even more reason to recommend Orbit sugarfree gum as part of their patients' daily oral healthcare routines."

### Orbit Professional White launched

The Wrigley Company has launched a new sugarfree pellet chewing gum, Orbit Professional White with sodium bicarbonate (Bi-White), which has replaced Orbit Ice White pellets.



Tooth whitening Orbit Professional has been launched in Ireland.

The launch is in response to growing public demand for tooth whitening products. Orbit Professional White provides all the oral care benefits traditionally associated with chewing sugarfree gum, but thanks to its unique formula, it also helps to reduce tooth stains and keep teeth naturally white.

### Dental guidelines report

A new report resource has been launched for reviewing requests for head and neck oral surgery and dental tests and procedures. The information, policies, procedures, forms and other tools that are contained in the report are aimed at increasing efficiency through a quality-based, cost-effective and focused review and authorisation strategy. For a complete index of this report, which costs €70 click on [www.researchandmarkets.com/reports/c11870](http://www.researchandmarkets.com/reports/c11870).

### Appointments

#### Colgate

GRAINNE TEEFY

Grainne Teefy has joined Colgate Ireland as a Dental Detailer. Grainne has a strong dental background having qualified as a dental nurse from the Dublin Dental Hospital and has also worked in the dental sales area. Grainne will be responsible for visiting dental practices nationwide and will be detailing Colgate's oral care brands.



#### Oral B

GRAINNE O'GORMAN

Oral-B has recently appointed Grainne O'Gorman as its territory manager for Ireland. Grainne intends to build on the strong links Oral-B has with the profession and will be the main contact in Ireland for the company. Grainne will be offering practices the opportunity to participate in Oral-B's lunch and learn sessions. She is also happy to provide assistance with merchandising and recommendation tools for Oral-B products.



### Treating chronic periodontal disease

General Medical has launched the Helbo Antimicrobial Photodynamic Therapy System, which is designed to provide effective long-term treatment of chronic periodontal disease. The system combines a photodynamic dye with laser technology, which destroys pathogenic bacteria in the biofilm. This shifts the balance between anaerobic pathogenic bacteria and aerobic healthy bacteria in favour of a healthy, pain free periodontal status. Consequently it delivers a long-term solution to chronic periodontal conditions, including AUG and ANUG, as well as peri-implantitis.



### New BDTA website

The British Dental Trade Association (BDTA) has launched its re-designed website [www.bdta.org.uk](http://www.bdta.org.uk). The enhanced editorial and picture content is set to make the website more informative and the reorganisation of the content is designed to make the site more user friendly to both the trade and the profession.



### Endodontic catalogue hits the shelves

QED catalogue. Bigger than any of its predecessors, it details the complete range of endodontic instruments and accessories. Featured in the catalogue are the company's new pre-sterilised K and H Type SteriFiles in individual blister packs. Sterilised by gamma irradiation, which enables them to be used straight from the packet, SteriFiles reduce the risk of "stick" injuries, cut costs and save a considerable amount of time.



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## The President speaks

Dr Gerry McCarthy, President of the Irish Dental Association, speaks to Daniel Attwood about his hopes for the year ahead, his frustrations over the continuing impasse over the DTSS scheme and his plans to relax and leave it all behind.



As a dentist in private practice, Gerry McCarthy may be typical of many in the dental profession, but what sets him apart is his willingness to make himself available to the association at various levels over the last number of years.

The benefits of being a member of the IDA are manifold he says, including policy and fee/salary negotiations, individual representation, representation at EU level, regular continuing education courses, credit union facilities and access to many social events, and this means the cost of membership is more than offset by these benefits. But there is more to membership of the IDA than the benefits listed, as Gerry explains. "The greatest benefit I have had is the friendship and support I receive from colleagues. Sure we compete with each other for patients, work, career and so on but the truth is we, as colleagues, have more in common than anyone else. Nobody understands better that hollow feeling you get when your waiting room is full and that tooth your extracting snaps, or the elation when you fit that perfect crown or bridge." Camaraderie aside, the IDA also plays a vital role in representing the profession. "It is incredibly important that we have a single voice when it comes to negotiations for the two Government schemes. Our negotiators give of their time freely and deserve our support. The Association represents us and lobbies for our interests. Membership provides the profession with this opportunity," says the President. "I worked in the public dental service for five years in County Clare and northwest Mayo. The Association is as relevant to people working in the public service as it is to any one in private practice. The achievements of our team in the recent benchmarking process were outstanding.

"Branch meetings offer the opportunity to interact and discuss issues, which is

particularly important for people like me who are practicing, often alone, in rural Ireland.

"Our Association is an integral part of the community. It depends for its lifeblood on the voluntary contributions of its active members whether it be at branch, sub-committee or council level," he explains. "The IDA, through branch meetings and courses, improves standards and, ultimately, it is our patients who benefit and therefore the wider community."

So was it this vision of being part of a profession that benefits the greater community that motivated a dentist in private practice in rural south west Ireland to become the President of the IDA?

"I always felt that one of the problems with our job is that we work on our own, especially those like me who are working in rural communities. I have always felt that we need to engage each other both for support and also to have a strong representative voice."

This uniting approach soon saw Gerry elected as President of the Kerry Branch of the IDA. From there, it was a progressive step to the position of Honorary Secretary of the national body. When it then became Kerry's year to elect a President, Gerry was the obvious choice.

Gerry is aware that he cannot become involved in every issue. "One can't take an active role in all aspects of issues affecting the profession," he explains. "The IDA, and indeed the profession, is fortunate to have various committees and sub-committees made up of experts who are well capable of taking care of their particular areas. People may often approach me about certain issues, but I know that the structures are in place to deal with them."

The main issue for the profession at the moment is the DTSS. "We're having great difficulties is finding a resolution to two main problems. The Department has delayed the

introduction of examining dentists and have thus delayed the review of the DTSS, which was due in the year 2000. If the Department officials would engage positively with our negotiators we could all move forward for the benefit of contracting dentists and more importantly our patients."

There is also a wider, but no less pressing, issue causing the President concern. "It is the perception of dentists that is continually reinforced by the media. We are a small profession and our services are, by their labour-intensive, hands-on nature, expensive. This makes us an easy target," explains Gerry. "This is a perception that makes me very uncomfortable. We are not a greedy profession but we are small and that makes us easy to pick on."

But the profession is not allowing this perception to go unchallenged. "There is a movement within the IDA to engage a public relations company in an attempt to improve the situation."

Gerry is also taking an active role in the review of the IDA that is being carried out by PriceWaterhouseCoopers. "This review is all about finding out where we are and where we are going as an organisation," explains the President. "If we see these things dealt with effectively, we will have achieved a lot in the year."

In addition, Gerry must also perform the official Presidential roles, such as chairing meetings and representing the IDA at functions, as well as one other critical role that every President of the IDA fulfils: organising the Annual Scientific Conference, which, this year, will be held in Killarney over the weekend of April 14-17.

"I will do my best to ensure we have as successful a conference as

possible," he explains. But the substantial responsibility that comes with organising the conference does not all fall at the President's feet. "Thankfully I have an excellent committee to rely on for the actual organisation. Pat Cleary very kindly is chairing the conference committee and all members of that committee have made huge contributions."

So, with a President in private practice, can delegates expect a conference that is mainly of interest to that field of dentistry?

"Of course it will be of interest to private practitioners," says Gerry. "However, it isn't geared solely towards private dentists. We looked at the programme of one of the world's biggest dental conferences and used that as a template for planning our range of topics and speakers. As a result, we have huge spread of topics, such as aesthetics, composites, implants crown and bridge, practice design and management, the anxious child, oral health and systemic diseases and much more.

"There's something of interest to everyone in the profession, from academics right through to trainee nurses."

The conference promises to be one to remember and should reflect Gerry's relaxed yet professional attitude.

This is an attitude that seems to go hand-in-hand with dentistry and is one that has clearly stood the President well since he commenced private practice in Kenmare.

But dentistry was not always the top of Gerry's aspirations. "Most of the time the job is rewarding," he says. "However, as with every job, there are days when I would prefer to be laying on a beach."

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# AIDS: the attitudes and experience of final year European dental students

## Keywords

AIDS; HIV; ARC; suspect; dental student; dentist; attitudes; behaviours; willingness to treat; ability to treat; treatment; referral; HIV testing; transmission; education

## Introduction

Previous studies have shown that many dentists worldwide are reluctant to treat patients infected with the HIV virus.<sup>1,2,3</sup> In some cases, dentists are refusing to care for patients who have AIDS; AIDS-related complex (ARC) or those who are at risk of contracting the disease.<sup>4</sup> The reluctance of dentists to treat these patients is a cause for concern because oral manifestations of HIV and AIDS are common and dentists can utilise their diagnostic and therapeutic skills in caring for these individuals.<sup>5,6</sup> Little is known about the attitudes and behaviours of dental students in relation to AIDS in their future careers. It is often assumed that, because newly qualifying dentists are more educated in regard to HIV, that this will be reflected in their attitudes and in their willingness to treat these patients. The purpose of this study is to evaluate final year dental students on their attitudes toward patients with HIV/ARC/AIDS/suspect cases, their undergraduate experience in this area, and how they would manage HIV related issues (patient, staff, themselves) in their future careers as qualified dentists. In addition, the survey evaluated dental students' concerns and identified their educational needs in relation to this area.

## Materials and methods

A questionnaire (see page 20) was developed and distributed to various dental schools in Europe. Permission was requested from the Dean of each school for final year students to participate in the project. The survey was conducted anonymously with assurance of confidentiality.

## The questionnaire evaluated

Students' attitudes to HIV and related infection

- if students in their future careers as dentists would treat suspected HIV patients, HIV patients, ARC patients, and/or AIDS patients in the various disciplines of dentistry;
- if students felt they were sufficiently educated with regard to HIV and AIDS; and,
- issues related to infection of the dentist and or a member of staff (employment, declaration to the appropriate authorities etc).

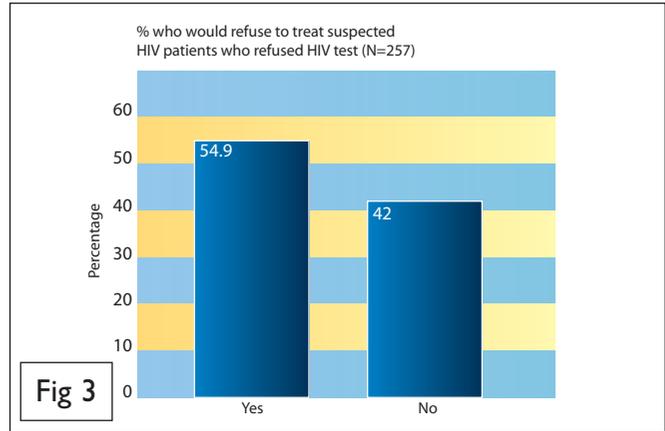
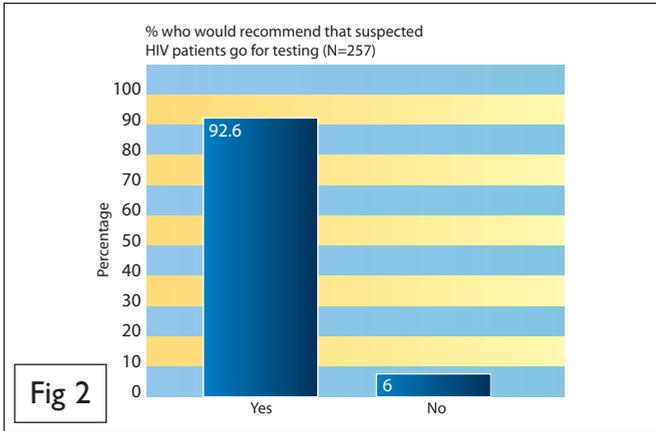
## Results

Two-hundred-and-fifty-seven dental students from a total of 11 dental schools responded, giving an average response rate of 55 per cent (**Table 1**).

Fifty-one per cent of the respondents were female; 47 per cent were male (five respondents did not specify gender).

Table 1	Name of school, country	No. of students surveyed	No. of respondents	% responses
	Cork, Ireland	26	25	96.2
	Dublin, Ireland	31	18	58
	Belfast, Britain	28	28	100
	Oslo, Norway	40	30	75
	Helsinki, Finland	100	7	7
	Gotenborg, Sweden	68	39	57.4
	Umea, Sweden	48	32	66.7
	Leuven, Belgium	55	22	40
	Ghent, Belgium	16	15	93.8
	Nijmegen, Netherlands	25	21	84
	Porto, Portugal	30	20	66.7
<b>Total</b>	<b>11 schools</b>	<b>467</b>	<b>257</b>	<b>55%</b>

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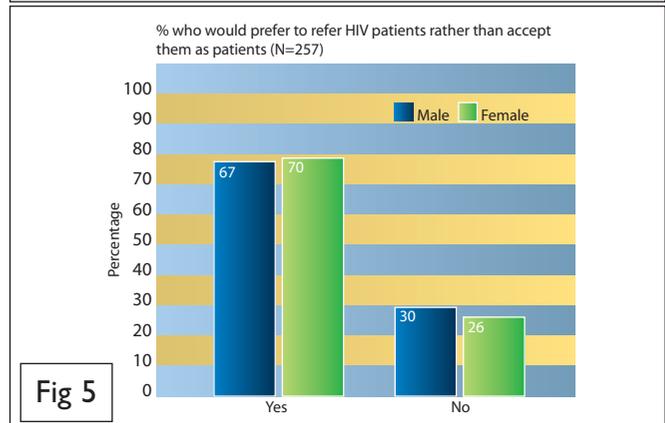
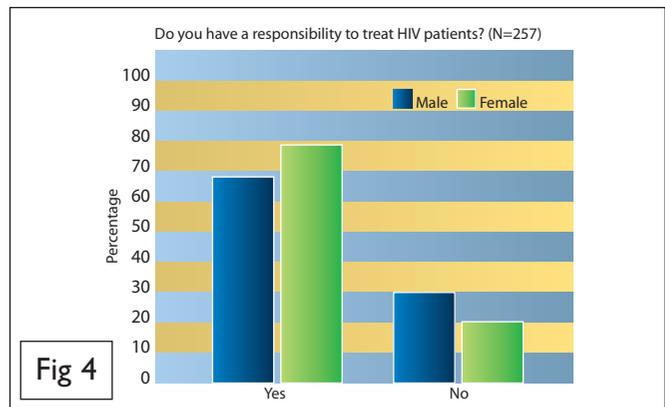
**The questionnaire** (shortened for publication)

- ▶ As a qualified dentist would you recommend that suspected HIV patients go for HIV testing?  Y/N
  - ▶ Would you treat a patient for general procedures in the following cases:
    - Suspected cases of HIV infection?  Y/N
    - HIV positive patients?  Y/N
    - AIDS related Complex?  Y/N
    - AIDS diagnosed?  Y/N
  - ▶ If a patient refused testing, would you refuse to treat him/her?  Y/N
  - ▶ Do you think you have a responsibility to treat HIV patients?  Y/N
  - ▶ Given a choice would you prefer not to treat HIV patients?  Y/N
- Indicate the risk to yourself of contracting the HIV virus in a dental capacity
- low
- moderate
- high
- none
- ▶ Would you prefer to refer HIV patients?  Y/N
  - ▶ Do you know when to refer patients with AIDS to physicians for medical (non-dental) problems?  Y/N
  - ▶ Do you think that you have the skills to treat the oral manifestations of HIV infection?  Y/N
  - ▶ Have you seen a HIV/AIDS patients in the dental surgery?  Y/N
  - ▶ Have you ever treated a HIV/AIDS patient?  Y/N
  - ▶ Do you think that you have been sufficiently educated with regard to HIV and AIDS?  Y/N
  - ▶ If one of your staff was diagnosed infected with the HIV virus, would you continue to employ that person?  Y/N
  - ▶ In the event that you became infected with the HIV virus, would you continue to practice and/or declare your HIV infection to the dental authorities if doing so meant that you could no longer practice dentistry?  Y/N
- State if you are male or female.

The majority of students (92 per cent) claimed they would recommend that suspected HIV patients should go for HIV testing (**Fig 2**). Fifty-five per cent of students reported they would refuse treatment to a suspected HIV patient if the patient refused the recommended HIV test, whereas 42 per cent would provide care regardless (**Fig 3**). A greater number of males (58 per cent) were inclined to refuse treatment when compared with females (50 per cent).

The majority of students (72 per cent) reported that they had a responsibility to treat HIV patients. Some students (25 per cent) felt that they did not have a responsibility in this regard. More females believed they had a responsibility to treat HIV patients (78 per cent) when compared with males (67 per cent) (**Fig 4**).

Given the choice, most indicated that they would prefer not to treat HIV



patients in their careers as dentists (79 per cent) and 68.5 per cent claimed they would prefer to refer HIV patients rather than accept them as patients (Fig 5).

Provision of dental care

The students reported that they would be more likely to treat the different categories of patients (HIV, ARC, AIDS, those at risk ) in conservative dentistry and least likely in minor oral surgical procedures (Fig 6).

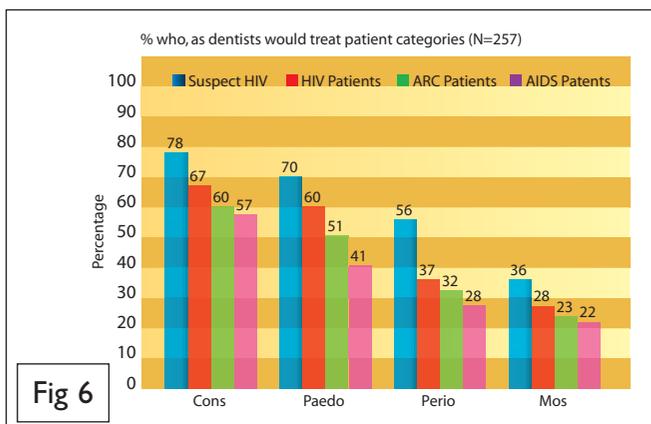


Fig 6

For any procedure, it is noted that, as the disease progresses through its stages of HIV, Aids Related Complex (ARC) and AIDS, these future dentists report a greater reluctance to treat the patient. While 78 per cent of respondents claimed they would treat a suspected HIV patient for conservative dental treatment, only 36 per cent claimed they would treat the same patient in a minor oral surgery procedure and 56 per cent would treat this patient for periodontal treatment. However, if the patient had been diagnosed as having AIDS, then only 57 per cent of the future dentists surveyed would provide conservative treatment; 21 per cent would provide minor oral surgery treatment and 28 per cent would provide periodontal treatment.

Knowledge and clinical ability

In response to the perceived risk of themselves, as dentists, contracting the HIV virus in a dental capacity (Fig 7), under half of the respondents

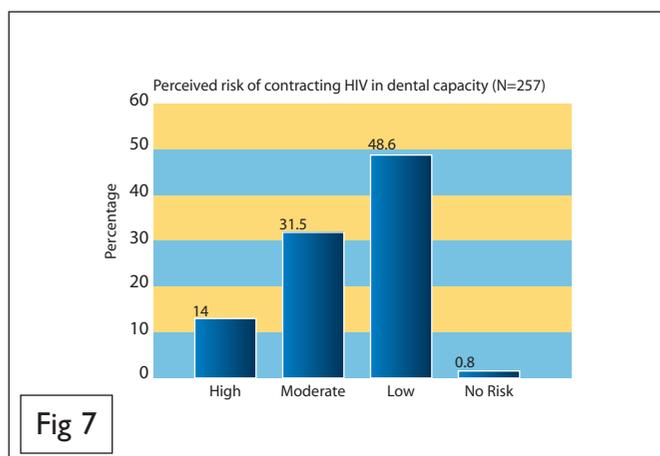


Fig 7

(48.6 per cent) perceived this risk to be low, 31.5 per cent estimated this risk to be moderate, while a minority of 36 students (14 per cent) thought it to be high. Only two students (0.8 per cent) claimed that there was no risk involved.

Many students (45 per cent) indicated that they did not know when to refer patients with AIDS to physicians for medical (non-dental) problems. Almost three-quarters of respondents claimed that they had not the skills to treat the oral manifestations of HIV infection (74.3 per cent).

Seventy-five per cent of students had not seen a HIV/AIDS patient in a dental setting, whereas 59 students (23 per cent) had.

Almost all (93.4 per cent) of students had never, to their knowledge, treated a HIV/AIDS patient. Only 14 students had treated a HIV or AIDS patient. The majority felt that they had not been sufficiently educated with regard to HIV and AIDS (63.4 per cent) (Fig 8).

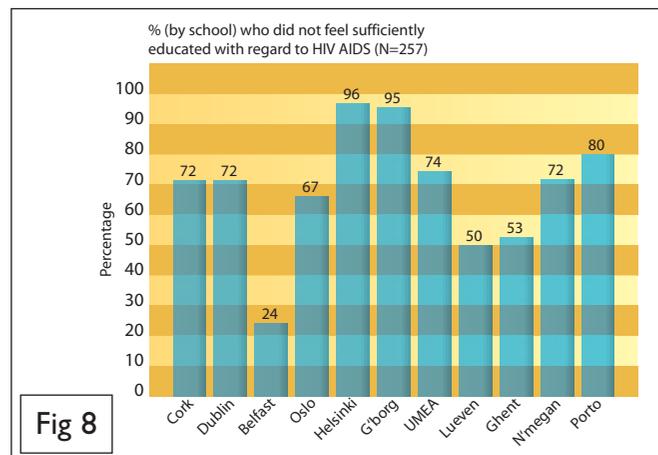


Fig 8

HIV infection in the dental team

Almost half (49 per cent) of the respondents claimed that they would not continue to employ a staff member who had become infected with HIV. There was no significant difference between males and females in this regard. In the event of contracting HIV themselves, 39.7 per cent would continue practicing dentistry, whereas 56 per cent would not continue. More females claimed they would not practice (63 per cent) when compared with males (50 per cent). Surprisingly, three-quarters of respondents would declare their HIV infection to the dental authorities even if this meant that they would no longer practice dentistry (75.5 per cent).

Discussion

The results of the survey raise a number of important issues about the attitudes of future European dentists to patients with HIV-related illnesses, and their ability or willingness to treat this group of patients. Most students had never knowingly treated an AIDS patient and most did not feel sufficiently educated with regard to HIV and AIDS.

Student knowledge

Students showed deficiencies in their knowledge about AIDS given that many do not know when to refer AIDS patients to physicians for medical (non-dental) problems, and nearly half of the students

thought there was a moderate or high risk of contracting the virus in an occupational capacity. The other half (48.6 per cent) perceived the risk to be low which in agreement with expert opinion.<sup>7,8</sup>

These findings are significant because a previous study by Gibson et al supported the view that dentists were able to use their scientific knowledge to reduce anxieties and assist in the resolution of their conflict with regard to treatment of HIV patients.<sup>9</sup>

#### Responsibility to patients with HIV

Although students admit to having a responsibility to treat HIV patients in their future careers, most would refer HIV patients rather than accept them as patients. Similar findings were reported by Gerbert in a survey of Californian dentists published in 1987.<sup>1</sup> There appears to be an inconsistency in that most respondents (92 per cent) would recommend that suspected HIV patients go for HIV testing, but only 55 per cent would provide treatment if they refused this test, this despite their admitted responsibility to treating HIV patients.

New guidelines on Infection Control Practice in Dentistry have been published by the Dental Council in November 2004 and are available online at <http://www.dentalcouncil.ie>.<sup>10</sup>

These guidelines update previously published advice on the practical measures needed to control cross-infection<sup>11,12</sup> and clearly define Irish dentists responsibilities in this area. Specifically, the guidelines state that a dentist or dental hygienist has an obligation to provide care to those in need. A decision not to provide treatment to an individual because he or she has AIDS or is HIV seropositive, Hepatitis B or C seropositive, based solely on that fact is unethical. It is also illogical since undiagnosed carriers of infectious diseases pass undetected through practices every day. Current evidence indicates that if recommended procedures (universal precautions) are followed and accidental inoculation by sharps is avoided, there is minimum risk of transmission of serious infectious diseases.<sup>10</sup> Refusal to treat a patient who was a carrier of a blood borne virus is potentially an issue of professional misconduct both in Ireland or the UK. A dentist could be sued if a patient was able to establish that the dentist was in breach of contract or failed in his duty of care, particularly if the basis of that failure was one of discrimination.

The fact that many students claim that they will not treat suspected HIV cases, HIV patients, patients with Aids Related Complex (ARC) and AIDS patients whatever the dental procedure is worrying both to the dental profession and to the infected patients. Although the majority would treat patients for conservative and prosthodontic treatment, very few claim that they would provide treatment for patients requiring minor oral surgery or periodontal procedures. One could assume that patients would be reluctant to disclose their HIV status if it meant they were unlikely to receive treatment from that dentist.

#### Issues relating to infection of dentists and staff

The dental authorities may be reassured to learn that three-quarters of the respondents claim that they would declare their HIV infection even if this meant that they would no longer be allowed practice dentistry. A minority would continue to practice if they become infected. However, the Irish guidelines state that it is the ethical responsibility of dentists, hygienists and dental nurses who believe that they may have been infected with HIV or other blood-borne viruses to obtain medical advice, including any necessary testing. If found to be infected they must place themselves under specialist medical

care, which would include counselling in respect of any appropriate changes in the healthcare worker's practice which would be in the best interest of protecting their patients. It is their duty to act upon the advice given which may include the modification or cessation of the practice of dentistry. The exclusion of exposure prone procedures would be warranted in the case of HIV or Hepatitis C. In addition, dentists who fail to obtain appropriate medical advice or fail to act upon that advice, when they know or believe that they may be HIV infected, may be charged with professional misconduct.

In this survey, almost half of respondents would cease to employ a staff member who became infected. However, if a staff member was sacked simply on the basis of being a blood borne virus carrier then an issue of discrimination on the basis of their disability could arise. In that case, the staff member would have to demonstrate that being infected was a disability and that the employer's action was motivated by discrimination.

In summary, the survey suggests that European dental students would benefit from further education in this area during their undergraduate careers and in particular to their responsibilities to provide treatment to all members of the community regardless of their HIV status.

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# Parents' preference as to whether they would like to accompany their child when receiving dental treatment – results from a national survey

## Precis

In this survey, the majority of parents (67 per cent) of eight-year-old children would prefer to accompany their child when receiving dental treatment.

## Abstract

Background and design: parental accompaniment of children during dental treatment has always been a contentious issue. One of the factors that should be considered is the preference of the parents. The aim of this paper is to report the preference of parents of eight-year-old schoolchildren in Ireland in relation to accompanying their child during dental procedures and is part of the National Survey of Children's Dental Health in Ireland, which was conducted between October 2001 and June 2002. The survey had a cross sectional design and parents of children (average age 8.4 years) selected for dental examination were asked to complete a questionnaire.

## Results

3,629 completed questionnaires were obtained from parents of eight-year-old children giving a response rate of 68 per cent. Sixty-seven per cent of parents expressed a preference to accompany their child during dental treatment, while nine per cent expressed a preference not to accompany their child. The sex of the child ( $p=0.33$ ) or the fact that the parents were holders of a medical card (surrogate for disadvantage) ( $p=0.08$ ) did not affect parents' preference. However, parents of a single child had a higher preference (78 per cent) for accompanying their child than did parents with greater than one child in the family unit (66 per cent) ( $p=0.0009$ ).

## Conclusion

If given the choice, the majority of parents would prefer to accompany their child when receiving dental treatment.

## Introduction

Parents play an important role in the dental health care of their children. When attending the dentist, the presence or absence of a parent in the surgery has been contentious. Historically, dentists have favoured excluding parents during treatment as it was believed that this would reduce conflicts of authority and negative behaviour. However, some authors report that parental presence in the surgery does not appear to increase disruptive behaviour in children and may possibly increase cooperative behaviour.<sup>1,2</sup> Freeman<sup>3</sup> suggests that the mother (parent) is an integral part of child patient dental care and that the mother may in fact be the child and dentists greatest ally in terms of management.

Dentists' attitudes appear to be changing towards increased parental involvement. A survey of the attitudes of paediatric dentists in the United Kingdom towards parental accompaniment, in 2000, report that 80 per cent of the dentists surveyed were in support of parental accompaniment during treatment.<sup>4</sup>

A questionnaire survey of 79 parents in Germany reported that 66 per cent of the parents surveyed wanted to be present with their child during care, while 34 per cent did not wish to be present.<sup>5</sup> In India, a questionnaire study of 1,350 parents found that 78 per cent of parents expressed their desire to be present with their child during dental procedures.<sup>6</sup>

In May 2003, the Irish Dental Council issued guidelines in relation to this area, recommending that "a blanket ban on parents from the dental surgery is no longer sustainable or justified. On the contrary, parents must be advised of and given the right to accompany their child into the dental surgery and remain with him/her during the course of dental treatment".<sup>7</sup>

To date, no data exist in Ireland in relation to parental choice of being present or absent from the dental surgery during dental procedures. The aim of this paper is to report the preference of parents of eight-year-old schoolchildren in Ireland in relation to accompanying their child during dental treatment.

## Materials and methods

Parents of children from second class (average age 8.4 years) were randomly selected and asked to complete a questionnaire and to return it to the school with the consent form prior to their child being dentally examined. The survey had a cross sectional design. Prior to the commencement of the survey<sup>8</sup>, ethical approval was obtained and the protocol - including questionnaire was piloted. The primary sampling unit was the school and a cluster sampling technique was used with schools as the clustering unit. The following question, the results of which are published in this paper, was included in the questionnaire:

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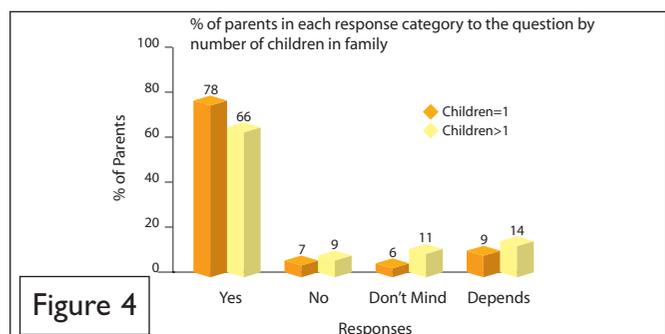
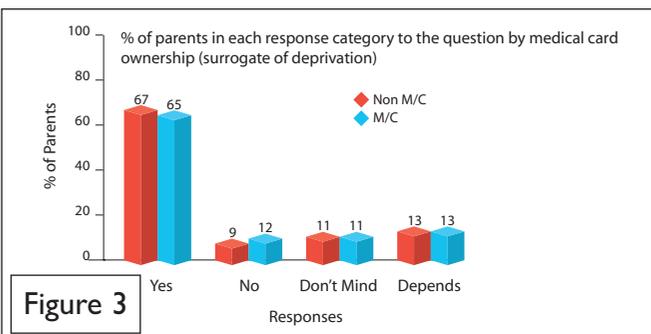
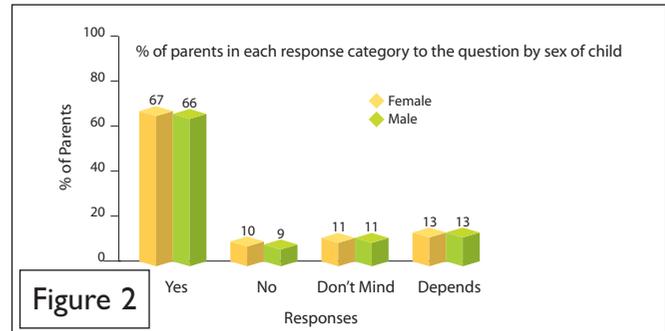
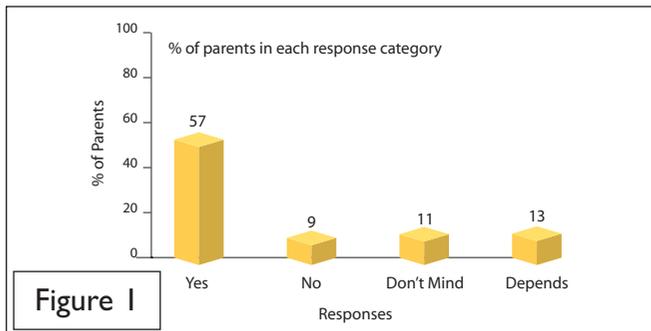
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Not all parents sit in the room with their child when the child is receiving dental treatment. Would you prefer to be in the room with your child when he/she receives treatment? Tick appropriate box.

- Yes
- No
- Don't mind
- Depends on the advice of the dentist/dental hygienist/dental nurse

In addition, information was collected in relation to the sex of the child, whether the child was a single child or had siblings and the parents' medical card status.

This study was part of the National Survey of Children's Dental Health in Ireland, which was conducted between October 2001 and June 2002.

The SAS® (Version 8.01) statistical package was used for analysis and the frequency distributions of the questionnaire responses were compared in SAS® using chi-square tests.

**Results**

Three-thousand-six-hundred-and-thirty-nine parents completed the question in relation to parents' preference of accompaniment of their child during dental treatment (response rate 68 per cent).

**Figure 1** reports the percentage of parents in each of the response categories 'Yes', 'No', 'Don't Mind' and 'Depends on the advice of the dentist/dental hygienist/dental nurse'. It was found that 67 per cent of parents surveyed expressed a preference to accompany their child during dental procedures. Only nine per cent expressed a preference not to do so. There was no difference in parents' preference whether their eight-year-old child was male (n=1,820) or female (n=1,809) (p=0.33) or whether they were holders of a medical card (p=0.08) (non M/C – non medical card holders (n=2755), M/C – medical card holder (n=839)) (**Figures 2 and 3**).

However, it was found that parents with only one child in the family (n=253) expressed a higher preference (78 per cent) for attending with the child in the dental surgery during dental treatment than parents (n=3304) with two or more children (66 per cent) (p=0.0009) (**figure 4**).

**Discussion**

This paper reports that the more than two-thirds of parents expressed a preference to accompany their child when receiving dental treatment. This is similar to findings in other countries.<sup>5,6</sup> Dentists should consider parents' views when deciding policies in relation to parental accompaniment of children during dental procedures. Because such a high percentage of parents expressed a preference for attending with their child, it would seem unwise for a dentist to have a blanket policy excluding parents during dental treatment of their child.

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## Necrotizing sialometaplasia: an important diagnosis – review of the literature and spectrum of clinical presentation

### Introduction

Necrotizing sialometaplasia was first described in 1973 by Abrams, Melrose and Howell<sup>1</sup>. A further five cases were reported the following year by Dunlap and Barker.<sup>2</sup> It is a rare, benign, variably ulcerated, inflammatory process, which is self limiting. It predominantly affects salivary tissue and usually involves the palate, although it has been reported at other oral and extra-oral sites. Recognition of the lesion is important because it may be mistaken for malignancy leading to inappropriately radical surgery. The entity is classified under "tumour-like" in the WHO Classification of tumours of the salivary glands.<sup>3</sup>

Barely 200 cases have been reported in world literature. The largest single series, comprising of a review of 69 cases, was reported by Brannon *et al* in 1991.<sup>4</sup>

Mean age of incidence is 49.8 years in men and 36.3 years in women.<sup>5</sup> The youngest reported case was in a 15-year-old.<sup>4</sup> There appears to be an increased incidence in males. Female to male ratios of 2.7:16 and 1.95:15 have been reported. Lynch *et al*<sup>6</sup> reported a preponderance in Caucasians, which was felt to be spurious, but in Brannon's series of 69 cases compared to 115 in the literature in 1991, there was a 5:1 preponderance of Caucasians over Afro-Carribeans. The disease does not respect status or rank or social class: no less a personage than a President of the United States of America may have had the disease.<sup>7</sup> Three quarters of cases affect the minor salivary glands of the palate.<sup>8</sup> Other oral sites include gingiva, lip, tongue, retro-molar pad and cheek. Necrotizing sialometaplasia has also been reported in the major salivary glands and a sub-acute variant has also been described.<sup>9</sup>

Extra-salivary sites at which the entity has been reported include the nose,

nasopharynx, larynx, trachea and lung. A similar lesion may occur in the skin and has been termed syringometaplasia<sup>10</sup>, and comparable histopathological appearances have been described in the breast following trauma.<sup>11</sup> The lesion has also been termed adenometaplasia when it occurs at extra-salivary sites.

Lesions analogous to sialometaplasia may occur spontaneously in dogs, particularly small terriers and have also been induced experimentally in rats and rabbits.

### Clinical features

Patients usually present with a rapidly growing swelling in the palate, which proceeds to ulcerate (**Figure 1**). Ulceration is not a feature of the sub-acute variant<sup>9</sup> (**Figure 2**). Clinical features in reported



Figure 1: Necrotizing sialometaplasia at the typical site. The ulceration is full-thickness, deep and there has been involvement and exposure of the underlying bone.



Figure 2: The sub-acute variant, unusually occurring bilaterally (note erythema also). Biopsy confirmed Necrotizing sialometaplasia, but the lesions did not ulcerate.

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series and meta-analyses of single cases have been reviewed.<sup>3,4,12</sup> A purulent exudate at the site of the lesion may be seen early in the evolution of the disease. Pain is a variable feature at the onset of the lesion, but may be intense and referral of the pain to the ear, eye and pharynx has been reported. Development of the lesion may, however, be painless and there are even reports of anaesthesia of the greater palatine nerve as the presenting feature<sup>12</sup>. It has been proposed that anaesthesia may be caused by involvement of the vasa nervorum in an ischaemic process. The lesions may occur synchronously, bilaterally and metachronously, but are usually unilateral. When ulceration occurs, it usually remains superficial, but full-thickness necrosis of the palate has been reported<sup>13</sup>. Healing occurs spontaneously in two to 12 weeks (**Figure 3**). Attempted treatment with intra-lesional steroids appears to confer no benefit on healing time of either the lesion or associated anaesthesia of the greater palatine nerve.<sup>12</sup>



*Figure 3: The same patient at six weeks. Spontaneous resolution well established. Complete healing occurred by three months.*

In the sub-acute variant the lesions are usually painful, ulceration is not a feature and histopathology demonstrates a sub-acute inflammatory infiltrate. However, these cases may simply represent one end of a spectrum of the disease.

The major histopathological differential diagnoses include: squamous cell carcinoma, adenocystic carcinoma, adenocarcinoma, low-grade, mucoepidermoid carcinoma and oncocytic malignancies. The clinical differential diagnoses also include: traumatic ulceration, major aphthous ulceration, syphilis, tuberculosis, deep mycosis, agranulocytosis, neutropenia, lymphoma and nicorandil-induced oral ulceration.

### **Aetiology and pathogenesis**

There is a general consensus that an ischaemic event in the salivary gland precedes the development of the lesion, although the aetiopathogenesis of Necrotizing sialometaplasia remains unknown. Ligation of the arterial supply to the major salivary glands may result in a similar histopathological appearance.<sup>14</sup> The disease has been reported in patients with sickle cell disease, where infarction may be a

feature in crisis and Buerger's disease and Raynaud's phenomenon, vasculopathies, which both predispose to ischaemia. Strong support for the cause being infarction has been offered by Batsakis and Manning.<sup>15</sup>

It has been suggested that Necrotizing sialometaplasia of the palate may represent an ulcerative or Necrotizing stage of leukokeratosis nicotina palati, although this now seems unlikely, but there is an association with smoking and alcohol.<sup>16</sup>

Direct trauma, intubation, bronchoscopy, fellatio, local anaesthetic injection, hot food and recurrent vomiting have all been reported as predisposing factors. Pressure from local space occupying lesions, an association with certain tumours, such as Warthin's tumour, Abrisokov's tumour, carcinoma of the lip, rapidly growing mesenchymal malignancy and salivary gland tumours<sup>18</sup> and local surgery have also been implicated as predisposing factors, as have addition of a vasoconstrictor to local anaesthetic solutions, local radiotherapy and cocaine use. The lesion may be more florid in pregnancy.<sup>17</sup>

There may be an association with upper respiratory tract infection within the previous few weeks, particularly acute or chronic sinusitis<sup>12</sup> and allergy has also been reported as predisposing factors. In these cases the ischaemia may be due to vasculitis secondary to immune complex deposition, similar to the proposed aetiopathogenesis of erythema multiforme or benign trigeminal sensory neuropathy.<sup>19</sup>

### **Histopathology**

Since the original description by Abrams Melrose and Howell in 1973, the histopathological features and differential diagnosis of Necrotizing sialometaplasia have been reviewed by a number of authors.<sup>18,20,21</sup>

Ischaemic lobular necrosis of sero-mucinous glands with maintenance of intact lobular architecture despite coagulative necrosis of the mucinous acini are the characteristic histopathological features<sup>1</sup>. Pale outlines of the acini are often present, with hypochromasia or absence of the nuclei. Histiocytes and granulation tissue may be seen in response to mucin extravasation. The inflammatory component is often minimal in the necrotic areas, but becomes prominent in the surrounding tissues. The diagnosis is complicated by ductal and acinar squamous metaplasia, since, to the unwary, this may mimic epithelial malignancy. Close scrutiny of the cells, however, reveals a relative lack of mitotic figures, minimal pleomorphism or hyperchromatism and benign nuclear morphology, although the diagnosis may be difficult.

Pseudoepitheliomatous hyperplasia, with thick elongated and complex rete processes of the overlying epithelium, and ductal metaplasia may resemble epithelial malignancy leading to misdiagnosis and inappropriately radical ablative surgery.<sup>7</sup> Necrotizing sialometaplasia closely resembles squamous cell carcinoma, low-grade mucoepidermoid carcinoma, adenocarcinomas and oncocytic tumours to the uninformed. The presence of specific histopathological features may depend on the age of the lesion at biopsy. Coagulative necrosis is a feature of early lesions, whereas fibrosis and squamous metaplasia are seen in older lesions.<sup>4</sup> Five stages of evolution of the lesion: infarction, sequestration, ulceration, repair and healing have been suggested by Anneroth and Hansen.<sup>16</sup>

## Management

Once a firm diagnosis has been made, the management of this condition is simply observation until the healing phase is complete and symptomatic treatment. Since the clinical and histopathological differential diagnosis includes serious disease, a biopsy is an essential component of the investigation phase and should always be performed. Microbiological culture, special histopathological stains, serology, haematological and radiological investigations may also be useful to exclude other diseases in the differential diagnosis.

Since the condition may occur de novo, after trauma or a surgical procedure or in association with another lesion, either benign or malignant<sup>22</sup>, close follow up is indicated until the healing phase is complete. Recognition of the histologic picture and the varied clinical settings in which Necrotizing sialometaplasia can be found is essential, to avoid misinterpretation of the biopsy and inappropriate, radical treatment for this benign reactive condition. With appropriate management, the prognosis is excellent.

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## Orthodontic bonded retainers

Drs Jonathan Butler and Paul Dowling review of the use of bonded retainers following orthodontic treatment and provide a guide to their maintenance and repair.

### Introduction

The objectives of this paper are to review the rationale for the use of retention following orthodontic treatment, and to describe the types of bonded retainers currently in use for this purpose. The clinical reliability and efficacy of these retainers is discussed and their impact on the oral tissues considered. The implications for oral hygiene and maintenance are noted and an account of how these appliances may be repaired in the case of failure is included.

### Abstract

Retention is usually necessary following orthodontic treatment to overcome the elastic recoil of the periodontal supporting fibres and to allow remodelling of the alveolar bone. The degree of change is variable and largely unpredictable. Bonded lingual retainers have been shown to be an effective means of retaining aligned anterior teeth in the post-treatment position in the long term.

Two basic designs of lingual bonded retainers are currently in use.

- Rigid mandibular canine-to-canine retainers are attached to the canines only. They are effective in maintaining intercanine width but less so in preventing individual tooth rotations.
- Flexible spiral wire retainers are bonded to each tooth in the segment, their flexibility allowing for physiological movement of the teeth. This design is more effective at preventing rotation of the bonded teeth.

Failure of bonded retainers may occur at the wire-composite interface, at the adhesive-enamel interface or as a stress fracture of the wire. Failure of a retainer may lead to unwanted tooth movement. In many cases it will be possible to repair the appliance in the mouth. However, in some instances it will be necessary to replace the retainer.

A disadvantage of fixed retainers is that they complicate oral hygiene procedures, and favour the accumulation of plaque and calculus. Despite this, the presence of a bonded retainer appears to cause no increase in incidence of caries or periodontal disease. Use of interdental cleaning aids is required to ensure adequate oral hygiene.

### Rationale

Retention may be defined as the holding of teeth following orthodontic treatment in the treated position for the period of time necessary for the maintenance of the result.<sup>1</sup> Retention is necessary because of the tendency for changes in tooth position to occur following completion of orthodontic treatment. This is commonly referred to as relapse, although change may be a more appropriate term, since the teeth do not necessarily return to their pre-treatment position, nor are they necessarily stable during the post-retention phase.<sup>2</sup> Decrease in the length and width of the dental arches is a normal physiological process, and occurs both in patients who have received orthodontic treatment and in untreated subjects with or without malocclusions.

This process, and its effect on the alignment of the teeth, has been extensively studied by Little and co-workers at the University of Washington.<sup>3,4</sup>

They concluded that this change in arch length and width continues well after the cessation of growth, into the fourth decade and beyond, although after 30 years of age, the constrictive trend is considerably decreased.

The degree of crowding that occurs as a result of this process is variable and unpredictable. No factors, such as type of malocclusion, length of retention phase, gender or age at start of treatment, or measurements of pre or post-treatment alignment, overjet, overbite, arch width or arch lengths appear to be of value in predicting the long-term result.

The increase in crowding is a continuous

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Figure 1: Rigid mandibular canine-to-canine retainer.



Figure 2: Mandibular flexible spiral wire (FSW) retainer.



Figure 3. FSW retainer exhibiting failure at the wire-composite interface at 43, and failure at the adhesive-enamel interface at 42.

process, although most change occurs in the first 10 years post-retention. From 10 to 20 years, deterioration may still occur but most changes will be modest.

Little et al found that 20 years after retention is discontinued, 90 per cent of patients will exhibit changes from the treated arch form that they would consider unsatisfactory.

The only way to ensure that these changes do not occur is to retain the teeth in their aligned position indefinitely.

When removable retainers are used for this purpose, the amount of wear will be out of the orthodontist's control, and long-term wear of such appliances is demanding on patients. Lack of compliance may therefore be a problem.

Lingually bonded retainers have been shown to be an effective alternative means of retaining aligned anterior teeth in their post-treatment positions, in the long term.<sup>5</sup>

### Types

Two main designs of lingual bonded retainers are currently in use:

- Rigid mandibular canine-to-canine (3-3) retainers (**Figure 1**); and,
- Flexible spiral wire (FSW) retainers (**Figure 2**).

Mandibular canine-canine retainers were first described in 1973.<sup>6</sup> This first-generation retainer was constructed from 0.028" round stainless steel wire, closely adapted to the lingual surfaces of the anterior teeth, and incorporated retentive bends or loops at either end. It was bonded to the lingual surfaces of the canines only, using the acid etch technique. This design of retainer is effective in maintaining intercanine width, but less well suited to retaining individual

rotations.

Subsequent variations in this design have included the use of thick (0.032") spiral wires, and sandblasting the ends of plain round 0.030"-0.032" diameter stainless steel wire, to eliminate the need for retentive bends to be used.<sup>7</sup> Alternatively, bonding of these retainers can be enhanced by the use of retentive pads incorporated at the ends of the wire.

Flexible spiral wire (FSW) bonded retainers utilise thin multi-stranded wires of between 0.015" and 0.020" diameter, bonded to each tooth in the segment, rather than the canines only.<sup>8</sup> This design is more effective at preventing rotation of the bonded teeth. The flexibility of these wires allows for physiological movement of the bonded teeth, which helps to prevent bond failure. However, care must be taken to ensure that the wire is entirely passive when bonded, as any distortion can result in the teeth being moved.

Recently, other materials, such as polyethylene ribbons, have been considered as alternatives to multi-stranded wire, but to date these have proved to be less suitable and cannot be recommended at this stage.<sup>9</sup>

### Clinical reliability

Bonded retainers, while they remain satisfactorily attached to the teeth, will effectively prevent unwanted tooth movement. Artun<sup>10</sup> noted that minor tooth movements may occur occasionally with rigid mandibular 3-3 type retainers, whereas no movements occur with correctly placed FSW retainers.

When mechanical failure of a retainer occurs, however, tooth movement can follow. This

may be a particular problem with FSW retainers, as one tooth may become detached from the wire without the patient's knowledge, and this tooth can then move out of alignment. With 3-3 type retainers, the patient will normally be aware of any debonds.

Failure of bonded retainers occurs mainly in one of three ways:

- Failure at the wire-composite interface (see **Figure 3**). This is the most common type of failure and is more likely if inadequate bulk of composite is used, or if the bulk of composite is reduced by abrasion during function.<sup>11</sup>
- Failure at the adhesive-enamel interface (see **Figure 3**), which may occur if moisture contamination occurs during the bonding process, or if the retainer is allowed to move during placement.<sup>12</sup>
- Stress fracture of the wire, usually small diameter spiral wires.

Reported failure rates vary, but most studies range between 20 per cent and 35 per cent overall failure, over varying observation periods.<sup>10,13</sup> It should be noted, however, that not all of these failures will result in unwanted tooth movement. Failures occur more frequently in maxillary retainers than mandibular, which suggests that occlusal trauma is a contributing factor. Care must therefore be exercised when placing maxillary retainers to ensure that they are clear of the opposing teeth during functional movements. To facilitate this, maxillary retainers are often extended only as far as the lateral incisors, in order to avoid interference with canine guidance (see **Figure 4**) Fracture of the wire becomes more likely the longer the retainer is in situ.



Figure 4. Maxillary flexible spiral wire (FSW) retainer.



Figure 5. Superfloss in use with a mandibular FSW retainer.



Figure 6. Tungsten carbide bur suitable for removal of residual composite from the tooth surface.

Dahl and Zachrisson<sup>15</sup> reported a much lower failure rate (11 per cent) for a FSW retainer constructed of five-stranded Penta One wire (Masel Orthodontics, 2701 Bartram Road, Bristol, PA 19007, USA) over a mean observation period of three years. They attributed this high success rate to meticulous attention to technique, including careful adaptation of the wire to the teeth, ensuring that no movement of the wire is allowed to occur during bonding, and placement of an optimal bulk of composite. They also felt that the flexibility of the five-stranded wire helped to reduce failures.

### Impact on the oral tissues

A disadvantage of fixed retainers is that, unlike removable versions, they complicate oral hygiene procedures. The presence of a wire crossing the interdental region creates areas that are difficult to clean, and favours the accumulation of plaque and calculus.<sup>16</sup> This tendency for deposits to accumulate is most notable in the areas gingival to the wire, and, in particular, the interproximal regions. In general, patients who have been wearing a retainer for an extended period of time will exhibit a greater build-up of deposits than shorter-term wearers.<sup>17</sup> However, despite these effects, the presence of a fixed retainer appears to cause no increase in incidence of caries or of gingival or periodontal conditions in the adjacent tissues, assuming that the retainers are carefully placed, with care to avoid contact between the wire and the interdental papillae or gingival margin, and the composite trimmed so as to avoid retentive areas. The accessibility to the free flow of saliva has been suggested as the major factor

in preventing demineralisation of enamel.<sup>18</sup>

### Hygiene and maintenance

When a fixed retainer is used, patients must be made aware of the importance of maintaining adequate oral hygiene, and how this can be achieved. Some form of interdental aid is essential, and Superfloss (Gillette Group UK Ltd London TW7 5NP UK) or similar is commonly recommended. This floss can be threaded between the teeth, gingival to the retainer, and used to clean the interproximal areas and, in the case of rigid 3-3 retainers, the areas of contact between the retainer wire and the teeth. With FSW retainers, the floss must be threaded individually into each interproximal area (see **Figure 5**).

Patients should be advised to continue to attend their general dental practitioner for regular check-ups, and professional hygiene measures should be carried out as necessary. Deposits of calculus that accumulate on the teeth, or along the wire, may be removed using either hand or ultrasonic instruments.

### Repair

In many cases where mechanical failure of a bonded retainer occurs, it may be possible to carry out a repair in the mouth. In other cases, such as where fracture of the wire has occurred, repair may not be an option, and the retainer should be removed, and a replacement constructed if necessary.

To repair a retainer that has become detached from one or more of the bonded teeth, it is first necessary to remove any composite material that remains on the affected teeth or the wire.

This can be achieved by using a multi-fluted tungsten carbide bur (see **Figure 6**) (Cat no. 8000 1172 L. Orthocare UK Ltd.5 Oxford Place, Bradford, W. Yorkshire, BD3 0EF, UK) in a conventional handpiece to remove material from the teeth, whilst composite retained on the wire may be addressed by grasping with a suitable instrument, such as a weingart pliers or artery forceps, and applying sufficient pressure to crush the material, which is then easily removed.

The tooth surface may then be cleaned with a prophy brush or cup, using a slurry of pumice and water, washed and dried, before application of acid etch and a bonding agent, using the manufacturer's recommended technique. Any standard composite material is then used to re-attach the retainer wire, taking care to ensure that it remains passive and the composite contoured to allow adequate bulk of material and eliminate retentive areas. All excess composite should be carefully removed with finishing burs.

### Conclusion

The use of orthodontic bonded retainers has increased in recent years and this trend would appear to be continuing. The advantages of fixed retainers over their removable counterparts include comfort, relative invisibility and the ability to be used for extended periods of time without placing major demands on patient compliance. An increasing number of patients may therefore be expected to present to their dental practitioners requiring maintenance or repair of these appliances. Often, these repairs can be carried out in the mouth, and do not

require any specialist equipment. Likewise, routine maintenance and cleaning of these appliances can be undertaken by the patient's general dental practitioner. Periodic reviews by the patient's specialist orthodontist are also necessary for as long as the retainer is in place.

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## Dental perspectives on neuropathic origin

Previous articles in this series reviewed two of the most common chronic pain conditions affecting the orofacial area, namely musculoskeletal and temporomandibular joint pain, and headache disorders. The final article in the series looks at neuropathic facial pain.

### Introduction

Neuropathic pains are those generated by injury, disease or dysfunction within the nervous system itself. Advances in pain research have provided insight into the complex neurobiological mechanisms underlying the spectrum of clinical conditions broadly referred to as neuropathic facial pain (**Table 1**). This article focuses on three clinical conditions in this category which highlight the contrast in clinical presentation and putative pain mechanisms.

### 1 Idiopathic trigeminal neuralgia (tic douloureux)

The best known of the cranial neuralgias is trigeminal neuralgia (TGN), which is defined as 'a sudden, usually unilateral, severe, brief, stabbing, recurrent pain in the distribution of one or more branches of the fifth cranial nerve.'<sup>1</sup> Pain intensity ratings vary from 'mild' to 'excruciating' or 'intolerable' and uncontrolled pain has been associated with suicide in some patients.

The most common presentation is that of 'electric shocks' or 'spasms' of pain, but the condition may also manifest as a dull aching discomfort (referred to as pretrigeminal neuralgia). The onset may be abrupt, with rapid onset of extremely severe pain, or it may have an insidious nature with slow progression of symptoms.

TGN most commonly affects the maxillary and mandibular divisions of the trigeminal nerve (either individually or in combination) and if the pain presents in tooth bearing areas, it may easily be misdiagnosed as odontogenic pain. Periods of remission are characteristic of the condition and further complicate the diagnosis. The vast majority of reported TGN cases are unilateral in location, but bilateral pain has been reported.

TGN affects male and females equally and

mostly affects patients in their fifth or sixth decade of life, although exceptions do occur.

The aetiology of this distressing condition is uncertain, even though patients may attribute the sudden onset of pain to recent dental interventions or facial injury. Current opinion focuses on compression of the trigeminal nerve root by a tortuous blood vessel. Space occupying lesions within the posterior cranial fossa may produce similar symptoms, but obviously the approach to treatment of this secondary or symptomatic type of trigeminal neuralgia is quite different.

Attacks of pain may be triggered by relatively innocuous activities such as shaving, washing the face, tooth brushing, etc. This potential to trigger pain by gentle movement of skin, tooth or lateral border of the tongue is unique to trigeminal neuralgia. These areas of acute sensitivity are referred to as 'trigger zones', which by definition ignite an attack of sharp, electrical pain on stimulation. Trigger zones may change in location or disappear completely, leaving the patient with spontaneous episodes of pain until the condition resolves.

The region most commonly affected is the infra-orbital area, which includes the incisor, canine and premolar teeth. It is not unusual for a canine or premolar tooth to act as a trigger zone, responsive to mechanical or thermal stimulation. The resultant pain is often

**Table 1**  
**Clinical conditions currently defined as neuropathic facial pain**

- Trigeminal neuralgia (and pre-trigeminal neuralgia)
- Post herpetic neuralgia
- Post traumatic neuralgia
- Atypical odontalgia
- Burning mouth syndrome (stomatodynia)

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excruciating but brief in duration. A latent period (two-to-four minutes) follows during which the pain cannot be provoked. This period of latency during which the pain is not triggerable, helps to distinguish between pain of pulpal origin and trigeminal neuralgia. Local anaesthetic injection either by nerve block or infiltration into the symptomatic region will successfully block the pain. This is somewhat surprising given the likelihood of this condition having a central origin.

#### Diagnosis and management

Diagnosis is largely dependent on review of the patient's history and exclusion of other possible sources of pain. Younger patients with symptoms of trigeminal neuralgia should be screened by a neurologist to rule out other neurological diseases (particularly Multiple Sclerosis). Idiopathic TGN will not be associated with neurological deficit in the distribution of the trigeminal nerve.

Optimum management includes MRI (magnetic resonance imaging) of the brain and brain stem (with and without gadolinium contrast medium). MRA (magnetic resonance angiography) may be helpful in confirming compression of the nerve root with aberrant blood vessels. Patients who present with symptoms in the first division of the trigeminal nerve should have an adequate ophthalmologic evaluation to rule out intraocular pathology.

Pain is generally well controlled with anticonvulsant medication. A variety of medications have proven efficacy in the control of TGN including Tegretol, Neurontin, and Epilim. All medications in this class have potentially serious side effects and careful attention must be paid to the suitability of the patient for the prescribed medication. The patient's response to the medication must be closely monitored and any lack of symptom control or development of adverse reactions may necessitate a change in medication. Polypharmacy is to be avoided as drug interactions are difficult to predict.

Surgical options exist for patients in whom pharmacological management is unsatisfactory or not possible or satisfactory. Currently, radiofrequency lesioning of the trigeminal ganglion is the most popular option. Vascular decompression surgery may also be considered in cases where blood vessels have been clearly shown to impinge on the nerve root. Unfortunately, all of the interventions appropriate to the management of trigeminal neuralgia have associated risks of morbidity and mortality. Thus the decision to proceed with invasive treatment cannot be undertaken lightly.

Pre-trigeminal neuralgia, as previously mentioned, presents as a dull aching pain, lasting for hours or even days at a time. In a tooth bearing area this is easily confused with toothache. Suspicion is often aroused by a lack of evident dental or periodontal pathology. Misdiagnosis inevitably results in unnecessary dental treatment. Merrill and Graff-Radford described 61 patients, 19 with pre-trigeminal neuralgia and 42 with trigeminal neuralgia who received more than 100 unnecessary dental treatments before an appropriate diagnosis and treatment were made.<sup>2</sup>

## 2 Neuropathic trigeminal pain arising from nerve injury

Neuropathic pain arising from nerve injury (traumatic neuralgia) within the trigeminal system presents a diagnostic and therapeutic challenge for dentists and pain clinicians.<sup>3,4,5,6</sup> The development of neuropathic pain as

### Key features of trigeminal neuralgia

- Sudden sharp pain described as electrical or stabbing.
- Pain intensity - excruciating.
- One or more divisions of trigeminal nerve affected.
- Trigger areas/zones in skin, muscle, tooth or tongue.
- Latent periods (two-to-four minutes) during which pain cannot be provoked.
- Periods of remission lasting days, weeks, months or occasionally even years.
- Pain is blocked by local anaesthetic injection in painful site.

### Proposed mechanisms for trigeminal neuralgia

- Compression of root entry zone (REZ) of trigeminal nerve by blood vessels or tumours.
- Demyelination of trigeminal nerve either centrally or peripherally Ignition hypothesis relating to trigeminal nerve cell bodies in gasserian ganglion becoming hyperexcitable with spontaneous discharge.
- 'Central sensitisation' of trigeminal nerve from constant over-activity leading to atypical pain pattern described as background dull aching sensation.

a consequence of major trauma to the face and oral cavity is well documented. Recent reviews have focussed attention on the complex relationship between dental factors and trigeminal neuropathic pain.<sup>7</sup> Routine procedures including endodontic therapy, extractions, restorations, crown preparations and occlusal equilibration have been identified as potential precipitating or complicating factors. Where a definitive diagnosis of neuropathic pain has already been made, it is important to avoid further invasive procedures that might aggravate an existing problem. Unfortunately, patients who are experiencing considerable pain will often seek out and encourage further procedures in an effort to alleviate their discomfort.

The mechanisms of neuropathic pain are summarised in **Table 2**. In essence this represents a complex interaction of peripheral and central neurological changes, possibly influenced by factors that are hormonal, microbial, genetic, chemical and behavioural. The extent to which recognised mechanisms of neuropathic pain are applicable to the trigeminal system has yet to be determined. In addition it seems likely that the neurophysiological adaptability of the trigeminal system would

**Table 2**  
**Mechanisms of neuropathic pain**

- Peripheral sensitisation
- Central sensitisation
- Ectopic discharge
- Cross talk between afferent fibres
- Loss of descending inhibitory controls
- Sympathetically mediated pain

offer a greater degree of resistance to the development of neuropathic pain.

The extent of the problem is difficult to estimate because epidemiological evidence is compromised by a lack of acceptable definitions for recognisable neuropathic pain conditions. It is difficult to understand why some patients can undergo major surgical intervention with little neurological change, while other patients develop significant pain after relatively minor procedures. Current research is focussing on genetic vulnerability and, if animal studies are a predictor of human response, then possessing certain 'pain' genes may determine whether or not patients develop persistent neuropathic pain.

**Diagnosis and management**

Major nerve resection may be clearly associated with neuropathic pain and the usual clinical symptoms of allodynia (increased response to light touch) and hyperalgesia (increased response to potentially painful stimulus) are easily identified. Application of the same diagnostic principles to the oral cavity is much more complex and to ensure a correct diagnosis of neuropathic orofacial pain all possible sources of odontogenic (dental) pain must be eliminated including root fracture, residual infection, endodontic failure and ill-fitting removable prosthesis.

Traumatically induced neuropathic pain is likely to be described as continuous aching, stinging or burning pain with little variation in intensity. The location is constant and pain-free intervals are rare. This type of chronic pain will continue for years if left untreated. The selection of appropriate treatment (treatment options are summarised in **Table 3**) is dependent on comprehensive assessment of the patient. Where medications are likely to be poorly tolerated or contra-indicated, local and regional nerve blocks may be effective. Supportive therapy from a pain psychologist/psychiatrist is essential for both diagnostic and therapeutic purposes.

**3 Atypical facial pain and atypical odontalgia**

Atypical facial pain remains a somewhat controversial diagnosis. This controversy is evidenced by its inclusion in the classification system of the International Headache Society and its failure to be classified by the International Association for the Study of Pain (IASP). It is a term applied

to pain that is not associated with underlying organic disease or demonstrable physical signs. The pain tends to be continuously present but poorly localised. Difficulty in determining the location of the pain, or pain which has a migratory nature, is strongly suggestive of atypical facial pain. It is generally unilateral but may spread to a wider area of the face or neck. Clinical, radiological and laboratory investigation will not show abnormality.

The term was initially described to encompass all facial pains that could not be classified as trigeminal neuralgia. Over time it was recognised in the dental literature as a distinct entity with definable characteristics. Pain location is characterised by lack of conformity with normal neurological or dermatomal boundaries. Confusion exists within the literature due to some reports basing the diagnosis on exclusion of all other entities while some authors define specific inclusionary criteria for the diagnosis.

The aetiology is uncertain but some reports implicate a vascular mechanism similar to migraine like headaches. Unfortunately, the evidence for this is inconclusive. Symptom reduction with the use of antidepressants originally suggested an emotional disorder but this theory also has its limitations. Only tricyclic antidepressants have been shown to be effective in controlling this type of pain, despite the existence of other medications that have vastly superior antidepressant effect. In addition, the dosage of tricyclic required is minimal and well outside the range normally used to control mood disorder.

**Atypical odontalgia**

Atypical odontalgia is considered to be similar in many respects to atypical facial pain with the exception that the pain is limited to the dentoalveolar region. It has also been referred to as phantom tooth, pain. Generally described as a throbbing discomfort within the tooth it is often misdiagnosed as toothache. This condition may be precipitated or aggravated by dental treatment and can move from tooth to tooth.

The migratory nature of this dental pain has suggested a central mechanism but the aetiology remains uncertain. Disinhibition of descending pain inhibitory controls has been proposed to explain the neuropathic nature of the pain. Marback suggested that there were some similarities to phantom limb pain, but this has not been validated<sup>89</sup>. Animal studies have shown that removal of tooth pulp (in cats) alter central pain pathways. While this might explain the possible induction of the pain problem, it is recognised that many patients with atypical odontalgia have intact pulps and have had no dental treatment prior to the onset of pain.

Rees and Harris have suggested an aetiology based on mood disorder and a 'catecholamine deficiency'. This theory may have been based on the success of tricyclics in treating atypical odontalgia, a group of medications that increase the availability of both serotonin and noradrenaline in the synaptic cleft. It is interesting to note that some of the newer antidepressants, which can selectively increase availability of either noradrenaline or serotonin alone, are not effective in treating atypical odontalgia.

**Summary**

The most common cause of intraoral pain is odontogenic and rarely presents a diagnostic challenge. Pain in a tooth site area that is not dental

**Table 3**  
**Treatment options for post-traumatic neuropathic pain**

Medications	
Anti-epileptics	Carbamazepine, Valproic Acid, Neurontin, Baclofen, Topiramate
Antidepressants	Tricyclics (amitriptyline, nortriptyline)
Nerve Blocks Local	Infiltration Anaesthesia, Maxillary Division Block, Mandibular Division Block
Regional	Stellate Ganglion Block, Sphenopalatine Ganglion Block

or periodontal in origin may be difficult to diagnose and treat. Successful management of non-odontogenic pain complaints is inherently dependent on taking a detailed 'pain history'. Treatments that are irreversible and potentially harmful to the underlying dentoalveolar structures must be avoided when the diagnosis is uncertain. Information gleaned from the pain history usually provides a provisional or working diagnosis, and this diagnosis must later be confirmed by specific testing (based on response to medication trials, imaging, laboratory tests, etc). Patients who suffer from chronic pain conditions are likely to show comorbidity with other pain problems (e.g., neuropathic pain with background muscle discomfort or temporomandibular disorders and headache problems). Thus, in more complex patients, the various elements that comprise the chronic pain condition must be identified and managed, for adequate resolution of the symptoms.

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## Periodontics

**Periodontal diseases and the risk of coronary heart and cerebrovascular diseases: a meta-analysis**

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**Key words**

Cerebrovascular disorders; coronary diseases; meta-analysis; periodontitis/complications; risk factors.

**Background**

This meta-analysis was conducted to examine the relationship between periodontal diseases and coronary heart diseases (CHD) and the cerebrovascular diseases (CVD) in observational studies.

**Methods**

This study was based on seven cohort studies and four studies of other designs that met pre-stated inclusion criteria. Information on study design, year of publication, study location, sample size, study population, participant characteristics, measurement of risk factors, exposure and outcome measures, matching, controlling for confounders, and risk estimates was abstracted independently by two investigators using a standard protocol.

**Results**

Subjects with periodontitis had an overall adjusted risk of CHD that was 1.15 times (95 per cent confidence interval [CI]: 1.06 to 1.25;  $P=0.001$ ) the risk for healthy subjects. There was no heterogeneity among the studies in the overall relative risk estimate ( $P=0.472$ ). As compared to healthy subjects, those with periodontitis had an overall adjusted relative risk of CVD of 1.13 (95 per cent CI: 1.01 to 1.27;  $P=0.032$ ).

**Conclusions**

Findings indicated that periodontal infection increases the risk of CHD and CVD. However, this meta-analysis provided no evidence for the existence of strong associations between periodontitis and CHD and CVD. Larger and better controlled studies involving socially homogeneous populations and measuring specific periodontal pathogens are required to identify a definite association between periodontal disease and the risk of coronary heart disease and cerebrovascular disease.

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## Education

**Predoctoral implant dentistry curriculum survey: European dental schools**

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**Key words**

Endosseous implants; dental implant education; implant dentistry; dental curriculum; oral implantology.

**Purpose**

In 2002, a survey of European dental schools was conducted. The purpose of the survey was to determine the curricular structure, teaching philosophies and materials used in predoctoral implant dentistry courses.

**Material and methods**

Fifty-six European dental schools were randomly selected from the Association for Dental Education in Europe representing 33 countries. A questionnaire was mailed to the predoctoral implant dentistry director/chairperson of the selected European dental schools. Of these, 40 schools returned the completed survey, resulting in a response rate of 71 per cent. The mean, median and range responses were computed where applicable.

**Results**

The results from this survey show that 80 per cent of the responding schools required a course in implant dentistry. Between 1997 and 1999, over one-third of responding schools (36 per cent) incorporated a predoctoral implant dentistry course into their curriculum. Eighty-seven per cent of the schools have some prosthodontists teaching the course. Thirty-seven per cent of schools are offering a laboratory course in conjunction with the implant course. Sixty-three per cent of the schools are not restoring implant cases at the predoctorate level. However, 68 per cent of schools reported that students are required to be present during implant surgery. Ten per cent of schools require that the implant-related laboratory work to be completed by the students.

**Conclusion**

Predoctoral implant dentistry education programmes vary from school to school. Yet a large percentage of schools agree on certain topics, including the importance of including implant education in predoctoral dental programmes.

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## abstracts

## Endodontics

**Effectiveness of different techniques for removing gutta-percha during treatment**A.V. Masiero\* and F.B. Barletta<sup>a</sup>

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**Keywords**

Gutta-percha; nickel-titanium; root canal retreatment; rotary instrumentation.

**Aim**

To evaluate the effectiveness of various techniques for removing filling material from root canals in vitro.

**Methodology**

Eighty extracted mandibular premolar teeth were selected for the study. The teeth were root filled using thermomechanical compaction of gutta-percha. After eight months, the filling material was removed and canals reinstrumented using the following techniques:

- Group I – hand instrumentation with K-type files (SybronEndo, Orange, CA, USA);
- Group II – K3 Endo System (SybronEndo);
- Group III – M4 System (SybronEndo) with K-type files (SybronEndo); and,
- Group IV – Endo-gripper system (Moyco Union Broach, York, PA, USA) with K-type files (SybronEndo).

The amount of filling debris remaining on root canal walls was assessed radiographically; the images were digitised and analysed using AutoCAD 2000 software. Total canal area, area of the cervical, middle and apical thirds, and area of remaining filling material were outlined by one operator. The ratios between these areas were calculated as percentages of remaining debris. Thereafter, data were analysed by means of one-way ANOVA and the post-hoc Duncan test to identify differences between the four techniques.

**Results**

Multiple comparisons of the percentages of remaining filling material in the entire canal did not reveal any significant differences between the methods of removal. However, when each third was analysed separately, significant differences for remaining debris were present between the groups. The apical third had the most remaining material, whilst the cervical and middle thirds were significantly cleaner ( $P=0.002$ ). Comparison of the techniques revealed that teeth instrumented with K3 rotary instruments had a lower ratio of remaining filling material in the apical third ( $P=0.012$ ).

**Conclusion**

In the apical third, K3 rotary instruments were more efficient in removing gutta-percha filling material than the other techniques, which were equally effective for the other thirds.

International Endodontic Journal. 2005; 38: 2-7.

## Health and safety

**The provision of dental care for patients with natural rubber latex allergy: are patients able to obtain safe care?**

A. Clarke, Burndale, Sands Road, Hunmanby Gap, Filey, N Yorks YO14 9QW, England.

**Background**

The number of people with allergy to natural rubber latex (NRL) has increased significantly in recent years.

**Aim**

To assess the experiences of latex-allergic patients in accessing appropriate dental care, and also the willingness and ability of general dental practitioners to provide care for these patients.

**Method**

Two self completing postal questionnaires, one to patients and one to general dental practitioners.

**Results**

The majority of latex-allergic patients are able to obtain dental treatment. Some do experience adverse reactions, which may be severe in spite of the precautions being taken. Although many general dental practitioners are willing to accept such patients for treatment, few appear to be aware of the necessary precautions required. Most do not have policies for the management of sensitised patients and staff, and a number are still using powdered natural rubber latex gloves, in spite of the risk to patients and staff.

**Conclusion**

Latex-allergic patients can usually obtain safe treatment in general dental practice, but more education of dentists about the risks associated with natural rubber latex is required. Information about the latex content of equipment would be advantageous.

British Dental Journal. 2004; 197: 749-752.

## Record keeping

Mike Clarke from Dental Protection explores the importance of maintaining accurate records.



One of the most frustrating aspects of dealing with a complaint or claim brought against a dentist is to find that the clinical aspects of the case are apparently quite defensible, but the record keeping is so poor that any defence becomes non-existent. This may appear a little odd, but is actually quite common.

Unfortunately, dentists are poor record keepers. This has nothing to do with any inadequacy in a dentist's training, but relates more to the fact that dentists see themselves as clinicians, rather than scribes. The importance of records, however, should never be underestimated, as frequently the dental record is often all that is left to demonstrate why a particular item of treatment was undertaken. It follows then that, where there is a dispute between a patient and a dentist about what may have happened, the judge will often favour the clinician's version of events, if it is noted within the records, arguing that a dentist has a duty to record all clinical details and, therefore, the entry is likely to be accurate. Therefore, five minutes spent making good notes can often make the difference between sleeping at night, or staring at the ceiling wondering what the consequence of a solicitor's letter might be.

### What makes a good clinical record?

To a large extent, it's not quantity that is important, but quality. Each dated entry should contain sufficient detail for another clinician to understand exactly what process or discussion was undertaken and why. Surprisingly then, it is not what is written in the record that is significant, but what is missing. For example, just because a tooth is not tender to percussion today, may seem irrelevant until you need to demonstrate how long symptoms have been present. Similarly, a missing social history can have tremendous significance in TMJ cases, where stress is the main causative factor.

Writing all this down can mean that the record starts to become of volume akin to *War and Peace*. The importance of abbreviations, therefore, becomes obvious. There are no real problems with shortening commonly used phrases, as long as you can demonstrate at a later date exactly what they mean. S/P is universally understood as scale and polish, whereas M++ is not immediately obvious as indicating grade-two mobility.

### Computerisation

In theory, keeping records on a computer should allow the dentist to write whatever he wants, as space is not an issue. In practice, this is rarely the case as computerised records are often even shorter due mainly to the dentist's poor keyboard skills.

Writing ULS MOD and leaving out any of the other relevant clinical information is easier for the inadequate typist. The records then become more of a menu of clinical items than a record of treatment. In extreme cases, this menu gets shortened even further to a four-digit number that represents the payment code for a state or insurance system.

It is of course important that a clinician be able to demonstrate the contemporaneous nature of any record. Most of the better computer programs include an audit trail that demonstrates when a particular entry was made, but this is not the case with less sophisticated systems, thus reducing their effectiveness.

As for manual records, they can be rewritten in part or in whole and, in theory, if done well can be visually difficult to challenge. It is worth remembering however that forensic techniques are such that even the age of an ink entry on a record card can be accurately determined. Adding or altering a record entry after the event, can prove highly embarrassing in court.

Records are not just about written notes, but include all aspects of clinical data. Radiographs, for example, are yet another source of problems for the average dentist. For obvious reasons, a radiograph must be of clinical value and yet all too often all that can be seen is a dark smudge or a heavily elongated image due to inappropriate processing or poor technique.

Considering that there are all manner of appliances available to assist a dentist in producing a good radiographic image, it is disappointing to see radiographs of such poor quality. The old saying that the standard of a dentist's radiographs reflect the standard of his dentistry, is probably quite apt.

A dental record therefore says something about a clinician that is unique as the clinicians themselves. A good record will never let a clinician down. A poor one might just as well not be there.

## Legal status of tooth whitening products

The Medical Devices Department of the Irish Medicines Board provides a clarification on the legal status of tooth whitening products in Ireland.

The issue of the classification of tooth whiteners was raised in the late 1990s in Europe, particularly in the UK where the House of Lords ruled that these products were not medical devices, but more appropriately classified as cosmetic products. Similar court cases took place in Sweden and Germany.

As there were differing views across Europe in relation to the appropriate classification of these products, the EU Commission has been trying to clarify this debate over the past few years. The Commission wrote to member states to remind them of this common understanding that tooth whiteners are more appropriately classified as cosmetic products and to ask them to apply the Community legislation correctly.

### Classification as cosmetic products

Tooth whitening products, either used by consumers or by professionals, are cosmetic products according to the definition of cosmetic products in Article 1 of Council Directive 76/768/EEC relating to cosmetic products.

The Directive provides that: "any substance or preparation intended for placing in contact with...the teeth...with a view, exclusively or principally, to cleaning them...or protecting them in order to keep them in good condition, change their appearance" is a cosmetic product.

Tooth whitening products that are placed on the market for the principal intended purpose of lightening discoloured teeth i.e., cosmetic purposes, whether or not they contain peroxide and regardless of concentration, cannot be considered as medical devices since they do not conform to the definition of "medical device" in Directive 93/42/EEC.

The EU Directive relating to cosmetic products is implemented in this country via S.I. No.870 of 2004, European (Cosmetic Products) Regulations 2004.

### Certain classifications as medical devices

For a product to be classified as a medical device, the product in question must have a medical purpose. The relevant Irish medical devices legislation is S.I. No 252 of 1994. All medical devices placed on the market bearing the CE marking must conform to the essential requirements of the medical devices legislation in relation to their class.

In spite of the general understanding concluded at EU level on the classification of tooth whitening products as cosmetic products, currently in some cases, the medical devices legislation is being inappropriately applied by some manufacturers to tooth whiteners with concentrations greater than that currently specified as acceptable in the cosmetic legislation.

### Restriction on amount of hydrogen peroxide present or released in oral hygiene products

The EU Directive relating to cosmetic products currently limits the amount of hydrogen peroxide in oral hygiene products to not more than 0.01 per cent present or released. Oral hygiene products with concentrations higher than this cannot be lawfully placed on the EU market as a cosmetic produce.

There are proposals currently being considered at EU Commission level to amend the cosmetic legislation so as to increase the threshold concentration to six per cent in various application forms (strips, tray etc). Consideration is also being given to the circumstances in which such products may be made available to consumers, e.g., under the supervision of a dentist or direct to consumers.

The opinion of the EU Scientific Committee on Cosmetic Products and Non-Food Products on this matter is expected to be delivered in early 2005. As soon as this opinion is delivered, the Commission and member states hope to be in a better position to take the necessary measures to update the Cosmetic Products Directive as appropriate.

### Need for product safety

It is important for manufacturers and any other persons placing any such products on the markets, to bear in mind that, whether the products concerned are intended as cosmetic products or as products for some other purpose, they are responsible at law for ensuring that any products supplied are safe under normal or reasonably foreseeable conditions of use.

### Conclusion

It is unlikely that precise legislative clarity will be available for a period of time for all tooth whitening products containing hydrogen peroxide that are at present being made available to the market. Some of these products, particularly those with concentrations greater than the expected limit of six per cent hydrogen peroxide, present or released, will remain borderline and will have to be examined on a case by case basis by the member states whose responsibility it is in the first instance to classify such products.

Product manufacturers considering placing tooth whitening products on the market with concentrations of hydrogen peroxide higher than those specified under the current cosmetic products legislation (i.e., >0.1 per cent) are advised to await the outcome of the Scientific Committee opinion and the resulting community legislation.

Manufacturers are also advised to carefully consider the mode of action and the intended purpose of the proposed produce taking account of the legislation prior to placing the proposed product on the market.

## Diary of events

### February 2005

#### Irish Endodontic Society Meeting

Date: February 24  
Venue: Dublin Dental Hospital  
Time: 7.30pm

### March 2005

Healthcare Risk Manager's Forum

#### Annual Scientific Conference

Date: March 2  
Venue: Great Southern Hotel  
Dublin Airport

For further information, E-mail  
risk.management@maile.hse.ie

Munster Branch  
Irish Dental Association

#### Trauma to Front Teeth

Professor Martin Kinirons  
Date: March 7  
Venue: Kingsley Hotel  
Time: 8pm

Metropolitan Branch  
Irish Dental Association  
Is a Radiograph a good Diagnostic  
Tool? - Dr Donal McDonnell

#### Annual General Meeting

Date: March 10  
Venue: Grosvenor Room, Berkeley  
Court Hotel, Dublin 4

South Eastern Branch  
Irish Dental Association

#### Annual Scientific Conference

Date: March 11  
Venue: Faithlegg House Hotel  
Waterford

AGM of South Eastern Branch members  
only at 4pm on March 11.

Annual Dinner Friday - evening  
March 11.

Golf Saturday, March 12 - Waterford  
Castle Golf Course.

Further details contact: Dr Maura Haran  
086-3485551.

IADR/AADR/CADR 83rd

#### General Session

Date: March 9-12  
Venue: Baltimore, Maryland, USA

For further information see upcoming  
events on [www.dentist.ie](http://www.dentist.ie)

Munster Branch  
Irish Dental Association

#### Dental Sleep Medicine - Bruxism, Apnoea and Snoring

Dr Eamonn Murphy  
Date: March 21  
Venue: Kingsley Hotel  
Time: 8pm

#### Irish Endodontic Society Meeting

Date: March 24  
Venue: Dublin Dental Hospital  
Time: 7.30p.m.

South African Dental Association

#### National Congress

Date: March 30 - April 2  
Venue: East London, South Africa  
For further details and registration  
contact [www.borderdental.za.net](http://www.borderdental.za.net) or  
[dawie.s@omnident.co.za](mailto:dawie.s@omnident.co.za)

### April

#### Irish Society of Periodontology Meeting

Dr Klaus Lang  
Date: April 1  
Venue: Davenport Hotel, Dublin  
Contact: Dr John Molloy 091-  
569110

Metropolitan Branch

#### Irish Dental Association - Golf outing

Date: April 10  
Venue: Powerscourt Golf Club  
Enniskerry, Co Wicklow

Munster Branch  
Irish Dental Association

#### Local Anaesthesia - Dr John Meechan

Date: April 11  
Venue: Rochestown Park Hotel  
Time: 8pm

#### IDA Annual Scientific Conference 2005

Date: April 14-16  
Venue: Great Southern Hotel  
Killamey, Co Kerry

### IDS 2005 - 31st International Dental Show

Date: April 12-16  
Venue: Cologne, Germany  
For further information see upcoming  
events on [www.dentist.ie](http://www.dentist.ie)

### May

#### XIV World Congress on Dental

**Traumatology**  
Date: May 5-7  
Venue: Reykjavik, Iceland  
World-renowned speakers will provide  
the latest scientific and clinical updates  
on the epidemiology, prevention and  
treatment of dental traumatology. For  
further information refer to congress  
website.

#### 2nd Conference of the "Oral Health Promotion Research Group - Irish Link"

Date: May 6-7  
Venue: Tullamore Court Hotel  
Theme: Evaluation and Beyond  
Booking forms distributed via principal  
dental surgeons. Others interested can  
get booking forms from Dr Mary  
O'Farrell, Principal Dental Surgeon,  
Chair OHPRG - Irish Link, Dental Clinic,  
Our Lady's Hospital, Navan, Co Meath.

Irish Dental Association

#### Golf - Lyttle Cup

Date: May 20  
Venue: County Louth Golf Club

#### AAO Annual Session 2005

Date: May 20-24  
Venue: San Francisco, California, USA  
Further information see upcoming  
events on [www.dentist.ie](http://www.dentist.ie)

### June

#### 1st International Symposium on Regional Anaesthesia and Pain Control

Date: June 16-19  
Venue: Hotel Excelsior  
Dubrovnik, Croatia  
Further information:  
<http://euroval.hr/kongresi/dubrovnik/eng/index.php>

### September

#### Sixth International Orthodontic Congress & 3rd Meeting of the World Federation of Orthodontists

Date: September 11-15  
Venue: Paris, France  
Further information see upcoming  
events on [www.dentist.ie](http://www.dentist.ie)

#### Medicine 2005

Date: September 19-22  
Venue: Minsk, Republic of Belarus  
See: [www.dentist.ie](http://www.dentist.ie)

### October

#### ADA - American Dental Association Annual Meeting

Date: October 7-10  
Venue: Philadelphia  
Pennsylvania, USA  
Further information see upcoming  
events on [www.dentist.ie](http://www.dentist.ie)

#### 33 - Expodental - 20 - Tecnodental

Date: October 19-22  
Venue: Milan, Italy  
Further information see upcoming  
events on [www.dentist.ie](http://www.dentist.ie)

#### IAPD Frontiers of Paediatric Dentistry

Date: October 31 - November 5  
Venue: Sydney, Australia  
Further information see  
[www.iapd2005.com](http://www.iapd2005.com)

### November

#### Greater New York Dental Meeting

Date: November 25-30  
Venue: New York, USA  
Further information see upcoming  
events on [www.dentist.ie](http://www.dentist.ie)

### December

#### First International Workshop of the International Cleft Lip and Palate Foundation

Date: December 3-6  
Venue: Balaji Cranofacial Hospital &  
Research Institute, 30, K.B. Dasan Road,  
Teynampet  
Chennai, India

## The Association's AGM

The Irish Dental Association's 2004 Annual General Meeting took place recently in Jury's Hotel, Dublin. The JIDA captures some of the lighter moments.



*Donal Atkins, IDA Secretary General, relates an off-the-record comment to Dr Roger Grufferty, IDA Honorary Secretary.*



*Dr Roger Grufferty, IDA Honorary Secretary, discusses the conference proceedings with Dr Maeve O'Connor, President, Public Dental Surgeons Group.*



*Dr Maeve O'Flynn, President, South Eastern Branch; and Dr Tom Houlihan, Chairman, GP Group; meet up before the AGM.*



*The Kerry men: Dr Jack Galvin, Dr Gerry McCarthy (President), Dr Jim Gleeson and Dr Brendan Coffey.*

## Metro Branch meets

The first scientific meeting of the year for the Metropolitan Branch, which was held at the Berkeley Court Hotel on January 20, enjoyed great support despite the intemperate weather. This was testimony to the quality of the talk delivered by Dr Therese Garvey and Dr Michael O'Sullivan on Interdisciplinary Management of Hereditary Dental Disorders.

The presentation proved popular with the audience as it highlighted the role of team work, communication and methodical planning in rising to the challenges provided by these needy patients. The audience enjoyed the mixture of thought-provoking and light-hearted moments; it is probably a mixture that works well in their day jobs.



*Drs Brian and Valerie Kavanagh.*



*Drs Karl Ganter, Johanna Glennon and Gail Johnston.*



*Drs Michael O'Sullivan, Therese Garvey and Eamon Croke.*

## Classified advert procedure

Please read these instructions prior to sending an advertisement. Below are the charges for placing an advertisement for both members and non-members. Advertisements will only be accepted in writing via fax, letter or email [fionnuala@irishdentalassoc.ie](mailto:fionnuala@irishdentalassoc.ie). Non-members must pre-pay for advertisements by cheque made payable to the Irish Dental Association. If a box number is required, please indicate this at the end of the ad (replies to box number X). Classified ads placed in the Journal are also published on our website [www.dentist.ie](http://www.dentist.ie) within 48 hours, for 12 weeks.

Ad	members	non-members
Length of ad up to 25 words	€75	€95
Length of ad 26 to 40 words	€90	€110

Non-members must send in a cheque in advance with their ad  
The maximum number of words for classified ads is 40. If you require an ad in excess of 40 words, then please contact:

### Rebecca Markey

IFP Media, 31 Deansgrange Road, Blackrock, Co Dublin  
Tel: 01-2893305 Fax: 01-2897546 Email: [rebecca@ifpmedia.com](mailto:rebecca@ifpmedia.com)

### Full-time positions

**Dentist** required for modern busy city centre practice in Galway. Computerised, OPG, digital radiograph. Apply to box no. J105.001.

**Dentist** wanted for long-term interest, associate initially, in busy practice one hour from Dublin. No medical card work. Orthodontist and hygienist. RVG, digital Panorax, air abrasion, microscope. Superb opportunity in area with low overheads. Contact box no. J105.005 or email [dencare@hotmail.com](mailto:dencare@hotmail.com).

**Associate** required with view to share. Thriving private/social welfare practice 40 minutes from Dublin. Suit friendly, quality motivated dentist (some experience). Tel: 086-2222443 after 8pm.

**Associate** required to join long-established dental practice, Dublin 9. Call Sharon on 01-8373714/5 or fax cv to 01-8572120.

**Locum** required mid-May-August 2005 to cover maternity leave, Co Kildare. Accommodation available. Contact: 087-2856224.

**Associate position available, full-time.** Modern computerised group practice. West Dublin. Tel: 01-4911214 (evenings).

**Locum** required part-time for four months approx. from April 2005 in Ennis. Tel: 087-6865780.

**Associate** wanted full-time to replace busy departing colleague. Two-surgery, modern practice. Navan, Co Meath, hygienist, start February 2005. References essential. Contact Geraldine: 087-6293496 or 046-9021348.

**Dublin 16.** Position available for qualified nurse with computer experience. Flexible hours available but must be prepared to work some late evenings. Top wages paid. Tel: 087-2561295.

**Associate, full/part-time** required for east Galway town - in busy modern practice with excellent support staff. Contact: 086-6093215 evenings.

**Locum dentist** required, from early April to early August 2005, to cover maternity leave in busy general dental practice. Well-established two surgery (dentist plus hygienist), five-day practice 30 minutes north of Dublin. Tel: 041-9846333 day or 086-8583366 evenings.

### Had enough of general practice?

An exciting opportunity exists for an independent, caring, quality motivated dental surgeon to join our specialist practice, Dublin city centre. A very attractive remuneration package is offered. Full-time and part-time positions are available. Tel: 042-9336517.

**Associate** required with early view to partnership, for busy, long established, east coast Co Wicklow practice. Tel: 087-2748584 after 7pm or email [norch@eircom.net](mailto:norch@eircom.net).

**Spare surgery available** immediately in Dublin city, in a busy one-man practice; would suit associate, part-timer or expense-sharing arrangement. Tel: 01-6746659/60.

**Locum dentist** required for busy practice in Co Mayo for maternity leave starting January. Tel: 098-24788 or email [drosemary@eircom.net](mailto:drosemary@eircom.net).

**Associate. Full-time** associate required for busy thriving practice in Co Tipperary. Modern, fully-equipped surgery, OPG, hygienist and excellent support team. Tel Linda: 087-2281282 or [themallpractice@eircom.net](mailto:themallpractice@eircom.net).

### Experienced dental surgeon

required to replace departing colleague. Excellent opportunity to join long established modern practice. Tel: 086-8536342 for details.

**Friendly associate** required for full-time position in Nenagh, Co Tipperary. OPG on site. One of the nurses is qualified to take OPGs. Tel: Jacques 087-6866180.

**Locum required** for busy, friendly practice in Co Meath (Dublin 25 miles). End July, August, September, October, November 2005. Tel: 087-2028147 or email [dent77@eircom.net](mailto:dent77@eircom.net).

**Hygienist position** available in southeast, general practice, to cover three months' maternity leave. Commencement date: beginning of June. Tel: 051-421443 or 087-2507830.

**Associate** required for dental practice, Galway City. Interest in implants. Tel: 091-770670 or 086-2254708.

**Associate** required full-time or part-time for large, three dentist practice in northeast. Dublin 50 minutes on motorway. Tel: 086-1741450.

**Norfolk, England.** Excellent opportunity for salaried dentist in newly refurbished ultra modern practice 30 miles north of Cambridge. Fully computerised, digital x-rays, digital Panorax, intra oral cameras, experienced staff. Low cost daily flights Norwich - Dublin. Contact +44-1362-821297 or +44-7900-216174.

**Locum** wanted for friendly west Cork practice February, March, April or portions of these months. Tel: 028-31991 evenings.

**Ipswich, UK.** Qualified (BDS or equivalent GDC registered) dentist required. NHS general dentistry. 40 hours weekdays plus emergency. Salary £32,000 aae. Contact William +44-7785-380448 or +44-1787-473874. Email: [dutoit@stansteadhall.fsnet.co.uk](mailto:dutoit@stansteadhall.fsnet.co.uk) Closing date: 15th April 2005.

## classified

**Part-time positions**

**Associate** required - Dublin 3. 2.5/3 days per week. Replacing retiring colleague. Newly equipped surgery, OPG, computerised. 10 minutes Dart station. Start July/August. Phone Ken 087-2506622 or 2984094 after 7p.m.

**Associate dentist** required part-time for modern practice in Swords, Co Dublin. For details contact Angela: 086-3999987 or 01-4630962.

**Hygienist** required for busy dental practice Dublin 7. Monday surgery initially with future possibility of Tuesday surgery. Tel: 086-3877201 evenings.

**Dentists** wanted, part-time. Permanent part-time positions available in Dublin city centre (D2) practice. Super conditions and remuneration. Call Emmet: 086-8187373.

**Positions sought**

**Experienced dentist** seeking part-time employment in the Munster area. Apply to box no. J105.002.

**Experienced dentist** available immediately for locumship full or part-time preferably in the mid-Munster region. Contact box no. J104.004.

**Experienced TCD graduate**

seeks position for one to two days per week anywhere within one hour commute of Dublin. Locum/associate/expense sharing positions considered. Available immediately. Tel: 087-3141301 after 6pm.

**Dental surgeon** available part-time. Experienced dental practitioner available to do up to three evenings and Saturdays. Preferrably in Dublin 15 and northeast areas. Tel: 086-8962554 after 4pm.

**Locum** position sought in the Dublin area by experienced dentist from February '05 to the end of May '05. Saturdays also an option. Tel Eoin: 087-9162333.

**Experienced dental practitioner** seeking part-time employment in Galway area. Tel: 086-8188969 after 6pm.

**Experienced dental surgeon**

seeks full/part-time position in the Dublin area. Available from February '05. Tel: 087-2784241 after 6pm.

**To let****Fully serviced spacious dental suite available to let.**

Suit orthodontist or endodontist looking to establish in good area. Replies to Sharon on 01-8373714/5 or fax cv to 01-8572120.

**Rent/lease fabulous new medical premises**, purpose built for dentist, up to 1,800sqft. Ample car parking spaces on site. Adjacent to long established GP group practice. Highly populated, new housing areas, Dublin West. Tel: 01-4593325 or 086-2533588.

**Medical rooms** to let adjacent to doctor's surgery, Knocknacarra, Galway. Total 250sqft. Tel: 086-8570370.

**Suction/chair broken down?** Mobile suction unit for hire. €50 per day, 200 per week. Tel: 086-2245017. Email: dentist@gums.ie.

**For sale****www.innovatedental.com**

25 practices sold - 25 practices for sale. Countrywide and Dublin city centre. Associates placed. Practice valuation. Expense sharing relationships established. Specialists established. Career direction advice. All facets of help and advice available. Contact: 086-8075273 or niall@innovatedental.com.

**South Dublin**, great opportunity - freehold, long lease, established practice, planning permission, parking, generating rent - 18,000 per year. LUAS. Very suitable specialist private practice. Contact: 086-8075273.

**Munster, associate/partnership, north Munster town.** Superb opportunity to join long established, modern, top class, very busy, private practice with great facilities. Contact: 086-8075273.

**Practice for sale.** Dublin city centre three miles. Superb location, freehold, very busy two-man practice, long established with huge potential to expand. OPG and hygienist. Mainly private. Contact: 086-8198887.

**For sale: 1. X-ray machine Philips Oralex 65. 2. X-ray developing box. 3. portable oxygen cylinder.** Contact: 01-2140679, Michael O'Rahilly.

**For sale (due to practice going digital). DURR XR25 fixer/developer**, two years old, PWO 1,000. Tel: 049-4332488 Dr J O'Riordan.

**Busy dental practice for sale.**

Experienced dentist required for the sale of a practice in a County Cork town. For more information contact Breda O'Donovan 021-4907000 or email bodonovan@deloitte.ie.

**One-man dental practice** for sale, freehold, well established; turnover 300K p.a. south Dublin suburbs, owner retiring; best offer. Quick sale. Tel: 087-7541833.

**Busy private practice for sale**, Dundalk. Long established, two-dentist fully private practice, prime location, elegant premises, seeks quality-motivated dentist, one partner retiring, other willing to introduce and mentor, in this general and special interest practice. Tel: 087-2930077.

**For sale. Dublin northside - leasehold dental practice.** Expense sharing in purpose built premises. Tel: 01-8379746.

**Fully-featured Irish dental practice software.** Supports DSW and GMS schemes. Download the complete program at <http://www.panaradental.com> for a free 30 day trial.

**Premises suitable for dental surgery Enniskerry, Co Wicklow.** Thriving, fast developing area, very attractive village approx. 1,200 sqft premises, generous parking. Phone 01-2864044 (day), 01-2767959 (evenings).

**Dental premises.** Excellent opportunity to establish a practice in a purpose-built, multi-disciplinary medical premises. Ample on-site parking. Huge demand for services in a rapidly expanding residential area. Contact Dr John McDermott, Healthwell Clinic, Clonsilla, Dublin 15. Tel: 01-8218986 or [www.healthwell.ie](http://www.healthwell.ie).

**Misc**

**Dentist travelling to orphanage in Belarus** in the Spring appeals to anyone - retiring or replacing equipment - who might be able to help with the provision of dental equipment or materials (e.g. chair, light, autoclave, other materials etc.) For further details contact Conor: 086-8519707.

**Dental suite available in Dublin 2.** Previously occupied by periodontist. Tel: 087-2322384 after 5pm.

**Sessions available in modern three-surgery practice in West Dublin.** Suit specialist. Tel: 086-2245017. Email [web@gums.ie](mailto:web@gums.ie).

## Spring 2005 quiz

Picture 1 shows a patient who presented complaining of chronic soreness in the upper anterior jaw on function. The patient had been wearing a maxillary complete denture opposed by six anterior mandibular teeth for 15 years.

Pictures 2 and 3 show the typical clinical presentation of this condition (before and after tissue conditioning).

- 1 What is the diagnosis?
- 2 What are the classic clinical signs?
- 3 What causes this?
- 4 How is it best avoided?

Entries to be submitted to  
Spring 2005 Quiz  
Irish Dental Association  
10 Richview Office Park  
Clonskeagh  
Dublin 14



Picture 1



Picture 2



Picture 3



### Winter 2004 quiz winner

The winner of the winter 2004 Quiz was:  
Dr Leila Kingston  
East Gate Dental Practice  
Ballincollig  
Co Cork

Dr Kingston correctly answered the following questions in relation to a painless lesion on the dorsum of the tongue that was an incidental finding in the examination of 42-year-old man.

- Q What is the likely diagnosis?  
A Median rhomboid glossitis – an area of depapillation in the midline of the tongue just anteriorly to the circumvallate papillae associated with candidal infection. It was previously thought to be a developmental lesion, associated with the tuberculum impar.
- Q How can the diagnosis be confirmed?  
A A swab can be taken and culture will show the presence of *Candida* spp.

- Q What are the risk factors for developing this lesion?  
A Denture wearing, xerostomia, smoking, use of a steroid inhaler, anaemia or haematinic deficiency, immunosuppression, uraemia, hypothyroidism and diabetes mellitus.
- Q What is the appropriate treatment?  
A Topical antifungals, e.g. mycostatin or miconazole, are usually adequate. Underlying causes should be addressed. Resistant cases may require a systemic azole antifungal, e.g. fluconazole.

The winter quiz was submitted by:  
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