

Volume 57 Number 1  
February/March 2011

  
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# Journal of the Irish Dental Association

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**References:** 1. Burwell A *et al.* J Clin Dent 2010; 21(Spec Iss): 66-71. 2. LaTorre G, Greenspan DC. J Clin Dent 2010; in press. 3. Efflant SE *et al.* J Mater Sci Mater Med 2002; 26(6):557-565. 4. Clark AE *et al.* J Dent Res 2002; 81 (Spec Iss A): 2182. 5. GSK data on file. 6. Du MQ *et al.* Am J Dent 2008; 21(4): 210-214. 7. Pradeep AR *et al.* J Periodontol 2010; 81(8): 1167-1113. 8. Sallan S *et al.* J Clin Dent 2010; in press. SENSODYNE® and the rings device are registered trademarks of the GlaxoSmithKline group of companies. Prepared November 2010. GSKCH/2011/0026.



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**The Journal of the Irish Dental Association:**  
 - is the only dental publication produced in Ireland;  
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5 EDITORIAL

6 PRESIDENT'S NEWS  
 The importance of practice management skills

7 IDA NEWS  
 IDA awaits High Court judgement ...  
 Annual Conference 2011 ... IDA meets HSE ... New President-Elect...

14 BUSINESS NEWS  
 Industry news for dentists

15 EU NEWS  
 Updates on amalgam and tooth whitening

18 ABSTRACTS

20 QUIZ

21 SPECIAL SUPPLEMENT  
 Dental Education in Ireland 2011

50 PEER-REVIEWED  
 50 The cyclooxygenase-2 inhibitor celecoxib and alveolar osteitis  
 J Al-Sukhun, H Penttilä  
 54 An audit comparing the discrepancies between a verbal enquiry, a written history, and an electronic medical history questionnaire: a suggested medical history/social history form for clinical practice  
 B Carey, L Stassen

60 PRACTICE MANAGEMENT  
 60 Consent to treatment for children and adults with learning difficulties

63 CLASSIFIED

66 DIARY OF EVENTS



News 10

*Dentists focus on business development*



Special supplement 21

*Dental Education in Ireland 2011*



Practice management 60

*Consent to treatment for patients with special needs*

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## Time for change

PROFESSOR LEO STASSEN invites us to learn from the past and plan for the future.

Election fever is upon us and we listen intently hoping that some politicians might listen to what the IDA has been saying to them and lead us forward in a coherent fashion. Forgetting the past and planning for the future is certainly good for those who have failed us but “always remember and learn from past mistakes, particularly if we can learn from mistakes made by others”. History has a way of telling us where we are going. If we do not set the standards we believe to be required, then we will get what we deserve.

This *Journal* is a special one and features an attempt to set a baseline for dental school education in Ireland. The supplement certainly gives us an understanding of the extent of dental education going on in the Republic, puts faces on the people involved and highlights our attempts to use limited resources together efficiently. It is our first effort to highlight the team, our administrative support and our students. Enjoy it and well done to Think Media.

There is an important advertisement in the *Journal* and it is for the Editor's position. We welcome any enthusiastic colleague, young or retired, with editorial, management and leadership skills, to consider the role. There is a time commitment but it is a most enjoyable and rewarding position. The editorial team have been very stimulating and thanks to all. The Think Media team have been visionary and the IDA has been very encouraging, stepping up to the mark and supporting our new proposals. It is a job that I will be sorry to leave.

IDA politics is always exciting and the IDA news (pp7-12) highlights the major work that is underway for members at present. CPD is particularly important to us and the CPD planning meeting on April 8 is something you might consider contributing to. It would seem sensible to include the CDE tutors from the dental schools in this group.

Members must be encouraged to seek advice from the Contract Review Service (p8) and if they do they will avoid many of the pitfalls that we hear about. The IDA website (p12) is due for review and now is the time to make your suggestions. Personally, I believe any site must be interactive and allow easy access to information. Access to your *Journal* is essential and I hope that this might be improved further in this next upgrade so that we can have access to past issues of the *JIDA* from at least the last five years, and be able to search it for peer-reviewed

publications, fact files, business management articles or IDA news easily. It is always great to see our colleagues gain awards in other parts of the world and Dr David Harris's visiting professorship to the Medical University of Warsaw is fitting reward for his work for the EAO (p12). Tom Feeney in the European section highlights amalgam, changes in funding for dentistry, tooth whitening, and the directive on patients' rights in cross-border healthcare (pp15-16). Importantly, he also emphasises the CED's strong and, I believe, correct health message on the Tobacco Products Directive (pp16-17).

Our peer-reviewed papers highlight an important piece of research into the management of post-operative pain with different medications and the incidence of alveolar osteitis (pp50-53), and a simple audit comparing methods clinicians can use to gather a medical history in a timely, efficient and reliable way (pp54-59). The important point is to choose one and to go through it with the patient at the chair-side.

Consent is always something that we require in clinical practice and Dr Foster gives us a very easy to follow overview of the legal perspective on obtaining consent for treatment of children and those with learning difficulties (pp60-62). It is a must read, especially the forthcoming changes highlighted on p62.

As usual, I have enjoyed reading the whole *Journal*, including the quiz (p20) and our abstracts (pp18-20) and seeing all the smiling pictures of our colleagues. It is a great *Journal*; Dr Dermot Canavan, Deputy Editor, and I are very proud to be a part of it and we will miss it like a friend.



Leo F. A. Stassen

**Prof. Leo F. A. Stassen**  
Honorary Editor

## The importance of practice management skills

The recent seminar in the Aviva Stadium highlighted the need for dentists to stay on top of management issues.

### Election 2011 – Dental Health for All

We now know that the long-awaited General Election will take place on February 25.

The IDA is undertaking a major campaign to bring our members' concerns, and those of our patients, to the attention of the political parties at national level, to local candidates on the doorsteps, and to the media.

We are particularly pleased that for the first time, in conjunction with the Irish Medical Organisation and the Irish Pharmacy Union, a major 'Health Hustings' event will take place on February 17. Representatives from all of the five main political parties will be invited to address our chief concerns and those of our medical and pharmacy colleagues at an open forum.

We want you to play your part in this important campaign, so this issue of the Journal contains some tools to help you get involved. Please ask candidates to read and sign the poster, which you can then display in your surgery. You could also ask your patients to raise these issues with candidates. Our 'manifesto' sets out the four key messages of the IDA's campaign – the drastic cuts to the PRSI and medical card schemes, the moratorium on recruitment to the Public Dental Service, and the failure to appoint a Chief Dental Officer. This document will also be sent to the political parties. Please bring it to the attention of candidates in your area. Help us to campaign for 'Dental Health for All'.



The IDA is back in action after the break and going full steam ahead for 2011. An excellent seminar – 'Moving your Practice in the Right Direction' – was held in the new Aviva Stadium on Saturday January 15. Approximately 200 members from all parts of the country attended. The presentations offered many positives, while providing good tools to assess your dental practice and helpful ideas on how to generate and improve productivity, which should help us all to cope with the prevailing difficult financial conditions.

The seminar was timely, as the New Year is a good time to reappraise all aspects of our dental offices, including our practice management. As dental professionals we spend most of our time 'in the zone' looking after our patients to the best of our abilities, while focused on our clinical skills and responsibilities. As a consequence we may forget about the 'bottom line'. It is something we are not taught about in dental school and it is often something that we find difficult to address. The advice from the experts on the day was that it is important to know who our patients are (i.e., age profile, most loyal, etc.) and to be aware of the precise state of our finances. Only then can we put in place the structures and plans that will help our practices to grow and profits to increase. This is essential for survival, and to allow investment in new equipment and materials, which will facilitate the best care of our patients.

There are many ways in which to refresh your knowledge of all aspects of dentistry throughout the year. The *Journal of the IDA* always contains excellent scientific and practice management advice for readers. The IDA Annual Conference takes place in Cavan from May 12 to 14, and will have a great line-up of speakers. Be sure to mark the dates in your diary! IDA branch meetings, which are free to all members, offer an excellent opportunity to obtain good advice. You

will find a full list of upcoming events on the last page of this Journal and I encourage you to check out the events listed for your area and, indeed, in areas near you. The Celtic Tiger road network makes everywhere accessible.

Finally, I encourage you to get involved and be informed. It is a good way for dentists to work towards ensuring that our country receives high quality oral healthcare provided in a positive practice environment.

I wish you and yours all the best for 2011 and look forward to meeting you in Cavan!

Dr Billy Davis  
IDA President





journal of the irish dental association

Iris Cumainn Fiaclóirí na hÉireann

## New President-Elect

Dr Andrew Bolas has been nominated by the PDS Group for the position of IDA President-Elect for 2011. Dr Bolas is Senior Dental Surgeon in the HSE Sligo-Leitrim area. He also lectures part-time in dental radiology in the Dublin Dental School and Hospital. A native of Belfast, Andrew received his BDS from Queen's University Belfast in 1991. He gained his FDSRCS in oral surgery and oral medicine in 1995 and moved to Sligo in 1997. Andrew passed an MSc in Dental Radiology in King's College London in 2000.



Andrew is the current President of the HSE Dental Surgeons Group of the IDA.

The IDA Council recently ratified Dr Bolas' nomination to the position of President-Elect.

## Time to renew – reduced IDA subscription rates 2011

### New concession rates

The IDA has introduced new concessionary rates. A 20% discount is available for dentists with an income below €50,000. A 60% discount is available for dentists with an income below €25,000. New concessionary rates have also been introduced for self-employed members on short-term leave from their practice (e.g., maternity leave).

### Unemployed dentists

The IDA is here to help. Dentists who find themselves in this position should contact IDA House to discuss membership subscriptions.

### Recent graduates enjoy reduced payments

It is free for dental graduates to join the IDA for one whole year post graduation. For the second year post graduation, we have introduced a new reduced rate of only €200.

### Payment options

There are a range of payment options available. IDA subscriptions may be paid yearly, half-yearly, quarterly or monthly by direct debit. Direct debit forms are available from IDA House.

## GSK continues with Sensodyne accreditation

We are delighted to announce that GSK – Sensodyne has agreed to continue with accreditation of their Sensodyne brand toothpaste. Sensodyne continues to be the only sensitive toothpaste accredited by the IDA.

Applications are invited for the position of

# Honorary Editor

The term of the current Honorary Editor of the *Journal of the Irish Dental Association* expires in May 2011.

The Journal is Ireland's leading dental publication with an extraordinary 81% usage rate amongst Irish dentists.\* It has a high standard of peer reviewed content; is published six times a year; has ABC certified circulation; and, is the only publication for Irish dentists that is produced in Ireland.

The role of Honorary Editor requires some experience of Editorial Boards, and involves time and commitment, but is very rewarding. There are set terms of office (three years) for all positions on the Editorial Board.

Support for the role is provided by the Journal Co-ordinator employed by the Irish Dental Association; and by the publishers.

If required, further information is available (confidentially) from the present Honorary Editor Professor Leo F.A. Stassen at Dublin Dental University Hospital (tel 01 612 7200, email [leo.stassen@dental.tcd.ie](mailto:leo.stassen@dental.tcd.ie)); or from Fintan Hourihan, Chief Executive, Irish Dental Association (tel 01 295 0072, email [fintan@irishdentalassoc.ie](mailto:fintan@irishdentalassoc.ie)).

Applications outlining experience and reasons for seeking the post should be marked 'Strictly Private and Confidential' and addressed to:

Applications for Honorary Editor  
The Journal of the Irish Dental Association  
Irish Dental Association  
Unit 2 Leopardstown Office Park  
Sandyford  
Dublin 18

\* Source Behaviour & Attitudes 2009 survey  
(81% of Irish dentists use the Journal to inform their practice decisions).

## Update from IDA House

IDA staff and committee members have been working hard to address a range of issues of importance to members.

### High Court update

The decision of Justice Roderick Murphy in the High Court Case taken by Drs Martin Reid and James Turner, with the support of the Irish Dental Association, is awaited. The hearing ran over two days in early December and judgement was reserved by Justice Murphy. A full report on the judgement and its implications for the DTSS will be circulated as soon as possible.

Meanwhile, we understand that a formal letter is to issue from the HSE shortly setting out its position as regards the DTSS for 2011. We have been led to believe that this will clarify that, regardless of the date in 2010 that patients received treatment under the DTSS, the reference period for patients' entitlement will be effective from the start of 2011, rather than since the date of their last treatment in 2010.

### HSE moratorium

The IDA has written to Cathal Magee, Chief Executive of the HSE, calling for a lifting of the current moratorium for dental grades in the HSE. Chief Executive Fintan Hourihan said that exempting the dental grades from the employment moratorium is one of the key recommendations of the PA Consulting Report, which examined public dental services in the HSE.

Mr Hourihan also makes the point that lifting the moratorium is integral to ensuring the maintenance of existing services in view of the diminishing numbers of dentists employed by the HSE. This is also seen by the IDA as a pre-requisite to agreeing to reforms and changes in work practices as proposed by the HSE.

### Incorporation of dental practices

The IDA has written to the Dental Council seeking clarification of the position regarding incorporation of dental practices. The Association has advised members that incorporation is not consistent with the provisions of the Dentists Act 1985.

However, in view of an increasing number of enquiries on the matter, the IDA has written to seek the official position of the Dental Council. The IDA has also asked that the Council would ensure clear communication of its policy on the matter and, in the interest of ensuring that all dentists are practising on an even playing pitch, that the Dental Council would proactively address incidences where practices may be taking advantage of the financial benefits associated with incorporation, thereby leaving other colleagues at a disadvantage.

### Clinical position papers

Position papers on amalgam, dietary guidelines and oral diseases, and paediatric dentistry are to be prepared and published by the Association. The move to publish these position papers is intended to

bolster the Association's position as an advocate for both dentists and their patients, and follows recommendations to this effect in the Association's strategic plan. Mr Paddy Fleming has accepted an invitation to Chair the group that will draft the position paper on paediatric dentistry, and nominations are also being sought from the General Practitioners Group, HSE Dental Surgeons, and the Irish Society of Dentistry for Children.

### Contract review service for members

The IDA is pleased to advise members that we now offer a contract review service. The IDA is available to review and advise on contracts/agreements received by dentists as employees, as associates in private practice and as prospective employers.

### Contracts of employment for dentists

Contracts of employment received by dentists as employees should be reviewed in order to ensure adherence to agreements made between the employer (HSE, dental schools, etc.) and the IDA.

### Buying/selling a practice

Members who are considering purchasing a practice are advised to ensure that there are written terms and conditions in place for all staff members employed in the practice. Members who are buying or selling practices are recommended to obtain appropriate professional advice.

### Current employers

Members are reminded that as employers you are obliged to set out terms and conditions in writing for all staff within two months of their commencing employment. Pro forma agreements for dental surgery assistants are available from IDA House.

### CPD planning meetings

A meeting of representatives from the 10 IDA branches, as well as representatives of the General Practice, HSE Dental Surgeons and Orthodontics Groups, is to take place on April 8 to plan and co-ordinate CPD activities for 2012. All branches and groups are asked to ensure attendance by a representative at this meeting. Members are welcome to forward, in writing, views on topics or speakers you would like included in CPD events. Comments will be brought to the attention of the branch and group officers at the meeting.

### Decontamination guidelines

New guidelines on decontamination requirements and practical advice for members on how to meet these standards are currently being prepared by the Quality & Patient Safety Committee under the chairmanship of Dr Eamon Croke. The guidelines are being drafted under the direction of Dr Nick Armstrong, a member of the committee, and will be circulated to members shortly.





## There is only one right direction for Ireland

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

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*Drs Keith Redmond, Ruth Stokes and Jason McEvaddy.*



*Drs Declan Hollywood, Paddy Malone, and Roger Ryan.*

## Focus on business development

‘Moving your practice in the right direction’ was the title of the Irish Dental Association’s seminar at the Aviva Stadium in Dublin in January, which was attended by over 200 members.



**Dr John Tiernan**, who is well known to IDA members from his work with Dental Protection, spoke about the importance of perspective – at which point he showed pre- and post-flood photographs of a restaurant that had been destroyed by the recent flooding in Australia. He felt very strongly that dentists are not competing with each other, but rather with the rest of the consumer world for disposable income. Working together, therefore, made a great deal of sense to him. John related the story of his work with the Caring Dental Group. In that Group, 10 local dentists worked together, demonstrating that the answer to difficulties lay in increasing the market rather than competing with each other.



**Leanne Papaioannou** is an international marketing consultant who specialises in innovative customer retention and loyalty marketing strategies. She spoke about the 80/20 principle and about why identifying the top 20% of your customers and working harder to retain their business can pay strong business dividends.



**Ray Gordon** is the IDA’s public relations consultant and spoke on raising your profile. He stressed that the fragmentation of media (there are 113 newspapers and 48 radio stations in Ireland) offers an opportunity in its own right, as well as the increased interest from media in lifestyle issues, including oral health. One of his main tips was that the provision of aggregate information is always of interest to media. For example, a dentist might report to the local media





*Drs Robin Foyle and Tom Feeney.*



*Drs Catherine Skelly, Madeleine O'Reilly, Tara Kelly and Ciaran Kirrane.*

that there was a 20% increase in caries recorded in adult patients in the last six months at his or her practice.



IDA Chief Executive **Fintan Hourihan** highlighted extremely positive satisfaction with services provided by Irish dentists (74% are extremely or very satisfied). People are saving more heavily than ever before and the challenge is to persuade them to invest in their dental health. These savings were about €8 billion in 2010 and represented about 10% of personal income.



**Dr Abbie Lane** is a member of the Royal College of Psychiatrists and in addition to her general work in psychiatry, she has specific responsibility for the Dublin County Stress Clinic. She estimates that stress costs in excess of €300 million a year in Ireland. Stress is a doubled-edged sword: a normal level of stress impels us to act productively, but too much leads to very marked health problems. She said that if irritability and sleep problems last for longer than two weeks, help should be sought. Suicide among males in the 30-55 age group is a major problem in Ireland, said Abbie, who also said that gaining control is the key to reducing stress.



**David McCaffrey** is an accountant who formed MedAccount with Steven Lynch and together they have in excess of 100 dental practices on their books. He stressed that every single practice is unique but that there are certain common threads running through all practice accounts at the moment. He observed that cash flow is absolutely critical, and can cause a lot of stress, and that it is

vital to get patients into the chair. David advised that leaflet drops and using the local papers are effective at generating interest, as is creating an occasion (e.g., a Valentine's Day promotion).



**Sheila Scott** is qualified in psychology, marketing counselling and training, and has been helping dentists in the UK to achieve success and profit for the past 20 years. She is now working in Ireland and says that the dentists she is working with are keeping their patients. Sheila says the key to good business lies in making sure that patients see the importance of dentistry.

Dentists, she says, should find out what patients want and communicate and prove the value of dentistry with confidence. And on that very point she is campaigning for her dentists to change the language of dentistry to health, and is developing a 14- to 17-point dental health check with those dentists.



**Kevin Rose**, a business consultant, and **Dr Simon Thackeray**, a dentist and a friend of Kevin's, made a joint presentation explaining how, working together, they successfully developed Simon's dental practice. That development programme was based on Simon's chief personal aim, something that Kevin recommended that everyone should write down as a focus for their life.



## IDA meets with HSE to discuss PA Consulting report

An IDA delegation, together with a delegation from IMPACT, met with the HSE Corporate Relations Services on January 18 to discuss the PA Consulting Group Report.

At the meeting the HSE outlined proposals with regard to the creation of an integrated services model, which would see the creation of 16/17 Integrated Services Areas (ISAs) across all services in the HSE. This new model would include three key areas of change for dental services: the establishment of a National Oral Health Office; the introduction of a single model of probity; and, the creation of a level of area management at ISA level. According to the HSE, its key priorities are the National Oral Health Office and the introduction of probity arrangements.

The IDA delegation set out the following key concerns and areas of priority for our members:

- The publication of the National Oral Health Policy is a priority.
- The appropriate complement of staff must be ensured.
- The dental service must be excluded from the moratorium.
- The professional and ethical obligations of dentists must be recognised.

- Principal dental surgeons must retain all current aspects of their role and responsibilities.
- Clinical line management must be guaranteed.
- The title of 'dental surgeon' must be protected for all grades.
- There must be a commitment to agreeing appropriate contracts of employment for all dental surgeons.
- The position of those in senior long-term acting positions must be regularised.
- There must be agreement on a properly funded scheme for vocational trainees.

The IDA delegation comprised Drs Andrew Bolas; Jim McCafferty; Jane Renehan; and Frances O'Callaghan; and Fintan Hourihan and Calre Dowling. Dr Joe Green is also a member of the negotiating team.

A second meeting with the HSE has been arranged for Friday, February 11, 2011. The HSE undertook to provide further information prior to this meeting.

Updates will be sent to IDA members by email.

## Learning by the Lakes May 12-15, 2011 – early birds

The brochure for the IDA Annual Conference was sent to all members before Christmas. Early booking rates are available for bookings made before March 11, 2011. To book your place, please contact IDA House.



## Metro Branch ASM

The Metropolitan Branch will hold its Annual Scientific Meeting in the Hilton Hotel, Charlemont, Dublin 2, on Friday February 18 next. Presentations will cover topics such as oral health and systemic diseases, medical emergencies, marketing, sales and communication skills, and finance. A full trade show will also be included on the day. For further information, contact Declan Corcoran, Email: declan@belfielddental.ie.

## IDA website upgrade

The IDA has appointed Webtrade to develop a new generation of the IDA website, which will be launched in the coming months. The developers have been tasked with overhauling the existing site and ensuring the ready availability of information to the profession, members of the Association, patients and the general public. Comments or suggestions on changes you would like to see incorporated into the website will be welcomed by the website committee, chaired by Dr Michael Crowe, Honorary Secretary of the Association. The committee also comprises Drs Mark Kelly, Karl Cassidy, Emlyn Bratton and Maurice Fitzgerald.

## Visiting professorship for Harris



Dr David Harris F.D.S.R.C.S.Eng., F.F.D., R.C.S.I., M.R.C.S.Eng., L.R.C.P.Lon., F.I.C.D. was appointed a visiting professor to the Medical University of Warsaw, Poland, in October 2010.

He holds a senior lecturer appointment in implant dentistry at Trinity College Dublin and is maintains a specialist oral surgery practice at Blackrock Clinic.

## Dental ethics

The Dental Council has proposed a revision to the Code of Practice for Professional Behaviour and Dental Ethics. The Dental Council is now consulting with the IDA and other stakeholders on the proposed revision.

## IDA nominations

The IDA has nominated Professor Brian O'Connell and Dr Marielle Blake as its nominees to the Board of the Dublin Dental School & Hospital.



# DR. PAUL A. TIPTON

B.D.S., M.S.C., D.G.D.P., U.K.

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- Anatomical carving for composites
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*Dr Caroline Ingamells, Lake District.*

*"Paul Tipton is very knowledgeable, demonstrating excellent practical tips. I recommend this course to all dentists wanting to absorb new knowledge in order to revolutionise the way they practice dentistry."*

*Dr Stephen J Legg, Derbyshire.*

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## DeCare launches waiting room magazine



Maureen Walsh, Managing Director (left) and Edel Jordan, Marketing Manager of DeCare Dental at the IDA event in the Aviva stadium.

DeCare Dental Insurance launched *Oral Health Zone*, a dental waiting room magazine at the IDA Aviva Conference. *Oral Health Zone* has been developed to fill the need for an informative dental patient magazine, which can be provided in the waiting room. It's packed with oral health tips, articles and advice, and is a valuable resource for dental patients throughout Ireland. Copies are available from DeCare.



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Dr Patrick J. Byrne, Dean.



## Updates on amalgam and tooth whitening

DR TOM FEENEY presents the latest news from the CED including the latest information on the EU Mercury Strategy, and an attempt to speed up progress on tooth whitening.

The topics of amalgam and tooth whitening continue to occupy much of the CED's time. Both items are very much part of everyday practice for most dentists. The CED is carefully monitoring the EU Mercury Strategy, which is currently under review, because of the implications this review may have for the delivery of restorative dentistry long term. As regards tooth whitening, the Commission is beginning to lose patience with the slow rate of progress in getting the whole issue resolved, and now has a new proposal to try to finally make progress.

### Amalgam

The EU Mercury Strategy is currently under review and the European Commission (EC) was scheduled to have this review completed by the end of 2010. The EC appointed a company called Biointelligence Services (BIOIS) to conduct the research for the review. The first draft report from BIOIS was published in June 2010 and a meeting was later hosted by the EC to present this report. The CED was represented at the meeting, as were other stakeholders and Member States. Feedback from the meeting will be taken into consideration in the final report.

There were some interesting comments from Member States:

- Sweden and Finland expressed their support for the actions identified by BIOIS for dental amalgam – namely the phasing out – stressing also that in order to do so it was necessary to build up an infrastructure, with suction devices and separators to deal with the amalgam waste.
- The Czech Republic and Spain were strongly against some actions identified by BIOIS since they would not be able to fulfil them, in particular the phasing out of dental amalgam. Spain mentioned that a phasing down could be considered.
- The UK mentioned that the BIOIS report had no impact assessment. A full cost-benefit analysis was necessary to know all the best options. The EC explained that BIOIS was only mandated to assess the environmental impact. The social and economic impacts were only to be assessed in a general way.

At the CED Brussels meeting, the CED Resolution on Amalgam was updated. The Resolution calls on Member States to ensure the full implementation and enforcement of EU waste laws, and fully supports examination into whether this is happening. In most Member States amalgam separators are used, and in many they are obligatory. Amalgam separators are an effective way of reducing harmful waste and remove a further 95% from the dental units' existing filtration systems, resulting in a total capture of 99%, and preventing waste amalgam entering the waste stream. The CED also encourages



national dental associations to share best practice on waste management and to support their members regarding compliance with waste management obligations.

In 2011 the Commission intends to undertake a full life cycle assessment of the use of mercury in dental amalgam. The CED will make sure that it continues to be involved in this process.

### Changes in funding for dentistry

At the recent Brussels meeting, a common theme running through country reports was government cuts in dental funding. Some examples are as follows:

**Hungary:** Continuing problems were reported because of reduced government expenditure for dental care and restrictions on items covered.

**Ireland:** Decreases in per-patient funding and restrictions of items covered under the Dental Treatment Services Scheme (DTSS) were reported, as were restrictions under the Dental Treatment Benefit Scheme (DTBS).

**Lithuania:** A fixed rate for payments by health insurance for prosthetic services was introduced; the difference for more sophisticated treatment is paid by the patient. There was a decrease of 11-14% in allocations from the Patient's Fund compared to 2008.

**The Netherlands:** Rates for orthodontics decreased by 34%, effective January 1, 2011; there was strong opposition from the NMT.

**Poland:** Expenditure of the National Health Fund lowered in 2010; the majority of dentists are now operating exclusively on the private market, outside of the general insurance scheme.

**Slovakia:** Financial problems were experienced by the largest insurance company. Pre-election promises of increased payments to the public insurance system were not fulfilled, particularly low payments for dentures.

### Tooth whitening

In the summer, the CED received a written request from the Commission to provide additional information on the current use of tooth-whitening products. The CED agreed to co-operate with the Commission, suggesting some changes to the Commission's questions to ensure that the answers would be relevant. The Commission agreed with the changes and the CED sent these questions to the CED members in the form of a questionnaire on August 31. The CED received 27 responses from 23 CED member associations and from four CED observer countries by October 12, 2010. These showed wide variations in the concentrations used by dentists and by patients, and underlined the need for order and structure to be brought to this area in the interests of patient safety.

The Commission has not yet enforced the current regulation (under the Cosmetics Directive), which establishes 0.1% as being the maximum authorised concentration of H<sub>2</sub>O<sub>2</sub> in finished products. This concentration is too low for tooth whitening; however, higher concentrations are not allowed, and any use of them, including by dentists, is illegal.

The Commission wants to see the whole tooth-whitening issue resolved; otherwise, it will start infringement procedures against Member States in order to enforce the current regulation. It now has a new proposal, namely that:

- under the 0.1% concentration, H<sub>2</sub>O<sub>2</sub> would be freely available;
- between 0.1% and 6% H<sub>2</sub>O<sub>2</sub>, first use is permitted by a dentist only, and the product should be supplied only by a dentist; and,
- H<sub>2</sub>O<sub>2</sub> is illegal above 6%.

This new proposal would provide clear regulation and would help those Member States that had no specific provisions against the use of tooth-whitening products by hairdressers and beauticians. It would also render the bleaching process legal for the first time, and dental practitioners would be in control of the product. There were advantages in that the CED would be helping to improve regulation (bleaching would be legal up to 6% H<sub>2</sub>O<sub>2</sub> and dentists would be the only ones that would supply this material), and the CED would be seen to be working positively with DG SANCO – a political advantage.

The CED supports the new proposal of the EC to regulate tooth-whitening products containing H<sub>2</sub>O<sub>2</sub> under the Cosmetic Products Directive.

### Questionnaire from the Czech Republic – sterile dental handpieces

A recent questionnaire from the Czech Dental Association contained the following question:

"Is there any obligation (legal or otherwise) in your country requiring the use of sterile dental handpieces in every procedure by

all persons involved?"

A total of 17 replies were received: 16 from CED members and one from a CED observer.

### Summary of answers

- Six countries (Bulgaria, Denmark, Latvia, Lithuania, Malta and the Slovak Republic) reported that there is a legal obligation to use sterile dental handpieces. Among these, Denmark reported that it also has binding guidelines and recommendations, and the Latvian Dental Association reported that it classified all dental handpieces as critical items that must be sterilised after each patient.
- Five countries (Greece, Ireland, Poland, the UK and Switzerland) reported that there are guidelines and/or recommendations issued by competent authorities and/or professional organisations.
- Eleven countries reported that there are no legal obligations. Among these, five countries stated that there are also no recommendations or guidelines.

### Main conclusion

In the majority of the countries there are no legal obligations to sterilise dental handpieces and in a considerable number of countries guidelines and/or recommendations still do not exist.

### Directive on the application of patients' rights in cross-border healthcare

On December 21, 2010, the Council approved the compromise text of the cross-border directive prepared on the basis of triologue consultations (the Council, the Parliament and the Commission), which concluded on December 15, 2010, in Strasbourg.

The compromise is in line with CED expectations and generally also with CED proposals set out in the September 2010 position paper. Specifically, CED concerns about including healthcare professionals in national contact points, and in assessment of healthcare technologies, and that national contact points should also provide information to healthcare professionals, are all included.

In addition, the wording on the information to be provided by healthcare providers to patients ("information on specific aspects of the healthcare services they offer and on the treatment options") is better than the wording in the Parliament's report, and should largely satisfy CED concerns that this information could include ranking of healthcare professionals. Finally, the IMI system will be used to exchange information between Member States about healthcare providers.

The next step will now be the vote in the European Parliament, currently still scheduled for January 19, 2011. The Directive could be in force as early as 2013.

### CED response to the public consultation on the Tobacco Products Directive

After comprehensive work by the CED Working Group Oral Health, the CED response to the public consultation on the Tobacco Products

Directive included the following:

- All tobacco products are hazardous to health – there is no safe level of usage. Therefore, the CED recommends that the scope of the Directive should include the regulation of any new tobacco products (such as low-emission or nicotine-free cigarettes), while the prohibition of any novel forms of oral tobacco, including snus, should be maintained.
- Herbal cigarettes are also harmful because it is the combustion and inhalation of smoke that causes most of the harm from smoking. Therefore, herbal cigarettes should be included in the scope of the Tobacco Products Directive and should also be subject to health warning requirements.
- All forms of nicotine-based products (that is, products containing nicotine but which are not tobacco products, such as electronic cigarettes, nicotine gel, drinks and sweets) are often marketed as alternatives to cigarettes, and in some cases as an aid to quitting smoking. Therefore, they should only be sold as quitting aids and should comply with specific safety and quality requirements under the same regulatory framework as pharmaceutical products, rather than under the scope of the Tobacco Products Directive. That includes evidence-based studies of the effectiveness of these products.
- Special attention should be paid to the specific protection of young people and women.
- The CED supports the adoption of a negative common list of tobacco ingredients. Tobacco products are highly toxic and addictive, and their content (main substances and additives) should be closely regulated. Tobacco smoke is a complex mixture of more than 4,800 substances, of which 90 are carcinogens or suspected to cause cancer. In addition, nicotine and co-carcinogens promote cancer development.
- The prohibition of ingredients such as sugars and sweeteners, flavouring substances, spices and herbs, in cigarettes and cigarette-like tobacco products is necessary. The prohibition of ingredients such as vitamins, ingredients associated with energy and vitality (e.g., caffeine), and ingredients with colouring properties (e.g., pink cigarette paper) should also be banned. Tobacco manufacturers and importers should report sales volume information by brand. This information is essential to help governments to ensure that product regulation is effective.

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**Complication and failure rates of fixed dental prostheses in patients treated for periodontal disease**

Brägger, U., Hirt-Steiner, S., Schnell, N., Schmidlin, K., Salvi, G.E., Pjetursson, B., et al.

**Objectives:** To evaluate the biological and technical complication rates of fixed dental prostheses (FDPs) with end abutments or cantilever extensions on teeth (FDP-tt/cFDP-tt), on implants (FDP-ii/cFDP-ii), and tooth-implant-supported (FDP-ti/cFDP-ti), in patients treated for chronic periodontitis.

**Material and methods:** From a cohort of 392 patients treated between 1978 and 2002 by graduate students, 199 were re-examined in 2005. Of these, 84 patients had received ceramo-metal FDPs (six groups).

**Results:** At the re-evaluation, the mean age of the patients was 62 years (36.2-83.4). One hundred and seventy-five FDPs were seated (82 FDP-tt, nine FDP-ii, 20 FDP-ti, 39 cFDP-tt, 15 cFDP-ii, 10 cFDP-ti). The mean observation time was 11.3 years; 21 FDPs were lost, and 46 technical and 50 biological complications occurred. Chances for the survival of the

three groups of FDPs with end abutments were very high (risk for failure 2.8%, 0%, 5.6%). The probability to remain without complications and/or failure was 70.3%, 88.9% and 74.7% in FDPs with end abutments, but 49.8-25% only in FDPs with extensions at 10 years.

**Conclusions:** In patients treated for chronic periodontitis and provided with ceramo-metal FDPs, high survival rates, especially for FDPs with end abutments, can be expected. The incidence rates of any negative events were increased drastically in the three groups with extension cFDPs (tt, ii, ti). Strategic decisions in the choice of a particular FDP design and the choice of teeth/implants as abutments appear to influence the risks for complications to be expected with fixed reconstruction. If possible, extensions on tooth abutments should be avoided, or used only after a cautious clinical evaluation of all options.

*Clin Oral Impl Res 2011; 22: 70-77.*

**An alternative impression technique for individuals with special care needs**

Topouzelis, N., Kotsiomi, E., Arhakis, A.

Impression making may be complicated in individuals with limited ability to co-operate with caregivers. An alternative technique for obtaining full-arch casts from sectional preliminary impressions is described. The technique is a modification of the procedure advocated for impression making in subjects with limited mouth opening. A pair of partial stock trays is selected to fit the right and left side of the arch. Two sectional irreversible hydrocolloid impressions are made separately. The first cast is placed into the second impression prior to pouring, to obtain a cast of the complete arch. The procedure was used during the treatment of an unco-operative young patient with Lesch-Nyhan syndrome and provided a simple and reliable means to obtain the diagnostic cast of the mandibular teeth. It is recommended not only for unco-operative patients, but also for patients with special needs, such as those with anatomical restrictions, functional impairment and movement disorders.

*Special Care Dentistry 2010; 30 (6): 266-270.*

**A retrospective study of 889 injured permanent teeth**

Hecova, H., Tzigkounakis, V., Merglova, V., Netolicky, J.

The aim of this study was to investigate pre-injury factors, causes of dental injuries and healing complications after traumatic injuries to permanent teeth. The analysed sample comprised 889 permanent teeth of 384 patients, who were treated in the Dentistry Department in the Faculty Hospital in Pilsen. Enamel-dentin fractures (233 teeth [26.2%]) and lateral luxations (207 teeth [23.3%]) were the most frequent injuries. The age of the patients at the time of injury varied between seven and 65 years. Predominantly, children were affected



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## QUIZ

Submitted by Dr David Finucane

1. Name the condition.



16



26



Maxillary permanent incisors.



46



36

2. How is the condition diagnosed?

3. What clinical problems are encountered in this condition?

Answers on page 49

(587 injured teeth [66%]). The most frequent causes of injuries in patients older than 11 years were various sport activities, predominantly bicycling. Pulp necrosis was observed in 239 teeth (26.9%). It was the most frequent post-traumatic complication in all types of dental traumas. Teeth with a completed root formation demonstrated a higher prevalence of pulp necrosis than teeth with an incomplete root formation in all types of luxation injuries. External root resorption was observed in 144 teeth. The rate of inflammatory resorption differed between the various types of luxation injuries (extrusive luxation 5.6%, lateral luxation 11.6%, intrusive luxation 33.3%). Following avulsion and replantation, active inflammatory resorptions were diagnosed in 13 (26.5%) of 49 replanted teeth, and ankylosis/replacement resorptions were observed in 21 (42.9%) of 49 replanted teeth. After avulsion, primarily, immature teeth were affected by these complications. Within the observation period of five years, 39 teeth (4.4%) had to be removed (16 teeth with root fractures, 19 avulsed and replanted teeth, three luxated teeth, and one tooth with crown-root fracture).

*Dental Traumatology 2010; 26 (6): 466-475.*

### Effects of feeding on non-nutritive sucking habits and implications on occlusion in mixed dentition

Montaldo, L., Montaldo, P., Cuccaro, P., Caramico, N., Minervini, G.

**Background:** Several studies have determined the effects of non-nutritive sucking habits on malocclusions, but provided conflicting results.

**Aim:** To analyse the influence of infant feeding in the presence of non-nutritive sucking habits in children after the first year of life, and to assess the effects of non-nutritive sucking habits on occlusion in mixed dentition.

**Design:** Data were collected by self-reported questionnaire and confirmed by personal interview. Parents of 1,451 children (aged seven to 11 years) were asked about their children's infant feeding and non-nutritive sucking habits. A clinical evaluation of dental arches included classification of molar relationship (angle classification), presence or absence of crossbite and open bite.

**Results:** Children with bottle or complementary feeding showed a higher risk of acquiring non-nutritive sucking habits after the first year of life ( $p < 0.01$ ). Non-nutritive sucking habits are associated with a greater risk of crossbite, open bite, and Class II molar relationship ( $p < 0.01$ ).

**Conclusions:** Parents should be educated about the benefits for mixed dentition of exclusive breastfeeding in the first six months of age. The activity of non-nutritive sucking should be diagnosed in a timely manner in order to reduce the development of posterior crossbite, anterior open bite, and Class II molar relationship.

*International Journal of Paediatric Dentistry 2011; 21: 68-73.*




Quiz answers (questions on page 20)

1. Molar–incisor hypomineralisation (MIH).
2. MIH diagnostic criteria and clinical appearance:<sup>1</sup>
  - first permanent molars and incisors: at least one first permanent molar must be affected.
  - demarcated opacities:
    - opacities at occlusal and buccal part of crown; and,
    - defects vary in colour (white, creamy, yellow-brown) and size.
  - enamel disintegration: degree of porosity of hypomineralised areas varies. Severely affected lesions are subject to masticatory-force break down ('post-eruptive breakdown').
  - atypical restorations: defects are generally shallow but broad, so traditional cavity design is not possible.
  - tooth sensitivity: problems achieving anaesthesia.
3. Clinical problems:
  - hypersensitivity of affected teeth (particularly molars);
  - difficulty achieving anaesthesia;
  - post-eruptive breakdown: molar cusps particularly affected (viz. picture of tooth 36);<sup>2</sup>
  - difficult to restore:<sup>3</sup> composite or glass ionomer restoration of molars may suffice as interim restoration, but definitive restoration may require onlays or crowns. If severely affected, planned extraction of molars may be necessary;
  - difficult to correct aesthetic problems of incisors:<sup>4</sup> bleaching is not always successful, and may increase sensitivity. Micro-abrasion is of limited value, as lesions often extend through full thickness of enamel. Composite inserts are generally successful, but are more destructive of tooth substance; and,
  - behaviour management problems:<sup>5</sup> affected children are subject to much treatment, which, due to difficulty achieving anaesthesia, may be painful. This can result in difficulty in accepting treatment. Sedation or general anaesthesia may be required.

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# The cyclooxygenase-2 inhibitor celecoxib and alveolar osteitis

## Abstract

**Purpose of the study:** The purpose of this study was to report our clinical experience, in a pilot study, of the use of the selective cyclooxygenase-2 (COX-2) inhibitor celecoxib, pre-emptively, to control pain in patients after surgical extraction of a mandibular molar tooth.

**Patient and methods:** This randomised, double-blind, placebo-controlled, prospective clinical trial was conducted over an eight-month period. Participants were randomly allocated to receive a standard oral dose of 200mg celecoxib, 400mg ibuprofen, or a placebo containing lactose, pre-emptively, one hour before surgery. Each patient was prescribed amoxicillin 500mg three times per day postoperatively for seven days. The participants were given standardised participant information sheets, and written informed consent was subsequently obtained from the participants prior to the commencement of the study.

**Results:** The results showed that 13% of the patients who had ibuprofen had severe pain two to three days postoperatively. This was diagnosed as alveolar osteitis, which is in line with the universally accepted outcome for the surgical extraction of mandibular molar teeth. Statistical analysis (Chi-square test) confirmed that the ibuprofen group had a significantly higher alveolar osteitis incidence than the celecoxib group ( $p \leq 0.05$ ) and the placebo group ( $p \leq 0.05$ ).

**Conclusion:** This is the first reported study to demonstrate that the use of celecoxib resulted in a significant decrease in the occurrence of alveolar osteitis.

**Key words:** Celecoxib, cyclooxygenase-2, COX-2 inhibitor, NSAIDs, ibuprofen, alveolar osteitis.

*Journal of the Irish Dental Association 2011; 57 (1): 50-53.*

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## Introduction

The cyclooxygenase-2 (COX-2) inhibitors widen the spectrum of pharmacological management of pain and inflammation for many patient groups.<sup>1</sup> Prior to the introduction of COX-2 inhibitors, patients were exposed to harmful side-effects associated with the long-term use of non-selective non-steroidal anti-inflammatory drugs (NSAIDs), such as gastric ulcer bleeding and perforations, or the risk of addiction with the long-term use of narcotics. COX-2 inhibitors offer greater

safety in conjunction with comparable efficacy, compared to simpler NSAIDs, in managing pain, including acute dental pain. COX-2 inhibitors are the medication of choice for use in patients with gastric disease for both prophylactic or post-treatment analgesic pain management. Until recently, COX-2 inhibitors were gaining more popularity for pain relief in general.<sup>1,2</sup> In fields such as oral surgery, there has been an increase in the prescribing of COX-2 inhibitors. The use of the traditional NSAID

ibuprofen had been challenged by these 'promising' COX-2 inhibitors.<sup>1</sup>

However, in the last few years interest in the cardiovascular effects of the relatively selective COX-2 inhibitors has been intense.<sup>1-4</sup> In October 2004, rofecoxib was withdrawn from world markets after a randomised placebo-controlled trial found that doses of 25mg/d increased rates of cardiovascular events in patients with colorectal polyps.<sup>1</sup> The results were confirmed by several large pharmaco-epidemiological studies.<sup>1-7</sup> Celecoxib continues to be widely used, despite meta-analyses of randomised controlled trials showing an increased risk of myocardial infarction.<sup>1,2</sup> The differences between rofecoxib and celecoxib appear important from both a clinical and regulatory standpoint. Based on the randomised data, celecoxib appears to be unsafe in doses of 400mg or more. However, at doses of 200mg or less there is no convincing evidence of an increased risk of cardiovascular events with celecoxib, which remains on international markets.<sup>1,2</sup> These results seem to point to different dose-effect gradients in the vascular compartment across the ranges of doses of celecoxib and rofecoxib that were used in clinical practice.<sup>1,2</sup>

Despite the abundance of research concerning the effectiveness of many analgesics, including their pre-emptive analgesic effectiveness, there is little information regarding the pre-emptive analgesic effectiveness of celecoxib at the lower dose of 200mg. Furthermore, review of the literature does not allow a judgment about whether any claimed advantages of celecoxib outweigh the elevated cardiovascular risk seen with high doses.<sup>2</sup>

The purpose of this study was to report our clinical experience, in a pilot study, on the use of the selective COX-2 inhibitor celecoxib, pre-emptively, to control pain in patients after surgical extraction of a mandibular molar tooth. This report documents the remarkable decrease in the occurrence of alveolar osteitis when celecoxib was used one hour pre-emptively. Alveolar osteitis (also known as dry socket) is a disruption to the healing of the alveolar bone following extraction of the tooth.<sup>12</sup> Alveolar osteitis occurs when the blood clot at the site of a tooth extraction is disrupted prematurely. This leaves the alveolar bone unprotected and exposed to the oral environment.<sup>12</sup> This is often extremely unpleasant for the patient, as symptoms include extreme pain (sometimes worse than the toothache that indicated the extraction), a foul taste, bad breath, and swelling in the infected area. There may also be lymph node involvement.

### Patients and methods

This randomised, double-blind, placebo-controlled, prospective clinical trial was conducted at Euro-Oral Hammaslääkärikeskus in Helsinki, Finland, over an eight-month period. Participants were randomly allocated to receive a standard oral dose of 200mg celecoxib, 400mg ibuprofen, or a placebo containing lactose, pre-emptively, one hour before surgery. The doses were selected based on the product labelling<sup>8-11</sup> and other currently available product information.<sup>8-11</sup> Each patient was given a prescription for 1,000mg of paracetamol as a rescue medication in case the study medication did

not provide sufficient pain relief. Each patient was prescribed amoxicillin 500mg three times per day postoperatively for seven days. Patients were not prescribed any postoperative analgesia apart from paracetamol as a rescue medication.

### Eligibility and exclusion criteria

Patients (n=464) who were healthy and classified as status I according to the American Society of Anesthesiologists physical classification were eligible for participation in the study. These patients were 229 men and 227 women who were scheduled to undergo surgical removal of a mandibular molar. The surgery was performed under local anaesthesia, with 2% lignocaine containing 1:80,000 epinephrine, by the same surgeon. Surgery time and the amount of anaesthetic used were recorded to gauge the degree of surgical difficulty. From six hours before surgery, patients were not allowed to take any medication that could affect the analgesic response. Patients were excluded if they had any conditions that contraindicated the use of NSAIDs or COX-2 inhibitors, were pregnant or nursing, had psychological or psychiatric conditions, were taking psychotropic medications, or had active ulcers or gastro-intestinal bleeding, liver dysfunction, inflammatory intestinal disease, or decreased kidney function. The participants were given standardised participant information sheets, and written informed consent was subsequently obtained from the participants prior to the commencement of the study. The institutional review board approved the protocol and the informed consent document.

For the analysis of differences in frequencies of postoperative complications, including alveolar osteitis, in various patient groups, the Chi-square test was applied, defining  $p < 0.05$  to be a significant difference. Statistical analysis was performed using the software SigmaStat 3.0 (SPSS Inc., USA).

### Results

Of the 464 participants, eight (1.7%) did not complete the trial because they failed to present at the postoperative review. A total of 229 men and 227 women participated in the study, with a mean age of  $38.9 \pm 7.7$  years. There were 72 men and 75 women in the celecoxib group, 80 men and 82 women in the ibuprofen group, and 77 men and 70 women in the placebo group. The mean weights for the celecoxib, ibuprofen and placebo groups were  $77 \pm 10$ ,  $74 \pm 14$ , and  $70 \pm 16$ kg, respectively. There were no significant differences in age or weight between the groups. The mean duration of surgery was  $30.9 \pm 21.6$  minutes and did not vary significantly between the groups. The mean volume of local anaesthetic administered was 5.1ml, and this volume did not differ significantly between the groups.

### Safety profile

No persistent or unexpected adverse events were reported. The most common adverse events were nausea (occurring in 22%, 13.3% and 18.1% of placebo, celecoxib and ibuprofen patients, respectively), headache (13.1%, 10.2% and 9.7%), and vomiting (10.3%, 3.3% and 4.1%). Vomiting occurred more frequently in placebo patients



Table 1: Incidence of alveolar osteitis (dry socket). Statistical analysis (Chi-square test) confirmed that the ibuprofen group had a significantly higher alveolar osteitis incidence than the celecoxib group ( $p \leq 0.05$ ) and the placebo group ( $p \leq 0.05$ ).

	Tooth number	Number of teeth extracted	Number of dry socket	Incidence of dry socket
Placebo	First molar	35	10	
	Second molar	50	11	
	Third molar (wisdom tooth)	62	10	
	<b>Total</b>	<b>147</b>	<b>31</b>	<b>21.1%</b>
Ibuprofen group	First molar	45	7	
	Second molar	51	9	
	Third molar (wisdom tooth)	66	5	
	<b>Total</b>	<b>162</b>	<b>21</b>	<b>13.0%</b>
Celecoxib group	First molar	39	0	
	Second molar	48	0	
	Third molar (wisdom tooth)	60		
	<b>Total</b>	<b>147</b>	<b>0</b>	<b>0.0%</b>

than in celecoxib patients ( $p < 0.05$ ). None of the other between-group differences in nausea or headache were statistically significant ( $p > 0.05$ ).

A total of 13% of the patients who took ibuprofen had severe pain two to three days postoperatively. This was diagnosed as alveolar osteitis, which is in line with the universally accepted outcome for the surgical extraction of mandibular molar teeth.<sup>12</sup> Alveolar osteitis occurred more frequently in placebo patients (21.1%). None of the celecoxib patients developed alveolar osteitis postoperatively. The ibuprofen group had a significantly higher alveolar osteitis incidence than the celecoxib group ( $p \leq 0.05$ ) and the placebo group ( $p \leq 0.05$ ). The use of the celecoxib resulted in a significant decrease in the occurrence of alveolar osteitis (Table 1).

## Discussion

The selective COX-2 inhibitors have been found to exert significant opioid-sparing effects after dental, gynaecologic, orthopaedic, and other non-cardiac surgical procedures, apparently without causing serious adverse effects.<sup>1</sup> Recently, studies of the long-term administration of COX-2 inhibitors have aroused concern regarding their potential to increase the risk of thromboembolic events after vascular surgery.<sup>1-3,14</sup>

To discuss the aetiology and the factors that could result in alveolar osteitis is beyond the scope of this study. We understand that the reason for dry socket happening could be a multi-factorial one, including the surgical management of the flap at the time of the surgery and postoperatively. However, the same surgeon operated on the patients and the same medical regimen was used for all patients postoperatively. Also, systematic review of the medication prescribed to the patients over the past two years revealed that the use of a

COX-2 inhibitor drug was the only variant that could possibly have resulted in the decreased incidence of dry socket. COX-2 inhibitors not only lack the antiplatelet effects of aspirin; by inhibiting the production of prostacyclin, they also disable one of the primary defences of the endothelium against platelet aggregation, hypertension and atherosclerosis.<sup>1,14</sup> COX-2 inhibitors also promote an imbalance in favour of vasoconstriction.<sup>1,14</sup> These biologic actions suggest that COX-2 inhibitors might increase the risk of clot formation. While this might have a harmful effect in patients undergoing vascular surgery, it might have a beneficial effect in stabilising the blood clot in the alveolar socket following dental extraction. Stabilising the blood clot would ultimately decrease the incidence of infection and alveolar osteitis postoperatively.

Based on the randomised data, celecoxib appears to be unsafe in doses of 400mg or more. However, at doses of 200mg or less there is no convincing evidence of an increased risk of cardiovascular events with celecoxib, which remains on international markets.<sup>1,3</sup> Higher and lower doses of celecoxib have been evaluated in the treatment of dental pain. However, higher doses have not been reported to provide significant additional analgesic effects, and lower doses were less effective than NSAIDs.<sup>3,12</sup> In studies of acute pain, celecoxib 200mg has been shown to provide analgesic effects significantly greater than those with placebo and comparable to those with aspirin 650mg, with a slight improvement in effect when the dose was increased to 400mg.<sup>1,11</sup> Similarly, ibuprofen 400mg provided maximum efficacy in patients with acute pain, with no additional clinical efficacy demonstrated at higher doses.<sup>3</sup> Overall, doses selected for the present study reflect the maximum single dose for the relief of acute pain postoperatively. The use of small doses of celecoxib 200mg pre-emptively shows promising results in reducing

pain and alveolar osteitis in patients undergoing surgical dental extractions.

### Conclusion

This is the first reported study to demonstrate that the use of celecoxib resulted in a significant decrease in the occurrence of alveolar osteitis.

### Disclaimer

We hereby certify that, to the best of our knowledge, no financial support or benefits have been received by us or any co-author, or by any member of our immediate family or by any individual or entity with whom or with which we have a significant relationship, from any commercial source, which is related directly or indirectly to the scientific work that is reported in the article. We understand that an example of such a financial interest would be a stock interest in any business entity that is included in the subject matter of the manuscript or that sells a product relating to the subject matter of the manuscript.

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# An audit comparing the discrepancies between a verbal enquiry, a written history, and an electronic medical history questionnaire: a suggested medical history/social history form for clinical practice

**Précis** A comprehensive medical/social history is an essential part of proper patient management.

## Abstract

In everyday practice, dentists are confronted with an increasing number of patients with complex medical problems. There is divergence of opinion among dentists regarding how to obtain a thorough medical/social history.

**Purpose:** The objective of this audit is to produce a standardised medical history in order to identify the medically compromised patient attending the general dental practitioner. At present in the Dublin Dental School and Hospital, there are three different methods: a verbal enquiry, and a written or an electronic questionnaire. This study was undertaken to identify any differences or discrepancies between each of the three methods in eliciting the medical history, and to determine whether one method was superior to the others. The results are used to recommend the most accurate method for obtaining a thorough health history for practitioners, both in a hospital and a general practice setting.

**Method:** One hundred and fifty charts within the Dublin Dental School and Hospital of all new patients at a randomly chosen clinic were selected and then audited: 50 charts from the oral and maxillofacial surgery assessment clinics (written *pro forma* questionnaire), 50 from the oral medicine clinic (consultant verbal enquiry), and 50 from A&E (electronic questionnaire) were compared to determine if an adequate medical history was taken, and to detect differences and discrepancies in patients' medical histories. The records pertained to 91 females and 59 males. The age distribution was 5-87 years for females and 3-85 years for males. The mean age was 45 years for females and 42 years for males.

**Results:** The written patient-administered *pro forma* questionnaire, combined with verbal verification by the clinician/consultant, proved to be the most useful and consistent method for detecting medical problems in dental patients. The consultant verbal enquiry alone showed more inconsistency than the other two methods. Based on these results, a modified questionnaire for use within all departments in the Dental Hospital has been proposed. This may also be suitable for use by general dental practitioners in their practice setting.

**Conclusion:** It is incumbent on the clinician/dentist to evaluate each patient's general health prior to delivering treatment in order to avoid unnecessary and preventable complications. The use of written patient-administered *pro forma* questionnaires is beneficial but must be verified by the examining clinician/dentist and assessed at each new visit (6-12 monthly) to be contemporaneous.

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### Medical history

1. Do you have any heart conditions, e.g., rheumatic fever/congenital heart defects/heart murmurs/previous endocarditis/other?
2. Have you ever had chest problems, e.g., bronchitis/asthma/ pneumonia/other?
3. Have you ever had any of the following: epilepsy/diabetes/jaundice/ hepatitis/liver disease?
4. Do you, or any member of your family, have a history of bleeding, in particular after extractions?
5. Are you taking any medications at present, either prescribed or over-the-counter drugs, e.g., systemic steroids/other?
6. Do you have any allergies, including allergies to medicines, e.g., penicillin/ aspirin/hay fever/eczema/latex/metals/other?
7. Have you ever been prescribed or taken over-the-counter slimming tablets?
8. Have you ever been prescribed human growth hormone?
9. Have you, or any of your family, had GA problems?
10. Do you or any members of your family have sickle cell disease?
11. Are you, or do you think you could be, pregnant?
12. Are you taking the oral contraceptive pill (OCP)?
13. Are you receiving medical care at the moment, or have you had a serious illness in the past?
14. Have you been in hospital in the past?
15. Do you know of any other relevant medical history we have not already covered?

### Social history

1. Do you drink alcohol? If yes, how many units per week?
2. Do you smoke? Cigarette/pipe/cigar/other? Number of units?
3. What are your family circumstances?
4. Are you employed at present?

FIGURE 1: Salud questionnaire.

## Introduction

A logical and well organised approach should be followed to record a patient's medical history. As the population continues to age, dentists are now more likely to be faced with an increasing number of patients with complex medical problems. Dental patients more frequently undergo local anaesthesia, sedation and more advanced dental procedures. Studies have shown that medical emergencies do occur in medically compromised patients attending general dental practice.<sup>1-3</sup> Within the Departments of Oral & Maxillofacial Surgery and Oral Medicine, and the Accident and Emergency (A&E) Unit, there are currently three different medical history systems in operation:

- an electronic medical history questionnaire administered by the clinician in A&E (Figure 1);
- a verbal enquiry by the clinician/consultant in oral medicine; and,
- a written patient-administered *pro forma* questionnaire, followed by a verbal verification, within oral and maxillofacial surgery clinics (Figure 2).

DUBLIN DENTALSCHOOL & HOSPITAL

DATE: .....

NAME: .....

CHARTNO: ..... AGE: ..... D.O.B.: .....

TELEPHONE: ..... (or neighbour) OCCUPATION: .....

MARRIED / SINGLE / PARTNER DO YOU HAVE ANY CHILDREN? IF SO, HOW MANY .....

HOW MUCH ALCOHOL DO YOU CONSUME? ..... HOW MUCH DO YOU SMOKE? .....

WOULD YOU LIKE TO GIVE UP SMOKING? YES / NO

		YES	NO			YES	NO
1	Do you feel healthy?	<input type="checkbox"/>	<input type="checkbox"/>	5.	Is there a possibility that you are pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
2	• Murmurs or rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	6.	Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>
	• Angina (chest pain)	<input type="checkbox"/>	<input type="checkbox"/>		• Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
	• Heart attacks	<input type="checkbox"/>	<input type="checkbox"/>		• Other drugs / medicines	<input type="checkbox"/>	<input type="checkbox"/>
	• High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		• Elastoplast	<input type="checkbox"/>	<input type="checkbox"/>
					• Other	<input type="checkbox"/>	<input type="checkbox"/>
3.	Do you suffer from chest complaints?	<input type="checkbox"/>	<input type="checkbox"/>	7.	• Do you suffer from fits (epilepsy) or are you prone to fainting attacks?	<input type="checkbox"/>	<input type="checkbox"/>
	• Coughs	<input type="checkbox"/>	<input type="checkbox"/>	8.	• Have you ever bled excessively	<input type="checkbox"/>	<input type="checkbox"/>
	• Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		• Following a cut or tooth extraction?	<input type="checkbox"/>	<input type="checkbox"/>
	• Asthma	<input type="checkbox"/>	<input type="checkbox"/>	9.	• Have you ever had hepatitis or Jaundice?	<input type="checkbox"/>	<input type="checkbox"/>
	• other	<input type="checkbox"/>	<input type="checkbox"/>	10.	• Do you have arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
4	• Are you receiving any tablets, medicines, Creams or ointments from your doctor at the moment? If yes please list: .....	<input type="checkbox"/>	<input type="checkbox"/>	11.	• Are you suffering with diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
	• Are you taking any or have you taken steroids in the past two years?	<input type="checkbox"/>	<input type="checkbox"/>	12.	• Are you attending your own doctor or hospital for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
	• Are you taking the contraceptive pill?	<input type="checkbox"/>	<input type="checkbox"/>	13.	• Do you wish to discuss anything in confidence?	<input type="checkbox"/>	<input type="checkbox"/>
14	Insurance Cover VHI <input type="checkbox"/> (level ABCDE) BUPA <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/>						

DOCTORS NAME AND ADDRESS .....

DENTIST'S NAME AND ADDRESS .....

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT: .....

Do you have any specific questions that you would like to ask about your oral / facial problem? .....

Oral Maxillofacial Health Unit APPROVED BY HCC FEB 07

FIGURE 2: Oral and maxillofacial surgery questionnaire.

These methods all have advantages and disadvantages but no research/audit basis. There is no agreement in the literature as to whether a written patient-administered *pro forma* medical history questionnaire or a verbal dialogue history is the most reliable method for collecting this information.<sup>4,7</sup> However, studies have shown that patient-administered *pro forma* questionnaires are more efficient, consistent and useful for subsequent documentation.<sup>4,6,7</sup> The EMRRH (European Medical Risk Related History) was found to be a useful tool in the detection of medically compromised patients in 10 European countries.<sup>8</sup> Some of these questionnaires can be very extensive and time consuming, and must be perceived by the clinician and patient to be of clinical/social value.

## Aim

The objectives of this audit were to produce a standardised medical history, to identify any differences or discrepancies between each of the

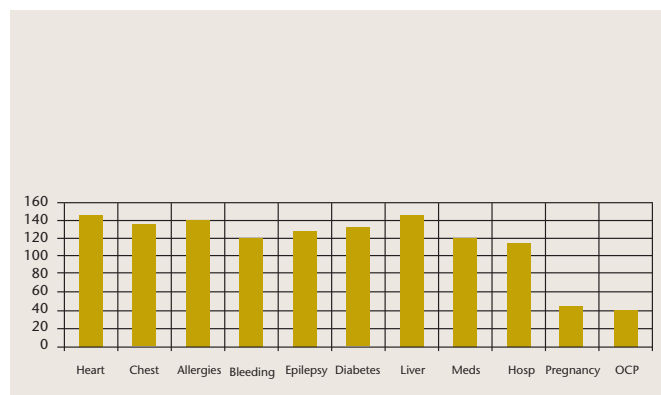


FIGURE 3: Topics about which questions were asked most frequently in all three questionnaires.

methods, and to determine if one method was superior to the others. The results will be used to recommend a method for obtaining a thorough health history for practitioners.

### Materials and methods

A total of 150 charts were studied; 50 charts from the oral and maxillofacial surgery (OMFS) assessment clinics (written *pro forma* questionnaire), 50 from the oral medicine clinic (verbal enquiry), and 50 from A&E (electronic questionnaire) were compared to detect any differences and discrepancies. The computerised questionnaire on Salud (a system for managing dental information in the Hospital) was used as the benchmark in this study. This questionnaire was approved by the Clinical Committee within the Hospital in 2004. The questionnaire is shown in Figure 1. The differences and discrepancies included variations in the aspects of the medical history covered in each of the three methods and the extent to which each method was completed. The most efficient method was determined by the degree to which each question was completed. The OMFS written *pro forma* questionnaire is a list of questions previously designed by the consultants within that specialty as representing important medical information related to the majority of OMFS surgeries. The questionnaire consists of a number of 'yes' or 'no' questions designed to detect medical problems. No set list of questions is followed within the oral medicine clinic and the medical history completed is entirely dependent on the examining clinician/consultant interrogation. Charts of 50 new patients in each arm of the study were selected from random clinics over a three-month period. The authors were unaware of the diagnosis/medical history, age or gender of the patients prior to the 'clinic' selection.

### Results

One hundred and fifty patient charts were audited. The patient population was 61% female and 39% male. The age distribution was 5-87 years for females and 3-85 years for males. The mean age was 45 years for females and 42 years for males.

The study found that all three types of health history assessment

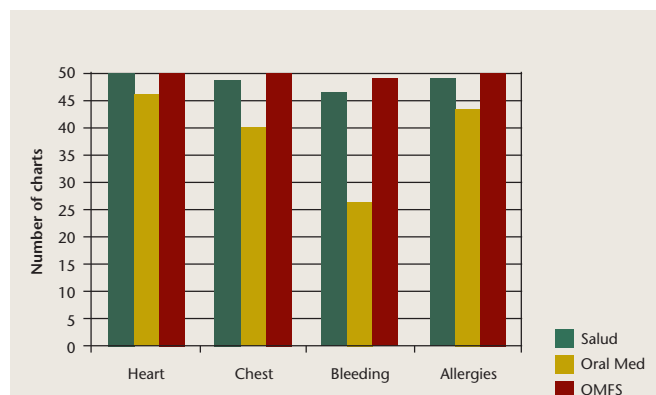


FIGURE 4: Differences in results between clinics relating to cardiovascular system, pulmonary system, bleeding and allergies.

addressed life-threatening conditions like heart problems (146), chest problems (138) and allergies (142). The next most common topics included bleeding (121), epilepsy (128), diabetes (134), liver problems (138) and current medications (122). The least mentioned subjects were previous hospitalisations (116), pregnancy (44) and use of the oral contraceptive pill (OCP) (42) (Figure 3). Information on infectious diseases like AIDS and hepatitis B, and the use of recreational drugs, was not often requested.

Considerable discrepancies were noted between the verbally administered questionnaire and the electronic questionnaire. There was a wide variation between the three different questionnaires in the type and frequency of questions asked. Topics that were asked most frequently were questions relating to heart problems, chest problems and allergies. The written *pro forma* questionnaire combined with verbal verification was the most accurate method, with heart problems, chest problems and allergies asked in 100% of cases. The electronic questionnaire on Salud also proved to be an efficient method with heart problems asked in 100% of patients, chest problems in 96% and allergies in 98%. The verbal dialogue history was the least efficient method, with 92% of patients being questioned on heart problems, 80% on chest problems and 86% on allergies. In relation to bleeding, the written patient-administered *pro forma* questionnaire was the most efficient with 98% of patients interrogated. The electronic questionnaire followed at 92%. The verbal enquiry requested this information in only 52% of patients (Figure 4).

In questions relating to epilepsy, diabetes, jaundice and hepatitis the written *pro forma* questionnaire combined with verbal verification was superior, with queries made regarding epilepsy in 98% of charts, diabetes in 100% and jaundice/hepatitis in 100%. The dentist-administered electronic questionnaire combined all these topics as a single question and this was asked in 94% of cases. Again, the verbal enquiry proved to be the least efficient, with values obtained for epilepsy, diabetes and jaundice/hepatitis being 64%, 74% and 82%, respectively. The study demonstrated that 58.7% of patients were taking medication on a daily basis. However, there appeared to be a huge

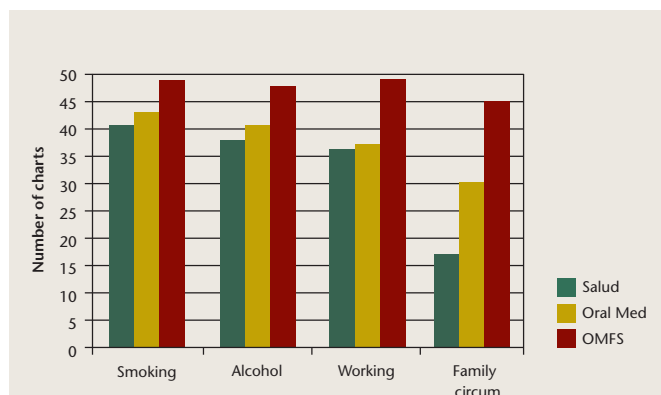


FIGURE 5: Social history results.

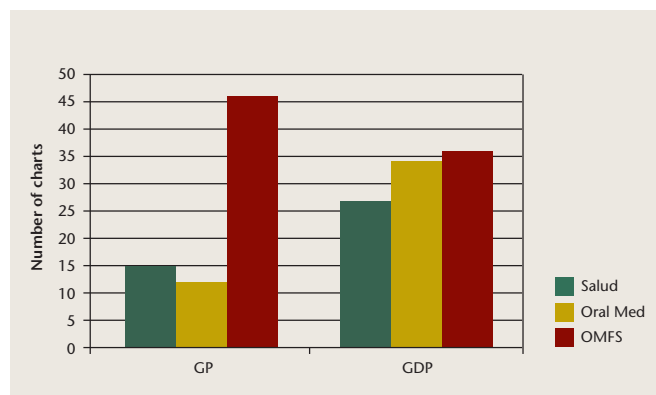


FIGURE 6: GP/GDP results.

discrepancy within all three questionnaires in relation to this topic. The verbal questionnaire in the oral medicine clinic achieved the greatest result with 100% of patients knowing the name of the drug and 52% knowing the dosage. However, this is based on the clinician researching the British National Formulary (BNF) and adding to the list. The Salud system also performed well, with 100% recalling the name, but only 40% recalling the dosages. The written *pro forma* questionnaire alone performed quite poorly. Only 70% of patients knew the name and 15% knew the dosages. However, this value did increase after verbal enquiry in the clinic with these values increasing to 81% and 36%, respectively.

A major flaw was noted in the medications question on Salud. Because the question was not of a simple 'yes/no' type, in cases where the patient was not taking medications, the question appeared on the system as if it was 'not asked' by the examining dentist. This accounted for the very high 52% of 'not asked' results. This might expose the hospital/clinician to medico-legal action if something important were missed and interpreted as not done.

Pregnancy and OCP results are shown only for women. Men made some interesting comments in the written *pro forma* questionnaire! There were a total of 17 women of child-bearing age in the electronic questionnaire used within the A&E clinic. Only 70% of females were questioned on the topic of possible pregnancy; 41% were questioned regarding the OCP. In the verbal enquiry, 0% of the 10 females were asked about pregnancy, 30% about the OCP. Within the patient-administered written *pro forma* questionnaire, 100% of women of all ages answered on the subjects of pregnancy and the OCP; 94% of males also answered this question and all were negative!

The verbal dialogue questionnaire failed to record whether the patient was receiving any other medical care at present in 90% of cases. This was answered in 82% of the electronic questionnaires and 96% of the written patient-administered *pro forma* questionnaires. As regards previous hospitalisations, the electronic questionnaire gained the best response, with an 82% response to this question. This topic was asked in 72% of the verbal enquiry cases. The question concerning previous

hospitalisations was not asked in the OMFS patient-administered *pro forma* questionnaire. However, in 70% of cases, this question was asked in the clinic.

Some 82% of patients in the electronic history on Salud and 96% of patients in the OMFS patient-administered *pro forma* questionnaire were asked about any other relevant medical history they wished to discuss, which was not already covered. Only 12% of patients were asked this question verbally in the oral medicine clinic.

The social history is an important aspect of a dental examination. The frequency of questions relating to smoking, alcohol consumption and employment scored high within all questionnaires (Figure 5). A&E was the least efficient of the three. The patient-administered *pro forma* questionnaire combined with verbal verification was the most consistent of the three methods, with a 98% and 96% response on questions concerning smoking and alcohol, respectively. The verbal enquiry also proved to be efficient on these topics, with smoking and alcohol habits being interrogated in 86% and 82% of cases. This is in comparison to the electronic questionnaire, where smoking was asked in 82% of patients and alcohol in 76%.

Analysis of GDP and GP details showed that the written *pro forma* questionnaire was the most consistent method for recording this information, with 92% and 72% of patients providing information on their GP and GDP, respectively. Only 30% of patients were asked for GP details and 54% for GDP details on Salud. A mere 24% of patients were questioned on their GP details and 68% on their GDP details in the verbal enquiry questionnaire (Figure 6).

The study revealed considerable variation between questionnaires in the type of questions asked. Topics more frequently asked in the verbal dialogue in the oral medicine clinic, but not the other two, included kidney problems (54%), GIT (50%), musculoskeletal (28%), neurological (22%), endocrine (18%), family history (18%), dermatological (12%) and anaemia (6%) (Figure 7). OMFS patients were further questioned on arthritis (100%) and previous steroid use (94%). In the A&E electronic record, enquiries were made into topics such as slimming medications (28%), sickle cell disease (40%), human growth hormone (66%) and



general anaesthesia (50%). These questions were frequently skipped by the majority of examining dentists in the A&E clinic.

## Discussion

The medical/social history is an essential part of patient care. It is incumbent on the clinician to obtain relevant patient history for the safe practice of dentistry. If the questionnaire/discussion is considered difficult to use or time-consuming, for example the EMRRH questionnaire,<sup>8</sup> the clinician might miss important patient information. Any medical problem that is missed might be of importance for the dental treatment. Indeed, reports have confirmed that medical emergencies occur in medically complex patients attending general dental practice.<sup>1,3</sup>

It was apparent that the patient-administered *pro forma* questionnaire, combined with verbal verification by the dentist, has proved to be the most useful method for detecting medical problems in dental patients. The verbal enquiry alone by the clinician showed more inconsistencies than the other two methods.

The *pro forma* questionnaire alone was not sufficient. Ten out of the 50 questionnaires had blank answers, highlighting the need to personally verify blank answers in the clinic. Patients do not always provide accurate or complete health information. The patient may not understand the terminology or may judge some conditions as unimportant or fail to recall significant facts at the time the questionnaire is completed. Brady and Martinoff in 1980 found that 32% of patients did not answer self-administered questionnaires correctly.<sup>7</sup> Scully and Boyle<sup>4</sup> in 1983 and Fenlon and McCartan<sup>5</sup> in 1992 found that self-administered questionnaires revealed significant discrepancies.<sup>4</sup> The use of written patient-administered *pro forma* questionnaires is beneficial and may encourage more truthful responses to sensitive questions. They can be filled in privately by the patient prior to the clinic or face to face with the clinician. The clinician can expand on any area that needs exploration.

Although the verbal history makes it possible to explain questions and may provide a good insight into patients' responses, it is time-consuming and relies on the clinician's memory, time and alertness. Within the Oral Medicine clinic, there was no systematic recording of relevant medical history and this was wholly dependent on the operator's preference. Important topics were frequently missed. Handwriting was also illegible in many charts. An advantage of using the electronic or patient-administered *pro forma* questionnaires is to avoid illegible handwriting issues.

Although the electronic questionnaire did yield good results, in many areas it did not. Ideally, it should be the most accurate, as a qualified dentist is asking and explaining the questions to the patient and seeking verification. Due to the fact that the electronic questionnaire was entered by the dentist and not the patient, this may invite the suggestion that patients' responses were incorrectly recorded. It emerged that some questions were not answered as they were not asked by the examining dentist. If the electronic questionnaire were properly constructed, taking state-of-the-art practice into consideration, it might reach the 'gold standard'.

The OMFS *pro forma* questionnaire was the most comprehensive. Some aspects not covered in the questionnaire yielded positive results when

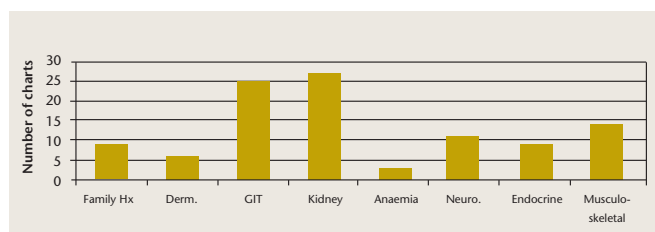


FIGURE 7: Questions asked in the oral medicine verbal dialogue questionnaire not included in the other two methods.

rechecked in the clinic. Previous hospitalisations, GI, thyroid, cancer, kidney, and psychiatric and dermatological problems were the most common conditions not covered in the questionnaire, which had given a positive response in the verbal questioning. Information on infectious diseases like AIDS, hepatitis and TB were often not asked in any of the three methods. Most of these conditions are not relevant in the vast majority of dental clinics, but ideally the information should be sought. Differences were encountered within all three questionnaires in relation to the medications (drugs) recorded. The issue of medication is particularly critical as an ever-increasing percentage of the population is taking at least one drug on a daily basis. The current drug history records the impact of any problem identified on other parts of the medical history. It may identify the existence of problems not highlighted by the patient. Checking a patient's medication (including dosages) is of vital importance. All medications should be checked against the British National Formulary. The electronic record gives the opportunity to electronically link to a drug's compendium.

A modified *pro forma* questionnaire for use in all departments in the Hospital has been proposed (Figure 8). This may be of use to GDPs in their practice setting. This modified questionnaire includes further questions on previous hospitalisation, HIV/hepatitis C status and use of recreational drugs. Bisphosphonate therapy and previous radiotherapy have recently been added to the OMFS questionnaire. Questions relating to slimming tablets, growth hormone, sickle cell disease and GA have been removed. The questionnaire invites the patient to add any further relevant information, allowing the patient to identify problems or diseases not addressed in the questionnaire. The patient and clinician sign the questionnaire on the date it is completed. It was discovered that the medical histories in the oral medicine clinic and Salud were not signed by the patient.

The medical questionnaire should be reviewed at each new visit (6-12 monthly) to incorporate new findings. It is a matter of clinical judgement how often the updating of the patient's medical history should take the form of a further written questionnaire or whether it is sufficient for it to be verified verbally. If verified verbally, the medical history questionnaire should be signed and dated by both the clinician and patient.

Although the patient-administered *pro forma* questionnaire is the most useful, efficient method of carrying out a preliminary screening for medical conditions, it should be combined with verbal enquiry into

Dublin Dental School and Hospital Confidential Medical History Form		Date: _____	
Title:	Name:		
DOB:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Occupation:
Address:			
Tel. No. Home:	Mobile:	Email:	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Do you have any children? <input type="checkbox"/> Yes <input type="checkbox"/> No		Ages _____	
Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No VHI/ BUPA/ Garda/ ESB Scheme/ Other			
Do you have a medical card? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Doctor's name and address:			
Dentist's name and address:			
		YES	NO
Do you feel healthy?		<input type="checkbox"/>	<input type="checkbox"/>
Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?		<input type="checkbox"/>	<input type="checkbox"/>
Do you have any heart conditions?			
-Congenital heart defect/ heart transplant/ replacement valve/ infective endocarditis		<input type="checkbox"/>	<input type="checkbox"/>
-Angina		<input type="checkbox"/>	<input type="checkbox"/>
-Heart attacks		<input type="checkbox"/>	<input type="checkbox"/>
-High blood pressure		<input type="checkbox"/>	<input type="checkbox"/>
Do you have any chest complaints?			
-Coughs		<input type="checkbox"/>	<input type="checkbox"/>
-Bronchitis		<input type="checkbox"/>	<input type="checkbox"/>
-Asthma		<input type="checkbox"/>	<input type="checkbox"/>
-Other		<input type="checkbox"/>	<input type="checkbox"/>
Have you had jaundice, hepatitis, liver or kidney disease?		<input type="checkbox"/>	<input type="checkbox"/>
Do you have diabetes or does anyone in your family?		<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from fainting attacks, giddiness, blackouts or epilepsy?		<input type="checkbox"/>	<input type="checkbox"/>
Do you bruise easily or bleed excessively following a cut or tooth extraction?		<input type="checkbox"/>	<input type="checkbox"/>
Do you have arthritis?		<input type="checkbox"/>	<input type="checkbox"/>
Please turn over →			

	YES	NO								
Are you receiving any medicines, tablets, creams, ointments, injections from your doctor? If yes, please list: _____	<input type="checkbox"/>	<input type="checkbox"/>								
Are you taking bisphosphonates?	<input type="checkbox"/>	<input type="checkbox"/>								
Have you had radiotherapy to the head and neck area?	<input type="checkbox"/>	<input type="checkbox"/>								
Are you allergic to any medicines, foods or materials (i.e. penicillin, latex, elastoplast, metals, other)?	<input type="checkbox"/>	<input type="checkbox"/>								
Are you, or do you think you could be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>								
Are you taking contraceptive drugs or medicine to regulate your periods?	<input type="checkbox"/>	<input type="checkbox"/>								
Do you take recreational drugs? E.g. Cocaine, heroin	<input type="checkbox"/>	<input type="checkbox"/>								
Are you in a risk group for blood borne viral infections (i.e. Hepatitis B, Hepatitis C, H.I.V. / Aids)?	<input type="checkbox"/>	<input type="checkbox"/>								
Have you been hospitalized? If yes, what for and when?	<input type="checkbox"/>	<input type="checkbox"/>								
Do you know of any other relevant medical history we have not already covered?	<input type="checkbox"/>	<input type="checkbox"/>								
<b>Social History</b>										
Do you smoke cigarettes, cigar or pipe? If yes, approximate consumption:	<input type="checkbox"/>	<input type="checkbox"/>								
Have you ever smoked? <input type="checkbox"/> Yes <input type="checkbox"/> No When did you stop?										
Do you consume alcohol? If yes, approximate consumption:	<input type="checkbox"/>	<input type="checkbox"/>								
I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT: Signature: _____										
Date: _____										
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Date: _____										

FIGURE 8: Proposed medical pro forma questionnaire.

any positive and blank answers. Complete and reliable answers have to be ascertained.

## Conclusion

This study was an audit of three different methods being used in a clinical setting and highlights the importance of audit to advise us of what we are doing rather than what we think we are doing. It is apparent that in order to achieve the maximum yield of information, a written patient-administered *pro forma* questionnaire should always be verified by an examining dentist. It is the responsibility of the dentist to identify patients with medical problems that would put them at risk during dental treatment. The medical questionnaire should be reviewed at each new visit (6-12 monthly) to incorporate new findings. This study has now enabled the DDSH to interpret a medical history *pro forma* in the electronic dental record, which can be signed by the patient, giving it 'authority'.

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## Consent to treatment for children and adults with learning difficulties

In the latest Dental Protection article, JAMES FOSTER looks at consent issues for vulnerable patients.

Dentists are facing an increasing number of challenges from patients, through complaints, litigation and, more frequently, from the Dental Council. Quite understandably, clinicians initially focus on defending the standard of the treatment provided. However, increasingly it is not the treatment itself that is brought into question: it is the quality of the consent process that is challenged.

If consent is not valid then the clinician may be vulnerable to the above challenges and, in addition, to civil or criminal proceedings for assault. We should perhaps consider the consent process to be of the same importance as the treatment itself, as the consequences of a successful challenge to both are comparable.

Consent is essentially a communication process and can be described as “the voluntary and continuing permission of the competent patient to receive a particular treatment based upon adequate knowledge of the purpose, nature and likely effects and risks of that treatment, including the likelihood of its success and any alternatives” (‘A Guide to Consent for Examination and Treatment’. Department of Health [UK], 1991). In addition, if costs are involved for treatment, then these should obviously be included.

There are four specific components to valid consent:

1. Capacity.
2. Information.
3. Voluntariness.
4. Authority.

The test of capacity currently applied in the Irish courts is the ‘C Test’, which derives from the English case of ‘Re C’. The test is in three parts, all of which have to be fulfilled for a patient to be deemed competent to make the decision they are being asked to consider:

1. Does the patient comprehend and retain treatment information?
2. Does the patient believe that information?
3. Does the patient weigh that information, balancing risks and needs to reach a decision?

In most situations, obtaining the patient’s valid consent to a procedure or treatment is a straightforward matter; however, there are groups of



patients where capacity may be an issue, such as children and adults with learning difficulties. In all circumstances, the overriding duties of the clinician are to respect the bodily integrity and right to self-determination of the patient and, where it is not possible to obtain a patient’s valid consent, to act in the patient’s best interests.

### Children

Although the age of majority is 18, the law in Ireland recognises that 16 and 17 year olds have the capacity to consent to dental treatment on their own behalf (Non-Fatal Offences against the Persons Act 1997, Section 23). Currently, it is not clear whether someone of this age has the right to refuse as well as consent to treatment, as this has yet to be tested in the courts. In theory, a parent or legal guardian can consent to treatment that a 16 or 17 year old is refusing. Thankfully, such situations are rare and would demand a decision from the court.

If a minor of 16 or over is incapable of giving consent, it may be obtained from the young person’s parent or guardian, or the court if necessary. If a child is under the age of 16, then in law the consent of the parent or legal guardian is required. In practice it is reasonable to seek the consent of a minor with the capacity to understand the nature and implications of the proposed treatment or procedure. Difficulties can arise, however, if the parents of a minor are in disagreement with clinicians or the patient about what is in the child’s best interests.

The Irish Constitution recognises the family as “a moral institution possessing inalienable and imprescriptible rights antecedent and superior to all positive law” (Constitution of Ireland – November 2004, Edition Article 41(1)). As a result it would be prudent of the clinician to ensure that parents are fully informed.

While, in the vast majority of cases, consent will be provided by a parent, or indeed a competent child, there are occasions where others can provide consent on behalf of a minor. A summary of who can act in this capacity is:

- the child’s mother;
- the child’s father, if married to the mother before or after the birth, or with court approval;
- legal guardians/testamentary (appointed in a will);



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- foster carers and health boards in specific circumstances (Consent to Medical Treatment for Foster Children, November 6, 1999), (Childcare (Amendment) Act 2007, Section 43(A));
- health boards with a court order; and,
- the courts.

In practice, a clinician should ensure that those attending with a minor are able to provide the necessary consent, as even the most innocent attendance can cause difficulties, such as when a patient attends with their siblings, grandparents, etc. In those situations where parental responsibility has been delegated to others, the appropriate documentation should be presented. If there is any doubt then advice should be sought.

### Forthcoming changes

The current Irish Law Commissions Consultation 'Children and the Law; Medical Treatment' makes over 20 provisional recommendations for reform, which are aimed at firstly ensuring that mature teenagers have their views fully taken into account when they seek treatment, and secondly at providing clarity to healthcare professionals in this potentially confusing area. The outcome of the consultation paper is still awaited; however, practitioners will need to be aware of any subsequent implications.

### Adults with learning difficulties

There are obviously similarities between adults with learning difficulties and children under the age of 16 in that the clinician has to make the decision as to whether the patient has capacity. Assessing a person's capacity or lack of it should follow a proper examination and assessment, to include conveying information to the patient, discussing

it with them to gauge their understanding and then asking open questions about salient points to see if they have been grasped.

At present, only the courts can consent to treatment on behalf of an incapacitated adult. However, this should not deny patients treatment, and there should be consultation between the clinician, the patient's relatives and any carers, in order to agree that a particular treatment is in the patient's best interests. Further opinion from a colleague can also be sought and the treatment provided should be the minimum to achieve the result required.

Significant changes may be on the way as The Mental Capacity and Guardianship Bill 2008 is currently being considered by the Oireachtas. In the meantime the basic principles of the English Mental Capacity Act – Code of Practice are considered to be useful guidance, which suggest involving others to seek views about the individual's best interests, and to see if they have information about the person's wishes, feelings, beliefs and values.

With the potential for challenge in relation to consent, colleagues need to ensure that they keep full and contemporaneous records, which can demonstrate the consent process and, if applicable, include the identity of others involved in the decision-making process.

As with all processes of communication, a common sense approach and caution when there is uncertainty should hopefully help to minimise the risk of challenge in this somewhat difficult and changing area of practice.

### James Foster LL.M BDS MFDGDP(UK)

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## FEBRUARY 2011



### Metropolitan Branch, IDA Annual Scientific Day

February 18

Hilton Hotel, Dublin 2

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

### Munster Branch, IDA – Scientific Meeting

February 22

Maryborough House Hotel

Speaker is Prof. John Whitworth on 'The wise man built his house ... concrete foundations and soggy bottoms in endodontics'.

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## MARCH 2011

### Head and Neck Reconstructive Surgery Conference

March 4

St Vincent's University Hospital, Education & Research Centre

For further information, contact Aongus Curran, Tel: 01-221 4277.

### Metropolitan Branch, IDA – Scientific Meeting and AGM

March 24

Hilton Hotel, Dublin 2

Speakers are: Dr Jason Owens on 'Location, location location – site consideration in implant placement', and Dr Raphael Bellamy on '100% – X the challenge of endodontic success'.

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### Kerry Branch, IDA – Scientific Meeting

March 24

Brehon Hotel, Killarney, 8.00pm.

Speaker is Dr Stephen Fennell, Radiological Institute of Ireland, on 'Update on radiological licensing requirements and code of conduct for Irish dentists'.

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### The International Dental Show (IDS) 2011

March 22-26

Cologne, Germany

For further information see [www.ids-cologne.de](http://www.ids-cologne.de).

## APRIL 2011

### The IDA Golf Society, Christmas Hamper Outing

April 1

Royal Dublin Golf Club

Tee reserved from 8.00am.

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### Kerry Branch, IDA – Scientific Meeting

April 7

Meadowlands Hotel, Tralee, 8.00pm.

Speaker is Dr Denise MacCarthy, Consultant Periodontologist at the Dublin Dental Hospital, on 'Oral care for oncology patients'.

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### Orthodontic Society of Ireland – Meeting

April 15-16

K Club, Co. Kildare

Speaker is Dr Hugo De Clerck. See [www.orthodontics.ie](http://www.orthodontics.ie) for more details.

## MAY 2011



### IDA Annual Conference 2011

May 11-14

Slieve Russell Hotel and Country Club,  
Ballyconnell, Co. Cavan

For further information contact IDA House,  
Tel: 01-295 0072.

### Irish Society of Dentistry for Children – Annual Scientific Meeting

May 19-20

Limerick

## SEPTEMBER 2011

### The 24th Annual Meeting and Refresher Course of the European Society of Head and Neck Radiology (ESHNR)

September 8-10

Congress Center Oud Sint-Jan, Bruges, Belgium

More information on the programme can be found on the website – [www.eshnr2011.be](http://www.eshnr2011.be).

## OCTOBER 2012

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

October 17-20

Sydney, Australia.

For further information see [www.iadh2012.com](http://www.iadh2012.com).



# Sensitive Pro-Relief™

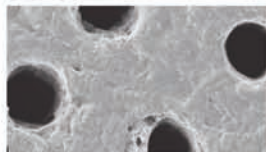
## TREATMENT PROGRAMME



## Finally, instant\* sensitivity relief patients can take home.

### A breakthrough: Pro-Argin™ Technology

#### BEFORE<sup>1</sup>



*In Vitro* SEM photograph of untreated dentine surface.

The tubules that lead to sensitivity are open

#### AFTER<sup>1</sup>



*In Vitro* SEM photograph of dentine surface after application.

The tubules are occluded for instant, lasting relief

With Pro-Argin™ Technology, you can finally provide instant\* and lasting relief from dentine hypersensitivity using the Colgate® Sensitive Pro-Relief™ Treatment Programme:

- In-surgery desensitising paste
- At-home everyday toothpaste

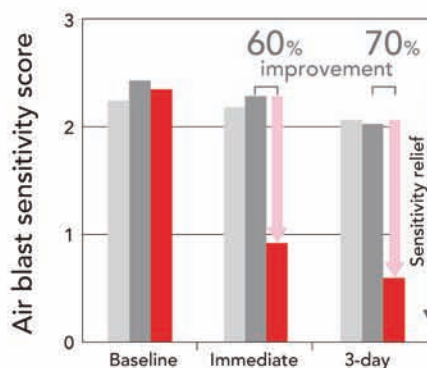
Pro-Argin™ Technology works through a natural process of dentine tubule occlusion that attracts arginine and calcium carbonate to the dentine surface to form a protective seal that provides instant relief.<sup>2</sup>

\*Instant relief is achieved with direct application of toothpaste massaged on sensitive tooth for 1 minute.

References: 1. Petrou I et al. *J Clin Dent.* 2009;20(Spec Iss):23-31. 2. Cummins D et al. *J Clin Dent.* 2009; 20(Spec Iss):1-9. 3. Nathoo S et al. *J Clin Dent.* 2009;20(Spec Iss):123-130.

### The results are revolutionary

Instant relief achieved with direct application of toothpaste massaged on sensitive tooth for one minute and continued relief with subsequent twice-daily brushing<sup>3</sup>



When applied directly to the sensitive tooth with a fingertip and gently massaged for 1 minute, Colgate® Sensitive Pro-Relief™ Toothpaste provides instant sensitivity relief compared to the positive and negative controls. The relief was maintained after 3 days of twice-daily brushing.

Legend:  
■ Colgate® Sensitive Pro-Relief™ Toothpaste  
■ Positive control: Toothpaste with 2% potassium ion  
■ Negative control: Toothpaste with 1450 ppm fluoride only

Ask your Colgate Oral Care Consultant about how instant relief from dentine hypersensitivity can benefit your patients.

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

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